LESSONS LEARNED: HPV VACCINE NATIONWIDE INTRODUCTION IN ZIMBABWE

July 2018

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Cover Photo. The First Lady, Auxillia Mnanganwa with an eligible girl as she is vaccinated by a nurse. The Honorable Minister of Provincial Affairs Monica Mutsvangwa looks on.

ACKNOWLEDGEMENT

This lessons learned document aims to capture the challenges and achievements of the HPV nationwide introduction in Zimbabwe to inform future integration of HPV and other vaccines into the routine immunization system. The Government of Zimbabwe sincerely appreciates the collaboration and able leadership of the Ministry of Health and Child Care (MoHCC) and the Department of the Zimbabwe Expanded Program on Immunization (ZEPI). The significant role contributed by Ministry of Primary and Secondary Education (MoPSE) from the demonstration phase through to the national rollout stage deserves special mention and applause. The dedication and professional approach to duty by the MoPSE leadership and staff across the board ensured the success of the national HPV vaccination roll-out. We would also particularly like to acknowledge and appreciate WHO, UNICEF, JSI, GSK, PATH, UNFPA and other equally important partners for their unequivocal technical, logistical, financial and moral contributions towards the success of the HPV vaccine rollout in Zimbabwe. We also wish to specifically acknowledge and appreciate the support provided by Gavi for enabling the Technical Assistance via JSI and particularly Gavi's financial support to the Zimbabwe Government for procuring the HPV vaccine and manpower capacity enhancement.

ACRONYM LIST

CBO	Community Based Organization
CSOs	Civil Society Organizations
GSK	Glaxo Smith Kline
HPV	Human Papilloma Virus
JSI	JSI Research & Training Institute, Inc.
MoHCC	Ministry of Health and Child Care
MoPSE	Ministry of Primary and Secondary Education
NGO	Non-Governmental Organization
UNICEF	United Nations International Children's Emergency Fund
UNFPA	United Nations Population Fund
WASN	Women Aids Network
WHO	World Health Organization
ZEPI	Zimbabwe Expanded Program on Immunization

EXECUTIVE SUMMARY

In 2014, Zimbabwe piloted the introduction of the Human Papilloma Virus (HPV) vaccine, using an introduction grant from Gavi, the Vaccine Alliance. The pilot was carried out in two districts – Beitbridge (Matabeleland South Province) and Marondera (Mashonaland East Province) – over a two-year period. This learning has been subsequently applied to nationwide introduction of HPV vaccination launched in May 2018 that is described in this document.

Throughout the first phase of introduction, the implementing agencies, led by the Ministry of Health and Child Care (MoHCC) and the Ministry of Primary and Secondary Education (MoPSE), followed a collaborative planning and monitoring process coordinated through a multi-partner HPV pilot committee, with technical representatives from WHO, UNICEF, JSI, and GSK. Other stakeholders included the Ministry of Justice, the Women Aids Network (WASN), human rights groups, community-based organizations (CBOs), youth and gender groups, and partner organizations. Strategies included school-based vaccination and enumeration as well as special outreach services to cater for girls that were out of school. The community, through the traditional leadership hierarchy, also played a pivotal role in the pilot, through program communication appeal in their respective locations.

The experiences from the pilot demonstrated the country's ability to overcome bottlenecks and succeed in reaching the coverage target of 80%. The Health Portfolio Committee was well-represented through the designated members; however there were some challenges engaging support for the introduction from appropriate stakeholders well in advance. Another bottleneck involved resistance from vaccine objectors or traditional medicine practitioners. A third important obstacle involved the heavy resource burden (human, time and financial) required for the original campaign style strategy.

This report details how the lessons learned from the pilot experience were applied for nationwide HPV vaccination introduction nationwide and provides recommendations and design and implementation considerations. Important factors that were addressed – and to keep in mind throughout the introduction process - include: planning, preparation, information dissemination, coordination with partners, capacity building, service delivery, monitoring and evaluation.

Integration

The School Health Policy Integration document allows for existing youth/gender health and education platforms to work together to maximize resources, realign health activities, and reach the target population. For girls out of school, community programs and organizations have been identified to assist in reaching adolescent girls in the community. Health education and health-related activities in schools were leveraged and health education curriculum were updated with messaging to explain and promote HPV vaccine to the target population. Vaccine administration was also integrated into previously programmed school-based health activities.

Engaging Civil Society Organizations (CSOs)

CSOs and NGOs played a critical role in the introduction of the HPV vaccine, and were identified and oriented early on. They were included in planning meetings and discussions and played a critical role in mobilizing communities. Inclusion of Media Houses in the HPV vaccine communication platform has also been instrumental in wider dissemination of correct information.

Community Participation

Influential leaders and community members were engaged in disseminating information and promoting the vaccine. The HPV Vaccine Health Portfolio Committee sought input from communities when developing

strategies for reaching the target population and identifying critical messages and addressing potential bottlenecks to ensure a successful introduction. Their support for HPV activities helped to build the community's confidence, and these community members were enlisted to conduct targeted advocacy and program communication in cases where there may have been vaccine resistance. Community involvement was also crucial in dispelling rumors, myths and misconceptions.

Considerations for Religious Organizations

Communications and messages targeted to religious-affiliated schools were crafted and tailored prior to introduction of the vaccine, including advocacy and messaging with the religious authorities and their administrative systems. Religious leaders were included in stakeholder meetings to ensure their active participation in the roll out.

Clear Communications Strategy

Communications were tailored to the target population – including having pamphlets and posters available in the local language/dialect with images from the community, and disseminated through channels with the widest reach and influence. In the most remote areas where there are scarce social networks, communication materials needed to be distributed ideally 2- 3 months prior to implementation and reinforcement efforts continually implemented.

Identifying the Target Population

A clear definition of the target population and communication with planners, educators/school administrators, mobilizers and parents/caregivers are important to help ensure more accurate population estimates and understanding of the targets. This can help avoid frustrations by caregivers/parents of girls who are not eligible, and to ensure efficient mobilization of the appropriate girls to be vaccinated. Zimbabwe has adopted the multi-age cohort approach, including girls 10-14 years old both in and out of school in the 2018-2019 roll-out year, with Grade 5 (or 10 year olds out of school) to be vaccinated in subsequent years.

Advocacy for Adequate Funding

Given the cost of the HPV vaccine and different strategies for reaching this non-traditional target population, advocacy and buy-in must be achieved with decision makers at the highest-level of government so that sufficient funds are planned, approved and allocated. A strong advocacy plan was developed by the country, with key messages emphasizing the cost benefit of HPV prevention through the vaccination strategy, as compared to the cost of HPV disease burden and treatment. In addition, a scaled approach was agreed upon for introduction of HPV vaccination so that the introduction costs are spread across years and more feasibly managed within existing budgets.

Capacity Building

A comprehensive training program for key players is essential prior to the introduction, in addition to refresher training after each dose to reduce drop-out. Key stakeholders targeted for training on the introduction strategy and sensitization on the benefits of vaccinating against HPV included health staff from national to the lowest level (i.e. health post staff and community health workers; caregivers, education practitioners; community leaders; religious leaders; local CSOs and NGOs).

Readiness Check

Before the introduction date, supervision was conducted to verify that preparations were in place, training had been completed, and materials and funding were available. In some cases, customized approaches were developed to motivate specific school and health leaders, when it was detected that they were not fully invested in the introduction. The IEC materials were distributed to the communities prior to the implementation of the HPV vaccination program.

INTRODUCTION

In 2013, Gavi, the Vaccine Alliance, initiated grants to countries to carry out pilot introductions of the human papilloma virus (HPV) vaccine. From September 2014 to November 2015, Zimbabwe implemented an HPV vaccination demonstration project in two districts: Beitbridge District in Matabeleland South Province and Marondera District in Mashonaland East Province. The selection of these districts was based on their populations' high representation of two major ethnic groups in Zimbabwe (the Ndebele and the Shona) and their high DTP3 vaccination coverage. In both districts, ten-year-old girls were identified as the target population to receive the vaccine through school-based or community strategies. Although the project was initially designed around administration of a 3-dose schedule, this was revised to a 2-dose schedule following updated guidance issued by WHO in 2014. The change of vaccination schedule resulted in the country having excess HPV vaccine at the end of the demonstration project. The remaining vaccine was scheduled to expire in August 2016. As this was more vaccine than the original pilot districts could use to complete an additional vaccination round before the expiration, the remaining vaccines were therefore administered in the original two pilot districts as well as an additional district (Kwekwe) to avoid any vaccine wastage. (This is referred to as the bridging project). The lessons learned in these two districts informed decision making and planning for national scale-up of HPV vaccination. The country decided to rollout the HPV vaccine nationwide in 2018 through an integrated strategy as part of the current EPI vaccination program.

In addition to the funding support for vaccine procurement and introduction activities, the Government of Zimbabwe expressed a need for technical assistance for the planning and introduction of the HPV vaccine nationwide. In response, Gavi awarded JSI Research & Training Institute, Inc. (JSI) a grant to provide technical assistance to the MoHCC in May 2017, in coordination with that of other in-country partners including WHO, UNICEF and GSK.

The following report provides a detailed summary of the preparations and implementation of the HPV vaccine rollout in Zimbabwe, as well as planning for follow up monitoring and evaluation post nationwide rollout. The document highlights successes, bottlenecks and lessons learned which can be used to inform decision-making for possible future introductions of other new vaccines in Zimbabwe and possibly globally.

KEY ACTORS

At the highest level, the HPV vaccine rollout program committee was well organized, with the MoHCC, MoPSE and essential partners including WHO, UNICEF, PATH, JSI, and GSK steering the program implementation.

To ensure continuity and ownership throughout the introduction at the lower levels, HPV committees were formed and worked effectively in each district to assist with coordination. The committees included representatives from the District Health Executives, Community Health Committees, school administrators, and a spectrum of community leaders. The objective of the committees was to ensure high HPV vaccination coverage through supporting advocacy and preparations for roll-out of the first dose. After the first dose was administered, the district committees, in consultation with the national committee, reviewed the coverage results and identified reasons and strategies with communities to address gaps in coverage. These committees were only anticipated to be active before and during administration of the first dose of the vaccine; however, they continue to function to address challenges with vaccine acceptance among the perennial religious vaccine objectors. Their roles are currently being reprised for the second dose in

order to continue advocacy efforts, including encouraging the vaccine objectors to realize the importance of the HPV vaccination.

Representatives from the education sector (including Regional Directors for Education, school teachers, and school administrators) also played an important role during the introduction phase, including identification of girls within the target population (based on school enrollment figures and registers) as well as advocacy and information dissemination to students and caregivers to motivate them to accept the vaccine. They also played a lead role in the mobilization of school girls slated to receive the vaccine, assisting with organization of the HPV vaccine sessions within the schools.

TIMELINES AND CHECKLISTS

During the first year, HPV vaccination scheduling was harmonized with the school calendar to coincide with less busy school periods and ideally before major examinations. To minimize potential school program disruptions, it was agreed that the HPV vaccination sessions only be carried out once per annum for the second dose and the subsequent cohort groups. This necessitated careful coordination and for introduction activities to be planned well in advance with the school administrators/staff (who were part of the planning committee and development of the timeline/workplan) to ensure that vaccination dates remained on-target. (See timeline in Annex I)

Since the MoHCC and MoPSE work closely together and have established strong communication, it was possible to have school registration data at the beginning of the school year to help with vaccine distribution and planning for the dates for the second dose and subsequent cohort doses.

One area identified for improvement during rollout of dose one was better integration of local civil society organizations (such as church groups and adolescent programs) into the planning processes. During year two, a strategy for stronger coordination was put in place and significant improvements were seen in communication, advocacy and involvement of all stakeholders, including with the leaders from the religious groups and Media Houses.

The first dose of HPV vaccine was administered in all districts in Zimbabwe from 14 –18 May 2018 during the national campaign week and a month-long mop up period that stretched from 19 May to 18 June 2018.

MAPPING AND IDENTIFYING TARGET POPULATION

Unlike the other vaccines in the routine immunization system in Zimbabwe which target infants, the HPV vaccination target is adolescent girls. The first dose during the rollout phase targeted a multi-age cohort from 10 – 14 years old, both in and out of school. In subsequent years, the target group will be girls in grade 5 and 10 years old for those out of school. Therefore, in order to calculate the target population and reach the eligible girls, the MoHCC and MoPSE coordinated efforts and also worked closely with CBOs, local community groups and leaders to identify eligible girls for vaccination. The need to reach girls at an age before they would be exposed to the virus (i.e. before they are sexually active) was the primary factor in determining the target population.

While most girls were reached on the first attempt during phase one of the introduction, the lack of a unified strategy for missed girls - to include messaging and social mobilization with schools, teachers and parents - was identified as a challenge that needed urgent attention. Although this was a priority for subsequent doses, there is need for further funding and targeting of resources specific to follow-up.

Based on a mapping of the public and private

schools in the pilot districts as well as a review of available school records, the majority of eligible girls attending school were concluded to be in the grade 5 class, in which girls were primarily between the ages of 10-14.In order to minimize the administrative burden of singling out just the 10 year old girls in each grade 5 class, it was agreed that the vaccine would be provided for all girls in this class in subsequent doses and for 10 year olds out of school.

Conventional school-based registers and community-based workers and traditional leadership were used to determine the target population and to help identify eligible girls out of school.

STRATEGY DEVELOPMENT, IMPLEMENTATION, AND EARLY RESULTS

All health facilities, both urban and rural, had HPV vaccine allocated for the campaign and mop up exercises. In the districts, each school designated one day for the vaccine to be administered by health workers, with health workers visiting one to five schools per day depending on the number of eligible girls at the school and the distance between schools. A challenge was reaching girls who were absent on the day of vaccination; however this was addressed during the mop-up phase. The month-long strategy was assumed to adequately cater for a majority of the previously missed girls.

In communities where teachers were heavily involved in the awareness/mobilization, it was observed that the coverage for girls in school was high. Knowledge of the benefits of the vaccine was well-appreciated.

Through implementation of the vibrant communications strategy, most eligible girls were available for vaccination during the campaign week, resulting in high coverage. Data as of October 1 are included in the table below and show an estimated national coverage of 95.4%. Data discrepancies and inaccurate negative wastage rates were noted in the initial calculations and data were reviewed through a verification process with provincial teams and partners in order to calculate final coverage estimates.

Learning from coordination of the HPV vaccination dates with schools

- The role of MoPSE staff should be recognized as equal to MoHCC staff, and compensation, such as travel reimbursement, should be distributed equally to staff of both Ministries.
- Due to the need to coordinate between institutions and stakeholders that may not already be involved in providing health services, it is critical that sufficient time be allotted to the planning process and advanced notice be provided on activities (including trainings, development and dissemination of communications materials, and scheduling of vaccine administration).

Table 1: Summary of coverage by province

Province	Est. Target Population (Zimstat)	Actual Population in Schools	Administered Doses	Doses Wasted	Wastage Rate	Coverage
Bulawayo City	38,158	37,280	37,247	33	0.09%	97.7%
Chitungwiza City	16,110	15,466	13,931	157	1.13%	96.0%
Harare City	72,332	61,555	58,132	66	0.11%	94.4%
Manicaland	128,962	125,765	124,460	406	0.33%	96.5%
Mashonaland Central	77,057	73,057	70,570	179	0.25%	94.7%
Mashonaland East	104,687	89,366	83,247	609	0.73%	93.2%
Mashonaland West	91,973	86,087	80,659	452	0.56%	93.6%
Masvingo	118,679	108,840	104,260	261	0.25%	96.0%
Matabeleland North	52,682	50,927	49,011	299	0.62%	96.2%
Matabeleland South	45,365	41,282	39,179	119	0.30%	94.9%
Midlands	118,493	116,953	112,463	204	0.18%	96.2%
National	**864,498**	**806,578**	**773,159**	**2,486**	**0.32%**	**95.4%**

FUNDING, THE CO-FINANCING PROCESS & COMMUNICATION WITH GAVI

Although Gavi funds were available for the HPV introduction, there were delays in release and availability of the funds in-country. Also, overall funding constraints for the HPV vaccine introduction limited the ability to carry out all activities for communication, introduction and monitoring/supervision as laid out in the micro-plan. For example, critical departments (including the health information staff and environmental health officers for follow-up of missed girls and timely relay of vaccination statistics) should be included in future microplanning to facilitate comprehensive execution of the planned activities. In addition, while funding for the first phase of the rollout included support for the vaccination activities to take place, due to the high costs involved with social mobilization and unforeseen gaps in funding to support printing of training materials, the available funds were not sufficient to satisfy the needs for initial rollout. As a result it therefore became necessary to request the Government of Zimbabwe to mobilize funds for village health workers and program implementation daily subsistence allowances for the campaign vaccination teams.

ADVOCACY AND AWARENESS BUILDING

Information on the vaccination schedule and target population was disseminated and displayed in health facilities prior to the launch. However, monitoring visits determined that this could have been made available further in advance of the vaccination day so that the community was better informed on the purpose of the vaccine, had time to ask questions, and could help to ensure that the girls were available on the vaccination days. It was also determined after the first round that community leaders, CSOs, NGOs, and schools should continue to be involved with the MoHCC, in partnership with the MOPSE, as resources and audiences, as they are better able to inform on community sensitivities. Also, because they are respected and trusted, they are well positioned to provide orientation and background information on HPV vaccine during field visits.

> Advance and continued advocacy and sensitization messaging are important – to inform possible gatekeepers that the purpose of providing HPV vaccine at this age is to reach the maximum number of girls to enable full protection against cervical cancer caused by HPV before sexual debut.

Key messages to promote during advocacy efforts in subsequent rounds/phases include:

- Information on the reason for the vaccine and prevention of cervical cancer
- Assurance that the vaccine is safe
- Information on the schedule and target population

Review of the first phase found that radio and television campaigns were effective when focused in areas with reliable transmission and where the messages were well-scripted, with the actions and reasons for the vaccination targeted to reach the widest audience. Dissemination of key messages via television proved effective in the urban areas, in addition to radio spots and support by local organizations and leaders. In Zimbabwe, as the majority of rural communities do not have access to television, communications should continue to be disseminated by radio and local organizations and leaders. Annex III provides key messages that were targeted to each of the key audiences for HPV vaccine introduction.

Avoiding vaccine "refusers" and missed opportunities

To avoid vaccination hesitancy, the MoHCC and MoPSE worked with respected leaders of groups of potential vaccination objectors to provide information on the HPV program. This resulted in more effective collaboration and helped to ensure that the majority of eligible girls received HPV vaccination in areas that had previously had vaccine refusals.

Learning from advocacy and awareness building

- In order to garner buy-in and motivate the districts/communities in the rollout phase, emphasize with community members/influencers that it is a privilege that they have been selected for support with HPV vaccination and ultimately reduction in cervical cancer burden.
- Use testimonials from known women in the community who have suffered from cervical cancer to inform the population about the danger and burden and to motivate them to get vaccinated in the future.
- Students themselves are good resources for disseminating key messages to guardians and decision-makers, and should be equipped with the skills and information they need to fulfil this role.
- It is critical that communications are tailored to the target population – including having materials available in the local language/dialect with images from the community, and disseminated through channels with the widest reach and influence, for instance through:
    - radio in communities with little access to television, and
    - high-level health officials whose medical advice is respected and taken seriously and local leadership as well as Village Health Workers.

HPV VACCINE LAUNCH

Figure 1. The First Lady Auxillia Mnangagwa giving Her Key Note Address at the National HPV Vaccine Launch in Mutare (Manicaland Province).

The HPV vaccine committee played a critical role in organizing the national launch, which was held on 2 May 2018. The national launch was hosted in Manicaland Province with the First Lady gracing the occasion as the guest of honor. Traditional chiefs also attended the launch and relayed the benefits of HPV vaccination against cervical cancer in Zimbabwe. Other participants included provincial leadership and the surrounding schools, children, and community members. The launch was therefore an opportunity to convene various actors in a display of support for the vaccine, with key messages broadcast widely on radio and television.

Learning from the launch

A well-publicized vaccine launch, attended by respected and influential community leaders who speak out in support of the vaccine with clear, scripted messages is a very effective way of garnering community buy-in.

Strategies for organizing a successful launch event included:

- Holding the launch at a school where the vaccination demonstration could be carried out in view of the public.
- Publicly vaccinating girls at the launch event to demonstrate that it is safe and easy.

CAPACITY BUILDING: TRAINING, IEC AND REPORTING MATERIALS

Recording, reporting & monitoring tools updated, printed, distributed

As introduction activities progressed, it was apparent that recording tools needed to be modified to distinguish between girls in school and girls not in school, and to specify the age of each girl who received the vaccine. In response, partners collaboratively developed an HPV name-based vaccination register (linked with the school register data, wherever possible). There were also a daily HPV vaccination tally sheet, an HPV tally sheet by age, as well as summary sheets and summary tables on doses administered by age, total doses administered, and coverage rates. These tools were distributed and used in the districts and facilities, with the reports by day and round consolidated by district focal points and submitted to provincial and then national levels. The reporting process was facilitated via ensuring that the health staff had these up-to-date tools and knew how to track, complete and submit them.

Capacity building of health workers and educators

HPV technical working group meetings were held monthly and then biweekly starting in February up until the launch -- to plan the first dose and outline the microplanning, training and monitoring processes. For subsequent phases, these groups will benefit from meeting earlier in the planning process, and the working groups should be continued regularly throughout the introduction and beyond, to include supervision, monitoring and refresher training, as needed. The timeline of activities followed is included in Annex I. Targets were met according to the timelines. However, in the future, it will be important to plan in advance for the required time needed for each activity in order to ensure that preparations are not rushed. Coordination between MoHCC and MoPSE is also necessary when developing a timeline of activities.

Trainings were held in all 11 provinces with five people trained at the provincial level who were then responsible for rolling out trainings to the districts. In total, 1486 health workers were trained in preparation for the launch. Refresher training with a focus on advocacy, communications, and social mobilization is needed in the future. National-level supportive supervision from both MoHCC and MoPSE should be strengthened to provide support to health workers.

KEY LESSONS LEARNED DURING ZIMBABWE'S HPV INTRODUCTION

Coordination and Leadership

- Successful rollout of HPV vaccine in Zimbabwe was made easier by the commitment of a sound and well-managed routine EPI.
- The cooperation between local representatives from MoHCC, MoPSE, partners, village health workers, political and traditional leaders facilitated effective micro planning and should be reinforced as HPV vaccination rolls-out in subsequent years.
- Continued MoHCC and MoPSE collaboration (e.g. meetings, joint monitoring, sharing of results and adaptation of lessons learned) is very critical for school-based initiatives, including subsequent phases of HPV vaccination.
- Engagement with a spectrum of political, traditional, and religious leaders increased acceptance of the HPV vaccine by the entire community.
- Community leaders, CSOs, NGOs, and schools are key resources and audiences, as they are best able to inform on community sensitivities

Advocacy and Communications

- Advocacy, and accurate dissemination of information and reasons for targeting the adolescent girls, helped the acceptance of the HPV vaccine by both caregivers and the target audience. This was supported by good rationale and evidence/confidence in the vaccination (e.g. seeing girls successfully vaccinated in the launch, wide use of media to explain HPV and cancer prevention).
- Interpersonal engagements, coupled with a vibrant communications strategy and team, proved to be an effective way to mobilize caregivers and the general population.
- Engagement with the Media Houses well before the event -- and providing accurate strategic information via multi-media tailored to audiences (e.g. radio and TV to urban areas; local radio and community organizations in rural areas) -- aided the flow of information across the spectrum of the population.

Funding, Reporting, and Capacity Building

- Timely and adequate funding when introducing a new vaccine plays a pivotal role in rolling out a quality and trouble-free program and needs to be actively ensured post-launch for sustainability.
- Timely training and continuous monitoring (with use and feedback on reporting tools, data and coverage) of MoPSE and Health staff officers are major catalysts for achieving and sustaining HPV vaccination coverage and equity.

ANNEX I: HPV VACCINE INTRODUCTION MILESTONES TOWARDS ROLL OUT

PLANNED ACTIVITY	SCHEDULED DATES	RESPONSIBLE PERSON	PROPOSED VENUE
HPV Vaccine Rollout Planning Meeting	8 -14 January 2018	MOHCC/JSI and other Stakeholders	Mutare
Teleconference Meeting with Gavi	19 February 2018	MOHCC/JSI and Partners	UNICEF Boardroom
Advocacy Stakeholders Meeting	23 February 2018	MOHCC/JSI and Stakeholders	EDC Boardroom, Kaguvi Building
TOT Workshop – National and Provinces	8 -9 March 2018	EDC	Mazowe Hotel
District Trainings &Microplanning	12 – 24 March	MOHCC/MoPSE/JSI	All Provinces
Data Collection on Target Population from Schools	Ongoing	MOPSE & MOHCC	All Schools
Recruitment of International and Local Consultants	March 2018	UNICEF	UNICEF
Provincial Sensitization Meetings	March 2018	MOHCC/ MoPSE	All Provinces
Consultative Meeting with Portfolio Committee on Health	10 April 2018	HPV Vaccine Steering Committee	Parliament Buildings of Zimbabwe
HPV Rollout Readiness Assessment	16 -20 April 2018	MoHCC /JSI and WHO	All Provinces
Media Houses Consultative Meeting	26 April 2018	HPV Vaccine Steering Committee	MOHCC Boardroom
Resources Distribution	10 – 15 April 2018	MOHCC	All Provinces
Follow Up Stakeholders Meetings	Every 2 weeks starting 1 March 2018	MoHCC/ MoPSE/JSI and Stakeholders	EDC Boardroom MOHCC
HPV Vaccine Launch	2 May 2018	MoHCC / MoPSE/JSI	Mutare
HPV Vaccination Roll out	14 – 18 May 2018	All Districts	All Districts
HPV Vaccine Vaccination Mop Up	19 May – 18 June 2018	All Health Facilities in the country	All Districts

ANNEX II: HPV VACCINE FEEDBACK MEETING PROGRAM

Date: 8 June, 2018 **Chair:** Mrs. Marembo

Venue: 3rd Floor Boardroom, MoHCC, Kaguvi Building

Time	Activity	Responsible Person
10:00 - 10:10	Registration & Tea	Ms. Tavaguta
10:10 - 10:15	Welcome Remarks □ Objectives of meeting □ Outputs □ Expected outcomes	Dr. Manangazira
10:15-10:30	HPV Vaccine Advocacy, Communication and Social Mobilisation □ Advocacy, Social Mobilisation and Communications for HPV Vaccine	Mr. Machacha
10:30- 10:45	UNICEF perspective on HPV Vaccine Communications • Crisis communication • HPV Vaccine Photo Essay	Titus
10:45 - 10:55	U Report : Post HPV Vaccine Campaign Poll Results (UNICEF)	Patience
10: 55 - 11:15	Community response to HPV Vaccine	Mr. Rusike
11:15 – 11:30	MoPSE feedback on the school HPV Programme • Parental and learner issues	Mr. Mushukutu
11:30 -11:50	Feedback on the HPV Vaccine Campaign □ HPV Vaccine Roll Out and Campaign □ Post HPV Vaccine Campaign Roll Out Activities	Mrs. Marembo
11:50-12:05	Reporting and confirming AEFI	City Health Rep, Harare
12:05 - 12:40	Discussion □ Question and Answer Session	Dr. Manangazira
12:40	LUNCH	ALL

ANNEX III: KEY MESSAGES FOR ADVOCACY/SENSITIZATION ON HPV INTRODUCTION

TARGET AUDIENCE	KEY MESSAGES
Parents/ Caregivers	Promote HPV vaccination for the good of girls' health Educate children on their personal health, including against early sexual activity
Community Leaders	Preventing cervical cancer with the HPV vaccine is the best option and it is important
Health Workers	Persuade everyone that the HPV vaccination is a government initiative Arrange the planning and vaccination schedule in a practical and participative manner Ensure the availability of the vaccine at the vaccination site, at the right time
Religious Organizations	Inform the community that prevention against illness is important Inform the community that the HPV vaccine is safe
School Administrators	Release eligible students on vaccination day for them to benefit from receiving the HPV vaccine
Teachers	Inform teachers/parents and children about the HPV vaccination program and its benefits Reassure everyone that the vaccine given at the schools in Zimbabwe is the same as recommended to other countries.
Slogan	"I am vaccinated, I am protected"
Target Population	Reassure the population that the HPV vaccine does not affect a girl's fertility

ANNEX IV: DAILY HPV VACCINATION TALLY SHEET

Province…… **Date……..**

District…….. **Team Number ……**

Health Facility/School/Outreach……

Target population: Girls 10-14 years		
	IN SCHOOL	**Non-school going children**
HPV VACCINE	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000
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Total		
AEFIs	00000 00000 00000 00000 00000 00000 00000 00000 00000 00000	00000 00000

Staff : Number of nurses_____ **No. of other Health Worker_____** **No. of non-health/volunteers_____**	**HPV** **Doses used_____** **Doses administered_____** **Doses wasted _____**

Post Coordinator _____ Signature_____

ANNEX V: DAILY HPV SUMMARY SHEET DOSE 1

NAME OF PROVINCE ……
DISTRICT……DATE ……

Total Doses Used…… Doses Administered……
Doses wasted……..…….

No. of Vaccinators…… No. of Other Health Workers…….
No. of Volunteers……

Coordinator ……..……

Name of School/ Health Facility		10 Years	11 Years	12 Years	13 Years	14 Years	Total
	In school						
	Out of school						
	In school						
	Out of school						
	In school						
	Out of school						
	In school						
	Out of school						
	In school						
	Out of school						
	In school						
	Out of school						

Signature…….……
(print name, title)
Comments:
_____-
_____
_____
_____
_____