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Ministry of Health & Family Welfare
Government of India

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Operational Guidelines for

ROLL OUT OF HPV VACCINATION CAMPAIGN

February 2026

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पुण्य सलिला श्रीवास्तव, भा.प्र.से.
सचिव
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Secretary

सत्यमेव जयते

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स्वास्थ्य एवं परिवार कल्याण विभाग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
Government of India
Department of Health and Family Welfare
Ministry of Health and Family Welfare

Message

Cervical cancer remains a significant public health challenge globally and in India. It is amongst the leading cancers affecting women and continues to impose a substantial health and socio-economic burden. Persistent infection with high-risk Human Papillomavirus (HPV) types has been established as the primary cause of cervical cancer, which is effectively preventable through timely vaccination.

Government of India has consistently accorded high priority to the prevention & control of cervical cancer through a comprehensive public health approach encompassing screening, early detection, and timely treatment. These sustained efforts reflect the government's commitment to reducing morbidity & mortality associated with the disease and advancing equitable access to essential preventive and curative services.

The National HPV Vaccination Campaign is a public health intervention to address cervical cancer in a systematic & preventive manner. Under this campaign, a single dose of HPV vaccine will be administered to 14-year-old girls through government health facilities across the country.

To facilitate standardized and effective implementation across States and Union Territories, detailed Operational Guidelines have been developed. These Guidelines are grounded in extensive technical deliberations, learnings from previous vaccine introductions, immunization campaigns, and valuable inputs from States & districts. They provide a comprehensive guidance framework to serve as a structured roadmap for key stakeholders, programme managers, and frontline health workers to enable appropriate level implementation and adherence to established protocols at all levels.

I hope that the effective implementation of these Guidelines will strengthen our collective goal toward reducing the burden of cervical cancer, advancing Universal Health Coverage, and securing a healthier future for the girls of India.

Date : 26.02.2025
Place : Delhi

Punya Salila
(Punya Salila Srivastava)

#StopObesity
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Message

Cervical cancer is the fourth most common cancer globally and the second most common among women in India. It is primarily caused by Human Papillomavirus (HPV), the most common viral infection of the reproductive tract and the leading cause of this cancer. It is the only cancer that can be prevented through vaccination.

Government of India has been implementing comprehensive prevention strategies against cervical cancer that includes population based screening and early diagnosis at Ayushman Arogya Mandirs (AAM) and timely near to home treatment at Day Care Cancer Centers (DCCCs), aiming to reduce the burden of this disease among women in the country.

In accordance with the recommendations from the National Technical Advisory Group on Immunization (NTAGI), HPV vaccination has been identified as a key tool for the prevention of cervical cancer, with girls as the primary target population for HPV vaccination.

To implement this, a National HPV vaccination campaign is being conducted, targeting 14-year-old girls at government health facilities, including Ayushman Arogya Mandir (AAM) Primary Health Centres (PHCs), Community Health Centres (CHCs), Sub-District Hospitals (SDHs), District Hospitals (DHs), and Government Medical Colleges and Hospitals (GMCHs) across the country. This approach aims to ensure quality, safety, and effective monitoring of the vaccination program. The HPV vaccination is voluntary and will be provided free of cost to all eligible girls.

Comprehensive Operational Guidelines have been prepared to guide the effective implementation of the programme. These guidelines provide States and Union Territories with detailed guidance on the disease burden, operational planning, cold chain management, conducting HPV vaccination sessions, AEFI management, safe injection practices, use of digital platforms, and communication strategies for the smooth execution of the National HPV vaccination campaign.

I am confident that these guidelines will enable the programme managers and health workers to carry out this critical intervention effectively and in a systematic manner.

(Aradhana Patnaik)

#StopObesity
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MESSAGE

Cervical cancer poses a significant public health challenge in India and has continued to daunt our efforts in preventing mortality and morbidity which arises due to the same.

Therefore to reduce incidence, the Government of India has undertaken sustained measures to address cervical cancer, including population-based screening for early detection, timely treatment services, capacity building of healthcare providers, and awareness initiatives to promote prevention and early care.

The National HPV Vaccination Campaign has been initiated in the country to strengthen the country's broader preventive healthcare system and supporting long-term public health outcomes as a proactive measure to fight against cervical cancer.

In line with this, these Operational Guidelines have been envisaged to provide program managers and healthcare workers with clear, practical guidance for the efficient delivery of the HPV vaccination with the in-built protocol to provide necessary information.

Frontline health workers remain central to the success of this initiative and their commitment & community engagement at the local level are critical.

Therefore, I hope that these guidelines will serve as a roadmap to provide due guidance and serve as a technical tool in the way forward and advancing our efforts to eliminate cervical cancer.

(Meera Srivastava)

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Preface

The rollout of the National HPV vaccination campaign represents a milestone, underscoring its public health significance and the Nation's commitment to disease prevention. Targeting 14-year-old girls nationwide is a formidable undertaking, yet India's robust immunization system is fully prepared to deliver this vital public health achievement.

India carries a significant burden of cervical cancer, the second most common cancer among women, accounting for approximately 10% of all cancers in women, with 78,499 new cases and 42,392 deaths reported in 2024 as per NCRP, ICMR. The estimated age-standardized incidence and mortality of cervical cancer in 2024 were 10.4 and 5.6 per 1,00,000 women, respectively. HPV16 and HPV18 together account for 77% of cervical cancer cases worldwide, while in India, this proportion is higher at 83%, highlighting the critical need for HPV vaccination in the prevention of cervical cancer.

India's HPV vaccination campaign rollout represents a decisive step toward providing every girl in India with the protection she is entitled to. The rollout of the HPV vaccination campaign builds on lessons from India's previous vaccination campaigns, including the Measles-Rubella campaign.

In line with the National Technical Advisory Group on Immunization (NTAGI) recommendation, the quadrivalent HPV vaccine is being introduced as a single-dose schedule, with evidence indicating comparable efficacy and duration of protection to a two-dose regimen. This schedule optimizes both immunological protection and operational feasibility and will contribute to improving coverage while reducing the dropout that often occurs between multiple doses. Currently, 90 countries have adopted the single-dose schedule in their national immunization programs.

These Operational Guidelines are designed to strengthen the capacity of immunization program managers at state, district, and sub-district levels for effective planning and implementation. This reference document can be used by professional bodies such as FOGSI, IAP, and IMA, as well as private practitioners.

I am confident that this represents a critical step in reducing cervical cancer–related morbidity and mortality in India and demonstrates our commitment to delivering quality public health interventions at scale.

(Dr. Pawan Kumar)

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We extend our appreciation to **Dr. Pawan Kumar, Additional Commissioner (UIP),** for steering the process with expert technical input, guidance, and thorough reviews throughout the development of these guidelines.

We express our sincere thanks to **Dr. Neerja Bhatla (Ex- Professor & Head, Obstetrician & Gynaecologist, AIIMS-Delhi)** for her technical guidance in refining these operational guidelines.

We express appreciations for the commitment and valuable contributions from the Ministry of Education, **Ministry of Women & Child Development, Ministry of Tribal Affairs and Department of Legal Affairs** in this initiative of Ministry of Health & Family Welfare.

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ACRONYMS

AAM	Ayushman Arogya Mandir
AB-SHWP	Ayushman Bharat- School Health and Wellness Programme
ACMO	Additional Chief Medical Officer
AEFI	Adverse Event Following Immunization
AFHC	Adolescent Friendly Health Centre
AH	Adolescent Health
AHWD	Adolescent Health and Wellness Days
AIIMS	All India Institute of Medical Sciences
ANM	Auxiliary Nurse Midwife
AOGIN	Asia Oceania Research Organization in Genital Infection & Neoplasia
APAAR	Automated Permanent Academic Account Registry
ASHA	Accredited Social Health Activist
ASR	Age Standardized Rate
AWC	Anganwadi Centre
AWH	Anganwadi Helper
AWW	Anganwadi Worker
BCC	Behavior Change Communication
BDO	Block Development Officer
BEO	Block Education Officer
BLCPC	Block Level Child Protection Committee
BMO	Block Medical Officer
BTFI	Block Task Force for Immunization
CBO	Community-Based Organizations
CBSE	Central Board of Secondary Education
CBWTF	Common Bio-Medical Waste Treatment Facility
CCE	Cold Chain Equipment
CCH	Cold Chain Handler
CCO	Cold Chain Officer
CCP	Cold Chain Point
CDPO	Child Development Project Officer
CDSCO	Central Drugs Standard Control Organization

CHC	Community Health Centre
CHO	Community Health Officer
CIF	Case Investigation Form
CIN	Cervical Intraepithelial Neoplasia
CLF	City Level Federation
CMO	Chief Medical Officer
COVID-19	Coronavirus Disease 2019
CPCB	Central Pollution Control Board
CRF	Case Report Form
CS	Civil Surgeon
CSO	Civil Society Organization
CSR	Corporate Social Responsibility
CT	Computed Tomography
CTC	Controlled Temperature Chain
CTF	City Task Force
DCGI	Drugs Controller General of India
DCPC	District Child Protection Committee
DEO	District Education Officer
DF	Deep Freezer
DH	District Hospital
DIKSHA	Digital Infrastructure for Knowledge Sharing
DIO	District Immunization Officer
DM	District Magistrate
DPMU	District Programme Management Unit
DPO	District Program Officer
DTFI	District Task Force for Immunization
DUDA	District Urban Development Authority
DVS	District Vaccine Store
Dy CMO	Deputy Chief Medical Officer
EMA	European Medicines Agency
EMRS	Eklavya Model Residential Schools
ESI	Employees' State Insurance
eVIN	Electronic Vaccine Intelligence Network
FAQs	Frequently Asked Questions

FDA	Food and Drug Administration
FEFO	First-Expired, First-Out
FIGO	International Federation of Gynaecology and Obstetrics
FM	Field Monitor
FOGSI	Federation of Obstetric and Gynecological Societies of India
GACVS	Global Advisory Committee on Vaccine Safety
GMCH	Government Medical College and Hospital
GMT	Geometric Mean Titre
HBCRs	Hospital-Based Cancer Registries
HCS	Head Count Survey
HF	Health Facility
HH	Household
HIC	High Income Country
HIV	Human Immunodeficiency Virus
HPE	Histopathological Examination
HPV	Human Papillomavirus
HRA	High Risk Area
HWA	Health and Wellness Ambassador
HWC	Health & Wellness Centres
IAP	Indian Academy of Pediatrics
IAPSM	Indian Association of Preventive and Social Medicine
IARC	International Agency for Research on Cancer
ICDS	Integrated Child Development Scheme
ICMR	Indian Council of Medical Research
ICSE	Indian Certificate of Secondary Education
IDSP	Integrated Disease Surveillance Programme
IEC	Information, Education and Communication
ILR	Ice-lined Refrigerator
IMA	Indian Medical Association
IMI	Intensified Mission Indradhanush
IPC	Interpersonal Communication
iTMIS	Immunization Training Management Information System
ITSU	Immunization Technical Support Unit

IVP	Intravenous Pyelogram
JAS	Jan Arogya Samiti
JE	Japanese Encephalitis
KVS	Kendriya Vidyalaya Sangathan
LHV	Lady Health Visitor
LMIC	Low- and Middle- Income Country
LRP	Learning Resource Package
LW	Link Worker
MAC	Multi Age Cohort
MAS	Mahila Arogya Samiti
MCs	Medical Colleges
MD	Mission Director
MLA	Member of Legislative Assembly
MO	Medical Officer
MoE	Ministry of Education
MoHFW	Ministry of Health and Family Welfare
MoHUA	Ministry of Housing and Urban Affairs
MoIB	Ministry of Information and Broadcasting
MOIC	Medical Officer In-Charge
MoMA	Ministry of Minority Affairs
MoPR	Ministry of Panchayati Raj
MoR	Ministry of Railways
MoRD	Ministry of Rural Development
MoS	Minister of State
MoSYA	Ministry of Sports and Youth Affairs
MoTA	Ministry of Tribal Affairs
MoWCD	Ministry of Women and Child Development
MP	Member of Parliament
MR	Measles Rubella
MRI	Magnetic Resonance Imaging
MSM	Men who have sex with men
NAG	National Advisory Group
NCCMIS	National Cold Chain Management Information System
NCCVMRC	National Cold Chain and Vaccine Management Resource Centre
NCDIR	National Centre for Disease Informatics and Research

NCERT	National Council of Educational Research and Training
NCRP	National Cancer Registry Programme
NESTS	National Education Society for Tribal Students
NHM	National Health Mission
NISHTHA	National Initiative for School Heads' and Teachers' Holistic Advancement
NRA	National Regulatory Authority
NRLM	National Rural Livelihoods Mission
NSS	National Service Scheme
NTAGI	National Technical Advisory Group on Immunization
NVI	New Vaccine Introduction
NVS	Navodaya Vidyalaya Samiti
NYK	Nehru Yuva Kendra
NYKS	Nehru Yuva Kendra Sangathan
OPD	Outpatient Department
OTP	One Time Password
PAHO	Pan American Health Organization
PBCRs	Population-Based Cancer Registries
PE	Peer Educator
PEN	Permanent Education Number
PET	Positron Emission Tomography
PHC	Primary Health Centre
PIB	Press Information Bureau
PIE	Post Introduction Evaluation
PMKK	Pradhan Mantri Kaushal Kendra
POL	Petroleum, Oil, and Lubricants (Transport fuel)
PQ	Prequalification
PRI	Panchayati Raj Institution
PTM	Parents Teachers Meeting
RBSK	Rashtriya Bal Swasthya Karyakram
RCM	Rapid Convenience Monitoring
RCTs	Randomized Control Trials
RGI	Registrar General of India
RH	Rural Hospital
RI	Routine Immunization
RMNCH+A	Reproductive, Maternal, Newborn, Child, and Adolescent Health
RVS	Regional Vaccine Store
SAGE	Strategic Advisory Group of Experts on Immunization
SBM	Swachh Bharat Mission
SCERT	State Council of Educational Research and Training
SDH	Sub-District Hospital
SDM	Sub-Divisional Magistrate
SHG	Self Help Group
SIO	State Immunization Officer
SNA	Swastha Nagrik Abhiyan
SSC	State Steering Committee
STFI	State Task Force for Immunization
STI	Sexually Transmitted Infection
SVS	State Vaccine Store
Td	Tetanus Diphtheria
TEG	Technical Expert Group
ToT	Training of Trainer
UDISE+	Unified District Information System for Education Plus
UIP	Universal Immunization Programme
USG	Ultrasonography
UT	Union Territory
VAERS	Vaccine Adverse Event Reporting System
VCCM	Vaccine and Cold Chain Manager
VE	Vaccine Efficacy
VHND	Village Health Nutrition Day
VHSNC	Village Health, Sanitation and Nutrition Committee
VLCPC	Village Level Child Protection Committee
VLPs	Virus-Like Particles
VSD	Vaccine Safety Datalink
WCD	Women and Child Department
WIC	Walk in Cooler
WMF	Wastage Multiplication Factor

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PURPOSE OF THESE GUIDELINES:

These guidelines are meant to guide and assist Immunization Programme Officers and other stakeholders, Managers at National, State, District and Sub-district levels, Administrators, and Health Workers to plan and rollout the Human Papillomavirus (HPV) vaccination Campaign.

The objective of these operational guidelines is to provide evidence-based technical information and ensure the operational feasibility of HPV vaccination Campaign.

These guidelines are developed using following global resources:

1. HPV Vaccine Profiles (https://www.gavi.org/sites/default/files/document/2022/Gavi-HPV-vaccines-profile-Jan_2022_0.pdf)
2. HPV VACCINE SCHEDULE OPTIMIZATION, Key considerations for decision-making, planning, and implementation, WHO 2023 (https://www.technet-21.org/en/hpv-vaccine-introduction/single-dose-schedule)
3. Considerations for human papillomavirus (HPV) vaccine product choice, second edition https://iris.who.int/bitstream/handle/10665/379113/9789240100930-eng.pdf?sequence=1andisAllowed=y
4. WHO Position Paper 2022 (https://iris.who.int/server/api/core/bitstreams/182d51d2-6d08-4963-a643-43d4bc843189/content)
5. HPV Dashboard (https://www.who.int/teams/immunization-vaccines-and-biologicals/diseases/human-papillomavirus-vaccines-(HPV)/hpv-clearing-house/hpv-dashboard)

Chapter 1
Introduction


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CHAPTER 1
Introduction

CERVICAL CANCER

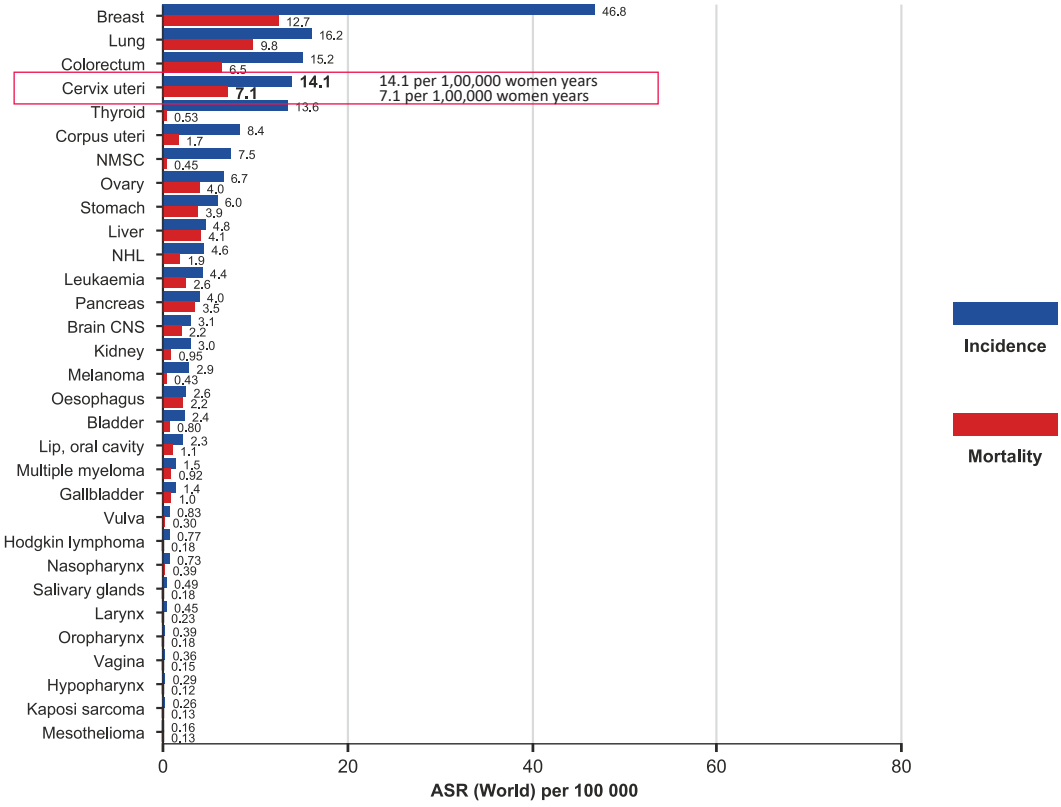
Cervical cancer is cancer of the lower end of the uterus, also known as the cervix. Cervical cancer is a preventable disease and is curable if detected early and treated adequately. Yet it remains one of the most common cancers and an important cause of cancer-related deaths in women across the globe. About 99.7% of cervical cancers are caused by persistent infection of the genital tract by high-risk types of human papillomavirus (HPV).[1]

HPV is the most common viral infection of the reproductive tract. While the majority of HPV infections are asymptomatic and resolve spontaneously, persistent infection with HPV may result in cervical cancer.[2]

CERVICAL CANCER: INCIDENCE AND MORTALITY (GLOBAL SCENARIO)

Globally, cervical cancer is the fourth most common cancer amongst women after breast, lung, and colorectal cancer. The estimated age-standardized incidence and mortality rates of cervical cancers in 2022 were 14.1 and 7.1 per 1,00,000 women-years, respectively (Figure 1), with an estimated 6,62,301 new cases and 3,48,874 deaths due to cervical cancer (Figures 2 and 3).

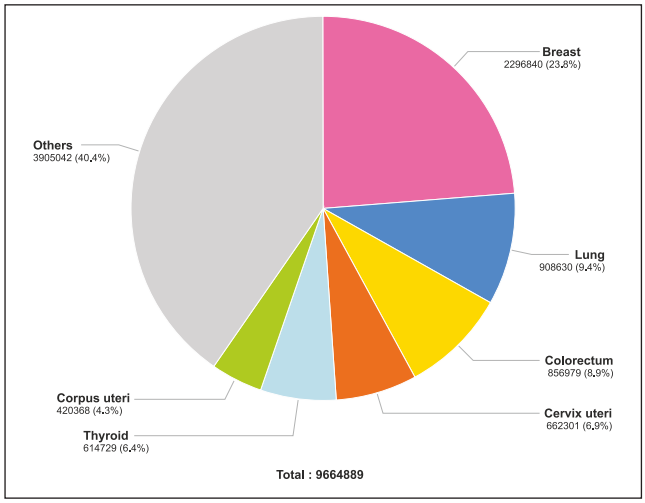
Figure 1: Estimated age-standardized incidence and mortality rates (World) in 2022, females, all ages



Source: Globocan 2022 (Available at https://gco.iarc.who.int. Accessed on 28 Jan 2026)

1. Walboomers, J. M., Jacobs, M. V., Manos, M. M., Bosch, F. X., Kummer, J. A., Shah, K. V., ... & Muñoz, N. (1999). Human papillomavirus is a necessary cause of invasive cervical cancer worldwide. The Journal of pathology, 189(1), 12-19. Available at: https://pubmed.ncbi.nlm.nih.gov/10451482/. Accessed on February 4, 2026.
2. World Health Organization. (2022). Human papillomavirus vaccines: WHO position paper, December 2022. Weekly Epidemiological Record, 97(50), 645–672. Available at: https://iris.who.int/server/api/core/bitstreams/182d51d2-6d08-4963-a643-43d4bc843189/content. Accessed on February 4, 2026.

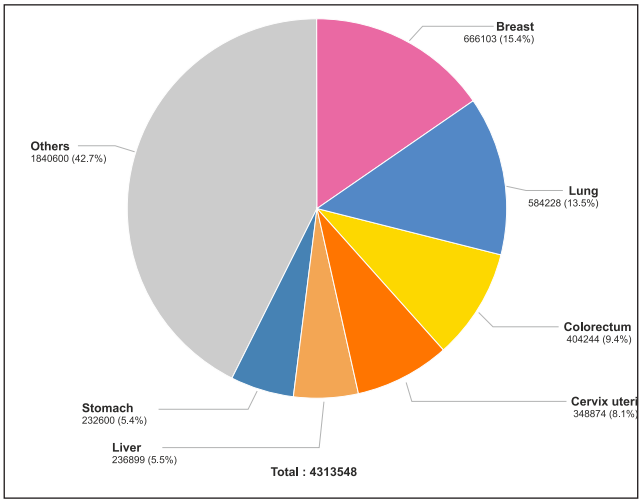
Figure 2: Absolute numbers of new cancer cases in 2022, World, females, all ages



Source: Cancer TODAY | IARC - https://gco.iarc.who.int (https://gco.iarc.fr/today/en/dataviz/pie?mode=cancerandpopulations=900andtypes=0andsort_by=value1andgroup_populations=1andsexes=2)

Accessed on 13.01.2026

Figure 3: Absolute numbers of cancer deaths in 2022, World, females, all ages

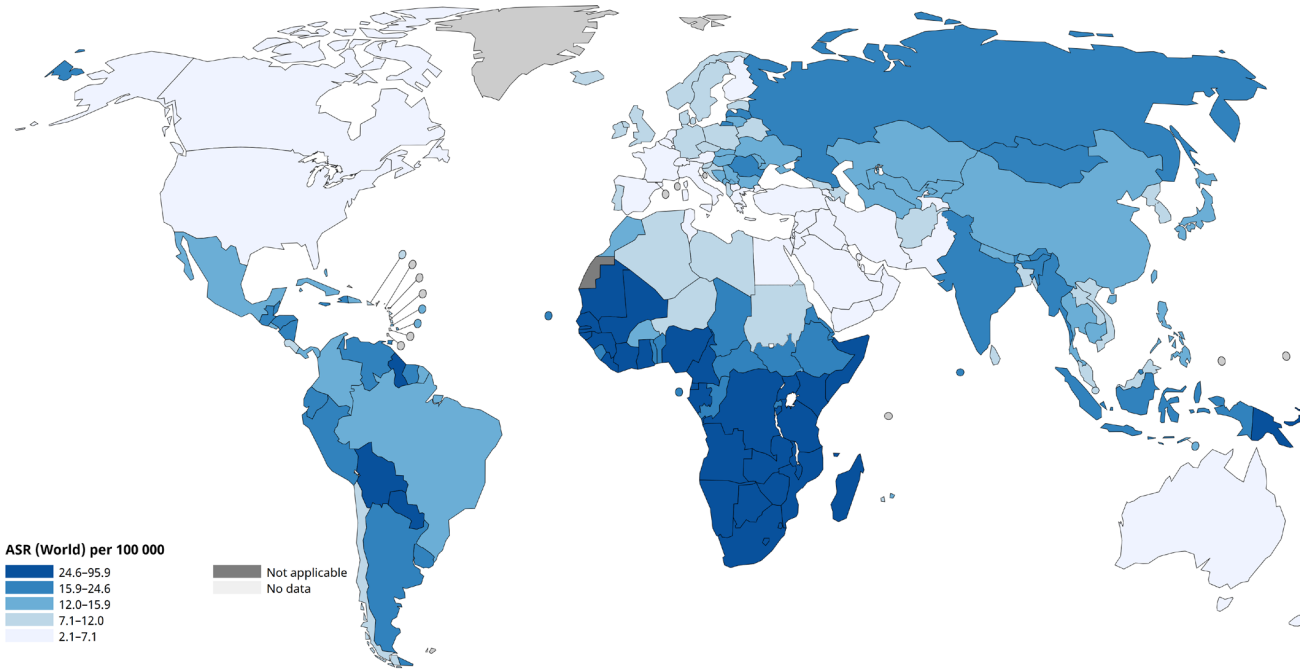


Source: Cancer TODAY | IARC - https://gco.iarc.who.int https://gco.iarc.fr/today/en/dataviz/pie?mode=cancerandpopulations=900andtypes=1andsort_by=value1andgroup_populations=1andsexes=2

Accessed on 13.01.2026

A large majority of cervical cancer cases in 2020 (88%) occurred in low- and middle-income countries (LMIC), where cervical cancer accounts for 17% of all cancers among women, compared with only 2% in high-income countries (HICs)[3]. Figures 4 and 5 capture the estimated age-standardized incidence and mortality rates of cervical cancer for all ages, globally. Regions with the highest risk include Eastern, Southern and Middle Africa, and Melanesia.

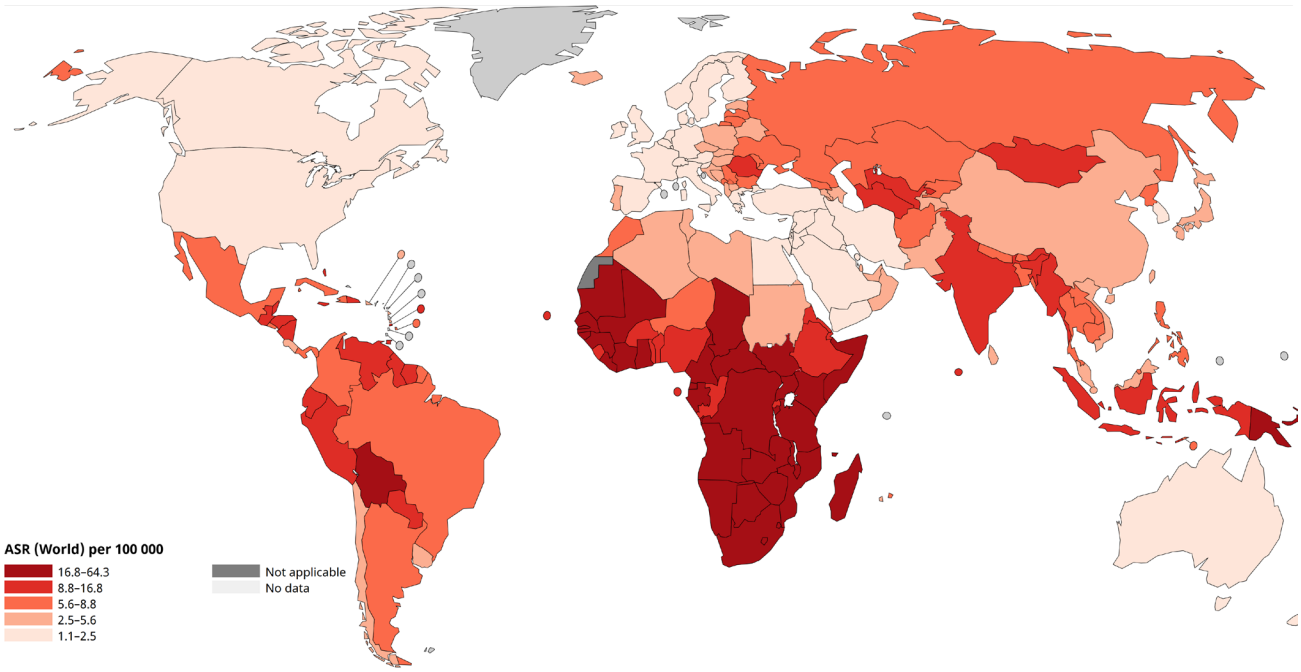
Figure 4: Estimated age-standardized incidence rates (World) in 2022, cervix uteri, females, all ages



Source: https://gco.iarc.fr/today/en/dataviz/maps-heatmap?mode=populationandsexes=2andcancers=23, Accessed on 28 Jan 2026

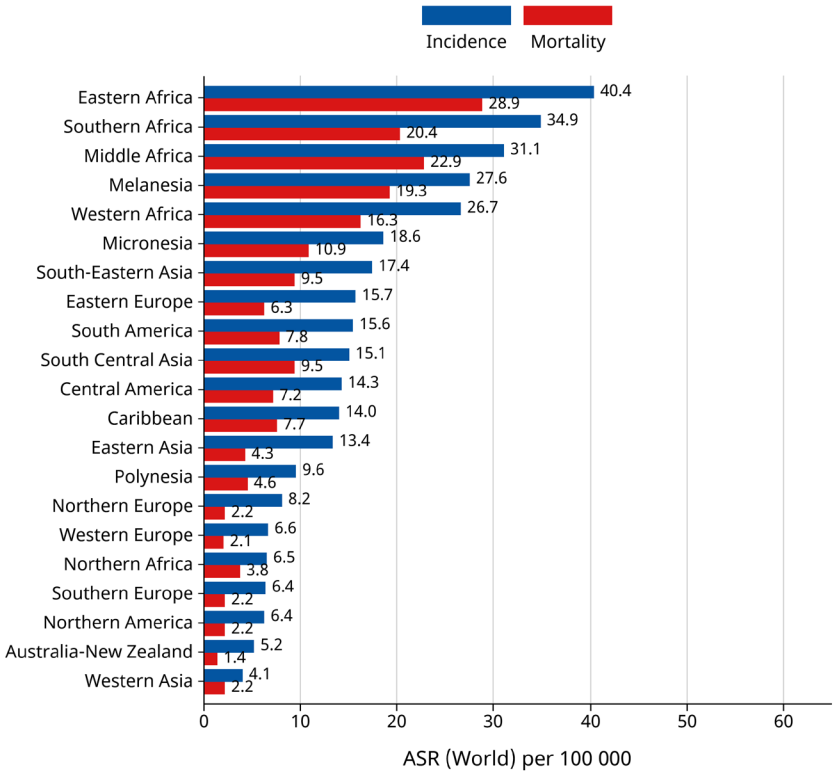
3. Ferlay, J., Ervik, M., Lam, F., Colombet, M., Mery, L., Piñeros, M., Znaor, A., Soerjomataram, I., & Bray, F. (2020). Global Cancer Observatory: Cancer Today. International Agency for Research on Cancer. https://gco.iarc.fr/today. Accessed on February 4, 2026.

Figure 5: Estimated age-standardized mortality rates (World), cervix uteri, females, all ages



In 2022, the age-standardized incidence rate (ASR) varied worldwide, with rates as high as 40.4 per 1,00,000 women in Eastern Africa and as low as 4.1 per 1,00,000 women in Western Asia (Figure 6). Asian countries, including Maldives, Indonesia, Myanmar and India have age-standardized incidence rate estimates of cervical cancer cases ranging between 18.0 to 24.5.[3]

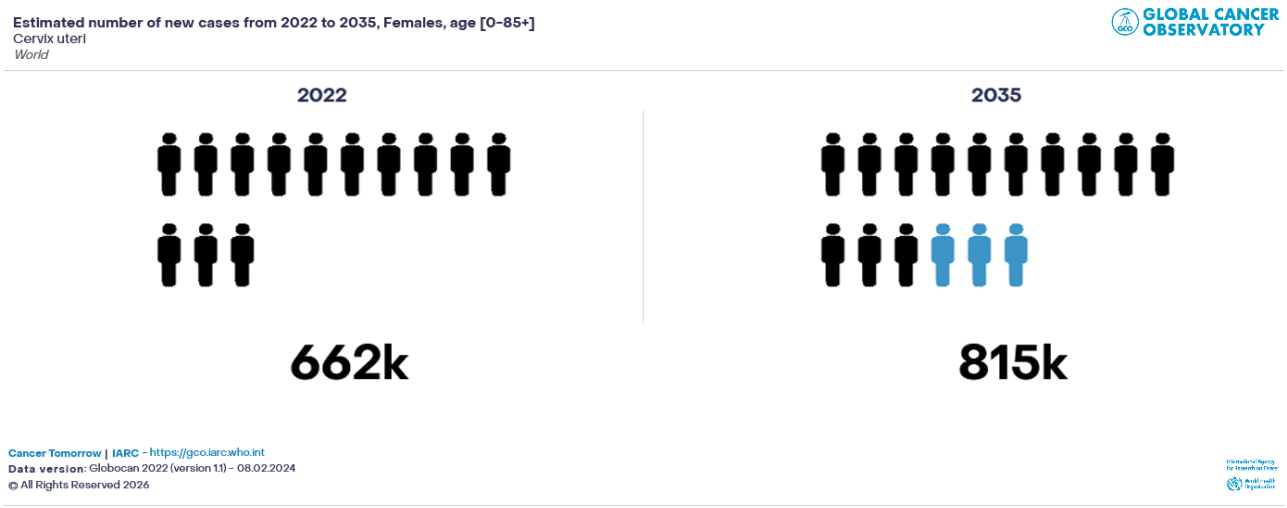
Figure 6: Age standardized incidence and mortality rates of cervical cancer in different world regions.

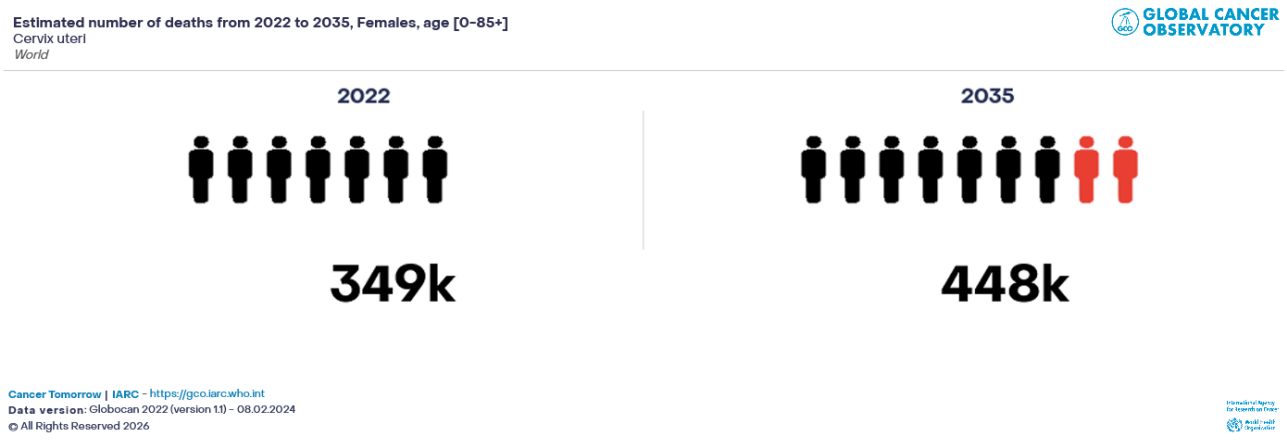


GLOBAL ESTIMATED CERVICAL CANCER PROJECTIONS

The visuals in Figure 7 show projected increase in cervical cancer cases and deaths by 2035. Unless prevention and control measures for cervical cancer are successfully implemented, it is estimated that globally by 2035, 815,000 new cases of cervical cancer will be diagnosed annually with 448,000 deaths.

Figure 7: Global Estimated Cervical Cancer Projections for 2035



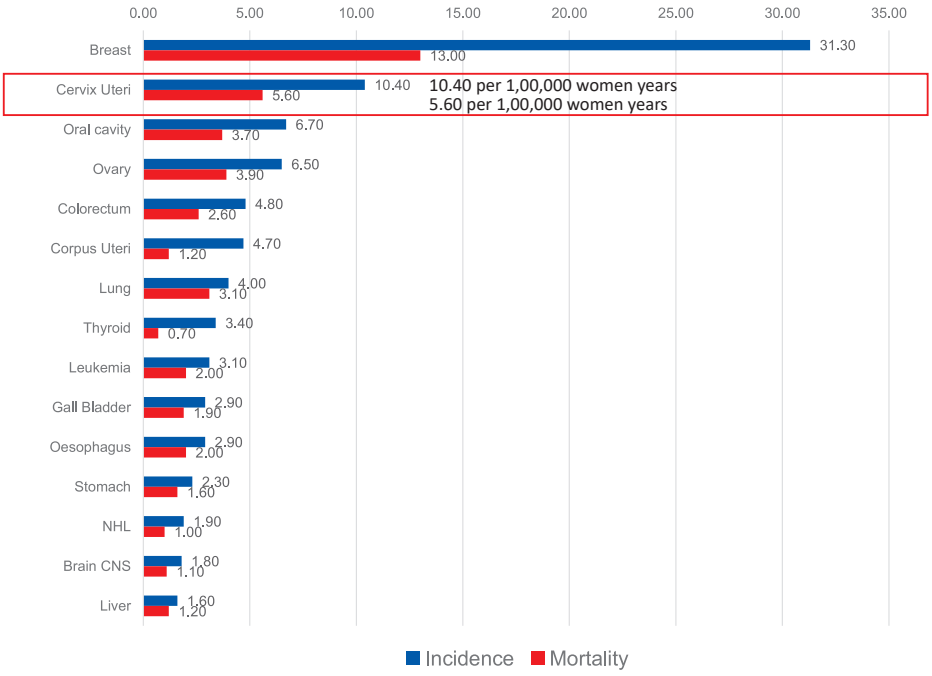


CERVICAL CANCER: INCIDENCE AND MORTALITY (INDIA SCENARIO)

Cancer surveillance in India has been systematically undertaken since 1981 through the National Cancer Registry Programme (NCRP) of the Indian Council of Medical Research (ICMR). The programme is coordinated by the ICMR–National Centre for Disease Informatics and Research (ICMR–NCDIR) and functions through a national network of Population-Based Cancer Registries (PBCRs) and Hospital-Based Cancer Registries (HBCRs). The NCRP provides comprehensive data on cancer incidence, mortality, survival, patterns, trends, and stage at diagnosis across the country.

Cervical cancer is the second leading cancer amongst women in India. The estimated age-standardized incidence and mortality rate of cervical cancer in 2024 were 10.40 and 5.6 per 1,00,000 women, respectively[4] (Figure 8).

Figure 8: Estimated age-standardized incidence and mortality rates (India) in 2024, females, all ages



In 2024, there were an estimated 78,499 new cases and 42,392 deaths due to cervical cancer (Figures 9 and 10). The majority of cervical cancer cases in India are diagnosed at a locally advanced stage (62.2%), which adversely affects treatment outcomes and survival.[4]

Figure 9: Absolute numbers of new cancer cases in 2024, India, females, all ages

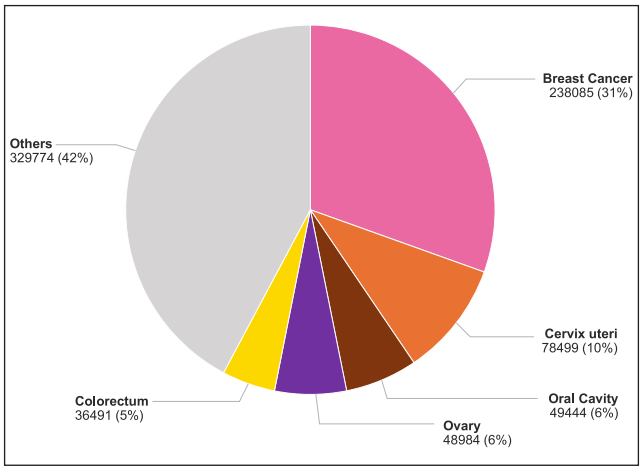
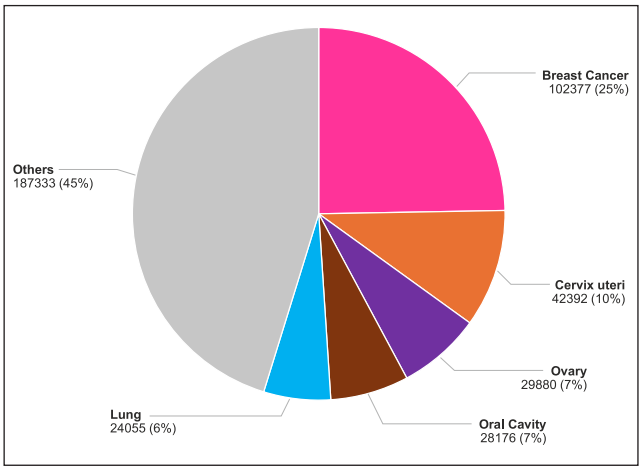


Figure 10: Absolute numbers of cancer deaths in 2024, India, females, all ages



4. Mathur, P., Sathishkumar, K., Das, P., Santhappan, S., Sankarapillai, J., Nath, A., ... & National Cancer Registry Programme Investigator Group. (2025). Cancer incidence and mortality across 43 Cancer registries in India. JAMA Network Open, 8(8), e2527805-e2527805. Available at: doi:10.1001/jamanetworkopen.2025.27805. Accessed on February 4, 2026.

Chapter 2
Disease and Vaccine

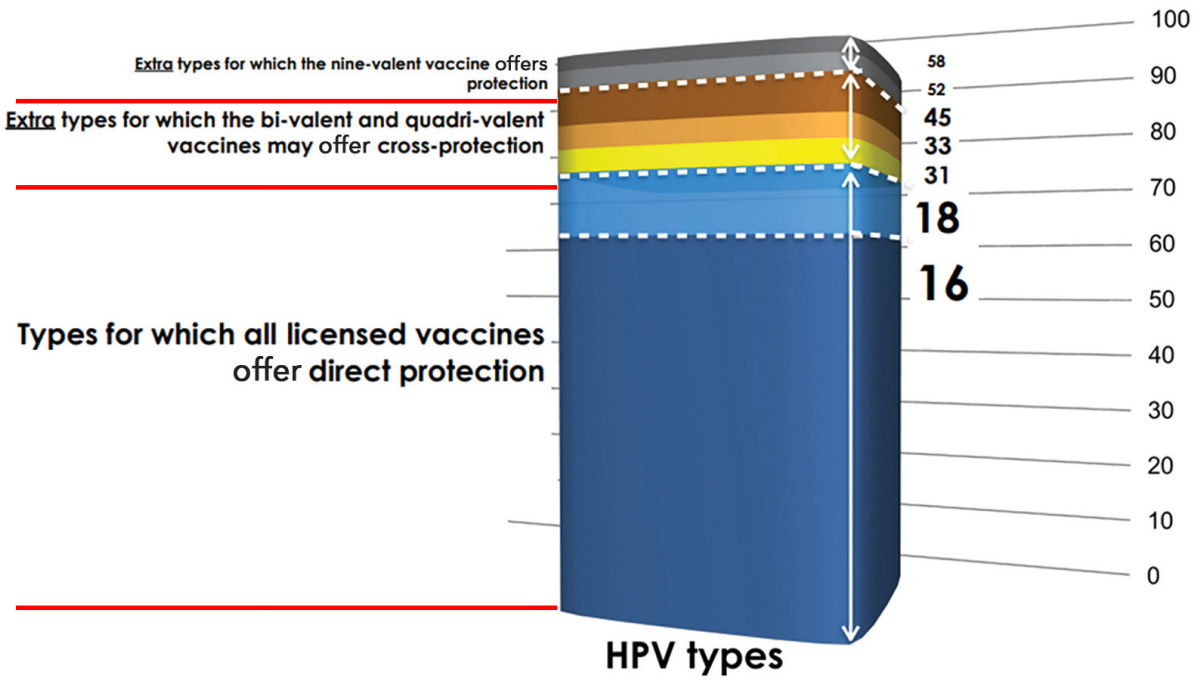
CHAPTER 2
Disease and Vaccine

HUMAN PAPILLOMAVIRUS (HPV) INFECTION

HPV belongs to the family Papillomaviridae. The virions are non-enveloped and contain a double-stranded DNA genome. HPV types are classified in various ways, including by their potential to induce cancer, i.e. high risk vs low-risk types. Currently 17 HPV types are defined as high-risk (oncogenic) and can cause cancer in humans (types 16, 18, 45, 33, 58, 31, 52, 35, 59, 39, 56, 51, 68, 73, 26, 69, and 82). Oncogenic risk varies by type, with type HPV16 being the most oncogenic (Figure 11).[5] HPV infection is the etiologic factor for several cancers including cervical, vulvar, vaginal, anal, penile and oropharyngeal cancers. However, as a public health problem, cervical cancer cases far outnumber the other cancers. Moreover, the attributable fraction of cancers caused by HPV is also highest for cervical cancer, making this the major focus for prevention programmes.

HPV16 and HPV18 together are responsible globally for 77% of cases of cervical cancer in women.[5] In India, the attributable fraction of these two types is higher at 83%[6] which makes it likely to have even better response with the quadrivalent HPV vaccines than the global experience.[7]

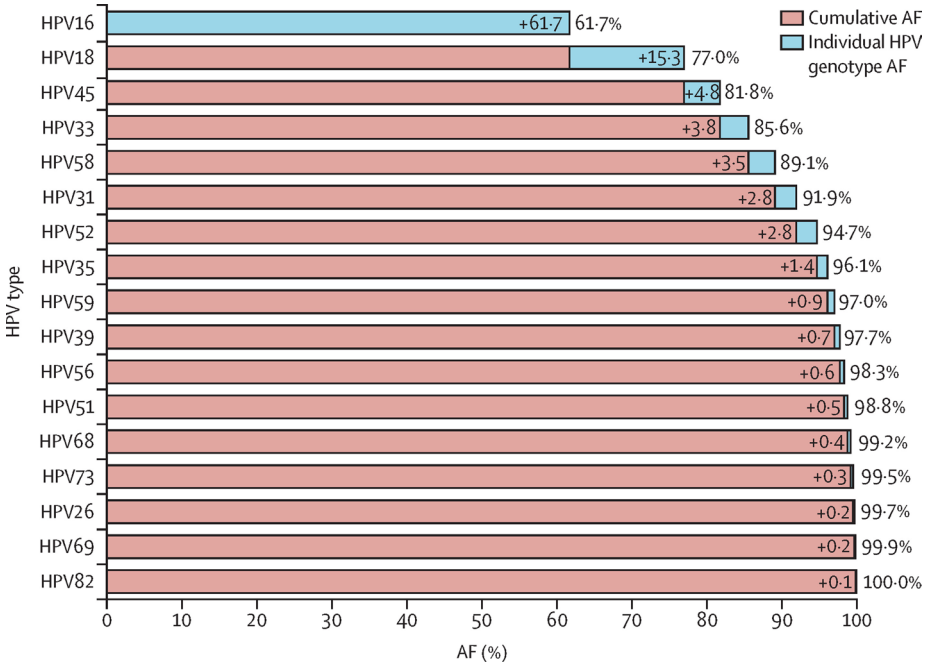
Figure 11: HPV types contribution to cervical cancer and protection offered by HPV vaccines



5. Wei, F., Georges, D., Man, I., Baussano, I., & Clifford, G. M. (2024). Causal attribution of human papillomavirus genotypes to invasive cervical cancer worldwide: a systematic analysis of the global literature. The Lancet, 404(10451), 435-444. Available at: DOI: 10.1016/S0140-6736(24)01097-3. Accessed on February 4, 2026.
6. ICO/IARC Information Centre on HPV and Cancer (2023) India: Human Papillomavirus and Related Cancers, Fact Sheet 2023. Available at: https://hpvcentre.net/statistics/reports/IND_FS.pdf. Accessed: 13 January 2026.
7. Bzhalava, D., Guan, P., Franceschi, S., Dillner, J., & Clifford, G. (2013). A systematic review of the prevalence of mucosal and cutaneous human papillomavirus types. Virology, 445(1-2), 224-231. Available at: https://doi.org/10.1016/j.virol.2013.07.015. accessed on Febrauary 4, 2026.

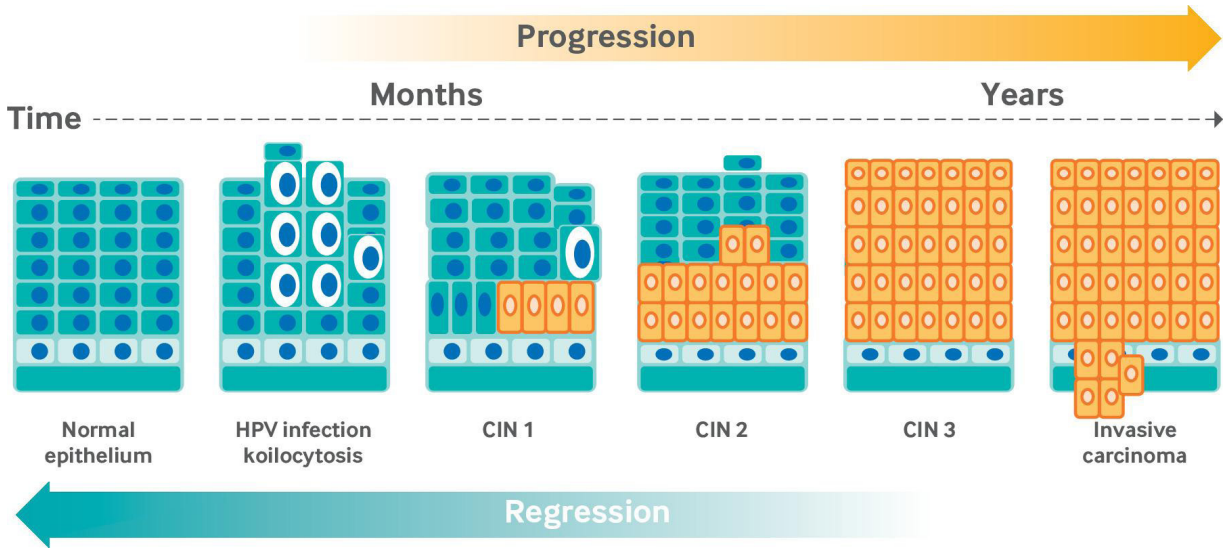
High-risk HPV types 16 and 18 are the primary contributors to disease burden, accounting for 77% of the cumulative attributable fraction, with coverage reaching nearly 95% when including the next five most prevalent genotypes (HPV45, 33, 58, 31, and 52), as shown in the figure 12 below:

Figure 12: Cumulative and individual attributable fraction (AF) of specific high-risk HPV genotypes.[5]



Most HPV infections are subclinical, with no significant symptoms or abnormality on physical examination, but these individuals are able to transmit infection. Simultaneous infection with more than one HPV type is often seen.

Figure 13: Progression of cervical disease after human papillomavirus infection (CIN=cervical intraepithelial neoplasia)[8]



8. Rahangdale, L., Mungo, C., O'Connor, S., Chibwesha, C. J., & Brewer, N. T. (2022). Human papillomavirus vaccination and cervical cancer risk. BMJ, 379, Article e070115. Available at: https://doi.org/10.1136/bmj-2022-070115. Accessed on February 4, 2026.

Although most infections are asymptomatic and usually clear up without intervention within 1-2 years, a small percentage of infections with specific HPV types may persist and result in morphological lesions ranging from normal to different stages of precancer (cervical intraepithelial neoplasia/CIN-1, CIN-2, CIN-3) and invasive cervical cancer (Figure 13)[9].

Even though HPV has been established as a predominant cause of cervical cancer, there are many cofactors that contribute to disease progression towards cancer. These include early coitarche, multiple partners of self or of partner, high parity, immunosuppression as in HIV or transplant cases, co-infection with sexually transmitted infections (STIs), smoked tobacco use, and long-term use of hormonal contraceptives. If infection from cancer-causing HPV types persists over a long period, women can develop pre-cancerous lesions and left untreated, some of these will develop into cervical cancer. This process takes, on average, 10-20 years from infection to the development of cervical cancer.[1,10]

CERVICAL CANCER

CLINICAL FEATURES

Early-stage of cervical cancer generally produces no signs or symptoms. The earliest clinical features are:

- Vaginal bleeding after intercourse, between periods or after menopause
- Prolonged vaginal discharge that may be bloody and have a foul odor
- An unhealthy appearance on examination, irregular surface, bleeding on touch, etc.

Signs and symptoms of more advanced cervical cancer include:

- A visible growth on the cervix, which may extend to the vagina
- Pelvic pain or pain during intercourse
- Fistula formation
- Sciatic pain

DIAGNOSING INVASIVE CARCINOMA

The initial workup and clinical staging of patients with invasive cervical cancer includes history and physical examination, chest radiography. Magnetic resonance imaging (MRI) is presently considered the radiologic modality of choice for evaluating tumor size, parametrial and vaginal spread. Likewise, positron emission tomography (PET) scanning has been reported as the best method to detect pelvic and para-aortic nodal disease in locally advanced cervical carcinomas, with a sensitivity and positive predictive value of 75%, and a specificity and negative predictive value of 92%.[11] Contrast enhanced computed tomography (CT) scan may be used where these are not available. Transvaginal or transrectal USG by an expert can also be used to assess size of the growth and parametrial involvement. Intravenous pyelogram (IVP) is seldom used since the advent of modern radiology methods.

PROGNOSIS AND MANAGEMENT

- Treatment depends on disease extent at diagnosis and locally available resources, usually radical hysterectomy or chemoradiation, or sometimes a combination of both.
- Less radical surgery and fertility preserving surgical procedures are becoming the standard of care for selected cases with low-risk, early stage disease.

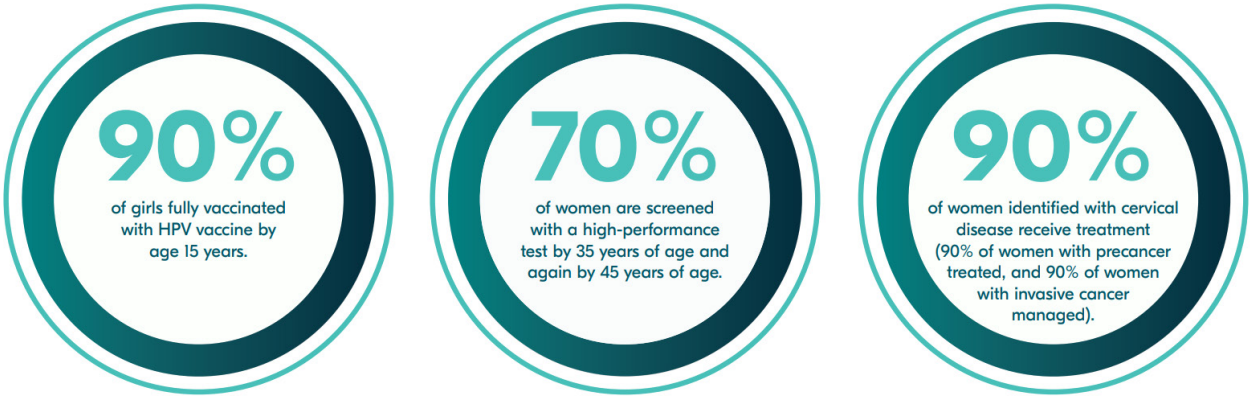
9. Hall, E., & Centers for Disease Control and Prevention (Eds.). (2021). Epidemiology and prevention of vaccine-preventable diseases (pp. 275-286). Atlanta, GA, USA: US Department of Health and Human Services, Centers for Disease Control and Prevention. Available at: https://www.merle-arbeitsmedizin.de/wp-content/uploads/2022/02/CDC-Pink-Book-Version-14th-Edition.pdf . Accessed on Febrauary 4, 2026.
10. Johnson, C. A., James, D., Marzan, A., & Armaos, M. (2019, April). Cervical cancer: an overview of pathophysiology and management. In Seminars in oncology nursing (Vol. 35, No. 2, pp. 166-174). WB Saunders. Available at: https://doi.org/10.1016/j.soncn.2019.02.003. Accessed on February 4, 2026.
11. Zhang, S., Xu, H., Zhang, L., & Qiao, Y. (2020). Cervical cancer: Epidemiology, risk factors and screening. Chinese Journal of Cancer Research, 32(6), 720. Available at: doi: 10.21147/j.issn.1000-9604.2020.06.05. Accessed on Febrauary 4, 2026.

- For women with metastatic or recurrent disease, the overall prognosis remains poor.
- Preliminary results of novel immunotherapeutic approaches, similarly to other solid tumors, have shown promising results so far[11].

COMPREHENSIVE APPROACH FOR PREVENTION OF CERVICAL CANCER

Cervical cancer is largely preventable. The Global Strategy to accelerate the elimination of cervical cancer as a public health problem, adopted by the World Health Assembly in 2020, recommends a comprehensive approach to cervical cancer prevention and control, including interventions across the life course. As per the framework, human papillomavirus (HPV) vaccination for girls is one of the recommended interventions for primary prevention. Cervical cancer screening programs using cost effective screening tests can be implemented for early detection of pre-cancerous conditions and cancers, with transition to HPV testing for twice in a lifetime screening by 35 and 45 years of age. Health systems should be strengthened for preventive, curative and palliative care services for cancers[12, 13].

Figure 14: Global Strategy to eliminate cervical cancer



The Global strategy to eliminate cervical cancer proposes:

- A vision of a world where cervical cancer is eliminated as a public health problem;
- A **threshold of 4 cases per 100 000 women-years** for elimination as a public health problem;
- **90-70-90 targets must be met by 2030** for countries to be on the path towards cervical cancer elimination:

The global strategy to eliminate cervical cancer as a public health problem will require (a) political support from international and local leaders; (b) coordinated cooperation among multisectoral partners; (c) broad support for equitable access in the context of universal health coverage; (d) effective resource mobilization; (e) health system strengthening; and (f) vigorous health promotion at all levels. The interconnected nature of gender and health must stand as the strategic center piece of interventions.

12. World Health Organization. (2020). Global strategy to accelerate the elimination of cervical cancer as a public health problem. Available at: https://www.who.int/publications/i/item/9789240014107 . Accessed on February 4, 2026.
13. Cibula, David, Maria Rosaria Raspollini, François Planchamp, Carlos Centeno, Cyrus Chargari, Ana Felix, Daniela Fischerová et al. "ESGO/ESTRO/ESP Guidelines for the management of patients with cervical cancer–Update 2023." Virchows Archiv 482, no. 6 (2023): 935-966. Available at: https://doi.org/10.1007/s00428-023-03552-3. Accessed on February 4, 2026.

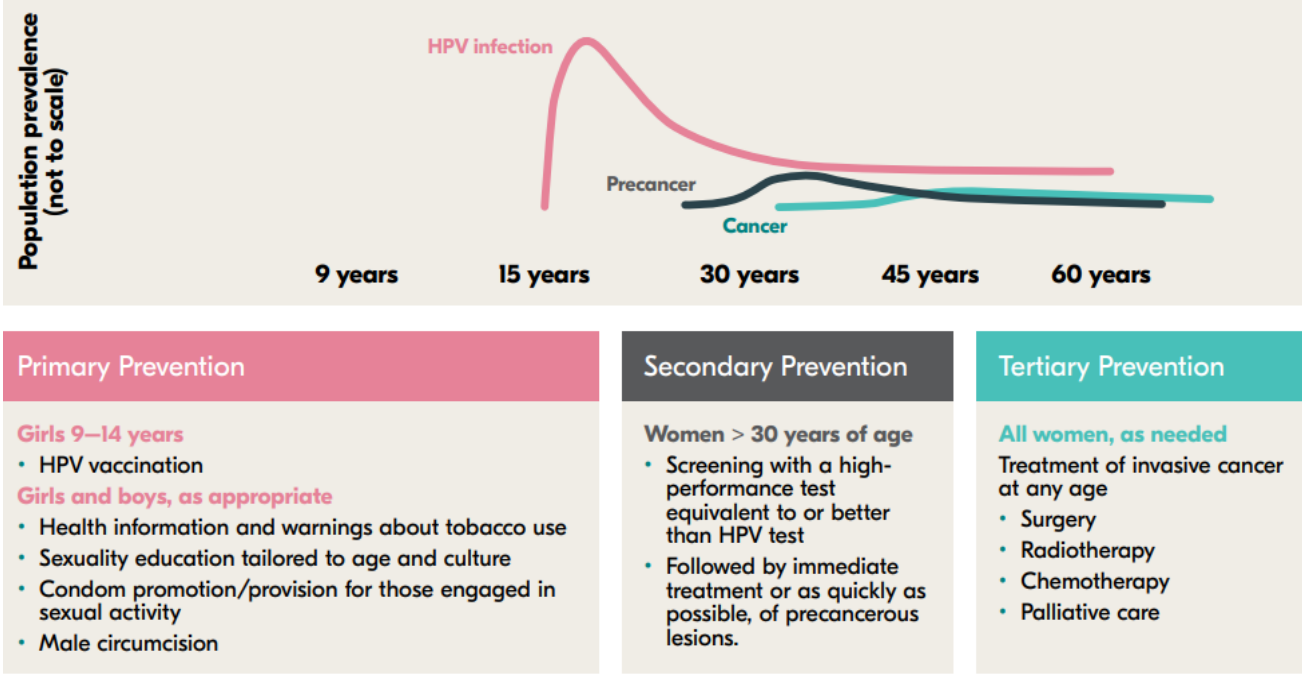
LIFE-COURSE APPROACH TO CERVICAL CANCER INTERVENTIONS

Cervical cancer prevention should encompass a multidisciplinary approach, including components from community education, social mobilization, vaccination, screening, treatment and palliative care.

Since 2009, WHO has recommended the inclusion of HPV vaccine into national immunization programmes in countries where cervical cancer is a public health priority and where cost-effective and sustainable implementation of the vaccine is feasible[14]. Since HPV vaccines do not protect against all HPV types that cause cervical cancer, vaccine introduction should be part of a coordinated and comprehensive approach for controlling cervical cancer, which includes:

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

Figure 15: Life-course approach to cervical cancer interventions



Source: https://iris.who.int/bitstream/handle/10665/336583/9789240014107-eng.pdf

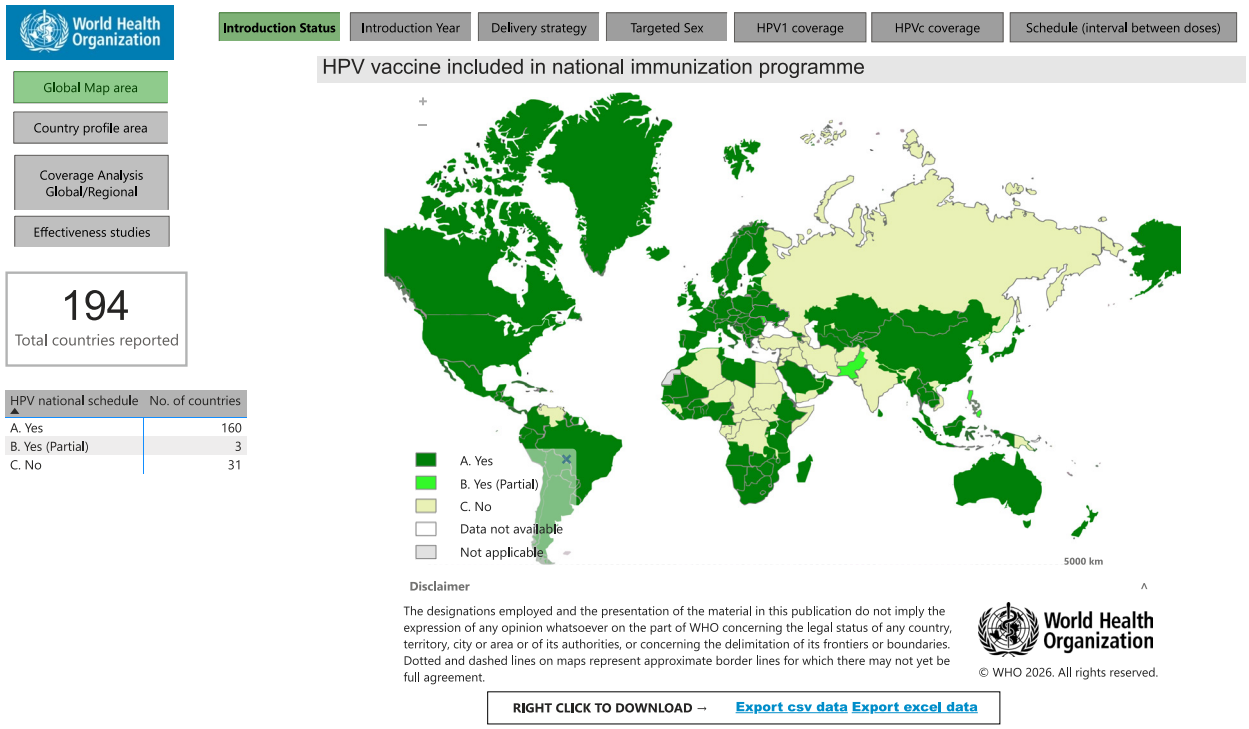
14. WHO (2009). Human papillomavirus vaccines: WHO position paper. Biologicals : journal of the International Association of Biological Standardization, 37(5), 338–344. Available at: https://doi.org/10.1016/j.biologicals.2009.04.005. Accessed on February 4, 2026

HUMAN PAPILLOMAVIRUS (HPV) VACCINES

HPV VACCINE INTRODUCTION: GLOBAL SCENARIO

As of February 2026, 160 countries have introduced the HPV vaccine in their national immunization programmes. (Figure 16).

Figure 16: Countries with HPV vaccine included in national immunization programme.
(Source: https://www.who.int/teams/immunization-vaccines-and-biologicals/diseases/human-papillomavirus-vaccines-(HPV)/hpv-clearing-house/hpv-dashboard) accessed on 2 February 2026



Out of the 10 South East Asia Region Countries, 8 (Bangladesh, Bhutan, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste) have introduced HPV vaccine in their National Immunization Programmes.

WHO POSITION PAPER, December 2022: Human Papillomavirus vaccine[2]

As per the WHO position paper 2022, the priority purpose of HPV immunization is the prevention of cervical cancer, which accounts for 82% of all HPV-related cancers. The 2020 WHO **Global Strategy to Accelerate the Elimination of cervical cancer as a Public Health Problem recommends** that **HPV vaccines should be included in all national immunization programmes and should reach 90% of all girls by age 15 by 2030.** Prevention of cervical cancer is best achieved through the immunization of girls before they become sexually active. All currently licensed bivalent, quadrivalent and nonavalent HPV vaccines have **excellent safety profiles** and have demonstrated **high efficacy** or have **met immune-bridging standards.** It is estimated that implementation of this strategy could **prevent 60 million cervical cancer cases and 45 million deaths over the next 100 years.**

Integration of vaccination with other preventive measures

HPV vaccines should be introduced as part of a coordinated and comprehensive strategy to prevent cervical cancer and other diseases caused by HPV. This strategy should include education about reducing behaviours that increase the risk of acquiring HPV infection, and information about screening, diagnosis and treatment of pre-cancerous lesions, cancer and risk factors. Access to quality screening and treatment services should be improved. **HPV vaccination is a primary prevention intervention and does not eliminate the need for screening later in life,** since the existing vaccines do not protect against all high-risk HPV types and will have limited impact on disease in unvaccinated women and those vaccinated at older ages. Opportunities should be identified to integrate HPV vaccination with other vaccine delivery or health interventions targeting adolescents

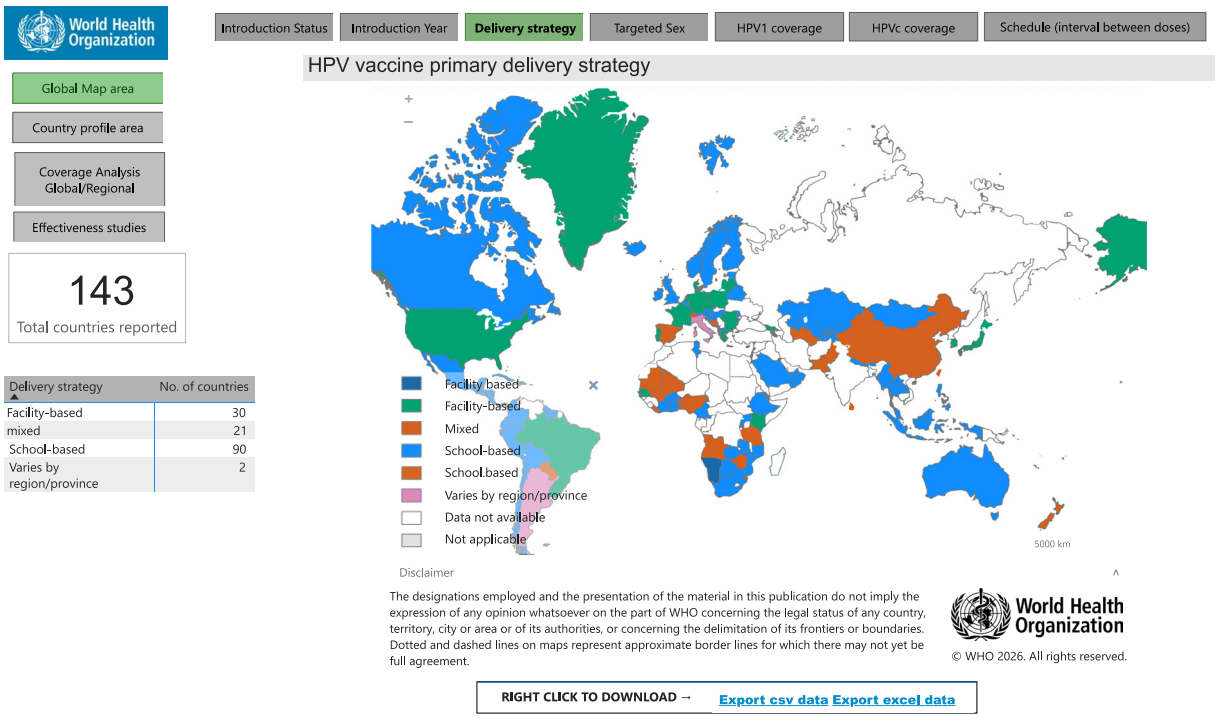
in school health programmes or adolescent health services. However, the introduction of HPV vaccination should not be deferred because other relevant interventions cannot be implemented at the same time. It is not necessary to screen for HPV or HIV infection prior to HPV vaccination.

Vaccination strategies

HPV vaccination can be introduced through a combination of delivery strategies, which could be based in **health facilities or schools, or part of community outreach or campaigns (Figure 17).** Figure 17 illustrates various delivery strategies for HPV vaccine introduction. Countries should use approaches that are (i) compatible with their delivery infrastructure and cold chain capacity, (ii) affordable and sustainable, and (iii) capable of achieving the highest possible coverage. **The primary objective of HPV programmes is to achieve the highest possible population protection among girls by the time they reach 15 years of age, multiple opportunities should therefore be provided for girls to receive their HPV vaccine doses.** Figure 17 shows the global distribution of HPV vaccine primary delivery strategy. At present, 30 countries are delivering HPV vaccine at health facilities, 90 through school based and 21 countries through a mixed delivery strategy (health facility and school both).

Catch-up vaccination of Multi Age Cohorts (MACs) of girls aged between 9 and 18 years at the time of introducing the HPV vaccine results in faster and greater population impact, as a result of increased direct and herd protection. This approach is cost-effective, offers opportunities for economies of scale in delivery and makes programmes more resilient to any interruptions in vaccination.

Figure 17: Delivery strategies for HPV vaccine introduction globally
Source: (https://www.who.int/teams/immunization-vaccines-and-biologicals/diseases/human-papillomavirus-vaccines-(HPV)/hpv-clearing-house/hpv-dashboard) accessed on 2 February 2026



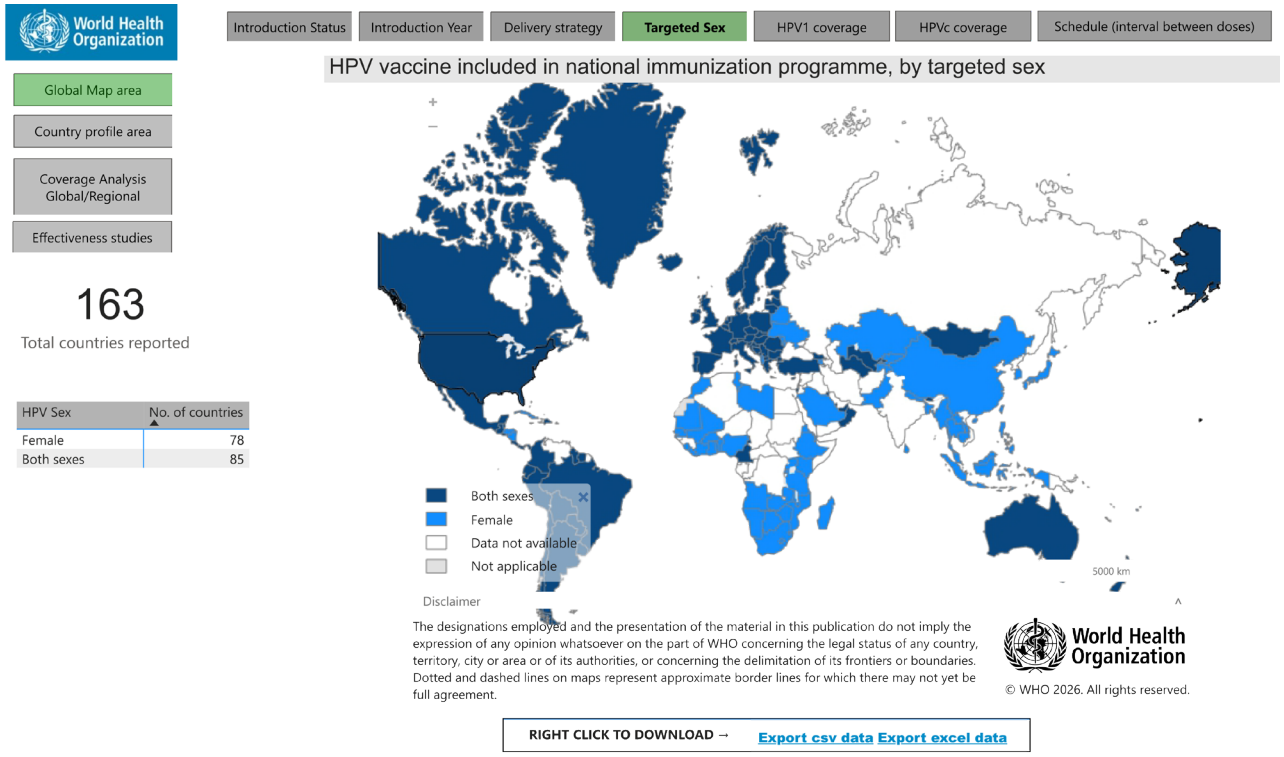
Primary and secondary target groups

For the prevention of cervical cancer, the WHO-recommended **primary target population for HPV vaccination is girls aged 9–14 years,** before they become sexually active. HPV immunization programmes should prioritize high coverage from the time of introduction. Achieving over 80% coverage in girls also generates herd immunity and reduces the risk of HPV infection for boys.

Vaccination of **secondary target populations, e.g. females aged >15 years, boys, older males or men who have sex with men (MSM),** is recommended only if this is feasible and affordable, and does not divert resources from vaccination of the primary target population or effective cervical cancer screening programmes.

The map in Figure 18 shows HPV vaccination strategies in 163 countries, indicating that 78 countries follow female-only vaccination while 85 have adopted gender-neutral programmes.

Figure 18: Countries following Female only or Both Sex (Gender neutral) HPV Vaccination
(Source: https://www.who.int/teams/immunization-vaccines-and-biologicals/diseases/human-papillomavirus-vaccines-(HPV)/hpv-clearing-house/hpv-dashboard) accessed on 2 February 2026



Vaccination schedule

Two-dose schedule

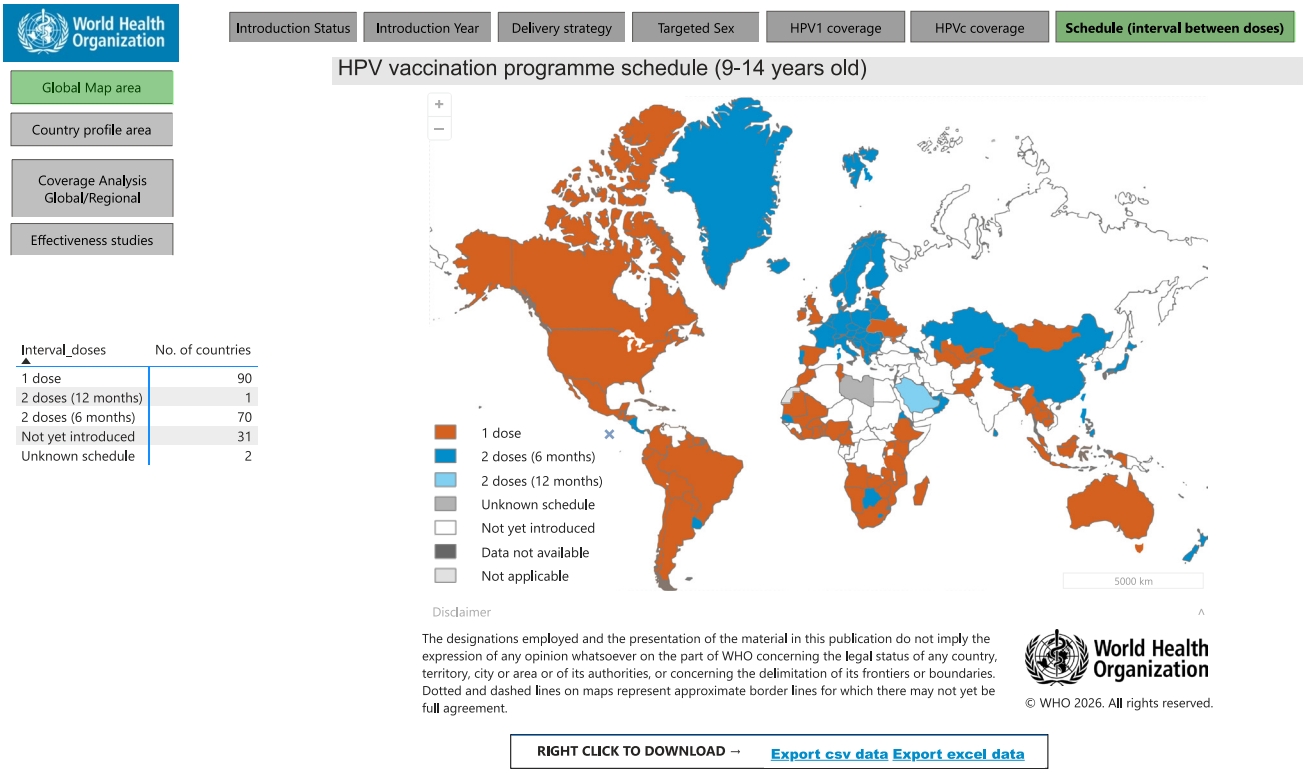
Current evidence supports the recommendation for a 2-dose schedule in the primary target group from 9 years of age and for all older age groups for which HPV vaccines are licensed. The minimum interval between the first and second dose is 6 months. A 12-month schedule results in higher Geometric Mean Titre (GMTs) and is suggested for programmatic and efficiency reasons. There is no maximum recommended interval between doses and longer intervals – up to 3 or 5 years – can be considered if useful from a programme perspective.

Alternative single-dose schedule

As an off-label option, a **single-dose schedule** can be used in girls and boys aged 9–20 years. Current evidence suggests that a single dose has comparable efficacy and duration of protection as a 2-dose schedule and may offer programme advantages, be more efficient and affordable, and contribute to improved coverage. From a public health perspective, the use of a single dose schedule can offer substantial benefits that outweigh the potential risk of a lower level of protection if efficacy wanes over time, although there is no current evidence of this. For single-dose schedules, HPV vaccines with data on efficacy or immunobridging are advised. To date, products for which efficacy and immunogenicity data support use in a single-dose schedule are Cervarix, Gardasil and Gardasil-9. Recently, Cecolin has been added as a recommended single dose HPV Vaccine[15].

15. World Health Organization. (2024, October 4). WHO adds an HPV vaccine for single-dose use. Available at: https://www.who.int/news/item/04-10-2024-who-adds-an-hpv-vaccine-for-single-dose-use. Accessed on February 4, 2026.

Figure 19: HPV vaccination programme schedule (9-14 years old)
(Source: https://www.who.int/teams/immunization-vaccines-and-biologicals/diseases/human-papillomavirus-vaccines-(HPV)/hpv-clearing-house/hpv-dashboard) accessed on 2 February 2026



As illustrated in Figure 19, as of February 2026, 90 countries have switched to single dose HPV vaccine schedule.

Schedule for Immunocompromised people

Individuals known to be immunocompromised or HIV-infected (regardless of age or antiretroviral therapy status) should receive at least two HPV vaccine doses (minimum 6 months interval) and, where possible, three doses.

Licensed HPV vaccines

Current evidence indicates that, from a public health perspective, all licensed HPV vaccines—whether bivalent, quadrivalent, or nonavalent—provide comparable immunogenicity, efficacy, and effectiveness in preventing cervical precancer and cancer primarily caused by HPV types 16 and 18 which together account for approximately 71% of cervical cancer cases globally. The choice of HPV vaccine should be based on an assessment of locally relevant data and on a number of considerations, including: the scale of the prevailing HPV-associated public health problem (cervical cancer, other HPV-associated cancers, anogenital warts); the population for which the vaccine has been approved; product characteristics, including data on single-dose efficacy; price; and programme considerations. For single-dose schedules, HPV vaccines with data on efficacy or immune-bridging are advised.

Vaccination of special populations

Immunocompromised women and men, including those living with HIV, and children and adolescents who have faced sexual abuse are at increased risk of HPV-related disease. It is recommended that these individuals are considered for vaccination against HPV as a priority as part of the public health programme. Travelers and health workers are not at increased risk of contracting HPV infection and should follow the vaccine recommendations for the general population.

Co-administration with other vaccines

HPV vaccines may be administered concomitantly with other routine vaccines containing diphtheria (d), tetanus (T) and acellular pertussis (pa), with no clinically relevant interference with antibody response to any of the components of either vaccine.

Interchangeable use of HPV vaccines

HPV vaccines have different characteristics, components and indications, and in settings where several vaccines are in use, efforts should be made to administer the same vaccine for all doses when using a multidose schedule. However, if the vaccine used for the prior dose(s) is unknown or unavailable, any HPV vaccine can be administered to complete the recommended schedule.

Vaccine immunogenicity, efficacy and effectiveness

HPV vaccines are highly immunogenic. The existing vaccines are delivered via the intramuscular route in the deltoid region, resulting in rapid access to draining lymph nodes, and are adjuvanted to induce a proinflammatory milieu conducive to initiating a strong humoral response with robust memory. In clinical trials, **a peak serum antibody titre was observed 4 weeks after the last dose;** titres then declined over the subsequent 12–18 months before stabilizing. **The serological response to vaccination is much stronger (1–4 logs higher) than the response after natural infection.** Natural infections deliver viruses via the mucosal route with limited inflammation. Vaccine-induced antibodies are thought to reach the site of infection by active IgG transudation in the female genital tract and exudation of interstitial antibodies at the sites of trauma in which infections initiate. The avidity of the polyclonal antibody response is much higher after vaccination than after infection but does not increase appreciably after boosting. Data are limited but, in studies comparing one-, two- and 3-dose schedules, geometric mean avidity indices in the group given one or two doses were non-inferior to those in the 3-dose group; antibody concentration in the single-dose group was inferior. The clinical significance of this is not yet known. The high efficacy of HPV vaccine seen in the clinical trials to date has precluded identification of a minimum protective antibody titre, and there is no known serological correlate of immunity. Particulate antigens, such as VLPs, can persist for years in lymph nodes and may be the mechanism for the observed avidity after single-dose HPV vaccination. HPV vaccines were originally licensed on the basis of their demonstrated clinical efficacy in preventing cervical precancer lesions in young adult women, and genital warts and anal neoplasia in men. The age extension to pre-adolescent and adolescent boys and girls, in whom efficacy trials were not deemed feasible (because of ethical considerations and the follow-up time from infection to development of detectable precancer lesions), was granted on the basis of immuno-bridging studies demonstrating that antibody responses in adolescents were non-inferior to those elicited in adults (as per WHO guidance considered sufficient for vaccine licensing).

High efficacy has been observed in an HPV-naive population for all licensed vaccines in studies that used HPV disease endpoints. A meta-analysis demonstrated that three doses of the bivalent (Cervarix) and quadrivalent (Gardasil) vaccines offered significant protection against cervical adenocarcinoma in situ associated with HPV16 and HPV18 among young women (aged 15–26 years): 88% reduction (95%CI 30–98%).

Vaccine safety

Since licensure in 2006, over 500 million doses of HPV vaccines have been distributed. Post-licensure surveillance globally has detected no serious safety issues to date except rare reports of anaphylaxis. Fainting has been reported more frequently following HPV vaccinations. These have been well studied and found not to be due to the HPV vaccine but are a result of anxiety related to fear of pain of injections. Recovery is quick with no long-lasting effects. The safety of the HPV vaccine has been regularly reviewed by the WHO's Global Advisory Committee on Vaccine Safety (GACVS) which has not identified any safety concerns. Data from all sources continue to be reassuring regarding the safety profile of HPV vaccines currently in global use.

HPV vaccines are safe and well tolerated and can be used in persons who are immunocompromised or HIV infected. Adverse events following HPV vaccination are generally mild and of short duration. HPV vaccines should not be given to anyone who has experienced a severe allergic reaction after a previous HPV vaccine dose, or to a component of the vaccine. Data on the safety of HPV vaccination in pregnancy are reassuring but limited. In the absence of well controlled studies in pregnant women, as a precautionary measure vaccination with HPV vaccine

is not recommended in pregnancy. If pregnancy occurs following the first dose of vaccination, the subsequent dose should be delayed until after the pregnancy. Termination of pregnancy is not indicated if vaccination was carried out inadvertently during pregnancy. Breastfeeding is not a contraindication for HPV vaccination.

Cost-effectiveness

Global cost-effectiveness analysis suggests that vaccinating pre-adolescent girls is usually cost-effective for cervical cancer prevention, particularly in resource constrained settings where screening and other cervical cancer prevention and control measures often have limited coverage. At current prices for the bivalent and quadrivalent vaccines, girls-only vaccination is cost-effective (compared with no vaccination) irrespective of the schedule or vaccine used, even when no cross-protection or herd protection is assumed. HPV vaccination is considered a "best buy" for cervical cancer prevention.

Cross-protection

All the licensed HPV vaccines provide high protection against HPV16 and HPV18. The nonavalent vaccine provides direct protection against high-risk HPV types 31, 33, 45, 52 and 58. Some bivalent and quadrivalent HPV vaccines provide partial cross-protection against these HPV types not included in the vaccine.

Evidence for a Single-Dose HPV Vaccination Schedule:

A number of rigorous studies have been conducted to determine the efficacy and immunogenicity of a single-dose regimen of HPV vaccines. Researchers have concluded that a single dose of HPV vaccine provides high levels of protection against high-risk strains of HPV, even several years after vaccination, and induces a robust immune response.

Data from clinical studies across multiple geographies suggest a single-dose regimen provides significant protection against HPV. A single dose delivers high levels of protection similar in magnitude to multi-dose regimens.

Study*	KENya Single-dose HPV-vaccine Efficacy (KEN SHE)[16]	Dose Reduction Immunobridging and Safety (DoRIS)[17, 18]	International Agency for Research on Cancer (IARC)[19]	Costa Rica HPV Vaccine Trial (CVT)[20]
Start year	2018	2017	2009	2004
Location	Kenya	Tanzania	India	Costa Rica
Key Findings	Single-dose vaccination with Gardasil®9 or Cervarix® was >95% effective in preventing new-onset persistent HPV 16/18 infection among African adolescent girls and young women up to 54 months post-vaccination.	Antibody levels among girls receiving a single dose of Gardasil®9 or Cervarix® were at least as high as those in women from the KEN SHE, CVT, or IARC studies where single-dose efficacy was shown. Data suggest the efficacy of a single dose of HPV vaccine can be inferred to the targeted 9–14-year-old age group.	One dose showed 92% efficacy with Gardasil® against persistent HPV 16/18 infection for at least 12 years. Comparable vaccine efficacy regardless of the dose regimen with Gardasil® (1, 2, or 3 doses).	Comparable efficacy from 1 and 3 doses of Cervarix® in protecting against HPV 16/18 infection as of 10 years post-vaccination.[19] 10X the level of antibody induced after a single dose, compared to after natural infection up to 16 years post-vaccination.[21]

16. Barnabas, R. V., Brown, E. R., Onono, M., Bukusi, E. A., Njoroge, B., Winer, R. L., ... & KEN SHE Study Team. (2021). Single-dose HPV vaccination efficacy among adolescent girls and young women in Kenya (the KEN SHE Study): study protocol for a randomized controlled trial. Trials, 22(1), 661. Available at: https://doi.org/10.1186/s13063-021-05608-8. Accessed on February 4, 2026.
17. Baisley, K., Kemp, T. J., Kreimer, A. R., Basu, P., Changalucha, J., Hildesheim, A., ... & Watson-Jones, D. (2022). Comparing one dose of HPV vaccine in girls aged 9–14 years in Tanzania (DoRIS) with one dose of HPV vaccine in historical cohorts: an immunobridging analysis of a randomised controlled trial. The Lancet Global Health, 10(10), e1485-e1493. Available at: DOI: 10.1016/S2214-109X(22)00306-0. Accessed on February 4, 2026.
18. Baisley, K., Kemp, T. J., Mugo, N. R., Whitworth, H., Onono, M. A., Njoroge, B., ... & Watson-Jones, D. (2024). Comparing one dose of HPV vaccine in girls aged 9–14 years in Tanzania (DoRIS) with one dose in young women aged 15–20 years in Kenya (KEN SHE): an immunobridging analysis of randomised controlled trials. The Lancet Global Health, 12(3), e491-e499. Available at: DOI: 10.1016/S2214-109X(22)00306-0 External Link. Accessed on February 4, 2026.
19. Malvi, S. G., Esmy, P. O., Muwonge, R., Joshi, S., Poli, U. R. R., Lucas, E., ... & Basu, P. (2024). A prospective cohort study comparing efficacy of 1 dose of quadrivalent human papillomavirus vaccine to 2 and 3 doses at an average follow up of 12 years postvaccination. JNCI Monographs, 2024(67), 317-328. Avaialble at: https://pubmed.ncbi.nlm.nih.gov/39529521/ Accessed on February 4, 2026.
20. Kreimer, A. R., Sampson, J. N., Porras, C., Schiller, J. T., Kemp, T., Herrero, R., ... & Costa Rica HPV Vaccine Trial (CVT) Group. (2020). Evaluation of durability of a single dose of the bivalent HPV vaccine: the CVT trial. JNCI: Journal of the National Cancer Institute, 112(10), 1038-1046. Available at: https://doi.org/10.1093/jnci/djaa011. Accessed on February 4, 2026.
21. Porras, C., Romero, B., Kemp, T., Fantin, R., Herrero, R., Hildesheim, A., ... & Kreimer, A. R. (2024). HPV16/18 antibodies 16-years after single dose of bivalent HPV vaccination: Costa Rica HPV vaccine trial. JNCI Monographs, 2024(67), 329-336. Available at: https://doi.org/10.1093/jncimonographs/lgae032. Accessed on February 4, 2026.

1. **In a Costa Rican study (CVT), follow-up evaluation of participants who had received fewer doses showed that a single dose of HPV vaccine provided a similar level of protection (82.1%) against high-risk strains of HPV as two or three doses (83.8% and 80.2%, respectively), even 11 years following vaccination.** Researchers examined the dose-specific vaccine efficacy of the bivalent HPV vaccine among 18–25-year-old women and determined that vaccine efficacy against high-risk strains of HPV was high, regardless of the number of doses received. Protection persisted for approximately 11 years following initial vaccination. Vaccine efficacy was 80.2% (95% CI = 70.7% – 87.0%) for three doses, 83.8% (95% CI = 19.5% – 99.2%) for two doses, and 82.1% (95% CI = 40.2% to 97.0%) for a single dose, with no statistically significant differences in either vaccine efficacy or infection rates across the three groups.

2. **A randomized trial of two vs three doses of quadrivalent vaccine that converted into an observational cohort study in India (IARC India) found that the protection provided by a single dose of HPV vaccine was comparable to that provided by two or three doses, even 10 years after vaccination.** Researchers compared the vaccine efficacy of a single dose of quadrivalent HPV vaccine to two and three doses in protecting against high-risk HPV strains. After 10 years of following the cohort of women, there were no significant differences in the frequency of incident HPV infection among adolescent women who received one, two, or three doses of HPV vaccine. The vaccine efficacy of a single dose was found to be 95.4% (95% CI 85.0 – 99.0), which did not differ significantly from the efficacy of two or three doses.

3. **In Tanzania, a randomized trial among 9–14-year-old girls (DoRIS) found that two years after vaccination, a single dose of HPV vaccine produced a non-inferior immune response for a high-risk strain of HPV compared to two or three doses.** Researchers examined the immune response two years after vaccination with a single dose of HPV vaccine. Compared to two or three doses, a single dose of either bivalent or nonavalent HPV vaccine produced non-inferior levels of antibodies against HPV 16. Although non-inferiority was not met for HPV 18 antibodies, at least 98% of girls who received a single dose of HPV vaccine were seropositive for these antibodies two years following vaccination.

4. **In a randomized trial in Kenya (KEN SHE), a single-dose of HPV vaccine was found to be 97.5% effective in preventing cancer-causing strains of HPV among 15–20-year-old girls.** Researchers examined the efficacy of single-dose bivalent (a single shot that can protect against two strains of a virus) and nonavalent HPV vaccines (a single shot that can protect against nine strains of a virus) among 15–20-year-old girls. After 18 months of follow-up, both the bivalent and nonavalent vaccines demonstrated 97.5% vaccine efficacy against high-risk strains of HPV. Researchers subsequently published results demonstrating similar vaccine efficacy three years following vaccination: bivalent vaccine efficacy remained at 97.5% (95% CI 90.0–99.4%), while nonavalent vaccine efficacy was 98.8% (CI 91.3–99.8%).

As of January 2026, the products for which efficacy and immunogenicity data support use in a single-dose schedule are bivalent (2vHPV, Cervarix® & Cecolin®), quadrivalent (4vHPV, Gardasil®), and nonavalent (9vHPV, Gardasil® 9) vaccines.[22]

HERD EFFECT OF HPV VACCINATION

HPV vaccination leads to a herd effect as per the evidence. When there is good coverage with HPV vaccine it leads to a herd effect, providing indirect protection to unvaccinated individuals by reducing the spread of the specific HPV-types.

22. World Health Organization. (2024). Considerations for human papillomavirus (HPV) vaccine product choice. World Health Organization. Available at: https://www.who.int/publications/i/item/9789240089167 Accessed on Febrauary 4, 2026

23. Rosenblum, H. G. (2021). Declines in prevalence of human papillomavirus vaccine-type infection among females after introduction of vaccine—United States, 2003–2018. MMWR. Morbidity and Mortality Weekly Report, 70. Available at: https://www.cdc.gov/mmwr/volumes/70/wr/mm7012a2.htm?utm_source=mp-fotoscapes. Accessed on February 4, 2026.

24. Tabrizi, S. N., Brotherton, J. M., Kaldor, J. M., Skinner, S. R., Liu, B., Bateson, D., ... & Garland, S. M. (2014). Assessment of herd immunity and cross-protection after a human papillomavirus vaccination programme in Australia: a repeat cross-sectional study. The Lancet infectious diseases, 14(10), 958-966. Available at: DOI: 10.1016/S1473-3099(14)70841-2 . Accessed on February 4, 2026.

- There is evidence of indirect protection of unvaccinated females through herd effects.[23,24]
- In a number of countries, substantial decreases in cases of genital warts have occurred following the introduction of a national HPV immunization programme using quadrivalent vaccine, with reductions observed in unvaccinated young men in settings with female-only programmes, indicating herd protection.[25,26]
- Achieving over 80% coverage in girls also reduces the risk of HPV infection for boys.[27]

SAGE RECOMMENDATIONS FOR HPV VACCINATION[28]

In June 2022, the Strategic Advisory Group of Experts on Immunization (SAGE) met to evaluate the evidence that has been emerging over past years that single-dose schedules provide comparable efficacy to the two or three-dose regimens. SAGE's review concluded that a single-dose Human Papillomavirus (HPV) vaccine (Gardasil, Cervarix, Gardasil 9) provides adequate protection against HPV, that is comparable to 2-dose schedules. As per the latest WHO document - Cecolin is also recommended for single dose schedule.[22]

NTAGI RECOMMENDATION FOR HPV VACCINATION[29]

In December 2017 and June 2022, the National Technical Advisory Group on Immunization (NTAGI), recommended the Roll Out of HPV Vaccination.

HPV VACCINE INTRODUCTION- INDIAN SCENARIO

The country already has an experience with HPV vaccine wherein HPV vaccine was introduced sub-nationally. In 2016, the Government of Punjab introduced HPV vaccine as a pilot program (state initiative) in 2 districts namely Bathinda and Mansa which had high annual incidences of cervical cancer (17.5 cases per 1,00,000 women in Bathinda and 17.3 cases per 1,00,000 women in Mansa)[30]. Punjab introduced two-dose quadrivalent vaccine targeting girls in class 6 (approximate age 11–12 years) in schools. In 2018, Sikkim became the first state to introduce the HPV vaccine across the state to target girls in the age group of 9-<14 years. (The lessons learnt from these introductions are mentioned in chapter 3).

HPV VACCINES AVAILABLE GLOBALLY

Out of the eight HPV vaccine products* available globally, four-Cervarix, Gardasil, Gardasil-9, and Cervavac are licensed by DCGI for use in India, as of February 2026.[31] India's HPV vaccination campaign will use the quadrivalent Gardasil HPV vaccine.

25. Bollerup, S., Dehlendorff, C., Jensen, H., Baandrup, L., Kjær, S. K., & Thomsen, L. T. (2016). Significant reduction in the incidence of genital warts in young men 5 years into the Danish human papillomavirus vaccination program for girls and women. Sexually Transmitted Diseases, 43(4), 238–242. Available at: https://pubmed.ncbi.nlm.nih.gov/26967300/ Accessed on February 4, 2026.
26. Ali, H., Donovan, B., Wand, H., Read, T. R. H., Regan, D. G., Grulich, A. E., Fairley, C. K., & Guy, R. J. (2013). Genital warts in young Australians five years into national human papillomavirus vaccination programme: National surveillance data. BMJ, 346, Article f2032. Available at: https://doi.org/10.1136/bmj.f2032. Accessed on February 4, 2026.
27. World Health Organization. (2018, October). Working group on human papillomavirus (HPV) immunization: Report to SAGE [Meeting report]. Available at: https://terrance.who.int/mediacentre/data/sage/SAGE_Docs_Ppt_Oct2018/8_session_HPV_vaccine/Oct2018_session8_WG-on-HPV.pdf. Accessed on February 5, 2026.
28. World Health Organization. (2022). Meeting of the Strategic Advisory Group of Experts on Immunization, April 2022: Conclusions and recommendations. Weekly Epidemiological Record, 97(24), 261–276. Available at: https://www.who.int/publications/i/item/who-wer9724-261-276. Accessed on February 4, 2026.
29. Government of India (2022) Minutes of the 17th National Technical Advisory Group on Immunization (NTAGI) Meeting, 28 June 2022. New Delhi: Ministry of Health and Family Welfare, Immunization Division. https://mohfw.gov.in/?q=en/Organisation/Departments-of-Health-and-Family-Welfare/immunization.
30. Bhatla N, Meena J, Kumari S, Banerjee D, Singh P, Natarajan J. Cervical Cancer Prevention Efforts in India. Indian J Gynecol Oncol. 2021;19(3):41. doi: 10.1007/s40944-021-00526-8. Epub 2021 Jun 2. PMID: 34095455; PMCID: PMC8170054.
31. World Health Organization. (2006). Guidelines to assure the quality, safety and efficacy of recombinant human papillomavirus virus-like particle vaccines (Technical Report Series, No. 962). Available at: https://screening.iarc.fr/doc/WHO_vaccine_guidelines_2006.pdf. Accessed on February 4, 2026.

Table 1: HPV Vaccine Products Available Globally[31]

Trade Name	Cecolin®	Walrinvax®	Cervarix™	Gardasil®	Cervavac®	Gardasil-9®
Valency	Bivalent	Bivalent	Bivalent	Quadrivalent	Quadrivalent	Nonavalent
Manufacturer	Xiamen Innovax Biotech Co. Limited (Innovax) China	Walvax Biotechnology Co. Ltd. China	GlaxoSmithKline Biologicals (GSK) Belgium	Merck/MSD USA	Serum Institute of India Ltd. (SIIL)	Merck/MSD USA
NRA	National Medical Products Administration, China	National Medical Products Administration, China	Federal Agency for Medicines and Health Products, Belgium	European Medicines Agency	Central Drugs Standard Control Organization (CDSCO), Drugs Controller General (India) (DCG(I))	European Medicines Agency
HPV types included	**16/18**	**16/18**	**16/18**	**16/18** and for anogenital warts 6/11	**16/18** and for anogenital warts 6/11	**16/18**/31/33/45/52/58 and for anogenital warts 6/11
Presentation	Single dose vial (0.5ml)	Single dose vial (0.5ml)	Single dose vial (0.5ml; 1 dose) Multidose vial (1.0 ml; 2 doses)	Single dose vial (0.5ml)	Single dose vial (0.5ml; 1 dose) Multidose vial (1.0 ml; 2 doses)	Single dose vial (0.5ml)
Expression system/ producer cells	Baculovirus derived from Trichoplusia ni	Saccharomyces cerevisiae (baker's yeast)	Saccharomyces cerevisiae (baker's yeast)	Escherichia coli	Pichia pastoris	Hansenula
Form	Liquid	Liquid	Liquid	Liquid	Liquid	Liquid
WHO PQ decision	2021	2024	2009	2009	-	2018
Storage	2-8° C	2-8° C	2-8° C	2-8° C	2-8° C	2-8° C
Shelf Life	36 months	24 months	60 months In multi-dose vial discard at the end of session or after 6 hours, which ever comes first.	36 months	36 months In multi-dose vial discard at the end of session or after 6 hours, which ever comes first.	36 months
Stability & CTC	-	-	Stability 3 days at 8-25° C	Stability 3 days at 8-42° C (CTC) and 4 days at 8-40° C (CTC)	-	Stability 3 days at 8-42° C (CTC) and 4 days at 8-40° C (CTC)
Vaccine vial monitor type	Type 14	Type 14	Type 30	Type 30	-	Type 30
Adjuvant	Aluminium hydroxide	Aluminium phosphate	ASO4 (Aluminium hydroxide & 3-deacylated monophosphoryl lipid A)	Aluminium hydroxyphosphate sulfate	Aluminium hydroxide	Aluminium hydroxyphosphate sulfate
Preservative	None	None	None	None	None	None

Trade Name	Cecolin®	Walrinvax®	Cervarix™	Gardasil®	Cervavac®	Gardasil-9®
Cold chain volume per dose (cm^3)	Carton of 10 vials: 14.29 cm^3	Carton of 20 vials: 11.8 cm^3	Carton of 1 vial : 28.8 cm^3 Carton of 10 vials : 5.7 cm^3 Carton of 100 vials : 4.8 cm^3	Carton of 10 vials: 15 cm^3	-	Carton of 10 vials: UNICEF supply: 18.4 cm^3 PAHO supply: 15.11 cm^3
Image						
Route of Administration	Intra Muscular	Intra Muscular	Intra Muscular	Intra Muscular	Intra Muscular	Intra Muscular
Minimum age indication (WHO)	≥ 9 years	≥ 9 years	≥ 9 years	≥ 9 years	-	≥ 9 years
Dosing schedule as per product insert	9-14 years: 2 doses (0.5 ml) 2nd dose 6 months after first or 3 doses at 0, 2 and 6 months ≥15 years: 3 doses at 0, 2 and 6 months	9-14 years: 2 doses (0.5 ml) 2nd dose 6 months after first or 3 doses at 0, 2 and 6 months ≥15 years: 3 doses at 0, 2 and 6 months	9-14 years: 2 doses (0.5 ml) 2nd dose 5-13 months after the first or 3 doses at 0, 1 and 6 months ≥ 15 years: 3 doses at 0, 1 and 6 months	9-13 years: 2 doses (0.5 ml) 2nd dose 6 months after first or 3 doses at 0, 2 and 6 months ≥14 years: 3 doses at 0, 2 and 6 months	9-14 years: 2 doses (0.5 ml) 2nd dose 6 months after first 15-26 years: 3 doses (0.5ml) at 0, 2 and 6 months	9-14 years: 2 doses (0.5 ml) 2nd dose 6 to 12 months after first or 3 doses at 0, 2 and 6 months ≥15 years: 3 doses at 0, 2 and 6 months
Availability of 1- dose efficacy or Immunobridging data	Efficacy inferred through Immunobridging	Immunobridging study planned	Efficacy data available	Efficacy data available	Immunobridging study undergoing	Efficacy data available
Special considerations	In rare cases, syncope (fainting) or vasovagal responses to injections, sometimes accompanied by tonic-clonic movements, may occur especially in vaccination of adolescents and young adults. To avoid injury from fainting, vaccine recipients should be seated and observed for at least 30 minutes after administration of HPV vaccine					
Adverse events	Local: injection site pain, redness swelling Systemic: fever, headache, fatigue, myalgia, arthralgia, irritability, loss of appetite, nausea, diarrhea Rare: hypersensitivity reactions including anaphylaxis					
Use in pregnancy	Vaccination should be postponed until after pregnancy Pregnancy testing not necessary before vaccination					
Contraindications	General: Hypersensitivity to the active substances or to any of the excipients of the vaccine					

* 2 more HPV vaccines are available globally: Cecolin 9 (nonavalent)-China and Tsegardex (Quadrivalent)-Russia

Chapter 3
Key Lessons Learnt

CHAPTER 3

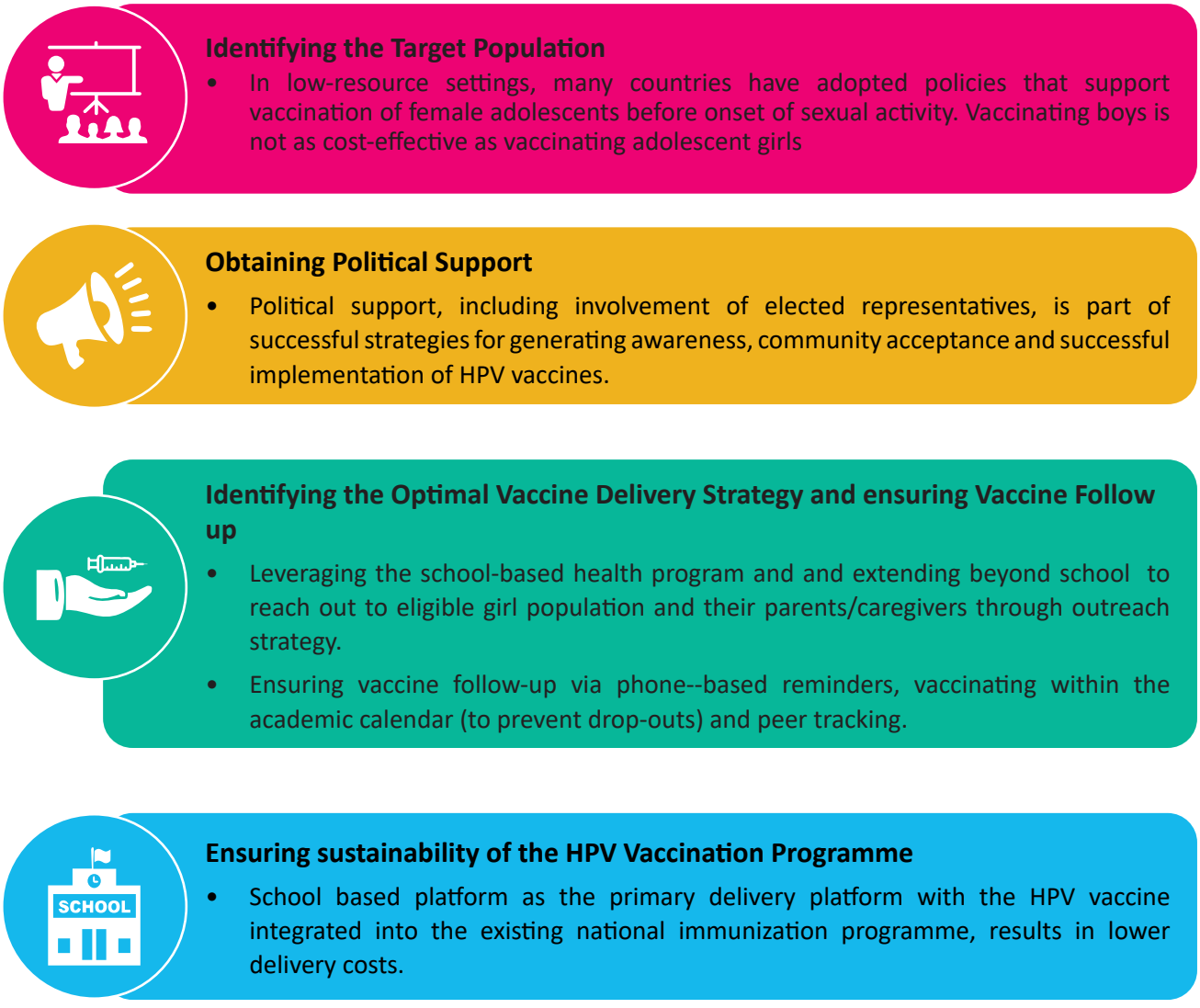
Key Lessons Learnt

Lessons learnt from the country's prior vaccination campaigns—such as Measles and Rubella campaign (MR- 9 months - <15 years), Polio campaign and Intensified Mission Indradhanush (IMI) campaigns, JE campaign (1-15 years) and COVID-19 vaccination campaign (12 years and above) have been reviewed. These campaigns varied in vaccine types, target age group, campaign schedules and geographies. Each campaign and its strategy has brought important learning to take forward. The learnings from these campaigns have been effectively leveraged for HPV vaccination campaign, wherever applicable. Global experiences have also been reviewed to capture wide range of potential challenges and possible solutions.

KEY LESSONS FROM GLOBAL HPV VACCINE INTRODUCTION

The HPV Vaccine Introduction across the globe has brought forth some key lessons that have helped in designing and implementation of the HPV vaccination strategy. (Figure 20).

Figure 20: Key lessons learnt during global HPV vaccine introduction



Limited knowledge of HPV and its Vaccine and concerns about Stigma and Safety

- The primary reason for vaccine acceptability was its effectiveness and protection against cervical cancer.
- Approaching wide range of target audience (girls, parents, teachers and key influencers) through appropriate sensitization and advocacy efforts.
- Addressing misinformation about vaccine's preventive health benefits through interactive communication with parents; social mobilization and the community.

Cost barrier

- Interventions based solely on financial incentives improved HPV vaccination coverage but did not contribute to sustained vaccine uptake.

EXPERIENCE AND LEARNINGS FROM OTHER VACCINATION CAMPAIGNS IN INDIA

Table 2: Experience and Learnings from Other Vaccination Campaigns in India

 **Intersectoral Coordination**	• Collaboration with the Education Department, Women and Child Development (WCD), and other line departments, along with programmes such as RBSK and other line departments in operational planning, generating awareness and beneficiaries mobilization for improving vaccine coverage. (Sikkim and Punjab HPV vaccination campaign, MR campaign, Td vaccination campaign and COVID-19 vaccination programme) • Sensitization meeting on HPV vaccination were conducted for program managers, along with the training of school principals, headmasters and nodal teachers, sensitization meeting for PRI members at village level, religious leaders (Sikkim and Punjab HPV vaccination campaign).
 **Demand generation**	• Media sensitization workshops were organized at the state and district level to sensitize representatives from print and electronic media regarding HPV vaccination, address the existing myths in the society, respond to asked questions, and the role of media in spreading awareness (Sikkim and Punjab HPV vaccination campaign) • WhatsApp was used as a communication platform, which proved to be a benchmark for communication to track the missed beneficiaries (Sikkim HPV vaccination campaign). • Involving teachers in spreading awareness resulted into optimum coverage (Sikkim and Punjab HPV vaccination campaign). • District Communication Core Group was constituted, comprising of DIO, Director (HRDD), District Program Manager (NHM), and Health Educator, to increase demand (Sikkim HPV vaccination campaign). • Mothers' meetings were conducted during the VHND sessions, media sensitization workshop, awareness generation speeches during gram sabha meetings, distribution of IEC material (leaflet) at newspaper shops, milk-shop and taxi stand counter, as well as miking at major places, markets and villages (Sikkim HPV vaccination campaign).

	• Advocacy visits to private schools which refused to participate in the campaign for discussing the benefits of HPV vaccine (Sikkim HPV vaccination campaign). • Parent-Teachers' Association meetings were conducted to generate awareness regarding HPV vaccination (Sikkim and Punjab HPV vaccination campaign). • Official launch ceremonies conducted at state, district, and several block levels which was covered by the media (Sikkim HPV vaccination campaign). • Follow-up visits were conducted to houses of girls left unvaccinated due to absenteeism, sickness, or refusals (Sikkim and Punjab HPV vaccination campaign). • Media briefings were conducted to highlight achievements and outline the way forward. • Pre-recorded messages about HPV vaccination from medical professionals were delivered to parents of target beneficiaries through Edusat Society during parent–teacher meetings to create awareness among parents and teachers. (Punjab HPV vaccination campaign). • Strong emphasis was given on effective communication and public engagement with parents and schools, health professionals, community leaders and the media, to build trust, address vaccine concerns, and support vaccine acceptance (Sikkim HPV vaccination campaign). • Need-based IEC materials were developed at the national level, which were customized for local settings. (Sikkim and Punjab HPV vaccination campaign, MR campaign and COVID-19 vaccination programme). • Engagement with adolescents and youth volunteers was carried out for demand generation (Sikkim HPV vaccination campaign).
 **Service delivery**	• Bottom-up microplanning was conducted at sub-district level, which entailed information about schools (government, government-aided, and private), list of beneficiaries (school and class wise), estimation of session wise logistics, composition of vaccination and supervisory teams, and monitoring plan for officials (Sikkim and Punjab HPV vaccination campaign, MR campaign, JE Campaign). • School based approach adopted for reaching children in the target age group (HPV vaccination campaign in Sikkim, MR campaign, COVID-19 Vaccination campaign). • The activity was started in schools for initial weeks (week 1st/2nd) followed by outreach sessions in week 3 and sweeping activity during the week 4 (MR Campaign, JE Campaign). • Health facility staff were mobilized to schools to administer the vaccine during the school campaigns. (Sikkim HPV vaccination campaign, MR campaign). In Punjab, eligible girls were mobilized to health facilities from the schools. • Facility-based and outreach sessions were conducted following the school-based campaign to reach the missed and out-of-school beneficiaries through mobile sessions for hard-to-reach population (Sikkim HPV vaccination campaign, MR campaign). • School vehicles and ambulances were kept on standby in most communities during the campaign for transporting any serious or severe AEFI cases. • Sufficient funds were allocated for training of health workers and teachers. • Mid-day meal was offered to all beneficiaries in the government schools before vaccination and officials from the Departments of Health and HRD monitored session sites to ensure that all target girls received the vaccine (Sikkim HPV vaccination campaign).

	• A special counterfoil card was used to track beneficiaries for the second dose of the vaccine. (Sikkim HPV vaccination campaign). • Standard reporting forms were developed for enumerating target population, monitoring the progress and reporting. (Sikkim HPV vaccination campaign) • Targeted training was organized for officials, school management committees, principals and teachers, District Immunization Officers, Medical Officers, Cold Chain Handlers, Auxiliary Nurse Midwives, and Accredited Social Health Activist workers. Detailed training was provided to vaccinators and medical officers on recognition, management, and reporting of Adverse Events Following Immunization (Sikkim and Punjab HPV vaccination campaign). • Key learnings from CoWIN were leveraged in the programme implementation, including session planning, beneficiary registration, bulk uploading, slot booking, digital certification, reminders, dropout tracking, and coverage reporting (COVID-19 vaccination programme). • Inventory management and real-time stock visibility of doses and syringes, along with temperature monitoring, were ensured through eVIN. • Preparedness assessment were conducted at all levels (State, District, Planning units and Schools) using a standard checklist (Sikkim HPV vaccination campaign). • AEFI management protocols were followed (Sikkim and Punjab HPV vaccination campaign). • Head count survey, due listing of unvaccinated and under-vaccinated were carried out (IMI). • Resource mobilization (hired vaccinators), additional sessions, Mobile teams and special teams for vaccination in hard-to-reach areas (IMI, Polio campaign). • Booth activities followed by house to house (mop up rounds) in Polio campaign.
 **Monitoring and supervision**	• High level of political and administrative ownership was ensured (Sikkim and Punjab HPV vaccination campaign, COVID-19 vaccination campaign and MR campaign). • Establishment of multi-level governance mechanisms to oversee and guide the campaign strategy (COVID-19 Vaccination campaign). • A robust mechanism for program oversight was implemented through State Technical Advisory Group, State Steering committee, STFI, DTFI and BTFI before each round. (Sikkim and Punjab HPV vaccination campaign, MR campaign). • Strong supervision and monitoring were conducted from the government officials at all levels (Sikkim and Punjab HPV vaccination campaign, MR campaign and COVID-19 vaccination programme). • School records were reviewed to ensure that all target beneficiaries were vaccinated (Sikkim HPV vaccination campaign). • Random checks were carried out for finger marking in the schools (Sikkim HPV vaccination campaign).

The above-listed strategies have been considered into the current operational guidelines for the HPV vaccine introduction in India.

Chapter 4
Strategy for Roll Out of HPV Vaccination Campaign

CHAPTER 4

Strategy for Roll Out of HPV Vaccination Campaign

IMPLEMENTATION STRATEGY FOR THE CAMPAIGN ROLL-OUT

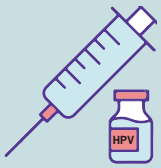
The Human Papillomavirus (HPV) vaccine is being introduced through a campaign-mode strategy implemented over a three-month period, targeting a single-age cohort of 14-year-old girls. A 14-year-old girl is defined as one who has celebrated her 14th birthday but has not yet celebrated her 15th birthday. The campaign follows an off-label single-dose schedule recommended by WHO and NTAGI.

As per the Registrar General of India (RGI) estimates 2021, the annual target population for girls aged 14 years across the country is approximately 1.2 crore. **The HPV vaccination is voluntary and obtaining consent from the parent/ guardian is mandatory before vaccination of girls. Vaccination will be done using parental/ guardian consent on U-WIN, if there is no internet or mobile network access, consent may be obtained on a hard copy as per the prescribed format.**

All eligible girls will be vaccinated at designated **government health facilities only** – Ayushman Arogya Mandir (AAM)-Primary Health Centres (PHCs), Community Health Centres (CHCs), Sub-District Hospitals (SDHs), District Hospitals (DHs), and Government Medical Colleges and Hospitals (GMCHs) – that have a Cold Chain Point (CCP) as per eVIN, dedicated medical officer for AEFI management, internet connectivity, printer, and desktop/laptop. The campaign will run for three months, with vaccines available daily. The sessions may be conducted as per the micro-plan, with flexible timings, generally from 9:00 A.M. to 2:00 P.M., or as decided by State/Union Territory (UT) based on local need. However, State/UT may decide the session time and may conduct the vaccination on public holidays and weekends as per the local need. The digital U-WIN platform will be used for registration, recording and reporting.

During the three-month campaign, HPV vaccination will be conducted separately from routine immunization (RI) sessions, and only the HPV vaccine will be administered by a dedicated vaccination team. After the three-month campaign, the HPV vaccine will be available at the same health facilities on Routine Immunization Days for girls aged 14 years.

Figure 21: Overview of the strategy for HPV Vaccine Introduction

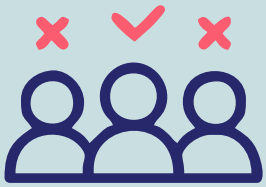


1. Vaccine name and characteristics:

- Gardasil (quadrivalent: 6,11,16,18), +2° to +8°C, freeze sensitive, VVM 30, non-live (recombinant) vaccine, single dose vial.

2. Target Population:

- Girls who have celebrated their 14th birthday but have not yet celebrated their 15th birthday.
- Girls aged 14 years = Approximately 1% of the total population
- Girls who will turn 15 years within 90 days of the campaign launch date are also eligible for vaccination, but only during the three-month campaign period. After the three-month campaign, the HPV vaccine will be available at the same health facilities on Routine Immunization Days for girls aged 14 years.



3. Exclusion criteria:

- Girls with moderate or severe illness should not be administered HPV vaccine until they have recovered.
- Girls who have had an allergic reaction to a previous vaccination or are known to be allergic to yeast to avoid getting vaccinated.
- Pregnancy.
- Girls outside the target age group.
- Girls previously vaccinated: For those who have already received any HPV vaccine (Gardasil/Gardasil-9/Cervarix/Cervavac - one or more doses), their vaccination status to be updated in the U-WIN portal.

4. Delivery platforms:

- Vaccination of all eligible girls will be carried out at **designated government health facilities only** - Ayushman Arogya Mandir (AAM)-Primary Health Centres (PHCs), Community Health Centres (CHCs), Sub-District Hospitals (SDHs), District Hospitals (DHs), and Government Medical Colleges and Hospitals (GMCHs).
- These facilities should have a **Cold Chain Point (CCP) as per eVIN, a dedicated medical officer for AEFI management, internet connectivity, printer, and desktop or laptop.**
- All HPV vaccine session sites to be linked to the nearest 24x7 Health Facility for AEFI management.

5. Campaign Duration:

- A **one-time single-age cohort campaign** will be conducted for a period of **three months at designated government health facilities only**, with the vaccine available daily during the cohort campaign period. This session will be conducted exclusively for HPV vaccination as per the micro-plan, with flexible timings, generally from 9:00 am to 2:00 pm. However, State/UT may decide the session time and may conduct the vaccination on public holidays and weekends as per the local need.
- During the three-month campaign, HPV vaccination will be conducted separately from routine immunization (RI) sessions, and only the HPV vaccine will be administered. After the three-month campaign, the HPV vaccine will be available at the same health facilities on Routine Immunization Days for girls aged 14 years.

6. Dose Schedule, route and site of administration:

- Single dose schedule, 0.5 ml per dose
- Intramuscular (IM), Left upper arm

7. Vaccination Team:

- Vaccinator (ANM/Male HW/LHV/Nurse/CHOs),
- Mobilizer (ASHA/AWW/Link worker/ASHA Coordinator),
- Verifier (Health Facility Staff),
- Volunteer (Field Monitor/Mahila Arogya Samiti member/Jan Arogya Samiti member/health staff)

Your Digital Vaccination Record U-WIN Click to Protect Lives

8. U-WIN:

- HPV vaccination related events will be recorded on U-WIN which is a digital vaccination portal of MoHFW. One can pre-register and schedule an appointment for HPV vaccination on U-WIN or directly walk-in to the Government Health Facility. Vaccination will be done using parental/guardian consent on U-WIN, if there is no internet or mobile network access, consent may be obtained on a hard copy as per the prescribed format.

9. U-Mentor:

- Monitoring at both the session site and in the community will be carried out using the standard form on the U-Mentor application.

Mentor
UIP Monitoring & Mentorship

10. Preparedness assessment tool - NVI Info:

- Readiness of the State, District, and Health Facility for the introduction of the HPV vaccine will be carried out using the standard form on the Preparedness assessment tool (NVI Info).

11. eVIN:

- All vaccine stocks and syringes to be managed and monitored through eVIN.

eVIN
LECTRONIC VACCINE
NTELLIGENCE NETWORK

12. General precautions to be followed to prevent AEFIs

Before Vaccination

- Ensure vaccine recipients are not on an empty stomach at the time of vaccination. Parents should be advised to ensure vaccine recipients have had breakfast or something to eat before their vaccination.
- Arrange for refreshments at the session site for any child who has missed breakfast at home.

During Vaccination:

- To reduce anxiety or syncope during HPV vaccination, provide a squeeze ball in the recipient's right hand and instruct her to squeeze it during vaccination.

After Vaccination

- Ensure recipients wait for 30 minutes after vaccination.
- Arrange for some engaging activities in the observation room to distract girls from post-vaccination pain and anxiety.
- Minimize overcrowding to reduce the chances of stress-related response.

13. Consent:

The HPV vaccination is voluntary and obtaining consent from the parent/ guardian is mandatory before vaccination of girls. Vaccination will be done using parental/guardian consent on U-WIN, if there is no internet or mobile network access, consent may be obtained on a hard copy as per the prescribed format

14. 5 key messages

The vaccinator should provide the following information to the caregivers, before vaccinating the girl:

- A single dose is sufficient to provide protection against HPV infection.
- Wait for 30 minutes after vaccination.
- Minor AEFIs are very common, mild in severity, self-limiting and resolve on their own within 2-3 days. Tab. Paracetamol in age-appropriate doses will provide relief.
- Visit the nearest 24x7 government health facility if any adverse events occur, or call the State/UT helpline number.
- Vaccination certificate can be downloaded from U-WIN portal.

Chapter 5
Core Operational Components

CHAPTER 5

Core Operational Components

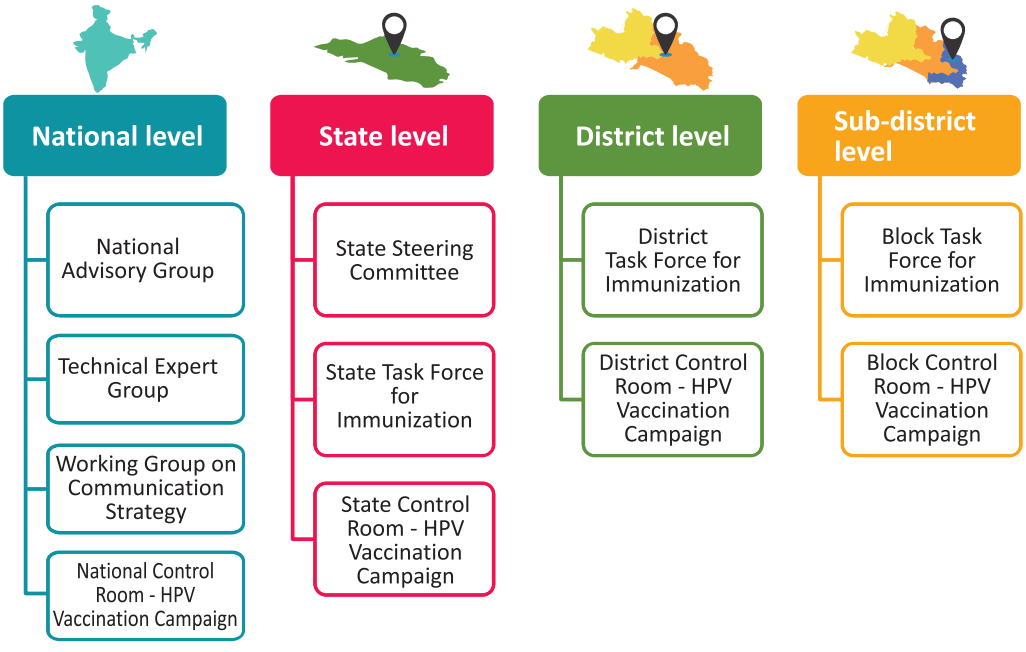
5A. COORDINATION AND HIGH-LEVEL OVERSIGHT (ROLES AND RESPONSIBILITIES)

The highest level of political and administrative ownership, commitment and support needs to be sustained for the successful implementation of the HPV vaccine Introduction. The National, State, and local Governments need to work together, complementing and supplementing each other's strengths.

ESTABLISHING IMPLEMENTATION GROUPS FOR ROLL OUT OF HPV VACCINATION CAMPAIGN

Coordination and participation of concerned Ministries/Departments at all levels are critical for the successful implementation of HPV vaccine Introduction. For this, constitution, activation and sensitization of coordination groups, including concerned ministries/departments and other stakeholders at national, state, district and sub-district levels for all aspects of the vaccine introduction are important. Regular meetings should be organized with clear objectives, agendas, and reports of actions taken from previous meetings. This should address strategic planning, implementation modalities, delineation of roles and responsibilities, review of progress, identification of challenges, formulation of solutions, incorporation of member feedback, and finalization of action points. Minutes of the meetings and action points should be shared with all the group members. The groups should ensure that activities are completed, adhering to guidelines and timelines. The overview of National, State, District and Sub-district level groups involved in HPV vaccine introduction is depicted in Figure 22.

Figure 22: Overview of National, State, District and Sub-district level groups involved in Roll Out of HPV Vaccination Campaign



NATIONAL LEVEL

NATIONAL ADVISORY GROUP (NAG) ON THE ROLL OUT OF HPV VACCINATION CAMPAIGN

National Advisory Group (NAG) is chaired by the Additional Secretary and Mission Director (NHM), Ministry of Health and Family Welfare (MoHFW). The role of the NAG is to:

- Provide oversight and guidance on all aspects of vaccine roll out in India, including operational planning and strategy development, introduction and implementation, cold chain management, vaccine logistics and distribution, preparedness assessment, capacity building, AEFI monitoring and management, communication and media response, and monitoring of program.
- Hold regular meetings involving different ministries for their active involvement and coordination in Roll Out of HPV Vaccination Campaign.
- Orient and engage the Education Department to leverage the UDISE+ portal for providing school-wise line listings along with number of eligible 14-year-old girls, WCD to reach all eligible girls through Mother Groups and Poshan Panchayats, MoRD to leverage the Aajeevika-NRLM network, MoHUA to utilize DAY-NULM networks, Ministry of Minority Affairs to reach Waqf establishments, and other relevant stakeholders to raise awareness about cervical cancer, promote HPV vaccine benefits, generate demand, and mobilize all eligible girls for vaccination (with special focus for out-of -schools girls) in settings such as high risk areas, industrial zones, mining areas, brick klins, migratory set-ups, orphanages, brothels (red light areas), and hostels.
- Review of State/UT preparatory activities in terms of capacity building, microplanning, cold chain preparedness, vaccine and logistic distribution plan, biomedical waste management, AEFI management and communication planning for anticipated for anticipated state specific challenges in terms of geographical terrain, network connectivity and hard-to-reach areas.
- Provide guidance on mobilizing human and other resources from various departments. Personnel with medical or health expertise may be utilized for vaccination, while others may support operations, IEC activities, resource mobilization, and community mobilization.
- Coordinate with States/UTs and regularly review progress on planning, readiness assessment, and implementation of the HPV vaccination program.
- Provide financial norms for the operational cost on three months HPV vaccination campaign.

TECHNICAL EXPERT GROUP (TEG)

A technical expert group is established by the Ministry of Health and Family Welfare (MoHFW) to coordinate the technical aspects of the introduction of the HPV vaccine. It is comprised of officials from the Immunization Division, Adolescent Health Division and Child Health Division of the Ministry of Health and Family Welfare (MoHFW), along with representatives from WHO, UNICEF, JSI, ITSU, ICMR-NCDIR, AIIMS, NCCVMRC, the Department of School Education and Literacy (Ministry of Education), the Ministry of Women and Child Development, and the Department of Legal Affairs (Ministry of Law and Justice).

The role of Technical Expert Group is to meet on a regular basis to:

- Develop Operational Guidelines for the introduction of the HPV vaccine and update it as required once the HPV vaccination program is rolled out.
- Review and document the global and local best practices on HPV vaccination.
- Develop HPV vaccine roll out plan keeping in mind the vaccine supplies, disease burden, opportune timing in the States/UTs.
- Develop an operational strategy for the campaign and assist States/UTs in capacity building, vaccine forecasting and distribution, microplanning, and all activities necessary to ensure effective implementation throughout the rollout.

- Undertake planning related to on preparedness assessment, cold chain management, microplanning, capacity building of health care workers and other stakeholders, communication strategies, AEFI management, and vaccine distribution and logistics.
- Utilize existing portal of Department of School Education and Literacy i.e. Unified District Information System for Education Plus (UDISE+) for line-listing schools and number of eligible girls, aged 14 years in each school.
- Define roles and responsibilities for functionaries at each level and for concerned stakeholders.
- Monitor the progress of States/UTs in the implementation of HPV vaccination initiative.
- Guide on the development of HPV vaccination module on U-WIN and eVIN.

WORKING GROUP ON COMMUNICATION STRATEGY

A Working Group on the Communication Strategy for the introduction of the HPV vaccine is constituted to assure all stakeholder are well informed about the importance of HPV vaccine and its operationalization in the country. This expert group has members from organizations which have experience in developing communication strategies. These include officials from Immunization division, Swastha Nagrik Abhiyan (SNA) division, Adolescent Health Division-RCH, ITSU, UNICEF, COP-Demand, UNDP, Girl Effect, JHPIEGO, and JSI.

The group's responsibilities include:

- Prepare a communication strategy for HPV vaccination in India, that will be used by all States/UTs.
- Guide on the development of communication materials.
- Conduct a desk review of various strategies and advocacy tools used globally in similar programs.
- Prepare a comparative analysis of global campaigns and key learnings relevant to India.
- Highlight the lessons learnt from Indian public health vaccination campaigns like MR, Td, Polio and Covid-19 and key takeaways from HPV vaccination campaign from State of Punjab and Sikkim.

NATIONAL HPV VACCINATION CONTROL ROOM

Apart from the three groups mentioned above, a National HPV Vaccination Control Room will be established within the Ministry of Health and Family Welfare. It will be led by the Additional Commissioner, Immunization Division and include officers and consultants from the division. The Control Room will monitor vaccination coverage, AEFI reporting, stock availability, media coverage, and any crisis, and will document best practices. It will provide daily feedback to ensure smooth and effective implementation of the initiative.

STATE-LEVEL

STATE STEERING COMMITTEE (SSC)

At the state level, the State Steering Committee (SSC) which is established under the chairpersonship of the State Chief Secretary will provide guidance and leadership for HPV vaccine roll out at the state level. The role of the SSC is to ensure effective planning, coordination, and resource mobilization, including human resources, as well as convergence of all government departments and partner agencies at the state level. The SSC will provide essential leadership among the departments involved and review progress. The SSC will provide oversight and guidance on all aspects of HPV vaccine roll out in the state, including preparation and implementation phases, as outlined below:

1) Preparatory phase

- Ensure active engagement of departments like Education, Women and Child Development, Information and Broadcasting, Ayush, Defence, Railways, Youth Affairs and Sports, Housing and Urban Affairs, Rural Development, Social Justice and Welfare, Tribal Affairs, Minority Affairs, Panchayati Raj, Labour and Employment, etc. for intersectoral coordination, and smooth implementation of the HPV vaccination campaign.

- Coordinate with the education department to provide district-wise line listing of all schools (private and government) with the number of eligible girls aged 14 years using UDISE+ portal and to plan PTM date for sensitization of parents/beneficiaries on HPV vaccination. This information is to be filled with in a specified microplanning format by DEO and to be shared with DIO.
- Coordinate with WCD to reach all eligible 14-year-old girls, engaging Mother Groups and Poshan Panchayats to ensure HPV vaccination messages reach the target population.
- Engage community networks, including School Management Associations, Aajeevika-NRLM and DAY-NULM program networks, Waqf establishments, and other relevant stakeholders, to raise awareness about cervical cancer, promote HPV vaccine benefits, generate demand, and mobilize all eligible 14-year-old girls for vaccination.
- Review regular preparatory meetings of the State Task Force For Immunization (STFI), District Task Force for Immunization (DTFI) and Block Task Force for Immunization (BTFI) are held.
- Ensure that adequate and timely resources are available for preparatory activities and operationalization of the rollout.
- Identify and activate a Helpline number for the information about the HPV vaccination campaign and for AEFI management.
- Compile feedback from preparedness assessment and facilitate necessary follow up actions.

2) Implementation Phase

- Provide an oversight on operational aspects of HPV vaccine introduction.
- Ensure active involvement of all concerned departments and stakeholders as per their pre-defined roles in the implementation of the HPV vaccine introduction.
- Review of coverage of HPV vaccine and guidance to STFI for corrective actions.
- May institute reward/ recognition mechanisms for best performing district/block/urban area/ ward etc.

STATE TASK FORCE FOR IMMUNIZATION (STFI)

The State Task Force for Immunization (STFI) will lead planning and implementation activities in the state. The Health Secretary / Mission Director will chair the STFI and the State Immunization Officer will serve as the Member–Secretary. State-level representatives of the State Programme Management Unit- NHM, State RMNCH+A partners, and representatives from other key departments such as Education, WCD, Housing and Urban Affairs, Social Welfare, Private Schools Association, Integrated Disease Surveillance Programme (IDSP), Panchayati Raj Institutions (PRIs), Transport, Media, Information and Public Relations, Minority Affairs, Aajivika-NRLM, ULBs, development partners working in Immunization and professional bodies like FOGSI, IMA, AOGIN India, cancer society, IAP, State RMNCH+A partners, religious leaders, etc. are to be member of this committee.

The STFI should be expanded by including relevant stakeholders for inter-departmental coordination. This should be effected through a new notification issued by the State. The role of the STFI is to:

Preparatory Phase:

- Prepare a training plan for all relevant staff to ensure completion of trainings at all levels in a timely manner.
- Provide guidance and set timelines for districts to plan and implement the introduction of the HPV vaccine.
- Ensure intersectoral coordination and optimal utilization of resources from the government and partners.
- Leverage the UDISE+ Portal of the Ministry of Education for line-listing of schools along with the total number of eligible girls aged 14 years for conducting Parent Teacher Meeting.

- Coordinate with WCD to leverage interventions for all eligible girls through Mother Groups and Poshan Panchayats to promote HPV vaccine uptake among the target population.
- Ensure active participation of professional bodies such as FOGSI, IMA, IAP and cancer societies.
- Provide technical and logistical support to plan, implement, monitor, and evaluate the HPV vaccination activities at the district level.
- Identify and activate a helpline number for the information about HPV vaccination campaign and AEFI management.
- Communicate with District Magistrates (DMs)/District Collectors (DCs) to convene meetings of the District Task Forces for Immunization (DTFI).
- Review the state's preparatory activities related to implementation strategy, training plan, microplanning, cold chain preparedness, vaccine and logistic distribution plan, biomedical waste management, AEFI management and communication planning to address state-specific challenges such as geographical terrain, network connectivity, and hard-to-reach areas. Revisit best practices and innovations from the MR campaign to address challenges and ensure good coverage.
- Identify vaccinators and hire alternate vaccinators to minimize disruption of Routine Immunization services during HPV vaccination campaign. Any authorized individual trained to administer injections may be considered a potential vaccinator.
- Ensure that State and District AEFI Committee members are oriented on AEFI surveillance and that regular meetings are conducted.
- Direct districts to undertake headcount surveys to prepare due lists of all eligible girls aged 14 years and to complete microplanning, including communication planning.
- Identify and engage influencers for community engagement and social mobilization.
- Ensure an adequate number of IEC materials (as per approved prototypes) are printed and disseminated to districts in a timely manner.
- Finalize communication planning well in advance of the HPV Vaccine introduction to create awareness and a conducive environment in the state.
- Develop a media plan to address rumor-mongering and respond appropriately to the media regarding program implementation, progress, safety, and AEFI.
- Ensure early tracking of social media and other platforms for potential misinformation and rumors related to the HPV vaccine that could affect acceptance.
- Ensure timely release of funds and dissemination of financial guidelines to districts.
- Develop a supervision plan for districts to oversee implementation, ensure accountability, participate in DTFI meetings, assess district preparedness, monitor HPV vaccination sessions, and conduct community-level monitoring.

Implementation Phase:

- Monitor districts to ensure the overall implementation of HPV vaccine initiative in accordance with the national guidelines.
- Deploy senior state-level health officials to designated districts to oversee implementation, ensure accountability, participate in DTFI meetings, assess district preparedness, monitor HPV vaccination sessions, and conduct community-level monitoring.

- Regularly coordinate with districts and urban local bodies to review and resolve issues related to training, microplanning, vaccine and logistics management, human resources, waste management, AEFI and IEC.
- Ensure reporting and timely investigation of all AEFIs cases and expedite causality assessments.
- Ensure coordination with partners and allocate result-based tasks. Ensure orientation and active involvement of professional bodies such as FOGSI, IAP, IMA, AOGIN India, Cancer Societies and representatives from relevant medical and public health institutions.

- Communicate advisories issued by the National level to districts and ensure their proper implementation.

STATE CONTROL ROOM ON HPV VACCINATION

Apart from the SSC and STFI, each state will establish a State Control Room, an operational unit responsible for overseeing and monitoring the implementation of the HPV vaccine introduction activities.

The State Control Room under the chairpersonship of the State Immunization Officer (SIO), with members including the State Cold Chain Officer, partner representatives, and local development partners will oversee planning, coordination, monitoring, and implementation of the HPV vaccination campaign, sharing daily reports with the National Control Room.

Its responsibilities include monitoring the preparedness, human resources, vaccine and cold chain management, logistics, intersectoral coordination, resource utilization, crisis management, and issuing necessary circulars to districts, as well as providing feedback to the SSC and STFI on progress and challenges. The control room will also ensure the State AEFI Committee meets before the campaign to review surveillance preparedness and expand AEFI reporting networks in medical colleges, private and public hospitals.

DISTRICT LEVEL

DISTRICT TASK FORCE FOR IMMUNIZATION (DTFI)

District Task Force for Immunization (DTFIs) should be sensitized under the chairpersonship of the District Collector (DC)/District Magistrate (DM) in each district. The District Collector/Magistrate shall be the **Focal Point** in the district for the planning, coordination, implementation, monitoring and review of HPV vaccination campaign. The Chief Medical Officer (CMO) / District Immunization Officer (DIO) should be the Member–Secretary. District-level officers from the district administration, health department including District Programme Management Unit (DPMU) members, **District Education Officer,** DPMU of District Program Officer (DPO), Aajeevika-NRLM, media, police, transport, PRI, Minority Affairs, District Urban Development Authority (DUDA), local bodies like municipalities, councils, etc. professional bodies, and partner organizations along with representatives from religious groups and opinion leaders shall serve as the participating members of DTFI.

DTFI may be expanded by including relevant stakeholders for the inter-departmental coordination. This should be effected by issuing new notification from DM/DC office on the expansion of task force.

The District Task Force (DTF) shall initiate discussions and planning for the HPV vaccination campaign prior to rollout. Meetings may initially be held on a monthly basis, with the frequency increased to fortnightly meetings two months before the campaign, and further to weekly meetings during the month preceding the campaign and continuing until its conclusion.

Preparatory phase:

- Develop training plan and ensure completion of training at all levels for all stakeholders.
- Ensure effective intersectoral coordination with the Education Department, WCD Department, NRLM–SHGs, immunization partner agencies, and professional bodies to disseminate accurate messages on cervical cancer and HPV vaccination for awareness generation, demand creation, and mobilization of all eligible 14-year-old girls.
- Ensure active participation of professional bodies (IMA, IAP, FOGSI), local CSOs, cancer societies, Rotary and Lions clubs.
- Engage District level School Management Associations and Committees.
- Leverage the UDISE+ Portal of the Ministry of Education for line-listing of schools along with the total number of eligible girls aged 14 years. This information is to be filled in a specific microplanning format by DEO and to be shared with DIO.
- Coordinate with WCD to leverage interventions for all eligible girls and use Mother Groups and Poshan Panchayats to promote HPV vaccine uptake among the target population.
- Provide technical and logistical support to plan, implement, monitor, and evaluate the HPV vaccination activities at the district level.
- Communicate with Sub-Divisional Magistrates (SDMs) to conduct meetings of the Block Task Forces for Immunization (BTFI).
- Review the District's preparatory activities related to implementation strategy, operational planning - macro and microplanning, cold chain preparedness, vaccine and logistic distribution plan, communication planning, and strategies to address district-specific challenges such as geographical terrain, network connectivity, and hard-to-reach areas.
- Prepare a list of health facilities for HPV vaccination sessions as per guidelines, ensuring session site must have a CCP as per eVIN, dedicated medical officer for AEFI management and internet connectivity, and a desktop/laptop with printer.
- Ensure mapping of HPV vaccination session sites with 24x7 health facilities that can provide emergency care, ensuring swift response to any medical emergencies.
- Identify 24x7 private hospitals and clinics and sensitize them on HPV vaccination campaign if needed as per local requirements. Ensure that District AEFI Committee members are oriented on AEFI surveillance and that regular meetings are conducted.
- Identify and engage influencers for community engagement and social mobilization.
- Ensure an adequate number of IEC materials (as per approved prototypes) are disseminated to Blocks/ Planning units in a timely manner.
- Finalize communication planning well in advance of the HPV Vaccine introduction to create awareness and a conducive environment in the district.
- Develop a supervision plan to oversee implementation and ensure accountability, including participation in BTFI meetings, assessment of health facility preparedness, monitoring of HPV vaccination sessions, and conducting community-level monitoring.
- Ensure dissemination of financial guidelines to all the blocks.

Implementation phase:

- Continuously monitor HPV vaccination coverage during the campaign and implement corrective measures as required.
- Respond promptly to adverse media reports or misinformation regarding the HPV vaccine.
- Ensure missed beneficiaries get vaccinated at the designated health facilities.
- Deploy monitors/observers to supervise vaccination sessions and conduct Rapid Convenience Monitoring (RCM).
- Hold daily review meetings to track progress and address issues.
- Coordinate regularly with blocks to resolve challenges related to, vaccine and logistics management, human resources, waste management, AEFI, and communication.
- Advise to involve Community Health Officers (CHO's) in the vaccination team and for the monitoring and supervision of the vaccination campaign.

Urban Task Force (UTF)/City Task Force (CTF)

In urban areas where the health services are under the ambit of Municipal Corporations, Urban/City Task Force functions similarly to the lines of District Task Force. It will be chaired by Municipal Commissioner, with the Municipal Health Officer/Chief Medical Officer serving as the Member Secretary. The urban task force will have similar composition and activities as District Task Force.

DISTRICT CONTROL ROOM-HPV VACCINATION

Apart from the District Task Force for Immunization (DTFI), a District Control Room should be set up at the district level, led by the District Immunization Officer (DIO), to oversee and monitor the implementation of the HPV vaccination initiative. Other members of the District Control Room will include District Program Officers, urban nodal officer, the nodal person for cold chain, and partner representatives working in the district. The control room will monitor the preparedness of blocks, health facilities, and urban areas on a day-to-day basis, oversee the implementation of the HPV vaccination initiative by reviewing the daily coverage, and provide feedback to the State Control Room. It will also monitor vaccine and cold chain management, human resources, logistics, intersectoral coordination, resource utilization, crisis management, and issue necessary advisories to the block level.

The District Control Room will ensure meetings of the District AEFI Committee, track the inclusion of medical colleges, private and public hospitals in the AEFI reporting network, and involvement of District AEFI committee in case investigations, when needed.

BLOCK LEVEL

BLOCK TASK FORCE FOR IMMUNIZATION (BTFI)

The Block Development Officer (BDO) serves as the Chairperson of the Block Task Force for Immunization (BTFI), with the Block Medical Officer In-charge acting as Member–Secretary. Other members include the ACMO/Dy CMO, Block Education Officer, CDPO from WCD, representatives from Minority Affairs, NRLM, media, police, ULB, PRI, and immunization partner agencies. The BTFI can be expanded to include additional stakeholders for enhanced inter-departmental coordination through a formal notification. Under the leadership of the BDO, the Block Task Force is responsible for supporting, supervising, monitoring, and ensuring the effective implementation of the HPV vaccine introduction within the block.

Block Task Force Meetings

The Block Task Force (BTF) should start HPV vaccination planning before rollout, holding monthly meetings initially and increasing to fortnightly two months prior to the campaign.

Preparatory Phase:

- Develop a comprehensive training plan and ensure timely completion of trainings for Medical Officers, Planning unit staff, Cold Chain Handlers, ANMs, CHOs, Supervisors, AWWs, and ASHAs.
- Ensure timely sensitization, and orientation of all relevant groups:
  - School Management Committees, Principals, and Headmasters
  - Parents during PTMs at schools
  - WCD department including AWWs and AWHs
  - Chairpersons and counselors of ULBs and PRIs
  - Religious leaders
  - Engage Self-Help Groups under Aajeevika NRLM
- Coordinate with WCD to reach all eligible girls through Mother Groups, Poshan Panchayats, and other interventions.
- Ensure conducting head count survey at least one month prior to the launch and prepare a due list of all eligible girls aged 14 years (those who have celebrated their 14th birthday but have not yet celebrated their 15th birthday) covering all villages, hamlets, tolas, wards, mohallas, HRA sites, industries, mining areas, brick kilns, migratory setups, orphanages, hostels, and correction centres. Review and submit the micro-plan to the District Immunization Officer (DIO).
- Ensure distribution of information cards (Refer to Annexure 6) to beneficiaries/caregivers by the surveyor and guide parents on registration in U-WIN portal.
- Identify health facilities for HPV vaccination sessions as per guidelines, ensuring session site must have a CCP as per eVIN, dedicated medical officer for AEFI management, internet connectivity, and a desktop/ laptop with printer.
- Map HPV vaccination session sites with 24x7 health facilities that can provide emergency care, ensuring swift response to any medical emergencies.
- Identify 24x7 hospitals and sensitize them on HPV vaccination campaign if needed as per local requirements.
- Ensure mapping of human resources; identification of waiting, vaccination, and observation rooms/areas; availability of adequate vaccine supplies and syringes; logistics and proper cold-chain management; availability of AEFI and anaphylaxis kits; biomedical waste management; and receipt of IEC materials.
- Review and monitor the planning unit communication plan and submit to DIO.
- Advocate with key stakeholders, including local media, to gain support for the campaign.
- Distribute IEC materials and ensure proper display.
- Identify and engage local influencers for community engagement and social mobilization.
- Conduct demand generation activities to raise awareness about cervical cancer and HPV vaccination and to address myths and disbelief.

Implementation phase:

- The Block Task Force may consider inauguration of vaccination drive by eminent personalities, elected representatives or senior officials, to provide visibility and stimulus to the campaign.
- Address issues related to vaccine and logistics management, human resources, waste management, AEFI, IEC, and any other emerging challenges.
- Monitor vaccine coverage on daily basis and implement mid-course corrective actions as needed.
- Ensure registration, recording and reporting is done on the U-WIN portal.
- Ensure immediate response to any reported AEFI and mapping of 24x7 AEFI management centers to every HPV vaccination session site.

- Support in any crisis communication.
- Review and monitor plans to vaccinate the missed beneficiaries.
- Maintain close interaction with key stakeholders, including media personnel for improving campaign visibility.
- Supervisors/monitors should conduct monitoring of session sites during the campaign and community-level monitoring one month after campaign initiation.
- Leverage RBSK for Human resource and mobility support.
- Involvement of Community Health Officers (CHOs) in the vaccination team and for monitoring and supervising the vaccination campaign.

BLOCK CONTROL ROOM-HPV VACCINATION

Apart from the Block Task Force, a Block Control Room should be set up at the block level, led by the Block Medical Officer (BMO) or designated nodal officer, to oversee and monitor the implementation of the HPV vaccination initiative at the block and Health Facility level. Other members of the Block Control Room may include the Block Programme Officer, PHC in-charges, nodal persons for cold chain, and representatives of partner agencies working in the block. It will collate, compile, and report daily coverage to the District Control Room.

5B. OPERATIONAL PLANNING (MACROPLANNING AND MICROPLANNING)

- **Macroplanning:** The Operational plan will provide a broad strategic framework for the Roll Out of HPV Vaccination Campaign. It follows a top-down approach, from the national level to the state level and then to the district level. This includes development of guidelines including communication strategy, estimation of targets, prioritization of States/UTs, vaccine and syringes requirement, indent placement, tender process, cold chain assessment and augmentation, preparation of training and monitoring tools, system readiness, establishment of monitoring mechanisms, and overall oversight, and review of progress.
- **Microplanning:** The process of microplan preparation starts using a bottom-up approach and should take into account the ground realities in different blocks/planning units and urban areas. The microplanning should include Head Count Survey, Due-listing, estimating target population, mapping of Human Resources, vaccine/logistic calculations and cold chain plan; demand generation and communication activities; training and supervision; monitoring and evaluation and AEFI surveillance.

MACROPLANNING

The operational plan will provide broad strategic framework for smooth implementation of HPV vaccine introduction. Key activities to be undertaken as part of the macroplanning at various levels are as follows:

NATIONAL LEVEL

- Develop the Operational Guidelines and Communication Strategy Guidelines for the HPV vaccine introduction.
- Estimate targets for each state/UT for HPV vaccination campaign.
- Prioritize States/UTs for the Roll Out of HPV Vaccination campaign based on the incidence of cervical cancer, governance, availability of HPV vaccine, logistics and resources, estimated targets and state/UTs preparedness.
- Develop training plan and advocacy material, standard communication materials prototypes, microplanning formats, reporting formats, monitoring formats, preparedness assessment checklist and data collection tools.
- Provision the HPV module on U-WIN portal for registering, recording and reporting of HPV vaccination events.
- Provision the HPV module on eVIN for recording and reporting of HPV vaccine stocks.
- Establishing National Control Room for monitoring the daily activities.
- Provide guidelines for management of AEFIs and reporting of minor, severe and serious AEFIs through the SAFEVAC module in U-WIN.
- Share operational guidelines, campaign dates, and budgetary provisions for operational costs; share training plans and materials; ensure readiness assessment prior to the campaign; and outline the technical assistance plan, including resource deployment at the State and District levels.
- Conducting training for each state and district level officials on HPV vaccination campaign.
- Monitor and review progress of the implementation activities and coverage during the campaign phase.
- Facilitate any mid-course correction, whenever required.
- Develop the Supervision Plan, outlining the role of the supervisors.
- Macroplanning at National and State level should include oversight on supply and distribution of vaccine and logistics.

STATE LEVEL

- Develop a strategy for the roll out of HPV vaccination program.
- Develop a plan on resource requirements based on vaccine doses, other logistics, district-wise targets, past experiences of campaign activity and communicate the same to the national level.
- Develop a plan for state-level coordination meetings and training workshops, including Training of Trainers.
- Set targets for each district for HPV vaccination campaign.
- Establish appropriate intersectoral sub-committees for operations and social mobilization.
- Establishing State Control Room for monitoring the daily activities.
- Develop a strategy and plan for advocacy and communication, in line with the national communication strategy guidelines.
- Translate IPC / IEC materials including key messages and FAQs, Information booklets, Posters, Banners, based on the prototypes received from the national level and develop a distribution plan.
- Communicate with districts regarding training plan, introduction strategy, financial norms for operational cost, vaccine and logistics distribution plan, campaign dates and technical assistance plan including district-level resource deployment.
- Identify and deploy state-level supervisors and external monitors, and develop a plan to supervise district preparedness, monitoring of the session and for Rapid Convenience Monitoring (RCM) and ensure mid-course corrections, and document lessons learned from the campaign.
- Define the roles and responsibilities of other departments and development partners.
- Develop a plan involving State AEFI Committee to expedite causality assessment of reported and investigated serious and severe AEFIs cases at the state level, assist districts in case investigations (when needed), monitoring district AEFI committee meetings, and ensure inclusion of medical colleges and public and private hospitals in the AEFI surveillance reporting network in each district.
- Identify a helpline number to provide information regarding 24x7 AEFI management centres, and first and second referral hospitals in all districts.

DISTRICT LEVEL

- Plan/organize a DTFI meeting chaired by the District Magistrate (DM) for the Roll Out of HPV Vaccination campaign.
- Develop a plan on resource requirements based on vaccine doses, logistics, funds, HR, session sites, days of the campaign, past experience of campaigns and communicate the same to the state.
- Develop a strategy for the roll out of HPV vaccination program.
- Compile block wise, estimated availability and requirements of the human resources, vaccines logistics, IEC materials etc.
- Develop a plan for capacity building, coordination meetings with other departments, and planning workshops.
- Develop a strategy and plan for advocacy and communication in line with the national communication strategy document on HPV vaccination.
- Develop an adaptation of the training curriculum, agenda and training materials disseminated from the state level.
- Establishing District Control Room for monitoring the daily activities.
- Identify available and required cold chain space.
- Define the roles and responsibilities of other departments and development partners.
- Communicate with blocks about the campaign dates, operational guidelines, budgetary provisions for operational cost, training plan and material and technical assistance plan including deployment plan for resources at blocks.

- Ensure that standard formats, training materials and communication materials are shared with the planning units well in time.
- Identify and deploy district-level supervisors and external monitors, and develop a plan to supervise sub district level preparedness, monitoring of the session and for Rapid Convenience Monitoring (RCM) and ensure mid-course corrections, assess and review the progress, and document lessons learned from the campaign.
- Ensure the District AEFI Committee meets before and during the campaign as frequently as needed to monitor the inclusion of medical colleges, public and private hospitals in the AEFI reporting network, linkage of session sites with 24x7 AEFI management centres, and other capacity building activities for investigation within 10 days of notification in all cases.

MICROPLANNING

The preparation of the microplan shall follow a **bottom-up approach**, considering the ground realities across all blocks, planning units, functional units, last service delivery points, and urban areas. Microplanning should commence **at least one month prior to the launch of the HPV vaccination campaign.** The microplanning process should begin with a sensitization meeting involving ANMs, CHOs, AWWs and ASHAs at the block or planning unit level.

Reaching The Unreached

A micro-plan should list all areas including HRAs. The high-focus areas / populations include:

- Hard-to-reach areas due to difficult geographic location (forest, tribal, far flung isolated pockets, tea estates, riverine islands).
- Unserved or underserved areas or areas with shortage / prolonged vacancy of health workers.
- Urban areas, especially unauthorized slums, makeshift huts, girls in juvenile homes, observation home, remand home, orphanages, ashrams, blind schools, girls living in hostels, red light areas, floating street girls as well as peri-urban new settlements.
- Migratory populations, or internally displaced, homeless.

Key strategies for covering the high-risk areas are as follows:

- Understanding and overcoming cultural, educational, logistical, political, linguistic, ethnic or religious barriers that prevent underserved populations from bringing their ward for immunization.
- House-to-house interpersonal communication with caregivers is critical.
- Deployment of extra supervisors/monitors and conducting extra community monitoring.

A comprehensive micro-plan shall ensure:

- **Inclusion of all areas -** all Villages / Hamlets/ Tolas/Ward/Mohalla/HRA Sites/Industry set up/Mining area/ Brick kiln area/Migratory setup/Orphanage/Hostels/Correction Centre/Red Light Areas under the Sub centre/ANM area.
- **Identification of all eligible beneficiaries** through a thorough headcount survey.
- **Identify health facilities** for HPV vaccination that have a CCP as per eVIN, a dedicated medical officer for AEFI management, internet connectivity, a desktop/laptop with printer.
- **Linkage** of HPV vaccination session site to 24×7 health facilities for AEFI management.
- **Plan the number of sessions** for the three-month (90 days) campaign based on the projected injection load.
- **Tag the target population** from non-session-site health facilities to the corresponding HPV vaccination session sites health facilities.
- **Form vaccination teams of four members including vaccinator, mobilizer, verifier and volunteer** with detailed rosters.

- **Prepare comprehensive logistics plans** covering all required supplies and resources.

The key points to be noted while developing the microplan are summarized in Table 3.

Table 3: Compilation of Microplan Templates

<table>
<tr><th>Activity - Item</th><th>Details</th><th>Calculation Method</th></tr>
<tr><td>Target population for HPV vaccination campaign</td><td>Estimates</td><td>1% (approximately) of the total population
For example: Village of 1,000 population -> 10 girls aged 14 years
Sub-centre with 5,000 population --> 50 girls aged 14 years
PHC with 30,000 population --> 300 girls aged 14 years</td></tr>
<tr><td colspan="3">Calculation of resources</td></tr>
<tr><td>Vaccines</td><td>Wastage Multiplication Factor (WMF)</td><td>Vaccine will be in a single dose vial presentation and the wastage multiplication factor (WMF) with 1% wastage will be 1.01
Wastage to be kept to minimum through proper microplanning.</td></tr>
<tr><td rowspan="3">Ancillary products</td><td>HPV vaccine dose</td><td>Equals target population i.e. All girls aged 14 years x 1.01</td></tr>
<tr><td>AD syringes</td><td>To be bundled equal to vaccine doses</td></tr>
<tr><td>Hub cutters</td><td>One per session site</td></tr>
<tr><td rowspan="2">Number of personnel</td><td>Supervisors</td><td>1 supervisor covering one health facility</td></tr>
<tr><td></td><td>
<table>
<tr><th>HR Team</th><th>Responsible Person and their Role</th></tr>
<tr><td>Vaccinator (1)</td><td>ANM / male HW / LHV/Nurse/CHO; and anyone authorized to administer an injection may be considered as a potential vaccinator and for recording of vaccination data on U-WIN.</td></tr>
<tr><td>Verifier (1)</td><td>Health Facility Staff; responsible for checking registration status and verification in the waiting room on the vaccination day.</td></tr>
<tr><td>Mobilizer (1)</td><td>ASHA / ASHA coordinator / AWW / Link Worker responsible for head count survey, pre-registration of girls on U-WIN, mobilization of beneficiaries and support in session site management.</td></tr>
<tr><td>Volunteer (1)</td><td>Field Monitor/member of Mahila Arogya Samiti/ member of Jan Arogya Samiti/health staff for session site crowd management.</td></tr>
</table>
</td></tr>
<tr><td rowspan="10">Other Team Supplies</td><td>Red plastic bags</td><td>1 per session</td></tr>
<tr><td>Black plastic bags</td><td>1 per session</td></tr>
<tr><td>Yellow plastic bags</td><td>1 per session</td></tr>
<tr><td>Indelible markers</td><td>1 per session</td></tr>
<tr><td>AEFI kit</td><td>1 per Health Facility / AEFI management center</td></tr>
<tr><td>Anaphylaxis kit</td><td>1 per session site</td></tr>
<tr><td>Squeeze balls</td><td>5-10 per session site</td></tr>
<tr><td>Poster</td><td>4 per health facility and per SC/ANM urban area for common places with high footfall.</td></tr>
<tr><td>Banner</td><td>2 per health facility and 2 per SC/ANM urban area for common places with high footfall.</td></tr>
</table>

Overview of microplanning formats:

A total of 14 microplanning forms including monitoring and reporting forms have been developed (annexed in the annexure section: Annexure 3). This includes 10 forms on micro-planning including monitoring and reporting and 4 forms on communication planning. A brief description of 10 microplanning forms including reporting and monitoring forms is provided in the table below, with a detailed explanation of their purpose and application presented thereafter. The 4 communication planning forms are described in detail in the Communication Strategy document.

Planning level	Form Number	Form Name	Utility
District Level	Form 1	District – wise line listing of schools – to be filled by DEO and submitted to DIO	Provides information on line listing of schools, no. of eligible girls aged 14 years and PTM date planned
Sub-centre level	Form 2	Head Count Survey Planning Form – be filled by ANM with support of ASHAs/ AWWs/ other mobilizers	Provides information on all the areas under the SC/Urban ANM area, estimated population, surveyor details, and survey dates
	Form 3	Head Count Survey Form – to be filled by surveyor (ASHA/AWWs/MAS/JAS member/Link worker)	Provides information on name-wise line listing of eligible girls; update the information of past HPV vaccination, if any, facilitate registration on U-WIN and distribution of information cards (Refer to Annexure 6)
Health Facility Level	Form 4	Health Facility Level Planning Form – to be filled by MOIC	Compile information from the SC/Urban ANM area micro plan (from form 2) and the school line-listing information (from form 1)
	Form 5	HPV vaccination centre planning form – to be filled by MOIC	Provides information on planning of number of sessions, roster details, vaccine requirement, logistics, manpower requirement, waste management, AEFI management, IEC material etc.
District level	Form 6	District Planning Form – to be filled by DIO	Compile the health facility-wise information
State level	Form 7	State Planning Form – to be filled by SIO	Compile the district information (From form 6)
Health-Facility level (HPV vaccination session site)	Form 8	Session Monitoring Form – to be filled by Supervisors/ Monitors	Session site monitoring checklist to provide hands-on support to vaccinators and improve service quality
All level	Form 9	Reporting Form – Use of Digital Platforms	Captures information on the number of eligible girls vaccinated, vaccine stock status and wastage and the number of AEFI cases
Community level	Form 10	Rapid Convenience Monitoring (RCM) Form – to be filled by Supervisors/ Monitors	Assess community-level uptake of the HPV vaccine, identify gaps or bottlenecks in coverage for corrective actions if required.

Form 1: District-wise school line listing and planning form

This marks the first step of microplanning, in which a district-wise line listing of schools (Government, Private, Madarsas, Residential schools), along with the number of eligible girls, will be compiled. The District Immunization Officer (DIO) will guide and provide the form to the District Education Officer (DEO) after sensitization of DEO and BEO by the DIO on HPV vaccination campaign.

While HPV vaccine will be administered at health facilities, this information will assist in orienting the eligible girls and their parents or caregivers and teachers as the majority of the target population is school-going. This will also excludes boys only schools.

SOP for filling Form-1:
The form consists of two parts: Part A and Part B.

Part A, containing columns a to j, to be filled by the District Education Officer during the planning phase of the vaccination activity.

Column a: School Name
Write the complete School Name as per UDISE+.

Column b: UDISE+ code
Write the UDISE+ code of the school.

Column c: Block/Urban Area
Write the Block/Urban Area where the school is located.

Column d: Address
Write the complete address of the school.

Column e: Number of girls aged 14 years
Mention the total number of girls aged 14 years (those who have celebrated their 14th birthday but have not celebrated 15th birthday yet)

Column f: Name of Principal/School Nodal
Write the name of the school Principal/School Nodal.

Column g: Mobile No.
Write the Mobile no. of the school Principal/School Nodal.

Column h: Parent Teacher Meeting (PTM) date Planned (Y/N)
Mention (Y/N) if a Parent Teacher Meeting date has been planned.

Column i: If Yes, Date
Write the date if it is planned.

Column j: Name & Mobile No of Block Education Officer
Write the name and mobile number of the Block Education Officer for the concerned school.

Part B, containing Column k, is to be filled by the District Immunization Officer (DIO).

Column k: School falls under which planning unit/Health Facility
Write the name of the planning unit/Health Facility under which this school falls.

Once completed, the form should be shared with all planning units and health facilities by DIO so that concerned Medical Officer of the Health Facility can conduct the sensitization of eligible girls, parents and teachers on the date identified for PTM.

District wise School listing and planning Form

FORM 1

HPV Vaccination Campaign Year/Month:	
State:	District/ Corporation:
Name of District Education Officer (DEO) & Mobile No.	Name of District Immunization Officer (DIO) & Mobile No.

PART-A: To be filled by District Education Officer using UDISE+ and timely submit to District Immunization Officer (DIO)											PART-B: To be filled by DIO & further share the filled form with all planning units/HFs
S. No.	School Name	UDISE+ code	Block/ Urban Area	Address	Number of girls aged 14 years*	Name of Principal/ School Nodal	Mobile No.	PTM date Planned (Y/N)**	If Yes, Date	Name & Mobile no of Block Education Officer	School falls under which planning unit /HFs
	a	b	c	d	e	f	g	h	i	j	k
1.											
2.											
3.											
4.											
5.											
6.											
7.											
8.											
9.											
10.											

*Girls aged 14 years [those who have celebrated their 14th birthday but have not yet celebrated their 15th birthday]
** PTM: Parents-Teacher Meeting

District Education officer Signature with date	District Immunization Officer Signature with date

Form 2: Head Count Survey Planning at Sub Centre/Urban Area

This form is to be filled by the ANM at the sub-centre and submitted to the Planning unit /HFs after Head Count Survey is completed. It records village-wise baseline information, including estimated households, projected beneficiaries, and details of the person conducting the survey with contact information. The Medical Officer must ensure the form is completed for all sub-centres and Urban ANM areas, including vacant sub-centres. (see SOPs for details).

***SOP for filling Form-2**:*

The form consists of two parts: Part A and Part B.

Part A, containing columns a to i, to be filled by the ANM before the Head Count Survey.

Column a: Write Names of ALL Villages / Hamlets/ Tolas/Ward/Mohalla/ HRA Sites/Industry set up/ Mining area/Brick kiln area/Migratory setup/Orphanage/Hostels/Brothels (Red Light areas)/Correction centre under the Sub centre/ANM area separately, one area in each row

Identify and enlist all areas and use one row for each village/ward/area under the sub-centre, and complete the remaining details in that particular row, and move to the next village/ward/area in the next row.

Column b: Estimated number of households (HH)
Write the total number of households in that village or ward/area etc.

Column c: Total Population
Write the total population of that village/ward/area, etc.

Column d: Estimated number of girls aged 14 years (~1% of the population)
The total number of 14-year-old girls is estimated to be approximately 1% of the population.

Column e: Name and contact number of ASHA / AWW /MAS/JAS/Link worker (mobilizers) designated for this area
Write the name and contact number of ASHA / AWW /MAS/JAS/Link worker who is assigned for this area.

Column f: Name and contact number of persons doing head count survey (Surveyor/s)
Write the name and contact number of the person/s who will conduct the Head Count Survey (HCS). If more than one person is involved in the HCS, write details of both.

Column g: Designation of Surveyor (encircle applicable)
Encircle the designation of the surveyor who will do the survey, if more than one surveyor, encircle them all as applicable.

Column h: Name and contact number of local influencers.
There are identified influencers in each designated village/ward/area, etc, who help the immunization teams to smoothly run the programme. Write the names of such influencers along with their contact number. There may be more than one influencer; write down the details of all of them for each village/area/ward, etc.

Column i: Dates Planned to conduct Headcount Survey from/ to
Write the dates from which the survey is planned and until when it will be completed for each village/ward/area.

Part B, containing column j and K, to be filled by ANM but after the Head Count Survey.

Column j: Total number of girls aged 14 years due for vaccination as per Head Count Survey (HCS) (Form 3)
Write the total no. of girls aged 14 years due for vaccination as per HCS
(This column information to be collated from the Form 3 (column – b)

Column k: Nearest 24x7 Health Facilities (PHC & above) for this area
Write the name of the nearest 24x7 health facility (PHC or higher) for this area.

Head Count Survey (HCS) planning at Sub Centre/Urban ANM area

FORM 2

(MO to ensure this format is filled for all sub-centres/Urban ANM areas including vacant sub-centres)

HCS planning Form: to be filled by ANM and to be submitted to Planning unit after Head Count Survey

HPV Vaccination Campaign Year/Month:			
State:	District/Corporation:	Block/Urban Area:	Planning unit (PHC/U-PHC/CHC):
Sub-centre/Urban ANM area _____		Whether Sub-centre / ANM area has full time ANM (encircle) : Full Time / Vacant/ Temporarily Vacant _____	
Name of ANM with Contact No.: _____	No. of ASHAs working in Sub-centre/ Urban ANM area:_____	Name of Medical Officer with phone no : _____	

PART-A: To be filled by the ANM before the headcount survey										PART-B: To be filled by ANM after Head Count Survey	
S. No.	Write Names of ALL Villages / Hamlets/ Tolas/Ward/ Mohalla/ HRA Sites/Industry set up/Mining area/Brick kiln area/Migratory setup/ Orphanage/Hostel/ center/ brothels (red light areas)/ Correction center under the Sub centre/ANM area separately, one area in each row	Estimated number of households (HH)	Total Population	Estimated number of girls aged 14 years (~1% of population)	Name & contact number of ASHA / AWW /MAS/JAS/ Link worker (mobilizers) designated for this area	Name and contact number of persons doing head count survey (Surveyor/s)	Designation of Surveyor (encircle applicable)	Name and contact no. of local influencers	Dates Planned to conduct Headcount Survey From / To	Number of Girls aged 14 years due for vaccination as per HCS (Form 3)	Nearest 24x7 Health Facility (PHC & above) for this area
	a	b	c	d	e	f	g	h	i	j	k
1.					1. Name & contact number of ASHA:- 2. Name & contact number of AWW:- 3. Name & contact number of MAS/JAS member: 4. Name & contact number of Link worker:-	1 2	ASHA, AWW / MAS/JAS/Link Worker/ Others	1 2			
2.					1. Name & contact number of ASHA:- 2. Name & contact number of AWW:- 3. Name & contact number of MAS/JAS member: 4. Name & contact number of Link worker:-	1 2	ASHA, AWW / MAS/JAS/Link Worker/ Others	1 2			
3.					1. Name & contact number of ASHA:- 2. Name & contact number of AWW:- 3. Name & contact number of MAS/JAS member: 4. Name & contact number of Link worker:-	1 2	ASHA, AWW / MAS/JAS/Link Worker/ Others	1 2			
Total											

Signature of ANM with date	Signature of Supervisor with date	Signature of Medical Officer with date

Form 3: Head Count Survey (HCS) cum due list of the beneficiaries (Girls aged 14 Years)

This form is to be filled by the surveyor. She will mention the date, first house visited, along with the house number, name, and address. Similarly, she will also mention the last house visited along with the house no, name, and address, and validated by the respective supervisor. This form provides the line-listing of all eligible girls aged 14 years.

SOP for filling Form-3:

The form consists of two parts: Part A and Part B.

Part A, containing column a to l, to be filled by the surveyor -ASHA/AWW/MAS/JAS/LW before the campaign

Column a: Household (HH) No. (as per Chullah).
Write the Household No. as per Chullah. There should be separate house numbers for each Chullah.

Column b: Name of Girls aged 14 years (should be a resident of this area)
Write the full name of the girl as mentioned in the Photo ID (those who have celebrated their 14th birthday but have not yet celebrated their 15th birthday).

(If in any HH No. there is more than one girl then write the name of girl in separate rows under the same HH No.)

Column c: Father's/Mother's/Guardian's Name
Write the name of father's/ mother's/ guardian's (if any other than parents)

Column d: Date of Birth of Girl aged 14 years
Write the Date of Birth of the girl as mentioned in the ID or from any other record or recall.

Column e: Photo ID Type
Write the photo ID type of the eligible girl. It should be preferably Birth Certificate, Aadhar Card, Ration Card, School ID, APAAR ID, Permanent Education Number (PEN), Transfer/School leaving/Matriculation Certificate, Passport, Bank passbook, Immunization card, A declaration given by the Head of the Orphanage/Child Care Home, an age declaration form signed by parents/guardian

Column f: Photo ID Number
Write the photo ID number of the photo ID mentioned.

Column g: Mobile No. (for U-WIN registration)
Write mobile number of the father/mother/guardian.

Past history of vaccination

Column h: Any history of HPV vaccination (Y/N)
Did the girl receive the HPV vaccination? if yes, write Y; otherwise, write N. It can be any HPV vaccine licensed in India.

Column i: If yes, date of last vaccination
Write the date of vaccination.

Column j: If yes, vaccine brand name
Write the brand name of the vaccine received. Select – 1.Gardasil, 2.Gardasil-9, 3.Cervavac, 4.Cervarix (write the code)

U-WIN Registration & Information Card

Column k: Facilitated pre-registration for vaccination or past vaccination updation on U-WIN? (Y/N)
Facilitate the pre-registration for HPV vaccine. If vaccinated in the past, it has to be updated in the U-WIN portal.

Column l: Provided information card (Y/N)
Surveyor to provide an information card to households with eligible girls, write Y if provided or N if not provided.

Part B, containing column m, to be filled by ANM

Column m: Girl aged 14 years due for Vaccination (Y/N)
Write Y if the girls aged 14 years is due for vaccination if she hasn't received any HPV vaccination.

The ANM must also record at the end of the form the total number of girls due for vaccination and the nearest 24×7 health facility (PHC and above) for the area.

Head Count Survey (HCS) cum due list of the beneficiaries (Girls aged 14 Years)

FORM 3

HPV Vaccination campaign Year/Month:			
State:	District/Corporation:	Block/Urban Area:	Planning unit (PHC/U-PHC/CHC):
Sub-centre/Urban ANM area _____	Village/ Mohalla: _____	Name & Mobile no of ANM: _____	
Name of ASHA/AWW/LW and Contact No.:			
Date:.....Last House visited today: House no.....Name..... & Address.....		Date:.....Last House visited today: House no.....Name..... & Address.....	

PART-A: To be filled by the ASHA/AWW/MAS/JAS/LW before the campaign												PART-B: To be filled by ANM
Sr. No	House hold No. (as per Chullah)	Name of girl aged 14 years* (should be a resident of this area)	Father's/ Mother's/ Guardian's Name	Date of Birth of Girl aged 14 years	Photo ID Type**	Photo ID Number	Mobile No. (for U-WIN registration)	Past history of vaccination			U-WIN Registration & Information Card		Girls aged 14 years due for Vaccination (Y/N)
								Any history of HPV vaccination (Y/N)	If yes, date of last vaccination	If yes, vaccine brand name 1. Gardasil 2. Gardasil-9 3. Cervarix 4. Cervavac (Write code)	Facilitated pre-registration for vaccination or past vaccination updation on U-WIN? (Y/N)	Provided Information Card (Y/N)	
	a	b	c	d	e	f	g	h	i	j	k	l	m
1.													
2.													
3.													
Total number of Girls aged 14 years due for Vaccination													
Nearest 24x7 Health Facility (PHC & above) for this area	1.												

*Girls aged 14 years [those who have celebrated their 14th birthday but have not yet celebrated their 15th birthday]
** Birth Certificate, Aadhar Card, Ration Card, School ID, APAAR ID, Transfer/School leaving/Matriculation Certificate, Passport, Bank passbook, Immunization card, A declaration given by the Head of the Orphanage/Child Care Home, Age Undertaking Form signed by parents/guardian

ASHA/AWW/MAS/JAS/LW Signature with date_____	Signature of ANM with date_____

Form 4: Health Facility (HF)-PHC/U-PHC/CHC-Planning Form

This form will be filled out by the MOIC during the planning phase of the vaccination. This form compile information from Form 1 and Form 2. After completion, this form has to be submitted to the District Immunization Officer (DIO).

SOP for filling Form-4:

The upper section of the form captures basic information along with details such as

- *whether the Health Facility is 24x7 (Yes/No)*
- *whether the Health Facility is a Cold Chain Point (CCP) as per eVIN (Yes/No)*
- *whether Health Facility has medical officer(s) available 24x7 for AEFI management (Yes/No)*
- *whether the Health Facility has internet access, a desktop/laptop computer, and a printer (Yes/No)*
- *whether the Health Facility has a functional ambulance (Yes/No)*

The form consists of two parts: Part A and Part B.

Part A, containing column a to j, populated using data from Form 2

Column a: Name of SC/ Urban ANM area
Write the name of all SC/Urban areas – whether Rural or Urban, under the Planning Unit to be filled.

Column b: Total population
Write the total population of SC/Urban areas

Column c: Estimated number of girls aged 14 years (~1% of population)
Write the estimated number of girls aged 14 years (approx.~1% of the population)

Column d: Number of girls aged 14 years based on the actual Head Count Survey by ASHA/AWW/LW/MAS/JAS (Form 2, Column J)
Number of girls (those who have celebrated their 14th birthday but have not yet celebrated their 15th birthday) aged 14 years based on the actual Head Count Survey by ASHA/AWW/LW/MAS/JAS (Form 2, Column J)

Column e: Name of ANM & Mobile no.
Write the Name and mobile number of the ANM.

Column f: Total number of ASHAs under the SC/Urban ANM area:
Write the total number of ASHAs under the SC/Urban ANM area of the planning unit.

Column g: Total number of AWW under the SC/Urban ANM area
Write the total number of AWWs under the SC/Urban ANM area of the planning unit.

Column h: Total number of MAS/JAS under the SC/Urban ANM area
Write the total number of MAS/JASs under the SC/Urban ANM area of the planning unit.

Column i: Total number of Link workers (mobilizers) under the SC/Urban ANM area
Write the total number of Link workers (mobilizers) under the SC/Urban ANM area of the planning unit.

Column j: Nearest 24x7 Health Facility for this area
Write the name of the nearest 24x7 health facility (PHC or higher) for this area.

Part B, containing column k to n, populated using data from Form 1

Column k: School Name
Write the name of the school falling under that Sub-Centre/Urban area.

Column l: Principal/School Nodal name
Write the name of the Principal/School Nodal of the school.

Column m: Mobile No.
Write the Mobile no. of the school Principal.

Column n: PTM date
Mention the tentative Parent Teacher Meeting (PTM) date so that MO along with healthcare team can go and conduct sensitization meeting on PTM date.

If there are more than two schools in the area then information on any additional school to be filled under additional rows below.

Health Facility (HF)-PHC/U-PHC/CHC-Planning Form

FORM 4

HF Planning Form to be filled by MO

HPV Vaccination Campaign Year/Month:				
State:	District/Corporation:	Block/Urban Area:	Planning unit (PHC/U-PHC/CHC):	HF is functional 24x7: Y/N
Name & Mobile no. of MO:	HF is a Cold Chain Point (CCP) as per eVIN: Y/N	HF has medical officer(s) available for AEFI management: Y/N	HF has internet, Desktop/Laptop & Printer: Y/N	HF has functional Ambulance: Y/N

PART-A: Sub-centre/Urban ANM area-wise information. To be filled from FORM 2											PART-B: School Information: To be filled from FORM 1			
S. No.	Name of SC/Urban ANM Area	Total Population	Estimated number of girls aged 14 years (~1% of population)	Number of girls* aged 14 years Based on actual Head count Survey by ASHA/ AWW/LW/Member MAS/Member JAS (Form 2, Column J)	Name of ANM & Mobile no.	Total number of ASHAs under the SC/ Urban ANM area	Total number of members of AWW under the SC/Urban ANM area	Total number of members of MAS/ JAS under the SC/ Urban ANM area	Total number of Link worker (mobilizers) under the SC/Urban ANM area	Nearest 24x7 Health Facility for this area	School name	Principal/School Nodal name	Mobile no.	PTM date
	a	b	c	d	e	f	g	h	i	j	k	l	m	n
Total														
*Girls aged 14 years [those who have celebrated their 14th birthday but have not yet celebrated their 15th birthday]														

Nodal MO Signature with date_____	MOIC Signature with date_____

Form 5 - Health Facility (HF) Session Site-Checklist-Planning Form

This form, to filled by the MoIC of Health Facilities - PHC, UPHC, CHC, SDH, DH, RH and GMCH - provides information for planning the number of sessions, roster plan of vaccination team, vaccine requirements, logistics, manpower, waste management, AEFI management, and IEC materials display. After completion, this form has to be submitted to the District Immunization Officer (DIO).

SOP for filling Form-5:

Row 1: Target population (girls aged 14 years) based on FORM 4 (Column d)
Write the total number of 14 years age girls which can be taken from column D of from 4 and fill week wise the required data. The Health Facilities which do not have target cohort of their own (for example DH, SDH, GMCH) will write NA in this column.

Row 2: Number of HPV vaccine doses required as per the target
Write the number of HPV vaccine doses required which is equal to number of eligible girls.

Row 3: Number of AD syringes required as per the target
Mention the total number of AD syringes required based on the doses.

Row 4: Number of sessions planned in 3 months (Week 1 to Week 12)
Please mention the number of sessions planned for each week from week 1 to week 12.

Row 5: Name & Mobile no. of Vaccinator deputed for HPV vaccination (Week 1 to Week 12)
Write the names and mobile numbers of the vaccinators that are deputed for the week wise vaccination from 1-12 weeks

Row 6: Name & Mobile no. of Verifier (Facility health staff; responsible for checking registration status & verification in the waiting room on the vaccination day) (Week 1 to Week 12)
Mention the name with mobile number of the verifier who will be checking registration status and verification in the waiting room on the session day week 1-12.

Row 7: Name & Mobile no. of Mobilizer (ASHA / ASHA coordinator/AWW/MAS/JAS/Link Worker to support in session site management) (Week 1 to Week 12)
Mention the name and mobile number of the mobilizer (ASHA / ASHA coordinator/AWW/MAS/JAS/Link Worker to support in session site management) (Week 1 to Week 12)

Row 8: Name & mobile no. of Volunteer (Field Monitor/MAS/JAS/health staff for session site crowd management) (Week 1 to Week 12)
Mention the Name & mobile no. of Volunteer (Field Monitor/MAS/JAS/health staff for session site crowd management) (Week 1 to Week 12).

Row 9: All the 4 members of the Vaccination team received dedicated training at block on HPV vaccination
Please describe if all the 4 members of the team received the HPV training.

Row 10: Number of Hub Cutter required? (1 per vaccinator)
Mention the total number of hub cutter required assuming 1 per vaccinator.

Row 11: Number of indelible marker pen required for finger marking? (1 per session)
Mention the total number of indelible marker pen required assuming one per session

Row 12: Number of Red plastic bags required? (1 per session)
Mention the total number red plastic bags required assuming one per session.

Row 13: Number of black plastic bags required? (1 per session)
Mention the total number black plastic bags required assuming one per session.

Row 14: Number of yellow plastic bags required? (1 per session)
Mention the total number yellow plastic bags required assuming one per session.

Row 15: Number of Anaphylaxis kits required? (1 per vaccinator)
Mention the total number of anaphylaxis kits required assuming one per vaccinator.

Row 16: Contents of Anaphylaxis kit are verified & Inj. Adrenaline is within expiry? (verify for each deputed vaccinator)
Please verify and mention (Y/N) if the contents of anaphylaxis kits are being verified and adrenaline injection is not expired; this should be verified for each deputed vaccinator.

Row 17: Vaccinators deputed for HPV vaccination is trained on administration of Inj. Adrenaline & AEFI reporting?
Please confirm if the deputed HPV Vaccinator is trained on how to administer adrenaline injection and AEFI reporting.

Row 18: Number of AEFI Kits required (1 kit per Health Facility)
Please mention the number of AEFI kits required assuming that 1 kit per health facility is needed.

Row 19: Contents of AEFI kit are verified & Inj. Adrenaline is within expiry
Please mention the AEFI kits are being verified, and inj. Adrenaline is within the expiry date.

Row 20: Medical officer(s) are available at the health facility to manage AEFIs
Please mention if there is a medical officer available for AEFI management at this facility.

Row 21: Medical officer(s) are trained on AEFI management and reporting
Please mention if MOs are trained on AEFI management and reporting.

Row 22: Medical Officer received dedicated training on HPV vaccination and Crisis Communication
Please mention if the dedicated medical officer received the HPV vaccination and crisis communication.

Row 23: Number of Squeeze balls required? (5-10 per Health Facility)
Please mention the number of squeeze balls required assuming 5-10 per health facility.

Row 24: Number of posters required? (4 per Health Facility)
Please mention the number of posters required assuming 4 per health facility.

Row 25: Number of banners required? (2 per Health Facility)
Please mention the number of banners required assuming 2 per health facility (area of high footfall).

Row 26: Functional desktops/laptops for U-WIN registration
Please mention the number of functional desktops/laptops for U-WIN registration that are available.

Row 27: Functional Internet/Wi-Fi for U-WIN?
Please mention if there is functional for U-WIN registration.

Row 28: Functional Printer for U-WIN Certificate, consent form and age undertaking form?
Please mention if there is functional printer for U-WIN certificate, consent form and age undertaking form.

Row 29: Dedicated Waiting Room or Area?
Please mention if there is a dedicated waiting room or area for HPV vaccination.

Row 30: Dedicated Vaccination Room or Area with privacy?
Please mention if there is a dedicated vaccination room or area with privacy.

Row 31: Dedicated Observation Room or Area?
Please mention if there is a dedicated observation room or area.

Row 32: Provision of running water & soap for hand washing before vaccination?
Please mention if there is provision for hand washing like running water and soap, before vaccination.

Row 33: Availability of adequate cotton swabs for cleaning skin before vaccination?
Please mention if there are adequate cotton swabs available for cleaning skin before vaccination.

Row 34: Functional ILR with working eVIN temperature logger?
Please mention if there is functional ILR with working eVIN temperature logger.

Row 35: Functional DF?
Please mention if there is functional DF.

Row 36: Sufficient Ice packs?
Please mention if there are sufficient ice packs available as per the due list.

Row 37: Availability of adequate stock of Paracetamol tablet
Please mention if there is adequate stock of paracetamol tablets based on the total number of girls.

Row 38: Functional Ambulance?
Please mention if there is a functional ambulance.

Row 39: Name of dedicated Cold Chain Handlers (CCH) with mobile number: CCH1 & CCH2?
Please mention the names of the cold chain handlers and also write their mobile numbers (CCH1 and CCH2

Row 40: Name & Mobile no. of linked Cold Chain Technician for this HF?
Please mention the name and mobile number of the linked cold chain technician for this health facility.

Row 41: Name and Mobile Number of linked VCCM for this HF
Please mention the name and mobile number of the linked Vaccine and Cold Chain Manager (VCCM) for this health facility.

Row 42: Name of 24x7 AEFI management centre/first referral hospital.
Mention the name of the 24x7 AEFI management centre and if this is a 24x7 HF then name of the first referral hospital for AEFI management.

Health Facility (HF) Session Site-Checklist-Planning Form (HPV Vaccination Campaign for 3 months) FORM 5

To be filled by MOIC of the Health Facility

HPV Vaccination Initiative Year/Month:			
State:	District/Corporation:	Block/Urban Area:	
Health Facility (PHC/U-PHC/CHC/SDH/RH/DH/GMCH) *:		MO Name:	Mobile no:

S. No.		Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10	Week 11	Week 12
1	Target population (girls aged 14 years) based on FORM 4 (Column d total)												
2	Number of HPV vaccine doses required as per the target?												
3	Number of AD syringes required as per the target?												
4	Number of sessions planned in 3 months (Week 1 to Week 12)												
5	Name & Mobile no. of Vaccinator deputed for HPV vaccination (Week 1 to Week 12)												
6	Name & Mobile no. of Verifier (Facility health staff; responsible for checking registration status & verification in the waiting room on the vaccination day) (Week 1 to Week 12)												
7	Name & Mobile no. of Mobilizer (ASHA / ASHA coordinator/ AWW/MAS/JAS/Link Worker to support in session site management) (Week 1 to Week 12)												
8	Name & mobile no. of Volunteer (FM/MAS/JAS/health staff for session site crowd management) (Week 1 to Week 12)												
9	All the 4 members of the Vaccination team received dedicated training at block on HPV vaccination	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
10	Number of Hub Cutter required? (1 per vaccinator)												
11	Number of indelible marker pen required for finger marking? (1 per session)												

S. No.		Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10	Week 11	Week 12
12	Number of Red plastic bags required? (1 per session)												
13	Number of black plastic bags required? (1 per session)												
14	Number of yellow plastic bags required? (1 per session)												
15	Number of Anaphylaxis kits required? (1 per vaccinator)												
16	Contents of Anaphylaxis kit are verified & Inj. Adrenaline is within expiry? (verify for each deputed vaccinator)	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
17	Vaccinators deputed for HPV vaccination is trained on administration of Inj. Adrenaline & AEFI reporting?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
18	Number of AEFI Kits required ?(1 kit per Health Facility)												
19	Contents of AEFI kit are verified & Inj. Adrenaline is within expiry ?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
20	Medical officer(s) are available at the health facility to manage AEFIs	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
21	Medical officer(s) are trained on AEFI management and reporting	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
22	Medical Officer received dedicated training on HPV vaccination and Crisis Communication	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
23	Number of Squeeze balls required? (5-10 per Health Facility)												
24	Number of posters required? (4 per Health Facility)												
25	Number of banners required? (2 per Health Facility)												
26	Functional desktops/laptops for U-WIN registration?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
27	Functional Internet/Wi-Fi for U-WIN?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
28	Functional Printer for U-WIN Certificate, consent form, age undertaking form?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

S. No.		Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10	Week 11	Week 12
29	Dedicated Waiting Room or Area?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
30	Dedicated Vaccination Room or Area with privacy?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
31	Dedicated Observation Room or Area?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
32	Provision of running water & soap for hand washing before vaccination?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
33	Availability of adequate cotton swabs for cleaning skin before vaccination?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
34	Functional ILR with working eVIN temperature logger?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
35	Functional DF?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
36	Sufficient Ice packs	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
37	Availability of adequate stock of Paracetamol tablet?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
38	Functional Ambulance?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
39	Name of dedicated Cold Chain Handlers (CCH) with mobile number: CCH1 & CCH2	Name_____ Mobile No_____ Name _____ Mobile No_____											
40	Name & Mobile no. of linked Cold Chain Technician for this HF	Name_____ Mobile No_____ __											
41	Name & Mobile no. of linked VCCM for this HF	Name_____ Mobile No_____ __											
42	Name of 24x7 AEFI management centre/first referral hospital	Address: _____Name & Mobile no. of Focal MO for AEFI Management_____											
*Write NA in front of Health Facility where it is not applicable													
MOIC Signature with date_____													

Form 6 – District Planning Form

This form will be filled by the DIOs and submitted to the SIO. It serves as a compilation format of all health facility-level information collected using Form No. 4.

SOP for filling Form-6:

Column a: List of all HF – PHC/U-PHC/CHC/SDH/RH/DH/GMCH
Write the complete list of all Health Facilities (HF) – Primary Health Centres (PHC) and above like Urban PHCs (U-PHC), Community Health Centres (CHC), Sub-District Hospitals (SDH), Rural Hospitals (RH), District Hospitals (DH), and Government Medical colleges and Hospitals (GMCH) in the designated area.

Column b: Name & Phone number of Nodal MO
Write the name and active phone number of the designated Nodal Medical Officer responsible for vaccination at the facility.

Column c: Health Facility is functional 24x7: Y/N
Write Y/N whether the HF is functional 24x7.

Column d: Health Facility has functional Ambulance: Y/N
Write Y/N whether the HF has a functional Ambulance.

Column e: Total Population
Mention the total population in the catchment area of the health facility. Write NA in front of Health Facility where it is not applicable such as DH, SDH and GMCH.

Column f: Estimated number of girls aged 14 years (~1% of population)
Calculate approximately ~1% of the total population to estimate the number of 14-year-old girls in the catchment area.

Column g: Number of girls* aged 14 years Based on actual Head count Survey by ASHA/AWW/LW/MAS/JAS (Form 4, Column D)
Write the exact number of 14-year-old girls from the head count survey conducted by ASHA, AWW, LW, MAS, or JAS, as recorded in Form 4, Column D.

Column h: Total number of ANMs
Mention the total number of ANMs currently in position under this health facility.

Column i: Total number of ASHAs
Mention the total number of ASHAs currently in position under this health facility.

Column j: Total Number of AWWs
Mention the total number of AWWs currently in position under this health facility.

Column k: Total number of MAS/JAS
Mention the total number of MAS/JAS member currently in position under this health facility.

Column l: Total number of Link Workers
Mention the total number of Link Workers currently available under this health facility.

Column m: Health Facility has a functional Cold Chain point as per eVIN(Y/N)
Indicate whether the health facility has a functional cold chain point (Y/N).

Column n: Health Facility has Medical Officer(s) available for AEFI Management (Y/N)
Confirm if the health facility has a Medical Officer for Adverse Events Following Immunization (AEFI) management (Y/N).

Column o: Health Facility has internet connection, desktop/laptop & printer for U-WIN (Y/N)
Verify if the health facility has an internet connection and desktop/laptop & printer for U-WIN (Y/N).

Column p: Health Facility identified as HPV vaccination Centre (Y/N)
Specify whether the health facility is designated as an HPV vaccination centre (Y/N).

Column q: If no in Column P, link the target population to nearest HPV vaccination centre
If Column P "No", link the target population for this health facility to the nearest HPV vaccination center.

District Planning Form

FORM 6

District Planning Form to be filled by DIO

HPV Vaccination Campaign Year/Month:																	
State:									District/Corporation:								
Name of DIO:									Mobile no.:								
S. No.	List of all HF/ PHC/U-PHC/ CHC/SDH/RH/DH/Medical College**	Name & Phone number of Nodal MO	HF is functional 24x7: Y/N	HF has functional Ambulance: Y/N	Total Population	Estimated number of girls aged 14 years (~1% of population)	Number of girls* aged 14 years Based on actual Head count Survey by ASHA/ AWW/LW/MAS/JAS (Form 4, Column D total)	Total number of ANMs	Total number of ASHAs	Total Number of AWWs	Total number of members of MAS/JAS	Total number of Link Workers	Health Facility has a functional Cold Chain point as per eVIN (Y/N)	Health Facility has Medical Officer(s) available for AEFI Management (Y/N)	Health Facility has internet connection, desktop/laptop & printer for U-WIN (Y/N)	Health Facility identified as HPV vaccination Centre (Y/N)	If no in Column P, link the target population for this health facility to nearest HPV vaccination centre
	a	b	c	d	e	f	g	h	i	j	k	l	m	n	o	p	q
1.																	
2.																	
3.																	
4.																	
5.																	
6.																	
7.																	
8.																	
9.																	
10.																	
Total																	
*Girls aged 14 years [those who have celebrated their 14th birthday but have not yet celebrated their 15th birthday] **Write NA in front of Health Facility where it is not applicable																	
DIO Signature with date_____									CMO/CS Signature with date_____								

Form 7 – State Planning Form

This form is to be completed by the SIO and submitted to the MoHFW. It serves as a compilation format of all district-level information collected using Form No. 6.

SOP for filling Form-7:

Information regarding Helpline number, for AEFI Management, identified for HPV vaccination Campaign

Column a: District
Write the name of the district.

Column b: Total population of the district
Please mention the total population of the district.

Column c: Estimated number of girls aged 14 years (~1% of population)
Write the estimated number of eligible girls aged 14 years, which is approximately 1% of the population.

Column d: Number of girls aged 14 years Based on actual Head count Survey by ASHA/AWW/LW/MAS/JAS (Form 6, Column G)
Write the total number of girls aged 14 years as per the actual count survey conducted by the ASHA/AWW/LW/MAS/JAS.

Column e: Total no. of Health Facilities (PHC/U-PHC/CHC/SDH/RH/DH/GMCH) in the district
Mention the total number of health facilities (PHC/U-PHC/CHC/SDH/RH/DH/GMCH) in the district.

Column f: Out of total no. of HFs, how many are 24x7?
Write the total number of health facilities which are functional 24x7 in each district out of the total no of health facilities.

Column g: Out of total no. of HFs, how many have functional Ambulance?
Write the total number of HF which have functional ambulances.

Column h: Out of total no. of HFs, how many have a functional Cold Chain point as per eVIN?
Mention the total no of HF which has functional cold chain points, as per eVIN.

Column i: Out of total no. of HFs, how many have a medical officer available for AEFI management?
Write the total number of health facilities which have a MO, available for AEFI Management.

Column j: Out of total no. of HFs, how many have internet connection, desktop/laptop & printer for U-WIN?
Write the total number of HF which has internet connection, desktop/laptop and printer for U-WIN.

Column k: Out of total no. of HFs, how many Health Facilities are identified as HPV vaccination Centre?
Mention the total number of HFs that are identified as HPV vaccination center.

State Planning Form

FORM 7

State Planning Form to be filled by SIO to be shared with MoHFW

HPV Vaccination Campaign Year/Month:	
State/UT:	
Name & Mobile no. of SIO:	Helpline no. for AEFI

S. No.	District	Total population of the District	Estimated number of girls aged 14 years (~1% of population)	Number of girls* aged 14 years Based on actual Head count Survey by ASHA/AWW/LW/MAS/ JAS (Form 6, Column G total)	Total no. of Health Facilities (PHC/U-PHC/ CHC/SDH/RH/DH/ Medical College) in the District**	Out of total no. of HFs, how many are 24x7?	Out of total no. of HFs, how many have functional Ambulance?	Out of total no. of HFs, how many have a functional Cold Chain point, as per eVIN?	Out of total no. of HFs, how many have a medical officer available for AEFI management?	Out of total no. of HFs, how many have internet connection, desktop & printer for U-WIN?	Out of total no. of HFs, how many Health Facilities are identified as HPV vaccination Centre?
	a	b	c	d	e	f	g	h	i	j	k
1.											
2.											
3.											
4.											
5.											
6.											
7.											
8.											
9.											
10.											
Total											

*Girls aged 14 years [those who have celebrated their 14th birthday but have not yet celebrated their 15th birthday]

**Only consider PHC and above PHC as Health Facilities (HFs)

SIO Signature with date_____	MD (NHM) Signature with date_____

Form 8: Session-Site Monitoring Form

Once the HPV vaccination campaign has started, supervisors/monitors will oversee HPV vaccination sessions, including cold chain points and AEFI-related activities, to ensure smooth implementation and quality service delivery. They will use the standard monitoring checklist (Form no. 8) on the U-Mentor application, shown on the next page, and visit at least four session sites per day. Throughout the three-month campaign, monitors will provide hands-on support, mentoring, and guidance to vaccinators, focusing on the following areas:

- Adherence to micro-plan and session schedules
- Manpower available at the session site
- Registration, recording and reporting on U-WIN
- Vaccine supply, logistics, and cold chain management
- Safe injection practices by ANMs and proper waste disposal
- AEFI management protocols being followed
- IEC material display
- Record-keeping and effective communication with beneficiaries

Health Facility (HF)_Session Site Monitoring Form

FORM 8

To be filled by MOIC of the Health Facility

HPV Vaccination Campaign Year/Month:			
State:	District/Corporation:	Block/Urban Area:	Setting: Urban / Rural:
Monitor Name & Mobile No:		Organization: Govt. /Partners (Please specify)	Designation:

			1	2	3	4
General Information	1	Name of the Health Facility: session site visited				
	2	Date & Time of Visit				
	3	Is session being conducted today?	Y / N	Y / N	Y / N	Y / N
	4	Does the Health Facility has a functional CCP as per eVIN?	Y / N	Y / N	Y / N	Y / N
	5	Does the Health facility has a medical officer available 24x7 for AEFI management?	Y / N	Y / N	Y / N	Y / N
	6	Does the Health facility has functional internet connection, desktop/laptop and a printer for U-WIN?	Y / N	Y / N	Y / N	Y / N
	7	Is this session planned on U-WIN?	Y / N	Y / N	Y / N	Y / N
Area, Manpower, U-WIN	8	Are adequate vaccinators assigned to this session as per no. of sessions planned in Form 5?	Y / N	Y / N	Y / N	Y / N
	9	Are vaccinators available as per micro plan in Form 5?	Y / N	Y / N	Y / N	Y / N
	10	Are all mobilizers (ASHA/AWW/Linkworker) available as per the micro plan in Form 5?	Y / N	Y / N	Y / N	Y / N
	11	Are all verifier available as per the micro plan in Form 5?	Y / N	Y / N	Y / N	Y / N
	12	Are all volunteer available as per the micro plan in Form 5?	Y / N	Y / N	Y / N	Y / N
	13	Are all the 4 members of the vaccination team trained for HPV vaccination at block level?	Y / N	Y / N	Y / N	Y / N
	14	Is there a separate room or area for waiting?	Y / N	Y / N	Y / N	Y / N
	15	Is there a separate room or area for HPV vaccination with privacy?	Y / N	Y / N	Y / N	Y / N
	16	Is there a separate room or area for observation?	Y / N	Y / N	Y / N	Y / N
	17	Does the session site use a Desktop/laptop for walk-in beneficiary registration & recording HPV vaccination on U-WIN?	Y / N	Y / N	Y / N	Y / N
	18	Are U-WIN vaccination certificates being printed and handed over to each beneficiary?	Y / N	Y / N	Y / N	Y / N
	19	Are adequate printed consent forms available at session site?	Y / N	Y / N	Y / N	Y / N
	20	Are consent forms being offered to parents/guardians for signature before vaccination (in case of no internet of mobile network access)?	Y / N	Y / N	Y / N	Y / N

			1	2	3	4
Session Site: Vaccine and other logistics	21	Is running water and soap available for hand washing before vaccination?	Y / N	Y / N	Y / N	Y / N
	22	Are adequate HPV vaccine doses available at the session site?	Y / N	Y / N	Y / N	Y / N
	23	Are adequate 0.5 ml AD syringes available at session site?	Y / N	Y / N	Y / N	Y / N
	24	Are adequate cotton swabs available at the session site?	Y / N	Y / N	Y / N	Y / N
	25	Are adequate Paracetamol tablets available at the session site?	Y / N	Y / N	Y / N	Y / N
	26	Are adequate squeeze balls available at the session site?	Y / N	Y / N	Y / N	Y / N
	27	Are HPV vaccine vials stored in vaccine carrier (with 4 conditioned ice packs)?	Y / N	Y / N	Y / N	Y / N
	28	Is there any vial with VVM in unusable stage inside the vaccine carrier?	Y / N	Y / N	Y / N	Y / N
	29	Is there any frozen vial inside the vaccine carrier?	Y / N	Y / N	Y / N	Y / N
	30	Is functional hub cutter available at session site?	Y / N	Y / N	Y / N	Y / N
	31	Is indelible marker pen for finger marking available at the session site?	Y / N	Y / N	Y / N	Y / N
	32	Number of vials used, and girls vaccinated are matching reasonably?	Y / N	Y / N	Y / N	Y / N
Vaccinators injection practices	33	Is the vaccinator recapping the needle?	Y / N	Y / N	Y / N	Y / N
	34	Is ANM touching the needle of the syringes anytime during drawing and administering vaccine to the beneficiaries? (Not following aseptic technique)	Y / N	Y / N	Y / N	Y / N
	35	Is vaccinator administering the vaccine through intramuscular route correctly?	Y / N	Y / N	Y / N	Y / N
	36	Is vaccinator administering the vaccine to the left upper arm?	Y / N	Y / N	Y / N	Y / N
	37	Are used syringes being cut using hub cutter immediately after use?	Y / N	Y / N	Y / N	Y / N
	38	Is the team marking left index finger after vaccinating the beneficiaries?	Y / N	Y / N	Y / N	Y / N
	39	Is the vaccinator giving 5 key messages to eligible girl/caregiver after vaccination?	Y / N	Y / N	Y / N	Y / N
	40	Are beneficiaries waiting for 30 minutes after HPV vaccination?	Y / N	Y / N	Y / N	Y / N
Biomedical Waste Management	41	Is vaccinator disposing cut hubs of syringes into hub cutter/white puncture proof container?	Y / N	Y / N	Y / N	Y / N
	42	Is vaccinator disposing expired or discarded vaccine vials, broken vials, empty unbroken vials into blue container?	Y / N	Y / N	Y / N	Y / N
	43	Is vaccinator disposing Plastic part of syringe or gloves into red bag?	Y / N	Y / N	Y / N	Y / N
	44	Is vaccinator disposing wrapper/ needle cap into black bag?	Y / N	Y / N	Y / N	Y / N
	45	Is vaccinator disposing cotton, expired tablet into yellow bag?	Y / N	Y / N	Y / N	Y / N

			1	2	3	4
AEFI Management at Session Site	46	Does the vaccinator have Anaphylaxis kit? (If No - Immediately ALERT Senior Official)	Y / N	Y / N	Y / N	Y / N
	47	If yes, does the kit have un-expired Inj. adrenaline, 24–25-gauge needles and insulin/ tuberculin syringes? If No - Immediately ALERT Senior Official) "	Y / N	Y / N	Y / N	Y / N
	48	Does the vaccinator know what to do in case of a serious and severe AEFI (primary care, referral and reporting)?	Y / N	Y / N	Y / N	Y / N
	49	Does the vaccinator know the correct dosage of Adrenaline to be administered in case of anaphylaxis for girls aged 14 years (0.3 ml in tuberculin or 12 units in insulin syringe)?	Y / N	Y / N	Y / N	Y / N
AEFI Management Centre	50	Is Medical Officer (MO) designated for AEFI Management Centre trained on AEFI Management and Reporting?	Y / N	Y / N	Y / N	Y / N
	51	Does the AEFI management centre have AEFI kit? (If No - Immediately ALERT Senior Official)	Y / N	Y / N	Y / N	Y / N
	52	If yes, does the AEFI kit have all the contents as per the guidelines including un-expired Inj. adrenaline, 24–25-gauge needles and insulin/ tuberculin syringes? If No - Immediately ALERT Senior Official)	Y / N	Y / N	Y / N	Y / N
	53	Does the MO know what to do in case of a serious and severe AEFI (primary care, referral and reporting)?	Y / N	Y / N	Y / N	Y / N
	54	Does the MO know the correct dosage of Adrenaline to be administered in case of anaphylaxis for girls aged 14 years (0.3 ml in tuberculin or 12 units in insulin syringe)?	Y / N	Y / N	Y / N	Y / N
Cold Chain Point	55	Are adequate HPV vaccine doses available in the ILR at CCP?	Y / N	Y / N	Y / N	Y / N
	56	Are adequate 0.5 ml AD syringes available at CCP?	Y / N	Y / N	Y / N	Y / N
	57	Are HPV vaccines stored at the right place in ILR?	Y / N	Y / N	Y / N	Y / N
	58	Does the ILR has a functional eVIN temperature logger?	Y / N	Y / N	Y / N	Y / N
	59	Does the temperature logbook is filled twice a day by CCH?	Y / N	Y / N	Y / N	Y / N
	60	Does the CCP has adequate number of ice packs?	Y / N	Y / N	Y / N	Y / N
	61	Does the CCP has functional cold boxes for emergency use?	Y / N	Y / N	Y / N	Y / N
	62	Does the vaccine stocks in eVIN, physical register and ILR are matching?	Y / N	Y / N	Y / N	Y / N

			1	2	3	4
Mobilization & Supervision	63	Has the Health Facility displayed 2 Banners of HPV vaccination?	Y / N	Y / N	Y / N	Y / N
	64	Has the Health Facility displayed 4 posters of HPV vaccination?	Y / N	Y / N	Y / N	Y / N
Interaction with Caregiver (ask at least 2 caregivers). If none, skip the question.	65.a	Caregiver 1:How did you come to know about this campaign? (Max 4 allowed) 1=From Health worker/ASHA/AWW before the campaign; 2=Poster/Banner/information card/Miking, 3=Newspaper/T.V./Radio 4= Social media; 5=School / Teachers Through PTM, Student's diary or mail/web site/WhatsApp; 6=Through sessions 7=Family/Friends/ Neighbours; 8= Community Influencers; 9= Other, please specify	1. Y/N 2. Y/N 3. Y/N 4. Y/N 5. Y/N 6. Y/N 7. Y/N 8. Y/N 9. Pls specify …………	1. Y/N 2. Y/N 3. Y/N 4. Y/N 5. Y/N 6. Y/N 7. Y/N 8. Y/N 9. Pls specify …………	1. Y/N 2. Y/N 3. Y/N 4. Y/N 5. Y/N 6. Y/N 7. Y/N 8. Y/N 9. Pls specify …………	1. Y/N 2. Y/N 3. Y/N 4. Y/N 5. Y/N 6. Y/N 7. Y/N 8. Y/N 9. Pls specify …………
	65.b	Caregiver 2:How did you come to know about this campaign? (Max 4 allowed) 1=From Health worker/ASHA/AWW before campaign; 2=Poster/Banner/information card/Miking, 3=News paper/T.V./Radio 4= Social media; 5=School / Teachers Through PTM, Student's diary or mail/web site/WhatsApp; 6=Through sessions 7=Family/Friends/ Neighbours; 8= Community Influencers; 9= Other, please specify	1. Y/N 2. Y/N 3. Y/N 4. Y/N 5. Y/N 6. Y/N 7. Y/N 8. Y/N 9. Pls specify …………	1. Y/N 2. Y/N 3. Y/N 4. Y/N 5. Y/N 6. Y/N 7. Y/N 8. Y/N 9. Pls specify …………	1. Y/N 2. Y/N 3. Y/N 4. Y/N 5. Y/N 6. Y/N 7. Y/N 8. Y/N 9. Pls specify …………	1. Y/N 2. Y/N 3. Y/N 4. Y/N 5. Y/N 6. Y/N 7. Y/N 8. Y/N 9. Pls specify …………

Form 9: Reporting Form

The Reporting Form collects following data via the U-WIN, eVIN, and SAFE-VAC portals:

U-WIN: number of sessions planned and held, no. of girls vaccinated,

eVIN: vaccine and syringe consumption, wastage rate

Safe-vac:

This reporting form will have information on daily basis and also have cumulative data.

No. of AEFI cases (Minor, Serious, Severe)

Reporting Form (Daily & Cumulative)*

FORM 9

HPV Vaccination Campaign Year/Month:												
State:			Date:									
			U-WIN			eVIN				SAFE-VAC		
S. No.	**Name of Health Facility**	**District**	**No. of sessions planned**	**No. of sessions held**	**No. of girls vaccinated**	**No. of vials consumed**	**Wastage (%)**	**No. of AD syringes - 0.5 ml consumed**	**Wastage (%)**	**No. of Serious AEFI**	**No. of Severe AEFI**	**No. of Minor AEFI**
	a	**b**	**c**	**d**	**e**	**f**	**g**	**h**	**i**	**j**	**k**	**l**
1.												
2.												
3.												
4.												
5.												
6.												
7.												
8.												
9.												
10.												
Total for today												
Cumulative total till previous day												
Cumulative total till today												
* To be developed using U-WIN, eVIN, SAFE-VAC												

Form 10: Community level monitoring

Community level monitoring form: Once the HPV vaccination campaign starts, monitors will conduct **House to House monitoring from the 5th week onwards** i.e., after the completion of one month of the campaign. The objective of RCM is to assess community-level uptake of the HPV vaccine, identify gaps or bottlenecks in coverage, and provide timely feedback for immediate corrective actions. RCM is conducted at the community level within the catchment area of the health facility using the standard checklist on the U-Mentor application. One monitoring format should be used for only one area. National or independent observers/external monitors are encouraged to conduct as many RCMs as possible.

Rapid Convenience Monitoring (RCM) Methodology

Area Selection: Try to identify missed areas such as farthest from the central point of community settlement/ area. Prioritize hard-to-reach populations, including isolated areas, socially segregated groups, street children, and working children in small enterprises or markets.

Monitors should go to the centre of the selected area, choose a direction by tossing a coin and begin with the first house closest to the identified direction. Parents or caregivers should be interviewed of the identified eligible girls aged 14 years, and vaccination status should be verified using left index finger marking/ vaccination certificate/U-WIN records, and/or caregiver recall.

Beneficiary Identification: Visit 10 households having eligible girls aged 14 years in the area. If more than one eligible girl is present in a household, include only one randomly selected beneficiary. Exclude girls who became eligible after the start of the campaign.

If upto **three eligible girls** are found unvaccinated, parents should be counselled on the importance of HPV vaccination and advised to register on U-WIN portal and visit the nearest health facility for vaccination.

If **four or more eligible girls** are found unvaccinated in the area, the findings should be immediately reported to the Supervisor/Medical Officer for conducting sensitization and community engagement interventions and then social mobilization of beneficiaries to the nearest HPV vaccination session site.

If any **Adverse Event Following Immunization (AEFI)** is identified during household visits, parents should be advised to visit the nearest health facility or designated AEFI management centre. Also, report AEFI to the concerned authority and note the details of AEFI.

RCM findings should be submitted to the Medical Officer In-charge/Facility In-charge, followed by daily feedback meetings to discuss observations and initiate corrective actions.

RCM activities should continue until the end of the campaign. RCM is a critical tool for identifying pockets of unimmunized beneficiaries and enabling timely mid-course corrections. Findings from external monitors should be used to inform actions such as re-training of vaccinators, revision of micro-plans, or conducting repeat sessions in low-coverage areas.

Rapid Convenience Monitoring (RCM) in the Community

FORM 10

HPV Vaccination Campaign Year/Month:			
State:	District/Corporation:	Block/Urban Area:	Village/ Mohalla:
HPV Vaccination Campaign Start Date:	Monitoring Date:	Monitor Name & Mobile No:	Designation:
Type of monitor: Govt. /Partners (Please specify)			

1. Conduct RCM in the community after completion of 1 month of HPV vaccination campaign. Use one format for only one area. Try to identify missed areas such as farthest from the central point of community settlement/area, segregated groups through house to house visits by assessing vaccination status of eligible girls of 14 years.
2. Methodology: Go to the centre of the area and pick up a direction by tossing a coin. Choose the first house closest to you in the identified direction. Talk to the parents and identify the eligible girl available in the household, assess HPV vaccination status through left index finger marking, vaccination card, U-WIN and/or recall. Visit 10 households having eligible girls aged 14 years and assess the HPV vaccination status.
3. If upto 3 eligible girls are found unvaccinated, counsel parents for HPV vaccination, inform them to get registered on U-WIN for vaccination at the nearest Health facility for HPV vaccination.
4. If 4 or more eligible girls are found unvaccinated, immediately report to the Supervisor/ Medical Officer for conducting sensitization and community engagement interventions and then social mobilization of the beneficiaries to the nearest health facility where HPV vaccine is being administered.
5. If any AEFI is noticed, advise parents to visit nearest health facility/AEFI management centre. Also report AEFI to concerned authority and note the details of AEFI on the back of this FORM.

Eligible girls Assessment Table:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**
Name and address of the eligible girl											
A).Eligible girl received vaccine during HPV vaccination Campaign ? (Yes/No) If not then record the reasons for non- vaccination in the table at the bottom											
Reason as mentioned by the caregiver/parents for "Why was their girl in eligible age group not vaccinated with HPV vaccine during the Campaign?" **Put a tick against most important reason(s). Multiple options (Max-4) allowed**											
1. Not aware of HPV vaccination Campaign / session											
2. Parents didn't give importance / Not aware of need for HPV Vaccination/ Others											
3. Family refused HPV vaccination											

Eligible girls Assessment Table:	1	2	3	4	5	6	7	8	9	10	Total
4. Scared of Injection											
5. Eligible girl was sick											
6. Inconvenient time / location / distance / waiting time											
7. Vaccine/vaccinator not available											
8. Fear of AEFI based on experience (fever, pain, swelling, hospitalization, death, disability)											
9. Negative media reports / social media / rumour											
10. Eligible girl had gone out of area											
11. Girl became eligible i.e., 14 years on the day of monitoring											
12. Others											
B). How did the family come to know about this campaign? (Mention code from below) Multiple options - (max4) allowed											
1=From Health worker/ASHA/AWW before the campaign 2=Poster/Banner/Information card/Miking, 3=Newspaper/T.V./Radio 4= Social media; 5=School / Teachers Through PTM, Student's diary or mail/web site//WhatsApp; 6=Through sessions 7=Family/Friends/Neighbours 8=Community Influencers; 9= Other, please specify											
C). Did the beneficiary develop any discomfort/ AEFI after vaccination? (Write -Yes / No)											
If yes, record the event from codes given below* (MONITOR should NOT prompt) "Multiple options - (max4) allowed " Note the details of AEFI on the backside of the form.											
* 1 = Pain; 2= Swelling; 3= Excessive crying; 4= Fainting; 5=Vomiting 6= Pain in abdomen; 7= injection site abscess; 8=any condition requiring hospital admission; 9= Others											
D) Are there any posters/banners about HPV vaccination displayed in the community?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

5C. RECORDING AND REPORTING – USE OF DIGITAL PLATFORMS

eVIN Module

This operational guideline describes how the electronic Vaccine Intelligence Network (eVIN) module supports HPV vaccine stock management, movement across all levels of the health system, from higher stores to last storage points, and the storage temperature along with stock management of syringes during the HPV vaccination campaign.

Overview of the eVIN Module

The eVIN module is a digital tool within the HPV operational framework that tracks HPV vaccine stocks, storage temperature, facilitates indenting between facilities, and records utilization at cold chain point level. It is used by vaccine stores and Cold chain points (Health facilities storing & distributing vaccines) at all levels to ensure that HPV vaccine stock availability, supply chain management are accurately recorded in real time and vaccine doses are kept at recommended storage and temperature.

Viewing HPV Vaccine Stock

Cold chain handlers can view available HPV vaccine stocks across facilities to plan their indents and distribution further. Under the "Stock Management" → "Closing Stock" →"Adolescent Vaccines" tab, total and batch-wise stocks of HPVV Gardasil, including available, allocated, and in-transit quantities are displayed.

Creating an Indent (Issuing Store/Facility)

When a lower-level facility requires HPV vaccines, the issuing store uses the eVIN module to create an indent in a structured sequence. This process ensures that vaccine requirements are clearly captured and ready for allocation and dispatch.

From the "Indent" tab, the issuing store selects "New Indent" and then chooses "Issue" to start an indent for a receiving store. The appropriate receiving facility is selected from the list, and the HPV vaccine is chosen using filters or navigation. Required doses are entered against HPVV Gardasil, and the details are saved before proceeding to the next screen. The estimated date of arrival, challan number, and order tag ("Routine" or "Critical") are recorded, with optional comments, and then reviewed and saved. After final review under "Drafts," the indent is submitted; a confirmation message appears, and the indent status changes to "Confirmed".

Allocating Vaccine Batches (Issuing Store/Facility)

Once an indent is confirmed, the issuing store allocates specific batches of HPV vaccine against that indent. This allocation links physical stock with the requisitioned quantities and prepares the indent for dispatch. Under "View Indent," the handler selects "Issue" from the drop-down and chooses the relevant "Confirmed" indent from the list. Through the three-bar menu, the "Allocate Stock" option is opened, and batch-wise doses are entered and saved. The allocated doses are reviewed for accuracy and once confirmed, the handler saves, reviews, and submits the allocation.

Marking "Ready for Dispatch" and Shipping (Issuing Store/Facility)

After allocation, the indent moves through two critical stages at the issuing store: "Ready for dispatch" and "Shipped." These steps capture the transition from store allocation to physical movement of vaccines. The "Confirmed" indent with completed allocation is selected, and via the three-bar menu the handler chooses "Ready for dispatch," optionally adding comments before confirming the updated status. Once the indent appears in "Ready to Dispatch" status, the handler again uses the three-bar menu to select "Ship indent," which generates a shipment and displays a "shipment created successfully" message; the indent then appears in "Shipped" status.

Fulfilling the Indent (Receiving Store/Facility)

At the receiving store or facility, the HPV vaccine consignment is recorded as received and verified against the

shipped indent in eVIN. This step updates stock at the receiving facility and completes the indent cycle. The cold chain handler at the receiving facility opens the “Indent” tab, selects “View indents,” and ensures that “Receipt” is chosen from the drop-down before selecting the relevant “Shipped” indent. Through the three-bar menu, “Fulfil Indent” is selected, and batch details, doses received, and date of actual receipt are verified and entered, with optional comments, before submitting. On successful submission, a confirmation message is displayed, and the indent status updates to “Fulfilled,” reflecting accurate stock receipt.

Recording Net Utilization (Cold Chain Point/Last Storage Point)

At the last storage point or cold chain point, net utilization of HPV vaccines is recorded to link issued doses with session-level use. This ensures that consumption data aligns with issues and supports monitoring of wastage and coverage. Under “Stock Management,” the cold chain handler selects “Issue / Net Utilization,” then chooses “Adolescent Vaccines” and HPVV Gardasil. The relevant batch issued to the session site is selected, date of actual transaction is entered, net utilization quantity is recorded with material status (e.g. “VVM Usable”), and the entry is saved and submitted after review.

In this way, the eVIN module for the HPV campaign forms a continuous digital chain that starts from stock visibility, moves through indenting and shipment, and ends with documented receipt and utilization at the last cold chain point, with each step supported by the referenced screenshots.

1. View Stock (All Level Stores/Facilities)

1. In Stock Management, click “Closing Stock”. (as shown in Fig. 23)
2. Under the “Adolescent Vaccines” tab, to view the total stock of HPVV Gardasil. (as shown in Fig. 24)
3. Click on the vaccine name “HPVV Gardasil” to view the stock details such as Available Stock, Allocated Stock, and In Transit Stock, followed by batch-wise stock details & quantity. (as shown in Fig. 25)

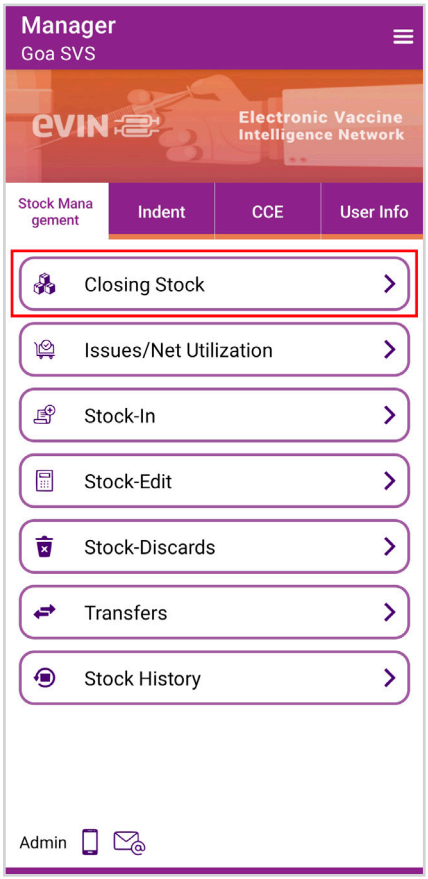


Fig. 23

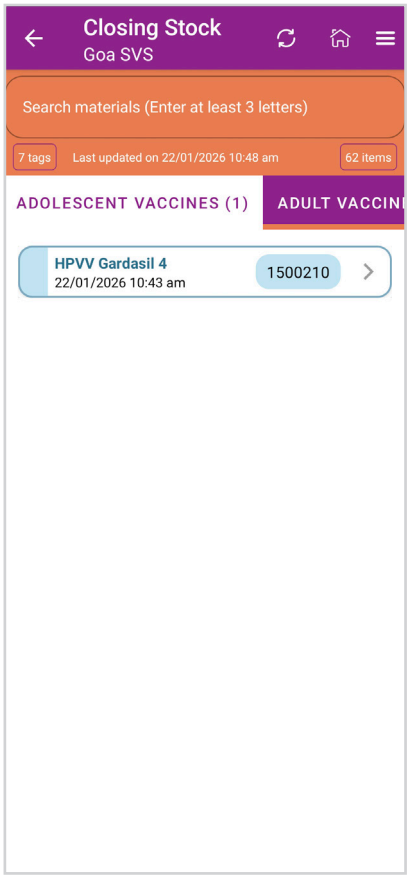


Fig. 24

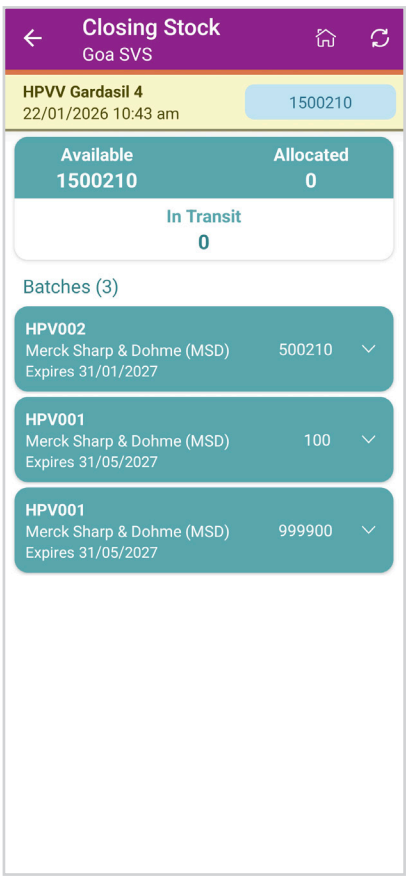


Fig. 25

2. Creation of Indent (Issuing Store/Facility)

1. Go to the “Indent” tab and click “New Indent”. (as shown in Fig. 26)
2. Click “Issue”. (as shown in Fig. 27)
3. From the list, choose the appropriate receiving facility name. (as shown in Fig. 28)

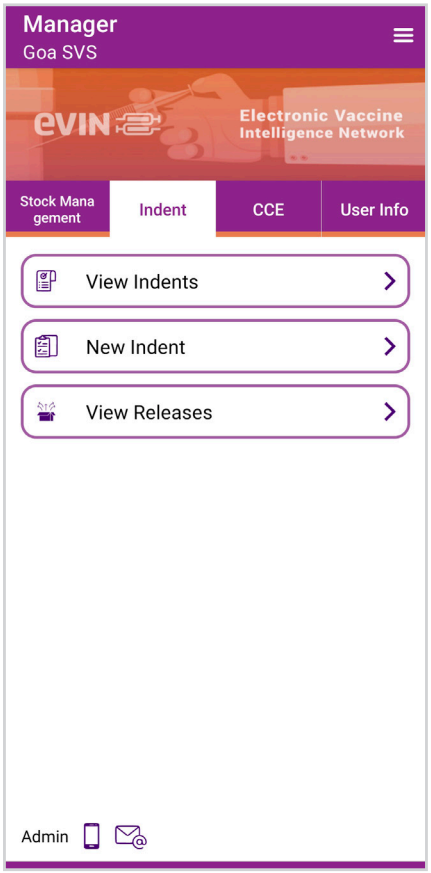


Fig. 26

Fig. 27

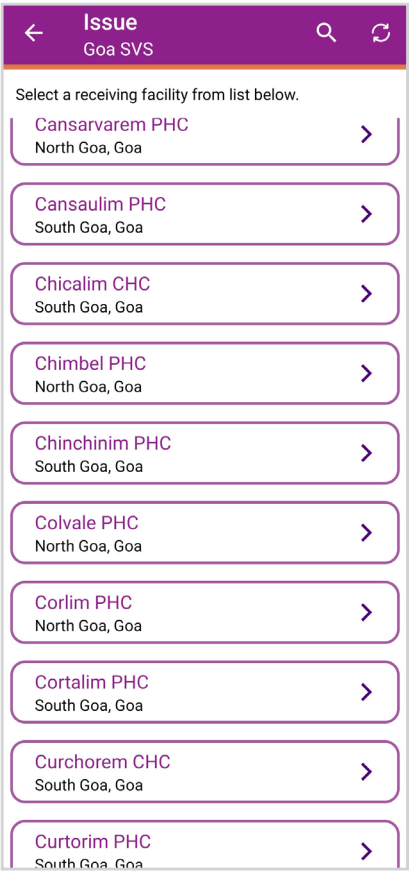


Fig. 28

4. Using filter option or navigation, select the vaccine name. (as shown in Fig. 29)
5. Enter the required number of doses to confirm for the facility. Click “Save” to confirm. (as shown in Fig. 30)
6. Click “Next” to proceed. (as shown in Fig. 31)

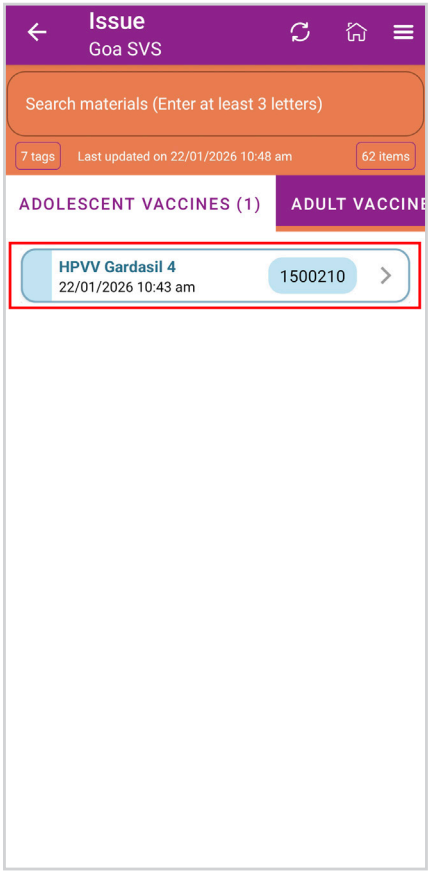


Fig. 29

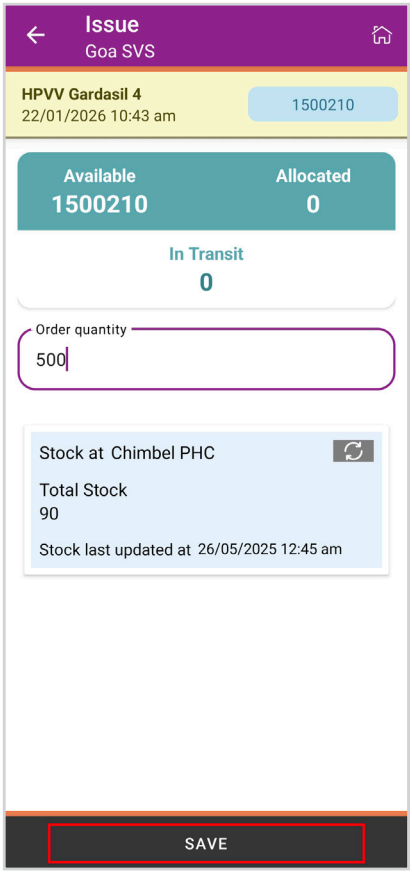


Fig. 30

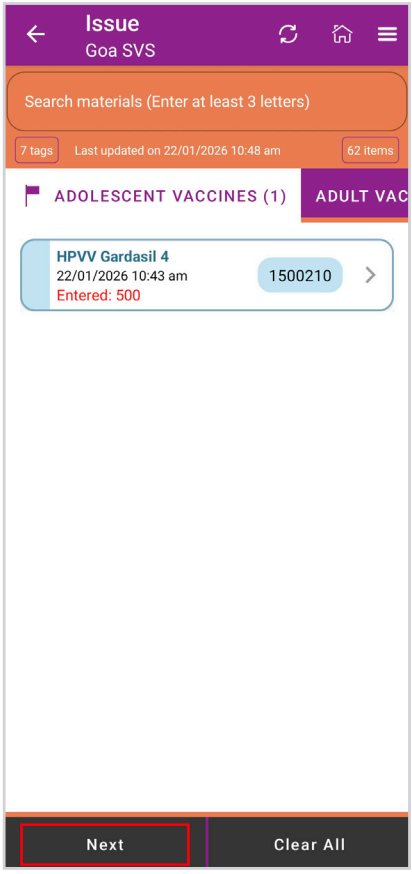


Fig. 31

7. Enter the Estimated date of arrival for the vaccine, add the challan number, choose from Order tags as “Routine/Critical” based on manner of order. Enter Comments in “Comments” section (optional) & Click “Review” to check the details. (as shown in Fig. 32)
8. Click “Save” to confirm the entry. (as shown in Fig. 33)
9. Click “Drafts” to review and finalize the process. (as shown in Fig. 34)

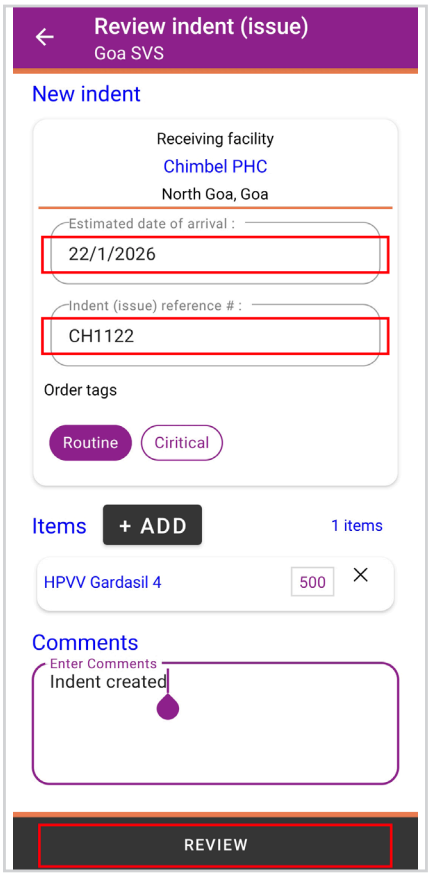


Fig. 32

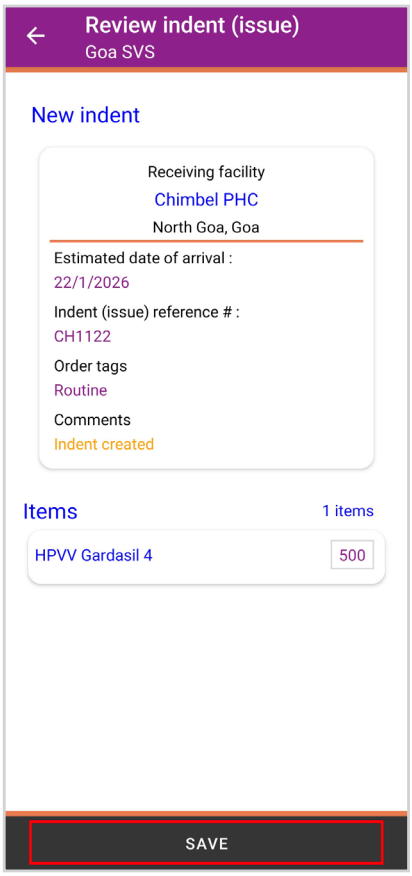


Fig. 33

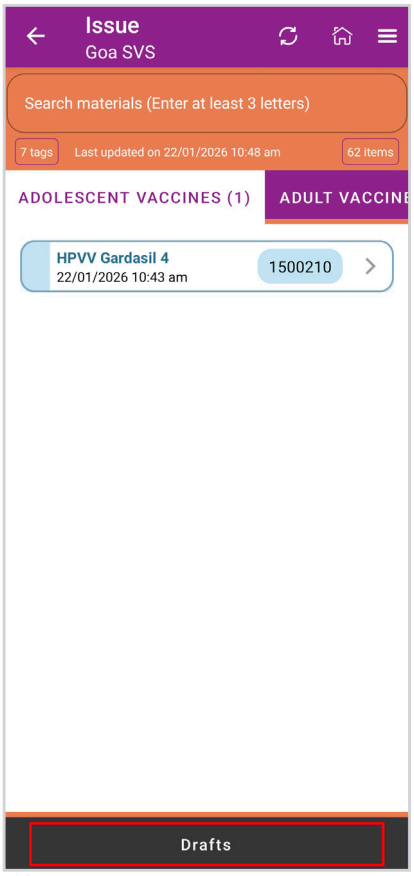


Fig. 34

10. Click “Submit” (as shown in Fig. 35)
11. A message is displayed "Indents submitted successfully". Click “OK” (as shown in Fig. 36
12. The Indent will then be placed in “Confirmed” Status

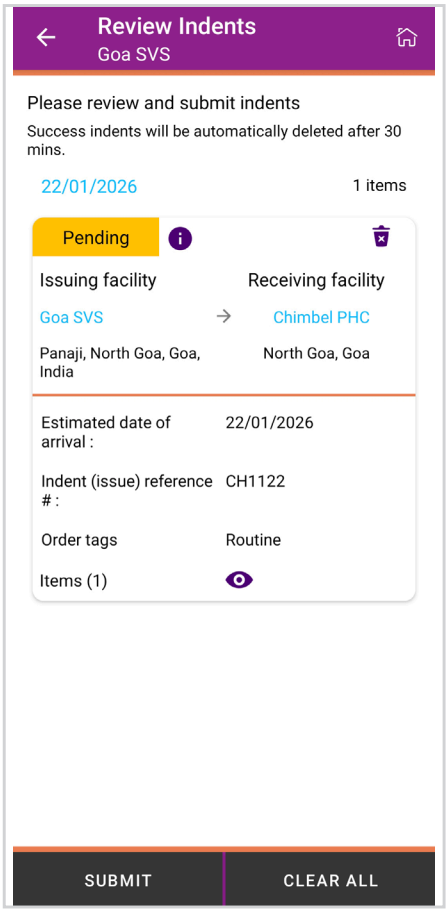


Fig. 35

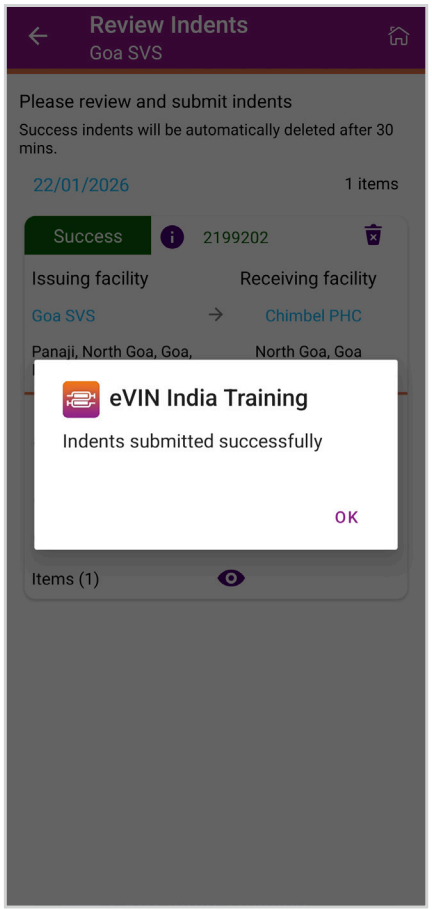


Fig. 36

3. Allocate Vaccine Batch (Issuing Store/Facility)

1. Go to the “Indent” tab and click “View Indent”. (as shown in Fig. 37)
2. From the drop-down menu (on upper left side of screen) select “Issue”. (as shown in Fig. 38)
3. Choose the created Indent with “Confirmed” status from the list—for example, in this case, the indent was created for Chimbel PHC. (as shown in Fig. 39)

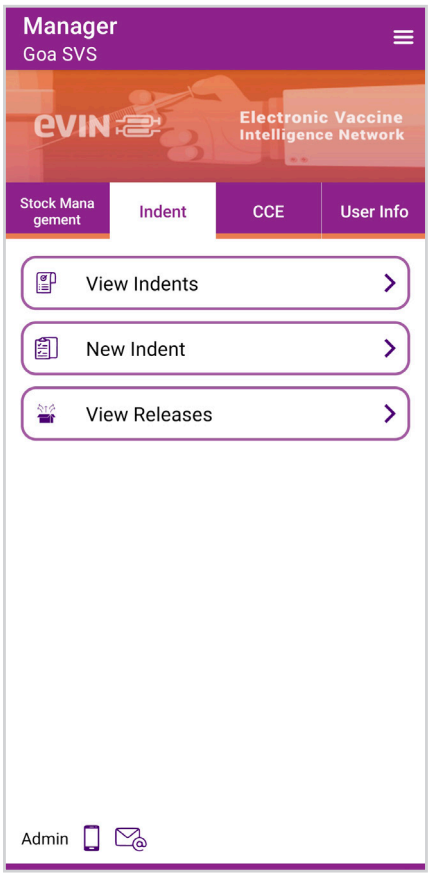


Fig. 37

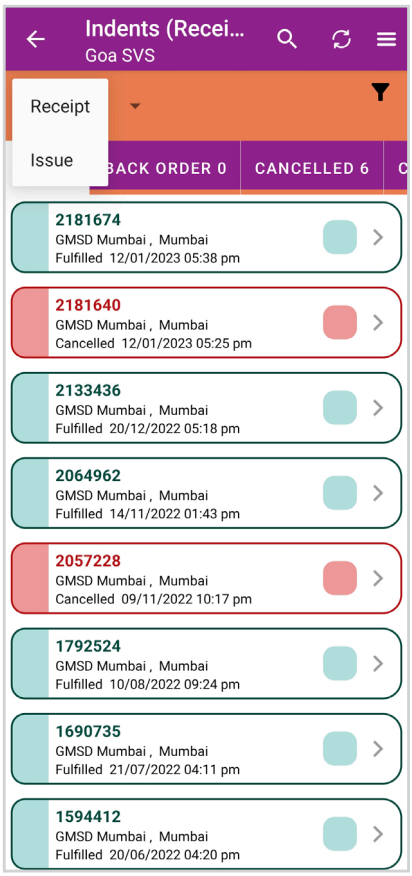


Fig. 38

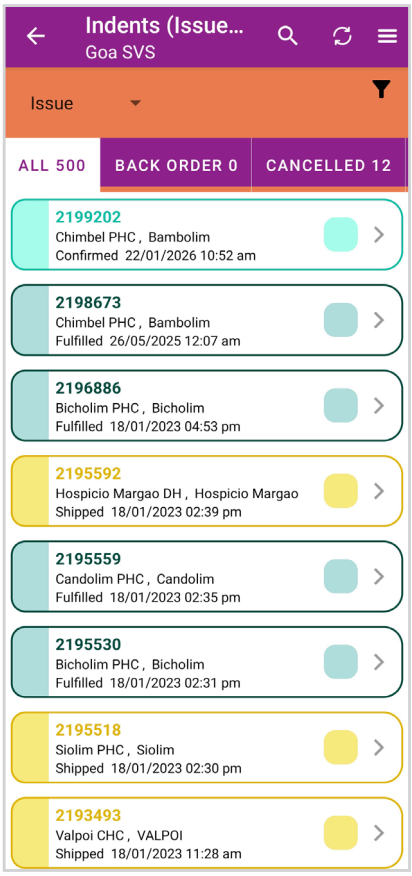


Fig. 39

4. Click on the three-bar menu (on lower right side of screen). (as shown in Fig. 40)
5. Select "Allocate Stock." (as shown in Fig. 41)
6. Enter the number of vaccine doses to be allocated from the batch(s). & Click "Save" to confirm (as shown in Fig. 42)

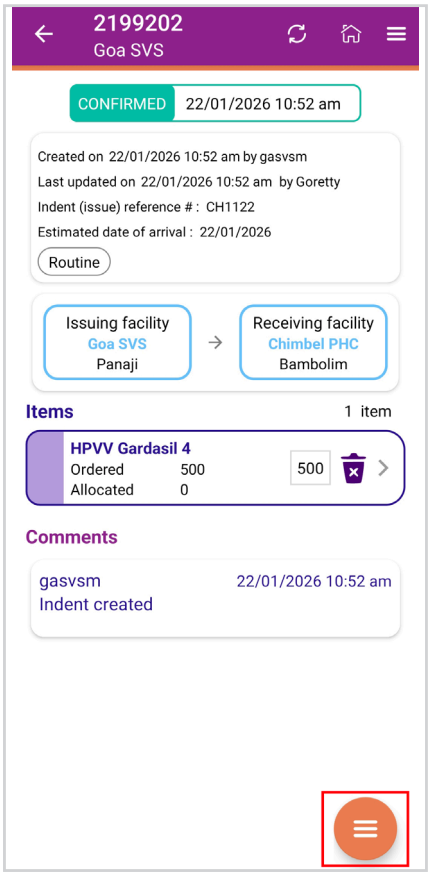


Fig. 40

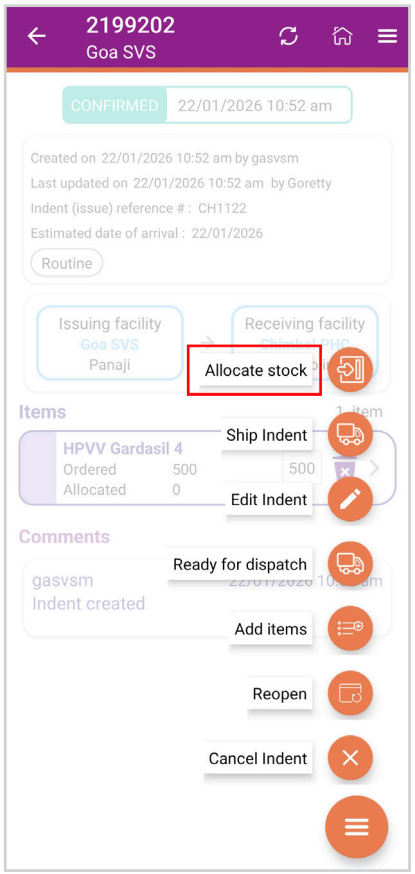


Fig. 41

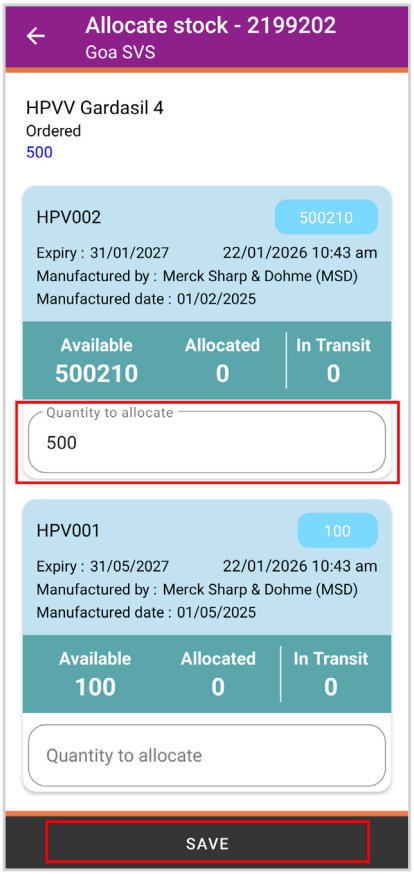


Fig. 42

7. Click “Save”. (as shown in Fig. 43)
8. Verify the doses allocated are correct. & click “Review”. (as shown in Fig. 44)
9. Click “Submit”. (as shown in Fig. 45)

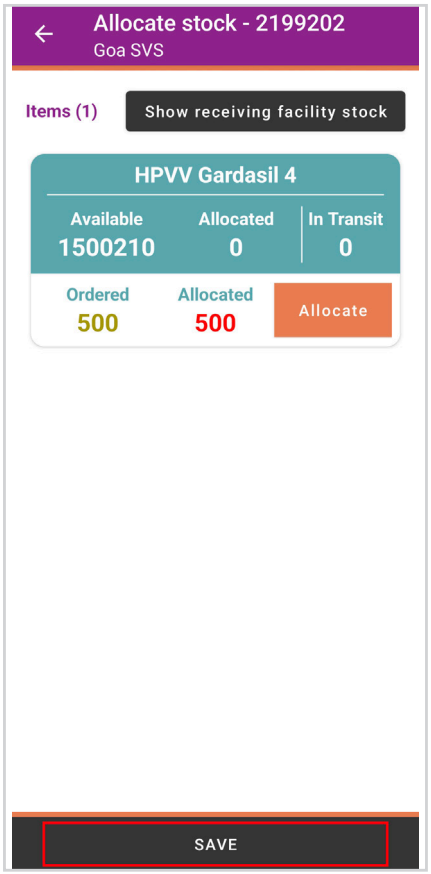


Fig. 43

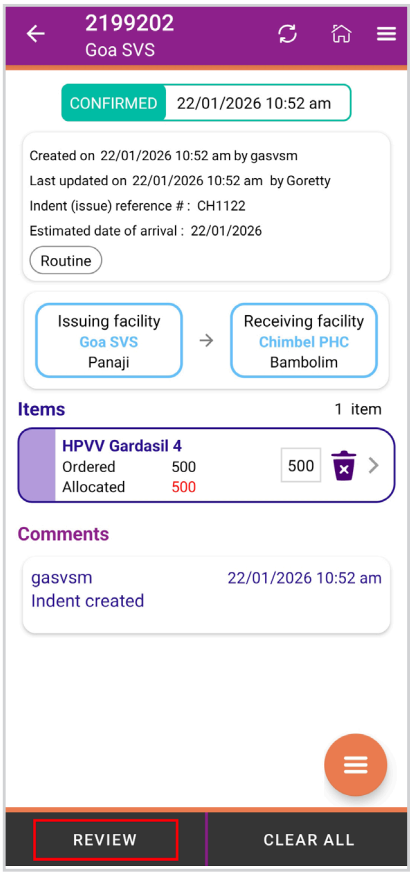


Fig. 44

Fig. 45

4. Ready for dispatch & Ship Indent (Issuing Store/Facility)

1. Select the Indent with “Confirmed” status and allocation done using above steps, click on the three-bar menu (on lower right side of screen) and select “Ready for dispatch” (as shown in Fig. 46)
2. Enter relevant comments (optional) & click on “Ready for dispatch”. (as shown in Fig. 47)
3. Click “YES” to update the Indent status as “Ready for dispatch”. (as shown in Fig. 48)

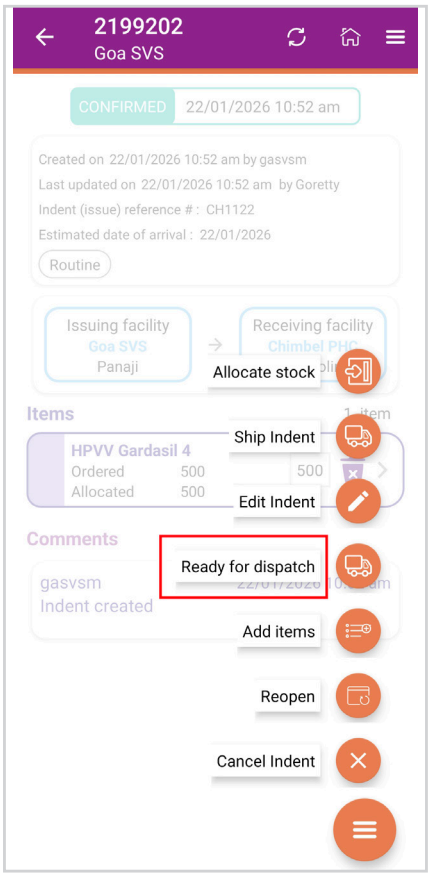


Fig. 46

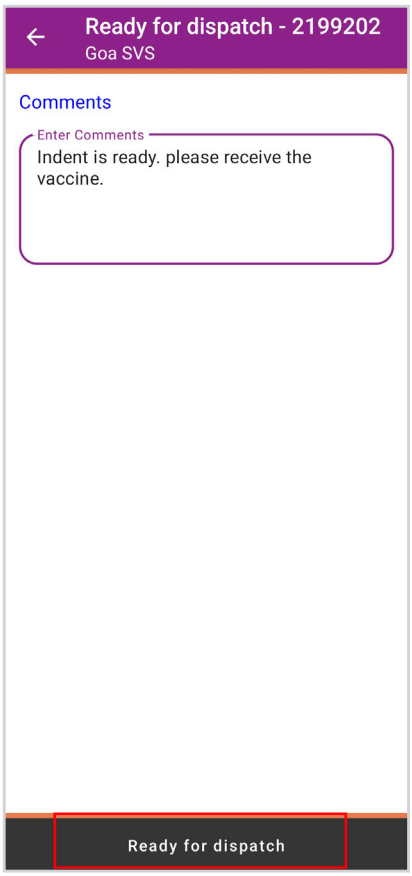


Fig. 47

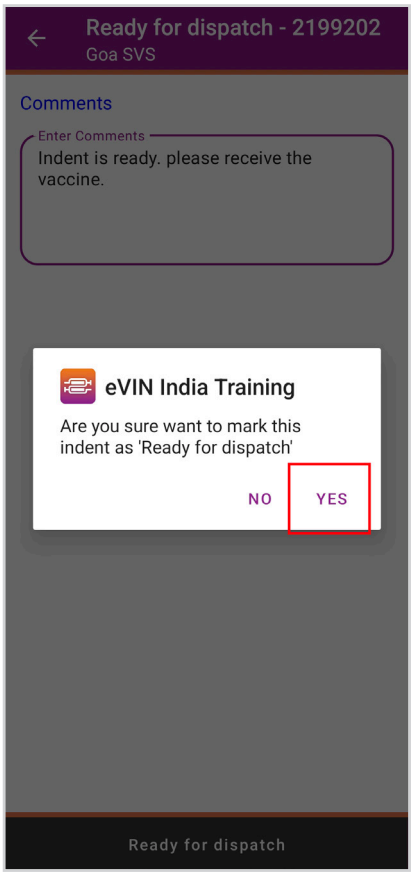


Fig. 48

4. Select the Indent with “Ready to Dispatch” status as done using above steps, click on the three-bar menu (on lower right side of screen). (as shown in Fig. 49)
5. Select “Ship indent”. (as shown in Fig. 50)
6. Message will be displayed as “shipment created successfully”. Click “OK” (as shown in Fig. 51)
7. The Indent will be updated to “Shipped” status. (as shown in Fig. 52)

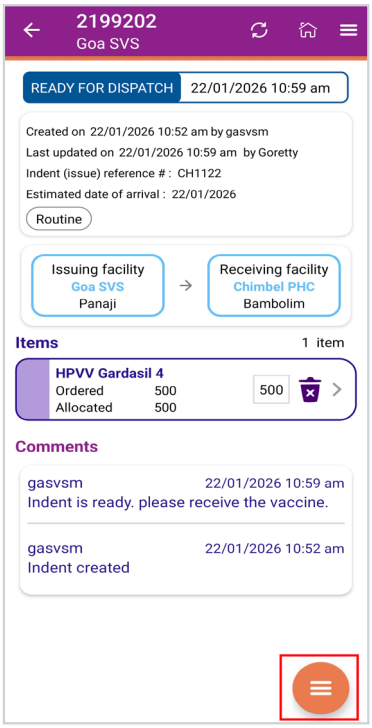


Fig. 49

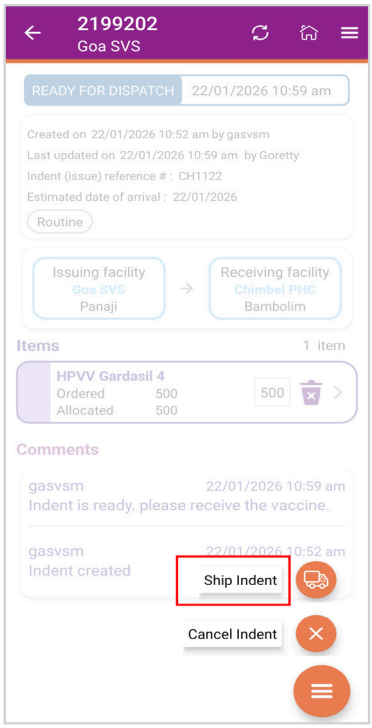


Fig. 50

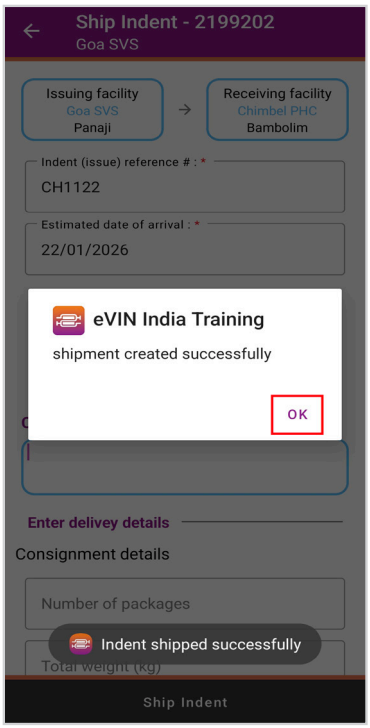


Fig. 51

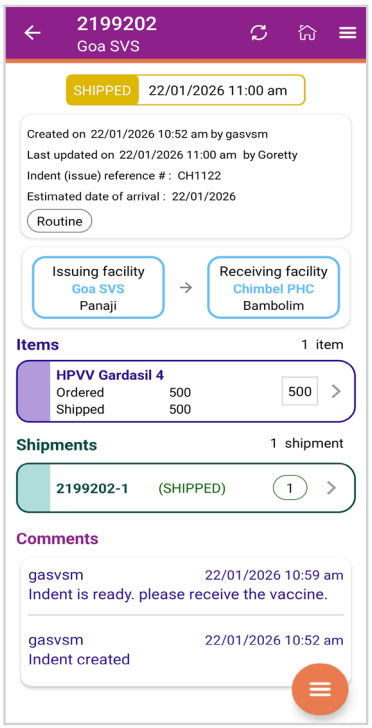


Fig. 52

5. Fulfil Indent (Receiving Store/Facility)

1. The receiving store handler need to click on “Indent” tab. & click “View indents”. (as shown in Fig. 53)
2. Ensure “Receipt” is selected from the drop-down menu (on upper left side of screen). & Select the Indent with “Shipped” status, which need to be fulfilled. (as shown in Fig. 54)
3. Review the Indent, and click on three-bar menu (on lower right side of screen). (as shown in Fig. 55)

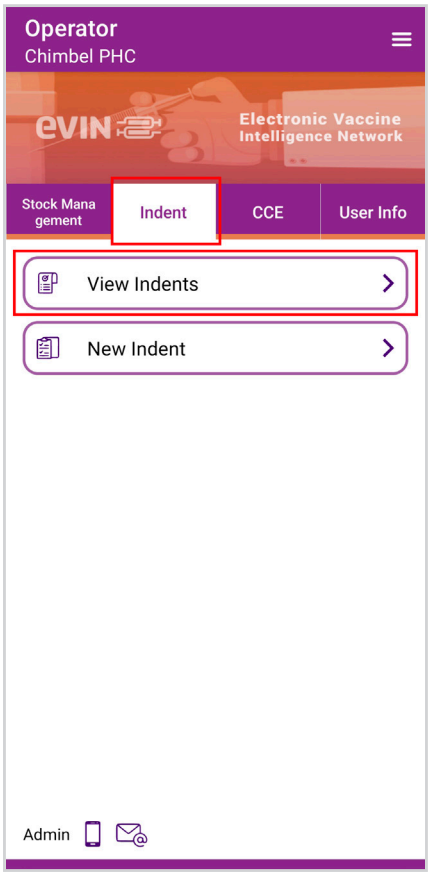


Fig. 53

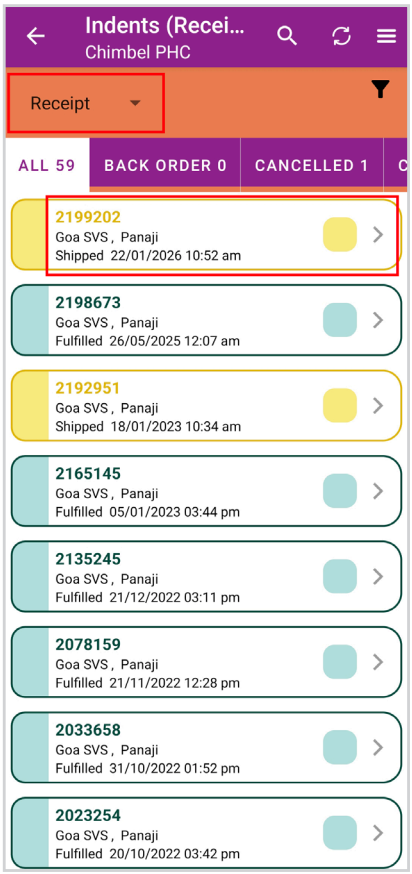


Fig. 54

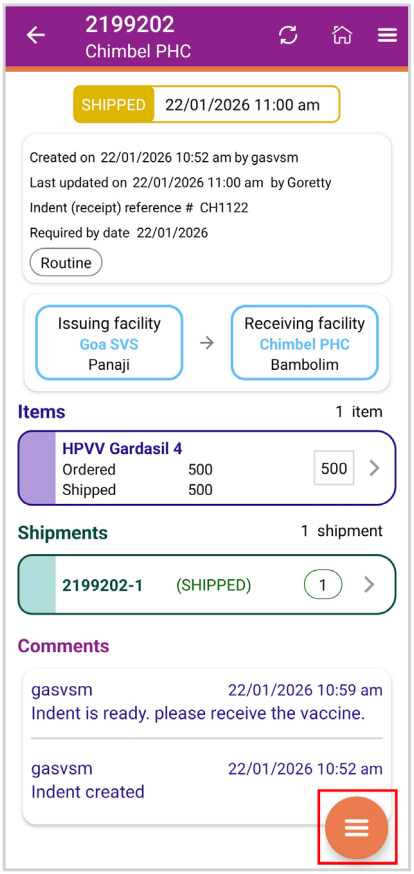


Fig. 55

4. Click “Fulfil Indent”. (as shown in Fig. 56)
5. Ensure that the Batch and doses quantities are as per the physically received dose quantities supplied, enter “Date of actual receipt” of the vaccine, mention relevant comments (Optional) & click “Submit”. (as shown in Fig. 57)
6. On successful submission of the Indent, a message “Indent Fulfilled Successfully” is shown. Click “OK” (as shown in Fig. 58)
7. Now, the Indent will be updated to “Fulfilled” status. (as shown in Fig. 59)

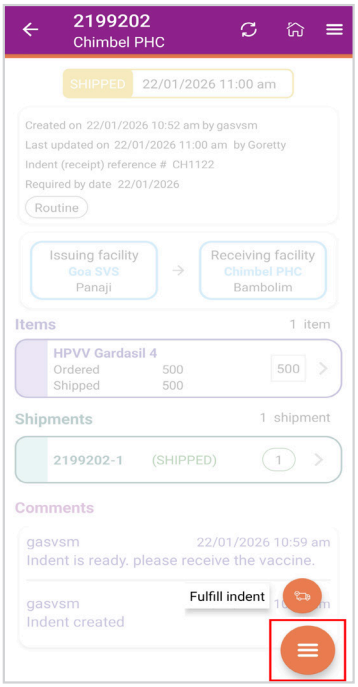


Fig. 56

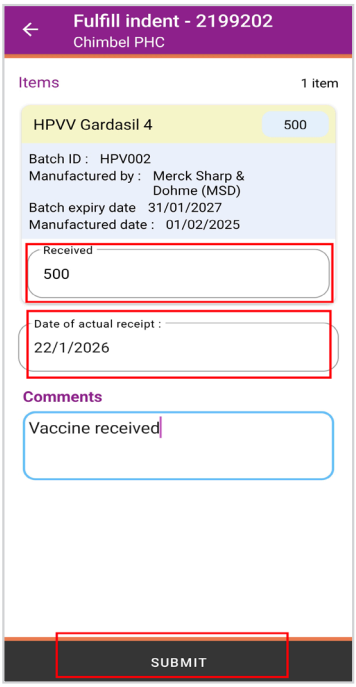


Fig. 57

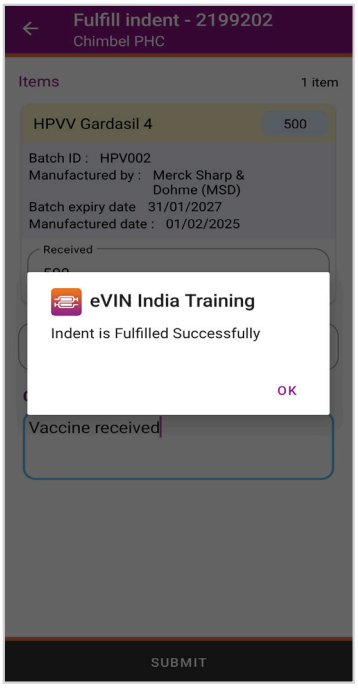


Fig. 58

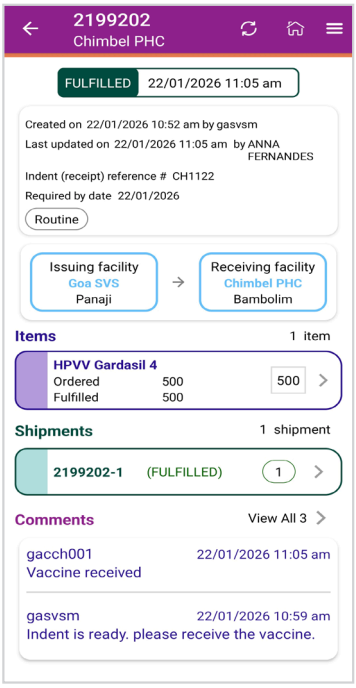


Fig. 59

6. Net Utilization (Cold Chain Point/Last storage point)

1. Under “Stock Management”, click “Issue / Net Utilization”. (as shown in Fig.60)
2. Click “ADOLESCENT VACCINES” & select “HPVV Gardasil”. (as shown in Fig.61)

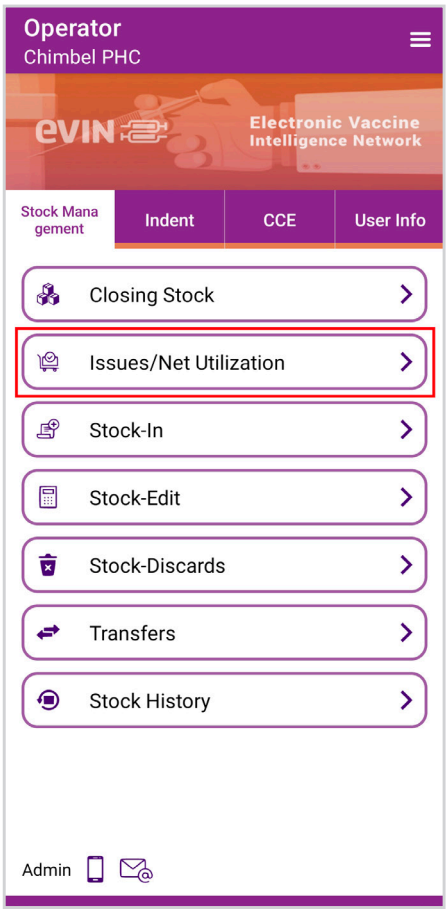


Fig. 60

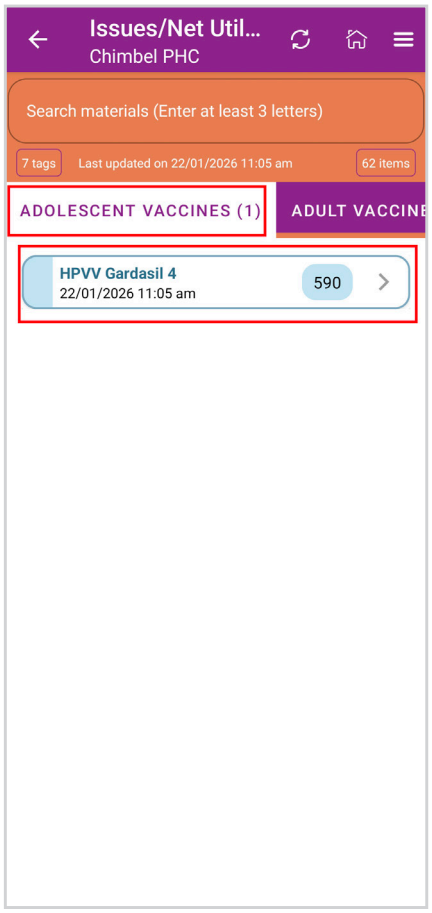


Fig. 61

3. Select the batch issued to the session site, select “Date of actual transaction”, Enter Net-Utilization” quantity, select Material Status as “VVM Usable” & click “Save”. (as shown in Fig. 62)

4. Review the details (in case of any correction in quantity or batch number, select “Undo”), click “Submit”. (as shown in Fig. 63)

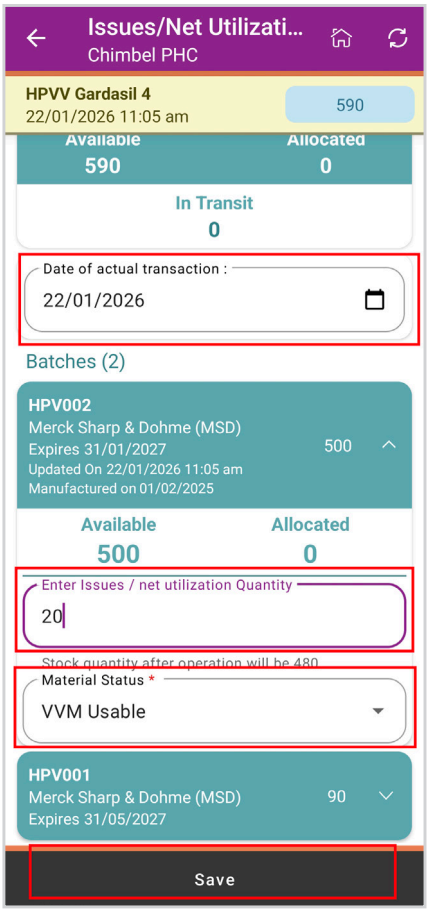


Fig. 62

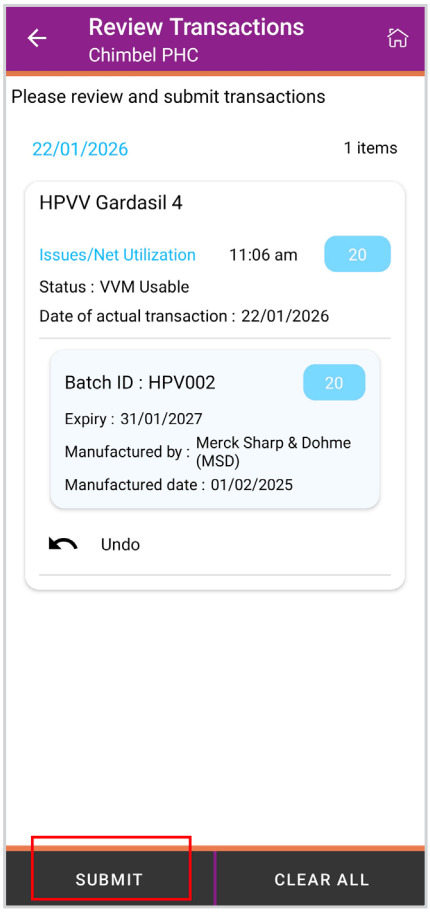


Fig. 63

U-WIN

HPV vaccination for all girls aged 14 years will be done through Health facility-based sessions. The U-WIN Platform would be used for registration, recording and reporting of HPV Vaccination for Health facility-based sessions. U-WIN will be considered as ‘Single Source of Truth’ for HPV Vaccination reporting.

PRE HPV VACCINATION CAMPAIGN

The preparatory activities for U-WIN for the HPV vaccination campaign, to be carried out by Programme Managers and Vaccinators/ANMs are as follows:

a. Programme Managers - The UIP program managers at all levels (national, state, district, sub-district, and planning units) will act as Programme managers for HPV vaccination and also as users for U-WIN administrator module. Training of Health Facility Manager will be organized on the following aspects:

- ***Finalize list of Vaccinators:*** Update the existing data of registered vaccinators, include any additional or newly hired vaccinators, and register all available vaccinators on U-WIN for the HPV vaccination. Ensure to conduct training of vaccinators on the U-WIN Vaccinator Module to enhance their skills in using the app for: Starting and ending the session, vaccinating registered beneficiaries, registering and vaccinating walk-in beneficiaries, and providing digital acknowledgment.

- ***Finalize list of Session Sites:*** Create HPV vaccination session sites in U-WIN at Planning Unit/Health Facility level which is a cold chain point (CCP).
- ***Prepare due list :*** Supervise the preparation of due list for 14-year-old girls based on the Head Count Survey capturing the details - name, DOB, photo ID type & number, and parent/guardian mobile number - in U-WIN.
- ***Microplanning for the HPV vaccination drive***: Prepare micro-plans assigning vaccinators, mobilizers, and other resources using U-WIN data.
- ***Monitoring and Reporting:*** Monitor the HPV vaccination drive using the Reports Module of U-WIN and utilize these digital dashboards to prepare presentations and updates.

b. Vaccinators –

- Pre-registration of the eligible beneficiaries.
- Supervise the surveyor to conduct house-to-house surveys.
- Populate the due list of eligible girls for registration in U-WIN.

DURING HPV VACCINATION CAMPAIGN

During the HPV vaccination campaign, the following activities will be performed on U-WIN by Program Managers, Vaccinators, and Parents/Guardians:

a. Program Managers -

- Health Facility Manager will create, publish, and manage HPV vaccination sessions in U-WIN during the HPV vaccination campaign.
- Plan session dates, times, and sites, and assign vaccinators and mobilizers.
- Monitor progress on session loads, due lists, and planned versus held sessions through the U-WIN Reports Module.
- District, State, and National UIP Program Manager can track vaccination coverage by session sites, CCPs, blocks, and districts.
- Conduct weekly reviews of stock levels, identify replenishment needs, and monitor temperature and equipment performance, with necessary follow-up actions.

b. Vaccinator

- The concerned ANM, under the supervision of the MO, will plan the HPV vaccination campaign using a standard format, including details such as the vaccinator's name, supervisor's name, required sessions, and other logistics.
- Ensure that the session starts and ends on time, completing all entries on the same day in U-WIN.
- Vaccination records must be entered in real time during the session, as no backlog entry will be allowed.
- At the end of each HPV session, the vaccinator will review and submit the U-WIN summary report on the same day.
- Based on this data, U-WIN will generate a list of left-out beneficiaries for further course of action.

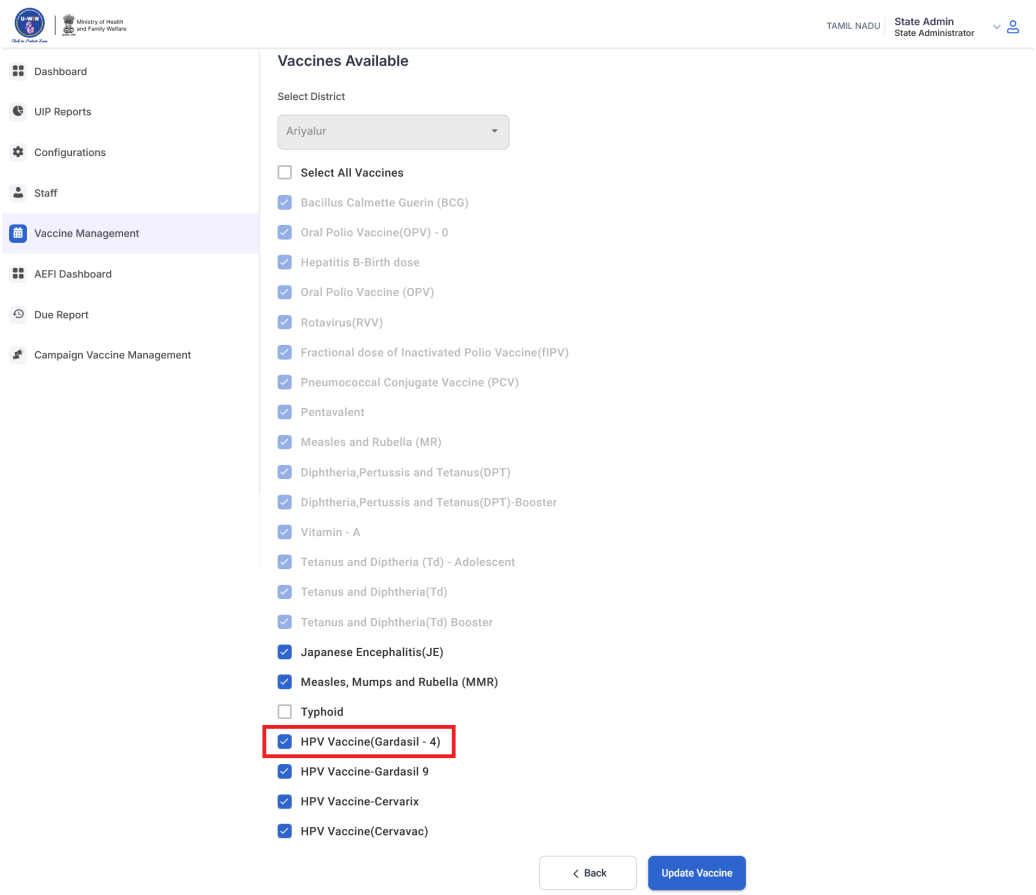
c. Parents/Guardian- Parents can pre-register/self-register, their daughter who is eligible for vaccination using their mobile number. It will be an OTP based registration. If not pre-registered, registration can be completed on-site during the session, along with providing consent for vaccination.

WORKFLOW IN U-WIN

Administrator module- State Administrator

The State admin must include the “HPV Vaccine” in the vaccine master list for all districts before the commencement of HPV vaccination.

Fig. 64

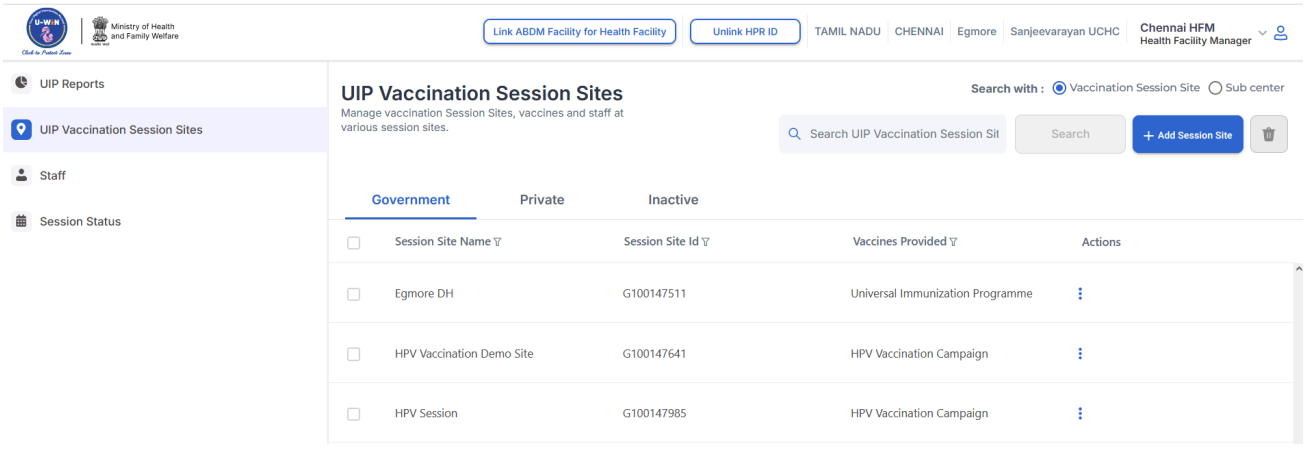


Administrator module- Health Facility Manager

Step 1. Addition of New Session site by Health Facility Manager in U-WIN

Health Facility Manager can add new HPV vaccination session site by clicking “Add Session Site” in U-WIN, as shown in the image below.

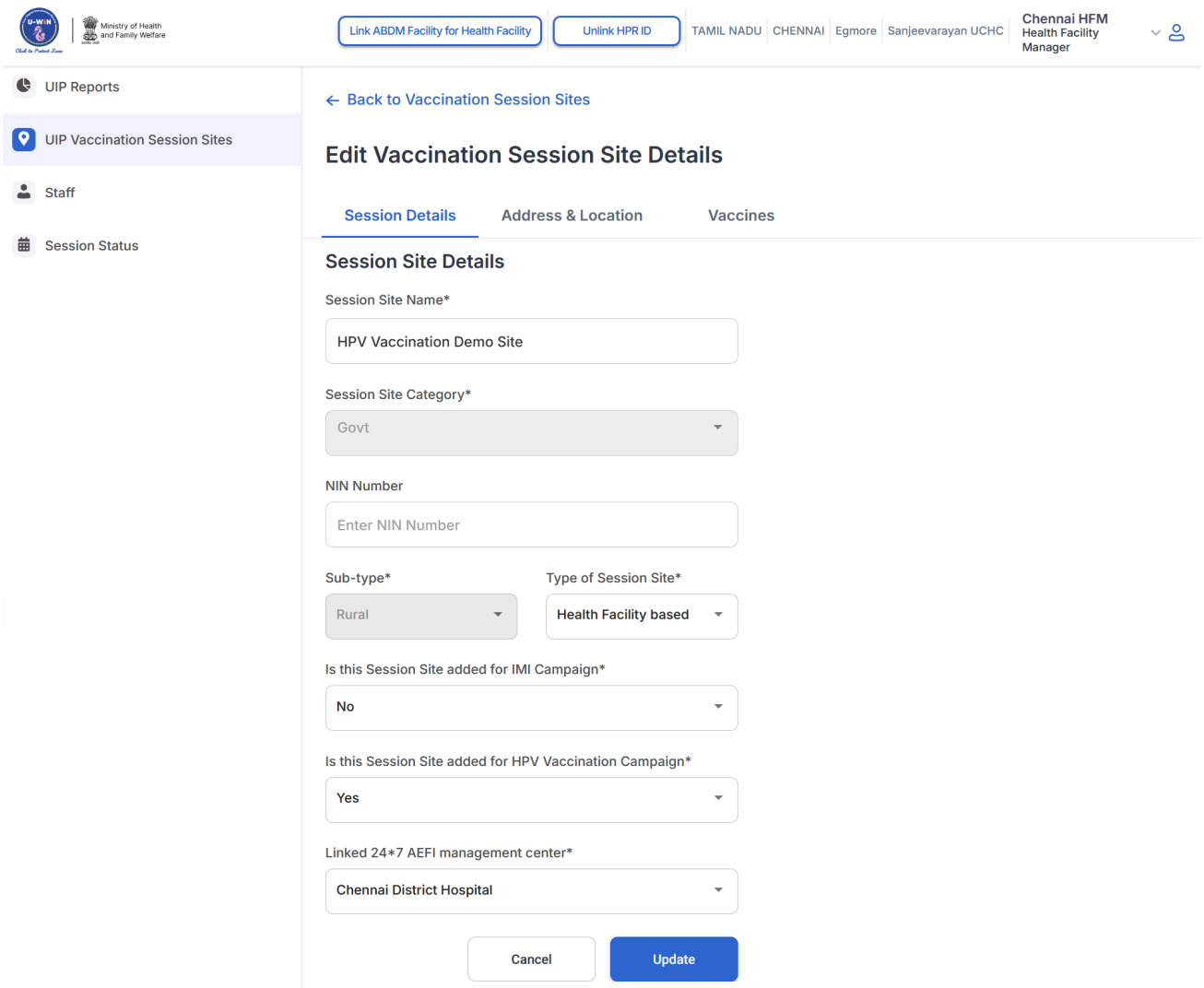
Fig. 65



The Health Facility Manager must enter the following details as shown in the image below:

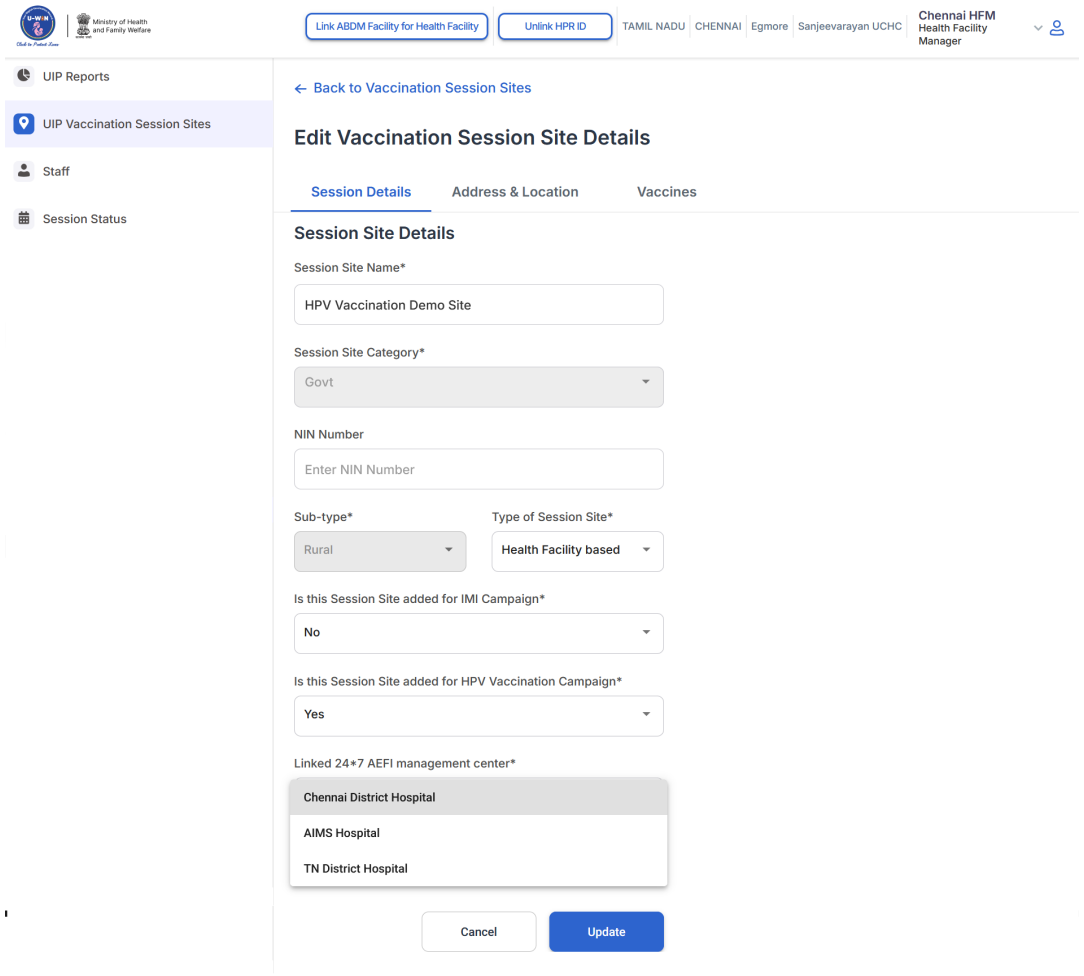
- Session Site Name
- Session Site Category- select Govt.
- Subtype – select “Rural/Urban” as applicable
- Type of Session Site - select Health Facility-based
- Is this Session Site added for HPV Vaccination Campaign - Select Yes

Fig. 66



Additionally, select the AEFI Management Centre closest to the session site using the “Linked 24×7 AEFI Management Centre” dropdown in U-WIN as shown in the image below.

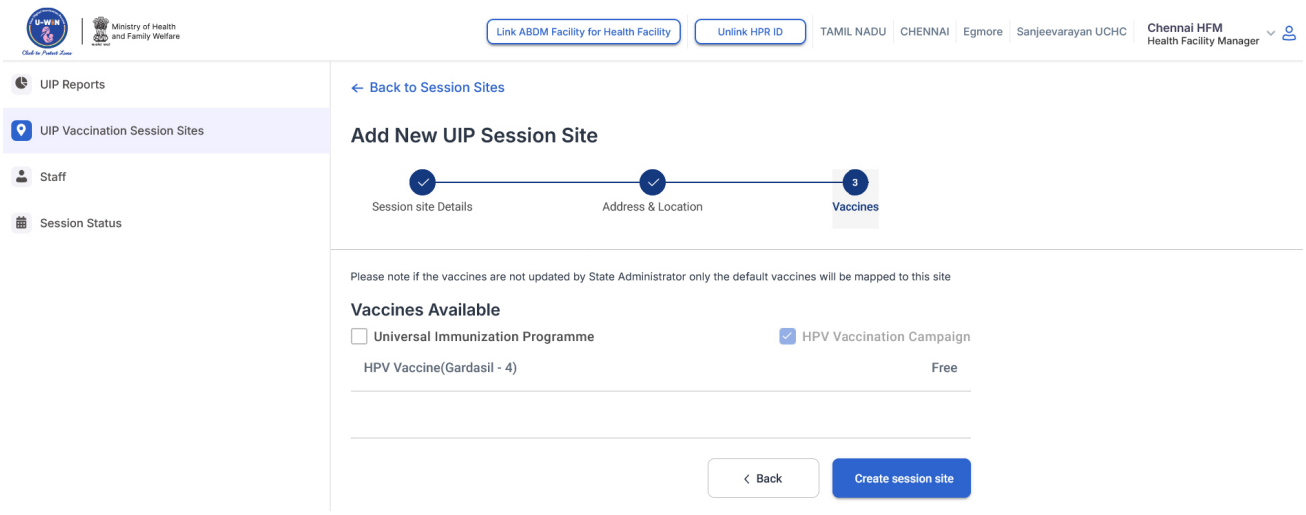
Fig. 67



Step 2. Addition of HPV Vaccine to sessions site by Health Facility Manager

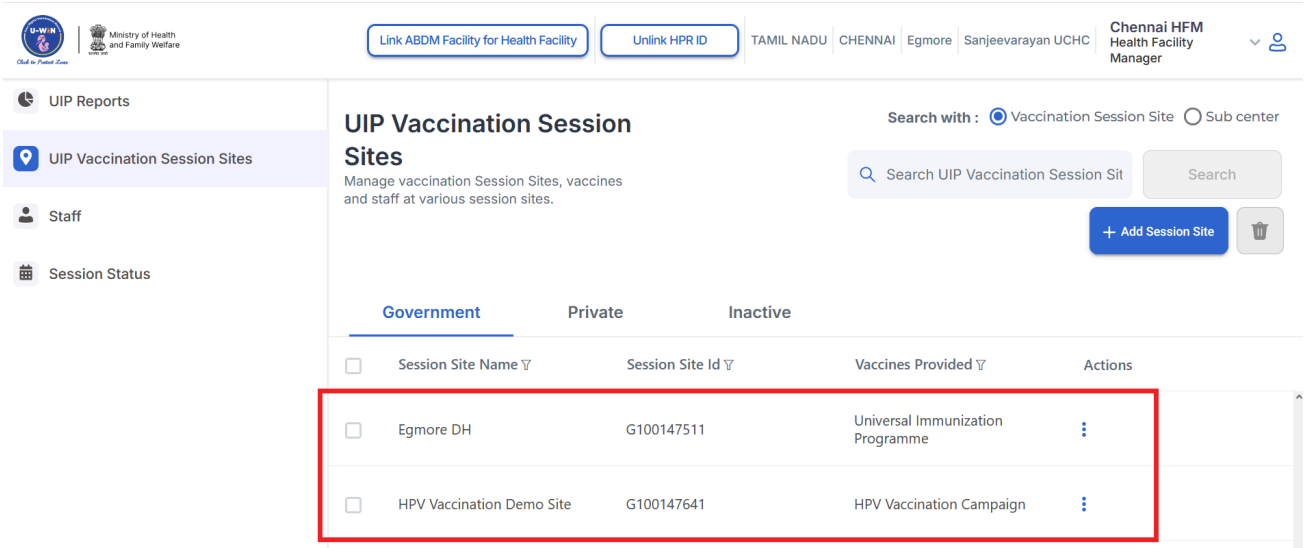
- In the last step during the creation of session site, Health Facility Manager needs to tick the checkbox for HPV Vaccine and click on “Create session site’.

Fig. 68



- Once the session site is created the Health Facility Manager can filter and view session sites that provide HPV vaccines as shown in the image below.

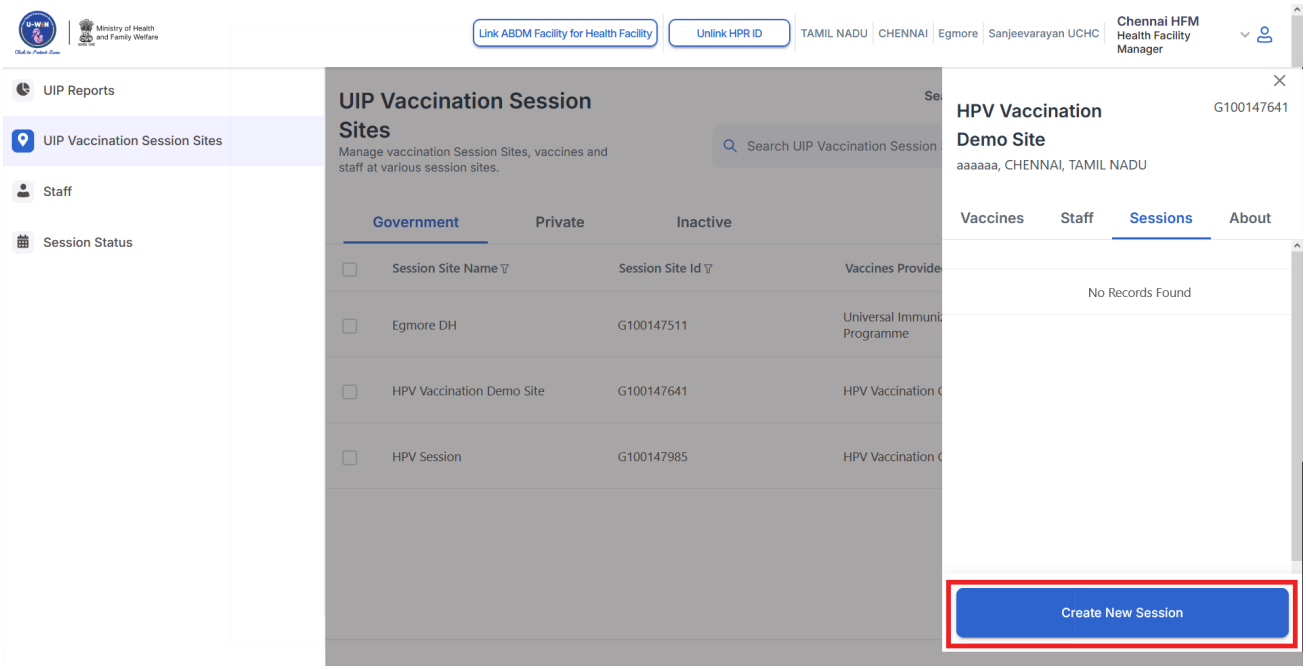
Fig. 69



Step 3. HPV Vaccination session creation by Health Facility Manager

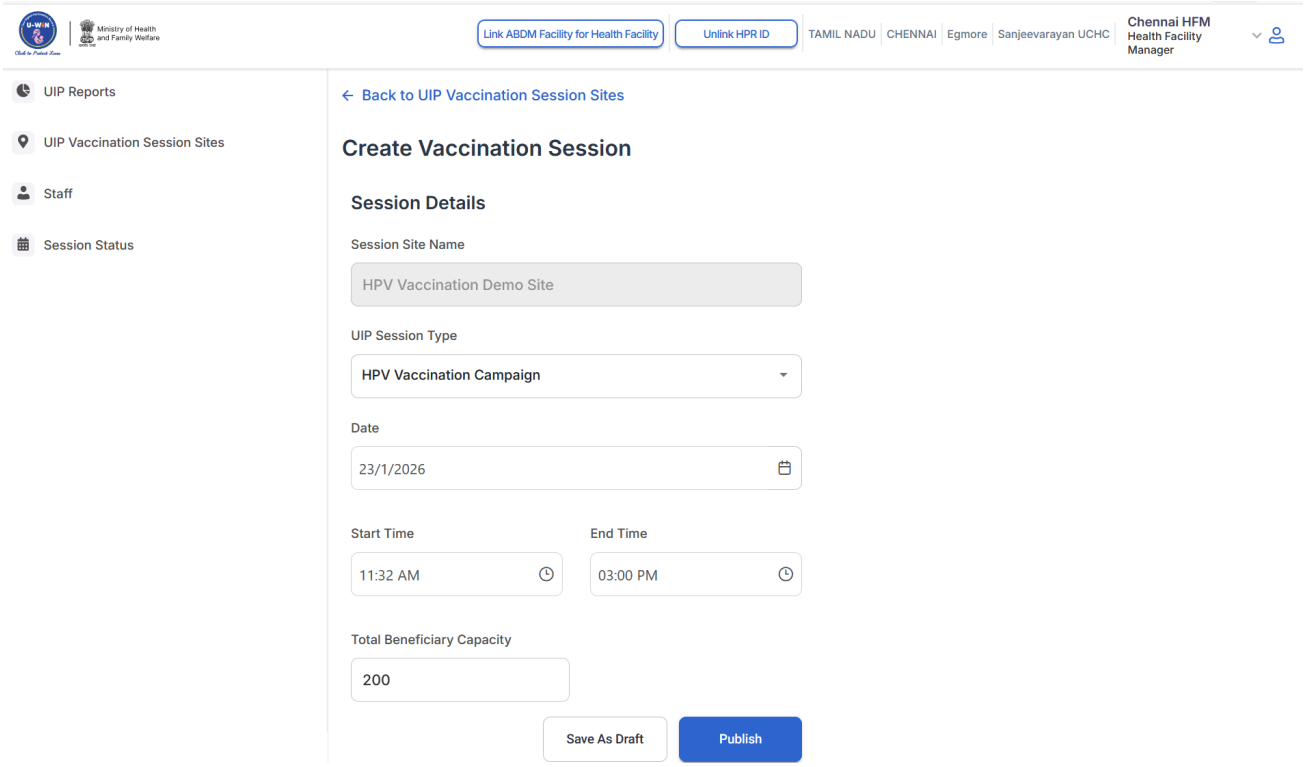
- Health Facility Manager can create HPV vaccination session by selecting the session site.
- After clicking on the session site, Health Facility Manager click on “Session” on the right side of the screen and then select “Create New Session” as shown in the image below.

Fig. 70



- In the UIP Session Type dropdown menu, the Health Facility Manager will enter sessions site name and then select “HPV Vaccination Session.” After entering the date, time, and beneficiary capacity, Health Facility Manager will publish the sessions by clicking “Publish" as shown in the picture below.

Fig. 71

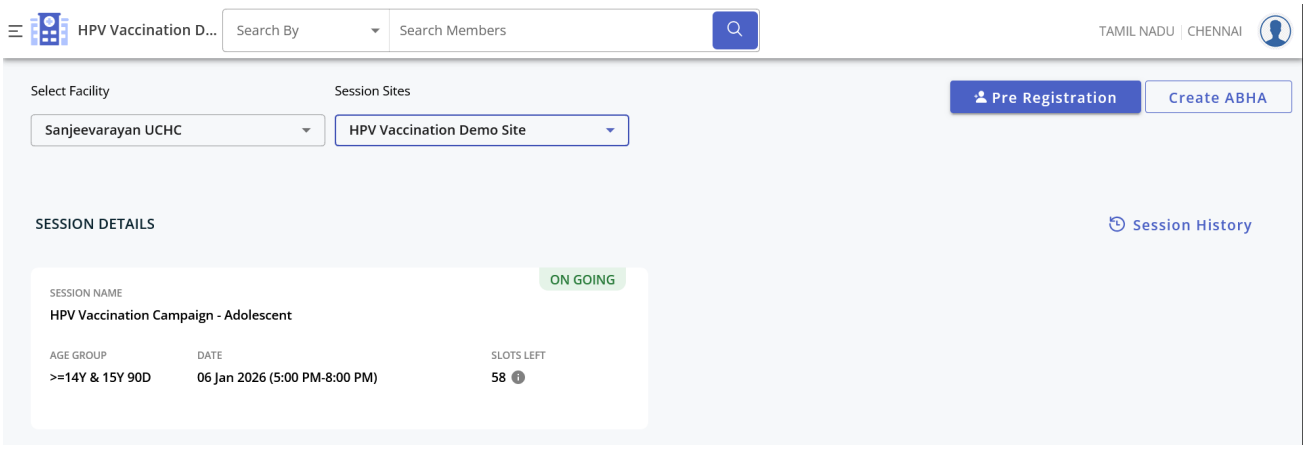


Vaccinator workflow

- Vaccinator can register the eligible beneficiaries through the following modes:
  - **Pre-Registration**
    - Eligible beneficiaries can be pre-registered in U-WIN for HPV vaccination prior to the start of the session.
  - **On-site Registration**
    - Eligible beneficiaries can be registered in U-WIN for HPV Vaccination after starting the HPV vaccination session.

Once logged in, the vaccinator must select the Facility and Session Site as the HPV vaccination session site from the drop-down menu, after which HPV vaccination session details such as age group (≥14 & <15 years), date, and available slots will be displayed as shown in the image below.

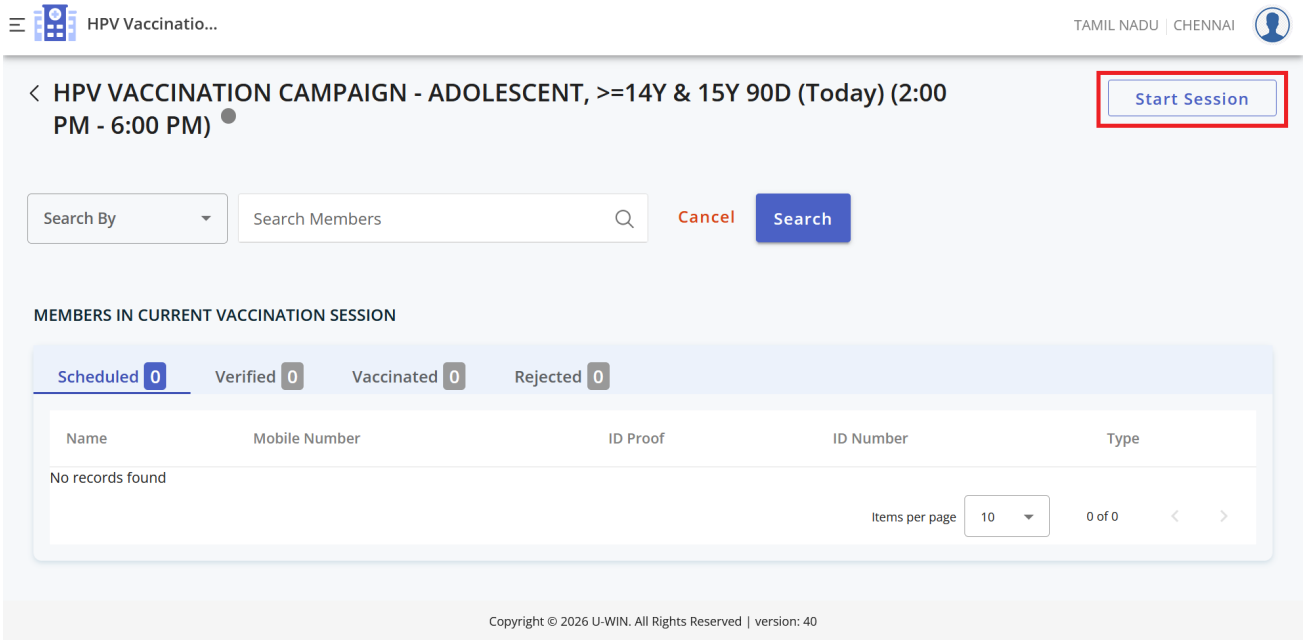
Fig. 72



- As shown in the image below, after clicking on the “Session Name”, the vaccinator must click “Start Session” in U-WIN.
- The vaccinator should search for or add the beneficiary to the session and schedule them in the ongoing session.

All pre-registered beneficiaries for the HPV vaccine can be searched using the mobile number or the ID provided during registration, shown in the image below:

Fig. 73



Steps for Pre-Registration or On-site Registration in U-WIN

The following details are required for the Pre-Registration or On-Site Registration as shown in the image below:

- Mobile number of the parent/guardian,
- Birth Year
- Date of Birth
- Category type (Adolescent or PVTG group),
- Name as per the ID
- Photo ID type
- ID number
- Consent Notice

Fig. 74

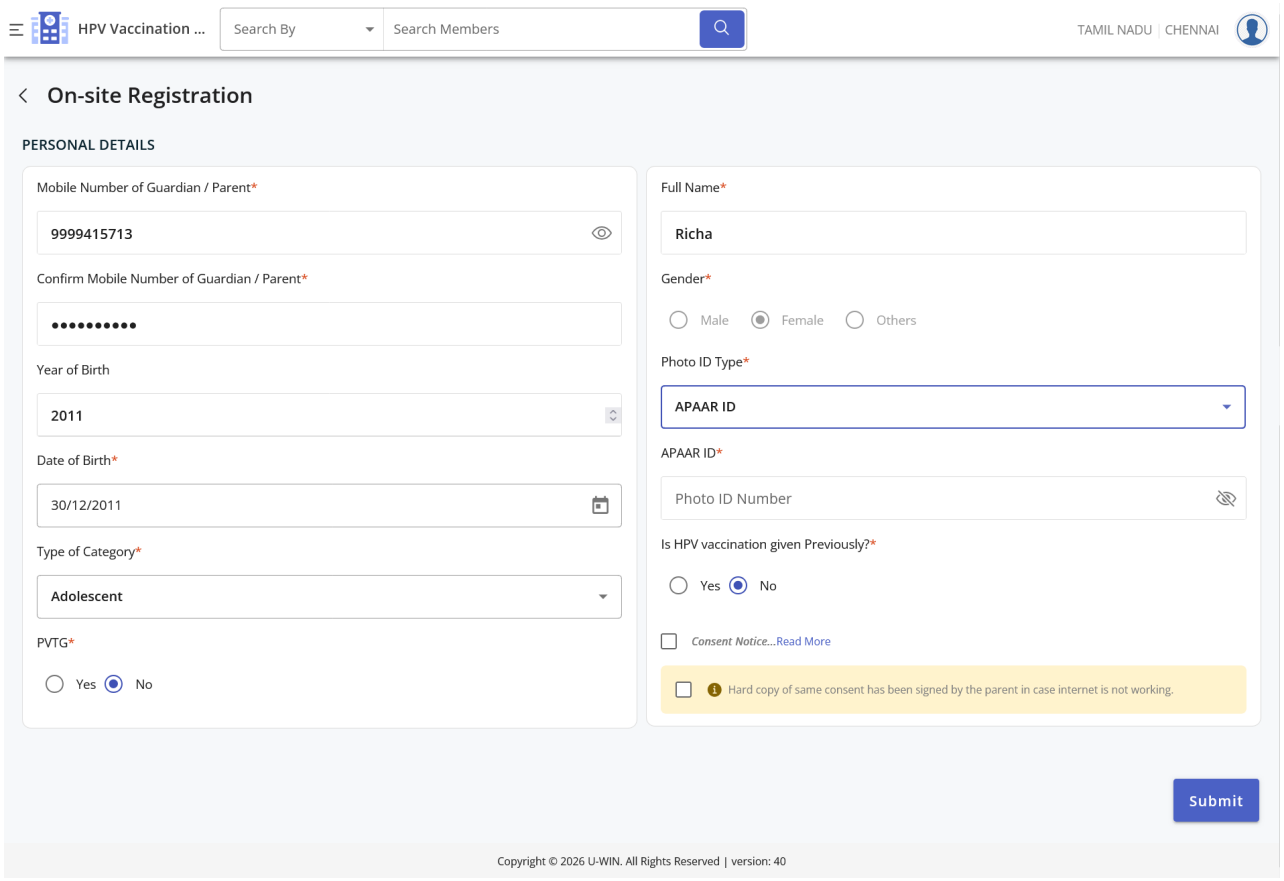
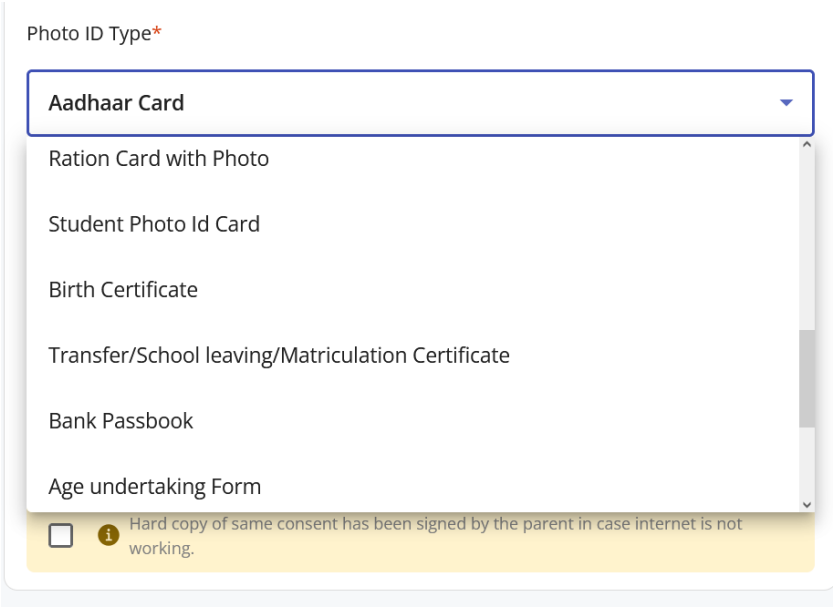


Photo ID Type in U-WIN

Vaccinator/Mobilizer is required to select the appropriate Photo ID type from the dropdown menu available in the U-WIN portal. The following Photo ID documents are listed in the U-WIN portal:

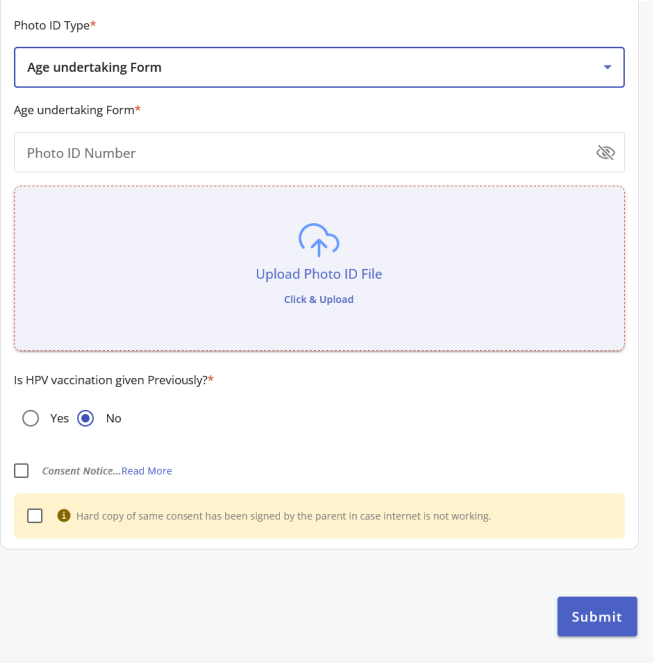
- Birth Certificate, Aadhar Card, Ration Card, School ID, APAAR ID, Transfer/School leaving/Matriculation Certificate, Passport, Bank passbook, Immunization card/A declaration given by the Head of the Orphanage/Child Care Home, Permanent Education Number (PEN), Age Undertaking Form signed by parents/guardian

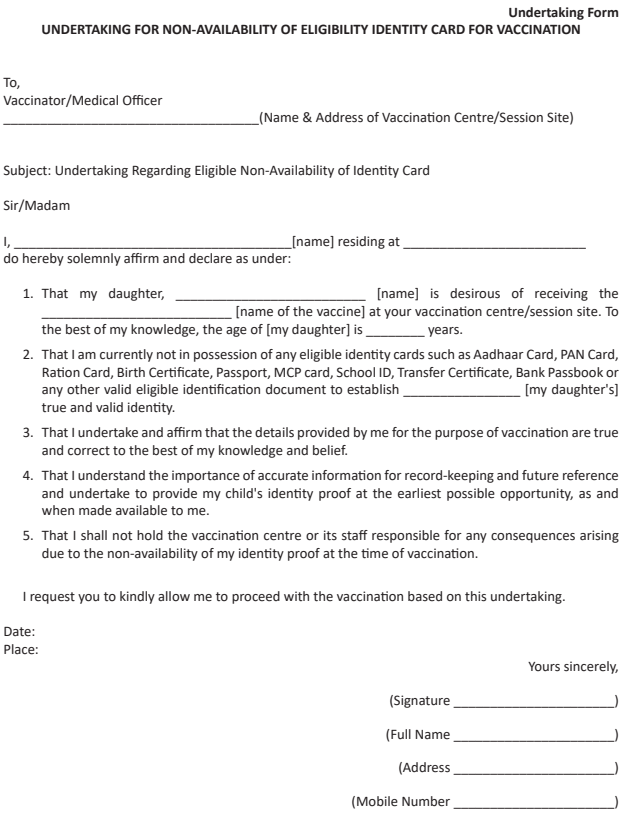
Fig. 75



In case of non-availability of any above listed photo ID verifying the beneficiary's age, the age undertaking form must be duly signed by the parent/guardian and uploaded on the U-WIN. The prototype of form is shown in the image below.

Fig. 76





Undertaking Form

UNDERTAKING FOR NON-AVAILABILITY OF ELIGIBILITY IDENTITY CARD FOR VACCINATION

To,
Vaccinator/Medical Officer
_____(Name & Address of Vaccination Centre/Session Site)

Subject: Undertaking Regarding Eligible Non-Availability of Identity Card

Sir/Madam

I, _____[name] residing at _____
do hereby solemnly affirm and declare as under:

1. That my daughter, _____ [name] is desirous of receiving the _____ [name of the vaccine] at your vaccination centre/session site. To the best of my knowledge, the age of [my daughter] is _____ years.
2. That I am currently not in possession of any eligible identity cards such as Aadhaar Card, PAN Card, Ration Card, Birth Certificate, Passport, MCP card, School ID, Transfer Certificate, Bank Passbook or any other valid eligible identification document to establish _____ [my daughter's] true and valid identity.
3. That I undertake and affirm that the details provided by me for the purpose of vaccination are true and correct to the best of my knowledge and belief.
4. That I understand the importance of accurate information for record-keeping and future reference and undertake to provide my child's identity proof at the earliest possible opportunity, as and when made available to me.
5. That I shall not hold the vaccination centre or its staff responsible for any consequences arising due to the non-availability of my identity proof at the time of vaccination.

I request you to kindly allow me to proceed with the vaccination based on this undertaking.

Date:
Place:

Yours sincerely,

(Signature _____)

(Full Name _____)

(Address _____)

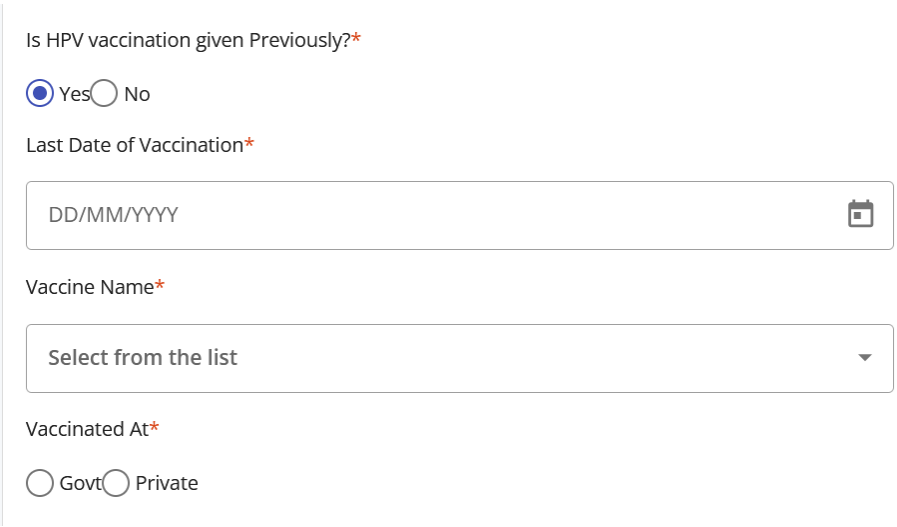
(Mobile Number _____)

UPDATING PREVIOUS HISTORY OF HPV VACCINATION

If any eligible girl is found to have been previously vaccinated with the HPV vaccine, the following details should be updated in U-WIN at the time of beneficiary registration or during beneficiary verification at the session site as shown in the image below: Has the beneficiary received the HPV vaccine previously? Select "Yes" or "No."

- If Yes, enter the date of the last vaccination in DD/MM/YY format.
- Select the vaccine name from the drop-down list.
- Select the place of vaccination: Government or Private.

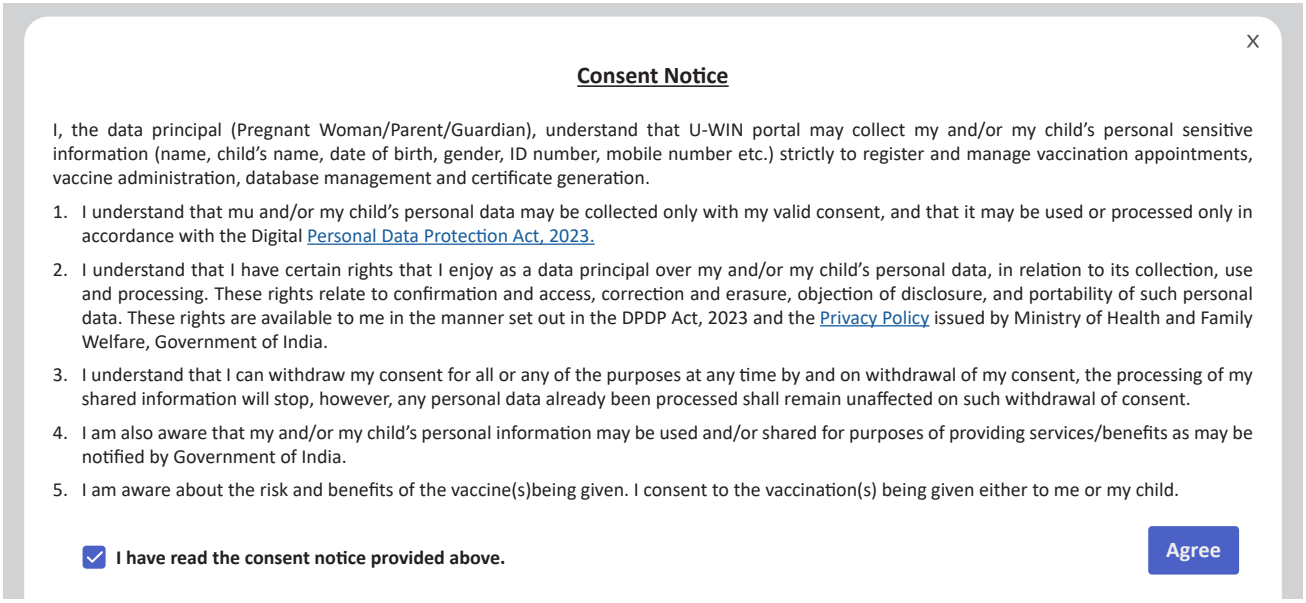
Fig. 77



Consent process

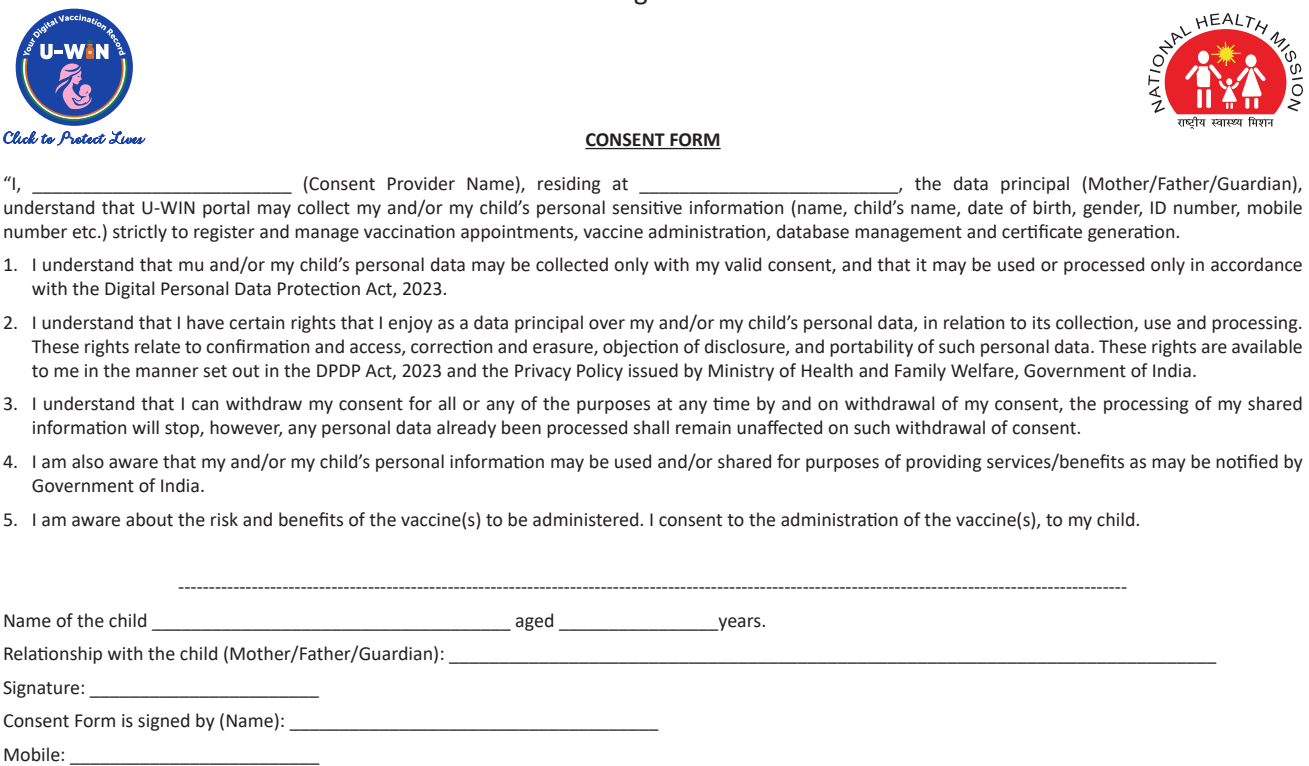
- Obtaining consent from the parent/guardian is mandatory at the time of self-registration, pre-registration or on-site registration.
- After selecting the checkbox next to the consent notice, a pop-up will appear. The vaccinator should read the consent notice verbally to the parent/guardian and obtain their consent for HPV vaccination by clicking “I have read the consent notice provided above".
- After clicking agree, an OTP will be received on the parent/guardian registered mobile number. This OTP must be entered to complete the beneficiary registration process.

Fig. 78



- In case of internet connectivity issues or non-receipt of the OTP, a hard copy of the consent form should be signed and submitted by the parent/guardian. The prototype of consent form is shown in the image below.

Fig. 79



CONSENT FORM

“I, _____ (Consent Provider Name), residing at _____, the data principal (Mother/Father/Guardian), understand that U-WIN portal may collect my and/or my child's personal sensitive information (name, child's name, date of birth, gender, ID number, mobile number etc.) strictly to register and manage vaccination appointments, vaccine administration, database management and certificate generation.

1. I understand that mu and/or my child's personal data may be collected only with my valid consent, and that it may be used or processed only in accordance with the Digital Personal Data Protection Act, 2023.
2. I understand that I have certain rights that I enjoy as a data principal over my and/or my child's personal data, in relation to its collection, use and processing. These rights relate to confirmation and access, correction and erasure, objection of disclosure, and portability of such personal data. These rights are available to me in the manner set out in the DPDP Act, 2023 and the Privacy Policy issued by Ministry of Health and Family Welfare, Government of India.
3. I understand that I can withdraw my consent for all or any of the purposes at any time by and on withdrawal of my consent, the processing of my shared information will stop, however, any personal data already been processed shall remain unaffected on such withdrawal of consent.
4. I am also aware that my and/or my child's personal information may be used and/or shared for purposes of providing services/benefits as may be notified by Government of India.
5. I am aware about the risk and benefits of the vaccine(s) to be administered. I consent to the administration of the vaccine(s), to my child.

Name of the child _____ aged _____years.

Relationship with the child (Mother/Father/Guardian): _____

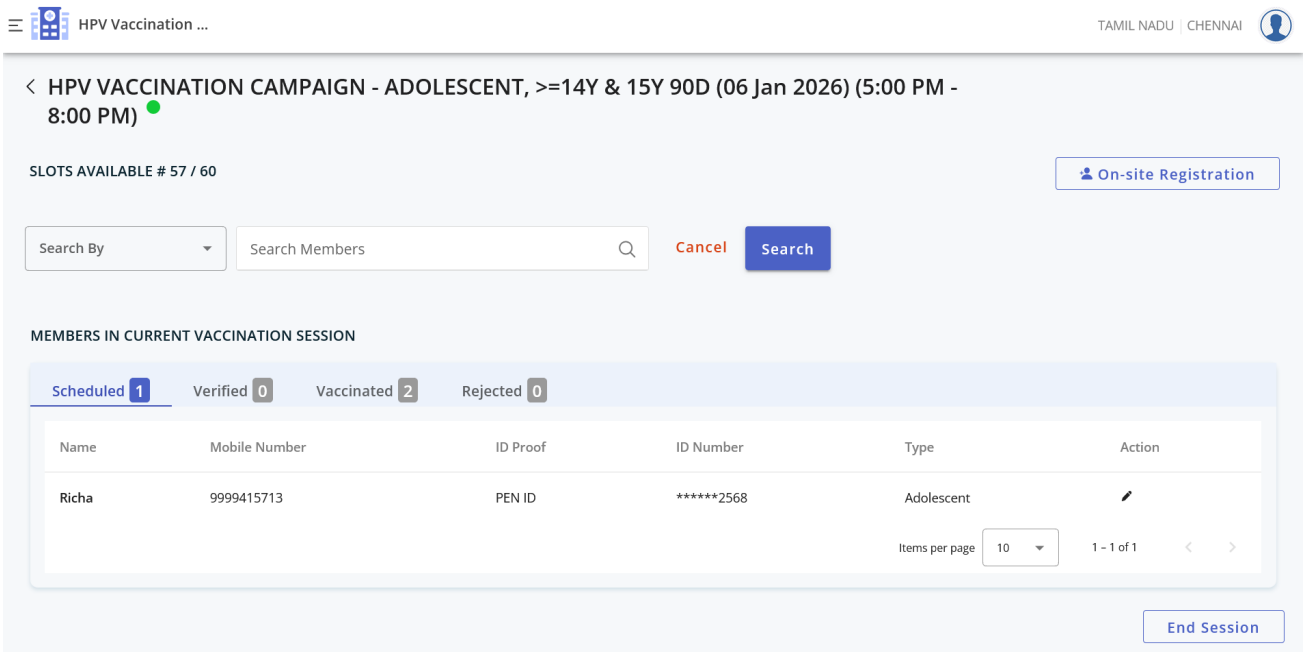
Signature: _____

Consent Form is signed by (Name): _____

Mobile: _____

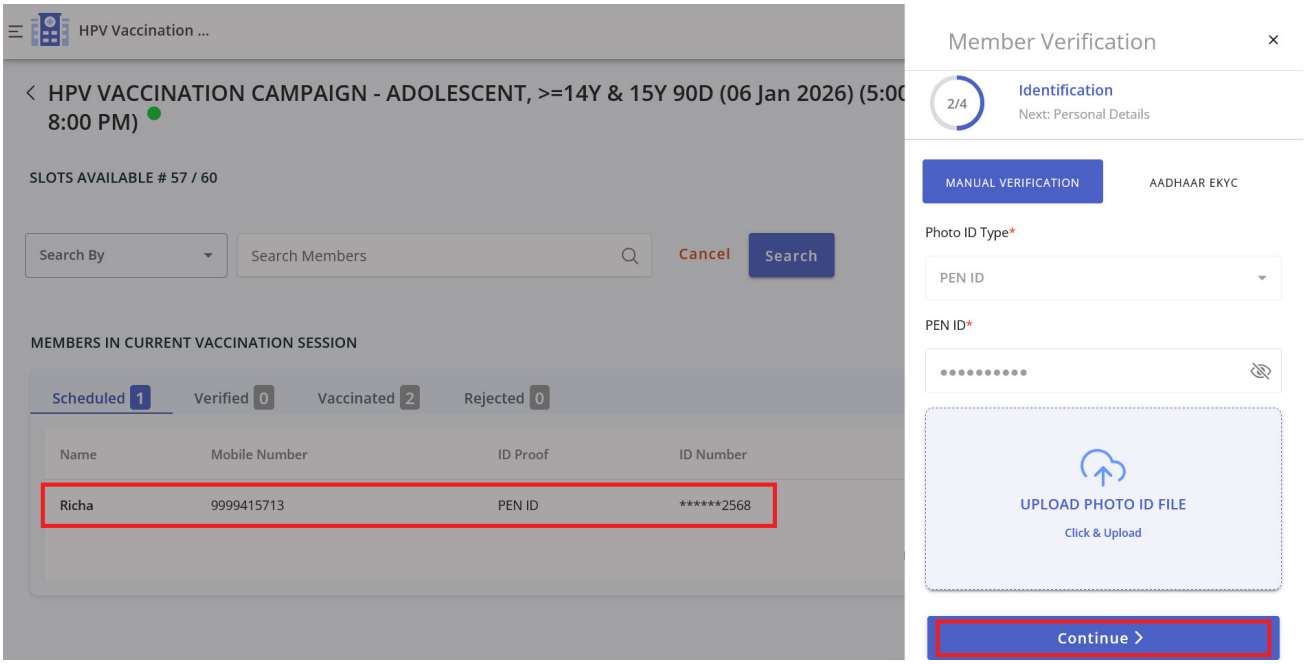
- After registration, the vaccinator can locate the beneficiary using the registered mobile number during the session.

Fig. 80



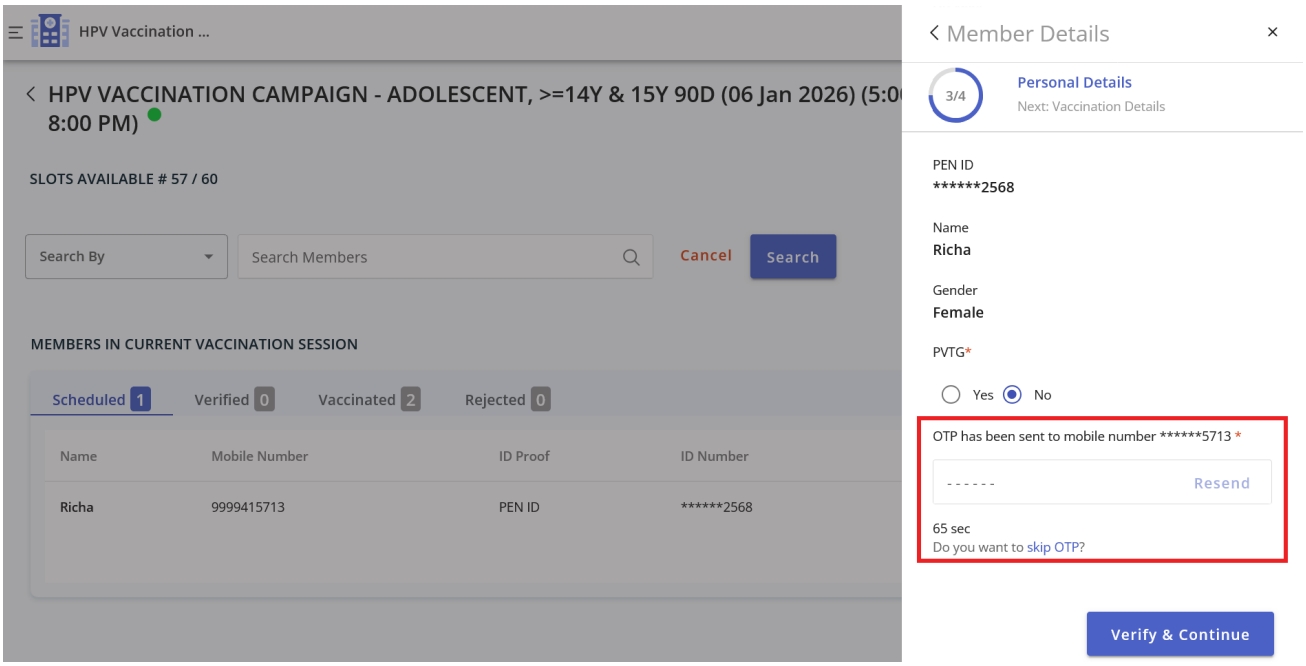
- Once a beneficiary is scheduled for a session, the vaccinator must verify the beneficiary by clicking on the beneficiary's name, as shown in the image below.

Fig. 81



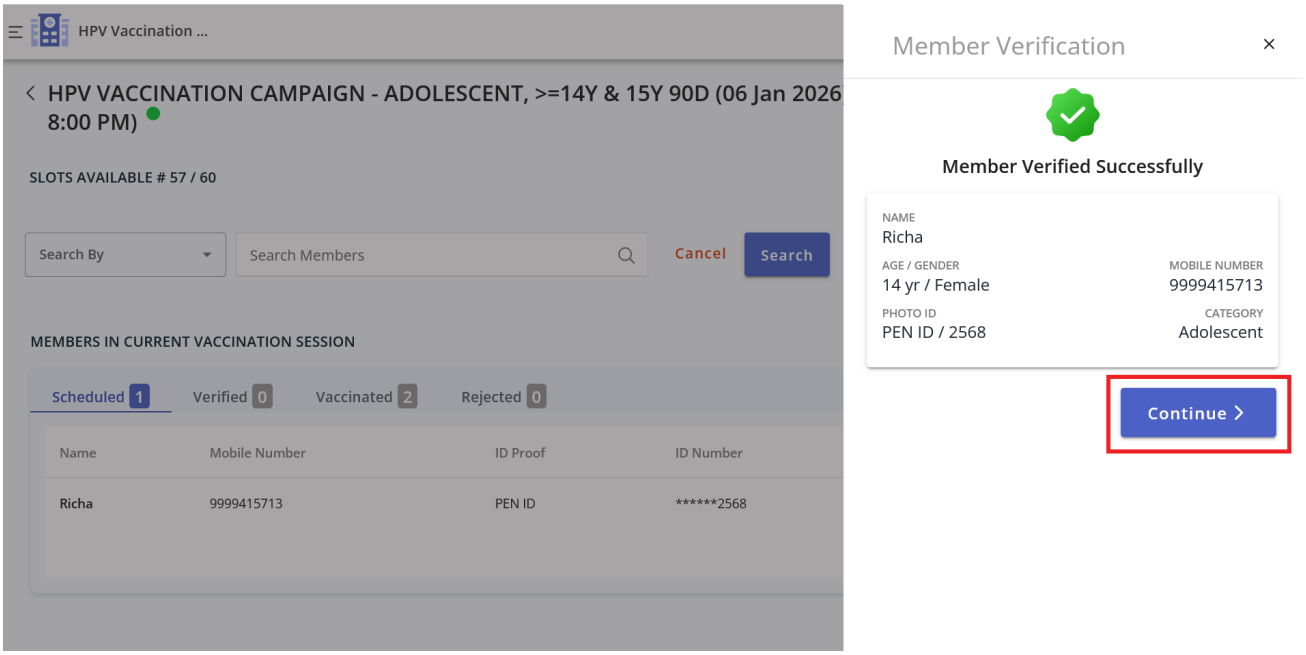
- For verification in UWIN, an OTP will be received on the registered mobile number.
- In case of non-receipt of OTP, vaccinator can verify the beneficiaries using alternate options by clicking on 'Skip OTP' option.

Fig. 82



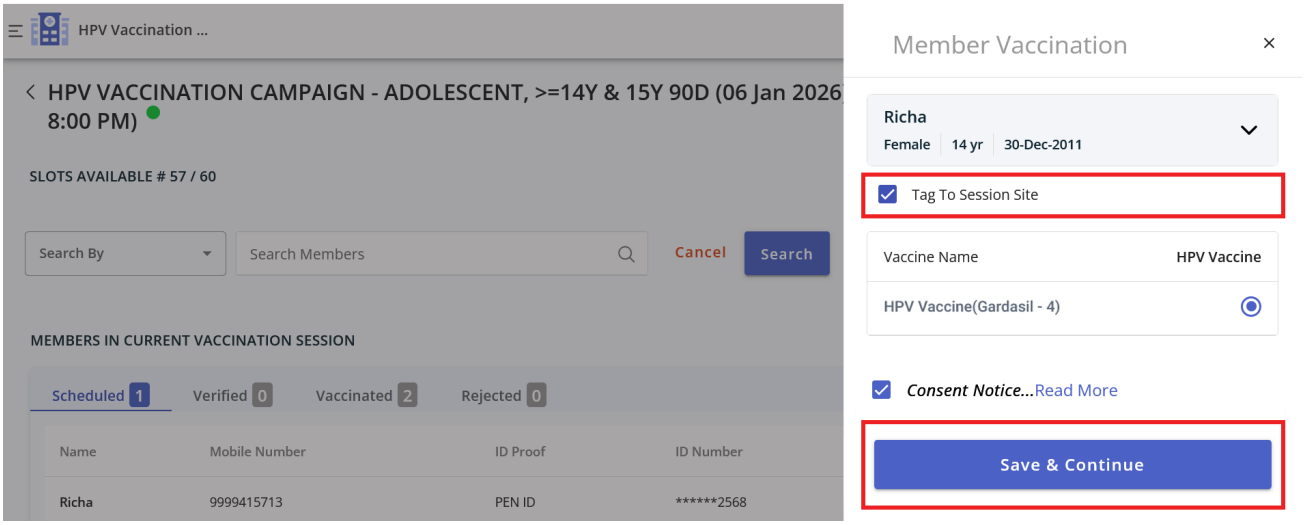
- After successfully verifying the beneficiary, the vaccinator must click "Continue" as shown in the image below.

Fig. 83



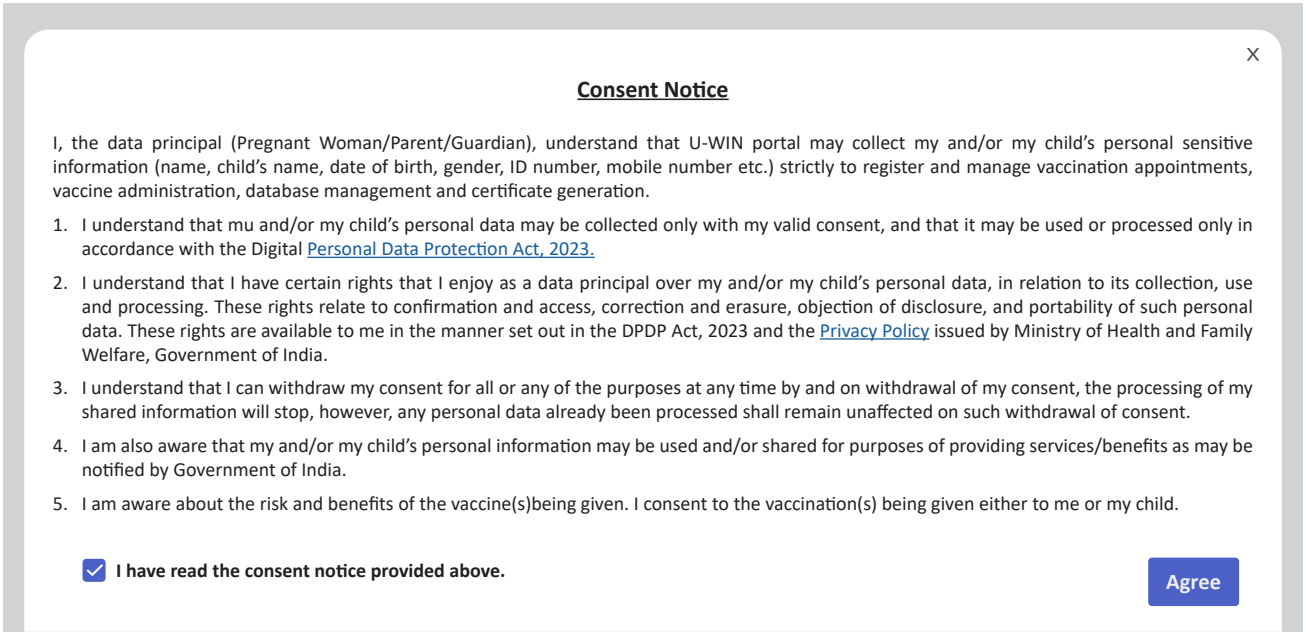
- Post verification, the vaccinator must tag the beneficiary by Block/Ward or session site, select “HPV Vaccination – Adolescent,” and click “Save and Continue" as shown in the image below.

Fig. 84



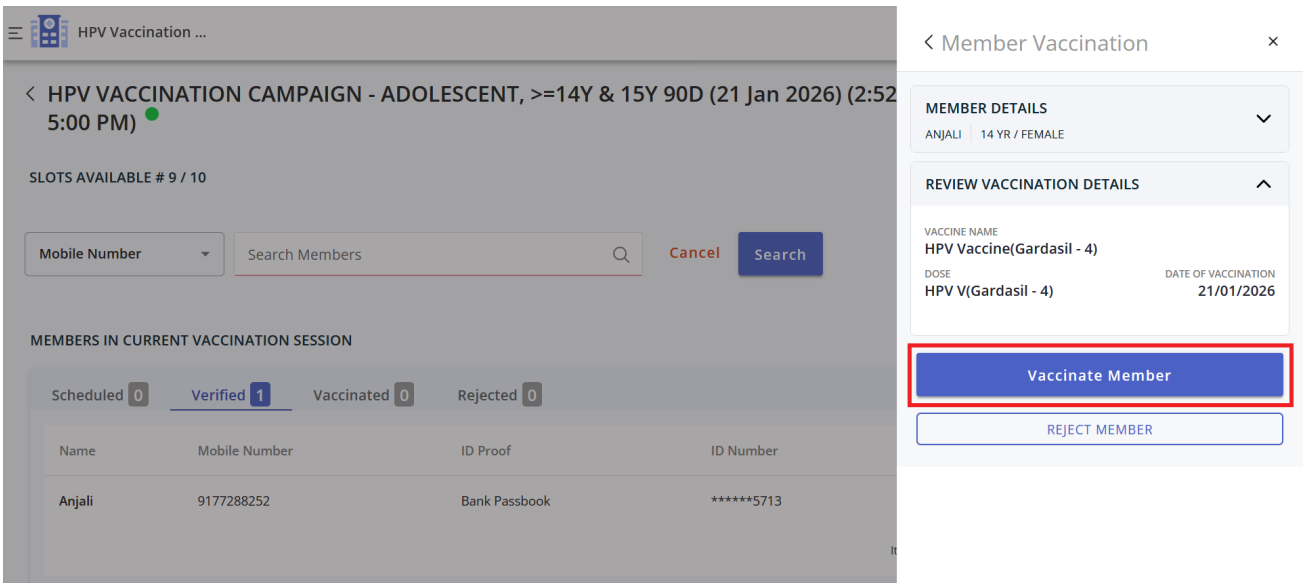
- The consent notice should be read by clicking “View more”, then acknowledged by selecting the checkbox, and finally by clicking “Agree" as shown in the image below.

Fig. 85



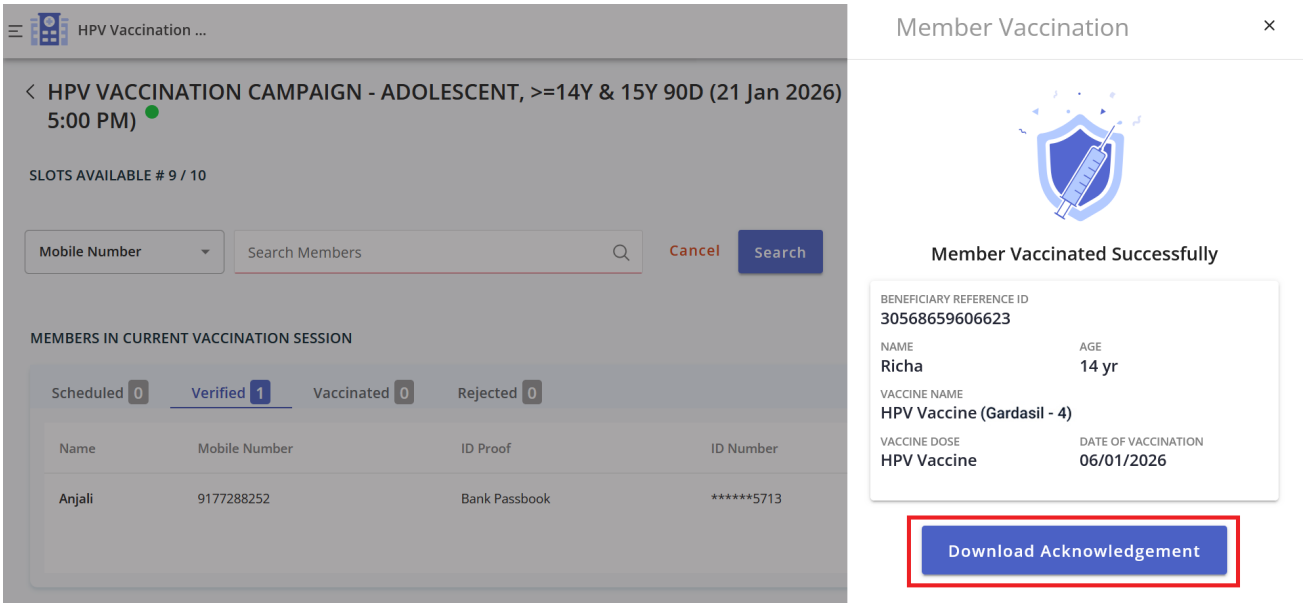
- After clicking “Agree” in the final step, the vaccinator then click “Vaccinate Member” in U-WIN as shown the image below.

Fig. 86



- After successful vaccination, the vaccinator can download the e-vaccination certificate as shown in the image below and provide a hard copy to the beneficiary.

Fig. 87



- The vaccination certificate can be downloaded via the Vaccinator module. The prototype of the vaccination certificate is shown below.

Fig. 88

HPV vaccination Certificate:

U-WIN Click to Protect Lives | सत्यमेव जयते | National Health Mission राष्ट्रीय स्वास्थ्य मिशन

E - VACCINATION CERTIFICATE
डिजिटल टिकाकरण प्रमाण पत्र

Ref ID:/ रेफ ID : 30568659606623
Beneficiary's Name:/ लाभार्थी का नाम : Richa
ABHA Number:/ ABHA नंबर : N/A
Guardian Name:/ अभिभावक का नाम: N/A
Vaccination Date:/ टीकाकरण की तारीख : 06-Jan-2026
Vaccinated By:/ टीका लगाने वाले का नाम : Vaccinator

Date of Birth:/ जन्म तारीख : 30-DEC-2011
Gender:/ लिंग : Female
ABHA Address:/ ABHA पता : N/A
Guardian ref ID:/ अभिभावक का रेफ ID: N/A
Vaccinated At:/ टीकाकरण का स्थान : HPV Vaccination Demo Site, CHENNAI, TAMIL NADU

BIRTH	1 ½ MONTHS	2 ½ MONTHS	3 ½ MONTHS	9 MONTHS
Date of Birth 30/12/2011	Next Vaccination Date 10/02/2012	Next Vaccination Date 09/03/2012	Next Vaccination Date 06/04/2012	Next Vaccination Date 25/09/2012
OPV-0 (DATE OF VACCINATION (dd/mm/yyyy): / /)	OPV-1 / /	OPV-2 / /	OPV-3 / /	MR-1 / /
Hep B - Birth Dose / /	Penta -1 / /	Penta-2 / /	Penta-3 / /	Vit A-1 / /
BCG / /	RVV-1 / /	RVV-2 / /	RVV-3 / /	JE-1 / /
	PCV-1 / /		PCV-2 / /	PCV-Booster / /
	fIPV-1 / /		fIPV-2 / /	fIPV-3 / /

16-24 MONTHS	5-6 YEARS
Next Vaccination Date 23/04/2013	Next Vaccination Date 28/12/2016
DPT Booster-1 (DATE OF VACCINATION (dd/mm/yyyy): / /)	DPT Booster-2 / /
MR-2 / /	SIA / OTHERS
OPV - Booster / /	VACCINE NAME / DATE GIVEN (dd/mm/yyyy)
Vit A-2 / /	
JE-2 / /	

VITAMIN A

	CHILD AGE	DATE GIVEN (dd/mm/yyyy)		CHILD AGE	DATE GIVEN (dd/mm/yyyy)
Vit A-3	2.0 Years	/ /	Vit A-7	4.0 Years	/ /
Vit A-4	2.5 Years	/ /	Vit A-8	4.5 Years	/ /
Vit A-5	3.0 Years	/ /	Vit A-9	5.0 Years	/ /
Vit A-6	3.5 Years	/ /	HPV Vaccine	14 Years	06/01/2026

Td VACCINE

Td 10	/ /	Td 16	/ /

In case any medical assistance is required after vaccination, please go to your nearest 24*7 Government Health facility- (Chennai District Hospital) or Contact at Toll free number- 104.

"Let no child suffer from any vaccine preventable diseases"
- Shri Narendra Modi,
Prime Minister

"कोई भी बच्चा किसी भी टीका निवारणीय रोगों से पीड़ित न हो"
- श्री नरेंद्र मोदी,
प्रधानमंत्री

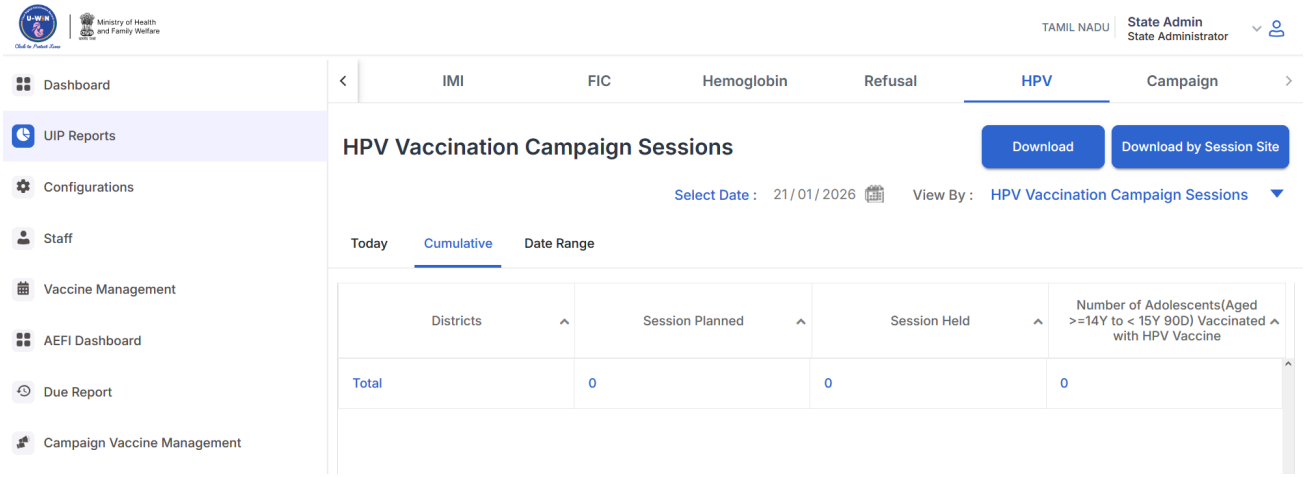
TAGGING OF IMMUNOCOMPROMISED PEOPLE

Girls with the known status of immunocompromised or HIV-infected should be tagged in U-WIN at the time of onsite registration or beneficiary allocation at the session. The certification from medical officer for immunocompromised status or HIV-infection will be required to be uploaded in U-WIN. If the beneficiary is immunocompromised or HIV-infected, three HPV Vaccine dose (0, 2nd and 6th month) will be administered to the beneficiary in U-WIN.

FREQUENCY OF REPORTING

HPV vaccination data should be entered in real-time on the U-WIN portal after the vaccine is administered to each beneficiary during the session. The coverage report will be available in U-WIN, with details available up to the session-site level as shown in the image below.

Fig. 89



FINAL REPORT AT STATE AND NATIONAL LEVEL

The final HPV vaccination campaign report will be prepared at the state and national levels, covering operational aspects, key observations, overcoming the challenges, lessons learnt, and recommendations.

POST HPV VACCINATION CAMPAIGN

Recording at Session Sites

- The vaccinator at the session site must record the administered HPV dose in U-WIN immediately (not beforehand or at the end of the day) before closing the session.
- The vaccinator must tally the HPV vaccine doses administered and ensure they match the figures recorded in U-WIN.
- The vaccinator must report the received, used, and returned vaccine doses and other supplies, including any wastage.
- The Medical Officer must ensure that all reported data is complete and accurate.

Reporting HPV vaccine Coverage

- Session-wise and planning unit-wise HPV vaccination campaign coverage report will be made available through U-WIN. These will be used to compile the daily coverage reports at the district, state and national level.
- U-WIN will generate a list of eligible girls who missed HPV vaccination using the due list. Additionally, Medical Officers will prepare daily qualitative reports on reasons for non-vaccination, any other challenges, suggest corrective actions, and share them with the Block Medical Officer.

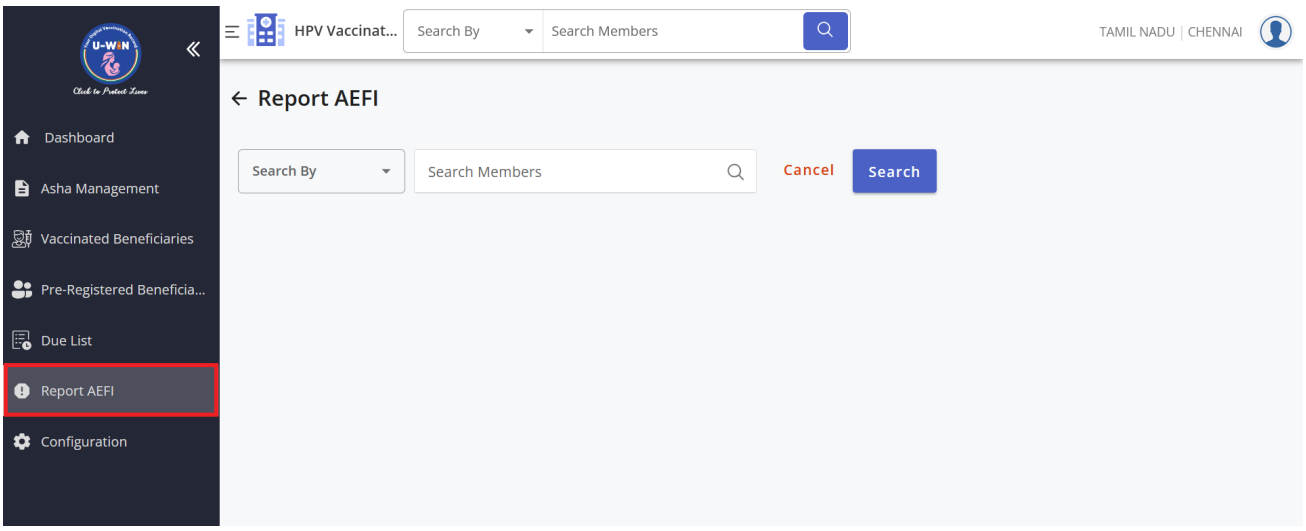
ADVERSE EVENTS FOLLOWING IMMUNIZATION (AEFI) REPORTING IN U-WIN

- All vaccinators or District Immunization officers can report the AEFI's through Vaccinator module or the District Administrator module using their U-WIN credentials.
- Vaccinator can report HPV vaccination–related AEFI for any beneficiary, irrespective of whether the vaccination was administered by him/her or by another vaccinator.

Workflow for the reporting of HPV vaccine related AEFI

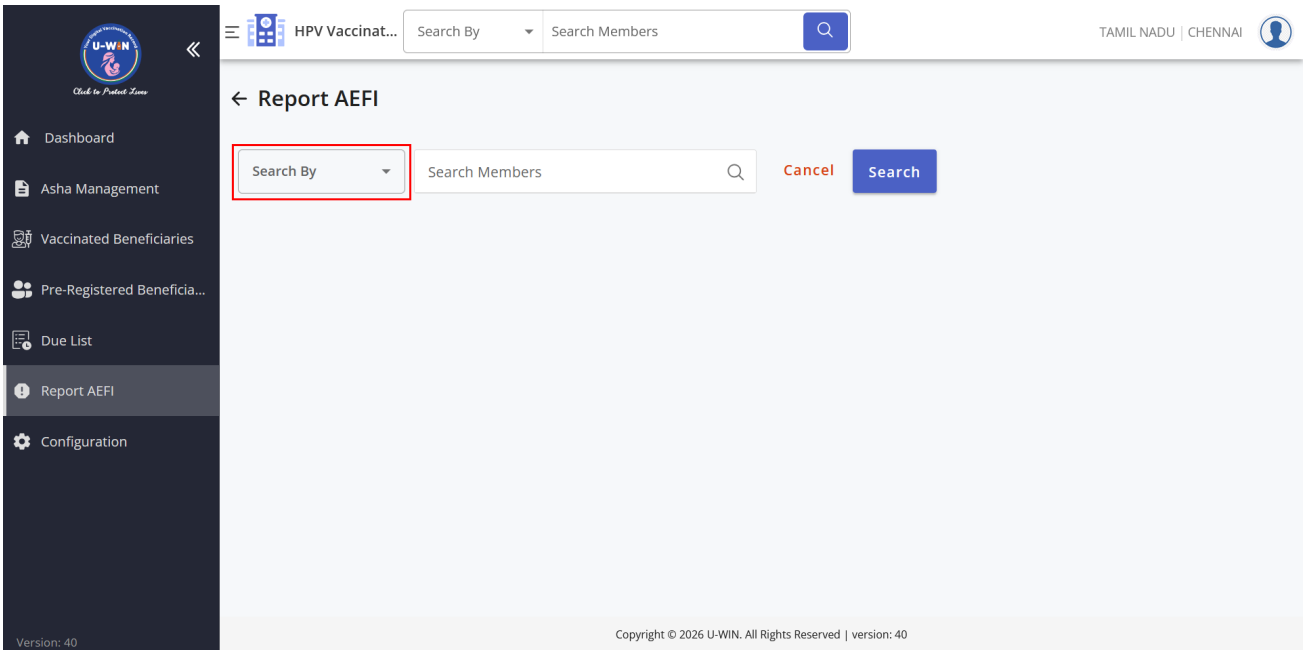
- **Step 1**: Vaccinator must log in to U-WIN using their valid user credentials. After successful login, the menu tab will appear on the left side of the screen. The Vaccinator can select the "Report AEFI" option from the menu option.

Fig. 90



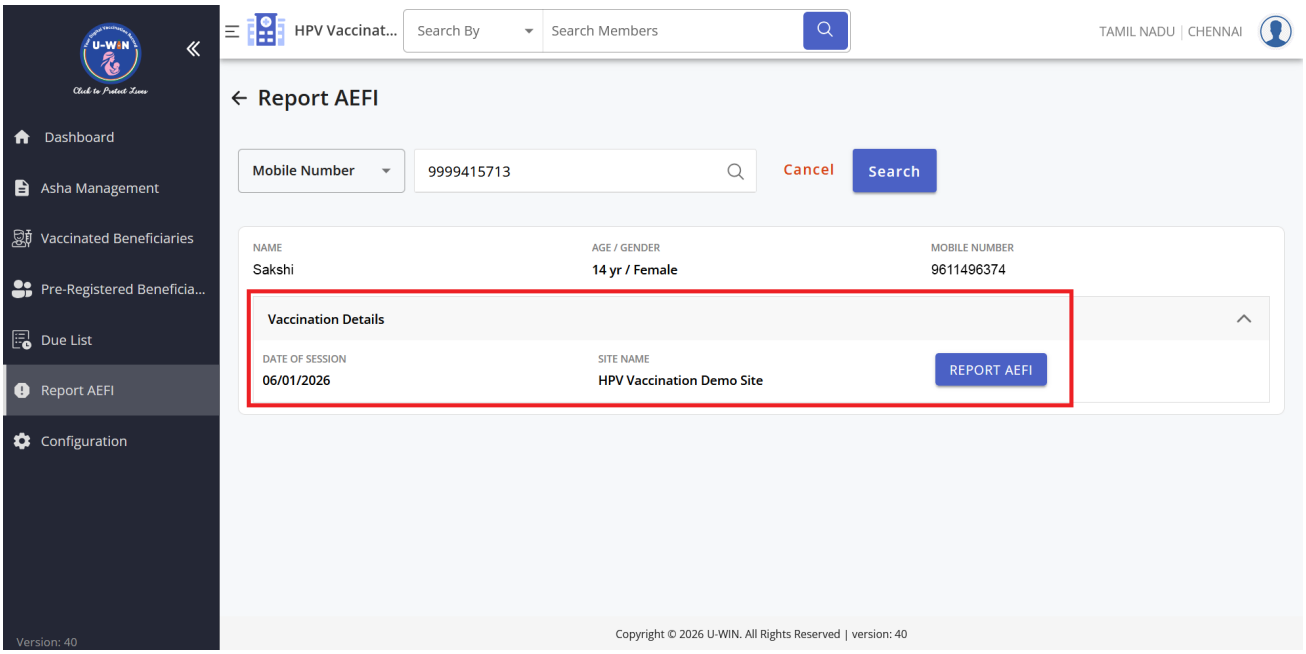
- **Step 2**: After selecting the "Report AEFI", vaccinator can click on the drop-down menu under the "Search by" option. Vaccinator can search for the beneficiary for whom AEFI is to be reported by selecting the appropriate option from the "Search by" drop-down menu.

Fig. 91



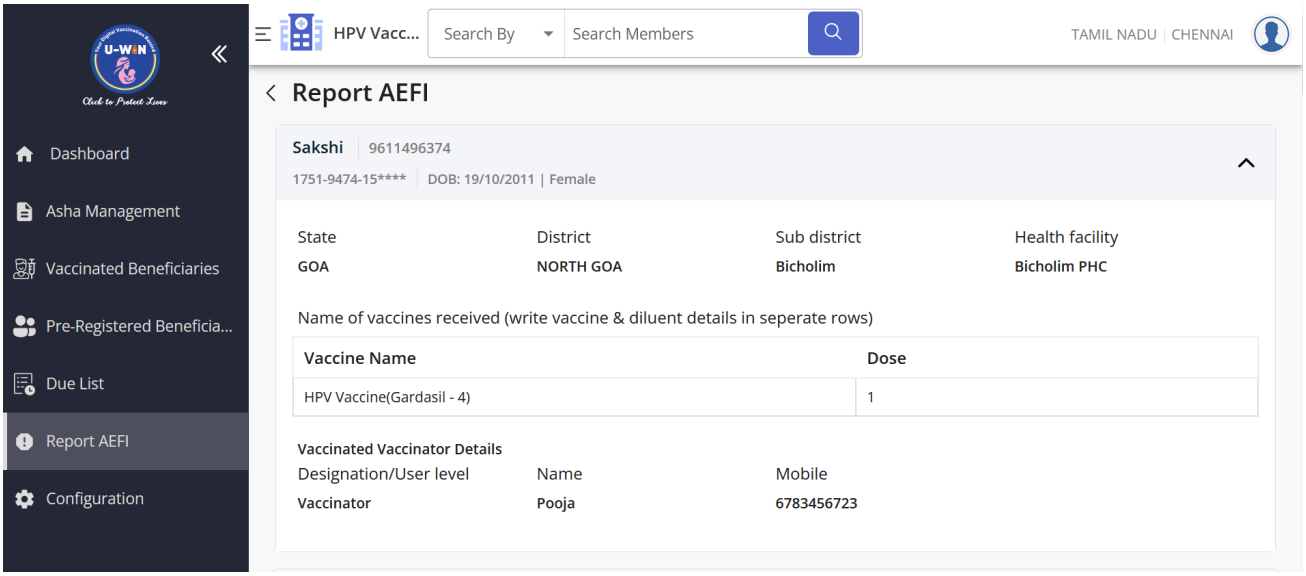
- **Step 3**: Vaccinator can view all beneficiaries registered with the selected option will be displayed. Click on the "Report AEFI" button corresponding to the beneficiary for whom the adverse event needs to be reported.

Fig. 92



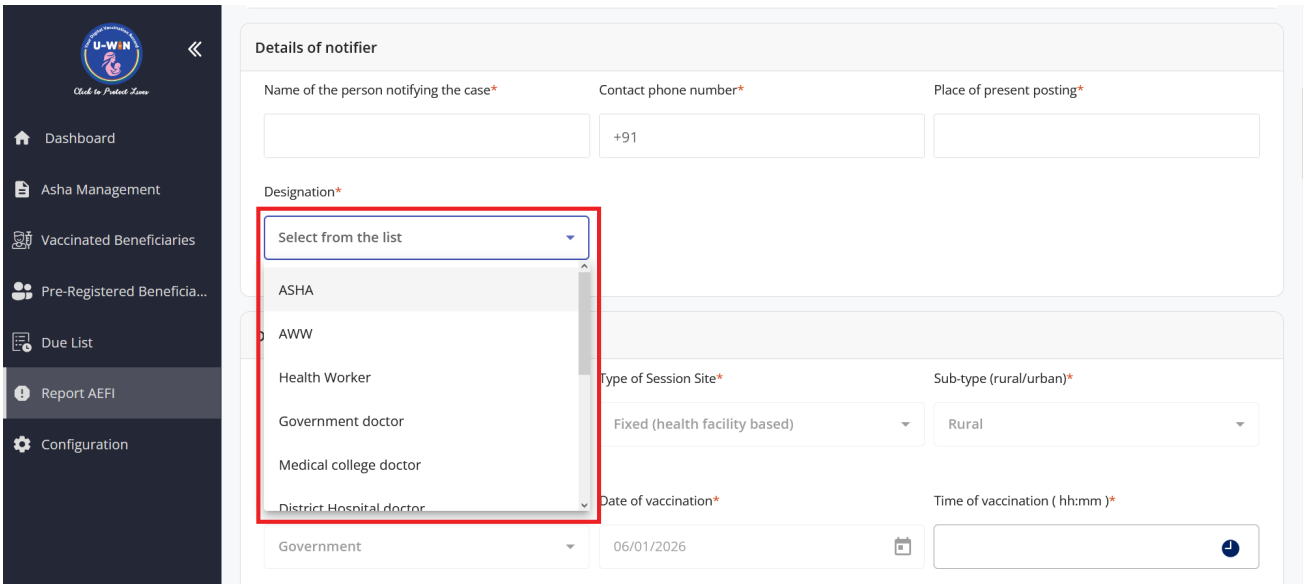
- **Step 4**: After clicking on "Report AEFI", the following pre-filled information will be displayed on the portal:
  - Name, Mobile number, Date of Birth, Gender, UWIN reference number of beneficiary.
  - State, District, Sub district, Health facility name where vaccination took place.
  - HPV Vaccine name and doses
  - Vaccinator name and mobile number

Fig. 93



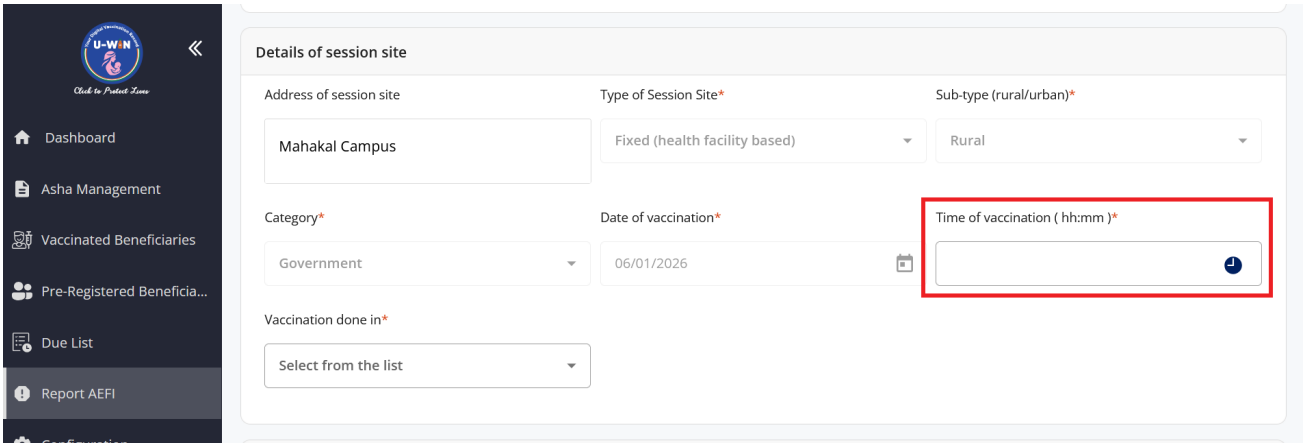
- **Step 5**: Vaccinator also needs to enter the details of notifier such as name of the person notifying the case, contact phone number, place of present posting and designation as per the drop down menu.

Fig. 94



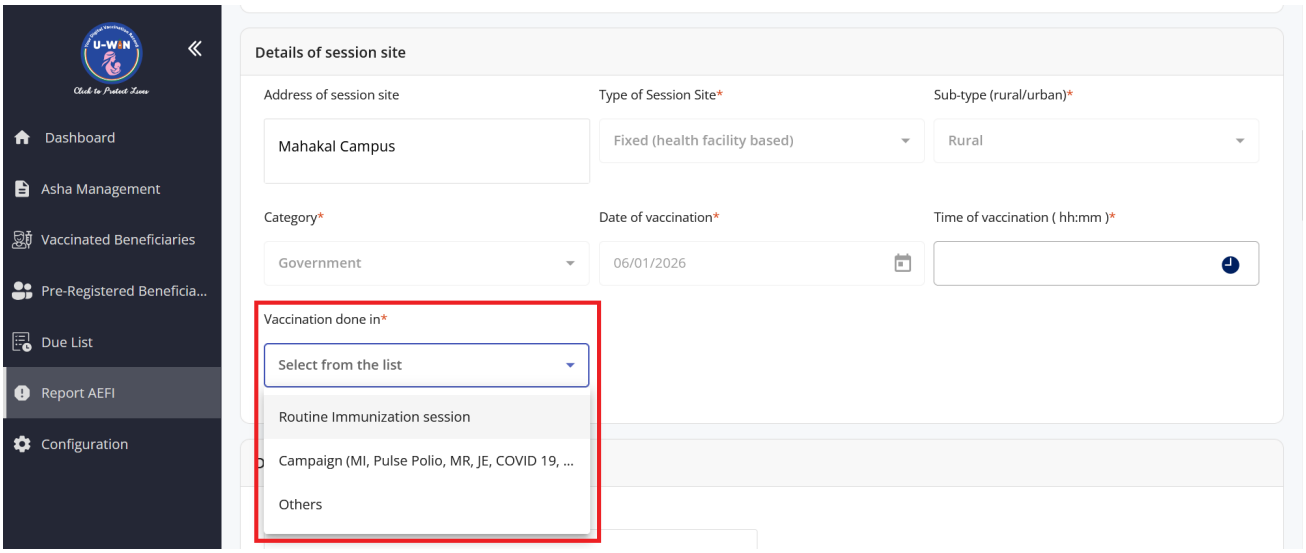
- **Step 6**: The "Details of the Session Site" section is pre-filled in the system and cannot be edited by the Vaccinator. Additionally, vaccinator should enter the "Time of Vaccination" in hh:mm format.

Fig. 95



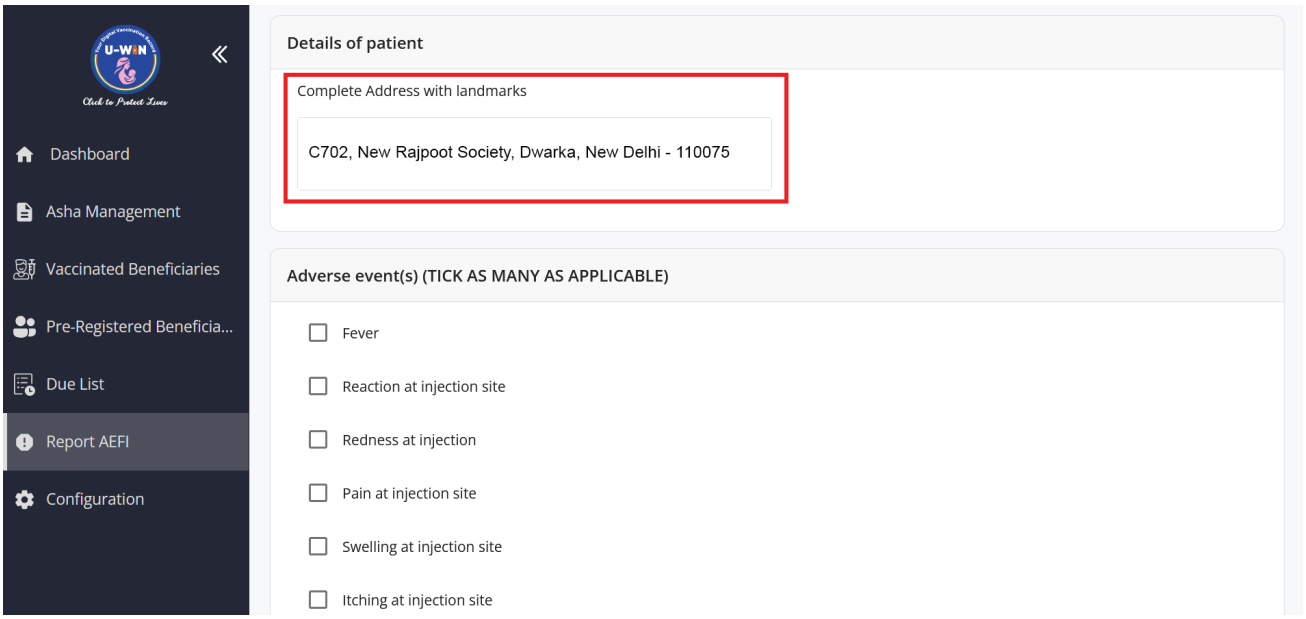
- **Step 7**: Vaccinator can select the “Campaign (MI, Pulse Polio, MR, JE, COVID-19, HPV)” option from the dop down menu of “Vaccination done in” list.

Fig. 96



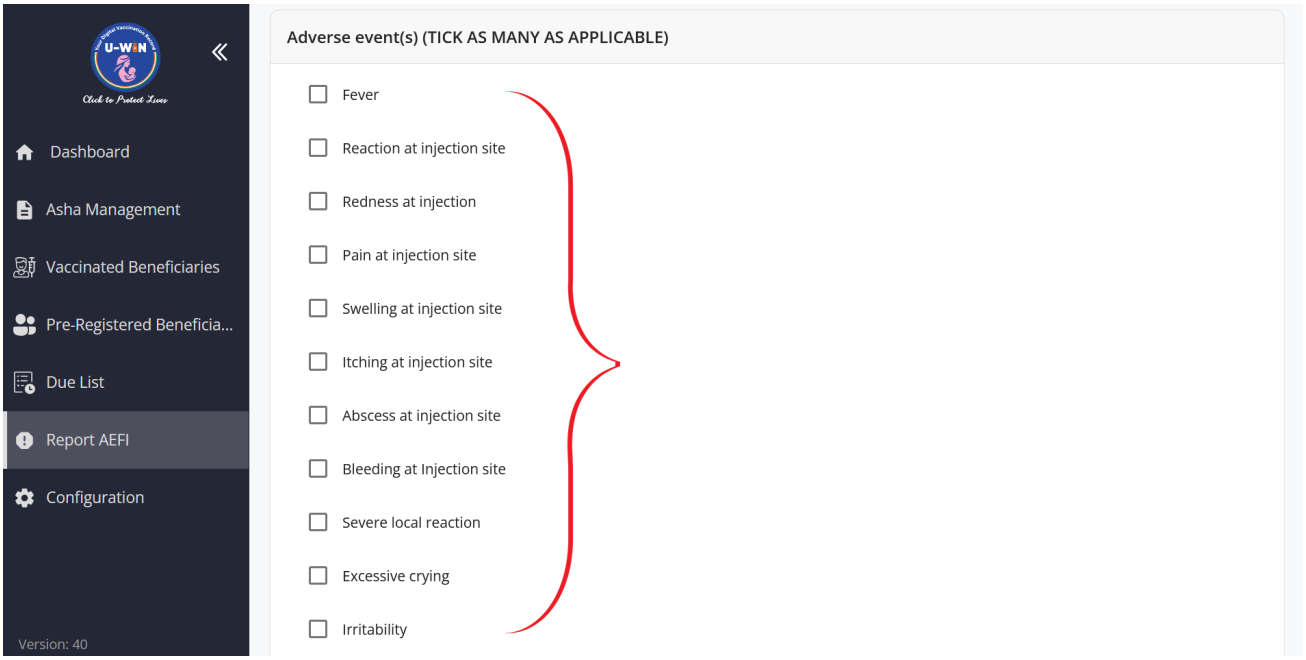
- **Step 8**: Vaccinator also needs to enter the complete address of the beneficiary/patient, including nearby landmarks, in the designated field.

Fig. 97



- **Step 9**: The Vaccinator should select the "Adverse Event(s)" as reported by the beneficiary or the father/ mother/guardian from the available list. If "Any other" is selected, the Vaccinator must specify the details of the adverse event in the provided field.

Fig. 98



- **Step 10**: Vaccinator should enter the date of onset of the first symptom in DD/MM/YYYY format, the time of onset of the first symptom in hh:mm format and indicate whether the beneficiary was hospitalized (Yes/ No).
- If the beneficiary is hospitalized, enter the date of hospitalization in DD/MM/YYYY format.
- Select "Death" – Yes or No from the drop-down menu as applicable.

Fig. 99

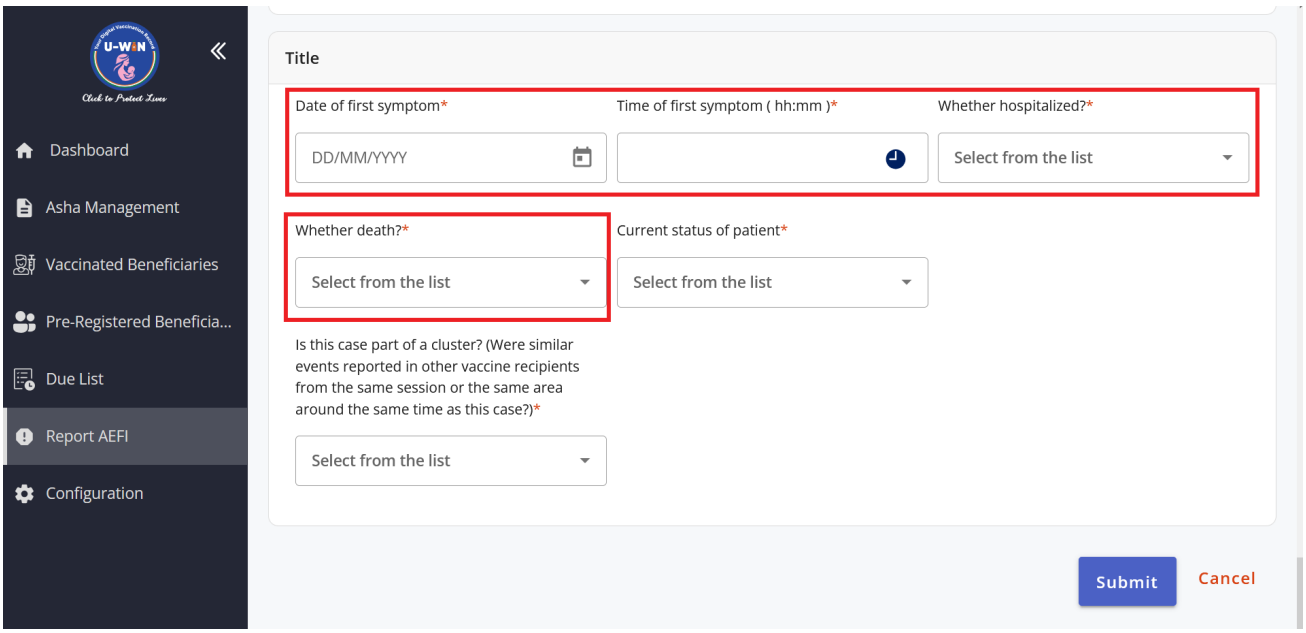
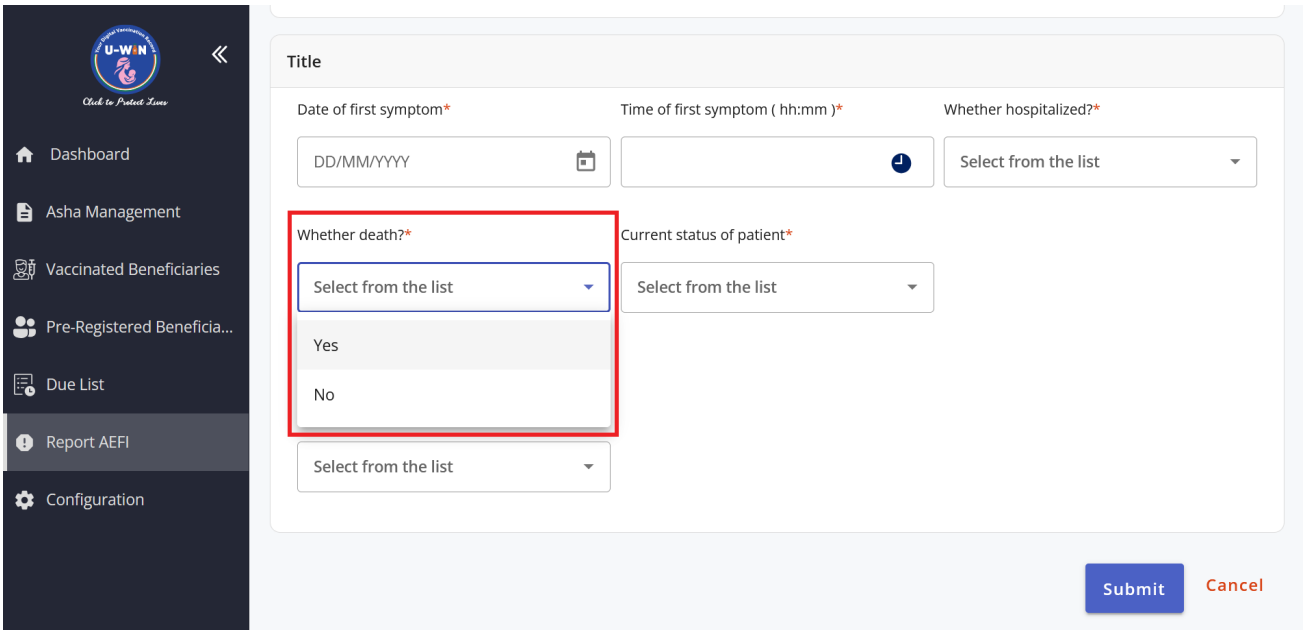
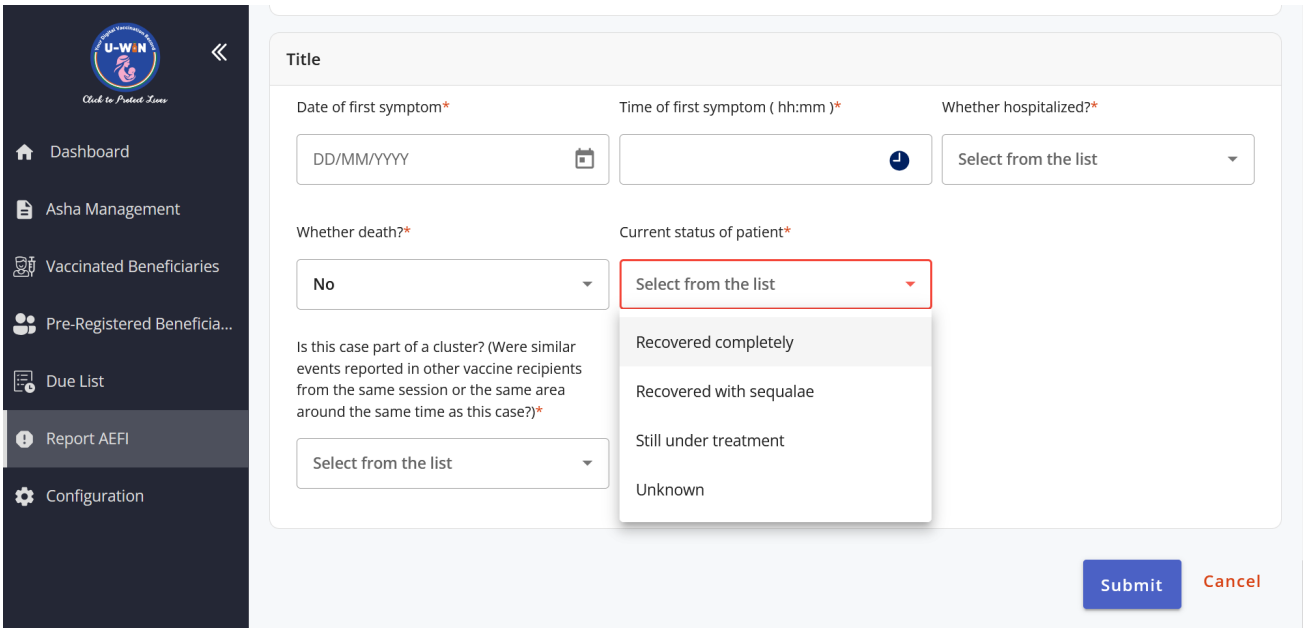


Fig. 100



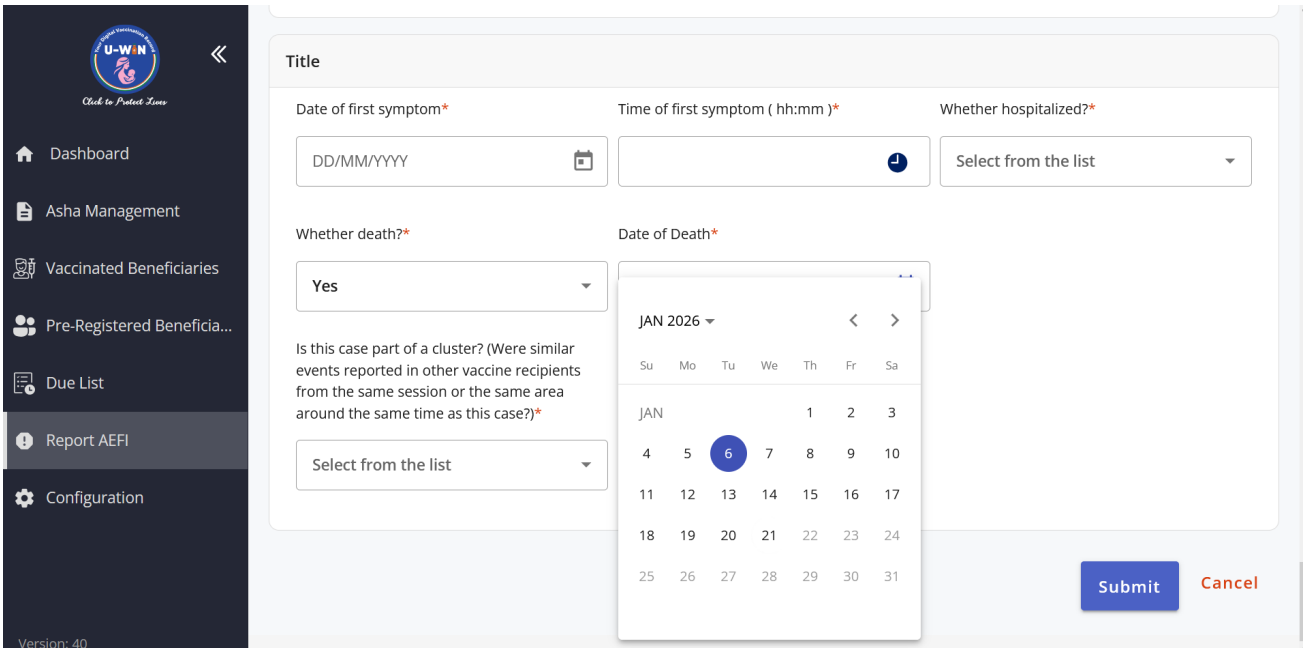
- If “No” is selected under “Whether Death?”, choose the appropriate option under “Current Status of Patient” from the drop-down list: Recovered completely / Recovered with sequelae / Still under treatment / Unknown.

Fig. 101



- If “Yes” is selected under “Death”, enter the date of death in DD/MM/YYYY format

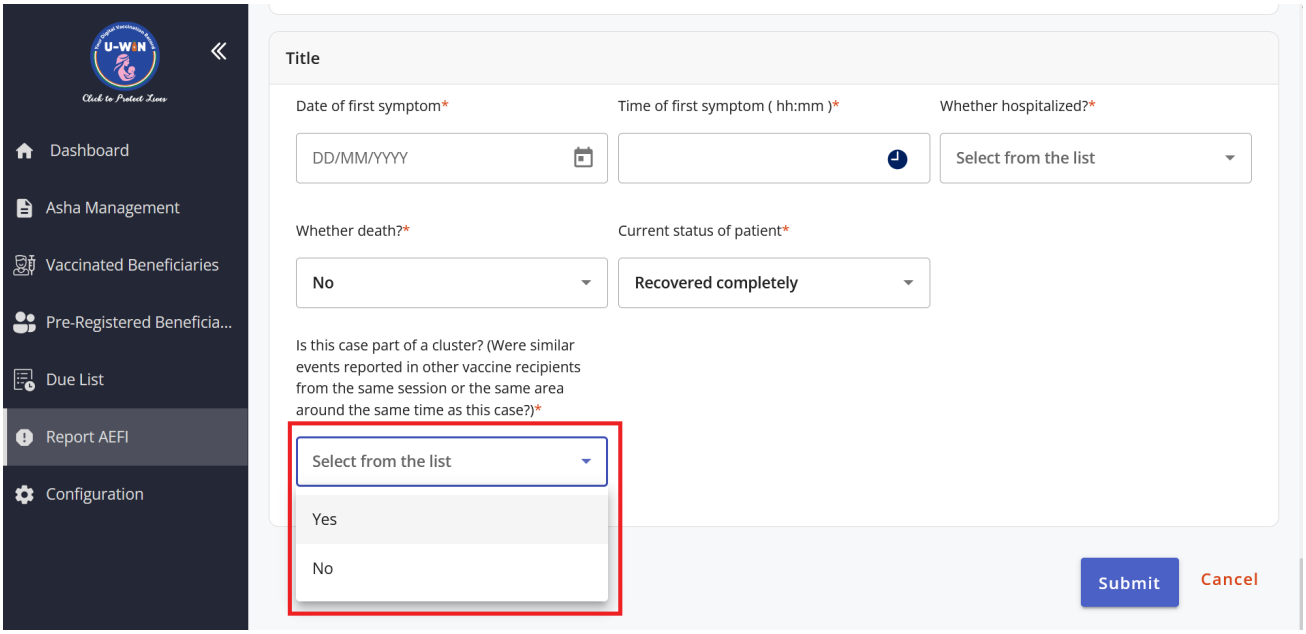
Fig. 102



- **Step 11**: Vaccinator can select “Is this case part of a cluster”- Yes if the case is part of a cluster; otherwise, or else select “No”.

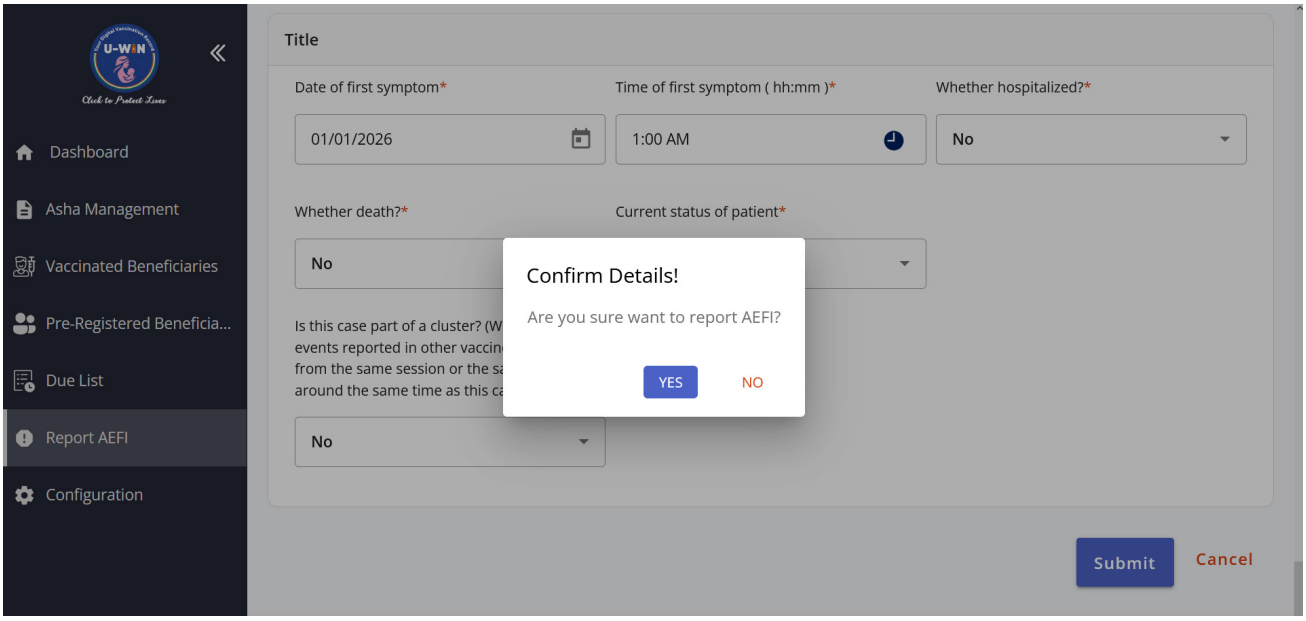
Once all required fields in the form are completely filled, vaccinator can click the “Submit” button to save and report the AEFI case.

Fig. 103



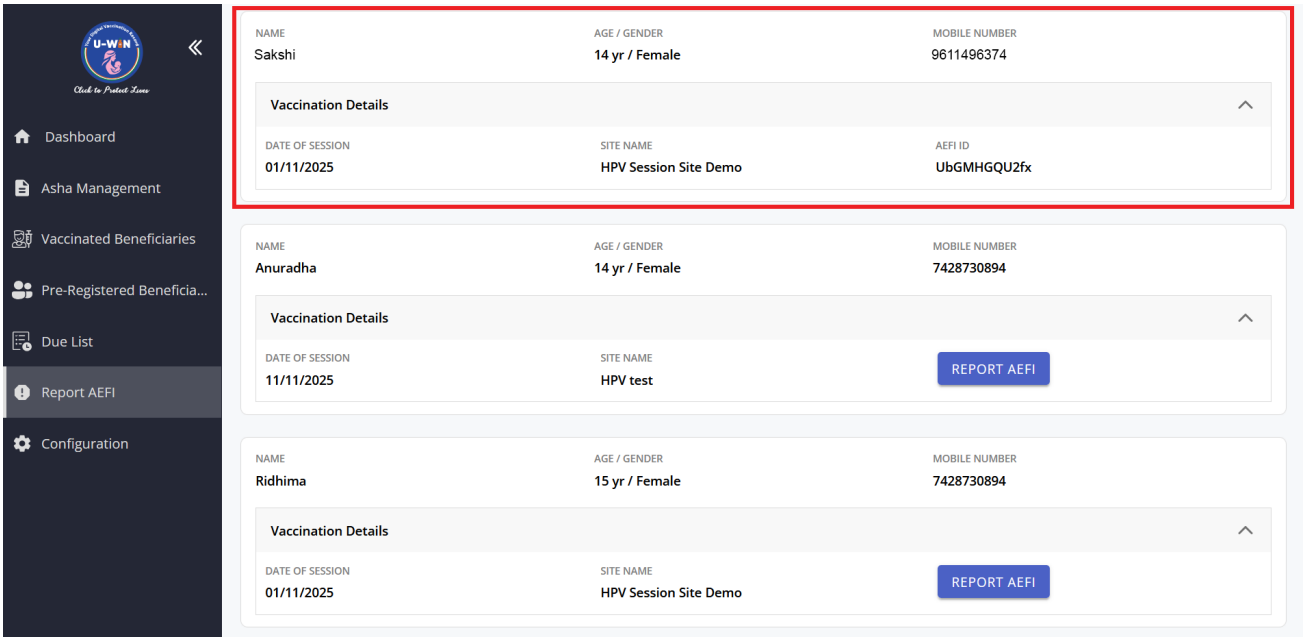
- **Step 12**: A confirmation prompt will appear after clicking “Submit.” Select “Yes” to finalize and submit the AEFI report.

Fig. 104



After the AEFI case is successfully submitted, an AEFI ID will be displayed next to the date of vaccination for which the AEFI was reported. The “Report AEFI” button will no longer be visible for that particular date, indicating that the report has been recorded.

Fig. 105



5D. COLD CHAIN AND VACCINE LOGISTICS MANAGEMENT (CCVLM)

An effective cold chain and vaccine logistics management system is an essential prerequisite for the successful new vaccine introduction. The smooth functioning of the immunization supply chain is critical for the delivery of immunization services.

Vaccine stores at all levels (state, regional, district and sub-district level) need to forecast their vaccine and logistics requirements to ensure that the right number of vaccine doses, logistics and cold chain equipment are available to vaccinate all eligible beneficiaries at a given time and place. Each level should assess its cold chain space and dry storage capacity, monitor the stock of vaccines and syringes in order to assess the lead-time and re-ordering levels.

The major steps in logistics management during HPV vaccination campaign are as follows:

- Order vaccines in advance;
- Make a written distribution plan for all levels of immunization supply chain. The plan should include;
    - o A specified responsible person at each post;
    - o Specify when and how supplies will be distributed;
    - o Disposal of injection waste as per CPCB norms.
- Ensure that vaccine and AD syringes are distributed in bundled form

The subsequent sections will discuss on each aspect of vaccine, logistics and cold chain system in greater details for the HPV vaccination campaign:

HPV VACCINE: CHARACTERISTICS AND VACCINE MANAGEMENT

HPV vaccine management should follow the same procedures as for other vaccines in the cold chain. The HPV vaccine should be stored between +2° to +8°C. The HPV vaccine is freeze sensitive and less heat sensitive and SHOULD NOT BE FROZEN, as it is exceptionally sensitive to temperatures lower than +2°C and may lose efficacy if frozen. If there is suspicion that a vaccine has been frozen, a shake test should be performed.

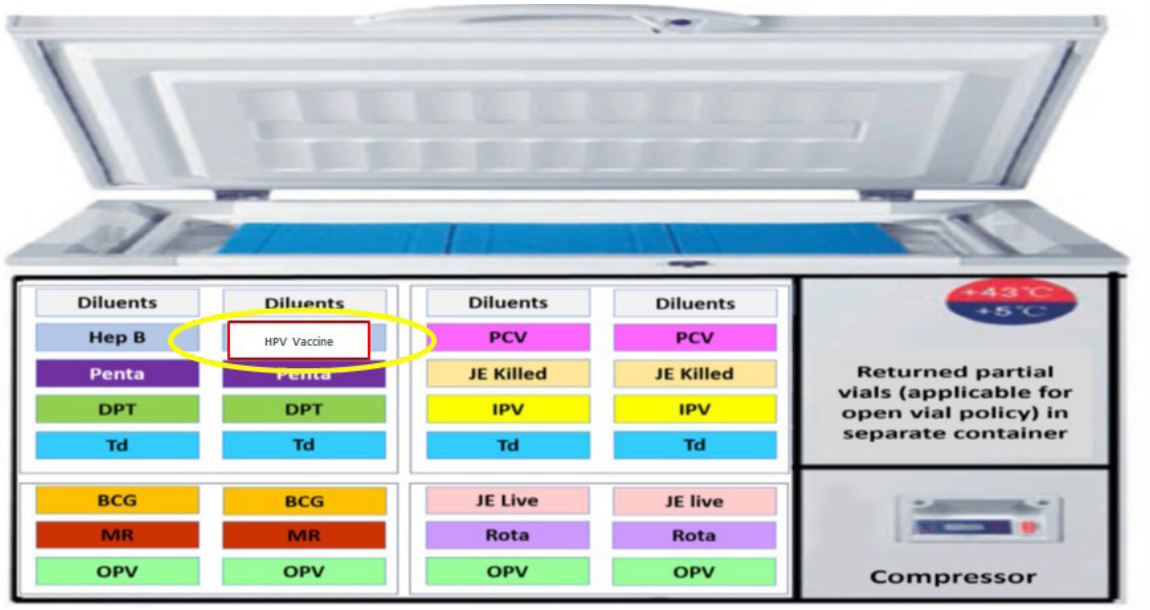
Vaccine storage:

Upon receipt and confirmation of quantity delivered, the vaccines should be stored in designated ILR. To ensure vaccine efficacy, proper storage and packing are essential. The HPV vaccine should be stored within the recommended temperature range in Walk-In Coolers (WICs) at State/Regional/District Vaccine Stores, and in ILRs at District Vaccine Stores and Last Cold Chain Points. The following storage practices are recommended:

- o In Ice-Lined Refrigerators (ILRs): Store HPV and other freeze-sensitive vaccines on the top, below diluents and Hep-B
- o In the front-opening ILR, no specific sequence of storage of vaccines is prescribed
- o In Walk-in cooler, store the vaccines on the shelves. Avoid placing any vaccine one meter in front of evaporators and behind the line of installation of evaporators

At the district level, cold chain space is primarily utilized for storing vaccines. At the sub-district level (health facility), cold chain space is required for both freezing ice packs and storing vaccines. With existing cold chain infrastructure, storage capacity for routine and campaign vaccines is generally sufficient at both district and sub-district levels. If required, redistribution of available cold chain equipment at the district level can be undertaken to rationalize availability as per the requirement.

Figure 106: HPV Vaccine placement in the ILR



HPV VACCINE HANDLING

In order to ensure correct storage and transportation of vaccines, the following procedures should be followed:

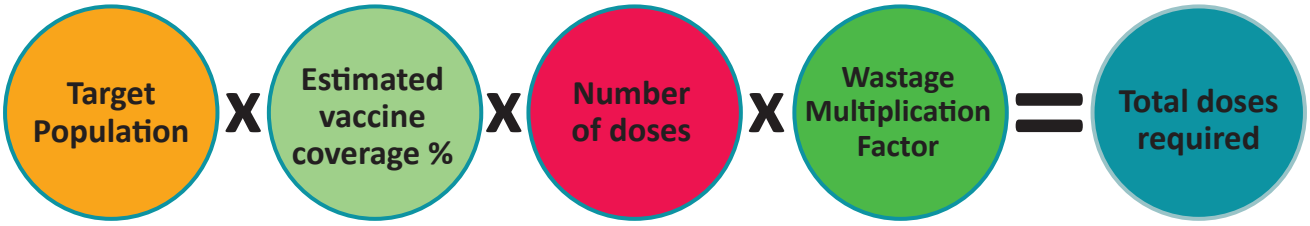
- Ensure insulated vaccine carriers are clean before use and at end of the day.
- HPV vaccine can be damaged if placed in direct contact with frozen ice packs that were inadequately conditioned, therefore, frozen ice packs should be conditioned before use.
- Allowing ice packs to condition means that the initial freezing temperature is lost, so the temperature in the insulated carrier does not drop below 0°C.
- Use a conditioning table. Remove the ice packs from the Deep Freezer and place them on the table to defrost (condition). Ice packs are adequately conditioned when beads of water cover their surface and a crackling sound of water is heard when they are shaken. Once conditioning is complete, the ice packs are ready for use.
- Dry the ice packs and line the walls of the insulated vaccine carrier with them.
- Place the vaccines in zipper bags.
- Properly conditioned ice packs constitute the best method to maintain the temperature of the insulated carriers and cold boxes.

VACCINE ESTIMATION

The HPV vaccine management will be fully integrated in the eVIN portal and will work in synchronization with the U-WIN. As the campaign spans for three months, HPV vaccine will be supplied in two aliquots: 50% before the campaign begins followed by replenishment of consumption on a monthly basis. This phased approach helps in managing cold chain space constraints and ensures uninterrupted supply. HPV vaccines will also be tracked in the stock-management system, both through physical records and in the eVIN.

HPV vaccine estimation will follow the standard UIP calculation methods, considering the target population size, expected coverage, number of doses, and vaccine wastage. As shown in Figure 107, the formula for calculating the required doses is:

Figure 107: Dose calculation



Target population: During the campaign, the 'best possible' estimate of eligible beneficiaries (all girls aged 14 years) will be derived through sources like ~1% of the total population and House-to-house survey.

**Target beneficiaries include all those who have celebrated their 14th birthday but have not yet celebrated their 15th birthday.*

Estimated vaccine coverage: Total expected coverage of the target population.

Number of doses: A single dose schedule is being followed for the initiative.

Wastage factor: Assuming vaccine wastage of 1%, the wastage multiplication factor(WMF) will be 1.01.

Calculation of HPV Vaccine Doses Required:

For a PHC catchment area with an estimated target population of 300 girls aged 14 years:

Expected coverage: 100%

Number of doses per girl: 1

Wastage factor: 1.01

The vaccine doses requirement is calculated as:

300 girls × 1.0 coverage × 1 dose × 1.01 wastage multiplication factor = 303 doses

These 303 doses should then be converted into vials as per the vaccine vial presentation.

HPV VACCINE STOCK MANAGEMENT (INVENTORY CONTROL)

All the guiding principles of stock management for eVIN like FEFO, reordering levels, lead time etc. need to be followed accordingly. The inventory system should ensure that vaccines with the nearest expiry date are used first in a system known as FEFO (first-to expire, first-out).

All stock transactions should be recorded on the same day (within 24 hours) in stock registers as well as eVIN.

The following activities can help in ensuring adequate supplies and cold chain space for storing vaccines:

- While distributing the vaccines and logistics from the State to the districts, oversight of State Immunization Officer and State Cold Chain Officer is required. Supply quantities should be based on the beneficiary estimates as per the planning template and not on basis of the demand by the districts;
- Supplies of vaccines should match the available cold chain capacity at State / District / Block level; in case of insufficient cold chain space at any store, the higher store/supplying store should consider supplying reduced quantity of vaccine in each tranche of supply and increasing the frequency of supplies to meet the demand.

- Readiness of the functional cold chain point to receive the stocks is required through repair and maintenance of the existing cold chain equipment, i.e. WICs, DFs, ILRs and stabilizers at all levels. Training of the cold chain handlers on cold chain and vaccine management should be ensured;
- Redistribution of vaccine stock during activity, both intra-state and within districts and health facilities based on requirement will be essential to minimize vaccine wastage.

ESTIMATING REQUIREMENT OF SYRINGES

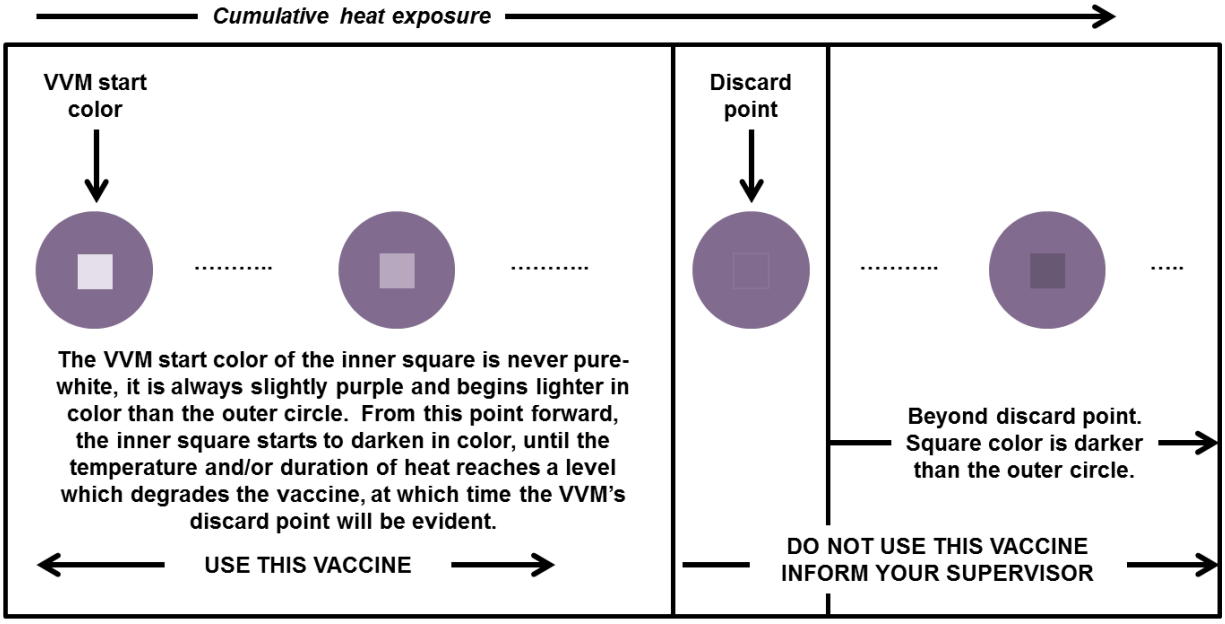
The auto-disable (AD) syringes (0.5 ml) should be used to administer the HPV vaccine. As each AD syringe is packed separately, the number of syringes required will be equal to the number of vaccine doses supplied.

COLD CHAIN MONITORING

The HPV vaccine is freeze sensitive and should never be frozen. Proper storage of vaccines and maintenance of the cold chain during storage and distribution are essential to prevent the loss of potency. Once a vaccine loses its potency, it cannot be regained. Any damaged vaccines must be discarded as per the existing guidelines.

All HPV vaccine vials have a Vaccine Vial Monitor (VVM-30). The VVM registers cumulative heat exposure, and colour from light to dark. The VVM on each vial must be checked before use. The vaccine should be used only if the inner square of VVM is lighter than the outside circle. If the inner square is the same colour, or darker than the outer circle, do not use the vaccine (Figure 108).

Figure 108: Interpretation of Vaccine Vial Monitor



COLD CHAIN EQUIPMENT ESTIMATION:

Electrical cold chain equipment estimation

The additional cold chain equipment requirement for HPV vaccine at all levels of the immunization supply chain can be estimated through the following steps should follow this:

Step 1: Calculation of existing CC space requirement:

Existing monthly CC space requirement = [target x CC volume x1]

Step 2: Additional cold chain space requirement for HPV vaccine:

Additional CC space requirement = [monthly number of doses required x number of months of supply x unit

cold chain space per dose (15 cm3 for single-dose vial). States will be informed prior on the vaccine product to be supplied.

**For secondary packaging of carton of 10 single dose vials, unit cold chain space per dose is 15 cm3 per dose.*

Step 3: Net additional cold chain space required for UIP, and HPV vaccine:

Net additional CC space required = [(CC space required for current UIP + CC space for HPV Vaccine) – Available CC space] (The available CC space at every level is accessible from the NCCMIS)

Step 4: Additional cold chain equipment requirement

Additional CCE required = net additional CC space required/ unit storage volume of respective CCE (rounded up to the next higher number)

An indicative list of average units CCE net storage volume for the different types of CCE is provided below for reference:

ILR: ILR(L) – 200 litres; ILR(S) – 100 litres

NON-ELECTRICAL COLD CHAIN EQUIPMENT ESTIMATION:

In addition to electrical cold chain equipment, passive cold chain equipment, such as cold boxes and vaccine carriers will also be required for the HPV vaccination campaign.

Cold boxes may be required during the HPV vaccination campaign for vaccine distribution and storage at temporary vaccine storage and distribution sites for effective population coverage. All such sites should be identified in the campaign micro plan and requirement of cold boxes should be calculated based on vaccine estimation for the population covered. An inventory update of all cold boxes should be undertaken. Cold boxes requiring minor repair and maintenance, such as thorough cleaning, fixing of metal clasps and handles, etc., should be identified and included in the cold chain crash repair activities. The calculation for cold box requirement can be calculated as follows:

Number of cold boxes required at temporary storage sites = Estimated cold chain space requirement based on estimated vaccine doses required/ unit cold chain storage volume of one cold box

[A large cold box has an average net vaccine storage capacity of 20 liters and a small cold box has a net storage capacity of around 5 liters.] Vaccines should be kept in vaccine carriers with 4 conditioned ice packs. In one vaccine carrier, around 40-50 single dose vials of quadrivalent Gardasil vaccine can be transported.

Table 4: Capacity of various Deep Freezers for Freezing and Storing Ice-packs

Manufacturer	Type	Model	Net Storage capacity (in L)	Icepack freezing capacity	Icepack storage capacity
Haier	DF –large	HBD-286	200	39	350
Vest frost	DF –large	MF-314	264	60	380
Haier	DF –small	HBD-116	80	18	140
Vest frost	DF –small	MF -114	72	25	130

Since the daily requirement of ice-pack is less than the freezing capacity of Deep Freezer, hence, the Cold Chain Point does not need any alternate arrangements for managing the ice-packs for the campaign.

MAINTAINING COLD CHAIN DURING VACCINATION SESSION

- Never expose the vaccine carrier or the vaccine vial to direct sunlight.
- All vaccines should be kept inside the vaccine carrier with the lid closed until a beneficiary comes for vaccination.
- The vaccine vial monitor (VVM) indicates whether the vaccine is usable or not. Vaccines should always be kept in a zip-lock plastic bag, away from water to protect the labels and the VVM.
- HPV vaccine must be stored between +2 to +8 °C, away from sunlight.
- The vaccine vial should **NOT** be placed on Ice-pack during the session.
- Once a vial is finished, the next vial should be taken out of the vaccine carrier only after arrival of another beneficiary at the session.

Maintaining cold chain after vaccination session

- At the end of the session, the unused vials with usable VVM should be clearly marked and kept separately in the ILR to be issued first during the subsequent session.
- The used vials must be kept in ILR in a separate box or in a Cold Box marked as 'Do not use' till the next session or 48 hours which ever earlier.

RECORDING AT COLD CHAIN POINTS (using eVIN)

The HPV vaccine management will be fully integrated into the Electronic Vaccine Intelligence Network (eVIN) to provide real-time information on vaccine stocks and flows, and storage temperatures. The eVIN logistics module will work in synchronization with the U-WIN beneficiary module. Both of these comprehensive cloud-based IT solutions will be used for planning, implementation, monitoring, and evaluation of HPV vaccination drive. eVIN will offer real-time dashboards on vaccine consumption and wastage.

- At each level, the quantities of vaccines and syringes received must be recorded in the designated standard registers as well as in eVIN.
- Details such as quantities received and dispatched, dates of receipt and dispatch, batch numbers, expiry dates, and VVM status must be recorded at the time of receipt and issue.
- Cold Chain Points must record the vaccine doses and syringes issued to the vaccination teams and those returned from the sessions to calculate net utilization on a daily basis.
- Records of vaccines and other logistics received, distributed, and returned must be included in daily, weekly, and end-of-activity reports submitted to the next level.
- It is mandatory to record the temperature of ILR and DF twice a day including Sundays and holidays.

ROLE OF COLD CHAIN HANDLER (CCH)

Cold Chain Handlers (CCH) – He/She will utilize the eVIN directory of CCHs at all levels (SVS, RVS/DiVS, DVS and CCP) and ensure their mapping on U-WIN. He/She will download and updated version of eVIN mobile application, incorporating the material tag of HPV vaccine and will carry out all HPV vaccine transactions in eVIN. He/She would also ensure adequate availability of HPV Vaccines at session site and monitor the reporting of HPV vaccine consumption.

EXAMPLE OF COLD CHAIN and LOGISTICS ESTIMATION

The Table 5 presents data for a PHC serving a population of 30,000, with 300 girls aged 14 years.

Table 5: Example of Cold Chain and Logistics Estimation

S. No.	Particulars	HPV Vaccination Campaign
1	**Target population**	300 girls aged 14 years
2	**No. of doses**	1
3	**Wastage multiplication factor**	1.01
4	**Estimated coverage**	100%
5	**Total doses required**	**Vaccine with single dose schedule:** 300 x 1.0 x 1 x 1.01 = 303 doses
	Supply cycle	The quantity and frequency of vaccine supply from higher-level store to lower-level store will depend on the duration of the campaign, consumption, and the storage capacity available at the receiving store.
6	**Additional cold chain space required**	Single-dose vial (one dose schedule): =15*303 =4.545 litres, if vaccine supplies made in tranches: 50% vaccine requirement: 2.27 litres
7	**Total 0.5 ml AD syringes required**	Equal to the number of vaccine doses (303 for the campaign)
8	**Dry Storage space required**	303 x 49.5 cucm = 14998 cucm or 14.99 L
9	**Vaccine Carriers required**	As HPV vaccination session will be held at Health Facility, and a maximum of 2–3 vaccine carriers will need to be prepared.
10	**Ice packs required**	4 icepacks per vaccine carrier E.g., for 2 vaccine carriers, 8 ice- packs will be required
11	**Vials per vaccine carrier**	In one vaccine carrier, around 40-50 single dose vials of quadrivalent Gardasil vaccine can be transported.

5E. MANAGING AEFI

ADVERSE EVENT FOLLOWING IMMUNIZATION (AEFI)

An AEFI is any untoward medical occurrence that follows immunization and which **does not necessarily have a causal relationship with the usage of the vaccine.** The adverse event may be any unfavorable or unintended sign, abnormal laboratory finding, symptom or disease. The occurrence of an adverse event after immunization does not necessarily imply that the vaccine is the cause of the adverse event. For the purpose of reporting, AEFIs can be minor, severe and serious.

Minor AEFIs are very common, mild in severity, self-limiting and resolve on their own within 2-3 days. Some examples are local pain, redness and swelling at injection site, fever, malaise, weakness, etc. Tablet paracetamol in age-appropriate doses will provide relief. Severe and serious reactions are very rare. **Severe AEFIs** are clinically severe (higher degree of intensity of an event) but are not serious (i.e. do not result in death, inpatient hospitalization or disability). **Serious AEFI** are the ones which have resulted in death, required inpatient hospitalization, resulted in persistent or significant disability/incapacity, congenital anomaly/birth defect, caused community/media concern or have occurred in a cluster (two or more cases of similar events) of AEFIs. If a case is admitted in the hospital irrespective of its clinical severity, it will be reported under serious category. All cases which have recovered but have sequelae (disability) will also be reported under serious category.

SAFETY PROFILE OF HPV VACCINES

More than 500 million doses of HPV vaccines have been distributed worldwide since these vaccines were licensed in 2006. The Global Advisory Committee on Vaccine Safety (GACVS) of the World Health Organization (WHO) has reviewed safety data related to HPV vaccines every year between 2007 and 2009 and from 2013 to 2015. In 2017, it conducted a comprehensive literature review and assessed safety data generated from all countries, including those with strong vaccine safety surveillance systems. The results of many high-quality studies using different methodologies conducted to assess the association of some new-onset chronic diseases suspected to be related to HPV vaccines were analyzed by GACVS during this review. It did not find any adverse event to be causally related to HPV vaccines.[32, 33, 34] In its 13th meeting, the National Technical Advisory Group on Immunization (NTAGI) of India, discussed safety issues reported following the use of HPV vaccines and noted that the safety of these vaccines has been reviewed by multiple medical authorities, forums and regulatory agencies globally including World Health Organization, Global Advisory Committee on Vaccine Safety (GACVS), Food and Drug Administration (FDA), European Medicines Agency (EMA) and International Federation of Gynaecology and Obstetrics (FIGO). Data from all sources continue to be reassuring regarding the safety profile of HPV vaccines. Available HPV vaccines have an excellent safety profile.

Majority of the vaccine reactions following HPV vaccinations are minor reactions such as local injection site reactions (pain, swelling and redness) and systemic reactions (fever, irritability, malaise, headache, fatigue, myalgia, arthralgia, rash, urticaria, gastrointestinal disorders, etc.).

Post-licensure surveillance has detected no serious safety issues linked to the HPV vaccine to date except rare reports of anaphylaxis (approximately 1.7 cases per million doses). Syncope (fainting) was established as a common anxiety or stress-related reaction to the injection and not because of vaccine per se.

32. Arana, J. E., Harrington, T., Cano, M., Lewis, P., Mba-Jonas, A., Li, R., Stewart, B., Markowitz, L. E., & Shimabukuro, T. T. (2018). Post-licensure safety monitoring of quadrivalent human papillomavirus vaccine in the Vaccine Adverse Event Reporting System (VAERS), 2009–2015. Vaccine, 36(13), 1781–1788. Available at: https://doi.org/10.1016/j.vaccine.2018.02.034. Accessed on February 4, 2026

33. Donahue, J. G., Kieke, B. A., Lewis, E. M., Weintraub, E. S., Hanson, K. E., McClure, D. L., Vickers, E. R., Gee, J., Daley, M. F., DeStefano, F., Hechter, R. C., Jackson, L. A., Klein, N. P., Naleway, A. L., & Nelson, J. C. (2019). Near real-time surveillance to assess the safety of the 9-valent human papillomavirus vaccine. Pediatrics, 144(6), Article e20191808. Available at: https://doi.org/10.1542/peds.2019-1808. Accessed on February 4, 2026.

34. Phillips, A., Hickie, M., Totterdell, J., Brotherton, J., Dey, A., Hill, R., Snelling, T., & Macartney, K. (2020). Adverse events following HPV vaccination: 11 years of surveillance in Australia. Vaccine, 38(38), 6038–6046. Available at: https://doi.org/10.1016/j.vaccine.2020.06.039. Accessed on February 4, 2026.

Contraindications and Precautions:

HPV vaccine is contraindicated in individuals with a history of severe allergic reaction to a component of the HPV vaccine or following a previous dose of the vaccine, including those with hypersensitivity to yeast. Pregnant women are also advised to delay vaccination until after pregnancy.

Vaccination should be postponed for individuals experiencing moderate or severe acute illness, allowing for recovery before vaccination.

PREVENTION AND MANAGEMENT OF AEFIs

General precautions to be followed to prevent AEFIs

Before Vaccination

- Advise parents to ensure that vaccine-recipients are not empty stomach before their vaccination appointment.
- Ensure that the session site, waiting area and observation rooms are well-ventilated and spacious to prevent over-crowding. Those waiting to receive vaccinations should not have a direct line of sight of the injection room.

During Vaccination:

- To reduce anxiety or syncope during HPV vaccination, provide a squeeze ball in the recipient's right hand and instruct her to squeeze it during vaccination.

After Vaccination

- Ensure recipients wait for 30 minutes after vaccination.
- Arrange for some entertainment in the observation room to distract children from post-vaccination pain and anxiety.
- Minimize overcrowding and adequate ventilation to reduce the chances of stress-related reactions.

Management of AEFIs

- Medical officers at the session site and 24x7 AEFI Management Centres should be trained in standard AEFI management, use of AEFI management kits and reporting procedures.
- All medical officers acting as supervisors of vaccination teams will have an AEFI management kit in the vehicle.
- Ensure contents of each AEFI kit are as follows (Figure 109):

Figure 109: AEFI management kit

  - Injection adrenalin (1:1000) solution – 3 ampoules
  - Disposable tuberculin/insulin syringes – 3 numbers
  - 24G/25G one inch needles – 3 numbers
  - Cotton swab – three numbers
  - Injection Hydrocortisone (100 mg) – 1 vial
  - I/V Fluids (Ringer lactate/Normal Saline): 2 units
  - I/V Fluids (5% Dextrose): 2 units
  - I/V drip set: 2 numbers
  - Scalp vein sets or IV cannula – 2 sets
  - Disposable Syringe (5 ml) and 24/25G IM needles – 3 sets
  - Adhesive tape: 1 number
  - Label showing: Date of inspection, Expiry date of Inj. Adrenaline and shortest expiry date of any of the components

- Drug dosage tables for Injection Adrenaline and Hydrocortisone
- At hospital setting, oxygen support and airway intubation facility should be available

- Nodal Medical Officer shall be responsible for reporting and managing any AEFIs during the vaccination session.
- Manage minor adverse events such as mild to moderate fever, local pain and swelling at injection site, malaise etc. with tablet Paracetamol SOS with a minimum interval of 4-6 hours between two doses.
- In case of adverse event/discomfort/illness, other than minor events:
  - Visit the nearest health facility for diagnosis and treatment.
  - Suspected anaphylaxis – Administer Inj Adrenaline as per dose chart. These are available in AEFI kits available at health facilities and Anaphylaxis kits which are available at every session site.
  - Transport case to the 24x7 AEFI management center, if required.
  - MO I/C will be responsible for providing mobility support for transporting any serious AEFI to a higher health facility, if needed. The contact details of the transport facility should be available at each vaccination site.
  - Inform the hospital to which the patient is being transported to, so that an MO is present to take over the patient.

ANAPHYLAXIS

Anaphylaxis is a rare but serious and life-threatening reaction to a vaccine. Therefore, each vaccinator at the session site should have an anaphylaxis kit that contains adrenaline to manage any suspected anaphylaxis at the session site. After vaccination, all beneficiaries need to be observed for 30 minutes. Any suspected case of anaphylaxis should be administered one age-appropriate dose of adrenaline immediately intramuscularly and emergency transport to be arranged to the nearest 24x7 AEFI management center or a healthcare facility with a medical doctor and emergency resuscitation equipment.

It is important to ensure that each vaccinator is trained to suspect anaphylaxis, and use the anaphylaxis kit. This training has to be included as part of the preparations of the campaign.

Recognizing and treating anaphylaxis

Anaphylaxis is a very rare but severe and potentially fatal allergic reaction. Before immunization, check for contraindications to immunization by asking about known allergies and previous adverse reactions to vaccines. Anaphylaxis should be suspected if there is early onset and rapid progression of more than one sign & symptoms of any two of the following three systems – respiratory, cardiovascular, and dermatological /mucosal.

System	Signs and Symptoms
Respiratory	• Swelling in tongue, lip, throat, uvula or larynx • Difficulty in breathing • Stridor (Harsh vibrating sounds during breathing) • Wheezing (breath with a whistling or rattling sound in the chest) • Cyanosis (bluish discolouration of arms and legs, tongue, ears, lips etc.) • Grunting (noisy breathing)
Cardiovascular	• Decreased level /loss of consciousness (fainting, dizziness) • Low blood pressure (measured hypotension) • Tachycardia (increased heart rate, palpitation)
Dermatological or mucosal	• Generalized urticaria (raised red skin lesion, rash with itching) • Generalized erythema (redness of skin) • Local or generalized angioedema- itchy/ painful swelling of subcutaneous tissues such as upper eyelids, lips, tongue, face etc. • Generalized pruritus (itching) with skin rash

HPV vaccine is administered in the deltoid region of the left arm. In case of suspected anaphylaxis, the preferred site of administration of injection adrenaline is the mid anterolateral aspect of the thigh. In case it is not possible to inject adrenaline in the thigh due to concerns of privacy, it may be administered in the deltoid muscles of any arm. Injecting adrenaline in the thigh is preferred as absorption is significantly faster and more reliable, which is critical in a life-threatening emergency.

An age-appropriate dose of injection Adrenaline must be given intramuscularly as soon as anaphylaxis is suspected. Every HPV vaccination centre should have health staff trained in treatment of anaphylaxis and an anaphylaxis kit with adrenaline injection. They should be familiar with its dosage and administration. It is important to ensure that vaccinators understand that a single, age-appropriate dose of adrenaline administered early to a suspect case of anaphylaxis can save the life of the vaccine recipient and reduce complications.

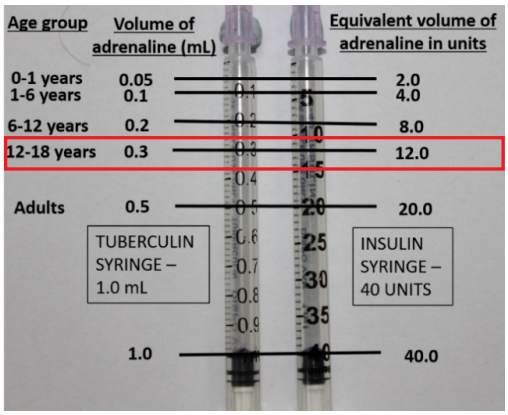
If, later on, the diagnosis turns out to be something other than anaphylaxis, the single dose will not harm the patient. All cases of anaphylaxis should be admitted for 24 hours even if recovery is quick and without sequelae. The case should be reported and investigated as a serious adverse event.

Contents of anaphylaxis kit (Figure 110)

The following are the contents of an anaphylaxis kit:

Figure 110: Anaphylaxis Kit

Figure 111: Markings of age-appropriate dosage of adrenaline in mL (tuberculin syringes) and equivalent volume in units when using insulin syringes



Anaphylaxis kit for ANM/vaccinator

1. Job aid for recognizing anaphylaxis; dose chart for adrenaline as per age
2. 1 ml ampoule of adrenaline (1:1000 aqueous solution) - 3 nos. (adrenaline ampoules may also labeled as epinephrine)
3. Tuberculin syringes (1ml) or insulin syringe (40 units) **without** fixed needles - 3 nos.
4. Detachable 24G/25G needles (1 inch) - 3 nos. Syringes and needles should be procured and distributed as bundle so that required syringes and needles must be available in the kit.
5. Swabs - 3 nos.
6. Updated contact information of DIO, Medical Officer(s) of PHC/CHC, referral centre and local ambulance services.
7. Format for quarterly certification of anaphylaxis kit by medical officer of PHC

Table 6: Injection Adrenaline (1:1000 solution) Dosage Chart IM

Age group (in years)	One inch needle gauge	Dosage (in mL) using 1 mL tuberculin syringe	Dosage (in units) using 40 units insulin syringe
0-1		0.05	2
1-6		0.1	4
6-12	24G/ 25G	0.2	8
12-18		0.3	12
Adults		0.5	20

Ensure that the contents of the anaphylaxis kits are within expiry date. Injection adrenaline particularly has short expiry dates. The medical officer of the PHC should certify once a quarter that the adrenaline injections will not expire over the next three months. If the MO-PHC finds that the adrenaline will expire in the next three months, these should be replaced immediately.

A system should be in place to ensure mobilization of a vehicle for immediate transportation of the patient to a doctor and facilities with resuscitation equipment (AEFI management centre or nearest health facility). For more details, please refer to the anaphylaxis guidelines (Operational Guidelines: Initial Management of Anaphylaxis using Injection Adrenaline by ANMs, 2018, MOHFW, GoI).

ANXIETY REACTIONS

Anxiety reactions can occur due to fear of injections and the pain related to needle pricks. While anyone can suffer from anxiety, it is commonly reported among adolescents. Clusters of anxiety reactions have been reported during immunization campaign sessions.

An anxiety spell can cause a vaso-vagal reaction leading to fainting, symptoms of hyperventilation (light-headedness, dizziness, tingling in the hands and around the mouth). During fainting, the individual suddenly becomes pale, loses consciousness and collapses to the ground. Fainting or syncope is sometimes accompanied by brief clonic seizure activity (i.e. pseudo-seizure, rhythmic jerking of the limbs), but this requires no specific treatment or investigation. Fainting is relatively common after immunization of adults and adolescents, but very rare in young children. It is managed by simply placing the patient in a recumbent position. Recovery of consciousness occurs within a minute or two, but patients may take some more time to recover fully.

Ensure vaccine recipients are not on an empty stomach before vaccination. Arrange for refreshments at the session site for any child who has missed breakfast at home.

Use muscle tensing method to prevent vasovagal reaction. **Ask the vaccine recipient to clutch/squeeze a ball in the hand of the arm not used for immunization during and after vaccination procedure, to distract the recipient at the time of vaccination.**

Actively observe girls for 30 minutes after vaccination. Distract beneficiaries by engaging them in activities such as watching a film, singing, story-telling, etc. Minimize overcrowding and provide adequate ventilation in the waiting room, vaccination room and observation room.

MEASURES FOR PEOPLE AT RISK OF VASOVAGAL REACTION

Teachers, parents and classmates can help identify vaccine recipients with a fear of needle pricks/injections. The following people are at risk of anxiety reactions:

- Young age particularly adolescents and females.
- Those with a history of anxiety reaction or had vasovagal syncope or acute stress response from previous vaccinations/injections or to the sight of blood or have a phobia of getting injuries.
- Those who have expressed the fear of injections or had vasovagal syncope previously with injections.
- Those who have received negative information regarding vaccination (from relatives, friends, or people they trust, media reports or messages on social media).

Such persons should be identified, reassured, and vaccinated in privacy (at least behind a screen). They should be distracted while vaccinating and observed for anxiety reactions (syncopal attacks) soon after vaccination. If possible, they should be vaccinated in a supine position and should continue to be in the supine position for at least 15 minutes post-vaccination. Thereafter they may be brought up to the sitting position and made to wait an additional 15 minutes. A trusted, familiar person who is himself not anxious or fearful of needle pricks may be present physically with the vaccine beneficiary at the time of vaccination.

- Immunize preferably in supine position.
- After immunization, let them remain in supine position for 15 minutes.

- A person immunized in a supine position, should adopt an upright position only if they have no vasovagal symptoms. Observe the beneficiary for another 15 minutes in sitting position.
- Ensure that the session site is arranged in such a manner that chances of injury following fall due to syncope is minimum.
- If available, arrange for a bed with the foot end elevated to manage cases of vasovagal syncope
- Arrangement of entertainment such as games or dance videos may be provided in the post-vaccination room to alleviate anxiety.
- Avoid overcrowding of the vaccination area.

DISTINGUISHING ANXIETY REACTIONS FROM ANAPHYLAXIS

Health workers may find it difficult to differentiate between anxiety reactions and anaphylaxis. Table 7 will help health workers in differentiating between fainting and anaphylaxis. It is important to convey to vaccinators that an age-appropriate dose of injection adrenaline administered intramuscularly in suspected cases of anaphylaxis, which eventually turn out not to be anaphylaxis, is safe and does not harm the patient. However, in case of true anaphylaxis, this one dose will be a life-saving intervention.

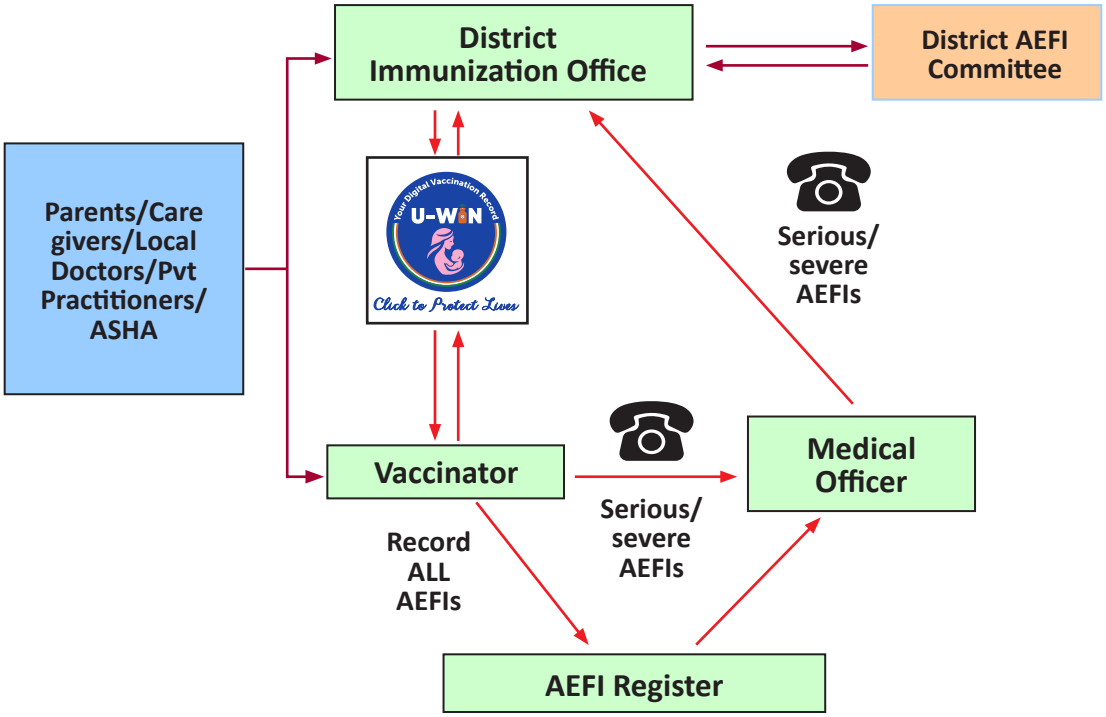
Table 7: Distinguishing Anaphylaxis from Fainting (vasovagal reaction)

	Vasovagal Reaction	Anaphylaxis
Onset	Usually at the time or soon after the injection	Usually between 5 and 30 minutes after injection
Systems involved		
Skin	Pale, sweaty, cold and clammy	Red, raised and itchy rash; swollen eyes, face, generalized rash
Respiratory	Normal to deep breaths	Noisy breathing from airways obstruction (wheeze or stridor)
Cardiovascular	Bradycardia, transient hypotension	Tachycardia, hypotension
Gastro-intestinal	Nausea, vomiting	Abdominal cramps
Neurological	Transient loss of consciousness, good response once in prone position	loss of consciousness, little response once in prone position

REPORTING, INVESTIGATION AND CAUSALITY ASSESSMENT OF AEFI

While HPV vaccines are safe, it is important to have a strong reporting network to capture all adverse events and investigate to find the cause of the serious and severe AEFIs, so that appropriate remedial action can be taken. Knowing that a strong adverse event monitoring system exists, and all adverse events are identified, evaluated, and managed will instill confidence in the community that vaccines are safe.

During HPV vaccination campaign, millions of doses of HPV vaccine will be administered in a short period of time. Public awareness campaigns for the need of vaccination and training of vaccinators, school authorities and other stakeholders may result in heightened sensitivity to adverse events. A large number of AEFIs are likely to be reported to the surveillance system. Reporting of an AEFI does not automatically imply that the vaccine is the cause of the event. The national AEFI surveillance operational guidelines will be followed for the reporting, investigation and causality assessment of AEFIs following HPV vaccination.



Recording of minor AEFIs

All AEFIs including minor AEFIs will be recorded by vaccinators in the HPV module of UWIN and in AEFI registers. AEFI registers should be available at all health facilities (planning units, cold chain points, etc.). When beneficiaries reach out for medical care for minor AEFIs, these should be recorded in AEFI registers and then in UWIN by the concerned vaccinator. Minor AEFIs are merely recorded in the UWIN and AEFI register and are not followed up for investigations and causality assessments. AEFI registers are reviewed at least once a month to elicit patterns of AEFI reporting which may need further action or analysis.

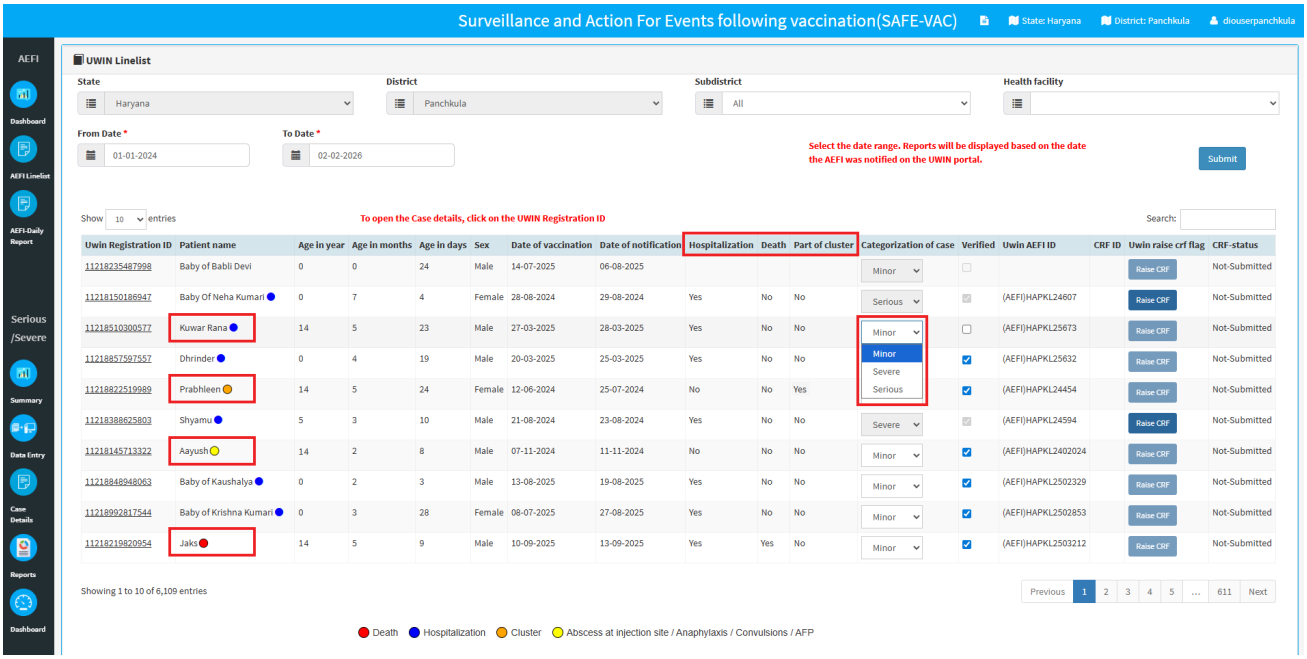
Immediate reporting of serious/severe AEFI cases

When vaccinators report adverse events in UWIN, they will choose the signs and symptoms from a given list of commonly reported events. They can also write details of events not in the given list in the “others” field. There are also options for the vaccinators to mark whether the beneficiary was hospitalized or died. All AEFIs reported by vaccinators in UWIN will be categorized as minor even if marked as a death or hospitalization or part of cluster. It is the DIO’s responsibility to verify minor AEFIs as minor and recategorize reported AEFIs marked as death or hospitalization or cluster by the vaccinator as serious. The DIO will ask the medical officer to send the filled Case Report Form (CRF) for severe/serious AEFIs.

The process of reporting AEFIs by vaccinators in UWIN is described in the chapter **5C Recording and Reporting – use of Digital Platforms** - under the sub section 'Workflow for the reporting HPV vaccine related AEFI'. The subsequent verification of the reported AEFIs by DIOs is described below:

Case Verification and CRF generation by DIO- Once the vaccinator submits the AEFI, it will become visible to the DIO of that district on the Dashboard page as part of the linelist of reported cases. The linelisted adverse events will be, by default, categorized as minor. Cases reported as death, hospitalized or part of a cluster will be denoted by red, blue and orange dots in front of the name of the case. Anaphylaxis, abscess at injection site, convulsions and AFP cases will be denoted by a yellow dot. This will help the DIO prioritize the cases displayed for verification. If it is a serious/severe case, the DIO will change the category using the drop down menu accordingly, click on the “Generate CRF” button and contact the Medical Officer to generate the CRF of the case.

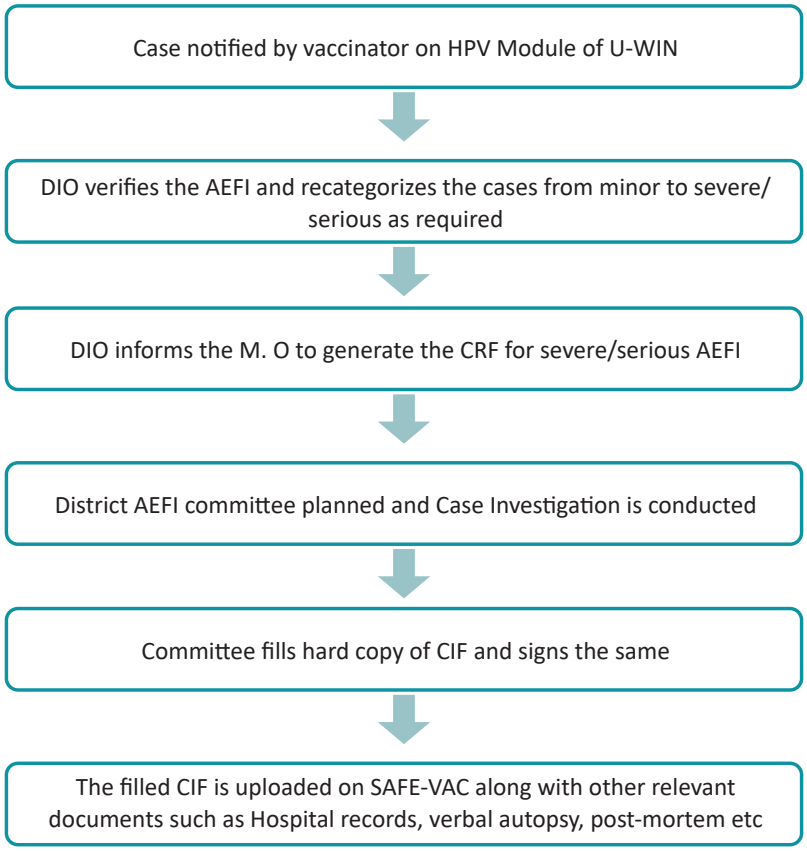
Figure 112: DIO dashboard with a list of cases reported by vaccinators



After vaccination, a very small proportion of vaccine recipients may have an adverse event. This could be due to reasons other than vaccination, but may be blamed on the vaccine. In order to investigate and find the real cause, all such AEFIs should be recorded in the AEFI register and immediately notified to a medical officer by the vaccinator. The medical officer will fill the Case Report Form (CRF) within 24 hours of notification and send it to the DIO. The nodal officers for vaccination services/ AEFIs at PHCS/CHCS/SDHs/District hospitals will be responsible for reporting and managing AEFIs.

Once the DIO receives the CRF from the MO/private practitioner, he verifies the details in another 24 hours and uploads it into SAFE-VAC. He can also generate the CRF directly in SAFEVAC. He initiates investigations immediately and completes it within 21 days of notification. The Case Investigation Format (CIF) is used to record the findings of the investigation, and this will also be uploaded in SAFE-VAC within 21 days of notification along with the records and documents as mentioned in the CIF, such as hospital records, vaccination cards, post mortem reports, etc. Any other record/ report/document received later such as Histopathological Examination (HPE) report or final cause of death report, laboratory test results, etc. can be uploaded on SAFE-VAC at a later stage.

Figure 113: Flowchart representing reporting of Severe/Serious AEFIs



After investigations are complete and CRF, CIF and all available supporting documents such as treatment records, etc., are uploaded in SAFE-VAC, the state AEFI committee conducts causality assessment of the case as early as possible but not beyond 100 days of notification. The results of the causality assessment of the case are also uploaded on SAFE-VAC. The national AEFI committee may also conduct its own causality assessment after reviewing the investigation reports, supporting documents and results of the causality assessment done by the state AEFI committee.

During HPV vaccination, AEFIs must be rapidly detected and promptly responded to or else it can undermine confidence in the vaccine and immunization program. This will ultimately have a negative impact on immunization program and the program objectives will not be achieved.

REPORTING ANXIETY CLUSTERS

Clusters of anxiety reactions are known to occur during immunization campaigns. **Reporting and investigating these are important to determine the real cause of the clusters and to rule out immunization errors or vaccine product-related reactions.** Reporting and investigating such clusters require extra human resources and time. The following process can be followed to enable the districts to complete the investigations within 21 days of notification of the cluster.

- **Fill individual CRFs with separate EPID numbers** for each individual case of the anxiety cluster.
- The district AEFI committee has to be involved in investigations. A psychiatrist, if available in the district, may be part of the investigating team.
- Fill separate Case Investigation Formats (CIFs) for each case of the cluster.
- Prepare and submit a detailed investigation report of the anxiety cluster consolidating the following details:
    - Session details

- Vaccine recipients
- Sequence of events
- Clinical signs and symptoms
- Cold chain assessment
- Epidemiological investigation
- A list of affected individuals.
- Individual hospital records, treatment documents, OPD slips, etc.

AEFI SURVEILLANCE DURING HPV VACCINATION CAMPAIGN

The district AEFI committee should ensure widening of the reporting network of AEFIs by ensuring that the DIO contacts district hospitals, CHCs, taluka hospitals, ESI, railways, medical colleges and hospitals in the private sector or autonomous institutions and sensitize staff to identify and report hospitalized AEFIs to him/her.

- The DIO should utilize opportunities such as monthly meetings of the local chapters of IMA, IAP and FOGSI to sensitize members to report AEFIs.
- All ANMs/ASHAs/AWWs and MOs must be sensitized to recognize and report AEFI promptly. They must know what to do in the event of an AEFI and the location of the nearest AEFI treatment center.
- The membership of the district AEFI committee should be widened to have an obstetrician-gynaecologist & psychiatrist as a member, who must be informed and involved from the beginning of the vaccination drive.
- The district AEFI committee will investigate all reported serious/severe AEFIs and also contribute to managing the media during crisis and otherwise.

REFERRAL SYSTEM FOR AEFI MANAGEMENT

- HPV vaccination sessions will be located in health facilities with a medical officer. Any AEFI which may rarely occur during the session will be managed by the medical officer.
- Each session will be tagged to a 24x7 AEFI Management Centre and a first and second referral hospital.
- The 24x7 AEFI Management Centre can be the same health facility in which the session site is located, if there is a medical officer available round the clock. If the health facility does not have a medical officer on duty after the session ends in the evening and at night, another nearby health facility with medical officers on duty round the clock will be the 24x7 AEFI Management Centre.
- The first referral will be a higher-level health facility such as the CHC or Sub Divisional Hospital or District Hospital with specialists available to manage the case. The second referral can be a multi-specialty hospital (medical college/state government hospital, etc.)
- The state/district may explore the possibility of setting up 24x7 AEFI management centers or referral centre in the private sector.
- Medical officers at the session site and 24x7 AEFI Management Centres should be trained in standard AEFI management, use of AEFI management kits and reporting procedures.
- All medical officers acting as supervisors of vaccination teams will have an AEFI management kit in the vehicle.
- The state can use an existing helpline number (usually 104) to respond to queries of vaccine recipients seeking location of the nearest 24x7 AEFI management centre. The district wise referral plans with list of session sites with tagged 24x7 AEFI management centres and first and second referral hospitals should be available with the staff manning the helpline.
- MO I/C will be responsible to provide mobility support for transporting any serious AEFI to higher health facility, if needed. The contact details of the transport facility should be available at each vaccination site.
- The 24x7 AEFI Management Centers and referral nodal officers will report the AEFI as per laid out procedures.

5F. SAFE INJECTION PRACTICES

Safe Injection Practices are a set of recommendations which are the foundation for preventing transmission of infections during patient care in all healthcare settings including immunization.

A safe injection is one that:

- Does not harm the recipient
- Does not expose the Health Workers (HWs) to any avoidable risks
- Does not result in waste, which is harmful for the community

The most common serious infections transmitted by unsafe injection practices are Hepatitis B, Hepatitis C, and HIV. Poorly administered injections can also cause injuries or drug toxicity when the wrong injection site, vaccine, diluent, or dose is used. It is necessary to dispose off used syringes and needles safely to prevent risks of accidental needle-stick injuries, and risk to the community at large.

Figure 114: Factors contributing to safe injection practices

Figure 115: Steps for safe injection practices

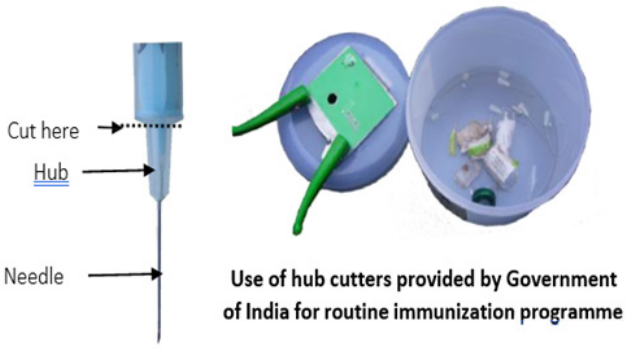
Simple ways to improve Injection Safety:

- Wash hands for 40–60 seconds with soap and water before and after the vaccination session. Not to use alcohol-based sanitizers.
- Cover any small cuts on the service provider's skin, if any.
- Avoid giving injections if the skin at the site of injection is compromised by any local infection such as a skin lesion, cut, or weeping dermatitis.
- Always use 0.5 ml auto-disable (AD) syringes while administering the HPV vaccine as these prevent person-to-person transmission of blood-borne pathogens.
- Use a new sterile packed AD syringe for each injection for each beneficiary.
- Do not use AD syringes that have damaged packaging or have passed the manufacturer's expiry date.
- Do not pre-fill the syringes.
- Check the expiry date and VVM of the vaccine vial. Do not use the vaccine if the VVM is not in a usable stage or if the vaccine has expired.
- Do not attempt to recap the needle. This practice can lead to needle–stick injuries.
- Immediately after injection, cut the AD syringe at the hub (the plastic part at the base of the needle) using a hub cutter. Discard the cut part in the red bag.
- Do not place the used syringes on a table or tray after the vaccination.

WASTE SEGREGATION AND DISPOSAL

The following steps should be adopted for the segregation and disposal of biomedical waste (Figures 116, 117 and 118) at the session.

Figure 116: Safe Practice for Needle and Syringe Disposal



Step 1: At the session site, ANMs to cut the needle of the AD syringe immediately after administering the injection using the hub cutter that cuts the plastic hub of the syringe and not the metal part of needle. The cut needles will get collected in the puncture-proof container of the hub cutter.

Step 2: Segregate and collect the plastic portion of the cut syringes in a Red bag or container. Ensure all color-coded bags and container should have biohazard symbol for safe biomedical waste management.

Step 3: Collect the broken vials/ampoules made of glass in the Blue bag or container for broken vials and used cotton swabs in a Yellow bag.

Step 4: Plastic wrappers of syringes, needle caps and empty paper/cardboard boxes should be collected in a black bag.

Step 5: All the waste generated during the session in Red, Black, Blue bag/container and Yellow bags along with the hub cutter waste shall be returned to the Cold Chain Point (CCP) for disinfection and disposal by the designated person as per the existing CBWTF guidelines and MoHFW guidelines.

Step 6: Discard the waste collected in black bag as dry general waste as per Central Pollution Control Board (CPCB) 2021 guidelines. Disinfect the materials collected in Yellow and Blue bags/containers, as well as the hub cutter container, using autoclave/microwave/hydroclave, or by chemical treatment with 1% sodium hypochlorite solution for 30 minutes to ensure complete disinfection.

All health facilities and health workers, government, must follow the national guidelines issued by MoHFW and the Central Pollution Control Board (CPCB) 2021 for the treatment and disposal of immunization waste.

Step 7: Wash the hub cutters properly with 1% sodium hypochlorite before reuse.

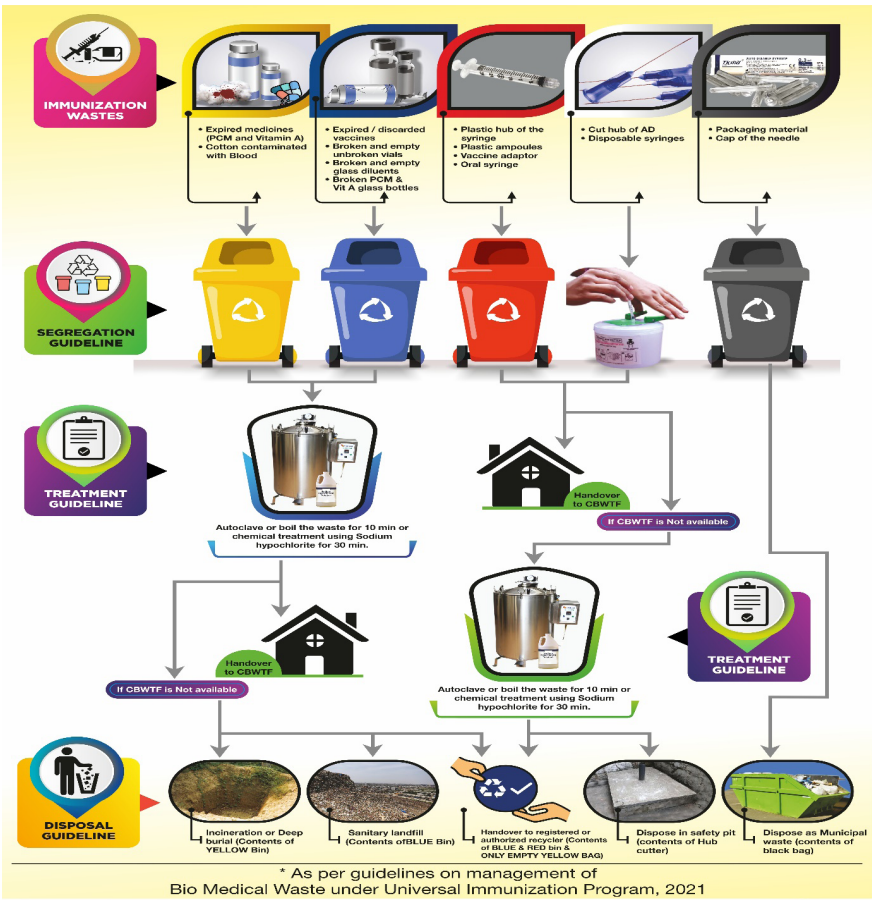
Step 8: Maintain proper records of the waste generation, treatment, and disposal of waste at the District Hospital/ Sub-district Hospital/Government Medical Colleges and Hospitals/Community Health Centres/Primary Health Centres/Urban -Primary Health Centres to ensure that the returned waste (needles, syringes, vials) corresponds to the stock issued to the health worker or vaccinator at the beginning of each session day.

Figure 117: Immunization Wastes Segregation Guidelines

Immunization Logistic	Particulars	Bags/Containers used
AD Syringes with packing	Cut hub of AD and disposable syringes	**White** [White coloured translucent, puncture-proof, leak-proof, tamper-proof containers]
	Plastic part of Syringe	**Red** [Red coloured non- chlorinated plastic bags (having thickness > 50 micron or containers)]
Vaccine parts	Vaccine adapter & dropper	
	Oral syringe	
Gloves	Used gloves	
Ampoules	Ampoules (plastic)	
	Ampoules (glass)	**Blue** [Container/ cardboard boxes with blue coloured puncture-proof, temper-proof containers]
Vaccines	Expired vaccine or Discarded vaccine	
	Broken vials	
	Empty unbroken vials	
Cotton	Cotton contaminated with Blood or body fluid	**Yellow** [Yellow coloured non chlorinated plastic bags (having thickness > 50 micron or containers)]
Vitamins	Expired Bottles of Vitamins	
Paracetamol	Expired tab/ Syrup	
Black bag: Packaging material, wrappers of syringe, and empty paper to go as dry general waste		

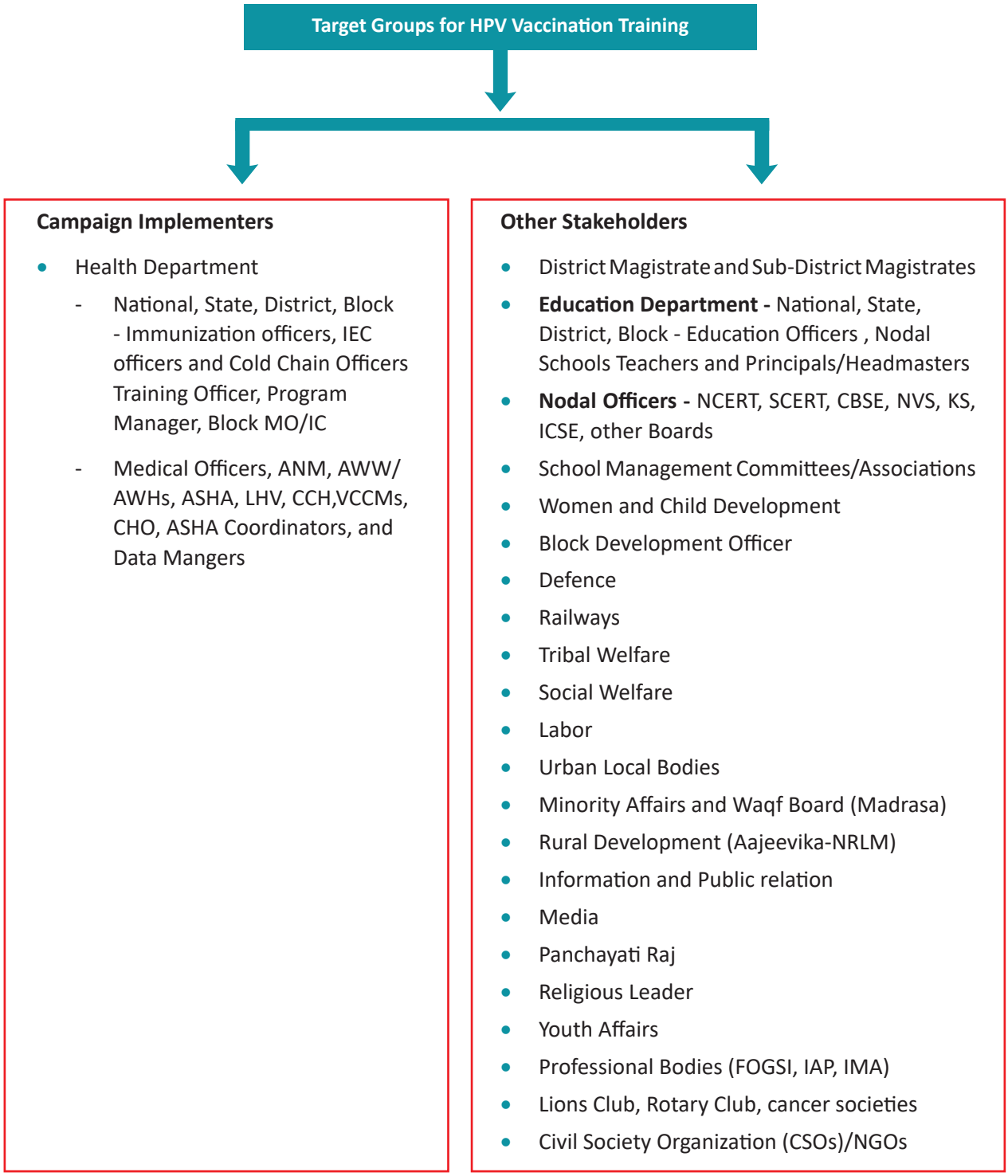
The graphical representation is as follows:

Figure 118: Job aid for Immunization Waste Disposal



5G. TRAINING AND ORIENTATION

The successful introduction of the HPV vaccine is largely depends on the timely completion of quality trainings for all the identified stakeholders are responsible for the roll-out of the HPV Vaccination Campaign. The key stakeholders who will play critical role in the implementation of the HPV vaccination initiative are:



Training /Orientation of functionaries at all levels is critical for the successful planning and implementation for the Roll Out of HPV Vaccination Campaign. Health-care providers are responsible not only for handling and administering the vaccine at vaccination sites but also for serving as a key source of information for parents and the community.

Similarly, for all relevant departments functionaries should be trained and oriented to raise awareness about cervical cancer, the benefits of the HPV vaccine, generate demand, and mobilize all girls aged 14 years to vaccination centers at health facilities.

Effective training enhances the skills required for campaign implementation of the initiative and builds the confidence of functionaries to raise awareness, dispel misinformation, and address queries or concerns from parents, eligible girls, the community, and the media.

Key objective of the trainings/orientations are to ensure that:

- Orient all programme managers, staff, and stakeholders on the HPV vaccination campaign.
- Ensure all stakeholders understand their roles and responsibilities.
- Ensure vaccinators have the knowledge and skills to administer the vaccine safely.
- Ensure cold chain handlers are aware of and understand the vaccine supply chain.
- Train nodal teachers to sensitize eligible girls and parents, raise awareness, dispel any misinformation and address questions.
- Equip all stakeholders to raise awareness, dispel misinformation and respond to concerns from parents, eligible girls, the community, and media.

TRAINING METHODOLOGY AND ASSESSMENT

All training sessions must be interactive and follow adult learning methodology, including, but not limited to, PowerPoint presentations, training videos, exercises, and discussions. At the district or sub-district level, each training batch should not exceed 40–50 participants. The number of batches should be planned based on the total number of health functionaries to be trained in the district or sub-district.

Participant registration, as well as the pre-test and post-test, will be conducted using the Immunization Training Management Information System (iTMIS). A pre-test and post-test using a standard questionnaire to be used to assess participants knowledge gain and address any doubts before the end of the training session.

TRAINING APPROACH FOR HPV VACCINE INTRODUCTION

Cascaded trainings are envisaged to build the capacity of all health workforce members involved in the HPV vaccine introduction. Table 8 gives an overview of the training cascading from National level up to district level along with the suggested timelines.

Regional/State Level:

Regional/State-level trainings will be conducted by the national team to train key state health functionaries, including Directors, SIOs, identified state-level master trainers, and officers from the district level such as DIOs, IEC officers, and CCOs. The training duration will be 1.5 days, **as per the agenda annexed as Annexure 1.** This training is critical, as it creates a pool of master trainers who will ensure that all medical officers, managers, supervisors, cold chain handlers and the frontline health workers in their respective districts are sensitized in a timely manner prior to the HPV Vaccine introduction.

District Level and Below:

Trainers trained at the Regional/State-level ToT will conduct one-day district-level training, **as per the agenda annexed as Annexure 2.** Participants will be District Cold Chain Officer, District IEC Officer, VCCM, District Program/ Data Manager, District Training Coordinator, Block Health Officers, Medical Officers and Immunization partners.

These Block Health Officers and Medical Officers, will subsequently conduct a 4-hour training for health workers, such as Block IEC Officer, Supervisors, Block Program/Data Manager, ANMs, Male HWs, LHVs, Nurse, CHOs, CCHs, and ASHA Coordinators. They will also orient ASHAs, AWWs, AWHs, MAS member, JAS member, Volunteer, Field Monitors through separate 2-hour sessions.

Table 8: Training Plan for Program Managers on Operational Guidelines from National to block level.

S. No.	Activity/Level	Participants	Facilitators
1	Regional/State Workshop (ToT) for HPV Vaccine introduction including Communication Strategy Duration: 1.5 days	State Immunization Officers, State Program Managers, State Training Officers, State Cold Chain Officers, State IEC Officers, District Immunization Officers and District IEC Officers	MoHFW Officials (Immunization Division) and National level Partners working for Immunization
2	District Workshop (ToT) for HPV Vaccine introduction including Communication Strategy Duration: 1 day	District Cold Chain Officer, District IEC Officer, VCCM, District Program/Data Manager, District Training Coordinator, Block Health Officers, Medical Officers and Immunization partners.	District Immunization Officer and District IEC officer
3	Block Workshop for HPV Vaccine introduction including Communication Strategy Duration: 4 hours	ANM/LHVs/Nurse/CHOs, CCHs, Block IEC officer, Supervisors, Block Program/ Data Manager and ASHA Coordinators	Block Health Officers and Medical Officer
4	Block Workshop for HPV Vaccine introduction including Communication Strategy (mobilizers) Duration: 2 hours	ASHA, AWWs, AWHs, MAS member, JAS member, volunteers and Field Monitors	Block Health Officials, Medical Officer and Supervisors

CONTENTS OF TRAINING:

Based on the Learning Resource Package (LRP)/training material provided, the trainings must ensure that the following topics are covered during the sessions, as outlined in the agenda template provided in the Annexure 1:

- **Overview and Operational Planning:** Objectives, rationale, strategy (macro planning and micro planning), campaign dates, and target age group.
- **New Vaccine module** of U-WIN + eVIN: U-WIN, eVIN and Safe-vac.
- **Cold Chain and Vaccine Management:** Handling and storage of vaccines.
- **Reporting and Management of AEFI:** Identification, reporting and management of minor, serious, and severe AEFI.
- **Safe Injection Practices:** Hand hygiene, waste segregation and proper disposal of immunization waste.
- **Preparedness Assessment:** Digital tool for State, District and Health Facility readiness assessment.
- **Session Management:** Organization and management of vaccination sessions at health facilities.
- **Roles and Responsibilities of Stakeholders:** Highlighting activities to be conducted at different levels by the state, district and block officials, and other stakeholders.
- **Cascade Training Plan:** Duration of each level of trainings, with identified participant list.
- **Financial norms:** Financial guidelines for the states, regarding the HPV vaccination campaign.
- **Key Communication Challenges and Strategies:** Community engagement strategies.
- **Crisis Communication and Media Plan:** Challenges and Strategies around crisis communication and media handling.

It is also important that all stakeholders work collectively, in coordination and synergy, for the successful planning and implementation of HPV vaccine introduction. Therefore, in addition to training on operational aspects, orientation of key stakeholders on HPV vaccination is critical for the success of the campaign. Table 9 gives an overview of cascading training from the national to the district level for identified key stakeholders, while Table 10 outlines the orientation plan for media sensitization at different levels.

Table 9: Orientation Plan of Key Stakeholders for Roll Out of HPV Vaccination campaign

S. No.	Activity	Participants	Facilitators
1	National orientation of Stakeholders for HPV Vaccine introduction Duration: 1 day	National level line departments including Education department, WCD, Nodal Officers - NCERT, CBSE, ICSE, Kendriya Vidyalaya Sanghathan (KVS), Navodaya Vidyalaya Samiti (NVS) Rural Development (Aajeevika- NRLM), Defense (Schools), Railways (Schools), Tribal Welfare (Schools), Social Welfare (Schools), Labor (Schools), PRI, ULB, Media, Waqf-Minority affairs, School Management Committees/Associations, professional bodies (FOGSI, IAP and IMA), Lions Club, Rotary Clubs, CSOs/NGOs, cancer societies.	National level Health officials (Immunization Division, National level Partners working for Immunization).
2	State level orientation of line departments for HPV vaccine introduction Duration: 0.5 day	District Collector/Magistrate and district officials from Education department, WCD, KVS, NVS, Rural Development (Aajeevika-NRLM), Defense (Schools), Railways (Schools), Tribal Welfare (Schools), Social Welfare (Schools), Labor (Schools), PRI, ULB, Waqf, School Management Committees/ Associations, professional bodies (FOGSI, IAP and IMA), Lions Club, Rotary Clubs, CSOs/ NGOs, cancer societies.	State level Health officials (Immunization Division Partners)
3	District level orientation of line departments for HPV vaccine introduction Duration: 0.5 day	Block Development officer and block officials from Education department, WCD, Rural Development (Aajeevika- NRLM), Defense (Schools), Railways (Schools), Tribal Welfare (Schools), Social Welfare (Schools), Labor (Schools), PRI, ULB, Waqf, School Management Committees/Associations, professional bodies (FOGSI, IAP and IMA), Lions Club, Rotary Clubs, CSOs/NGOs, cancer societies.	District level Health officials (Immunization Division)

Table 10: Orientation Plan for Media Sensitization at Different Levels

S. No.	Activity	Participants	Facilitators
1	National Media Sensitization Workshop Duration: 0.5 day	Print, electronic, radio, publications, health reporters and editors	MoHFW officials, senior media advisors, PIB officer
2	State Media Sensitization Workshop Duration: 0.5 day	Print, electronic, radio, publications, health reporters and editors	State Health and senior media advisors, SIO, PIB officer
3	District Media Sensitization Workshop Duration: 0.5 day	Print, electronic, radio, publications, health reporters and editors	District Magistrate, DIO, PIB Officer

MONITORING OF TRAINING

- Each training session held at block level must be reported to the district level and recorded in iTMIS.
- At least 10% of all block level training should be monitored by district programme officers and their feedback must be documented at the district level by CMO / DIO.

5H. ROLES AND RESPONSIBILITIES OF KEY STAKEHOLDERS

Collaboration among Ministries/Departments, professional bodies, partner organizations, and health authorities at State, District, and Block level is essential for effective implementation of the HPV vaccination campaign in reaching the target population. Strong intersectoral convergence is required in planning and execution across States and Union Territories (UTs).

The one-time single-age cohort introduction of the HPV vaccine requires coordinated, multi-sectoral engagement, including local governments, school authorities, community and religious leaders, civil society organizations, media, and communities, to ensure high coverage, acceptance, and programme sustainability. The following outlines the roles and responsibilities of key Ministries/Departments, and stakeholders involved in the Roll Out of HPV Vaccination campaign.

1. NATIONAL AND STATE LEVEL FUNCTIONARIES

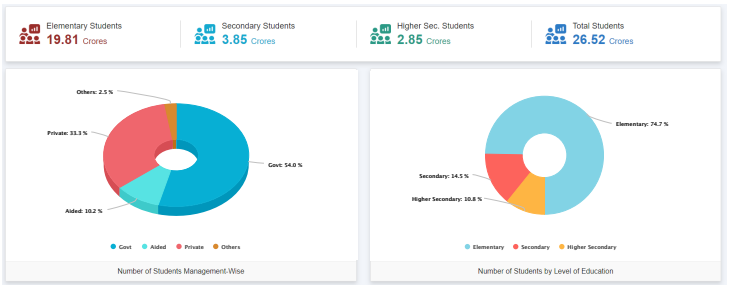
For successful Roll Out of HPV Vaccination campaign, inter-ministerial/departmental coordination is essential.

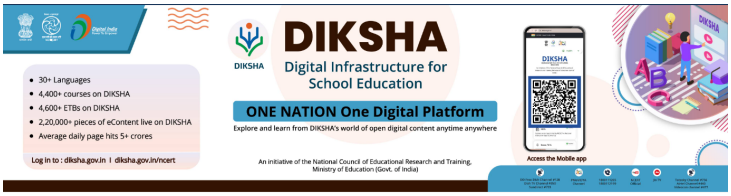
1a. Ministries

A. Ministry of Education (MoE):

The Ministry of Education will undertake the following key roles to support the HPV vaccination campaign:

- Attend the meetings/workshops/training related to HPV vaccination led by the Health Department.
- Issue directions to NCERT, CBSE, ICSE, Kendriya Vidyalaya Sangathan (KVS) and Navodaya Vidyalaya Samiti (NVS) to promote HPV vaccine awareness across government and private schools and support the mobilization of the session site.
- Coordinate with Government and Private School Management Associations/Committees at National, State and district level.
- Disseminate all IEC materials shared by the MoHFW across all levels - from national to school level to aid in communication with the parents/guardian.
- Leverage the digital platforms such as UDISE+, DIKSHA and NISHTHA for displaying the IEC material on HPV vaccination.
- Ensure sharing of line-listing of schools having no. of eligible girls aged 14 years using the UDISE+ portal and planned Parents Teachers Meeting (PTM) date with the local health department.
- Encourage schools to appoint a nodal teacher for leading sensitization efforts and act as liaisons with local health officials and organise special Parent–Teacher Meetings (PTMs) focused on HPV vaccination, where parents are informed about cervical cancer prevention, vaccine safety and benefits, nearby vaccination sites, vaccination dates and timings, and guide self-registration on the U-WIN portal.
- Support in circulating the importance of HPV vaccine through the official social media handles of the Education Department of State/UT with all the stakeholders at district/block and school levels for creating awareness about the vaccine.
- Ensure information reaches parents through information cards (Refer to Annexure 6), WhatsApp groups, circulars, emails, PTMs, diaries, and other channels from the schools.
- Promoting the campaign through school assemblies, newsletters, health days,





and classroom discussions, reinforcing positive messages and addressing misconceptions.

- Ensuring inclusion of girls enrolled in non-traditional or informal educational settings, such as madarsas, or community-based learning centres, coaching institutes, unrecognized schools etc.
- Participating in periodic review meetings with health department to share feedback, challenges, and successes for continuous improvement

B. Ministry of Women and Child Development (MoWCD):

The Ministry of Women and Child Development plays a vital role in promoting HPV vaccination by supporting awareness generation, community mobilization, and coordinated efforts to reach eligible adolescent girls. Its role includes:

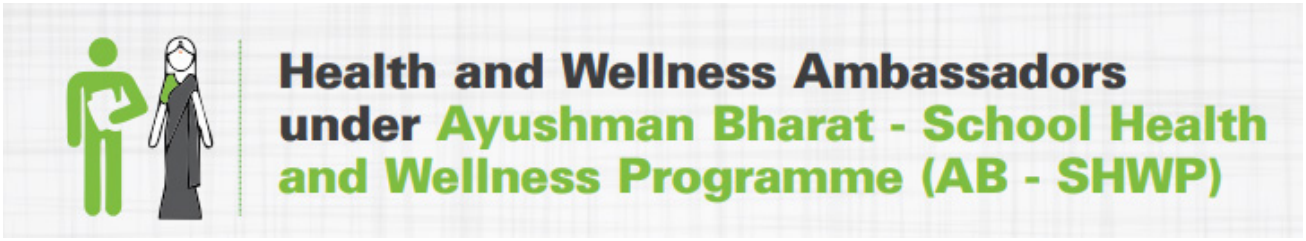
- Participate in the meetings/workshops/trainings led by the Health Department.
- Disseminate all IEC materials shared by the MoHFW across all levels to aid in communication with the parents/guardian.
- Utilize the POSHAN Tracker to display IEC materials on HPV vaccination.
- Leveraging MoWCD platforms such as Poshan Abhiyaan sessions, Mission Shakti, Kishori Shakti Yojana, and Beti Bachao Beti Padhao for service delivery and IEC activities related to HPV vaccination.
- Promote HPV vaccination through official social media channels.
- Ensure Anganwadi centres display posters and other IEC materials on HPV vaccination.
- Ensure AWWs support ANMs and ASHAs in conducting headcount surveys to prepare line lists of all eligible girls in their areas and support the mobilization efforts and informing parents/guardian about the nearest health facility offering HPV vaccination.
- Involve AWWs as mobilizers in the HPV vaccination team at session sites, in accordance with the micro-plan, responsible for pre-registration of girls on U-WIN, mobilization of beneficiaries, and support in session site management.
- Encouraging peer-to-peer learning among adolescents to spread positive experiences with the HPV vaccine through platforms like Kishori Shakti meetings etc.
- Leveraging Anganwadi workers' trusted presence to integrate HPV vaccine messaging into routine interactions.
- Participate in periodic review meetings with Health Department to share feedback and strengthen implementation.

C. Adolescent Health Division, Ministry of Health and Family Welfare:

The Adolescent Health Programme is an existing platform through which adolescent health is addressed in the country. The strength of the adolescent health programmes can be effectively leveraged for the following:

School Health and Wellness Programme

- Health and Wellness Ambassadors to be identified as nodal for HPV vaccination in addition to the overall role of school Principal/ Headmaster.
- Health and Wellness Ambassadors to be trained and oriented on their role for HPV vaccination campaign.
- Facilitate special Parent–Teacher Meetings (PTMs) to sensitize parents of girls aged 14 years, inform parents about cervical cancer and HPV vaccination.
- Make a list of number of all girls aged 14 years class-wise with the support of class teacher.
- Build capacity of Health and Wellness Messengers (2 students/class) for spreading awareness in school, family and community.
- Orient all students and teachers during quarterly Adolescent Health and Wellness Days and weekly Health and Wellness Days at schools.



Peer Education Programme:

- **During monthly Adolescent Friendly Club meetings, ANMs** will orient ASHAs and Saathiyas on awareness cervical cancer and importance of HPV vaccination.
- **Peer Educators (PE)** called as **Saathiyas,** will be engaged from the village level to generate awareness about cervical cancer and mobilize eligible girls for HPV vaccination at the health facility.
- **ASHA** workers will coordinate with Saathiyas to ensure smooth implementation of peer education activities on HPV vaccination at health facilities.
- **Block Adolescent Health Coordinator** will ensure ASHAs and Saathiyas to raise awareness and generate demand for the vaccine during Quarterly Adolescent Health and Wellness Days (AHWD) at AWCs.

Adolescent Friendly Health Centres (AFHC):

- Orient the counselors of AFHCs on HPV vaccination so they can inform, educate, and counsel adolescent girls, their parents, and other influencers at AFHCs and during biweekly outreach activities in schools, youth clubs, and the community.
- Information, Education and Communication materials to be provided and displayed at AFHCs and use widely in outreach activities.
- Utilize existing convergences between adolescent health division and education department for smooth implementation of HPV vaccination.

- Organize awareness sessions by health care providers on prevention of cervical cancer aligning with established days to celebrate Kishori Swasthya, cervical cancer awareness week, National immunization awareness month, etc.

D. Ministry of Rural Development (MoRD):

- Ensure functionaries of Aajeevika-NRLM to disseminate accurate information about the HPV vaccination campaign to village households through the SHG Cluster Federations, Village Federations, and individual SHGs. This network will create awareness about the cervical cancer, benefits of HPV vaccine, generating demand for the HPV vaccine and mobilization of all girls aged 14 years for vaccination.
- Proactive involvement of State and District Mission Management Unit in vaccine roll out planning, implementation and monitoring.

E. Ministry of Housing and Urban Affairs (MoHUA):

- Ensure dissemination of information about the HPV vaccination campaign to urban slum households through City Level Federation (CLF) and Area Level Federations (Ward/Slum) of SHGs. This network will create awareness about the cervical cancer, benefits of HPV vaccine, generating demand for the HPV vaccine and mobilization of all girls aged 14 years for vaccination.
- Proactive involvement of NULM - State Mission Management Unit and NULM - City Mission Management Units in vaccine roll out planning, implementation and monitoring.
- Reach out to urban street vendors and residents of shelter for urban homeless to inform about the HPV vaccination campaign and ensure that eligible girls in the vulnerable population ae not missed out from the benefits of the HPV vaccine.

- Ensure complete involvement of urban local bodies to support HPV vaccination.
- Specific directions to big municipal corporations for involvement in the campaign.
- Identification of nodal persons from urban local bodies for convergence with health department for HPV vaccination.
- Involvement of Zila Preraks and Swachhagrahis under Swachh Bharat Mission (SBM) for generating awareness on HPV Vaccination.
- Identifying and encouraging involvement of local CSOs.

F. Ministry of Panchayati Raj (MoPR):

- Conduct community meetings for generating awareness on importance of HPV vaccination.
- Proactive involvement in communication strategies for the area.
- Co-ordination and supporting health department in mobilization of beneficiaries and addressing doubts and queries of the hesitant families.
- Review of activities in the area during meetings of Gram Sabha and Zila Parishads.
- Gram panchayat Vikas Adhikari (village development secretaries), Lekhpals, village Pradhans, and panchayat members should mobilize the community to attend the HPV vaccination session site for maximum coverage.
- Involve VHSNC for community sensitization and awareness activities.
- Village Health Sanitation Committee and Jan Arogya Samiti will support the HPV vaccination campaign in the following ways:

- Identify volunteers to assist on the session day.
- Identify and mobilize missed beneficiaries to maximize coverage.
- If needed, utilize untied VHSNC/UHND funds for transporting AEFI cases to the nearest AEFI management center.

G. Ministry of Sports and Youth Affairs (MoSYA):

- Involvement of Nehru Yuva Kendra (NYK) and National Service Scheme (NSS) for generating awareness and mobilization of beneficiaries for the HPV vaccination campaign.
- Mobilize resistant/reluctant families for vaccination.

H. Ministry of Information and Broadcasting (MoIB):

- Support in wide dissemination of IEC material pertaining to HPV vaccination.
- Coordination with Indian Broadcasting Federation, Private Radio channels and explore areas of support
- Including CSR for private FM channels.

I. Ministry of Railways (MoR):

- Supporting in the HPV vaccination in every possible way.
- Awareness generation through IEC in rails and stations.

J. Ministry of Tribal Affairs (MoTA):

- Ensure mobilizing girls from the schools managed by Tribal Department such as Tribal Welfare Schools, Eklavya Model Residential Schools etc. to the health facility for vaccination.
- Engagement of National Education Society for Tribal Students (NESTS) for orientation of Principals and Teachers of Eklavya Model Residential Schools (EMRSs).
- Identifying local key influencers from the community for promoting HPV vaccination campaign and increase uptake of the vaccine.

K. Ministry of Minority Affairs (MoMA):

- Engage the Central Wakf Council and State/UT Wakf Boards for disseminating right information to Wakf establishments.
- Create awareness and mobilize minority communities to ensure all eligible beneficiaries are vaccinated.

L. Medical Colleges:

- The medical colleges will be engaged to conduct assessments, reviews, conduct training and monitoring of various activities related to HPV vaccination. The staff should be identified from medical colleges and trained to create a pool of master trainers for conducting MO and Health worker trainings.
- Medical colleges will be part of the reporting network of the Adverse Event Following Immunization (AEFI) surveillance system with an AEFI Surveillance Nodal Officer, AEFI register and sensitization meetings with all casualty/emergency staff, paediatric, medical and gynaecology departments. The AEFI Surveillance Nodal Officer will be in direct touch with the District Immunization Officer for reporting and cross reporting of hospitalised AEFI cases.

M. Professional bodies (FOGSI, IMA and IAP):

- Issuing formal communications to members encouraging active involvement in the HPV vaccination campaign.
- Disseminating IEC materials and encouraging their display across member clinics and institutions, using them while talking to patients, and using the social media handles of the association and individual members to spread awareness about the need for the HPV vaccine.

- Leading advocacy efforts by encouraging members to participate in state/district-level meetings on HPV vaccination through professional networks and policy forums.
- Ensuring members are updated with accurate information about the Campaign including vaccine safety, efficacy, dose schedule and guidelines.
- Addressing misinformation through media engagement, public sensitization workshops, and thought leadership.
- Facilitating timely reporting and oversight of Adverse Events Following Immunization (AEFIs).

N. CSOs

- CSOs will help to identify and map communities with unvaccinated girls in the eligible age group, by active engagement with community and community representatives.
- Identification of local influencers and their capacity building to function as ambassador for HPV vaccination.
- Support in rationalizing distribution of workload among the FLWs and building their capacities to enable positive people centred interaction and experience during contact sessions.
- Conducting Community and Stakeholder Engagements with PRIs / ULBs/ VHSNCs/ CBOs/SHGs/MAS/JAS to identify capacity-building needs and areas of improvement with respect to community mobilization for HPV vaccination.

O. NGOs / other voluntary organizations, National Cadet Corps, National Service Scheme and Nehru Yuva Kendra

- Create community awareness for HPV vaccination Campaign by engaging community leaders and disseminating IEC materials.
- Help to mobilize parents to the session site and support vaccination teams during activity.

P. Other Government ministries and departments like Home Affairs, Defense, Telecom, Labor and Employment, Employees' State Insurance, Information and Broadcasting, etc.

- Government offices should display IEC materials like posters and banners.
- Police wireless may be used to convey urgent messages for HPV Vaccination Campaign.
- Concerned departments should allow the key messages of the HPV Vaccination Campaign to be printed on telephone, electricity, and water bills.
- Telephone exchanges, and mobile service providers (government and private) may be requested to send text and voice messages.

1b. Partner Organizations

Partner organizations play a critical role in the HPV vaccination Campaign through technical support, capacity building, monitoring, and guidance. Their key responsibilities include:

- Provide technical expertise.
- Support in developing technical guidelines as well as communication strategy.
- Assist in completing the preparedness assessment checklist.
- Support trainings at the national as well as state level.
- Monitoring of the session as well as community monitoring.
- Provide feedback and support mid-course corrections.

2. STATE LEVEL

Roles and responsibilities of Mission Director (NHM)

- Lead planning, implementation, and monitoring across the state.
- Guide districts on timelines, microplanning, training, cold chain, and IEC.
- Leverage coordination with all the relevant departments to ensure all eligible girls get vaccinated.
- Monitor district preparedness, AEFI surveillance, and operational challenges.

Roles and responsibilities of State Immunization Officer

- Monitor daily preparedness and activity implementation.
- Coordinate human resources, logistics, and other support.
- Share coverage reports with the National Control Room.
- Provide feedback to SSC and STFI.
- Ensure the State AEFI Committee is functional and prepared.

3. DISTRICT LEVEL

Roles and responsibilities of District Magistrate / District Collector

- District Magistrates (DMs) to be the focal point for the HPV Vaccination Program and will ensure interdepartmental coordination between WCD Aajeevika, Saksham Anganwadi, Education, Health and any other program or forums as deemed fit.
- Ensure that all the required trainings of functionaries as mentioned in the Operational Guidelines have been timely conducted for:
    - Health Program Managers, Medical Officers, ANMs, ASHAs
    - School Management Committees, Principals, School Nodal Teachers
    - Chairman, counsellor of ULB and PRI
    - IAP, IMA, FOGSI, Lions Club/Rotary/Cancer societies
    - Media and Information Bureau
    - Religious leaders
- Regularly monitor the preparedness, progress, and implementation of the HPV vaccination Campaign and ensure that timely corrective actions are taken.
- Communicate with other stakeholders like IMA, IAP, FOGSI, Lions/Rotary clubs and cancer societies while clarifying expectations and their roles.
- Engage with School Management Associations in the district.
- Provide leadership to the program and ensure that all the enlisted stakeholders participate in the DTF.
- Deploy senior officials from the administration and other departments to supervise the planning and implementation of the Campaign in various blocks including rural and urban areas of the district.
- Undertake meetings with School Management Committee/Principals Headmasters and nodal teachers, especially from the private schools.
- Sensitize leading private practitioners and key pediatricians along with school management committee/ Principals in the district to get their cooperation in advance, so that they can give the right advice to parents for their daughters to receive the HPV vaccine.

- Meet with religious and community / social leaders to advocate for the HPV vaccination Campaign and to seek assistance with communication, social mobilization, and transportation as appropriate.
- Chair the district media sensitization workshops and designate a media spokesperson (CMO/ DIO) to represent the health department.
- Facilitate in identifying local brand ambassadors, like cancer survivors, child celebrities etc. and provide all support to bring them on board.

Chief Medical Officer / District Health Officer / Civil Surgeon / District Medical and Health Officer

- Ensure timely district-level preparedness, including microplanning, training, supervision, communication, cold chain management, inter-departmental coordination, and AEFI management.
- Conduct supportive supervision visits to blocks to assess preparedness and oversee implementation, providing on-the-job training as needed.
- Ensure DTFI meeting to be conducted and district-level media sensitization workshops.

Roles and responsibilities of District Immunization / RCH Officer

- Ensure the DTFI meeting is conducted.
- Ensure effective intersectoral coordination to disseminate accurate messages on cervical cancer and HPV vaccination for raise awareness, demand generation, and mobilization of all eligible 14-year-old girls.
- Ensure active participation of other stakeholders - IMA, IAP, FOGSI, local CSOs, cancer societies, Rotary and Lions clubs.
- Coordinate with DEO to share the line-listing of schools and the total number of eligible girls aged 14 years using UDISE+ portal.
- Provide technical and logistical support to plan, implement, monitor, and evaluate the HPV vaccination Campaign at the district level.
- Review the District's preparatory activities related to microplanning, cold chain preparedness, operational planning, communication planning, and strategies to address district-specific challenges.
- Ensure that District AEFI Committee members are oriented on AEFI surveillance and that regular meetings are conducted.
- Identify and engage influencers for community engagement and social mobilization.
- Ensure adequate number of IEC materials (as per approved prototypes) are disseminated to Blocks/ Planning units in a timely manner.
- Finalize communication planning well in advance of the Campaign to create awareness and a conducive environment in the district.
- Develop a media plan to address rumor-mongering and respond appropriately to the media regarding program implementation, progress, safety, and AEFI.
- Participate in BTFI meetings, assess Health Facilities preparedness, monitor HPV vaccination sessions, and conduct community-level monitoring.
- Review and assess the daily coverage during the initiative.

4. BLOCK LEVEL

Roles and responsibilities of Block Medical Officer (BMO)

- Ensure BTFI meeting to be conducted as per the timeline.
- Develop a comprehensive training plan and ensure timely completion of training of Medical Officers, Planning unit staff, Cold Chain Handlers, ANMs, Supervisors, and ASHAs.

- Ensure timely sensitization, and orientation of all relevant groups:
  - School Management Committees, Principals, and Headmasters
  - Parents during PTMs at schools
  - WCD department including AWWs and AWHs
  - Chairpersons and counselors of ULBs and PRIs
  - Religious leaders
  - Engage Self-Help Groups under Aajeevika NRLM
- Ensure completion of headcount survey to prepare a due list of all eligible girls aged 14 years. Review and submit the micro-plan to the District Immunization Officer (DIO).
- Identify health facilities for HPV vaccination sessions as per guidelines, ensuring session site must have a CCP as per eVIN, dedicated medical officer for AEFI management and internet connectivity, a desktop/ laptop with printer.
- Map HPV vaccination session sites with 24x7 health facilities that can provide emergency care, ensuring swift response to any medical emergencies.
- Map human resources and review preparedness status; follow up on identified gaps. Ensure adequate vaccine stock, syringes, cold chain management, logistics, and availability of anaphylaxis kits with the vaccinators.
- Coordinate with WCD to reach all eligible girls through Mother Groups, Poshan Panchayats, and other interventions.
- Review and monitor the planning unit communication plan and submit to DIO.
- Advocate with key stakeholders, including local media, to gain support for the Campaign.
- Ensure distribution of information cards (Refer to Annexure 6) to beneficiaries/caregivers by the surveyor and guide parents on registration on U-WIN portal.
- Distribute IEC materials and ensure proper display.
- Identify and engage local influencers for community engagement and social mobilization.
- Conduct demand generation activities to raise awareness about cervical cancer and HPV vaccination and to address myths and disbelief.
- During the Campaign monitoring of sessions and community monitoring.
- Review the daily coverage and resolve issues related to vaccine and logistics management, AEFI, biomedical waste, HR or any other challenges.
- Ensure registration, recording and reporting to be done on U-WIN.
- Review and monitor plan to vaccinate missed beneficiaries.
- Use the activity session-site microplans to strengthen routine immunization (RI) session microplans at the block level.
- Document experiences, innovations, and lessons learnt.

5. ROLE OF FIRST-LINE SUPERVISOR

First-line supervisors will be accountable for all aspects of the Campaign in areas allocated to them. Each supervisor will supervise three teams. Supervision of sessions as well as community monitoring will be conducted by supervisors/Monitors form the health department and development partners. They should be familiar with the area allocated to them. All supervisors must receive training prior to the activity in the technical as well as operational aspects. Each supervisor should be independently mobile.

Pre-activity tasks

- Familiarize yourself with the allocated area.
- Assist the BMO/PHC-MO in preparing micro-plans, including: Selection of vaccinators, ASHAs, AWWs, volunteers and verifiers.
- Preferably, team supervisors should be from the same area they supervise, as this ensures familiarity with local communities.
- Ensure that the vaccine and logistics plan is prepared.
- Ensure ANMs, ASHAs, AWWs, and volunteers attend scheduled training sessions.
- Conduct random field visits to confirm that ASHAs have completed house-listing of target beneficiaries and to assess the activity preparations using the preparedness assessment checklist.

During activity tasks

- Supervisors should use the monitoring checklist to assess the quality of activities at session sites.
- At the end of each day, supervisors will analyze coverage data.
- Attend the evening block-level meeting and provide feedback to the MO.
- Supervisors must ensure that any AEFI occurring during the session, or reported afterwards is recorded in the AEFI registers.
- All serious cases, including deaths, hospitalizations, or clustered incidents, must be promptly reported to the MO/MO in charge.

Post-activity tasks

- Supervisors will do RCM after one month of the activities.

6. ROLE OF IMPLEMENTERS AT HPV VACCINATION SITES (VACCINATOR, MOBILIZER, VERIFIER AND VOLUNTEER)

Proper implementation of activities at the vaccination session sites is the key to success. At the session site, there is a team of four members comprising of vaccinator, mobilizer, verifier and volunteer. Each member has a specific role in the HPV vaccination Campaign as described below.

6.1 Roles and responsibilities of the vaccinator

Pre-activity

- Assist in conducting the headcount survey to prepare line listing of all the eligible girls aged 14-year to estimate the target population.
- Submit the microplan to the planning unit including vaccine delivery and logistics requirement.
- Providing updated and accurate information on the sub-centre/urban area, including new permanent or temporary settlements, hamlets etc.
- Participating in training and coordinating with ASHAs, AWWs, and volunteers to ensure attendance at scheduled training sessions.
- Liaising with community leaders in the catchment area to ensure completion of target beneficiary listing by ASHAs/AWWs.

During activity

- Organize HPV vaccination session site as per the microplan, with the help of the team - mobilizer, verifier and volunteer.
- Ensure that all IEC materials including poster, banner is displayed at the right place at the session site.

- Check that all logistics (vaccines, syringes, indelible markers, anaphylaxis kit, cotton swab) have been received in sufficient quantity.
- Check that HPV vaccine is within expiry date and the VVM is in usable stage.
- Administer vaccine following all safety norms. Dose is 0.5 ml and should be administered intramuscularly in the left upper arm. The site is important for survey purposes.
- Ensure every vaccinated girl receives an HPV vaccination certificate.
- Supervise and guide ASHA, AWWs and volunteers in her team.
- Ask each beneficiary to wait for at least 30 mins after vaccination.
- Respond promptly to AEFIs and ensure reporting of AEFI.
- Remain at the session site for 1 hour after vaccinating the last girl, to manage any AEFI.
- Ensure all immunization waste generated during vaccination is returned to the CCP from which logistics were issued.
- Ensure registration, recording and reporting on U-WIN portal.

6.2 Roles and Responsibilities of Mobilizer

Pre-activity

- Participate in microplanning meetings/trainings at block and sub-centre levels.
- Identify hard-to-reach areas (tribal belts, urban slums, informal schools, industrial settings, red light areas, construction sites, orphanages, correction centers) and conducting headcount surveys and preparing name-based line lists of all eligible 14-year-old girls.
- Distribution of HPV vaccination Information Card (Refer to Annexure 6) to parents of eligible girl.
- Informing families about vaccination dates and encouraging them to get their daughters registered on U-WIN portal and get vaccinated.
- Support eligible parents to self register on U-WIN portal. Helping parents to update vaccination status of girls on U-WIN who are already vaccinated.
- Spreading awareness about cervical cancer and the HPV vaccine in the community.
- Assisting ANMs in estimating session site logistics, vaccine carrier needs, and other requirements.

During activity (at session site)

- Being present at the vaccination site as per the micro-plan to assist the ANM with session setup and manage the crowd at the session site, including drinking water and seating arrangements, along with verification and coordination.
- Mobilizing eligible girls to HPV vaccination session sites.
- Support ANM/Data Entry Operator for walk in registration of beneficiaries in U-WIN platform.
- Assist in marking left index finger of eligible girls.
- Monitoring for Adverse Events Following Immunization (AEFI) and support ANM to provide immediate care as per training
- Educating parents and girls on post vaccination care and reassuring them about mild side effects.

Post activity

- Identify and mobilize missed beneficiaries to nearest session site for vaccination.
- Assisting in AEFI follow-ups and reporting any adverse events noticed post vaccination, referring the beneficiary to 24x7 nearest health facility in case of any emergency in evening/late night.
- Participating in review and feedback meetings at the sub-centre or PHC.

6.3 Roles and Responsibilities of Volunteer

Pre-activity

- Participate actively in training activities before the Campaign.
- Support in activities being undertaken for creating awareness and social mobilization.
- Support in the preparation of due list.

During activity

- Assist in crowd management and session site management.
- Mark the left-hand index finger of each vaccinated girl, only for the 3 month duration of the activities.

6.4 Roles and Responsibilities of Verifier

- Verify that all eligible beneficiaries have arrived at the session site according to the due list.
- Confirm the index finger marking has been done after vaccination.
- Ensure beneficiaries are observed for 30 minutes post-vaccination.

6.5 Roles and Responsibilities of Principal, School Nodal Teacher and Class Teacher:

Pre-activity

- Appoint a nodal teacher to liaise with the health department.
- Conduct parent–teacher meetings with Medical Officers/ANMs/CHOs and use platforms such as SMS and WhatsApp to build confidence in the vaccine by sharing information about HPV vaccination, cervical cancer, and vaccine safety, address concerns, dispelling myths and information about nearest vaccination center and vaccination dates.
- Guide parents in registering on U-WIN.
- Distribute information card (Refer to Annexure 6) to eligible girls/parents.
- Conduct creative awareness-building activities (quizzes, slogans, art).

During activity

- Remind students and parents of vaccination dates and nearby vaccination centres.
- Use morning assemblies and IEC materials for reinforcement.
- Encourage students to share vaccine-related information with their families.
- Provide emotional encouragement and guidance to hesitant students.

Post-activity

- Empower vaccinated girls to act as peer health ambassadors.
- Organize talks or events with health professionals.
- Keep HPV vaccination/cervical cancer awareness messaging alive through events like Health Day or National Girl Child Day.
- Share feedback from parents or students with health authorities.
- Organize talks or events with health professionals, including sessions to encourage missed beneficiaries to get vaccinated.

5I. HOW TO ORGANIZE HPV VACCINATION SESSION

HPV vaccination session will be conducted at designated government health facilities only – Ayushman Arogya Mandir (AAM)-Primary Health Centres (PHCs), Community Health Centres (CHCs), Sub-District Hospitals (SDHs), District Hospitals (DHs), and Government Medical Colleges and Hospitals (GMCHs) – that have a Cold Chain Point (CCP) as per eVIN, dedicated medical officer for AEFI management, and internet connectivity, printer, and desktop/laptop.

The campaign will run for three months (90 days), with vaccines available daily. The sessions will be conducted as per the micro-plan, with flexible timings, generally from 9:00 A.M. to 2:00 P.M. However, State/UT may decide the session time and may conduct the vaccination on public holidays and weekends as per the local need. The digital U-WIN platform will be used for registration, recording and reporting. During the three-month activities, HPV vaccination will be conducted separately from routine immunization (RI) sessions, and only the HPV vaccine will be administered by a dedicated vaccination team. After the three-month activities, the HPV vaccine will be available at the same health facilities on Routine Immunization Days for girls aged 14 years. A vaccination team at the session site should consist of four members—namely, a vaccinator, a verifier, a mobilizer, and a volunteer—and must be present as per the micro-plan.

Vaccination Team	Responsible Person(s) and their Role(s)
Vaccinator (1)	ANM/male HW/LHV/ Nurse/CHO and anyone authorized to administer an injection; responsible for recording the vaccination data on U-WIN.
Verifier (1)	Health-Facility staff; responsible for checking registration status and verification in the waiting room on the vaccination day.
Mobilizer (1)	ASHA/ASHA coordinator/AWW/Link Worker; responsible for head count survey, pre-registration of girls on U-WIN, mobilization of beneficiaries and support in session site management.
Volunteer (1)	Field Monitor/Mahila Arogya Samiti member/Jan Arogya Samiti member/health staff, responsible for session site crowd management.

IDEAL HPV VACCINATION SESSION SITE SETUP

An ideal HPV vaccination session site should have three demarcated rooms/areas:

1. Waiting Room/Area

2. Vaccination Room/Area

3. Observation Room/Area

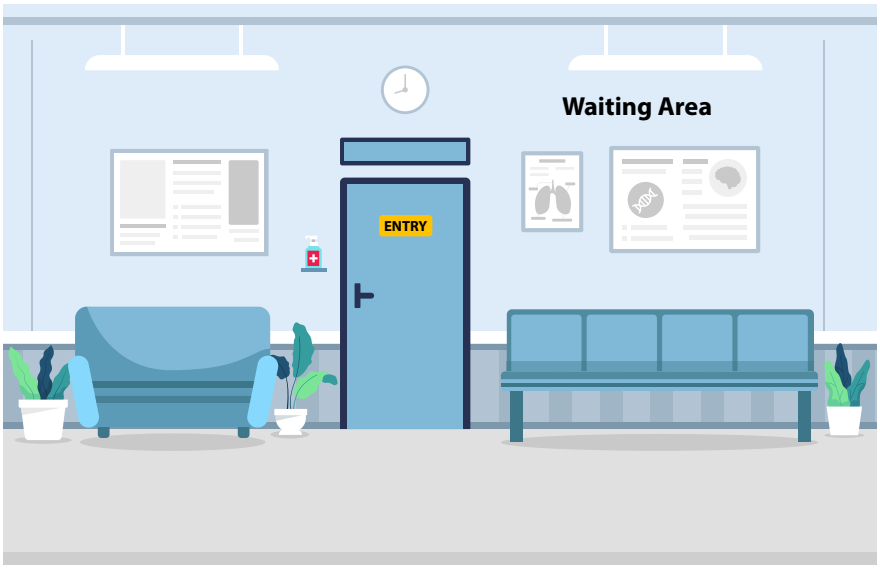
The HPV vaccination session site should have the following general requirements to ensure smooth functioning, comfort, and safety of beneficiaries:

- The rooms should preferably have two doors: one for entry and one for exit.
- Rooms/areas should be well-ventilated. A well-ventilated area is one that can be achieved through open windows and natural ventilation.
- Adequate queue management and crowd control system outside the waiting area.
- The vaccination site should be accessible to the differently abled individuals.
- Adequate seating arrangements should be available at the site.

1. **Waiting Room/Area (Figure 119):** The waiting room/area should preferably be a separate room or a clearly demarcated and covered area. The following to be ensured:

- Designate a separate entry and exit, if possible.
- Waiting area may be partially indoor and partially outdoor, with adequate arrangements for chairs, benches, and drinking water.
- Covered waiting area to protect beneficiaries from adverse weather conditions such as cold or rain etc.
- Avoid criss-cross movement of beneficiaries at session site.
- Facility for hand washing/ sanitization at entrance.
- IEC materials on HPV vaccination to be displayed.

Figure 119: Waiting Room/Area



2. **Vaccination Room/Area (Figure 120):** The vaccination room/area to ensure privacy by permitting only one beneficiary at a time. The following logistics to be made available:

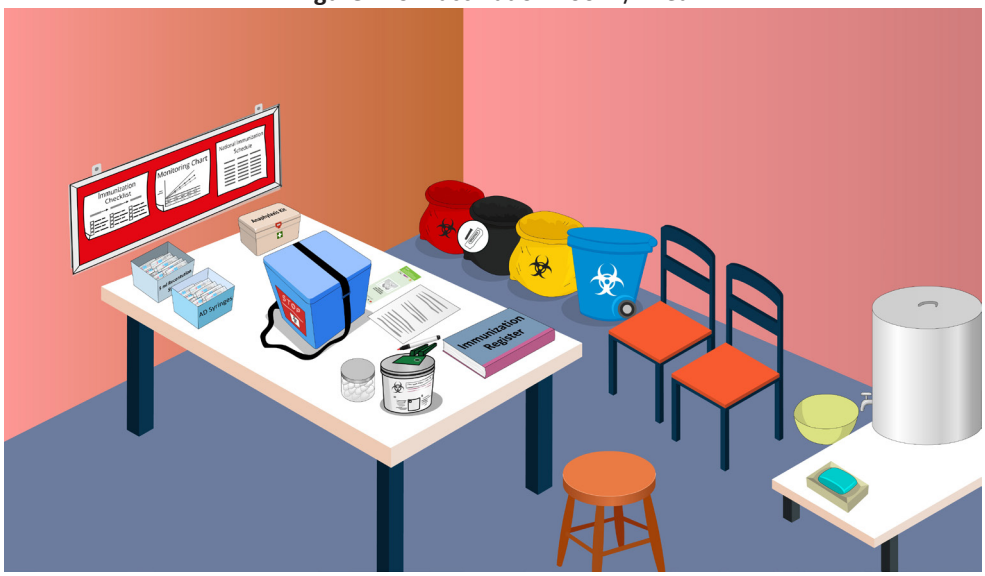
   - o One table (4 feet X 2 feet), two chairs
   - o Vaccine carrier with conditioned ice-packs
   - o Adequate HPV vaccine doses
   - o Adequate numbers of 0.5 ml AD syringes
   - o Hand sanitizer, running water with soap
   - o Cotton swabs
   - o Adequate paracetamol tablets
   - o Squeeze balls
   - o Hub cutter
   - o Screen for privacy
   - o Anaphylaxis kit
   - o Red, yellow and black bags, puncture proof blue container and waste basket
   - o Indelible marker for finger marking of beneficiary

Privacy

Privacy to be ensured during vaccination. Female vaccinators are preferred. If male vaccinators are used, a female staff member or ASHA/AWW should be present in the vaccination room. Practical measures to reduce fear and distress include:

- Using a screen for privacy
- Have girls wait outside the vaccination room
- Managing small groups and providing squeeze balls

Figure 120: Vaccination Room / Area



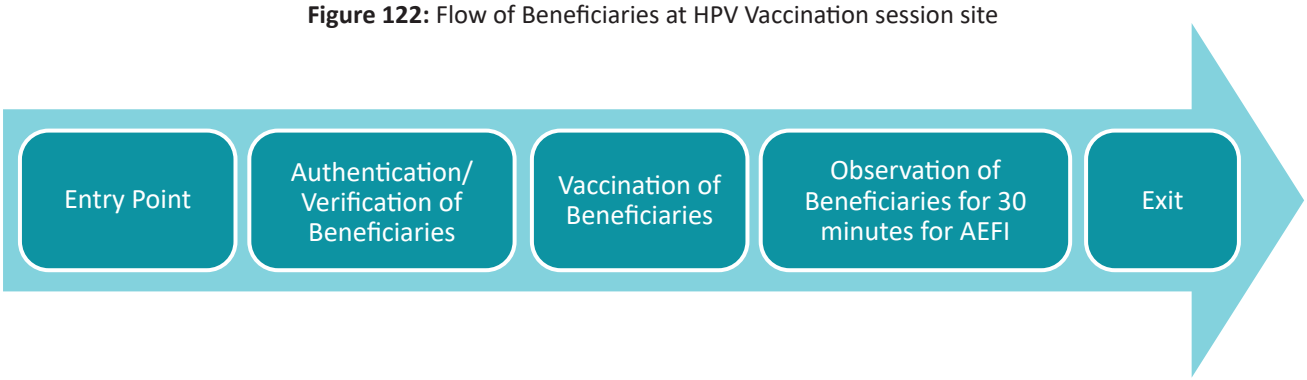
3. **Observation Room/Area (Figure 121): T**he observation area to provide a comfortable 30-minute post-vaccination wait for beneficiaries with necessary facilities and information. The following to be ensured:

- Adequate seating, drinking water, and toilet facilities.
- Beneficiary marked on the left-hand index finger after vaccination, only for the 3 month duration of the activities.
- IEC materials on HPV vaccination displayed.

Figure 121: Observation Room / Area

Flow of Beneficiaries at HPV Vaccination session site (Figure 122): The team, including vaccinators, verifiers, volunteers, and mobilizers, assigned to the vaccination session site should ensure flow of beneficiaries at sessions site as per the roles and responsibilities mentioned below:

Figure 122: Flow of Beneficiaries at HPV Vaccination session site



Important 5 key messages to be given to the caregivers/beneficiaries:

The vaccinator should provide the following information to the caregivers, before vaccinating the girl:

- A single dose is sufficient to provide protection against HPV infection.
- Wait for 30 minutes after vaccination.
- Minor AEFIs are very common, mild in severity, self-limiting and resolve on their own within 2-3 days. Tablet paracetamol in age-appropriate doses will provide relief.
- Visit the nearest government health facility if any adverse effects occur, or call the State/UT helpline number.
- Vaccination certificate can be downloaded from U-WIN portal.

5J. PREPAREDNESS, SUPERVISION, MONITORING AND EVALUATION

The HPV Vaccine Campaign provides an opportunity to strengthen the overall monitoring of the Routine Immunization (RI) program. Effective monitoring ensures smooth implementation, identifies gaps in real-time, and supports corrective actions to maintain high coverage and public confidence.

Monitoring and supervision will be undertaken at national, state, and district levels by the team of monitors/ observers during both the preparatory and implementation phases. Monitors will oversee the quality of training sessions, assess preparedness at the state, district, and health facility levels, monitor vaccination session sites during the activities, and conduct community monitoring to provide guidance, track progress, and share observations with the state, district, and block task forces for timely follow-up and corrective actions. It is recommended that monitoring activities begin 2–3 months before the scheduled activities of the vaccine. Effective oversight of implementation activities is essential at all levels.

Standardized formats and operating procedures have been developed at the National level to review the preparedness, microplanning, monitor the trainings, HPV vaccination session sites and community level coverage of HPV vaccination.

Timeline of Monitoring Activities

1. Before the Campaign – Preparedness Assessment

Preparedness assessment can be started once State/UT has completed microplanning activity and submitted Form 7 to MoHFW. Before the rollout of the HPV vaccine, States/UTs must assess the readiness of their health systems for the Roll Out of HPV Vaccination Campaign. India has successfully introduced several new vaccines in recent years—including COVID-19, Measles-Rubella (MR), Rotavirus (RVV), and Pneumococcal Conjugate Vaccine (PCV)—by using preparedness assessment tools prior to rollout. A similar preparedness assessment for the HPV Vaccine Campaign will be conducted at the state, district, and health facility levels using a standardized checklist on the NVI Info application in the following areas:

- Planning and coordination
- Resource identification
- Beneficiary prioritization
- Microplanning
- Training and supervision
- Monitoring and evaluation
- Vaccine and logistics management, including cold chain plan
- Safety surveillance (AEFI surveillance)
- Biomedical waste management
- Demand generation and communication activities

The Digital Tool for Preparedness Assessment is a user-friendly platform designed to facilitate seamless data entry and provide a customized experience for users at every level. It centralizes essential functions—including data collection, storage, and real-time monitoring—within a single, integrated digital environment. By transforming raw data into actionable insights, the tool offers thematic visualizations and tracks Key Performance Indicators (KPIs) through an interactive interface. Furthermore, a dynamic dashboard and embedded digital library ensure

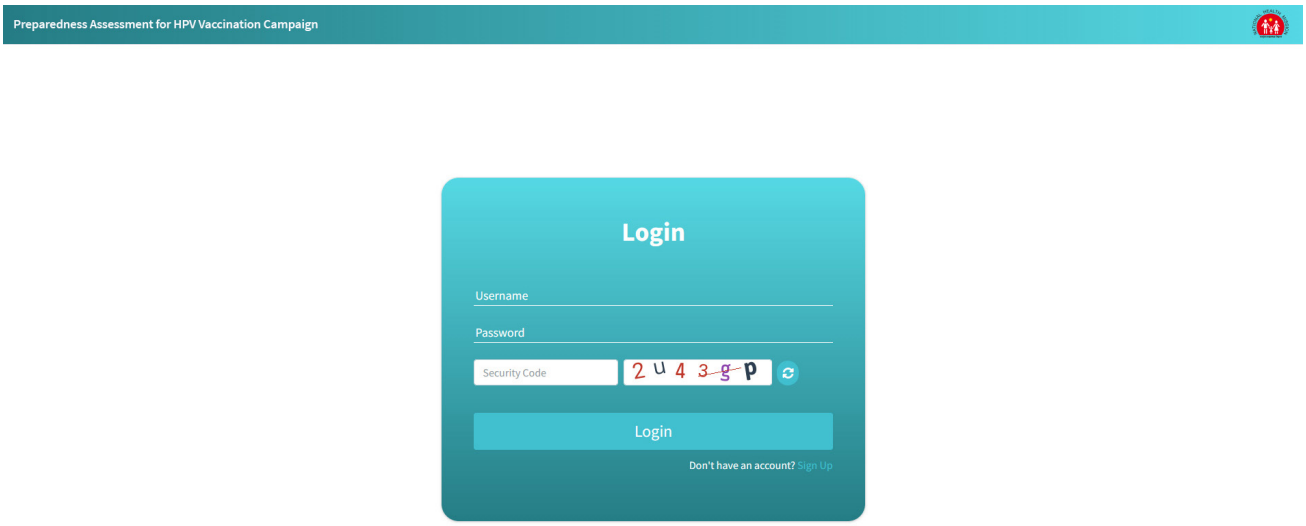
that investigators have constant access to vital resources and information. Highly versatile in its application, the assessment can be efficiently administered either in person or remotely to suit diverse operational needs.

Preparedness Assessment Checklist

To access the web application of Preparedness Assessment

https://www.nviinfo.org

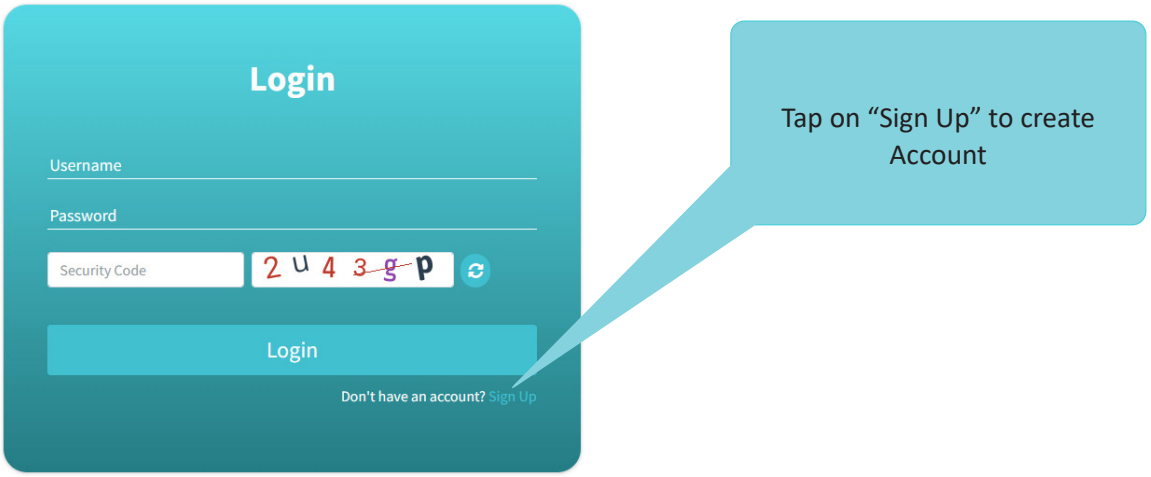
Fig. 123



Login Page

This is the main login screen for the Preparedness Assessment for HPV Vaccine Campaign application (NVI Info). Users must enter their Username, Password, and Security Code (Captcha) to access the system. After filling in the credentials, click the Login button to proceed to the checklist and dashboard.

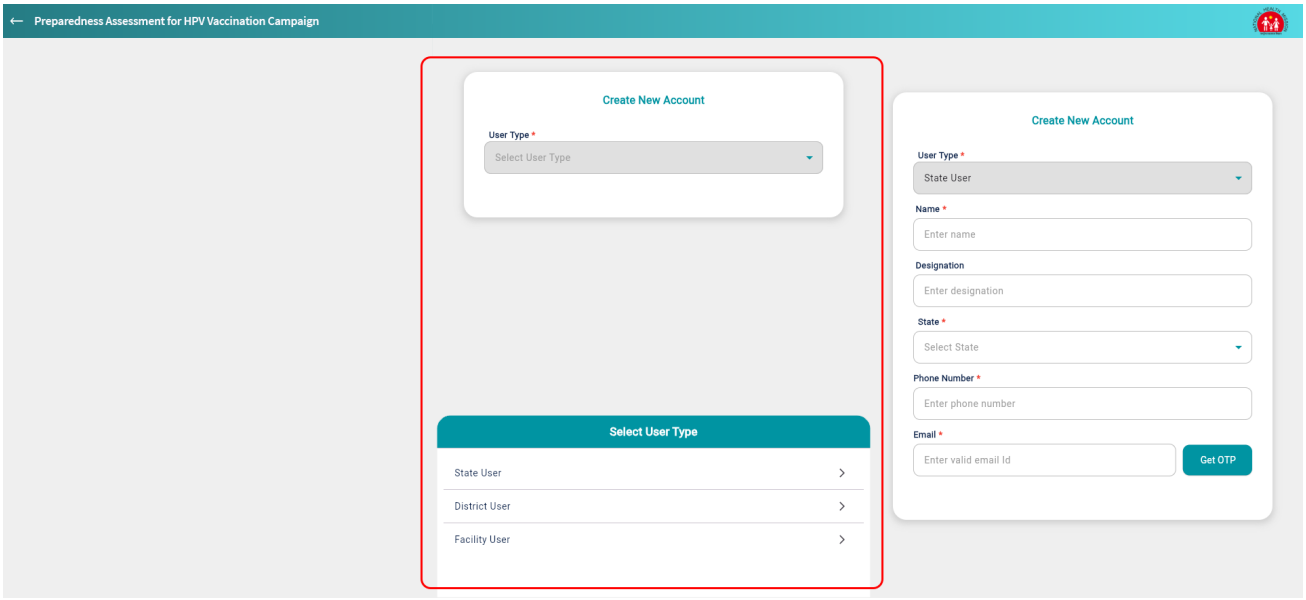
Fig. 124



Create New Account

Choose your user role to create an account.

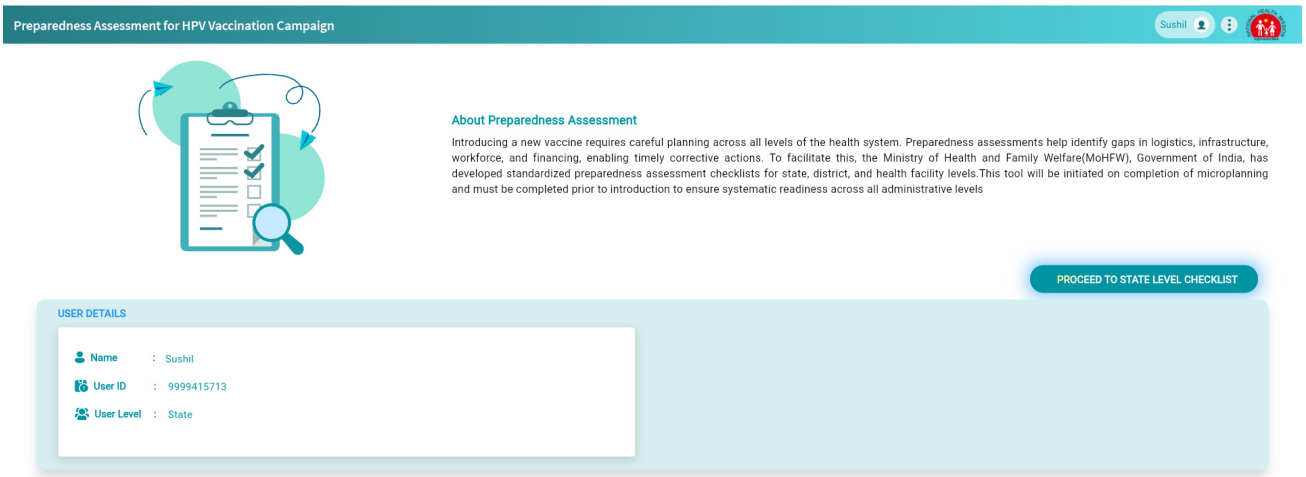
Fig. 125



Landing Page – State Level

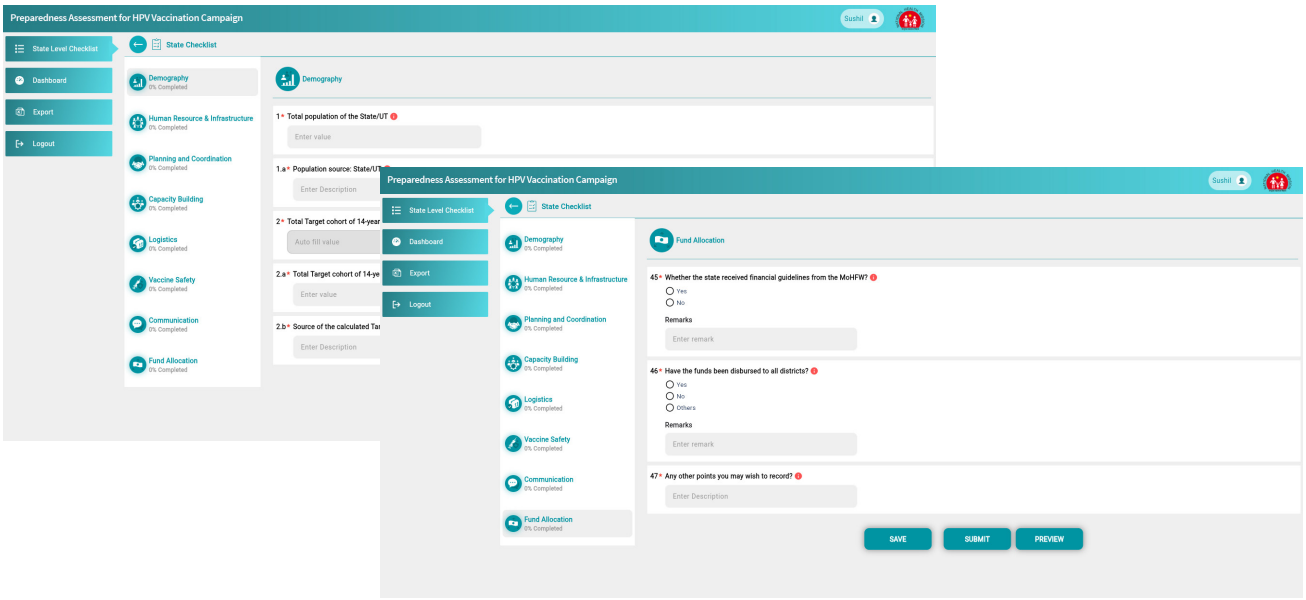
This is the landing page shown after login. It provides an overview of the New Vaccine Campaign Preparedness Assessment. It displays user details and includes a button to proceed to the State-Level Checklist for data entry.

Fig. 126



State level checklist

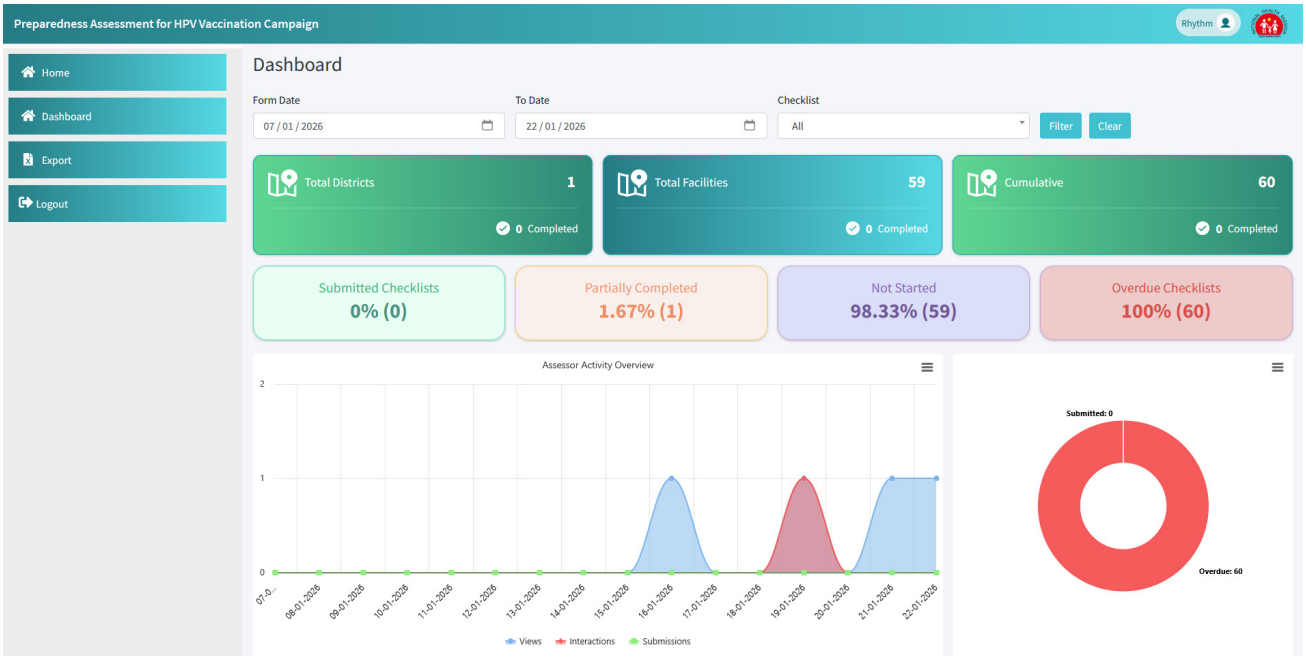
Fig. 127



Dashboard – State Level

This dashboard provides an overview of assessment progress within a specific state. It displays the total number of districts and health facilities, along with checklist completion percentages. The graph and pie chart show submitted and pending assessments, enabling state officials to track readiness and performance at the district and facility level.

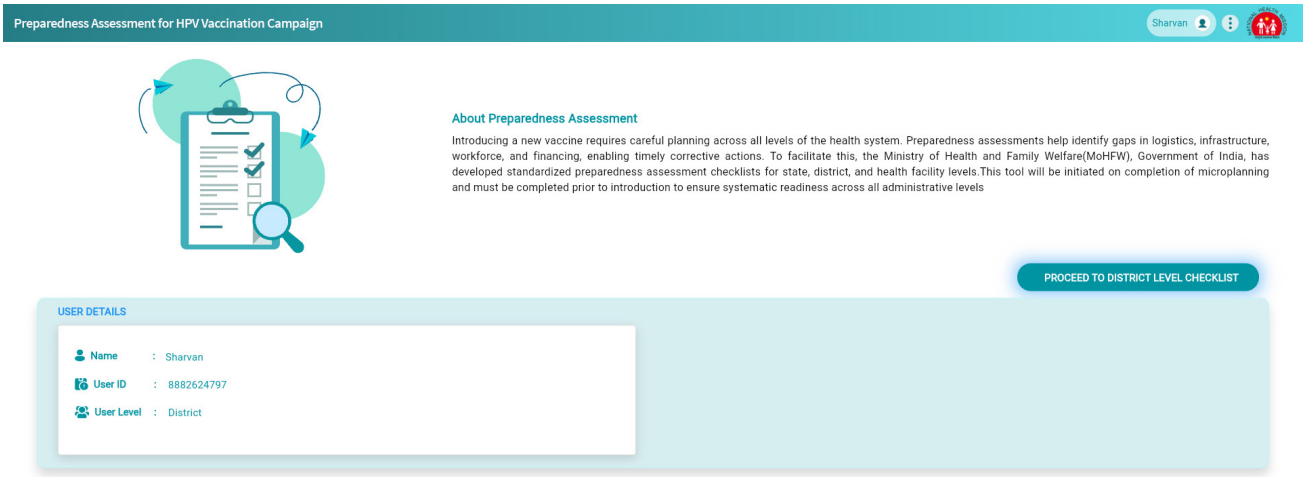
Fig. 128



Landing Page – District Level

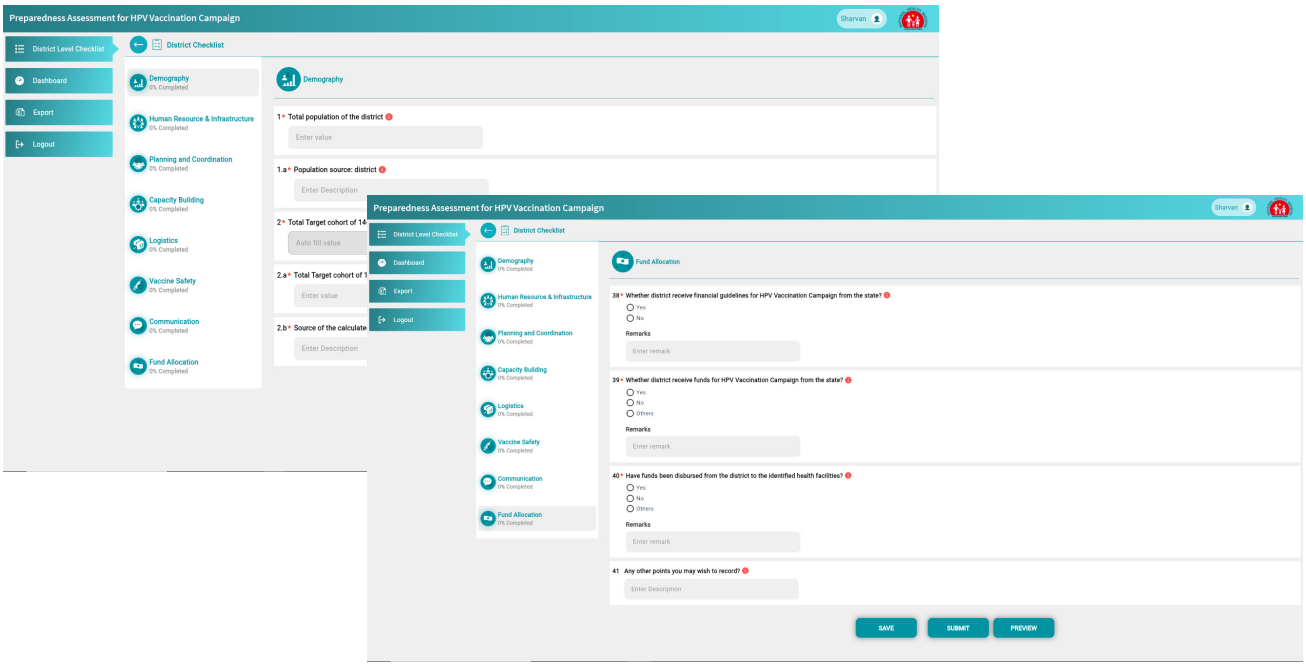
This is the landing page shown after login. It provides an overview of the New Vaccine Campaign Preparedness Assessment. It displays user details and includes a button to proceed to the District-Level Checklist for data entry.

Fig. 129



District level checklist

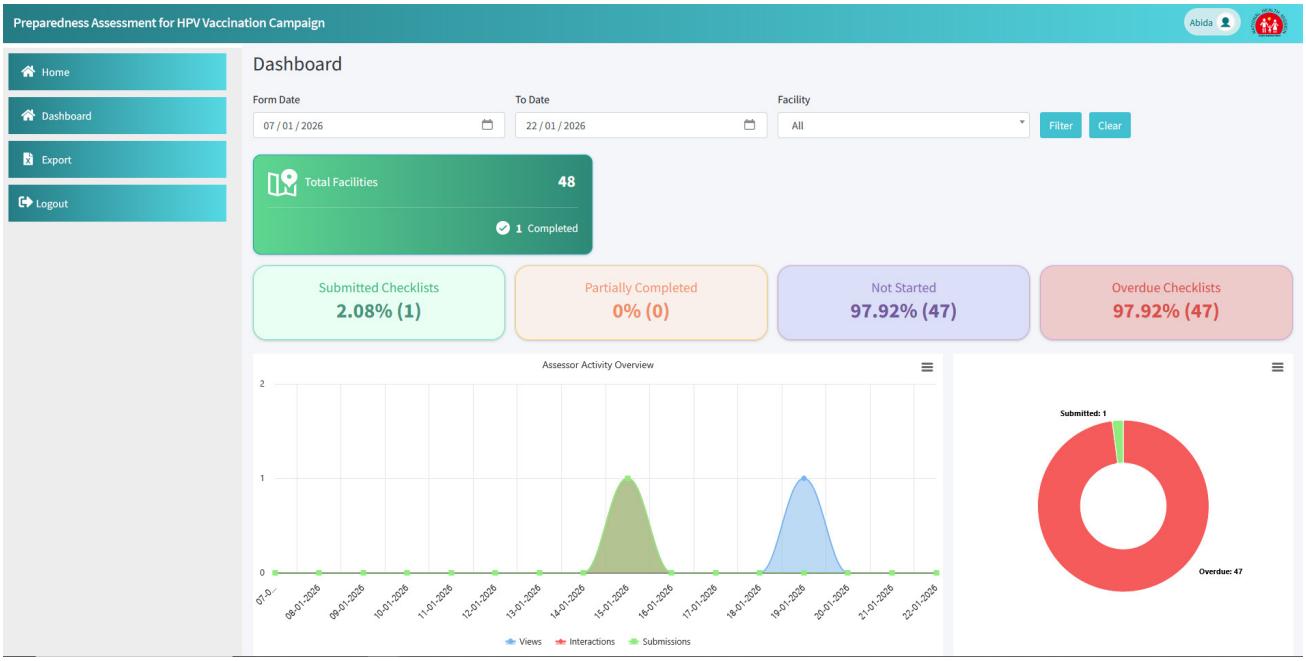
Fig. 130



Dashboard – District Level

This dashboard shows assessment progress for all health facilities within a district. It highlights the total number of facilities, and the percentage of submitted, partially completed, not started, and overdue checklists. Graphs display daily assessor activity and submission trends, helping district officials monitor facility-level readiness.

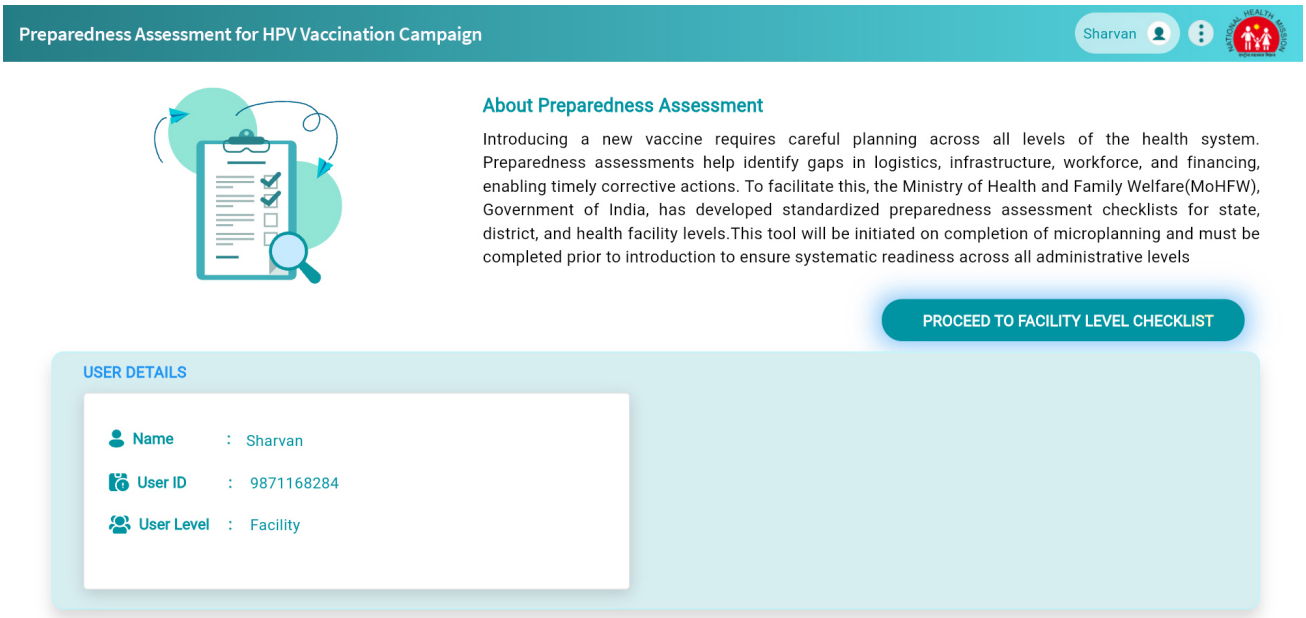
Fig. 131



Landing Page – Facility Level

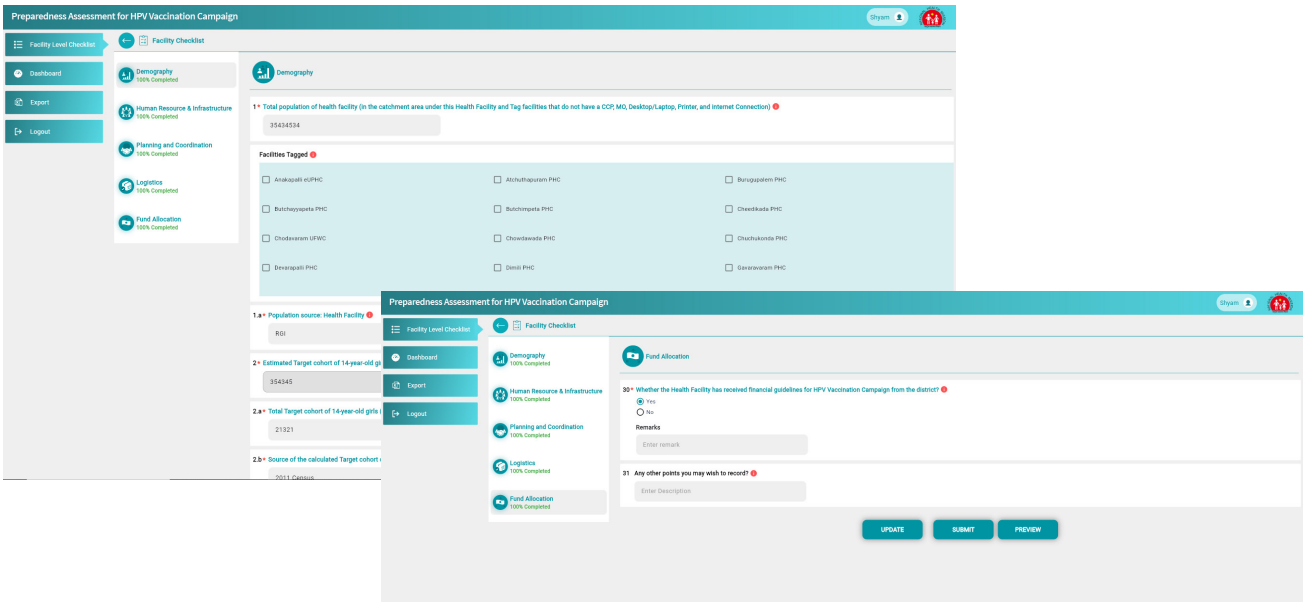
This is the landing page shown after login. It provides an overview of the New Vaccine Campaign Preparedness Assessment. It displays user details and includes a button to proceed to the Facility-Level Checklist for data entry.

Fig. 132



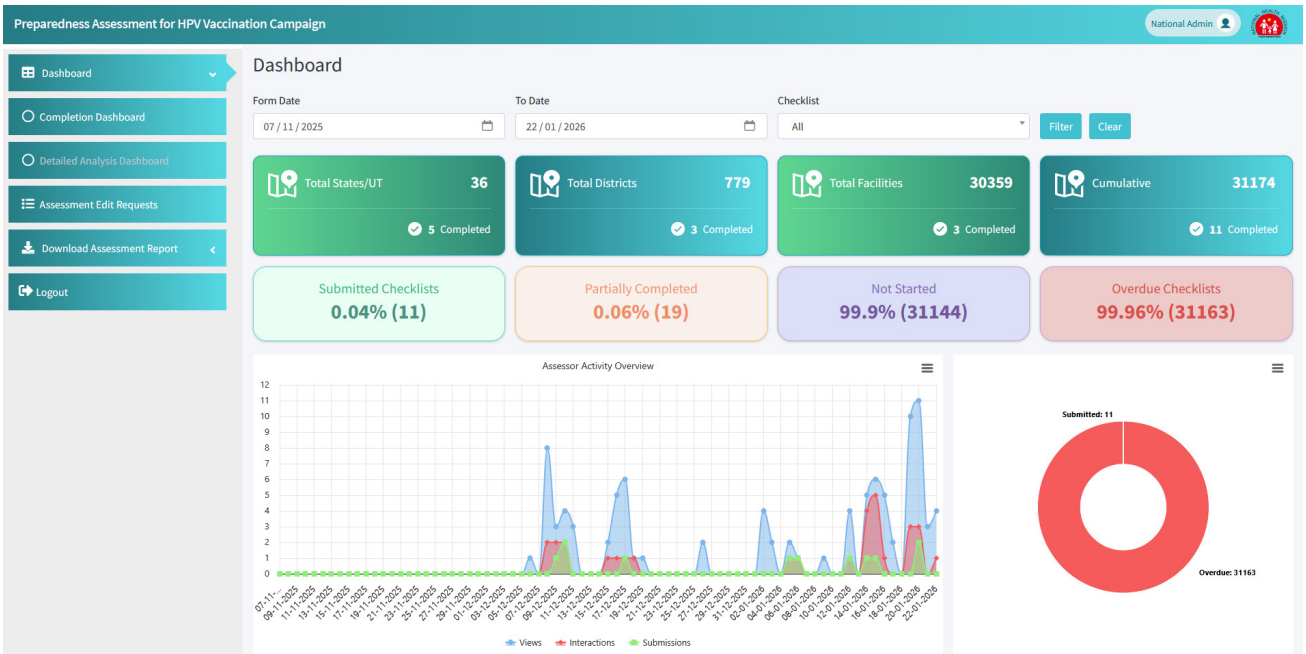
Facility level checklist

Fig. 133



Dashboard (National Level)

Fig. 134



Summary

Digital Tool for Preparedness Assessment: This user-friendly tool is designed and developed to facilitate & support the end user for smooth and seamless data entry. The tool can be used at multiple level so that the end user at each level can have a customised experience. It transforms raw assessment data into actionable insights through several core capabilities:

- A single digital platform that can cater to multiple functions - data collection, data storage, real time monitoring, real time cleaning of quantitative data along with thematic area wise data visualization.
- A dynamic dashboard for monitoring and visualization of data, as well as digital library embedded in the tool to aid investigators with digitized resources and information for easy reference.

- Visualize Key Performance Indicators through (KPIs) an interactive User Interface.

The assessment can be administered in person or remotely.

Based on the key gaps identified through the preparedness assessment, states and districts must develop mitigation plans. The HPV vaccination should start only after all preparedness activities, including training, have been completed.

2. During the Campaign (3 month activity) - HPV vaccination session site monitoring

During the initial phase, supervisors/monitors will oversee HPV vaccination session sites, including cold chain point and AEFI related activities, to ensure smooth implementation and quality service delivery. Monitor will use the standard monitoring checklist **(Form no. 8)** available on the U-Mentor application, as detailed in Chapter 5(B). Monitors will regularly visit session sites throughout the three-month activities to provide hands-on support to vaccinators and improve service quality. Monitors will also provide mentoring and guidance to vaccinators to uphold service standards. Their focus will include:

- Adherence to micro-plan and session schedules
- Manpower available at the session site
- Registration, recording and reporting on U-WIN
- Vaccine supply, logistics, and cold chain management
- Safe injection practices by ANMs and proper waste disposal
- AEFI management protocols being followed
- IEC material display
- Record-keeping and effective communication with beneficiaries

Also, Adverse Events Following Immunization (AEFI) monitoring is a critical component of the HPV vaccination program to ensure the safety and well-being of beneficiaries. During the vaccination activities, it is essential that vaccinators must have anaphylaxis kit. Vaccinators and designated Medical Officers must be well-trained to recognize and manage serious or severe AEFIs. Regular monitoring ensures that AEFI committees are active, reporting systems are functional, and healthcare workers are trained in timely identification and reporting of adverse events. Additionally, health facilities not operational 24x7 should be linked with nearby 24x7centers that can provide emergency care, ensuring swift response to any medical emergencies. This comprehensive approach strengthens the confidence in vaccine safety and supports effective immunization delivery.

3. After one month of the activity - Rapid Convenience Monitoring (RCM)

During the HPV vaccination Campaign, monitors will conduct **House-to-House monitoring from the 5th week onwards** i.e., after the completion of one month of the activities. The objective of RCM is to assess community-level uptake of the HPV vaccine, identify gaps or bottlenecks in coverage, and provide timely feedback for immediate corrective actions. RCM is conducted at the community level within the catchment area of the health facility using the standard checklist **(Form 10)** on the U-Mentor application as detailed in Chapter 5(B). National or independent observers/external monitors are encouraged to conduct as many RCMs as possible.

4. 6-12 months post HPV Vaccine Campaign – Post-Introduction Evaluation (PIE)

The roll-out of any new vaccine is an opportunity to strengthen health systems and improve the reach of immunization services. WHO recommends that a Post Introduction Evaluation (PIE) to be conducted within 6–12 months of roll-out of a new vaccine.

The aim of such evaluation is to assess community acceptance and its impact on the existing immunization system, to derive lessons for necessary corrective measures. Although a PIE is done in the context of new vaccine roll-out, the exercise provides a broad overview of the performance of the immunization program and thus boosts the confidence to further **scale up and introduce new and underutilized vaccines in the program.**

5K. FINANCIAL NORMS FOR OPERATIONAL COST UNDER HPV VACCINATION CAMPAIGN (THREE MONTHS)

During the three-month campaign period, certain operational costs will be incurred for activities such as micro-planning, head count survey and due listing, vaccine transport and delivery, human resource training, planning and monitoring, information, education and communication (IEC), injection safety, and logistical support. The financial norms, as outlined in the table below, have been developed to guide the planning and execution of these activities.

Table 11: Financial norms for Operational Cost under HPV Vaccination Activities (Three Months)

Domain	Activity	Norms used for Calculations
Micro-planning, Head Count Survey and Due listing	Micro-planning at Subcenter (SC)/ Primary Health Centre (PHC)/Community Health Centre (CHC)/District for incidental expenses like printing formats, photocopying, stationary etc.	Unit cost @ Rs. 100/- per SC, Rs. 1000/- per PHC/CHC and Rs. 1000/- per District.
	ASHA incentive for head count survey and due listing (before the vaccination Campaign)	Rs. 300/ASHA before the Campaign
Vaccine Transport and Delivery	Pool fund for transport (POL) of vaccines from district to Cold Chain Points, over and above the approved in PIP	Unit cost @ Rs. 10,000/- per district per month for maximum 3 months
Human Resource and Training	District level trainings for arranging training materials, refreshment, and other miscellaneous expenses.	Unit cost @ Rs. 150/- per trainee for 30 participants
	PHC/Block level trainings for arranging training materials, refreshment, and other miscellaneous expenses.	Unit cost @ Rs. 100/- per trainee for 20 participants
	Honorarium for 1 Trainer (Trained at State level) from Medical Colleges for imparting training at districts	Unit cost @ Rs. 1000 per trainer
	Honorarium for vaccination team of 4 members (ANM, ASHA, AWW/link worker, Volunteer/Data Entry Operator/ health staff)	Unit cost @ Rs. 100/- per team member for each session
Planning and Monitoring	One Planning meeting of maximum 30 persons each per district for arranging printing materials, refreshments & other misc. expenses	Unit cost @ Rs. 150/- per participant
	Weekly Review Meetings up to 6 meetings of maximum 30 persons each per district for arranging printing material, refreshments & other misc. expenses	Unit cost @ Rs. 150/- per participant
	Weekly Review Meetings up to 6 meetings of maximum 10 persons each per Health Facility for arranging printing material, refreshments & other misc. expenses	Unit cost @ Rs. 100/- per participant
	Daily Review Meting at Health Facility & District level	Critical activity to be conducted every day.

Domain	Activity	Norms used for Calculations
Information, Education and Communication (IEC)	Poster, Banner Poster: 4 posters per Health Facility and 4 posters per SC/ Urban ANM area for common places with high footfall. Banner: 2 banner per Health facility and 2 banner per SC/ Urban ANM area for common places with high footfall.	Unit cost @ Rs. 4/- per poster; Unit cost @ Rs. 200/- per banner
	Miking for 3 days/ week for 3 months per sub center area and urban ANM area	Unit cost @ Rs. 300/- per day
	Additional pool for innovations to create awareness, mobilization such as social media, media workshop etc.	Unit cost @ Rs. 2,00,000/- per state
Injection Safety	Red, Yellow & Black Plastic Bags with 3 bags per session	Unit cost @ Rs. 3/- per bag
	White and Blue Puncture proof containers per session site (Health Facility)	Unit cost @ Rs. 50/- per container
	AEFI & Anaphylaxis Kits (additional or replacement only): 1 AEFI kit per Health Facility identified for HPV vaccination and 1 Anaphylaxis kit per session site	Unit cost @ Rs. 200/- per AEFI kit per Health Facility and Rs 100/- per anaphylaxis kit per session site
	Indelible Marker Pen for finger marking, Zipper bags, Cotton roll, squeeze ball	Unit cost @Rs. 100/- per session
	Printing Cost of Microplanning formats, Reporting Formats, Information cards, Vaccination cards, etc.	Unit cost @Rs. 20/- per beneficiary
Miscellaneous	Miscellaneous cost	Unit cost @ Rs. 10,000 per district

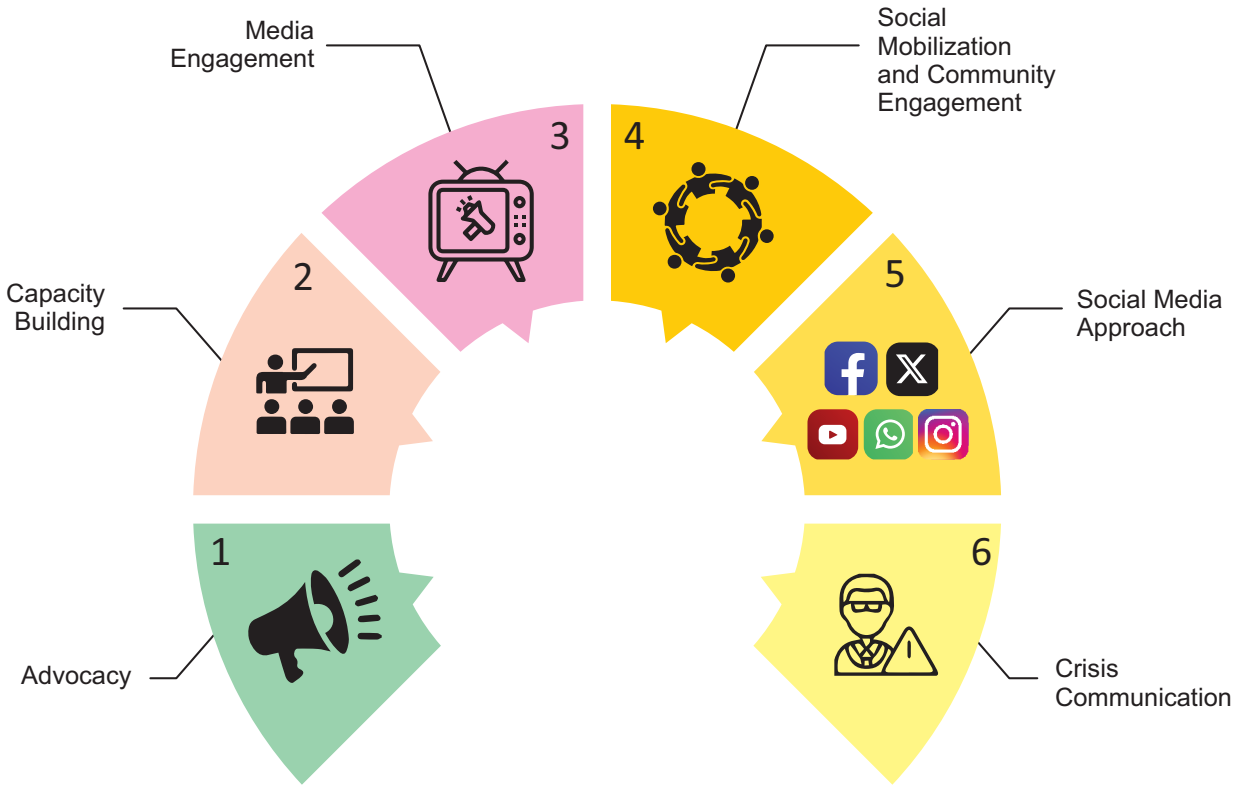
5L. COMMUNICATION AND SOCIAL MOBILIZATION

Strategic communication is the cornerstone for creating and sustaining demand and public confidence in vaccines and vaccination programmes. For the successful roll-out and sustained uptake of the HPV vaccine in India, a dedicated communication strategy has been developed.

The key objectives of this communication strategy are to:

1. Build knowledge and awareness about cervical cancer, its severity, and burden.
2. Raise awareness and build confidence in the HPV vaccine.
3. Generate demand for the HPV vaccine and ensure its sustained uptake among all girls aged 14 years (those who have celebrated their 14th birthday but have not yet celebrated their 15th birthday), both in and out of school, through a community-driven approach.
4. Enable and empower healthcare programme managers, care providers, frontline workers, schools, community and religious leaders, and other stakeholders and influencers to effectively communicate evidence-based messages about cervical cancer and HPV vaccination, and to address public queries.
5. Counter myths and misinformation about cervical cancer and HPV vaccination through clear, reassuring, and evidence-based communication - before, during, and after vaccine roll-out - to build and sustain public trust.

Figure 135: Key elements of communication strategy



TARGET AUDIENCE AND KEY STAKEHOLDERS

Figure 136: Key Stakeholders

Beneficiaries and Caregivers

- All girls aged 14 years (those who have celebrated their 14th birthday but have not yet celebrated their 15th birthday)
- Parents and caregivers making the decision to vaccinate their daughters

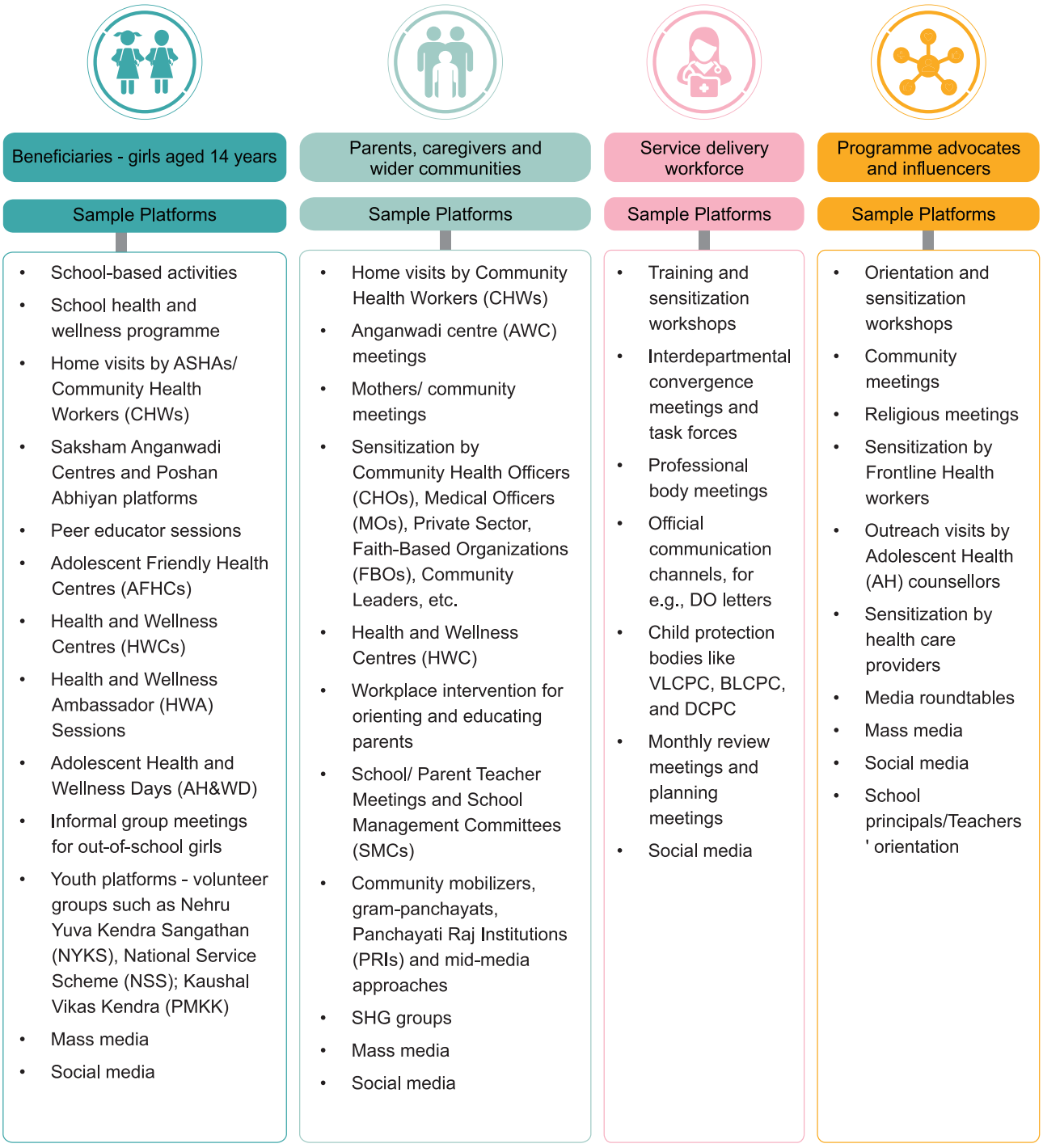
Service Delivery Workforce

- Immunization programme managers and medical officers
- Community Health Officers (CHOs) and nursing staff of Primary Health Centres
- Frontline Health Workers - Accredited Social Health Activists (ASHAs), Auxiliary Nurse Midwives (ANMs), Anganwadi Workers (AWWs)
- Medical Practitioners, including gynaecologists, paediatricians, and faculty from the community medicine department
- Key state/district level officials (within Health and Integrated Child Development Services (ICDS)), National Health Mission (NHM) staff at block level etc.
- Alternative medicine (AYUSH) practitioners
- IEC/ communication officers

Programme Advocates and Influencers

- Social and religious influencers, including young celebrities, ambassadors, survivors, champions, peer/digital influencers, community and religious leaders
- National/state media, including digital and print media
- Healthcare practitioners, including obstetricians, gynaecologists, and oncologists
- PRIs and elected representatives like MPs, MLAs, including panchayat representatives
- Youth-led forums, Civil Society Organizations (CSOs), and Community-Based Organizations (CBOs) working on adolescent issues
- Mahila Arogya Samitis (MASs) and Self-Help Groups (SHGs)
- Professional bodies including The Federation of Obstetric and Gynaecological Societies of India (FOGSI), Indian Medical Association (IMA), Indian Academy of Paediatrics (IAP), etc.
- Non-health government departments, including education, women and child development, district administration, etc.
- School staff, including principals, management, and teachers
- Administration within informal and religious schools
- Managers of Adolescent health programmes and school health and wellness programmes

Figure 137: Target audience-wise communications approach



COMMUNICATION ACTION PLAN AND TIMELINES

Synchronized commitment and efforts by government mechanisms at all levels (i.e., National, State, District, Block, and school levels) are vital for the successful planning and implementation of communication activities for the HPV Vaccine Campaign in India.

For detailed strategy, please refer to the Communication Strategy Document and Crisis Manual.

Chapter 6
Frequently Asked Questions (FAQs) on Human Papillomavirus (HPV) Vaccination for Medical Officers

FREQUENTLY ASKED QUESTIONS FOR MEDICAL OFFICERS

UNDERSTANDING CERVICAL CANCER AND HPV

1. What is cervical cancer?

Cervical cancer is the **cancer of the lower end of the uterus, also known as the cervix. Around 99.7%** of cervical cancers are due to the Human Papilloma Virus (HPV). While the majority of HPV infections are asymptomatic and resolve spontaneously, persistent infection with HPV may lead to cervical cancer.

2. What are the signs and symptoms of cervical cancer?

Early-stage cervical cancer generally produces no signs or symptoms. The **earliest clinical features** include vaginal bleeding after intercourse, between periods, or after menopause. Other early symptoms include watery, bloody vaginal discharge that may be heavy and have a foul odor, as well as an unhealthy appearance on examination characterized by an irregular surface or bleeding on touch. **Signs and symptoms** of more advanced cervical cancer include a visible growth on the cervix which may extend to the vagina, pelvic pain or pain during intercourse, fistula formation, and sciatic pain.

3. What is the burden of cervical cancer in India?

Cervical cancer is the **second leading** cancer amongst women in India. In 2024, there were an estimated 78,499 new cases and 42,392 deaths due to cervical cancer according to the NCRP-ICMR. The age-standardized estimates for cervical cancer in 2024 indicated an incidence of **10.4 per 1,00,000** women and a mortality rate of **5.6 per 1,00,000** women.

4. What is HPV and what are the types?

HPV is a double-stranded DNA virus which belongs to the family Papillomaviridae. More than 200 HPV types are classified into high-risk versus low-risk types. Currently, 17 HPV types are defined as high-risk, or oncogenic, and cause cancer in humans, including types 16, 18, 45, 33, 58, 31, 52, 35, 59, 39, 56, 51, 68, 73, 26, 69, and 82. HPV 16 and HPV 18 together are responsible globally for 77% of cervical cancer cases and 83% of cervical cancer cases in India.

5. What is HPV infection?

HPV infection is the most common sexually transmitted infection (STI) of the reproductive tract and causes a range of conditions in men and women. Most infections are asymptomatic and clear up without intervention within 1 to 2 years. A small percentage of infections with specific HPV types may persist and result in morphological lesions ranging from normal to different stages of precancer (cervical intraepithelial neoplasia: CIN-1, CIN-2, CIN-3) and invasive cervical cancer. Apart from cervical cancer, HPV infection can cause anal, oropharyngeal, vulvar, vaginal, and penile cancers.

6. How does the HPV infection spread?

HPV infection passes easily between sexual partners and can be transmitted through any intimate skin-to-skin genital contact, including vaginal, anal, or oral contact. HPV is presumed to be communicable during both acute and persistent infections.

7. Can HPV be passed from a mother to her child during pregnancy?

Though rare, HPV infection can pass through mother-to-child transmission when the infant passes through an infected birth canal. This usually clears through innate immunity, but in some cases, it may result in recurrent respiratory papillomatosis in the larynx.

8. What is the incubation period of HPV?

The estimated incubation period from HPV infection to genital wart development is 2 weeks to 8 months, with the majority of genital warts appearing 2 to 3 months after an HPV infection. For cervical cancer specifically, it can take 5 to 20 years for HPV-infected cervical cells to develop into pre-cancers and then into cancer.

9. Is there an immune response after natural HPV infection?

HPV infections are restricted to the epithelial layer of the mucosa and do not usually induce a vigorous immune response. After natural infection, 70% to 80% of women seroconvert, but their antibody responses are typically slow to develop and of low titre and avidity.

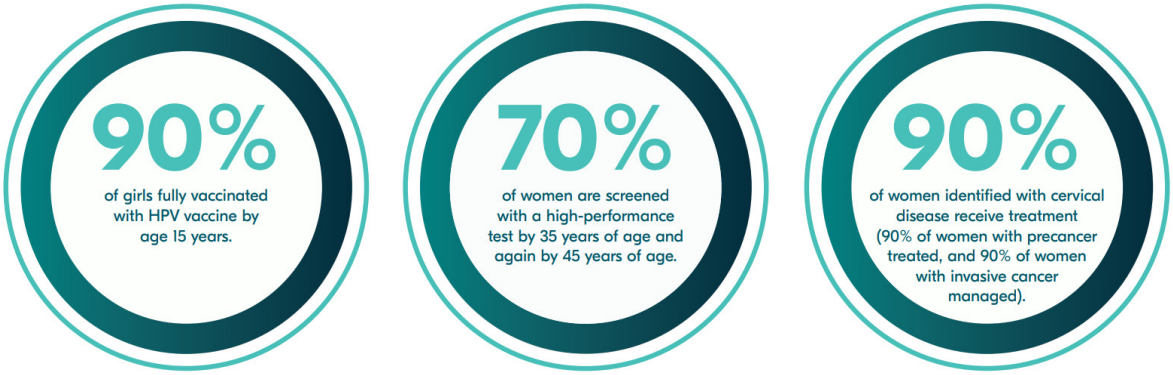
10. How to diagnose invasive cervical cancer?

The initial workup and clinical staging of patients with invasive cervical cancer include history, physical examination, and chest radiography. Magnetic resonance imaging (MRI) is presently considered the radiologic modality of choice for evaluating tumor size, parametrial spread, and vaginal spread. Likewise, positron emission tomography (PET) scanning has been reported as the best method to detect pelvic and para-aortic nodal disease in locally advanced cervical carcinomas, with a sensitivity and positive predictive value of 75% and a specificity and negative predictive value of 92%. Computed tomography (CT) scans may be used where these are not available.

GLOBAL STRATEGY FOR ELIMINATION OF CERVICAL CANCER

11. What is the Global strategy for the elimination of cervical cancer?

The strategy sets a threshold of 4 cases per 100,000 women-years for elimination as a public health problem, requiring that the 90-70-90 targets be met by 2030 for countries to be on the path to cervical cancer elimination.



12. Why does the Global Strategy recommend HPV vaccines to be included in national immunization initiatives?

The primary goal of HPV immunization is to prevent cervical cancer, which represents 83% of all HPV-related cancers. Prevention of cervical cancer is best achieved through the immunization of girls before they become sexually active. It is estimated that the implementation of this strategy could prevent 6 crore cervical cancer cases and 4.5 crore deaths over the next 100 years.

HPV VACCINE

13. Can cervical cancer be prevented?

The risk of cervical **cancer can be reduced by timely HPV vaccination and cervical screening.** The Human Papillomavirus (HPV) vaccine is being introduced to protect women from cervical cancer. The HPV vaccine primarily prevents cancers caused by high-risk types, especially types 16 and 18, which account for approximately 83% of cervical cancer cases in India.

14. How does the HPV vaccine work?

The HPV vaccine, which consists of virus-like particles (VLPs), triggers an immune response once introduced, creating antibodies that protect against future infection by specific cancer-causing HPV types.

15. Does HPV vaccination provides Herd Effect/Herd Protection/Indirect Vaccine Effect?

Yes, the HPV vaccine leads to a herd effect as per the evidence. When there is good coverage with the HPV vaccine, it leads to a herd effect, providing indirect protection to unvaccinated individuals by reducing the spread of specific HPV types. There is evidence of indirect protection of unvaccinated females through herd effects. In a number of countries, substantial decreases in cases of genital warts have occurred following the roll-out of a national HPV immunization programme using the quadrivalent vaccine, with reductions observed in unvaccinated young men in settings with female-only programmes, indicating herd protection. Achieving over 80% coverage in girls also reduces the risk of HPV infection for boys.

16. Does HPV vaccine provide lifelong protection against cervical cancer?

The HPV vaccine has been in the market since 2006, and data so far show that it offers long-lasting protection, with current studies showing its effectiveness for over 12 years and potentially much longer according to initial proof-of-concept studies. The antibody levels plateau after 7 months in all studies, and there is no evidence to suggest that a booster dose is needed several years after the primary HPV vaccination, although data continues to be evaluated. Analysis of a large multicentre, prospective, cohort study comparing 1-, 2-, and 3-dose regimens of quadrivalent (Gardasil) vaccine in females aged 10-18 years showed that vaccine effectiveness against HPV 16/18 infections was high (>90%) for a median follow-up of 12 years post-vaccination for all schedules.

17. How long does it take for antibodies to develop after receiving HPV vaccine?

In clinical trials, a peak serum antibody titre was observed 4 weeks after the last dose.

18. What are the HPV vaccines available in India?

In India, **four HPV vaccines—Cervarix, Gardasil, Gardasil-9, and Cervavac—**are licensed by the DCGI for use.

Trade Name	Cervarix®*	Gardasil®*	Gardasil-9®*	Cervavac®*
Valency	Bivalent	Quadrivalent	Nonavalent	Quadrivalent
Manufacturer	GlaxoSmithKline Biologicals (GSK) Belgium	Merck/MSD USA	Merck/MSD USA	Serum Institute of India (SII)
HPV types included	16/18	6/11/16/18	6/11/16/18/31/33/45/52/58	6/11/16/18
Date of WHO Prequalification	08 July 2009	20 May 2009	09 February 2018	-
Adjuvant	AS04 (Aluminium hydroxide and 3-deacylated monophosphoryl lipid A)	Aluminium hydroxyphosphate Sulfate	Aluminium hydroxyphosphate Sulfate	Aluminium hydroxide
Expression system/ producer cells	Baculovirus derived from Trichoplusia ni	Saccharomyces cerevisiae (baker's yeast)	Saccharomyces cerevisiae (baker's yeast)	Hansenula
Efficacy and immunogenicity data for single -dose Schedule use	Yes	Yes	Yes	Immuno-bridging study ongoing

19. Which type of HPV infection can be prevented by the Quadrivalent HPV vaccine?

The Quadrivalent HPV vaccine protects against infection from **four HPV types,** including two high-risk types that cause most HPV-related cancers **(types 16 and 18)** and two low-risk types that cause most genital warts **(types 6 and 11).**

20. Does the HPV vaccine prevent all types of cancer?

No, it primarily prevents cancers caused by high-risk HPV types, especially types 16 and 18, which account for approximately 83% of cervical cancer cases in India.

21. Can the quadrivalent vaccine treat HPV infections or HPV-related cancers?

No, the HPV vaccine is preventive; it does not treat HPV infection or HPV-related cancers and diseases.

22. Is the HPV vaccine a live vaccine?

No, the HPV vaccine is not a live virus vaccine. It is a non-live, recombinant vaccine which contains Virus-like particles (VLPs) but not the actual virus, lacks viral genetic material, and cannot cause HPV infection.

23. What preservative is used in the quadrivalent HPV vaccine?

There is no preservative in the quadrivalent HPV vaccine.

ELIGIBILITY AND VACCINE TIMING

24. Which age group is eligible for HPV vaccination?

Under the current GOI guidelines, girls aged 14 years (those who have celebrated their 14th birthday but have not yet celebrated their 15th birthday) are eligible for the HPV vaccine. Due to the limited global supply of the HPV vaccine, India is initially focusing on vaccinating a single age group of 14-year-old girls to ensure that those who are about to cross the upper age limit of 15 years have the opportunity to get protected.

25. Why are only girls being vaccinated against HPV and not boys?

The NTAGI and WHO position paper has recommended HPV vaccination as the tool for the prevention of cervical cancer and recommended girls as the primary target population for HPV vaccination. Achieving over 80% coverage in girls will reduce the risk of HPV infection for boys.

26. Can adolescent girls who have celebrated their 15th Birthday receive the HPV vaccine?

Under the current GOI guidelines, only girls aged 14 years but less than 15 years should be vaccinated. Girls who will turn 15 years within 90 days of the Campaign launch date are also eligible for vaccination, but only during the three-month campaign period. After the three-month campaign period, the HPV vaccine will be available at the same health facilities on Routine Immunization Days for girls aged 14 years.

27. Why isn't the HPV vaccine recommended for older adults?

The vaccine is **most effective and durable** when given at a younger age, ideally before exposure to the virus. As people get older, the chances of prior HPV exposure increase, making the vaccine less effective.

28. Why is the HPV vaccine being introduced in a special Campaign?

The HPV vaccine is currently being introduced through a special Campaign **to ensure availability of trained health workers, proper vaccine storage, and close safety monitoring.** This careful rollout helps build a strong foundation before it becomes part of the routine immunization schedule.

DOSE, SCHEDULE, EFFICACY AND PROTECTION

29. What is the dose, route, site of administration and dose schedule for the HPV vaccine?

The quadrivalent HPV vaccine (Gardasil) is a liquid vaccine administered as a single 0.5 ml intramuscular dose in the left upper arm at 14 years of age. The Government of India has chosen a single-dose schedule HPV vaccine over a two- or three-dose schedule, as it offers comparable efficacy and duration of protection to a two-dose schedule.

30. Why is Government of India (GoI) using Gardasil vaccine instead of Gardasil 9 vaccine in its HPV vaccination Campaign?

The primary objective of HPV vaccination is to prevent cervical cancer, which accounts for 82% of all HPV-related cancers. Gardasil provides protection against four HPV types (6, 11, 16, and 18), while Gardasil 9 extends protection to nine types. Despite the broader protection of Gardasil 9, HPV 16 and 18 alone contribute to approximately 83% of cervical cancer cases in India. Thus, by focusing on the high-risk strains, the government's strategy is a highly effective approach to reducing the overall disease burden.

31. Does Gardasil (qHPV) vaccine provides cross-protection for types in nonavalent vaccine (31,33, 45, 52 and 58)?

Yes, the qHPV vaccine provides partial cross-protection against these HPV types not included in the vaccine.

32. How effective are HPV vaccines?

HPV vaccines are **93-100% effective in preventing cervical cancer and are highly immunogenic.** The serological response to vaccination is much stronger than the response after natural infection.

33. Is single-dose HPV vaccine effective?

Currently, one dose of HPV vaccine **(Gardasil, Gardasil-9, Cervarix, and Cecolin)** in young girls is effective and provides sufficient protection against persistent HPV infection as per the WHO.

34. What is the duration of protection after quadrivalent HPV vaccine single dose?

For a single-dose schedule, antibody titres have been shown to be stable for over 12 years, and follow-up studies are ongoing. There is no evidence to suggest that a booster dose is needed after primary HPV vaccination.

VACCINE SAFETY

35. Are HPV vaccines safe?

Yes. As with all vaccines, the safety and effectiveness of HPV vaccines are monitored very carefully. Studies have demonstrated the safety and effectiveness of HPV vaccines, and since licensure in 2006, **over 50 crore doses have been distributed as of December 2022.** Post-licensure surveillance has detected no serious safety issues to date except rare reports of anaphylaxis.

36. Is it safe to vaccinate a girl during menstruation?

The HPV vaccine does not affect periods or puberty. So, it is safe to administer the HPV vaccine if the girl is menstruating.

37. Will HPV vaccination affect a girl's fertility? Will it affect her chances of getting pregnant later?

No. As per the available evidence and literature, there is no impact on fertility or future pregnancies.

38. Can HPV vaccine be given during pregnancy?

No. HPV vaccines are not recommended for use in pregnant women. However, in 16 Randomized Control Trials (RCTs) including more than 25,000 participants, no specific safety concerns were identified for the outcome of pregnancy, spontaneous abortion, miscarriage, stillbirths, or fetal development.

39. Can HPV vaccine be given while breastfeeding?

Yes. The HPV Vaccine **is safe while breastfeeding,** and vaccines given to lactating women do not affect the safety of breastfeeding for mothers or infants.

40. Can the HPV vaccine be co-administered with other vaccines?

Yes. The HPV vaccine can be **safely co-administered** with other routine vaccines such as Td, MR, and JE.

41. Can individuals known to be immunocompromised or with HIV infection be administered HPV vaccine?

Yes. Individuals known to be **immunocompromised or HIV-infected** can be administered **two doses (at 0 and 6 months) or three doses (at 0, 2, and 6 months),** after consultation with a specialist.

42. Does family history of cervical cancer affect a girl's eligibility for the HPV vaccine?

No. Family history of cervical cancer does not affect a girl's eligibility for the HPV vaccine.

43. What are the exclusion criteria for HPV vaccination?

Following are the exclusion criteria for HPV vaccination:

- A girl with moderate or severe illness should wait until she has recovered.
- Those who had an allergic reaction to previous vaccination or are known to be allergic to yeast should avoid getting vaccinated.
- Pregnancy
- Girls out of the target age group range under the current HPV vaccination Campaign.
- Girls who have been previously vaccinated should not receive HPV vaccine again. Additionally, her vaccination status needs to be updated in U-WIN.

44. Which finger is to be marked after HPV vaccination?

The left index finger should be marked after HPV vaccination.

45. Can it be given to TB patients, cardiac disease patients, patients on epilepsy treatment, sickle cell/thalassaemia cases?

Yes, the HPV vaccine can generally be given to patients with these conditions because the HPV vaccine is a non-infectious recombinant vaccine prepared from purified virus-like particles (VLPs) that does not contain a live virus and cannot cause the disease itself. However, a medical specialist's advice is to be taken before HPV vaccination in the following patients:

1. **Tuberculosis (TB) Patients:** Patients with TB can receive the HPV vaccine. There is no evidence that the vaccine interferes with TB medication or worsens the infection. However, it is often preferred to wait until a patient has completed the initial intensive phase of TB treatment or is clinically stable before administering vaccines to ensure the body can mount a strong immune response. While the HPV vaccine is generally safe and recommended for people with chronic conditions, a consultation with a medical specialist is a necessary step.
2. **Cardiac Disease Patients:** The vaccine is safe for individuals with heart conditions. While the HPV vaccine is generally safe and recommended for people with chronic conditions, a consultation with a medical specialist is a necessary step.

3. **Patients on Epilepsy Treatment:** Epilepsy is not a contraindication for the HPV vaccine. The medications used to treat seizures do not interact with the vaccine. Some adolescents experience a "vasovagal" reaction (fainting) after getting a shot. Because this could be mistaken for a seizure in an epilepsy patient, it is standard practice to have the patient sit or lie down for 15 minutes after the injection. While the HPV vaccine is generally safe and recommended for people with chronic conditions, a consultation with a medical specialist is a necessary step.
4. **Sickle Cell & Thalassemia Cases:** Vaccination is strongly encouraged for these patients. Because sickle cell and thalassemia can affect the spleen's function (functional asplenia), these individuals are considered at higher risk for infections. While most healthy teens need only 1 dose, adolescent patients with significant immune suppression or certain blood disorders may be advised to follow a 2-dose (at 0 and 6 months) or 3-dose schedule (at 0, 1-2, and 6 months) to ensure full protection. While the HPV vaccine is generally safe and recommended for people with chronic conditions, a consultation with a medical specialist is a necessary step.

SPECIAL SITUATIONS

46. Where should the eligible girls residing in hostels be included during the headcount survey?

During the head count survey, eligible girls aged 14 years are to be listed as per their residence. Since most of these girls may not be living in their homes but residing in hostels, hostels need to be listed in the ASHA areas and head count surveys must be done in such residential hostels to ensure eligible girls are reached for mobilization. The provision for head counting in residential schools/hostels has been made in the micro-planning formats.

47. Should the HPV vaccine be given to an eligible girl visiting from other States/UTs?

Yes, the HPV vaccine should be given to all eligible girls, irrespective of the States/UTs they are coming from, provided they haven't received any dose of HPV vaccine anywhere.

48. Can HPV Vaccine be given to Transgender people?

Yes, the HPV vaccine can be given to transgender people.

49. Do women need to get screened for cervical cancer if they have been vaccinated?

Yes, even if they have received the HPV vaccine, they **still need regular screening for cervical cancer as recommended by the health care provider.**

50. Can someone with abnormal pap smear results take the HPV vaccine?

Yes, but it won't treat abnormalities, although it can still offer protection from other HPV types.

51. Can someone who is already exposed to HPV take the vaccine ?

A girl may not know if she is already exposed to HPV unless it is established by medical diagnosis. If she is in the recommended age, she is encouraged to take the HPV vaccine, though it may not halt the progress of the disease due to already existing HPV exposure from sexual activity.

52. Can someone who has already taken HPV vaccine still get HPV infection or suffer from cervical cancer ?

Yes, even if a girl has received the HPV vaccine, she can still get HPV infection or cervical cancer, which are caused by non-vaccine types of viruses.

53. Does the vaccine also protects against genital warts?

Yes, the quadrivalent vaccine being provided under the government's Campaign protects against HPV types 6 and 11 that cause genital warts.

54. If an eligible girl is already given a licensed HPV vaccine in private sector and the parents insists for the quadrivalent dose again under the GOI Campaign, do we vaccinate her?

No, as per the GOI guidelines, any girl who has already received any licensed HPV vaccine shouldn't be given the quadrivalent vaccine in the Campaign if it is confirmed that she is vaccinated with one dose of any HPV vaccine.

55. An eligible girl at the HPV vaccination session claims that she doubts she is already vaccinated against HPV in private sector, what to do?

The medical officer will have **to try to ascertain** the fact if she is vaccinated by verifying her records through the parents. If there is **no evidence** of vaccination, you can vaccinate her with the quadrivalent vaccine.

56. What if we vaccinated any eligible girl with the quadrivalent vaccine under the Campaign and later the parents disclose that she was already vaccinated against HPV in private?

In such cases, we need to counsel and convince the parents that they need not worry. Even if the girl was previously vaccinated against HPV with any licensed vaccine, **there is no harm** and the girl will still be protected from HPV infection.

57. What if a girl misses her dose of HPV vaccine during the HPV vaccination Campaign?

The girls or the parents should contact the medical officer/ASHA/ANM of their area, or visit their nearest government health facility which is a HPV vaccination centre to get the girl vaccinated.

58. What to do in case of Non-Availability of Eligible Identity Card for HPV Vaccination?

In case of non-availability of any eligible ID card for age verification of girls aged 14 years, a parental undertaking should be taken and uploaded on U-WIN.

Undertaking Form

UNDERTAKING FOR NON-AVAILABILITY OF ELIGIBILITY IDENTITY CARD FOR VACCINATION

To,

Vaccinator/Medical Officer

_____

_____(Name & Address of Vaccination Centre/Session Site)

Subject: Undertaking Regarding Eligible Non-Availability of Identity Card

Sir/Madam

I, _____[name] residing at _____

do hereby solemnly affirm and declare as under:

1. That my daughter, _____[name] is desirous of receiving the _____ [name of the vaccine] at your vaccination centre/session site. To the best of my knowledge, the age of [my daughter] is _____ years.
2. That I am currently not in possession of any eligible identity cards such as Aadhaar Card, PAN Card, Ration Card, Birth Certificate, Passport, MCP card, School ID, Transfer Certificate, Bank Passbook or any other valid eligible identification document to establish _____ [my daughter's] true and valid identity.
3. That I undertake and affirm that the details provided by me for the purpose of vaccination are true and correct to the best of my knowledge and belief.
4. That I understand the importance of accurate information for record-keeping and future reference and undertake to provide my child's identity proof at the earliest possible opportunity, as and when made available to me.
5. That I shall not hold the vaccination centre or its staff responsible for any consequences arising due to the non-availability of my identity proof at the time of vaccination.

I request you to kindly allow me to proceed with the vaccination based on this undertaking.

Date:

Place:

Yours sincerely,

(Signature _____)

(Full Name _____)

(Address _____)

(Mobile Number _____)

59. What should the vaccinator do if a girl is brought to the health facility for HPV vaccination, but there is no internet connectivity to register her on the U-WIN portal?

In case there is no internet connectivity at the health facility, the vaccinator can proceed with vaccination by taking a photocopy of the age proof from the parent/caregiver and recording their signature on the physical consent form. The vaccination data should be uploaded to the U-WIN portal once internet access is available to ensure proper documentation and record-keeping.

60. Can private hospitals be engaged for HPV vaccination campaign?

No, as of now under the HPV vaccination campaign, only Government Health Facilities (AAM-PHCs, U-PHCs, CHCs, SDH, DH, GMC&H) with the criteria of having CCP as per eVIN, a dedicated Medical Officer for AEFI management, and internet connectivity including a Desktop/Laptop with Printer will provide the HPV vaccination. However, private hospitals which are 24x7 functional can be made AEFI management centres after sensitizing and training them on the HPV vaccination program and AEFI management guidelines.

61. How to manage anaphylaxis?

HPV vaccine is administered in the deltoid region of the left arm. In case of suspected anaphylaxis, the preferred site of administration of injection adrenaline is the mid anterolateral aspect of the thigh. In case it is not possible to inject adrenaline in the thigh due to concerns of privacy, it may be administered in the deltoid muscles of any arm. Injecting adrenaline in the thigh is preferred as absorption is significantly faster and more reliable, which is critical in a life-threatening emergency.

Injection adrenaline (1:1000 solution) dosage chart IM

Age group (in years)	One inch needle gauge	Dosage (in mL) using 1 mL tuberculin syringe	Dosage (in units) using 40 units insulin syringe
0-1		0.05	2
1-6		0.1	4
6-12	24G/ 25G	0.2	8
12-18		0.3	12
Adults		0.5	20

Annexures

Training on HPV Vaccination Campaign **Annexure-1**

AGENDA

Day 1			
Time	**Topic**	**Duration**	**Type**
8:30 - 9:00	**Registration**		
9:00 - 9:30	**Introduction of Participants**		
9:30 - 10:00	Overview of UIP & recent updates	30 min	Presentation
10:00 - 11:00	Macroplanning & Microplanning for vaccine	60 min	Presentation & Group Work
11:00 - 11:30	**Tea Break**		
11:00 - 12:30	New Vaccine module of U-WIN + e VIN (including digital consent)	60 min	Presentation
12:30 - 13:00	Cold Chain and Vaccine management	30 min	Presentation
13:00 - 14:00	**Lunch Break**		
14:00 - 14:40	Reporting and management of AEFI	40 min	Presentation
14:40 - 15:10	Safe Injection Practices	30 min	Presentation
15:10 - 15:40	Preparedness Assessment	30 min	Presentation
15:40 - 15:55	How to conduct a session	15 min	Presentation
15:55 - 16:15	**Tea Break**		
16:15 - 16:45	Roles and Responsibilities of Stakeholders	30 min	Presentation
16:45 - 17:15	Cascade Training plan	30 min	Presentation
17:15 - 17:30	Open Discussion-Q&A	15 min	
Day 2			
Time	**Topic**	**Duration**	**Type**
9:00 - 9:30	Financial norms and Q & A	30 min	Presentation and Discussion
9:30 - 10:20	Key Communication Challenges and Strategies • Messaging framework and stakeholder engagement • Addressing misinformation and hesitancy • How to use IEC materials effectively	50 min	Presentation and Discussion
10:15 - 11:15	Crisis Communication Challenges and Solutions in Action	60 min	Presentation Activity: 5-6 real-life crisis scenarios
11:15 - 12:00	Developing Communication (Media) Plan	30 min	Presentation + Activity: scenario specific template filling
12:00 - 12:15	Open Discussion-Q&A	15 min	
12:15 - 12:30	Closing & Next Steps	15 min	
	Lunch Break		

Draft agenda for District workshop **Annexure-2**

AGENDA

Date:		Venue:		
Time	**Topic**	**Duration**	**Type**	**Facilitators**
8:30- 9:00	**Registration**			
9:00 - 9:30	**Introduction of Participants**			
9:30-10:00	Overview of UIP & recent updates	30 min	Presentation	SIO
10:00-11:30	Macroplanning & Microplanning for vaccine	90 min	Presentation & Group Work	Master trainers
11:30-11:45	**Tea Break**			
11:45-12:15	New Vaccine module of U-WIN + e VIN (including digital consent)	30 min	Presentation	Master trainers
12:15-12:30	Cold Chain and Vaccine management	15 min	Presentation	Master trainers
12:30-13:15	Reporting and management of AEFI and Safe Injection Practices	45 min	Presentation	Master trainers
13:15 -13:45	**Lunch Break**			
13:45-14:00	Preparedness Assessment	15 min	Presentation	Master trainers
14:00-14:15	How to conduct a session	15 min	Presentation	Master trainers
14:15-14:30	Roles and Responsibilities of Stakeholders	15 min	Presentation	Master trainers
14:30-14:45	Training of frontline workers	15 min	Presentation and Discussion	DIO
14:45-15:15	Open Discussion-Q&A	30 min	Discussion	SIO & DIO
15:15-15:30	**Tea Break**			
15:30-16:00	Key Communication Challenges and Strategies	30 min	Presentation and Discussion	Master trainers
16:00-16:30	Crisis Communication- Challenges and Solutions in Action	30 min	Presentation and Group Activity	Master trainers
16:30-17:00	Developing Communication (Media) Plan	30 mins	Presentation and Group Activity	Master trainers
17:00-17:15	Open Discussion-Q&A	15 min	Discussion	SIO & DIO
17:15-17:30	**Closing remarks and next steps**	15 mins	Discussion	SIO & DIO

District wise School listing and planning Form

Annexure-3

FORM 1

HPV Vaccination Campaign Year/Month:											
State:				District/ Corporation:							
Name of District Education Officer (DEO) & Mobile No.						Name of District Immunization Officer (DIO) & Mobile No.					
PART-A: To be filled by District Education Officer using UDISE+ and timely submit to District Immunization Officer (DIO)											**PART-B: To be filled by DIO & further share the filled form with all planning units/HFs**
S. No.	**School Name**	**UDISE+ code**	**Block/ Urban Area**	**Address**	**Number of girls aged 14 years***	**Name of Principal/ School Nodal**	**Mobile No.**	**PTM date Planned (Y/N)****	**If Yes, Date**	**Name & Mobile no of Block Education Officer**	**School falls under which planning unit /HFs**
	a	**b**	**c**	**d**	**e**	**f**	**g**	**h**	**i**	**j**	**k**
1.											
2.											
3.											
4.											
5.											
6.											
7.											
8.											
9.											
10.											
*Girls aged 14 years [those who have celebrated their 14th birthday but have not yet celebrated their 15th birthday] ** PTM: Parents-Teacher Meeting											
District Education officer Signature with date						District Immunization Officer Signature with date					

Head Count Survey (HCS) planning at Sub Centre/Urban ANM area

FORM 2

(MO to ensure this format is filled for all sub-centres/Urban ANM areas including vacant sub-centres)

HCS planning Form: to be filled by ANM and to be submitted to Planning unit after Head Count Survey

HPV Vaccination Campaign Year/Month:			
State:	District/Corporation:	Block/Urban Area:	Planning unit (PHC/U-PHC/CHC):
Sub-centre/Urban ANM area _____		Whether Sub-centre / ANM area has full time ANM (encircle) : Full Time / Vacant/ Temporarily Vacant _____	
Name of ANM with Contact No.: _____	No. of ASHAs working in Sub-centre/ Urban ANM area:_____	Name of Medical Officer with phone no : _____	

PART-A: To be filled by the ANM before the headcount survey										PART-B: To be filled by ANM after Head Count Survey	
S. No.	Write Names of ALL Villages / Hamlets/ Tolas/Ward/ Mohalla/ HRA Sites/Industry set up/Mining area/Brick kiln area/Migratory setup/ Orphanage/Hostel/ center/ brothels (red light areas)/ Correction center under the Sub centre/ANM area separately, one area in each row	Estimated number of households (HH)	Total Population	Estimated number of girls aged 14 years (~1% of population)	Name & contact number of ASHA / AWW /MAS/JAS/ Link worker (mobilizers) designated for this area	Name and contact number of persons doing head count survey (Surveyor/s)	Designation of Surveyor (encircle applicable)	Name and contact no. of local influencers	Dates Planned to conduct Headcount Survey From / To	Number of Girls aged 14 years due for vaccination as per HCS (Form 3)	Nearest 24x7 Health Facility (PHC & above) for this area
	a	b	c	d	e	f	g	h	i	j	k
1.					1. Name & contact number of ASHA:- 2. Name & contact number of AWW:- 3. Name & contact number of MAS/JAS member: 4. Name & contact number of Link worker:-	1 2	ASHA, AWW / MAS/JAS/Link Worker/ Others	1 2			
2.					1. Name & contact number of ASHA:- 2. Name & contact number of AWW:- 3. Name & contact number of MAS/JAS member: 4. Name & contact number of Link worker:-	1 2	ASHA, AWW / MAS/JAS/Link Worker/ Others	1 2			
3.					1. Name & contact number of ASHA:- 2. Name & contact number of AWW:- 3. Name & contact number of MAS/JAS member: 4. Name & contact number of Link worker:-	1 2	ASHA, AWW / MAS/JAS/Link Worker/ Others	1 2			
Total											

Signature of ANM with date	Signature of Supervisor with date	Signature of Medical Officer with date

Head Count Survey (HCS) cum due list of the beneficiaries (Girls aged 14 Years)

FORM 3

HPV Vaccination Campaign Year/Month:			
State:	District/Corporation:	Block/Urban Area:	Planning unit (PHC/U-PHC/CHC):
Sub-centre/Urban ANM area _____	Village/ Mohalla: _____	Name & Mobile no of ANM: _____	
Name of ASHA/AWW/LW and Contact No.:			
Date:.....Last House visited today: House no.....Name..... & Address.....		Date:.....Last House visited today: House no.....Name..... & Address.....	

PART-A: To be filled by the ASHA/AWW/MAS/JAS/LW before Activities												PART-B: To be filled by ANM
								Past history of vaccination			U-WIN Registration & Information Card		
Sr. No	House hold No. (as per Chullah)	Name of girl aged 14 years* (should be a resident of this area)	Father's/ Mother's/ Guardian's Name	Date of Birth of Girl aged 14 years	Photo ID Type**	Photo ID Number	Mobile No. (for U-WIN registration)	Any history of HPV vaccination (Y/N)	If yes, date of last vaccination	If yes, vaccine brand name 1. Gardasil 2. Gardasil-9 3. Cervarix 4. Cervavac (Write code)	Facilitated pre-registration for vaccination or past vaccination updation on U-WIN? (Y/N)	Provided Information Card (Y/N)	Girls aged 14 years due for Vaccination (Y/N)
	a	b	c	d	e	f	g	h	i	j	k	l	m
1.													
2.													
3.													

Total number of Girls aged 14 years due for Vaccination	
Nearest 24x7 Health Facility (PHC & above) for this area	1.

*Girls aged 14 years [those who have celebrated their 14th birthday but have not yet celebrated their 15th birthday]
** Birth Certificate, Aadhar Card, Ration Card, School ID, APAAR ID, Transfer/School leaving/Matriculation Certificate, Passport, Bank passbook, Immunization card, A declaration given by the Head of the Orphanage/Child Care Home, Age Undertaking Form signed by parents/guardian

ASHA/AWW/MAS/JAS/LW Signature with date_____	Signature of ANM with date_____

Health Facility (HF)-PHC/U-PHC/CHC-Planning Form

FORM 4

HF Planning Form to be filled by MO

HPV Vaccination Campaign Year/Month:				
State:	District/Corporation:	Block/Urban Area:	Planning unit (PHC/U-PHC/CHC):	HF is functional 24x7: Y/N
Name & Mobile no. of MO:	HF is a Cold Chain Point (CCP) as per eVIN: Y/N	HF has medical officer(s) available for AEFI management: Y/N	HF has internet, Desktop/Laptop & Printer: Y/N	HF has functional Ambulance: Y/N

PART-A: Sub-centre/Urban ANM area-wise information. To be filled from FORM 2											PART-B: School Information: To be filled from FORM 1			
S. No.	Name of SC/Urban ANM Area	Total Population	Estimated number of girls aged 14 years (~1% of population)	Number of girls* aged 14 years Based on actual Head count Survey by ASHA/ AWW/LW/Member MAS/Member JAS (Form 2, Column J)	Name of ANM & Mobile no.	Total number of ASHAs under the SC/ Urban ANM area	Total number of members of AWW under the SC/Urban ANM area	Total number of members of MAS/ JAS under the SC/ Urban ANM area	Total number of Link worker (mobilizers) under the SC/Urban ANM area	Nearest 24x7 Health Facility for this area	School name	Principal/School Nodal name	Mobile no.	PTM date
	a	b	c	d	e	f	g	h	i	j	k	l	m	n
Total														

*Girls aged 14 years [those who have celebrated their 14th birthday but have not yet celebrated their 15th birthday]

Nodal MO Signature with date_____	MOIC Signature with date_____

Health Facility (HF) Session Site-Checklist-Planning Form (HPV Vaccination Campaign for 3 months) FORM 5

To be filled by MOIC of the Health Facility

HPV Vaccination Campaign Year/Month:			
State:	District/Corporation:	Block/Urban Area:	
Health Facility (PHC/U-PHC/CHC/SDH/RH/DH/GMCH) *:		MO Name:	Mobile no:

S. No.		Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10	Week 11	Week 12
1	Target population (girls aged 14 years) based on FORM 4 (Column d total)												
2	Number of HPV vaccine doses required as per the target?												
3	Number of AD syringes required as per the target?												
4	Number of sessions planned in 3 months (Week 1 to Week 12)												
5	Name & Mobile no. of Vaccinator deputed for HPV vaccination (Week 1 to Week 12)												
6	Name & Mobile no. of Verifier (Facility health staff; responsible for checking registration status & verification in the waiting room on the vaccination day) (Week 1 to Week 12)												
7	Name & Mobile no. of Mobilizer (ASHA / ASHA coordinator/ AWW/MAS/JAS/Link Worker to support in session site management) (Week 1 to Week 12)												
8	Name & mobile no. of Volunteer (FM/MAS/JAS/health staff for session site crowd management) (Week 1 to Week 12)												
9	All the 4 members of the Vaccination team received dedicated training at block on HPV vaccination	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
10	Number of Hub Cutter required? (1 per vaccinator)												
11	Number of indelible marker pen required for finger marking? (1 per session)												

S. No.		Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10	Week 11	Week 12
12	Number of Red plastic bags required? (1 per session)												
13	Number of black plastic bags required? (1 per session)												
14	Number of yellow plastic bags required? (1 per session)												
15	Number of Anaphylaxis kits required? (1 per vaccinator)												
16	Contents of Anaphylaxis kit are verified & Inj. Adrenaline is within expiry? (verify for each deputed vaccinator)	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
17	Vaccinators deputed for HPV vaccination is trained on administration of Inj. Adrenaline & AEFI reporting?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
18	Number of AEFI Kits required ?(1 kit per Health Facility)												
19	Contents of AEFI kit are verified & Inj. Adrenaline is within expiry ?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
20	Medical officer(s) are available at the health facility to manage AEFIs	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
21	Medical officer(s) are trained on AEFI management and reporting	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
22	Medical Officer received dedicated training on HPV vaccination and Crisis Communication	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
23	Number of Squeeze balls required? (5-10 per Health Facility)												
24	Number of posters required? (4 per Health Facility)												
25	Number of banners required? (2 per Health Facility)												
26	Functional desktops/laptops for U-WIN registration?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
27	Functional Internet/Wi-Fi for U-WIN?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
28	Functional Printer for U-WIN Certificate, consent form, age undertaking form?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

S. No.		Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9	Week 10	Week 11	Week 12
29	Dedicated Waiting Room or Area?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
30	Dedicated Vaccination Room or Area with privacy?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
31	Dedicated Observation Room or Area?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
32	Provision of running water & soap for hand washing before vaccination?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
33	Availability of adequate cotton swabs for cleaning skin before vaccination?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
34	Functional ILR with working eVIN temperature logger?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
35	Functional DF?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
36	Sufficient Ice packs	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
37	Availability of adequate stock of Paracetamol tablet?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
38	Functional Ambulance?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
39	Name of dedicated Cold Chain Handlers (CCH) with mobile number: CCH1 & CCH2	Name_____ Mobile No_____ Name _____ Mobile No_____											
40	Name & Mobile no. of linked Cold Chain Technician for this HF	Name_____ Mobile No_____											
41	Name & Mobile no. of linked VCCM for this HF	Name_____ Mobile No_____											
42	Name of 24x7 AEFI management centre/first referral hospital	Address: _____Name & Mobile no. of Focal MO for AEFI Management_____											
*Write NA in front of Health Facility where it is not applicable													
MOIC Signature with date_____													

District Planning Form

FORM 6

District Planning Form to be filled by DIO

HPV Vaccination Campaign Year/Month:																	
State:									District/Corporation:								
Name of DIO:									Mobile no.:								
S. No.	List of all HF/ PHC/U-PHC/ CHC/SDH/RH/DH/Medical College**	Name & Phone number of Nodal MO	HF is functional 24x7: Y/N	HF has functional Ambulance: Y/N	Total Population	Estimated number of girls aged 14 years (~1% of population)	Number of girls* aged 14 years Based on actual Head count Survey by ASHA/ AWW/LW/MAS/JAS (Form 4, Column D total)	Total number of ANMs	Total number of ASHAs	Total Number of AWWs	Total number of members of MAS/JAS	Total number of Link Workers	Health Facility has a functional Cold Chain point as per eVIN (Y/N)	Health Facility has Medical Officer(s) available for AEFI Management (Y/N)	Health Facility has internet connection, desktop/laptop & printer for U-WIN (Y/N)	Health Facility identified as HPV vaccination Centre (Y/N)	If no in Column P, link the target population for this health facility to nearest HPV vaccination centre
	a	b	c	d	e	f	g	h	i	j	k	l	m	n	o	p	q
1.																	
2.																	
3.																	
4.																	
5.																	
6.																	
7.																	
8.																	
9.																	
10.																	
Total																	

*Girls aged 14 years [those who have celebrated their 14th birthday but have not yet celebrated their 15th birthday]

**Write NA in front of Health Facility where it is not applicable

DIO Signature with date_____	CMO/CS Signature with date_____

State Planning Form

FORM 7

State Planning Form to be filled by SIO to be shared with MoHFW

HPV Vaccination Campaign Year/Month:	
State/UT:	
Name & Mobile no. of SIO:	Helpline no. for AEFI

S. No.	District	Total population of the District	Estimated number of girls aged 14 years (~1% of population)	Number of girls* aged 14 years Based on actual Head count Survey by ASHA/AWW/LW/MAS/ JAS (Form 6, Column G total)	Total no. of Health Facilities (PHC/U-PHC/ CHC/SDH/RH/DH/ Medical College) in the District**	Out of total no. of HFs, how many are 24x7?	Out of total no. of HFs, how many have functional Ambulance?	Out of total no. of HFs, how many have a functional Cold Chain point, as per eVIN?	Out of total no. of HFs, how many have a medical officer available for AEFI management?	Out of total no. of HFs, how many have internet connection, desktop & printer for U-WIN?	Out of total no. of HFs, how many Health Facilities are identified as HPV vaccination Centre?
	a	b	c	d	e	f	g	h	i	j	k
1.											
2.											
3.											
4.											
5.											
6.											
7.											
8.											
9.											
10.											
Total											

*Girls aged 14 years [those who have celebrated their 14th birthday but have not yet celebrated their 15th birthday]

**Only consider PHC and above PHC as Health Facilities (HFs)

SIO Signature with date_____	MD (NHM) Signature with date_____

Health Facility (HF)_Session Site Monitoring Form

FORM 8

To be filled by MOIC of the Health Facility

HPV Vaccination Campaign Year/Month:			
State:	District/Corporation:	Block/Urban Area:	Setting: Urban / Rural:
Monitor Name & Mobile No:		Organization: Govt. /Partners (Please specify)	Designation:

			1	2	3	4
General Information	1	Name of the Health Facility: session site visited				
	2	Date & Time of Visit				
	3	Is session being conducted today?	Y / N	Y / N	Y / N	Y / N
	4	Does the Health Facility has a functional CCP as per eVIN?	Y / N	Y / N	Y / N	Y / N
	5	Does the Health facility has a medical officer available 24x7 for AEFI management?	Y / N	Y / N	Y / N	Y / N
	6	Does the Health facility has functional internet connection, desktop/laptop and a printer for U-WIN?	Y / N	Y / N	Y / N	Y / N
	7	Is this session planned on U-WIN?	Y / N	Y / N	Y / N	Y / N
Area, Manpower, U-WIN	8	Are adequate vaccinators assigned to this session as per no. of sessions planned in Form 5?	Y / N	Y / N	Y / N	Y / N
	9	Are vaccinators available as per micro plan in Form 5?	Y / N	Y / N	Y / N	Y / N
	10	Are all mobilizers (ASHA/AWW/Linkworker) available as per the micro plan in Form 5?	Y / N	Y / N	Y / N	Y / N
	11	Are all verifier available as per the micro plan in Form 5?	Y / N	Y / N	Y / N	Y / N
	12	Are all volunteer available as per the micro plan in Form 5?	Y / N	Y / N	Y / N	Y / N
	13	Are all the 4 members of the vaccination team trained for HPV vaccination at block level?	Y / N	Y / N	Y / N	Y / N
	14	Is there a separate room or area for waiting?	Y / N	Y / N	Y / N	Y / N
	15	Is there a separate room or area for HPV vaccination with privacy?	Y / N	Y / N	Y / N	Y / N
	16	Is there a separate room or area for observation?	Y / N	Y / N	Y / N	Y / N
	17	Does the session site use a Desktop/laptop for walk-in beneficiary registration & recording HPV vaccination on U-WIN?	Y / N	Y / N	Y / N	Y / N
	18	Are U-WIN vaccination certificates being printed and handed over to each beneficiary?	Y / N	Y / N	Y / N	Y / N
	19	Are adequate printed consent forms available at session site?	Y / N	Y / N	Y / N	Y / N
	20	Are consent forms being offered to parents/guardians for signature before vaccination (in case of no internet of mobile network access)?	Y / N	Y / N	Y / N	Y / N

			1	2	3	4
Session Site: Vaccine and other logistics	21	Is running water and soap available for hand washing before vaccination?	Y / N	Y / N	Y / N	Y / N
	22	Are adequate HPV vaccine doses available at the session site?	Y / N	Y / N	Y / N	Y / N
	23	Are adequate 0.5 ml AD syringes available at session site?	Y / N	Y / N	Y / N	Y / N
	24	Are adequate cotton swabs available at the session site?	Y / N	Y / N	Y / N	Y / N
	25	Are adequate Paracetamol tablets available at the session site?	Y / N	Y / N	Y / N	Y / N
	26	Are adequate squeeze balls available at the session site?	Y / N	Y / N	Y / N	Y / N
	27	Are HPV vaccine vials stored in vaccine carrier (with 4 conditioned ice packs)?	Y / N	Y / N	Y / N	Y / N
	28	Is there any vial with VVM in unusable stage inside the vaccine carrier?	Y / N	Y / N	Y / N	Y / N
	29	Is there any frozen vial inside the vaccine carrier?	Y / N	Y / N	Y / N	Y / N
	30	Is functional hub cutter available at session site?	Y / N	Y / N	Y / N	Y / N
	31	Is indelible marker pen for finger marking available at the session site?	Y / N	Y / N	Y / N	Y / N
	32	Number of vials used, and girls vaccinated are matching reasonably?	Y / N	Y / N	Y / N	Y / N
Vaccinators injection practices	33	Is the vaccinator recapping the needle?	Y / N	Y / N	Y / N	Y / N
	34	Is ANM touching the needle of the syringes anytime during drawing and administering vaccine to the beneficiaries? (Not following aseptic technique)	Y / N	Y / N	Y / N	Y / N
	35	Is vaccinator administering the vaccine through intramuscular route correctly?	Y / N	Y / N	Y / N	Y / N
	36	Is vaccinator administering the vaccine to the left upper arm?	Y / N	Y / N	Y / N	Y / N
	37	Are used syringes being cut using hub cutter immediately after use?	Y / N	Y / N	Y / N	Y / N
	38	Is the team marking left index finger after vaccinating the beneficiaries?	Y / N	Y / N	Y / N	Y / N
	39	Is the vaccinator giving 5 key messages to eligible girl/caregiver after vaccination?	Y / N	Y / N	Y / N	Y / N
	40	Are beneficiaries waiting for 30 minutes after HPV vaccination?	Y / N	Y / N	Y / N	Y / N
Biomedical Waste Management	41	Is vaccinator disposing cut hubs of syringes into hub cutter/white puncture proof container?	Y / N	Y / N	Y / N	Y / N
	42	Is vaccinator disposing expired or discarded vaccine vials, broken vials, empty unbroken vials into blue container?	Y / N	Y / N	Y / N	Y / N
	43	Is vaccinator disposing Plastic part of syringe or gloves into red bag?	Y / N	Y / N	Y / N	Y / N
	44	Is vaccinator disposing wrapper/ needle cap into black bag?	Y / N	Y / N	Y / N	Y / N
	45	Is vaccinator disposing cotton, expired tablet into yellow bag?	Y / N	Y / N	Y / N	Y / N

			1	2	3	4
AEFI Management at Session Site	46	Does the vaccinator have Anaphylaxis kit? (If No - Immediately ALERT Senior Official)	Y / N	Y / N	Y / N	Y / N
	47	If yes, does the kit have un-expired Inj. adrenaline, 24–25-gauge needles and insulin/ tuberculin syringes? If No - Immediately ALERT Senior Official) "	Y / N	Y / N	Y / N	Y / N
	48	Does the vaccinator know what to do in case of a serious and severe AEFI (primary care, referral and reporting)?	Y / N	Y / N	Y / N	Y / N
	49	Does the vaccinator know the correct dosage of Adrenaline to be administered in case of anaphylaxis for girls aged 14 years (0.3 ml in tuberculin or 12 units in insulin syringe)?	Y / N	Y / N	Y / N	Y / N
AEFI Management Centre	50	Is Medical Officer (MO) designated for AEFI Management Centre trained on AEFI Management and Reporting?	Y / N	Y / N	Y / N	Y / N
	51	Does the AEFI management centre have AEFI kit? (If No - Immediately ALERT Senior Official)	Y / N	Y / N	Y / N	Y / N
	52	If yes, does the AEFI kit have all the contents as per the guidelines including un-expired Inj. adrenaline, 24–25-gauge needles and insulin/ tuberculin syringes? If No - Immediately ALERT Senior Official)	Y / N	Y / N	Y / N	Y / N
	53	Does the MO know what to do in case of a serious and severe AEFI (primary care, referral and reporting)?	Y / N	Y / N	Y / N	Y / N
	54	Does the MO know the correct dosage of Adrenaline to be administered in case of anaphylaxis for girls aged 14 years (0.3 ml in tuberculin or 12 units in insulin syringe)?	Y / N	Y / N	Y / N	Y / N
Cold Chain Point	55	Are adequate HPV vaccine doses available in the ILR at CCP?	Y / N	Y / N	Y / N	Y / N
	56	Are adequate 0.5 ml AD syringes available at CCP?	Y / N	Y / N	Y / N	Y / N
	57	Are HPV vaccines stored at the right place in ILR?	Y / N	Y / N	Y / N	Y / N
	58	Does the ILR has a functional eVIN temperature logger?	Y / N	Y / N	Y / N	Y / N
	59	Does the temperature logbook is filled twice a day by CCH?	Y / N	Y / N	Y / N	Y / N
	60	Does the CCP has adequate number of ice packs?	Y / N	Y / N	Y / N	Y / N
	61	Does the CCP has functional cold boxes for emergency use?	Y / N	Y / N	Y / N	Y / N
	62	Does the vaccine stocks in eVIN, physical register and ILR are matching?	Y / N	Y / N	Y / N	Y / N
Mobilization & Supervision	63	Has the Health Facility displayed 2 Banners of HPV vaccination?	Y / N	Y / N	Y / N	Y / N
	64	Has the Health Facility displayed 4 posters of HPV vaccination?	Y / N	Y / N	Y / N	Y / N

			1	2	3	4
Interaction with Caregiver (ask at least 2 caregivers). If none, skip the question.	65.a	Caregiver 1:How did you come to know about this Campaign? (Max 4 allowed) 1=From Health worker/ASHA/AWW before the Campaign; 2=Poster/Banner/information card/Miking, 3=Newspaper/T.V./Radio 4= Social media; 5=School / Teachers Through PTM, Student's diary or mail/web site/WhatsApp; 6=Through sessions 7=Family/Friends/ Neighbours; 8= Community Influencers; 9= Other, please specify	1. Y/N 2. Y/N 3. Y/N 4. Y/N 5. Y/N 6. Y/N 7. Y/N 8. Y/N 9. Pls specify …………	1. Y/N 2. Y/N 3. Y/N 4. Y/N 5. Y/N 6. Y/N 7. Y/N 8. Y/N 9. Pls specify …………	1. Y/N 2. Y/N 3. Y/N 4. Y/N 5. Y/N 6. Y/N 7. Y/N 8. Y/N 9. Pls specify …………	1. Y/N 2. Y/N 3. Y/N 4. Y/N 5. Y/N 6. Y/N 7. Y/N 8. Y/N 9. Pls specify …………
	65.b	Caregiver 2:How did you come to know about this Campaign? (Max 4 allowed) 1=From Health worker/ASHA/AWW before Campaign; 2=Poster/Banner/information card/Miking, 3=News paper/T.V./Radio 4= Social media; 5=School / Teachers Through PTM, Student's diary or mail/web site/WhatsApp; 6=Through sessions 7=Family/Friends/ Neighbours; 8= Community Influencers; 9= Other, please specify	1. Y/N 2. Y/N 3. Y/N 4. Y/N 5. Y/N 6. Y/N 7. Y/N 8. Y/N 9. Pls specify …………	1. Y/N 2. Y/N 3. Y/N 4. Y/N 5. Y/N 6. Y/N 7. Y/N 8. Y/N 9. Pls specify …………	1. Y/N 2. Y/N 3. Y/N 4. Y/N 5. Y/N 6. Y/N 7. Y/N 8. Y/N 9. Pls specify …………	1. Y/N 2. Y/N 3. Y/N 4. Y/N 5. Y/N 6. Y/N 7. Y/N 8. Y/N 9. Pls specify …………

Reporting Form (Daily & Cumulative)*

FORM 9

HPV Vaccination Campaign Year/Month:												
State:			Date:									
			U-WIN			eVIN				SAFE-VAC		
S. No.	**Name of Health Facility**	**District**	**No. of sessions planned**	**No. of sessions held**	**No. of girls vaccinated**	**No. of vials consumed**	**Wastage (%)**	**No. of AD syringes - 0.5 ml consumed**	**Wastage (%)**	**No. of Serious AEFI**	**No. of Severe AEFI**	**No. of Minor AEFI**
	a	**b**	**c**	**d**	**e**	**f**	**g**	**h**	**i**	**j**	**k**	**l**
1.												
2.												
3.												
4.												
5.												
6.												
7.												
8.												
9.												
10.												
Total for today												
Cumulative total till previous day												
Cumulative total till today												
* To be developed using U-WIN, eVIN, SAFE-VAC												

Rapid Convenience Monitoring (RCM) in the Community

FORM 10

HPV Vaccination Campaign Year/Month:			
State:	District/Corporation:	Block/Urban Area:	Village/ Mohalla:
HPV Vaccination Campaign Start Date:	Monitoring Date:	Monitor Name & Mobile No:	Designation:
Type of monitor: Govt. /Partners (Please specify)			

1. Conduct RCM in the community after completion of 1 month of HPV vaccination Campaign. Use one format for only one area. Try to identify missed areas such as farthest from the central point of community settlement/area, segregated groups through house to house visits by assessing vaccination status of eligible girls of 14 years.
2. Methodology: Go to the centre of the area and pick up a direction by tossing a coin. Choose the first house closest to you in the identified direction. Talk to the parents and identify the eligible girl available in the household, assess HPV vaccination status through left index finger marking, vaccination card, U-WIN and/or recall. Visit 10 households having eligible girls aged 14 years and assess the HPV vaccination status.
3. If upto 3 eligible girls are found unvaccinated, counsel parents for HPV vaccination, inform them to get registered on U-WIN for vaccination at the nearest Health facility for HPV vaccination.
4. If 4 or more eligible girls are found unvaccinated, immediately report to the Supervisor/ Medical Officer for conducting sensitization and community engagement interventions and then social mobilization of the beneficiaries to the nearest health facility where HPV vaccine is being administered.
5. If any AEFI is noticed, advise parents to visit nearest health facility/AEFI management centre. Also report AEFI to concerned authority and note the details of AEFI on the back of this FORM.

Eligible girls Assessment Table:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**
Name and address of the eligible girl											
A).Eligible girl received vaccine during HPV vaccination Campaign? (Yes/No) If not then record the reasons for non- vaccination in the table at the bottom											
Reason as mentioned by the caregiver/parents for "Why was their girl in eligible age group not vaccinated with HPV vaccine during the Campaign?" **Put a tick against most important reason(s). Multiple options (Max-4) allowed**											
1. Not aware of HPV vaccination Campaign / session											
2. Parents didn't give importance / Not aware of need for HPV Vaccination/ Others											
3. Family refused HPV vaccination											

Eligible girls Assessment Table:	1	2	3	4	5	6	7	8	9	10	Total
4. Scared of Injection											
5. Eligible girl was sick											
6. Inconvenient time / location / distance / waiting time											
7. Vaccine/vaccinator not available											
8. Fear of AEFI based on experience (fever, pain, swelling, hospitalization, death, disability)											
9. Negative media reports / social media / rumour											
10. Eligible girl had gone out of area											
11. Girl became eligible i.e., 14 years on the day of monitoring											
12. Others											
B). How did the family come to know about the Campaign? (Mention code from below) Multiple options - (max4) allowed											
1=From Health worker/ASHA/AWW before activity; 2=Poster/Banner/Information card/Miking, 3=Newspaper/T.V./Radio 4= Social media; 5=School / Teachers Through PTM, Student's diary or mail/web site//WhatsApp; 6=Through sessions 7=Family/Friends/Neighbours 8=Community Influencers; 9= Other, please specify											
C). Did the beneficiary develop any discomfort/ AEFI after vaccination? (Write -Yes / No)											
If yes, record the event from codes given below* (MONITOR should NOT prompt) "Multiple options - (max4) allowed " Note the details of AEFI on the backside of the form.											
* 1 = Pain; 2= Swelling; 3= Excessive crying; 4= Fainting; 5=Vomiting 6= Pain in abdomen; 7= injection site abscess; 8=any condition requiring hospital admission; 9= Others											
D) Are there any posters/banners about HPV vaccination displayed in the community?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

A. State level communication planning template

FORM 11

State/UT Level Communication Plan				
Name of the State/UT:		**State Immunization Officer:**		**State IEC/Media Officer:**
Advocacy	STFI meeting	Date:	Date:	Date:
	Stakeholder Orientation/Meeting (Including of FOGSI/ IMA/IAP members, Education Department and Key Religious leaders/influencers)	Date: Responsible Person:	Date: Responsible Person:	Date: Responsible Person:
	Formation of Core Group for media management including crisis communication (Include experts who can handle media and social media)	Date: Responsible Person: Members of Core Group: Frequency of Meeting:		
	Media Sensitization workshop	Date: Responsible Person: Name of identified Media spokesperson:		
	Interdepartmental Convergence Meeting	Date:	Date:	Date:
	Identified local celebrity/brand ambassador for the Campaign	Local celebrity: Activities: Date: Responsible Person:		
	Any Other Activity			
Capacity Building	State ToT including communication training for district officials	Date: Responsible Person:		
	Media Spokes Person Training	Date: Responsible Person:		

Media Campaign and Social Media	Constitution of task force for communication activities including social media	Members: Frequency of Meeting:
	Media Campaign Roll Out	
	Dedicated Social Media Page (Facebook/X etc)	Yes/No If Yes, name & number of accounts & number of members: Frequency of posting: Monthly/Weekly/Daily
	Social Media Campaign Roll Out	Date: Responsible Person:
	Launch event	Date: Responsible Person:
IEC Materials	IEC Material translation in local language and printing	Date: Responsible Person:
	Distribution of IEC materials to districts	Date: Responsible Person:

District-Level Activities Compilation (Please indicate "Yes" or "No" for each activity planned by the district.)		District 1	District 2	District 3	District 4	District 5	District 6	District 7	District 8	District 9	District 10	Total (Count Only Yes)
Advocacy	DTFI meeting											
	Stakeholder Orientation/Meeting (Including of FOGSI/ IMA/IAP members, Education Department and Key Religious leaders/influencers)											
	Formation of Core Group for media management including crisis communication (Include experts who can handle media and social media)											
	Media Sensitization workshop											
	Identified Media Spokesperson											

	Interdepartmental Convergence Meeting											
	Identified local celebrity/brand ambassador for the campaign											
	Any Other											
Capacity Building (The number of trainings planned at each level should be filled)	Training of block level health functionaries i.e. BCMOs, Medical Officers, BPM, Block IEC Coordinator etc.											
	Orientation of Education department											
Media Campaign and Social Media	Constitution of task force for communication activities including social media											
	Media Campaign Roll Out											
	Social Media creatives (numbers)											
	Dedicated Social Media Page (Facebook/X etc)											
	Launch events											
IEC Material	IEC Material Distribution to Blocks											

Note:
I- This is the responsibility of State IEC/ communication nodal/ SEPIO to collect information from district and compile the state sheet.
II - He/ she needs to submit this template to Director health services, Mission Director (NHM) during the planning phase.
III-This template needs to be discussed in state ToT and will be basic tool for communication planning in state and district.

B. District level communication planning template

FORM 12

District Level Communication Plan				
Name of the State/UT:		**Name of District:**		**District IEC/ Media officer:**
Advocacy	DTFI meeting	Date: Responsible Person:	Date: Responsible Person:	Date: Responsible Person:
	Stakeholder Orientation/Meeting (Including of FOGSI/ IMA/IAP members, Education Department and Key Religious leaders/influencers	Date: Responsible Person:		
	Formation of Core Group for media management including crisis communication (Include experts who can handle media and social media)	Date: Responsible Person: Members of Core Group: Frequency of Meeting:		
	Media Sensitization workshop	Date: Responsible Person: Name of identified Media spokesperson:		
	Interdepartmental Convergence Meeting	Date: Responsible Person:	Date: Responsible Person:	
	Identified local celebrity/brand ambassador for the initiative	Local celebrity: Activities: Date: Responsible Person:		
	Any Other Activity	Date: Responsible Person:		
Capacity Building (For Vaccination Campaign communication)	Training of Block Officials (i.e. BCMOs, BPM, MOs, Block IEC coordinator)	Date: Responsible Person:		
	Orientation of Education department	Date: Responsible Person:		

Media Campaign and social media	Constitution of task force for communication activities including social media	Members: _____ Frequency of Meeting: _____
	Media Campaign Roll Out	Date: _____ Responsible Person: _____
	Dedicated social media Page (Facebook/X etc)	Yes/No If Yes, name & number of accounts & number of members: Frequency of posting: Monthly/Weekly/Daily
	Social Media Campaign Roll Out	Date: _____ Responsible Person: _____
	Launch event	Date: _____ Responsible Person: _____
IEC Materials	Printing/Distribution of IEC materials to blocks	Date: _____ Responsible Person: _____

Block-Level/Panning Unit Activities Compilation (Please indicate "Yes" or "No" for each activity planned by the block.)		Block 1	Block 2	Block 3	Block 4	Block 5	Block 6	Block 7	Block 8	Total (Count Only Yes)
Advocacy	BTFI meeting									
	Meeting with School principals/management Committee/Nodal Officer									
	Joint Education and Health core group meeting									
	Microplanning meeting (For communication)									
	Meeting with key religious leaders/ influencers / PRI at block level									
	Any Other Activity									

Capacity Building (For Vaccination Campaign Communication)	Orientation of ANMs									
	Orientation of ASHAs/AWWs/ MAS/JAS/SHGs/ CSOs/RBSK									
	Orientation of Teachers									
Social media	WhatsApp messaging groups created									
	Other									
IEC Material	IEC Material Distribution to Sub-centres and Schools									

NOTE:-I This template will be compiled by the District IEC/BCC Officer or Consultant. If no dedicated IEC personnel are available, the District Immunization Officer will then be responsible for compiling the information in coordination with the Block IEC/BCC Officer

II- One copy needs to be with the concerned person who is looking after IEC/Communication and one copy needs to be submitted to the Chief District Medical Officer (CDMO)/ Chief Medical Officer (CMO) during the planning phase.

C. Block/Planning Unit level communication planning template

FORM 13

Block/Planning Unit Level Communication Plan				
Name of the District:		**Name of PHC/Planning unit:**		**Name of MO I/C:**
Advocacy	BTFI meeting	Date: Responsible Person:	Date: Responsible Person:	Date: Responsible Person:
	Meeting with School principals/ management Committee/Nodal Officer	Date: Responsible Person:	Date: Responsible Person:	Date: Responsible Person:
	Joint Education and Health core group meeting	Date: Responsible Person:	Date: Responsible Person:	Date: Responsible Person:
	Microplanning meeting (For communication)	Date: Responsible Person:		
	Meeting with key religious leaders/ influencers/PRI at block level	Date: Responsible Person:		
	Any Other Activity	Date: Responsible Person:		
Capacity Building (For Vaccination Campaign communication)	Orientation of ANMs	Date: Responsible Person:		
	Orientation of ASHAs/AWWs/ MAS/ JAS/SHGs/CSOs/RBSK	Date: Responsible Person:		
	Orientation of Teachers	Date: Responsible Person:		
Social Media	WhatsApp messaging groups created	Members: Frequency: Members: Frequency:		
	Other	Date: Responsible Person:		
IEC Material	IEC materials distribution to Sub-Centre and Schools	Date: Responsible Person:		

Sub Centre Level Activities Compilation (Please indicate "Yes" or "No" for each activity planned by the sub centre.)		PHC/ Planning Unit	SC-1	SC-2	SC-3	SC-4	SC-5	SC-6	SC-7	SC-8	Total (Count Only Yes)
		.....	.....	.....	.....	.....	.....	.....	.....	.....	
Social Mobilization	Mother's meeting										
	Community/ Influencer's meeting										
	VHSNC Meeting										
	Govt. school teacher's coordination meeting										
	Private school teachers coordination meeting										
	Parent Teachers Meeting										
	Rallies	Date:									
	Mosque/Temple/Church/ Gurudwara announcements										
	IPC sessions										
	Miking Other (Specify)	Date: Areas:									
Mid Media Activities	Posters and Banners in community										
	Posters and Banners in Schools										
	Info booklet for community influencers										
	Info booklet for School Teachers										
	Info booklet for ANMs	Number									
	Info booklet for ASHAs/AWWs	Number									
	Info booklet for local medical doctors	Number									
	Any other activity										

NOTE:-I This template to be filled by IEC/BCC Officer/consultant (person responsible for IEC) in their absence MO I/C needs to fill this format in discussion with ANM/ANM supervisors/ ASHA Coordinator
II- This needs to be submitted to the person in-charge for IEC at the district during the planning phase g and Keep one copy at PHC level for record keeping and monitoring.

D. Sub Centre level template

FORM 14

Sub-Centre Level Communication Plan			
Name of the district	Name of the facility- CHC/PHC/Planning Unit	Name of Sub-Centre	Name of ANM:	Name of ASHAs and AWW:

	Social mobilization activities											Mid-media activities				
S.No.	Name of Village/Urban Area	Mother's meeting	Community/ influencer's meeting	VHSNC meeting for vaccination Campaign	Govt. school teachers' orientation/ coordination meeting	Private School teachers' orientation/coordination meeting	Parent Teacher's Meeting	Rallies	Mosque (e.g., Friday prayers topic)/Temple/ church/ Gurudwara announcement	IPC sessions	Others (specify)	Posters and Banner in community	Posters and Banner in Schools	Info booklet for community	Info booklet for school	Any other activity
1.		Date & Time	Date & Time	Date & Time	Date & Time	Date & Time	Date & Time	Date & Time	Date & Time	Date & Time	Date & Time					
		.....	.....	.....	.....	.....	.....	.....	.....	.....	.....					
		Responsible person	Responsible person	Responsible person	Responsible person	Responsible person	Responsible person	Responsible person	Responsible person	Responsible person	Responsible person	Numbers	Numbers	Numbers	Numbers	
		.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	
2.		Date & Time	Date & Time	Date & Time	Date & Time	Date & Time	Date & Time	Date & Time	Date & Time	Date & Time	Date & Time					
		.....	.....	.....	.....	.....	.....	.....	.....	.....	.....					
		Responsible person	Responsible person	Responsible person	Responsible person	Responsible person	Responsible person	Responsible person	Responsible person	Responsible person	Responsible person	Numbers	Numbers	Numbers	Numbers	Numbers
		.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....

NOTE:-I This template to be filled by ANM in coordination with ASHA, AWW, Teachers and PRI members.

II- This needs to be submitted to Medical Officer at CHC/PHC/Planning unit during the planning phase and keep one copy at Sub Centre level for record keeping and monitoring.

Pre-Activity preparedness assessment checklists

Annexure-5

Checklist A: Readiness Assessment for HPV Vaccination Campaign- State Level

State/UT:	Total Number of districts:	Date of assessment:
Name of SIO:	Contact Details:	Helpline no. for AEFI:

Demography	**Number**
Total population of the State/UT	
Total Target cohort of 14-year-old girls (those who have celebrated their 14th birthday but have not celebrated their 15th birthday) in the State/UT (Approx. 1% of total population)	
Human Resource and Infrastructure	**Number**
Number of Ayushman Arogya Mandir-PHCs with cold chain point, dedicated MO, computer with printer, and internet connectivity	
Number of CHCs with cold chain point, dedicated MO, computer with printer, and internet connectivity	
Number of SDHs with cold chain point, dedicated MO, computer with printer, and internet connectivity	
Number of DH/Civil hospitals with cold chain point, dedicated MO, computer with printer, and internet connectivity	
Number of Medical Colleges with cold chain point, dedicated MO, computer with printer, and internet connectivity	
Number of ANMs/ vaccinators in position	
Number of ASHAs in position	
Number of AWWs in position	
Number of other mobilizers in position	
Number of Data Entry Operators in position	
Number of Cold Chain Handlers in position	
Number of 24x7 health facilities	
Number of health facilities with dedicated ambulances	

Activities			Achieved	Actions suggested during the assessment
Planning and Coordination	1	State Steering Committee meeting (SSC) held/ planned under the chairpersonship of the Chief Secretary at least once during the last 30 days?	Held/planned / Not held	
	2	State Task Force meeting on Immunization (STFI) conducted/planned during the last 30 days?	Held/planned / Not held	
	3	Has the State assigned observers/supervisors for the HPV vaccine rollout?	Y / N	
	4	Has the state ensured availability of training materials?	Y / N	
	5	Have all health facilities (identified as HPV vaccination centre) mapped schools (with eligible girls) in their catchment area?	Y / N	
	6	Have all districts (identified as HPV vaccination centre) developed plans for sensitization at school through Parent Teacher Meeting (PTM)?	Y / N	
	7	Have the information cards (for distribution during PTM) been distributed to all the districts?	Y / N	
	8	Has the state set up a state control room for the HPV vaccination Campaign?	Y / N	
Capacity building	9	Has the state completed the district ToTs?	Y / N	
	10	Has the orientation of religious leaders or key influencers at the state level been completed?	Y / N	
	11	Has the orientation for Professional bodies (IMA, IAP & FOGSI, IAPSM, Medical College) been completed?	Y / N	
Logistics	12	Does the state have sufficient cold chain space to store HPV vaccine?	Y / N	
	13	Has the state received HPV vaccines?	Yet to receive / received partial doses / received all doses	
	14	Has the state developed the plan for distribution of vaccine to the districts?	Y / N	
	15	Does the state have adequate quantities of 0.5 ml AD syringes for HPV Vaccination Campaign - (as per actual requirement)?	Y / N	
	16	Did the state plan to purchase Indelible marker pens for finger marking?	Y / N	
	17	Is the distribution plan made for sending indelible marker pens to the districts?	Y / N	

Activities			Achieved	Actions suggested during the assessment
Vaccine Safety	18	Did the state AEFI committee meet at least once prior to HPV vaccination?	Y / N	
	18a.	If yes, date of last State AEFI Committee meeting?		
	19	Did the state AEFI committee discuss the HPV vaccination in the last meeting?	Y / N	
	20	Has the training of the AEFI committee for the HPV Vaccination Campaign been completed?	Y / N	
	21	Did the state AEFI committee review the status of inclusion of medical colleges in the AEFI reporting network?	Y / N	
	22	Is the mapping of all 24x7 health facilities done?	Y / N	
	23	Has every HPV vaccination centre tagged to a 24x7 health facility?	Y / N	
Communication	24	Is there a dedicated IEC officer for the HPVV campaign in the state?	Y / N	
	25	Is there a state communication and demand generation strategy in place for HPV vaccination?	Y / N	
	25a.	If yes, please specify.		
	26	Are IEC materials (poster/banner/information card) printed?	Y / N	
	27	Did the state Plan the ceremonial launch event?	Y / N	
	28	Did the state conduct a state media workshop?	Y / N	
	29	Did the state complete the crisis communication workshop?	Y / N	
Fund allocation	30.	Did the state receive financial guidelines from the MoHFW?	Y / N	
	30a.	If yes, whether state disseminate financial guidelines to districts?	Y / N	
	31	Are the funds distributed to all districts?	Y / N	
	32	Any other points you may wish to record		

Pre-Activity preparedness assessment checklists

Checklist B: Readiness Assessment for HPV Vaccination Campaign- District Level

State/UT:	District:	No. of Block:
Date of assessment:	Name of DIO:	Contact Details:

Demography	**Number**
Total population of the district	
Total Target cohort of 14-year-old girls (those who have celebrated their 14th birthday but have not celebrated their 15th birthday) in the State/UT (Approx. 1% of total population)	
Human Resource and Infrastructure	**Number**
Number of Ayushman Arogya Mandir-PHCs with cold chain point, dedicated MO, computer with printer, and internet connectivity	
Number of CHCs with cold chain point, dedicated MO, computer with printer, and internet connectivity	
Number of SDHs with cold chain point, dedicated MO, computer with printer, and internet connectivity	
Number of DH/Civil hospitals with cold chain point, dedicated MO, computer with printer, and internet connectivity	
Number of Government Medical Colleges with cold chain point, dedicated MO, computer with printer, and internet connectivity	
Number of ANM vaccinators in position	
Number of ASHAs in position	
Number of AWWs in position	
Number of other mobilizers in position?	
Number of Data Entry Operators in position	
Number of Cold Chain Handlers in position	
Number of 24x7 health facilities	
Number of health facilities with dedicated ambulances	

Activities			Achieved	Actions suggested during the assessment
Planning and Coordination	1	Number of District Task Force meetings on Immunisation (DTFI) conducted during the last 30 days?		
	2	Has the district assigned observers/supervisors for the HPV Vaccination Campaign?	Y / N	
	3	Have all health facilities in the district (identified as HPV vaccination centre) been mapped, and schools (with eligible girls) in their catchment area?	Y / N	
	4	Have all health facilities (identified as HPV vaccination centre) developed plans for sensitisation at school through Parent Teacher Meeting (PTM)?	Y / N	
	5	Has the information cards (for distribution during PTM) been distributed to all health facilities (identified as HPV vaccination centre)?	Y / N	
	6	Have the consent forms (for signature at the HPV vaccination centre) been distributed to all identified health facilities?	Y / N	
	7	Do all facilities (identified as HPV vaccination centres) have a dedicated HPV vaccination room/ space with privacy, including areas for observation, and waiting?	Y / N	
	8	Has the district set up a district control Room for the HPV vaccination Campaign?	Y / N	
Capacity building	9	Has the district workshop for HPV Vaccination Campaign been completed?	Y / N	
	10	Has the training of cold chain and data handlers been completed?	Y / N	
	11	Has the orientation for Professional bodies (IMA, IAP & FOGSI, IAPSM, Medical College) been completed?	Y / N	
	12	Has the orientation of religious leaders or key influencers at the district level been completed?	Y / N	
Logistics	13	Does the district have sufficient cold chain space to store the HPV vaccine?	Y / N	
	14	Has the district received the HPV vaccine (as per the requirement)?	Yet to receive / received partial stocks/ received all stocks	
	15	Does the district have adequate quantities of 0.5 ml AD syringes for HPV Vaccination Campaign - (as per actual requirement)?	Y / N	
	16	Has the district received Indelible marker pens for finger marking?	Yet to receive / received partially / received all	
Vaccine Safety	17	Did the district AEFI committee met at least once prior to HPV Vaccination Campaign?	Y / N	
	17a.	If yes, date of last district AEFI Committee meeting?		
	18	Did the District AEFI committee discuss the HPV vaccination in a meeting within the last months?	Y / N	

Activities			Achieved	Actions suggested during the assessment
Communication	19	Is there someone designated for IEC activities related to HPV vaccination in the district?	Y / N	
	20	Does the district have key communication and demand generation strategies in place on HPV vaccination?	Y / N	
	20a.	If yes, please specify.		
	21	Are IEC materials (poster/banner/information card) printed?	Y / N	
	22	Has the district planned for the ceremonial launch event?	Y / N	
Fund allocation	23	Whether district receive financial guidelines for HPV Vaccination Campaign from the state?	Y / N	
	24	Whether district receive funds for HPV Vaccination Campaign from the state?	Y / N	
	25	Have funds been disbursed from the district to the identified health facilities?	Y / N	
	26	Any other points you may wish to record	Y / N	

Pre-activity preparedness assessment checklists

Checklist C: Preparedness assessment for HPV Vaccination Campaign - Health Facility

State/UT:	District:	Name of Block:
Name of Health Facility:		Date of assessment:
Type of facility: PHC/UPHC/CHC/SDH/RH/DH/Medical College		
Name of MOIC:		Contact Details:

Demography	**Number**
Total population of health facility (in the catchment area under this Health Facility) *	
Total Target cohort of 14-year-old girls (those who have celebrated their 14th birthday but have not celebrated their 15th birthday) in the Health Facility (Approx 1% of the total population) *	
* Write NA if not applicable	
Human Resource and Infrastructure	**Number**
Number of ANMs/ vaccinators in position (in the catchment area under this Health Facility)	
Number of ASHAs in position (in the catchment area under this Health Facility)	
Number of AWWs/LWs/MAS/JAS in position (in the catchment area under this Health Facility)	
Number of other mobilizers in position (in the catchment area under this Health Facility), please mention who are other mobilizers?	
Number of Data Entry Operators in position	
Number of Cold Chain Handlers in position	

Activities			Achieved	Actions suggested during the assessment
Planning and Coordination	1	Has the facility mapped all schools (with eligible girls) in its catchment area?	Y / N	
	2	Has the facility planned/conducted sensitization at school through the Parent Teacher Meeting (PTM)?	Y / N	
	3	Has the facility received information cards for distribution during PTM?	Y / N	
	4	Are consent forms printed to offer at identified session sites for HPV vaccines?	Y / N	
	5	Does this facility have dedicated MO posted full time?	Y / N	
	6	Is this facility a functional Cold chain point (functional ILR, DF, Cold Box, and vaccine carrier)?	Y / N	
	7	Does this facility have functional desktops/laptops for U-WIN?	Y / N	
	8	Does this facility have an internet connection/Wi-Fi for Pre-registration for U-WIN and reporting?	Y / N	
	9	Does this facility have a functional printer?	Y / N	
	10	Does the facility have a dedicated HPV vaccination room/space with privacy, including areas for observation, and waiting?	Y / N	
	11	Has the facility completed the microplanning form [Form 2, 4, and 5] for HPV vaccination?	Y / N	
	12	Training workshop for the Healthcare workers completed?		
Logistics	13	Health facility has sufficient cold chain space to store the HPV vaccine?	Y / N	
	14	Is this a 24X7 facility?	Y / N	
	14a.	If not, name the 24X7 health facility to which it is tagged		
	15	Does this facility have a dedicated ambulance?	Y / N	
	16	Has the Health Facility received HPV vaccine?	Yet to receive / received partial stocks/ received all stocks	
	17	Does the health facility have adequate quantities of 0.5 ml AD syringes for HPV Vaccination Campaign - (as per actual requirement)?	Y / N	
	18	Indelible marker pens for finger marking received by health facility?	Yet to receive / received partially / received all	
	19	Does the facility have Anaphylaxis kit?	Y / N	
	20	Does the facility have AEFI kit?	Y / N	
	21	Has the facility received 2 HPV banners, and 4 HPV posters for HPV vaccination Campaign?	Yet to receive / received partially / received all	
Fund allocation	22	Whether the Health Facility has received financial guidelines for HPV Vaccination Campaign from the district?	Y / N	
	23	Any other point you may wish to record?		

Information Card **Annexure-6**

Click to Protect Lives

सत्यमेव जयते
Ministry of Health & Family Welfare
Government of India

राष्ट्रीय स्वास्थ्य मिशन

Information Card

Dear Parents / Guardian

Good health is the foundation of every child's success and happiness.

The Government of India is offering the HPV vaccine for girls aged 14 years (those who have celebrated their 14th birthday but not yet celebrated their 15th birthday) through campaign mode in only Government Health Facilities (Ayushman Arogya Mandir - PHCs, Community Health Centres, Sub-District Hospitals, District Hospital and Government Medical Colleges & Hospitals). HPV vaccination is voluntary, and prior parental consent is mandatory.

The duration of this campaign is three months (90 days) during which the HPV vaccine is available everyday. Thereafter, the vaccine will be available at the same health facility as per Routine Immunization (RI) sessions for girls aged 14 years.

This vaccination is the only proven shield against cervical cancer, which is a major cause of death globally among women. Leading doctors and healthcare organizations worldwide recommend that this vaccine should be administered to the young girls at the right age to safeguard them from HPV infection at a later stage.

HPV vaccination related events will be recorded on U-WIN which is a digital vaccination portal of the Ministry of Health and Family Welfare, Government of India.

You can self-register and schedule an appointment for HPV vaccination on U-WIN or directly walk-in to the below mentioned Government Health Facility.

Name of Health Facility: _____

Date of Campaign: From ____/____ To ____/____

Kindly bring your daughter's ID card for age proof of 14 years at the vaccination centre.

Benefits of the Vaccination

Protection from Life-threatening Diseases
One shot of HPV vaccine today can safeguard your daughter from life-threatening cervical cancer in future

Proven Safety
Trusted by millions of families worldwide in more than 159 countries

Global Standard
Recommended by WHO and leading medical experts

Make sure your daughter does not miss this golden opportunity.
For more details, please contact your nearest ASHA/ANM at the nearest Government Health Facility.

This programme is supported by the Government of India and follows all safety protocols and guidelines.

Self-register your daughter on the U-WIN digital platform for HPV vaccination and get to know more about HPV vaccination
Visit on https://uwin.mohfw.gov.in/home

www.mohfw.gov.in
@MoHFW_INDIA
@MoHFWINDIA
@mohfwindia
@mohfwindia