Community Conversations on Vaccines, Season 5, Episode 2: Engaging Communities to Prevent Cervical Cancer with HPV Vaccination: Lessons from India and Uganda with Rehana Riyawala and Doreen Tuhebwe

English Transcript

Francesca - 00:00:10: Welcome to Sabin Vaccine Institute's Community Conversations on Vaccines, presented by Immunization Advocates.

Vince - 00:00:17: In this podcast, we speak with professionals closest to vaccine delivery and decision making in low- and middle-income countries to hear the latest in immunization challenges and explore programs and tools to build and maintain community trust and vaccine equity.

Francesca - 00:00:32: We're your hosts, I'm Francesca Montalto

Vince - 00:00:43: And I'm Vince Blaser.

Francesca - 00:00:44: Today we have two wonderful guests with us. Our conversations are going to focus on HPV vaccination efforts and what is really needed to increase HPV vaccine uptake.

Vince - 00:00:56: Yeah, Francesca, we really wanted to devote an episode specifically to this virus HPV and to cervical cancer. Most cases of this disease are preventable through vaccination and screening, yet we sadly see the toll of it, which often strikes women from their 30s to 50s, really unfortunately growing worldwide.

Vince: Cervical cancer is the fourth most prevalent cancer among women across the globe, but it is the leading cause of cancer-related deaths for women in 36 countries, and that's across Africa, Asia, Latin America. According to WHO, a devastating 342,000 women died of cervical cancer in 2020, which was higher than the maternal death toll. And a staggering 90% of new cases and deaths occur in low- and middle-income countries. It's a very highly inequitable disease. Death rates from cervical cancer vary fiftyfold between countries.

Vince: Despite the introduction of the HPV vaccination in 2006 and strong evidence that that vaccination can reduce the incidence of cervical cancer by nearly 90%, the coverage of HPV vaccination, which was already low, it declined during the pandemic to only 12% of the targeted population, which that number is painfully low.

Vince: And so as we speak today, there's some major efforts by global institutions and national governments to increase the uptake of HPV vaccination, something that WHO is calling the revitalization. Gavi, the vaccine alliance has set a target for supporting 86 million HPV vaccinations in the next two years. Huge national rollouts in high-population countries, Bangladesh, Ethiopia, India, Indonesia, Nigeria, Pakistan are planned in the next couple of years. And so there's a lot for us to consider as a global immunization community. And so we're really delighted to have two guests today who work directly with some of the populations most impacted by this virus and this disease.

Francesca - 00:02:55: Yes, we're really excited to have these guests with us today. Our first guest, Doreen Tuhebwe, a research fellow at the Makerere University School of Public Health in Uganda, and a Sabin Social and Behavioral Research Grant partner, who is attending and presenting at VARN2023 right now. And we also have with us Rehana Riyawala, the vice president of the Self Employed Women's Association in India. Doreen and Rehana, welcome to the show.

Doreen - 00:03:25: Thank you.

Rehana - 00:03:25: Thank you.

Vince - 00:03:25: Well, Rehana, you and I just met back in February in Gujarat, where you live. And as Francesca was saying, you work for SEWA. Tell us a little bit more about SEWA, like who the organization represents and what you all do and why.

Rehana - 00:03:40: Yes, Self Employed Women's Association SEWA is a member-based organization of poor women workers from the informal economy. SEWA's current membership is in 18 states of India and has a membership of 2.5 million poor women workers and we also have a presence in the neighboring countries.

Rehana: SEWA team goals are full employment and self-reliance by full employment that provides with work security, income security, social security and food security as well. And self-reliance, it's not just economical self-reliance, but then we also see to it that the decision-making power of the woman also increases.

Rehana: SEWA strategy is a joint strategy of struggle and development wherein we facilitate the members representation, economic empowerment, collective strength and increased bargaining power. And to achieve this, we follow an integrated approach, organizing for collective strength, capacity building to stand firm in the competitive market, capital formation for risk mitigation and fight poverty, social security to enhance well-being and productivity.

Rehana: Talking about the healthcare at SEWA, it has been experienced that the health of the poor members and the families is their wealth. If the health of the poor deteriorates the avenues to earn livelihood becomes limited. Also, it has been experienced that stable livelihood is equally important to meet medical emergencies. And given their economic status, the women members ignore the health in its early phase and seek the doctor in the last phase, forcing them to curb their income avenues and take proper medication and risks. To prevent the members from such vicious cycles, SEWA capacitates its member on various well-being and health aspects through providing awareness education, trainings, creating linkages and health providers and various government health programs to attain maximum benefit of its member.

Rehana: SEWA does this through its approach of building a cadre of grassroots leaders who facilitate education to women members on preventive care. Health of community members is one of the 11 question yardsticks developed by these women members of SEWA to evaluate their growth annually.

Vince - 00:05:54: Thanks and with those millions of women that you reach, you took on this topic of HPV vaccination and with some support from GAVI, you looked at some of the potential issues of HPV vaccination acceptance in India. Can you just share a little bit more about what this research was and what you found?

Rehana - 00:06:12: Well, the research which SEWA undertook was a part of the program taken up by GAVI in 2018 and it was with the various stakeholders to provide the support to the national bodies and other relevant stakeholders in their decision-making process towards introduction of HPV vaccines into the public health programs in India, thereby contributing to the primary prevention of cervical cancer in India.

Rehana: SEWA led one of the major components of the program, which was to understand and document community-level knowledge, community perception, as well as community fears and misconceptions regarding vaccines. Cervical cancer and cancer in general, community stakeholders' perspective on HPV vaccine and its role in prevention of cervical cancer. And further elaborate the

community concerns and facilitate decision makers to take an informed decision for introduction of HPV vaccination within India's national immunization program, communication, and deliver strategy to build a roadmap for the launch of the vaccine.

Rehana: The study assessment was conducted in four states that is Gujarat, Rajasthan, Sikkim and Uttar Pradesh. And the areas which we covered brought in the perspective of both rural and the urban populations. Both qualitative and quantitative methods were used to collect data. A toolkit was developed and a cadre of 20 barefoot leaders were trained who conducted interviews and FGDs. with various stakeholders as well as quantitative survey of mothers and daughters aged between 9 to 14 years. We gathered qualitative data through interviews and focus group discussion with identified stakeholders from the community, which included mothers, community health care service providers, ASHA, ANMs, SEWA leaders, teachers, community influencers like Panchayat, Sarpanch, local leaders, young professionals and the fathers as well.

Rehana: The broad finding of the study was that all the stakeholders believed that cancer is a deadly disease and there is an urgent need to take steps to prevent younger generation from cancer. After understanding about cervical cancer and its etiology through SEWA's barefoot leaders, there was universal acceptance to HPV vaccine across all other stakeholders. Decision-making capacity of the mothers was improved and mothers were willing to learn more about cervical cancer and HPV vaccine. To launch HPV vaccine, community meetings through SEWA leaders, ASHA and doctors will be the most effective strategy to engage poor families and their daughters.

Rehana: This is very important because when we were doing this study at that time the vaccine was launched in the state of Sikkim and 80% of the mothers in the Sikkim felt that they need more information on the HPV vaccine and cervical cancer. And another aspect which we found in our study was also need for awareness and education to the front-line health workers such as ASHA, ANM, as regards to cervical cancer and HPV vaccine. Vaccination delivery should be at the location where the community has trust, whether it could be school or PHC center. For the poor, the vaccine should be free.

Rehana: 47% of the mothers surveyed had no or minimal education on cervical cancers and HPV vaccine. Across all states, 76% of the mothers had heard of cancer, but only 42% had heard of cervical cancer. Overall awareness of the HPV vaccine was low. Only a quarter of mothers knew the connection between the HPV infection and cervical cancer. However, 45% of the mothers were aware of HPV vaccine, thanks partly to the information and education that was provided in various meetings by the SEWA leaders. Also, 95% of the mothers which we interviewed agreed that their daughter should be vaccinated against HPV. The most common concern among the mothers who explained their reservations about getting the vaccine was its side effects and infertility. Most mothers agreed that the health centers was the best place to administer the vaccine.

Francesca - 00:10:28: Thank you so much for sharing. And I see Doreen and Vince, you're both nodding along. These are such important findings. And Doreen, you're coming to us from the end of day two of VARN2023 in Bangkok, Thailand. You're presenting your findings of the research that you undertook, which has a lot of parallels to what Rehana just shared and described. Can you tell us a little bit more about your research design and the findings?

Doreen - 00:10:53: Thank you. The research that I did 2019, 2020, came at a time in Uganda where we had launched the HPV vaccine rollout in Uganda in 2015, but the uptake was low. First dose was pretty high, was at 80%, but the completion of the second dose by that time was 41%, 44%. So there were lost gains. The Ministry of Health was concerned. We were concerned at the time. We knew that the vaccine was new, but we knew that it had benefits and the research was clear.

Doreen: So around that time when the call came up for social behavior interventions from Sabin Vaccine Institute, at that time I was working in a Banpua community called Seni, the largest slum in Kampala, the capital Kampala in Uganda. So at that time I was working on a reproductive health intervention with adolescents, creating a service delivery model with them that they thought would avail them productive health services and there I see this call. And among the reproductive health challenges, HPV vaccination was one of those things that had come up. And that's when we conceptualized this research.

Doreen: We did the community participatory research with the adolescents in Seni, adolescent girls aged 10 to 15 years. We are working with them using qualitative methods to try to understand for those that had been vaccinated, what enabled them to be vaccinated. And to ask them, could you be interested to become peer educators, agents of change in your community, to identify unvaccinated peers in your community and refer them and interest them in the vaccine, refer them to the health facility. So that was the concept.

Doreen: So when we started along, we learned together with the community. We learned that, okay, how do you enter the community? You have to engage the community health workers, the Village Health Team members, the VHTs, like call them, to map out, to identify the vaccinated adolescents, invite them for discussion. Really being a space using a local language, doing the interviews from their community in one of the homes of the VHT. We were able to have them get interested in taking on that advocacy role. And we did a follow-up phase of like 12 weeks and were empowering them through mentorship meetings. How do you communicate and deliver a message around what cervical cancer is, but then the benefits of the HPV vaccine in preventing cervical cancer and the anticipation of injection pain. Because one of the things was the girls fear the injection. So they don't want to take the injection, but communicating that the injection will pain you, but you'll benefit more.

Doreen: You know, and then we learned that it's important for the girls when you link the HPV vaccine with child birth, that, okay, you know, cervical cancer affects your reproductive health system, but HPV vaccine will protect you. And then you'll be able to give birth in the future. Because they always had fears like Rehana was saying around side effects of child birth. So the messaging had to be that about cervical cancer and HPV vaccine and less about how the virus is transmitted through sexual behavior, because that created stigma and a sense of shame around the discussion.

Doreen: Through the follow-up, they were able to identify and vaccinated girls, refer them. And so we learned at the end of the day that, you know, it's possible for peer educators, adolescent peer educators to use the peer to peer education approach to engage in vaccinated peers and they improve the attitudes towards the vaccine and stimulate acceptance of the vaccine. And the adolescent peers, educators could be the linkage to the health facility.

Doreen: We also learned that of course caretakers had to always consent to vaccination. Some of them were afraid, they would fear, but then we realized it was a mechanism that those that would tell their daughters not to get vaccinated, it meant they were presenting an opportunity for us, for the community health workers to engage with them more so that they can understand the benefits of the vaccine.

Doreen: But then we also learned that through social influence, vaccination uptake could increase. So the approach of peer to peer education and social influence was feasible in this setting, an urban poor community where they're in an urban setting, but they don't really have proximity to knowledge and they don't have linkage, but the mechanism of peer to peer education can be that approach. So broadly that's what we learned.

Vince - 00:14:56: Well, thanks Doreen. And it's fascinating to hear some of the parallels and some unique challenges in both in the Indian states that Rehana worked at and then in Kampala where your research was conducted, Doreen.

Vince: And I wanted to ask both of you, just this kind of building off what I opened with in that we have this situation of low coverage of a vaccine that is highly effective, but is delivered to the target population, primarily this adolescent girls and young adults. And so there is a huge public health benefit that can come from this vaccination and early screening for cervical cancer, but there has been obvious challenges.

Vince: You both talked about a few of those. Rehana, you mentioned the ASHAs, which are the community health workers in India, and Doreen, you mentioned the village volunteers. So in each place they're called something different, but a similar sort of construct, right? Maybe talk a little bit more about that or any other things that you think some of these policymakers and leaders need to be maybe considering maybe more than has happened in other vaccination or other health service rollouts as they are trying to kind of scale up reaching the target population for this vaccination.

Doreen - 00:16:10: I will just draw my lessons from the work that I did in this urban poor community. I realized that this urban poor community had more minority groups than just saying urban poor. We have those who are born and raised there and the adults since I worked with, because they could easily have the trust. Some of them were in school, they were vaccinated, but then they were like, we also host refugees there from Somalia. Those are closed communities. We didn't even get close to them, but we probably know that they have, their HPV vaccination is even lower. Then there were what you call the rural urban migrants. They are those who come in to work in the bars, in the Islam setting, to work as housemaids. They are not in school, but they are young. They are 13, they are 14, they are 15. Some of them have married early. They should be benefiting from the vaccine. So we learned that the communities were different. They had multiple complexes in terms of identities and governments need to be aware that in those unique populations like urban poor settings, we need to know who is there and who's left behind.

Doreen: For me, I thought that was important because even in the study that I did, I couldn't have representation of all those groups. Some of them didn't even know the local language of Uganda, they couldn't speak English. We couldn't use Swahili, they didn't know it. They knew their mother tongue from the rural communities where they came from, but you knew they were eligible to take up the vaccine. You can't even communicate about it. Even as the adults and peer educators engaged, you felt they could not really socialize with them because they were not friends. Remember, we're using a social influence approach for you to interest your friend to love the vaccine because you received it. So I would believe that governments need to be aware about those differences in order to generate demand creation, which is context specific, leave no one behind.

Doreen: And I think for me, I also thought that integration was key because as we talk with adolescents about HPV vaccine, some of them thought they had received the vaccine because they received the tetanus vaccine. And then along the way, there was a measles rubella campaign that ran that was targeting, I think, two-year-olds up to 15-year-olds in Uganda around the time of 2019, 2020 before COVID. So they thought they had received the vaccine. So when you tell them about the vaccine, they're like, oh, I received the vaccine. How many doses did you receive? I received one. When would you go for the second one? They didn't tell me to go for the second one. And then we realized, okay, so which card did you get? I got the pink card, but the HPV vaccine is a purple card. We wish all these vaccines had been integrated. It meant that these adults and someone who had interfaced with the health system, but they did not benefit from the opportunity to get all the vaccines.

Vince - 00:18:40: Thanks, Doreen. And I should note, because you had mentioned this challenge on second dose a couple of times, the WHO Strategic Advisory Group of Experts on Immunization as an external advisory group looked at data. There's some strong data showing a strong effectiveness of one dose of HPV vaccination among some population. I think there's some research among the general target population. Last year, WHO changed the guidance into which countries for the early adolescent population could go to a one dose schedule. So this is something that countries are currently deciding. And there's obviously implications there of a one dose or two dose schedule. It's generally, I know that second dose, as you say, is often a challenge. Rehana, any reflections on generally what some of these leaders who are planning these rollouts, some elements that you think they need to pay attention to?

Rehana - 00:19:32: Yes, in India, like many of the low-income families in the informal sector struggle to access vaccines, leading to a high rate of unvaccinated children. This poses significant risks to their health and perpetuates poverty cycles. And thus for the successful rolling out of the HPV immunization program, it is important to understand the factors contributing to unvaccinated and work towards it.

Rehana: As Doreen also mentioned, first and foremost, there needs to have the access wherein the community member does not have the time and resources. They often migrate from one place to another for work and so they do not have that access and or else they are also living at a distance places from the health facilities. They do not have knowledge about the vaccine dates and time and many times it's also the cultural factors such as beliefs of given religion and caste and traditional and patriarchal customs also affects that. And most importantly, it's also the lack of awareness on the benefits of the vaccine and fear of the side effects and myths and misconceptions about the same. And so it is very important that the rolling out strategy or say the demand creation should consider various aspects.

Rehana: First and foremost, the approach taken should be multi-stakeholders, wherein the governments, health care professionals, communities, local leaders, CSOs, and NGOs must work together, create awareness, address neets and misconceptions to achieve high coverage rates and avoid working in silos. Another which I would say was to develop a comprehensive communication strategy, which would work out as an acceptance, can be addressed. These factors and tailoring communication strategies in a manner that leverages and ensures retentions. For example, we can have posters, videos, role plays, etc. and that has to be in the local dialect and so on only the acceptance level from the community would be coming in.

Rehana: Another thing which I would say is also to increase the reach and accessibility, it is critical to ensure that vaccination services are readily available in the school, healthcare facilities, and outreach programs. Additionally, like we can also have organized the camps at the location which are convenient to the community members because that would really end the schedule also which is acceptable to the community members because this will ensure increased vaccine uptake as the mothers won't have the fear of taking their work day off. So we should also work towards the integrated approach of the community healthcare needs alongside the HPV vaccine and that would bring in more ownership and participation as well from the community.

Doreen - 00:22:27: Another question for Rehana, as you plan to roll out the HPV vaccination in India, have you also thought about integrating the parts of HPV vaccination with cervical cancer screening? There have been some thoughts here. I don't know if you've been here at the conference here. I don't know if you're now in India where it's very important for people to link cervical cancer prevention with HPV vaccination. So therefore, as you roll out HPV vaccine, you drum-up cervical cancer screening at the same time so that those two move together and you can, you know, like draw mileage from the two. We didn't do that in Uganda. I think we first rolled out really the HPV vaccine and then maybe I

think it's HIV that brought out cervical cancer as more women who have HIV started to have more cervical cancer and we started to see cervical cancer as an AIDS-defining disease. Then we drummed up cervical cancer screening. So I don't know for you, have you thought about those two prongs together?

Rehana - 00:23:20: We can consider integrating other community healthcare needs like wash or routine immunization, the malnutrition and other primary health care needs of the members apart from the HPV vaccine uptake and that would really work out. And we at SEWA are also working on the NCD care for the members so we can link that with the screening of the NCD care of the members as well.

Francesca - 00:23:46: Actually, I recently wrote a blog looking at HPV but more specifically looking at the youth and adolescent autonomy participation and advocacy to increase HPV vaccine uptake. This blog is available if listeners want to read it at immunizationadvocates.org. I am curious with both of your research and work with communities, what have you seen as a particular challenge health systems have in not only reaching youth and adolescents but in communicating with them and in working with them and how do you feel those challenges can be addressed?

Doreen - 00:24:24: I think what I've learned from the work is that we need to be as a health system flexible enough to understand that we have different profiles of our adolescents. A rural adolescent is not the same as an urban adolescent and urban adolescent is not typically the same as an urban poor adolescent. So I think health workers have always maybe had the challenge where they just target the age group. Oh, we are targeting nine-year-olds to 15-year-olds but whatever they are, they are different in their experiences. Some of them have initiated sex, some of them haven't. Some of them are going to school, some of them are not going to school, some of them have ever had a child, some have not. So every time you interface with them, they've had experiences. You need to meet them based on their experience. So I feel like one of the challenges has we have not really tried to differentiate the model of reach for the different profiles of adolescents.

Doreen: Now I know from a programming perspective, it's expensive. It's expensive. You'd rather have one model, use it and catch everybody but you're not catching everybody. So I think we just need to be aware of the fact and start to communicate with stakeholders and say what are the options. The adolescents will not come to the health facility because even in our study, we had to link them systematically and follow them. Say on this specific day, those who are interested, we are going to walk to the health facility together. So that they cross the road. When they reach there, they don't have to wait for long. They get the vaccine and they are able to go home or go back to school. So it was important for us to realize that them coming to the facility is not always easy but we can facilitate through community outreaches, the combination of using school models. So the different models of service delivery to reach young people will be important and of course how we communicate to them. Sometimes all the messages are in English. Not all of them speak English.

Doreen: We talk about social media. Many of them are high tech but some of them are really not. Especially in the rural communities. Some of them don't have even enough money to buy the Internet. For them to buy the Internet, you're asking them to find the money. Where are they going to find the money? Before you know it, you're actually in a way pushing them to do sex work in order to get money to buy Internet so that they can go on Facebook and learn about a message. So we just need to be sensitive and learn more. I don't have direct answers but I feel like for the young people, we shall need to just be aware about who they are, be flexible and innovative in how to reach them and generate that interest and listen more. If they say I don't want the vaccine, understand why. Don't judge the youth. Don't call them young and immature but understand them and their reasons and meet them at some point. Those are my thoughts.

Vince - 00:27:00: Rehana, Doreen talked about the importance on school-based policy. The school introduction, having it available relative to school. There's also an issue of reaching those who have dropped out of school. What are your thoughts on this topic on reaching youth and adolescent populations?

Rehana - 00:27:19: At SEWA, we have a lot of young generation members who are also organized with SEWA. So we would say that this could be done through training the cadre of leaders to spread the key messages on immunization and the disease that could be because these are the leaders in whom the community has the trust. And so like, the community would be listening to these leaders as they have the trust, they are from the community itself and these leaders could go on to several household visit, community meetings and educate the community members. And like our experiences with the pilot of HPV clearly shows that there is need to work in a very holistic and integrated approach together with the education, and we also need to address other issues and the needs of the women in the community. This will lead to a strong sense of ownership and belongingness.

Rehana: If this is done through the community leaders, for the community and through the community leaders itself, at the same time, we also believe that coordinated and integrated efforts wherein SEWA leaders have proactively created linkages with the ASHAs and Anganwadi, the frontline workers in India for the immunization outreach, and this would really reduce the duplication and maximize the reach.

Rehana: We would also recommend that the data-integrated approach should be taken, and these are the young leaders who are good at working with the mobile and technology. So how could we collect and analyze the data and allow them to track and follow up with the members? Lastly, because we have the leadership from the community itself, and we have this trained SEWA health ambassadors, the community could also access the telemedicine services of SEWA wherein they need to get in touch with the doctor or getting their concerns addressed and seek medical advisors at no cost. Say with this integrated approach and depending upon the needs of the members, the leaders would be trained on multiple topics and subsequently create awareness in the communities and increase the demand and uptake.

Francesca - 00:29:29: So as we close out this episode, what we like to do on this podcast is ask for short closing messages to leaders around the world and across disciplines. Doreen, if you want to start, do you have a closing message, a quick statement that you want leaders around the world to know is important to increase and sustain high uptake of HPV vaccines and eliminate cervical cancer?

Doreen - 00:29:53: I think the global strategy for cervical cancer elimination is a good opportunity to promote the three prongs for cervical cancer prevention, HPV vaccination, screening, and treatment. You know, having those three prongs, one vaccination, two screening, three treatment. I think as leaders, let's gather our efforts. And leaders within our own risk, as a researcher, you as a journalist, the other practitioners, let's all gather along and identify those opportunities for service delivery models, for demand creation, for integration within the broader reproductive health services, and mobilize resources that are needed from human, the time, the financing, the vaccine supply. Sometimes the vaccines may not be enough, and really refine the approach.

Doreen: Because I feel like this is the opportunity to have everything in check. You know, some countries are going single dose, other countries are still using the two-dose series. Let's harmonize for each country and come up with a strategy, come up with a plan, and cost it, and then have everybody on board to increase HPV vaccination uptake. It will be different for different people. I think we should all be ready for the challenge, and not be afraid to step out and learn, and listen, and learn again, and refine. And then before you know it, we shall have the best strategy to reach those that are most in need. And at the end of the day, make sure we leave no one behind, because sometimes we are

flowing with those that are moving along with the vaccine, and leaving some of those clusters of people in hard to reach areas, in urban poor communities, in conflict settings. We leave them behind, and yet they are probably the ones that need the vaccine the most. So everyone, let's all get up. This is our business, everybody's business, and let's all do better and do more.

Vince - 00:31:35: Here, here, Doreen, and the WHO initiative to eliminate cervical cancer, we will put on our website alongside this episode that you just mentioned. Rehana, what is your short closing message to leaders from the world?

Rehana - 00:31:49: I would emphasize two major things in my closing messages. A, walk in a holistic and integrated manner with the community-based organizations like SEWA, which has the trust of the community and the women's leadership. And B, a comprehensive communication strategy should be worked out in awareness among the community members and front-line health workers on the disease, how it is caused, importance of vaccine, address the efficacy, myths, and misconception. Also, there is a need to address the other issues and the needs of the women in the community, and this would bridge the gap between the community and vaccination.

Francesca - 00:32:28: Thank you so much. And before we close out for today, Doreen, I have to ask, I'm not there. And I've heard such great things. How is VARN2023 going?

Doreen - 00:32:37: VARN2023 is going well. It's exciting to see everybody here, the researchers, the leaders, people for representing governments, INGOs, CBOs, and everybody is having a common goal. The common goal is vaccination, turning vaccines into vaccination. And everybody is sharing knowledge, learning their experiences, what they've been doing in their programs, what they think and work, and asking tough questions and, you know, making connections.

Vince - 00:33:02: As you said, Doreen, I mean, there are so many very important lessons learned. Of course, going back even further than the COVID pandemic, but especially from the last few years. And we talked about a major challenge, a major opportunity to address a major public health challenge in the HPV space today. But there's many challenges that we have going forward. And I agree there's high energy right now we needed and we need to kind of continue to work and collaborate together. So we're so thrilled that we got to speak with the two of you today. And as we move forward, our last episode of this season is going to talk a little bit more about re-imagining immunization programs as a whole and where do we go going forward? So we very much appreciate your thoughts today and look forward to continuing the conversation.

Doreen - 00:33:50: Well, thank you for inviting me. And we thank all our partners here at VARN, Sabin Vaccine Institute, UNICEF, Gavi, you know, being with them on this journey and seeing their commitment as international partners. You as a country, you gather yourself and say, I also want to do more with all the partners. So for me, it's really to say thank you and thank you, Francesca and Vince, for the opportunity. Thank you, Rehana, for sharing. I've learned a lot from you. I'd never thought about working with a women's group. Maybe I should go and learn about that in Uganda. And you never know. You know, we can also drive some mileage, especially around cervical cancer screening, which is sometimes stigmatized when you screen people think, oh, because you're having sex, that's why you're screening, you're exposed. But really just knowing that it's to protect yourself when you protect yourself, you protect your family, you don't die young and leave orphaned children. So really, I feel like working with women groups for cervical cancer is innovative and it's the way to go. So thank you for sharing.

Rehana - 00:34:48: Thank you. It's all sister to sister learning and we look forward to learning from each other. And thank you, Vince and Francesca for giving this opportunity. And Doreen, it was also

great meeting you and learning some of your work, which you have been doing. Wonderful meeting you all.

Vince - 00:35:04: Thank you all so much.

Francesca - 00:35:07: Community Conversations on Vaccines is brought to you by the Sabin Vaccine Institute and presented by Immunization Advocates. To find out more about the Sabin Vaccine Institute and how our programs are working toward a world free from vaccine-preventable diseases, visit sabin.org. Find Community Conversations on Vaccines at immunizationadvocates.org/podcasts, or wherever you get your podcasts. Be sure to click subscribe to be the first to hear future episodes. On behalf of the team here at the Sabin Vaccine Institute, thanks for listening.