



HPV Vaccination in Africa

LESSONS LEARNED FROM A PILOT PROGRAM IN UGANDA

Two vaccines to prevent human papillomavirus (HPV) infection, the primary cause of cervical cancer, are now approved for use in many countries. Low- and middle-income countries often face significant obstacles to integrating new vaccines into their national immunization programs, meaning that the people living in these countries must wait many years for access to life-saving interventions currently available in higher-income settings. In 2006, PATH initiated the *HPV Vaccines: Evidence for Impact* project in order to generate evidence to help policymakers and planners worldwide make informed decisions regarding regional and national vaccine-introduction efforts and international financing for improved cervical cancer prevention.

Uganda is one of the countries chosen by PATH as a site for the *HPV Vaccines* project, along with India, Peru, and Vietnam. In Uganda, cervical cancer accounts for 40 percent of all cancers recorded by the cancer registry, and over 80 percent of women with cervical cancer are diagnosed with advanced disease. Through a demonstration project conducted in 2008–2009 in selected districts, HPV vaccine was made available to more than 10,000 girls. The Uganda project was implemented by the Uganda National Expanded Program on Immunization (UNEPI) of the Ministry of Health with technical support from PATH, and operations research was conducted by the Child Health and Development Centre (CHDC) and PATH.

The data resulting from the project provide critical evidence to the government of Uganda about when and how best to introduce cervical cancer vaccine nationwide. The experience of Uganda is and will be helpful to neighboring countries and other countries in the African region. This report interprets the results and summarizes helpful lessons for policymakers and program managers, especially those in sub-Saharan Africa, looking to shape their own HPV vaccination programs.



Primary school girls wait to receive HPV vaccinations as part of a demonstration project implemented by the government of Uganda with technical support from PATH.

“The high coverage rates indicated that sensitization and mobilization efforts had paid off: stakeholders clearly accepted the HPV vaccinations.”

**–Dr. Gerald Kalule Ssekitto, District Health Officer, Nakasongola District
Ministry of Health, Uganda**

For more information

For more information about PATH's cervical cancer vaccine project, please visit www.path.org/cervicalcancer or www.rho.org.

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Lessons learned: Developing and implementing an HPV vaccination strategy

TARGET GROUPS AND VENUES FOR VACCINATION

- Lesson 1:* Schools can successfully be used as a venue for HPV vaccinations.
- Lesson 2:* Identifying eligible girls based on their grade/class in school may be easier than identifying them by age in some contexts, but may also present challenges for age-focused reporting and evaluation systems.
- Lesson 3:* Adding HPV vaccine to an existing health program can reduce the incremental costs of including HPV vaccine in the national immunization schedule.

OPERATIONAL ISSUES

- Lesson 4:* Adequate preparation of health and education systems, including human resources, facilitates success.
- Lesson 5:* Close coordination by the health and education sectors leads to effective community mobilization and vaccine delivery.
- Lesson 6:* Monitoring and supportive supervision strengthen health worker capacity and improve performance.

Lessons learned: Training, community mobilization, and information and education

HEALTH WORKER AND TEACHER TRAINING

- Lesson 7:* Separate training of teachers and health workers allows for focus on their specific roles, complemented with a joint session for both groups to solidify collective understanding.
- Lesson 8:* Adequate time and consistent content for training sessions help ensure health worker and teacher motivation and capacities.

COMMUNITY OUTREACH

- Lesson 9:* Vaccine uptake can be improved by providing evidence-based education and outreach at least one month before immunization begins.
- Lesson 10:* Visible endorsement by national and district government leaders is critical to community acceptance.
- Lesson 11:* Additional support is needed to ensure that remote areas are reached by educational outreach activities.
- Lesson 12:* Teachers and health workers play complementary roles in raising awareness in communities.

MESSAGING

- Lesson 13:* Information on preventing cervical cancer, HPV vaccination, and the three-dose schedule are key building blocks for community education messages.
- Lesson 14:* Communities become reassured as they gain direct experience with HPV vaccine.
- Lesson 15:* Making comprehensive educational materials with simple language and graphics widely available can help raise community awareness.