HPV VACCINE COMMUNICATION

Special considerations for a unique vaccine

2016 update
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Acknowledgements

This guide is the result of the collaboration and hard work of many people. The World Health Organization’s Immunization, Vaccines and Biologicals Department commissioned and provided oversight to its preparation as part of an effort to consolidate existing and new information about HPV vaccine communication. The section on “the basics” draws from several sources of previously published material and from the author’s experience. A November 2015 WHO Global Learning meeting on HPV Vaccine Introduction and a 2015 review of HPV vaccine introductions published by the London School of Hygiene and Tropical Medicine and PATH inform this work.* Immunization programme managers and their teams in Latvia, Malaysia and Rwanda helped the author learn about and understand the issues through field visits. WHO also thanks the health workers, headmasters, teachers, community leaders, mothers, fathers and girls who took the time to share their thoughts, and through this, help us do a better job.

The original 2013 version of this guide and this 2016 update were written by Christine McNab. Paul Bloem, Tracey Goodman and Susan Wang of WHO’s Immunization, Vaccines and Biologicals Department provided technical oversight. Scott LaMontagne of PATH and Abdelkader Bacha and Jonathan Shadid of UNICEF provided comments on the 2016 update.

A short note on terminology

In this guide, “communication” encompasses the areas of advocacy, social mobilization, behaviour and social change and crisis communication.

What is new in this guide

This updated version of the guide reflects:

1. WHO’s October 2014 changes to the recommended HPV vaccine schedule.
2. Updated facts, evidence and experience from low, middle and high-income countries that have introduced HPV vaccine.
3. An enhanced section on crisis communication.
4. Additional information about the opportunities for integration with comprehensive cervical cancer programs and adolescent health interventions and on the consent process.

* For the 2015 London School of Hygiene and Tropical Medicine/PATH review of HPV vaccine experience across 37 low and middle-income countries, see http://www.rho.org/HPVlessons/.
Executive summary

This guide presents communication guidance for countries introducing human papillomavirus (HPV) vaccine at the national or sub-national levels. HPV vaccination is a key strategy for comprehensive cervical cancer control and prevention. By the end of 2015, more than 65 countries introduced HPV vaccine into their national immunization programmes, with more than 30 of them were approved for Gavi-supported introductions.

HPV vaccine presents some challenging issues for communities. Concerns about the HPV vaccine are a common feature of its introduction. HPV vaccine is targeting girls before they become sexually active in order to prevent acquisition of a sexually transmitted infection (STI). WHO recommends that two doses of the currently licensed HPV vaccines be administered to 9–13-year-old girls to prevent infection with two types of human papillomavirus that account for about 70% of cervical cancer cases. The full benefits of HPV vaccine in reducing infection and the subsequent risk of cervical cancer will only be appreciated years and even decades after girls have been vaccinated. Countries introducing HPV vaccine should invest in a communication plan for the introduction and sustained delivery of HPV vaccine so that it becomes positively associated with adolescent girls and a socially-acceptable demanded service.

This guide offers guidance in three main areas: the first is advice on basic communication planning and implementation for immunization; the second discusses specific considerations for HPV vaccine; and the third on crisis communication. The basic elements of an immunization communication plan include:

- building a cross-sectoral team;
- clear programme and communication objectives;
- understanding community knowledge, attitudes and practices;
- SMART objectives and sensible strategies;
- defined target audiences with activities and messages for each that use appropriate channels and materials;
- a crisis communication plan to manage problems including adverse events following immunization; and a monitoring and evaluation plan.

The specific considerations of HPV vaccine draw on the experience of countries which have either introduced the vaccine nationally or conducted demonstration projects, from partner experience, as well as from several reviews and evaluations in low, middle and high-income countries and the published literature. This part includes advice about cross-sectoral advocacy, team building and formative research; consent; a description of the recommended target groups; the importance of careful planning so that the messages reaches hard-to-reach girls; thoughts on integration with additional services, and advice about effective messaging, materials and communications channels.

Many countries introducing HPV vaccine have faced specific challenges or crises that required communication preparedness. The guide therefore includes a section on preparing for and implementing a crisis communication plan.

Finally, the guide includes summary tables, tips, frequently asked questions, sample materials and resources, all intended to provide immunization managers and communication specialists with the tools they need to ensure a high-quality strategic communication plan.
SPECIAL CONSIDERATIONS FOR A UNIQUE VACCINE
Human papillomavirus (HPV) vaccine has one of the highest per-person impacts on mortality of all vaccines. First licensed in several high-income countries in 2006, the vaccine is being steadily introduced into more countries. The World Health Organization (WHO) recommends vaccination for 9–13-year-old girls as the most cost-effective public health measure against cervical cancer, as part of a comprehensive cervical cancer control strategy. Given the vaccine’s unique characteristics and based on country experiences, WHO recommends investment in a communication strategy for the introduction of HPV vaccine.

Low- and middle-income countries, where more than 85% of cervical cancer deaths occur, can particularly benefit from HPV vaccine. By the end of 2015 more than 65 countries introduced national HPV vaccine programmes and a number of others had or planned to introduce pilot or demonstration programmes. The pace of introduction in low-income countries eligible for support from Gavi, the Vaccine Alliance, is increasing. More than 30 countries are approved presently for GAVI-supported demonstration programmes and national introductions.

Global and country experience in communication for immunization continues to grow as countries build on existing knowledge, add new vaccines and endeavour to increase equitable coverage of national immunization programmes. Despite this experience, challenges persist and new ones develop as the public health community struggles to engage some communities and families in immunization, leading to suboptimal coverage. The lower uptake of some vaccines can be caused by poor service delivery; a lack of knowledge about the threat of vaccine-preventable

1. Lee L et al. The estimated mortality impact of vaccinations forecast to be administered during 2011–2020 in 73 countries supported by the GAVI Alliance. Vaccine, 2013, Decade of Vaccines Supplement, 2:861–872. Specifically, the reviews finds that “First-dose measles, human papillomavirus, and hepatitis B vaccination are expected to have the highest per-person impact and avert 16.5, 15.1, and 8.3 deaths per 1000 persons vaccinated, respectively.”
diseases, the risks and benefits of vaccines; complacency; mistrust of government, health workers and manufacturers; and alternative health or religious beliefs. These challenges underscore the importance of early integration and investment in a strategic communication plan including a crisis communication plan for immunization programmes.

There is a growing body of knowledge and information on HPV vaccine communication. In most low- and middle-income countries, demand and coverage with HPV vaccine is high. While HPV vaccine presents exciting opportunities for public health, experience reveals communication challenges in some countries and communities. People mistrust it because it is new and is mistaken for an experimental vaccine, targeted only at young adolescent girls, or they believe it will lead to increased sexual activity. In some countries, paediatricians, gynaecologists or religious leaders have misunderstood the purpose or value of HPV vaccine, leading to resistance and low coverage. In a handful of countries, HPV vaccine has been rejected due to misinformation.

This guide summarizes good practices for HPV vaccine communication based on material from several sources, including country and partner experiences, the findings of country reviews; recognized “best practices” for communication, advocacy and social mobilization for public health; and learning from other relevant programme and partner experiences.
Who should use this guide?

This guide should be read together with WHO’s Principals and considerations for adding a vaccine to a national immunization programme: From decision to implementing and monitoring and WHO’s HPV Vaccine Introduction Guide.²

National immunization managers, national and district social mobilization teams, partners and international agency staff involved in HPV vaccine introduction can use this guide to plan and implement a communication strategy for HPV vaccine introduction and its sustained delivery. Additional partners involved in cervical cancer control, reproductive health, adolescent health, women’s health and other critical sectors such as education will also benefit from this guide.

Readers may also wish to consult resources on communication for immunization, health programming, cervical cancer, adolescent, sexual and reproductive health. Some key resources are listed at the end of this document.

The structure

- SPECIAL CONSIDERATIONS FOR A UNIQUE VACCINE
- PART I – THE BASICS
  Describes good public health communication practices and principles applicable to any country health communication programme.
- PART II – HPV VACCINE
  HPV VACCINE: focuses on why HPV vaccine merits additional considerations, and describes key features countries should build into their HPV vaccine communication plans.
  Considerations for communications – Crisis communication for HPV vaccine
- CONCLUSION AND SUMMARY
  Summary tables: a sample communication plan, diagrams and tips boxes throughout the document help guide the reader to the most important content.
- ANNEX: CRISIS COMMUNICATION
- FAQ, MATERIALS AND RESOURCES
  - Frequently asked questions: offers basic guidance to answer common questions about HPV vaccine.
  - Materials and resources: included at the end of the report for reference and further study.

PART I: THE BASICS
INTRODUCTION

Immunization should be a social norm, wherein the demand for and access to immunization for all members of every community is normal, socially acceptable health behaviour. The introduction of HPV vaccine should be approached as a long-term ongoing strategy to help prevent cervical cancer, and communities should demand it as a social norm for their adolescent girls. Strategic communication will help to create that norm.

Communication theories posit that people undergo a process to reach a decision to take a new action or to change a behaviour. This process usually begins with a person who is unaware of an intervention – such as vaccination. Through communication activities, they become aware, consider the intervention, adopt the intervention, repeat and demand it, and promote the intervention to their community. Strategic communication and engagement are a key parts of this process, along with the provision of high quality, accessible and reliable health services. This is an iterative process that can take time.

Good communication practices for immunization

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Good communication practices for immunization

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3. The different communication theories and approaches are documented and explained in other literature and will not be repeated here. For more on communication theories such as COMBI and C-Change, see the articles and resources listed on the Communication Initiative’s website: http://www.comminit.com. For information and resources on Communication for Development (C4D) see UNICEF’s website: http://www.unicef.org/cbsc.
Changing human behaviour: a process

People generally undergo an iterative process towards taking a new action or changing a behaviour.

**CHANGING HUMAN BEHAVIOUR: A PROCESS**

1. Be completely unaware of HPV vaccine.
2. Gain awareness through communication.
3. Consider HPV vaccine based on knowledge gained from several sources.
4. Take action to have her daughter vaccinated.
5. Proactively have her second daughter vaccinated.

Many factors play a role in the success, including the perception of threat of HPV and cervical cancer, the degree to which she trusts the vaccine, the message and its source, what action friends and family are taking and access to the HPV vaccine.

**For example, over time a parent or caregiver may:**

1. Be completely unaware of HPV vaccine.
2. Gain awareness through communication activities.
3. Consider accepting HPV vaccine based on knowledge gained from several sources.
4. Take action to have their daughter vaccinated.
5. Proactively take their second daughter for vaccination.
6. Promote HPV vaccine in their community.

Many factors play a role in the caregiver’s decisions, including understanding cervical cancer, the perception of risk of HPV infection, the degree of trust in the vaccine, the sources of information and the messages, the actions of friends and family and the daughter’s access to the HPV vaccine.
PART 1: THE BASICS

Communication principles

Health communication should adhere to key principles and be grounded in a human rights approach.

1. Promote community engagement

One goal of primary health care is for communities to own and demand the health programme or intervention. This can take time. Within communities, there will be many voices – some actively supportive, others passively accepting and some actively opposed. Communication should identify and engage all groups, their leaders and other influencers. It is human nature to want to learn, challenge assumptions and ask questions. Interpersonal communication and community participation will be key to successful communication. Over time this will produce improved, more sustainable health behaviours and outcomes.

2. Promote equity

Good public health practice is to ensure all people who need an intervention are reached. Yet, one in five children are not receiving the vaccines they need. Many of these are marginalized and hard-to-reach populations. Sometimes these populations do not know a service is available, language barriers create misunderstandings, or a supportive environment is absent. Communication strategies should aim to “reach the unreached” – families who may be day labourers, migrants, nomads and minority groups. Reaching unvaccinated children including adolescent girls protects these communities, and is essential to achieve immunization and cervical-cancer control goals.

C4D promotes the following principles:

- Create spaces for a plurality of voices, promote narratives of communities, encourage listening, dialogue and debate and the meaningful participation of children and women.
- Inclusion, self-determination, participation and respect by ensuring that marginalized and vulnerable groups are prioritized and given visibility and voice.
- Link community perspectives and voices with sub-national and national policy dialogue.
- Address the whole person – including the cognitive, emotional, social and spiritual aspects in addition to survival and physical development.
- Build the self-esteem and confidence of parents, care providers, adolescents and children.

Communication for Development Principles

United Nations agencies generally promote “Communication for Development” or “C4D”, a participatory process using advocacy, social mobilization, and social and behavioural change activities to empower individuals and communities to take actions and improve their lives.
The theory, reality and need to advocate for communication

Strategic communication requires investment.

Successful public health can be equated to a three-legged stool. One leg is availability of the intervention itself (e.g. the vaccine and logistics); the second is a trained, motivated cadre of health personnel; and the third is public acceptance and demand. Without the last element, the investment in the vaccines, logistics and health-worker training is wasted.

All of the elements described in the previous section represent the ideal for communication planning and implementation. However, experience shows that the ideal is sometimes far from possible.

In reality, health departments may have one or two communication/social mobilization officers working simultaneously on multiple projects. External partners might also be equally stretched. The time required to take all of these steps may not be available. Often, the situation analysis is done too rapidly with insufficient information. A national KAP survey may require several months to complete, while the programme may be scheduled to begin earlier. Funding may arrive late, seriously disrupting the plan. SMART objectives may have all been deemed “priorities” but were in reality too numerous to achieve. Staff working on the project may have personal family matters that require their extended time away from work.

Communication activities are often under-resourced, but to achieve success in a public health programme, it is important to advocate for increased resources.

Planning is one way to make the investment case. A thoughtful communication plan which demonstrates, with evidence, how it will contribute to better public health outcomes is more likely to attract resources than a plan that proposes only IEC materials. Immunization programming can benefit from the number of partners involved in the communication working group. Get them involved early. Enlist their support to help with the situation analysis and the development of evidence-based plans. The preferred result is a persuasive communication plan with the resources required to achieve the desired public health outcomes.
A note on country context

Some countries may not require as much investment in additional communication.

Countries where public confidence in government programming is high and where clear communication systems from national to community level may be able to use existing structures to communicate effectively about a new public health programme. People will accept and even demand the vaccination because they trust their leaders to offer health interventions that benefit communities and the country.

A note of caution: with increasing access to the Internet, much more information is available rapidly than previously.

This includes misinformation about HPV and other vaccines. The information may look official and cite researchers and other scientists. Anti-vaccination groups can make a compelling case to an untrained person who may already have questions about vaccines. Rumours can begin quickly in communities and be amplified nation-wide through mobile phones, inexpensive videos and social media tools.

Clear information can include:

- A cover letter to community leaders accompanied by a simple, concise question and answer document that helps community leaders explain HPV vaccine.

- Training and information, education and communication (IEC) materials for health workers so they understand the intervention and can communicate clearly and confidently with the community.

- Using the Internet to disseminate information. Some countries have established specific HPV vaccine websites in local languages which offer facts, answer common questions, address rumours and provide copies of IEC and media materials for easy download.

As a reference, the World Health Organization’s [http://www.who.int/immunization/diseases](http://www.who.int/immunization/diseases) provides updated information about HPV, cervical cancer and all other vaccine preventable diseases.
The essential elements for communication planning

An HPV vaccine communication plan includes the following basic elements.

1. **A communication team**

   Countries generally assemble a team to work on communication for a health programme or intervention. This team, whether a sub-committee or working group, will be a key part of the larger planning team that may include operations, procurement, logistics and overall management. The team should include communication experts from government and relevant partner organizations and representation from the different sectors involved in the programme, such as youth and educators.

2. **Technical programme objectives**

   The communication strategy must support achievement of the technical programme objectives. In the case of HPV vaccine, this may be “to achieve > 70% coverage of the target population in year 1, > 80% in year 2, while reaching >75% of hard-to-reach girls and increasing awareness of cervical cancer screening” to contribute to the achievement of cervical cancer control goals.

3. **Situation analysis**

   A situation analysis forms the foundation for all communication planning and makes it possible to plan and budget for high-impact activities.

   It also provides the baseline against which to measure progress. A situation analysis takes time and human and financial resources to do well – but without investment in this step, communication efforts and funds may be wasted on the wrong audiences with the incorrect messages and activities. The situation analysis should examine:

   - Existing data sources including surveys (e.g. multiple-indicator cluster surveys (MICS) and demographic health surveys (DHS), immunization coverage surveys, school enrolment).
   - Immunization programme information including reviews, administrative data, monitoring data.
   - Knowledge, attitudes, practices (KAP) surveys and behavioural analyses of the main audiences.
   - Reports from media, donors and other partners.
   - Maps including social and satellite maps.

   If there is insufficient existing information, formative research may be necessary. This can range from large KAP surveys to smaller samples including key informant interviews and focus group discussions in the target population.
4. **SMART communication objectives**

Based on the situation analysis, set “SMART” communication objectives that will express the specific ways in which communication activities can help to deliver the technical programme objectives. “SMART” is an acronym that means “specific, measurable, attainable, results-oriented, and time-bound”.

Example: “Partner with the education sector so that teachers can provide three key messages about HPV vaccine to target age girls 10 days before the vaccine’s introduction.”

- **TIPS**
  - Objectives should be realistic. Ensure they are not too ambitious and can be achieved in the time allotted.
  - Prioritize the number of SMART objectives – do not set so many that they become overwhelming and unattainable.

5. **Target audiences**

Knowing the target population will help to ensure the right messages, materials, activities and languages.

- **TIPS**
  - For some interventions the target audience may be quite broad – for example health workers or target-age girls.
  - For others, it may be very specific: perhaps the director of health in one state or province or the president of an association.

6. **Define messages for each audience**

Different audiences will respond to different messages. While there may be some common messages (e.g. x disease is dangerous and can be prevented), a health minister will be convinced by different information than a finance minister, and a mother may need different information than a health worker. Messages should:

- target the audience,
- be simple and easy to understand; no jargon, and
- include a call to action.

Ideally, messages should be based on a “message map” for each audience. The example below provides key messages and the supporting facts. These messages and facts form the basis for all communication materials, including brochures, media campaigns and training materials.
Stakeholder/Audience: rural female caregivers

Situation analysis: 90% of rural female caretakers surveyed know nothing about cervical cancer or HPV vaccine

SMART Objective: more than 65% of rural female caretakers know three messages about HPV vaccine before the 2nd dose is administered

<table>
<thead>
<tr>
<th>KEY MESSAGE 1: HPV vaccine protects girls from most cervical cancer.</th>
<th>KEY MESSAGE 2: HPV vaccine is safe and effective.</th>
<th>KEY MESSAGE 3: Protect your girls! Make sure all grade 6 girls receive two doses of HPV vaccine.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting Fact 1.1 Cervical cancer is a leading cause of cancer in women in this country.</td>
<td>Supporting Fact 2.1 Health workers are trained to provide HPV vaccine safely.</td>
<td>Supporting Fact 3.1 The government immunization schedule recommends two doses of HPV vaccine for target age girls spaced six months apart (or not more than 12–15 months apart).</td>
</tr>
<tr>
<td>Supporting Fact 1.2 HPV vaccine protects against infection with HPV types that cause 70% of cervical cancer.</td>
<td>Supporting Fact 2.2 HPV vaccine is delivered with an auto-disable (AD) syringe that is used only once and then safely disposed.</td>
<td>Supporting Fact 3.2 Two doses are recommended by WHO to give optimum protection.</td>
</tr>
<tr>
<td>Supporting Fact 1.3 Research shows a decline in HPV infections in populations where HPV vaccine has been introduced.</td>
<td>Supporting Fact 2.3 Many studies conducted in developing and developed countries have found HPV vaccine to be safe and effective.</td>
<td>Supporting Fact 3.3 The exception are girls who are receiving HPV vaccine for the first time at age 15 or older, or girls who are immuno-compromised (e.g. HIV+). These girls require three doses.</td>
</tr>
</tbody>
</table>

• TIP
  » Test the messages with the audiences. Rapid focus groups can help to ensure that people understand the messages and know what action to take.
7. **A mix of strategies, activities and channels to reach the audiences**

These should directly support achievement of the communication objectives. Audiences will be reached and engaged through a mix of strategies, activities and channels.

- **Strategies** are the approaches taken to achieve objectives and include advocacy, social mobilization, social and behaviour change, and crisis communication.

- **Activities** are the actions taken to support a strategy and can include, for example, advocacy meetings, creating strategic partnerships, discussions between the health worker and caretaker, publishing information materials and hosting media events.

- **Channels** are the ways in which a message reaches the audience, and can include influencers such as a health worker, family member, religious or political leader, the mass media or social media.

**Different audiences respond to different strategies, activities, and channels.**

*For example:*

- A high-level advocacy meeting between the health team and finance minister may be the key activity required to remove a funding bottleneck.

- A mother may need to be reached through several channels including a popular health radio programme, interpersonal communication with her trusted health worker, through a sermon at the church or a mosque announcement, and through the educational system, such as a letter to parents from the school headmaster.

**Different strategies and activities have very different cost implications**

*For example:*

- Television typically costs the most and may only reach those wealthy enough to own televisions.

- Mobilizing a trusted community-based organization to communicate about the programme in every village is also costly but may have more impact on parental demand and acceptance.
8. **Create branded materials**

The strategies and activities will have a bearing on the package of materials required. Materials should be tailored to the audience, and should be branded in a uniform way. They should include government and partner logos.

**Examples of materials include:**

- Advocacy presentations.
- A list of key messages.
- Frequently asked questions (FAQs).
- “Issues management” advice.
- Information, education and communication materials (leaflet, posters, flipcharts).
- Training materials for health workers and teachers.
- A media kit for journalists.

**Factors to consider:**

- Materials should be clean, simple and legible.
- For non-specialists, materials should use images, simple graphics and fewer words.
- Materials should have a common look and “brand”, use a unifying logo, colour, type font and design scheme, together with government and partner logos.
- Pre-test the materials with the target audiences for appeal, relevance, comprehension, acceptability, persuasion and recall. In practical terms, a country team might test messages and materials at the same time.
- Use HPV vaccine materials to include short complementary messages about cervical cancer screening, adolescent health or routine immunization.
- Create a distribution plan so materials arrive in the right place on time.
- Include electronic distribution – by e-mail, through the Internet and through social media where available.

**TIPS**

» Is the language and artwork appropriate for illiterate populations or language minorities?
» Are the physical depictions of people culturally appropriate, including for minorities?
» Is there a clear call to action?
» How is the print quality? It can be tempting to save money by printing with low-quality ink and paper, but if the material fades or tears quickly, it may be money wasted.
» Will the material really be used? Posters, for example, can work well in a country where health clinics or schools routinely hang posters in a visible location, but not where distribution is poor or there is a lack of practical hanging tools such as sticky tape or thumb tacks.
9. **A crisis communication plan**

HPV vaccine has been subject to rumours and linked with adverse events following immunization (AEFI) in many countries.

Complacency, misinformation, adverse events and a lack of confidence in health systems can lead to a crisis in immunization programming, quickly eroding trust in EPI including HPV vaccine.\(^4\) Recovery from such a crisis can take years and can lead to extremely low immunization coverage rates over a prolonged period of time. Crisis preparation and management can avert costly problems.

The rise of Internet access and social media means that information – facts and rumours, celebration and scares - can spread more quickly than before. Events or public perceptions in other countries – even other continents – can have an impact on people’s understanding of and trust in vaccines. People who have questions, mistrust the health establishment and/or favour homeopathic medicine will find lots of information on the Internet that supports their views, and can spread this information through their social networks. This misinformation can result in greater risk of a crisis if there is a serious AEFI, including those that turn out to be unrelated to vaccination.\(^5\)

The *Global Vaccines Safety Blueprint* recommends that every country develop a vaccine safety communication plan as part of an integrated communication plan, aimed particularly at communities, health care workers and decision-makers. The Blueprint stresses that any vaccine safety concerns should be investigated and promptly communicated appropriately.\(^6\)

Crisis communication for health has become more evidence-based over time – with experience drawn from misinformation related to HPV and measles-mumps-rubella, Severe Acute Respiratory Syndrome, H1N1, multiple crises in polio eradication, Ebola in west Africa, and other health emergencies.

*For more on crisis communication, see page 57 of this guide.*

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\(^4\) There are several examples listed in *Building Trust and Responding to Adverse Events Following Immunization in South Asia: Using Strategic Communication*, UNICEF ROSA, 2005.

\(^5\) For more on AEFI surveillance, including investigation, analysis and communication, see the *Global Manual on Surveillance of Adverse Events Following Immunization*, WHO, 2014, [http://www.who.int/vaccine_safety/publications/aefi_surveillance](http://www.who.int/vaccine_safety/publications/aefi_surveillance).

10. A monitoring and evaluation plan

Communication-specific outcomes can be difficult to measure as communication efforts tend to contribute to overall programme outcomes. Nonetheless, the communication plan should include monitoring and evaluation components.

Implementing a monitoring plan with clear indicators can determine whether the plan is on track and focus on where to make adjustments. It will form the basis of reports to programme managers, oversight bodies and donors.

A mid-term or end-of-project evaluation will highlight project challenges and outcomes and can make recommendations to guide future programmes in the country and globally.

A monitoring and evaluation plan requires contemplation about objectives, targets and milestones, together with indicators and methods to assess the plan’s outcomes.

Set overall targets based on the SMART objectives to track progress and achievements.

Example – By Year 3:

- > 90% of teachers of target age girls know why girls should be vaccinated.
- > 75% of caregivers can describe how to prevent cervical cancer.
- > 80% of hard-to-reach girls know where to access HPV vaccine.

Set milestones as interim goals towards achievement of the plan.

Example – By Year 1:

- 100% of health workers in 6 districts are trained in interpersonal communication.
- 75% of caregivers report they have attended a community meeting about HPV vaccine.

Set indicators – including input, output/process and outcome - against which to measure progress.

Input indicators: track the resources or “inputs” invested into the programme (e.g. staff, volunteers, funds, equipment)

Examples:

- Number of staff hired on time.
- % of funds released by a certain date.
- Number of documents produced on time.
Output/process indicators: track the activities and products completed (e.g. training workshops, community meetings held, radio announcements aired).

Examples:
- Number of interpersonal communication training workshops held at district level on time.
- Number of radio announcements aired on radio prior to introduction.
- Number of IEC packages delivered to health centres on time.

Outcome indicators: track the results or changes in the target population as a result of the activity.

Examples:
- % of teachers who know three key messages about HPV vaccine.
- % of caregivers who cite health workers as the source of information about HPV vaccine.
- % change in vaccine uptake in a formerly vaccine hesitant area.

For example, coverage surveys should include questions about “source of information” that can reveal whether communities are learning about HPV vaccine through the channels prioritized in the communication plan, “reasons for accepting vaccination” that can show whether communication played a role and “reasons for non-vaccination” that may uncover the circulation of rumours or other problems.7

Ideally, an independent external evaluation should be part of the plan and budget. If this is not possible, an honest internal evaluation with partners could also be scheduled. In order to assess outcomes, a programme may require a larger survey (such as a KAP survey) or use different sources of information including key informant interviews, coverage surveys, post-introduction evaluations, rapid exit surveys, programme monitoring, reports and information published in the media.

• TIPS
  Monitoring indicators require:
  » A baseline to know the starting point against which to measure progress.
  » Setting priorities: do not monitor everything. Pick things that are realistic to monitor and will demonstrate progress and challenges.
  » A validation source: e.g. from supervisory reports, rapid surveys, monthly reporting.
  » A frequency for validation: e.g. quarterly.
  » Incorporation into existing EPI reporting tools as much as possible – such as administrative reporting tools, coverage surveys, or post-introduction evaluations.

### SMART objective / Target
Within three years, 90% of teachers of target age girls know three key messages about HPV vaccine

### Activity
Annual teacher orientations

### Baseline
10% of teachers know why girls should be vaccinated

### Indicators

- **Input indicator**
  Number of information leaflets printed per teacher
  
  - **Validation**
    Communication team reports
  
  - **Frequency**
    One per year

- **Output indicator**
  Percentage of teachers attending orientation meetings
  
  - **Validation**
    Orientation sign-in sheets and teacher registries
  
  - **Frequency**
    One per district per year

- **Outcome indicator**
  Percentage of teachers who can provide three key messages about HPV vaccine
  
  - **Validation**
    Survey
  
  - **Frequency**
    One per year with HPV vaccine monitoring

### 11. A work plan with a budget

Once the essential elements of the communication strategy are mapped, integrate them into a work plan. The work plan should include a list of activities, the responsible person, the funds required for each element, the deadline for each activity and space for status reports. The work plan and budget may need to be authorized by the national programme coordination group.
12. Adjust the work plan as required

Communication is a continuous process, with the goal of ensuring HPV vaccination becomes a social norm. The plan will need refining as the programme continues. If monitoring and other reports indicate an activity is not working as anticipated, it should be stopped or adjusted. Investments in communication may change over time as a programme becomes more integrated into the community and accepted as a regular part of health programming.
Sample HPV vaccine communication plan

Programme objective
Achieve more than 90% coverage of Grade 5 girls and 10-year-old out-of-school girls with two doses of HPV vaccine this calendar year.

Situation analysis

In the majority population
In most of the country, 10% of target-age girls are not in school, for a total of 50 000 girls. Based on demographic surveys and knowledge of the culture, about 80% of out-of-school girls are helping in the home, and 20% are working in the family business (shops, street stalls, small restaurants). Community attitude towards immunization is positive (e.g. DTP3 = 87%). A new community survey shows that 60% of female caregivers know very little or nothing about cervical cancer and that 90% of female caregivers know very little or nothing about HPV and HPV vaccine. Previous experience in the country shows that these caregivers trust the First Lady and primary health-care workers. Almost every community listens to the 18:00 national news on the radio.

In the minority population
In six districts of “x” Province, more than 80% of target-age girls are not in school, comprising 10 000 target-age girls. They mainly work on their family farms. Community attitudes about immunization are less positive (e.g. DTP3 = 70%). The community survey shows that 80% of female caregivers know very little or nothing about cervical cancer and that almost 100% of female caregivers know very little or nothing about HPV and HPV vaccine. Previous experience shows that this community mistrusts the government but trusts their religious leaders and midwives.
## Sample communication plan

### SMART objective

80% of caregivers can answer three basic questions about cervical cancer and HPV vaccine by the end of the year.

### Target audiences

1. Caregivers of Grade 5 girls, and 10-year-old out-of-school girls in the majority population

   **Messages**
   
   - Cervical cancer is a leading cause of death for women in our country.
   - A virus called human papillomavirus, which is transmitted through sexual activity, causes cervical cancer. Most women will get this virus when they are younger. Some will develop cervical cancer.
   - We are offering a safe, effective vaccine that will prevent most cervical cancer.
   - All Grade 5 girls in school, and 10-year-old girls not attending school should be vaccinated.
   - Protect your daughters. Be sure they receive 2 doses of the cervical cancer vaccine this year.

   **Strategies, activities, & channels**
   
   1. Advocacy: with First Lady and ask her to launch HPV vaccine one week before introduction.
   2. Social and behavioural change with community: HPV vaccine community information session in every catchment area.
   3. Social and behavioural change through radio media: public service announcement to run before the 18:00 national news every day for two weeks before and during the week of introduction.

2. Caregivers of 10-year-old girls in minority population in “x” Province.

   **Messages**
   
   Same as above with these additions:
   
   - HPV vaccine is safe and is used in neighbouring countries,
   - Bring your 10-year-old girls to discuss the HPV vaccine with your community midwife, and have her vaccinated.

   **Strategies, activities, & channels**
   
   1. Social and behavioural change: orientation meeting with midwives and religious leaders.
   2. Midwives lead community information sessions with religious leaders present in all catchment areas.

### Materials

2. Training package including interpersonal communication (IPC) skills for all health workers and teachers responsible for immunization.
3. Package of IEC materials (poster, leaflet) to be used at community information sessions.
3. Three versions of the public service announcement.
4. Same as above in local language.
5. Orientation package for midwives and religious leaders.

### Targets

1. Launch covered on all major media.
2. 90% of community meetings held.
3. 60% of people surveyed cite PSA as a source of information.

### Indicators

- **Input**: % of IEC materials arrived in time for the health information session.
- **Process**: % of community information sessions held.
- **Outcome**: % of caregivers who can answer three basic questions about HPV vaccine and cervical cancer.

Note: this is not a comprehensive plan, and data and information have been created only for the purpose of this exercise.
Considerations for communication

This section outlines the elements of the communication planning process discussed in the last section and identifies key considerations for the introduction of HPV vaccine. The section also looks at broader, common lessons that have emerged from low-, middle- and high-income countries.

Why HPV vaccine is unique

HPV vaccine is different in several ways from other new vaccines targeted at infants.

<table>
<thead>
<tr>
<th>Characteristics of HPV vaccine</th>
<th>Potential communication issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Targeted at pre-adolescent and adolescent girls</td>
<td>– May be in or out of school; if out of school, harder to reach. – Concerns about girls’ fertility and sexual activity. – Concerns about why the vaccine is not available to all women or to boys and men.</td>
</tr>
<tr>
<td>An injected vaccine</td>
<td>– Fear of injections amongst target-age groups. – Higher risk of mild AEFI including fainting.</td>
</tr>
<tr>
<td>Characteristics of HPV vaccine</td>
<td>Potential communication issues</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------------------</td>
</tr>
</tbody>
</table>
| A newer vaccine               | – Concerns about safety, side-effects and efficacy, or “experimentation”.  
|                               | – Concerns about manufacturing origin; whether it meets religious standards (e.g. halal). |
| A relatively expensive vaccine | – Concerns from health professionals, including gynaecologists, about budget priorities. |

| Provided in a two-dose schedule in a six-month (or 12–18 month) timeframe | – Maintaining support of schools for multiple health worker visits.  
|                                                                      | – Reaching girls who drop out, change or are not in school with both doses. |

| Protects against HPV – a little-known sexually transmitted infection | – Explaining HPV infection risks and prevalence in clear, non-judgmental and culturally appropriate terms.  
|                                                                  | – Not confusing with HIV or other sexually-transmitted infections. |

| Protects against cervical cancer which manifests years after HPV infection | – Cervical cancer may not be well-known or easily discussed.  
|                                                                      | – Gaining and maintaining support when the benefits of HPV vaccine may not be seen for several years, unlike vaccines against outbreak-prone vaccine-preventable diseases like measles. |

| Protects against 70% of cervical cancers | – Explaining that it does not protect against all causes of cervical cancer.  
|                                         | – Explaining that cervical cancer screening is still necessary.  
|                                         | – Explaining that cervical cancer screening is necessary but may not be widely available. |

| Of interest to several disciplines and sectors | – Opportunity to involve immunization, child health, adolescent health, HIV/STIs, cancer, sexual and reproductive health and education partners.  
|                                               | – Opportunity to integrate communication strategy and messaging with several areas including cervical cancer prevention, adolescent health, education and others. |

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a. By July 2016, WHO had prequalified bivalent- and quadrivalent-HPV vaccines, which protect against 70% of cervical cancers. A 9-valent HPV vaccine, which protects against up to 90% of cervical cancers was under review for pre-qualification by WHO.
Countries have learned several lessons about communication for HPV vaccine introduction. Here are a few excerpts of reported experiences, both positive and challenging. Most of these experiences were reported at the November 2015 WHO Global Learning meeting on HPV Vaccine Introduction.

**IMPORTANCE OF MAPPING STAKEHOLDERS AND BUY-IN**

One European country experienced high resistance from several health associations, which publicly branded introduction of HPV vaccine as too expensive. Their resistance sparked additional questions and concerns from health workers and parents, and contributed to low coverage.

One African country was surprised when the human rights commission – which was not invited to the initial stakeholder meetings – threatened to sue the government as it had misunderstood HPV vaccine to be an experimental new intervention that might damage girls’ fertility. Days before implementation the country immunization manager had to act quickly and meet with the commission to explain the purpose and safety of HPV vaccine.

A southern African country says one of the biggest success factors for introducing HPV vaccine was involving parent–teacher associations and teachers’ unions. They could mobilize girls for immunization and help solve problems reaching school girls.

**CONSIDERING CONSENT**

Countries use different approaches to consent, ranging from more formal, written or verbal consent to more informal, implied consent procedures between health workers and caregivers. These provide both opportunities and challenges.

One South-East Asian country successfully uses a written consent form that is sent home to parents for signature. Without written consent, girls are not vaccinated. The form also includes an AEFI checklist for parents to report even mild adverse effects to the health system.

Other countries use “implied consent” where all caregivers are invited to a community information or parent teacher association meeting and informed about HPV vaccination. The health workers then consider that consent has been given for all girls that come for vaccination in the community or school.

Several countries report that by not seeking formal consent for routine immunization, some communities became suspicious when this was introduced for the HPV vaccine, and wondered whether the vaccine was experimental.

Many countries note that regardless of the consent process used in public schools, private schools tend to insist on “opt-in” consent forms distributed to every girl and signed by caregivers.
WORKING WITH TRADITIONAL AND RELIGIOUS LEADERS

Countries report there are several examples of how working, or not working with religious leaders affected the acceptance of the HPV vaccine.

One African country reports that it made a special effort to engage the Chief of a district, who was also the head religious leader. The good news was that all of his followers brought their girls for HPV vaccine immunization. The challenge was they had not engaged the minority religious leader in the area. The result? His followers did not bring their girls for vaccination. The lesson: engage religious and traditional leaders who will appeal to different populations in the community.

One South-East Asian country’s religious leaders issued an Islamic fatwa nationally, declaring the HPV vaccine to be safe and important for girls’ health.

MESSAGES AND MATERIALS

Countries report it is important to keep messages simple and jargon-free. However, many stress the importance of creating different types of information packages for different audiences. This includes more sophisticated messaging for media that, for example, will address concerns people may have read on the Internet.

CONSIDERING TRANSLATION AND CONSISTENCY

One language – One Pacific country reports that though populations speak multiple languages, it elected to maintain all HPV vaccine materials in English – which is nationally understood – so as to eliminate confusion about the messages.

Multiple languages – Other countries report that translation is essential for each language group.

Consistency across materials – Mistakes observed include the county that printed slightly different information about the target age group on different materials as there had been no final proof-reader.

COMPREHENSIVE CERVICAL CANCER PREVENTION AND CONTROL

Some countries promote a dual message for their populations: “Girls, get vaccinated now to protect your future! Mothers, get screened to protect your health today!” When promoting screening, it is important that screening services are available.

ADOLESCENT HEALTH INTEGRATION

In one southern African country, health workers distribute a “Me, My Body, My Life” magazine to all grade-4 students while HPV vaccine is being administered as part of the school health programme. Boys and girls receive the magazine so that boys also benefit from the HPV vaccination session. Students can read a range of topics including puberty, immunization, bullying, exercise, resisting alcohol and drugs, and then answer questions, do activities, and write journal-style entries about the topics. There are references to helplines and the importance of talking to trusted adults if they have concerns or questions.

FUNDING AND SUSTAINABILITY

Late release of funds: One country prepared and pre-tested high-quality materials in several languages. However, due to the late release of funds, the country had to print and distribute the materials many weeks after HPV vaccination began. “We had to convince people at the same time we were trying to vaccinate
them,” said one health leader. This caused undue concerns in the community and short-term problems for the programme.

Sustaining funding – One high-income country reports parental difficulties to find the latest information, due to the reduction in the communication budget in the years following the HPV vaccine’s introduction. “There is a new cohort of parents and girls every year,” said one cervical cancer expert from the country, “and they need to have access to clear and updated information.” The lesson: ensure a sustained communication budget.

Including communication in procurement: Some middle-income countries report the negotiations for vaccine procurement ensure the manufacturers include funding for the communication strategy.
Getting started: what to consider and what to do

Experience from other countries suggests the several broader lessons for HPV vaccine communication.

Start early

While not unique to HPV vaccine, it is best to start communication planning early. Given the distinctive attributes of HPV vaccine and the potential for community concerns, planning several months in advance of introduction allows for the research, situation analysis and pre-testing needed to successfully introduce this new vaccine. Starting early also means having budgets approved early – which translates into materials that are ready on time.

Build a cross-sectoral team

HPV vaccine may be delivered through the existing immunization structures, but the health implications and benefits cut across many sectors and programmes.

The programme planning team and the communication team should integrate relevant sectors early. Each country should map all relevant sectors. These can include:

- the cervical cancer team,
- women’s health practitioners, including gynaecologists and obstetricians,
- adolescent health practitioners including paediatricians,
- the Ministry of Education,
- groups such as women’s, girls, youth and education associations,
- service clubs - such as Lions and Rotary – which are often involved in immunization,
- religious organizations and associations, or
- relevant counterparts in UN agencies such as WHO, UNICEF, and UNFPA, and international NGOs such as PATH and other local partners.

Working across sectors and programmes expands human and financial resources, taps existing knowledge, promotes new ideas and builds large networks that can reach people at all levels of society with consistent messaging. Building a strong multi-sectoral partnership is also an opportunity to ensure no group feels its “territory” is being threatened. At the same time, this approach requires more time to harmonize agendas and build consensus around messages and activities.

There will be concerns

Country experience shows that some communities and health workers will have concerns about HPV vaccine. Countries can anticipate concerns and rumours about:

- **The source and relative newness of the HPV vaccine** – The vaccine may be perceived to be a new experimental product from wealthy countries that is being tested in poorer countries.

- **The words “demonstration project”** can also trigger suspicion that this is an experimental vaccine. Some countries undertaking Gavi-supported “demos” have called it a “learning process” or found other ways to describe why just a few districts are being targeted.

- **Communities and health workers may want more information** about the safety, efficacy, side effects, long-term effects and experiences with HPV vaccine in other countries.

- **The targeting of young girls** – Some people may wonder if HPV vaccine will have an impact on girls’ fertility. They may take the idea further and suggest there is a plot to sterilize girls. Others may wonder if vaccination will encourage girls to become promiscuous, despite studies that demonstrate otherwise. Recognizing that HPV is an STI, some may misunderstand the need to vaccinate girls early, protest that their girls are not yet sexually active and believe that vaccination is not yet necessary. People may wonder why boys are not being vaccinated too as is happening in a few countries. Women may wonder why older adolescents and adult women are not being vaccinated.

- **The cost of the vaccine to the national health budget** – In countries paying for the vaccine with national funds, professional health associations may wonder why HPV vaccine is being introduced given its expense and fear this may impact decisions to fund other vaccines or services such as cervical cancer screening and treatment.

Advocacy with groups that may have specific concerns

Some influential groups – such as health professional associations, private schools, parent-teacher associations, religious associations, other civil society actors - may have specific concerns about HPV vaccine which, if unaddressed, can lead to serious consequences. They can interrupt HPV vaccine delivery with one widely publicized news release. These groups may mistakenly focus on girls’ fertility or sexuality. They may question whether the vaccine meets standard religious criteria

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9. Several studies show that HPV vaccine has no correlation with promiscuity or with neurological disease. For example, a study of more than 260,000 girls, published in 2014 found that concerns over increased promiscuity following HPV vaccination are unwarranted, with strong evidence that HPV vaccination has no significant effect on clinical indicators (STIs, pregnancy) of sexual behaviour. See Smith, L et al. Effect of human HPV vaccination on clinical indicators of sexual behaviour among adolescent girls: the Ontario Grade 8 HPV Vaccine Cohort Study. CMAJ, 8 December 2014. A 2014 Scandinavian study showed no correlation between HPV vaccination and multiple sclerosis. See: Nikolai Madrid Scheller et. al. Quadrivalent HPV Vaccination and Risk of Multiple Sclerosis and Other Demyelinating Diseases of the Central Nervous System. JAMA, 2015;313(1):54-61. doi:10.1001/jama.2014.16946. For more on HPV vaccine’s safety profile, see this report from the Global Advisory Committee on Vaccine Safety: http://www.who.int/vaccine_safety/committee/topics/hpv/dec_2013 and this WHO 2014 position paper: http://www.who.int/wer/2014/wer8943.pdf?ua=1.
(e.g. halal). One country experienced high resistance from several health associations, which publicly criticized the introduction of HPV vaccine as being too expensive. Their resistance sparked more questions and concerns from health workers and parents, and contributed to low coverage which persisted for several years.

**TIP**

» It is important to anticipate concerns, identify and engage with influential groups early. Discuss and address their concerns and bring them into a wider coalition – so that they not only tolerate HPV vaccine, but proactively support it.

**Understand and plan for the hard-to-reach girls**

Hard-to-reach girls including those who are not in school may also be at higher risk of HPV infection and developing cervical cancer. These may include girls:

- who have low socioeconomic status,
- who remain home to help with child-rearing or the family business,
- living in remote regions,
- from minority cultures including nomadic groups,
- with disabilities,
- who move frequently with their families (e.g. migrant or seasonal workers),
- who attend school only part time,
- who have left home and live in dense, urban areas, or
- who are HIV-positive.

Some countries report it is very difficult to enumerate, locate, mobilize and immunize these girls. One country reported very high coverage of girls in school (more than 95% administrative coverage) but much lower for girls out-of-school (less than 65%). While challenging, a communication plan should attempt to reach these girls through channels they trust – whether through household and community outreach, popular social media, messages through peer networks, adolescent friendly health services, housing, employment settings or popular youth venues. The messages should stress the risks of cervical cancer, benefits of the vaccine, the two-dose schedule and the fact the government is offering the vaccine free of charge.

**The first year will have some challenges**

Even with good preparation, challenges are likely to emerge during the first year of HPV vaccine introduction. These may relate to service delivery but can include rumours and misunderstanding about the vaccine. Good communication planning can anticipate this and provide audiences the information they need to understand and support the programme.
Knowledge will likely be low

Experience and available research to date show that knowledge about cervical cancer, HPV and HPV vaccine is poor particularly in low- and middle-income countries.

- A recent survey in rural India of more than 1000 women, of whom 85% were literate, revealed that none had heard of HPV or its side-effects.\textsuperscript{10}
- Formative research in Lao PDR found low knowledge amongst mothers and community leaders about the correlation between HPV and cervical cancer.\textsuperscript{11}
- A survey of 449 ethnically diverse women in Malaysia found that knowledge of HPV, HPV vaccine, cervical cancer risk factors and cervical screening was extremely poor.\textsuperscript{12}
- In a survey of 289 women attending medical clinics in urban Botswana more than half said they did not know what causes cervical cancer, and almost none attributed it to HPV infection.\textsuperscript{13}
- Formative research in Uganda found recognition of cancer as a serious health problem, and awareness of a link between cervical cancer and sexual activity, but very little knowledge about HPV.\textsuperscript{14}

High coverage can be achieved

Despite poor knowledge, demand for HPV vaccine has generally been good in many low-, medium- and high-income settings. In Rwanda, for example, women were demanding the HPV vaccine for themselves as well as for their daughters. In Malaysia, a catch up HPV vaccine programme was added to extend vaccination to 18-year-old girls. Many countries achieved good coverage. Both Rwanda and Malaysia reported coverage of more than 85% of the in-school population. A coverage survey of Tanzania’s and Senegal’s demonstration programmes revealed coverage well above 90%. The demonstration project in Uganda resulted in 85% coverage in the school-based programme. In England, more than 84% of 12–13-year olds were fully vaccinated from 2010–2014. Both Australia (2014) and Canada (2013) report that about three-quarters of the target population received all doses.

\textsuperscript{11} WHO WPRO with the Lao PDR University of Health Science. Cervical Cancer, Immunization, HPV and HPV Vaccine; A Rapid Knowledge, Attitude and Practice Assessment in Lao PDR; September 2013, unpublished.
\textsuperscript{14} PATH and Child Health and Development Centre (CHDC). Shaping a Strategy to Introduce HPV Vaccines in Uganda: Formative Research Results from the HPV Vaccines: Evidence for Impact Project. Seattle: PATH; 2009.
**HPV vaccine in communication planning**

**Multi-year communication plan and budget**

The ultimate goal of HPV vaccine introduction is to integrate it as a long-term cervical cancer prevention tool, whereby HPV vaccination of target-age groups becomes a social norm. Countries may want to reduce the HPV vaccine communication budget after the first year. However, each year brings a new cohort of target-age girls and their parents, and they may be learning about HPV vaccine for the first time. New health workers and teachers will join the system and be trained or oriented. A large-scale mass-media campaign may not be necessary each year, but communication to remind audiences about the reasons, dates and schedule of the HPV vaccine programme; opportunities to ask questions (e.g. radio call-in programmes, school and community meetings); informative literature; monitoring and responding to rumours and concerns will be necessary for some time until HPV vaccine becomes routine within the health system.

**Situation analysis and formative research**

Depending on the country, the situation analysis may require formative research for an HPV vaccine communication plan.

Research and experience to date in many countries shows a similar set of communication-related issues, as captured in the table on page 24. Within communities this includes a relatively low level of knowledge about cervical cancer, HPV and HPV vaccine; a fear of cancer; and a desire to protect children from disease. Some caregivers, health workers and community leaders will be concerned about targeting adolescent girls with a vaccine for a sexually transmitted infection. Some will worry about side effects and safety. Communities that traditionally do not support vaccination will possibly reject the HPV vaccine. Other considerations are summarized in the table on page 24.

A situation analysis for the communication plan should consider these issues, together with: country experience introducing other new vaccines or public health interventions, any previous KAP studies on immunization and health, adolescent health information, school enrolment, sociocultural studies, demographic and health surveys, multiple indicator cluster surveys, mass media analyses and other sources. Analysing these sources should provide a lot of information that will inform the communication strategy’s situation analysis.

New research, which can range from a small series of focus group discussions and key informant interviews to more comprehensive surveys, can add critical information. Some countries with high levels of routine immunization coverage, for example, have challenges introducing HPV vaccine. Research may reveal surprising results and findings about the target populations and indicate other areas that require improved communication (e.g. on knowledge about cervical cancer and screening, or the roles that fathers play in decisions to immunize girls).
Sample research questions for health workers, community members:

**ABOUT CERVICAL CANCER**
- What is cervical cancer?
- What causes cervical cancer?
- Who is at risk of cervical cancer?
- How can it be prevented?
- What is it called in the local language?

**ABOUT HPV**
- What is HPV?
- What problems does it cause?
- How is it transmitted?
- How can it be prevented?

**ABOUT HPV VACCINE**
- What is HPV vaccine?
- How many doses are required?
- At what age?
- Would you accept it for you/your daughter/in your community?
- Why or why not?

**ABOUT IMMUNIZATION**
- What do you think of vaccines? (positive/negative) Why?
- Are your children/is your community fully vaccinated?
- Why/why not?
- Who makes decisions about vaccination in your family?

**ABOUT SOURCE OF INFORMATION**
- Who do you trust to give you health information?
- How do you prefer to get health information (e.g. face-to-face, news media, SMS, social media, outdoor media other)?
- What sources make you uncomfortable or suspicious? Why?
Formative research, including focus group discussions and key informant interviews, is also part of the communication engagement process and can signal genuine care about addressing the views of target groups. It can also help to pinpoint language and terminology for sometimes sensitive areas such as sexual behaviour and anatomy, or for colloquial language, as well as new information channels used by target-age girls (e.g. use of specific social media).

If a country would like to conduct formative research in advance of HPV vaccine introduction, partners including WHO and PATH can provide guidance. Such research should be conducted months in advance of the planned introduction so that the results can inform the communication strategy. It should be designed to inform a comprehensive cervical cancer control strategy, including education, HPV vaccine introduction, screening and treatment.15

THE ISSUE OF CONSENT

• **Consent**, by definition, must be informed, understood and voluntary and the person giving it must have the capacity to make the decision. Consent procedures for immunization will vary by country, and can include formal, written consent (e.g. the caregiver signs a form); verbal consent; and implied consent (e.g. attendance and agreement at a community information meeting). Consent can be “opt-in” whereby caregivers proactively agree to their child being immunized, or “opt-out” whereby vaccination proceeds unless the caregiver indicates otherwise.

• **For HPV vaccine**, countries have found that the introduction of new consent procedures – formal written opt-in procedures, for example, when consent for immunization has traditionally been verbal opt-out – has led to suspicion that the HPV vaccine is experimental or risky. In general, countries have had better HPV vaccine immunization outcomes when consent is opt-out; and several countries have switched to an opt-out approach after one year of trying an opt-in approach. In addition, countries have generally found that lengthy consent procedures resulted in some girls missing the opportunity to be vaccinated. Finally, countries report that private schools generally required some form of written caregiver consent (opt-in or opt-out).

• **In any case, both consent letters and information sessions** to parents are a good opportunity to communicate with parents about related messages. For example, on the importance of cervical cancer screening in women, cervical cancer risk factors such as smoking, or additional services available to adolescents.

WHO’s *Considerations regarding consent in vaccinating children and adolescents between 6 and 17 years old* provides additional guidance to countries on the issue of consent (http://bit.ly/VaccineConsent); and the PATH/LSHTM HPV Vaccine lessons learnt & recommendations also provides data on HPV vaccine consent in countries (www.who.org/HPVlessons).

HPV vaccine audiences

Each of the following audiences are important. Their understanding, engagement and support can make the difference between success and failure of the HPV vaccine effort. Naming these specific audiences does not exclude others. Countries should analyse who else must be reached – whether it be community leaders, traditional healers, civil society, popular artists or others.

TARGET-AGE GIRLS

Girls are a core audience. They should demand the vaccine and promote it to their family and peers. Girls need basic information:

- They need to know why a health worker will give them an HPV vaccine injection, how many doses they require, when and where they will receive them.
- Younger girls may not need to know all of the details. In fact, girls surveyed generally care most about one issue: will the injection hurt?
- All girls should be told the normal side effects of the injection and know when side effects require a visit to a health clinic.
- Ideally, the girl should learn enough at the time of HPV vaccine injection to recall that when she is older she should still go for cervical cancer screening.
- Girls are a channel of information to their friends, parents, sisters and aunts – they can bring home information that others can read and discuss, or talk about it with their sisters or friends. This includes information for mothers/sisters/aunts to be screened for cervical cancer.
- Where consent is required, girls should be informed about how the consent process works.
- As already mentioned, hard-to-reach girls require special consideration.

Trusted channels of information for girls:
Caregivers – Teachers – Extended family, including aunts, grandparents, brothers and sisters – Community leaders – Religious leaders – Media, including social media

CAREGIVERS IN THE IMMEDIATE AND EXTENDED FAMILY

Reaching caregivers can be difficult. In Rwanda, for example, fewer than 20% of girls surveyed cited their parents as their source of information for HPV vaccine. In Malaysia, fewer than 5% cited parents as a source. Parents and caregivers should feel informed so they can discuss and promote HPV vaccination with their daughters, give consent, and know where to ask should they have questions.

- Caregivers may have concerns about their daughter’s health, the potential for promiscuity, perceived impacts on menstruation and fertility, vaccine safety, side effects and long-term effects.
- Some caregivers will have access to the Internet and read negative news reports and rumours – in the absence of correct information and engagement they can pass false information through the community.
• Many caregivers will believe their daughter is too young to seriously discuss or give consent for HPV vaccination.
• In many countries, the father will be responsible for giving formal consent and needs to be reached with information he trusts.
• Mothers, grandmothers or aunts in the extended family may be a key source of information. They will also benefit from information about cervical cancer screening and treatment.
• Caregivers may seek multiple sources of information about HPV vaccine. If they hear about it through school, for example, they may also seek advice from their health worker, friends or trusted community leaders.
• In countries with cervical cancer screening, reaching out to mothers, aunts and older sisters is also an opportunity to reach eligible women with messages about cervical cancer screening.

**Trusted channels of information for caregivers:**
Other family members – Peers/friends – Teachers and headmasters – Community leaders
Religious leaders – Local and national officials – Scientific experts – Local and mass media
(the actual publication/programme will vary by community)

**HEALTH WORKERS INCLUDING COMMUNITY HEALTH WORKERS**

Health workers are an essential audience. Their active support and promotion of HPV vaccine can have an impact on demand and coverage. Health-worker interpersonal communication skills with girls, caregivers, teachers and community leaders are a key to success.

Health workers may have questions about the HPV vaccine, or about the biological links between HPV, the vaccine and cervical cancer. They may also want to learn about other STIs or other types of cancer. Health workers may also have access to the Internet and will search for more information on these issues. They too could find false information and rumours.

Health workers should:
• undergo training including interpersonal communication (IPC) training,
• undergo training to identify and address the special needs of adolescents beyond vaccination, and
• have access to materials they can learn from, and they can use to teach others – such as a leaflet, a *Frequently Asked Questions* list, and a poster with images and simple phrases.

**Trusted channels of information for health workers:**
Their family and peers – District and national supervisors – Experts – Gynaecologists, oncologists, researchers, academics – Health professions’ associations – Some information on the Internet – International authorities, e.g. WHO
HEADMASTERS AND TEACHERS

If HPV vaccine delivery is school-based, headmasters and teachers will be on the front lines of the programme and can be a linchpin to success. They are frequently a source of information cited most by girls. They may give permission to health teams to vaccinate in schools and use valuable class time for vaccination sessions. They may also actively participate in training or orientations, register girls, educate girls about the vaccine, remind them of the schedule, and arrange consent with parents. They can also help with the sessions in other ways, for example by recording attendance, updating and maintaining vaccination cards at school and referring girls who missed a session to the nearest health facility. They may also coordinate information with health workers and with parents through parent-teacher associations.

Headmasters and teachers should receive tailored training on HPV vaccine separate from health workers (and in collaboration with the Ministry of Education and any private school associations) covering key messages and their roles and responsibilities.

• They should have formal opportunities to coordinate with health workers (e.g. joint meetings).
• They should have access to IEC materials that both explain HPV vaccine, and engage and mobilize caregivers and daughters.

Trusted channels of information for headmasters and teachers

Family and peers – Ministry of Education – Health workers – Health and science experts Local and national officials – Community leaders – Mass media (will vary depending on the source)

PROFESSIONAL, CULTURAL AND RELIGIOUS ASSOCIATIONS

Relevant associations should be identified, engaged in advocacy and included as a direct partner or within the broader coalition of supporters. When they are confident in the programme, their leaders can become champions and advocate publicly for caretakers to have their girls vaccinated. These include:

• Professional medical or nursing associations. Recommendations from health care providers are a factor in people’s decision to have their daughters vaccinated. Several countries co-brand their HPV vaccine programmes with the association of gynaecologists or obstetricians; paediatricians and cancer specialists are also important. Trusted health practitioners can be involved in interviews and public service announcements promoting HPV vaccine.
• Religious and traditional leaders’ associations. In several countries, buy-in from religious leaders has been critical to the HPV vaccine programme. Messages sent through churches and mosques are often cited as an important source of information and correlate with vaccine uptake.
• Women’s groups and associations.
• Adolescent health advocates.
• Youth groups and adolescent support services.

**Trusted channels of information**

They will vary from group to group. As associations are identified, map out the channels of information that they will trust most. Each group may need different kinds of evidence-based information – such as the burden of cervical cancer in the country, the costs of treatment and the cost-benefit of HPV vaccination. They may also want more evidence and information from other countries.

**MEDIA**

The media can be champions for HPV vaccine through accurate reporting and prominent placement of stories. However, if there is an information gap, they can also be quick to report misinformation they might find from other sources. They may, for example, be targeted by anti-vaccination groups who will lead them to false information. Media will vary from country to country and have greater or lesser trust in government programmes.

**The media need:**

• An orientation, with trusted experts, on HPV vaccine well before its introduction.
• An ongoing relationship with the EPI programme, including people they can call with questions.
• Briefing materials including a news release, fact sheet, FAQs.
• Timely responses to their questions that meet their publication deadlines.
• Access to a spokesperson at all times, including in times of crisis.

**Trusted channels of information for media**

They will depend on the country and the type of media (e.g. state-owned or private sector) but generally media value the following sources for news stories:

Senior political leaders – Independent experts, e.g. gynaecologists, oncologists, researchers, academics – International organizations such as WHO or UNICEF – Senior leaders of associations including health or religious associations – Community leaders and members

Media also value sources who will give “the other side” of the story – this includes sources who may oppose HPV vaccine.
HPV vaccine programmes in Rwanda, Uganda and Peru; each show the importance of involving teachers and health workers in the communication process.

In Rwanda, every district health centre hosted joint meetings with health workers, community leaders, headmasters and teachers before each round of vaccination. Educators learned about HPV vaccine and their roles in ensuring their students were reached in the classroom. Rwandan girls surveyed cited school and health workers as two of the top three sources of information about HPV vaccine (radio ranked first).

In Uganda’s HPV vaccine demonstration project found that close collaboration between the community, teachers and health workers was a key factor in higher coverage. “Joint planning meetings in advance of vaccinations were essential to the success of the vaccination programme. The participation of teachers, health workers, and community leaders in the meetings provided an opportunity to coordinate work plans, time lines, resources, interventions, monitoring and reporting. This also promoted close collaboration between the departments of health and education and encouraged a cooperative environment during vaccination sessions.”

This kind of collaboration was credited with some of the success in a demonstration project in Peru: “Feedback from parents and their daughters indicated that although many initially reacted to the new vaccine with scepticism and doubt, these doubts were overcome by educational efforts by teachers and health workers, as well as information parents sought independently.” In Peru there was also evidence that where teachers were not engaged, the programme was affected. “In places where teachers were not involved in or supportive of vaccination, there was also distrust or lack of engagement among parents. For example, one health worker described how teachers at one school failed to actively coordinate educational community meetings, which meant that no parents showed up.”

a. Results of a post-introduction evaluation in Rwanda, October 2012.
Effective messages

There is no magic formula for HPV vaccine messaging, and it will vary between and within countries. Knowledge of the country populations, a thorough situation analysis and pre-testing will help to guide messages. For HPV vaccine, key messages include:

- **A CANCER VACCINE**

  In general, countries refer to the HPV vaccine as a “cancer vaccine”, rather than a vaccine against a sexually transmitted infection. This is sensible for many reasons. For one, people will know about and fear cancer more than HPV (which they may have never heard about). If the perceived benefit is to prevent a cancer, the vaccine will pique more interest and demand. Secondly, the terminology is accurate as the main purpose of the vaccine is to prevent cervical cancer. Third, reference to a “cancer vaccine” may diminish concerns that the vaccine is linked to increased sexual activity or fertility. Where boys are also being vaccinated, messages can include the benefits of protection against anal, penile and cancers of the mouth and throat (though boys may respond more to the threat of genital warts which the 4-valent HPV vaccine also protects against).

  **ONE CAUTION** – The biology of HPV, its sexually related route of transmission and link to cervical cancer is an inevitable message that must be explained. This is important as there is often a mistaken belief that “my daughter is too young to be having sex” and she therefore should not be vaccinated. All caregivers and health workers need to understand that the vaccine will be most effective if administered before exposure to HPV, before sexual activity begins. It is a key secondary message that can be delivered by a trusted, well-known national health practitioner to health workers, teachers, caregivers and community leaders. This message requires varying levels of sophistication depending on the audience.

  The explanation can be factual and straightforward and should stress:
  - that HPV is very common,
  - the majority of the population will become infected with HPV,
  - some of these infections will develop into cervical cancer,
  - the immune reaction to two vaccine doses is much better in girls 9 to 13 years of age than in older girls,
  - vaccinating girls today will protect them from a virus that could cause cancer in the future.

  Countries will know the most culturally appropriate way to convey the message. Some countries, for example, stress that “unmarried girls” should be protected, understood as girls who are not yet sexually active.

  **REMEMBER:**
  Girls who are 15 years or older when they receive the first dose, or girls who are immunocompromised should receive three doses (at 0, 1–2 and 6 months).
PART II: HPV VACCINE

- GOVERNMENT ENDORSEMENT

It should be clear that the government endorses the vaccine, through public statements (launch, interviews, speeches) and on the materials (through texts and logos).

- TWO DOSES

In order to confer maximum protection, WHO recommends that HPV vaccine be delivered as a two-dose schedule for girls under fifteen years of age, with an interval of 6 months between the two doses that can be extended to a 12–15 month interval. As drop-out is a risk, stress the schedule in communications to girls, caregivers, health workers, teachers, community leaders and other relevant audiences.

- WHERE AND WHEN

Messages must include information about when and where the vaccine will be available. Lack of awareness about where and when vaccination will take place is associated with non-vaccination.

- EVIDENCE

People have many questions about HPV vaccine. Evidence from research and country experience can help to engage and convince people. Different kinds of evidence will appeal to different groups. Families may need basic information about cervical cancer and vaccine safety, whereas more senior leaders and decision-makers may need to know more about the cost-benefit or want more detailed scientific information.

• Provide basic evidence about the cervical cancer incidence in the country and why it is important. For example:
  - Cervical cancer is one of most common cancers affecting women. It is the (x) highest cause of cancer in women in our country.
  - Cervical cancer is one of the deadliest cancers affecting women.
  - It is a deadly disease that causes (x) number of deaths each year.
  - Cervical cancer can be prevented through vaccination, cervical screening and treatment.
  - We are offering a vaccine, free of charge, that can protect girls against most cervical cancer.

• Evidence about the cost-effectiveness of introducing the vaccine is also important and convinces health practitioners about the merits of the vaccine as the most cost-effective way to prevent cervical cancer.

• Evidence about HPV prevalence. People may not see cervical cancer as much of a problem. A gynaecologist may only see a handful of cervical cancer cases during the course of her career, and to her, the HPV vaccine may not seem like a priority.

16. For the latest WHO recommendations on the routine immunization schedule, please check the WHO web site: http://www.who.int/immunization/policy/immunization_tables/en/.
• Evidence about vaccine safety:
  − the HPV vaccine is approved and licensed by the national authorities;
  − it is recommended by WHO;
  − multiple studies show the vaccine is safe;
  − additional messages – that the vaccine is halal for example – may also be helpful.

• Evidence from other countries: People in many countries really want to know “what is happening” with HPV vaccine in other countries. Therefore, provide information about the number of countries using HPV vaccine (and judge whether populations will be more motivated by the fact it is being used in higher-income countries, in neighbouring culturally similar countries or both), the safety record in other countries and studies showing the safety and benefits of HPV vaccine from countries which introduced the vaccine several years ago.17

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**TESTIMONIALS**

People like to see and hear other people’s experience. A short testimonial from a mother who lost a sister to cervical cancer, for example, about why she chose to protect her daughter helps other mothers relate to someone advocating for HPV vaccine. A testimonial from a famous actress who has vaccinated her daughters could also be effective. Trusted national leaders, gynaecologists or other experts could also offer effective testimonials. These could be used in pamphlets, in television or radio broadcasts.

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**SIDE EFFECTS**

An HPV vaccine injection, like almost any intramuscular injection, will have some mild side effects. Girls, caregivers, health workers and teachers should be aware of the common side effects so they know that these are normal. Journalists should be briefed on these as well, to reduce the risk of reporting incorrectly on AEFI issues. These groups also need to know when side effects are serious enough for girls to see a health practitioner. Depending on the setting, this kind of information can be told to girls verbally but should be available in a question-and-answer document for health staff and teachers. In Malaysia, for example, every consent form sent home to parents included an AEFI checklist so that parents could report even mild adverse effects to the health system.

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**INTEGRATED WITH CERVICAL CANCER SCREENING**

Countries with cervical cancer screening can produce integrated cervical cancer prevention messages. Messages can encourage both girls and their mothers to take action to prevent cervical cancer. An example would be a campaign that reads, “Girls – get immunized! Women – get screened!”

17. WHO has prepared vaccine information sheets with the observed rates of vaccine reactions, including for HPV vaccine. They are available here: http://www.who.int/vaccine_safety/initiative/tools/vaccinfosheets/en/.
INTEGRATED WITH ADOLESCENT HEALTH

Countries integrating adolescent health services with HPV vaccine – such as deworming tablets or other vaccines – should ensure HPV vaccine materials include messages about these additional interventions. Countries with adolescent health programmes – nationally, in schools, health clinics, youth centres or through associations - should consider integrating HPV vaccine messaging into adolescent health information materials. They can also use the HPV vaccination and messaging to strengthen referrals to other interventions for adolescents.18

Malaysia had a host of factors to consider when it prepared its HPV vaccine communication plan.

Malaysian citizens include ethnic Malays, Indians, Chinese and other communities who speak different languages and use different media in daily life. “Some groups read the newspaper more” the head of public health communication explains, “while others watch more television, so we have to tailor materials to all of these groups in the different languages and channel them in different ways.”

Malaysia produced materials in four languages and ensured the visual portrayal of different ethnicities. The Ministry of Health paid for media spots by strategically purchasing space on radio programmes, in newspapers and television shows preferred by different groups. They also tailored more materials for girls including upbeat, fun designs and used social media sites like Twitter and Facebook to engage girls and answer their questions. The Ministry also publishes HPV vaccine materials on its website, where they can be downloaded and reprinted.

Malaysian HPV vaccine materials also pictorially show the pathway of HPV to the cervix and where it causes cancer. When asked in a survey, about 7 in 10 rural girls correctly identified “sexual activity” as the source of HPV.

In summary, Malaysia knew its population’s cultures, languages and media preferences very well, and tailored material to different groups. Malaysia also presented factual information about HPV and cervical cancer so that the population had a basic understanding of how HPV was transmitted and why the vaccine should be given to girls before they were sexually active.

Since Malaysia introduced HPV vaccine, confidence in the programme has grown and Malaysia reports high coverage, increasing from 98 to 99.6% in the 2010–2014 period.
Materials and channels

Countries will know which materials and channels work best for their populations. In addition to the guidance offered in the first section of this document, HPV vaccine-specific guidance includes the following:

- **Keep materials clean and simple** – Fewer words and more images work best, particularly for lay audiences.

- **Use every opportunity** – Messages can be printed, for example, on the back of the HPV vaccine immunization card. The Minister of Health can talk about HPV vaccine in speeches about maternal and child health. A short message can be given in a concert by a singer popular with adolescent girls. Think through all opportunities to include HPV vaccine and cervical cancer messages.

- Produce a long, standard *frequently asked questions (FAQ)* reference guide – with every conceivable question. Use this as the basis for shorter printed FAQs for different audiences including health workers (for their training and as a reference), journalists, professional associations, etc. Use it also as the basis for talking points for speeches and media interviews. There is a standard FAQ included at the end of this guide.

- **Girls just want to have fun** – Think of ways to reach girls with language and materials they can relate to and have fun with. Materials that are colourful with modern designs will attract girls’ attention. What games or entertainers are popular with girls? Can they be integrated into the designs? In countries where text messaging and access to smart phones is more common, there may be opportunities for quizzes and games in collaboration with the mobile phone service provider.

- **Hotlines** – Some countries have set up phone hotlines so that girls, parents and other audiences can call and ask questions. This can be an effective way for people to have a real conversation with an expert about HPV vaccine. If a hotline is established, consider the resource implications – it will require sufficient numbers of knowledgeable operators to answer questions over a defined period of time.

- **A mix of channels is important** including face-to-face communication from trusted leaders: When asked how they heard about HPV vaccine, surveyed girls cite multiple sources of information, including radio and television, school teachers, health workers and church or mosque announcements. A study from Viet Nam and Uganda showed that parents were more likely to have girls’ immunized when they had spoken to community influencers including health workers, family and community leaders – which had a greater impact than only receiving IEC materials. The 2015 PATH/LSHTM meta-review of experience in 37 countries also showed that face-to-face communication was the most effective way of mobilizing communities, especially those that were likely to refuse vaccination.
• **Hard-to-reach girls** may be found in both urban and rural areas: when planning for hard-to-reach girls, consider those in large, densely populated cities who may need to be reached via television, peers and their caregivers, as well as those in remote areas, nomadic communities or girls affected by humanitarian crises.

• **The Internet and social media** – Use of these mediums will completely depend on the country setting. Where access to social media is high, countries might consider setting up a Facebook or Twitter account devoted to adolescent health, including HPV vaccine. These are resource-intensive activities, however, and require almost daily monitoring and updates. This can be considered where the social media environment is highly accessible. Countries with good Internet access should consider dedicating a web site to HPV vaccine (or to the vaccination programme in general) where anyone can access evidence-based information, materials and FAQs. Provided it is updated on a regular basis (e.g. quarterly), this site can be a reliable source of information.

• **TIP**

  » If materials are translated, ensure the translation is 100% accurate and consistent across all materials – particularly about key information including the target age group, and where and when the vaccine is available.

• **Training and orientation** – Given the importance of interpersonal communication for successful HPV vaccine programming and the potential for rumours and questions, ensure close collaboration with the training and orientation team to create the training and orientation packages. There will probably be one opportunity to train and orient health workers, teachers, community leaders, and media; they will all need to receive consistent messages that have been created and tested by the communication team. All of these audiences will want to be equipped with simple messages that can engage communities, together with answers to common questions and rumours. Use the opportunity to equip health workers in particular with basic interpersonal communication skills – essential for HPV and all vaccine delivery.
There is a good chance the HPV vaccine programme will face rumours at the very least, and could face more serious programming issues if AEFIs occur and are not handled rapidly and effectively. Given the importance of this topic, a thorough explanation of crisis communication is provided on page 57.
CONCLUSION & SUMMARY
Conclusion

Cervical cancer, caused by sexually transmitted HPV, is the second most common cancer in women worldwide and results in about 266,000 deaths each year. Due to poor access to screening and treatment services, more than 85% of deaths occur in women living in low- and middle-income countries.

WHO recommends HPV vaccination together with cervical cancer screening and treatment as the most effective way to dramatically reduce death and illness caused by cervical cancer. The vaccine is being introduced in an increasing number of countries, and millions more girls could be fully immunized by the end of this decade.

As described in this guide, HPV vaccine is unique and requires careful thought and investment in communication. A successful HPV vaccine communication plan requires teams to start early, to expect a few challenges, to adjust as necessary and to persist well beyond HPV vaccine introduction so that HPV vaccination becomes a regular, sustainable and socially expected cervical cancer prevention intervention. This will require an investment of time and money.

Experience shows that where countries achieve sustained high coverage with HPV vaccine, continuous investment in strategic communication played a critical role. High coverage will reduce cervical cancer and improve the health and lives of girls and women for generations to come.
Summary: planning and considerations for HPV vaccine

COMMUNICATION IS:
- A process – People need time to change behaviours – to learn, absorb and confirm information, make a decision to act on it and encourage others to do the same.
- About community engagement – It is a conversation and not a lecture.
- About equity with plans to engage hard-to-reach populations.
- An investment – Effective communication activities will cost money and time. The return on investment is improved immunization coverage and better health for girls and women.
- Imperfect – Communication involves human beings, and we cannot predict what people will think or do in every situation.

HPV VACCINE IS DIFFERENT
- Start early – Early planning can lead to on-time implementation. Begin communicating with communities about a month before the vaccine is introduced.
- Build a cross-sectoral team – HPV vaccine introduction involves immunization, education, cancer, sexual and reproductive health, adolescent health, youth, professional associations and other key members of civil society.
- Conduct a situation analysis including formative research if necessary. It is important to understand how different audiences understand and will respond to HPV vaccine.
- Plan for a multi-year effort – It will take time for HPV vaccine to “settle” in and be accepted as a part of a routine programme.
- There will be concerns – HPV vaccine is new in the country; it is targeted at adolescent girls; it may not seem like a priority, and there may be rumours about whether it is a “trial”, its safety and about fertility.
- Government endorsement is important for a successful programme.
- Identify and engage all groups that may have concerns. Ensure advocacy plans for them.
- Understand and plan for hard-to-reach girls. Who and where are these girls? In the future, they may have the least access to cervical cancer screening even when it is available in the country.
- Interpersonal communication from trusted influencers can have the most impact. Train health workers and teachers to communicate effectively about HPV vaccine and ensure religious and community leaders understand and know how to promote it.
- The first year will have some challenges – It is a new programme and there will be bumps, but…
- High coverage can be achieved – HPV vaccine will save lives. Communication has been key to high coverage in countries with successful programmes.
**WHAT** | **WHY?** | **HOW / WHAT?**
--- | --- | ---
**1. Communication team** | – Needs multisectoral support.  
– Engagement with communities is a job for a team, not one person. | Include communication experts from the government sectors involved in education, cervical cancer prevention and control, adolescent health, immunization and other relevant partners.

**2. Programme objectives** | – Clear programme objectives set the stage for communication planning. They describe the target population, the target coverage, the strategy and the timeline for completion. | Agreed by the inter-country coordination team or other oversight body.

**3. Situation analysis** | – Understanding your audiences will help to design a strategic communication plan that uses resources most effectively. | – Analyse existing knowledge (about populations and health, including immunization).  
– If necessary, conduct formative research using focus groups, key informant interviews and ideally surveys to get a baseline regarding knowledge, attitudes, behaviours and practices for cervical cancer, vaccination, HPV and HPV vaccine.

**4. SMART Objectives** | – Will help to prioritise activities and develop the most effective communication strategy  
– Will allow measurement of outcomes | Use the situation analysis to prioritize activities that will achieve the most relevant results.

**5. Target audiences** | – The more specific the target audience, the more focussed the strategies and activities.  
– Different audiences may be suspicious or have more questions about HPV vaccine.  
– It is a new vaccine for everyone including health workers.  
– Audiences who do not understand HPV vaccine may derail the programme (e.g. media, religious organizations).  
– Education sector will likely be part of the delivery strategy and therefore needs to be included in the communication strategy.  
– Ensure training, including IPC training for health workers; and for headmasters and teachers. | – Target-age girls (in school, out-of-school, hard-to-reach).  
– Caretakers in immediate and extended family.  
– Headmasters and teachers.  
– Health workers.  
– Professional (e.g. ob/gyns/cancer), cultural (e.g. youth, women’s and religious associations).  
– Media.
### 6. Messages for each audience

<table>
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<tr>
<th>WHAT</th>
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<tbody>
<tr>
<td>– Different groups will need and respond to different kinds of information, from simple messages to more complex ideas about cost-benefit.</td>
<td>– Test your messages with audiences.</td>
<td>– Calling it “a cancer vaccine” has been most effective.</td>
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<tr>
<td>– People want evidence.</td>
<td>– Government endorsement is essential.</td>
<td>– Ensure messages include where and when to go for vaccination.</td>
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<tr>
<td>– Health workers will appreciate more in-depth information.</td>
<td>– Caution: people still need to know the way HPV is transmitted, that the vaccine is required before sexual activity begins and that it works best in girls aged 9–13.</td>
<td>– Requires two doses for girls aged 9–13, 6 months apart.</td>
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<tr>
<td>– Health workers should provide information about side-effects.</td>
<td>– Requires three doses for girls aged 15 or older, or those who are immuno-compromised (at 0, 2 and 6 months).</td>
<td>– Use evidence including:</td>
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<tr>
<td>– Health professional associations may need to be convinced about the cost-benefit.</td>
<td></td>
<td>» cervical cancer incidence and deaths,</td>
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<td>– People may worry about safety because it is a new vaccine.</td>
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<td>» HPV prevalence,</td>
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<td>» cost-benefit of introduction,</td>
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<td>» vaccine safety, track record, and</td>
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<td>» evidence about use in other countries.</td>
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<td></td>
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<td>– Provide testimonials that are attractive to caregivers and girls.</td>
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<td>– Be open about common side-effects and what girls should do, when they should seek medical help.</td>
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<td>– Integrate messages with adolescent health.</td>
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<td>– Ensure messages include a call to action.</td>
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### 7. Strategies, activities, and channels

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<tbody>
<tr>
<td>– Different audiences will respond to a mix of different strategies and activities.</td>
<td>– Selecting sources and channels people trust is critical.</td>
<td>– Many audiences will respond to the messages if delivered by different trusted sources and reinforced through a mix of channels such as a trusted national leader, a popular radio programme and the community health worker or midwife.</td>
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<td>– Advocacy activities include one-on-one meetings or briefings with specific small groups.</td>
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<tr>
<td>– Social mobilization works with organizations to engage communities to take action.</td>
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### 7. Strategies, activities, and channels (continued)

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<th>WHAT</th>
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<tr>
<td>– Social and behavioural change communication works more directly with communities including health workers, community leaders and caretaker so that HPV vaccine becomes a social norm.</td>
<td>– Experience in countries shows people respond best to interpersonal communication from trusted community members including health workers and teachers.</td>
<td></td>
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<tr>
<td>– Trusted channels of information will vary between audiences.</td>
<td>– Different communities may respond to different types of sources and channels, such as their own community leaders or local radio stations.</td>
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<tr>
<td></td>
<td>– As the main target audience is girls, package their messages in appealing way (fun SMS text messages, internet or social media where available).</td>
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<td></td>
<td>– Consider strategies to reach urban girls, who are bombarded with many messages every day.</td>
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<td>– Some countries have successfully used telephone hotlines to answer community questions.</td>
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### 8. Materials

There are a range of materials to create for different audiences. They can include:

– an advocacy presentation with a lot of data and evidence for decision-makers,
– training materials for health workers and teachers,
– facts sheets, FAQs,
– news materials and media kits,
– materials for the community including simple posters, leaflets, banners, radio announcements, drama scripts, cartoon books, text messages and training materials.
– Pre-test materials for appeal, relevance, comprehension, acceptability, persuasion and recall.
– Keep materials simple with the main messages easy to read and absorb. Use more images than text for laypeople.
– Use every opportunity – print messages, for e.g. on the back of girls’ immunization cards if they take these home.
– Mutually reinforcing messages by trusted community leaders, teachers, health workers and religious leaders can have excellent results.
– Produce a comprehensive “frequently asked questions” document that you can use respond to all questions. Update this as you hear more questions.
– Correctly translate materials into local languages and ensure the translations are consistent.
– Ensure a physical and electronic distribution plan.

### 9. Crisis communication plan

– HPV vaccine is consistently subject to rumours about safety and fertility.
– There is a chance that any adverse event associated in time and place with HPV vaccine will be wrongly associated with the vaccine.
– Plan for a crisis, in consultation with stakeholders, and secure funding.
– Include standard operating procedures in the plan.
– Protecting public health is paramount in a crisis.
## 9. Crisis communication plan (continued)

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<th>WHAT</th>
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| – There is a heightened risk of adverse events following immunization during a campaign because of the large number of injections being given in a short period of time.  
– Target-age girls can be prone to fainting.  
– A badly handled event can lead to the rapid spread of misinformation and have a long-term impact on your immunization programme. | – Analyse the situation if a crisis occurs – for geographic location, scale, potential risk to human health and immunization programme.  
– If investigation is required, ensure it occurs rapidly and report the results.  
– Communicate quickly, transparently, and regularly.  
– Tell people what actions they should take.  
– Listen to public concerns and respond to them compassionately.  
– Announce when the crisis is over.  
– Analyse the impact on the programme, and adjustment to make in the future. |

## 10. Monitoring and evaluation plan

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<th>HOW / WHAT?</th>
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| – Allows tracking of progress and adjustments during the course of the programme.  
– Provides evidence to demonstrate the value of the investment in communication.  
– An evaluation can help to improve the programme in future. | – A baseline can be established from the situation analysis.  
– Set targets, milestones and indicators.  
– Determine how to measure progress – whether through mini surveys, in-process monitoring, post-introduction evaluation, focus groups, national surveys or a combination.  
– Integrate some communication monitoring with the larger HPV vaccine programme monitoring. |

## 11. A work plan with budget

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<th>HOW / WHAT?</th>
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| Any plan requires a detailed work plan. | – Assign tasks to specific individuals and give deadlines.  
– Determine and secure the budget. |

## 12. Adjust the work plan as required

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<th>WHAT</th>
<th>WHY?</th>
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| Communication is a continuous process involving human beings. | – Use monitoring to determine what is working and what is not.  
– If an activity is not working as anticipated, stop or adjust it.  
– Be alert to rumours or misinformation and act rapidly to correct.  
– Continue to invest in communication for HPV vaccine for several years until it is fully “normalized” in the national immunization programme. |
Crisis communication for HPV vaccine

This section offers a summary of crisis communication. For more information, consult the following resources which were used to develop this section:

» WHO European Regional Office’s 2013 guide: Vaccine Safety Events: Managing the Communication Response. A Guide for Ministry of Health EPI managers and Health Promotion Units.¹⁹

» A WHO e-learning course entitled Vaccine Safety Basics including a case study on how a potential HPV vaccine crisis was averted in the United Kingdom.²⁰

» The Global Polio Eradication Initiative’s Issues Management Guide, October 2014.²¹

A crisis in immunization including for HPV vaccine can occur for several reasons.

*Examples include:*

- Increasing vaccine hesitancy amongst some groups due to complacency or a lack of confidence in vaccines and vaccine manufacturers.

- An adverse event following immunization (AEFI):
  - A coincidence – an event that is perceived to be linked – e.g. an onset of a debilitating disease occurring near the time of immunization.

²⁰. URL: http://vaccine-safety-training.org/c-introduction.html
²¹. URL: http://www.wpro.who.int/immunization/documents/polioendgame/issues_management_guide-countries.pdf
This can include mass psychogenic events, where several girls become ill at the same time. This has occurred in a few countries including Brazil and Colombia. Such a case in Japan is described on page 64.

– A serious AEFI – while rare – can be due to programme error or a reaction to the vaccine that leads to serious illness, injury or death; and possibly to a vaccine recall.

- Poor communication about changes in immunization policy or schedules – e.g. an introduction of a new vaccine – including HPV vaccine, without involving relevant stakeholders including paediatricians, gynaecologists or religious leaders.
- Events including safety scares, rumours or changes in the HPV vaccination programme in another country, even on a different continent.
- Misinterpretation of new research reported in the media.
- Misinformation from the Internet that spreads in a community.
- Groups with their own, possibly unrelated agenda (e.g. political) spread rumours to destabilize a programme, or even take violent action against health workers.

**TIP**

» The normal risks of AEFI – including swelling at the site of injection or fever must be communicated by health workers to all caregivers and girls before immunization to avoid misunderstandings.

**Be prepared**

- **Create a crisis communication plan for EPI as part of the EPI communication plan, and a specific plan for HPV vaccine. When a crisis happens, it is too late.**

  **The plan should include:**

1. Sources to scan regularly for potential crisis such as the media, the Internet, AEFI reports, community leaders.

2. Consultation and agreement with key stakeholders (e.g. Minister, EPI manager, NITAG, AEFI committee, district level health authorities, education authorities, major partners).

  *Be aligned with the procedures for an AEFI with regards to investigation, vaccine management, protection of public health.*

3. Terms of reference, members and contacts for a crisis communication team. The team should include communication and technical experts.

4. Identify and secure a funding source should plans need to be implemented.
5. Standard Operating Procedures:
   − a chain of command with clear roles and responsibilities for key players,
   − trigger points or thresholds of when and where to put plans into action (e.g. a social media message, a grievance submitted from a community, a first news report),
   − a guiding timeline for action for the first 24 hours, 3 days, 1 week, 1 month,
   − a description of how and when investigations will occur,
   − a list of stakeholders: those who make decisions; those who should be consulted; those who take action; those who should be kept informed,
   − a process for designating and training a spokesperson,
   − a process for updating and distributing talking points,
   − a general list of agreed strategies, activities and channels for communication (e.g. stakeholder meetings, holding statements, news release, news conference, radio programmes),
   − methods to listen to the views and concerns of all groups, and engage with them – for example, prepare how to monitor public concerns through community contacts, the media and social media, and
   − a monitoring and evaluation plan.

6. Resources including:
   − A listing of facts that will help with messaging, including the baseline evidence on AEFIs for different vaccines\(^{22}\).
   − Contact lists: for all stakeholders who need regular updates; for media; and of influential champions for immunization (such as reproductive health or cancer specialists).

Ensure training and orientation for key stakeholders. When stakeholders have information in advance, they know what normal issues to expect, how to communicate about potential problems, and what to do if one occurs.

*Those requiring training and orientation include:*

1. Health workers who should be fully aware of normal AEFIs and how to communicate them to teachers, caregivers and girls; how to avoid them; what to do and who to contact if one occurs.

2. Headmasters, teachers: who should also be aware of normal AEFIs, how to communicate with girls; how to help with immunization management (e.g. ensuring girls sit quietly after vaccination); and who to call should a serious AEFI occur.

3. Community leaders: who should be aware of normal AEFIs, how to communicate them to the community and who to call should a serious AEFI occurs.

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\(^{22}\) Reliable sources of information include WHO’s fact sheets: [http://www.who.int/mediacentre/factsheets](http://www.who.int/mediacentre/factsheets) and position papers: [http://www.who.int/immunization/policy/position_papers](http://www.who.int/immunization/policy/position_papers).
4. Journalists: who should be fully oriented on several aspects of HPV vaccine before it is introduced: its purpose, rationale for target age group, safety record, impact, introductions in other countries including common rumours, normal AEFIs, and who to contact for information.

- **TIP**
  » Maintain good relationships with journalists who can help to report accurate information should there be a crisis.

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**Implement: when crisis occurs**

- **WHERE AND WHEN TO RESPOND?**
  The prime communication objectives during vaccine-related crises are:
  - to understand and manage the cause of the crisis so there are no further risks to people’s health, the immunization programme or the health system,
  - to maintain and restore trust and confidence in immunization,
  - if damaged, restore trust and confidence in the immunization programme in the medium and long term.

- **BE PROACTIVE** – Aim to stop the crisis before it gets large.

- **ACTIVATE** the crisis communication committee and plan.

- **ANALYSE** – Learn and confirm what is happening:
  - What has happened? Collect information from trusted sources.
  - Why is it happening?
  - Where is this happening – in a single community, region, nationally?
  - Analyse why and how it will affect the programme. Is this a low, medium or high impact event?
  - Is the crisis getting public attention and affecting public trust in vaccines?
  - Does it require an investigation? If so, this should happen rapidly.
TAILOR the strategy to the situation.

If, for example, the crisis is not receiving public attention, a local meeting with the community may be adequate. If the crisis is causing nationwide anxiety, the communication plan requires a rapid national response.

- Set specific communication objectives – for example, to stop a rumour, change behaviours, protect the public, call for collective action.
- Identify target audiences and understand their concerns, information and engagement needs.
- Decide how best and how often to communicate with the target audiences.

DESIGNATE a respected and trained spokesperson if the crisis requires a public response. People tend to trust scientists and experts more than politicians. The spokesperson should be trained by an expert. They must take part in all crisis-related meetings, and coordinate updated talking points. They should be the sole source of information for journalists.

COORDINATE

- Between technical and communication experts
- With other relevant parties – such as local health units and schools

IF IN DOUBT, COMMUNICATE

From a public trust standpoint, it is better to provide too much information than too little. Take control of the story by communicating first – rapidly, proactively, accurately and transparently. Silence can be perceived as an admission of guilt. Information voids will be filled by others who may not have the public interest at heart.

GOING PUBLIC

- Timing: the public announcement should be timely (e.g. within a day) and partners should be advised when it’s happening so they are prepared
- Transparency: messages should be jargon-free, factually accurate, up-to-date and include any relevant calls to action
- Inform core stakeholders before going public, so they are not taken by surprise
- Prepare and update information and materials regularly. Make public information available on a website and/or in social media. Materials can include:
  - key messages appropriate to each audience about health risks, uncertainties and actions to take to protect oneself,
- talking points, updated and circulated regularly to everyone who needs them,
- frequently asked questions,
- news releases and holding statements, and
- materials for minority language groups.

• Use empathetic language – people want to know you understand their concerns, even if they prove to have no basis in evidence.
• When you do not have all the information or answers, say so – it is ok to tell the public that you “don’t know”, but then find out and follow up rapidly with more information.
• Listen to the public and their concerns – update messages to address these through media statements or community meetings. Dismissing concerns can push people towards anti-vaccine groups and strengthen that voice.
• Consider setting up a hotline with trained staff who can answer questions.
• Respect the human rights of all groups. For example, do not stigmatize specific groups as the importers or carriers of disease.

■ AS THE CRISIS CONTINUES
• Consider quantity and timing of information – provide consistent regular updates so that stakeholders know what to expect. These may be daily at first, and then bi-weekly, and weekly depending on the nature of the crisis.
• Have regular – even daily – coordination meetings with the crisis team to discuss progress, concerns, roles, responsibilities and strategies.
• Ensure stakeholders continue to receive updated information including advance notice of media briefings.
• Continue to listen to the public and address their concerns.
• Monitor the plan – adjust, update and provide information as it evolves.

■ WHEN THE CRISIS IS OVER: ANNOUNCE, ANALYSE, UPDATE
• Make an announcement that the crisis is “over” when it truly is over – do not make premature statements.
• Assess what lasting impact it might have on the immunization programme, and make plans to address any potential ongoing concerns. This can include an updated communication plan if the crisis will affect the immunization programme for the medium and long term.
**TIP: DEVELOPING KEY MESSAGES FOR CRISSES**

Key messages are short statements designed to communicate essential information and points, including necessary actions to the public, news media, or health workers. They reflect the essential information you want to convey and can also function as “sound bites” during media interviews. Having key messages prepared in advance will allow you to communicate quickly and effectively.

**Points to consider when developing key messages:**

- List the 3 or 4 things you really want health workers, the public or the media to know, and the actions they should take.
- Ensure the key messages:
  - are specific, clear and concise,
  - use words and examples that your audience will understand,
  - include clear information about what the public should and should not do,
  - avoid jargon and technical terms,
  - are backed up with supporting facts and evidence, and
  - are positive – talk about what you are doing, can and will do; not what you cannot.

**TIP: THE AUDIENCES TO CONSIDER THROUGHOUT A CRISIS**

- **The Minister of Health**, other relevant Ministries and senior government/policy staff – do they agree with the plan? Do they have specific concerns? In a large crisis, the head of state may need to be involved.
- **Political and other opposition**: provide them with correct information in a timely manner, proactively meet with key leaders to explain the situation.
- **Health workers**: is their role clear? Are they armed with the right information to address and help manage the crisis? Do they know about AEFIs? Communicate with them early and often.
- **Professional associations**: including paediatricians, oncologists and gynaecologists.
- **Partners**: what is the plan to discuss issues with them and provide information? How can they help to manage the crisis?
- **Journalists** can help to manage a crisis with correct, timely information – but can also spread rumours quickly if they are misinformed. Media may have a low understanding of what vaccines are for and how they work. They may favour publicizing the negative aspects of the story. Be proactive and give them the factual information they need to report the story. Meet with media regularly to provide transparent updates. As part of the ongoing communication plan, foster relationships with key media so they have a good understanding of vaccine issues.
- **Traditional and religious leaders**: what are their beliefs? Do they have questions or concerns? How can they be engaged to address these and help to inform their communities?
- **Communities**: which communities are most concerned? Why? How are they being heard? Consider working directly with them to help address concerns and curb the crisis.
- **Sub-groups within communities**: consider at-risk minorities, women, and people with disabilities.
Cautions and lessons from global experience with HPV vaccine

Despite global scientific evidence underscoring the HPV vaccine’s safety and continued reassurance about the safety profile of the HPV vaccines, there have been serious crises with HPV vaccine programmes in a handful of countries, mainly with perceived AEFIs linked temporally, but not causally to HPV vaccine.23

The United Kingdom – averting a potential crisis within 24 hours

The situation – In the United Kingdom in September 2009, there were reports that a 14-year-old girl had died within hours of an HPV vaccination. Local school authorities incorrectly sent a correspondence (later corrected) to parents that said the girl had died due to a “rare, but extreme reaction to the vaccine.”

The response – The local health authorities rapidly issued a statement including the facts of the deaths, expressed sympathy with family and friends, and announced a full investigation would be immediately undertaken. The statement also warned that “no link can be made between the death and the vaccine until all the facts are known and a post-mortem takes place.” Media officers briefed journalists with whom they had relationships and urged them not to speculate about the story. A preliminary post-mortem showed the girl had died due to a rare, underlying condition and that the vaccine played no role. Within minutes, communication officers contacted media with this information, in time for the 10 p.m. national evening news. The government continued to fully back the HPV vaccine. By the following day, media interest in the story tapered off.24

Japan’s HPV vaccine story

The situation – In Japan in March 2013, reports linked HPV vaccine to a series of adverse events in about 50 girls, including “complex regional pain syndrome.” “Victims groups” emerged to provide their stories and the media was quick to report these, despite no evidence linking the adverse events with the vaccine. A local authority provided compensation to those claiming their daughters had been affected, thus suggesting a causal link. Anti-vaccine groups gained control of the narrative and the loss of public confidence in HPV vaccine has resulted in extremely low coverage. “Cervical cancer vaccine victim” branches expanded in the country. Evidence of HPV vaccine’s safety, published by the Global Advisory Committee on Vaccine Safety, were never published in the media.

23. For more on HPV vaccine safety, see reports from the Global Advisory Committee for Vaccine Safety, published at: http://www.who.int/vaccine_safety/committee.
24. For more on this case, see the WHO’s Case Study C: How a potential HPV vaccination crisis was averted, which is part of a Vaccine Safety Basics E-learning course: http://vaccine-safety-training.org (accessed August 2015).
The response – In June 2013, the Vaccine Adverse Reactions Review Committee met and Japan’s Ministry of Health, Labour and Welfare decided to temporarily suspend recommendation of HPV vaccine. Health authorities were instructed to no longer actively recommend or promote the vaccine, though it is still available by request. Until early 2016, this decision remains and results of any investigations have not been made public.

The result – Public trust in the vaccine is eroded and HPV vaccine coverage is very low. News from Japan has reached other countries, where it has had an impact on the knowledge and beliefs about HPV vaccine amongst some communities.

The evidence and lessons – A group of researchers who recorded a dramatic decrease in HPV vaccine coverage in one Japanese city noted that: “No vaccine safety signal has been recorded in Japan. Instead, individuals who have the misfortune to be unwell with rare or difficult to treat disorders have been encouraged by anti-vaccination advocates to blame the HPV vaccine, especially in an unrestrained media environment and with little reassurance and systematic addressing of these events by the government.”

In March 2014, the Global Advisory Committee on Vaccine Safety (GACVS) issued a statement to stress that it had not found any safety issue that would alter any of the current recommendations for use of the vaccine. The GACVS noted its concern “by the claims of harm that are being raised on the basis of anecdotal observations and reports in the absence of biological or epidemiological substantiation.” The committee continued that “allegations of harm from vaccination based on weak evidence can lead to real harm when, as a result, safe and effective vaccines cease to be used.” The 2014 GACVS statement was not reported in the Japanese media. In December 2015, the GACVS addressed the issue of Japan again and stated that “review of clinical data by the national expert committee led to a conclusion that symptoms were not related to the vaccine, but it has not been possible to reach consensus to resume HPV vaccination. As a result, young women are being left vulnerable to HPV-related cancers that otherwise could be prevented.”

27. For the full text of the latest GACVS statement see http://www.who.int/vaccine_safety/committee/topics/hpv (accessed January 2016).
Frequently asked questions

These Frequently Asked Questions (FAQ) are adapted from WHO’s Comprehensive Cervical Cancer Control Guide.28

ABOUT HPV

Question: What is HPV?

Answer: Human papilloma virus, or HPV, is a common virus that is easily spread by skin-to-skin sexual contact with another person involving genital skin, even without sexual intercourse. Most HPV-infected people have no signs or symptoms, so it is possible to spread the infection to another person unknowingly. Most HPV infections are eliminated by the body in the first few years. Those that are not eliminated are termed “persistent” and may cause cervical cancer.

Question: Why are HPV vaccines needed?

Answer: HPV vaccines are needed because they greatly reduce the occurrence of cervical cancer, a principal cause of death from cancer among women in less developed countries.

Question: Do all women with HPV infection get cervical cancer?

Answer: No. In most women, HPV infections are eliminated by the body in the first few years. Among many different types of HPV only a few can cause cervical cancer if they are not eliminated by the body and persist for 10–20 years. Of the group of HPV viruses that cause cervical cancer, two of these – HPV types 16 and 18 – are the cause of 7 out of every 10 cervical cancers. Infection with these two HPV types can be prevented by HPV vaccination, so these vaccines can protect against 70% of cervical cancer if given as recommended. In addition, cervical cancer can be prevented among women who have HPV infection if they participate in screening and treatment. If women aged 30–49 years are screened for changes in the cells of the cervix (pre-cancer), which are caused by persistent HPV infection, and treated as needed, then cervical cancer deaths would become rare even though HPV is common.

Question: How common is cervical cancer caused by HPV?

Answer: HPV is the main cause of cervical cancer. There are 528 000 cases of cervical cancer diagnosed each year. Of the 266 000 women who die every year from cervical cancer in the world, the great majority live in developing countries.

 ABOUT HPV VACCINATION

Question: Will the HPV vaccines keep my daughter from getting cervical cancer?

Answer: Yes. The HPV vaccines prevent infection with the two types of HPV that cause most cervical cancers. All sexually active people should also practise behaviours that prevent the spread of sexually transmitted infections (e.g. delaying initiation of sexual activity, using condoms, and having as few sexual partners as possible).

Women who have been vaccinated should also be screened for cervical cancer when they are older.

Question: What are the WHO prequalified HPV vaccines currently available?

Answer: As of January 2016, two HPV vaccines are currently prequalified by WHO. These vaccines are: Cervarix® (made by GlaxoSmithKline) and Gardasil® or Silgard® (made by Merck).

Question: How are the two HPV vaccines similar?

Answer: Both vaccines provide very effective protection against 70% of potential cases of cervical cancer (because they both target HPV types 16 and 18). Both vaccines are very safe. Both vaccines cannot cause disease because they don’t contain live viruses.

Both vaccines are given as injections (shots) and require two doses for girls younger than 15 years old, and three doses for immuno-compromised girls (including those known to be living with HIV) and for girls aged 15 years and older.
**Question:** How are the two HPV vaccines different?

**Answer:** The vaccines are made up of different components to increase the body’s production of antibodies. One vaccine (Gardasil® or Silgard®) also provides protection against genital warts (because it also targets HPV types 6 and 11).

**Question:** Who should get vaccinated?

**Answer:** WHO recommends that girls should be vaccinated when they are aged 9–13 years. The vaccines are not recommended in girls younger than 9 years of age.

**Question:** What is the recommended schedule (or timing) of the two-dose HPV vaccine schedule?

**Answer:** Two doses (shots/injections) are recommended for girls below 15 years of age, the second dose six months after the first. The provider who gives the vaccine will inform each girl who is vaccinated (and her parents) when she needs to return for the final dose. There is no maximum interval between the two doses; however an interval of not greater than 12–15 months is suggested. If the interval between doses is shorter than five months, then a third dose should be given at least six months after the first dose.

**Question:** What is the recommended timing of the three-dose HPV vaccine schedule?

**Answer:** When three doses are recommended (i.e. for girls aged 15 years or older, and for those known to be immuno-compromised and/or HIV-infected, regardless of whether they are receiving antiretroviral therapy), the second dose should be received one or two months after the first dose (depending on the type of vaccine), and the third dose should be received six months after the first dose.

The provider who gives the vaccine will inform each girl who is vaccinated (and her parents) when she needs to return for the next or final dose. It is not necessary to screen for HPV infection or HIV infection prior to HPV vaccination.

**Question:** Can HPV vaccines cure or get rid of HPV infections or cervical cancer, if a girl or woman is already infected with HPV when she gets the vaccine?

**Answer:** No. An HPV vaccine cannot cure HPV infections that may be present in a girl when she is vaccinated; neither can it cure cervical cancer or pre-cancer abnormalities, or prevent progression of disease in women who are already infected with HPV when they receive the vaccination.

**Question:** Will a woman between the ages of 30 and 49 years still need to be screened for pre-cancer and cancer even if she was fully vaccinated when she was a girl?

**Answer:** Yes! It is very important for adult women to get cervical cancer screening when they are 30–49 years old, even if they were previously vaccinated. This is because although the vaccine is very effective, it does not prevent infection from all types of HPV that cause cervical cancer.
**Question:** Can girls who are living with HIV be vaccinated?

**Answer:** Yes! Studies show that HPV vaccine is safe to administer to girls who are living with HIV. Vaccination for these girls is recommended prior to sexual debut, just as it is for all other girls. Girls who are living with HIV or are otherwise immuno-compromised should receive three doses of HPV vaccine at 0, 1–2 and 6 months, whether or not they are already 15 years old.

**Question:** Why are boys not vaccinated?

**Answer:** The vaccine can protect boys from anal, penile, mouth and throat cancers, which are far less common than cervical cancer. Some developed countries with larger health budgets are vaccinating boys. However, at the moment WHO does not recommend vaccinating boys as a priority because the vaccine is costly and to have the largest public health impact and prevent cervical cancer it’s more effective to focus on reaching high coverage among girls.

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**COMMON WORRIES ABOUT HPV VACCINATION**

**Question:** Are the HPV vaccines safe and effective?

**Answer:** Yes. Many studies conducted in developing and developed countries have found both vaccines to be very safe and effective. Both vaccines have been administered to millions of girls and women around the world without serious adverse events. As with all vaccines, the safety of these vaccines is monitored very carefully.

Common, mild adverse reactions include pain and redness where the shot was given, fever, headache and nausea. Sometimes girls who get the HPV vaccine (or other vaccines) faint, so girls should be watched for 15 minutes after vaccination; if they feel faint they should lie down to avoid getting hurt.

**Question:** Why do people faint after getting HPV vaccines?

**Answer:** Adolescents are particularly prone to fainting after any medical procedure, including receiving vaccines, because they are often very nervous before coming into the vaccination room. To prevent falls and injuries due to fainting, ask the girl receiving the vaccine to be sitting before, during and for 15 minutes after the vaccine is given.

**Question:** My daughter is too young to be having sex – why is HPV vaccine recommended for such young girls?

**Answer:** For the HPV vaccine to work best, it is very important to vaccinate girls before they have any sexual contact with another person.
This is because a young girl can be infected with HPV even the very first time she has sexual contact (even just skin-to-skin contact near the vagina and penis). Also, tests have shown that the vaccine produces better protection from HPV infection when given at this age compared to older ages. The vaccines cannot treat a girl who is already infected with HPV.

**Question:** Will HPV vaccination affect my daughter’s fertility? Will it be more difficult for her to become pregnant or to carry a pregnancy to term?

**Answer:** No! There is no evidence that HPV vaccination will affect a girl’s future fertility or cause any problems with future pregnancies.

**Question:** Are all recommended doses needed for my daughter to be fully protected from HPV? Is one dose not enough?

**Answer:** Like some other vaccines, the HPV vaccine requires more than one injection. Without all the recommended doses, the vaccine might not be completely effective in preventing cervical cancer. It is important that a girl receives all doses and observes the minimum and maximum intervals between the doses, in order to be fully protected.

**Question:** Is HPV vaccine safe in pregnancy?

**Answer:** HPV vaccines are not recommended for use in sexually active or pregnant girls or women. However, studies have shown that the vaccine causes no problems for the mothers or the babies born to women who received the HPV vaccine during pregnancy.

If a girl or woman receives the HPV vaccine when pregnant, this is not a reason to consider ending a pregnancy. But, to be on the safe side, until more is known, girls and women should not be vaccinated while pregnant.

**Question:** Are there any contra-indications to being vaccinated?

**Answer:** If a girl has had a serious allergic reaction to another vaccine or a previous dose of the HPV vaccine, then she should not receive HPV vaccine, to avoid serious reactions.
Materials

Samples of materials

The following are examples of HPV vaccine communication material produced in Malaysia, Rwanda and Latvia.
Examples of HPV vaccine websites with sample materials

Note that country HPV vaccine immunization policy may vary by target age, gender and doses required.

- Argentina has an FAQ and presentation in Spanish about HPV vaccine and the prevention and control of cervical cancer: http://www.msal.gob.ar/index.php/component/content/article/46/185-vph.


- The U.S. Centers for Disease Control and Prevention site includes an FAQ and other information: http://www.cdc.gov/hpv/parents/vaccine.html.
Resources

Cervical cancer and HPV vaccine

- WHO’s HPV Vaccine Introduction Clearinghouse includes comprehensive information which helps programme and communication managers learn, plan, target, deliver and communicate about HPV vaccine introduction: http://www.who.int/immunization/hpv/en/
- RHO Cervical Cancer is a site aimed at decision makers and programme planners in low-resource settings. It provides several resources on HPV vaccine introduction, communications planning and lessons, including from PATH’s HPV vaccine pilot projects in Peru, Uganda and Viet Nam and the 2015 PATH/LSHTM HPV Vaccine Lessons Learnt & Recommendations: www.rho.org

Communication for immunization

- WHO Euro has links to several excellent resources, including for advocacy, and tailoring immunization: http://www.euro.who.int/en/health-topics/disease-prevention/vaccines-and-immunization

Communication for development

- UNICEF has published a set of guides on planning, monitoring and evaluating communication for development activities: http://www.unicef.org/cbsc/index_43099.html
- Johns Hopkins University Center for Communication Programs offers several links to communication planning, implementation and monitoring resources: http://www.jhuccp.org
- The Communication Initiative is a communication for development community and its website includes several resources: http://www.comminit.com/

Crisis communication

- A WHO e-learning course entitled Vaccine Safety Basics provides cases studies and practical advice: http://vaccinesafety-training.org/

Formative research

- PATH’s Conducting Formative Research for HPV Vaccination Program Planning offers practical guidance from PATH: http://www.path.org/publications/detail.php?id=2241
- A guide for developing knowledge, attitude and practice surveys from WHO/Stop TB Partnership provides a step-by-step guide to conduct a KAP survey. While the examples are most relevant to tuberculosis control,
the steps are relevant to undertaking any KAP survey about a public health topic. http://whqlibdoc.who.int/publications/2008/9789241596176_eng.pdf

The consent process

- WHO’s Considerations regarding consent in vaccinating children and adolescents between 6 and 17 years old provides additional guidance to countries on the issue of consent (http://bit.ly/VaccineConsent); and the PATH/LSHTM HPV Vaccine lessons learnt & recommendations also provides data on HPV vaccine consent in countries (www.rho.org/HPVlessons).

*All links were accessed in January 2016.