GIAHC Women Deliver 2023 Q&A

1. **What is the address to access the current and prior presentation recordings?**

giahc.org/wd

2. **Would love to hear from any of the speakers on how to counter misinformation or ignorance about the risks of vaccination, especially in LMICs like India & Africa, where the parents/guardians might be illiterate or have misconceptions about vaccination.**

Misinformation and fear about vaccination is a long-standing challenge in many countries. Before any HPV vaccination rollout, setting up community-based programs to engage parents and guardians in discussion (prior to introduction) is needed. It may also be useful to make the argument that the HPV vaccination is a continuation of childhood vaccination programs. Many countries have been successful with their child immunization programs.

3. **I understand that Innovax was given WHO PQ in 2021, do you think this will impact the market and supply chain for HPV vaccination? Given that historically only two manufacturers have made the vaccine.**

Yes, you are right, the expansion of additional vendors of vaccine is expected to remove the HPV vaccine shortage in the market. Cecolin (by Innovax) is also WHO

4. **Which kind of HPV test did Clinton Health Access Initiative use? Was it affordable? Was it a RDTs or PCR?**

We've been leveraging unutilized capacity on PCR platforms. Here's a good resource on HPV test pricing: https://aslm.org/diagnostic-pricing-database/

The test prices have been coming down, but affordability is definitely still a constraint on testing volumes in LMICs.

5. **Our big challenge here in India is to convince rural women who are hpv + to get evaluation and treatment. These women are usually asymptomatic at the time of HPV dx and have to undergo a lot of hardships to take the next step. So the "nontangible benefits" are hard to sell… in the absence of any current symptoms.**

This is definitely a challenge. One approach we've seen work well is when women from the community who have been affected by cervical cancer raise awareness about their experience and the benefits of screening and treatment. The Teal Sisters in Zambia are a great example of this.

6. **Excellent report from Rwanda, can you please give some context to human resources and logistics required for the electronic data systems used for clients tracking and navigations? This seems like the cornerstone for achieving fidelity in the Cervical Cancer screening program.**

The electronic tracking system is used offline on Android tablets by nurses at the health facility to register clients and log in samples collected. These are uploaded to a server when they connect to the Internet at the end of the day. Laboratory staff input results can be accessed by providers. Test results are sent by SMS to clients. Providers are able to view records and follow up with women. Patient navigators are also given follow-up lists.

7. **How easy is it to make follow-ups for cervical cancer suspects? Because they can even go to their traditional doctors and not come back**

Yes, we do see a loss to follow-up. Strong patient tracking systems and resources to ensure that health workers can reach out to women who have not come for follow-up visits are key to ensure as many women as possible receive appropriate support through the health system.

8. **Any insights/ learnings through the HIV Integrated models?**

Women register as community health workers at screening. This makes it easier to make a physical follow-up. We use text, phone calls, and home visits by CHW to follow up with clients.

9. **I know a huge challenge is free screening (through study or national programs) but still the need to pay for unaffordable treatment, which deters some women from wanting to get screened because they would rather not know. How would you imagine navigating this?**

There is definitely much more work to do on access to affordable treatment for invasive cancer. We do aim to communicate the ease of treatment for pre-cancer, which is part of the national screening and treatment programs.

10. **Are there age restrictions for vaccines like I've seen here?**

It depends on each country. WHO recommends that 90% of girls between 9-14 yrs be vaccinated- hence this might be more readily covered by governments and insurance companies. Other countries like Australia in their program provided HPV vaccine during catch up to females up to age 26 years. The primary trials included this age range. For individual vaccination (personal purchase) there are countries in the West that approve up to ages 45 years. In LMIC, whose vaccine is supported by GAVI this age range is between 9 to 15 years and countries differ in their decision on which group to offer HPV vaccine in their National Program.

11. **My question is a bit in a different realm...but curious if a panelist could speak to attitudinal or knowledge barriers in developing nations. In the US--it seems lack of knowledge and parental hesitancy are barriers to uptake. What about developing nations?**

The largest barrier to treatment is the partner's refusal to woman abstaining post-treatment. Insertion of the speculum is undesirable, a preference for traditional medicine, and the myths that bring about shame to women.

12. **Is CureCervicalCancer testing performed by real-time PCR multiparametric test?**

Yes, it is.

13. **What would be the ideal transport medium for sample collection at CureCervicalCancer?**

We use a dry sample mode so just in a ziplock bag will work.

14. **What are some strategies we can use to encourage men to advocate for cervical cancer prevention and to help eliminate stigmas around this cancer?**

My experience in the community is men need similar knowledge, so when you educate the women it's important to ensure the men are also involved. So awareness awareness awareness to the men.

15. Thanks! If a sample needs to be preserved is it possible to use VTM?

This is possible however it also presents challenges such as fragility of sample handling risk of spillage etc, and in case of logistical challenges it might be expensive to transport among other challenges**,** In our case we do collect dry samples that can be transported without a medium, and can also stay outside refrigeration up to 3-5 days. This has contributed immensely to the possibility of scaling Household HPV self-sample collection at the community level by use of community health volunteers who use just ziplock bags to handle and transport the dry samples.

16. @Martha Brady, regarding VYA - not much is happening on this at the grassroots level. How to get involved?

1. There will likely be sessions at WD focused on this younger age cohort(look for that).
2. See attached a report I co-authored some years ago about this age group.
3. There will be a variety of INGOs that work with this age group – will need to determine which orgs are operating at the country level and what kinds of projects/programs they are offering.

17. How has political commitment benefitted, any examples?

There is a 1st Ladies advocacy support for the HPV vaccine program and the Rwanda program was a great beneficiary of the same. Political will makes a huge difference to uptake and resource allocation.

CureCervicalCancer - In our case, political commitment has played a pivotal role in both formation and implementation of HPV testing and Treatment, the political class in Kisumu County has committed to extend their Human Resources i.e. Healthcare workers both from the community and facility level to support our program, specifically the Community Health Volunteers have supported the household level HPV sample collection as well as following up HPV positive clients to come for treatment. We are beginning to also see cost-sharing aspects such as paying for transport for CHVs and HCPs to attend CCC-organized training and even supporting public address awareness campaigns through providing vehicles, fuel, and personnel among other support. We capture all the commitments in a collaborative framework signed under an MoU.

CRUK - Political commitment is key to having policies that are fit for purpose and that are implemented, this is why our program focuses on policy research and advocacy, to be able to build on or generate political will. Political will and commitment tend to be very big barriers to having many cancer prevention policies enacted.

GIAHC We need to talk to politicians in the language they understand- such as return on investment- by investing in girls and women. Please refer to our recording in session 1 for details: https://www.giahc.org/giahc-wd2023/