Knowledge and Awareness of HPV Vaccine and Acceptability to Vaccinate in Sub-Saharan Africa: A Systematic Review

Stacey Perlman1, Richard G. Wamai2, Paul A. Bain3, Thomas Welty4, Edith Welty4, Javier Gordon Ogembo5*

1 Pathfinder International, Watertown, Massachusetts, United States of America, 2 Northeastern University, Boston, Massachusetts, United States of America, 3 Countway Library of Medicine, Harvard Medical School, Boston, Massachusetts, United States of America, 4 Cameroon Baptist Convention Health Services, Bamenda, Cameroon, 5 University of Massachusetts Medical School, Worcester, Massachusetts, United States of America

Abstract

Objectives: We assessed the knowledge and awareness of cervical cancer, HPV and HPV vaccine, and willingness and acceptability to vaccinate in sub-Saharan African (SSA) countries. We further identified countries that fulfill the two GAVI Alliance eligibility criteria to support nationwide HPV vaccination.

Methods: We conducted a systematic review of peer-reviewed studies on the knowledge and awareness of cervical cancer, HPV and HPV vaccine, and willingness and acceptability to vaccinate. Trends in Diphtheria-tetanus-pertussis (DTP3) vaccine coverage in SSA countries from 1990–2011 were extracted from the World Health Organization database.

Findings: The review revealed high levels of willingness and acceptability of HPV vaccine but low levels of knowledge and awareness of cervical cancer, HPV or HPV vaccine. We identified only six countries to have met the two GAVI Alliance requirements for supporting introduction of HPV vaccine: 1) the ability to deliver multi-dose vaccines for no less than 50% of the target vaccination cohort in an average size district, and 2) achieving over 70% coverage of DTP3 vaccine nationally. From 2008 through 2011 all SSA countries, with the exception of Mauritania and Nigeria, have reached or maintained DTP3 coverage at 70% or above.

Conclusion: There is an urgent need for more education to inform the public about HPV, HPV vaccine, and cervical cancer, particularly key demographics, (adolescents, parents and healthcare professionals), to leverage high levels of willingness and acceptability of HPV vaccine towards successful implementation of HPV vaccination programs. There is unpreparedness in most SSA countries to roll out national HPV vaccination as per the GAVI Alliance eligibility criteria for supporting introduction of the vaccine. In countries that have met 70% DTP3 coverage, pilot programs need to be rolled out to identify the best practice and strategies for delivering HPV vaccines to adolescents and also to qualify for GAVI Alliance support.

Introduction

The introduction of vaccines has been one of the most effective public health interventions for combating infectious diseases [1,2]. The establishment of the Expanded Programme on Immunization (EPI) in 1974 by the World Health Organization (WHO) led to the global eradication of smallpox and has greatly reduced the burden of several infectious diseases, including poliomyelitis, measles, tuberculosis, tetanus and diphtheria in many parts of the world [2]. Despite slow progress in increasing vaccine access and immunization coverage, the EPI has reported 83% coverage of infants worldwide of the three doses of Diphtheria-tetanus-pertussis (DTP3) vaccine in 2011, similar to coverage in 2009 (82%) and 2010 (85%) [1,3]. Expansion and delivery of life-saving vaccines in the 2010–2020 “decade of vaccines” is expected to save 6.4 million lives, valued at hundreds of billions of dollars in low and middle-income countries [4]. Currently, DTP3 coverage by age 12 months is a key indicator of immunization program performance of a country and is associated with the level of capacity to effectively manage and deliver a new vaccine to a target cohort [5,6].

Worldwide, 15% of all cancer cases and nearly 26% of cancer cases in developing countries are attributable to infectious agents, particularly viruses [7]. Cervical cancer, which is caused by the human papillomavirus (HPV), is the leading cause of cancer mortality among women in sub-Saharan Africa (SSA) [8,9]. The approval and recommendation of two vaccines – Gardasil and Cervarix – provide a huge opportunity to curb the burden of cervical cancer [10]. As one of the key strategies in preventing cervical cancer in developed countries, providing HPV vaccines in...
low and middle income countries is a critical pillar for meeting the global action plan for closing the cancer divide [5]. However, outstanding barriers to achieving this goal in low-income countries remain. These include high cost of vaccine and vaccine delivery [11], low cervical cancer screening levels [12], poor health system capabilities [11,13], inaccessibility to medical care [14], low awareness and knowledge of HPV and cervical cancer [14–18], and failure of cervical cancer to be recognized as a major health concern [19].

Several recent developments have emphasized HPV vaccine as an important prevention strategy. The 2009 WHO position paper on HPV vaccines recommended they be included in routine national immunization programs as a public health priority [20]. Furthermore, one of the goals of the 2006 Global Immunization Vision and Strategy (GIVS) is to introduce new vaccines to all eligible populations within five years of introduction in national programs [3]. Additionally, major milestones during 2007–2011 have brought access to HPV vaccines within reach for many adolescents in low-income countries. In May 2013, for the first time ever, a public offer was made by GAVI Alliance for a price of $4.50 per dose for both Gardasil and Cervarix to low-income countries [21], a drastic reduction from $350 for the required three doses [22,23].

Currently, the GAVI Alliance uses two criteria to determine eligibility for vaccination support, including HPV vaccine: 1) a DTP3 threshold of 70% national coverage (WHO/UNICEF estimates) and 2) a pilot demonstration of the ability to deliver a complete multi-dose series of vaccines to at least 50% of the target vaccination cohort in an average sized district in a country [24]. Recently, Rwanda was the first country to take advantage of the low pricing through a partnership with pharmaceutical manufacturer Merck, achieving 93% coverage of HPV vaccination of all grade six adolescent girls in 2011 [25–27], which is, to the best of our knowledge, the highest in the world. Through other sources of subsidized HPV vaccines, 88.9% of girls were fully vaccinated in Uganda using a school-based pilot program supported by PATH International in 2009 [28]. A similar HPV vaccination pilot initiative was recently undertaken in Cameroon [15], Tanzania [29], Lesotho [30] and South Africa [31]. More recently, Kenya became the first SSA country to receive GAVI Alliance support to roll out a HPV vaccine pilot project (see: http://www.gavialliance.org/support/nvs/human-papillomavirus-vaccine-support). GAVI Alliance also announced that in 2014 it will support the first nationwide introduction of HPV vaccine in Rwanda for girls of all eligible ages, as well as other HPV demonstration projects in Mozambique, Zimbabwe, Ghana, Madagascar, Malawi, Niger, Sierra Leone, and Tanzania (see: http://www.gavialliance.org/support/nvs/human-papillomavirus-vaccine-support).

These developments, coupled with SSA’s recent success in reaching 70% coverage for other routine vaccines, namely measles, hepatitis B, Influenza, tuberculosis and polio since 1990 [3], provide strong evidence of how introducing HPV vaccine can be achieved in other countries meeting the GAVI Alliance eligibility criteria. The success of pilot demonstrations in Rwanda, South Africa, Cameroon, Lesotho, Tanzania and Uganda also provide lessons on how to design and implement national HPV vaccination programs tailored for a specific group of individuals in resource-limited regions.

Nevertheless, introducing HPV vaccine in SSA offers unique challenges, especially due to limited awareness of cervical cancer, its relationship to HPV, concerns about safety and future fertility, and political factors [32], as seen in recent cases in Rwanda [26,27] and Cameroon [33]. These unsubstantiated rumors about side effects or adverse outcomes that may not be casually related to the vaccine may negatively impact public trust and adversely impact HPV immunization programming leading to suspension of the program altogether as recently experienced in Japan [34] and India [35].

In this study, we assessed the knowledge and awareness of cervical cancer, HPV and HPV vaccine, willingness and acceptability to vaccinate through a systematic review of peer-reviewed literature. We further identified the fulfillment of GAVI Alliance eligibility criteria among countries in SSA. To the best of our knowledge this is the first systematic review of the potential readiness for introduction of HPV vaccine in the sub-continent, which reveals further insight into some of the unique challenges that need to be addressed.

Methods

Identification of Studies

Studies examining awareness, knowledge of cervical cancer, HPV and acceptability of HPV vaccines in SSA were identified by searching PubMed/MEDLINE (NCBI), Embase (Elsevier), African Index Medicus (AIM), and POPLINE (K4Health) from their earliest dates through July 11, 2013. Bibliographies of relevant reviews and eligible studies were examined for additional sources. The search was performed by a librarian (PAB) using terms for papillomavirus vaccines and vaccination, acceptability or awareness, and the names of all SSA countries (Appendix S1). The search was conducted without language restriction. Titles and abstracts of identified articles were reviewed by two authors (SP and JGO) and categorized as relevant using the criteria outlined below.

The review was conducted using methodology reported in the National Health Service Centre for Reviews and Dissemination report, supplemented by Harden’s recommendations for systematic reviews of qualitative studies [36]. We also adhered to guidance on methods for conducting and reporting systematic reviews in the PRISMA statement where it could be applied to mixed method reviews [37]. Two authors (JGO and RGW) appraised the quality of the studies using a checklist developed by the National Institute for Health and Clinical Excellence [38], and surveys using a checklist adapted from Pettigrew and Roberts [39] provided in supplementary Table 1 and Table 2, respectively.

Inclusion Criteria

Studies included in the review needed to meet the following criteria: 1) it occurred in a SSA country; 2) it was published in 2006 or later, after HPV vaccination was introduced; 3) it focused on one or more of the three key demographics (adolescents, parents/guardians, healthcare workers); and 4) it examined at least one or more of the following key themes: a) level of awareness of HPV and/or cervical cancer; b) level of knowledge of cervical cancer and/or awareness; c) willingness to vaccinate; d) and acceptability of HPV vaccine. Studies that conducted a pilot HPV vaccination program were automatically included in the review. Animal studies were excluded from the review.

Article Review

A systematic review of the identified studies was then performed summarizing key results. The authors’ findings were treated as primary data and studies were synthesized using a framework approach. Data were extracted and organized by key information such as demographic, method and sample size, and key findings of the study about levels of knowledge, awareness, willingness and acceptability. Any strategies for vaccination or increasing awareness (whether recommended or implemented strategies) were also
### Table 1. A summary of countries included in the systematic review.

| Country      | Total Number | Total Number of Articles | Total Number of Studies | Total Number of Countries |
|--------------|--------------|--------------------------|-------------------------|---------------------------|
| Botswana     | 1            | 1                        |                         |                           |
| Cameroon     | 5            | 2                        |                         |                           |
| Ghana        | 1            | 1                        |                         |                           |
| Kenya        | 2            | 2                        |                         |                           |
| Lesotho      | 1            | 1                        |                         |                           |
| Mali         | 1            | 1                        |                         |                           |
| Nigeria      | 5            | 1                        |                         |                           |
| Rwanda       | 1            | 1                        |                         |                           |
| South Africa | 4            | 4                        |                         |                           |
| Tanzania     | 4            | 4                        |                         |                           |
| Uganda       | 3            | 3                        |                         |                           |
| Zambia       | 1            | 1                        |                         |                           |
| Zimbabwe     | 1            | 1                        |                         |                           |

| Demographics of Studies* | Girls (Pupils) | Medical Professionals | HCW | Gyn | Nurses | Non-traditional healers | Parents | Women | University students | Age 12–26 | Age 12–84 | Age 15–49 | Age 16–64 | Age 18–44 | Age 18–65 | Women from HIV-1 discordant couples | Not Applicable/Unspecific |
|--------------------------|----------------|-----------------------|-----|-----|--------|------------------------|---------|-------|---------------------|-----------|-----------|-----------|----------|-----------|----------|----------------------------------|-------------------------|
|                          | 6              | 8                     |     |     |        |                        |         |       |                     |           |           |           |          |           |          |                                  |                         |

| Methods         | Survey          | Focus Groups          | School-based Vaccination | Assessment of Vaccination Programs | Case Control Study | Cross-Sectional Study of Delivery Strategies | Discussion/Interviews | KAP Studies | Randomized Controlled Trials | Review |
|-----------------|-----------------|-----------------------|---------------------------|-------------------------------|-------------------|---------------------------------|--------------------|-------------|--------------------------------|--------|
|                 | 17              | 2                     | 2                         | 1                             | 1                 | 1                               | 1                  | 1            | 1                              | 1       |

| Acceptability of HPV Vaccine (12 Studies) | High – 12 | Moderate – 2 | Low – 0 |
|------------------------------------------|-----------|-------------|--------|
| Acceptability of cervical cancer Screening (1 Study) | High – 1 | Low – 0 |
| Willingness to Recommend HPV Vaccines (5 Studies) | High – 5 |
extracted along with factors influencing acceptability of HPV vaccine.

**Analysis**

Levels of awareness, knowledge, acceptability and willingness were broken down into these categories: 1) awareness of cervical cancer, HPV and/or HPV vaccine; 2) knowledge of cervical cancer, HPV and/or HPV vaccine; 3) acceptability of HPV vaccine (and in one case, acceptability of cervical cancer screening); and 4) willingness to vaccinate or get vaccinated. Willingness was broken down further into categories based on how each individual article defined it as seen in Table 1. Levels of awareness, knowledge, acceptability and willingness to vaccinate were summarized based on how each individual study categorized the levels (high, low or moderate). The articles were then tallied for each relevant category. Some articles had multiple levels of awareness and knowledge, resulting in one article being counted more than once (i.e. one article may have high awareness of cervical cancer but low awareness of HPV). Strategies for vaccination/increasing awareness and factors influencing acceptability provided qualitative insight and allowed us to identify important themes for awareness, implementation and acceptability of HPV vaccination.

**Results**

**Overview of Studies Examined**

The literature search returned 142 unique records as summarized in the flow chart (Fig. S1). Review of selected article bibliographies uncovered 10 other articles. A total of 124 relevant articles were selected and reviewed and 29 articles based on 27 studies in 13 different SSA countries met the inclusion criteria. Ten studies focused on women, with ages ranging from 12 to 84, eight studies focused on medical professionals, five focused on parents and six focused on girls in primary schools. Six countries implemented HPV vaccination pilot programs (Cameroon, Lesotho, Rwanda, South Africa, Tanzania and Uganda). Table 1 shows a detailed summary of identified studies and Table 2 summarizes the key findings from each study.

**Study Quality**

Two qualitative studies were considered to be of good standard while one was considered moderate and one was considered poor. Nearly all of the surveys were well conducted and 17 of these had a sample size greater than 200 respondents. Sixteen of those had a response rate greater than 70%. The remaining studies varied in quality from moderately good to poor [30].

**Awareness and Knowledge of Cervical Cancer and HPV**

Fifteen studies examined awareness of cervical cancer, HPV and/or HPV vaccine among specific demographic groups. Levels of awareness were mixed with 11 studies demonstrating high awareness, nine studies demonstrating low awareness and two studies demonstrating moderate awareness. Levels of knowledge of cervical cancer, HPV and HPV vaccine were consistently low. Of the 16 studies examining knowledge of cervical cancer, HPV and HPV vaccine, all noted low levels of knowledge, three reported no knowledge, and two reported moderate knowledge. Six countries implemented HPV vaccination pilot programs (Cameroon, Lesotho, Rwanda, South Africa, Tanzania and Uganda). Table 1 shows a detailed summary of identified studies and Table 2 summarizes the key findings from each study.

**Willingness and Acceptability of HPV Vaccine and Cervical Cancer Screening**

Categories of willingness varied across studies: willingness to recommend HPV vaccine (five studies); willingness to get vaccinated (four); willingness to get daughter vaccinated (four); willingness to participate in vaccine trials (one); “interest” in the vaccine for daughters (one); and “interest in learning more about the vaccine” (one). All studies reported high rates of willingness in their respective categories. Twelve studies examined acceptability levels of HPV vaccine and one study examined acceptability of

---

**Table 1.**

| Category | Low | High |
| --- | --- | --- |
| Awareness of CC, HPV and/or HPV Vaccine (15 Studies) [14,15,17,40–43,53,55–57,59,61,64,67] | 9 | 11 |
| Knowledge of Cervical Cancer, HPV and/or HPV Vaccine (16 Studies) [14,29,42,56–67] | 16 | 1 |
| Interest in Vaccine for Daughters (1 Study) [61] | 0 | 1 |
| Interest in Learning More about Vaccine (1 Study) [62] | 0 | 1 |
| Willingness to Get Vaccinated (4 Studies) [42,43,53,59] | 0 | 4 |
| Willingness to Get Daughter Vaccinated (4 Studies) [14,17,40,53] | 0 | 4 |
| Willingness to Participate in Trials (1 Study) [60] | 0 | 1 |
| Interest in Vaccine for Daughters (1 Study) [63] | 0 | 1 |

---

doi:10.1371/journal.pone.0090912.t001
| Study, Country | Demographic | Sample Size/Method | Level of Knowledge/ Awareness of HPV, CC and Vaccine | Acceptability/Willingness | Strategies for Vaccination/ Increasing Awareness | Factors Influencing Acceptability |
|---------------|-------------|--------------------|-----------------------------------------------|--------------------------|-----------------------------------------------|----------------------------------|
| [25] Rwanda    | Girls – Primary school | 93,888 (1st round vaccination); School-based vaccination & Community Sensitization | Not discussed | High Acceptability - Achieved 93.23% coverage after first three-dose course of vaccination | School-based Vaccination; Nationwide population sensitization campaign implemented months in advance of vaccination. | Not discussed |
| [31] South Africa | Girls – Primary School (9–12 years)  | 1,926 (1st round vaccination); School-based vaccination strategy | Not discussed | High Acceptability – 97.8% coverage after three-dose course of vaccination | School-based vaccination strategy used/highly recommended; Awareness, information and education sessions on cervical cancer, screening, and an HPV demonstration project were conducted with school principals, governing bodies and teachers. | Not discussed |
| [30] Cameroon  | Girls - (9-18 years) | 1,033 girls vaccinated out of 1,600 targeted girls; Assessment of Gardasil Access Program: Health facility vaccination site | Not discussed | Moderate acceptability – 64.9% estimated program coverage | Health facility vaccination strategy; More in-depth discussion sessions with parents and caregivers, evaluations of the knowledge of and attitudes toward HPV vaccination in these audiences will be important to the success of future HPV vaccination campaigns. | Not discussed |
| [30] Lesotho   | Girls – (9-18 years old) | 33,818 girls vaccinated out of 40,100 girls targeted; Assessment of Gardasil Access Program: Mixed vaccination strategy (clinic-based and school-based) | Not discussed | High acceptability - 71.4% estimated program coverage | Overall results of the 8 vaccination programs indicate that school-based strategies were most effective for reaching girls aged 9-13 years while mixed models had better overall performance compared with models using just one of the method’s. | Not discussed |
| [29] Tanzania  | Girls – Primary School | 5,532 eligible for vaccination; 3,332 for class-based delivery; 2,180 for age-based delivery; Randomized. Control Trial: Phase IV cluster-randomized trial of 2 vaccine delivery strategies: age-based (targeting girls born in 1998) and class-based (targeting girls in school class 6) | Not discussed | High Acceptability – Achieved 76.1% coverage of all three doses (total of age-based and class-based delivery strategies) | School-based vaccination divided into two delivery strategies: age-based and class-based. A sensitization campaign was conducted prior to vaccination by providing teachers, parents/guardians and girls with verbal and written information about HPV vaccination through multiple formats. | Head teachers at 3 private schools randomized to the age-based strategy, with an estimated 25 eligible pupils in total, would not permit vaccination, fearing negative parental feedback. |
| Study, Country | Demographic | Sample Size/Method | Level of Knowledge/Awareness of HPV, CC and Vaccine | Acceptability/Willingness | Strategies for Vaccination/Increasing Awareness | Factors Influencing Acceptability |
|----------------|-------------|--------------------|--------------------------------------------------|--------------------------|-----------------------------------------------|---------------------------------|
| [68] Tanzania  | Pupils/Adults| 404 Case Control Study of HPV vaccine receivers and non-receivers | Low knowledge of cervical cancer among girls; Moderate knowledge of HPV vaccine among girls - “Vaccine specifically mentioned” as cervical cancer prevention - (52.8% among cases; 74.3% among controls) | High acceptability - see Watson-Jones et al. 2012a | School-based vaccination | Acceptance of vaccine among adult controls: Prevention of cervical cancer was the primary reason. Other reasons included health benefits, knowing someone who had cancer and encouragement by the project team. Among pupil controls: protection of cervical cancer, health benefits, parental wishes. Rejection of vaccine among adult cases: concerns over side effects or infertility; insufficient knowledge about the vaccine; daughter was absent from school on the vaccination day. Rejection of vaccine among pupil cases: they had been absent from school the day of vaccination; both parents had refused permission for vaccination; concerns about side effects; afraid of injections; infertility concerns. Sensitization messages and parent meetings are critical for vaccine acceptance while persistent concerns about vaccine side effects and potential impact of fertility need to be closely addressed in a national vaccine program. It is important to give parents and pupils time to reconsider their decisions about vaccination – those who initially did not accept vaccination would have done so if offered another opportunity. |
| [57] Cameroon  | Healthcare workers | 401; Survey; cross-sectional, self-administered | High awareness - cervical cancer; Low knowledge about cervical cancer among nurses & midwives; Low knowledge about HPV vaccine among Healthcare workers (exception among gynecologists). | High willingness to recommend among those who believe HPV vaccine can prevent cancer: *Low belief that HPV vaccine prevents cancer: Only 44%. | Continuing medical education programs including nurse-midwives should be conducted at hospital level to spread knowledge about cervical cancer prevention. | Not discussed |

---

**Table 2.** Cont.
| Study, Country | Demographic | Sample Size/Method | Level of Knowledge/ Awareness of HPV, CC and Vaccine | Acceptability/Willingness | Strategies for Vaccination/ Increasing Awareness | Factors Influencing Acceptability |
|---------------|-------------|--------------------|-----------------------------------------------------|--------------------------|---------------------------------------------|----------------------------------|
| [67] Oral Presentation Nigeria | Healthcare workers - Gynecologists | 118; Survey: cross-sectional | High awareness - HPV, cervical cancer and HPV vaccine; Low knowledge - eligibility and schedule of HPV vaccine | Not discussed | 87.4% suggested incorporation into national immunization program; 34.5% agreed vaccination should be precondition for school enrollment; 16.1% agreed client should pay for vaccine. | Not discussed |
| [55] Nigeria | Healthcare workers (female) | 177; Survey: cross-sectional | High awareness of cervical cancer; High awareness of HPV; Moderate awareness of HPV vaccine | High acceptability of HPV vaccine (defined as willingness to recommend to their adolescent daughters, other adolescents or sexually unexposed daughters | Necessary strategies: public enlightenment, subsidize cost and improve access/availability. There is a need for public enlightenment, which have the potential of creating awareness and improving acceptability and uptake of most health-care programs. | Not discussed |
| [62] South Africa | Healthcare workers – nontraditional healers known as Sangomas | 12; Focus Groups | Low knowledge – HPV; No knowledge – HPV vaccine; Moderate knowledge – Cervical Cancer (“somewhat familiar”) | Not discussed but after learning about HPV vaccine, participants were excited about the possibility to prevent cervical cancer. There was high desire to learn more. | Participants stressed the important of educating parents, especially fathers about HPV. HPV and cervical cancer prevention workshops are important and useful tools for educating the public. Collaborate/engage with Sangomas to develop culturally appropriate prevention strategies given they have great access to community members. | Not discussed |
| [54] Tanzania | Healthcare workers, Teachers, Parents, Female Pupils & Religious Leaders | 169; Discussion & Interviews: Qualitative sub-study using group discussions and in-depth interviews | Almost no knowledge - Cervical Cancer, HPV or HPV vaccine; Only healthcare workers had knowledge but low | High acceptability: high acceptability to receive HPV vaccine among pupils; high acceptability of HPV vaccine for daughters among rest. | Positive views on intensive sensitization to increase awareness from all respondents. School-based delivery programs need adequate sensitization to prevent past instances of rumors undermining such campaigns. Respondents in favor of age-based vaccination. | Parents - “Prevention is better than cure”; Girls - Avoid dangerous disease like cervical cancer; Most participants - Trusted safety of vaccine. |
Table 2. Cont.

| Study, Country | Demographic | Sample Size/Method | Level of Knowledge/ Awareness of HPV, CC and Vaccine | Acceptability/Willingness | Strategies for Vaccination/ Increasing Awareness | Factors Influencing Acceptability |
|----------------|-------------|--------------------|-------------------------------------------------------|---------------------------|------------------------------------------------|----------------------------------|
| [58] Cameroon  | Nurses      | 76; Survey: Exploratory | Low levels of knowledge about HPV infection, symptoms and prevention of cervical cancer; Moderately high level of knowledge about HPV vaccine | High level of willingness: Two-thirds (69.7%) would recommend HPV vaccine to targeted 9–13 year old girls | Recommend intensive on-the-job continuing education program for current nursing staffs and other health care workers regarding the importance of cervical cancer screening, HPV as an STI and the role of HPV vaccine in the prevention of cervical cancer. Training should be systematically included in nurses’ education curricula so newly trained nurses can effectively promote and provide HPV immunizations when they are universally available. | Not discussed |
| [64] Tanzania  | Nurses      | 137; Survey: Cross sectional questionnaire | Low knowledge - cervical cancer; Low awareness/ knowledge - HPV vaccine | Not discussed | Health promotion and disease prevention policies, awareness campaigns and screening programs. Integration of screening services into existing programs. | Not discussed |
| [43] Nigeria   | Nurses (female) | 178; Survey: Cross-sectional, descriptive | High awareness - cervical cancer and HPV; Low knowledge - HPV infection; Low awareness & Knowledge - HPV vaccine | High willingness to be vaccinated; High willingness to recommend | A well-designed HPV education program integrated into a national cervical cancer prevention and control program is needed to bridge information gap | Reason for rejection to recommend to adolescents: Main reason given: Insufficient knowledge about vaccine & complications. Other reasons given: Too young Not yet sexually active Not at risk for HPV Vaccination encourages promiscuity. No reasons discussed for nurses accepting vaccine for themselves |
| [17] Cameroon  | Parents     | 337; Survey: Cross-sectional | High awareness - cervical cancer, HPV, HPV vaccine | High willingness for daughters; High willingness to recommend | Recommended community-based sensitization to increase awareness | In order highest to lowest: Effectiveness, Side effects, Healthcare provider recommendation, Cost |
| Study, Country | Demographic | Sample Size/Method | Level of Knowledge/Awareness of HPV, CC and Vaccine | Acceptability/Willingness | Strategies for Vaccination/Increasing Awareness | Factors Influencing Acceptability |
|---------------|-------------|--------------------|---------------------------------------------------|--------------------------|-----------------------------------------------|----------------------------------|
| **Botswana**  | Parents/Adults | 372; Survey: Cross-sectional | High Awareness – cervical cancer; Low Awareness - HPV/HPV Vaccine | High willingness for daughters | Willingness to get daughters vaccinated at schools - programs in Botswana should consider schools as potential venues. Spread information by addressing several health belief model constructs associated with high acceptability. | Belief that cervical cancer and genital warts were serious health problems (perceived severity); Access to vaccine; Recommendation from doctor (lower if from nurse) |
| **Uganda**    | Parents/Guardians | 1,489; Cross-sectional study: three delivery strategies (School-based strategy and school-based strategy combined with Child Days Plus Programme in Uganda) | Not discussed | High acceptability - 90.5% coverage in year 1 and 88.9% coverage in year 2, through school-based strategy; Moderate acceptability – 52.6% in year 1 and 60.7% in year 2, vaccination coverage through School-based combined with Child Days Plus. | School-based Vaccination and School-based Vaccination Combined w/Child Days Plus Programme. | Protection against cervical cancer; Prevention of disease; Vaccines thought good for health or wanted girl to be healthy. |
| **Continuation of LaMontagne et al. 2011** | Parents/Guardians | 1,489; Cross-sectional study | Not discussed | High acceptability – overall acceptability for two different vaccination strategies (school-based and school-based combined with Child Days Plus) based on LaMontagne et al. 2011. | School-based Vaccination and School-based Vaccination Combined w/Child Days Plus Programme. | Exposure to community influencers was an important factor when parents made decisions about HPV vaccination for their young adolescent daughters. Exposure to information, education and communication (IEC) materials only marginally increased vaccine uptake; it is the people with whom parents and other guardians speak, and not the type of IEC materials and activities they are exposed to, that facilitates uptake of the HPV vaccine. HPV vaccination programs should focus on comprehensive communication strategies that utilize key community influencers and stakeholders as opposed to targeted delivery of IEC materials and activities. |
| Study, Country | Demographic | Sample Size/Method | Level of Knowledge/Awareness of HPV, CC and Vaccine | Acceptability/Willingness | Strategies for Vaccination/Increasing Awareness | Factors Influencing Acceptability |
|----------------|-------------|--------------------|------------------------------------------------------|--------------------------|-----------------------------------------------|----------------------------------|
| **Nigeria**    | Women (university students) | 375; Survey: Cross-sectional | Low awareness – HPV; Moderate awareness – cervical cancer; Low knowledge – cervical cancer risk factors | High willingness; High acceptability | Public health education efforts through community and media involvement to ensure acceptance and uptake - educational approaches through radio, television and folk media; vaccine advocacy | Reasons for rejection: Fear of side-effects; Fear of the unknown; Controversies surrounding vaccines. Predictors of Acceptability: Age; Medical Education; Knowledge of HPV/Awareness of cervical cancer. |
| **Cameroon**   | Women (12–26) Adolescents | 553; Survey: Cross-sectional survey | High awareness - HPV, cervical cancer and HPV Vaccine | High acceptability for themselves; High willingness to recommend | Recommended community-based sensitization to increase awareness | Not discussed |
| **Zimbabwe**   | Women (12–84) Rural | 514; Survey: Descriptive | Low awareness/ knowledge - Cervical cancer and cervical cancer screening | High acceptability - cervical cancer screening after educational intervention | Government should recognize cervical cancer as major public health concern; mass education on preventing STIs, targeting adolescents and young adults. Education curricula of nurses and physicians should incorporate promotion of cervical cancer screening and treatments to increase awareness. The HPV vaccine should be incorporated into the Zimbabwe Expanded Programme on Immunization (ZEPI); Dialogues should be initiated among community representatives to dispel myths of immunizations. | Not discussed |
| **Kenya**      | Women (15–49) | 147; Survey: Questionnaires administered by interviewers | Limited awareness - cervical cancer and cervical cancer screening; No knowledge - HPV vaccine | High interest for daughters; Not willing to pay for vaccine | Basic education campaign is necessary for introduction of HPV vaccine to achieve optimal prevention | Main factors influencing women to vaccinate their daughter: If it protected against cervical cancer and free (95%); If it protected against cervical cancer and genital warts and free (95%); If it protected against genital warts and free (94%); If it required only one shot (86%). |
| **Nigeria**    | Women (16–66) | 198; Survey: Cross-sectional | Low knowledge – Cervical cancer; No knowledge – HPV vaccine | Not discussed | There is a need to establish an intensive and sustainable awareness campaign on preventing cervical cancer | Not discussed |
| Study, Country       | Demographic                      | Sample Size/Method           | Level of Knowledge/ Awareness of HPV, CC and Vaccine | Acceptability/Willingness | Strategies for Vaccination/ Increasing Awareness | Factors Influencing Acceptability |
|---------------------|----------------------------------|------------------------------|------------------------------------------------------|--------------------------|--------------------------------------------------|-----------------------------------|
| [14] South Africa   | Women (18–44)                    | 86; Survey                   | High awareness - cervical cancer; Low awareness - HPV; Low knowledge - HPV, cervical cancer; *Women unfamiliar w/HPV, cervical cancer and HPV vaccine | High willingness for daughters if recommended by provider | Recommendation to develop prevention and education messages and social marketing campaigns to increase awareness. | 46% of women surveyed were very likely to vaccinate based on provider recommendation; Most important factor when deciding to vaccinate from highest to lowest: Unsure/ Do not know; Provider Recommendation; Side Effects; Effectiveness; Cost |
| [66] South Africa   | Women (18–44)                    | 24; Focus Groups             | Limited knowledge about HPV, cervical cancer and HPV vaccine | High acceptability for children - once vaccine explained* *Acceptability - contingent upon request for more information/education | Focus on primary prevention strategies such as culturally appropriate multigenerational educational materials for girls, mothers and grandmothers; Provide access to prevention education, screening, treatment and obtain knowledge needed to make informed reproductive health decisions. | Main factor influencing acceptability was keeping their children safe and protect them. The majority of women felt they were okay with the vaccine as long as someone explains what the shot is for and how it will help their children. |
| [41] Ghana          | Women (18–65)                    | 264; Survey: Based on the Health Belief Model | High awareness - cervical cancer; Low awareness - HPV vaccine | High acceptability for themselves & daughters | Schools are ideal venue for vaccine distribution; Community health education programs which are best directed through clear school health education programs, public TV health announcements. | Perceived risk for cervical cancer (themselves & daughters); Access to vaccine; Social support for vaccine use. |
| [53] Zambia         | Women (18–65)                    | 319; Survey: Cross-sectional | High awareness - cervical cancer | High willingness to vaccinate themselves and daughters; High acceptability of HPV vaccine | Health clinics were cited as most often as women's source of information regarding vaccination, making clinics a logical venue for cervical cancer education. | Cost was the only acceptability factor examined. Only 47.4% would pay something for the vaccine. |
| [59] Kenya          | Women from HIV-1-discordant couples | 409; Questionnaire administered by clinical staff | High awareness – HPV; Low Knowledge – HPV; Low awareness – HPV vaccine | High willingness to be vaccinated | There is a need for education surrounding cause and prevention of cervical cancer – not just for vaccination but also for Pap screening and self-sampling. | Cost – willing to vaccinate if available at little or no cost. |
| [60] Mali           | Unspecified                      | 51; Knowledge, Attitudes, Practices (KAP) Studies | Low Knowledge - HPV | High Willingness to Participate in vaccine trials | Not discussed | Not discussed |
All 12 studies reported high levels of acceptability of HPV vaccine. However, multiple levels of acceptability were found within the studies because some assessed and compared different vaccine delivery strategies within and in different countries.

**Strategies and Factors for Increasing Awareness and Acceptability of HPV Vaccine**

Of the 27 studies, 26 discussed strategies for vaccination and increasing awareness. Studies in the six countries in the review where HPV vaccination pilot programs were conducted discussed the implementation strategies used for vaccination while the remaining countries in this review discussed recommended strategies for implementation. Rwanda, South Africa Tanzania and Uganda used school-based strategies achieving 93.2%, 97.8%, 71.6% and 88.9% vaccine uptake, respectively [25,28]. Lesotho used a mixed vaccination strategy (clinic and school-based) [30]. Cameroon used three distinct approaches to deliver vaccines namely school-based, health facilities and community outreach programs in churches and mother-to-daughter [15,17,18]. In addition, all studies, with the exception of Lesotho specifically mentioned that sensitization campaigns were used in their vaccination strategies [30]. Rwanda conducted a nationwide campaign while South Africa, Tanzania, Cameroon and Uganda conducted focused educational campaigns to targeted groups [15,25,28,29,31]. Two studies in both Botswana [40] and Ghana [41] recommended schools as the ideal venue for HPV vaccine delivery.

Education for increasing awareness was a strong theme throughout the majority of studies. Recommended strategies to implement sensitization programs included community health education programs, continuing medical education for nurses, midwives, doctors and other healthcare workers, and health promotion and policy programs including awareness through social and mass media (i.e. public radio, television and folk media).

Factors influencing acceptability also varied. Twelve studies addressed reasons for acceptability of HPV vaccine. Two studies in Nigeria [42,43] discussed reasons for rejection among nurses and university students while one study in Tanzania [29] noted that head teachers at three private schools would not permit vaccination, fearing negative parental feedback. In Nigeria [43], nurses’ reasons included: insufficient knowledge about HPV vaccine; girls were too young and not sexually active; girls are not yet at risk to HPV infections; and it encourages promiscuity. In addition, university students who rejected the HPV vaccine based their decisions on fear of side effects, fear of the unknown, and controversies surrounding the vaccine [42]. Themes surrounding acceptability included access to the vaccine, side effects and effectiveness, protection against and prevention of cervical cancer, provider and teacher recommendations, support from the National Immunization Program and cost [42,43].

**GAVI Alliance Eligibility Based on DTP3 Levels and Pilot Demonstration Projects on HPV Vaccine Delivery**

Of the 13 countries included in this review, 12 have achieved 70% coverage or higher of the DTP3 vaccine since 2003, one of GAVI Alliance’s criteria for vaccine support; the exception is Nigeria (Table 3). Six of those countries had an HPV vaccination pilot program (Cameroon, Lesotho, Rwanda, South Africa, Tanzania and Uganda). There were 31 sub-Saharan African countries not included in the review because there were no studies based in these countries that met the inclusion criteria. The majority of these countries did not start consistently reaching cervical cancer screening (Table 1). All 12 studies reported high levels of acceptability of HPV vaccine. However, multiple levels of acceptability were found within the studies because some assessed and compared different vaccine delivery strategies within and in different countries.

---

### Table 2. Cont.

| Study, Country | Level of Knowledge/CC and Vaccine | Strategies for Vaccination/Increasing Awareness | Factors Influencing Acceptability |
|---------------|----------------------------------|-----------------------------------------------|----------------------------------|
| [70] Uganda   | Not applicable                    | Opportunities for universal rollout of vaccine and policies for strengthening health systems. Create vaccine acceptance driven through aggressive communication strategy. Build synergies between HPV vaccination and other health programs. School-based strategy proved effective. | Not applicable |
| [70] Uganda   | Not applicable                    | Opportunities for universal rollout of vaccine and policies for strengthening health systems. Create vaccine acceptance driven through aggressive communication strategy. Build synergies between HPV vaccination and other health programs. School-based strategy proved effective. | Not applicable |

---

GAVI Alliance Eligibility Based on DTP3 Levels and Pilot Demonstration Projects on HPV Vaccine Delivery

Of the 13 countries included in this review, 12 have achieved 70% coverage or higher of the DTP3 vaccine since 2003, one of GAVI Alliance’s criteria for vaccine support; the exception is Nigeria (Table 3). Six of those countries had an HPV vaccination pilot program (Cameroon, Lesotho, Rwanda, South Africa, Tanzania and Uganda). There were 31 sub-Saharan African countries not included in the review because there were no studies based in these countries that met the inclusion criteria. The majority of these countries did not start consistently reaching cervical cancer screening (Table 1). All 12 studies reported high levels of acceptability of HPV vaccine. However, multiple levels of acceptability were found within the studies because some assessed and compared different vaccine delivery strategies within and in different countries.
coverage levels of 70% or higher until 2005 (Table 4). From 2008 through 2011, all countries, with the exception of Mauritania, have maintained coverage at 70% or above (Table 4).

**Discussion**

This review identified low levels of knowledge and mixed levels of awareness on cervical cancer, HPV and HPV vaccine, and high levels of acceptability of HPV vaccine among all key demographics. In particular, high acceptability of HPV vaccine despite the lack of knowledge about cervical cancer and HPV represents an opportunity for increased education and awareness strategies about cervical cancer, HPV and HPV vaccine. This is important to help key demographics understand the transmission of HPV, its characteristics and associated risks [17,44], and the benefits of HPV vaccine.

Engaging all key demographics through improved and increased education will elevate public trust, which is a critical component of successful implementation of widespread vaccine coverage. Incidences such as those seen in Japan, India and Rwanda [26,27,34,35,45] have challenged public trust in HPV vaccines. Additionally, the qualitative insight provided by this review shows that factors influencing acceptability are often tied to issues of public trust, such as concerns over side effects and safety. This is not only a concern in low- and middle-income countries. For instance, Japan’s Ministry of Health recently withdrew its recommendation for administering HPV vaccine because of reports of side effects, although it still pays for the vaccine for parents consenting to immunize their daughters [34].

Anti-vaccination groups frequently post inaccurate information about vaccine side effects on the web, which is publicized by both local and national media [46,47]. These examples indicate the need to constantly engage and educate the public to avoid the risk of health programs failing [48,49]. While it may not be advisable or possible to respond to all such misinformation, it is essential to counteract it by providing scientifically correct information in a proactive manner so people will seek appropriate medical advice for clarification [50].

Tailored community-based interventions and sensitization programs are a viable means to achieve this for multiple reasons. They have the potential to curb concerns about safety and effectiveness of the vaccine while dispelling negative myths or controversies [45]. Specific training for healthcare workers, the first contact point for patients, will provide them with the accurate knowledge and information necessary to discuss cervical cancer, HPV and HPV vaccine with their patients as well as the ability to properly detect, screen and test for HPV and cervical cancer [18,43].

In addition to understanding levels of knowledge, awareness and acceptability, this review uncovered encouraging trends concerning SSA countries’ eligibility for GAVI Alliance support. Only six countries have currently met the two criteria required by the GAVI Alliance to support introduction of the HPV vaccine at a lower cost of US$4.50 per dose [21]. Of the six, Rwanda has already achieved 93.2% vaccine coverage among girls in grade six and is taking the lead to enroll all eligible girls for HPV vaccination through GAVI alliance support in 2014.

Further, our analysis of national vaccine coverage for DTP3 in SSA shows rapid expansion from just one country reaching 80% in 1980 to 35 countries in 2010 [6]. Of the 31 countries that did not meet the review inclusion criteria, only Mauritania did not consistently achieve GAVI Alliance’s eligibility criteria requiring DTP3 coverage levels greater than or equal to 70% (Table 4). Of the countries included in this review, only Nigeria failed to meet this threshold. The challenges in Nigeria are perhaps unique especially in the context of the recent polio vaccine boycott and killings [51]. This calls for interrogating vaccine acceptance determinants using, for instance, the health-belief model [45] and addressing these through a re-emphasis on contextualized public communication and education to mitigate resistance and to build trust [6].

Such consistently high DTP3 coverage levels among the majority of SSA countries indicates structural health system capabilities to deliver simple vaccines to the population [1,3]. This further demonstrates the feasibility for these countries to deliver multi-dose vaccines, such as HPV, for 50% of a target vaccination cohort in an average size district, which would qualify them for SSA countries’ eligibility for GAVI Alliance support. Only six countries have met the criteria required by the GAVI Alliance to support introduction of the HPV vaccine at a lower cost of US$4.50 per dose [21]. Of the six, Rwanda has already achieved 93.2% vaccine coverage among girls in grade six and is taking the lead to enroll all eligible girls for HPV vaccination through GAVI alliance support in 2014.

### Table 3. Reported Estimates of DTP3 Coverage in sub-Saharan Countries Included in this review.

| Country     | 2011 | 2010 | 2009 | 2008 | 2007 | 2006 | 2005 | 2004 | 2003 | 2002 | 2001 | 2000 | 1999 | 1998 | 1997 | 1996 | 1995 | 1994 | 1993 | 1992 | 1991 | 1990 |
|-------------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| Botswana    | 84   | 80   | 79   | 75   | 77   | 80   | 80   | 95   | 90   | 89   | 91   | 92   | 90   | 89   | 85   | 80   | 90   | 93   | 90   | 85   | 80   |
| *Cameroon  | 82   | 84   | 80   | 77   | 80   | 77   | 75   | 95   | 94   | 90   | 94   | 87   | 79   | 80   | 84   | 77   | 77   | 87   | 80   | 75   | 75   |
| Ghana       | 91   | 94   | 94   | 94   | 94   | 84   | 84   | 80   | 80   | 99   | 76   | 84   | 72   | 68   | 60   | 51   | 51   | 48   | 48   | 40   | 40   |
| Kenya       | 88   | 83   | 75   | 81   | 85   | 80   | 76   | 93   | 73   | 84   | 80   | 63   | 79   | 64   | 36   | 77   | 84   | 50   | 42   | 40   | 41   |
| *Lesotho    | 69   | 75   | 72   | 91   | 91   | 90   | 87   | 71   | 62   | 60   | 72   | 69   | 58   | 64   | 56   | 53   | 52   | 55   | 47   | 66   | 67   |
| Mali        | 88   | 92   | 89   | 99   | 91   | 95   | 95   | 86   | 79   | 74   | 61   | 54   | 47   | 56   | 52   | 53   | 49   | 39   | 46   | 38   | 34   |
| Nigeria     | 61   | 74   | 71   | 57   | 69   | 72   | 38   | 38   | 38   | 21   | 21   | 26   | 34   | 29   | 43   | 39   | 56   | 57   | 75   | 74   | 77   |
| *Rwanda     | 97   | 97   | 97   | 97   | 99   | 95   | 89   | 96   | 88   | 77   | 90   | 85   | 77   | 98   | 90   | 85   | 79   | 83   | 85   | 89   | 57   |
| *South Africa | 97  | 91   | 99   | 98   | 97   | 99   | 87   | 94   | 82   | 81   | 96   | 76   | 76   | 73   | 73   | 72   | 81   | 79   | 81   | 74   | 74   |
| *Tanzania   | 92   | 91   | 85   | 86   | 83   | 90   | 90   | 95   | 95   | 89   | 87   | 79   | 76   | 79   | 79   | 79   | 82   | 81   | 84   | 83   | 81   |
| *Uganda     | 82   | 80   | 83   | 79   | 85   | 80   | 84   | 87   | 81   | 72   | 61   | 58   | 60   | 56   | 61   | 72   | 74   | 79   | 73   | 71   | 77   |
| Zambia      | 81   | 84   | 98   | 95   | 92   | 97   | 91   | 94   | 91   | 88   | 76   | 92   | 70   | 63   | 61   | 90   | 78   | 83   | 82   | 81   | 87   |
| Zimbabwe    | 93   | 89   | 73   | 75   | 85   | 90   | 85   | 80   | 75   | 75   | 77   | 81   | 70   | 78   | 80   | 83   | 80   | 73   | 79   | 89   | 78   |

Source: WHO http://apps.who.int/immunization_monitoring/globalsummary/timeseries/tscoveredt3p.html.
*Country with HPV Vaccination Pilot Program.
doi:10.1371/journal.pone.0090912.t003
As this review shows, engaging all stakeholders at multiple levels in countries that meet these requirements is necessary for successful HPV vaccine implementation. Governments should leverage the high levels of acceptability and willingness to vaccinate by increasing education for healthcare workers, women/girls, and parents/guardians. Governments should also determine appropriate strategies for disseminating information and vaccine delivery by building upon current infrastructures, such as existing EPIs and school-based programs. This has been shown to be an effective approach because it relies on the involvement of multiple critical stakeholders from the government down to the community level, as seen in Rwanda, South Africa, Uganda, and Tanzania [2,6,25,26,28,31]. Tailored community-based sensitization campaigns aimed at a targeted population, as used in Cameroon, also proved effective [15,17,18]. Thus, using hybrid delivery system models may be more beneficial as per country experiences in the EPI and can help inform and determine best practices when developing HPV vaccine pilot programs [4,6].

Conclusions

The objective of this study was to provide a systematic review of knowledge and awareness of HPV vaccine, willingness to vaccinate, and acceptability of the vaccine, as well as fulfillment of GAVI Alliance’s eligibility criteria for vaccine assistance in SSA. To the best of our knowledge, this is the first systematic review of the potential readiness for introduction of HPV vaccine in the subcontinent. Examining the region collectively offers insight into its readiness and ability to implement HPV vaccination on a broader scale while shedding light on the successes, challenges, and lessons of implementation.

From this review, three important themes have emerged. (1) There are high levels of acceptability and willingness to vaccinate.
These should be harnessed by national governments to establish and implement HPV vaccination strategies that build upon existing infrastructures. (2) Overall, six SSA countries qualify for GAVI Alliance assistance to introduce HPV vaccine at a national level. (3) Lastly, there is a need for increased education and awareness among all three key demographics about HPV, HPV vaccine and the burden of cervical cancer as a disease.

The combination of required DTCP3 coverage, high acceptability of HPV vaccine and high willingness to vaccinate, indicates the readiness and potential for SSA countries to introduce HPV vaccine to the population. Successfully doing so will depend on implementing tailored delivery strategies that fit each country’s needs and engaging the government at all levels. Building upon the lessons learned from GAVI Alliance eligible SSA countries will pave the way for those SSA countries still working to meet the criteria. These countries should also take advantage of and benefit from the “decade of vaccines” and the GIVS when there is a re-dedication by donors to meet these goals [4,6].

Limitations

There were some limitations in this review. The studies reviewed lacked consistency in regards to psychometric characteristics used. Not all of the studies used a theoretical framework, consistent labeling of themes examined, or rigorous testing and validation of the measures as previously outlined [52]. While some assessed levels of knowledge and awareness of cervical cancer and HPV, others did not. Still others discussed levels of willingness to vaccinate and acceptability of HPV vaccine while others did not.

References

1. Chauke-Moagi BE, Mumba M (2012) New vaccine introduction in the East and Southern African sub-region of the WHO African region in the context of GISVs and MDGs. Vaccine 30: C3-C8.
2. Levine OS, Bloom DE, Cherian T, de Quadros C, Sow S, et al. (2011) The future of immunisation policy, implementation, and financing. The Lancet 377: 439-444.
3. WHO (2012) WHO and UNICEF Progress towards global immunization goals – 2011. Geneva: World Health Organization. 35 p. p.
4. Ozawa S, Stack ML, Bishai DM, Friberg IK, et al. (2011) Introducing the HPV vaccine to the population: the lives of 6.4 million children valued at $211 billion could be saved. Health Affairs 30: 1010–1020.
5. Knauf MF, Fenik J, Shulman L (2011) Global Task Force on Expanded Access to cancer care and control in developing countries.
6. Machingaidze S, Woyengo CS, Husey GD (2013) Strengthening the Expanded Programme on Immunization in Africa: Looking beyond 2013. PLoS medicine 10: e1001405.
7. Parkin DM (2006) The global health burden of infection-associated cancers in the year 2002. International journal of cancer 116: 3059–3044.
8. Ferlay J, Shin HR, Bray F, Forman D, Mathers C, et al. (2010) Estimates of worldwide burden of cancer in 2008: GLOBOCAN 2008. International journal of cancer 127: 2893–2917.
9. Jemal A, Bray F, Center MM, Ferlay J, Ward E, et al. (2011) Global cancer statistics. CA: a cancer journal for clinicians 61: 69–90.
10. Markowitz LE, Dunne E, Saraiya M, Lawson H, Chesson H, et al. (2007) Key challenges and issues. New England Journal of Medicine 356: 1908–1910.
11. Gakidou E, Nordhagen S, Obermeyer Z (2008) Coverage of cervical cancer screening in 57 countries: low average levels and large inequalities. PLoS medicine 5: 1839–1848.
12. Francis SA, Nelson J, Liverpool J, Soogun S, Mofammere N, et al. (2010) Examining attitudes and knowledge about HPV and cervical cancer risk among women attending for cervical screening in Johannesburg, South Africa. Vaccine 29: 8026–8032.
13. Sitas F, Parkin DM, Chirenje Z, Stein L, Mpofu N, et al. (2006) Disease and mortality in sub-Saharan Africa. World Bank-frik PDF.
14. Francis SA, Nelson J, Liverpool J, Soogun S, Mofammere N, et al. (2010) Examining attitudes and knowledge about HPV and cervical cancer risk among women attending for cervical screening in Johannesburg, South Africa. Vaccine 29: 8026–8032.
15. Ayisi CA, Wamai RG, Odhoo GO, Perelman S, Welby E, et al. (2012) Awareness, Acceptability and Uptake of Human Papilloma Virus Vaccine Among Cameroonian School-Attending Female Adolescents. Journal of community health 37: 1127–1135.
16. Chan ZC, Chan TS, Ng KK, Wong ML (2012) A Systematic Review of Literature about Women’s Knowledge and Attitudes toward Human Papillo- mavirus (HPV) Vaccination. Public Health Nursing 29: 481–489.
17. Wamai RG, Ayisi CA, Odhoo GO, Perelman S, Welby E, et al. (2012) Assessing the effectiveness of a community-based sensitization strategy in creating awareness about HPV, cervical cancer and HPV vaccine among parents in North West Cameroon. Journal of community health 37: 917–926.
18. Wamai RG, Ayisi CA, Odhoo GO, Perelman S, Welby E, et al. (2013) Awareness, knowledge and beliefs about HPV, cervical cancer and HPV vaccines among nurses in Cameroon: an exploratory study. Int J Nurs Stud 50: 1399–1406.
19. Louie KS, De Sanjose S, Mayaud P (2009) Epidemiology and prevention of human papillomavirus and cervical cancer in sub-Saharan Africa: a compre- hensive review. Tropical Medicine & International Health 14: 1287–1302.
20. WHO (2009) Human papillomavirus vaccine. WHO position paper. 118–131 p.
21. Youngblood R (2013) GAVI injects new life into HPV vaccine rollout. Lancet 381: 1688.
22. GAVI (2011) GAVI welcomes lower prices for life-saving vaccines.[press release], June 6, 2011.
23. Agosti JM, Goldie SJ (2007) Introducing HPV vaccine in developing countries: key challenges and issues. New England Journal of Medicine 356: 1908–1910.
24. Wigle J, Coast E, Watson-Jones D (2013) Human papillomavirus (HPV) vaccine implementation in low and middle-income countries (LMICs): Health system experiences and prospects. Vaccine.
25. Binagwaho A, Wagner CM, Gatema M, Karama C, Nutt CT, et al. (2012) Achieving high coverage in Rwanda’s national human papillomavirus vaccination programme. Bulletin of the World Health Organization 90: 623–629.
26. Binagwaho A, Wagner CM, Nutt CT (2011) HPV vaccine in Rwanda: different disease, same double standard. The Lancet 378: 1916.
27. Ouedraogo N, Muller O, Jahn A, Gerhardus A (2011) Human papillomavirus vaccination in Africa. The Lancet 378: 315–316.
28. LaMontagne DS, Barge S, Thi Le N, Mugsha E, Penny ME, et al. (2011) Human papillomavirus vaccine delivery strategies that achieved high coverage in low-and middle-income countries. Bulletin of the World Health Organization 89: 821–830.
29. Watson-Jones D, Bailey K, Ponsiano R, Lemme F, Remes P, et al. (2012) Human papillomavirus vaccination in Tanzanian schoolgirls: cluster-random- ized trial comparing 2 vaccine-delivery strategies. Journal of Infectious Diseases 206: 678–686.
30. Ladner J, Besson MH, Hampshire R, Tapert I, Chirenje M, et al. (2012) Assessment of eight HPV vaccination programs implemented in low income countries. BMC Public Health 12: 370.
31. Moodley I, Tashiah N, Mubawia V, Denny L (2013) High uptake of Gardasil vaccine among 9–12-year-old schoolgirls participating in an HPV vaccination
