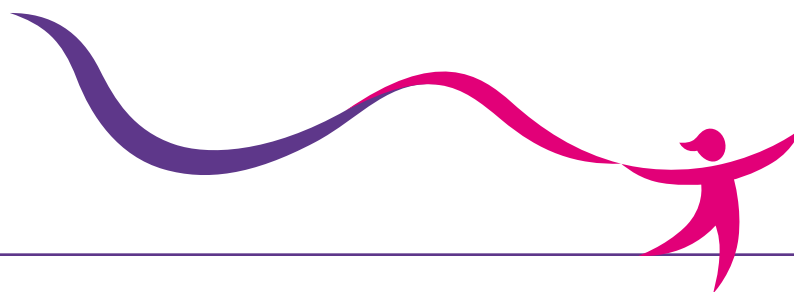


HPV VACCINE COMMUNICATION

Special considerations
for a unique vaccine



World Health
Organization



HPV VACCINE COMMUNICATION

Special considerations
for a unique vaccine

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This report is the result of the thinking, collaboration and hard work of many people. The World Health Organization's Immunization, Vaccines and Biologicals Department commissioned and provided oversight of this report as part of an effort to consolidate existing and new information about HPV vaccine communication. The section on "the basics" draws from several sources of previously published material and the author's experience. Assessments of HPV vaccine demonstration projects undertaken and published by PATH helped to lay a foundation for this work. Immunization programme managers, their teams and partner organizations were a tremendous help in the effort to understand and learn from activities in Latvia, Malaysia and Rwanda. Of course, this kind of work would never be possible without the collaboration of the health workers, headmasters, teachers, community leaders, mothers, fathers and girls who took the time to tell us what they think, and through this, help us all to do a better job.

The report was written by Christine McNab, with technical support from Tracey Goodman and Susan Wang in WHO's Department of Immunization, Vaccines and Biologicals Department.

A short note on terminology

In this report, "communication" is generally intended to encompass the areas of advocacy, communication and social mobilization.

Executive summary

This report presents communication guidance and specific considerations for countries that plan to introduce **human papillomavirus (HPV)** vaccine into their national immunization programme. HPV vaccine presents important opportunities for cervical cancer prevention. By the end of 2012, more than 40 countries had introduced HPV vaccine into their national immunization programmes, and numerous other countries are planning to introduce the vaccine.

New vaccine introduction is a hallmark of the Decade of Vaccines, but HPV vaccine is unique for many reasons. WHO recommends that the currently licensed HPV vaccines should primarily be targeted at 9–13 year-old girls to prevent infection with two types of human papillomavirus known to lead to about 70% of cervical cancers. The benefits of HPV vaccine will only be appreciated years, and sometimes decades, after girls have been vaccinated. HPV vaccine is also targeting girls before they become sexually active in order to prevent acquisition of a sexually transmitted infection (STI). Many communities find these topics challenging. For these reasons and others, countries introducing HPV vaccine should invest in a communication plan for introduction and well beyond.

This report aims to offer guidance in two main areas: The first is to offer advice on basic communication planning and implementation for immunization; the second is to discuss specific considerations for HPV vaccine. The basic elements of a communication plan include building a cross-sectoral team; having clear programme and communication objectives; understanding community knowledge, attitudes and practices; setting SMART objectives; defining target audiences with key messages for each; ensuring use of the right strategies, activities, channels and materials for each audience; having a risk communication plan for adverse events following immunization; and ensuring a monitoring and evaluation plan.

The specific considerations for HPV vaccine draw on experience from several countries which have either introduced the vaccine nationally or conducted demonstration projects, and from recent reviews commissioned by WHO of three low- and middle-income countries. This section includes advice about cross-sectoral advocacy, team building and formative research; a description of the recommended target groups; the importance of careful planning so that communication reaches hard-to-reach girls; and advises on effective messaging, materials and channels.

This report also recognizes several important points. The first is that the ideal communication plan described here is not always possible to implement due to time or resource limitations. The second is that HPV vaccine communication is a relatively new area, and there is still much to learn. Countries will bring their own approaches to communicating about HPV vaccine based on national knowledge and context. However, whatever the constraints, the report also stresses that communication is a key component of any successful public health programme, and an investment in communication for HPV vaccine is particularly important given its unique qualities. Experience shows that countries can achieve high coverage with HPV vaccine. The goal of an HPV vaccination programme is for high coverage, a reduction in cervical cancer and improvement in the health and lives of women for generations to come.



HPV Vaccine Communication

SPECIAL CONSIDERATIONS FOR A UNIQUE VACCINE



Introduction

Human papillomavirus (HPV) vaccine has one of the highest per-person impacts on mortality of all vaccines.¹ The vaccine is relatively new and is being introduced steadily into more countries. The World Health Organization (WHO) recommended target group for vaccination is 9–13 year-old girls who have not yet become sexually active.

Low- and middle-income countries, where more than 85% of cervical cancer deaths occur, can particularly benefit from HPV vaccine. As of December 2012, more than 40 countries had introduced national HPV vaccine programmes and a number of others had introduced (or planned to introduce) pilot or demonstration programmes. The pace of introduction in low-income countries is expected to increase as GAVI-eligible countries apply for support.

WHO recommends investment in a communication strategy for introduction of HPV vaccine.²

1. Lee L et al. The estimated mortality impact of vaccinations forecast to be administered during 2011–2020 in 73 countries supported by the GAVI Alliance. *Vaccine*, 2013, Decade of Vaccines, Supplement 2:B61-B72. Specifically, the review finds that "First-dose measles, human papillomavirus, and hepatitis B vaccination are expected to have the highest per-person impact and avert 16.5, 15.1, and 8.3 deaths per 1000 persons vaccinated, respectively."
2. *Comprehensive Cervical Cancer Prevention and Control: a healthier future for girls and women*, World Health Organization, (http://www.who.int/immunization/hpv/learn/comprehensive_cervical_cancer_who_2013.pdf, accessed 28 May 2013).

Global and country experience in communication for immunization has grown over many decades. There is a lot known about what works, and yet the public health community struggles to engage some families in immunization. A lack of knowledge about the threat of vaccine-preventable diseases, risks and benefits of vaccines, mistrust of government and health workers, poor service delivery and alternative health or religious beliefs play a role in lower uptake of some vaccines. These challenges underscore the importance of early integration and investment in a thoughtful communication plan for immunization programmes.

HPV vaccine presents exciting opportunities for public health, but its own unique communication challenges. There is a growing body of knowledge and information on HPV vaccine communication.³ Experiences in some countries show that some people question the vaccine because it is new or because they believe vaccination will lead to increased sexual activity. In some countries, gynaecologists or religious leaders misunderstand the purpose or value of HPV vaccine. Yet in many countries, demand and coverage with HPV vaccine is high; for example, some older women ask why they too cannot be vaccinated.

In order to better understand and learn from country experiences with HPV vaccine communication, particularly experiences of low- and middle-income countries, the World Health Organization's Immunization, Vaccine and Biologicals Department commissioned reviews of three country programmes. The reviews, conducted by the author of this report, took place in Latvia, Malaysia, and Rwanda in late 2012 with full participation of the governments of each country.

This report summarizes good practices for HPV vaccine communication, based on material from several sources, including the findings of the country reviews; recognized "best practices" for communication, advocacy and social mobilization for public health; and learning from other relevant programme and partner experiences.

3. For an up-to-date collection of the latest information on HPV, cervical cancer, HPV vaccine and its introduction, see the WHO's HP Vaccine Introduction Clearinghouse: <http://www.who.int/immunization/hpv/>

Who will benefit from this report?

This report offers some practical advice on how to organize and implement a communication plan for the introduction of HPV vaccine. It aims to offer guidance to partners involved in the effort to prevent cervical cancer. This includes national immunization managers, national and district social mobilization teams, partners and agency staff involved in HPV vaccine introduction. It also includes partners involved in cervical cancer, reproductive health, adolescent health, women's health and other sectors such as education.

This report focuses particularly on HPV vaccine communication and offers lessons and information from country experiences, together with references to existing literature. Programme implementers may also wish to consult resources on communication for health programming, cervical cancer, adolescent, sexual and reproductive health. Some key resources are listed at the end of this document.

The structure

This report is written in two parts.

■ **PART I – THE BASICS**

Aims to describe good public health communication practices and principles applicable to any country health communication programme.

■ **PART II – HPV VACCINE**

Looks specifically at HPV vaccine, explains why it is unique, and describes key areas countries should consider and build into their HPV vaccine communication plans.

Summary tables, diagrams and tips boxes throughout the document help guide the reader to the most important content.

The report also contains examples of materials from other countries and resources for further study.



HPV Vaccine Communication

PART I: THE BASICS



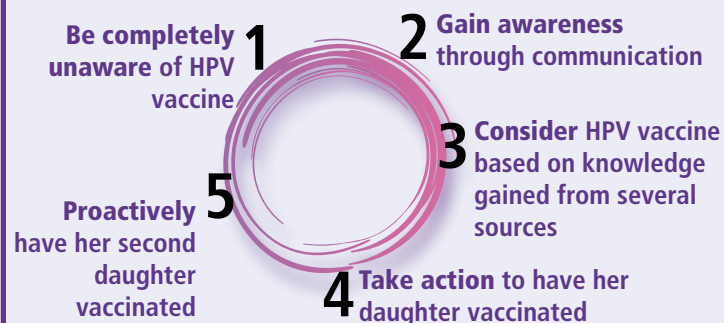
Good communication practices for immunization

There are several, often-interlinked communication theories (e.g. diffusion of innovation, health belief model, convergence theory) and approaches to communication (e.g. COMBI, C4D, C-Change). These generally assume that people need to go through a process to reach a decision to take a new action or to change a behaviour. Broadly speaking, this process begins with a person who is not aware of an intervention, who (through communication) becomes aware, then considers the intervention, then takes the action and then repeats (demands) it. Strategic communication and engagement is a key part of this process, coupled with provision of safe, effective, accessible and reliable health services. This is an iterative process and can take time.

CHANGING HUMAN BEHAVIOUR: A PROCESS

People generally go through an iterative process towards taking a new action or changing a behaviour.

For example a mother may:



Many factors play a role in the success, including the **perception of threat** of HPV and cervical cancer, the degree to which she trusts the vaccine, the message and its source, what action friends and family are taking and access to the HPV vaccine.

The different communication theories and approaches have been widely documented and explained in other literature and will not be repeated here.⁴ Countries may already have adapted these kinds of approaches to the national setting or are using their own unique approaches. While each approach proposes different ways of thinking about communication, they all contain the same basic elements that should be part of any communication plan.

The essential elements for communication planning



4. Renata Schiavo's 2007 book *Health Communication: From Theory to Practice* concisely summarizes theories and practices and offers practical planning suggestions. It can be found here: <http://www.ihepsa.ir/files/h2.pdf>. For More on COMBI and C-Change see www.commit.com, and for more on C4D, see UNICEF's web site: www.unicef.org/cbsc/ and http://www.unicef.org/cbsc/in2dex_43099.html for a series of useful planning documents.

Any health communication plan, including an HPV vaccine communication plan should include the following basics elements.

1. A communication team

Planning and implementing a national communication, advocacy and social mobilization programme is a job for more than one person. Countries usually convene a team to work on communication for a health programme or intervention. This team, whether a sub-committee or standing working group, should be a key part of the larger planning team that may include operations, procurement and overall management. The team should include communication experts from government and from relevant partner organizations and should ideally include representation from the different sectors involved in the programme.

2. Technical programme objectives

Understand what the technical programme wants to achieve. In the case of HPV vaccine, this may be “to achieve >70% coverage of the target population in year 1, and >80% in year 2.” The smarter the programme objective, the easier it is to define SMART communication objectives.⁵

3. Situation analysis

A situation analysis forms the foundation for all communication planning and helps to ensure the communication work is as strategic and targeted as possible by using resources for activities that will have the most impact. It takes time, human and financial resources to do well – but without investment in this step, communication efforts may be wasted on the wrong audiences with the wrong messages and activities. The situation analysis should examine the technical programme aims, the status of relevant programmes (e.g. routine immunization) and knowledge, attitudes, practices and behaviours of the main audiences. It can draw on existing knowledge (e.g. best practices in communication for the country, known trusted channels and sources of information), existing global and national studies and surveys, and, ideally, new formative research specific to the intervention. This new research can include focus group discussions, interviews with key audiences and even a national survey (of vaccine acceptance, for example) that will help to set a baseline against which to measure communication efforts.

Draw on existing knowledge and new information about people's knowledge and practices.

5. SMART objectives refer to those that are specific, measurable, achievable, relevant and time-bound.

4. SMART communication objectives

Based on the situation analysis, set “SMART” communication objectives that will express the specific ways in which communication activities can help to deliver the programme objectives. “SMART” is an acronym that means “specific, measurable, attainable, relevant, and time-bound”. For example, if the analysis finds that a key national association does not support the programme in question, a SMART advocacy objective would be to work with that association to gain their commitment and have them issue a public statement supporting the intervention by a certain date. Ask tough questions and be sure the objective addresses each of the SMART targets. The objective may be specific, measurable, relevant and time-bound, but if it is not realistic, it is not SMART. Prioritize and keep the number of SMART objectives smart too – do not set so many that they become unattainable.

5. Target audiences

Any good communication plan should target audiences that are as specific as possible. For some interventions this may be quite broad – for example health workers or target-age girls. For others, it may be very specific: perhaps the director of health in a specific state or province or the district administrator of a specific district. Knowing exactly who you are targeting will focus attention to messages, materials, activities and languages, and it will help to make the communication plan as strategic and effective as possible.

Target audiences should be as specific as possible. “The public” is too broad.

6. Messages for each audience

Different audiences will respond to different messages. While there may be some common messages (e.g. *x* disease is dangerous and can be prevented), a health minister will be convinced by different information than a finance minister, and a mother may be convinced by and need different information than a health worker. Ideally, messages should be based on a “message map” for each audience that summarizes the specific audience (e.g. low-income mothers), briefly explains the issue (e.g. 90% of low-income mothers surveyed do not know what cervical cancer is), the desired outcome (e.g. more than 65% of low-income mothers know what cervical cancer is within one year of the start of the programme) and the key messages with supporting facts in one table. These messages and evidence then form the basis for all of the communication materials, including speeches and talking points for media. Messages should give information that addresses questions and concerns (“Cervical

- Different audiences will response to different messages
- Test your messages
- Include a call to action

cancer is mainly caused by the human papillomavirus. The HPV vaccine is safe and effective.”) and **include a call to action** (“Protect your daughter! Make sure she is vaccinated!”).

It is also important to **test the messages** with the intended audiences. This may not be possible with all audiences, but some rapid focus groups can help to make sure people really understand the messages and that they will provoke the desired behaviour.

7. Strategies, activities and channels to reach the audiences

These should directly support achievement of the communication objectives. Communication includes many types of strategies. Examples include advocacy, social mobilization, interpersonal communication and mass media (including social media and text messages). Many audiences will be reached through a mix of strategies, activities and channels. Again, the situation analysis will help to pinpoint the kinds of strategies and activities that should result in the most rewarding outcomes. For example, a high-level meeting between the health team and finance minister may be enough to remove a bottleneck to funding, but a mother may need to be reached through a popular health radio programme, through interpersonal communication with her trusted health worker, through a sermon at the church or a mosque announcement, and through the educational system, such as a letter to all parents from the school headmaster. **Different strategies and activities have very different cost implications.** Television typically costs the most (unless it is state-sponsored) and may only reach the elite. Mobilizing a trusted community-based organization to communicate about the programme in every village is also costly but may have more impact on parental demand and acceptance.

TRUST AND SOURCES OF INFORMATION

People are more likely to believe information from sources they trust. The communication plan should consider each channel of information and invest in the most trusted. Which radio programmes do people trust the most? Is there a senior health practitioner who would be a trusted spokesperson? A beloved actress who has daughters she will have vaccinated? Also, consider language and minority groups who may trust different sources.

8. Create branded materials

The strategies and activities will have a bearing on the package of materials required. Materials should be tailored to the audience. They can include an advocacy presentation, a list of key messages, a question and answer document, and advice for managing difficult issues for leaders; information, education and communication materials for the community; training materials for health workers and a media kit for journalists.

Factors to consider with any materials should include the points listed below.

- The materials should have a common look and feel or “brand”, use a unifying logo, colour, type font and design scheme.
- **Pre-test the materials** with the target audiences. In practical terms, a country team might test messages and materials at the same time.
- Can the opportunity be used to include short complementary messages about, for example, routine immunization or cervical cancer screening?
- Will the material really be used? Posters, for example, can work well in a country where health clinics or schools routinely gather and hang posters, but not in countries with a poor distribution system and a lack of practical tools such as sticky tape or tacks for hanging.

• Think beyond the poster. What will the audience respond to most?

• Make a distribution plan. Materials sitting in a box will not have any impact.



- Is the language and art-work appropriate – for literate populations or language minorities?
- Are the physical depictions of people culturally appropriate, including for minorities?
- How is the print quality? It can be tempting to save money by printing with low-quality ink and paper, but if the material fades or tears quickly, it may be money wasted.
- Create a distribution plan so materials arrive in the right places, on time.
- Think about electronic distribution as well – by email, online through the world wide web, and through social media where it's available.

9. A risk communication plan for adverse events following immunization (AEFI)⁶

Following vaccination, there may be events such as redness or swelling at the site of injection, and less-common events such as a fainting or slight illness. Very occasionally, particularly during a campaign when millions of injections may be given over the course of a few days, there may be a serious AEFI. Ideally, health workers will have the authority and the equipment required to manage it. But these very rare events sometimes are handled badly. Or an event that appears to be an AEFI may be caused by something else (e.g. children who are sick from food poisoning at the time of the campaign). People who oppose the campaign may start rumours. Whatever the source, this can seriously destabilize a campaign and other immunization efforts. An AEFI plan should include standard operating procedures for handling the situation, a description of the authorized chain and timing of investigation and information sharing, authorized spokespersons, contacts lists of stakeholders and media and suggested strategies (with funds set aside) to rapidly reach key audiences including parents, health workers, the media, partners and decision makers. In this type of crisis, the aim is to rebuild trust with the key audiences.

The plan should aim to ensure an honest, rapid investigation and reliable, regular reporting on the situation. It should explain the actions that have been and will be taken to ensure the root causes of the AEFI (whether truly linked or perceived to be linked) are investigated and fixed in the short and long-term.

ELEMENTS OF AN “AEFI” PLAN

- Standard operating procedures for handling the situation
- Description of how and when investigations will occur
- Description of how and when information and updates are communicated
- Authorized spokespersons
- Contact lists internally, for media, partners
- Strategies to communicate with different stakeholders
- Funding
- Consensus on the plan amongst key players

10. A monitoring and evaluation plan

Communication outcomes can be difficult to measure. Communication efforts often contribute to overall programme outcomes, rather than produce them directly. Nonetheless, like any plan which involves money and time, the communication plan should include on-going

6. For more on why and how to prepare an AEFI risk communication plan, see the UNICEF and WHO document *Building trust and responding to adverse events following immunization in South Asia: using strategic communication* ([http://www.unicef.org/rosa/immunisation_report_17May_05\(final_editing_text\).pdf](http://www.unicef.org/rosa/immunisation_report_17May_05(final_editing_text).pdf)). Readers should also refer to WHO's Vaccine Safety Basics e-learning Course (2013) training module, which includes extensive chapters on AEFI's and risk communication planning and implementation. <http://www.vaccine-safety-training.org/>

monitoring so that the team can measure if the plan is on track and adjust as necessary, the team can report on the plan to coordinating bodies or other donors, and the team can determine if the plan is achieving the desired outcomes and adjust if it is not.

A mid-term or end-of-project evaluation will determine the overall project outcomes and can make recommendations that will guide the programme or future similar programmes in the country and even globally. A monitoring and evaluation plan requires thought about objectives, targets and milestones, together with indicators and methods to assess the plan's outcomes.

- One example of a measurable communication outcome is to change people's level of knowledge
- Integrate communication monitoring indicators in the overall programme monitoring plan

- The SMART objectives agreed at the outset of the planning are inherently measurable.
- Set targets as appropriate. For example, if the plan is to engage six community-based organizations in the activity, or to fund 10 radio drama episodes, or to raise mothers' understanding of cervical cancer > 65%, it is easier to measure and report back on what was actually achieved. Other areas for which to set targets may be "source of information" – for example, that "50% of families surveyed should hear about the programme through radio announcements".
- Milestones help to determine if a project is on track. Achieving milestones set the stage to take it to the next level. For example, a milestone may be to train 3000 community workers in interpersonal communication by the end of June, which sets the stage for such communication to occur with communities.



- Monitoring requires indicators. These include input (e.g. percentage of high-risk communities with trained community mobilizers), process (e.g. percentage of planned activities held), output (e.g. percentage of health facilities clearly displaying a poster), and outcome indicators (percentage change in knowledge about the particular health issue). Impact indicators are also important (e.g. percentage of target-age population reached with intervention), but these are usually the result of a combination of factors – including the availability of the intervention, the quality of health staff and community demand. They are often difficult to attribute only to communication activities.
- Communication-related monitoring indicators should be integrated into larger programme monitoring wherever possible. For example, in-process campaign monitoring or immunization coverage surveys should include questions about “source of information” that can reveal whether communities are learning about the project through the channels you have invested in, “reasons for vaccination” which can show whether communication played a role and “reasons for non-vaccination” which may uncover the circulation of rumours.⁷
- In order to assess outcomes, a programme may require a larger survey (such as a knowledge, attitude and practice survey) or use different sources of information including coverage surveys, post-introduction evaluations, “dipstick” rapid surveys and programme monitoring to gather information.
- Ideally, an independent evaluation should occur. If this is not possible, an honest internal evaluation including the partners could also be scheduled.

11. A work plan with a budget

Once the essential elements of the communication strategy are mapped out, integrate them into a work plan. The work plan should include a list of activities, the responsible person, the funds required for each element, the deadline for each activity and space for status reports. The work plan and budget may need to be authorized by the larger programme coordination group.

12. Adjust the work plan as required

Communication is a continuous process and will need refining as the programme continues. If an activity is not working as anticipated, it can be stopped or adjusted. Investments in communication may change over time as a programme becomes more integrated into the community and accepted as a regular part of health programming.

7. The polio eradication programme provides practical reports about communication indicators at <http://www.polioinfo.org/>. Waisbord S et al. examine real-time communication monitoring in *Communication for polio eradication: improving the quality of communication programming through real-time monitoring and evaluation*. *Journal of Health Communication*. 2010, 15 Suppl 1:9-24.

A sample communication plan

Programme objective

Achieve more than 90% coverage of 11 year-old out-of-school girls with three doses of HPV vaccine this year.



Situation analysis

In the majority population

In most of the country, 10% of target-age girls are out of school, for a total of 50 000 girls. We know that 80% of out-of-schools girls are at home helping in the household, and 20% are working in the family business (shops, street stalls, small restaurants). Community attitude towards immunization is positive (e.g. DTP3 = 87%). A new community survey shows that 60% of female caregivers know very little or nothing about cervical cancer and that 90% of female caregivers know very little or nothing about HPV and HPV vaccine. Previous experience in the country shows that these caregivers trust the first lady and PHC health workers. Almost every community listens to the 18:00 national news on the radio.

In the minority population

In X Province, more than 80% of target-age girls are out of school, comprising 10 000 target-age girls. They mainly work on their family farms. Community attitude towards immunization are less positive (e.g. DTP3 = 70%). The community survey shows that 80% of female caregivers know very little or nothing about cervical cancer and that almost 100% of female caregivers know very little or nothing about HPV and HPV vaccine. Previous experience shows that this community mistrusts the government but trusts their religious leaders and midwives/health workers.

Sample communication plan

SMART objective	Target	Messages	Strategies and channels	Materials	Target	Indicator
80% of caregivers can answer three basic questions about cervical cancer and HPV vaccine by end of year.	1. Caregivers of 11-year-old girls in majority population.	<ul style="list-style-type: none"> – Cervical cancer is a leading cause of death for women in our country. – A virus called human papillomavirus, which is transmitted through sexual activity, and causes cervical cancer. Most women will get this virus in their lifetime. Some will develop cervical cancer. – Our country will offer a proven vaccine that will prevent this cancer. – All 11-year-old girls should be vaccinated. – Protect your daughters. Bring them to the health clinic for anti-cancer vaccination three times on X date. 	<ol style="list-style-type: none"> 1. Launch with First Lady one week before HPV vaccine introduction begins. 2. HPV vaccine community information session in every catchment area. 3. Public service announcement (PSA) before the national news to run every day for two weeks before introduction. 	<ol style="list-style-type: none"> 1. Branded promotional materials for launch. Launch speech. 2. Training package including interpersonal communication (IPC) skills for health workers. 3. Public service announcement. 	<ol style="list-style-type: none"> 1. Launch covered on all major media. 2. 90% of community meetings held. 3. 60% of people cite PSA as a source of information. 	<p>Input: % of IEC materials arrived in time for health info sessions.</p> <p>Process: % of community meetings held.</p> <p>Outcome: % of caregivers who can answer three basic questions about HPV vaccine and cervical cancer.</p>
	2. Caregivers of 11-year-old girls in minority population in X Province.	<p>Same as above with additions:</p> <ul style="list-style-type: none"> – HPV vaccine is safe and is used in neighbouring countries. – Bring your 11-year-old girls to discuss the vaccine with your community midwife/health worker and get her vaccinated. 	<p>Special training for community midwives and religious leaders.</p> <p>Midwives lead community information session with religious leaders present.</p>	<ul style="list-style-type: none"> – Same as above, in local language. – Training package including IPC for midwives and religious leaders. 		

Note: this is not a comprehensive plan, and data and information have been created only for the purpose of this exercise.

Communication principles

Health communication, particularly for an intervention meant to reach defined populations in every community, should adhere to two key principles grounded in a human rights approach.

1. Promote community engagement

One goal of primary health care is for communities to own and demand the health programme or intervention. This can take time. Within communities, there will be many voices – some actively supportive, others passively accepting and some actively opposed. Communication should identify and engage all groups, their leaders and other influencers. It is human nature to want to learn, challenge assumptions and ask questions. Interpersonal communication and community participation will be key to successful communication and over time will produce better, more sustainable health outcomes.

2. Promote equity

Good public health practice aims to reach all people. Yet in 2012, for example, more than 22 million children did not receive a single vaccination. There is a correlation between marginalized and hard-to-reach populations and their health status. Sometimes these populations do not know a service is available, or language barriers may mean they do not understand what it is for or why they need it. Therefore, like health services, communication strategies should aim to “reach the unreached.” This can also be programmatically strategic. Reaching the last groups of unvaccinated children – day labourers, migrants, nomads and marginalized groups – with polio vaccine, for example, is the only way to eradicate wild poliovirus.

The theory, the reality and the need to advocate for communication

Communication, including social mobilization and advocacy, requires investment. Successful public health can be equated to a three-legged stool. One leg is availability of the intervention itself (e.g. the vaccine and logistics); the second is a trained, motivated cadre of health personnel; and the third is acceptance and demand from the people. Without the people, investment in the intervention itself and the health worker training is wasted – and the programme cannot be successful. A new vaccine may be available, but if the population does not understand what it is for and why it benefits them – they will not automatically run to demand it. Worse, they may begin or believe damaging rumours about it.

All of the elements described in this previous section represent the ideal for communication planning and implementation. However, experience shows that the ideal is sometimes far from possible.

In reality, countries may have one or two communication/social mobilization officers

Communication requires investment. A new vaccine may be available, but if the public does not understand how it benefits them, they will not automatically demand it.



in primary health working on multiple projects at once, with external partners who are equally stretched. The time required to take all of these steps may simply not be available. Often, the situation analysis is done too rapidly without enough information. A national KAP survey may require months to complete, while the programme may be scheduled to begin much sooner. Funding may come late, seriously disrupting the most considered plans. SMART objectives may have all been deemed “priorities” but were in reality too numerous to achieve. Staff working on the project may have personal matters in their family which require their extended attention away from work.

There is recognition that communication activities are under-resourced, but to achieve success in a public health programme, there is an obligation to advocate for increased resources. Planning is one way to do this. A thoughtful communication plan which demonstrates, with evidence, how it will contribute to better public health outcomes is more likely to attract resources than a plan that proposes only IEC materials for example. One advantage with immunization programming is the number of partners involved who often form part of the communication working group and can assist with the plan. Get them involved early. Enlist their support to help with formative research and evidence-based plans. The result can be a convincing communication plan that receives the resources required to help achieve public health outcomes.



A note on country context

Some countries may simply not require as much investment in additional communication. Countries where population trust in government programming is very high and which already have clear communication structures from national to community level, for example, may be able to use these existing structures to communicate effectively about a new public health programme. People will accept and even demand the intervention because they trust their leaders to offer health programmes that benefit communities and the country.

However, there is one note of caution. Increasing access to the Internet means much more information is rapidly available than ever before. This includes, unfortunately, false information about some public health interventions, including vaccines in particular. The information may look official and cite researchers and other scientists. The “anti-vaxers” as they are known, can make a compelling case to an untrained person who may already have questions about vaccines. Rumours can begin quickly in communities and be amplified nation-wide through mobile phones, inexpensive videos and social media tools.

Therefore, it is important to ensure that even in countries with high public trust and clear communication structures, the information passed through those structures helps to explain the intervention adequately and gives community leaders the tools they might need to explain it. A letter of instruction, for example, could include a broader question and answer document, which gives correct, accessible information about the intervention that can be read and explained easily to communities. Health workers should also be well trained to understand the intervention they are providing so they too can answer questions from the community. Countries should also be sure to use the internet to disseminate information. Some countries have established specific HPV vaccine websites in local languages which offer facts, answer common questions, address rumours and provide copies of information, education, communication and media materials for easy download. As a potential reference, the World Health Organization web site (www.who.int) provides clear information about all vaccine preventable diseases and the vaccine which prevents them.

When introducing HPV vaccine every country can benefit from a communication plan. A good plan can attract resources.

As demonstrated in the next section, there are also many unique considerations for HPV vaccine that demand a real investment in communication at the time of introduction and well beyond.



HPV Vaccine Communication

PART II: HPV VACCINE



Unique considerations for communication

This section outlines the elements of the communication planning process and identifies key considerations for the introduction of HPV vaccine. The section also looks at wider, common lessons that have emerged from countries as diverse as Latvia, Malaysia and Rwanda. Experiences from these and other countries offer important communication lessons, ideas and practices. As more countries plan to introduce HPV vaccine, they can draw on these experiences as they prepare and implement communication plans.

Why HPV vaccine is unique

HPV vaccine is different from other new vaccines that are targeted at infants (e.g. rotavirus, pneumococcal).

Characteristics of HPV vaccine	Potential communication issues
Targeted at pre-adolescent and adolescent girls	<ul style="list-style-type: none"> – May be in or out of school; if out of school, harder to reach. – Potential concerns about fertility and sexual activity. – Potential concerns about why the vaccine is not available to all women or to boys/men.
An injected vaccine	<ul style="list-style-type: none"> – Fear of injections amongst target-age group.
A new vaccine	<ul style="list-style-type: none"> – Potential concerns about safety and efficacy, or “trials”.
A relatively expensive vaccine	<ul style="list-style-type: none"> – Potential concerns from health professionals about priorities.
Provided in a three-dose schedule within six months	<ul style="list-style-type: none"> – Maintaining support of schools for several health worker visits. – How to reach girls who drop out or are not in school.
Protects against HPV – a little-known sexually transmitted infection	<ul style="list-style-type: none"> – Explaining HPV risks and prevalence in clear, culturally appropriate terms. – How not to confuse with HIV or other sexually transmitted infections.
Protects against cervical cancer which manifests years, or even decades, after HPV infection	<ul style="list-style-type: none"> – Cervical cancer may not be well-known in community. – The benefits of HPV vaccine may not be seen for decades, unlike vaccines against outbreak-prone vaccine-preventable diseases.
Protects against 70% of cervical cancers	<ul style="list-style-type: none"> – Explaining that it does not protect against all causes of cervical cancer. – Explaining that cervical cancer screening is still necessary.
Of interest to several disciplines and areas	<ul style="list-style-type: none"> – Opportunity to involve immunization, child health, adolescent health, HIV/STIs, cancer, sexual and reproductive health, education partners. – Opportunity to integrate communication strategy, messaging with several areas such as cervical cancer prevention, adolescent health.

Getting started: what to consider and what to do

Experience from other countries suggests the following broader lessons for HPV vaccine communication.

Start early

While not unique to HPV vaccine, it is best to start communication planning early. Given the unique attributes of HPV vaccine and the potential for community concerns, early planning several months in advance of introduction allows for the formative research, situation analysis and pre-testing needed to successfully introduce this new vaccine. Starting early also means having budgets approved early – which translates to having materials ready on time.

Planning early means budgets can be approved early – ensuring that implementation can take place on time.

One country that was reviewed had designed high-quality materials in all relevant languages. However, due to the late release of funds, the country had to print and distribute the materials many weeks after HPV vaccination had begun. “We had to convince people at the same time we were trying to vaccinate them,” said one health leader. This caused undue concerns in the community and short-term problems for the programme.

Build a cross-sectoral team

HPV vaccine may be delivered through the immunization structures, but the health implications and benefits cut across many sectors and programmes. The programme planning team and the communication team should integrate relevant sectors early. These include: the noncommunicable disease unit for cervical cancer; women’s health practitioners, including gynaecologists and obstetricians; adolescent health practitioners; the Ministry of Education; and groups such as women’s and youth associations. Service clubs such as Lions and Rotary are also involved in immunization. The group can include relevant counterparts in partner agencies such as WHO, the United Nations Children’s Fund, the United Nations Population Fund and others. It can be **united under the aim of preventing cervical cancers** (as opposed to preventing a sexually transmitted infection).

Working across sectors and programmes has many advantages. It expands human and financial resources, taps existing knowledge, promotes new ideas and builds large networks that can reach people at all levels of society with consistent messaging. It is also an opportunity to

ensure no group feels its “territory” is being threatened. At the same time, this approach requires more time to harmonize agendas and build consensus around messages and activities.

There will be concerns

In all countries that were reviewed, communities and even health workers had concerns about HPV vaccine. Countries can anticipate concerns about:

- **The source and relative newness of the HPV vaccine** – HPV vaccine can be perceived to be a new product made in a wealthy country that is being tested in poorer countries. In the countries reviewed, people and health workers wanted more information about the safety, efficacy, side effects, long-term effects and experiences with HPV vaccine in other countries.
- **The targeting of young girls only** – Some people may wonder if HPV vaccine will have an impact on girls’ fertility. They may take the idea further and suggest there is a plot to sterilize girls. Others may wonder if vaccination will encourage girls to become promiscuous. Recognizing that HPV is an STI, some may misunderstand the need to vaccinate girls early, protest that their girls are not yet sexually active and believe that vaccination is not yet necessary. People may wonder why boys are not being vaccinated too, particularly as they are in a handful of other countries. Women may wonder why all women, or older adolescents are not being vaccinated.
- **The cost of the vaccine to the national health budget** – In countries paying for the vaccine with national funds, professional health associations may wonder why HPV vaccine is being introduced given its expense compared with other vaccines.

Advocacy with groups that may have specific concerns

Linked to the two main points above, it is important to anticipate that some groups or associations may have specific concerns about HPV vaccine. Some of these groups can stop HPV vaccination with one widely publicized news release. They may mistakenly focus on girls’ fertility or sexuality, or question whether the vaccine meets standard religious criteria (e.g. halal). One country experienced high resistance from several health associations, which vocally condemned introduction of HPV vaccine. This sparked more questions and concerns from health workers and parents. Two years later, the country is still trying to overcome this hurdle.

The groups included in advocacy might not be brought directly onto the planning team, but instead into a wider supportive coalition. These can include health professional associations, private schools or religious associations. It is important to engage early, discuss and address concerns and ensure these groups not only tolerate the HPV vaccine programme, but actively support it.

Understand and plan for the hard-to-reach girls

The girls who are hard to reach with HPV vaccine – who may have less overall access to the health and education system – may also be the girls who are at higher risk of developing cervical cancer and would benefit most from the vaccine. These girls may come from different demographic groups in different countries. They may have a disability. In some countries, they may be out of school due to poverty or access; girls who frequently move with their families and change schools; or attend school only part-time. They may have left school early and are working at home or labouring in low-wage jobs in dense urban areas. One country reported very high coverage of girls in school (more than 95% administrative coverage) but much lower for girls out-of-school (less than 65%). While challenging, a communication plan should attempt to reach these girls through channels they trust – whether through household and community outreach, messages through peer networks, adolescent housing, employment settings or popular venues. The messages should stress the risks of cervical cancer, benefits of the vaccine, the three-dose schedule and the fact the government is offering the vaccine is free of charge.

The first year will have some challenges

Even with good preparation, challenges are likely to emerge during the first year of HPV vaccine introduction. These may involve service delivery but can include rumours and misunderstanding about the vaccine. Good communication planning can anticipate this and equip audiences with the information they require to understand and explain the programme.

High coverage can be achieved

Ultimately, HPV vaccine is a safe, effective, important vaccine that will protect women from 70% of cervical cancer – a disease no woman wants to have. A recent study in *Vaccine* noted that HPV vaccine is projected to have the second-highest per-person impact on mortality in GAVI Alliance-eligible countries.⁸ In the longer-term, high HPV vaccine coverage will reduce the economic and human costs of cervical cancer. The vaccine is particularly beneficial in settings where women have less access to cervical cancer screening. In Rwanda, for example, women were demanding the HPV vaccine for themselves as well as their daughters. In Malaysia, a separate HPV vaccine programme was added for 18-year-old girls. Many countries have achieved good coverage. Both Rwanda and Malaysia have reported coverage more than 85% of the in-school population. In the United Kingdom, 84% of 12–13 year olds were fully vaccinated in 2010–2011. Canada has achieved 85% coverage of target-age girls in some provinces. The demonstration project in Uganda resulted in 85% coverage in the school-based programme.

8. Lee L et al. The estimated mortality impact of vaccinations forecast to be administered during 2011–2020 in 73 countries supported by the GAVI Alliance. *Vaccine*, 2013, Decade of Vaccines, Supplement 2:B61-B72.

HPV vaccine in communication planning

Multi-year communication plan and budget

Every new health intervention requires a communication plan, and integration of messages into wider programming is necessary once the intervention is “normalized”. Countries may want to reduce the HPV vaccine communication budget after the first year. However it is important to remember that each year brings a new cohort of target-age girls and their parents, and they may be learning about HPV vaccine for the first time. New health workers and teachers will join the system. A large-scale television campaign may not be necessary each year, but communication to remind audiences about the reasons, dates and schedule of the HPV vaccine plans and schedule; opportunities to ask questions (e.g. radio call-in programmes, or school and community meetings), informative literature; and monitoring for and responding to rumours and concerns will be necessary for some time until HPV vaccine becomes routine within the health system.

Formative research

Published studies, country experience introducing other vaccines or public health interventions, together with other data, will definitely inform the design of the HPV vaccine communication plan. However, because HPV vaccine is new and has unique traits, it is difficult to simply transfer an existing immunization communication plan to HPV vaccine. Some countries with high levels of routine immunization coverage, for example, have challenges introducing HPV vaccine. Formative research may reveal surprising results and findings about the target populations and indicate other areas that require improved communication (e.g. on knowledge about cervical cancer and screening).⁹ Formative research, including group discussions and key informant interviews, are also part of the engagement process and signal genuine care about addressing the views of target groups. For HPV vaccine, it can also help to pinpoint language and terminology issues for sometimes sensitive areas such as sexual behaviour and anatomy, or for colloquial language and new information channels used by target-age girls (e.g. use of SMS or social media).

HPV vaccine audiences

Experience shows that each of the following audiences are important and that engagement and support from some of them can make the difference between success and failure of the HPV vaccine effort. Naming these specific audiences does not exclude others – it is a given that

9. *Conducting formative research for HPV vaccine program planning: practical experience from PATH*. PATH, 2012 (<http://www.path.org/publications/detail.php?i=2241>, accessed 28 May 2013).

countries will know who else must be reached – whether it be community leaders, traditional healers, popular artists or others.

- **Target-age girls**

This group is an obvious starting point. The girls need to know why a health worker needs to give them an injection, three times in just six months. Girls may not need to know all of the details. In fact, girls surveyed generally care most about one issue: *Will the injection hurt?* They should understand the normal side effects of the injection and know when to visit a health clinic. Ideally, the girl should learn enough at the time of HPV vaccine injection to recall that when she is older she should still go for cervical cancer screening (which may be available by the time she is eligible). Girls are also a channel of information for their friends, parents, sisters and aunts – bringing home information which others can read and discuss, or talking about it with their sisters or friends. As already mentioned, **hard-to-reach girls require special consideration.**

- **Caregivers in the immediate and extended family**

Reaching caregivers can be difficult. In Rwanda, for example, fewer than 20% of girls surveyed cited their parents as a source of their information for HPV vaccine. In Malaysia, fewer than 5% cited parents as a source. Parents and caregivers should feel informed so they can discuss HPV vaccination with their daughters and know where to ask should they have more questions.

This group will potentially have concerns about their daughter's health, the potential for promiscuity, perceived impacts on menstruation and fertility, vaccine safety, side effects and long-term effects. Some parents may have access to the Internet and in the absence of good information can learn and pass false information through the community. Many parents will believe their daughter is too young to seriously discuss or give consent for HPV vaccination. In many countries, the father will be responsible for giving formal consent and needs to be reached with information. Mothers, grandmothers or aunts in the extended family may explain HPV vaccine to the girls. Experience shows that caregivers may seek multiple sources of information about HPV vaccine. If they hear about it through school, for example, they may also seek advice from their health worker, friends or trusted community leaders. In countries with cervical cancer screening, reaching out to mothers and aunts is also an opportunity to reach eligible women with messages about cervical cancer screening.

- **Headmasters and teachers**

If HPV vaccine delivery is school-based, headmasters and teachers will be on the front lines of the programme. They may give permission to health teams to vaccinate in schools, use class time for vaccination sessions, participate in training, educate girls about the vaccine, remind them of the schedule and, in some places, help with the sessions, record attendance and update

registers and vaccination cards. They may also coordinate information with health workers and with parents through parent-teacher organizations. In other words, the headmasters and teachers can be a linchpin to the success of the whole exercise. They should have specific training (ideally in collaboration with the Ministry of Education and any private school associations), formal opportunities to coordinate with health workers (e.g. joint meetings) and access to materials they can use which both make them comfortable with the programme and help them to engage and mobilize parents and daughters.

- **Health workers**

They are also a core audience. Experiences in countries show that their active advocacy of the HPV vaccine can have an impact on uptake. Informal surveys also show that they themselves may have questions about the HPV vaccine or about the biological links between HPV, the vaccine and cervical cancer. They may also want to take the opportunity learn about other STIs or other types of cancer. Health workers may also have access to the Internet and will search for more information on these issues. They need to be equipped, as an integral part of their training, to be a trusted source of information to community leaders, parents, girls, teachers and others. They will benefit from: training on HPV, HPV vaccine (in addition to training on safe handling and administration), cervical cancer and interpersonal communication with girls and families.

- **Professional, cultural and religious associations**

These have been discussed under the “advocacy” section on page 24, but it is worth noting again that relevant associations should be identified, engaged in advocacy and brought in as



Rwanda's HPV vaccine communication materials show parents with their daughters, and messages are in Kinyarwanda, Rwanda's official language.



Community collaboration success

HPV vaccine programmes in Rwanda, Uganda and Peru; each show the importance of involving teachers and health workers in the communication process.

In **RWANDA**, every district health centre hosted joint meetings with health workers, community leaders, headmasters and teachers before each round of vaccination. Educators learned about HPV vaccine and their roles in ensuring their students were reached in the classroom. Rwandan girls surveyed cited school and health workers as two of the top three sources of information about HPV vaccine (radio ranked first).^a

UGANDA's HPV vaccine demonstration project found that close collaboration between the community, teachers and health workers was a key factor in higher coverage. "Joint planning meetings in advance of vaccinations were essential to the success of the vaccination programme. The participation of teachers, health workers, and community leaders in the meetings provided an opportunity to coordinate work plans, timelines, resources, interventions, monitoring and reporting. This also promoted close collaboration between the departments

of health and education and encouraged a cooperative environment during vaccination sessions."^b

This kind of collaboration was credited with some of the success in a demonstration project in **PERU**: "Feedback from parents and their daughters indicated that although many initially reacted to the new vaccine with scepticism and doubt, these doubts were overcome by educational efforts by teachers and health workers, as well as information parents sought independently." In Peru there was also evidence that where teachers were not engaged, the programme was affected. "In places where teachers were not involved in or supportive of vaccination, there was also distrust or lack of engagement among parents. For example, one health worker described how teachers at one school failed to actively coordinate educational community meetings, which meant that no parents showed up."^c

a. Results of a post-introduction evaluation in Rwanda, October 2012.

b. Uganda Ministry of Health and PATH. *HPV Vaccination in Africa: Lessons Learned from a Pilot Program in Uganda*, 2011.

c. Peru Ministry of Health, Instituto de Investigacion Nutricional, PATH. *HPV Vaccination in Latin America: Lessons learned from a pilot program in Peru*, 2010.

a direct partner or within the broader coalition of supporters. These include professional medical associations (several countries co-brand their HPV vaccine programmes with the association of gynecologists or obstetricians), religious, traditional leaders and women's and youth groups. They may need different kinds of evidence-based information – such as the burden of cervical cancer in the country, the costs of treatment and the cost-benefit of HPV vaccination. They may also want more evidence and information from other countries. When they are confident in the programme, their leaders can turn into champions and advocate publicly for the parents to have their girls vaccinated. Messages can be spread in churches or mosques. Trusted health practitioners can be involved in interviews and public service announcements.

- **Media**

The media can be champions for HPV vaccination through accurate reporting and prominent placement of stories. However, if there is an official information gap, they can also be quick to report misinformation they might find from other sources. They may, for example, be targeted by anti-vaccination groups who will lead them to false information. Media will vary from country to country and have greater or lesser trust in government programmes. Countries have had success organizing special pre-campaign briefing sessions for journalists, where experts

provide an overview and time to ask questions. A well-organized news conference with trusted speakers representing the HPV vaccine team can also help to set a positive tone for the campaign.



Effective messages

There is no magic formula for HPV vaccine messaging, and it will vary between and even within countries. Knowledge of the country populations, formative research and pre-testing will help to guide the messages you use. Some basic guidance specific to HPV vaccine includes the following:

■ **A CANCER VACCINE** – In general, countries refer to the HPV vaccine as a “**cancer vaccine**”, rather than a vaccine against a sexually transmitted infection. This is sensible for many reasons. For one, people will know and fear cancer more than HPV (which they may have never heard about). If the perceived benefit is to prevent a cancer, the vaccine will probably pique more interest and demand. Secondly, the nomenclature is accurate as the main purpose of the vaccine from a public health standpoint is to prevent cervical cancer. Third, reference to a “cancer vaccine” may diminish concerns that the vaccine is linked to increased sexual activity or fertility.

ONE CAUTION – The biology of HPV, its sexually related route of transmission and link to cervical cancer is an inevitable message that must be explained. This is important as there is often a mistaken belief that “my daughter is too young to be having sex” and she therefore should not be vaccinated.¹⁰ All caregivers (and health workers) need to understand that the vaccine will be most effective if administered **before sexual activity begins**. This message requires different levels of sophistication depending on the audience. The explanation can be factual and straightforward and should stress, for example, that **the vast majority of the population will become infected with HPV** and that some of these infections will develop into cervical cancer. This is a key message that can be delivered by a trusted, well known national health practitioner. The message that you are protecting girls today from a virus that could cause cancer in the future could be one way to explain this. So while the headline message describes a cervical cancer vaccine, sub-messages should explain the risk and prevalence of HPV, and the reasons why girls should get the vaccine before they are sexually active.

■ **THREE DOSES** – WHO recommends¹¹ that HPV vaccine be delivered as a three-dose schedule within six months. As drop-out is a risk, it is important to stress in messaging to girls, caregivers,

10. A study of 1398 girls published in *Pediatrics* in October 2012 found there was no increase in sexual activity among girls who had been vaccinated against HPV. See: HPV vaccination does not change sexual behaviors in teens. *Pediatrics Journal Watch*, 2012, 2012:1031-5.

11. For latest WHO recommendations, please check the WHO web site: http://www.who.int/immunization/policy/immunization_tables/en/index.html.

health workers, teachers, community leaders and other relevant audiences that girls require three doses for the vaccine to confer sufficient long-term protection.

■ **EVIDENCE** – People have many questions about HPV vaccine. Evidence from research and country experience can help to engage and convince people. Different kinds of evidence will appeal to different groups. Families may need basic information about cervical cancer and vaccine safety, whereas more senior leaders and decision-makers may need to know more about the cost-benefit or want more detailed scientific information.

- Provide basic evidence about the **cervical cancer incidence** in the country and why it is important (e.g. cervical cancer is one of the top (#) cancers affecting women. Cervical cancer will affect 1 of every # women in our country. It is a deadly disease that causes # deaths each year. We now have a vaccine that can protect women against most cervical cancer).
- Evidence about **cost-benefit** of introducing the vaccine is also important and convinces health practitioners about the merits of the vaccine, versus using cervical cancer screening alone. Remember that a gynaecologist may only see a handful of cervical cancer cases during the course of his or her practice, and to them individually, the HPV vaccine may not seem necessary.
- Evidence about **HPV prevalence**.
- Evidence about **vaccine safety** (for example, that it is approved and licensed by the national authorities and recommended by WHO) and evidence from studies demonstrating the vaccine is safe.
- Evidence **from other countries**: People in many countries really want to know “what is happening” with HPV vaccine in other countries. Therefore, provide information about the number of countries using HPV vaccine (and judge whether populations will be more motivated by the fact it is being used in Western countries, in neighbouring countries or both), the safety record in other countries and studies showing the safety and benefits of HPV vaccine from countries which introduced the vaccine several years ago.¹²

■ **TESTIMONIALS** – People like to see and hear other people’s experience. A short testimonial from a mother, for example, about why she chose to protect her daughter helps other mothers relate to someone advocating for HPV vaccine. A testimonial from a famous actress who has vaccinated her daughters could also be effective. Trusted national leaders, gynaecologists or other experts could also offer effective testimonials. These could be used in pamphlets, in television or radio broadcasts.

12. WHO has prepared vaccine information sheets with the observed rates of vaccine reactions, including for HPV vaccine. They are available here: http://www.who.int/vaccine_safety/initiative/tools/vaccinfosheets/en/index.html



Multicultural Malaysia, messages and mixed media

Malaysia had a host of factors to consider when it prepared its HPV vaccine communication plan.

Malaysian citizens include ethnic Malays, Indians, Chinese and other communities who speak different languages and use different media in daily life. “Some groups read the newspaper more” the head of public health communication said, “while others watch more television, so we have to tailor materials to all of these groups in the different languages and channel them in different ways.”

Malaysia produced materials in four languages and ensured portrayal of different ethnicities. The Ministry of Health media buys strategically targeted the radio programmes, newspapers and television shows preferred by different groups. They also tailored more materials for girls including upbeat, fun designs and used social media sites like Twitter and Facebook to engage girls and answer their questions. The Ministry also publishes HPV vaccine materials on its web site, where they can be downloaded and reprinted. Malaysian HPV vaccine materials also pictorially show the pathway of HPV to

the cervix and where it causes cancer. When asked in a survey, about 7 in 10 rural girls identified “sexual activity” as the source of HPV.

In summary, Malaysia knew its population’s cultures, languages and media preferences very well, and tailored material to different groups. Malaysia also presented factual information about HPV and cervical cancer so that the population had a basic understanding of how HPV was transmitted and why the vaccine should be given to girls before they were sexually active.

Kesan Sampingan
 Pelikan ini adalah selamat.
 Seperti pelikan lain, anda mungkin mengalami sakit atau bengkak di tempat suntikan.
 Sekiranya, anda mengalami masalah lain akibat suntikan, iba dipanggil rawatan cecairan di klinik atau hospital yang berdekatan.

Kadangan yang Tidak Membenarkan Anda Menerima Pelalian
 Anda tidak akan diberi pelalian atau suntikan sekiranya:
 - Anda mengalami kecacatan yang menghalang anda menerima suntikan.
 - Anda mengalami demam atau penyakit yang serius di hospital.
 - Anda hamil.

Peranan Anda
 Partikan anda berfikir dengan baik untuk pelikan kepada ibu bapa dengan segera.
 Dapatkan pengetahuan terkini dari ibu bapa pelikan untuk memastikan anda menerima pelikan yang selamat.

Terlepas Tarikh Temujanji
 Jika anda tidak hadir atau tidak hadir ke sekolah pada hari pelikan, tarikh temujanji baru akan diberi oleh anggota kesihatan.

Maklumat Tambahan
 Maklumat tambahan berkaitan pelikan HPV boleh didapati melalui:
 - Doktor atau anggota kesihatan di sekolah atau di klinik.
 - Laman www.moh.gov.my atau www.moh.gov.my

13
 pg td dah suntik HPV ok je..

CEGAH KANSER SERVIK MELALUI PELALIAN HPV

■ **SIDE EFFECTS** – An HPV vaccine injection, like almost any intramuscular injection, will have some mild side effects. Girls, parents, health workers and teachers should be aware of the common side effects so they know that these are normal. Journalists should be briefed on these as well, to reduce the risk they will misreport on AEFI issues. These groups also need to know when girls should see a health practitioner. Depending on the setting, this kind of information can be told to girls verbally but should be available in a question-and-answer document for health staff and teachers. In Malaysia, for example, every consent form sent home to parents included an AEFI checklist so that parents could report even mild AEFIs to the health system.

■ **INTEGRATED WITH CERVICAL CANCER SCREENING** – Countries with cervical cancer screening can produce integrated cervical cancer prevention messages. Messages can encourage both girls and their mothers to take action to prevent cervical cancer. An example would be a campaign that reads, “Girls – get immunized! Women – get screened!”

■ **INTEGRATED WITH ADOLESCENT HEALTH** – Countries offering adolescent health programming – whether national programmes or those offered at sub-national levels in schools, youth centres or through youth associations – can consider including HPV vaccine messages in their adolescent health education materials as a key intervention for better health.

Materials and channels

Countries will know which materials and channels work best. In addition to the guidance offered in the first section of this document, HPV vaccine-specific guidance includes the following:

- **Keep materials clean and simple.**
- **Use every opportunity:** Messages can be printed, for example, on the back of the girls’ immunization card. The Minister of Health can talk about HPV vaccine in speeches about maternal and child health. Perhaps a short message can be given in a concert by a singer popular with adolescent girls. Think through all opportunities to include HPV vaccine and cervical cancer messages.
- Produce a long, standard **frequently asked questions (FAQ) reference guide** – with every question you can think of, including challenging questions. Use this as the basis for shorter printed FAQs for different audiences including health workers (for their

training and as a reference), journalists, professional associations, etc. Use it also as the basis for talking points for speeches and media interviews. Note that WHO plans to provide a basic FAQ you can draw from.

- **Girls just want to have fun:** Think of ways to reach girls with language and materials they can relate to and have fun with. Materials that are colourful with modern designs will attract girls' attention. What games or entertainers are popular with girls? Can they be integrated into the designs? In countries where text messaging is common, there may be opportunities for text-based quizzes and games if you collaborate with the mobile phone service provider.
- **Hotlines:** Some countries have experience setting up phone hotlines so that girls, parents and other audiences can call and ask questions. This can be an effective way for people to have a real conversation with an expert about HPV vaccine. If you do set up a hotline, consider the resource implications – you will need enough knowledgeable operators to answer questions over a defined period of time.
- **A mix of channels is important:** Girls cite multiple sources of information, including radio and television, school, health workers and church. Do not rely on any single source. Radio and television are often cited most as sources of information.
- **Hard-to-reach girls may be found in both urban and rural areas:** When planning for hard-to-reach girls, consider those in large, densely populated cities who may need to be reached via television, peers and their parents, as well as those in remote areas, nomadic communities or girls affected by humanitarian crises.
- **The Internet and social media:** Use of these mediums will completely depend on the country setting. Where access to social media is high, countries might consider setting up a Facebook or Twitter account devoted to adolescent health, including HPV vaccine. These are resource-intensive activities, however, and require almost daily monitoring and updates. If the social media environment is highly accessible, this can be considered. Countries with good Internet access should also consider dedicating a web site to HPV vaccine (or to the vaccination programme in general) where any audience can access evidence-based information, materials and FAQs. Provided this is kept updated (e.g. checked quarterly), this site can be a reliable source of information.



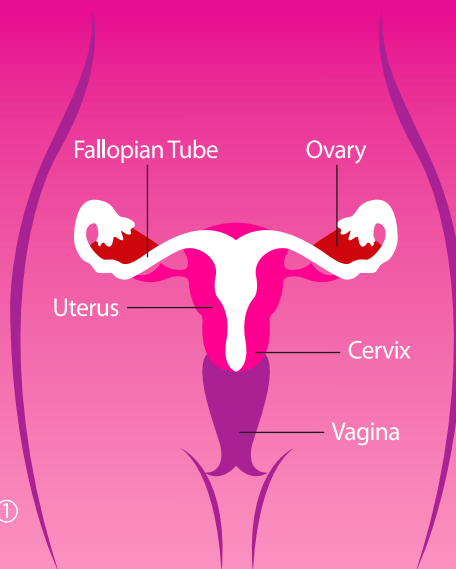
WHAT IS CERVICAL CANCER ?

Cervical cancer occurs at the entrance of the womb (cervix).

It is the third most common cancer among women following breast cancer and colorectal cancer.

In Malaysia, around 1,500 women are diagnosed with cervical cancer annually.

Cervical cancer accounts for 6% of deaths due to cancer among women. ①

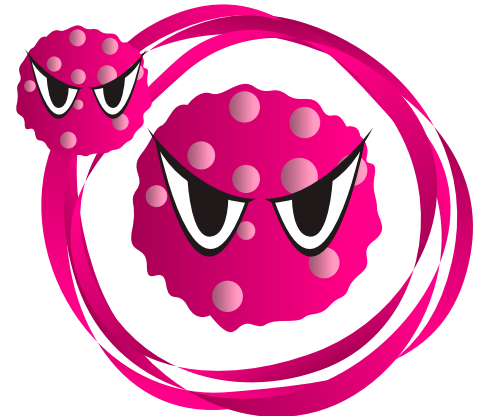


① National Cancer Registry, 2006.

WHAT IS HUMAN PAPILLOMAVIRUS (HPV) ?

HPV is the main cause of cervical cancer.

Every married woman is at risk of HPV infection.



WHAT IS HPV IMMUNISATION ?

HPV Immunisation prevents cervical cancer caused by HPV infections.

Three injections will be given on the upper arm over a six month period as shown in the table:

- | | |
|-------------------------|---|
| First Injection | – The date set for HPV immunisation in school or at the clinics |
| Second Injection | – One month after the first injection |
| Third Injection | – Six months after the first injection |

The vaccine is not made from any dubious source.



Conclusion

Cervical cancer, caused by sexually transmitted HPV, is the second most common cancer in women worldwide and results in about 274 000 deaths each year. Due to poor access to screening and treatment services, more than 85% of deaths occur in women living in low- and middle-income countries.

HPV vaccine is a WHO-recommended intervention, and together with cervical cancer screening and treatment may dramatically reduce the death and illness caused by cervical cancer. The vaccine is being introduced in an increasing number of countries, and millions more girls could be fully immunized by the end of this decade.

As described in this report, HPV vaccine is unique and requires careful thought and investment in communication. A successful HPV vaccine communication plan requires teams to start early, to expect a few challenges, to adjust as necessary and to persist well beyond HPV vaccine introduction. It will cost some money, and it will be a lot of work.

Experience shows that countries can achieve high coverage with HPV vaccine in this decade, and good communication can help to achieve that. The goal of an HPV vaccination programme is for high coverage to lead to reduction in cervical cancer and improvement in the health and lives of women for generations to come.



HPV Vaccine Communication

SUMMARY



Planning and considerations for HPV vaccine

Communication is:

- **A PROCESS.** People need time to learn, absorb and confirm information, and then make a decision and act on it.
- **ABOUT COMMUNITY ENGAGEMENT.** It is a conversation and not a lecture.
- **ABOUT EQUITY.** It plans to reach harder-to-reach populations.
- **AN INVESTMENT.** Effective communication activities will cost money and time. The return on investment is improved immunization coverage and improvement in the health and lives of women.
- **IMPERFECT.** Communication involves human beings, and we cannot predict what people will think or do in every situation.

Remember, HPV vaccine is different

- **START EARLY.** This is not a routine communication programme. Early planning leaves time for formative research and can lead to on-time implementation.
- **BUILD A CROSS-SECTORAL TEAM.** HPV vaccine introduction involves immunization, cancer, sexual and reproductive health, adolescent health, education, youth and professional associations.
- **CONDUCT FORMATIVE RESEARCH.** Because HPV vaccine is new, this is the only way to understand how people will feel and act.
- **PLAN FOR A MULTI-YEAR EFFORT.** It will take time for HPV vaccine to “settle” in and be accepted as part of a routine programme.
- **THERE WILL BE CONCERNS.** HPV vaccine is new; it is targeted at adolescent girls; it may not seem like a priority.
- **IDENTIFY GROUPS THAT MAY HAVE CONCERNS.** Ensure advocacy plans for them.
- **UNDERSTAND AND PLAN FOR HARD-TO-REACH GIRLS.** Who and where are these girls? They may have the least access to cervical cancer screening even when it is available in the country.
- **THE FIRST YEAR WILL HAVE SOME CHALLENGES.** It is a new programme and there will be bumps, but...
- **HIGH COVERAGE CAN BE ACHIEVED.** HPV vaccine will save lives. Communication has been key to high coverage in countries with successful programmes.

Key elements

See the table on the following pages.

What	Why	How / What
1. Communication team	<ul style="list-style-type: none"> Communicating an important national programme that needs multisectoral support. Engagement with communities is a job for a team, not one person. 	Include communication experts from the government sectors involved in cervical cancer prevention and control, as well as other relevant partners.
2. Programme objectives	<ul style="list-style-type: none"> Clear programme objectives set the stage for communication planning. They describe the target population, the target coverage, the strategy and the timeline for completion. 	Agreed by the Inter-country coordination team or other oversight body.
3. Situation Analysis	<ul style="list-style-type: none"> Understanding your audiences will help to design a strategic communication plan that uses resources most effectively. 	<ul style="list-style-type: none"> Use existing knowledge (about populations and health, including immunization). Conduct formative research using focus groups, key informant interviews and ideally surveys to get a baseline regarding knowledge, attitudes, behaviours and practices for cervical cancer, vaccination, HPV and HPV vaccine.
4. SMART Objectives	<ul style="list-style-type: none"> Will help to prioritise activities and develop the most effective communication strategy. Will allow you to measure the outcomes. 	<ul style="list-style-type: none"> Use the situation analysis to prioritize activities that will get the best results.
5. Target Audiences	<ul style="list-style-type: none"> The more specific your target audience, the more you can focus efforts and activities. An HPV vaccine programme has different audiences. They may be more suspicious or have more questions about HPV vaccine. It is a new vaccine and new set of issues for everyone including health workers. Audiences who do not understand HPV vaccine may derail the programme (e.g. media, religious organizations). The education sector will likely be part of the delivery strategy and therefore needs to be well-informed. Integrate training where community health workers, headmasters and teachers can learn together. 	<ul style="list-style-type: none"> Target-age girls (in school, out-of-school, hard-to-reach). Caregivers in immediate and extended family. Headmasters and teachers. Health workers. Professional (e.g. ob/gyns), cultural (e.g. youth, women) and religious associations. Media.
6. Messages for each audience	<ul style="list-style-type: none"> Different groups will need and respond to different kinds of information. People want evidence. 	<ul style="list-style-type: none"> Test your messages with audiences. Calling it "a cancer vaccine" can be effective.

What	Why	How / What
6. Messages for each audience <i>continued</i>	<ul style="list-style-type: none"> – Health workers will appreciate more in-depth information. – Health professional associations may need to be convinced about the cost-benefit. – People may worry about safety because it is a new vaccine. 	<ul style="list-style-type: none"> – CAUTION – People still need to know the way HPV is transmitted, that the vaccine is required before sexual activity begins and that it will not be as effective in older women who have probably already been infected with HPV. – Requires three doses within six months. – Use evidence including: <ul style="list-style-type: none"> • cervical cancer incidence, • HPV prevalence, • cost-benefit of introduction, • vaccine safety, track record, and • evidence about use in other countries. – Provide testimonials. – Be open about common side-effects and what girls should do, and they should seek medical help. – Integrate messages with cervical cancer screening. – Integrate messages with adolescent health education. – Be sure the message includes a call to action.
7. Strategies, activities and channels	<ul style="list-style-type: none"> – Different audiences will respond to different strategies. Advocacy may be necessary for some, whereas media, interpersonal communication, social mobilization or a combination will be necessary for others. – Girls will likely receive information from very different sources than mothers, health workers or other audiences. 	<ul style="list-style-type: none"> – Selecting sources and channels people trust is critical. – Many audiences will respond to the messages if delivered by different trusted sources and reinforced through a mix of channels such as a trusted national leader, a popular radio programme and the community health worker or midwife. – Different communities may respond to different types of sources and channels, such as different types of community leaders or different radio stations. – As the main target audience is girls, package their messages in ways that will appeal to them (fun SMS text messages, Internet or social media where available). – Think through strategies to reach urban girls, who are bombarded with many messages every day. – Some countries have successfully used telephone hotlines to answer community questions.
8. Materials	<ul style="list-style-type: none"> – Materials include an advocacy presentation with a lot of data and evidence, to simple posters and T-shirts, banners, radio announcements, drama scripts, leaflets, cartoon books, text messages and training materials. 	<ul style="list-style-type: none"> – Keep materials simple with the main messages easy to read and absorb. – Use every opportunity – print messages, for example, on the back of the girls' immunization card if they take these home.

What	Why	How / What
8. Materials <i>continued</i>		<ul style="list-style-type: none"> – Mutually reinforcing messages by trusted community leaders, teachers, health workers and religious leaders can have excellent results. – Produce a comprehensive “frequently asked questions” document that you can use respond to all questions. Update this as you hear more questions. – Translate materials into local languages. – If you are printing materials, ensure a distribution plan.
9. Risk communication plan	<ul style="list-style-type: none"> – There is a chance that any adverse event associated in time and place with HPV vaccine will be wrongly associated with the vaccine. – There is a heightened risk of adverse events following immunization (AEFI) during a campaign because of the large number of injections being given in a short period of time. – Target-age girls can be prone to fainting. – A badly handled event can lead to the rapid spread of misinformation and have a long-term impact on your immunization programme. 	<p>Elements of the plan include:</p> <ul style="list-style-type: none"> – standard operating procedures for handling the situation ; – description of how and when investigations will occur; – description of how and when information and updates are communicated; – authorized spokespeople; – contact lists internally, for media, partners; – strategies to communicate with different stakeholders; – funding; and – consensus on the plan amongst key players.
10. Monitoring and evaluation plan	<ul style="list-style-type: none"> – Allows you to track progress and make adjustments during the course of the programme. – Allows you to demonstrate the value of the investment in communication. – An evaluation can help to improve the programme in future in your country and other countries. 	<ul style="list-style-type: none"> – A baseline can be established from the situation analysis. – Set targets, milestones and indicators. – Determine how to measure progress – whether through mini surveys, in-process monitoring, post-introduction evaluation, focus groups, national surveys or a combination. – Integrate some communication monitoring with the larger HPV vaccine programme monitoring.
11. A work plan with budget	<ul style="list-style-type: none"> – Any plan requires a detailed work plan. 	<ul style="list-style-type: none"> – Assign tasks to specific individuals and give deadlines. – Determine the cost for the plan. – Ensure the budget is available early. The best plans are only a document without resources for implementation.
12. Adjust the work plan as required	<ul style="list-style-type: none"> – Communication is a continuous process involving human beings. 	<ul style="list-style-type: none"> – Use monitoring to determine what is working and what is not. – If an activity is not working as anticipated, stop or adjust it. – Be alert to rumours or misinformation and act rapidly to correct. – Continue to invest in communication for HPV vaccine for several years until it is fully “normalized” in the national immunization programme.

Materials and resources

Samples of materials

The following are examples of HPV vaccine communication material produced in Malaysia, Rwanda and Latvia.



Examples of HPV vaccine web sites with sample materials

- Australia's HPV vaccine page: <http://hvp.health.gov.au/>
- The Canadian provincial government of British Colombia uses videos, including testimonials and quick facts: <http://immunizebc.ca/diseases-vaccinations/hpv>
- Malaysia has made all of its HPV vaccine communication materials available for download at: <http://www.myhealth.gov.my/>



 **IMMUNISE AUSTRALIA** <http://immunise.health.gov.au>
A joint Australian, State and Territory Government initiative

HPV and me
my health, my future

Comic book for young men and women
An HPV vaccination comic book for Aboriginal Torres Strait Islander young men and women is now available.

Vaccinating against Human Papillomavirus (HPV) is the best way to prevent HPV-related cancers and disease. The HPV vaccine is being provided free in schools as part of the National Immunisation Program.

From February 2013, males aged 12-13 years can take part in the school-based national Human Papillomavirus (HPV) vaccination program. Males aged 14-15 years will also be able to receive the vaccine through a catch-up program in 2013 and 2014. Females aged 12-13 years will continue to be able to receive the vaccine at school.

This site provides information, answers to common questions and a range of downloadable resources about the HPV school-based vaccination program for parents, students and health professionals.

Resources

- WHO's HPV Vaccine Introduction Clearinghouse: <http://www.who.int/immunization/hpv/en/>
- KaiserEDU.org summarizes key, mainly U.S.-based research on HPV vaccine, including on outreach and public awareness.
<http://www.kaiseredu.org/Issue-Modules/HPV-Vaccines-and-Cancer-in-the-US/Policy-Research.aspx>
- GAVI Alliance Partner's Forum, November 2012, Session Summary: *HPV vaccination and best practices in reaching adolescent girls*
<http://www.gavialliance.org/library/pf2012-sessions/10-%E2%80%9393-hpv-vaccination-and-best-practices-in-reaching-adolescent-girls/>
- Cervical Cancer Action (www.CervicalCancerAction.org) publishes a global progress report about cervical cancer prevention in English, French and Spanish.
- RHO Cervical Cancer (www.rho.org) is a resource web site aimed at decision makers and programme planners in low-resource settings. It provides several resources on HPV vaccine communications planning and lessons, including:
 - “Accessing Community Readiness”, a resource guide to conduct formative research for HPV vaccine programme planning
 - Lessons from an HPV vaccine pilot project in Peru
 - Lessons from an HPV vaccine pilot project in Uganda
- PATH has developed advice on conducting formative research for HPV vaccine introduction: *Conducting formative research for HPV vaccine programme planning: practical experience from PATH* (2012)
<http://www.path.org/publications/detail.php?i=2241>
- UNICEF has published a set of guides on planning, monitoring and evaluating communication activities here:
http://www.unicef.org/cbsc/index_43099.html
- *A guide for developing knowledge, attitude and practice surveys* from WHO/Stop TB Partnership provides a step-by-step guide to conduct a KAP survey. While the examples are most relevant to tuberculosis control, the steps are relevant to undertaking any KAP survey about a public health topic.
http://whqlibdoc.who.int/publications/2008/9789241596176_eng.pdf
- *The Pink Book: Making Health Communication Programs Work* is a guide developed by the American National Cancer Institute. <http://www.cancer.gov/cancertopics/cancerlibrary/pinkbook/page1>
- Johns Hopkins University Center for Communication Programs offers links to communication planning resources.
<http://www.jhuccp.org/>
- *Health Communication: from Theory to Practice* by Renata Schiavo (2007) clearly explains communications theories and approaches, and provides guidance for planning. <http://www.ihepsa.ir/files/h2.pdf>

