BENEFITS OF HPV VACCINATION IN REDUCING THE RISK OF CERVICAL CANCER, ADDRESSING MISCOMMUNICATIONS.

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Outline

- Cervical cancer definition
- Cervical cancer statistics
- Prevention strategies
- Current status of HPV vaccination in Uganda
- Miscommunications

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Definition of Ca. cervix and statistics

Cervical cancer is an abnormal growth of cells that occur in and at the mouth of the uterus linked to high risk HPV type infection.

Cervical cancer is the fourth most common cancer among women globally, with an estimated 570 000 new cases in 2018.

All countries are affected, but the incidence is higher in low- and middle-income countries.

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Age-standardized incidence rates vary from 75 per 100 000 women in the highest-risk countries to fewer than 10 per 100 000 women in the lowest-risk countries

Nearly 90% of the 311 000 deaths worldwide in 2018 occurred in low- and middle-income countries.

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Cervical cancer is leading cause of cancer death in Uganda. Each year 6413 incident cases per year.

4301 women die per year. Incident rates (54.8/100,000). Mortality rate is 40.5/100,000 women

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Ca. cervix prevention strategies

These are split into primary and secondary.

Primary prevention involves HPV vaccination of adolescent girls which is the most effective long-term intervention for reducing the risk of developing cervical cancer.

The great long-term benefit of HPV vaccination makes it important to initiate and sustain this approach in all countries.

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There is also strong evidence that high HPV vaccination coverage leads to protection of unvaccinated individuals through herd immunity, further enhancing the protective effect for the community.

WHO’s current guidelines recommend that young adolescent girls between 9 and 14 years receive two doses of vaccine to be fully protected

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In addition to HPV vaccination, a comprehensive prevention strategy must include age-appropriate information on sexual and reproductive health, safer sexual practices – such as delaying sexual debut, decreasing the number of sexual partners, condom use, and male circumcision where appropriate – and cessation of tobacco use.

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Secondary prevention - The principal goal of secondary prevention is to reduce cervical cancer incidence and mortality by identifying and treating women with precancerous lesions.

Cytology-based screening has been successfully used to achieve these goals when implemented as part of national programs with high coverage.

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In settings where resources exist for patient follow-up, additional diagnostic tests (colposcopy and pathology) and disease management.

In low- and middle-income countries cytology-based programs have been difficult to implement, and where they have been implemented screening coverage is low.

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Visual inspection of the cervix with acetic acid followed by treatment (screen and treat) is an alternative approach to secondary prevention in resource-constrained settings.

Although relatively easy to establish, the quality of such visual inspection depends heavily on the provider and its sensitivity is variable.

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HPV vaccination

Currently there are six licensed HPV vaccines three bivalent, two quadrivalent, and one nonavalent vaccine.

Those that have been prequalified are being marketed in countries throughout the world.

All vaccines are highly efficacious in preventing infection with virus types 16 and 18, which are together responsible for approximately 70% of cervical cancer cases globally.

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The vaccines are also highly efficacious in preventing precancerous cervical lesions caused by these virus types.

The quadrivalent vaccine is also highly efficacious in preventing anogenital warts, a common genital disease which is virtually always caused by infection with HPV types 6 and 11.

The nonavalent provides additional protection against HPV types 31, 33, 45, 52 and 58.

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The primary target group in most of the countries recommending HPV vaccination is young adolescent girls, aged 9-14. For all vaccines, the vaccination schedule depends on the age of the vaccine recipient.

As per the December 2022 WHO Position on HPV vaccines, WHO recommends the following schedule:

- A one or two-dose schedule for girls aged 9-14
- A one or two-dose schedule for girls and women aged 15-20
- Two doses with a 6-month interval for women older than 21

A minimum of 2 doses and when feasible 3-doses remain necessary for those known to be immunocompromised and/or HIV-infected.

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Uganda started HPV vaccination in 2008 as pilot programs in 2 districts, followed by national roll out in 2015

Quadrivalent Human Papilloma Virus (HPV) vaccine that targets HPV type 6, 11, 16 and 18 to be used for nationwide scale up immunization against cancer of the cervix.

The HPV immunization is targeting all 10 year old girls in and out of school.

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Miscommunication about HPV vaccine

- HPV vaccines are not safe
- HPV vaccines do not decrease the incidence of cervical cancer
- The HPV vaccine is only for teenage girls and women
- HPV vaccines can cause infertility
- Young children don't need the HPV vaccination
- Women who get the HPV vaccine don't need to get Pap tests

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References

- WHO strategic ca. cervix elimination 2020

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