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HPV Vaccine: It Is Not Just a Girl Thing



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Seventy nine million Americans, most in their late teens and early 20s, are infected with HPV.¹ HPV causes anal, penile, throat, cervical, vulvar, and vaginal cancer. Given the disease burden of this infection, approval of the vaccine for use in the United States in 2006 was landmark.

Vaccination rates remain persistently low among males, with only 27% having received at least one dose of the vaccine

While initially approved for immunization of non-sexually active girls, the recommendation rapidly expanded to universal vaccination of girls between 9-11 years of age with catch-up vaccination for women up to 26 years of age. This has led to a decrease in genital warts and cancers by 71% among adolescent girls.¹ Unfortunately it took 5 years for the Advisory Committee on Immunization Practices (ACIP) to adjust their recommendation from permissive vaccination to universal vaccination of males. Additionally, 2018 ACIP guidelines recommend universal and catchup vaccination only to 21 years of age in the general population and to 26 years old in men who have sex with men or immunocompromised men.² In 2011 only 2% of eligible males were vaccinated and 7 years later, vaccination rates remain persistently low among males, with only 27% having received at least one dose of the vaccine.² Advice to permissively vaccinate adolescent males has created far-reaching disparities. Males receiving primary care in suburban settings are less

commonly vaccinated than those in urban settings or family planning clinics. In addition, younger adolescent males are less frequently vaccinated than older adolescent males.³

It is astonishing that a safe, effective, and widely accessible cancer-preventing vaccine is not being widely used! This begs the question-- why is the US not aggressively vaccinating its young men when we know that following the 2018 guidelines would lead to a 62-82% reduction disease burden, and a 22-27% reduction in cancers in males within 30 years?³

There are many reasons for this disparity; however, much of the responsibility falls on policy makers and health care providers. Providers were concerned with the social acceptability of administering a vaccine to prevent a virus acquired from sexual contact. Policy makers emphasized the cost-benefit analysis in administering the vaccine only to girls. Subsequent marketing campaigns focused on cervical cancer and girls becoming "one less". Providers still preferentially address the vaccine with girls and parents believe that the vaccine is only for girls. While acceptability among adolescent boys and young adult men is high, acceptability is highest when his physician strongly recommends the vaccine.⁴

Thus, despite universal recommendation for college-aged males, 45% reported having no knowledge of the vaccine.⁵

What do these practices and knowledge deficits mean for men's health and our societal values?

Quote this article as:

Distinguishing vaccine recommendations based on sexual practices forces young people to choose between disclosure and health

The health danger is obvious-- increased HPV-related illnesses and cancers. The social dangers however are more subtle. The recommendation of universal vaccination at later ages only in men who have sex with men promotes a heteronormative bias further stigmatizing sexual minority youth. Disclosure of sexual orientation typically occurs in late adolescence or young adulthood, thus a young person may not have disclosed their sexual orientation to guardians or physicians making a vaccination decision. Additionally, there are young men who engage in sex with other men as practice or experimentation and consider themselves heterosexual. Distinguishing vaccine recommendations based on sexual practices forces young people to choose between disclosure and health. This is a dangerous prospect given the biopsychosocial risks associated with disclosure. Finally, this recommendation fails to account for the protection against oropharyngeal cancers that this vaccine confers. Oral sex is widely practiced by young men with sexual partners of both genders, further strengthening the argument for the importance of universal vaccination.



Another social consequence is that the rationale that male vaccination is cost-ineffective in men of the benefits already received through the higher vaccination rates among girls and women reinforces the idea that the responsibilities of family planning and reproductive health fall primarily on women in heterosexual relationships. Family planning campaigns target women and sex education touts the health consequences of unplanned sex only as they relate to women. These messages have indirectly taught men that reproductive health is not their responsibility. As a result, men are less likely to seek STI testing, treatment, and prevention strategies such as the HPV vaccine. In a world that strives to promote gender parity, these health messages run contrary, doing a disservice to males by denying them the opportunity to actualize their own health outcomes.

Why does any of this matter? Where do we go from here? If we want to ensure that the next generation of young people are healthy and equitable then one effective step toward that goal is to reshape our conversation around the HPV vaccine. We should recommend the vaccine to all youth, regardless of their gender, age, or sexual orientation, current or future. We should frame conversations about sexual health not just around risk and consequences but also prevention, safety, and choice. ■

CONFLICTS OF INTEREST

None of the authors have any disclosures

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