FAMILY EDUCATION TRUST SUBMISSION TO THE HOUSE OF COMMONS HEALTH SELECT COMMITTEE

NEW DEVELOPMENTS IN HIV/AIDS AND SEXUAL HEALTH POLICY

(See http://www.parliament.uk/parliamentary_committees/health_committee/hc121104_41.cfm for the terms of reference for the Inquiry.)

1. The Family Education Trust was founded in 1971 to carry out research into the causes and consequences of family breakdown, and to publicise the findings of such research.

2. The Trust has always made the welfare of young people its special concern, and adopted the operating title of Family and Youth Concern to express this. We are therefore particularly concerned that the rapid spread of sexually transmitted infections is concentrated amongst those in the younger age groups, where such infections can result in maximum harm.

3. We note with regret that since the Committee report of 11th June 2003, the sexual health crisis has worsened:

   a) The overall conception rates for under 16s have remained at much the same level since 1975 (1) and the latest figures show a small rise in conceptions in under-18s in England and Wales from 42.7 to 42.8 per 1,000 (2)
   b) In 2003, for women resident in England and Wales, the total number of abortions was 181,600, compared with 175,900 in 2002, (a rise of 3.2 per cent and the highest ever annual total) and the under-16 abortion rate was 3.9 per 1,000 compared with 3.7 per 1,000 in 2002 (3)
   c) In 2003, the total number of new HIV diagnoses was 6,606 – more than twice the number in 1998 (4)
   d) Many non-HIV STIs continue to rise. Chlamydia is now the commonest STI diagnosed in England, Wales and Northern Ireland, rising by 8 per cent from 82,558 to 89,431 from 2002 to 2003. Syphilis is of particular concern because of the rate of increase (28 per cent in men 32 per cent in women) from 2002-3. (5)

A. Proposed charges for overseas patients with HIV/AIDS

4. We are opposed to anything that would act as a disincentive to overseas patients accessing services for the detection, control and treatment of STIs, including HIV. We note the HPA report of December 2004 (6) which focuses on migration from high-risk areas such as sub-Saharan Africa as a major factor in the heterosexual spread of HIV in the UK.

B. Progress in implementation

5. The report (p.25) identifies the primary causes of the deterioration in sexual health but gives no recommendations as to how these primary factors may be modified. No country in the world including Thailand has seen its HIV rates decline without a decrease in promiscuous sexual partnerships (7). There is an increasing recognition that condoms, even when used consistently and correctly, cannot, in isolation from other behavioural change, lead to improved sexual health as the following quotations show:

> "The past decade has seen substantial increases in high-risk sexual behaviours in the British population. Although condom use has also increased, this is likely to have been offset by greater increases in unsafe sex." (8)

"The possibility that presenting casual sex using a condom as socially acceptable, enjoyable and safe might increase sexual risk behaviour in the general public cannot be dismissed. Condom promotion need not increase sexual activity to produce a negative effect." (9)

6. The report (p.78) states that the committee sees "no benefit in preventative approaches based primarily around promoting abstinence". Since the report was published however the evidence showing that abstinence has had a major part to play in the dramatic reduction of HIV incidence and prevalence in Uganda has continued to grow. (10-12) There have been several authorities recommending that the lessons learned from the Ugandan success be applied in other countries. (13-14)

7. The experience of the USA is particularly impressive. The conception rate in 15-19 year-olds fell by over 28 per cent from 120.2 to 85.6 per 1,000 from 1990-2000. The comparable figures for the UK were a fall of 7 per cent from 68 to 62.8 per 1,000. Abortion figures for this age group showed a 41 per cent fall in the USA from 42 to 24.8 per 1,000 whereas in the UK the fall was 2.6 per cent from 26 to 25.3 per 1,000. The teenage abortion rate is now lower in the USA than in the UK. (15, 16)

8. The only peer reviewed published evidence of which we are aware that examines the reasons for these trends in the USA from 1990-1995, attributes two-thirds of the decline in conceptions to single teenagers to increased abstinence. (17)

9. The latest figures show that teenage abstinence is still increasing in the USA. The proportion of never-married females at 15-17 years of age who had ever had sexual intercourse dropped significantly from 38 percent in 1995 to 30 percent in 2002. For males the comparable figures fell from 43 percent to 31 percent. (18) Though contraceptive use also increased at first intercourse, there can be little doubt that such a large increase in teenagers abstaining from intercourse will have made a substantial contribution to the reduction in teenage conceptions to single mothers from 1995-2002 as it did in 1990-95.

10. One of our trustees predicted in 2001 (19) that the increased availability of emergency pills from pharmacies would be accompanied by an increase in STIs because the opportunity to counsel and advise on, screen for and treat STIs, would be lost without the encounter with a doctor or nurse. This prediction has proved correct, though the link has not been proved to be causal. We strongly recommend it would help improve sexual health if the manufacturers of emergency pills were to place a warning on the packet or product leaflet, that the user is at risk of an STI as well as pregnancy, and listing contact details for further help.

Prepared by

Trevor Stammers BSc, MRCGP, DRCOG, DPAB on behalf of

Family Education Trust
Jubilee House
19-21 High Street
Whitton
Twickenham
TW2 7LB

16 December 2004

References

1. Paton D The economics of abortion, family planning and underage conceptions *J Health Econ* 2002 21 207-25
2. www.statistics.gov.uk/pdfdir/hsq1104.pdf
3. www.publications.doh.gov.uk/public/sb0414.htm
4. www.hpa.org.uk/infections/topics_az/hiv_and_sti/publications/annual2004/fop_3_hiv.pdf
5. http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/publications/annual2004/fop_4_sti.pdf
6 www.hpa.org.uk/hpa/news/articles/press_releases/2004/041124_hiv_annual_report.htm
7. Wilson D Partner reduction and the prevention of HIV/AIDS *BMJ* 2004 328 848-9
8. www.hpa.org.uk/infections/topics_az/hiv_and_sti/publications/sexual_health.pdf
9. Hearst N Chen S Condom promotion for AIDS prevention in the developing world: is it working? *Studies in Fam Planning* 2004 35 39-45
10. Stoneburner RL Low-Beer D Population-level HIV declines and behavioural risk avoidance in Uganda *Science* 2004 304 714-8
11. Hogle J, Green EC, Nantulya R, Stoneburner J et al *Whatever Happened in Uganda? Declining HIV prevalence, behaviours change and the national response* USAID-Washington and The Synergy Project TvT Associates, Washington D.C. 2002
www.usaid.gov/pop_health/aids/Countries/africa/uganda_report.pdf
12. Shelton JD, Halperin DT, Nantulya Vinand et al Partner reduction is crucial for balanced "ABC" approach to HIV prevention *BMJ* 2004 328 891-3
13. Halperin D et al The time has come for common ground on preventing sexual transmission of HIV *Lancet* 2004 364 1913-4
14. Low-Beer D, Stoneburner RL Behaviour and communication change in reducing HIV: is Uganda unique? *African J of AIDS Research* 2003 2 9-21
15. www.guttmacher.org/presentations/trends.pdf for USA figures
16. www.nationalstatistics.gov.uk for UK figures
17. Mohn JK Tingle LR Finger R An analysis of the causes of the decline in non-marital birth and pregnancy rates for teens from 1991-1995 *Adoles and Fam Health* 2003 3 39-47. www.afhjournal.org
18. www.cdc.gov/nchs/data/series/sr_23/sr23_024.pdf
19. Stammers T Emergency contraception from pharmacists misses opportunity *BMJ* 2001 322 1245