# Background information

Country: [Enter]

Date: [Enter]

# Guidance and Instructions on how to complete the HPV implementation plan

The HPV Implementation Plan is the sentinel component of the application to Gavi for a new HPV vaccine introduction. This template provides technical guidance and specific instructions for completing each section. The sections are divided into key programme components. Prior to each section, technical guidance based on the evidence base, country experience, lessons learned, and technical partners’ inputs is provided to support a quality HPV implementation plan.

Countries are also strongly encouraged to reach out to other countries with existing HPV vaccination programmes and technical partners (in-country, regional, and global) for learning and guidance about successes and challenges for introduction and success of HPV vaccination programmes.

# HPV lessons learned

As relevant, countries applying for HPV that have already conducted a demonstration or pilot programme, should include details on specific lessons learned for HPV vaccine delivery from any evaluation reports available.

Countries that have not conducted an HPV demonstration/pilot programme should aim to include details on specific lessons learned from the demonstration/pilot programmes of other countries that have informed their national roll out plans. Please refer to the following resources for information on HPV lessons learned.

* WHO HPV VACCINE INTRODUCTION CLEARING HOUSE: <https://www.who.int/teams/immunization-vaccines-and-biologicals/diseases/human-papillomavirus-vaccines-(HPV)/hpv-clearing-house>
* LSHTM/PATH HPV Lessons Learnt on HPV vaccine introduction: <https://www.path.org/resources/hpv-lessons-learnt/>
* JSI lessons learned on HPV introduction:

<https://www.jsi.com/project/human-papillomavirus-hpv-vaccine-national-introduction/>

* UNICEF lessons learned and field guides on HPV vaccine communication:

<https://globalhpv.com/>

|  |  |  |
| --- | --- | --- |
| **Key programmatic areas** | **Lessons Learned** | **How these areas have been addressed for the national scale up.** |
| Planning and preparation |  | e.g. details on population identification and registering girls. engagement of non-health (e.g. schools) and cancer prevention and other stakeholders. |
| Training | e.g.  Some vaccinators trained for administering the first HPV dose were transferred from the demonstration project area and their replacements had limited knowledge of HPV. | e.g.  The number of health workers trained will be increased and not limited to only vaccination teams HPV training will be integrated into the annual EPI orientation trainings for new staff |
| Communication & social mobilization |  |  |
| Delivery strategies |  |  |
| Uptake (first dose) & Coverage (both doses) |  |  |
| Reporting & monitoring |  |  |
| Financial and Programmatic Sustainability |  |  |

For each district in which the demonstration/ pilot programme was implemented, please complete the following: *Copy and paste to add more tables as needed.*

\**Countries that have not conducted a demo programme should leave this table blank*

|  |  |
| --- | --- |
| **District Information** | |
| Name of the district |  |
| Target population eligible for HPV vaccination | e.g. all girls aged 10 years or all girls in primary grade 4 |
| Size of target population for HPV vaccination in the district |  |
| Describe how the district was selected (e.g. rural v/s urban) |  |
| Delivery strategy(ies) used (e.g. school based, health centre based, campaign) for different populations (e.g. in-school girls, out-of-school girls, girls absent on day of vaccination, etc.) |  |
| Coverage achieved (disaggregated by age, dose 1 and dose 2 and in and out of school, if data are available). |  |
| **District Information** | |
| Name of the district |  |
| Target population eligible for HPV vaccination | e.g. all girls aged 10 years or all girls in primary grade 4 |
| Size of target population of the district |  |
| Describe how the district was selected (e.g. rural v/s urban) |  |
| Delivery strategy(ies) used (e.g. school based, health centre based, campaign)  for different populations (e.g. in-school girls, out-of-school girls, girls absent on day of vaccination, etc.) |  |
| Coverage achieved (disaggregated by age, dose1 and dose 2 and in and out of school, if data is available). |  |

# Target population(s) for HPV vaccination

In this section, countries will be required to describe their target population to reach girls with HPV vaccination.

For the prevention of cervical cancer, the WHO-recommended primary target population for HPV vaccination is girls aged 9-14 years. In line with these WHO recommendations, Gavi provides support for **HPV vaccination in girls aged 9-14 years**[[1]](#footnote-2).

The choice of the target ages and/or school grades for the routine and additional multi-age cohorts among girls 9 to 14 years should be guided by a good understanding of local factors such as: average age for school enrolment, if knowledge of age is culturally or socially unimportant/ limited (e.g., lack of birth certificates), and ability to accurately estimate and identify girls at specific ages prior to and during delivery of HPV vaccines.

## Sources of target population data

1. Provide a source for **the eligible target population of girls** (e.g., recent census, national statistics office, UN Population estimates, etc.) and date: [Enter source & date]
2. If including schools as a location to deliver HPV vaccines, provide a source for **the school enrolment data (**e.g., national statistics office, Ministry of Education (MOE), recent census, school registers, etc.) and date: [Enter source & date]

* Provide the percentage of primary school enrolment for the target population (girl enrolment): [Enter %]
* Provide the percentage of secondary school enrolment for the target population (girl enrolment): [Enter %]
* Provide the average age of entry for secondary school: [Enter years]

1. If available, provide a source for **the out-of-school (OOS) girls data** (e.g., national statistics office, MOE, recent census, school registers, etc.) and date: [Enter source & date]

* If available, provide data on OOS for primary school
* If available, provide data on OOS for secondary school

## Target population for routine and MAC

Please specify whether girls will be vaccinated by selection of a specific age(s) or a specific school grade(s).

|  |
| --- |
| [Enter description] |

If you are vaccinating by grade, provide information on the % age distribution in that grade and describe how you will ensure girls under 9 or over 14-years will not be vaccinated. (*Note: girls in the grade should be same age in order to achieve programme target and calculate meaningful coverage rate*)

|  |
| --- |
| [Enter description] |

If the country plans to vaccinate by age group, please provide information on how the eligibility of the girls, especially those out of school, will be determined - by age at time of vaccination, (e.g. all 10 year old girls); or year of birth, e.g. all girls born in the year 2014.

|  |
| --- |
| [Enter description] |

Please complete table 2.2.1.a vaccination by specific age or table 2.2.1.b by specific school grade, based on answer to previous question.

Table 2.2.1.a: Vaccination by specific age

|  |  |
| --- | --- |
| **Routine cohort (for vaccinations year-on-year)** | |
| **Source and year of population data** |  |
| Specific age chosen | *e.g. 9-year olds* |
| Target population of girls in chosen age |  |
| **Additional multi-age cohort (if applicable) (for one-off vaccinations during the initial year of introduction)** | |
| **Source and year of population data** |  |
| Specific age-range chosen | *e.g. 10 – 14 year olds* |
| Target population of the 10 year old girls |  |
| Target population of the 11 year old girls |  |
| Target population of the 12 year old girls |  |
| Target population of the 13 year old girls |  |
| Target population of the 14 year old girls |  |
| **Total Target population of Routine and Multi-age cohort (as defined above)** |  |

If girls are to be vaccinated by a specific grade, please specify grade and provide the below data relative to the target grade:

Table 2.2.1.b: Vaccination by specific school grade

|  |  |  |
| --- | --- | --- |
| **School grade** | **Average age of girls in school grade** | **Number of girls in grade** |
| *E.g. Grade 4* | *E.g. 9-years old* | 0 |
| **TOTAL** | | **0** |

|  |  |  |
| --- | --- | --- |
| **School grade** | **Average age of girls in school grade** | **Number of girls in grade** |
| *E.g. Grade 5* | *E.g. 10-years old* | 0 |
| *E.g. Grade 6* | *E.g.11-years old* |  |
| *E.g. Grade 7* | *E.g. 12-years old* |  |
| *E.g. Grade 8* | *E.g. 13-years old* |  |
| *E.g. Grade 9* | *E.g. 14-years old* |  |
| **TOTAL** | | **0** |

# Subnational area and target population characteristics

For countries with decentralised administration or financing for routine EPI program activities, brief contextualization of key characteristics of subnational areas, such as states, provinces, or regions, may be helpful for the HPV implementation plan review. Please complete the table below for all such subnational areas in the country.

Subnational profile

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Characteristic | Region 1 [name] | Region 2 [name] | Region 3 [name] | Add more columns as needed |
| DPT3 coverage |  |  |  |  |
| DPT1 coverage |  |  |  |  |
| Total population (% urban) |  |  |  |  |
| Access considerations (e.g., seasonal, geographic, security, etc.) |  |  |  |  |
| % of population immunized by outreach |  |  |  |  |
| Total target (girls 9-14 years): Ministry of Education estimate |  |  |  |  |
| Total target (girls 9-14 years): Bureau of Statistics / National Census Office estimate |  |  |  |  |
| Total target (girls 9-14 years): other data source, e.g., UNPOP |  |  |  |  |
| Final targets requested for Gavi support (disaggregated by age)  9 year old girls  10 year old girls  11 year old girls  12 year old girls  13 year old girls  14 year old girls |  |  |  |  |
| % of girls enrolled in primary school |  |  |  |  |
| % of girls enrolled in secondary school |  |  |  |  |
| If planning a phased HPV introduction, indicate year each region will start HPV vaccination |  |  |  |  |

# Dosing schedule for HPV vaccination

In this section, countries will be required to indicate the HPV vaccination dosing schedule they will utilize for the national introduction of HPV vaccines .

For the prevention of cervical cancer, the WHO-recommended primary target population for HPV vaccination is girls aged 9-14 years. Current evidence suggests that either a single-dose[[2]](#footnote-3) or 2-dose schedule may be used among the primary target population for HPV vaccination with comparable efficacy and duration of protection.

WHO recommends at least 2 doses and optimally 3 doses for immunocompromised populations, including HIV+ girls

Off-label single dose considerations:

* Progammatic fit
* MOH approves
* NITAG (or equivalent) endorses
* NRA informed
* Country understands implications

In line with WHO recommendations for the primary target population, for countries applying to Gavi for a new HPV vaccine introduction Gavi provides support for **HPV vaccination in girls aged 9-14 years**[[3]](#footnote-4) with either a 2-dose schedule or single-dose alternative schedule (off-label). A 2-dose schedule should have a minimum interval of 6 months, and optimally 12 months, between doses.

**Programmatic considerations (1-dose schedule).** A single-dose schedule is off-label and can offer programme and financial advantages, such as reducing drop-out rates in a 2-dose schedule, simplifying data recording and reporting, reducing space requirements in the cold chain, reducing vaccine waste, and reduced cost for vaccine supplies. While a “one and done” approach can provide some programmatic efficiencies, not all girls may be reached at the first opportunity for vaccination. Countries should build into their plan additional vaccination opportunities for girls that may have been missed due to absence, non-attendance, illness, hard to reach or other considerations.

**Programmatic considerations (2-dose schedule).** When selecting the dosing interval (e.g., 0, 6 months vs. 0, 12 months), countries are strongly encouraged to carefully consider programmatic trade-offs between health facility versus school-based delivery, vaccination coverage, ease of follow-up for second dose, cost of delivery, and other operational factors. For these reasons, several Gavi countries have opted for a single, yearly vaccination round (0, 12 month) where eligible girls can get their first or second dose. On the other hand, some countries have preferred to maintain a bi-annual dosing schedule (0,6 months) to complete the 2-dose schedule within the same school calendar year, thereby potentially reducing vaccination dropout rates. These trade-offs will vary by country context.

|  |
| --- |
| [Enter HPV vaccination schedule as 2-dose or 1-dose] |
| Please attach endorsement for the vaccination schedule by the NITAG (or equivalent), ICC, and/or NRA (if required by your country). |

For the dosing schedule selected, please describe how populations of girls that may require additional doses, such as immune-compromised or HIV+, will be reached, mentioning vaccination location, frequency of opportunities, and tracking mechanisms to ensure they complete the required dosing schedule.

|  |
| --- |
|  |
|  |

# Delivery strategies for HPV

In this section, countries will be required to describe their delivery strategies to the routine (year-on-year) and multi-age cohort (introduction year) populations, as defined above, with HPV vaccination.

Please refer to the Gavi HPV application guidelines and the [WHO Guide to Introducing HPV Vaccine into National Immunization Programmes for information on delivery strategies](http://apps.who.int/iris/bitstream/handle/10665/253123/9789241549769-eng.pdf?sequence=1). Other technical resources for determining effective delivery strategies for your country context can be found in the Key Resources list of the HPV section in the [Gavi Vaccine Funding Guidelines](https://www.gavi.org/sites/default/files/support/guidelines-2022/Gavi_Programme_Funding_Guidelines_ENG.pdf).

Countries are encouraged to select HPV vaccine delivery strategies that leverage the existing structures, processes, and procedures that are utilised for other vaccinations. As much as possible countries should select approaches that can be sustained year-on-year after introduction using available resources. Countries may need a variety of strategies to reach different populations of girls eligible for HPV vaccine (e.g., those in school, those not attending). Health facilities, leveraging existing (and already financed) routine outreach sessions, periodic visits to schools near health facilities, and time-limited campaign-like approaches reaching large numbers of girls in a short time can be considered in combining to maximize the program’s reach and increase equity.

For strategies that may leverage a time-limited opportunity for HPV vaccine delivery (operationally similar to campaign-like vaccinations), countries should consider:

* **Integration:** Potential to make use of existing campaign days (e.g., Child Health Days), Measles Rubella or tetanus containing vaccination activities (e.g. opportunity for integration with 3rd tetanus booster (as same target population), national immunisation week, deworming tablet distribution, and other opportunities that co-delivery with a single dose of HPV vaccine may provide, and the cost-sharing, platform-leveraging, and/or sustainability implications of such use.
* **Sustainability and impact on the routine system:** The sustainability of campaign-like delivery approaches must be carefully assessed. If this mode of delivery is being used, then the impact of this strategy on the routine service delivery should be mentioned, as well as a justification of how costs will be covered in subsequent years. Please note HSS grant funding cannot be used to pay for traditional vaccination campaigns.
* **Financing of periodic campaigns:** Countries with very small and difficult to access population (e.g., island states) or hard-to-reach groups (e.g., conflict zones) may wish to conduct a campaign every 3-5 years. However, countries must note that Gavi will only provide a VIG at the time of HPV national introduction and one-time operational cost support for a MAC. Thus, countries who select this approach will have to self-finance these periodic campaigns and provide evidence of adequate funds as well as government commitment.

In the sections following, please provide information on all HPV vaccine delivery strategies that will be implemented (e.g. schools as venues for vaccination), in combination with health facilities, routine outreach for out-of-school girls, or other innovative locations/approaches that a single dose of HPV vaccine may provide (if that is the dosing schedule selected). Please be sure to indicate which populations will be reached in each location selected and how they will be reached. Additional information for countries electing to use a 2-dose schedule is also required in this section. Please note the relevant areas.

## Using schools as a location for vaccinations:

Please describe why this delivery strategy has been chosen.

|  |
| --- |
| [Enter description] |

Kindly provide information on the performance of the existing routine immunisation platform in terms of the frequency of outreaches to schools per month, currently in place or planned?

|  |
| --- |
| [Enter description] |

State whether additional outreaches are needed for school-based delivery strategies for HPV vaccine? If yes, country to kindly indicate if these additional outreaches are only needed to support the multi-cohort vaccination or will be needed for routine HPV delivery year-on-year.

|  |
| --- |
| [Yes or No] |

If additional outreaches are needed for the routine HPV delivery, then the country is requested to explain how resources will be sustained after Gavi’s vaccine introduction grant (VIG) and operational support grant (for multi-age cohort only) are utilized for the first year of the program (e.g. reinforcement through HSS funds, government domestic resources, and establishment of school immunisation services, other donor support, etc.).

|  |
| --- |
| [Enter description] |

Please describe the school-based strategy (school year, holidays, examinations, frequency of vaccination (based on dosing schedule selected), consent process, strategies for missed girls, linking with school and/or district education office).

|  |
| --- |
| [Enter description] |

If the 2-dose HPV vaccination schedule has been selected, describe how this vaccination location will be utilised for identification of girls requiring a second dose and the timing and frequency for the delivery of the second dose. *Note: Clarify in the budget how much funds will be allocated for second dose activities*.

|  |
| --- |
| [For 2-dose schedule only, Enter description] |

Please describe how the vaccination strategy will be adapted for private, religious schools and other schools not part of the public-school network (e.g. consent process, stakeholder engagement).

|  |
| --- |
| [Enter description] |

Kindly describe the collaboration between MoH and MoE at central, provincial and district levels, including the role of school staff and teachers during vaccination (e.g. national level planning committees)

|  |
| --- |
| [Enter description] |

Kindly describe how this vaccination location and population reached for HPV vaccination addresses any possible equity or gender barriers for HPV vaccine delivery.

|  |
| --- |
| [Enter description] |

## Using health facilities as a location for vaccination:

Please describe why this approach has been chosen.

|  |
| --- |
| [Enter description] |

Please provide details on how health facility vaccination will be leveraged to increase HPV vaccine uptake e.g. mandatory health checkups, referrals of eligible girls to the heath facility by schools.

|  |
| --- |
| [Enter description] |

Please elucidate on how the health facilities will generate registers of eligible girls (esp. out of school girls) in their catchment area and follow-up those missed for HPV vaccination (regardless of dosing schedule used).

|  |
| --- |
| [Enter description] |

If the 2-dose HPV vaccination schedule has been selected, describe how this vaccination location will be utilised for identification of girls requiring a second dose and the timing and frequency for the delivery of the second dose. *Note: Clarify in the budget how much funds will be allocated for second dose activities*.

|  |
| --- |
| [For 2-dose schedule only, Enter description] |

Kindly describe how this vaccination location and population reached for HPV vaccination addresses any possible equity or gender barriers for HPV vaccine delivery.

|  |
| --- |
| [Enter description] |

## Using community venues as locations for vaccination:

Please describe why this approach has been chosen.

|  |
| --- |
| [Enter description] |

Please describe how community vaccination will be planned (locations, integration with outreach for infant outreach or other existing touchpoints for adolescent health, involvement of community healthcare workers/volunteers, schools, special communication).

|  |
| --- |
| [Enter description] |

Please elucidate on how the community (e.g. CHWs) will help to identify, generate registers of eligible girls (esp. out of school girls) in their area and follow-up those missed for HPV vaccination (regardless of dosing schedule used).

|  |
| --- |
| [Enter description] |

If the 2-dose HPV vaccination schedule has been selected, describe how this vaccination location will be utilised for identification of girls requiring a second dose and the timing and frequency for the delivery of the second dose. *Note: Clarify in the budget how much funds will be allocated for second dose activities*.

|  |
| --- |
| [For 2-dose schedule only, Enter description] |

Kindly describe how this vaccination location and population reached for HPV vaccination addresses any possible equity or gender barriers for HPV vaccine delivery.

|  |
| --- |
| [Enter description] |

## Leveraging campaigns of other health interventions (including immunisation) to deliver HPV vaccines:

Please describe why this approach has been chosen.

|  |
| --- |
| [Enter description] |

Please indicate whether existing immunisation campaign days will be leveraged e.g. Measles Rubella or tetanus containing vaccines, supplementary immunisation activities, etc.?

|  |
| --- |
| [Enter description] |

Please indicate whether any other existing health interventions using campaigns will be leveraged e.g. Child Health Days/ Weeks, Malaria bednet or deworming distribution, or others?

|  |
| --- |
| [Enter description] |

If the 2-dose HPV vaccination schedule has been selected, describe how this vaccination location will be utilised for identification of girls requiring a second dose and the timing and frequency for the delivery of the second dose. *Note: Clarify in the budget how much funds will be allocated for second dose activities*.

|  |
| --- |
| [For 2-dose schedule only, Enter description] |

If the campaign is being used only for the first year, including routine and multi- age cohort vaccination, describe how coverage will be maintained in subsequent years when transitioning to routine HPV vaccination in Year 2.

|  |
| --- |
| [Enter description] |

Kindly describe how this vaccination location and population reached for HPV vaccination addresses any possible equity or gender barriers for HPV vaccine delivery.

|  |
| --- |
| [Enter description] |

## Coverage and Equity:

Describe the population of disadvantaged adolescent girls that will be reached e.g., HIV+ population, out of school girls, ethnic minorities, girls living with a disability etc *(please link to sections 5.1, 5.2, 5.3, and 5.4 above)*

WHO recommends at least 2 doses and optimally 3 doses for immunocompromised populations, including HIV+ girls

|  |
| --- |
| [Enter description] |

Equity and gender barriers can have an impact on the availability and access to immunization services and contribute to low coverage, especially for HPV vaccines. These barriers can be socio-economic, cultural, age- or gender-based. Some examples of barriers identified include limited autonomy of girls in health decisions, geographic conditions (e.g., remote location, slums, isolated community), literacy level, cultural norms related to gender roles and access to health services, health worker or community leaders concerns about specific vaccines, amongst others.

To encourage countries to consider how gender or equity barriers may affect their draft HPV implementation plans (as described above), in the table below, please identify any specific barrier for the population listed and describe gender-responsive strategies that will be incorporated into the HPV implementation plan to address these barriers and how they will be tailored to ensure disadvantaged girls are fully vaccinated according to the dosing schedule selected and follow-up mechanisms for those missed or those needing multiple doses of HPV vaccine. If a prior equity analysis for immunization services has already been done, countries are encouraged to use the information and findings from that work to inform the content for the table below.

Table 4.1 Summary of equity and gender issues

|  |  |  |
| --- | --- | --- |
| **Population** | **Describe identified equity and/or gender barriers (include available data)** | **How HPV implementation plan will address the identified barrier** |
| **Adolescent girls**   * Those in school * Those out of school or irregularly attending |  |  |
| **Caregivers / Parents** |  |  |
| **Health workers** |  |  |
| **Other community stakeholders** (e.g., community leaders, religious leaders, etc.) |  |  |

# Social Mobilisation, Demand generation and Communication plan

The country is requested to describe how its plans for communication and social mobilisation reflect the unique needs of the programme and can be sustained (regardless of dosing schedule) in the introduction year and in subsequent years.

There are significant resources and experiences countries can draw from to inform effective communication and social mobilisation plans. Some key resource for HPV communications can be found in the Resources list of the HPV section in the Gavi Vaccine Funding Guidelines.

Countries are strongly encouraged to reach out to other countries and technical partners (in-country, regional, and global) to learn of successful experiences, effective examples, and lessons learned for communication and social mobilisation for HPV vaccination.

The communication and social mobilisation plan should address:

* **Key messages and channels:** Key messages and mechanisms for reaching the target population and key stakeholders, out-of-school girls and additional multi-age cohorts (including communication and sensitisation on the vaccination schedule and follow-up if using a 2-dose schedule) as part of a communication strategy based upon knowledge, attitudes, behaviours, and practices research and human centred design and myriad examples of successful approaches and materials from other countries see Key Resources section of the HPV vaccine funding guidelines)..
* **Community engagement:** Plans for the engagement of key stakeholders including girls, parents, health professionals (e.g., paediatricians, gynaecologists, obstetricians, cancer specialists, etc.), teachers and school administrators, religious leaders, youth and women-led CSOs.
* **Missed vaccinations:** Plans and budget for communication and social mobilisation activities needed for girls or communities missed for HPV 1 (if using single dose schedule) and girls who may have missed HPV 2 (if using 2-dose schedule).
* **Risk and crisis communications:** A crisis communication plan (including communication and training for Adverse Events Following Immunisation (AEFIs) and AEFI monitoring and risk management) to address the spread of rumours which can threaten the acceptability of an HPV vaccination programme.

Regardless of the delivery strategy(ies) employed for HPV vaccine delivery, community sensitisation and demand generation activities should be conducted and the location of vaccination included in all messaging. Demand generation activities can foster understanding in the community of all opportunities for vaccination to overcome access or gender-related barriers to vaccination.

Please complete the table below to provide the country’s preliminary thinking about the social mobilisation, demand generation and communication plans for HPV vaccine delivery at all locations included in the delivery plan outlined in section 5 above.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Audience** | **Messages** | **Method of delivery** | **Who delivers** | **Frequency & Timing** |
| *e.g., Eligible girls* | *e.g.-*   |  | | --- | | * *Basic facts about cervical cancer.* * *Basic facts about the preventive HPV vaccine* * *Benefits of being vaccinated* * *Their role in HPV vaccination* | | *e.g., leaflets, radio, info session at school, house visit, etc.* | *e.g., teachers, health workers, district official, etc.* | *e.g. daily, weekly, twice before programme starts; day of vaccination, two weeks before programme begins, etc.* |
| *e.g., parents, teachers,* |  |  |  |  |
| *e.g., teachers* |  |  |  |  |
| *e.g., health workers* |  |  |  |  |
| *e.g., district officials* |  |  |  |  |
| *e.g., community groups* |  |  |  |  |
| *e.g., media* |  |  |  |  |
|  |  |  |  |  |

If the 2-dose HPV vaccination schedule has been selected, please provide a plan outline of communication, social mobilisation and other activities needed to reduce drop outs for 2nd dose, especially for annual vaccination schedules. *Note: Clarify in the budget how much funds will be allocated for second dose activities*.

|  |
| --- |
| [For 2-dose schedule only, Enter description] |

Provide an outline of a crisis communication plan to effectively respond to AEFI, anti-vaccine movement, rumors, and misconceptions. (e.g. specific committees, communication with media, spokespersons, training healthcare workers on AEFI, etc.…)

|  |
| --- |
| [Enter description] |
|  |

## Community-Based Organisations (CBO)/Faith-based Organisation (FBOs)/Civil Society Organisation (CSO) engagement

As Gavi deepens the focus on equity, civil society organisations (CSOs) play a central role in **reaching underserved and hard-to-reach communities**; **complementing public service delivery**; and in **generating demand for immunisation, including tackling misinformation and vaccine hesitancy**. Countries are strongly encouraged to engage with civil society organisations (CSOs) to pursue opportunities of collaboration in the social mobilization and communication activities prior to national rollout.

Meaningful civil society and community engagement provides a **vital feedback loop** from the communities to decision-makers – to ensure that any gaps can be quickly identified, emerging problems and challenges addressed, and successes identified that can quickly be **replicated and taken to scale.** CSOs may include stakeholders working in child health, adolescent health, social mobilisation, community education, cancer, maternal health, reproductive health, health promotion and programme communication, youth and women’s groups, professional associations (e.g., gynaecologists, paediatricians, midwives, nurses, oncologists, and others).

Please describe whether, how, and which CBOs/FBOs/CSOs will be included in the delivery and community linkages of HPV vaccines including building upon previous engagement with EPI activities e.g. youth and women led community networks, including any specific planned activities the CBO/FBO/CSO will conduct, e.g. demand generation activities, increase coverage of “hard to reach” areas and vulnerable girls, sustainability for each year’s cohort.

|  |
| --- |
| [Enter description] |

# Integration

## Adolescent health integration:

Irrespective of the delivery strategies, provide a description of existing health services and/or health education currently being provided to young adolescents (both girls and/or boys) within the 9-14 year old age group.

|  |
| --- |
| [Enter description] |

Please describe any potential for integration of planned HPV vaccination activities with the delivery of other vaccinations, such as tetanus (with or without diphtheria) booster dose, and/or other adolescent health interventions described above.

|  |
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| [Enter description] |

## Cervical Cancer Screening:

Describe the existing cervical cancer prevention and control activities. What are the opportunities for integration with HPV vaccination? E.g. Integrated demand generation, service delivery

|  |
| --- |
| [Enter description] |

# AEFI surveillance

Please describe how will the country record, report, monitor, investigate and respond to AEFI? E.g. procedures for what should be reported, involvement of NITAG or NRA, AEFI forms and notification system, healthcare worker training, incorporation of HPV in national AEFI guidelines.

|  |
| --- |
| [Enter description] |

# Training and Orientation

Please describe which stakeholders (health workers/ teachers/ other professionals and media) will be provided training or orientation for the HPV introduction.

|  |
| --- |
| [Enter description] |

Kindly provide a description of the initial training and orientation plans for each of the stakeholders mentioned above, including recent assessment of health worker skills and knowledge; AEFI education; duration and content of training at each level; types of people to be trained at national and district levels.

|  |
| --- |
| [Enter description] |

# Vaccine logistics and waste management

Please describe what impact HPV vaccine delivery strategy (e.g., multi-age cohort, school based, and frequency of vaccination) will have on current waste management facilities, how increased waste volume generated will be handled, current cold chain capacity at different levels of the system and source of these data, current status of vaccine stock management system, and any planned improvements and plans to increase supervision for vaccine management as part of the vaccine introduction.

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| --- |
| [Enter description] |

# Potential synergies with other vaccine introductions

Describe potential synergies across planned introductions/campaigns (e.g. if other vaccine introductions are planned in the same year as the HPV vaccine, there should be synergies at least in vaccine distribution from national / regional stores to lower levels, training / orientation for health workers, and social mobilisation activities). Also describe the country’s capacity to manage multiple vaccine introductions including mitigation strategies to address programmatic and financial risks.

|  |
| --- |
| [Enter description] |

1. Countries that may be interested in vaccinating other populations (e.g. girls ≥ 15 years or boys) should note that the government will have to bear the full operational and vaccine procurement costs to reach these additional populations. [↑](#footnote-ref-2)
2. Per WHO guidelines, “for single-dose schedules, HPV vaccines with data on efficacy or immunobridging are advised.” [↑](#footnote-ref-3)
3. Countries that may be interested in vaccinating other populations (e.g. girls ≥ 15 years or boys) as a part of a new introduction of HPV vaccines should note that the government will have to bear the full operational and vaccine costs to reach these additional populations. [↑](#footnote-ref-4)