HAPPI
PARTNERSHIP FOR ACCELERATING HPV VACCINATION

Evidence-based summary of lessons learned in HPV vaccine program implementation in LMICs:

PREPARATIONS

A review of diverse program implementation experiences globally shows remarkable consistency in lessons learned to effectively plan and prepare for national HPV vaccine introduction.

CREATING THE ENABLING ENVIRONMENTS

Successfully introducing and sustaining an HPV vaccine program requires political will and leadership from, and integration into, the existing National Immunization Program (NIP). Program introduction also requires significant, early input and buy-in from other lead agencies, including ministries of health (MOH), education (MOE), and finance (MOF), and the ecosystem of health care stakeholders (e.g., those working in cancer control, non-communicable diseases, family and women's health, and adolescent health). A broad coalition engaged at the highest levels and across policy portfolios maximizes the chance of program success by demonstrating consistent leadership and intent.

Additional momentum and support for the program can be created by engaging early with relevant non-governmental and external stakeholders at both the national and sub-national levels, e.g., health, community, and religious advocates, leaders and influencers. Clear communication with community and religious leaders, schools, health workers, communities, parents, and girls should inform them of key program parameters and plans to garner community buy-in.

COORDINATION

A high-level working group is necessary for working with national stakeholders to comprehensively plan and maintain the program, with NIP leading key implementation activities. Another advantage of strong intersectoral leadership is the potential to leverage and increase resources beyond the health sector budget. A successful working relationship between MOH and MOE is pivotal for any effective HPV vaccine delivery at schools.

MICROPLANNING

Once central leadership is established, momentum and coordination need to be replicated at the subnational and local levels to undertake detailed microplanning. The MOH and MOE should jointly conduct microplanning, including schools, prior to vaccinations. National microplanning will involve the development of an implementation plan (including "delivery strategy"), communication plan, crisis communication plan, AEFI monitoring plan, logistics plan, and data recording and reporting procedures. These activities will include creation of HPV data collection recording and reporting forms and updates to electronic systems for routine vaccines to include HPV vaccination data. Regular monitoring of the progress of preparatory activities at the national, subnational, and local levels should occur centrally (e.g., facilitated by regular meetings, dashboards, and checklists). Delays are common and should be anticipated; however, maintaining momentum and providing consistent, clear updates to local teams remains essential throughout the process.

TRAINING

Training for health care workers and other implementers, including school staff and health communicators/health promotion/health education staff, should be planned and prepared using adult learning techniques, e.g., interactive hands-on activities and experiential learning. Cascade training is frequently used and can be successful, but it requires regular refreshers and ongoing sessions for both new and existing staff. All training should specifically include strategies to respond to vaccine hesitancy. Ensure training materials are prepared and training scheduled in a timely manner ahead of the program launch or any vaccine delivery.

ENABLERS	
✓	Coordination between health and education sectors at all levels
✓	Detailed microplanning at all levels
✓	Early planning
✓	Strong political commitment
✓	Buy-in from all stakeholders and good coordination among ministries and partners
✓	Leveraging preexisting trust in vaccination programs/school-based health program
✓	Training for all pertinent actors in advance of vaccine implementation
✓	Microplanning and communication techniques for addressing vaccine hesitancy in training
✓	Refresher trainings prior to second dose, if applicable
✓	Clear plan for vaccine delivery strategy and articulation of eligibility
✓	Plans to reach out-of-school girls who missed vaccinations at school
✓	Plan mop-up vaccination activities for girls missed and to increase vaccine uptake
✓	Prioritization of MOH/MOE MOU sign-off and funding to ensure timely program planning and launch
✓	Early vaccine procurement, distribution, and logistics with other planning activities
✓	On-time funding to lower levels during planning to facilitate resource availability for implementation
✓	Strong enabling environment for coordinated, timely action
✓	Official notification of support from MOE cascading to lower education levels
✓	Plans for vaccination services at private schools
✓	Plans for logistical challenges with integration with other programs

OBSTACLES	
X	Poor political commitment / leadership
X	Lack of coordination between stakeholders
X	Funding and procurement delays, which impacts availability of resources and vaccines in facilities
X	Poorly developed introduction plans, especially at local levels. Poor planning is strongly correlated with lower coverage.
X	Unclear or changing eligibility criteria
X	Delayed vaccine procurement and/or delayed distribution of funds, vaccines, and materials
X	Public expression of concerns about vaccine introduction by medical associations
X	Unaddressed anti-vaccine sentiments
X	Insufficient training/sensitization of all pertinent actors, especially school staff and relevant health care specialists (e.g., gynecologists)
X	No refresher training in response to staff turnover or new staff at health facilities.
X	Combining training with trainings on other vaccines, which results in less time spent on HPV
X	Misalignment with school calendar, e.g., exam periods or holidays, for school-based delivery

A comprehensive list of references can be found in a separate document, available here.

This brief summarizes new evidence building on a comprehensive review of HPV vaccine delivery experiences across 46 low- and middle-income countries, published in 2016 by PATH and the London School of Hygiene & Tropical Medicine. The updated brief was developed by the HPV Vaccine Acceleration Program Partners Initiative (HAPPI) Consortium and may be used freely. The HAPPI Consortium is managed by JSI together with our partners Clinton Health Access Initiative (CHAI), the International Vaccine Access Center (IVAC) at the Johns Hopkins Bloomberg School of Public Health, Jhpiego, and PATH.