LETTER to the EDITOR **Editorial Process:** Submission:06/24/2025 Acceptance:04/16/2026 Published:05/18/2026

Comment on: Introduction of the HPV Vaccine among Young Girls to Reduce the Long-Term Risk of Cervical Cancer in Eswatini

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Dear Editor

We read with great interest the recent article by Maseko et al. entitled "Introduction of the HPV Vaccine among Young Girls to Reduce the Long-Term Risk of Cervical Cancer in Eswatini" [1]. This work provides a timely, comprehensive, and highly relevant case study documenting the rollout of a school-based HPV vaccination program within a resource-constrained, high cervical cancer burden setting. The meticulous description of the campaign's planning, execution, and evaluation stages offers valuable insights and a replicable model for other sub-Saharan African contexts striving to achieve HPV vaccination coverage.

Notably, the campaign's success in vaccinating 46,512 girls, achieving 55.9% coverage within a condensed timeframe, is commendable given the structural challenges. The application of the Ishikawa (Fishbone) framework to dissect implementation barriers reflects a rigorous approach grounded in implementation science, adding robustness to the analysis. Nevertheless, several findings prompt further reflection, especially when contextualized against similar initiatives in comparable low- and middle-income countries (LMICs).

For example, Rwanda's landmark nationwide school-based HPV vaccination campaign achieved coverage exceeding 90% during its initial rollout by employing decentralized coordination mechanisms coupled with proactive parental engagement strategies [2]. In contrast, Eswatini's comparatively lower uptake, particularly among older adolescents (37.3% coverage in 14-year-olds), highlights critical gaps. Incorporating Rwanda's pre-vaccination community dialogue model and extending vaccination activities to better align with school calendars and adolescent mobility patterns may enhance Eswatini's future coverage rates.

Similarly, Vietnam's pilot HPV vaccination program demonstrated the benefits of localized microplanning, enabling flexible outreach sessions—including weekend and after-school vaccinations—that accommodated community-specific needs [3]. Eswatini's campaign might consider adopting such adaptive temporal strategies to mitigate the observed vaccination fatigue post-second campaign day.

The study acknowledges external disruptions, such as misinformation and healthcare worker strikes. However, a more proactive and systematic risk communication plan might have preempted these challenges. In India, HPV vaccine rollouts have effectively leveraged media training for health workers and integrated social listening frameworks to identify and counteract vaccine hesitancy early [4]. Eswatini could benefit from embedding similar crisis communication protocols to foster trust and program resilience.

An essential avenue for future work lies in assessing long-term impact beyond immediate vaccination metrics. While Maseko et al. provide valuable data on initial coverage, longitudinal follow-up is imperative to evaluate reductions in HPV infection rates and cervical lesion incidence. Evidence from Australia and the UK demonstrates >50% decreases in high-grade cervical lesions within 5–7 years following vaccine introduction [5, 6]. Building robust cancer registries and monitoring infrastructure in Eswatini will be critical to enable comparable outcome-focused evaluations.

We also advocate exploring mixed-delivery vaccination models that combine school-based campaigns with mobile outreach targeting out-of-school girls and geographically hard-to-reach populations. Hybrid strategies have improved equitable access in countries such as Tanzania and Ghana [7], addressing broader social determinants of health influencing vaccine uptake.

Thailand's national HPV vaccination program exemplifies a successful model achieving relatively high coverage in its early implementation phase [8]. Leveraging existing school health infrastructure and community-based approaches could further optimize HPV vaccine delivery in Eswatini.

In summary, the study by Maseko et al. makes a significant contribution to the growing body of evidence on HPV vaccination implementation in resource-limited settings. We commend the authors and encourage stakeholders in Eswatini to integrate adaptive timing, tailored age-specific messaging, rigorous crisis communication, and longitudinal impact assessment into future efforts to maximize and sustain vaccine impact.

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