FAMILY EDUCATION TRUST SUBMISSION TO THE HOUSE OF COMMONS HEALTH COMMITTEE INQUIRY ON SEXUAL HEALTH

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 would like to draw attention to three key areas where much unequivocal research is available but appears to be unknown to policy makers.

A. Sexual Health is improved in two-parent families.

4. Data from the 2000 UK National Survey of Sexual Attitudes and Lifestyles (NATSAL) study (1) clearly shows that the children of two-parent families are far less likely to have intercourse under the age of 16, or under the age of 18, than those from other backgrounds (1).

5. Those from two-parent families are also more likely to use contraception and to be more sexually competent at first intercourse (1). Girls from two-parent homes are less likely to have an abortion before age 18 (1). Both boys and girls from two-parent homes are less likely to have an STI (1).

6. Support for parents in helping them to stay together is a totally neglected imperative in teenage sexual health. The vital input of two-parent families in improving their children's sexual health is beyond dispute and there is much evidence to back the large impact of family structure on sexual health (2,3,4,5,6,7,8,).

7. Since the majority of two-parent families will be married couples, we also note that resources put into marriage support services will also indirectly improve the sexual health of teenagers.

8. We recommend the establishment of sex education programmes (such as that used by Blake et al (3)) which facilitate involvement and participation from parents.

9. We also encourage the promotion of projects enabling parents to communicate with their children more effectively about sexual behaviours and values such as the Parent Line series of books (9).

10. We would strongly discourage the promotion and funding of school sex education materials which alienate parents, such as those recently recommended by the Scottish Executive (10, 11) which have subsequently been banned by at least four Scottish councils.

B. Condom promotion on its own does not improve sexual health

11. Far too much unsubstantiated reliance is put into condom promotion, when there is little or no convincing evidence that this works on its own (12,13).

The problems with condom promotion include:-

a) 80% of unplanned pregnancies result from contraceptive (mainly condom) failure rather than non-availability of contraception (14,15).

b) Condom use at first intercourse is not a good indicator of sexual health promotion success since

   i) even when they are used, in up to a third of cases they are put on too late (16)
   ii) their use declines with the length of a sexual relationship (16)
   iii) they have a 3% failure rate even when used perfectly (17)

c) in use by teenagers, condom failure is around 14% (i.e. one in seven) (17)

d) Risk displacement means that more condom use may encourage greater frequency of intercourse which then negates the protection conferred by the condom in the first place (18)

e) There is no evidence that condoms protect against the most frequent STIs such as Human Papilloma Virus (HPV) which causes both genital warts and cervical cancer (19,20)

12. We recommend that condom distribution programmes must take into account the known complication of risk displacement and be accompanied by education about the importance of partner selection and reduction. The lack of protection against HPV from condoms should also be made known more widely.

C. There has been gross imbalance in the emphasis given to HIV/AIDS instead of other much more widely prevalent STIs.

13. The myth that "everyone is at risk of AIDS" needs to be clearly refuted (21). There are over a million new presentations of STIs at GUM clinics each year, but only about 3,000 new reports of HIV infection (22). More people die from falling downstairs in the UK each year than from AIDS (23). The very title of the Government's strategy unfortunately perpetuates an unwarranted emphasis on AIDS for a Western nation. The focus of education needs to be on those diseases which are most prevalent – chlamydia and HPV in particular, which cause high levels of infertility and cancer of the cervix and anus.

14. We recommend that resources be transferred from AIDS education into programmes which emphasise the diseases which are most prevalent and represent the greatest threat to health to the vast majority of the population, whilst still giving due weight to the seriousness of HIV infection.

Conclusion

15. The spread of STIs, particularly amongst young people, has become a cause of concern to policy makers and members of the medical profession. Unfortunately, the response has tended to emphasise early detection and treatment, with much less attention being paid to primary prevention. In so far as prevention is envisaged, there is a reliance on the use of condoms which, for the reasons given above, we feel to be unwarranted (22).

16. The most realistic approach to reducing the spread of STIs amongst young people is to encourage the postponement of the onset of sexual relationships, or their discontinuation if they have already begun at a young age. We regret that the Government's national strategy for sexual health and HIV and its teenage pregnancy strategy appear to attach little or no importance to this (22, 24).

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