**UNITED REPUBLIC OF TANZANIA**



**MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT GENDER, ELDERLY AND CHILDREN**

**HUMAN PAPILLOMA VIRUS (HPV) VACCINE INTRODUCTION GUIDELINE**

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**IMMUNIZATION AND VACCINE DEVELOPMENT (IVD) PROGRAM**

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**DECEMBER 2017**

**FOREWORD**

Ministry of Health, Community Development, Gender, Elderly and Children through Immunization and Vaccine Development Program (IVD) has objective of contributing to reduction of child and maternal mortality and morbidity caused by vaccine preventable diseases. The program was provided with the responsibility to ensure provision of quality immunization services to children and the women of child bearing age, to prevent them from diseases and control vaccine preventable diseases within the country. The program current is providing vaccines which prevent 11 diseases as follows; Tuberculosis, Poliomyelitis, pertussis, Diphtheria, Measles, Rubella, Meningitis, Pneumonia, diarrhea, Tetanus, Hepatitis B.

Immunization and Vaccine Development Program urged to prevent more disease and improve quality of life of Tanzanian by introducing new vaccine. In the country cervical cancer is leading cause of death among women, this necessitate introduction of Human Papilloma Virus (HPV) Vaccine country wide as one of strategy for cervical cancer prevention.

The Ministry has a role of developing guidelines to make sure the quality of health services meet National and International standards. Therefore, HPV vaccine guideline developed to provide guidance to supervisor at national, regional and district levels on developing micro planning, training, advocacy and social mobilization, service delivery, cold chain and logistic, Adverse Effect Following Immunization, Data collection and monitoring.

The ministry is making a call to supervisors at all level to use knowledge available in this guideline to ensure that all target girls are reached with HPV vaccine. It is our hope that this work will save life of women and reduce mortality and morbidity caused by cervical cancer within the country.



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# ABBREVIATION

AD Auto disable syringes

AEFI Adverse Event Following Immunization

AMREF African Medical and Research Foundation

BCG Bacillus Calmette Guerin

CCHP Comprehensive Council Health Plan

CHMT Council Health Management Team

CHAI Clinton Health Access Initiative

CVS Central Vaccines Store

cMYP Comprehensive Multi-Year Plan

DEO District Education Officer

DIVO District Immunization Vaccine Officer

DHO District Health Officer

DMO District Medical Officer

DRCHCO District Reproductive and Child Health Coordinator.

DVS District Vaccine Stores

DQA Data Quality Audit

DQSA Data Quality Self-Assessment

EPI Expanded Program on Immunization

HMIS Health Management Information System

HPV---------------------------------Human Papilloma Virus

IEC----------------------------------Information Education and Communication

JSI John Snow Inc

JHPIEGO John Hopkins Program for International Education in

 Gynecology and Obstetrics

LPG Liquefied Petroleum Gas

MCH Maternal and Child Health

MCSP------------------------------ Maternal Child Survival Program

MEWATA--------------------------Medical Women Association of Tanzania

MOEVT----------------------------Ministry of Education and Vocational Training

MOHCDGEC---------------------Ministry of Health, Community Development, Gender, Elderly

 and Children

NBS National Bureau of Statistics

NIDs National Immunization Days

NTD Neglected Tropical Diseases

PHCC Primary Health Care Committee

PIE Post Introduction Evaluation

PORALG President Office, Regional and local Government

RAS Regional Administrative Secretary

RCHS Reproductive and Child Health Services

REO Regional Education officer

RIVO Regional Immunization and Vaccine Development Officer

RMO Regional Medical Officer

RRCHCO--------------------------Regional Reproductive and Child Health Coordinator

RVS Regional Vaccines Store

SIAs Supplemental Immunization Activities.

SNIDs Sub National Immunization Days

TDHS Tanzania Demographic Health Survey

UNICEF United Nations Children’s Fund

VEO---------------------------------Village Executive Officer

VVM Vaccine Vial Monitor

WHA World Health Assembly

WEO Ward Executive Officer

WICR-------------------------------Walk-in Cold Room

# Chapter 1: INTRODUCTION

## 1.1 HPV Infection and Cervical cancer

Cervical cancer is caused by the human papillomavirus (HPV). More than 100 HPV types have been identified to date, about 40 of which can infect the genital area. Two high-risk types of HPV, types 16 and 18, account for about 70% of all cervical cancer cases. HPV can also cause other types of anogenital cancer (vagina, vulva, anus, and penis), head and neck cancers, and genital warts in both men and women.

Immunodeficiency is the strongest known cofactor for HPV in cervical. In people living with HIV compared to people who are not, HPV infections are more likely to occur, persist, and progress to cancer. HPV is sexually transmitted and most people become infected sometime during their lifetime, usually soon after becoming sexually active. Most infections are asymptomatic and usually clear up without any intervention within a few months, and about 90% clear within two years. A small proportion of infections with certain types of HPV can persist and progress to cancer. If infection from cancer-causing HPV types persists over a long period of time, women can go on to develop precancerous lesions that, if left untreated, develop into cervical cancer. This process takes on average of 20 - 30 years from infection to development of cervical cancer.

Cervical cancer is the fourth most common cancer among women worldwide. It is estimated that each year there are approximately 528,000 new cases and more than 266,000 deaths from cervical cancer. More than 85% of all new cases and deaths occur in less developed countries, partly because routine cervical cancer screening and treatment are not widely available. Unless cervical cancer prevention and control measures are successfully implemented, it is estimated that by 2030, approximately 800,000 new cases of cervical cancer will be annually diagnosed. The vast majority of these cases will be in developing countries.

Tanzania has a population of 14.88 million women ages 15 years and older who are at risk of developing cervical cancer. Current estimates indicate that every year 7,304 women are diagnosed with cervical cancer and 4,216 (58%) die from the disease. Cervical cancer ranks as the most frequent cancer among women in Tanzania and the most frequent cancer among women between 15 and 44 years of age.

About 3.3% of women in the general population are estimated to harbor cervical caused by HPV-16/18 infection at a given time, and 68% of invasive cervical cancers are attributed to HPVs serotype 16 or 18.

## 1.2 Cervical Cancer: Signs and Symptoms, Diagnosis and Treatment

Symptoms of cervical cancer tend to appear only after the cancer has reached an advanced stage, and may include:

* Irregular, inter-menstrual or abnormal vaginal bleeding, usually after sexual intercourse.
* Back, leg, and/or pelvic pain
* Fatigue, weight loss, loss of appetite
* Vaginal discomfort or odorous discharge which may be pale, watery, pink, brown, or bloody
* Single swollen leg

More severe symptoms may arise in the very advanced stages, including severe anaemia, renal failure, fistulae (rectal/vesico-vaginal), and lymphoedema.

Diagnosis of cervical cancer is not easy and must be done by a specially trained health worker.

## 1.3 Comprehensive approach to prevention of cervical cancer

WHO recommends inclusion of HPV vaccination into national immunization programmes in countries where cervical cancer is a public health priority and where cost-effective and sustainable implementation of the vaccine is feasible as in Tanzania. Because HPV vaccines do not protect against all HPV types that cause cervical cancer, vaccine introduction should be part of a coordinated and comprehensive approach to cervical cancer control which includes:

* Prevention primarily through vaccination of 9-14-year-old girls prior to exposure and acquisition of HPV infection
* Secondary prevention through screening and treatment of adult women for pre-cancerous lesions, and
* Tertiary and palliative care for women affected by cervical cancer.

### 1.3.1 Primary prevention

* For girls 9-14 years HPV vaccination is recommended

***For men and women***

* Health information and warnings about tobacco use
* Condom promotion/provision for those engaged in sexual activity
* Male circumcision

### 1.3.2 Secondary prevention

For women >30 years of age screening and treatment as needed (with low cost technology VIA followed by cryotherapy) and HPV testing for high risk HPV types (e.g. types 16, 18 and others)

## 1.4 HPV Vaccine

The vaccines are most effective when administered to a person prior to exposure to HPV. HPV vaccines are not therapeutic and cannot be used for treatment of cervical cancer or HPV infection.

HPV vaccines used in Tanzania under immunization programme protects against four HPV serotypes 16 and 18, HPV 6 and 11 (quadrivalent vaccine).

9-valent HPV vaccine which includes the additional five HPV serotypes 31, 33, 45, 52 and 58 compared to the quadrivalent vaccine is currently undergoing WHO review for prequalification and might be available for in the future. The 9-valent vaccine can be used for prevention of cervical, vulvar, vaginal, and anal cancers caused by HPV serotypes 16, 18, 31, 33, 45, 52 and 58, pre-cancerous or dysplastic lesions caused by HPV serotypes 6, 11, 16, 18, 31, 33, 45, 52, and 58, and genital warts caused by HPV types 6 and 11.

***NB:*** *At the time of printing of this guide, the authorities in Tanzania have only approved quadrivalent to be used as HPV vaccine to prevent cervical cancer for all eligible girls*

## 1.5 HPV vaccination challenges and opportunity

In Tanzania, the introduction of HPV vaccine into the national immunization programme is more complicated than adding a new infant vaccine. HPV vaccination has a number of special considerations that offer both challenges and opportunities for immunization programmes.

### 1.5.1 Challenges:

* No existing service delivery platform (or immunization contacts) to access a target population of 9-14-year-old girls for the 2-dose schedule.
* Sensitivities around HPV vaccination providing protection against a sexually transmitted infection (STI), offered for girls-only, and recurrent concerns about Adverse Events Following Immunization (AEFIs) and vaccine safety -- despite a solid safety record.
* Requires a robust communication and social mobilization strategy to assist with acceptance, ensure completion of schedule, and to decrease costs related to tracking drop-outs. Additionally, preparedness for crisis communication is essential.
* Cost – HPV vaccine is not only relatively more expensive to procure than other vaccines , but the operational costs of vaccine delivery are also substantial high (depending on the strategy, HPV vaccine delivery costs can be considerably higher than for new infant vaccines).
* New technical or programmatic issues such as learning how to properly locate the target population and calculate its accurate size and denominator; adopting new coverage monitoring methods; introducing informed consent processes; dealing with adolescent concerns; etc.

### 1.5.2 Opportunities:

* HPV vaccination does not protect against all types of HPV. Cervical screening programmes available can be used as the platform for promotion of the vaccination
* Integration of HPV vaccination with the delivery of other health services for 9-14-year-old children, provides opportunities to establish primary care for a new age group of children and health system strengthening.
* HPV vaccination broadens stakeholders and partners for immunization, including those from reproductive health, adolescent health, school health, cancer control, HIV prevention, and women’s health.

## 1.6 Recommended target age and vaccination schedule

* Girls aged 9-14 years prior to becoming sexually active.
* Two (2) doses with a 6-month interval.
* There is no maximum interval between the two (2) doses, however, an interval of not greater than 12-15 months is suggested to enable girls to complete the schedule promptly before becoming sexually active.
* A 3-dose schedule (i.e. at 0, 2, and 6 months) is recommended for females 15 years and older, and for those known to be immunocompromised and/or HIV-infected (regardless of whether they are or not receiving antiretroviral therapy).

**It is not necessary to screen for HPV infection or HIV infection prior to HPV vaccination**

# Chapter 2: EXPERIENCE OF HPV VACCINATION DEMONSTRATION PROJECT

1.

## 2.1 Introduction

1.

Prior to Country wide introduction of HPV vaccines, Tanzania decided to do demonstration project in one region of Kilimanjaro which covered all **seven** councils of Kilimanjaro region. The Objective was to get experience and learn by doing. In addition, the country wanted to get experience and use that experience to scale HPV vaccination countrywide. The demonstration was done for two consecutive years of 2014 using campaign mode and 2015 in which the mode used was routine. In all these years the financial support was from Gavi.

## 2.2 First year of HPV Vaccination Demonstration Project

HPV vaccination was introduced in April 2014 in which the targeted girls were those in class 4 with age 9 and above and out of school girls aged 9 years. The annual target for this cohort was 20,750 girls. HPV vaccine used was Quadrivalent (Gardasil) and given in two dose schedule at six month apart. Delivery strategy used was campaign strategy in which each round took. Two rounds of vaccinations were conducted in the first year of demonstration project. First round was conducted from 5th to 9th May 2014 while the second round was conducted from 3rd to 7th November 2014.

### 2.2.1 Major pre-implementation activities during first round.

1. Regional Stakeholders meeting in the region involved the High Government Management in the Region and Local Government Authority include Administration (both from Health and Education) at regional and district levels, Religious Leaders, Immunization and Cervical Cancer stakeholders from National and Regional levels. Objective of the stakeholders meeting was to conduct advocacy, sensitization and soliciting involvement in the implementation of HPV vaccination.
2. Cascaded trainings was conducted from the Regional to the Health Facility level including School Teachers, Community Leaders and Community Health Workers. This was immediately followed by registration of all eligible girls in and out of schools in which total of 18,705 girls were registered. Intensive social mobilization was conducted which included parents and teachers meetings.
3. Health facility micro planning for introduction was done involving health workers, school teachers, community leaders and community health workers to identify and agree on vaccination posts and dates.

### 2.2.2 Major pre-implementation activities during Second round

For the second round there was intensified social mobilization, updating of the girls’ registrations, review and updating of the health facilities’ micro plans.

### 2.2.3 Administrative results

In the first round, a total of 17,638 (94%) girls were vaccinated (17,222 in school and 416 out of school while in the second round total of 17,170 were vaccinated in school and 406 were from out of school to make total of total 17,576 (92.6%.)

### 2.2.4 Coverage Survey results

Coverage survey results indicate 93% of eligible girls were fully vaccinated (two doses), while 6% were partially vaccinated (single dose) and only 2% were not vaccinated by history and card. 60% of eligible girls were having HPV vaccination cards at home. Only 54% knew what the vaccine protects against however 87% have heard of cervical cancer mostly in the radio.

### 2.2.5 Lesson learnt in the first year

* Good coverage achieved within one week.
* The activity was not routine immunization but a campaign. This means every year the country had to do two rounds of campaign
* Vaccination was not integrated with other routine immunization services. Focus was on HPV vaccination only.
* For the whole week of the campaigns other health services were paralyzed to ensure the campaign is successfully implemented
* Everyone involved in the campaign was paid allowances.
* Generated data was not easy to be captured in the Routine Immunization monthly data.

## 2.3 Second year of HPV Vaccination Demonstration Project

Second National, Regional and District Stakeholder meeting was held in February 2015 to review the implementation of the first year and evaluate if the objectives was achieved prior to scaling up nationwide. Regional Implementation report, Post Introduction Evaluation Report and Coverage Survey report were reviewed. All recommendations were reviewed and two major decisions were made which included:

1. Change the strategy from campaign to routine mode
2. Use the specific age cohort of 9 years either in school or out of school

*According to National Bureau of Statistic (NBS) the annual target for 9 years old girls was 21,665 in Kilimanjaro.*

As of April 1st, 2015, the HPV vaccine was routinely available at health facilities on weekdays, and through outreaches at primary schools (with varying number of sessions and frequency across districts).

### 2.3.1 Major pre-implementation activities

1. Health Workers were oriented on the changes on eligibility criteria in which single age cohort of 9 years old girls in and out of school were eligible and they will be vaccinated using routine immunization mode.
2. The vaccination data will be captured as part of health facilities routine immunization data using the existing data monitoring and management tools.
3. Each health facilities was requested to update the routine immunization health facilities micro plans and include all the schools in their catchment areas as outreach posts.
4. Health facility micro plan process involved health workers, school teachers and community leaders to identify and agree on the number of outreach services and dates per month.
5. Registration of all eligible girls in schools and those out of school and intensive social mobilization was conducted which included parents and teachers meetings.

### 2.3.2 Administrative results in second year using routine mode

A total of 19,299 (89%) girls were vaccinated with first dose and 16,918 (78%) completed the second dose.

### 2.3.3 Coverage results

Coverage survey for the 2nd year indicated that demonstration program was quite successful is reaching eligible girls in Moshi DC and Same: vaccine uptake (first-dose coverage) was 97.9% in Moshi DC and 85.3% in Same DC. After 14 months of HPV vaccine delivery (April 2015 to May 2016), only 2.1% of eligible girls had not been reached by the program in Moshi DC, as opposed to 14.6% in Same DC. From an evaluation standpoint, restricting the window of opportunity for reaching a single-age cohort to 12 months (or April 2015 to March 2016); HPV vaccine coverage for 2 doses would have been 74.2% in Moshi DC and 70.7% in Same DC.

### 2.3.4 Lesson learnt in the second year

* Distribution of HPV vaccines was done with other antigens using the normal distribution matrix.
* Inadequate allowance for outreach because of addition outreach to school which was not included in CCHP
* Stock out of HPV vaccine for more than 3 months
* Late arrival of RI reporting tools
* Girls were not coming to Health Facilities for HPV vaccination
* Lack of HPV vaccination Cards
* Increased task to H/F service provider to visit school

Chapter 3: PLANNING AT NATIONAL, REGIONAL, DISTRICT AND HEALTH FACILITY LEVEL

## 3.0 Introduction to Planning

Tanzania has planned to introduce HPV vaccine countrywide in April 2018. Prior to introduction, a detailed planning process will need to be conducted. The target population, delivery strategy, vaccination schedule, and logistics need to be carefully considered. This chapter provide step-by-step guidance in planning process for HPV introduction at National, Regional, Council and health facility level

### 3.1 National level Planning

The process of National level planning starts with updating the cMYP to include HPV vaccine particularly on the dates of introduction. A detailed introduction plan will need to be developed. The plan outlines all activities and steps required for a successful introduction by programme component, identify government departments, institutions or external partners that are responsible for each activity, and include a timeline and detailed budget.Given the unique considerations for HPV vaccine introduction and time constrains, IVD has identified sequencing activities in a detailed chronogram that highlight critical milestones necessary for the HPV vaccine introduction to proceed smoothly. The planned activities included but not limited to:

* Develop and disseminate HPV vaccine work plans
* Develop and share fact sheet
* Develop and share Microplanning and data tools
* Develop and disseminate Guidelines and IEC materials (ToT)
* Registration of eligible girls in both schools and communities
* Pretesting the IEC materials
* Develop minimum checklist for HPV vaccine activities within RI
* Print training guidelines materials and Vaccination cards
* Share micro planning tools with subnational level
* Develop budget for orientation and micro planning exercise
* Orient Subnational level trainers (RHMT/CHMTs) on how to conduct cascade orientation for lower level
* Disseminate operational plan and budget with subnational level
* Distribution of funds to subnational level
* Conduct readiness assessment
* Introduction of HPV vaccine Countrywide
* Communicate with subnational levels to ensure engagement of education sector and other stakeholders
* Confirm account information
* Intra introduction assessment
* Post introduction Evaluation

## 3.2 Regional and Council Level Planning

### 3.2.1 How to identify the target population for HPV vaccination?

HPV vaccination is recommended for girls aged 9 to 14 year-old. For the first two consecutive years of 2018 and 2019, Tanzania will provide HPV vaccine to girls aged 14 years and if everything goes well, in 2020 all girls aged between 9 to 14 years will be given HPV vaccine. Starting from 2021 and beyond, only 9 years old girls will be eligible for HPV vaccines. These target age cohorts were chosen because they are the average age of girls before becoming sexually active. These girls can be found in two main areas:

* At primary or secondary schools (for those in school), and
* At the community (for out of school girls)

The micro plan template provided as Annex 4 will be used to identify the target population for HPV vaccination. The following planning sections will be used:

* 1a Schools that has the targeted population for HPV
* 1b Communities that has target population for HPV
* Total number of target population for HPV

In addition to target population, other issues have to be considered in planning HPV vaccinations includes:

* Vaccines and Supplies requirement for HPV vaccination
* Data management for HPV vaccination
* Waste management
* Advocacy, Communication and Social mobilization
* Training of health workers and the community

In completing micro planning tool, all relevant personnel must be involved at regional and council levels such as; Immunization and Vaccine Officers, Reproductive health Coordinators, Education Officers, Community/Village leaders and Health care workers.

## 3.3 Health Facility Level Planning

Health facilities is the primary delivery point of HPV vaccination. Detailed micro planning is essential particularly linking with schools and communities. Health facility micro-plans should include:

* **What:** Activities to be done (sensitization, mobilization, registration of target girls, vaccination, mapping)
* **When:** Dates of vaccination, schedule for community and school sensitization/mobilization, immunization
* **Where:** List of schools, facility or outreach post
* **Who:** Health worker, VHW, teacher, target girls, contacts of school authorities
* This should feed into the district and sub country micro plan

The health facility micro plan template provided see mwongozo wa mchanjaji page 28-34 will be used to identify the target population for HPV during health facility micro plans.it contain the following information that has to be filled

* 1a Shule za Msingi na Sekondari
* 1b Vijiji
* 1c Walengwa
* 1d Idadi ya Chanjo
* 1e Taarifa za taka (Waste management)
* 1f Uhamasishaji

Since majority of the targeted population are at schools, each targeted school should be visited for the purpose of:

* Sensitization of teachers and girls
* Display posters and share flyers
* Scheduling the dates for immunization in schools
* Scheduling the dates for immunization in communities (for non-school going girls)

## 3.4 Determining the age of girls who are eligible for HPV vaccination

The target age of 14 years’ old girls will be determined using an approach of “year of birth” that is, all girls born in the year 2004 will be 14 years old in 2018 while all those born in 2005 will be 14 years old in 2019. This approach determines that all girls born in 2004 are eligible in 2018 because they all will have turned 14 years of age in 2018. Those born in 2005 will be 14 in 2019. In this scenario, when the HPV vaccine is introduced it is announced that all girls born in 2004 should receive HPV vaccination in 2018 and those born in 2005 should receive HPV vaccination in 2019. Regardless of when the vaccine doses are offered or administered, the cohort who is eligible in that year receives the vaccination. Additionally, in places with limited knowledge or records for exact date of birth, girls, parents, health workers, and teachers may be more likely to know or determine a year of birth using significant events

## 3.5 Estimation of the number of girls to be vaccinated with HPV Vaccine

In order to plan, forecast vaccine supply, and be able to calculate coverage, an accurate estimate of the number of girls in the target age group is required. Each council/HF should make this calculation using up-to-date national or local population data obtained from national bureau of statistics (NBS) offices.

## 3.6 Where to identify targeted girls for HPV vaccination

Once the target population and its size has been determined, it is necessary to understand where the girls may be located in order to plan and reach them for vaccination. Girls who are attending school may be found at schools. It is important to remember that, in the first three years eligible girls can be found in both Primary and/or Secondary schools. It is also important to note that not all eligible girls attend school. Out of school girls may be dispersed and difficult to locate. They may be in the formal or informal labor market, assisting families with agriculture, household chores, tending livestock, or other activities in the community. Reaching girls who are members of pastoralist communities or live in remote locations may require specific strategies.

Councils and Health facilities are encouraged to work with education, census, labour, school health, communities and other sectors to map the situation in their council/HF, including estimations of the proportion of girls attending / not attending schools.

# Chapter 4: HPV VACCINATION IMPLEMENTATION

## 4.1 Coordination

### 4.1.1. National Coordination

* + The Rollout of the HPV vaccine in Tanzania is spearheaded by the National Inter-Agency Coordinating Committee (ICC). Membership of the ICC includes Government Ministries of: Ministry of Health, Community development gender elderly and children (MOHCDGEC), and Presidents Office, regional and local government authority (PORALG) in collaboration with the Ministry of Education (MOE), CSOs: Tanzania Pediatric association (TPA), Association of Gynecologists and Obstetricians in Tanzania (AGOTA), Medical Women Association of Tanzania (MEWATA) and Red Cross , Development Partners: WHO, UNICEF, USAID, CHAI, JSI,
* The regional and districts will be responsible for coordinating the rollout at regional and district levels. The main coordination will be through the PHC committees of the two levels respectively. The PHC will be extended to include the appropriate and available stakeholders at the levels.
* The National IVD Technical Working Group with members from Government and Partners is responsible for coordinating, planning and ensure the rollout is implemented under the guidance of the National ICC.
* Other subcommittees working at National level are the advocacy, communication and social mobilization, logistics, training and the monitoring and evaluation committee.

The National IVD technical Working Groups:

1. Technical Working Group will be responsible for:
* Coordination of planning and implementation of the activity
* Develop the implementation field guide
* Micro planning process and budgeting
* Supervising and monitoring the whole operation of HPV rollout
1. Logistics Working Group will be responsible for:
* Estimating the required number of bundled vaccines, cold chain equipment, and transport.
* To develop a vaccine distribution plan and ensure timely distribution of vaccines and other supplies
* Reviewing the cold chain storage capacity and readiness at all levels and supervising the availability of adequate and functional cold chain for all regions, districts and health facilities.
1. Social Mobilization Working Group will be:
* Secretariat of the National Social Mobilization and Advocacy High level Committee
* Coordinating the National, Regional and District launching
* Conducting Community mobilization activities to create demand for the vaccines and in conjunction to technical team, give guidance to response on all questions associated with HPV vaccination.
* Develop Crisis management plan in case of a crisis mainly caused by rumors
* Development of IEC materials (posters, leaflets etc), media (jingles, radio and TV spots etc)
* Support all efforts of advocacy, communication and social mobilization for the HPV vaccine
1. Training Working Group will be responsible for all aspects of the HPV vaccine trainings at all levels.
* Develop, reviewing and adapting training documents and operational guides.
* Coordinate the printing of the training guidelines
* Plan the training for all health workers
* Provide and ensure the training guidelines and materials are distributed to regions
* Supervising and monitoring the trainings to ensure quality of training
* Keep records of who have been trained
1. Monitoring and Evaluation Working Group will be responsible for:
* Developing, printing and distributing data collection tools such as tally sheets, supervisory checklists, Monitoring and evaluation forms / tools
* Monitoring all aspects of the planning and implementation of the entire exercise
* Ensure availability of the monitoring tools at all levels
* Planning for the monitoring and evaluation of the HPV vaccine roll out

## 4.2. Regional and district coordination

### 4.2.1 Region Coordination

The Region Health Management Team (RHMT) and the Regional education department supported by other immunization stakeholders, Adolescent health stakeholders and cervical cancer intervention stakeholders based in the Region etc. Their main responsibility is to develop regional macro-plans, coordinate, supervise and monitor the rollout.

* The Regional Technical Team will work under guidance of the Regional Commissioner (RC) and Regional Administrative Secretary (RAS) through the regional PHC. The Regional technical team led by RMO and RIVO will supervise the district rollout.
* The regional technical team will subdivide into technical, logistics, social mobilization and monitoring teams
* Coordination will be Headed by the Regional Commissioner
* Involve all stakeholders
* Coordinate planning and rollout at regional level
* Coordinate integration lead by the RC involves both the RMO and the REO and other stakeholders

Technical team led by the Regional Medical Officer. Involves both the Health and Education department

* Lead the micro planning process and budgeting for the region
* Plan and coordinate the training
* Provide and ensure the training guidelines and materials are distributed to regions
* Supervising and monitoring the trainings to ensure quality of training
* supervising and monitoring the whole operation of HPV rollout
* Ensure availability of the data collection tools such as tally sheets, supervisory checklists, Monitoring and evaluation forms / tools in councils and health facilities
* Monitoring all aspects of the planning and implementation of the exercise

Logistics Working Group will be led by RIVO working closely with other RHMT members and will be responsible for:

* Estimating the required number of bundled vaccines,
* Ensuring vaccines are ordered and timely distributed to the districts.
* Development of logistics plan to ensure supplies are delivered to the districts
* Reviewing the cold chain storage capacity for the region. Check all the councils and health facilities.

Social Mobilization Working Group will be responsible for;

* Regional launching
* Conducting Community mobilization activities to create demand for the vaccines and in conjunction to technical team, respond to all questions associated with HPV vaccination
* Crisis management plan in case of a crisis mainly caused by rumors
* Ensure availability IEC materials
* Support all efforts of advocacy for the HPV vaccine in the region
* Communicate with local media

### 4. 2.2 Council Coordination

The Council Health Management team (CHMT) supported by other immunization stakeholders based in the District Council their main responsibility is to develop council micro plan, coordinate, supervise and monitor the planning and management of the rollout in the council.

The District Coordination will work under guidance of the District Commissioner and District Executive Director through District Primary Health Care Committee.

***Coordination***

* Headed by the District Commissioner
* Involve all stakeholders
* Coordinate planning and rollout at district level
* Coordinate integration lead by the DC involves both the DMO, DEO and other stakeholders

***Technical team*** led by the District Medical Officer. Involves both the Health and Education department

* Lead the micro planning process and budgeting for the district
* Plan and coordinate the training
* Provide and ensure the training guidelines and materials are distributed to the health facilities
* Supervising and monitoring the trainings to ensure quality of training
* supervising and monitoring the whole operation of HPV vaccine rollout at district level
* Ensure availability of the data collection tools such as tally sheets, supervisory checklists, Monitoring and evaluation forms / tools in councils and health facilities
* Monitoring all aspects of the planning and implementation of the exercise at district level

Logistics Working Group led by the DIVO will be responsible for:

* Estimating the required number of bundled vaccines,
* Ensuring vaccines are timely ordered and distributed to the health facilities
* To develop a logistics plan to ensure vaccine are delivered to the health facilities
* Reviewing the cold chain storage capacity and readiness for the facilities.

Social Mobilization Working Group will be responsible for:

* District launching
* Conducting Community mobilization activities to create demand for the vaccines and in conjunction to technical team, respond to all questions associated with HPV vaccination.
* Crisis management plan in case of a crisis mainly caused by rumors
* Ensure availability of IEC materials
* Support all efforts of advocacy for the HPV vaccine in the region
* Communicate with local media

## 4.3 Training of HPV vaccine rollout

The training will be conducted in a cascade method/manner, starting from national, regional, district and health facility level. The training will have information on:

* Introduction to HPV infection and cervical cancer
* HPV vaccine attributes and storage conditions
* HPV vaccine eligibility and contraindications
* HPV vaccine administration
* Recording and monitoring of HPV vaccine doses.
* Adverse Effects Following Immunization and its reporting.
* Data Management
* Social Mobilization including communicating about HPV vaccine with key stakeholders

Teachers will also receive training on their specific tasks during implementation of HPV vaccination example providing education to parents and girls, registration of girls, preparation of vaccination session in schools, recording vaccination and make follow up of eligible girls to make sure they receive two doses of HPV vaccine

## 4.4 Supportive supervision

Supportive supervision will be conducted to regions and districts.

* This will enable the National, Regional and District levels to assess the implementation during routine vaccination and in the intensified months.
* The supportive supervision will inform the National, Regional and district levels on the performance of implementation and associated challenges during the HPV Vaccine introduction so that identified issues can be addressed.
* Supervisor schedules and integrated checklist tools will be reviewed/adapted to include HPV vaccine.

**Pre-rollout:** Pre rollout Supervision will assess the readiness of the rollout to identify gaps and rectify for efficient and effective rollout. Develop a checklist for pre-implementation supervision.

**Supervision during the rollout:** Should ensure the rollout is implemented. Check for adequacy in vaccines, cold chain, and human resource. Give special attention to the out of school girls with the community to confirm the girls are reached. School going girls should also be checked to ensure/confirm that all eligible girls are reached

Once HPV vaccine is introduced, implementation should be periodically monitored through supportive supervision, which includes “on-the-job” training. Supportive supervision strengthens the capacities of health workers and improves performance; visits can be used to provide feedback, update health staff on this and other vaccinations, enhance motivation, and identify future training needs. Staff should be specifically asked about HPV vaccine coverage and any problems (supply or demand) that they face with all vaccine including HPV Vaccine.

**Roles of National Technical Coordinators for the Regional Rollout**

* Provide technical support to the subnational levels for the HPV rollout training for the health facilities training
* Support Regional Team to review the plan and ensure they are on track for rollout in the region which will include identifying gaps and together discussing solutions
* Ensure the Council level implementation plans are with the Region and there are regional maps showing all Councils and Health Facilities service areas (Especially where there are hard to reach out of school girls)
* Ensure availability of vaccines, cold chain and logistics materials
* Ensure training is on schedule
* Ensure advocacy and social mobilization activities are on track
* Ensure involvement of all stakeholders including local media
* Ensure launch has been planned
* As part of the Regional team, monitor and supervise implementation of Council Supervisors
* Ensure AEFI monitoring is on track
* Ensure the crisis management protocol of handling rumors is available
* Ensure the waste management plan is clear.
* Support Regional Team to conduct the Regional level stakeholders meeting to discuss HPV vaccination rollout
* Ensure coordination between Health, Education, Adolescent health and Cervical Cancer prevention

**Regional Technical Officer**

* Regional Technical Coordinators from the Regional Technical Team will supervise the councils.
* Support Council Team to develop the comprehensive Council micro plan
* Support Council Team to conduct the Council level stakeholders meeting to discuss on HPV
* Ensure there are Council maps showing all the Health Facility service areas, schools, villages/ streets, vaccination post fixed and temporary, roads with distance and population.
* Ensure the Health Facility service area level implementation plans are displayed at the
* Ensure the availability of vaccines, cold chain and logistics materials
* Ensure the protocol of handling rumors and providing statements in case AEFI occur to assure the public is discussing in the District PHC Meetings
* Monitoring and auditing all AEFI
* Ensure the proper waste management
* Data collection and compilation

**Council Supervisor**

* Support the Health Facility in charge to conduct the stakeholders meeting
* Ensure there is a Health Facility service area map showing all the villages, settlements/streets, vaccination post, roads and population
* Ensure the hard to reach areas and special population are reached
* Ensure the availability of vaccines, cold chain and logistics materials
* Ensure the availability of emergency drugs for AEFI
* Ensure the waste management
* Monitoring and supervision of the rollout
* Data collection and compilation
* Ensure School, Health facility, community and Parents linkages

## 4.5 Implementation strategy for the rollout

* The rollout will be launched on the 2nd of April, 2018
* The routine immunization services will be the strategy used to deliver HPV vaccine in Tanzania.
* Health Facilities will be the main point of provision of the vaccine as other antigens in the routine immunization and vaccines will be available on a continuous basis every day of the year.
* Eligible girls may be vaccinated either at health facility, outreach posts or schools depending on the joint planning between Health facilities, Schools and Communities within the catchment area.
* Outreach services are part of routine immunization services.
* Schools will be used as addition outreach posts to reach all eligible school girls.

##  *ELIGIBILITY*

The vaccine as adapted from the WHO recommendation and guidance from the MOHCDGEC is for ages 9-14 years. It is not cost effective to provide the vaccine to girls’ already sexually active and therefore exposed to the virus.

In the first two years of rollout (2018 and 2019) eligible girls will be the upper age limit of 14 years. This is due to global HPV vaccine shortage. The target will be all **girls who will turn 14 years starting from January 1st to December 31st 2018 and 2019 respectively.**

* In 2020, the third year of HPV introduction, eligible girls will be 9-14 years.
* Starting from 2021 and beyond, (the fourth year and beyond) eligible girls will be age cohort of 9 years old. Targeted Girls will be vaccinated based on the age at the time of the first dose, using the date of birth of the girl.

***NB:*** In the fourth year girls between 10 to 14 years who missed one or both doses in third year of introduction will receive the missing dose and girls who are15 years old and have only received first dose in 2nd year will be given a 2nd dose

### 4.5.1 Vaccination Age Groups and Immunization Schedule

***Vaccination Schedule***

* The recommended vaccination schedule is 1st dose administered at first contact and 2nd dose administered 6 months after first dose.
* HPV vaccine is very effective and provides almost complete immunity after two doses.

**Note:** HIV infected girls need three dose to have complete immunity and the vaccination schedule is (0, 2 and 6)

***Registration of eligible girls***

* Registration of eligible girls in schools will be done by School Teachers using the designed Register Form which will be indicating the name of the girl, age, name of the parent, parent physical address, date of vaccination for both the first and second dose.
* Registration of eligible girls out of school will be done by Community Health workers and Community Leaders using the designated Register form indicating the name of the girl, age, name of the parent, parent’s physical address, date of vaccination for both first and second dose.
* In situation where the printed register will not be available, the normal exercise book will be used and columns will be made in exercise book to give the same information as in register form.
* All eligible girls will be registered irrespective of their previous vaccination status. Those already vaccinated will be noted and information recorded in the register and will be given vaccination card.

## 4.6 Administration of HPV vaccine

## How to organize an HPV vaccination session

Vaccination sessions for HPV vaccine will be similar to those organized for infant immunizations. As with other vaccines, immunization sessions for HPV vaccine should have all the necessary supplies and materials for effective delivery.

## Immunization Sessions in Schools

Preferably all immunization sessions if conducted at schools should be conducted indoors. It may be necessary to use a classroom for the immunization activity. If a classroom is used, students must be re-located for the duration of the activity. Teachers should plan ahead of time which room at the school is going to be used for immunizations. The room must be:

* Clean with furniture moved out of the way
* Large enough to allow for girls to waiting to be vaccinated
* Have a large desk or table available for health worker to set up necessary supplies

## *Roles and Responsibilities of Staff at the Immunization Session Post*

The following staff should be available at the immunization post to screen eligible children, vaccinate, and keep proper records:

***At school***

* Teacher (school health coordinator) as recorder
* Health Worker as the vaccinator.

***At the Community/village***

* Health worker as vaccinator
* Community health worker as recorder
* Community leader as supervisor in his/her village

## Setting up the Immunization Session Post

The immunization session post needs to be well organized to create conducive environment for efficient delivery of immunization services. The following areas are essential:

* Waiting area
* Registration/screening
* Immunization table
* Check point/ recording area (Tallying area)
* Observation area (girls must wait at least 15 minutes after being vaccinated)

Design the immunization post for efficient flow and avoid “bottle necks”, excess crowding, long waiting times, or confusion.

### 4.6.1 Role of the Teacher

* Sensitizes students and the school community about HPV/cervical cancer vaccine prior to the day of vaccination
* Assists in the setting up of the vaccination post at his/her school
* Calls eligible students to the vaccination post
* Helps to screen the eligible girls coming for the immunization based on date of birth and register (primary screening)
* Fills the girl’s name and the date of vaccination on the card and gives the card to the girl for safe keeping
* Updating the registers for girls who have been vaccinated
* Controls the crowd (enforces queue)
* Ensures a one-way-flow through the post
* Thanks the child for coming
* Report any reported/observed AEFI to Health workers

### 4.6.2 Roles of Health Worker A (Vaccinator)

* Screen girls coming for the immunization based on date of birth (secondary screening)
* Ensures adequate vaccine is packed in the vaccine carrier with at least three conditioned icepacks
* Ensures adequate availability of auto-disable syringes and needles
* Prepares each AD syringe for administration before each vaccination
* Vaccinates all eligible girls
* Ensures vaccination area remains safe and clean
* Ensures correct storage of vaccine and other supplies
* Ensures safety in immunization procedures
* Monitor any reactions and responds to questions from parents/caretakers/children
* Fills AEFI forms if needed and reports any AEFI cases to supervisor using normal AEFI reporting channels

### 4.6.3 Roles of the Community health worker

* Sensitization and educating parent/guardian and the community on importance of HPV vaccine.
* Registration of all targeted girls not attending school in the village
* Preparation of vaccination post in the village if the village doesn’t have dispensary.
* Helps to screen the girls with 14 year old coming for the immunization based on date of birth and register (primary screening)
* Fills the girl’s name and the date of first immunization on the card and gives the card to the girl
* Ticking children who have been immunized from the register
* Tallies HPV vaccinations following each injection
* Gives health advice to the girl about HPV vaccine and possible side effects
* Informs the child of the next vaccination date

### 4.6.4 Role of community leader

* Advocacy and social mobilization of HPV vaccine in his/her village.
* To supervise registration of all targeted girls out of school in his/her village
* To supervise setting up of vaccination post in his/her village, if no dispensary in the village.
* Follow up of all registered girls to make sure they have got vaccine.
* Helps to screen the girls with 14 years coming for the immunization based on date of birth

**Administration of the vaccine**

HPV vaccine is administered by intramuscular (IM) injection at the left shoulder see the picture below;

 

In addition to following all the basic requirements for any injectable vaccine, a few additional steps before and after are required to properly administer HPV vaccine to the girls

**Steps prior to HPV vaccine injection**

1. Verify eligibility of the girl
2. Ensure name, address (if collected), and date of birth or age is recorded in vaccine register
3. Ensure girl understands purpose, benefit and risks of vaccination, as well as of not receiving the vaccine
4. If required, check written consent received
5. Verify girl assents to vaccination
6. Ensure no contraindications
7. Check vaccination card and determine if 1st or 2nd dose is due
8. Ensure the girl is seated for vaccination
9. Ensure the arm is clear and clean
10. Administer the vaccine
11. The vaccine is administered into the left upper arm 0.5 intramuscular

# Chapter 5: VACCINE MANAGEMENT

## 5.1 Forecast and quantification for HPV vaccine

In general, HPV vaccine forecast and quantification follow the standard procedures for calculating vaccine supply of other vaccines and be integrated into existing mechanisms to order other vaccines. HPV vaccine is integrated into the stock-management system and vaccine orders must be timed such that the supply is not disrupted.

Doses required for the annual supply is based on the size of the target population, estimates of vaccine coverage of the first dose, and vaccine wastage.

At national, regional and district level, the number of doses needed per year/specified time is calculated from the formula below

$Vaccines needed=Target populationxCoverage X Number of doses per schedule X$ Wastage factor

## 5.2 Target will be obtained from NBS estimation and registration (at school and in the community)

As the vaccines is in 1-dose vial the estimated vaccines wastage is 5% and hence wastage factor will be calculated as follows;

$Wastage factor=\frac{100}{(100-Wastage Rate)}$

 $=\frac{100}{(100-5)}$ =1.05

$HPV Vaccines needed=Target population X Coverage X Number of doses per schedule$ **X** 1.05

For example, if the target population for the 14 years old for district **X** per year is 2000 and expected coverage is 90%

$HPV Vaccines needed=2000 X 0.9 X 2 X$ 1.05

 =3780 doses

Always add 25% of the amount calculated as a buffer;

So the amount to order if the ordering were to be done once per year is

 =3780 doses + (3780 doses **X** 0.25)

 **=3780+945=4725 doses**

The delivery of the HPV vaccine should be accompanied by 0.5 ml syringes and safety boxes.

**The amount of syringes needed are equal to target population X expected coverage X doses X wastage factor + 25% Buffer.**

$Wastage factor for 0.5ml syringes =\frac{100}{(100-Wastage Rate)}$

 $=\frac{100}{(100-10)}$ =1.11

So 0.5ml syringes needed are;

= (2000 **X** 0.9 **X** 2 **X** 1.11) + 25%

= (3996 Syringes) + (3996 X 0.25)

=3996+999

**Total syringes required is 4995**

The additional safety boxes needed are;

1 safety box can hold 100 used syringes and needles so the additional safety boxes needed is

$Wastage factor for safety boxes =\frac{100}{(100-Wastage Rate)}$

 $=\frac{100}{(100-10)}$ =1.11

$\frac{4995}{100}=49.95 which is equal to 50$ X wastage factor

= 50 X 1.11

Total Safety boxes required will be 55.5 = **56 Safety Boxes**

**Wastage rates**

|  |
| --- |
| HPV Vaccines 5%Syringes 10%Safety boxes 10% |

Three months after introduction of the vaccine in the routine immunization the consumption can be reviewed at the health facility level and consumption method used in the computation of the quantity of vaccines to be ordered.

Distribution of the HPV vaccines will be integrated with other vaccines at the district level and no increased number of distribution frequency is expected.

## 5.3 HPV Vaccine storage

HPV vaccine management should follow the same procedures as for other vaccines in the cold chain. Upon receipt and confirmation of quantity delivered, the vaccines should be placed in designated refrigerators. All HPV vaccines should be stored between +2° to +8°C.

Regular temperature monitoring procedures should be maintained in all cold storage equipment and checked twice daily throughout the year, including weekends and holidays. Fridge tags and/or other WHO prequalified remote temperature monitoring devices should be used in the refrigerators (freeze tags should always be used during transportation of vaccines).

**HPV vaccines SHOULD NOT BE FROZEN as they are exceptionally sensitive to temperatures lower than +2°C and lose efficacy if frozen.**

Vaccines subjected to temperatures lower than +2°C should not be used.

HPV vaccines cannot be placed directly on or near the freezer portion of refrigerators, and HPV vaccines should not be stored near the liners or walls of cold boxes and or ice-packs in vaccine carriers.

Proper procedures for conditioning ice-packs in vaccine carriers or use of cool water packs in vaccine carriers should be followed.

**HPV vaccines are sensitive to light and should be stored in the safe place away from direct light.**

## 5.4 HPV Vaccine Vial Monitor (VVM)

HPV vaccine has VVM sticker at the top of the vial which records cumulative heat exposure through a gradual change in color. The VVM status will hence decide which vaccines can safely be kept after a cold chain break thus minimizing unnecessary vaccine wastage.





**Cumulative heat exposure**

# Chapter 6: INJECTION SAFETY

## 6.1 Ensuring Safe Injections

The auto-disable syringe is the preferred type of disposable injection equipment for administering vaccines.

This type of syringe is the preferred choice for conducting mass vaccination and routine immunization. Use of auto-disable syringes minimize the risk of person to person transmission of blood borne pathogens because it cannot be reused.

* Unsafe injection practices put clients, health workers/service providers, and the community at risk of injection abscesses and blood-borne diseases.
* A safe injection in immunization is one where:
	+ A potent vaccine is administered using the right technique/procedure, at the right site, and administering the correct vaccine and dose using the right needle and syringe
* According to WHO, a safe injection:
	+ Does not harm the recipient,
	+ Does not expose the provider to any avoidable risk, and
	+ Does not result in any waste that is injurious to the community

 

* A sterile packed 0.5 ml auto-disable syringe must be used for each injection for each child. Immediately after injecting the child place the syringe in the safety box.
* DO NOT leave the syringes lying on the table, in a tray or anywhere else after injection: put it straight into the safety box.
* DO NOT ATTEMPT TO RECAP THE NEEDLE. This practice can lead to needle stick injuries.
* Do not use auto-disable syringes from damaged or punctured sterile packs or which have passed the manufacturers’ expiry date.

## 6.2 Monitoring injection safety

Supervisors need to be trained in the monitoring of injection safety and to include relevant questions in their supervisory checklists during the implementation. The Implementation Checklist should be used as a tool for a rapid assessment on injection safety in each supportive supervision visits.

### 6.2.1 Procedures to ensure a safe vaccination injection

* Ensure a clean working environment.
* Lay the vaccination table in an orderly manner (vaccine carrier, auto-disable syringes, dressing jar/clean plastic bowl for cotton swabs, gallipots for cool boiled water for cleaning the site of injection).
* Wash hands before preparing vaccines and giving injections. Cover small cuts before administering the vaccines. Ensure a clean working environment.
* Use a new AD syringe and needle for every client.
	+ Inspect the packaging very carefully. Discard a needle or syringe if the package has been punctured, torn or damaged in any way.
	+ Observe the non-touch technique. Do not touch any part of the needle that has to come into contact with the vaccine or the client. Discard a needle that has touched any non-sterile surface.
	+ Draw the vaccine into the syringe only when there is a girl ready for vaccination.
	+ Do not load several syringes with vaccine in an anticipation of large turn up.
	+ Avoid giving injections at a site of skin that has a local infection, e.g. chicken pox.
	+ Position or hold client properly and administer the vaccine according to the recommended technique (HPV vaccine is administered intramuscularly).
	+ NEVER recap needles after use.
	+ Every used syringe and needle should be put in the safety box provided.
	+ The safety boxes should not be overfilled or made wet 100 syringes and needles per safety box, or when the safety box is ¾ filled).
	+ Do not put the used swabs or empty vaccine vials in the safety box.
	+ Collect all the filled safety boxes and deliver to the nearest health facility at the end of each session for proper disposal.
	+ Every vaccination site (static or outreach) should be left clean

## 6.3 Ensuring Safe Disposal of Injection Equipment

***Disposal of Used syringes and needles***

* All used syringes and needles must be disposed immediately after use by dropping them into the safety boxes provided in all vaccination posts. These boxes reduce the risk posed by contaminated needles and syringes to both the health staff and the general public.
* Vaccinators should place used needles and syringes in safety boxes immediately after administering vaccine.
* Close the nearly (approximately 3/4) full box securely shut and store the box in a safe place until it can be properly disposed of, so as to prevent infecting yourself, other health care workers and the community.
	+ To avoid an occupational hazard, safety boxes should not be over-filled.
	+ One box can hold 90 to 100 syringes and needles.
* Used syringes should not be transferred from one container to the other, and must not be left in a public area of the post or health facility.
* Do not transfer filled safety boxes from one place to the other if you expect any damage to the containers to allow spill or uncontrolled drop of used sharps.

***Remember***

* *The safety boxes should be properly assembled according to instruction printed on the boxes.*
* *The open safety boxes with used syringes and needles are DANGEROUS*

## 6.4 Handling and disposal of Safety boxes

Used syringes and needles at immunization posts will be discarded in the safety boxes provided for the purpose. Once safety box is nearly full (approximately ¾), safety boxes will be disposed of as follows:

* For immunization posts located at a distance of less than 5 km from incinerators, the filled safety boxes should be collected for incineration and those more than 5 km from incinerators should be collected and burnt in a 1m deep pit at the vaccination posts.
* In-charges will oversee the ultimate disposal by either burn and bury or by the pit method



**Pit Burning (Steps by step)**

* Choose an unused area for the burning site, as far from buildings as possible. The area should be cleared.
* Dig a pit at least 1.5 meter wide and 2 meters deep
* Place the filled safety boxes in the pit. Mix paper, leaves, or other flammable materials among the boxes to help them burn.
* Warn people to stay away and avoid smoke, fumes, and ash from the fire.
* Burn until all boxes are destroyed
* You can re-use the pit on subsequent disposals, covering completely each layer of burned waste with a thin layer of soil till the pit is almost ¾ filled.
* Cover it with soil

**Posts in Urban areas**

Explore availability of appropriate waste disposal such as incinerator in urban area or designate a suitable disposal location for a burn and bury pit. In charges will also oversee the ultimate disposal of sharps.

**Disposal of Other Wastes**

Any other waste should NOT be put into the safety boxes. Instead, other waste should be disposed of in a bin and burned regularly along with the safety boxes.

# Chapter 7: ADVOCACY, COMMUNICATION AND SOCIAL MOBILIZATION FOR HPV

## 7.1 Introduction

To ensure that the Introduction of HPV vaccine is done smoothly and all eligible girls are reached, effective communication and advocacy strategies are very important before, during and after introduction. Increasing community awareness through timely, complete and appropriate communication is the key to successful and sustainable HPV vaccine introduction. In order to achieve this all potential stakeholders to enable a successful introduction and acceptance of HPV vaccine at National, Regional, Districts, Health facility and community level need to be reached with different approaches towards the introduction period. The Immunization and Vaccine Development Program (IVD) should ensure that health workers get the most detailed information as they may need to be convinced about the importance of HPV vaccine, and need to provide information and answer questions from parents, girls, and the community, as well as for their own understanding to be able to answer questions they may receive.

Experience has shown that parents’ decisions are heavily influenced by receiving information from sources they trust - principally their families and close friends, local health workers, their teachers and religious leaders. Parents also like to receive information through interpersonal, direct communication and discussions. To ensure all local Personnel trusted sources of information are conversant and communicate accurately about HPV vaccine and its benefits, local government authorities should ensure effective use of Local available forums and platforms to pass right messages at the right time before the introduction.

Materials such as short “frequently asked questions” or simple brochures in locally understood languages should be used to reinforce verbal messages.

A variety of other activities and channels should be considered. These include public media such as posters, billboards, and announcements in the community, at churches and mosques, or on the radio. In areas with access, television spots, mobile phone text messaging (SMS), and social media are important and effective communication channels, particularly for young people.

The timing of communication and social mobilization activities is critical to ensure there is a penetration of information to all audiences in good time prior to HPV vaccination. Each target audience may be different in the intensity and frequency required and this have to be plan from National level to lower levels.

## 7.2 Advocacy and sensitization meetings

Advocacy and sensitization meetings have to be conducted at different levels. The first advocacy meeting will involve the MOHCDGEC Officials and Immunization and Vaccines Development (IVD) Partners where the IVD Program Manager will lead the meeting. The second National level advocacy meeting will involve all stakeholders i.e. MOHCDGEC,PORALG,MOEVT,MOF,WHO,UNICEF,JSI,CHAI,PATH,JHPIEGO,AMREF,MEWATA,AGOTA,PAT,RED –CROSS,LIONS CLUB,TCDC,JHU, Religious Leaders, Related NGOs with gender and women advocates, media groups and influential leaders including politician. This extended national level advocacy meeting will be chaired by the Hon. Vice president.

At Regional and District levels the Extended PHC Meeting involving all Stakeholders including Religious Leaders and politicians should be utilized to advocate for HPV vaccination introduction. Advocacy and IEC materials including PPT have to be used to inform members on cervical cancer, HPV Vaccine and support needed from them.

 At health facilities, health facility workers should effectively pass messages to parents, caretakers and other clients at health facility on the introduction of HPV vaccine with clear explanations of benefits and beneficiaries of the Vaccine through interpersonal communication and developed IEC Materials.

 At community levels, different message has to be communicated using existing structures. Ward Development Committees (WDC) and Village / Mtaa councils, Village Health Committees (VHC), Community Health Workers (CHWs), influential people and existing community groups have to be fully involved in planning, implementation, monitoring and evaluation of HPV vaccine introduction. WEOs and VEOs in collaboration with health facilities should convene the meetings involving other local available bodies and structures to discuss and plan on how to have a successful introduction of HPV vaccine in their area of jurisdictions.

At schools, head teachers and school health teachers have to be part of planning and implementation for the successful introduction. School Teachers, Parents and guardians sensitization meetings have to be convened by the Village/Mtaa chairperson through involvement of health facility Governing Committee (HFGC).

Eligible girls in schools and out of schools have to be sensitized on the importance and value of being vaccinated with HPV vaccine using the forum of Community Leaders and Religious Leader. Therefore health facilities should plan and send official letters and IEC Materials to religious leaders and request them to announce and communicate to their followers during congregations on the importance and benefits of young girls to be vaccinated with HPV Vaccine.

##  7.3 Mass media involvement

Across all levels, sensitization has to be done using available and affordable mass media including National and community TV and Radio, social media and folk media in respective Regions and Districts. IEC materials, TV and radio spots have to be developed at National level and get distributed to Regions and districts for mass consumption. National, Regional and District personnel should arrange interviews and talk shows in TVs and radios to educate community on cervical cancer and mobilize them for utilization HPV vaccine. Also officials at National, Regional and District levels should seek for free airtime in the media to broadcast messages related to HPV vaccine before, during and after the introduction.

## 7.4 Launching

Launching should be done at National and District levels in April 2018. At National level, Launching ceremony will be done in Dodoma and expected to be officiated by Her Excellence Vice President of The United Republic of Tanzania.. Districts in Collaboration with Regions should prepare their own Launching events and at District level, the launching ceremony should be officiated by District Commissioners or Regional Commissioners depending on their availability and time. Key messages related to cervical cancer and the importance and benefits of HPV vaccine should be passed clearly to the community through prepared speeches, bongo fleva and traditional performances, songs, poems and IEC materials.

##  7.5 Identifying the audiences

Because HPV vaccine will be new, targeting an age group not normally included in the EPI schedule, could have some potential sensitivity, it is important that communication messages reach every group that will have an interest in the vaccine. Each audience should be mapped out, and each will require specific messages – some requiring more information than others. For example, depending on literacy and culture, girls and their parents will require basic information about the vaccine, vaccination program and schedule, using simple easy-to-understand language. However, others in the community such as community and religious leaders, government officials, and health and education authorities may need more targeted messages to foster their understanding of the program, the government’s rationale for including HPV vaccine in the national immunization schedule, the vaccine safety and the benefit for girls.

School headmasters and teachers arevery important audience hence should also be reached as they will be having an active role in supporting vaccinations at school.

Professional organizations, cultural and religious organizations, politicians, and the media are also important audiences as they need to support vaccination in their communities.

**Summary of communication activities for HPV vaccine introduction for different audiences**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| AUDIENCE | MESSAGE CONTENTS | RESPONSIBLE PERSON/GROUP | ACTIVITIES | MATERIALS |
| Eligible girls  | * Basic facts about cervical cancer
* Basic facts about the preventive HPV vaccine
* Benefits of being vaccinated
* Eligibility
* Their role in HPV vaccination
 | * Teachers
* Health workers
* Religious leaders
* Parents
* CHWs
* Community leaders
 | * Sensitization meeting
* Distributing materials
* Radio and TV messages
 | * HPV leaflet
* Formal letters
* Posters
 |
| Parents  | * Facts about cervical cancer and prevention
* Availability of vaccine
* Facts about the vaccine
* Their role & responsibility
* Other Primary preventive measures
 | * Health workers
* Community Health Workers
* Teachers
* Religious leaders
* Community leaders
 | * Orientation sessions
* Distributing materials
* Radio messages
* Publish information in local media
* Community film shows
 | * HPV leaflet
* Radio and TV messages
* Fact sheet
* Posters
 |
| School administration, School management and teachers  | * Facts about cervical cancer and prevention
* Availability of preventive vaccine
* Facts about the vaccine
* Age-appropriate approaches to addressing cervical cancer with children
* Their roles & responsibilities
 | * District education officers (primary and secondary)
* Ward education officer
* DIVO
* School health coordinators
* District community health coordinators
* Health workers
* CHWs
 | * Orientation sessions
* Distributing materials
* Radio messages
* Publish information in local media
* Official letter
 | * HPV leaflet
* HPV guidebook
* Radio and TV messages
* Fact sheet
* Posters
 |
| Community leaders  | * Burden of disease
* Importance and benefits of prevention
* Availability of preventive vaccine
* Facts about the vaccine
* Key messages to help dispel misinformation
* Their roles & responsibilities
 | * Health workers
* Community Health Workers
* Teachers
* Religious leaders
* LGA director
 | * Orientation sessions
* Distributing materials
* Radio messages
* Fact sheets
 | * HPV leaflet
* HPV guide
* Radio and TV messages
 |
| Members of PHC committee at Region and District levels | * Burden of disease
* Importance and benefits of prevention
* Availability of preventive vaccine
* Facts about the vaccine
* Key messages to help dispel misinformation
* HPV vaccine introduction phases in Tanzania
* Their roles & responsibilities
 | * IVD
* RIVO
* DIVO
 | * PHC meeting
 | * PPT
* Fact sheet
* Leaflets
 |
| Extended high level advocacy meeting | * Burden of disease
* Importance and benefits of prevention
* Availability of preventive vaccine
* Facts about the vaccine
* Modalities of HPV vaccine introduction in Tanzania
* HPV vaccine Introduction Phases in Tanzania
* Key messages to help dispel misinformation

Their roles & responsibilities | * Permanent Secretary
* CMO
* IVD Program Manager
 | * Extended high level advocacy meeting
 | * PPT
* Fact sheet
* Leaflets
 |
| MOHCDGEC officials and partners meeting | * Burden of disease
* Importance and benefits of prevention
* Availability of preventive vaccine
* Facts about the vaccine
* Key messages to help dispel misinformation
* Introduction phases in Tanzania
* HPV vaccine introduction phases in Tanzania
* Their roles & responsibilities
 | * Permanent Secretary
* CMO
* IVD Program Manager
 | * MOHCDGEC officials and partners meeting
 | * PPT
* Fact sheet
* Leaflets
 |

## 7.6 Rumours and crisis management

HPV vaccines have an excellent safety profile, experience from other countries indicate that misperceptions about HPV vaccine risks can have serious consequences, and in some cases, can completely stop the progress to all HPV vaccination activities in the public.

Experience with HPV vaccine demonstration conducted in Kilimanjaro shows that there was some resistance especially in schools owned by faith based organizations. There were rumors that this vaccine can lead to infertility. The rumors and resistance kept on disappearing as time went on as a result of continuing advocacy and social mobilization through use of Regional, District and Local leaders and ultimately those who were against HPV vaccine accepted at last.

 National, Regional, Districts and health Facility levels should ensure clear communication about the safety and common side effects of the vaccine, together with endorsement from trusted leaders. Communication helps build trust with the public. This involves including information on possible side effects in any education material or messaging used when communicating with parents and the community. Awareness among health workers and the public of possible adverse events will also reduce fear and misunderstanding and facilitate early recognition and treatment of side effects. It is very important to engage the media (through journalist briefings, information packages, etc.) prior to HPV introduction, because if they are not well informed about the facts, media can often amplify any rumors, leading to a larger crisis.

**7.6.1. Things to consider when planning for crisis management:**

* Orient Health care providers, CHW, VEO, WEO, Influential people and religious leaders on how to detect and how to respond to rumors.
* Provide accurate information to the media personnel about the vaccine introduced through media seminar and press conference
* Prepare media materials in advance to facilitate a rapid response to such negative claims.
* Inform the regional and Council advocacy and social mobilization committees to be prepared so to respond to questions.
* Using regional and Council Commissioners as spokesperson in their area of jurisdiction quell the rumors and reassure the community.
* Regional Commissioners and Council Commissioners working with Regional medical Officers and District Medical Officers Should be the Spokesperson in case of questions from Media and Community

The following communication response procedure and plan has to be followed in case of any crisis such as rumors, allegations and AEFI that can have a negative effect on public acceptance of HPV vaccines and trust in the immunization program for a rapid effective response:

* CHW, VEO, WEO, Influential people and religious leaders to detect crisis and magnitude in the community and report to health facility level for technical clarification and assistance.
* At health facility level the HF in charge should assist CHW, VEO, WEO, Influential people and religious leaders to clarify crisis if manageable at that level.
* Health facility should report crisis to District management for information sharing and further actions if needed
* If the crisis persist the DMO should arrange for Extended PHC Meetings involving RHMT and Region secretariat in order to reach consensus on the way forward
* After investigation of the crisis a press release should be arranged in collaboration between the District and Regional management team to inform the community
* At this level information should be shared to the National team, If crisis still exist and continues to spread, the National level should intervene through conducting thorough investigations and provide timely response though appropriate channels
* If the crisis is AEFI related, it should be thoroughly dealt with using the available AEFI protocol and information shared appropriately to the appropriate levels.

**Layout of Crisis management Information flow**

Health facility

Rumors in communityy levelfacility

CHWs, Community leaders to investigate

 MEDIA

Council Health Management Team

National Level/IVD

Regional Health Management Team

**7.7. Key HPV vaccine Communication facts and messages to be communicated at deferent levels**

* HPV vaccine for young girls protects them from cervical cancer later in life when they are grown women with families of their own.
* Cervical cancer affects the reproductive organs of women and is a leading cause of death among women of child bearing age.
* Girls should be vaccinated when they are young before exposure to HPV
* You can protect your daughter and her future by getting her vaccinated
* The vaccine is safe, causes no major side-effects, and will not harm a girl’s ability to have children in the future
* HPV vaccine is available free-of-charge at (location) (date, time)
* Most girls should be vaccinated twice, with 6 months (or indicate chosen schedule) between doses
* The government supports HPV vaccination and has added it to the national immunization program.

# Chapter 8: LINKING HPV VACCINATION WITH OTHER HEALTH INTERVENTIONS

## 8.1 Introduction

HPV vaccine introduction can be a stimulus to health officials and policy makers to improve and strengthen other health services at national, regional, and local levels. HPV vaccination can help strengthen other adolescent health interventions.

Delivering HPV vaccination with other interventions may promote sharing of resources and knowledge across program, optimize costs and logistics, and serve to integrate a variety of services in a more efficient, effective and sustainable way. It will be important to select an intervention that is age-appropriate, effective, and that will not negatively impact HPV vaccine delivery.

## 8.2. What We Know For a Fact

There are few interventions targeting young adolescents and those that do exist are often not adequately reaching them. This is because the number of contacts of adolescents with the health system is generally low. Immunization program are well known for achieving good coverage. Therefore the introduction of HPV vaccination can provide an entry point for other health interventions targeting 9-14 year olds.

### 8.2.1 Synergies

Examples of Health Interventions

* Community health worker networks can be mobilized to assist adolescents in accessing various health services,
* Vaccine introduction may also serve as an opportunity to improve adolescent health education
* Health communication is a key component to successful HPV vaccine implementation, and can be used to deliver a variety of other health messages as well.
* Other Interventions to Link With HPV Vaccination
* Cervical Cancer Screening
* Dental School Health Program
* NTD – De-worming programs

HPV vaccination can use various delivery strategies and platforms to reach adolescent girls, especially the hard to reach. The choice of strategy or strategies is influenced by considerations and the characteristics of the target population. Hard to-reach areas and populations need special community approach

We will have to use a combination of approaches, regular routine immunization, school health outreach, but we might sometime need special consideration for the hard to reach out of school populations especially when conducting the PIRI.

## 8.3. Platforms for Synergy

* Involve the programs during Micro planning for the Regions and districts
* Make them part of the HPV stakeholders community
* Make them part of the Region and district coordination
* Should be involved at the health facility social mobilization and communication activities
* Should be part of the supervision pre-rollout, during rollout and post rollout. To ensure the program is integrated with the HPV vaccination service provision

Chapter 9: MONITORING AND EVALUATION

## 9.1 Monitoring tools

The main recording and reporting tools that are used for immunization have been adapted to include HPV vaccine. These are:

• Immunization register

• Tally sheet

• Immunization card (Home-based Record)

• Defaulter tracking system

• Stock record

• Integrated monthly report

**9.1.1. Immunization registers**

Immunization registers record doses given to an individual and helps health workers keep track of each dose that has been administered and the completion of the vaccination series. The immunization register is the basis for tracking individual immunization status (should for example, the vaccination card be lost) and for tracking defaulters.

Depending on the HPV vaccination delivery strategy that is being used it may not always be possible to take the immunization register away from the health facility. In these circumstances, IVD recommends the use of temporary register sheets which can be copied back into the main register after the outreach has been completed.

Each dose of HPV vaccine delivered to every eligible girl should be recorded against their name in the register. When used effectively and the records are organized in manner that facilitates identifying particular children, registers can be an additional tool for health workers to be aware of who has missed doses and allow for tracking of defaulters. An example is provided in the box below

 Immunization registers include the following data

* A unique identification number, if possible;
* Name of the girl
* Date of birth
* Sex of the vaccine recipient (HPV vaccine is only given to girls);
* Name and mobile phone number of parent/guardian, if feasible, to facilitate reminders
* Space to record date and dose administered (e.g., dose 1 or dose 2);

Note: The date of the first dose is usually the registration date

## 9.1.2. Tally sheets

Tally sheets are the forms that health workers use to document an immunization session by making a record for every dose of vaccine given. Tally sheets should be used at all vaccination sessions whether at the health center, fixed outreach, school, or conducted by mobile teams. Use the same tally sheet for fixed post, outreach, schools etc. This will ensure easy follow up of performance. Tally sheets are also useful in tracking both doses delivered and any vaccine doses wasted. IVD tally sheets have been updated to incorporate all doses of HPV vaccines in the routine vaccination schedule. Supportive supervision visits should also monitor appropriate use and completion of the tally sheet to improve the quality of data reporting.

## 9.1.3. Immunization cards

Immunization or vaccination cards are an essential tool to track immunization history, and are easily adaptable for HPV vaccine. The vaccination card can:

• Enable health workers to determine which doses are due

• Serve as a reminder for the next visit/dose

• Facilitate coverage surveys

• Serve as documented proof of immunization status if required for any other reasons

(i.e. later in life for cervical cancer screening)

IVD has developed HPV vaccination cards (to be held by clients) which capture client identification particulars and HPV vaccination statuses for all doses. The card has also incorporated the brief fact about HPV vaccine to continue raising community awareness.

For HPV vaccination given at schools, the vaccination card should be kept at the school until the series is completed, at which time the card is given to the girl for safe-keeping and documentation of completion of both doses of HPV vaccine.

## 9.2. Monthly report

HPV vaccine immunization data should be collected on a monthly basis at each level of the health system, as is done for all other vaccines on the national immunization schedule. This may be done in a form as part of the integrated monthly report. The integrated monthly report contains critical data on most of the components of the immunization system in summary format for both easy recording and easy tracking. It is a valuable tool for management of the programme’s achievements and to monitor progress throughout the year. The integrated monthly report has been updated to accommodate HPV vaccine immunization data.

## 9.3 Tracking doses and defaulters

As with other vaccinations, it is important to follow-up eligible girls who fail to present for either the first or second dose of HPV vaccine. High levels of defaulting could be an indication of more systemic problems in the community, such as lack of confidence or trust in the vaccine, or in-service delivery, such as stock outs. A system to track drop-outs is an integral part of the Reaching Every Child (REC) strategy. The REC approach can and should be used to ensure high coverage with HPV vaccine below**.**

Five “REC” components to increase immunization coverage

1. Planning and management of resources – better management of human and financial resources.

2. Reaching target populations – improving access to immunization services by all.

3. Linking services with communities – partnering with communities to promote and deliver services

4. Supportive supervision – regular on-site teaching, feedback and follow-up with health staff.

5. Monitoring for action – using tools and providing feedback for continuous self-assessment and improvement.

Two common ways of monitoring and follow-up of defaulters are the immunization registers and reminder cards (sometimes called “Tickler Boxes”).

(i) **Using the immunization register** – regularly review the immunization register to identify girls who may have failed to receive their second dose of HPV vaccine when due.

(ii) **Reminder cards** – another way to identify “drop-outs or defaulters” is to make copies of the vaccination card for HPV vaccine. File a copy of the card in a box with dividers by month as shown below. The reminder card is put in the month that the missed dose of vaccine is due. Health workers can use community messaging, reminders to parents, mobile phone texts, or other mechanisms to send reminders of the need for attending to receive the missed vaccine dose. Tracking every month will provide consistency and make the exercise a regular part of the work of the health Centre staff.



## 9.6 Coverage monitoring

Calculating HPV vaccine coverage is necessary for monitoring the impact of vaccine on a population, as well as for evaluating the performance of a vaccine programme toward meeting objectives. As with other EPI vaccines, administrative coverage can be supplemented by coverage surveys.

Since HPV vaccination is recommended as a 2-dose series of vaccines administered 6 months apart to 9-14-year-old girls, HPV vaccine coverage monitoring requires collection of coverage data by dose and by age. At a minimum, the girl’s date of birth or age, date of vaccine administration, and dose number should be recorded each time a vaccine is administered.

A coverage monitoring wall chart for HPV vaccination should be maintained and displayed in the health facility. This chart should include the target population of girls at the health facility service area, and record the number of girls vaccinated per month, per dose, over time, until the target is reached. If campaign-style delivery is used, then setting up the charts showing two-time points can be used to provide a visual record of the administrative coverage (per outreach per dose).

## 9.8 Evaluation tools

Tanzania has adapted the WHO common evaluation tools so that they may be used for HPV vaccination. These tools measure similar outcomes of programme performance as conducted for other new vaccine introductions, but are modified to accommodate several unique features of HPV vaccine delivery.

Tanzania will conduct evaluation of HPV vaccine after its introduction in accordance with WHO recommendation by either of the following approaches, Post-Introduction Evaluation, EPI Programme Reviews or Vaccination Coverage Surveys.

# Chapter 10: ANNEXES

## ANNEX 1: SAMPLE VACCINATION CARD (KADI YA CHANJO YA HPV)

Ukurasa wa nje (Umekunjwa mara 2 pia)

|  |  |  |
| --- | --- | --- |
| **UKWELI KUHUSU CHANJO YA KUKINGA SARATANI YA MLANGO WA KIZAZI (HPV Vaccine)** | ***Hakikisha unajikinga na Saratani ya Mlango wa Kizazi******Ni muhimu ukamilishe chanjo zote mbili*** | **JAMHURI YA MUUNGANO WA TANZANIA** |
| **WIZARA YA AFYA, MAENDELEO YA JAMII, JINSIA, WAZEE NA WATOTO** |
| * Chanjo ya HPV inakinga maambukizi ya virusi vinavyosababisha saratani ya mlango wa kizazi
* Saratani ya mlango wa kizazi inaongoza kwa kuua wanawake nchini Tanzania
* Chanjo ya HPV inatolewa mara mbili ili kupata kinga kamili
* Chanjo hii hutolewa bila Malipo
 | **KADI YA CHANJO YA KUKINGA** **SARATANI YA MLANGO WA KIZAZI****(HPV-VACCINE)***(Kadi hii itunzwe sehemu salama)* |

**Ukurasa wa ndani (ukunjwe mara 2)**

|  |  |  |  |
| --- | --- | --- | --- |
| **MPANGO WA TAIFA WA CHANJO** | **Chanjo** | **Tarehe ya chanjo** | **Tarehe ya kurudi** |
| **UTAMBULISHO WA MTEJA WA HPV- VACCINE** |
| **Namba:** | **HPV-Vaccine** **ya kwanza** |  |  |
| **Jina:** |
| **Tarehe ya kuzaliwa:** |
| **Mzazi/Mlezi:** |
| **Jina la shule:** |
| **Jina la Mwalimu Mkuu:** | **HPV-Vaccine ya pili**(Miezi 6 baada ya chanjo ya kwanza) |  |  |
| **Kijiji au Mtaa:** |
| **Kata:** |
| **Wilaya:** |
| **Mkoa:** |

ANNEX 2: School Register



## Annex 3: Community Register



## ANNEX 4: COUNCIL MICROPLANING TOOLS

|  |
| --- |
| 1. **Council HPV vaccine Micro planning tool: HEALTH FACILITIES AND SCHOOLS**

Region : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Council: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name of District Medical Officer : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_ /\_\_\_ /\_\_\_\_\_\_ |
|  No.  |  Name of Health Facility  |  Name of School  | Primary/Secondary School  | Type of Vaccination session | Number of 14 years old girls (born in 2004)  | Name of Head teacher  |  Contact Phone for Head Teacher  | Name of School Health Coordinator at School  | Contact Phone for school Health Coordinator |
|  |   |  |   |  |  |  |  |  |  |
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|  | 1. **Council HPV vaccine Micro planning tool: HEALTH FACILITIES AND VILLAGES**

Region : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of District Medical Officer : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_ /\_\_\_ /\_\_\_\_\_\_ |  |
|  |  |  |  |  |  |  |  |  |  |
|  No.  |  Name of Health Facility  |  Name of Village  |  Name of hamlet/Kitongoji  | Number of 14years old girls (born in 2004) who are Out of School | Type of vaccination session (fixed/community) | Name of VEO/MEO | Contact Phone for VEO/MEO | Name of Village/Mtaa Health Worker |  Contact Phone for Village Health Worker  |
|   |   |   |   |   |   |   |  |   |   |
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Signature of District Medical Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Council HPV vaccine Micro planning tool: Target**

Region: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Council: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| No. | Name of Health Facility  |  Total Number of schools  | Total number of 14 years old girls in schools  |  Total Number of villages  | Total number of hamlets / vitongoji | Total number of 14 years old out of school girls |  Total number of 14 years old Girls in and out of schools | Total Number of fixed vaccination sessions | Total Number of outreach sessions (Community) | Total Number of outreach sessions (Schools) |
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Name of District Medical Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of District Medical Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3.0 Council HPV vaccine Micro planning tool: BUNDLED VACCINES**

Region: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Council: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of District Medical Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- |
| No.AA5:H21  |  Name of Health Facility  |  Target for HPV  |  Vaccines and supplies  |
|  HPV vaccines doses  |  HPV vaccines vials  |  AD Syringes  |  Safety boxes  |
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Signature of District Medical Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Council HPV vaccine Micro planning tool: DATA MANAGEMENT TOOLS**

Region: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Council: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of District Medical Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- |
| No.  |  Name of Health Facility  |  Total number of 14 years old girls |  HPV cards  |
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Signature of District Medical Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Council HPV vaccine Micro planning tool: WASTE MANAGEMENT**

Region: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Council: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of District Medical Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| No.  |  Name of Health Facility  |  Waste management  |
|  Functioning Incinerator  |  Using burn and bury method  | Others |
|  |   |  |  |  |
|   |   |   |   |  |
|   |   |   |   |  |
|   |   |   |   |  |
|   |   |   |   |  |
|   |   |   |   |  |
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|   |   |   |   |  |

Signature of District Medical Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **8.0 Council HPV vaccine Micro planning tool: COMMUNICATION**

Council: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of District PHC Members

Name of District Medical Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| No  |  Name of Local Radio stations  |  Name of Local TV stations/cable  |  |  |  |  |  |
| 1 |   |   |  |  |  |  |  |
| 2 |   |   |  |  |  |  |  |
| 3 |   |   |  |  |  |  |  |
|  |  **Name of Health Facilities**  |  **Number of village health committees**  |  **No of Churches/Mosques**  |  **No .of Primary Schools**  |  **Megaphones available**  |  **Other**  |  **Requirements/ needs/asks**  |
|  1  |   |   |   |   |   |   |   |
|  2  |   |   |   |   |   |   |   |
|  3  |   |   |   |   |   |   |   |
|  4  |   |   |   |   |   |   |   |
|  5  |   |   |   |   |   |   |   |

Signature of District Medical Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_