**Tanzania HPV VACCINE INTRODUCTION**

Generating and Sustaining Community Demand

**Rolling Advocacy Communication and Social Mobilisation Strategy**

**April 2018**

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# **Acronyms**

**ACSM** Advocacy Communication and Social Mobilisation

**AEFI**  Adverse Events Following Immunisation

**CDC** Centre for Disease Control (United States)

**CHAI** Clinton Health Access Initiative

**CHW**  Community Health Worker

**cYMP** Comprehensive Multi-Year Plan

**DHMT** District Health Management Team

**DHPO** District Health Promotion Officer

**DIVO** District Immunization and Vaccines Officer

**DMO** District Medical Officer

**DRCHCO** District Reproductive and Child Health Coordinator

**EVM** Effective Vaccine Management

**FAQs** Frequently Asked Questions

**GAVI** Global Alliance, Vaccines and Immunisation

**GoT** Government of Tanzania

**HPU** Health Promotion Unit (MOHCDGEC)

**HPV** Human Papillomavirus

**ICC**  Inter-Agency Coordinating Committee

**IEC** Information Education and Communication

**IVDP**  Immunisation and Vaccine Development Programme (MOHCDGEC)

**KAP**  Knowledge Attitude and Practice

**MAC** Multi-Age Cohort

**MEWATA** Medical Women’s Association of Tanzania

**M&E**  Monitoring and Evaluation

**MOEVT** Ministry of Education and Vocational Training

**MOF**  Ministry of Finance

**MOHCDGEC** Ministry of Health, Community Development, Gender, Elderly and Children

**MR2** Measles and Rubella 2nd Dose

**OOS**  Out of School

**PCV** Pneumococcal Conjugate Vaccine

**PIE**  Post Introduction Evaluation

**PORALG** President’s Office, Regional and Local Government

**RHMT** Regional Health Management Team

**RHPO** Regional Health Promotion Officer

**RI**  Routine Immunisation

**RIVO** Regional Immunisation and Vaccines Officer

**RMO**  Regional Medical Officer

**RRCHCO** Regional Reproductive and Child Health Coordinator

**SAC**  Single-Age Cohort

**SOPs**  Standard Operating Procedures

**TCRA**  Tanzania Communications Regulatory Authority

**TDHS** Tanzania Demographic and Health Survey (2015)

**TNRA**  Tanzania National Regulatory Authority

**TV** Television

**UNICEF** United Nations Children’s Fund

**USAID** United States Agency for International Development

**VEO** Village Executive Officer

**VHC** Village Health Committee

**WDC** Ward Development Committee

**WEO** Ward Executive Officer

**WHO** World Health Organisation

**WQ** Wealth Quintile

# **Foreword**

**TBC.**

# **Executive Summary**

This Rolling Strategy has been developed to guide the design, implementation, and monitoring and evaluation of Advocacy Communication and Social Mobilisation interventions in support of HPV vaccine introduction in Tanzania. The strategy is focused on priorities for the 12 months from May 2018 to April 2019 and is intended for use by implementing partners at the National, Regional and District/Council level.

The Strategy has been developed in in consultation with the Ministry of Health, Community Development, Gender, Elderly and Children, and with HPV partners represented in the Immunisation and Vaccine Development Programme, Technical Working Group.

Experience from the 2014 HPV Demonstration in Kilimanjaro Region, and from HPV vaccine introductions in other African countries suggest several key communications challenges will need to be addressed in Tanzania. These include:

* Limited awareness of HPV vaccine benefits and efficacy among poor and geographically isolated communities, and within households with lower levels of education.
* The potential for negative rumours and HPV vaccine misconceptions to circulate/escalate and undermine community trust and optimal coverage.
* Potential confusion about HPV vaccination eligibility criteria and dose schedules (within the community and among health workers and teachers).
* Ensuring sufficient attention is paid to the potential difficulties of tracing, registering and sensitising out-of-school eligible girls on the benefits and efficacy of the HPV vaccine.
* Vaccine supply shortages and stock-outs and the potential impact this may have on public confidence in the HPV vaccine; and
* Inadequate prioritisation of *strategic* communications planning and resource mobilisation by HPV vaccine introduction partners.

To address these challenges, the Strategy proposes a judicious and synergistic mix of advocacy, communication and social mobilisation interventions that will *– if effectively planned and implemented –* contribute to achieving optimal HPV vaccination coverage among eligible girls, and community trust in the HPV vaccine.

The Strategy reviews available evidence on community awareness in relation to cervical cancer and the HPV vaccine; assess the potentials of key communication channels; analyses key audience information needs at the primary, secondary and tertiary levels; and, proposes the key communication approaches and interventions needed to maximise vaccination coverage, and to freeze out rumours and misconceptions. Also emphasised is the importance of developing local strategies for reaching out-of-school girls, and the need to ensure sustained demand for the HPV vaccine.

The Strategy contains a Rolling Action Plan designed to allow regular updating and revision by HPV vaccine introduction partners, and the Immunisation Technical Working Group and its Advocacy, Communication and Social Mobilisation Sub-Committee.

The strategy also contains guidance on monitoring, evaluation and supervision, including proposed indicators, a Regional and District level social mobilisation checklist and suggested modalities and tools for active supervision. Key evaluation steps are proposed and include mid-term and annual reviews at 6 and 12 months intervals and post-introduction surveys to assess the effectiveness of communication and social mobilisation activities; and, to inform future strategic adjustments for strengthened planning and implementation.

# **1: Introduction**

This Rolling Advocacy, Communication and Social Mobilisation (ACSM) Strategy *(the Strategy)* has been prepared to support the successful 3-year introduction of Human Papillomavirus (HPV) Vaccine into Tanzania’s Routine Immunisation (RI) System, commencing 23 April 2018. It provides guidance on generating and sustaining public and institutional demand for *(and trust in)* the HPV vaccine; and, on how communications challenges arising before, during and after HPV vaccine introduction can be addressed. The Strategy is intended to guide the ACSM work of all HPV vaccine introduction partners at the National, Regional and District/Council levels over the coming three years (2018 – 2020), with a specific focus on the 12 months from May 2018 to April 2019.

The Strategy is linked to the Government of Tanzania (GoT), Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC), Immunization and Vaccine Development Programme (IVDP), 2017 HPV Vaccine Introduction Plan; the 2016 – 2020 MOHCDGEC National Communication Strategy for Routine Immunisation; and, the MOHCDGEC Community Health Programme. It also reflects key accountabilities and modalities for ACSM detailed in the MOHCDGEC/IVDP 2018 HPV Vaccine Introduction Guidelines.

The Strategy is informed by evidence from a variety of sources, including: lessons from a HPV vaccine demonstration in the Kilimanjaro region in 2014 and related coverage data; knowledge attitude and practice (KAP) data collected in 2013 to inform the introduction of pneumococcal and rotavirus vaccines; the 2015 Effective Vaccine Management (EVM) Assessment for Tanzania; the 2015 Tanzania Demographic and Health Survey (TDHS); and, documented global and regional evidence relating to HPV vaccine introduction in other countries. The Strategy is also informed and guided by consultations with the MOHCDGEC Health Promotion Unit (HPU), the IVDP Technical Working Group and HPV vaccine introduction partners in Tanzania. [[1]](#footnote-1)

This Strategy defines clear communications actions and accountabilities essential for successful HPV vaccine introduction and for the sustainable inclusion of the vaccine within Tanzania’s RI schedule.

However, importantly, the Strategy is intended to function as a ‘living’ document that can be updated and revised to reflect shifting circumstances, priorities and/or management and coordination arrangements.

The Strategy narrative describes the background and rational for HPV vaccine introduction in Tanzania; key programme and ACSM objectives; and, management and implementation arrangements. It also assesses public awareness of cervical cancer and the HPV vaccine; trust in vaccination services; and, key HPV vaccine introduction audiences and their information needs. The Strategy narrative then details key communications interventions required at the national, regional and district/council levels; provides guidance on risk communication and ensuring sustained demand; and, proposes modalities for monitoring and evaluation.

In addition, the Strategy contains as Annexes an ACSM Risk Analysis(Annex A); a description of key ACSM products and related priorities (Annex B); a rolling *‘real-time’* action plan which illustrates the status of recommended communications activities (Annex C); a Regional and District Level ACSM checklist (Annex D); and, a proposal for the engagement of Regional and District Level Health Promotion Officers for strengthened sub-national social mobilisation (Special Annex).

# **2: Background and Rationale for HPV Vaccine Introduction**

## ***2.1. Burden of Cervical Cancer***

In Tanzania, cervical cancer *(a preventable disease)* is the number one cause of women’s morbidity and mortality. Tanzania also has the highest incidence of cervical cancer in East Africa.

Evidence presented in the 2017 HPV Introduction Plan and the United Republic of Tanzania, Human Papillomavirus and Related Diseases Report[[2]](#footnote-2) clearly illustrates the acute burden of cervical cancer in Tanzania: The data show:

* 15.9 million Tanzanian women over the age of 15 are at risk of cervical cancer
* 7305 annual cases, and 4216 deaths
* Over the past 5 years, 80% of women with cervical cancer cases presented at an advanced stage and of those, only 1 in 5 survive
* 35,000 cases of cervical cancer each year

## ***2.2. Prevention of Cervical Cancer***

Access to preventive screening services for cervical cancer *(early detection and the treatment of pre-cancerous lesions before they progress to cervical cancer)* is improving in Tanzania but remains restricted for poor and/or rural women. Accessing treatment is also a major challenge for women with advanced cervical cancer.

Infection with the human papillomavirus is recognised as a major cause of cervical cancer. Fortunately, infection with HPV types 16 and 18 – *the cause of some 70% of all cervical cancers –* can be prevented by vaccinating girls before sexual debut. For Tanzania, this represents a practical and cost-effective means to reduce the huge personal, social and economic burden of cervical cancer.

## ***2.3. Government Commitment and Progress to Date***

Accordingly, the GoT and stakeholders are fully committed to scaling up primary prevention, including through the successful introduction of the HPV vaccine.[[3]](#footnote-3) To reach this point key achievements have been realised. These include:

* **2011:** Recognition within the National Cervical Cancer Prevention and Control Strategic Plan that HPV vaccine introduction is a key strategy for primary prevention.
* **October 2012:** Use of HPV vaccines endorsed by National Immunisation Inter-Agency Coordinating Committee (ICC). ICC approves application process to the Global Alliance on Vaccine Immunization (GAVI).
* **July 2013:** ICC approve HPV vaccine demonstration project for Kilimanjaro region.
* **May and November 2014:** Two rounds of HPV vaccinations successfully conducted in first year of demonstration project with high coverage (schoolgirls aged 9 and over in Standard 4, and 9-year-old out-of-school (OOS) girls in Kilimanjaro region).
* **April 2015:** HPV vaccine introduced into RI system for Kilimanjaro region.
* **May 2016:** ICC endorses GAVI application for national introduction to RI targeting only 9-year-old girls.
* **August 2016:** ICC requests IVDP to delay application to GAVI and to negotiate a revised application covering national introduction for girls 9 – 14 years of age in the first year, and for all girls aged 9 in the second year.
* **2017:** ICC endorses WHO Recommendation for HPV Vaccination to immunize 9-14 years girls in the first year of introduction, followed by RI for 9-year-old girls in subsequent years. A first Zanzibar National ICC also endorses the WHO Recommendation. Subsequently, and as a consequence of a global shortage of HPV vaccine, ICC endorses vaccination only for 14 years old girls in 2018 and 2019, followed by multi age cohort (MAC) of 9-14 years old girls in 2020, and a single age cohort (SAC) of 9 years old girls for subsequent years.

Government commitment to HPV introduction is also evident in the 2016 Comprehensive Multi-Year Plan (cYMP) for immunization which commits to the introduction of the HPV vaccine (and 6 other new vaccines) for the Tanzanian mainland and Zanzibar by 2020. Other key objectives under the 2016 – 2020 cYMP include development of new vaccine introduction plans; capacity development for micro-planning; strengthened monitoring and evaluation; and, effective advocacy and social mobilisation.

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# **3: HPV Vaccine Introduction Goals, Objectives and Eligibility Criteria**

*The overarching goal* of the national HPV introduction is *“to reduce the personal, social and economic burden of cervical cancer in Tanzania by ensuring at least 80% HPV vaccination coverage rates among eligible girls, and sustained demand for the vaccine” [[4]](#footnote-4)*

*The key objective* of national HPV vaccine introduction is to ensure all eligible girls are fully immunized against HPV infection and protected from cervical cancer.

The table below shows HPV vaccination coverage targets*[[5]](#footnote-5)*.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **2018** | **2019** | **2020** | **2021** |
| **Eligible Girls (14 years)** | 80% | 80% |  |  |
| **Eligible Girls (9-14 years)** |  |  | 80% |  |
| **Eligible Girls for subsequent years (9 years old)** |  |  |  | 80% |

***Source:* IVDP HPV Introduction Plan**

*In terms of eligibility*, the upper age limit for eligible girls in 2018 and 2019 will be 14 years for 1st dose of the HPV vaccine. Only girls who are aged 14 when they present for vaccination will be eligible for 1st dose HPV vaccination in 2018 and 2019. Both in-school and out-of-school 14-year-old girls will be targeted for vaccination.

For 2020, girls must be aged between 9 and 14 years of age to be eligible to receive their 1st dose of the HPV vaccine. For 2021 the target cohort will be girls aged 9 years, and girls aged 9 to 14 who missed either their first or second HPV vaccination.

Girls who have received their 1st dose of the HPV vaccine are eligible to receive the 2nd dose after 6 months and will remain eligible for the 2nd dose up to 12 months after receiving their 1st dose.

# **4: Communication Goals and Objectives for HPV Introduction**

The Communication Strategy is designed to support the work of HPV vaccine introduction partners to realise the overarching goal of the 2018 HPV vaccine introduction in Tanzania *(as stated above, and in the HPV Vaccine Introduction Plan).*

In this context, the Communication Strategy has the following objective:

* To support and guide HPV introduction partners in the implementation of intensive and sustained communication and social mobilisation interventions that generate and sustain high levels of community demand for the HPV vaccine and contribute towards achieving 80% coverage among eligible girls (including eligible OOS girls) in 2018, 2019 and 2020.

The specific objective of the Strategy is to support and guide HPV introduction partners in the implementation of intensive and sustained communication and social mobilisation interventions which results in:

* Eligible girls and their caregivers: a) being aware cervical cancer can be prevented through HPV vaccination; b) understanding HPV vaccine is safe and effective; and, c) accepting and proactively consenting for HPV vaccination.

# **5: Management and Implementation Arrangements for HPV Vaccine Introduction**

From 23 April 2018, the HPV vaccine will be delivered free of charge through Tanzania’s RI system.[[6]](#footnote-6) For the first three years of introduction (2018 – 2020) two months of every year will be designated for intensified HPV vaccination. For 2018, intensified immunisation activities will take place in May and in November. For subsequent years, districts will decide when to implement intensified immunisation activities in consultation with the regions and depending on local circumstances.

Health facilities will be the main providers of the HPV vaccine, alongside existing outreach services for RI. Eligible girls will also be able to receive the HPV vaccine at schools, and as such the Ministry of Education and Vocational Training (MOEVT) is a key partner, and critical to achieving a successful introduction.

HPV Vaccine introduction is the overall responsibility of the MOHCDGEC IVDP in collaboration with the MOEVT and the President’s Office, Regional and Local Government (PORALG); supported by immunization partners through the national IVD Technical Working Group (TWG). The IVDP contains six main sections. These are: Administration; Immunization Operations; Training and Social Mobilization; Logistics, Cold Chain and Vaccine Management; and, Surveillance and Data Management. The overall functions of the IVDP include policy formulation and the development of guidelines and standards for strategic planning, and for budgeting immunization activities across the country. Other functions include monitoring, training, technical support to the regions and districts, supervision, facilitating procurement of vaccines, equipment and related supplies, as well as ensuring quality service delivery.

At the national level the IVDP TWG (and its Sub-Committees) has overall responsibility for implementation of the HPV introduction. The National IVDP TWG is coordinated by the National ICC (mainland and Zanzibar). The ICC is chaired by the MOHCDGEC Permanent Secretary and its membership includes WHO, UNICEF, the United States Agency for International Development (USAID), the United States Center for Disease Control (CDC), the Paediatric Association of Tanzania, the Government of Tanzania National Regulatory Authority (TNRA), the Red Cross, the Clinton Health Access Initiative (CHAI) and the Lions Club. The ICC meets quarterly and convenes ad hoc meetings as appropriate.

At the regional level, interventions are coordinated by the Regional Immunisation and Vaccines Officer (RIVO) and supported by the Regional Reproductive and Child Health Coordinator (RRCHCO), both of who report to the Regional Medical Officer (RMO). At District/Council level, there is a District Immunization and Vaccines Officer (DIVO) and a District Reproductive and Child Health Coordinator (DRCHCO) who report to the District Medical Officer (DMO).

RIVOs and DIVOs oversee immunization services in the regions and districts, including the management of Regional Vaccine Stores. The distribution of vaccines from the region to the district is managed by the RIVO although districts can collect their vaccines from the region when regions are unable to facilitate delivery. At the District level, supportive supervision is scheduled monthly at health facility level but is sometimes delayed or cancelled because of human and financial resource constraints.

At the health facility level, vaccinations are given by Public Health Nurses (PHN), who are also responsible for outreach services, social mobilization and data management.

In terms of implementation modalities, HPV vaccine introduction will be achieved through the RI system, and as such will rely on MOHCDGEC and IVDP infrastructure and human resources to achieve coverage targets, provide supportive supervision and ensure effective data management and monitoring.

Assuming stable vaccine supply, health facilities will provide HPV vaccination on a continuous basis. Eligible girls will be vaccinated either at health facilities, outreach posts or schools depending on joint planning arrangements agreed between health facilities, schools and communities within catchment areas. RI outreach services will be employed to maximise coverage, and depending on planning arrangements, schools may be used as additional outreach posts during intensified immunisation months.

Prior to implementation, several key tasks were identified in the HPV Introduction Plan as being of key importance for successful implementation. These include:

* Development of comprehensive HPV Introduction Guidelines. These guidelines will address all required activities, and clearly delineate accountabilities at different levels.[[7]](#footnote-7)
* The development of a communications strategy to guide advocacy and social mobilisation.
* The implementation of advocacy and communications activities that support introduction.
* The development and dissemination to all levels of a risk and crisis communication plan, protocols and standard operating procedures (SOPs) to manage negative rumours and misconceptions, and/or any dramatic escalation of negative rumours or misconceptions.
* The development of training materials and manuals and the roll out trainings for Regional and District Health Management Teams (in English) and for Health Workers and School Health Teachers (in Swahili).
* The development by health workers, teachers and community leaders of quality micro plans to ensure all eligible girls from government and non-government schools (and OOS girls) are vaccinated.
* Sensitisation and engagement of girls, parents, caregivers and communities, and vaccine demand generation
* Registration and socialisation of eligible school girls by teachers, and OOS girls by Community Health Workers (CHW) and community leaders.
* Parents and teacher’s meetings, and community level meetings, to generate demand and support for introduction.
* HPV vaccine distribution to the regions and transfer on to the districts and health facilities.

# **6: Communication Strategy Overview**

This Communication Strategy delineates actions and processes to generate and sustain demand for the HPV vaccine among eligible girls, their parents and caregivers, and within the broader community for the 12 months to April 2019. It is intended to provide guidance to National, Regional and District/Council level programme implementers in relation to key ACSM challenges, and how they can best be addressed.

Following mid-term and annual reviews of ACSM support for HPV introduction at the National and Regional Level – *and the generation of key KAP evidence in the first quarter of 2019 (see section 15) –* the Strategy will need to be revised to reflect changing circumstances, and/or any emerging ACSM challenges (e.g. vaccine refusals or low coverage among OOS girls).

The Strategy delineates clear actions and processes to promote understanding of the HPV vaccine’s benefits and efficacy; minimise risks associated with misconceptions and negative rumours; and, enhance capacity for community level social mobilisation.

The Strategy is underpinned by the following guiding principles:

* The importance of partnership, collaboration and transparency
* The generation and use of evidence for planning
* Respect for human rights
* Ensuring equitable and pro-poor coverage
* Sensitivity to local needs and contexts
* HPV vaccine introduction sustainability in the RI system

The Strategy advocates for a synergistic, mutually reinforcing mix of communications approaches. The communications approaches are:

* ***Advocacy:*** Interventions and activities designed to influence, generate and maintain the support and participation of opinion leaders, decision-makers and programme implementers.
* ***Social mobilisation:*** Sensitizing and empowering a wide variety of stakeholders to gain and sustain their support, and to act for the attainment of common objectives.
* ***Communication for social change:*** Processes aimed at empowering and enabling community members (eligible girls, their parents and caregivers) to adopt a particular behaviour (vaccination).
* ***Interpersonal communication:*** Face to face communication including positive appraisals between individuals and within groups focused on exploring and addressing concerns, and on providing accurate, action-orientated and motivational information.
* ***Transparent communication:*** Facilitated by and between stakeholders (verbally or through the dissemination of updates, action plans, briefing notes and guidance) to enhance programme management and implementation.

The actions and processes described in this Strategy are targeted at three general categories of audiences: primary audiences *(eligible girls and their parents and caregivers)*; secondary audiences *(health workers and health volunteers, professional associations, teachers and school administrators, local religious and community leaders, civil society, community and faith based organisations);* and, tertiary audiences *(National, Regional and District level government authorities, politicians at all levels, media agencies and journalists, private sector influencers, bilateral and multilateral donors, and HPV vaccine introduction partners).*

Communication and social mobilisation activities will target each of these three key categories of audiences described above, as well as specific sub-audiences within these categories. Interventions are designed in accordance with evidence-based best practice for social mobilisation, advocacy and public communication in support of RI and new vaccine introduction.

The design and prioritisation of activities is informed by: lessons from the 2014 HPV demonstration and related coverage and KAP data; the communications related new vaccine introduction experiences of other countries in the East Africa region; stakeholder institutional knowledge and experience; and by the need to maximise impact and cost-effectiveness.

The Strategy delineates a range of communications and social mobilisation interventions, approaches and activities to support HPV vaccine introduction including National, Regional and District level advocacy meetings; briefings for journalists and media agencies; public service announcements on radio and television; the distribution of brochures and information packages; and the training of sharp-end health workers, teachers, and others with the capacity to advocate for *– and promote –* the efficacy of the HPV vaccine. Importantly, the Strategy also delineates activities that can enhance communication between immunisation partners and lead to overall improvements in the management and implementation of HPV introduction, and its longer-term sustainability within Tanzania’s RI schedule.

Before detailing approaches to advocacy, communication and social mobilisation employed to support of HPV vaccine introduction, and before mapping out and sequencing the key actions to be taken, the Strategy will consider: lessons from the 2014 Kilimanjaro HPV Demonstration, and the HPV vaccine information and behavioural needs of key audiences.

# **7: Lessons from New Vaccine Introductions in Tanzania and the HPV Demonstration**

The Post Introduction Evaluations (PIE) for the dual introduction of Rotarix and pneumococcal conjugate vaccine (PCV) in December 2012, and for the introduction of the combined Measles and Rubella 2nd Dose (MR2) vaccine in April 2014, both reveal successful implementation and introduction, resulting in high and increasing coverage. However, in relation to communications and social mobilisation, some challenges did become apparent.

For Rotarix and PCV, social mobilisation for introduction was less challenging given the target cohort was infants who *– along with their caregivers –* have regular contact with health workers and health facilities, in turn enabling regular, sustained, opportunities for interpersonal communication between health workers and caregivers on the benefits of Rotarix and PCV vaccines. Moreover, the introduction of Rotarix and PCV was further enabled and streamlined by existing and widespread support and acceptance in Tanzanian communities for the vaccination of infants against common childhood diseases.

However, while the introduction of the MR2 vaccine in October 2014 also resulted in high coverage, the PIE revealed inadequate community awareness of vaccine benefits and efficacy, and a lack of knowledge among some health workers of the need to vaccinate infants at 18 months. Introduction of the MR2 vaccine was preceded by a nation-wide catch-up campaign targeting 21 million children aged 9 months to 15 years. According to the post introduction coverage survey the campaign resulted in 88.5% coverage on the Tanzania mainland and 93.1% coverage in Zanzibar, despite inadequate community knowledge and awareness of vaccine benefits and efficacy. This suggests *(corroborated by stakeholders)* public trust in vaccination services in Tanzania *– and in public health services and public health recommendations –* is high in Tanzania.

Experiences from the 2014 Kilimanjaro region HPV demonstration in 2014 (implemented in 7 Councils/Districts) also suggest that community acceptance of the potential efficacy of vaccines is high. For example, despite the post HPV demonstration coverage survey revealing just 54.1% of parents and caregivers in the Moshi DC and Same Districts of Kilimanjaro region understood the HPV vaccine prevents cervical cancer (and only 27.9% reporting having discussed the vaccine with their child), coverage was still above 90%.[[8]](#footnote-8)

Awareness among eligible girls was however much higher, suggesting the effectiveness of communicating the benefits of the vaccine through the education/school system. The HPV vaccine demonstration PIE report reveals that 61% of eligible girls in Same, and 91% in Moshi DC, were aware of the benefits of the HPV vaccine. Unfortunately, awareness among OOS girls was not assessed.

In relation to interpersonal communication on HPV vaccine efficacy and benefits, teachers were by far the most frequently cited source of information for 44% of parents and caregivers in Moshi DC, and Same (23%). The HPV vaccine demonstration PIE report does not specify the percentage of parents that discussed the HPV vaccine with health workers in Moshi DC but for Same just 8% of parents and caregivers discussed the vaccine with health workers.

In terms of public communication, radio announcements and announcements in mosques and churches were most frequently cited sources. Respectively, 70% and 25% of parents and caregivers in Moshi DC cited radio announcements and radio talk shows, respectively, as source of public information (Same 53% and 37%), and 39% cited hearing announcements in churches and mosques (Same 33%); clearly indicating the importance of radio as a communication channel, and of working with religious leaders for effective social mobilization.

Overall, the HPV vaccine demonstration coverage survey data shows that parents and caregivers most frequently received information at the community level through the radio and from teachers and religious and community leaders. Just 8% of parents indicated receiving a leaflet or brochure as the most helpful source of information.

In terms of HPV vaccine resistance, less than 1% of parents reported negative rumours about the vaccine as a reason for not vaccinating their child. For AEFI, 5% (29 out of 560) of parents and caregivers reported their child having experienced a side effect as a consequence of receiving vaccination. Only 3% of the parents and caregivers who reported a side effect considered it necessary to report symptoms to a health worker.

Other lessons from the 2014 HPV vaccine demonstration include:

* Few households retained vaccination cards (Same 26.8% and Moshi DC 53.2%), but nevertheless just 24 out of 560 parents and caregivers reported their child missing the second dose.
* Almost all eligible girls received the HPV vaccine at schools – just 1% received vaccination at health facilities – and high coverage was directly related to the delivery of the vaccine at schools, high enrolment rates among girls attending primary school standard 4, and the effective dissemination of key information by teachers.
* Understanding of HPV vaccine eligibility criteria among girls, parents, health workers and teachers was sometimes inadequate, resulting in ineligible girls receiving vaccination, and girls receiving vaccinations out of synch with the HPV vaccination schedule.
* The absence of clear guidance on follow up for girls who missed HPV vaccination, or the second dose.

The HPV vaccine demonstration PIE report concludes by making the following specific recommendations in relation to advocacy, social mobilisation and communication:

* Develop a comprehensive social mobilization and communication strategy informed by evidence on the most effective approaches well in advance of implementation..
* Begin conducting community mobilisation at least two months prior to commencing HPV vaccination.
* Reinforce messages on an integrated approach to HPV-related cancers to include HPV vaccination and other primary prevention methods *(protected sex, no tobacco use, and screening for cervical cancer).*

# **8: Awareness of Cervical Cancer and Public Trust in Vaccination Services**

## ***8.1. Awareness of Risks***

Unfortunately, there has been no national level survey on knowledge and awareness of HPV infection, cervical cancer, perceived risks, or on vaccine benefits and efficacy among the public, or within the health or education systems.

However, anecdotal evidence and stakeholders’ views allow some general assumptions to be made about awareness of HPV infection and cervical cancer. Since 2008 JPHIEGO has been actively supporting the MOHCDGEC to scale up cervical cancer screening and prevention. The Medical Women’s Association of Tanzania (MEWATA) has also worked independently to raise awareness on prevention and screening.

Because of these efforts, stakeholders report awareness of the risks and threats of HPV infection and cervical cancer in the community *– and within the health system –* has increased steadily over recent years. These efforts will help pave the way for the introduction of the HPV vaccine by strengthening institutional support within the medical community and by generating public demand for the vaccine. However, inevitably, awareness of risks and knowledge of the HPV vaccine as a preventive strategy will be widely inconsistent across the country and will correlate to levels of education and other socio-economic factors. Nevertheless, it is reasonable to assume enclaves of strong support for the vaccine do exist *– especially among tertiary and secondary audiences –* and that these enclaves of support can be actively encouraged and enabled to promote HPV vaccine efficacy, and the prevention of cervical cancer within the wider community. There have been no reports of any significant hesitancy or mistrust of the vaccine within the medical community, or civil society, which reaffirms an assumption of generalised tertiary and secondary support.

In relation to the public, stakeholders also anecdotally report enclaves of strong support and demand for the HPV vaccine with communities often asking, “when is the HPV vaccine is coming?”. The high incidence of cervical cancer and the social and economic burden of the disease also suggest that the risks of cervical cancer are understood *– to varying degrees –* within communities, and especially among women and families who have been personally affected by the disease.

Regarding understanding the benefits of the HPV vaccine and its efficacy as a strategy to prevent HPV infection among girls (before sexual debut), very little evidence – *except for coverage data from the Kilimanjaro demonstration –* is available.

## ***8.2. Trust in the HPV Vaccine and Vaccine Providers***

Levels of trust in the soon to be introduced HPV vaccine, and public feelings about its introduction in 2018 have also not been comprehensively assessed. However, evidence from the introduction of PCV and Rotarix vaccines, and from the HPV vaccine Kilimanjaro demonstration, show high levels of vaccine acceptance and high coverage despite incomplete and inconsistent levels of knowledge about benefits and efficacy.

Since 1975 Tanzania has progressively expanded the coverage and reach of immunisation services and has steadily increased the number of districts with coverage above 90% for DPT3 *(proxy indicator for effectiveness of RI systems).*[[9]](#footnote-9) There are communities and districts in Tanzania *(often poorer and more geographically isolated from services)* where childhood immunisation coverage is sub-optimal. However, generally high levels of coverage across the country, and the Tanzanian immunisation systems visibility as a tangible public health success story, have undoubtedly bolstered public trust and confidence in immunisation and the efficacy of vaccination services over the last two decades.

International evidence also suggests high levels of public trust in vaccination services can translate into high acceptance of vaccines; and, high levels of vaccination coverage, despite sub-optimal awareness. For example:

* A systematic review of 14 studies of HPV vaccine acceptability in 10 Sub-Saharan African countries revealed, that despite low vaccine-related knowledge and awareness, acceptability of the HPV vaccine for daughters was high (range 59% - 100%).[[10]](#footnote-10)
* Another review of 27 studies representing 13 Sub-Saharan African on HPV knowledge, awareness, acceptability and willingness to vaccinate concluded that the factors influencing acceptability are most often tied to issues of public trust.[[11]](#footnote-11)

## ***8.3. Ease and Convenience of Access***

Closely related to trust is ease and convenience of access to vaccination services. That is, if vaccines are accessible and communities utilise vaccination services relatively equitably and at scale, this over time builds and sustains public confidence and trust in vaccine services.

As noted above, Tanzania has successfully established and consolidated an effective immunisation programme (IVDP) which has achieved steady improvements in immunisation coverage, leading to a significant reduction in the burden of childhood disease. For example, 10 years after DPT3 vaccination was introduced, childhood pertussis was all but eliminated. Measles has been close to eliminated, and Tanzania has been certified Polio free since 2015. Consequently, it is reasonable to conjecture that public trust in immunisation services has been progressively supported and underpinned by the successes of Tanzania’s immunisation system. Immunisation services are also provided free of charge, which further supports public acceptance of services, and promotes utilisation.

However, as noted, there are still districts in Tanzania where immunisation coverage is sub-optimal, and some communities are not being adequately reached by health services *(including outreach services).* Within these communities, trust in immunisation services may be less robust.

## ***8.4. Vaccine Rumours and Misconceptions***

Even though 93.6% of eligible girls received both doses of the HPV vaccine during the Kilimanjaro demonstration, evidence suggests that there were refusals and hesitancy. 29 out of the 560 parents and caregivers interviewed for post HPV demonstration coverage survey partially vaccinated their daughters (only one dose) claiming they were either unaware of the programme, or that their daughter was absent from school on the day of vaccination. Only 7 respondents refused vaccination on the grounds of either safety or the rumour that the HPV vaccine causes infertility. However, while refusals were low, the Kilimanjaro demonstration coverage survey found that a total of 37.3% of parents and caregivers surveyed had heard rumours the vaccine was not safe (Moshi DC 48.9% / Same 25.7%).

Clearly there is no room for complacency. A 2016 review of HPV vaccine delivery in 28 countries revealed that HPV vaccine refusals can occur at multiple levels – among girls and parents, in the community and at schools *(especially in private and faith-based schools).* Hesitancy among health workers to recommend the vaccine is also observed as a trigger for parental refusal.

Even though by any standard vaccine refusal was low for the Kilimanjaro HPV demonstration, the Kilimanjaro region was chosen for the demonstration because of its high school enrolment rates, which allowed for effective social mobilisation with eligible schoolgirls, and facilitated high coverage rates through school-based vaccination. Moreover, Kilimanjaro region also has a reputation for being a hub for education where parents often send their children to study; and, for having a relatively well-educated population. For example, the 2015 TDHS shows Kilimanjaro has among the highest levels of household educational attainment, and among the highest primary and secondary school net attendance ratios in the country.[[12]](#footnote-12) According to the TDHS, 7.2% and 6.8% of girls and women (over 6 years of age) have no education in Kilimanjaro and Dar es Salaam respectively, whereas nationally 24.1% women have no education. While no reliable data is available to correlate awareness of cervical cancer, HPV infection and of the HPV vaccine with household or caregiver levels of education in Tanzania, international evidence suggests it is reasonable to assume such a correlation exists.

Consequently, and despite evidence to suggest strengthened awareness within the medical system and in within some communities, it is reasonable to assume there remain many eligible girls, caregivers and communities across the country that have either low levels of knowledge and awareness, or none at all. Particularly in poorer locations where educational attainment and school enrolment are less than ideal, it will prove challenging to ensure consistent public trust in the vaccine, and high coverage.

The most persistent and potentially disruptive rumours emerging in relation to the HPV vaccine in East Africa have related to the vaccine causing infertility. Having many children is traditionally seen as a strategy to enhance household security in sub-Saharan African countries. As such, sustained efforts over recent decades to control fertility in some countries, including Tanzania, have led to suspicions about public health interventions perceived as related to fertility control. Because girls are targeted for vaccination before sexual debut, and because HPV infection is associated with sexuality, and cervical cancer is associated with the female reproductive organs, rumours about the HPV vaccine causing infertility *– or being intended to cause infertility –* can take hold. This may be particularly true for isolated communities, communities where educational opportunities are limited, where poverty is acute, or where harmful traditional practices are common. As a 2015 UNICEF review of communications support for new vaccine introduction in Eastern and Southern Africa region reported, the HPV vaccine met with some suspicion or resistance in all demonstration and introduction countries.[[13]](#footnote-13)

# **9: Audience Analysis and Information Needs**

Despite the absence of Tanzania-specific formative research to inform communications interventions in support of HPV vaccine introduction, several key challenges and opportunities can be identified for each of the key audiences to be reached with information and messages on the HPV vaccine, and the rationale for its introduction.

## ***9.1. Primary Audiences***

Primary audiences include in and out-of-school eligible girls, soon to be eligible school girls and all other schoolgirls in both private and public schools; and, caregivers and parents of all ages. Each of these sub-audiences also have key information and communication needs.

|  |  |
| --- | --- |
| **Primary Audiences Information Requirements** | |
| ***Information needs: All primary audiences*** | |
| * Facts about cervical cancer and prevention * Importance of prevention * Benefits of the HPV vaccine | * Eligibility for vaccination * Possible low-level AEFIs * Common myths and misconceptions about the HP vaccine * Vaccine safety |
| ***Information needs: Secondary sub-audiences*** | |
| **In school eligible girls** | * Vaccination schedule * Importance of tracing and referring OOS girls for vaccination * Importance of being vaccinated |
| **Soon to be eligible in school girls and other in-school girls** | * Importance of HPV vaccination * Future eligibility criteria * Supporting OOS girls and friends to accept vaccination |
| **Caregivers and parents** | * Consent issues * Importance of encouraging vaccination * HPV vaccine and infertility rumours * Importance of advocacy within the community for HPV prevention |

## ***9.2. Secondary Audiences***

Secondary audiences for communications interventions in support of HPV introduction include health workers and health volunteers; school administrators and teachers; local religious, community and civil society leaders; and local media representatives.

|  |  |  |
| --- | --- | --- |
| **Secondary Audiences Information Requirements** | | |
| ***Information needs: All secondary audiences*** | | |
| * Facts about cervical cancer and prevention * Importance of prevention * Modalities for HPV vaccine introduction * Benefits of the HPV vaccine * Vaccine safety | | * Responses for frequently asked questions * Ensuring personal advocacy for HPV vaccination * Responding to rumours and misconceptions * Age-appropriate approaches to prevention |
| ***Information needs: Secondary sub-audiences*** | | |
| **Health workers and health volunteers, district community health coordinators** | * Importance of good interpersonal communication and respecting clients * Working with eligible girls, parents, caregivers and the community to maximise coverage and to trace defaulters * Reaching of OOs girls with outreach services * AEFI response and monitoring * Vaccine availability and supply | |
| **District/Ward Education Officers, school administrators and teachers, School Health Coordinators** | * Approaches to ensuring eligible girls are well informed about HPV introduction and the rationale * Collaborating with girls in school to reach OOS girls with social mobilisation * Location and timing of vaccination services * Consent and registration processes * Vaccination procedures and possible AEFI | |
| **Local religious, community and civil society leaders** | * Key HPV introduction issues to be discussed with the community * Addressing and responding to misconceptions * Referral for additional information * Delivery modalities and locations * Responses to frequent questions * Role of religious leaders in community mobilisation | |
| **Local media** | * Arguments and facts to dispel local rumours and misconceptions * Importance of positive coverage * Information relating to regional HPV vaccine launches * The importance of engagement with communities to maximise coverage * The importance of media coverage for promoting the vaccine | |

## ***9.3. Tertiary Audiences***

HPV vaccine introduction stakeholders and partners including the MOHCDGEC and the Government of Tanzania demonstrate strong political commitment to HPV vaccine introduction, and broad awareness of the benefits introduction will bring for individuals, families and the nation. Key stakeholders expect strong political commitment will support and underpin effective implementation by Regional and District/Council level authorities, teachers and health workers.

However, at the tertiary level there are sub-audiences with key information requirements. Levels of knowledge and awareness in relation to HPV vaccine introduction within these sub-audiences varies so it is essential to fill unseen gaps in knowledge through a wide and consistent dissemination of sufficient and accurate key information, tailored towards the needs of each different group. This also applies to sub-audiences within secondary and primary audiences where knowledge and awareness is likely also inconsistent. Certain key information relating to HPV vaccine introduction is needed at *all levels* but emphasising specific messages for key sub-audiences will help to ensure high coverage and effective programme implementation.

The table overleaf identifies tertiary sub-audiences and their general and specific information needs.

|  |  |
| --- | --- |
| **Tertiary Audiences Information Requirements** | |
| ***Information needs: All tertiary audiences*** | |
| * Social and economic burden of cervical cancer * Facts about cervical cancer and prevention * Importance of prevention * Process/modalities/accountabilities for HPV vaccine introduction * Importance if investing GoT resources for HPV vaccination for cervical cancer prevention | * Benefits and efficacy of the HPV vaccine * Potential introduction challenges and solutions * Ensuring personal and institutional advocacy for HPV vaccination and it introduction * Responding to rumours and misconceptions * Vaccine safety |
| ***Information needs: Tertiary sub-audiences*** | |
| **Political leaders / Members of Parliament** | * Importance of working with constituents and promoting HPV vaccination and cervical cancer prevention * Importance of supporting HPV vaccine introduction and sustainability in the RI system |
| **Regional and District/council authorities** | * Guidance on ensuring effective oversight for implementation, including for ACSM |
| **Regional and District/council Primary Health Care Committees** | * Phases of introduction * Vaccine availability, supply and sustainability * Accountabilities of health works and teachers * Modalities and options for effective social mobilisation, especially for OOS girls * The importance of responding quickly to vaccine misconceptions and rumours |
| **Religious and civil society leaders** | * Key issues to be discussed with communities * Addressing and responding to misconceptions * Delivery modalities and locations * Responses to frequent questions |
| **Media agencies and journalists** | * Arguments and facts to dispel rumours and misconceptions * Importance of positive coverage * Information relating to national HPV vaccine launches and high-level participation * The importance of engagement with communities to maximise coverage * The importance of media coverage for promoting the vaccine |
| **Private sector partners** | * Actual and potential private sector advocacy for HPV introduction * Options for private sector engagement and in-kind contributions * HPV introduction and corporate social responsibility * Brand visibility and partnership |
| **Professional Associations (e.g. medical and nursing associations)** | * Importance of advocacy with constituents for the HPV vaccine * Information about possible rumours and misconceptions and arguments and facts to dispel rumours and misconceptions * Key HPV introduction advocacy and communication challenges |
| **HPV vaccine introduction partners** | * Importance of collaboration, partnership and transparency * Ensuring effective communication and decision making * Assessing and addressing introduction risks |

# **10: Strategic Communications Interventions for HPV Introduction**

Several communications channels and approaches will be employed to deliver key information and behavioural messages at different levels. These include:

* Mass media including television, radio and newspapers to raise general awareness, promote vaccine efficacy and stimulate public discussion.
* Social media including WhatsApp and Facebook to share experiences, best practices and disseminate key guidance on managing rumours and misconceptions to health workers, teachers and community leaders.
* SMS messaging to widely disseminate simple messages that promote HOV vaccine uptake.
* Information, education and communication materials (e.g. brochures, posters and banners) to provide visibility for the vaccine introduction and to promote key messages on HPV vaccine benefits and efficacy.
* Effective interpersonal communication, especially by health workers and volunteers, teachers and community leaders.
* Community dialogue generated around the benefits and efficacy of the HPV vaccine and its role as a part of a broader strategy for the prevention of cervical cancer.
* Peer to peer approaches which promote positive dialogues amongst eligible – and soon to be eligible girls – in relation vaccine benefits and efficacy.
* Cascaded HPV vaccine introduction trainings at the Regional, District and facility level which will develop institutional and individual capacity for community mobilisation in support of HPV vaccine introduction; and, raise awareness on vaccine benefits and efficacy among key secondary audiences.

At all levels, ACSM interventions broadly aim to raise perceptions of the risks of cervical cancer; promote the benefits and efficacy of the vaccine and its free-of-charge availability within the RI system; promote and engender trust and confidence in vaccination services; and, mitigate risks posed by misinformation and rumours.

Positive perceptions of need, and of vaccine efficacy, imply that individuals, families, institutions and communities understand and consider the risks and threats to personal, family and public health posed by HPV infection and cervical cancer, as well as the benefits and efficacy of the vaccine. Behavioural theorists argue the greater the perception of threat and risk *(and the more susceptible individuals, families and communities feel to the dangers of risks and threats)* the more likely it is that preventive action will be taken.[[14]](#footnote-14)

Motivations to vaccinate and vaccine acceptance are also positively influenced by perceptions that the vaccine is efficacious and needed, having trust in the vaccine and the vaccine provider, and by ease and convenience of access to the vaccine.[[15]](#footnote-15) In Tanzania, all these factors are relevant to ensuring high levels of demand for the HPV vaccine, and high coverage.

Communication approaches and interventions for HPV vaccine introduction work synergistically to reach tertiary, secondary and primary audiences, and to reinforce information and communication between audiences, and between sub-audiences. Key approaches and interventions are described below:

## ***10.1. Communication Strategy Development and Introduction Guidance***

Ensuring that HPV vaccine introduction programme objectives and accountabilities (including in relation to ACSM) are clearly articulated and well understood by all stakeholders at all levels is critical to effective implementation. As such, it is essential to ensure the timely dissemination to all stakeholders at the National, Regional and District/Council of all relevant strategic guidelines. These include: the IVD HPV Vaccine Introduction Plan and Introduction Guidelines; training plans and materials; and, protocols and Standard Operating Procedures for risk and crisis communication. Ensuring the early development and dissemination of a comprehensive and evidence-based ACSM strategy will also help to optimise Regional and District/Council level preparedness for HPV introduction and strengthen planning for social mobilisation and outreach.

## ***10.2. Key Message Development and Revision***

Key messages reinforce the identity of public health interventions, consolidate information about the rationale for the intervention and its benefits, and facilitate a consistent and clear dissemination of basic motivational information that has relevance at multiple levels.

Key messages in support of the HPV vaccine introduction can be revised at any time if required or appropriate *(e.g. if negative rumours are circulating)* but there is an overall need for messaging to be well targeted and to *“stay on message”* – to be consistent*.* As such, key messages for public and community-level dissemination will be developed and tested with a variety of audiences before integration into other communication and social mobilisation activities. Key topics for message development will include:

* Cervical cancer prevalence and risks
* Vaccine benefits and efficacy
* Vaccine safety
* Free of charge HPV vaccine provision
* Eligibility and 2nd dose schedule (retention of vaccination cards)
* Location and dates of outreach services
* Working together to reach OOS girls
* Appropriate responses to emergent rumours / vaccine misconceptions

To ensure the widespread dissemination of key messages several channels will be employed; especially, broadcast media, the distribution of IEC materials, public advocacy meetings, and media coverage. However, ensuring consistent messaging across *all supportive communications interventions and activities* will reinforce *– and provides a banner and headline for –*  more detailed information disseminated at various levels.

## ***10.3. Producing and Broadcasting Radio and TV spots***

Poorer, less well educated and rural communities in Tanzania are less likely to access mass media in Tanzanian (newspapers, radio, television (TV), mobile phones and internet). Regarding access to newspapers, television and radio, key data from the 2015 TDHS reveal:

* Boys and men access media more frequently than girls and women. For example, 43.2% of girls a15 to 19 listen to the radio once a week, rising to 51.9% for boys of the same age.
* For TV, 26.9% of girls 15 – 49 watched TV at least once in the preceding week, rising to 74.7% for the highest wealth quintile (WQ), falling to 2.2% for the lowest), and to 5.4% for girls and women with no education. All percentages are marginally higher for boys and men across all categories of access.
* For radio, 43.2% % of girls 15 – 49 watched radio at least once in the preceding week, rising to 63.5% for the highest wealth quintile (WQ), falling to 22.1% for the lowest), and to 26.2% for girls and women with no education.

In this context, radio and tv announcements alone will be insufficient to influence and convince all people to ensure eligible girls are vaccinated. Much more will need to be done to reach and positively influence the perception and intentions of caregivers, parents and eligible girls, especially in poorer communities with less educational opportunities; less access to media; challenges accessing immunisation and health services; and, higher rates of school drop-outs and OOS girls.

However, the broadcast of radio and TV spots creates significant visibility for the HPV vaccine introduction and its benefits at many levels, and forms a reference and conversation point from where issues are discussed and communicated in communities. Even if viewed only once or twice a radio or TV broadcast on the benefits and importance of HPV vaccine can stimulate ongoing discussions in families, communities and professional and social circles, which in turn can generate demand for additional information and discussion, and lead to an increasing ground swell of interest and public support.

Public interest and engagement in HPV vaccine introduction is supported through the visibility broadcast media provides, and by the urgency and relevance of their content. Public interest in the HPV vaccine and its benefits, and any concerns raised within the community can then be addressed through radio and TV talk shows, or through responses posted in newspaper editorials or online.

Radio and TV panel discussions and radio interviews with key experts will also be used to address topics emerging of interest to various audiences *(for example, integrated approaches to cervical cancer prevention; the need to reach OOS girls with the HPV vaccine, and poor communities with prevention services more generally; or, discussions about vaccine safety).* They can also be used – if required – to address any rumours or misconceptions that arise in the lead up to HPV vaccine introduction.

## ***10.4. Producing and Disseminating Information, Education and Communication Materials***

IEC materials that address the risks of cervical cancer and the benefits and efficacy of the HPV vaccine *(e.g. posters, t-shirts, banners, spare-tyre wheel-covers, brochures and leaflets)* also promote visibility for HPV vaccine introduction and help to establish a tangible and visual campaign identity for the introduction. Although just 8% of the post HPV demonstration coverage survey respondents (parents and caregivers) identified IEC materials as a source of information, this figure perhaps belies the wider impact of disseminating IEC materials. International public health experience has shown that in addition to promoting visual identity, IEC materials also stimulate discussion in the community and serve as a reference point, resource and information source for teachers, health workers and community leaders engaged in community level social mobilisation activities.

## 

## ***10.5. Social Media and SMS Messaging to Disseminate Messages and Information***

There has been a steady increase in the number of Tanzanians ever accessing the internet, with Tanzania Communications Regulatory Authority (TCRA) data published by Reuters showing 23 million people accessed the internet in 2017. Of these, 19 million accessed the internet with a cell phone (up from 18 million in 2016).[[16]](#footnote-16)

However, internet penetration and regular internet usage remain low in rural Tanzania, and among the poor. Although three years old, data from the 2015 TDHS demonstrate a clear trend of limited access in some communities and reveal, for example, that just 9.9% of girls and women have ever accessed the internet (20.6% for boys and men). As would be expected, internet usage correlates with coming from an urban area, having more education, being less poor and being male. Internet usage among rural and/or poor girls and women was negligible at the time of the TDHS. Across the bottom three wealth quintiles, the percentage of girls and women having ever accessed the internet ranges from 0.7% to 1.4%, then jumps to 6.6% and 29.7 for the two highest wealth quintiles.

Consequently, outside of urban and better-off populations, social media may have limited relevance for Tanzanians, particularly in poor and rural areas. However, in the Tanzanian context it can be used effectively as a tool for online discussion among social and professional groups, and for the dissemination and promotion of guidance to frontline health workers and volunteers, school teachers and community leaders *(e.g. via WhatsApp/Facebook user groups)*. Like broadcast media and IEC, social media interventions can also work to raise the profile and visibility of HPV vaccine introduction, and to generate momentum around media and private sector engagement, public advocacy events (including the national launch) and the engagement of eminent persons and celebrities.

Mobile phone penetration in Tanzania has also grown significantly with 2017 TCRA data showing 40.17 million mobile phone subscribers. Although many Tanzanian people cannot afford the costs of internet usage on their phones *(more than twice as many people subscribe to cellular networks than access the internet on their phones)* they can receive SMS notifications free of charge.

SMS messages and notifications have the potential to significantly raise awareness around the HPV vaccine introduction and a range of related issues. Information and messages that can be disseminated via SMS messaging can include district/council level information on vaccination times and eligibility, messages on the importance of referring eligible OOS girls for vaccination, messages on vaccine benefits and efficacy, and information to dispel vaccine misconceptions and rumours. For health workers and teachers, SMS messaging can be used to relay critical information about, for example, vaccine availability and supply, vaccine safety and issues to be discussed with communities.

## ***10.6. Media Briefings and Engagement***

Working with national, regional and local media outlets and encouraging them to promote HPV vaccine introduction can further enable positive evidence-based public debate, and promote balanced, fact-based media coverage of preparations and vaccine introduction. Ensuring well in advance of vaccine introduction that media agencies and journalists are welcomed as partners, and brought on board as HPV vaccine advocates, is essential. For these reasons it is critical to promote responsible media coverage and ensure comprehensive national and regional briefings for media agencies and journalists that respect for their role as arbiters of public opinion.

## ***10.7. Engaging the Private Sector***

Private sector interests can provide critical support to advocacy and communication for HPV vaccine introduction, while at the same time generating significant publicity for their businesses. For the Tanzania HPV vaccine introduction, approaching telecommunication companies (Vodacom and Airtel) to provide free HPV vaccine introduction SMS messaging will be a key priority.

## ***10.8. Identifying High Profile HPV Vaccine Champions***

The identification and engagement of potential HPV vaccine champions is another means by which to ensure dynamic media coverage, promote the vaccine and mitigate the risk of rumours and misconceptions. A range of individuals *(well-known Tanzanian cervical cancer survivors, respected celebrities, political leaders and renowned public health experts)* will be identified to actively advocate for HPV vaccine introduction through, for example, high profile public appearances, participation in panel discussions and the consistent delivery of key messages on vaccine safety and efficacy.

## ***10.9. Conducting National and Regional Launches***

National and regional launches demonstrate Government and partner commitment to HPV vaccine introduction and provide a high-visibility opportunity to advocate for the benefits of HPV vaccine introduction, and its importance as a key strategy for the prevention of cervical cancer. National and regional launches also provide opportunities to showcase expert opinion on vaccine introduction and cervical cancer prevention, and to highlight the need to reduce the burden of the disease. Ensuring the participation of HPV introduction champions will also raise the profile of launches and generate increased public interest and positive media coverage.

## ***10.10. National Level Briefings for Parliamentarians and Religious Leaders***

To maximise political support for the HPV vaccine introduction, a high-level briefing of political leaders will be convened in the national capital Dodoma. During the briefing senior politicians from across the political spectrum will be provided with key information on the burden of cervical cancer in Tanzania, prevention efforts to date, the need for the HPV vaccine, and on processes for its sustainable introduction into the RI system. Other issues covered will include the need to provide clear and consistent messages about vaccine quality, benefits and efficacy to constituents, and how to address vaccine misconceptions and rumours in the community. Key resource people for the briefing of parliamentarians will include technical experts from the MOHCDGEC and the IVDP. Senior political leaders will also participate and urge parliamentarians to work with constituents to ensure effective implementation, and high coverage.

A national level briefing will also be organised for senior religious leaders in Dar es Salaam. At this briefing, religious leaders will be briefed on cervical cancer, prevention and the efficacy of the vaccine. Open discussions on potentially sensitive issues will be encouraged to reach consensus on the importance of introducing the vaccine, and their role as advocates for the vaccine and its introduction. Given the high levels of public trust in religious leaders in Tanzania, it is critical potential rumours and misconceptions are unpacked and debunked to ensure that religious leaders are prepared to use their authority and their networks to dispel false perceptions about the vaccine.

## ***10.11. National Level Briefing for Senior MOHCDGEC, MOEVT and PORALG Officials and Technical Experts***

A high level national advocacy meeting will also be convened with participation by senior official and technical experts from the Ministry of Finance (MoF), MOHCDGEC, MOEVT and PORALG. Key objectives for this meeting will be to sure up inter-ministerial support for introduction; address any emerging challenges; and discuss approaches to ensuring sustainability of the HPV introduction.

## ***10.12. National, Regional and District Stakeholder Advocacy Meetings***

Stakeholder advocacy meetings will be conducted at the National, Regional and District level. At the national level stakeholder advocacy meetings will bring together experts from the MOHCDGEC and the IVDP, officials from MOEVT, MoF and PORALG, and HPV vaccine introduction partners to discuss and review implementation modalities, key challenges and solutions, and modalities to maximise coverage.

At the regional and district/council level, stakeholder advocacy meetings will be linked into regional and district/council extended Primary Health Care Committee (PHCC) meetings and will include the Regional and District Health Management Teams (RHMT/DHMT) representation by Regional and District Medical Officers (RMO/DMO), PORALG, MOEVT, regional and district level religious and community leaders, and local media. At the regional and district levels, stakeholder advocacy meetings will address key national level issues relating to HPV vaccine introduction, as well as regional and district level implementation, and potential challenges and strategies for community level social mobilisation.

National, regional and district/council level stakeholder meetings will also present opportunities for positive local media coverage.

## ***10.13. Training Teachers and Health Workers***

Ensuring the active engagement of school health coordinators, teachers and health care workers and volunteers (CHWs) will be critical to the success of the HPV vaccine introduction. As such comprehensive trainings will be provided at facility level to cover cervical cancer prevention; vaccine benefits and efficacy; vaccine delivery; potential incidences and monitoring of AEFI; registration of eligible girls; modalities for parental consent; dealing with rumours and misconceptions; effective interpersonal communication with parents, caregivers and eligible girls; and, community-level social mobilisation. A key product from these trainings will be the development of micro-plans that address achieving target coverage *(number of eligible girls to be vaccinated in catchment area)*, and modalities for ensuring effective social mobilisation.

## ***10.14. Community-Level Social Mobilisation***

Micro-plans developed at the community level will determine the number of eligible in and out of school girls requiring vaccination, and modalities for raising awareness and demand among parents and caregivers, and in the community. Key messages will be conveyed to the community using existing community level mechanisms including through schools, Ward Development Committees (WDC), Village Councils, Village Health Committees (VHC), CHWs, Ward and Village Level Executive Officers (WEO and VEO), religious and community leaders, and existing community groups and discussion forums. Mobilising OOS girls for vaccination will be a key priority (see next section).

## ***10.15. Outreach at Schools[[17]](#footnote-17)***

As noted in the Introduction and Section 5 of the strategy, the MoEVT is a key partner for HPV Introduction, and critical to reaching eligible girls with the HPV vaccine. Although the HPV vaccine will be delivered through the RI system, outreach will be conducted at schools to maximise coverage. As such, ensuring the ongoing engagement of MoEVT personnel at the National, Regional, District and community level are fully engaged in planning, implementation and monitoring and evaluation will be critical to reaching optimal coverage. As such, it will be critical to ensure Regional and District Education Officers (REOs and DEOs) and School Health Coordinators are fully included in regional and district trainings, and that school Head Teachers and Teachers participate in facility-level trainings and micro-planning.

For eligible girls in school, teachers will be the main conduits of relevant and appropriate information and advice to eligible girls, parents and caregivers on vaccine benefits, safety and efficacy, and as such must be appropriately briefed on key HPV related issues, and on how to utilise existing forums (e.g. Parents and Teachers Associations) to strengthen community demand for the HPV vaccine.

## ***10.16. Engaging with Young People for HPV Vaccination***

Reaching OOS girls and ensuring optimal HPV vaccination coverage among all eligible girls will be further enhanced by engaging with adolescent girls of all ages, not only eligible girls. Inevitably, questions will be raised in the community and by adolescent girls in relation to HPV vaccine introduction and the HPV vaccine itself. HPV vaccine introduction eligibility criteria may, for example, lead girls to question why only 14-year-old girls can benefit.

For this reason, and to avoid possible resistance among adolescent girls more generally, it is essential that efforts are made to sensitise adolescent girls of all ages on HPV vaccine benefits, safety, efficacy and 2nd dose schedule; and, in relation to why eligibility criteria must be restricted. Moving forward, sensitisation on HPV vaccine benefits and efficacy should be widened to incorporate cervical cancer and screening, and adolescent reproductive and sexual health.

## ***10.17. Sharing Experiences and Best Practice***

Documenting and sharing experiences and best practice during, prior and post HPV vaccine introduction will contribute to strengthened implementation and enhanced coverage. As such, it is proposed to establish a HPV vaccine introduction web portal (linked to the main MOHCDGEC website) where coverage data and other information can be shared.

The web portal would serve as a repository for IEC materials, radio and TV broadcast materials; videos of panel discussion and interviews; photographs and human-interest stories; press releases and key media coverage; as well as technical guidelines, key messages and other useful materials such as the HPV Introduction Plan and the Communication Strategy.

The web portal will also serve as a platform for the sharing of experiences and best practice relating to, for example, reaching OOS girls or working with community leaders; and, for online discussions among health workers and teachers relating to improving vaccination coverage. Ensuring, during implementation, regions and councils/districts upload their latest coverage data would also work to heighten coverage by engendering a sense of competition and an interest in high-coverage achievements across the country.

A public version of the web portal (restricted access) can also be promoted by HPV vaccine introduction advocates at all levels as a key source of more detailed information.

# **11: Risk and Crisis Communication**

The extent to which rumours and misconceptions relating to the HPV vaccine introduction will surface prior and during implementation is uncertain. However, evidence from the Kilimanjaro demonstration clearly shows that rumours about the vaccine being unsafe and/or causing infertility were widely circulating. Consequently, there is a very real possibly that rumours and misconceptions will re-emerge for the introduction.

International evidence has repeatedly shown that rumours and misconceptions can if left unchecked result in fear of the vaccine, public apprehension, vaccine hesitancy and significant shortfall in vaccine coverage. In Tanzania, these rumours and misconceptions pose a threat to the HPV vaccine introduction, and to the efficacy of the HPV vaccine introduction as a key preventive strategy.

As such, it is essential to develop strategies, protocols and standard operating procedures to manage the risks posed by circulating rumours, and any potential crisis resulting from a sudden escalation of rumours or misconceptions.

Managing communication risks – *risk communication ­­–* must be mainstreamed throughout all communications interventions by ensuring that partners and stakeholders at all levels are fully briefed about vaccine safety and efficacy and are provided with key messages that respond to the emergence of negative rumours and misconceptions. Key actions that must be taken include:

* Ensuring that RHMTs and DHMT take measures to assess the potential emergence of rumours and misconceptions and develop context-specific modalities to dispel these rumours and misconceptions.
* Ensuring that health workers and teachers are aware of potential side effects and AEFIs and respond appropriately by reassuring parents, vaccinated girls and the local community.
* Ensuring that health workers, teachers and community and religious leaders are sensitised to identify the emergence (potential or actual) of rumours and misconceptions.
* Providing journalists and media agencies with key information that discredits potential rumours and misconceptions, and with information and messages that they can utilise to dispel rumours when covering HPV vaccine introduction.

When rumours and misconceptions spiral out of control they pose a very real and tangible threat to vaccine legitimacy and public trust which can work to very quickly derail implementation and coverage. Even though mass media is generally supportive of government-led interventions in Tanzania, andthere does not appear to be a significant organised anti-vaccination movement that could exploit the surfacing of rumours and misconceptions, there is a still a risk that fear and hesitancy could take hold in the community and pose a significant threat to programme implementation.

As such, it is essential that crisis communication guidelines (including protocols and SOPs) are developed and disseminated at the regional and district/council levels. Critical actions prescribed within these guidelines will include:

* Mechanism to monitor the circulation of rumours and misconceptions in the general community and in the media, and to communicate concerns between the national, regional and district/council levels.
* The determination at the national, regional and district/council levels of key spokespersons and media focal points available and prepared to address emerging and circulating rumours and misconceptions (e.g. Regional and Council/District Commissioners and/or RMOs and CMOs).
* The formation of a risk and crisis communication committee at the Regional and District/Council level which can be quickly mobilised when needed – committee members would include RMOs and DMOs, WEOs and VEOs; regional and district/council level education officer and school headmasters; health facility in-charges; and local religious leaders and media representatives.
* The pre-positioning of critical information and key messages on vaccine safety that can be used to dispel negative rumours and misconceptions.
* SOPs that guide the sequencing of, and modalities for, official responses to rumours and misconceptions – i.e. when to speak in support of the vaccine, where to speak in support of the vaccine, and key messages to be reinforced.

# **12: Reaching Out of School Girls**

The Kilimanjaro HPV Demonstration and international evidence have shown that ensuring optimal coverage among OOS girls is challenging. High coverage among eligible school girls is almost guaranteed when the education system is an active partner for introduction because eligible in-school girls are a ‘captive audience’ who can be readily reached with key messages and mobilised (at school) by teachers to seek vaccination. This is demonstrated by the Kilimanjaro HPV Demonstration PIE which clearly shows that the highest levels of HPV related knowledge and awareness was found among in-school girls, indicating the effectiveness of the teaching environment as a platform for disseminating key information and messages.

However, because OOS girls are not in contact with the education system convincing them to vaccinate proved challenging during the Kilimanjaro demonstration, and in other countries where the HPV vaccine has been introduced. In addition, reaching OOS girls can also prove challenging because OOS girls are more likely to come from hard-to-reach or geographically isolated areas (a disincentive to school attendance), from poorer families, and / or from families/households with lower levels of literacy and/or educational attainment. Finally, it is important to note that incentives were paid to CHWs for the tracing and registration of OOS girls during the 2014 Kilimanjaro HPV Demonstration, and that the absence of any incentives for CHWs during the 2018 HPV introduction may undermine CHW motivation for the tracing and registration of OOS girls.

As such there is a need for dedicated and context specific strategies to reach OOS girls at the District/Council level. These District/Council level strategies must take into consideration age-specific school enrolment data and the total estimated number of OOS girls, and the general situation and circumstances of eligible OOS girls *(e.g. whether they are married, which religious community they are part of, where they are living, and their level of access to health facilities).* The intensity of efforts to reach OOS girls will need to be much greater in areas with lower school enrolments.

To reach OOS eligible girls, community leaders (WEOs and VEOs) and community health workers are expected to work together to trace OOS girls and to ensure the referral of OOS girls during vaccination outreach activities. However, other community actors including religious leaders, social workers and community groups will also need to be fully aware of the need to reach eligible OOS girls, and fully engaged as advocates for the HPV vaccine.

However, the IVDP advocates for a decentralised approach to HPV Vaccine Introduction and expects Regions and Districts/Councils to develop their own specific strategies for maximising coverage, including for OOS girls. In this context, several key options for improving coverage among OOS girls are suggested below:

* Developing accurate quantitative estimates of the number of eligible OOS girls that need to be reached.
* Ensuring that the challenges of reaching OOS girls and the need for local and context specific strategies to address these challenges are thoroughly discussed during Regional, District/Council and facility level trainings.
* Ensuring that local challenges to reaching OOS girls are identified (e.g. through undertaking Council and Village level focus group discussion with community members and representatives, and with OOS girls) and subsequently addressed in facility level micro-planning for ACSM.
* Convening District and Council level discussions and meetings to clarify accountabilities and challenges, and to identify and discuss possible local-level solutions to reaching OOS girls.
* Ensuring that teachers, CHWs and community leaders communicate that eligible OOS girls are welcome to participate in school-based outreach for HPV vaccination.
* Integrating the registration and sensitisation of OOS girls with other interventions undertaken by CHWs (e.g. MNCH, adolescent health, HIV/AIDS and/or nutrition interventions under implementation in the Region/District/Council).
* Encouraging local schools to engage in-school eligible girls to work with CHWs and community leaders to trace, register and sensitise OOS girls – this will also serve to empower in school girls and increase their levels of knowledge and awareness in relation to HPV vaccine benefits and eligibility
* Mobilising community and faith-based organisations to support the tracing, registration and sensitisation of OOS girls

# **13: Sustaining Demand**

Optimising and sustaining demand for the HPV vaccine is critical, not only during the pre-introduction phase but for the full three years of the HPV vaccine introduction programme. Ensuring ongoing demand for the HPV vaccine in 2018, 2019 and 2020, and coverage greater than 80%, will require the mobilisation and allocation of additional resources (human and financial); as well as, the distillation of key evidence emerging from the introduction for each successive year of implementation, and the use of this evidence to inform ongoing ACSM activities.

Moving forward, demand for the HPV vaccine will be bolstered, sustained and monitored in accordance with approaches set out in the MOHCDGEC/IVDP 2016 – 2020 National Communication Strategy for RI. Relevant objectives contained within the national strategy and to be reached by 2020 include: a 50% increase in community and family level awareness of the RI schedule; a 60% increase in community and family level awareness importance of completing RI schedule; and, a 50% increase in participation and support of males in the family for RI. Other more general objectives include: promoting a health service culture; strengthened AEFI communication; establishing a network of RI supportive communication partners; and, increased awareness at all levels around new vaccines.

However, and as discussed previously, ensuring demand for the HPV vaccine presents unique challenges not encountered when promoting RI to parents and caregivers of children under 5. These include the targeting of a single-age cohort of 14-year-old girls, and the questions this may raise in the community about, for example, discrimination against other girls or boys, and/or in relation to why this specific age group is being targeted; the need to reach OOS girls who do not have regular contact with either the health or education system; and, the possibility of negative rumours and or misconceptions emerging in relation to the vaccine. As such, additional ACSM interventions – above and beyond what is required for RI - will need to be prioritised to ensure ongoing and sustained demand for the vaccine. These will include:

* Sustained periodic public advocacy in support of the HPV vaccine undertaken by the MOHCDGEC (especially IVDP and HPU); HPV vaccine champions; and, professional associations such as MEWATA.
* National level monitoring of the broadcasting of key messages and their impact, and subsequent revision (if necessary) of messages, and additional national-level broadcasting of radio and TV spots.
* Ongoing media engagement at the national and regional levels to maximise positive and promotive coverage.
* Sustained engagement with the MoEVT at the National, Regional and District/Council level to maintain the active engagement of the education sector, head teachers, school health coordinators and teachers.
* Regional and District/Council level assessments of social mobilisation efforts for reaching OOS girls and evidence-based revisions of plans and strategies for social mobilisation.
* Refresher trainings for front line health workers, CHWs and teachers focused on addressing identified shortfalls in approaches to community mobilisation.
* Sustained vigilance with regard to the monitoring of negative rumours and misconceptions at all levels, and adaptive message development to dispel emerging rumours and misconceptions.
* Strengthened engagement between MOHCDGEC IVDP and the MOHCDGEC Health Promotion Unit, and between MOHCDGEC, MOEVT and PORALG counterparts in support of sustained demand for the HPV vaccine.
* The finalisation and dissemination of monitoring, evaluation and supervision tools for use at the District/Council level; and, the revitalisation and strengthening of regional and district level ACSM committees.

Over the longer term, efforts to continue to bolster and sustain demand will be further supported by:

* The rationalisation and professionalisation of the CHW system, and the strengthening of immunisation outreach services.
* Training for CHWs on inter-personal communication for immunisation *(planned for 2018 in 15 low-performing districts).*
* The integration of HPV vaccine messaging with information about cervical cancer prevention more generally, and a progressive shift towards promoting a dialogue at all level on the value of the HPV vaccine as part of the national cervical cancer prevention programme – this approach has the potential to both demystify and destigmatise the HPV vaccine, and to provide a platform and context for a broader and more intensive level of community engagement.
* The increased use of peer to peer approaches among adolescent girls to promote and sustain demand.
* The strengthening and increased engagement of Village Health Committees to raise community awareness of cervical cancer prevention and the role of the HPV vaccine.
* Maximising the efficiency and effectiveness of immunisation outreach services by looking for opportunities to pool resources across other key community level health interventions (e.g. for RCH, HIV/AIDS or Adolescent Health)

# **14: National, Regional and District ACSM Accountabilities**

Confusion about roles and responsibilities, timing for second doses, eligibility criteria, stages of introduction, and strategies for ensuring demand can all undermine coverage and sustainability. As such, it is essential that HPV vaccine introduction accountabilities are clearly demarcated and communicated to stakeholders at all levels. This includes, for example, ensuring that national introduction partners (*both Government of Tanzania and non-government)* are clear about their specific advocacy and social mobilisation responsibilities; that regional authorities provide appropriate oversight to Districts/Councils; that teachers and health workers and CHWs understand the importance of mobilising eligible in and out of school girls for vaccination; and, that community and religious leaders agree to support and advocate for HPV vaccine introduction.

## ***14.1. National Level***

Under the IVD TWG, the ACSM sub-committee has overall responsibility for the design, implementation and monitoring of quality ACSM activities to support HPV vaccine introduction. The ACSM is chaired by the MOHCDGEC HPU which also has responsibility for the coordination of all other MOHCDGEC health promotion interventions. As HPV vaccine introduction moves from preparatory planning, to implementation, to optimising and sustaining demand, the oversight of the HPU will become critical; not only to ensure an ongoing focus on ACSM, but also to coordinate and integrate ACSM interventions for HPV vaccine introduction with other ACSM activities undertaken to support key MOHCDGEC programmes.

Specific ACSM national level accountabilities are contained in the Rolling Action Plan (see Annex A). However, in general, the ACSM sub-committee and its members must ensure the following:

* Regular operational and strategic discussions within the ACSM sub-committee; clear and transparent communication and information flows between MOHCDGEC stakeholders and HPV introduction partners; and, the regular dissemination of updates on progress and challenges.
* The timely development of an evidence-based and comprehensive ACSM strategy and action plan for HPV introduction.
* The timely dissemination of the ACSM strategy to regional and district level implementing partners.
* The development, testing, revision (as needed) and dissemination of HPV vaccine introduction key messages.
* The development of ACSM components for the HPV Vaccine Introduction Guidelines and attendant training programmes, and their timely dissemination to the Regions and Districts.
* The development and dissemination of a risk and crisis communication action plan, including SOPs and communications protocols.
* The development and dissemination of ACSM monitoring templates and supervision tools to the Regions and Districts.
* National level advocacy, media engagement and media monitoring (including for rumours and vaccine misconceptions).
* Appropriate monitoring and evaluation of ACSM activities, and of their impact on community awareness and demand for the vaccine.
* Monitoring and evaluation of the effectiveness of ACSM interventions; and
* As needed revision and adjustment of ACSM strategies and guidance.

## ***14.2 Regional and District Level***

At the Regional and District Levels, the management and coordination of ACSM activities is overseen by the Regional and District Primary Health Care Committees, the Regional and District Health Management Teams and by Regional and District ACSM committees (where they are in place). PORALG and Regional and District Immunisation and Vaccination Officers have direct responsibility for ensuring compliance with HPV vaccine introduction policy and guidance. Key regional and district level accountabilities include ensuring:

* Effective advocacy with regional and district level political leaders, other local government authorities, media agencies and religious leaders.
* That ACSM is comprehensively covered in all cascaded trainings (Regional, District and facility-level).
* The full engagement of Regional and District Education Officers, School Health Coordinators and teachers in training, planning and implementing ACSM activities.
* The engagement of religious and community leaders (WEOs and VEOs) in training, planning and implementation of ACSM activities.
* The transfer of IEC materials to the districts and the appropriate positioning of IEC materials at the community level (e.g. at facilities, in schools, and at community meeting places).
* Facility-level micro-plans that include clear ACSM strategies, modalities for ensuring follow up and 2nd dose compliance, and activity schedules for intensified immunisation months and ongoing community mobilisation.
* The development of local and context-specific strategies for school-based outreach, and for tracing, registering and sensitising eligible OOS girls on HPV vaccine benefits and efficacy.
* Thorough briefings for Public Health Nurses, CHWs, School Health Coordinators, teachers and community leaders (WEOs and VEOs) on the importance of reaching OOS girls, and on modalities and accountabilities for reaching OOS girls.
* Monitoring the emergence of rumours and vaccine misconceptions in communities.
* Regional and district level risk and crisis communications focal points and spokespersons are fully briefed on the potential threat posed by rumours and misconceptions, and guided on how, where and when to respond[[18]](#footnote-18)

# **15: Monitoring and Supervision**

## 

## ***14.1. Monitoring***

Regular monitoring of vaccine delivery (both doses) and coverage will be undertaken at facility level and coordinated at the District/Council, Regional and National levels by the IVDP.

The HPV vaccine delivery strategy implies ‘progressive routinization’ and consequently progress and coverage will need to be assessed and evaluated at key stages of implementation *(e.g. after intensified immunisation months and at the end of each year of the three annual stages of implementation).*

In addition to routine administrative coverage monitoring, a mix of strategies and methods will be needed to assess the effectiveness of implementation, garner lessons learned and to inform any strategic adjustments required. Strategies employed will include: administrative reporting; coverage surveys; opinion polls; media monitoring; KAP surveys; rapid qualitative assessments; mid-term reviews at the National, Regional and District/Council level; and, development and operationalisation of the HPV vaccine introduction web portal.

To facilitate the effective monitoring of ACSM interventions, key indicators are proposed in the table below.[[19]](#footnote-19)

|  |  |
| --- | --- |
| **Outcome Indicator** | **Means of Verification** |
| * % of eligible girls and caregivers / parents who believe all eligible girls should receivethe HPV vaccine | Post introduction KAP survey |
| **Output Indicators** | **Means of Verification** |
| * % of OOS girls/schoolgirls/parents/caregivers with basic knowledge of cervical cancer | Post introduction KAP survey |
| * % of OOS girls/schoolgirls/parents/caregiver who know that cervical cancer is a preventable disease | Post introduction KAP survey |
| * % of girls who consider themselves at either high/low/no risk from cervical cancer | Post introduction KAP survey |
| * % of 9-14-year-old girls who agreed that the HPV vaccine prevents cervical cancer | Post introduction KAP survey |
| * % of OOS girls/schoolgirls/parents/caregivers who would consent to their daughter, sister, or friend aged 9-14 years receiving the HPV vaccine | Post introduction KAP survey |
| * % of parents/caregivers who gave consent for HPV vaccination | Post introduction KAP survey |
| * % of girls/parents/caregivers reporting a positive respectful vaccination experience at health facilities | Post introduction KAP survey |
| **Process Indicators** | **Means of Verification** |
| * % of positive HPV introduction related reports in the media (relative to negative reports) | Media monitoring |
| * % of social mobilization activities implemented (relative to activities planned) | District activity reports |
| * % of districts that developed social mobilisation micro-plans (including specific plans for reaching out-of-school girls | Availability of facility level micro-plans for social mobilisation / post training evaluations |
| * % of health-workers and teachers trained and sensitized on social mobilisation at facility level | District activity reports / post training evaluations |
| * % of Districts who reported insufficient resources for social mobilisation (e.g. funding, IEC materials, human resources) | District activity reports |
| * % of Regions/Districts that conducted media sensitization and engagement activities | Region/District activity reports |
| * % of regional and district level reports of negative vaccine related rumours or misconceptions | Region/District activity reports |
| * % of reports of rumours or misconceptions addressed within 24 hours | Region/District activity reports |

## ***15.2 Supervision***

Supportive supervision *– including for regional and district level ACSM activities –* will be provided primarily by IVDP staff with support from regional and district level MOEVT and PORALG staff. Public Health Nurses, Community Leaders (WEOs and VEOs) and School Health Coordinators will oversee community level social mobilisation, including for OOS girls.

HPV vaccine introduction partners will also provide supervision for key implementation-related tasks and assist the IVDP to provide oversight for regional and district level stakeholder advocacy and PHCC meetings. Partners will also supervise and support cascaded trainings at the regional and district levels.

Given constraints on the capacity of the IVDP and partners to provide supportive supervision, the provision of supportive supervision will be prioritised for intensified immunisation months.

Supervision tools to be utilised include:

* Post facility level training evaluation questionnaires
* District / facility level checklists (see annex D)
* Facility level micro plans

# **Annex A: Risk Analysis**

Apart from the emergence and/or potential escalation of negative rumours, vaccine misconceptions and vaccine hesitancy or refusals, there are several other ancillary risks and threats to the effectiveness of communications and social mobilisation activities, and ultimately to HPV vaccine introduction coverage and sustainability.

Despite often being positioned as a sub-component, quality communication in support of any public health intervention or programme is effectively a cross-cutting priority which can be negatively impacted by disruptions to a range of other programme components *(in addition to risks posed by poor planning and implementation for communications and social mobilisation).*

In this context, ACSM partners must remain vigilant and mindful of these risks, monitor the implementation of other HPV vaccine introduction programme components and work together to minimise and/or mitigate risks as they arise.

Key international evidence relating to communications support for immunisation and new vaccine introduction (including for the HPV vaccine) indicate the following potential risks relating both to immunisation programme components, and the planning and implementation of communications support:[[20]](#footnote-20)

***Programme related risks:***

* Inadequate prioritisation of ACSM support by donors, the ICC or the TWG
* Insufficient – or delayed – resource allocation for ACSM activities (including cascaded trainings)
* Vaccine supply shortages and the potential restricted availability (impacts negatively on demand)
* Insufficient resources for immunisation outreach services
* Inadequate unpacking of programme assumptions
* Challenges with registration and consent processes
* Confusion over eligibility criteria and 2nd dose schedule

***Key Communications Planning and Implementation Related Risks:***

* Insufficient investments in formative research for message and strategy development
* Lack of an adequate baseline for monitoring and evaluation
* Failure to mainstream communication priorities across programme components
* Inadequate, systemic, attention paid to community level social mobilisation, and reaching OOS girls
* Inadequate unpacking of communications assumptions
* Key guidelines and briefing notes prepared late, or not comprehensively disseminated
* Delays in the production and dissemination/broadcast of IEC materials and TV and radio spots
* Late or inadequate mobilisation of vaccine champions and high-profile advocates, political leaders and/or religious leaders and media agencies
* Inadequate guidance for risk and crisis communication and AEFI reporting
* Inadequate oversight of ACSM modalities within training preparations and materials
* Inadequate mobilisation and briefing of front-line implementers (health workers, CHWs, teachers, and community level social mobilisers)
* Inadequate community engagement in planning and implementation
* Unclear arrangements for facility and schools-based outreach during intensified immunisation activities
* Lack of transparency and/or effective communication of accountabilities at different levels, and between key partners

# **Annex B: ACSM Products**

To support ACSM approaches and interventions key communication products and communications activities will need to be developed and prioritised. The table below details these products and activities and illustrates the inter-connectedness of communications components, and the strategic synergies between key interventions.

|  |  |  |
| --- | --- | --- |
| **Approach / intervention** | **Key communication products required[[21]](#footnote-21) [[22]](#footnote-22)** | **Related communication priorities** |
| **Key messages** | * Formative research (FGDs/KIAs) | * Developing and testing simple messages for different topics (e.g. fertility rumours, vaccine safety, cervical cancer prevention, crisis situations) * Dissemination via media/IEC/champions etc. * Strategic integration and mainstreaming |
| **Branding and visibility** | * HPV introduction visual identity (logo’s, headlines, banners, colour schemes) * Partner / institutional / corporate logos/recognition | * Consultative design and testing * Partner agreements on introduction logo / visual identity * Mainstreaming into communications products / interventions |
| **Broadcast media** | * Radio and TV spots | * Content and design * Production * Pre-testing * Revision and approval * Broadcast strategy and budgeting * Broadcasting and monitoring impact |
| **Information, education, communication materials** | * Key information brochures and factsheets; * Leaflets and flyers with key messages; * Posters and banners with key messages * Wheel covers | * Content and design * Production * Pre-testing * Revision and approval * Distribution / dissemination strategy – (to whom when, and how – including to vaccination sites) * Branding and visibility |
| **Social media / SMS messaging** | * IEC materials * Radio and TV spots * FAQs * Key Messages | * Circulate and promote IEC materials and radio and TV spots with social media and SMS messaging * Distribute key messages to key audiences via SMS * Circulate positive media coverage |
| **Media briefings / engagement** | * FAQs * Briefing notes and factsheets * IEC materials (caps and t-shirts) * HPV media kit (incl. soft copies of key materials) | * Preparations for media briefings (venue, logistics, participation, key topics covered) * Development of media package * Distribution of HPV intro caps and t-shirts * Motivating and requesting positive coverage |
| **Private sector engagement** | * FAQs * Briefing notes * IEC materials (caps and t-shirts) | * Identify potential partners – e.g. Vodacom / Airtel * Identify potential sponsors (e.g. airlines/hotel chains/financial institutions) * Negotiate possible support. |
| **HPV vaccine champions** | * IEC materials (caps and t-shirts) * FAQs * Briefing notes * Key messages | * Identify potential and actual champions * Form an alliance among champions * Briefing of champions * Identify strengths of champions (i.e. specific issues / themes that they can add value to) * Facilitate participation of champions at advocacy and media events |
| **National Launches** | * FAQs * Briefing notes * IEC materials | * National launch preparations (venue, logistics, participation, key-speeches, panel discussions) * Ensuring high level political representation * Media coverage |
| **Stakeholder meetings** | * HPV vaccine Introduction plan * HPV introduction communications strategy * Introduction guidelines * Social mobilisation guidance note | * Ensuring importance of social mobilisation emphasised * Affirmation of specific regional and district/council level accountabilities * Support development of regional and district/council level social mobilisation plans |
| **National briefings for religious and political leaders** | * FAQs * Briefing notes * IEC materials | * Ensuring social mobilisation – and social mobilisation accountabilities, roles and responsibilities – adequately covered * Enlisting support for social mobilisation through political and religious networks * Ensuring adequate emphasis on the importance of interpersonal communication and reaching OOS girls |
| **Training school teachers and health workers** | * Vaccine Introduction Guidelines * Guidance note on micro-planning for social mobilisation (including for OOS girls) * Guidance note on risk and crisis communication protocols and SOPs, and managing AEFIs * Training materials * IEC materials and guidelines for effective use * Key messages | * Supporting inclusion of community social mobilisation activities in micro-planning * Ensuring inclusion of risk and crisis communication protocols and SOPs in trainings * Ensuring risk and crisis communication focal points identified |
| **Community-level social mobilisation** | * Social mobilisation micro-plans * IEC materials * FAQs * Registration /consent forms | * Supporting allocation of community level resources and responsibilities for sensitisation * Monitoring community sensitisation * Promoting innovation |
| **Reaching OOS girls** | * ACSM Strategy * Social mobilisation micro-plan for OOS girls * IEC materials * FAQs * Registration forms | * Supporting development of context-specific social mobilisation plans to reach OOS girls * Monitoring community sensitisation * Promoting innovation |
| **Promoting accountability** | * Vaccine Introduction Guidelines * HPV introduction plan and communication strategy * Summarised HPV communications strategy * Social mobilisation guidelines * Work plans and budgets * Key performance indicators * Specific edicts and communiques | * Monitoring implementation * Identifying and resolving communication and social mobilisation bottlenecks * Ensuring effective functioning of IVDP ACSM sub-committee (transparency and clear partner accountabilities) * Timely dissemination of key documents and guidelines |
| **Monitoring and sharing experiences and best practice** | * National HPV vaccine introduction web-portal * M&E guidance note | * Dissemination of M&E guidance * Web-portal design and operationalisation * Promoting the sharing of challenges and best practice for social mobilisation and reaching OOS * Encouraging regions and district/councils to share weekly/monthly coverage data * Sharing videos, photographs and human-interest stories |
| **Operationalising risk and Crisis Communication** | * Updated/revised risk and crisis communication strategy * Risks and crisis communication guidelines (protocols and SOPs) * AEFI protocols and reporting forms | * Mainstreaming of risk communication through all communications approaches * Ensuring that national, regional and district level advocacy meetings address the mainstreaming of risk communication * Ensuring that trainings for health workers and teachers address the need to identify, report and manage negative rumours and misconceptions * Dissemination of crisis communications guidelines (protocols and SOPs) to the regions and districts |

# **Annex C: Rolling Action Plan**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Tanzania HPV Vaccine Introduction Rolling Advocacy, Communication and Social Mobilisation Action Plan** | | | | | | | | | | | | | | | |
| **ACSM Actions** | **Responsible Agency/Dept.** | **Status** | **Time Frame (May 2018 – April 2019)** | | | | | | | | | | | | **Projected and Indicative 12 Month Budget** |
| **Completed** | **May** | **June** | **July** | **August** | **September** | **October** | **November** | **December** | **January** | **February** | **March** | **April** |
| **Pending** |
| **Ongoing** |
| **Finalisation** |
| **ACSM strategy** | | | | | | | | | | | | | | | |
| ACSM strategy finalised | UNICEF/MOH |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| MOH/IVDP validation of ACSM strategy | UNICEF/IVD |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| Electronic distribution to Regions/Districts | MOH/IVD |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| **National and Regional Launches** | | | | | | | | | | | | | | | |
| IEC materials in place | UNICEF / IVD |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| High level participation secured | IVD |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| Media coverage secured | UNICEF / IVD / GAVI |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| **National Advocacy** | | | | | | | | | | | | | | | |
| National stakeholders meeting | IVD / Partners |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| Parliamentarians | JPHIEGO/IVD |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| Religious leaders | MEWATA |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| MOH/MOEVT/MOF/PORALG high-level briefing | JPHIEGO/IVD |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| Identification / engagement of HPV champions | IVD/UNICEF |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **ACSM Actions** | **Responsible Agency/Dept.** | **Status** | **Time Frame (May 2018 – April 2019)** | | | | | | | | | | | | **Projected and Indicative 12 Month Budget[[23]](#footnote-23)** |
| **Completed** | **May** | **June** | **July** | **August** | **September** | **October** | **November** | **December** | **January** | **February** | **March** | **April** |
| **Pending** |
| **Ongoing** |
| **Finalisation** |
| **Media engagement** | | | | | | | | | | | | | | | |
| Media briefing package developed  (incl. soft copies of IEC and broadcast materials) | IVD/UNICEF |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| National media briefing | MoH/Partners |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| Regional / District Media Briefings | MoH/Partners |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| Coverage promoted | MoH/ Partners |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| Coverage monitored | MoH |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| **Branding and visibility** | | | | | | | | | | | | | | | |
| HPV introduction visual identity established and mainstreamed for public advocacy and materials | Partners |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| Media coverage for public advocacy events | MoH / Partners |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| **Broadcasting (radio and TV spots)** | | | | | | | | | | | | | | | |
| Production / testing / approval | MoH / UNICEF |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| Broadcast strategy in place | MoH / UNICEF |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| Ongoing Broadcasting | MoH / WHO |  |  |  |  |  |  |  |  |  |  |  |  |  | 100,000 |
| Monitoring coverage | MoH |  |  |  |  |  |  |  |  |  |  |  |  |  | 10,000 |
| **IEC materials** | | | | | | | | | | | | | | | |
| Production / testing / approval | MoH / UNICEF |  |  |  |  |  |  |  |  |  |  |  |  |  | 80,000 |
| Distribution and positioning | MoH / UNICEF |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Private sector engagement** | | | | | | | | | | | | | | | |
| Scoping of opportunities | MoH |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| Advocacy with Vodacom for free SMS messaging | MoH |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| **ACSM Actions** | **Responsible Agency/Dept.** | **Status** | **Time Frame (May 2018 – April 2019)** | | | | | | | | | | | | **Projected and Indicative 12 Month Budget** |
| **Completed** | **May** | **June** | **July** | **August** | **September** | **October** | **November** | **December** | **January** | **February** | **March** | **April** |
| **Pending** |
| **Ongoing** |
| **Finalisation** |
| **Social media / bulk SMS messaging** | | | | | | | | | | | | | | | |
| Distribution of key materials through WhatsApp | MOH |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| Establishment of WhatsApp users group for risk and crisis communication focal points |  |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| Distribution of key messages via SMS | MOH |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| **Risk / crisis communication** | | | | | | | | | | | | | | | |
| Plan in place | MoH |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| Protocols / SOPs in place | MoH |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| National level spokespersons briefed and coached on key responses |  |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| Summary guidance disseminated for regional/district partners, health workers, teachers, community and religious leaders) | MOH |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| Modality for monitoring rumours in the media and community operationalised at national/ regional level | MOH |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| Contracted media monitoring |  |  |  |  |  |  |  |  |  |  |  |  |  |  | TBD |
| **Training** | | | | | | | | | | | | | | | |
| RHMT and DHMT trainings |  |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| Facility level trainings (micro-planning for social mobilisation and OOS girls) |  |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| Training / Briefing of RHPOs/DHPOs (see Special Annex). |  |  |  |  |  |  |  |  |  |  |  |  |  |  | TBD |
| Training / Briefing of CHWs, Teachers and Community leaders on reaching OOS girls |  |  |  |  |  |  |  |  |  |  |  |  |  |  | TBD |
| **ACSM Actions** | **Responsible Agency/Dept.** | **Status** | **Time Frame (May 2018 – April 2019)** | | | | | | | | | | | | **Projected and Indicative 12 Month Budget** |
| **Completed** | **May** | **June** | **July** | **August** | **September** | **October** | **November** | **December** | **January** | **February** | **March** | **April** |
| **Pending** |
| **Ongoing** |
| **Finalisation** |
| **Monitoring and Evaluation** | | | | | | | | | | | | | | | |
| M&E framework developed, and indicators agreed |  |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| M&E guidance disseminated to regions/districts |  |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| Regional / District level monitoring of social mobilisation activities |  |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| Rapid assessment (quantitative + qualitative) for lessons and good practices |  |  |  |  |  |  |  |  |  |  |  |  |  |  | TBD |
| National / Regional mid-term review |  |  |  |  |  |  |  |  |  |  |  |  |  |  | TBD |
| Post introduction survey |  |  |  |  |  |  |  |  |  |  |  |  |  |  | TBD |
| KAP Survey |  |  |  |  |  |  |  |  |  |  |  |  |  |  | TBD |
| HPV web-portal designed and operational |  |  |  |  |  |  |  |  |  |  |  |  |  |  | TBD |
| Ongoing monitoring of ACSM approaches and documentation of lessons and best practices |  |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| **Supervision** | | | | | | | | | | | | | | | |
| Supervision of RHMT /DHMT trainings (ACSM and risk communication) |  |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| District / Council monitoring and reporting guidance disseminated for social mobilisation |  |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| RHPO/DHPO supervision of social mobilisation incl. For OOS girls. (see Special Annex) |  |  |  |  |  |  |  |  |  |  |  |  |  |  | NA |
| **Total Projected and Indicative 12 Month Budget:** | | | | | | | | | | | | | | |  |

# **Annex D: Regional/District /Facility-Level ACSM Checklist**

|  |  |  |
| --- | --- | --- |
| **Action** | **Completed (C) / Pending (P)** | **Notes:** |
| **Modalities and schedules for Region – to District – to facility – supervision of ACSM approaches established** |  |  |
| **ACSM Supervisory Role of RHPOs/DHPOs formalised (See Special Annex)** |  |  |
| **RHMT and DHMT trained and sensitised on importance of social mobilisation/reaching OOS girls/risk communication** |  |  |
| **Facility level trained on importance of social mobilisation/reaching OOS girls/risk communication** |  |  |
| **Mechanism for Regional and District level monitoring of rumours established and operational** |  |  |
| **Regional and District risk communications focal points briefed and coached on key responses** |  |  |
| **Facility level training inclusive of school health coordinators and teachers** |  |  |
| **Facility level micro-plans cover social mobilisation and identify key activities including schedules for outreach at schools and community mobilisation meetings** |  |  |
| **Assessment of District / Council level challenges in reaching OOS girls** |  |  |
| **District / Council level plan for reaching OOS girls developed and operationalised** |  |  |
| **CHWs / Community Leaders briefed on plans for reaching OOS girls and sensitised on vaccine benefits and efficacy** |  |  |
| **Guidance on District / Council level M&E received, and District / Council level M&E plan developed** |  |  |

# **Special Annex: Engaging Regional and District Level Health Promotion Officers**

As of April 2018, it has come to light that a cadre of Regional and District Level Health Promotion Officers (RHPOs and DHPOs) – under the supervision of the MOHCDGEC Health Promotion Unit – have not been incorporated into HPV introduction planning for supportive ACSM *(or scheduled regional and district level trainings)*. RHPOs and DHPOs have now been deployed to every Region and District in Tanzania and as such it is now essential that arrangements are urgently made to ensure that RPHOs and DHPOs are engaged and utilised to support ACSM for HPV introduction.

Under current arrangements RIVOs and DIVOs are accountable for ensuring a successful introduction of the HPV vaccine (incl. for ACSM). However, unlike the RHPOs and DHPOs, the RIVOs and DIVOs are in the most not qualified or trained to oversee social mobilisation activities. Moreover, RIVOs and DIVOs are expected to take responsibility for all other introduction components (e.g. monitoring vaccine supply and coverage), and as such the effectiveness of social mobilisation would be enhanced, not only through the provision of technical and supervisory support by the RHPOs and DHPOs, but also by allowing RIVOs and DIVOs to focus their efforts on other key programme components.

In addition, ensuring effective social mobilisation will require pro-active supervision and the provision of ongoing technical guidance to Public Health Nurses, School Health Coordinators, Teachers, community leaders and CHWs. In this context, the full engagement of RHPOs and DHPOs can ensure:

* The provision of direct supervision and guidance for social mobilisation and reaching OOS
* Effective coordination between health facilities, schools, teachers, community leaders and health workers for school-based outreach
* The development, operationalisation and coordination of context-specific action plans for reaching OOS girls
* The sharing and exchange of Regional and District level lessons and best practices
* The effective monitoring of rumours and vaccine misconceptions; the coordination and coaching of risk communication spokespersons; and, the development of appropriate local responses
* The monitoring and evaluation of impact, outputs and key processes to support sub-national social mobilisation

1. **Key HPV vaccine introduction partners include the Global Alliance Vaccines and Immunisation (GAVI), the Word Health Organisation (WHO), the United Nations Children’s Fund (UNICEF), JPHIEGO Tanzania, Clinton Health Access Initiative (CHAI), the Medical Women’s Association of Tanzania (MEWATA), the Tanzanian Red Cross, the Lions Club, the Tanzanian Association of Gynaecologists and Obstetricians (AGOTA), PATH Tanzania, and the** [**Tanzania Communication and Development Centre**](https://www.devex.com/organizations/tanzania-communication-and-development-center-tcdc-79311) **(TCDC).**  [↑](#footnote-ref-1)
2. **ICO/IARC Information Centre on HPV and Cancer (HPV Information Centre). Human Papillomavirus and Related Diseases in Tanzania. Summary Report 27 July 2017.** [↑](#footnote-ref-2)
3. **For more information on the HPV vaccines see the IVDP HPV Introduction Plan (section 5.1)** [↑](#footnote-ref-3)
4. **This Goal requires validation by MoH** [↑](#footnote-ref-4)
5. **Since the HPV Vaccine Introduction Plan was developed the coverage target has been adjusted down from 90% to 80% as a consequences of vaccine supply restrictions. Also, because of concerns about vaccine supply, the target age cohort has been changed from girls aged 9 to 14 to cover only girls aged 14 only for 2018 and 2019.** [↑](#footnote-ref-5)
6. **For a detailed Tanzania specific routine immunization situation analysis see: MOHCDCEG 2016 – 2020 *National Communication Strategy for Routine Immunisation*** [↑](#footnote-ref-6)
7. **Introduction guidelines will be developed with reference to the WHO Guide to Introducing the HPV Vaccine into National Immunization Programmes. See:**

   [**http://www.who.int/immunization/documents/ISBN\_9789241549769/en/**](http://www.who.int/immunization/documents/ISBN_9789241549769/en/) [↑](#footnote-ref-7)
8. **A total of 560 parents and caregivers were interviewed in Moshi DC and Same for the PIE.** [↑](#footnote-ref-8)
9. **As of 2015, DPT3 coverage was above 90% for 124 districts on the Tanzania mainland, and between 80-89% and below 80% for 22 and 17 districts respectively.**  [↑](#footnote-ref-9)
10. **Cunningham, (et. Al.) 2014. HPV vaccine acceptability in Africa: a systematic review. *Preventive medicine*, *69*, 274-279.** [↑](#footnote-ref-10)
11. **Perlman S. (et. Al.) 2014 Knowledge and Awareness of HPV Vaccine and Acceptability to Vaccinate in Sub-Saharan Africa: A Systematic Review. PLoS ONE 9(3): e90912** [↑](#footnote-ref-11)
12. **Gallagher (et al), 2016. Lessons learnt from human papillomavirus (HPV) vaccine demonstration projects and national programmes in low-and middle-income countries.** [↑](#footnote-ref-12)
13. **UNICEF, 2015. Communications Support for New Vaccine Introduction and Routine Immunization in the Eastern and Southern Africa Region: 2011 to 2015 (unpublished)** [↑](#footnote-ref-13)
14. **The Extended Parallel Process Model (EPPM) is a model which illustrates links between perceptions and their potential to effect behaviour change. Interventions and messaging are built upon notions of ‘perceived threat’, which is linked to notions of perceived vulnerability and perceived susceptibility. For more information see:**

    [**http://www.healthcommcapacity.org/wp-content/uploads/2014/09/Extended-Parallel-Processing-Model.pdf**](http://www.healthcommcapacity.org/wp-content/uploads/2014/09/Extended-Parallel-Processing-Model.pdf) [↑](#footnote-ref-14)
15. **See, for example:** [**www.who.int/immunization/policy/sage/en/**](http://www.who.int/immunization/policy/sage/en/) [↑](#footnote-ref-15)
16. [**https://www.reuters.com/article/us-tanzania-telecoms/tanzania-internet-users-hit-23-million-82-percent-go-online-via-phones-regulator-idUSKCN1G715F**](https://www.reuters.com/article/us-tanzania-telecoms/tanzania-internet-users-hit-23-million-82-percent-go-online-via-phones-regulator-idUSKCN1G715F) [↑](#footnote-ref-16)
17. **Private schools in Tanzania must be registered and fall under the jurisdiction of the MOEVT. As such, ensuring vaccination for eligible girls in private schools did not prove especially problematic during the Kilimanjaro HPV demonstration *(unlike some HPV demonstration and introduction countries, e.g. Malawi).* Private school teachers were trained, and private schools were utilised as vaccination sites. However, the HPV demonstration PIE did report that private schools were less flexible regarding consent processes and expected parents of eligible girls to grant formal consent for vaccination. Ensuring consent processes are communicated to private school well in advance of introduction should mitigate any potential challenges this issue may present.**  [↑](#footnote-ref-17)
18. **Risk and crisis communication focal points at the regional and district levels are defined in the IVD HPV Vaccine Introduction Guidelines (section 7.6)** [↑](#footnote-ref-18)
19. **NB: In the absence of nationally representative pre-introduction surveys on HPV vaccine introduction related KAP among health workers, teachers, parents, caregivers and eligible girls, baselines will need to be approximated (based on KAP data from the Kilimanjaro demonstration) or established in the early phases of implementation.**  [↑](#footnote-ref-19)
20. **For examples, see:**

    **UNICEF, 2015. Communications Support for New Vaccine Introduction and Routine Immunization in the Eastern and Southern Africa Region: 2011 to 2015**

    1. **WHO, 2016. HPV Vaccine Communication: Special considerations for a Unique Vaccine**
    2. **Ladner (et al), 2016. Experiences and lessons learned from 29 HPV vaccination programs implemented in 19 low and middle-income countries, 2009-2014. *BMC Health Services Research*, *16*(1), 575**
    3. **Rainey (et al), 2011. Reasons Related to Non-Vaccination and Under-Vaccination of Children in Low and Middle-Income Countries: Findings from a Systematic Review of the Published Literature, 1999–2009. *Vaccine*, *29*(46), 8215-8221.**
    4. **Favin (et al), 2012. Why Children are Not Vaccinated: A Review of the Grey Literature. *International health*, *4*(4), 229-238.**
    5. **USAID, 2014. Bottlenecks and Breakthroughs: Lessons Learned from New Vaccine Introductions in Low-resource Countries, 2008 to 2013**

    [↑](#footnote-ref-20)
21. **Because key messages, branding, and visibility, radio and TV spots and IEC materials all work to raise conscious and unconscious awareness, convey critical information and create visibility for HPV introduction, they are all core communication products that support and backstop *all* communications approaches and interventions.**  [↑](#footnote-ref-21)
22. **In this section guidelines refer to any prescriptive document relating to implementation and reaching HPV vaccine introduction objectives disseminated to regional and district/council level authorities and implementing partners.**  [↑](#footnote-ref-22)
23. **NA: already funded / no cost implication; TBD: to be determined.**  [↑](#footnote-ref-23)