



HPV Vaccination in Latin America

GUIDANCE FOR PROGRAM MANAGERS AND IMPLEMENTERS FROM A PILOT PROGRAM IN PERU

In 2006, PATH initiated the *HPV Vaccines: Evidence for Impact* project in order to help make vaccines to prevent cervical cancer available to women worldwide—especially in countries where women are most likely to die of the disease. To help address the fact that women in these countries often face delayed access to new health technologies, the HPV Vaccines project aims to generate evidence to help policymakers and planners make informed decisions regarding regional and national vaccine introduction efforts and international financing plans.

The project is being implemented in four countries: India, Peru, Uganda, and Vietnam. Peru has some of the highest cervical cancer incidence and mortality rates of the Latin American and Caribbean region. Through a demonstration project in 2008–2009 in selected areas of the country, HPV vaccine was made available through schools to all girls aged nine years or older in grade five. The Peru project was implemented by the National Expanded Program for Immunization (ESNI) of the Ministry of Health (MINSA) with technical support from PATH, and evaluated by MINSA/ ESNI, PATH, and the Instituto de Investigación Nutricional (IIN). IIN evaluated vaccine coverage, acceptability, and feasibility of the strategies implemented in the demonstration project, while MINSA/ESNI and PATH collaborated to estimate the associated costs. Detailed results of the evaluation will be published in detail elsewhere, but some highlights include:

- Coverage rates were above 80% in all Peru project sites, and loss to follow-up of girls who started the three-dose series was low.
- Incremental program costs of reaching girls with the HPV vaccine were lower in urban and peri-urban locations than in remote rural areas, since health workers could more easily access schools to reach eligible girls.
- Vaccinating girls in schools was judged feasible, based on its negligible impact on routine infant immunization coverage.

Lessons learned from Peru may be applicable to other countries with similar cultural, economic, and health contexts. This overview summarizes helpful lessons for policymakers and program managers looking to design their own HPV vaccination programs.



Girls who received the HPV vaccine in Piura, Peru.

“Illness can be stopped in time if we know about the disease and carry out prevention activities...whether cervical cancer, breast cancer, or dengue, prevention is the important thing.”

—Teacher involved in pilot HPV vaccination

For more information

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

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Lessons learned: Developing and implementing an HPV vaccination strategy

TARGET GROUPS AND VENUES FOR VACCINATION

- Lesson 1:* Delivering HPV vaccine through easily accessible primary schools can achieve high coverage levels at reasonable incremental program costs.
- Lesson 2:* Early coordination between the health and education sectors is necessary to establish a feasible vaccination schedule for a multi-dose vaccine.
- Lesson 3:* Health workers should aim to visit schools just once per dose, and follow-up of girls who miss doses should be carried out through health centers.

OPERATIONAL ISSUES

- Lesson 4:* Carefully scheduling vaccine requests can help optimize cold storage capacity.
- Lesson 5:* Approaches to parental consent should be the same for all vaccines.
- Lesson 6:* A vaccination program protocol can help to maintain quality, facilitate training, standardize delivery, and engender community trust.
- Lesson 7:* Teachers can provide lists of girls eligible for vaccination.
- Lesson 8:* Clear, concise guidance is required to standardize adverse event reporting.
- Lesson 9:* Vaccination reporting systems should be designed to minimize health worker burden and confusion.

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

HEALTH WORKER AND TEACHER TRAINING

- Lesson 10:* Training health workers and teachers to become trainers themselves increases motivation and builds in-country capacity.
- Lesson 11:* A participatory approach and simple, visual training materials are key components of an effective training strategy.
- Lesson 12:* The value of intensive training must be balanced with the expense and time required for implementation and participation.
- Lesson 13:* For school-based vaccinations, teachers require tailored outreach that is less time-intensive than training sessions designed for health workers.

“The logistical part has worked well, because everything is prepared. Even the driver has been trained: he knows how to collect biologicals, vaccines, he knows what a syringe is, and what materials they need.”

–Health worker involved in pilot HPV vaccination

COMMUNITY OUTREACH

- Lesson 14:* Using a range of approaches to community outreach is important, including mass media.
- Lesson 15:* Initial resistance to vaccination can be overcome by giving parents time to gather information and providing evidence-based education and outreach for decision-making.
- Lesson 16:* Trusted and influential individuals in the community can serve as champions and information sources regarding vaccination.
- Lesson 17:* The health and education sectors play complementary roles in community outreach.
- Lesson 18:* Girls themselves play a key role in educating parents and each other about vaccination.

MESSAGING

- Lesson 19:* Effective educational messages address community needs, doubts, and concerns.
- Lesson 20:* Addressing the desire to prevent or avoid cancer and have a healthy future, and reinforcing positive views of vaccination, are good building blocks for key messages.
- Lesson 21:* Simple language and pictures are best to convey key messages for diverse audiences.
- Lesson 22:* People will seek out supplementary information independently.