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HPV Vaccination Gaps: Why Access Alone Does Not Ensure Cervical Cancer Prevention

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Mains: GS-II, health services, women and policy implementation; Prelims: HPV, U-WIN and WHO 90-70-90 targets



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Why is this in the news?

An Indian Express report on 17 November drew attention to uneven uptake within the national HPV vaccination campaign. It reported coverage of about 9% in Maharashtra and about 2% in Mumbai. The national figure of 79.51% was attributed to an October 14 U-WIN campaign report, while state details were described as updated to November 15. These are not a same-day state-national comparison.

The exam-relevant issue is how an available preventive service reaches eligible adolescents. WHO also issued a statement on November 17 calling attention to unequal access to cervical cancer screening and treatment.

India's HPV vaccination programme

The official PIB account of February 28, 2026 says the nationwide programme was launched from Ajmer. It targets approximately 1.15 crore girls aged 14, with vaccination free at government health facilities. After the initial intensive campaign, vaccination was to continue on routine immunisation days.

The programme uses Gardasil-4, a quadrivalent vaccine targeting HPV types 6, 11, 16 and 18. Vaccination aims to prevent targeted infections; it is not treatment for an existing cancer. Health workers determine individual eligibility and clinical suitability.

How HPV relates to cervical cancer

Persistent infection with high-risk human papillomavirus types can cause changes in cervical cells that may eventually develop into cancer. An HPV infection does not automatically mean cancer. Prevention therefore involves a continuum from preventing infection to detecting precancer and providing treatment.

Vaccination and screening are complementary. A vaccine reduces future risk, whereas screening helps identify precancerous changes. Increasing the number of screening tests is insufficient if women with positive results cannot obtain further assessment, treatment and follow-up.

> **Related reading:** Cancer in India: ICMR-NCRP estimates

The WHO 90-70-90 framework

WHO's global strategy sets three targets for 2030:

- 90% of girls fully vaccinated against HPV by age 15.
- 70% of women screened using a high-performance test by age 35 and again by age 45.
- 90% of women with precancer treated and 90% of women with invasive cancer managed.

Elimination as a public health problem requires reaching and maintaining an incidence below four new cases per 100,000 women annually. It does not mean immediate zero cases or worldwide disappearance of the disease in 2030.

U-WIN: a tool, not a substitute for outreach

PIB describes self-registration on U-WIN, registration assisted by a health worker and walk-in registration at a facility. Vaccination certificates can also be downloaded from the platform. eVIN, by contrast, supports vaccine stock and logistics management.

Digital records help monitor services but cannot guarantee equitable access. Out-of-school adolescents, migrant families and people without reliable phone or internet access can be missed. Local beneficiary lists, community contact and offline assistance need to work alongside digital records.

Reading low coverage responsibly

A coverage gap is a useful signal, not proof of a single cause. The eligible-population estimate, reporting date, access to sessions, parental knowledge and trust all require examination. The news report contains two different numerical bases for Maharashtra's target population; this article does not choose one denominator to calculate a new rate.

A reported adverse event following immunisation does not by itself establish that vaccination caused it. Equally, a claim of zero risk is not an appropriate basis for trust. PIB describes observation, medical support and AEFI management arrangements. Transparent information and accountable services matter more than absolute assurances.

Policy lessons for Mains

Possible responses include school and community outreach, trained health workers answering parental concerns, special efforts to reach out-of-school girls and district-level identification of missed groups. These are policy suggestions, not newly announced decisions in the news report.

Performance should be assessed through coverage of the eligible group, social and geographic gaps, follow-up with missed beneficiaries and continuity from screening to treatment. Counting doses or sessions alone can hide unequal use. The policy task is to close the gap between launching a service and ensuring that people can use it fairly.

Prelims Practice Questions

Question 1. Consider the following statements about HPV prevention:

Statement 1: HPV vaccination completely removes the need for cervical cancer screening.

Statement 2: Gardasil-4 used in India's national programme targets four HPV types.

Which of the statements given above is/are correct?

(a) 1 only

(b) 2 only

(c) Both 1 and 2

(d) Neither 1 nor 2

▼ **Answer and Explanation**

Correct answer: (b)

Statement 1 is incorrect: vaccination and screening are complementary, and vaccination does not treat an existing cancer.

Statement 2 is correct: Gardasil-4 targets HPV types 6, 11, 16 and 18.

Question 2. In WHO's cervical cancer 90-70-90 targets, the number 70 refers to:

(a) Screening 70% of women with a high-performance test by the specified ages

(b) Vaccinating 70% of girls by age 18

(c) Building only cancer hospitals in 70% of districts

(d) Giving medicine to 70% of women without testing

▼ **Answer and Explanation**

Correct answer: (a)

The target is screening 70% of women by age 35 and again by age 45 using a high-performance test. The other pillars are vaccination and treatment or management.

Mains Practice Question

Why does availability of preventive healthcare not automatically lead to equitable uptake? Discuss with reference to regional gaps in HPV vaccination. (150 words)

Answer Outline

Introduction:

Preventive programmes such as HPV vaccination reduce risk before disease develops, but national averages can conceal locally excluded groups.

Main Body:

Access: distance, timing, out-of-school adolescents and digital barriers.

Trust: health literacy, misinformation and transparent answers to safety concerns.

Governance: reliable eligible-population estimates, date-consistent coverage, local monitoring and links between vaccination, screening and treatment.

Responses: community outreach, offline support and district-level identification of gaps.

Conclusion:

Success should be measured by equitable coverage and continuity of care, rather than procurement or session counts alone.

Frequently Asked Questions (FAQ)

Who is targeted by India's HPV campaign?

The national campaign targets girls aged 14. A government health worker should advise on individual eligibility and clinical suitability.

Does an HPV vaccine treat cancer?

No. It is intended to prevent targeted HPV infections, not to treat an existing cancer.

Does vaccination replace screening?

No. WHO's strategy combines vaccination, screening and timely treatment.

Are the reported Maharashtra and national percentages from the same date?

No. The cited report uses a national campaign report dated October 14 and state details updated to November 15. They should not be read as a same-day ranking.

Sources

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- www.pib.gov.in
- www.who.int
- www.who.int

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