Lessons Learned from HPV Vaccine Introduction in the Americas

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Main Topics

• Introducing the HPV vaccine in the Region – background
• PAHO Immunization Technical Advisory Group (TAG) recommendations – Panama meeting 2017
• Lessons learned: Guatemala meeting, October 2017
• Conclusions
Countries and Territories with the HPV Vaccine in the National Immunization Program, January 2018

Data source: WHO/IVB Database, as of 26 January 2018
Map production Immunization Vaccines and Biologicals (IVB), World Health Organization

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Region of the Americas: 31

- Introduced* to date: 79 countries (40.7%)
- Not Available, Not Introduced/No Plans: 115 countries (59.3%)
- Not applicable

* Includes partial introduction
Countries and Territories with the HPV Vaccine in the National Immunization Program, Region of the Americas, 2017

Canada (2007-2009)
USA (6/2006)
Mexico (10/2012)
Belize (11/2016)
Honduras (5/2016)
Panama (10/2008)
Colombia (8/2012)
Ecuador (2/2014)
Peru (2/2015)
Bolivia (4/2017)
Chile (9/2014)
Dominican Republic (4/2017)
Guyana (2/2011, 5/10 regions)
Suriname (11/2013)
Brazil (3/2014)
Paraguay (3/2013)
Uruguay (4/2013)
Argentina (10/2011)
Aruba (11/2014)
Anguilla (5/2016)
Bahamas (5/2015)
Bermuda (4/2007)
Barbados (1/2015)
Cayman Island (11/2012)
Jamaica (10/2017)
Puerto Rico (6/2006)
Saba (1/3 Dutch municipalities, 2012)
Saint Maarten (9/2013)
St. Eustatius (1/2013)
St. Vincent and Grenadines (10/2017)
Trinidad and Tobago (2/2013)

Source: WHO/PAHO JRF 07/07/2017 and countries report
(*) Month and year of introduction
Five countries use the bivalent vaccine
20 use the quadrivalent
Two use the nonavalent

15/27 countries reported complete data on the dose, population and coverage for the second or third dose
Coverage between 10%-96% (median between 50%-55%)

Six countries use the gender neutral strategy in 2016: Barbados, Bermuda, Canada, Panama, Trinidad & Tobago, and United States (two more in 2017 are Argentina and Brazil)

Approximately 2.9 millions girls from 9-14 years of age* with complete vaccination

Source: WHO/PAHO JRF 07/07/2017

*No data received on doses administered in Canada and United States
TAG congratulates PAHO Member States that have recently decided to introduce HPV vaccine into their routine immunization programs. TAG reiterates the importance of prioritizing high coverage in girl cohorts aged 9-14 years to ensure full protection against HPV among girls and induce herd immunity among boy populations. Currently available vaccines have comparable safety profiles and provide similar protection against cervical cancer.

Given the substantial health benefit of HPV vaccination, TAG encourages Member States that have not yet introduced the vaccine into their routine immunization schedules to evaluate its feasibility, cost-effectiveness, and other relevant criteria for decision-making at the national level in order to consider including this vaccine in the routine immunization schedule.

TAG urges PAHO Member States to carefully consider their approaches to communication around the HPV vaccine, making sure to generate audience-specific messages. Additionally, TAG calls on PAHO to support intercountry exchanges on lessons learned regarding communication on the safety of HPV vaccine and crisis management.

TAG requests that PAHO support Member States’ efforts to better document HPV vaccination coverage at the subnational and national levels and to use these data to target strategies and achieve optimal coverage among target groups for the full vaccination series.

Whenever possible, Member States should monitor the impact of HPV vaccination.
Lessons learned: Guatemala meeting conclusions, October 2017

Concern about AEFI

- Despite the fact that the HPV vaccine is a safe vaccine, with mild-to-moderate local and systemic adverse events, rumors and sociogenic events that have occurred in the Region have caused parents to be concerned, which has had a negative impact on coverage levels.

Scope of coverage (goal >80%)

- The countries have had difficulty achieving the goal of vaccinating 80% of the girls. School-based vaccination has been shown to facilitate the scope of coverage. However, complementary strategies must be sought in order to vaccinate those who do not go to school or who attend school but reject the vaccine.
Lessons learned: Guatemala meeting conclusions, October 2017

• Calculation of coverage

• According to analysis of the data from countries available on the JRF for 2016, some problems mentioned in relation to calculation of coverage were:
  • Some countries do not report the doses administered, but rather only coverage;
  • Some do not report the target population;
  • Some have considered the girls enrolled for vaccination as the target population to receive the first dose;
  • Some do not consider the cohorts and report more girls vaccinated with the second dose than the first.
Lessons learned: Guatemala meeting conclusions, October 2017

• Communication (summary of main lessons learned according to 24 countries):

• An integrated communication plan is needed, including crisis response and messages tailored to each audience. There should be a permanent communication team. The Ministry of Health should maintain the communication budget. Communication actions should be carried out at least twice a year (continuously, if possible); it has been difficult to communicate the second dose.

• Strategic partners in the media need to be identified and the media needs to be made aware of the vaccine. The influence of social networks in disseminating information should not be underestimated. Rapid response to rumors and crises is required.

• Monitoring is important in order to change and adjust the campaign; anti-vaccination movements should be monitored in order to be prepared to respond to them. Attention should be paid to the situation in neighboring countries.
Prior to introducing the vaccine, the country should develop a plan to introduce new vaccine, with special emphasis on a communication plan.

Crisis Plan

Collective sociogenic events have occurred in the Region, and a country’s rapid response is essential to maintain the vaccine’s credibility.
Vaccine Safety

• The HPV vaccine, as has happened in the past with many other vaccines, is surrounded by several myths about its safety that have led to reducing its use among populations or to governments withdrawing their vaccine recommendations.

• Some studies reported that beliefs in vaccination risks being higher than benefits were more common with the HPV vaccine.
Vaccine Safety: Rumors

The vaccine causes infertility

It will stimulate girls’ sexual activity

The vaccine causes serious health problems

Guillain Barre Syndrome; POTS (Postural Orthostatic Tachycardia Syndrome); CRPS (Chronic Regional Pain Syndrome)
How to Avoid Some of the Side Effects Associated with the HPV Vaccine

- Fainting is a common event among adolescents after many procedures that cause anxiety or very minimal pain (vasovagal syncope). To avoid fainting after HPV vaccine administration, it is recommended that girls should be seated or lying down and be closely observed for 15 minutes after the vaccination*; avoid waiting standing up for a long time prior to vaccination.

- Fainting episode after HPV vaccine may trigger a sociogenic mass event.

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Figure 6. Nombres del diario compuestos en las versiones digitales de Globe Gothic, en calibre medio y negrita.

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Conclusions

• 31 countries and territories of the Region of the Americas have introduced the HPV vaccine. However, it is a challenge for the Region to calculate the coverage due to different strategies used.

• PAHO is developing a guideline standardizing coverage calculation, based on WHO recommendations. It is recommended that each country follow the cohorts according to the age of birth and the date of the vaccination.

• High coverage in girls is recommended.

• Continued communication strategies must be considered.
HPV coverage calculation at 15 years old

A birth cohort

15 years old in the current year

Children/teenagers from 9-14 years old receiving the HPV vaccine

First dose at 9

1st dose at ≥9

Years before

6

How many had been vaccinated?

First dose at 10

1st dose at ≥10

5

First dose at 11

1st dose at ≥11

4

First dose at 12

1st dose at ≥12

3

First dose at 13

1st dose at ≥13

2

First dose at 14

1st dose at ≥14

1
Thank you!