

INTEGRATING SCHOOL ENGAGEMENT AND FACILITY-BASED SCREENING TO STRENGTHEN HPV VACCINATION IN KENYA.

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Introduction

Human papillomavirus (HPV) vaccination was introduced in Kenya in 2019, but coverage remains below target with 2022- estimates at 56% for the first dose and 28% for the second. Uptake has been constrained by two main barriers:

- Vaccine hesitancy among caregivers and communities, fuelled by misinformation and
- Reliance on costly, inconsistent school-based outreach, limiting sustainable delivery especially during school closures.

Recognizing these challenges, Kenya pursued dual strategies.

- i. School-based engagement led by the Ministry of Education (MOE) to overcome resistance and
- ii. Outpatient department (OPD) screening to leverage routine health visits for vaccination.

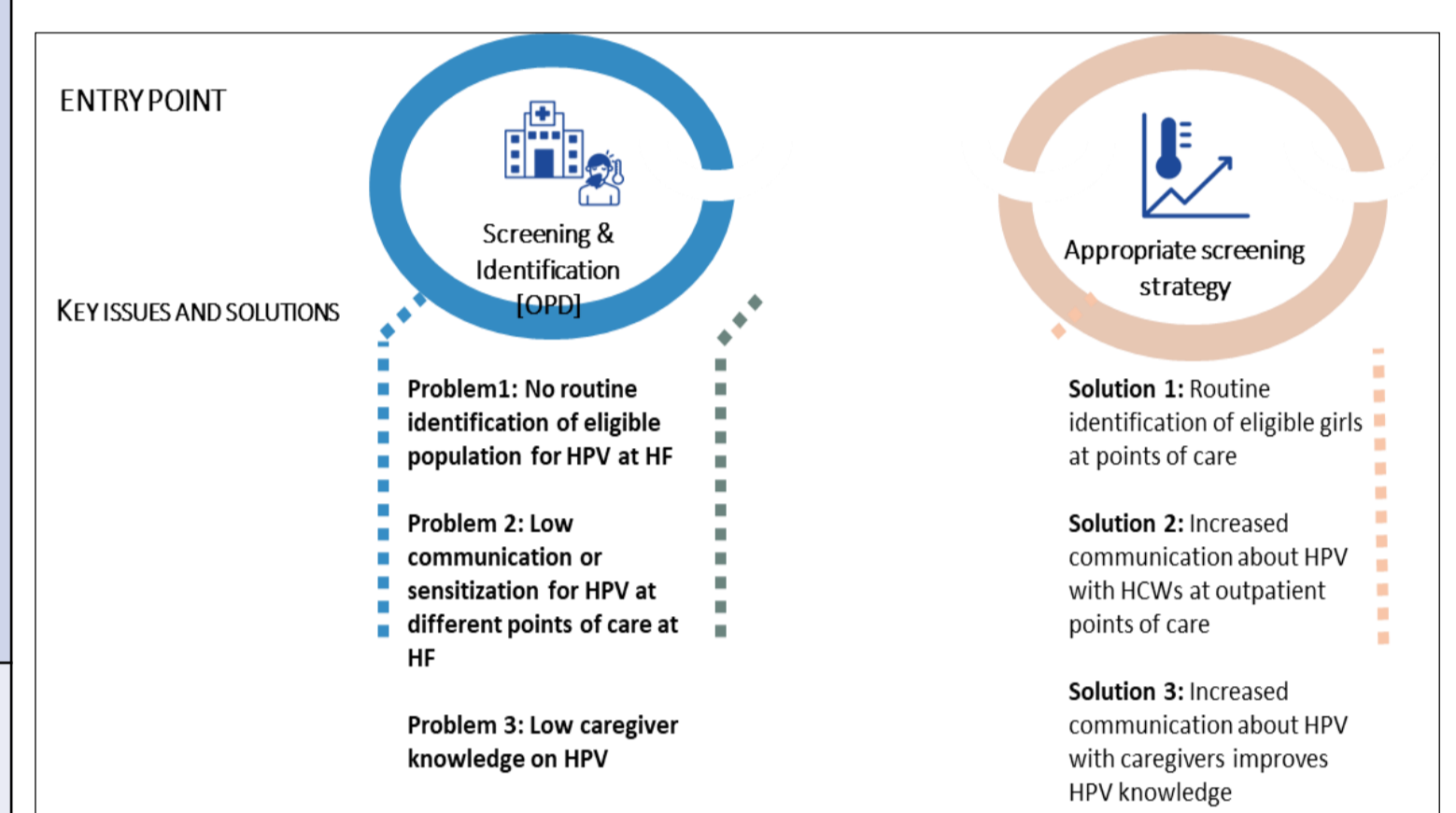
Both of these approaches demonstrate complementary pathways to improving adolescent uptake.

Methods

The methodology combined two complementary approaches, a Ministry of Education–led school-based engagement model addressing hesitancy through trusted platforms and a facility-based outpatient department (OPD) screening model integrating eligibility checks into routine service delivery to strengthen HPV vaccination coverage.

Intervention	Primary Targets	Activities	Scale / Numbers	Evidence Type
School-based hesitancy reduction (MOE-led)	Girls 10–14 (students) - Caregivers/parents (indirect, via school events) Teachers & school leadership	School health committees formed (teachers, nurses, health officers) Teacher trainings on HPV messaging - Reactivation of health clubs Peer-led forums: poetry, drama, dialogues Community engagement at school events with visible MOE leadership	Nationwide roll-out through MOE directives (qualitative data) Reached students, teachers, and caregivers via multiple forums (no numeric counts reported) Observed outcomes: greater caregiver trust, normalized HPV conversations	Qualitative: shifts in attitudes, improved confidence and message retention
Facility-based OPD screening (multi-county + Kisii pilot)	Girls 10–14 attending OPD Caregivers accompanying them Health workers (triage nurses, clinicians, MCH nurses, pharmacists)	Eligibility checks at triage Counselling on HPV - Immediate vaccination or referral Stamping/patient cards to ensure completion End-of-day follow-up by HCWs to close referral loops	11 counties, 85 facilities surveyed 13,901 OPD visits (girls 10–14) in 4 months 9,521 (68%) were unvaccinated but eligible Kisii pilot: 60% eligible, 95% of those vaccinated same day Facilities with OPD screening achieved 1.8x higher HPV-1 and 2x higher HPV-2 coverage than non-screening sites	Quantitative: patient-flow analysis, eligibility conversion rates, and coverage impact

Potential Direct outputs of OPD screening implementation



VACCINES ELIGIBILITY ACTIVE SCREENING		
Facility.....Age.....Sex.....		
Date.....		
ANTIGEN	Immunization status up-to-date YES/NO	Action needed Referred (R)/NOT Referred (NR)
Routine Vaccines (R). Indicate missed antigen		
HPV VACCINE (10-14 YEARS)		
COVID-19 VACCINES 15 YRS AND ABOVE		

If immunization status is NOT up-to-date, ACTION is needed. REFER to nurse for vaccination at the MCH. Review the card before patient exits the facility

Results/conclusions

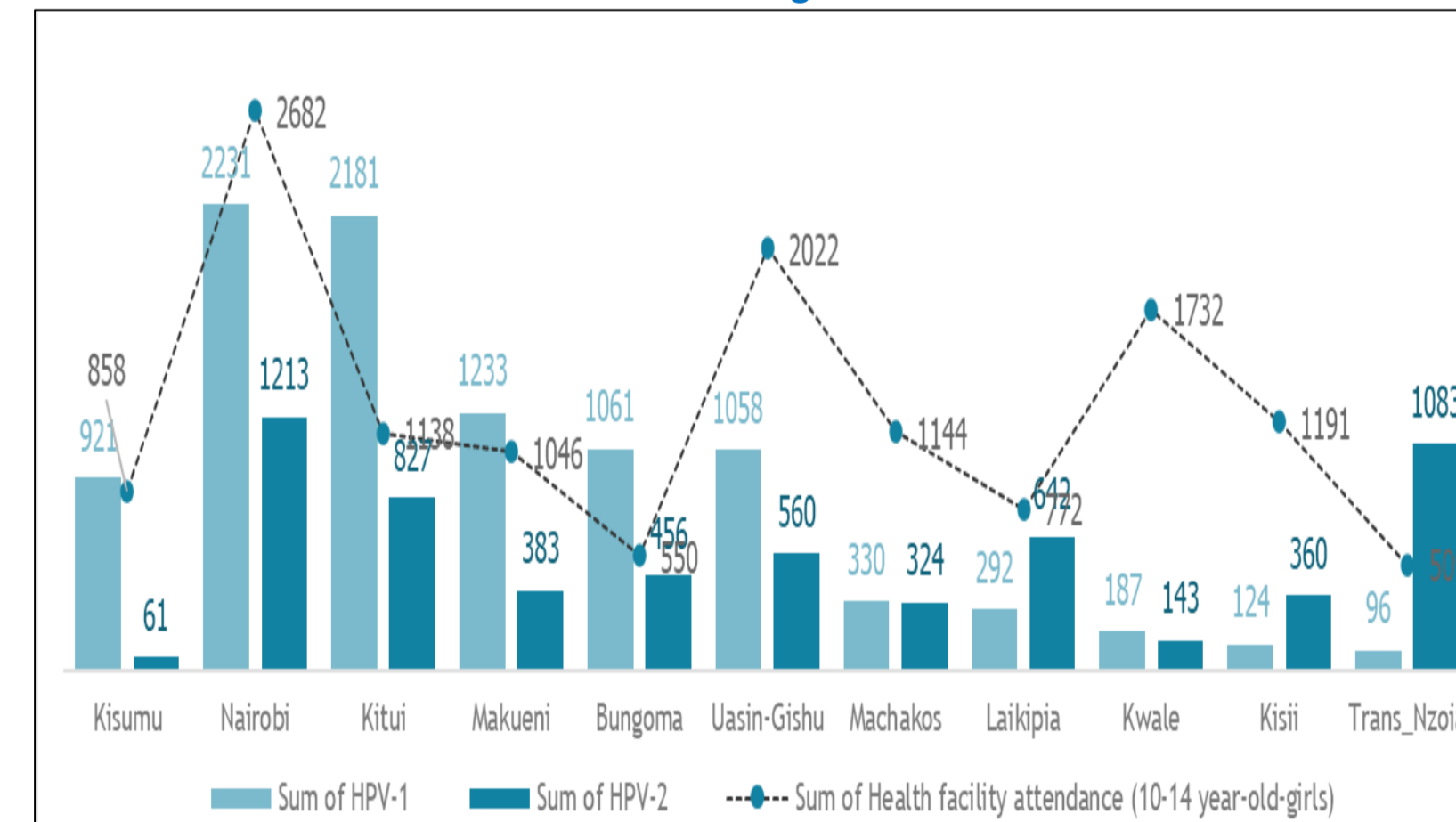
The results from both models demonstrate complementary strengths

Intervention	Stakeholders Targeted	How Impact Was Measured	Key Results / Outcomes
School-based hesitancy reduction (MOE-led)	Students (girls 10–14) Caregivers/parents Teachers & school leaders - Communities	Teacher and health official observations Reports from school health committees Community event feedback Qualitative assessment of parental attitudes	-Greater trust among caregivers and students toward HPV vaccine Increased student participation in health clubs Schools became trusted health spaces Normalization of vaccine dialogue at community level
Facility-based OPD screening:	a) Multi-county survey (11 counties, 85 facilities)	Girls 10–14 attending OPD Caregivers Health workers at triage & MCH	OPD attendance monitoring (13,901 visits in 4 months) Eligibility analysis (vaccination status) Uptake comparison between screening vs. non-screening facilities Patient flow mapping
	d) Facility-based OPD screening – Kisii pilot (4 facilities, Bonchari sub-county)	Girls 10–14 Caregivers Triage nurses, clinicians, MCH nurses, pharmacists	Real-time tracking of eligibility at triage Same-day vaccination follow-up End-of-day reconciliation by HCWs
	c) Cross-cutting – Health worker engagement	- Nurses, clinicians, pharmacists, CHVs	- Feedback surveys (post-intervention) - Routine reporting

School sensitization and vaccination sessions



HPV Coverage i



Conclusion:

- Combining school-based engagement with OPD-based screening offers a powerful, complementary model, building trust while ensuring consistent delivery.
- Scaling both approaches bridges equity gaps, reaching every girl regardless of schooling status.
- This dual pathway strengthens sustainability, accelerates progress toward national HPV coverage goals and positions Kenya as a model for innovative, equitable adolescent health strategies.

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Intégrer l'engagement scolaire et le dépistage en établissement pour renforcer la vaccination HPV au Kenya

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Résumé détaillé :

Depuis l'introduction du vaccin contre le HPV dans le programme de vaccination de routine du Kenya en 2019, la couverture reste inférieure aux objectifs : en 2022, 56 % des filles admissibles avaient reçu la première dose et seulement 28 % avaient reçu la seconde. Deux obstacles principaux limitent cette couverture : l'hésitation vaccinale, alimentée par des rumeurs persistantes, et la dépendance à des campagnes scolaires ponctuelles coûteuses qui s'interrompent lors des fermetures d'écoles. Pour relever ces défis, le ministère de l'Éducation a dirigé une stratégie d'engagement scolaire destinée à sensibiliser les élèves, les enseignants et les parents. Des comités de santé scolaire ont été créés, des enseignants ont été formés à la communication sur le HPV, des clubs de santé ont été réactivés et des forums dirigés par les pairs (poésie, théâtre, discussions) ont permis de normaliser les conversations sur la vaccination. Cette approche qualitative a renforcé la confiance des parents et encouragé les élèves à considérer l'école comme un lieu de santé.

Parallèlement, un modèle de dépistage en consultation externe (OPD) a été mis en place dans 11 comtés. Dans 85 établissements de santé, les infirmières et cliniciens vérifiaient l'éligibilité au HPV lors de la visite, conseillaient les patientes et administraient immédiatement le vaccin ou organisaient un suivi. Sur 13 901 visites de filles de 10 à 14 ans au cours de quatre mois, 68 % (9 521) étaient non vaccinées mais admissibles. Dans le sous-comté de Bonchari (Kisii), 60 % des filles étaient éligibles et 95 % d'entre elles ont été vaccinées le jour même. Les établissements qui pratiquaient le dépistage OPD avaient une couverture de la première dose 1,8 fois plus élevée et de la deuxième dose deux fois plus élevée que les établissements sans dépistage. Les travailleurs de santé ont indiqué que la plupart des filles fréquentant les consultations externes étaient admissibles et que les discussions systématiques en triage amélioraient la sensibilisation. Les auteurs concluent que la combinaison d'une mobilisation scolaire intensive et d'un dépistage en établissement crée un modèle complémentaire et équitable qui réduit l'hésitation, garantit une offre continue et pourrait combler les écarts de couverture lorsque les campagnes scolaires sont interrompues.

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