Consultation response to the JCVI interim position statement on HPV vaccination of men who have sex with men (MSM)

Written response submitted by Terrence Higgins Trust

January 2015

Executive Summary

- Terrence Higgins Trust welcomes the recommendation of the JCVI to offer the HPV vaccination to men who have sex with men (MSM) aged 16-40.
- We hope the vaccine will be made available as soon as possible to provide MSM with protection against HPV related cancers and genital warts.
- We would welcome an explanation for the use of an upper age limit of 40, given ongoing HIV and STI transmissions in MSM aged over 40.
- The JCVI should assess how the HPV vaccination programme would benefit GUM clinic attendance and HIV/STI diagnoses.
- The success of a MSM programme would depend on how it is marketed. The Department of Health should consider how to encourage MSM to receive the vaccination and the JCVI should provide national and regional goals that would achieve effective coverage.
- As the JCVI considers that the vaccination is effective for groups of adults aged 16-40, it should assess the possibility of offering the vaccination to women who remain at risk of cervical and other cancers.
- Men who only have sex with women will have no direct protection from the vaccination programme. Although herd immunity is the goal, this will not be achieved for those older than the first cohort and will still leave an unquantified proportion of men at risk. The risk of HPV from these men having sex with women from the UK or abroad who are not vaccinated should be assessed, and the size of this at-risk group of heterosexual men modelled.
- The vaccination programme as it stands will offer less effective coverage to future MSM than their female peers as it will be offered at a later age and after sexual activity begins, and only to those who attend a GUM clinic which will limit the possibility of a “herd immunity” effect for the MSM population.
- The only way to provide effective protection against HPV related cancers and diseases for MSM, as well as other men, is to offer the HPV vaccination to all 12 and 13 year old boys and girls.
- Following the answer to a Parliamentary Question by John Baron MP to the Secretary of State for Health, we would welcome further explanation as to why the modelling for the boys vaccination has been extended to early 2017.
1. Introduction

1.1. Terrence Higgins Trust is the UK’s largest HIV and sexual health charity. We are a campaigning and membership organisation which advocates on behalf of people living with or affected by HIV or poor sexual health.

1.2. Terrence Higgins Trust welcomes the opportunity to respond to the interim advice of the JCVI to offer the HPV vaccination for MSM.

1.3. We believe that MSM of any age should be offered the HPV vaccination as a population that receives no indirect protection from a female only vaccination programme. MSM continue to experience sexual health inequalities compared to the heterosexual and female populations, especially in HIV and HPV acquisition and HPV related cancers and diseases.

1.4. In addition we believe that all boys aged 12 and 13 should be offered the vaccination to provide direct protection not only for all males who will be MSM, but for all men. The herd immunity argument is both inaccurate in its estimation of protection of men’s risk against HPV acquisition and inequitable as a health protection strategy. We look forward to the JCVI’s report in 2015/16 on male vaccination.

1.5. We further urge the JCVI, Department of Health and Government to consider the implications of the findings that show populations above the previous age threshold of 18 could benefit from the HPV vaccination. There should be a review into why the MSM population aged 16–40 should be offered the HPV vaccine when women, and men who do not have sex with men, of the same age are not.

2. Terrence Higgins Trust welcomes the interim advice of the Committee to offer the HPV vaccination to MSM aged 16–40.

2.1. MSM currently lack the direct or indirect protection from HPV related cancers and diseases that women and heterosexual men receive from a female-only vaccination. Extending the vaccination to MSM will bring down incidences of genital warts, anal, penile and other cancers, and decrease the risk of HIV transmission in a population that already experiences significant health inequalities.

2.2. Offering the HPV vaccination in GUM clinics has the potential to improve MSM’s sexual health overall. By tying in the HPV vaccine to other STI tests people will be diagnosed and treated sooner. The number of men having sexual health checks will increase. This will bring down undiagnosed HIV and other STIs and prevent onwards transmission.

2.3. The JCVI has not provided information on what number of MSM aged 16–40 will need to be vaccinated in order to disrupt HPV transmission in the overall MSM population. The JCVI should provide guidance to the Department of Health around numbers needed for the programme to be effective. The Department of
Health can then consider whether a public awareness campaign for the MSM population will be necessary to increase GUM attendance and vaccination uptake.

3. Comments on the validity of the assumptions and findings of the modelling and cost-effectiveness study

Upper age limit

3.1. No methodology or assumption explanation is given for why the upper age limit of 40\(^1\) has been decided for this recommendation.

3.2. HIV and STI transmission continue to occur in MSM aged over 40, and continue to affect MSM disproportionately compared to heterosexual men. As with most cancers, HPV related cancers in men increase with age. The reasoning for the 40 upper age limit is therefore unclear in terms of HIV, STI or cancer incidence.

3.3. If the age limit is based upon the efficacy of the vaccine up to 40 and its lack of efficacy post 40, the evidence used for this should be available.

3.4. If the age limit is based upon population behaviour, then the evidence used regarding sexual behaviour of different age populations of MSM should be available.

3.5. MSM are proportionally more at risk of acquiring STIs, including HPV, than heterosexual males even after age 40. There were 394 cases of genital warts in MSM aged 45-64 in 2013, representing 15% of all male genital warts cases in this age group. The proportion of male genital warts incidences that are among MSM increases with age. In younger age groups MSM account for 6%, 9% and 11% of the 20-24, 25-34 and 34-44 age groups respectively.\(^2\) This age group therefore remains at ongoing risk of HPV acquisition and so the rationale for an upper age limit must be provided.

3.6. Sexual health inequality and HPV acquisition also affect HIV transmissions in the 40+ MSM population. HPV infection can increase the risk of HIV transmission, and MSM aged 40 and over represented 32% (933/2,947) of all HIV diagnoses in MSM in 2013. Those aged 50 and over represented 10% (308/2,947) of the total.\(^3\) As nearly a third of HIV transmission in MSM occurs in those aged 40 and over, the merits of a HPV vaccination age limit should be assessed in terms of HIV prevention and protecting those who will be diagnosed with HIV.

---

\(^1\) JCVI interim position statement on HPV vaccination of men who have sex with men (MSM), paragraph 14, p. 4 (November 2014).


3.7. The upper age limit must be justified in light of increasing cancer diagnoses, continuing sexual health inequality, and a high proportion of HIV diagnoses in the 40+ MSM population.

**Lower age limit**

3.8. There is no reason given for why the HPV vaccination should only be available for MSM aged 16 and over.

3.9. There will be boys who identify as gay or bisexual at 14 and 15, or even 12 and 13 when their female peers are being offered the HPV vaccination.

3.10. As the HPV vaccine is more effective at a younger age and before sexual activity begins, the vaccination should be available to teenage MSM as soon as possible, including being available for 12-15 year old boys who identify as gay or bisexual and want to have protection.

3.11. In addition, the JCVI should provide information on what the difference in efficacy this programme will cause for MSM against their female peers. How much more at risk will a MSM who can only access the vaccine from 16, and potentially after sexual activity, be at of HPV acquisition and related diseases than a female peer of the same age offered the vaccination at 12/13?

**Vaccination uptake**

3.12. The JCVI interim position states “there was little evidence on the levels of uptake which could be expected”.\(^4\) However the Hepatitis B vaccination is also offered in GUM clinics to MSM. The JCVI should provide information on offers and uptake of the Hepatitis B vaccination among MSM in GUM clinics.

3.13. If vaccination offers are not regularly made or taken, and if GUM clinic attendance is low among MSM, then the programme may have limited impact. It would be worth considering how else the programme can reach the maximum number of MSM, including offering it via GP practices.

**GUM clinic attendance**

3.14. The JCVI has used data sources of rates of MSM attendance at GUM clinics.\(^5\) There is no indication that the JCVI has assessed the impact of the offer of HPV vaccinations on GUM clinic attendance. The offer of a HPV vaccination, that is most effective at an earlier age and before sexual activity, will bring more MSM and especially young MSM into GUM clinics. This could increase GUM clinic attendance which would not only be crucial in maximising HPV vaccination coverage but also diagnosing MSM asymptomatic HIV and STI infections.

---

\(^4\) JCVI interim position statement on HPV vaccination of men who have sex with men (MSM), paragraph 23, p. 6 (November 2014).

\(^5\) JCVI interim position statement on HPV vaccination of men who have sex with men (MSM), paragraph 17, p. 4 (November 2014).
3.15. The increase in GUM clinic attendance will be dependent on whether a health awareness campaign is also run by local authorities to encourage MSM to get the vaccination. This should be assessed for young MSM aged 16–18 against the success of the catch-up vaccination for 16–18 year old women in the first years of the female only vaccination programme.

**MSM population and identity**

3.16. It would be useful for the JCVI to provide the data sources it used to estimate the MSM population. While the vaccination is welcome for men who will identify as MSM in a GUM clinic, this vaccination programme will not provide coverage for men who will not tell a medical professional they have had or may have sex with men.

3.17. The JCVI should provide information on how many MSM who do not identify their sexuality to a medical professional will be left outside of the vaccination programme, and the impact on effectiveness at decreasing HPV infections and possible “herd immunity” within the MSM population.

**4. Limitations of the proposal**

**MSM**

4.1. While MSM who attend a GUM clinic to receive a vaccination will benefit from the protection offered against HPV related diseases, the programme will not offer the same level of protection for MSM as it does for women.

4.2. No boys who will receive the HPV vaccination at the same time as the girls in their year group. This is a problem for those boys who will go on to have sexual relationships with men in their adult lives because:

- MSM are at risk of HPV infection immediately after starting sexual activity. The young MSM who begin sexual activity before receiving the vaccination will have no protection from initial HPV acquisition.

- Immunity is greater if the vaccine is administered before age 16. By not being offered the vaccination earlier, MSM will continuously experience a lower level of protection than women.

- Current attendance of GUM clinics by MSM would mean they are very likely to acquire HPV before attending a clinic to be vaccinated. The median age of first attendance at a Southampton GUM clinic was 28, by

---

6 JCVI interim position statement on HPV vaccination of men who have sex with men (MSM), paragraph 17, p. 4 (November 2014).

which point a high proportion of people have had two or more sexual partners.\(^8\)

- The vaccination will be increasingly less effective the later in life a man identifies as MSM. The vaccination programme should not provide inequitable coverage because some people “come out” later than others.

- The vaccination programme will not achieve the same level of coverage among MSM as it does among women. A school programme has the benefit of getting all the girls in a year group vaccinated at the same time, as well as offering follow up injections, in the school environment. Not all MSM will attend a GUM clinic, not all MSM will identify as MSM to a medical professional, and there is less likelihood that an adult will return to a GUM clinic for the second dose of the vaccination than a child who has to return to school.

- A MSM vaccination programme offered in GUM clinics will offer less protection, later and with less coverage than the girls vaccination programme. This will leave MSM at higher risk of HPV infection, of developing a HPV related disease, and of acquiring HIV or another STI.

**Men who only have sex with women**

4.3. Except for those who will identify as MSM and attend a GUM clinic to be offered the vaccine, all boys remain at risk of HPV. If these boys go on to have sexual relationships in their adult lives with women who were born in countries without a female vaccination programme or with British women who were not vaccinated they will be at risk of HPV and related cancers and diseases.

4.4. Maintaining a “herd immunity” argument against the need for boys to be vaccinated, when this argument was initially made on modelling for how the HPV vaccination could prevent cervical cancer, is unjustifiable. Without significant modelling and evidence that a justifiable majority of heterosexual men will never have sex with a woman who is not vaccinated (older than the 2008 cohort, not vaccinated at school, from outside the UK), the risk of HPV related diseases and cancer falls discriminately on men. The JCVI should present modelling on men’s sexual relationships with women who are not vaccinated.

4.5. We cannot predict which 12 and 13 year old boys will go on to have sex with men or with unvaccinated women in their adult lives. As such, they are all at risk of HPV and require protection that is most effectively given before sexual activity.

---

\(^8\) Clarke et al., ‘Genitourinary medicine clinics may not see young men who have sex with men before they become infected with human papillomavirus (HPV),’ *BMJ*, 349 (2014).

64.8% of heterosexual men aged 16–24 have had 2 or more partners - Natsal, ‘Changes in sexual attitudes and lifestyles in Britain through the life course and over time: findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal), *The Lancet*, 382, (2013).
Women who have not been offered the vaccination

4.6. The advice that MSM aged 16-40 should be offered the vaccination due to ongoing risk of HPV infection leading to cancers and genital warts presents an implication for women aged 16-40. As the vaccination was originally provided to prevent cervical cancer, the evidence that the vaccination is effective enough in protecting against HPV and related cancers to be recommended for MSM aged 16-40 means it may also be effective in protecting women of the same age. The JCVI should comment on whether there is evidence enough for evaluating the cost-effectiveness of offering women who were older than the first cohort the HPV vaccination.

4.7. The JCVI position statement says that the vaccination of older MSM is cost-effective due to ongoing HPV acquisition and a burden of genital warts. But while there were 1,156 diagnoses of genital warts in MSM aged 25-34 in 2013, there were 8,122 diagnoses in women in the same age group and year. This is evidence there are still a significant number of women who have not been offered the vaccination who are at continuing risk of HPV acquisition and related diseases.

4.8. A vaccination programme for MSM aged 16-40 without a vaccination programme for women of the same age, or at least women whose sexual activity puts them at greater risk of HPV acquisition, would be inequitable.

5. Modelling the impact and cost-effectiveness of vaccinating adolescent boys

5.1. On Monday 5 January 2015, John Baron MP raised a Parliamentary Question to the Secretary of State for Health about when the JCVI was expected to make a recommendation for vaccinating adolescent boys against HPV. The Public Health Minister, Jane Ellison MP, answered that modelling by Public Health England may not be finished until early 2017. This is a significant delay from previous statements by Ministers for Health that a recommendation would be expected in late 2015.

5.2. We would welcome further explanation as to why the modelling has been extended by over a year. We would also seek clarification as to why there is separate modelling work being designed by Warwick University and what the benefits are of having two modelling investigations. It would be useful to know what the focus of the two pieces of modelling will be and how the findings will support or build on one another.

---

6. **Summary**

6.1. While we welcome the recommendation to offer the vaccination to MSM aged 16–40, there are many questions as to why the vaccination should continue to be limited in the way it is. Crucially, assumptions around MSM aged over 40 are not presented, and thus there is no justification for why older MSM, who are a significant proportion of HIV and STI diagnoses, should be excluded.

6.2. This recommendation also points to evidence that suggests women aged 16–40 who are at risk of HPV acquisition and cancers would benefit from the vaccination.

6.3. While a vaccination for MSM over 18 cannot provide universal coverage, the recommendation must be assessed against its success for future MSM who will not be offered the vaccine at the same age in school as their female peers. By the time MSM have left school, the most at risk will be the ones least likely to be offered the vaccination – those who do not attend GUM clinics and those who do but do not identify as MSM to medical professionals. These men have been consistently difficult to get to test for HIV, and have subsequently been the group where the majority of late HIV diagnosis occurs. The same will occur for HPV. Additionally, the HPV vaccination is less effective when given at a later age and after sexual activity begins, and so offering at GUM clinics will certainly provide an unequal level of protection for MSM as for women who are vaccinated in school.

6.4. The only effective way to provide protection against HPV acquisition and related cancers and diseases in men, both those who have sex with men and those who don’t, is to offer the HPV vaccination to all 12 and 13 years old boys and girls.

7. **For Further Information**

For more information please contact Kieran Aldred, Campaigns and Parliamentary Officer, kieran.aldred@tht.org.uk or telephone 0207 812 1632.