HPV—A Challenge to the Provinces

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Canada’s first HPV vaccine programs started with federal grants to the provinces to immunize girls age 9–17.1 Starting with this age group was not expected to reach all females who might be appropriate candidates (age 9–26), as the older age group was required to pay for the vaccine and the cost could diminish their interest or be prohibitive.

The provinces began free vaccine programs in 2007 and 2008 with one school grade. Quebec offered the most comprehensive coverage: a school-based program for girls in grade 4 and coverage through family physicians for all girls under the age of 18. Outside Quebec, the provinces were more restrictive although limited catch-up provisions were established to reach girls in grade 9 who were not previously immunized.2 Most notably, Saskatchewan and Manitoba have extended coverage to any girls born after 1996 who missed the school-based program3,4 and Quebec’s program now covers any females who initiated the vaccine before age 18 or October 1, 2010.5 The “once covered, always covered” approach is expected to increase the size of the immunized population.

The HPV vaccine program for girls met pockets of resistance from parents unwilling to give consent for their daughters to be immunized. (Table 1) The lowest rates of uptake, as a percentage of the target age group, were in Western Canada and Ontario, with the highest in Eastern Canada. School-based immunization for HPV falls far short of the rates achieved for other vaccine programs; in BC it is 30 per cent lower than the rates for other school-based vaccines.6

This situation gives rise to concerns about how to control HPV-related cancer. Immunizing girls does not protect the men having sex with men. Indeed, the disappointing uptake of the vaccine for girls in some provinces will mean that a considerable percentage of that entire generation will develop an avoidable risk of chronic disease and cancer.

Three pieces of advice are offered to the provinces.

1. Learn from Quebec, Manitoba and Saskatchewan and adjust existing programs to provide “once covered, always covered” HPV vaccines. This will increase the number of people who are protected from avoidable diseases and cancers.

2. Heed the advice of the National Advisory Committee on Immunization.7

“The public health and economic burden of anogenital warts in Canada is considerable, particularly among men whose incidence rates and incidence rate ratios compared to females have been increasing in recent years.

In addition, cost effectiveness needs consideration.

Provinces and territories will need to compare the impact of vaccinating males with that of vaccinating additional female cohorts.

While not directly comparable, lessons learned from gender-targeting of other vaccines should be considered. For example, like rubella, control of HPV among women may only be achievable through a gender-based (female only) vaccination policy if vaccine coverage among women is extremely high. Factors such as vaccine refusal, cost and weaknesses in vaccine delivery systems may support a gender-neutral (universal) policy to adequately control disease.

Furthermore, if herd immunity effects are significant, this may improve the impact of the program on health equity which is a significant factor in cervical cancer epidemiology.”

3. Consider the merits of a gender-neutral approach to vaccination.8

• “Female-only vaccination will not protect men who have sex with men from HPV and HPV-related diseases;
• The fastest way to achieve the greatest protection for females from cervical cancer and its precursors is to vaccinate males as well as females;
• Vaccinating males is a more equitable public health policy and recognizes that both genders contribute to the transmission of HPV;
• Vaccination of males may be more acceptable to some cultural groups than vaccinating females;
• Genital warts and HPV-related cancers in males represent costly and emotionally burdensome conditions that can be prevented more expeditiously by vaccinating both males and females; and
• Historically, implementation of risk-based (or gender-based) vaccination policies have been less effective and more confusing to the public.”

References
6 Naus M, Ogilvie G. Human papillomavirus vaccine program in BC: A good start with room for improvement. BCMJ, Vol. 52, No. 2, March 2010, page(s) 95 BC Centre for Disease Control.