A bold step towards a cervical cancer-free future

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As the world observes International Women's Day, India's interim Union Budget 2024-25 has emerged as a beacon of hope, particularly in the realm of women's health. The Narendra Modi government's support in encouraging the vaccination of girls (from nine to 14 years) against cervical cancer stands out as a pivotal move towards safeguarding women's well-being.

The '90-70-90' targets, global programmes

Despite advances in health care, cervical cancer remains the second most common cancer among women in India, with 1.27 lakh cases and around 80,000 deaths being reported annually. Human papillomavirus (HPV) is a primary culprit in the development of cervical cancer. In response to this pressing public health challenge, HPV vaccination emerged as a cornerstone of a comprehensive strategy for disease prevention and health promotion. The World Health Organization has outlined the '90-70-90' targets by 2030 – for 90% of girls to be fully vaccinated with the HPV vaccine by age 15, for 70% of women to undergo cervical cancer screening tests by the age of 35 and 45, and for 90% of women with cervical cancer to be treated. These targets represent milestones in the global effort to eradicate cervical cancer and highlight the pivotal role of India's call for HPV vaccination in achieving this goal.

Across the world, over 100 countries have implemented HPV vaccination programmes, resulting in a notable decline in the incidence of cervical cancer. A study out of Scotland illuminates the real-world impact of HPV vaccines. The findings show that there have been no reported cases of cervical cancer among women born between 1988 and 1996 who received full HPV vaccination between the ages of 12 and 13. Australia, which initiated HPV vaccination for girls in 2007 and expanded to include boys in 2013, is poised to eliminate cervical cancer by 2035.

Similarly, the successful HPV vaccination campaign in Rwanda, Africa, has significantly reduced the prevalence of vaccine-targeted HPV types, particularly among women who participated in their catch-up programme in 2011. These global success stories underscore the importance of prioritising vaccination for tackling cervical cancer.

Closer to home, six out of the 11 South East Asia Region countries have introduced the HPV vaccine nationwide, i.e., Bhutan, Indonesia, the Maldives, Myanmar, Sri Lanka, and Thailand. Bhutan was the first low-middle income country (LMIC) to introduce a nationwide HPV vaccination programme for girls (12 to 18 years) in 2010 and achieved an initial coverage of 95% of targeted girls. Bhutan is also one of the only LMICs to have begun vaccinating boys as well (in 2021). Ongoing programme assessments and research in Thimphu have observed a reduction in the prevalence of HPV types targeted by the vaccine, indicating the programme's broader impact on reducing HPV transmission in the community.

The push for HPV vaccination for girls, in the 2024-25 interim Budget, marks a new era in women's health in India

The Sikkim model

The key to the success of any vaccination campaign is a robust communication strategy that educates and empowers communities. Within India, Sikkim's exemplary approach to HPV vaccination is an example of an effective public health strategy. Through targeted efforts to educate teachers, parents, girls, health-care workers, and the media about the benefits of the HPV vaccine, Sikkim achieved vaccination coverage of 97% during its campaign rollout in 2018. It provides a compelling example of effective communication and outreach. This rigorous effort has not only dispelled myths and misconceptions but has also fostered trust and confidence in the vaccination process.

India's recent milestone in developing its indigenous quadrivalent vaccine, Cervavac, marks a significant stride towards ensuring accessibility and affordability. Developed by the Serum Institute of India in collaboration with the Department of Biotechnology, and priced at ₹2,000 a dose, Cervavac is cheaper than available vaccines, and holds promise in the fight against HPV infections and cervical cancer.

Whenever India plans to expand its vaccination programme, there is also an opportunity to include adolescent boys, thereby maximising the impact of HPV vaccination in preventing HPV transmission and HPV-related diseases. Also, in line with recent evidence, it has been recognised that one dose of HPV vaccine provides similar protection to that provided by two or three doses.

Drawing inspiration from global and local triumphs, India is ready to make significant strides in combating cervical cancer through HPV vaccination. India's track record in vaccination campaigns, exemplified by the widespread acceptance and coverage of the COVID-19 vaccine, instils confidence in the feasibility of scaling up HPV vaccination efforts. India's ability to reach remote and underserved populations highlights the inclusivity and accessibility of its vaccination programmes, laying a solid foundation for the success of the HPV vaccination initiative.

The importance of HPV vaccination extends beyond individual health outcomes. It has the potential to alleviate the societal and economic burden of cervical cancer. Cervical cancer predominantly strikes women during their prime years, exerting a profound toll on both their families and communities. Premature deaths of young mothers due to cervical cancer negatively impact health and education outcomes in children. By preventing HPV infections, vaccination diminishes the occurrence of cervical cancer and its associated health-care expenses, ultimately fostering the overall welfare and productivity of women.

Meet the challenges

However, challenges persist, particularly in addressing vaccine hesitancy and ensuring equitable access to HPV vaccination. To overcome these hurdles, concerted efforts are needed to engage communities, dispel misinformation, and strengthen health-care infrastructure. The interim Budget also announced the rollout of U-WIN throughout the country. U-WIN, like Co-WIN that was designed to track the COVID-19 vaccination campaign, is a portal that will maintain an electronic registry of all immunisations across the country and enable vaccination programmes to be responsive in real time.

On the supply side, ensuring access to vaccination services is imperative, particularly in underserved populations. And to improve demand among the community, awareness must be improved. Vaccine hesitancy, fuelled by myths and misinformation, poses a significant barrier to the acceptance of HPV vaccines across different regions. Cultural and societal norms are also a factor, highlighting the importance of tailoring messages to resonate with diverse communities. Utilising diverse channels such as social media and community workshops can amplify reach. Including HPV information in health education in schools can be a step to generate demand among adolescents.

Collaborations between government agencies, community partners, health-care providers, and civil society organisations will be instrumental in building trust and ensuring the success of HPV vaccination programmes. We can build upon our experiences of the successful nationwide rollout of COVID-19 vaccines amidst a landscape of pervasive digital and mass misinformation. Moreover, public-private partnerships are instrumental in ensuring equitable access to vaccination services, thereby advancing the collective goal of safeguarding women's health against cervical cancer.

Thus, India's inclusion of HPV vaccination in the interim Union Budget 2024-25 heralds a new era in women's health.

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The determinant in 'more women in the job market'

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There is growing demand from social scientists, governments and international organisations, such as the World Bank and the International Monetary Fund, that women's participation in the economy/labour market should increase to promote economic growth of India. It is believed that when women's participation rate, which is one of the lowest in Asia, increases, it will bring prosperity to the Indian economy.

Key factor of patriarchy

Why is women's participation in the labour market in India so low?

Though there are various explanations such as low human capital, and even discrimination against women, the root cause is patriarchy, which is a social system marked by the supremacy of the father/man in the family, community and society. As Marina Watanabe says, patriarchy is "a social structural phenomenon in which males have the privilege of dominance over females". This supremacy is manifested: in values, attitudes, and customs in the society; in ownership of assets, incomes and wealth; and in institutes and organisations that govern our society and economy. With economic growth and increasing education, the strength of patriarchy has perhaps declined in some ways. However, the overall culture of male dominance over women has not changed much in our traditional society.

Under patriarchy, men are considered to be the breadwinners and women are expected to be the homemakers. That is, women are responsible for household upkeep, and for providing care to the child and those who are old, sick and the disabled in the family. Even when there is hired help, it is the woman who is responsible for household upkeep and care.

Though performed with love, this work of women is inferior work for several reasons. This work is unpaid and invisible as time use data are not available on a regular basis in India, and, therefore, not covered under national policies. It is repetitive (performed every day) and boring. There is no upward mobility, and, therefore, a dead-end job. There is no retirement and no pension. This implies that a significant part of the total labour force available to the economy is locked up in low productivity and inferior kind of work, which is performed mainly by women. Women perform this work not necessarily by free choice or by any particular efficiency in this work but because it is largely imposed on women as a social construct. As this work is outside the purview of economic policies, the drudgery of work, the time stress, technology and low productivity of this type of work and working conditions of workers are outside the purview of policy making. This is unjust, unfair, and unacceptable.

As a result, many women do not enter the labour market due to their high domestic responsibilities. When the others enter the labour market, they enter with domestic responsibilities on their shoulders, implying that there is no level playing field for them from the beginning. Again, they usually have lower human capital (thanks to social norms); restricted mobility due to their domestic responsibilities.

Therefore, their choice is gendered in the labour market. They tend to prefer work that is close to home, part time or flexible work, and which has a safe work environment. Consequently, they overcrowd in stereotyped low productivity jobs and lag behind men in all average labour market outcomes such as participation, wages, and diversification of work. This is clearly not the optimum use of women labour power in the economy. Therefore, women's participation in the labour market must be raised.

India raising the participation rate of well-educated women in the labour market could also lead to a huge army of exploited domestic workers

Greater participation, but also exploitation

As women with higher education and professional qualifications in India tend to participate more in the labour market, it is argued by experts that greater women's education will raise their participation rate in the labour market.

However, this is only half truth, as this increase in participation is backed by an army of domestic workers, who are known to be highly exploited in the Indian economy.

Women's participation in the labour market can increase at all levels mainly by reducing their burden of unpaid domestic work and care by reducing the drudgery/strain of work or improving productivity of women's work (for example, providing fuel-efficient stoves in cooking in place of primitive stoves that use fuel wood); by providing infrastructural support to reduce the burden of their work (for example, water supply at the doorstep); by shifting a part of unpaid work to the mainstream economy (for example, child care, disabled care, care of the old can be provided by the government, the market or by civil society organisations to the mainstream economy).

The burden of unpaid domestic work on women can also be reduced by redistributing this work to other household members, mainly men. These steps will release women from the burden of unpaid work to a significant extent and give them free time to acquire higher education and new skills, or to participate in productive work in the labour market.

Address the issue of subordination

If we want not only women's participation but also gender equality in the labour market, households will have to provide equal opportunities to men and women within the household, i.e., by sharing the "inferior work", or unpaid domestic work and care by men and women. However, irrespective of sharing, what is critical is removing the subordination of women in the household by sharing the responsibility of unpaid household work by men and women.

On hired domestic workers, there is an International Labour Organization Convention that provides minimum basic rights to domestic workers in the world. These include a weekly day off, limited hours of work, overtime compensation, minimum wages and minimum social security. It is unfortunate that India has not even ratified this Convention. If India raises the participation rate of (well-educated) women in the labour market along with a rapid increase in the size of domestic workers, the gains in terms of economic growth will be lost as it will create a huge army of highly exploited domestic workers also.