HAUTE AUTORITÉ DE SANTÉ

RECOMMENDING
PUBLIC HEALTH STRATEGIES

RECOMMENDATION

Human Papillomavirus (HPV) vaccination

Human Papillomavirus vaccination: extension of the catch-up vaccination cohort to men and women up to and including 26 years of age

Validated by the HAS Board on 30 April 2025

Summary

Currently, vaccination against HPV is recommended in France for girls and boys aged from 11 to 14 years inclusive, with catch-up vaccination for both sexes in 15 to 19 year-olds. It is also recommended for men who have sex with men (MSM) up to and including 26 years of age.

The HAS was consulted on 27 March 2023 by the pharmaceutical company MSD, which holds the marketing authorisation for Gardasil 9, in order to review the Gardasil 9 vaccination recommendation strategy, proposing extension of the catch-up cohort to the general population (both men and women) up to and including 26 years of age. This request was also relayed on 25 June 2023 by the IMAGYN association (gynaecological cancer patient initiative), and the HAS' Technical Committee for Vaccinations, which wanted to reassess this matter itself.

The aim of the HPV vaccination strategy review work carried out by the HAS was to assess the relevance and validity of extending the current catch-up vaccination cohort (15-19 year olds) to individuals of both sexes aged from 20 to 26 years inclusive, taking into account, in particular, the clinical data (immunogenicity, efficacy, safety) of the Gardasil 9 vaccine in subjects aged 20 to 26 years at the time of vaccination. Available data on real-world efficacy, impact, vaccine acceptability and the results of medico-economic studies relating to HPV catch-up vaccination were also taken into account.

To this end, the HAS took into consideration the following elements:

- The clinical characteristics (viral clearance kinetics) of HPV infections:
  - HPV infections are among the most common sexually transmitted infections in the general population, with almost 80% of sexually active people infected at some point in their lives;
  - In the majority of cases (90%), particularly in young women under the age of 30, HPV infection is transient and is eliminated by the immune system within 12 to 24 months;
  - In 5 to 10% of infected individuals, the **infection persists**, leading to the development of cell abnormalities that may cause genital warts or **precancerous lesions** of the cervix, which can progress **to the cancer stage**, in around 10% of cases, over a period of 10 to 30 years.

- Natural immunity to HPV:
  - Seroconversion, which is not systematic, may occur several months or even several years after infection, and affects a variable number of women (in the region of 50 to 70%);
  - Natural acquired immunity to HPV infection may not be sufficient and may not protect against subsequent reinfections, even with the same HPV type.

- Prevalence of HPV infection:
  - In women, a prevalence peak is observed at between 20 and 24 years of age, before decreasing rapidly up to 35-44 years of age. Beyond the age of 45, a plateau phase is observed in France, although a second peak in infections is observed in some countries, probably as a result of reactivation of persistent low-level HPV infection, linked to the phenomenon of immunosenescence in older women;
  - In men, European data have demonstrated a marked increase in the prevalence of infections between the 15-19 years age group (around 24% and 18% for any type of HPV and for HPV-HR, respectively) and the 20-24 years age group (around 32% and 24% for any type of HPV and for HPV-HR, respectively), with the peak being observed at between 25 and 29 years of age (24%) for HPV-HR;
  - Almost three-quarters of people under 25 years of age have no HPV infection; the risk of primary infection and reinfection persists throughout life, making sexually active men and women a permanent reservoir of infection.

- Vaccination coverage (VC) data in France in the target cohort (11-14 years of age) and in the current catch-up cohort (15-19 years of age):
  - In girls: VC has increased over the past five years; the VC for one dose in 15-year-old girls was 54.6% on 31 December 2023, i.e. an increase of 6.8% compared to 2022. The complete schedule VC (2 doses) at 16 years of age was 44.7%, i.e. an increase of 3.2% compared to 2022;
  - In boys: VC has increased since the introduction of vaccination in 2021. The VC for one dose in 15-year-old boys was 25.9% on 31 December 2023, i.e. an increase of 13.1% compared to 2022, but nonetheless remains lower than the VC for girls. The complete schedule VC (2 doses) at 16 years of age was 15.8%, i.e. an increase of 7.3% compared to 2022;
  - Today, the catch-up vaccination initiated for 15 to 19-year-olds remains limited in both sexes, with vaccination having been initiated at between 12 and 13 years of age in the majority of cases. A minority of girls (4.8%) and boys (1.9%) begin their HPV vaccination after 18 years of age.

- The burden of HPV-related disease:
  - Each year, HPV infections are responsible for around 100,000 cases of anogenital warts, 35,000 precancerous lesions, and 6,400 cases of cancer, almost half of which are cervical cancer;
  - Cervical cancer is a preventable cancer, with 3,159 new cases and 1,100 deaths reported in 2023. Three-quarters of cervical cancer cases occur in women between 25 and 64 years of age;
  - Although they are less common than cervical cancers, anal and oropharyngeal cancers associated with HPV infection have increased in the last 30 years, particularly in women, related to evolving sexual practices.

- Available treatments:

- There is currently no specific treatment for HPV infections. The therapeutic management of precancerous cervical lesions and cervical cancer is based on invasive procedures that can have major consequences on a woman's ability to carry a pregnancy to term in the future.

- The existence of an organised cervical cancer screening programme in France since 2018:
  - The cervical cancer screening coverage rate was 59.5% over the 2020-2022 period, i.e. a rate below European targets and those of the French 2021-2030 Cancer Plan set at 70% for 2030, highlighting the importance of stepping up HPV vaccination, which is the only primary prevention lever;
  - The reduction in the number of non-hospital gynaecologists observed over the past ten years could increase disparities in access to cervical cancer screening, particularly in underserved areas.

- The current HPV vaccination recommendations in France:
  - In 2025, HPV vaccination using the nonavalent Gardasil 9 vaccine is recommended in France for girls and boys aged from 11 to 14 years inclusive (target cohort) according to a 2-dose schedule, with catch-up possible up to the age of 19 years (catch-up cohort) according to a 3-dose schedule. Since 2016, HPV vaccination has been recommended in MSM up to the age of 26 years;
  - Targeted vaccination of a group of people based on sexual orientation is difficult to implement outside specific structures. This creates inequality of access to HPV vaccination between women and men; with the latter able to benefit from French national health insurance system funding of the vaccine beyond the age of 19 years, without indicating their sexual orientation to their physician or pharmacist.

- International recommendations:
  - In April 2025, the majority of European countries (21/28) had HPV catch-up vaccination programmes for young women and/or young men, including nine countries offering vaccination up to the age of 25/26 years (Belgium, Croatia, Ireland, Italy (women), Portugal (if initiated before 17 years of age), United Kingdom, Slovenia, Switzerland and Sweden);
  - The Netherlands and Austria have recently introduced temporary HPV catch-up vaccination programmes for an average duration of 18 months, in the general population: up to 26 years of age in the Netherlands (campaign ended on 30 June 2024) and up to 30 years of age in Austria (campaign ongoing until 31 December 2025);
  - In Australia, Canada and the USA, catch-up vaccination is offered up to 25-26 years of age. In the USA and Canada, vaccination of adults over 27 years of age is possible on the advice of a clinician. In Australia, vaccination is recommended up to the age of 45 years in MSM only.

- Clinical immunogenicity data in individuals aged 16 to 26 years:
  - In clinical trials, the non-inferiority of immune responses with the Gardasil 9 vaccine has been demonstrated in the per protocol immunogenicity population (PPI) (subjects seronegative and PCR-negative to the vaccine HPV types assessed): i) in young women aged 16 to 26 years, in comparison with those obtained in girls and boys aged 9 to 15 years, and ii) in

young men aged 16 to 26 years, in comparison with those obtained in young women of the same age;

- Vaccination using Gardasil 9 of young women already infected with one or more vaccine HPV types (i.e. seropositive and PCR negative for a given vaccine HPV type) led to an anamnestic response, characterised by higher MGT values one month after vaccination, suggesting activation of immune memory;
- Maintenance of a long-term (humoral) immune response has been demonstrated in young women aged 16 to 26 at the time of vaccination, for up to 8.5 years after the third dose of vaccine;
- Clinical co-administration data in adolescents aged 11 to 15 years have demonstrated that the antibody response to the Gardasil 9 vaccine was not altered in the event of simultaneous administration with vaccines against meningococcal disease (tetravalent ACWY vaccines), diphtheria, tetanus, pertussis and poliomyelitis (dTap-IPV vaccines). These results observed in adolescents can be extrapolated to young adults aged 20 to 26 years, and support the possible concomitant administration of the three vaccines - Gardasil 9, ACWY and dTap-IPV - in this age group.

– Clinical efficacy data in individuals aged 16 to 26 years:
  - In young women aged 16 to 26 years at the time of vaccination, the efficacy of the Gardasil infection against CIN 2/3 lesions and AIS related to HPV 16 and 18 was 98.2% (95% CI: 93.5 - 99.8) in the per protocol population and 51.8% (95% CI: 41.1 - 60.7) in the modified intention to treat population (i.e. a population that could include women already infected with HPV before vaccination), with a median follow-up of 3.6 years;
  - The long-term clinical efficacy of Gardasil (VE = 100%) in the prevention of CIN 2/3 lesions has been demonstrated in young women aged 16 to 26 years, for up to 12 years, on average, after vaccination (per protocol population);
  - In young men aged 16 to 26 years at the time of vaccination, the efficacy of the Gardasil vaccine in the per protocol population was 90.6% (95% CI: 70.1 - 98.2) against genital lesions related to HPV 6, 11, 16 and 18 (median follow-up of 2.4 years). In the FAS population, which could include individuals already infected with HPV before vaccination, the Gardasil vaccine demonstrated an efficacy of 68.1% (95% CI: 48.8 - 79.3) against external genital warts related to HPV 16 and 18 and an efficacy of 54.2% (95% CI: 18.0 - 75.3) against AIN 2/3 related to HPV 6, 11, 16 and 18 (subgroup of MSM subjects);
  - Long-term protection for up to 11.5 years post vaccination (VE = 100% for the Gardasil vaccine) was observed in young men aged from 16 to 26 years at the time of vaccination, against genital warts and external genital lesions, in the per protocol population and in the modified intention to treat population;
  - As regards HPV 31, 33, 45, 52 and 58 genotypes, the efficacy of the Gardasil 9 vaccine was assessed only in young women aged 16 to 26 years, demonstrating an efficacy of 97.4% (95% CI: 85.9 - 99.9) in the per protocol population and 80.6% (95% CI: 33.7 - 94.3) in the modified intention to treat population, against high-grade genital lesions (of the cervix, vulva, vagina) (median follow-up of 3.6 years);
  - Long-term clinical efficacy data have been published for women vaccinated at between 16 and 26 years of age, and confirm, 12 years after vaccination, an efficacy of 100% for the

Gardasil 9 vaccine against cervical lesions (CIN 2/3), AIS and cervical cancer related to HPV 16, 18, 31, 33, 45, 52 and 58 in the per protocol population;

- The clinical efficacy data confirm the existence and maintenance of vaccine efficacy in young men and women aged 16 to 26 years at the time of vaccination with Gardasil or Gardasil 9, irrespective of their status in terms of previous HPV infection. However, the vaccine efficacy observed in the ITT or FAS population remains lower than that reported in the per protocol population, for the same follow-up duration.

– The real-world efficacy data for HPV vaccines (bivalent, quadrivalent and nonavalent vaccines) obtained in women in the prevention of high-grade CIN2+/CIN3+ lesions or cervical cancer, derived from six observational studies conducted based on Scandinavian national registries:
  - In women vaccinated before the age of 20: the six studies demonstrate a high vaccine efficacy against precancerous lesions (CIN2+/CIN3+) and cervical cancer, especially when vaccination is initiated before 17 years of age, with VE estimates ranging from 35% to 88%. From 17 to 20 years of age, the vaccine efficacy is moderate (30% to 60%), but decreases compared to vaccination carried out at a younger age;
  - In women vaccinated after the age of 20: a trend towards modest efficacy (of around 15%) is observed in four of the six observational studies in vaccinated women, with heterogeneous results depending on the studies and endpoints assessed. One study (Lei et al., 2020) nonetheless reports an efficacy of 62% against invasive cervical cancer. Two of the six studies did not find any protective effect of vaccination, highlighting a less consistent efficacy in this age group;
  - An analysis of methodological biases using the ROBINS-I tool was conducted for each of the six studies and demonstrated a number of biases (confusion, selection, classification) in all the studies, with an overall risk judged to be severe for all of them. However, given the observational nature of these studies, the presence of an overall risk of bias classed as being at least moderate is expected, without this invalidating their conclusions, however.

– HPV vaccine safety data in individuals aged 20 to 26 years:
  - During clinical development, it was shown that the clinical safety profile of the Gardasil 9 vaccine remained satisfactory in adults (16 to 26 years of age), with a vaccine safety comparable to that observed in adolescents (9 to 15 years of age). Long-term follow-up clinical studies also demonstrated a satisfactory safety profile of the Gardasil 9 vaccine for up to 8 years after vaccination in the population of young women aged 16 to 26 years;
  - The last national pharmacovigilance report on the Gardasil 9 vaccine, published in 2025, indicates the absence of any new safety signals, but highlights the need to continue monitoring adverse post-vaccine events. The regional pharmacovigilance centre responsible for the vaccine's pharmacovigilance confirms that the data available currently (obtained via the pharmacoepidemiological studies conducted for the Gardasil and Cervarix vaccines) make it possible to rule out a significant increase in the risk of several categories of autoimmune diseases in the vaccinated population. However, it highlights the fact that an update of French pharmacoepidemiological data would be useful in order to confirm or refute this risk;
  - The last PSUR for the Gardasil 9 vaccine (covering the period from 10 June 2021 to 09 June 2022) indicates that no new safety signals were detected over the period covered;

- Available post-marketing data since 2019 confirm the previous conclusions concerning the absence of a significant increase in the risk of autoimmune diseases; a systematic review with meta-analysis conducted by Boender et al. published in 2022, based on 25 studies, demonstrated that the absolute and relative risk of Guillain-Barré syndrome following HPV vaccination remained very low.

- Catch-up vaccination impact data in individuals aged 20 to 26 years:
  - In women, extension of the catch-up programme in girls and young women up to the age of 27 years in Denmark has resulted in a significant reduction in high-grade (CIN3+) precancerous lesions of the cervix in the general population, in a context of particularly high vaccination coverage and screening programme participation. Similar results have been obtained in Norway, where catch-up vaccination has resulted in a marked reduction in high-grade (CIN2+) precancerous lesions of the cervix, particularly those related to the HPV-16 and 18 genotypes, in women eligible for catch-up vaccination and participating in the screening programme;
  - In men, the impact data available also reveal positive indirect effects of global vaccination of girls (target and catch-up cohorts) in terms of reduction of the prevalence of genital warts and penile infections, thereby protecting young men against the vaccine HPV genotypes.

- Data on the acceptability of HPV vaccination in the adult French population (SLAVACO and ICOVAC surveys):
  - The SLAVACO (2021-2022) and ICOVAC (2023-2024) surveys reveal a favourable trend in attitudes towards HPV vaccination in the adult French population, with i) an increase in favourable opinions, ii) a decrease in indecision and iii) a reduction in disparities linked to age, gender and level of education;
  - The improvement in terms of favourable opinion of HPV vaccines is particularly marked in the 18-24 years age group, reflecting a change in perception and growing acceptance of this vaccination among young adults;
  - Media coverage of the HPV school vaccination campaign, launched in 2023, has helped reduce indecision in young adults aged 18 to 26 years, who expressed their overall support for the campaign.

- Data estimating the economic burden associated with HPV-induced cancers in France:
  - The French studies available highlight the significant economic burden of HPV-induced cancers, with overall discounted costs (hospitalisation, outpatient care and daily benefits) estimated at between €543 million and €829.1 million in 2023. Male cancers - primarily head and neck cancers - account for two-thirds of these costs, with the other third being associated with women's cancers;
  - The cost of cervical cancer in 2023 was estimated to be €100.1 million for 7,286 hospitalised patients, according to French Medical IT Programme (PMSI) database figures. This estimate is consistent with previous evaluations, putting the cost of cervical cancer at between €109.4 and €112.6 million euros;

- Data from medico-economic studies on HPV catch-up vaccination conducted in a developed country context:
  - Six publications reported that HPV catch-up vaccination programmes were cost-effective, in particular in the Netherlands and Sweden;
  - The efficiency of catch-up strategies varied depending on a number of parameters: cost, vaccine efficacy and duration of protection, hospital burden, healthcare costs, willingness-to-pay (WTP) thresholds specific to each country, vaccination coverage and political framework;
  - These results can be transposed to the French context, with adjustments to take into account its specific features.

At the end of its assessment, taking into account:

- **The need to guarantee equal access to HPV vaccination after the age of 19 years, irrespective of gender and sexual orientation**;
- The fact that HPV infections are among the most common sexually transmitted infections in the general population, with almost 80% of sexually active people infected at some point in their lives;
- A natural acquired immunity to HPV that is generally insufficient and may not protect against subsequent reinfections, even with the same HPV type;
- The persistence of HPV in 5 to 10% of infected individuals, potentially causing precancerous lesions of the cervix, which can progress to cancer;
- **The prevalence of HPV infections**, and the fact that almost three-quarters of people under 25 years of age have no active HPV infection, thereby exposing them to a risk of primary infection or reinfection;
- The fact that the risk of HPV infection persists throughout life in sexually active men and women;
- **The HPV vaccination coverage still judged to be insufficient in France on 31 December 2023, both in the target cohort** (one-dose VC at 15 years of age: 54.6% in girls and 25.9% in boys) **and in the catch-up cohort**, in girls (4.8% in the 18-19 years age group) and in boys (1.9% in the 18-19 years age group);
- **National targets in terms of vaccination coverage** (target of 80% in 2030 set by the French National Cancer Institute (INCa) and the National Sexual Health Strategy), **as well as international targets** (target of 90% in 2030 set by WHO), required to drastically reduce the incidence of cervical cancer;
- **The momentum generated by the national school vaccination campaign** launched in October 2023 in France's public and private secondary schools, resulting in a 17% increase in vaccination coverage for girls and a 15% increase for boys in the target cohort between the start and end of the first phase of the first campaign in 2023;
- **The high burden represented by precancerous lesions and HPV-induced cancers**; in particular, cervical cancer, with 3,159 new cases and 1,100 deaths due to this cancer in 2023;
- **The cervical cancer screening coverage rate (59.5% over the period 2020-22), which is below the target of 70% by 2030**, reinforcing the importance of vaccination, which is the only primary prevention lever;
- **The absence of specific antiviral treatments against HPV infections**, but the existence of invasive procedures that can have major consequences on a woman's ability to carry a pregnancy to term;
- **The existence of HPV catch-up vaccination programmes up to the age of 26 years,** or even older, in several countries in Europe and internationally;
- **The non-inferiority of the Gardasil 9 vaccine in terms of immunogenicity** in girls and young women aged 16 to 26 years compared to boys and girls aged 9 to 15 years, as well as the non-inferiority of the Gardasil 9 vaccine, in terms of immunogenicity, in boys and young men aged 16 to 26 years compared to young women in the same age group;
- **The existence of an anamnestic response** in young women already infected with one or more HPV types and vaccinated with Gardasil 9;
- **The long-term persistence of the immunogenicity of the Gardasil 9 vaccine**, in young women aged 16 to 26 years at the time of vaccination, for up to 8.5 years after the third dose of Gardasil 9 vaccine;

- **Co-administration data**, demonstrating that the antibody responses to the Gardasil 9 vaccine are not altered in adolescents aged 11 to 15 years in the event of simultaneous administration with vaccines against meningococcal disease (tetravalent ACWY vaccines) and dTap-IPV vaccines), with it being possible to extrapolate these data to young adults;
- **The clinical efficacy demonstrated in young women aged 16 to 26 years at the time of vaccination** of the Gardasil/Gardasil 9 vaccines in the per protocol population (VE of 96.0% to 100%) and in the modified intention to treat population (mITT) (i.e. a population of women who may already have been exposed to HPV before vaccination), with a VE of 46% to 85.7% for the prevention of CIN 1/2/3 lesions, AIS, VaIN 2/3, VIN 2/3, cervical cancer or in the prevention of persistent HPV infections present for more than 6 and 12 months;
- **The clinical efficacy demonstrated in young men aged 16 to 26 years at the time of vaccination** of the Gardasil/Gardasil 9 vaccines in the per protocol population (VE of 74.0% to 100%) and in the FAS population (i.e. a population of men who may already have been exposed to HPV before vaccination), with a VE of 54.2% to 68.1% for the prevention of external genital lesions (genital warts, PIN 1/2/3 or AIN 2/3 (MSM subpopulation)), related to HPV 6/11/16/18;
- **The long-term persistence of the clinical efficacy of the Gardasil 9 vaccine** in young women and men aged 16 to 26 years at the time of vaccination, in the per protocol population, for up to 12 years, on average, after the third dose of vaccine;
- **A trend towards maintenance of a real-world vaccination efficacy of HPV vaccines in women vaccinated after the age of 20,** of close to 15%, particularly after a complete vaccination schedule (3 doses), in the prevention of high-grade precancerous lesions (CIN2/3+) and/or cervical cancers;
- **Maintenance of a favourable safety profile of the Gardasil 9 vaccine in adults**, with a safety comparable to that observed in adolescents, and the absence of any demonstrated link to date between HPV vaccination and the development of autoimmune diseases, including Guillain-Barré syndrome (GBS);
- **The impact of HPV vaccination programmes** with multiple cohorts, including catch-up vaccination, on reducing the prevalence of HPV-induced infections in the general population linked to reduced circulation of the virus;
- **The increase in favourable opinions with respect to this vaccination in adults aged 18 years or more** (increasing from 58% in 2021 to 75% in 2024), with, in particular, improved acceptance of the HPV vaccine in the 18-24 years age group (SLAVACO and ICOVAC surveys);
- **The high economic burden generated in France** of HPV-induced cancers, in terms of hospitalisations, outpatient care and sick leave;
- **The efficiency of catch-up vaccination programmes** in developed countries similar to France.

The HAS recommends extension of HPV catch-up vaccination using the Gardasil 9 vaccine to young men and young women up to and including 26 years of age, who have not been vaccinated during adolescence at 11 to 14 years of age (target cohort), irrespective of their sexual orientation. The objective is to reduce the burden related to HPV-induced cancers, in particular cervical cancer.

The HAS points out that HPV vaccination is all the more effective if initiated early, i.e. in adolescence, before individuals become sexually active. Consequently, the priority must be to continue improving HPV vaccination coverage in the target cohort, i.e. to vaccinate adolescents - both girls and boys - aged 11 to 14 years.

The HAS highlights the fact that, in accordance with the current vaccination schedule, any new HPV vaccination must be initiated using the Gardasil 9 nonavalent vaccine (produced by MSD). From the age of 15 years, the Gardasil 9 vaccine must be given following a 3-dose schedule (M0, M2, M6). The three doses must be administered in less than one year.

The HAS specifies to healthcare professionals that the Gardasil 9 vaccine may be administered concomitantly with the following vaccines recommended in the young adult population: the dTap-IPV booster at the age of 25 years and catch-up vaccination against invasive meningococcal disease (ACWY vaccines), now recommended at between 15 and 24 years of age.

The HAS warns that there is a risk of malaise and syncope following administration of the Gardasil 9 vaccine, as indicated in the summary of product characteristics (SmPC) for Gardasil 9, and invites healthcare professionals to observe vaccinated individuals for 15 minutes following injection of the vaccine. Measures should be taken to prevent any risk of injury in the event of fainting.

To date, the data are deemed to be insufficient to recommend the use of Gardasil 9 during pregnancy; consequently, it is preferable to delay vaccination until after a pregnancy.

The HAS draws the attention of public authorities to the need to monitor vaccination coverage rates in the different cohorts (target cohort and catch-up cohort) in order to identify, if applicable, any risk of shift of the vaccination initiation age to older ages. It therefore recommends that the efficacy of the catch-up vaccination strategy in this cohort be assessed in 5 years' time, in terms of the vaccine initiation rate.

The HAS highlights the importance of a clear, effective communication strategy aimed at healthcare professionals, parents and adolescents, in order to remind them that the protection offered by the Gardasil 9 vaccine is optimal when it is administered as early as possible, i.e. from 11 years of age. It is essential to stress the fact that vaccination should not be delayed until adulthood and that the priority remains vaccination of adolescents in the target cohort (11-14 years). It is essential to raise awareness of this fact among healthcare professionals in order to guarantee optimum vaccination coverage from the earliest age.

To this end, the HAS reiterates the fact that a free school vaccination campaign aimed at pupils in their second year of secondary school is currently being implemented in public and private schools in France, subject to parental authorisation.

In women, the HAS also stresses that vaccination is not a substitute for cervical cancer screening, since the vaccine does not protect against all types of high-risk HPV, nor against HPV infections already present at the time of vaccination. Regular gynaecological check-ups, includ-

ing screening, therefore remain essential for vaccinated women over 25 years of age. In a context of an increase in sexually-transmitted infections, the HPV catch-up strategy represents an additional prevention lever, helping to reduce the circulation of HPV viruses in the general population, as well as the overall burden of HPV-induced infections.

The HAS recommends that the free preventive check-up offered to all 18 to 25 year-olds in France should be seen as an opportunity by healthcare professionals to offer HPV catch-up vaccination to young women and men who were not vaccinated as adolescents.

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