

PE1477/N

Petitioner Letter of 23 June 2016

I note the letter of 26 May 2016 from the Scottish Government.

I wish to draw to the attention of the Committee a letter signed by 13 eminent UK experts on HPV and its related diseases which was recently sent to the Secretary of State for Health in England. The letter (attached as an Appendix) sets out very clearly and concisely the rationale for gender-neutral vaccination.

I welcome the decision of the Scottish Government to implement the JCVI's recommendation to establish an HPV vaccination programme for men who have sex with men to be delivered via sexual health clinics. However, as the experts' letter makes clear, a programme for MSM cannot protect the whole MSM community – because it will reach too few too late (most MSM will already have been infected with HPV) – and will do nothing to protect men who have sex with unvaccinated women.

Nevertheless, it would be very helpful if the Committee could urge the Scottish Government to introduce the MSM programme quickly – no timetable has been announced to date – and to recommend that it is rolled out across the whole of Scotland. England is introducing a pilot programme first which will inevitably limit access to the vaccine even though vaccinating as many MSM as possible as soon as possible is a public health priority.

I would also like to make clear that the JCVI's modelling, although complex, is nonetheless limited in scope. As the experts' letter states, the JCVI does not take account of social care or welfare benefit costs, for example, or the costs of morbidity and mortality to employers. The JCVI also pays no attention to issues of ethics, equality or the quality of life of people who have suffered from HPV-related diseases. I would like to request that the Committee informs the Secretary of State for Health in England of its concern about the narrowness of the JCVI's approach and requests that he explores ways to broaden its assessment of the evidence to take account of all pertinent issues.

In summary, I therefore request that the Committee:

1. Notes the letter to the Secretary of State for Health in England signed by 13 experts in the HPV field.
2. Urges the Scottish Government to introduce the MSM HPV vaccination programme quickly and on a national basis.
3. Informs the Secretary of State for Health in England of its concern about the narrowness of the JCVI's approach and requests that he explores ways to broaden its assessment of the evidence to take account of all issues pertinent to HPV vaccination policy.

Jamie Rae

APPENDIX

Dear Secretary of State

HPV vaccination for adolescent boys

Under the auspices of HPV Action, we are writing as clinicians, scientists and academics with a special interest in human papillomavirus and its associated diseases (anal, cervical, oral, penile, vaginal and vulval cancers, anogenital warts and recurrent respiratory papillomatosis) to urge you to expedite a decision to extend the national HPV vaccination programme to include all adolescent boys.

We are very concerned about the Joint Committee on Vaccination and Immunisation (JCVI) timescale for a decision on vaccinating boys. As you will know, its assessment of this issue began in 2013 and a decision was expected in 2015. This was then put back to 2017. If a decision is made in 2017 to vaccinate boys, implementation of the programme might well not begin until 2020.

Up to 80% of sexually active men will acquire HPV at some point in their lives and, with each year that passes, some 400,000 more boys are left unprotected. Even if a vaccination programme for boys does start in 2020, over 2.5 million boys will by then have missed out on vaccination in the period since 2013. We strongly recommend that JCVI is allocated the resources necessary to enable a decision to be made in the current year.

We firmly believe that vaccinating boys as well as girls would:

1. Protect more women from HPV-related diseases. Even though the UK achieves a high uptake for its vaccination programme for girls, some 10% of girls remain unprotected. Vaccination uptake is also variable and in some parts of the country, notably several London boroughs, vaccination rates in girls are far lower than the national average.
2. Protect men who have sex with men (MSM). Because MSM derive no benefit from the girls' programme, we welcome the JCVI's recommendation that HPV vaccination should be offered to MSM via sexual health clinics and believe this should be implemented on a national basis without delay. However, we note that the average age of first attendance at GUM clinics is 28 years and we therefore have doubts that this intervention will reach most MSM; even more importantly, it is well-established that the optimal time for vaccination is before sexual debut. Our view is that the only certain way to protect MSM adequately is to vaccinate all boys.
3. Protect men who have sex with women who have not been vaccinated in the UK or elsewhere. The NATSAL-3 study of sexual behaviour showed that many men, especially younger men, have sex with women from other countries; many of these have no or low-uptake HPV vaccination programmes. Approximately 15% of 25-34 year old males have had at least one sexual partner from outside the UK in the past five years.

4. Ensure that both men and women receive equitable protection from HPV-related diseases. The total burden of these diseases affects men and women about equally and we therefore believe that there is a strong ethical argument for the equal protection of both sexes. We recommend that you ask the JCVI to consider ethical and equality issues as part of its assessment.
5. Reduce significantly the costs of treating HPV-related diseases. We note that the cost of treating anogenital warts alone in the UK is an estimated £58.44 million a year; the secondary care costs of treating HPV-related oropharyngeal cancer are likely to exceed £21 million a year. Even though we have reservations about the JCVI's approach to assessing cost-effectiveness (it does not take account of social care or welfare benefit costs, for example, or the costs of morbidity and mortality to employers), we believe that it would nevertheless be cost-effective within existing published models to vaccinate boys at an achievable vaccine price.

We reject the argument that a 90% vaccination rate for girls is sufficient to protect males if there is also a programme for MSM. As stated above, many MSM will not receive protection when it is most needed before sexual debut and significant numbers of heterosexual men have sex with unvaccinated women (whether in parts of the UK where vaccination rates are lower, with UK women who are too old to have been eligible for HPV vaccination as an adolescent or with women from other countries).

We are aware that an increasing number of countries – Australia, Austria, Canada, Israel, Switzerland, the USA, the German region of Saxony and the Italian regions of Emilia-Romagna and Sicily – now recommend HPV vaccination for both sexes. The Norwegian Institute of Public Health and Ireland's Health Service Executive have also recommended that boys be included in their national vaccination programmes. The UK has an opportunity to be part of an international effort to eradicate HPV-related diseases as well as protect its own population better.

We very much hope you will now ask the JCVI to accelerate its assessment of the vaccination of boys and draw the Committee's attention to this letter. We look forward to receiving your response; please reply to Peter Baker, HPV Action's Campaign Director, at the address above.

Please note that this is an open letter that we are also making available to the media and directly to the public.

Yours sincerely

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