HPV VACCINATION FOR BOYS – EQUALITY ISSUES
SUBMISSION TO THE DEPARTMENT OF HEALTH
BY HPV ACTION

Key messages

a. Boys and men are at significant risk of HPV infection and the serious diseases it can cause.
b. Not vaccinating boys and men would leave many at risk, particularly but by no means exclusively MSM.
c. The new MSM vaccination programme is not sufficient to protect MSM effectively.
d. Even if the JCVI believes it is not cost-effective to vaccinate boys, vaccination is nevertheless required on equality grounds.
e. A decision not to vaccinate boys could constitute direct sex discrimination under the terms of the Equality Act 2010 and would therefore be unlawful.
f. A decision not to vaccinate boys could exacerbate wider men’s health inequalities.

1. HPV Action is pleased to be able to submit its views on the equality issues concerning HPV vaccination for boys to the Department of Health (DH). We trust these will be fully considered by DH during its completion of the equality analysis.

2. HPV Action is a collaborative partnership of 48 organisations which share the goal of gender-neutral HPV vaccination in the UK. Its members are listed in the appendix below.

3. HPV infection in men and women is very common. One multinational study found that about 65% of men tested positive for at least one HPV type and, of these, around 30% had an oncogenic type.¹

4. HPV can cause cancer as well as anogenital warts and, more rarely, recurrent respiratory papillomatosis (RRP) in both sexes. Although HPV is commonly understood to be a cause of cervical cancer, it is now also known to be a significant cause of anal, head, neck, penile, vaginal and vulval cancers. Women are more likely to develop cancer as a result of HPV but the proportion of cancers in men is increasing. Men who have sex with men (MSM) are particularly
vulnerable to HPV-related cancers, particularly anal cancer. There is no screening programme for HPV-related in cancers in men. Men bear a significantly greater burden of anogenital warts than women.

5. The incidence of HPV-related disease in men in the UK is not accurately known in large part because the proportion of cancer cases attributable to HPV varies from study to study. However, HPV Action estimates, based on Cancer Research UK and CDC data, that about 2,300 new cases of HPV-related cancer – penile, anal, head and neck – are diagnosed each year in men in the UK. There are also likely to be around 43,000 new male cases of anogenital warts caused by HPV. The impact of RRP is less certain but a UK study recently estimated the prevalence to be over 900 cases and it can be assumed that about half of these are male. Together, these figures represent a significant burden on men.

6. The incidence of HPV-related head and neck and penile cancers is increasing sharply. The rate of head and neck cancers, which is about four times higher in men than women, is expected roughly to double between 1995 and 2025. The penile cancer incidence rates have increased by almost a quarter (23%) over the past decade.

7. Anal cancer incidence rates have increased in males aged 50-59 and 60-69 in the UK since the early 1990s with the largest increase in males aged 50-59 for whom rates increased by 74% between 1993-1995 and 2012-2014. Men who have sex with men (MSM) carry an unequal burden of anal cancer (15:1 compared with heterosexual men). MSM rates are in fact similar to cervical cancer rates prior to the introduction of screening. HIV-positive MSM have an up to 80-fold estimated higher risk than HIV-negative men or women of developing anal cancer.

8. The JCVI’s interim statement on extending the HPV vaccination programme to boys, published in July 2017, suggests that the vaccination of girls protects boys to the extent that vaccination of the latter is not cost-effective. HPV Action accepts that vaccinating girls does protect some boys and men – but only if their sexual partners have been vaccinated. 15% of each cohort of 12/13 year old girls in the UK are currently not vaccinated. Furthermore, men’s sexual partners are not just from the UK and many other countries have no HPV vaccination programme or a much more limited one. (In France, for example, only about one quarter of girls are vaccinated.) Men also do not have sexual contact just with women in the age group which has so far benefitted from the vaccination programme. Furthermore, around one in 10 men report forming a new sexual partnership while overseas in the past five years. The proportion among younger men is far higher: 13% of 16-24 year olds and 15% of 25-34 year olds. Men who had partners who lived outside the UK were also more likely to pay for sex and female sex workers are known to have a high prevalence of infection with high-risk HPV types.

9. MSM derive no benefit from the vaccination of girls and are therefore at particular risk. This risk is only partly mitigated by the new MSM vaccination programme. In our view, and in that of our members whose work focuses on the sexual health of MSM, the programme offers too little too late because most MSM at high risk of
HPV infection will probably have been infected before their first visit to a GUM clinic. The median age of first presentation of MSM to sexual health services in England between 2009-14 was 32 years. A recent study of MSM attending a London sexual health clinic found that 45% had a current HPV infection with type that can cause cancer or anogenital warts, suggesting that a significant proportion of MSM will already have been infected before they are offered HPV vaccination. A proportion of MSM attending clinics will also be unable to access the programme because they will choose not to disclose their sexual identity or may not self-define as a man who has sex with men. There is a further concern that recent funding cuts to sexual health services means that their capacity to offer an effective HPV vaccination service to MSM will be reduced.

10. It is probable that the proportion of men who have sex with other men is increasing as a result of what has become known as ‘sexual fluidity’. Men who define themselves as heterosexual may have sex with other men occasionally or regularly, behaviour that increases their risk of exposure to HPV infection. A survey of British adults published by YouGov in 2015 found that while 85% of men described themselves as heterosexual, a significantly lower proportion (68%) defined themselves as ‘completely heterosexual’ and 20% disclosed a sexual experience with another man.

11. The best way to protect MSM is to vaccinate in adolescence, before sexual debut (and therefore before exposure to HPV), and when the immune response is greatest. But questioning boys in this age group about their sexual orientation would be impractical (because orientation for many will not yet be firmly established) as well as unethical and it would almost certainly be opposed by parents and boys themselves. The only effective solution is therefore to vaccinate all boys.

12. The issue of whether it is cost-effective to vaccinate boys is a very contested one about which HPV Action has made its views clear to JCVI. However, it is certain that, whether or not it is deemed cost-effective, a vaccination programme for girls alone will leave many boys and men vulnerable to HPV infection and the diseases HPV can cause. This point is accepted by JCVI in its interim statement, the conclusion of which states: ‘Clearly, there is benefit in vaccinating boys.’ This is also the view of many clinicians: a HPV Action survey in 2017 of about 1,700 GPs and dentists found that 95% were in favour of gender-neutral vaccination.

13. HPV Action has argued for some time that JCVI should have taken full account of equality issues in its own decision-making on the issue of vaccinating boys. We do not consider that the JCVI, as a public body, can or should have delegated responsibility for the consideration of equality issues to DH.

14. Whether it is the DH or the JCVI that considers the equality issues, full account must be taken of the very clear legal duties on statutory health services with respect to equalities. The Equality Act 2010 states that ‘A person (a “service-provider”) concerned with the provision of a service to the public or a section of the public (for payment or not) must not discriminate against a person requiring
the service by not providing the person with the service’ and that it is direct discrimination if ‘A person (A) discriminates against another (B) if, because of a protected characteristic, A treats B less favourably than A treats or would treat others.’ It is our view, based on legal advice, that a decision not to vaccinate boys would constitute direct sex discrimination and would therefore be unlawful.

15. The Health and Social Care Act 2012 places a duty on the Secretary of State for Health to ‘have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service.’ The NHS Constitution, which health services are required by law to take account of in their decisions and actions, states that ‘the NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.’ Even if it is not cost-effective to vaccinate boys, which we do not accept, vaccination is nevertheless required on equality grounds.

16. HPV Action also contends that it is not equitable or ethical to expect girls alone to bear the burden of HPV vaccination. The vaccine is very safe but some recipients can experience bothersome temporary side effects. It is also inequitable for girls to be solely responsible for tackling this sexually transmitted infection. This should, surely, be the responsibility of both sexes equally. The vaccination of only girls reinforces a very traditional message about sexual health. It should also be borne in mind that vaccinating boys would help to protect the 15% of girls who currently are not vaccinated.

17. The equality analysis should take into the wider inequalities in men’s health. It is now widely accepted that in many important respects men’s health outcomes are poorer than women’s with life expectancy being the most obvious example. For cancer specifically, the age-standardised incidence rate for males was 674 per 100,000 in the UK in 2014; the comparable figure for women was 550. The mortality rate for males was 340 and 234 for females. HPV vaccination for boys can contribute to a reduction in wider sex and gender inequalities in health.

18. There is a steep social gradient in men’s health outcomes that could, potentially, be exacerbated by not vaccinating boys through a national programme. This is because HPV vaccination is now becoming more widely available on a private basis – Superdrug and Boots, for example, now offer HPV vaccination for boys at a cost of £150 per dose (two doses are required for those aged under 15). It is highly probable that the boys who will receive private HPV vaccination will be from more affluent and better-informed groups while those from more disadvantaged groups will lose out.
APPENDIX

HPV Action's 48 members:


REFERENCES