School-Based HPV Vaccine Delivery

Tanzania

May 2026

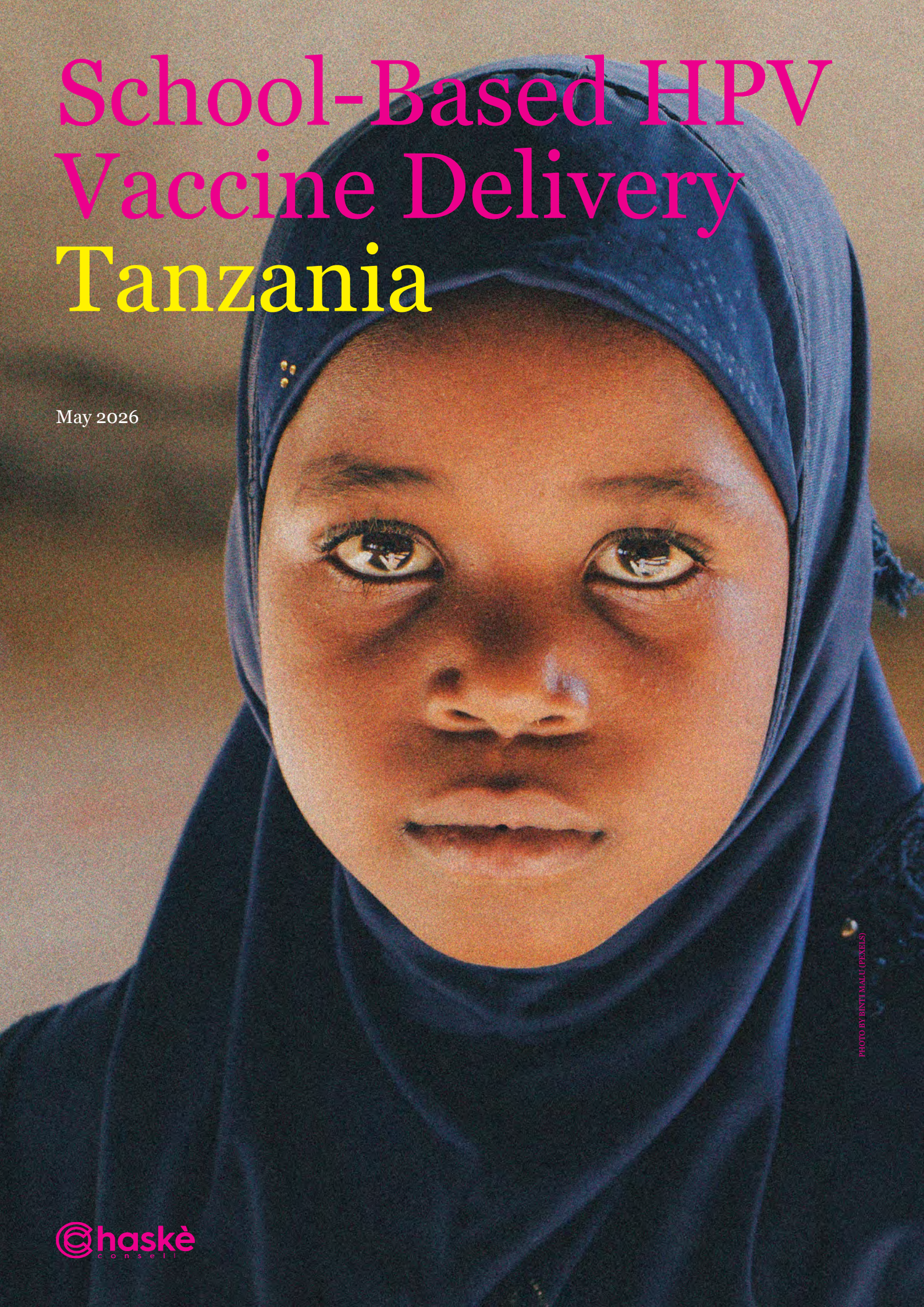


PHOTO BY BINTI MALU (PEXELS)

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Glossary of terms

Term	Definition
AEFI	Adverse Event Following Immunization
CHW	Community Health Worker
DIVO	District Immunization and Vaccine Officer
DMO	District Medical Officer
EPI	Expanded Programme on Immunization
GBV	Gender-Based Violence
HPV	Human Papillomavirus
HPV+	Human Papillomavirus Plus (Integrated Adolescent Health Services Model)
IVD	Immunization and Vaccine Development Unit
LGA	Local Government Authority
LMIC	Low- and Middle-Income Country
MoE	Ministry of Education
MoH	Ministry of Health
NSHNP	National School Health and Nutrition Program
OOS	Out-of-School
PORALG	President's Office – Regional Administration and Local Government
RIVO	Regional Immunization and Vaccine Officer
SHP	School Health Program
SRHR	Sexual and Reproductive Health and Rights
TIMR	Tanzania Immunization Registry
VIMS	Vaccine Information Management System
VigiMobile	Vaccine Safety Mobile Reporting Tool
WASH	Water, Sanitation and Hygiene

Making school health a lasting investment in our children's future

Imagine a nine-year-old girl sitting in a classroom today. She has a future she is only beginning to imagine. Whether she gets the chance to live it should not depend on where she lives, whether she attends school, or whether a health programme happens to reach her. As the leading cause of cancer death among women in many countries of sub-Saharan Africa, cervical cancer takes the lives of around 76,000 African women every year. That is too many of us. Behind every woman lost are people who loved her, depended on her, and hoped she would recover. Yet this is a cancer we know how to prevent. Ours is the story of a gap between what we know and what we are able to deliver.

Adolescence is the moment to close that gap. Vaccinating girls against human papillomavirus (HPV) before they are exposed to the virus is highly effective. Schools are where most girls can be reached, and school health programmes bring together health workers, teachers, families and communities around the well-being of girls. School health programmes must also reach girls who are out of school, so that no girl is left behind.

The four reports in this series, produced by Haskè Conseil, examine what it takes to achieve sustainable results. A cross-country analysis of seven countries and three country studies on Tanzania, Côte d'Ivoire and Indonesia explore why similar interventions produce different results. Their central message is clear: lasting protection depends less on the intensity of campaigns than on strong institutions, with shared responsibility between health and education, predictable funding, recognised frontline staff and the trust of families and communities.

We therefore call on governments to make school health a lasting national responsibility, backed by law and by public funding that covers the everyday costs of delivery. We ask ministries of health and education to plan together, development partners to invest in national capacity beyond funding cycles, and civil society and community leaders to build the trust on which every programme depends.

We thank the Gates Foundation for its collaboration throughout the research process, and Tanzania Health Promotion Support (THPS) and Athari Advisors for supporting the research in Tanzania and Côte d'Ivoire. We also thank the government institutions, UN agencies, implementing partners and civil society organisations consulted across the three country studies.

Thirty years from now, that girl should be living the life she imagined, surrounded by the people she loves. The decisions we make today will help determine whether she gets that chance. No African woman should die of a cancer we already know how to prevent.



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Executive summary

In 2018, Tanzania integrated HPV vaccination into the National School Health and Nutrition Program (NSHNP), enabling a rapid and equitable rollout through a coordinated, school-based platform. Since the HPV vaccination program started, national coverage has remained above 90%, reflecting strong operations and institutional capacity. NSHNP's routines, workforce, and governance made HPV vaccination a sustainable school service. NSHNP coordination across the Ministry of Health (MoH), Ministry of Education (MoE), the President's Office – Regional Administration and Local Government (PORALG), and local actors provided a long-standing foundation for vaccine delivery. Because this platform was already familiar to schools and health teams, HPV vaccination entered a routine, multisectoral system with established planning and delivery mechanisms. Quarterly school health days – already used for deworming, nutrition screening, and menstrual hygiene education – created predictable opportunities to vaccinate girls aged 9–14. Trained school health teachers, trusted by parents and students, supported mobilization and consent. Cross-ministerial coordination aligned education and health calendars, clarified responsibilities, and reinforced accountability from national to school level.

School health services in Tanzania date back over a century, beginning with hygiene and deworming activities in 1921. The program was progressively formalized through national guidelines and consolidated as the NSHNP in 2016, co-led by the MoH and MoE, and operationally coordinated through PORALG. By the time HPV vaccination was introduced, NSHNP already functioned as a multisectoral delivery platform with defined roles, established routines, and embedded accountability channels from national to school level. A 2014 Kilimanjaro pilot served as proof of concept and informed the national rollout from 2018. These features illustrate the institutional value of NSHNP beyond any single intervention.

Several program design features have contributed to Tanzania's success in the area of HPV vaccination:

- **The MoH–MoE–PORALG governance arrangement** gives PORALG convening authority above the line ministries, reducing inter-sectoral competition and routinizing alignment of education and health calendars.
- **Service bundling – the HPV+ model** – combines HPV vaccination with deworming, nutrition assessments, menstrual hygiene education, oral and dental care, and SRHR services, improving operational efficiency and reinforcing community perception of vaccination as part of a broader health package.
- **Digital tool**s – the Tanzania Immunization Registry (TIMR), the Vaccine Information Management System (VIMS), and VigiMobile for AEFI reporting – provide a national backbone for individual-dose tracking, supply visibility, and safety surveillance.
- **Trained school health teachers act as the local coordination layer**, while Community Health Workers (CHWs) extend reach to out-of-school girls.
- **HPV vaccination was layered onto a functioning school-health architecture** rather than implemented as a parallel campaign, which lowered the political and operational barriers to scale-up.
- **Embedding HPV in the Expanded Programme on Immunization (EPI)** for procurement, cold chain management, and AEFI monitoring meant that school-based teams did not operate in isolation but rode on a mature delivery system.
- **Quarterly school health rounds** further normalized HPV delivery as part of routine service provision, supported by district planning cycles and TIMR/VIMS data flows.

Sustaining these gains depends on addressing persistent gaps, particularly:

- **There is no ring-fenced national or district budget line for school health outreach**, including HPV; facilities allocate limited funds and often depend on partner support, which leads to partial implementation in resource-constrained districts. School health teachers play frontline roles but receive no formal compensation for their additional responsibilities, threatening motivation and continuity.
- **Logistics constraints – fuel shortages, limited transport, and heavy workloads** – limit visit frequency and reach, particularly for schools more than 10 km from health facilities and for nomadic or pastoralist communities.
- **Misinformation linking HPV vaccination to infertility persists** where parents miss sensitization sessions, and digital literacy and connectivity gaps weaken the real-time monitoring potential of TIMR and VIMS.

These constraints highlight priorities for further strengthening NSHNP. Establishing a dedicated national budget line for school health would ensure predictable resource flows for outreach, logistics, training, and supervision rather than reliance on facility-level absorption. Formalizing incentives and recognition for school health teachers — through stipends, official roles, or workload adjustments — would help retain this critical workforce. Expanding mobile outreach and microplanning to underserved areas, standardizing cross-sector training, and strengthening community feedback mechanisms linked to TIMR and VIMS would further consolidate program performance and equity.

Tanzania's approach also highlights transferable lessons for other low- and middle-income countries:

- **Leverage existing school health platforms first**, rather than launching standalone HPV campaigns; the predictability of school calendars and trusted teacher networks lowers transaction costs and improves sustainability.
- **Ensure multisectoral governance from the outset**, with shared ownership between health and education ministries and clear roles for local government, as in Tanzania's MoH–MoE–PORALG structure.
- **Plan and budget for logistics and teacher incentives** – high coverage depends not only on vaccines and messages but on fuel, transportation, and the frontline actors who deliver and mobilize for the program.
- **Start with high-coverage, low-complexity interventions**, such as deworming and routine school-based vaccination, to build operational proof points before scaling to more complex services.
- **Embed HPV within a broader adolescent health package**, as in Tanzania's HPV+ model, so the vaccine is one component of a comprehensive, predictable school health offering.
- **Use data and microplanning as management tools, not just reporting tools**, with district-level planning shaping outreach, logistics, and supervision cycles in real time.
- **Integrate education and health data systems**, even where full technical interoperability is still evolving, to improve targeting, reduce dropout, and support equity in delivery.

Key risks remain. Reliance on facility-level absorption of outreach costs makes the program vulnerable to fiscal shocks and donor-funding cycles, particularly for the non-vaccine components of school health. Misinformation can erode public confidence quickly, with rumors around HPV and infertility recurring in specific regions. Reaching out-of-school adolescents – concentrated in remote, mobile, or pastoralist communities – remains operationally demanding and disproportionately costly per dose, which can compromise equity if dedicated outreach financing is not sustained.

Ultimately, Tanzania's experience suggests that NSHNP is not just a delivery channel but a national institutional platform. By reinforcing NSHNP's foundations – teacher capacity, predictable financing for outreach, digital data systems, and routine multisectoral coordination – the country can both protect its HPV vaccination gains and lower the cost of introducing future adolescent health interventions.



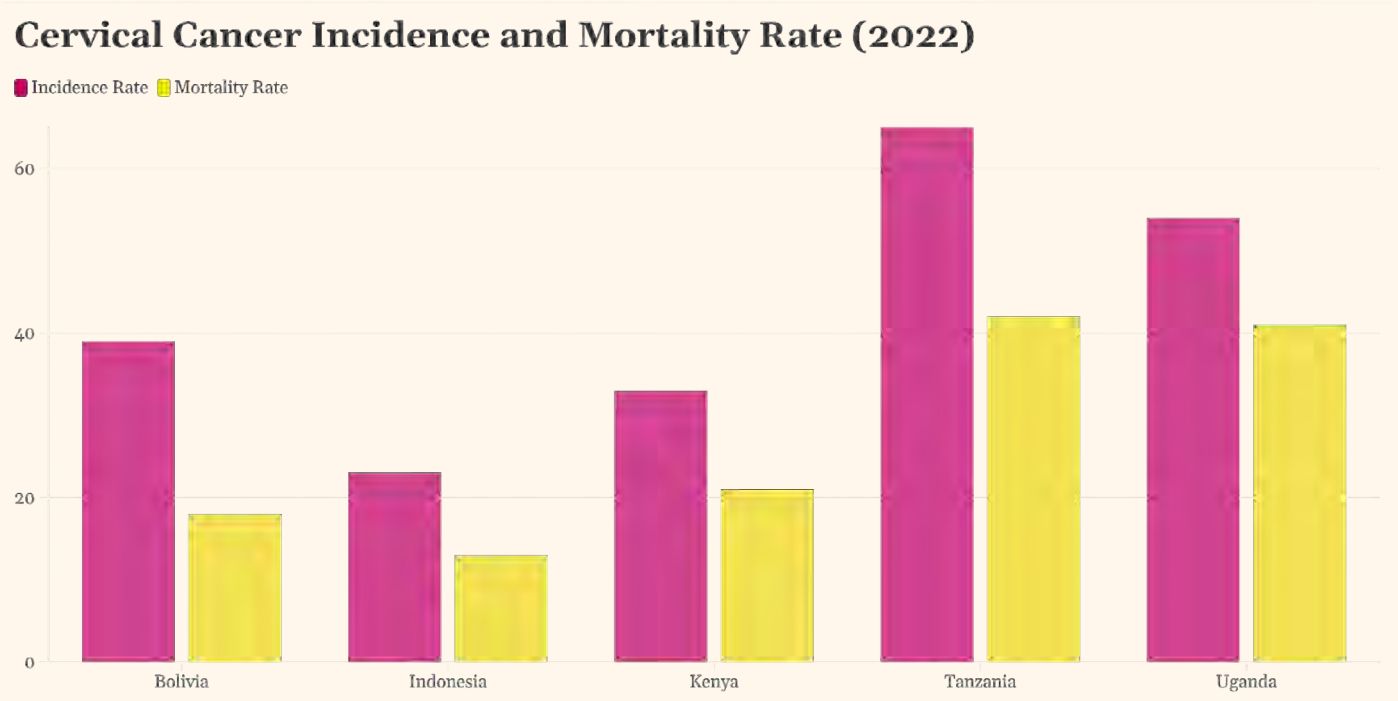
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Background & rationale – why schools and why NSHNP first

Cervical cancer poses a critical public health threat in Tanzania, with an incidence rate of 64.8 per 100,000 women and a mortality rate of 42.2 per 100,000 as of 2022.[1] Each year, approximately 10,000 women are diagnosed with cervical cancer and more than 6,500 die from the disease.[2] The risk is further amplified by HIV prevalence, as women living with HIV are four to five times more likely to experience persistent HPV infection.[3] Against this backdrop, Tanzania's decision to anchor HPV vaccine delivery in schools—and specifically through the National School Health and Nutrition Program (NSHNP)—was both strategic and contextually appropriate.

Figure 1: Snapshot of Tanzania's HPV burden

Incidence rate per 100,000 women:	Mortality rate per 100,000:	Number of women at risk of developing cervical cancer:	Number of women diagnosed annually:	Number of women that die from HPV:
64.8	**42.2**	**18.8M**	**10,000**	**6,500**



Sources: International Agency for Research on Cancer, WHO, Dashboard, 2025, ICO/IARC Information Centre on HPV and Cancer, HPV Information Centre, 2023, CMAJ, Human papillomavirus and HIV coinfection and the risk of neoplasia of the lower genital tract: a review of recent developments, 2003, Tanzania HIV Impact Survey 2022-2023, 2023, Haskè Conseil Analysis, 2025

1 International Agency for Research on Cancer, WHO, Dashboard, 2025.
2 ICO/IARC Information Centre on HPV and Cancer, HPV Information Centre, 2023.
3 Ibid

With net primary school enrolment around 87%, schools offer the most reliable and equitable platform to reach the target population of nine-year-old girls.[4,5] Primary education in Tanzania spans Standards 1 to 7, typically reaching girls between ages 6 and 14, with Standard 4 capturing most nine-year-olds. This age-grade alignment made the school platform ideal for vaccine delivery. The NSHNP, officially launched in 2016, is a multisectoral program jointly led by the Ministry of Health (MoH) and Ministry of Education (MoE), and coordinated by the President's Office for Regional Administration and Local Government (PORALG). Rooted in a century-old tradition of school health services in Tanzania, the program has evolved into an integrated platform for deworming, nutrition screening, eye care, SRHR education, and now HPV vaccination.

The 2014–2015 Kilimanjaro HPV Vaccine Pilot

In 2014–2015, Tanzania conducted a two-year demonstration project in the Kilimanjaro Region to test the feasibility of delivering HPV vaccine through schools and community outreach. The pilot, supported by Gavi and coordinated by the Ministry of Health, targeted 9-year-old girls through school-based delivery in the first year (campaign approach) and integrated routine delivery in the second year.

Key highlights:

- **High coverage:** Administrative data showed ~93% coverage for both doses in 2014 and up to 95% dose-2 coverage in some districts.
- **Operational learning:** The pilot surfaced early lessons on parental consent, cold chain logistics, teacher engagement, and data recording, all of which informed national rollout planning.
- **Platform validation:** Results demonstrated that school-based delivery was both effective and acceptable, reinforcing the strategic decision to embed HPV vaccination into the NSHNP during national scale-up in 2018.

Sources: Mphuru A, Li AJ, Kyesi F, Mwengee W, Mazige F, Nshunju R, Shayo B, Giattas MR, Loharikar A, Lyimo D. National introduction of human papillomavirus (HPV) vaccine in Tanzania: Programmatic decision-making and implementation. Vaccine. 2022 Mar 31;40 Suppl 1(Suppl 1):A2-A9. doi: 10.1016/j.vaccine.2021.04.025. Epub 2021 May 4. PMID: 33962839; PMCID: PMC9601814. JSI, Introducing Human papillomavirus vaccine in Tanzania, 2020.

Recognizing the operational and cost advantages of using an existing platform, the government chose to integrate HPV vaccination into the established school health infrastructure—including trained school health teachers, district school health coordinators, and community engagement networks—through quarterly school health days. According to MoH officials and implementing partners, this decision was informed by the success of the 2014 Kilimanjaro pilot and driven by considerations of cost-efficiency, rapid scalability, and the familiarity communities already had with school-based health delivery. The NSHNP's design also allowed for reaching out-of-school girls through decentralized planning, mobile services, and community health workers.

Embedding HPV vaccination in the NSHNP brought multiple advantages[6], as confirmed by a 2023 study published in Health Policy and Planning:

- **Efficiency**: School-based delivery under the NSHNP appears to have been more cost-efficient than facility-based delivery, in part because bundling HPV vaccination with other adolescent services (such as deworming, menstrual hygiene education, and SRHR) helps amortize transport, cold-chain, and supervision costs.
- **Scalability**: Tanzania's pre-existing school health governance and delivery structures enabled a relatively rapid national rollout following the Kilimanjaro pilot in 2014. Rather than setting up parallel systems, the government integrated HPV into the routine quarterly health outreach

4 The Net Enrolment Rate (NER) measures the percentage of children of official school age who are enrolled in a given level of education. Unlike the Gross Enrolment Rate, it excludes students who are either too young or too old for that level, providing a more precise indicator of age-appropriate school participation.

5 World Bank Group, Databank, schooling rate, 2025.

6 Gallagher, K. E. et al. (2023). Human papillomavirus (HPV) vaccination program in Tanzania: Ongoing costs and operational context of a routinized program. Health Policy and Planning, 38(4), 486–495.

calendar, leveraging trained school health teachers, established microplanning processes, and interministerial coordination through MoH, MoE, and PORALG. These systems reduced start-up time and costs and allowed the country to reach national coverage in just a few years.

- According to the Gallagher et al. (2023) study, **coverage for school-based delivery in the contexts studied was in the 80–90% range**, generally higher than facility-based models, in part because caregivers did not need to travel or arrange separate visits. This comparison, though, reflects a specific operational context and is not directly generalizable.
- **Sustainability**: By embedding HPV vaccination into the NSHNP, Tanzania institutionalized the intervention within a budgeted, monitored, and multisectorally coordinated national program. Unlike stand-alone campaigns, HPV delivery is now part of a routine, multiservice platform that enjoys consistent political and community support—making it more resilient to fluctuations in external funding or staffing.

In summary, the NSHNP provided a useful platform that helped Tanzania reduce time to scale and supported high reported uptake; this should be read alongside the contributions of EPI vaccine financing, complementary outreach to out-of-school girls, and broader community engagement, which also shaped outcomes. The integration of HPV vaccination within this program reflects Tanzania's broader effort to institutionalize adolescent health within its education and health systems.

KEY DEMOGRAPHICS

In Tanzania, formal education is structured into primary and secondary cycles that broadly align with key child and adolescent age groups relevant for school-based health delivery. Primary education spans Standards 1 to 7 and typically enrolls children aged 6 to 13 or 14 years, with most pupils entering Standard 1 at age six. Secondary education is divided into two phases: lower secondary (Ordinary Level), comprising Forms 1 to 4 and generally covering ages 14 to 17, and upper secondary (Advanced Level), comprising Forms 5 and 6 and typically enrolling youth aged 18 to 19. This age–grade structure means that most 9-year-old girls – the primary target group for routine HPV vaccination, are enrolled in Standard 4 of primary school, making primary schools the most reliable and equitable platform for reaching the eligible cohort. Older adolescents, including those in Forms 1–4, are relevant primarily for catch-up vaccination and broader adolescent health services rather than routine HPV delivery.

Enrollment patterns further reinforce the suitability of primary schools as the core delivery platform for school-based health services in Tanzania. Net enrollment in primary education is high, at approximately 85–90% nationally, reflecting near-universal participation in the primary cycle, particularly in Standards 1–4. Enrollment drops more sharply at the transition to secondary education, with lower secondary net enrollment estimated at around 30–35%, and further attrition in upper secondary levels. These patterns mean that primary schools capture the largest and most socioeconomically representative share of the target age cohort for HPV vaccination, while secondary schools are less reliable as universal platforms. As a result, Tanzania's decision to anchor routine HPV vaccination within primary schools – while using outreach and community-based strategies to reach out-of-school and older adolescents – reflects both demographic realities and equity considerations.

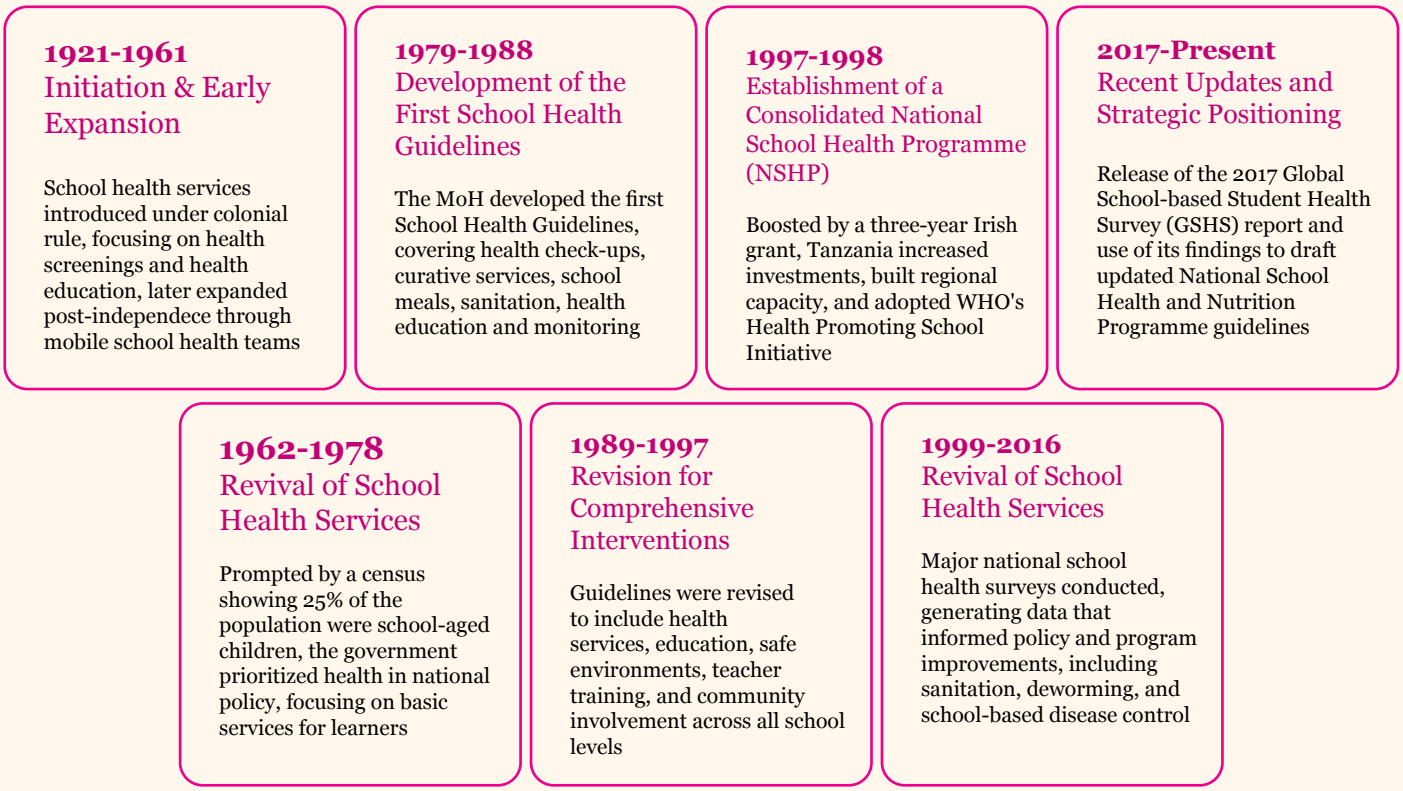
NSHNP: history and structural evolution

ORIGINS AND EVOLUTION

Tanzania's school health infrastructure is among the oldest in sub-Saharan Africa, with formal school health services dating back to 1921. Initially focused on hygiene education, deworming, and basic health checks during the colonial period (1921–1977), the program progressively evolved to address a broader set of student health needs.[7] Between 1978 and 1999, the government formalized its structure by introducing national school health guidelines and expanding services to include nutrition, sanitation, and school-based health education.[8,9]

In 2017, the program was formally consolidated as the National School Health and Nutrition Program (NSHNP), co-led by the MoH and the MoE, and coordinated operationally through the President's Office for Regional Administration and Local Government (PORALG). This reform marked a shift toward comprehensive, integrated service delivery, with an expanded mandate covering Sexual and Reproductive Health and Rights (SRHR), Gender-Based Violence (GBV) and Violence Against Children (VAC) prevention, mental health promotion, and vaccination services, including HPV.[10]

Figure 2: Evolution of the NSHNP



SCOPE OF SERVICES

The NSHNP delivers a comprehensive package of preventive and promotive services in both schools and surrounding communities. These include:

7 Sando et al. (2024). School health and nutrition services for children and adolescents in Tanzania
8 Ibid.
9 Mosha et al. (2011). School health services in Tanzania: Past experience and the way forward
10 United Republic of Tanzania Ministry of Health. (2018). Policy Guidelines on School Health Services in Tanzania

- **Sexual and Reproductive Health (SRHR)** education
- **HPV and other vaccination services** through outreach and in-school sessions
- **Nutrition services**: deworming, screenings, and health education
- **Health checkups:** vision, oral, and physical screening
- **WASH (Water, Sanitation, and Hygiene)** improvements and education
- **Mental health and psychosocial support**
- **Malaria prevention**, including mosquito net distribution
- **GBV and VAC prevention** through awareness and referral mechanisms

The inclusion of these services has evolved over time. Nutrition, SRHR, and WASH were introduced during the early phases of Tanzania's school health efforts in the 1900s. The integration of vaccination into SHP delivery became more prominent from 2018, with HPV serving as a flagship antigen. Mental health was also formally introduced in 2018 and has recently been strengthened: it is now embedded in teacher training modules and integrated into the national curriculum for both primary and secondary schools, with formal rollout pending final ministerial approval.[11]

While this list reflects the broad scope of the NSHNP, operational delivery relies on a "service bundling" strategy. To maximize coverage and resource efficiency, these services are synchronized into "School Health Days." For the 9–14 age cohort, most notably Grade 4 students, HPV vaccination is systematically delivered alongside high-reach interventions like deworming and nutritional screenings. This integrated approach not only streamlines logistics for health teams but also facilitates higher parental acceptance by normalizing school visits as comprehensive, predictable health check-ups rather than isolated, anxiety-inducing events.

This broad and evolving scope made the NSHNP a natural and evidence-backed platform for integrating new interventions such as HPV vaccination. In 2018, all stakeholders involved in school health met to identify and agree on the set of activities to be included in the program – helping codify its structure and ensuring alignment with national adolescent health priorities. Building on the findings from the 2014 Kilimanjaro pilot, the MoH, MoE, and PORALG agreed during the program's 2018 national rollout to embed HPV vaccination within existing school health rounds – leveraging the NSHNP's established credibility, trusted personnel, and operational routines to ensure efficiency and sustainability.[12]

The Role of the EPI

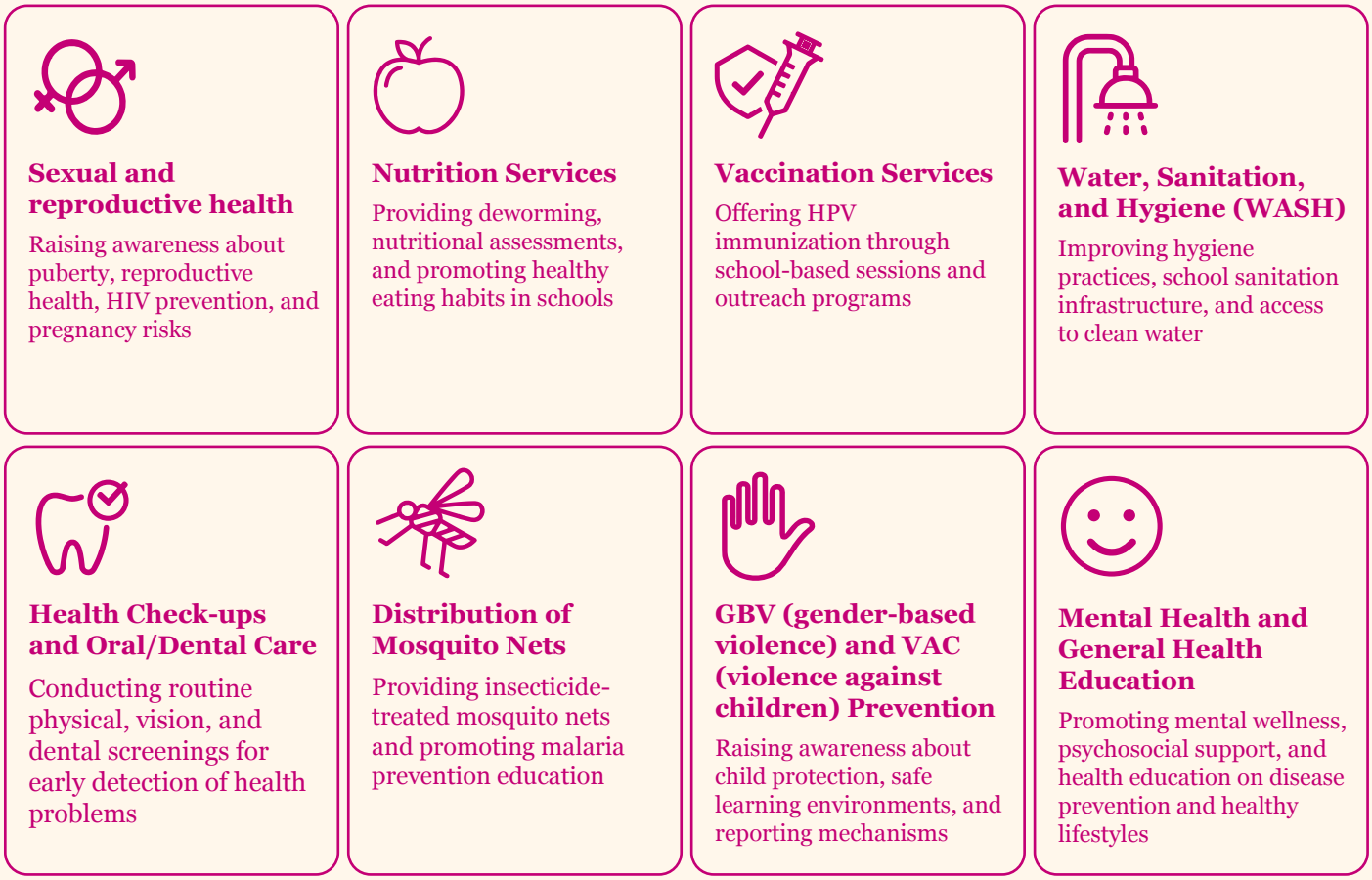
The Expanded Programme on Immunization (EPI), managed by the MoH, is the technical authority for all vaccines in Tanzania, including HPV. It oversees vaccine procurement, financing, cold chain management, and data systems, and is supported by global partners such as Gavi, WHO, and UNICEF.

While EPI governs the technical and logistical aspects of vaccine delivery, HPV vaccination is operationally implemented through the National School Health and Nutrition Program (NSHNP). This model leverages schools as the primary platform for reaching adolescent girls while aligning with Tanzania's national immunization strategy.

This dual structure – technical oversight by EPI, and delivery via the NSHNP – allows HPV vaccination to benefit from both the robust immunization infrastructure and the trusted school health platform, enhancing sustainability, efficiency, and coverage.

11 Haskè Conseil, Interviews with Tanzania stakeholders, 2025.
12 Ministry of Education, Science and technology, Policy Guidelines on school Health services in Tanzania, 2018.

Figure 3: Key focus areas of Tanzania's NSHNP



Source: Ministry of Education, Science and Technology, Policy Guidelines on School Health Services in Tanzania, 2018, Haskè Conseil, Interviews with Tanzania stakeholders, 2025, Haskè Conseil Analysis, 2025

OTHER VACCINES DELIVERED BY THE NSHNP

To situate HPV vaccination within Tanzania's broader school health delivery platform, it is important to distinguish between vaccines that are routinely delivered through early childhood Enhanced Programme on Immunization (EPI) services and those that are specifically delivered through school-based platforms under the NSHNP. While the NSHNP functions as a multiservice adolescent health platform, HPV vaccination remains the only vaccine systematically and routinely delivered through schools nationwide. Other immunizations primarily occur through facility-based EPI services in early childhood, with schools occasionally serving as outreach points during special campaigns or catch-up activities.

The following table summarizes vaccines relevant to school-age delivery, their target age groups, and delivery platforms.

Table 1: Different vaccines offered by NSHNP and the age groups it serves

Vaccine / Antigen	**Target age group**	**Primary delivery platform**	**Role of schools / NSHNP**
HPV	Girls aged 9 years (routine); 10–14 years (catch-up)	School-based delivery via NSHNP, supported by EPI	Core vaccine delivered during quarterly school health rounds; schools are the primary routine delivery platform
Measles–Rubella (MR)	9 months (MR1); 18 months (MR2)	Health facility–based EPI	Schools may serve as temporary outreach points during national campaigns or mop-up activities
Tetanus–Diphtheria (Td)	Pregnant women; adolescent girls (campaign-based, variable)	Facility-based or campaign-based	Schools occasionally used during adolescent Td campaigns, but not part of routine SHP delivery
Polio (OPV/IPV)	Under 5 years	Facility-based EPI; mass campaigns	Schools may be used as community mobilization or campaign sites, not routine delivery points
BCG, Pentavalent, PCV, Rotavirus	Infants (<1 year)	Facility-based EPI	No role for schools
COVID-19 (historical)	Adolescents and adults (campaign-dependent)	Campaign-based	Some districts temporarily used schools as vaccination sites during emergency rollout

FINANCING AND INCENTIVES

Financing for the SHP in Tanzania is shared between the MoH and the MoE, but implementation is largely decentralized, with primary financial execution taking place at the health facility level under the PORALG. This structure reflects the multisectoral nature of the NSHNP, where both health and education systems contribute in different but complementary ways.

A key feature is that vaccines are financed through the EPI, managed by the MoH. This ensures that HPV vaccination is integrated into Tanzania's routine immunization framework, alongside other antigens. EPI financing facilitates vaccine procurement, cold chain support, distribution logistics, and training – allowing HPV to benefit from the country's broader immunization infrastructure.

On the education side, the MoE supports school coordination, health promotion, and the participation of school personnel. Teachers – especially school health focal points – are not formally compensated for their

additional responsibilities under the NSHNP. They typically receive occasional stipends or refreshments during partner-supported activities. Healthcare workers are entitled to allowances for school outreach activities, funded from facility-level budgets. Community Health Workers (CHWs) receive a government-regulated stipend (~TZS 100,000 or USD 40/month), which is their only regular payment and not an additional salary, as their role remains largely voluntary, and undergo a standardized six-month training program.[13] Their role in mobilization, especially for out-of-school girls, is crucial.

While this financing system functions under the current structure, it remains constrained by the absence of a dedicated national SHP budget line. Without earmarked funding, outreach is dependent on the planning capacity and financial flexibility of individual health facilities and districts. This often results in partial implementation – where only core interventions like deworming or vaccination proceed, while broader adolescent health services are deprioritized.

Table 2: Financing flows for school-based health and HPV vaccination under Tanzania's NSHNPs

Financing source	**Managing institution**	**Primary uses within NSHNP / HPV delivery**	**Indicative scale and characteristics**
Expanded Programme on Immunization (EPI)	Ministry of Health (central) > regions > districts	Vaccine procurement (HPV); national and subnational cold chain; vaccine distribution; forecasting and supply management; immunization training; supervision; data systems (TIMR, VIMS, VigiMobile)	Centrally financed; largest and most stable cost component; largely insulated from district-level budget variability
Health facility operational budgets (PORALG)	President's Office – Regional Administration and Local Government (PORALG) > LGAs > health facilities	Health worker outreach allowances; transport and fuel for school visits; per diems; basic outreach logistics for quarterly SHP rounds	Decentralized and highly variable; dependent on facility prioritization and fiscal space; key constraint on outreach frequency and geographic reach
Ministry of Education (MoE) recurrent budgets	Ministry of Education > schools	School coordination; scheduling of health days; use of school infrastructure; health promotion activities	No dedicated SHP or HPV line; in-kind contributions dominate; teachers not formally compensated for NSHNP tasks
Community Health Worker (CHW) national stipend scheme	Ministry of Health (national framework) > districts	Monthly stipends (~TZS 100,000 / USD ~40); six-month standardized training; community mobilization; identification and follow-up of out-of-school girls	Nationally standardized stipend; modest but predictable; critical for equity and outreach to OOS populations
Development partners (Gavi, UNICEF, WHO, others)	External partners in coordination with MoH and PORALG	Pilot financing; training and refresher training; social mobilization; digital tools; cold-chain expansion; technical assistance	Time-bound and project-based; front-loaded during pilots and scale-up; catalytic rather than recurrent
Household / community contributions	Parents, caregivers, community leaders (informal)	Consent processes; attendance at sensitization meetings; opportunity cost of participation	Non-financial but operationally significant; affects uptake and equity, especially where sensitization is weak

13 I don't have this footnote

Financing for school-based HPV vaccination in Tanzania reflects a hybrid, absorption-based model rather than a purpose-built school health financing architecture. Vaccines and core immunization functions are securely financed through the EPI, while delivery costs are decentralized and absorbed into existing facility and district budgets under PORALG. This structure enabled rapid national scale-up without creating new budget lines but results in uneven implementation across districts, particularly for outreach-intensive components. The absence of a dedicated national SHP budget line and the lack of formal incentives for teachers mean that non-vaccine costs – transport, supervision, and community engagement – remain the binding constraints on program expansion and service bundling beyond HPV.



PHOTO BY DMITRY LIMONOV (PEXELS)

School-based HPV vaccine delivery

NSHNP delivery platforms and program design – how the NSHNP anchors service delivery

QUARTERLY SCHOOL HEALTH ROUNDS: THE CORE OPERATING MODEL

Under the NSHNP, school health days are organized once per quarter across all public primary schools. These rounds are coordinated jointly by school health teachers, school heads, and health facility staff from the catchment area. Activities are pre-planned based on student enrolment data, cold-chain logistics and vaccine stock, outreach and mobile team scheduling and national guidance on adolescent health priorities.[14] These rounds deliver the bundled package of services (deworming, SRHR, mental health, vaccination services, including HPV, etc.). The vaccination program is part of the SHP for school children; however, the primary health facilities of the respective catchment areas are involved in providing HCWs as vaccinators in both schools and surrounding communities.[15] When HPV vaccination was introduced in 2018, it was layered into the existing NSHNP round structure, enabling Tanzania to scale up without creating a parallel program.

Each delivery cycle follows a predictable routine. Teachers help prepare the school environment, mobilize students, and manage post-vaccination observation. Health workers – mobilized from local health facilities – bring vaccines, cold boxes, AEFI kits, and data forms or tablets.

Despite the relative efficiency of this delivery model, several operational constraints persist. First, the reliance on health workers from primary health facilities can create temporary service disruptions at facility level during school health rounds, particularly in rural districts where staffing levels are already limited.

Second, logistical challenges related to transport, cold-chain maintenance, and vaccine stock management can affect outreach activities in remote or geographically dispersed communities.

Third, coordination between the education and health sectors requires careful micro-planning and timely communication, as discrepancies between school enrolment records and health facility data may complicate the identification of eligible cohorts. Finally, reaching out-of-school girls remains operationally demanding, often requiring additional community mobilization efforts and mobile teams, which increases both logistical complexity and program costs. These constraints highlight the importance of strong district-level coordination and adequate resource allocation to sustain the integrated delivery model.[16,17,18]

COMPLEMENTARY CHANNELS: REACHING OUT-OF-SCHOOL GIRLS

From the perspective of health care workers, school outreach is the operational arm of SHP delivery. When schools fall within proximity to health facilities, Community Health Workers (CHWs) conduct routine outreach visits, delivering bundled services – such as health education, HPV vaccination, and deworming – on a planned schedule. This integrated delivery reflects the “HPV Plus” approach (HPV vaccination combined with broader adolescent health services through schools), which improves efficiency by grouping interventions – such as vaccination, nutritional and visual screening, and deworming, into a single session rather than multiple visits. By consolidating services, the approach reduces operational costs and minimizes repeated

14 Ibid.
15 Haskè Conseil, Interviews with Tanzania stakeholders, 2025
16 Tanzania’s human papillomavirus (HPV) vaccination program: Community awareness, feasibility, and acceptability of a national HPV vaccination program, 2019, PubMed Central, 2022
17 National introduction of human papillomavirus (HPV) vaccine in Tanzania: Programmatic decision-making and implementation, PubMed Central , 2022
18 Tanzania’s 5-million-girls HPV vaccination campaign a “success”, GAVI, 2024

mobilization efforts for the health system.[19] In more remote settings, mobile outreach teams are deployed, with CHWs often spending the night in communities to reach hard-to-access schools. These differentiated strategies ensure comprehensive coverage regardless of school location, while preserving the standardized SHP service package.

Despite strong primary school enrolment (~87%)[20], not all girls are reached through schools. To close this gap, NSHNP coordinates with the EPI to implement complementary outreach and mobile services:

- Outreach teams travel up to 10 km from facilities
- Mobile teams reach girls in remote islands, pastoralist zones, and nomadic areas

CHWs are crucial in identifying out-of-school (OOS) girls[21], sensitizing households, and tracking refusals. Sessions are bundled with nutrition checks, deworming, and SRHR education – ensuring OOS girls receive holistic care, not just vaccination. This layered outreach mirrors the school-based routine but adjusts for distance, logistics, and social context – critical for equity and national coverage consistency.

HPV AS AN INTEGRATED COMPONENT, NOT A STANDALONE CAMPAIGN

HPV vaccination is integrated within the school health platform but governed technically by the EPI. This means that:

- Vaccines are procured and distributed by the MoH through EPI systems
- Cold-chain planning is managed by Regional and District Immunization Officers
- AEFI is monitored via VigiMobile[22]
- Coverage data is entered into the digital database (vaccine delivery by school and individual girl, dose completion monitoring) TIMR

This dual ownership, clinical by EPI, operational by NSHNP, has contributed to rapid rollout by minimizing startup delays – new delivery protocols were not needed, and the operational teams (teachers, health workers, district officers) already had experience from existing SHP rounds. At the same time, long-term sustainability is supported by embedding HPV into the routine EPI planning cycle, cold chain infrastructure, national reporting systems (TIMR), and supervisory routines, rather than managing it as a vertical or donor-driven campaign.[23]

There are however still challenges in the system. Health workers face fuel shortages, limited transport, and high workloads, which limit their ability to reach mobile schools or remote villages consistently. Nomadic communities and small islands are especially difficult to serve, and although mobile outreach is included in microplans, actual execution often depends on donor support or district-level improvisation.

TRAINING

Training and capacity building are coordinated under the NSHNP to ensure alignment between the health and education sectors. Implementation follows a multilevel cascade:

19 Feasibility and sustainability of a school-based platform for integrated delivery of HPV vaccination with adolescent health services in Tanzania: qualitative insights from stakeholders, Pubmed Central, 2023
20 World Bank Group, Databank, schooling rate, 2025
21 Refers to those not enrolled in formal education who are reached through community outreach and mobile services.
22 Mobile application used to report AEFI cases, ensuring prompt documentation and follow-up on vaccine safety.
23 Refers to the quarterly school health rounds organized under Tanzania's National School Health and Nutrition Program (NSHNP). They are named « health days » in the academic calendar.

- National teams orient regional trainers.
- The Regional Immunization and Vaccination Officer (RIVO) and the District Immunization and Vaccination Officer (DIVO); the critical logistics officers responsible for managing the cold chain, vaccine stock levels, and the coordination of immunization activities at the regional and district levels, respectively; train facility-level health workers using standardized packages.
- Teachers receive brief orientations on vaccine communication, consent, and AEFI monitoring from their catchment health facilities. They are not authorized to administer vaccines.
- CHWs are trained and incentivized to mobilize OOS girls, acting as links between schools, communities, and health facilities.

These sessions cover both public and non-formal education settings. Routine supportive supervision by district and regional health teams reinforces messages and informally assesses retention. Refresher trainings are folded into routine EPI district meetings to onboard new staff without dedicated workshops, though not all teachers nationwide have received HPV orientation.

To address these gaps, the government – with support from partners such as WHO and UNICEF – have invested in refresher training, tablet distribution, and simplified digital reporting formats, particularly in councils with historically low data quality and significantly reducing data lag times.[24]

INTEGRATION OF HPV VACCINATION INTO NSHNP: FROM PILOT TO NATIONAL ROUTINE

Tanzania's journey toward nationwide HPV vaccination reflects strategic planning and incremental expansion.

2014
Demonstration Project

Conducted in Kilimanjaro Region, this pilot tested the feasibility of school-based vaccination and identified operational bottlenecks such as parental consent, teacher coordination, and cold chain management.

2018
National Rollout

The government launched the nationwide program targeting girls aged 9–14 years, initially using a two-dose schedule. HPV vaccination became a cornerstone of school-based health days.

2021-2023
HPV+ Pilots

The introduction of HPV+ in regions such as Njombe, Mbeya, Iringa, Songwe, and Dar es Salaam combined HPV vaccination with complementary adolescent health services. These pilots showed improved acceptance when vaccination was part of a broader health package.

2024
Shift to single-dose schedule

Following updated World Health Organization (WHO) recommendations, Tanzania transitioned to a single-dose schedule focused on nine-year-old girls. Catch-up campaigns continue for older girls who missed earlier opportunities.

Source: Ministry of Education, Science and technology, Policy Guidelines on school Health services in Tanzania, 2018; Haskè Conseil, Interviews with Tanzania stakeholders, 2025; Haskè Conseil Analysis, 2025

Since its national introduction in 2018, Tanzania has delivered the HPV vaccine to girls aged 9–14 years using a two-dose schedule through school-based platforms. In 2023, the program transitioned to a single-dose schedule focused on 9-year-old girls, following updated WHO

24 Haskè Conseil, Interviews with Tanzania stakeholders, 2025

recommendations.[25] Delivery is primarily conducted through primary schools, especially targeting girls in Standard 4, where enrolment aligns with the eligible age group.[26] During quarterly School Health Program (SHP) rounds, health care workers visit schools to vaccinate eligible girls, while school health teachers organize class lists, contact parents, and manage follow-up. The inclusion of private and religious schools has further expanded access, although their participation remains voluntary.[27]

To maintain flexibility and maximize reach, HPV vaccination is administered on a rolling basis as girls turn nine, with no fixed national vaccination day. However, many districts synchronize vaccination campaigns with World Immunization Week in April, using it as a strategic opportunity for intensified outreach and visibility.[28] Catch-up campaigns are also conducted for girls aged 10–14 who may have missed their dose, ensuring broader coverage and equity.[29] This layered approach allows HPV vaccination to be firmly embedded within the NSHNP's quarterly platform, while also leveraging global moments and local adaptations to drive uptake.[30]

25 WHO, Global Cancer Observatory, Dashboard, 2025
26 Ibid.
27 Interviews with Tanzania stakeholders, 2025
28 Ibid.
29 Ibid.
30 Ibid.

Governance and coordination

GOVERNANCE, COORDINATION & THE ROLE OF NSHNP

Tanzania's school health governance is structured across three core institutions[31]:

- **Ministry of Health** (MoH): Leads strategic planning, health workforce mobilization, vaccine policy and financing (including through the EPI).
- **Ministry of Education** (MoE): Ensures alignment with the curriculum, school calendars, and school-level logistics. It co-chairs governance at the national level.
- **President's Office** – Regional Administration and Local Government (PORALG): Operates as the implementation arm, translating national policies into action via Local Government Authorities (LGAs) and facilities.

These institutions coordinate under the umbrella of the NSHNP – with formal roles and reporting channels established from national to community levels.[32] At the national level, the governance of the NSHNP is co-led by the MoH – through its Directorate of Preventive Services and the School Health and Nutrition Coordination Unit – and the MoE. This leadership is supported by other key ministries such as the Ministry of Community Development, the Prime Minister's Office – One Health and Nutrition, the Ministry of Livestock and Fisheries, and the Ministry of Home Affairs. Development partners, including WHO, UNICEF, and UNESCO, are integrated into these structures and contribute to strategic planning, technical guidance, and capacity-building efforts.

Table 3: Mapping of technical responsibilities by development Partner

Partner	**Key Focus Area**
WHO	Clinical standards, AEFI protocols, and technical vaccine safety guidance.
UNICEF	Cold chain logistics, supply chain management, and community-level social mobilization.
UNESCO	Curriculum development, teacher training modules, and school-based health education frameworks.

National-level policies and plans are operationalized through PORALG, which oversees the rollout of interventions via decentralized local government authorities (LGAs). This cascading governance model facilitates continuity and coherence across levels of implementation. At the regional level, oversight is provided by Regional Administrative Secretaries (RAS), with technical leadership from Regional Immunization and Vaccine Officers (RIVOs), Regional Health Promotion Coordinators, and Regional School Health and Nutrition Coordinators. At the district level, coordination is managed by District Executive Directors in collaboration with District Medical Officers (DMOs), District Immunization and Vaccine Officers (DIVOs), and District School Health and Nutrition Coordinators, among others. These actors are responsible for microplanning, stock management, team assignment, and joint review of performance data.

Within schools, the NSHNP empowers designated school health teachers to act as focal points for planning and delivering school health interventions. These teachers play a pivotal role in HPV vaccination by organizing class rosters, informing and mobilizing parents, preparing physical spaces for vaccination, supervising post-vaccination observation, and communicating with health

31 Ministry of Education, Science and technology, Policy Guidelines on school Health services in Tanzania, 2018; Haskè Conseil, Interviews with Tanzania stakeholders, 2025; Haskè Conseil Analysis, 2025.
32 Ministry of Education, Science and technology, Policy Guidelines on school Health services in Tanzania, 2018; Haskè Conseil, Interviews with Tanzania stakeholders, 2025; Haskè Conseil Analysis, 2025.

workers. Community health workers complement these efforts by helping identify and reach out-of-school girls and support mobilization during community outreach.

The NSHNP serves not only as a coordination mechanism but also as an operational platform. Its quarterly school health outreach model allows for the bundling of multiple adolescent health services, including HPV vaccination, and ensures a routine rhythm of delivery that communities, schools, and health facilities can plan around. The strength of this model lies in its ability to align calendars, resources, and responsibilities across sectors. Regular coordination meetings are held at regional and district levels, where education and health actors jointly review vaccine stocks, micro plans, and student data to prepare for upcoming sessions.

The governance structure also ensures that HPV vaccination benefits from integration into Tanzania's broader immunization framework. The MoH's Immunization and Vaccine Development (IVD) unit[33] provides national oversight under the Expanded Programme on Immunization (EPI), while the NSHNP manages delivery at the school and community levels. This collaboration allows for technical and logistical consistency while leveraging the credibility and accessibility of the school health platform.

In addition to operational coordination, this structured governance has enabled Tanzania's NSHNP to evolve into a platform for policy influence. The National Technical Advisory Committee for SHP has successfully advocated for the review of national training modules and the integration of health and nutrition content into the school curriculum, demonstrating the program's growing institutional leverage across both the health and education sectors.

Tanzania's NSHNP governance model combines centralized technical authority with highly decentralized execution, anchored by PORALG's unique role as an implementation authority above sectoral ministries. While the Ministry of Health retains control over vaccine policy, financing, and immunization systems through the EPI, delivery is operationalized through local government structures that coordinate health facilities, schools, and community actors. The designation of school health teachers as focal points institutionalizes school-level ownership without transferring clinical responsibility, while quarterly coordination cycles at district and regional levels routinize collaboration across sectors. This governance configuration has enabled HPV vaccination to be embedded within both the national immunization framework and the education system, without creating parallel delivery structures—though it also concentrates implementation risk at subnational levels where capacity and resources vary.

33 A division within the MoH overseeing immunization programs, data management, and coordination with partners.

Table 4: Governance structure and functional roles for school-based health and HPV vaccination in Tanzania

Governance level / actor	Institution(s)	Core mandate within NSHNP	Primary functions for HPV delivery	Indicative authority and influence
National – Policy & technical authority	Ministry of Health (MoH) – Directorate of Preventive Services; Immunization and Vaccine Development (IVD) Unit / EPI	Sets national health policy; vaccine policy; immunization standards; financing of vaccines	Vaccine selection and scheduling; procurement; cold-chain standards; AEFI policy; national data systems (TIMR, VIMS, VigiMobile); technical guidance	High technical authority; controls vaccine financing and standards; limited direct delivery role
National – Education sector leadership	Ministry of Education (MoE)	Aligns health interventions with education policy, curriculum, and school calendars	School participation; curriculum integration (health, SRHR, HPV awareness); designation of school health teachers	High agenda-setting influence within schools; no direct financing authority
National – Cross-sector coordination & implementation oversight	President's Office – Regional Administration and Local Government (PORALG)	Translates national policy into subnational implementation through LGAs	Oversees rollout through regions, councils, and facilities; enforces coordination between health and education actors	Strong convening and enforcement power; critical for multisectoral alignment
National – Advisory & partner coordination	National School Health Technical Advisory Committee; WHO, UNICEF, UNESCO, others	Strategic advice; capacity building; system strengthening	Training modules; guidelines; pilot support; technical assistance	Influential but non-binding; catalytic rather than directive
Regional – Oversight & supervision	Regional Administrative Secretaries (RAS); RIVOs; Regional SHN Coordinators	Supervises district performance; ensures policy compliance	Oversight of cold chain; supervision of HPV delivery; performance reviews	Moderate authority; bridges national guidance and district execution
District – Planning & coordination	District Executive Directors; DMOs; DIVOs; District SHN Coordinators	Microplanning; coordination of health and education actors	School scheduling; team assignment; outreach planning; stock management; data review	High operational control; effectiveness varies by district capacity
Health facility – Service delivery	Health facilities under LGAs	Frontline implementation of SHP rounds	Vaccine administration; AEFI management; outreach to schools and communities; data entry	Operational authority; constrained by staffing, transport, and budgets
School level – Frontline coordination	School heads; designated school health teachers	Organize school-based health activities	Class listing; parent mobilization; preparation of vaccination spaces; post-vaccination observation; follow-up	High social legitimacy; no formal decision or financing power
Community level – Equity & outreach	Community Health Workers (CHWs); community leaders	Link schools, households, and facilities	Identification of out-of-school girls; household sensitization; follow-up	Critical for equity; limited formal authority

CASCADING GUIDANCE: FROM POLICY TO PRACTICE

Downward Communication (National to Community):

- "Cascading" Guidance: Policy shifts or operational updates move from the Ministry of Health (IVD) down to the RIVO/DIVO via standard notification memos, and then to school health focal points through district-level trainings.
- Community Engagement Hubs: For parent-facing communication, the system leverages school-based Health Committees and religious leaders. Information is disseminated using standardized "Counseling Cards" provided by the national level to ensure the messaging regarding HPV is consistent and accurate across all rural districts.

How Tanzania built and sustained the governance and financing model for school-based HPV delivery

External partners have supported Tanzania's school health system by working through existing government structures rather than creating parallel ones – financing pilots, digitizing data systems (TIMR/VIMS), and supporting cascade training. This approach contributed to system strengthening in three specific ways:

- Institutionalization through Absorption: Integrating HPV vaccination into the National School Health and Nutrition Program (NSHNP) allowed for immediate "routinization," preventing the system fatigue often caused by vertical, standalone campaigns.
- Strengthening Multisectoral Governance: By reinforcing the collaboration between the Ministry of Health, the Ministry of Education, and PORALG, partner support helped solidify a cross-ministerial coordination framework that now serves as a template for other adolescent health interventions.
- Operational Validation & Scale-up: Partner-funded pilots (e.g., the 2014 Kilimanjaro pilot) provided the evidence base needed to scale the "HPV Plus" integrated model nationwide, proving that bundled services (vaccination, nutrition, and hygiene) increase overall system efficiency.

Community engagement & NSHNP as the demand engine

Community engagement is a cornerstone of Tanzania's HPV vaccination success, and the NSHNP has played a pivotal role in creating trust, awareness, and consistent demand for school-based health services. By embedding HPV vaccination within an established platform with predictable routines, designated school health focal points, and pre-existing channels of communication between schools, parents, and health workers, the NSHNP created a structured environment where communities were already accustomed to receiving health services. This familiarity reduced uncertainty, enhanced trust, and allowed vaccine days to be planned and communicated through existing teacher–parent–community linkages. Coordination between school calendars, health facility schedules, and community sensitization efforts ensured that outreach was aligned, reducing missed opportunities and increasing timely uptake.



Sources: WHO, UNICEF, Dashboard, 2023.

TRUSTED MESSENGERS: TEACHERS AND SCHOOL STRUCTURES

Designated school health teachers are central to the NSHNP's engagement model. As the trusted interface between schools, students, and parents, they organize sensitization sessions, manage communications before and after vaccine days, and answer concerns related to vaccine safety and efficacy. They also liaise directly with health workers and community leaders, ensuring alignment of messages and clarity of information at all levels. Their established role in school and community life gives their messages a unique legitimacy.[34] In the case of HPV vaccination, where resistance is often higher than for other interventions, school health teachers play a particularly critical role by providing counselling to parents on the SHP and the HPV vaccine specifically. They frequently call for and organize special meetings with caregivers to explain the vaccine's benefits, dispel myths (especially those linking it to infertility), and build parental trust and acceptance.

LEVERAGING EXISTING COMMUNITY NETWORKS

Rather than launching independent outreach efforts for HPV vaccination, Tanzania has effectively used existing social and community structures to build awareness and drive uptake. In many

34 Ministry of Education, Science and technology, Policy Guidelines on school Health services in Tanzania, 2018

areas, teachers engage with vikoba (village savings and loan associations) and parent–teacher associations (PTAs) to share key information and dispel persistent myths – particularly those linking HPV vaccination to infertility. These platforms provide regular forums where teachers and community health workers can meet with caregivers to answer questions and generate buy-in.[35]

STUDENT HEALTH CLUBS AS PEER ADVOCACY PLATFORMS

The NSHNP also promotes student participation through school health clubs, where adolescents learn about health topics such as puberty, menstrual hygiene, nutrition, and vaccination. These clubs have helped normalize conversations about HPV and cervical cancer, empowering students to become peer educators. Many girls report that it was through these clubs that they first learned about the vaccine and later convinced hesitant caregivers to allow vaccination.[36]

CURRICULUM INTEGRATION AND HEALTH LITERACY

By incorporating health topics, including HPV and cervical cancer, into the primary school curriculum, the NSHNP ensures that accurate, age-appropriate information reaches students in a sustained and structured manner. This institutional approach to health education has been especially effective in rural areas, where rumors and misinformation are more likely to spread in the absence of reliable communication channels.[37]

Curricular integration was the result of a multi-sectoral codification process led by the MoH, MoE, and PORALG and informed by the 2014 Kilimanjaro pilot. Health and cervical-cancer content was woven into existing teaching guides, with delivery aligned to the school health rounds calendar so that education sessions precede vaccination dates.

MULTI-ACTOR SUPPORT AT COMMUNITY LEVEL

CHWs, trained and incentivized through national schemes, play a critical role in identifying and mobilizing out-of-school girls, often going door-to-door to raise awareness and support outreach campaigns. Religious leaders, traditional chiefs, and local government authorities are also engaged at various levels to reinforce messages, enhance legitimacy, and align community expectations with national health goals. In practice, this engagement often takes the form of community sensitization meetings organized ahead of vaccination rounds, during which district health teams brief local leaders on the objectives of the program, eligibility criteria, and key messages related to HPV prevention. These leaders then disseminate information through existing community platforms such as religious gatherings, village assemblies, and local administrative meetings. In some areas, local authorities also support microplanning by helping identify hard-to-reach populations and coordinating outreach activities with community structures.

By institutionalizing community engagement within a broader, multisectoral program, Tanzania has created a self-reinforcing cycle of awareness, trust, and participation. While the intensity of this engagement may vary across districts depending on local administrative capacity and community dynamics, the involvement of trusted local figures has proven important in addressing misinformation and strengthening public confidence in vaccination programs. Instead of relying on temporary or donor-driven campaigns, the NSHNP embeds health communication into everyday structures of school and community life. This makes it a powerful demand engine, particularly for HPV vaccination, an intervention that historically faces high levels of hesitancy in many contexts.

35 Ibid.
36 Ibid.
37 Ibid.

Table 5: Key differences between School Health Program (SHP) and outreach to schools in Tanzania

Feature	**School Health Program (SHP)**	**Outreach to Schools**
Institutional framework	Integrated, government-endorsed program co-led by MoH, MoE, and PORALG	Often donor-driven or campaign-based; lacks full multisectoral ownership
Governance	Formal coordination structure from national to school level	Operates via ad hoc collaboration between health workers and school staff
Routine & predictability	Delivered quarterly, following a national calendar and operational routines	Episodic, based on partner funding availability or specific campaigns
Scope of services	Bundled package: HPV, deworming, SRHR, nutrition, mental health, etc.	Often focused on single interventions (e.g. vaccination only)
Community & school engagement	Leverages school health teachers, student clubs, and parent structures	Limited engagement; messaging may not be integrated into school routines
Cost-efficiency	Shared logistics and trained workforce reduce cost per contact	Higher cost per girl due to one-off visits and standalone logistics
Data & planning integration	Uses TIMR, VIMS, and school enrolment data for microplanning and follow-up	Less integrated with health and education data systems
Sustainability	Part of a long-term government program with embedded systems	Dependent on external funding; may lack continuity
Reach & equity	Covers most public schools; complemented by outreach to out-of-school (OOS) populations	May miss remote or OOS populations unless separately planned
Example in Tanzania	HPV vaccination embedded within NSHNP since 2018, part of the quarterly school health rounds	Early HPV delivery (2014 pilot) also included outreach, but shifted to SHP for scale-up

Despite the program's progress, some challenges persist:

- Digital literacy gaps among teachers and some health workers limit full utilization of available tools.
- Internet connectivity in rural and remote regions causes delays in uploading data.
- Inconsistent orientation for new teachers results in variable quality of data recording at school level.



PHOTO BY BINTI MALU (PEXELS)

Data, monitoring & NSHNP-driven microplanning

Tanzania's success in school-based HPV vaccination is underpinned by a robust data management and microplanning system, much of which is structured and operationalized through the NSHNP. The program's strong foundation in school-level reporting, local planning cycles, and cross-sector coordination has enabled real-time tracking, evidence-based decision-making, and rapid course correction.[38]

SCHOOL-LEVEL DATA COLLECTION AND REPORTING

At the frontline of data generation are school health teachers and health workers, who jointly maintain vaccination registers and individual health cards for students. These records include key information such as the girl's name, school, age, dose status, and location. This system supports immediate dose verification and follow-up, especially for second dose tracking prior to the 2024 shift to a single-dose schedule.

Teachers and health workers ensure that attendance rosters are cross-checked against class lists to minimize missed doses. This real-time reconciliation of data – sometimes using basic paper registers and, increasingly, digital tools – ensures that each vaccination round produces a verified, up-to-date list of coverage and gaps.

DIGITAL INTEGRATION: TIMR, VIMS & VIGIMOBILE

Tanzania has made significant strides in integrating digital tools into its immunization infrastructure. Tanzania Immunization Registry (TIMR) enables health workers to monitor coverage by school, district, and region, track missed doses, and prepare for catch-up rounds. It also supports real-time dashboards that guide planning and supervision.

However, several operational challenges persist. Unstable internet and power outages slow real-time data entry, especially in rural facilities. Equipment issues and limited technical support cause delays in synchronization. Health workers must often enter data twice – on paper and in TIMR – creating inconsistencies. Denominator discrepancies arise when TIMR counts exceed census estimates, complicating coverage calculations. Finally, interoperability gaps with systems such as CRVS limit the ability to track children who move between districts.[39,40]

Vaccine Information Management System (VIMS) complements TIMR by tracking vaccine stock levels, cold chain status, and supply chain performance. This helps pre-empt facilities shortages and maintain a continuous supply during SHP rounds.

VigiMobile, a mobile tool with offline functionality, is used to report and manage Adverse Events Following Immunization (AEFI). District officers and health workers submit reports, which feed into national safety surveillance systems and improve response times to potential incidents. Together, these systems form a comprehensive digital backbone for HPV vaccination delivery. While connectivity issues still affect real-time uploads in rural areas, the increasing use of tablets, offline syncing, and partner-supported training has helped reduce data lags and improve quality.[41,42]

38 Ministry of Education, Science and technology, Policy Guidelines on school Health services in Tanzania, 2018
39 Electronic Immunization Registry in Improving Vaccine Supply Chain Availability in Tanga City Council, Tanzania, PubMed Central, 2021
40 Impact des registres électroniques de vaccination et des systèmes d'information de gestion logistique électronique dans quatre pays à revenu faible ou intermédiaire : Guinée, Honduras, Rwanda et Tanzanie, MEDRXIV, 2025
41 Ministry of Education, Science and technology, Policy Guidelines on school Health services in Tanzania, 2018
42 Haskè Conseil, Interviews with Tanzania stakeholders, 2025

MICROPLANNING AND OPERATIONAL FLEXIBILITY

The NSHNP's success lies in its routine microplanning structure, which provides the operational architecture for each school health round, including HPV vaccination. Microplans are prepared annually at the council level and updated quarterly, detailing:

- Lists of schools and their enrolment data
- Expected number of eligible girls by age and grade
- Route maps for health worker visits
- Estimated vaccine and logistics needs
- Communication strategies and outreach schedules

These plans are reviewed regularly in coordination meetings, particularly those led by District immunization and vaccine officers and District school health and nutrition coordinators. Adjustments are made based on previous coverage data, feedback from field teams, and updates from national health authorities.[43]

This iterative planning model allows districts to rapidly reallocate resources, adjust timelines, and respond to emerging challenges, such as stockouts, community hesitancy, or poor weather conditions affecting access to remote schools.

DATA USE FOR DECISION-MAKING AND SUPERVISION

One of the strengths of the NSHNP-linked system is that data is not only collected but actively used. Coverage data informs supervisory visits, enables targeted coaching of underperforming districts, and drives the scheduling of make-up rounds or OOS-focused outreach. At higher levels, data from TIMR and VIMS is consolidated and used by national technical working groups and planning bodies to monitor overall vaccine uptake and district performance, identify equity gaps (e.g. rural vs. urban coverage), forecast future vaccine needs and evaluate program effectiveness over time. Through this integrated data strategy, Tanzania has evolved from paper-based tracking to a dynamic, school-linked system that strengthens SHP delivery and improves national immunization oversight.

As of 2024, reported HPV vaccination coverage reached approximately 107% in administrative data, indicating strong reach. This figure may not fully reflect true population coverage, however, because multi-age cohort targeting (including girls up to age 15) is sometimes paired with a denominator based only on 9-year-old girls. This denominator misalignment can inflate apparent coverage rates and points to the need for improved denominator accuracy and age-disaggregated tracking.[44] Reported regional performance was high in this period, with no district falling below 80% coverage according to program data – a benchmark used in Tanzania's monitoring framework. These figures support the operational strength of the SHP-linked delivery model, while also pointing to the importance of refined denominator definitions and catch-up tracking in ongoing monitoring.[45]

MICROPLANNING AND PRIORITIZATION STRATEGY

Tanzania's microplanning approach uses a "bottom-up" logic in which each health facility develops a plan tailored to its school catchment area. Plans focus on a small set of priority indicators – reconciling enrolment lists with CHW community data to identify out-of-school girls; mapping cold-chain logistics for hard-to-reach schools; verifying parent orientation and consent materials

43 Ministry of Education, Science and technology, Policy Guidelines on school Health services in Tanzania, 2018
44 Ibid.
45 Ibid.

before each round; and confirming supplies for the bundled non-vaccine services. Districts are tiered by past performance and geographic barriers, with TIMR data triggering reallocation of fuel or per diem budgets within 48 hours when coverage drops mid-round.



PHOTO BY: DWAYNE JOE (UNSPLASH)

What worked – how NSHNP strengths translated into rapid HPV scale-up

Tanzania's experience highlights structural, programmatic, and demand-side levers that together helped the NSHNP support a rapid and broadly equitable HPV scale-up. The successes below are best understood as the combined effect of multisectoral governance, embedded school-level actors, predictable delivery cycles, complementary outreach for out-of-school girls, and trusted community engagement – rather than the school platform alone.

Then, implementation was made possible by the presence of designated school health teachers in nearly every public primary school. These focal points were already accustomed to coordinating health activities, compiling class lists, organizing school health days, and communicating with parents. Their active role in HPV vaccination days – from preparing classrooms to observing students' post-vaccination – ensured operational smoothness and helped foster trust among families, especially in areas where health worker presence is limited. Teachers' existing relationships with parents allowed for quicker myth-busting and reassurance in response to rumors around vaccine safety or infertility.

At the same time, the NSHNP's quarterly outreach cycle offered a predictable rhythm for delivery. Schools were already used to receiving integrated health services – including deworming, nutrition checks, or eye screening – during school health days, and HPV vaccination was simply layered into these routines. This allowed for efficient microplanning, avoided unnecessary disruption to learning schedules, and reduced the need for standalone immunization campaigns. Finally, the program's flexibility and reach proved critical to equity. The NSHNP incorporates outreach and mobile services to cover schools located more than 10 km from health facilities and to reach out-of-school girls in remote or nomadic communities. In several regions, Tanzania piloted the HPV+ model, bundling HPV vaccination with adolescent health services such as menstrual hygiene education, nutrition screening, and SRHR promotion. This approach not only aligned with NSHNP objectives but also improved community acceptance by presenting the vaccine as part of a broader, holistic care package.[46]

Together, these features – multisectoral governance, embedded school focal points, predictable delivery cycles, equitable outreach, and service bundling – helped Tanzania reach consistently high reported HPV coverage while limiting parallel costs and disruption. Rather than building a new system from scratch, the country layered HPV onto its existing school health infrastructure to make adolescent vaccination more routine. Evidence from the Gallagher et al. (2023) costing study reports an ongoing cost of approximately US$26.41 per fully vaccinated girl (including vaccine at US$5/dose), with delivery costs excluding the vaccine of approximately US$3.09 per dose (US$9.76 per girl) and finds class-based delivery to be more efficient than alternative modalities in the contexts studied. These figures are specific to the study's sites and time period and should be interpreted accordingly.[47]

46 Haskè Conseil, Interviews with Tanzania stakeholders, 2025
47 Costs of delivering human papillomavirus vaccination to schoolgirls in Mwanza Region, Tanzania; Pubmed Central, 2012

Table 6: NSHP and HPV Scale-Up: What worked, what didn't, and transferable lessons

Theme	What enabled performance (Tanzania)	Constraints & risks	Transferable lesson for LMICs
Institutional platform	*School health delivery was embedded within the long-standing National School Health and Nutrition Program (NSHNP), creating predictable access to schools and shared expectations among teachers, health workers, and communities.*	NSHNP strength varied by district; where school health routines were weak, HPV delivery depended more heavily on ad hoc outreach capacity.	Anchor new adolescent health interventions in existing school health platforms rather than creating parallel delivery systems.
Governance & coordination	Placement of coordination under PORALG enabled cross-sector alignment across health, education, and local government, reducing fragmentation at district and school levels.	Coordination relied on informal practices in some districts; limited use of formal MOUs or circulars created vulnerability to staff turnover.	Locate coordination authority above sectoral silos and formalize roles early to protect routines from personnel changes.
Data & Microplanning	Use of school enrolment registers and age–grade targeting (Standard 4) enabled pragmatic microplanning and rapid scale-up without complex individual-level registries.	Enrolment data quality varied; out-of-school girls were difficult to enumerate, and denominator inconsistencies complicated coverage interpretation.	Accept "good-enough" data for scale, while progressively strengthening linkages between education records and immunization data systems.
Human resources	Delivery leveraged existing health workers for administration and teachers for mobilization and consent, minimizing the need for new cadres or incentives.	Teacher workloads were high and largely uncompensated; sustained reliance on goodwill risks fatigue over time.	Use existing cadres to scale quickly, but plan early for workload management and non-financial incentives.
Social & cultural alignment	Early community sensitization and the framing of HPV vaccination as part of routine child health services reduced resistance and normalized uptake.	Periodic misinformation spikes required reactive engagement; trust depended heavily on local leadership and teacher credibility.	Invest in continuous, locally grounded social mobilization rather than one-off campaigns.
Service design & legitimacy	Quarterly school health outreach rounds made HPV delivery predictable and routine, reinforcing legitimacy as a standard government service rather than a special campaign.	Where outreach was irregular, vaccination risked being perceived as episodic or externally driven.	Routinization and predictability are as important as technical design in building legitimacy.
Logistics & equity	School-based delivery achieved rapid, low-cost scale, while mobile teams and community outreach extended coverage to hard-to-reach and out-of-school populations.	Geographic dispersion, transport costs, and cold-chain constraints increased marginal costs for last-mile equity.	Combine school-based delivery with targeted outreach, and budget explicitly for equity-driven logistics.
Financing & partners	HPV delivery costs were largely absorbed into existing EPI and local government budgets; partners supported training, cold-chain strengthening, and introduction phases.	Non-ring-fenced operational funding created vulnerability to delays and uneven district execution.	Prioritize absorption into domestic systems, using partners for time-bound system strengthening rather than recurrent delivery costs.

KEY SUCCESSES AT A GLANCE

- **Governance and coordination.** A multisectoral framework aligns national policy and local execution. The MoH and MoE, supported by PORALG, oversee planning, implementation, and supervision through designated officers at each level. PORALG's position above line ministries strengthens accountability and convening power.
- **Service bundling (HPV+)**. HPV vaccination is delivered with other adolescent services – deworming, nutrition assessments, menstrual hygiene education, oral/dental care, and SRHR – under the HPV+ model. Bundling improves efficiency and increases perceived value.
- **Pivotal role of school health teachers:** As local coordinators, they lead parent engagement, mobilization, roster verification, and observation for adverse events. They use standardized counseling materials to secure consent, cross-check class lists to target eligible students, and manage a supervised recovery area after vaccination. Their presence streamlines school visits and bridges clinical teams and students.TIMR and VIMS support real-time data entry during school rounds, improving stock oversight, AEFI reporting, and program monitoring
- **Inclusion of out-of-school (OOS) girls:** the NSHNP's outreach component is designed to reach remote, mobile, or pastoralist communities through mobile teams supported by Community Health Workers (CHWs). Despite relatively high primary school enrolment (around 85–90%), some girls remain out of school due to socioeconomic factors, early marriage, or remoteness. CHWs identify these girls, engage families, and organize community vaccination sessions, often in collaboration with local leaders. This combined school- and community-based approach helps reduce access inequalities; the extent to which it closes the equity gap varies across districts.[48,49,50]

48 National introduction of human papillomavirus (HPV) vaccine in Tanzania: Programmatic decision-making and implementation, PubMed Central, 2022

49 I don't have this footnote.

50 Tanzania's human papillomavirus (HPV) vaccination program: Community awareness, feasibility, and acceptability of a national HPV vaccination program, 2019, PubMed Central, 2022

What did not work – where NSHNP constraints limited performance, and priorities for strengthening

First, the absence of a dedicated budget line for school health – including HPV vaccination – remains a structural weakness. Although the NSHNP is jointly owned by the Ministry of Health (MoH) and Ministry of Education (MoE), its financing is largely decentralized and fragmented. Outreach costs, such as transport and allowances for health workers, are expected to be absorbed by local health facilities under PORALG, which already operate with constrained resources. As a result, the scope and frequency of outreach are heavily dependent on facility-level prioritization and the availability of external partner support. In many instances, this has led to partial implementation, where only core services like vaccination or deworming are delivered, while broader adolescent health services are dropped due to cost.

Then, although school health teachers play a critical role, they are neither formally compensated for their additional responsibilities nor systematically trained. These teachers are expected to coordinate vaccination days, compile class rosters, liaise with parents, and support observation – all on top of their teaching workload. However, they do not receive formal allowances, and cascade orientations are not consistently implemented across the country. In some districts, teacher understanding of HPV remains limited, which undermines their ability to dispel misinformation or respond confidently to parental concerns. Without institutionalized support or incentives, this essential workforce remains undervalued and under-leveraged.

In parallel, **logistical constraints – especially in hard-to-reach areas – continue to affect equity.** Staffing shortages also limit the quality of microplanning, leading to outdated estimates, missed girls, and inaccurate vaccine forecasts. While a centralized, aggregate percentage for national health workforce shortages is not currently tracked as a single KPI, operational reports from the Immunization and Vaccine Development (IVD) unit and stakeholder consultations indicate that primary health facilities operate under chronic staffing deficits. This reality necessitates a reliance on “resilience-by-design” rather than simple workforce expansion.

To manage these shortages, the program relies on the bundling, task-shifting, community-led mobilization, and cascade-training mechanisms described in earlier sections, supplemented by efforts to integrate HPV-related orientation into routine EPI district planning meetings.

While these mitigation strategies have been successful in maintaining consistent coverage, the program has reached a point of saturation. Future sustainability will require moving beyond task-shifting toward more formal institutionalization, including formal incentives for School Health Teachers and the deployment of dedicated technical support teams for districts located more than 10 km from primary facilities.

Digital divide and training gaps have been an issue. While digital tools such as the Tanzania Immunization Registry (TIMR) and the Vaccine Information Management System (VIMS) are robust, facilitating registration, tracking of vaccinated children, and management of vaccine logistics, their effectiveness depends on digital literacy and connectivity. In rural areas, delayed data uploads and unfamiliarity with reporting tools can weaken real-time monitoring and reduce the potential benefits of these systems.[51]

TIMR and VIMS together provide a national digital backbone for individual-dose tracking and stock/cold-chain management. Reported national HPV coverage in 2024 was approximately 107%, and program data indicate that no district fell below 80% in that period. Tablet use and offline synchronization have helped reduce data lags in supported rural councils, though gaps in

51 Electronic data tools help advance immunization equity in Tanzania, PATH case study, 2023

connectivity and digital literacy remain.

Finally, **persistent community misinformation – particularly around infertility and the safety of the HPV vaccine – continues to affect uptake in specific regions.** While national campaigns and school health teachers help to counter these myths, gaps in community engagement remain. Parents who do not attend sensitization meetings, or who rely on hearsay, are more likely to delay or refuse vaccination. The lack of standardized, community-wide messaging beyond schools means that coverage can fluctuate based on rumor cycles or religious misconceptions.

These constraints do not undermine the NSHNP's overall effectiveness – but they do highlight the need for targeted investment in teacher support, outreach financing, and community engagement mechanisms. Without addressing these operational bottlenecks, Tanzania risks plateauing in coverage, especially in rural or underserved areas where school-based health delivery alone may not be sufficient.

PRIORITIES FOR STRENGTHENING TANZANIA'S NSHNP

Tanzania's school-based HPV vaccination success is grounded in a century-old institutional platform that brings health services directly to learners. As other countries consider similar models, Tanzania's experience offers both actionable areas for internal strengthening and transferrable lessons for other LMICs aiming to integrate adolescent health services within school-based delivery.

To maintain momentum, expand reach, and embed HPV vaccination as part of a broader adolescent health package, Tanzania should prioritize the following improvements:

- **Establish a dedicated national budget line** for School Health Program (SHP): Currently, HPV outreach is often financed through general health facility budgets or donor contributions, leading to inconsistent resource flows. A dedicated line would ensure predictable funding for outreach, logistics, training, and supervision.
- **Formalize incentives and recognition for school health teachers**: Teachers are the frontline of community mobilization and student engagement yet receive no official compensation for SHP-related tasks. Tanzania could institutionalize small stipends, formal roles, or recognition mechanisms (e.g., performance-based awards or workload adjustments) to retain and motivate these critical actors.
- **Expand mobile outreach and microplanning to underserved areas:** Schools more than 10 km from health facilities, including those in island, pastoralist, or nomadic regions, remain hard to reach. Targeted investments in transport, fuel, and microplanning tools will help expand equitable access.
- **Standardized and scale training across sectors:** While cascade training exists, it remains uneven. A standardized, cross-sectoral training package for health workers, teachers, and community health workers – with digital formats for remote regions—would strengthen program consistency and reduce misinformation.
- **Strengthen community feedback and data integration:** Expand tools for capturing parental feedback and community concerns; link this information with existing digital platforms (e.g., TIMR and VIMS) to improve responsiveness and adjust strategies in real time.

Lessons for other LMICs – operational principles and practical sequencing

Tanzania's experience provides operational principles for other countries seeking to scale adolescent health services through schools:

Leverage existing school health platforms first:
In the absence of a formal school health structure, the implementation strategy follows a three-stage transition:

- **Stage 1: The "Service Bundle" Pilot (Proof of Concept):** Instead of launching a standalone HPV program, health ministries should initiate a pilot round that bundles HPV with at least one other high-visibility service (e.g., deworming or vision screening). This minimizes the appearance of a "vaccine-only" program—which can invite skepticism – and establishes the school as a trusted health access point.
- **Stage 2 – School Health Liaison.** Where no focal points exist, countries should designate a 'School Health Champion,' usually a senior teacher. With training, materials, and coordination with the local health facility, this role supports scheduling, consent processes, and data reporting.
- **Stage 3:** Policy Codification and Formalization: The final stage involves scaling the pilot into a national policy. This requires the Ministry of Health and the Ministry of Education to sign a Memorandum of Understanding (MoU) that explicitly defines roles – specifically who handles cold chain, who manages the student database, and how transport costs are shared. Without this formal agreement, school-based health efforts often collapse when donor funding for the initial vaccination round ends.

Critical Success Factors for "New-Start" Countries:

- **Bottom-up micro-mapping:** Countries without a school health structure should map every school – public, private, and religious – and assign each one a "Primary Health Facility of Responsibility" to create a permanent link between clinic and classroom.
- **Digital-first reporting:** Countries without legacy paper-based reporting systems should bypass them and implement a mobile-first registry from day one. Real-time visibility into coverage helps maintain political momentum and supports budget justification.
- **Community socialization:** Where community trust is weak, programs should invest in early communication – engaging traditional and religious leaders to validate the initiative and lend their credibility until the school health platform earns its own.
- **Ensure multisectoral governance from the outset:** Success depends on shared ownership. A strong School Health Program (SHP) should be co-led by ministries of health and education, with clear roles for local governments, as in Tanzania's MoH-MoE-PORALG structure and an entity with proven convening power of ministries.
- **Plan and budget for logistics and teacher incentives:** High coverage depends not only on vaccines and messages, but also on fuel, transportation, and frontline actors. Teacher engagement cannot be assumed; resources should reflect their critical role in mobilization and implementation.
- **Start with high-coverage, low-complexity interventions:** Begin with platforms that already reach most girls, such as primary schools, targeting girls aged 9 to 14 years old, and interventions with known delivery pathways (e.g., vaccination, deworming). This creates early wins and operational proof points.
- **Embed HPV within a broader adolescent health package:** Tanzania's HPV+ model shows that bundling services like menstrual hygiene, SRHR education, and mental health support improves community buy-in and adolescent engagement.

- **Use data and microplanning as management tools, not just reporting tools:** District-level planning should go beyond target-setting to actively shape outreach, logistics, and supervision cycles, like Tanzania's quarterly TIMR reviews, which drove higher outreach and coverage.
- **Integrate education and health data systems:** Tanzania's experience highlights the value of closer coordination between education and health data systems in school-based vaccination programs. Although full technical integration between the Tanzania Immunization Registry (TIMR) and education databases is still evolving, district teams routinely use school enrolment lists during microplanning to estimate target populations and identify eligible cohorts. This coordination enables more accurate targeting of school-based vaccination activities, improves dose forecasting, and facilitates follow-up for missed cases. For other LMICs implementing HPV vaccination through schools, strengthening interoperability – or at minimum operational coordination – between education and health data systems can help reduce dropout rates and improve equity in vaccine delivery. These lessons are not one-size-fits-all. But they offer a pragmatic roadmap: start with what already exists, coordinate across sectors, train the frontline, and deliver consistently through structures that communities already trust.

Appendix: List of stakeholder consultations

1. Bahe Town Council, School vaccination provider, Tanzania
2. Immunization and Vaccine Development Unit, Dodoma, Tanzania
3. Jhpiego, Tanzania
4. Ministry of Health, Dodoma, Tanzania
5. Regional Immunization and Vaccination Office (RIVO), Dar es Salaam, Tanzania
6. United Nations Children's Fund (UNICEF), Tanzania
7. World Health Organization (WHO), Tanzania

About Haskè Group

Through its three entities, Haskè Conseil, Haskè Ventures, and Ignite.E, Haskè Group supports a diverse range of actors (including governments, the private sector, technical and financial partners, NGOs, foundations, and universities) in the formulation and implementation of high-impact strategic solutions.

Haskè Group positions itself as a catalyst for innovative strategies, combining technical expertise, systemic vision, and a sense of action. The group is involved in public policy consulting, private sector development, entrepreneurship, and the creation of sustainable ecosystems, while supporting the localization of strategies and the co-creation of solutions with stakeholders.

Haskè Group draws on deep knowledge of local realities, a strong multi-stakeholder network, and a community-embedded approach to deliver solutions rooted in lived realities. This field presence enables Haskè Group to bridge strategic vision and operational impact.

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