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The newsletter on Human Papillomavirus because we can envisage cervical cancer elimination

nº 37 Interview with

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What makes the HPV vaccine special?

While vaccines to prevent Human Papillomavirus (HPV) infection have proven to be extremely effective in both protecting against HPV, as well as reducing the risk of cervical cancer caused by HPV strains, acceptance of cancer-preventing vaccine has struggled to reach high levels of acceptance in many countries. Most importantly, it has the least coverage in the poorest countries that have some of the highest burdens of cervical cancer.

What are the main reasons for this low acceptance rates?

The reasons for less-than-optimal coverage are varied, but there are a few themes. The most frequent reasons for hesitation and refusal of vaccination are safety concerns. Some also feel as if the vaccine is too new and without enough safety evidence. Another barrier, especially in low and middle-income countries, is the cost of the multi-dose vaccine. Other reasons for reluctance and refusal include the sensitivities around the vaccine protecting against a sexually transmitted infection. In some settings, cultural mores inhibit doctors from discussing the vaccine with parents. Some parents think the vaccine is given at too young an age to be relevant to their daughter who is not old enough to be engaged in sexual relationships. Other parents have expressed concerns, and refuse the vaccine for their daughters, as they are worried that the vaccine may promote promiscuity - a perception that has been disproved by multiple studies. In some settings, populations have distrusted the vaccine because of suspicions as to why it is only given to girls and not boys, sparking rumours that the vaccine is a ploy to sterilize girls and can cause infertility. Gender-neutral vaccination programmes are more likely to be acceptable and raise fewer questions, rather than those who single out girls only, and targeting reproductive ages.

These are largely reasons expressed by individuals – parents or caregivers, doctors or other vaccinators, or the adolescent girls themselves. In other cases, the introduction of the vaccine is debated at a policy level, with constituencies pushing for and against the vaccine for reasons of cost, deba-

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tes as to whether the vaccine is needed given options of cervical screening, and notions that big business is influencing government decisions. This mix of reasons for vaccine questioning and refusal, has led in some cases to the suspension of HPV vaccination programmes such as in India in 2010, and the suspension of the HPV vaccine recommendation in Japan in 2014.
There is no consistent pattern of distribution among those who accept, hesitate or refuse vaccine. In some cases, a vaccine scare can provoke a dramatic drop in vaccine acceptance across the population as in Japan, where acceptance dropped from over 75% to under 1% or in Colombia, where acceptance dropped from over 85% to 5%, after groups of girls reported neurological and mobility problems suspected to be related to their HPV vaccination. In other instances, there are small pockets of those hesitate or refuse a vaccine, with the general population largely accepting. In cases where there is an individual – or individuals – who lead a constituency against the vaccine, the impacts on the confidence of the population can be significant.

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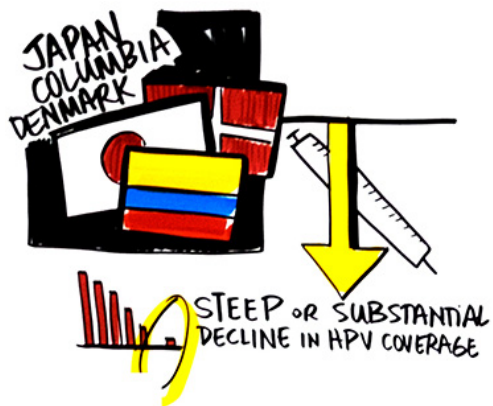

Figure 1: Vaccine scare can provoke a substantial decline in HPV vaccine coverage. In Japan, due to the HPV vaccination crisis, uptakes rates dropped from over 75% to under 1%. In Colombia, the vaccine uptakes dropped from over 85% to 5%, after groups of girls reported neurological and mobility problems suspected to be related to their HPV vaccination.black X, representing stopping HPV.

Which is the best approach to deal with a crisis of confidence?

When vaccine scares do occur, the most important thing to remember is that facts do not calm emotions. Prompt empathy and listening is very important to those who feel that they – or their children – have been negatively affected by the vaccine. The longer there is no response or no effort to consult with and listen to those affected, the more time there is to spread anxiety, seed suspicions and fuel panic.

Although some encourage focusing on the cancer prevention value of the HPV vaccine as a way to distract from the more sensitive issues around sexuality, it is important to also be transparent about the mode of HPV transmission. HPV is a sexually transmitted infection. Pretending it is only about cancer prevention does not build trust. Celebrate the power of the vaccine in both reducing the risk of HPV infection and preventing cervical and other cancers. ■