ECO Good Practice Guide on HPV Vaccination: a Factsheet

Make it policy. Make it happen. Make it last

ACCESS & EQUITY

Principles

Principle 1. Establish who has access to HPV vaccination

Is access to HPV vaccination clearly defined and consistent for the target population?

Countries should clearly establish who has access to HPV vaccination through appropriate health policy or regulatory instruments, ensuring access is consistent over time, and not varying by location or discretionary restriction.

Principle 2. Ensure financial access to HPV vaccination

Are cost and reimbursement arrangements a barrier to HPV vaccination?

Countries should ensure that HPV vaccination is provided free of charge or fully reimbursed for the target population, and that reimbursement and financing arrangements do not create barriers to access.

Principle 3. Design access arrangements that prevent systematic exclusion

Do HPV vaccination policies and access arrangements avoid the systematic exclusion of specific population groups?

Countries should design HPV vaccination eligibility and access arrangements in a way that prevents the exclusion of specific population groups, including where overall high vaccination coverage may mask persistent access gaps, by using complementary delivery pathways, culturally and linguistically appropriate communication, and targeted outreach for populations not reliably reached through routine models.

Justification & Scientific Evidence

Clear definition of who has access to HPV vaccination is a core programme design requirement and a necessary condition for equitable access

WHO guidance on HPV vaccination consistently treats the definition of a target population (as defined in national policy) as a central element of vaccination policy and programme design. Explicit emphasis is given to defining eligible age cohorts and aligning eligibility criteria with delivery strategies in order to reach the intended eligible population, and to avoid systematic exclusion of specific groups, such as adolescents who are not enrolled in school [1, 2]. Decisions on how eligibility is defined for example by age, year of birth, or school grade, have direct implications for programme feasibility, coverage measurement, and the risk of missing subpopulations [2]. In the European context, where HPV vaccination is now implemented for both girls and boys, these access principles are therefore relevant to all eligible adolescents included in national HPV vaccination policies.

This is consistent with Immunization Agenda 2030 (IA2030), which emphasises that immunisation services should be deliberately designed and delivered in ways that are responsive to the needs of individuals and communities [3].

Evidence from WHO guidance on refugees and migrants indicates that lack of clarity around eligibility, and access conditions, can prevent individuals from being offered or seeking vaccination in practice, even where entitlement exists in policy [4]. Limited provider knowledge of migrants' health needs and eligibility may result in missed vaccination opportunities, and discourage uptake [4].

Removal of point-of-use financial barriers is necessary to ensure equitable access to HPV vaccination

In Europe, the European Council Recommendation on vaccine-preventable cancers explicitly calls on

Member States to provide HPV vaccination free of charge and/or fully reimbursed for those for whom vaccination is recommended, and to ensure access and uptake among vulnerable populations and high-risk groups [5].

This policy position is reinforced by systematic review evidence indicating that perceived costs and uncertainty about charges at the point of use can act as barriers to HPV vaccination uptake in some settings, particularly among disadvantaged or underserved populations [6].

Routine HPV vaccination policies and delivery models can systematically exclude specific population groups unless access arrangements are deliberately designed to prevent this.

In the context of HPV vaccination programmes in Europe, high overall vaccination coverage does not on its own, ensure equitable access. Routine immunisation systems may systematically miss vulnerable populations unless delivery strategies are deliberately adapted [7]. IA2030 frames equitable access as a core system objective and emphasises that the benefits of immunisation are not spread equally. It highlights that systematic exclusion can occur when immunisation services are not deliberately designed to address subnational and population-level inequities related to socio-economic, geographic, cultural and gender-related barriers [3]. The exclusion of these groups often arises from the way eligibility rules, delivery settings, timing or administrative requirements interact with people's lived circumstances, rather than from individual choice or refusal.

Even when free-of-charge vaccination and clear national eligibility rules are in place, HPV vaccination programmes can systematically miss groups facing structural barriers: migrants and refugees with administrative obstacles, marginalised communities, people experiencing homelessness, MSM, people with higher-risk sexual behaviour, and people in carceral settings. For example, school-based approaches may miss adolescents who are not enrolled in school unless complementary strategies are implemented, illustrating how delivery pathways that work well for most of the population may exclude specific groups [1]. WHO guidance on the integration of refugees and migrants into immunisation policies provides one concrete example of these mechanisms, documenting how lack of explicit inclusion in policy and delivery arrangements can result in exclusion from routine vaccination services, even in the presence of formal entitlement [4]. This requires monitoring and review arrangements that can identify persistent access gaps across population groups, so that exclusion is recognised and addressed in practice.

Case Studies

Poland

In Poland, HPV vaccination has been recommended since 2008 for girls aged 11-12 years, with catch-up recommendations for older adolescents, but was not included in the mandatory immunisation programme. As vaccination in primary health-care settings required an additional charge, HPV vaccine uptake remained low, with coverage among adolescents estimated at 7.5%-10%, and access varying where some districts introduced locally financed vaccination programmes [8].

To address this, Poland introduced a nationwide HPV vaccination programme in 2023 as part of the National Oncology Strategy 2020-2030. The programme established a clear national entitlement to free HPV vaccination for girls and boys aged 12-13 years and integrated HPV vaccination within a broader cancer prevention framework [9]. Early implementation data indicate that uptake remains low, highlighting that while the removal of financial barriers was a necessary step, additional system components such as public awareness, engagement of healthcare workers, and coordinated implementation strategies are critical to achieving equitable reach [10].

Netherlands

The Netherlands provides a diagnostic example of how persistent access gaps can occur even in high-performing HPV vaccination programmes, underscoring the need for deliberate system design to prevent systematic exclusion.

HPV vaccination is provided free of charge through the National Immunisation Programme with clear eligibility and centralised invitations. Nevertheless, population-level analyses demonstrate persistent differences in uptake between population groups. A national database study found lower HPV vaccination uptake among adolescents with one or two parents born in Morocco or Turkey, those living in areas with lower socioeconomic status, and those with indicators of lower general willingness to vaccinate, such as not having received MMR vaccination [11]. Qualitative research indicates that these differences are partly linked to health-system and delivery factors, including limited awareness-raising on HPV, insufficient provision of tailored information, language barriers and lack of coordination between services [12]. More recently, a regional HPV 18 years+ vaccination campaign found higher knowledge and vaccination uptake among young adults exposed to the campaign, suggesting that complementary, targeted approaches outside routine adolescent delivery may help reach populations not reliably served by standard pathways [13].

Further Reading & Bibliography

- WHO: Guide to Introducing HPV vaccine into national immunization programmes
- WHO: Scaling-up HPV vaccine introduction
- WHO: Ensuring the integration of refugees and migrant in immunization policies, planning and service delivery globally

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