Questions before starting an HPV vaccination programme

- What proportions of cervical cancer and other HPV related disease in a region or country are attributable to the HPV types targeted by the available vaccines?
- What fraction of cervical cancer overall will be prevented by a vaccine against HPV 16 and 18?
- Will immunity induced by vaccines alter the distribution of other, non-vaccine HPV types?
- Will a vaccination programme against a sexually transmitted infection prove acceptable to adolescents who are not yet sexually active and their parents?
- Should teenage boys be vaccinated as well as teenage girls?
- Will booster vaccinations be necessary, and if so, when?
- How will a vaccination programme affect current programmes for cervical cancer screening, and how and when should screening change in response?
- What benefits might vaccination confer on adults who are already infected with HPV?
- Should older sexually active adults be included as part of a catch-up campaign at the outset of a vaccination programme?
- Should any catch-up campaign be aimed at specific subgroups of the population?
- What will be the cost effectiveness of various strategies for vaccination programmes?

anogenital warts would decrease the costs of treatment and reduce the workload of sexual health services.

Important questions need answering before a programme of HPV vaccination can be introduced (box). Furthermore, because the incubation period between HPV infection and development of invasive cervical cancer is long, prevention of cancer by a vaccination programme will not be obvious for 10 to 20 years. Earlier, the rates of abnormal cervical smears showing early stages of CIN will diminish, and the need for follow-up after screening will be reduced.

Efforts at prevention have had a limited effect so far on the occurrence of sexually transmitted infections.¹² Current trends in sexual behaviour, with 44% of women and 52% of men aged 16 to 24 in Britain reporting three or more sexual partners in the past five years,¹³ are probably increasing the incidence of HPV infection. The need for a programme of HPV vaccination can only intensify, and every country should be planning actively to implement and budget for early vaccination. The vaccines under evaluation already

have the potential to prevent a substantial proportion of cervical cancer cases, and a second generation of HPV vaccines containing additional high risk types and combined with other vaccines is being developed. Should these first and second generation HPV vaccines prove as effective as they promise, we hope that the new International Finance Facility for Immunisation¹⁴ will be used to accelerate their delivery in the poorer parts of the world, where the benefits will be greatest.

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Left behind: the legacy of hurricane Katrina

Hurricane Katrina puts the health effects of poverty and race in plain view

The sinking of the *Titanic*, during which women in first class cabins were more likely to survive than those booked into cheaper decks, has been used to illustrate the effects of income and social class on health (T LaVeist, personal communication, 2005). In the aftermath of hurricane Katrina, Americans have been shocked and shamed

to realise that they still don't have enough lifeboats for all of our citizens. Live images of uncollected corpses and families clinging to rooftops made vivid what decades of statistics could not: that being poor in America, and especially being poor and black in a poor southern state, is still hazardous to your health.

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This may truly be a “teachable moment” about the impact of poverty and race on health. The gap in health between white and black Americans has been estimated to cause 84 000 excess deaths a year in the United States, a virtual Katrina every week.¹ Because the victims gradually succumb to various diseases such as diabetes, cardiovascular disease, alcohol and drug abuse, cancer, and HIV infection, they rarely capture the public’s attention in the way the victims of Katrina have. As a result, health inequality has persisted despite decades of important health gains, economic growth, and progress on racial issues in the United States.

It would be a mistake, however, to assume that the problems highlighted by hurricane Katrina are a unique legacy of southern racism or a problem affecting black Americans or America alone. The same factors that placed the poorest residents of New Orleans in harm’s way—unemployment, poverty, neglect of communities, and alienation—contribute to health disparities for poor children and adults and those from minority groups throughout the United States,² in the United Kingdom,³ and in other Western countries.^{4,5} But the aftermath of hurricane Katrina provides clear lessons about what changes in policy government and private agencies must make to tackle health inequalities.⁶

Fund prevention, not rescue. The recent UN International Strategy for Disaster Reduction notes the need to “invest to prevent,”⁷ yet a comprehensive plan for protecting the Gulf Coast languished for years because it seemed too expensive to implement: the costs of hurricane Katrina to the US treasury are now expected to rise as high as \$200 billion. Pressure on healthcare budgets for the poor continues to squeeze services for primary care and prevention owing to soaring costs for emergency visits and for admissions to hospital and long term care, many of which might be preventable with better functioning systems of ongoing care. Nowhere are the high costs of deferring investment in health more evident than in a poor state such as Louisiana, which ranks 48th among 50 states in levels of health insurance, 45th in public health spending, 50th in overall health and second in the costs to the federal government of caring for its older and disabled citizens.^{8,9}

Strengthen the infrastructure for public health. The individual heroism evident among those who responded to the emergency in Louisiana and Mississippi and in health workers who struggle every day to meet the needs of poor communities cannot make up for a frayed infrastructure. Recent reports have called attention to the neglect of the public health infrastructure in the United States and the United Kingdom.^{10,11} Strengthening this infrastructure will depend on improving the workforce, information systems, and organisation both locally and nationally.

Adopt policies that support responsible choices. Democracies cannot completely protect their citizens from the freedom to make bad choices. Yet hurricane Katrina’s effects vividly illustrate how the choices available to us differ depending on where we live and how much money we have. Many who “chose” to stay in the path of the storm had no cars with which to escape, no faith that their property would be protected, and no insurance to cover their losses. Similarly, promoting personal responsibility as the solution to health

problems such as obesity will not work if we do not reduce the barriers to exercise and healthy diets in poor urban communities, where parks and supermarkets are less common than fast food chains and stores selling alcohol. The problem is particularly acute in the US, where efforts to intervene early against chronic diseases such as hypertension and diabetes are hampered by a system that continues to leave 45 million citizens without health insurance.

Improve communication about critical threats to health. The failure of basic communication after the hurricane fed a downward spiral of the early recovery efforts. The lack of an authoritative source of information fostered confusion and rumours which exacerbated the chaos and sense of panic. Similar challenges hinder efforts to confront health problems in poor and ethnic minority communities, where a legacy of distrust of government and medical establishments provides fertile ground for misunderstanding, myths, and conspiracy theories about health issues. Rebuilding trust will require actively including the community in any planning and research which affects them, improving cross cultural training of health workers, and tapping into the informal information networks in these communities.

Build strategies that foster accountability. A variety of investigations will eventually sort out the failings and scattered successes of the preparations for and response to hurricane Katrina. And, although our ability to measure health disparities is improving, we still need better mechanisms to promote accountability for reducing them. Public and private healthcare organisations and both local and national governments will need to negotiate their shared responsibility for a problem that has many sources and no single solution.

Strengthen communities. It now seems that many of the most horrific stories to come out of New Orleans—roving gangs of rapists, snipers firing on helicopters—were exaggerated or untrue. But the perception of crime and disorder which impeded the response to hurricane Katrina also undermines efforts to attack health disparities. Problems of drugs and alcohol misuse and attendant crime and violence take direct tolls on health and lower the priority given by government and other organisations to health issues. The healthcare sector alone cannot tackle problems which require support from good schools, businesses, religious institutions, other community organisations, and law enforcement agencies.^{3,12}

In the rush to rebuild in the southern states, Americans should pause to think more deeply about what it would take to create more equitable and healthier communities in New Orleans and throughout the affected areas. It is essential that these lessons are heeded in any plans for recovery. It is even more important that we and others apply these lessons to help the many other individuals and communities with poor health who continue to languish out of the public eye.

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Mandatory reporting to the police of all sexually active under-13s

New protocols may undermine confidential sexual health services for young people

Confidential sexual health services for young people are under threat. This summer, following the Richard Report into the killings of Jessica Chapman and Holly Wells,¹ several protocols relating to the disclosure of information about sexually active young people have been issued by area child protection committees in England and Wales. At the same time the government is consulting on a new version of its statutory guidance on child protection, *Working Together to Safeguard Children*.² The protocols require mandatory reporting of all sexually active young people under 13 to the police and the collection of data in relation to sexually active young people under 16. Although the protocols' legal status is unclear and the intended uses of data about under 16 year olds are uncertain, their combined effects are predictable: health professionals can no longer assume that their work with this age group will be in confidence, and young people will turn their backs on health services.

Of course it is right that the appalling murders of Jessica Chapman and Holly Wells led to a thorough review of the processes for vetting those who work with young people. The 10 year old girls were killed three years ago in Soham, Cambridgeshire, by Ian Huntley, a school caretaker whose history of sex with underage girls had not been disclosed to his employers or local police. Nevertheless, on an issue as complex as this, where the vital interests of very large numbers of young people are at stake, the consequences of policy change need to be carefully thought through, and initiatives to protect young people need to be sensitive and nuanced. The panicked introduction of prescriptive guidance that fetters professional discretion could damage the interests of those it is designed to protect. Sir Michael Bichard, the head of the inquiry into the Soham murders, described the protocols as "heavy-handed." He also said that it was important not

to "bring into criminal jurisdiction non-abusive relationships."³

Providing proper care to sexually active young people is challenging. The United Kingdom has one of the highest rates of teenage pregnancy in Europe.⁴ More than a quarter of under-16s are sexually active, and early age at first intercourse is significantly associated with not using contraception and with pregnancy.⁵ For young people, confidentiality is the single most important aspect of services for sexual health.⁶ We also know that sexual abuse is widespread,⁷ and that many young people are coerced into early sexual activity that they will regret later.⁸ Securing the trust of such young people—if it can be done at all—takes time, sensitivity, and patience and requires sound professional judgment. None of this will sit comfortably with the forced completion of the checklists that these protocols demand or with proposals that information must be shared within a rigid time frame.

Before the patchy introduction of these protocols, best practice in relation to confidentiality and young people was based on the House of Lords judgment in the Gillick case.⁹ The judgment related to the legality of providing contraception to a girl under the age of 16 without informing her parents. The judgment recognised that the guiding issue was the intelligence and understanding of the young person. A duty of confidentiality is never absolute, and doctors always advise young people under the age of 16 who seek contraception to discuss the issue with their parents or guardians. Nevertheless, where a young person understands fully the proposed treatment, his or her autonomy and confidentiality should be respected. These new protocols seem to imply a retreat from the Gillick judgment. Will doctors who implement them invite legal and professional action? The GMC's guidance is clear: confidentiality can be breached without consent only where there is a risk of serious harm to the patient or others.¹⁰

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