

**‘A five year sexual health  
promotion strategy  
and action plan’**

**A SUBMISSION**

*This Submission by the Maranatha Community, Northern Ireland  
is in response to the above Consultation Document published by the  
Sexual Health Promotion Working Group of the  
Department of Health, Social Services  
and Public Safety, Northern Ireland*

March 2004

# SUBMISSION

*to the Sexual Health Promotion Working Group of  
the Department of Health, Social Services and Public Safety, Northern Ireland  
by the Maranatha Community. This is in response to the consultation document  
'A five year sexual health promotion strategy and action plan'.*

## **1. Introduction**

- 1.1 We warmly welcome the consultation looking at sexual health in Northern Ireland and wish to contribute to the consultation process.
- 1.2 We are concerned that the issue of human sexuality should be dealt with in the context of mature, loving, responsible relationships based upon the ideal model of the marriage-based family.
- 1.3 Any sexual health strategy must take a holistic approach. The draft action points will potentially founder if they ignore this wider context of promoting social stability and cohesion.
- 1.4 The underlying cause for the crisis in Sexual Health must be recognised as behavioural. It is promiscuity and risk-taking that undermine programmes designed to improve Sexual Health.
- 1.5 We are concerned that The Sexual Health Promotion Strategy and Action Plan in its present form will provide only limited protection to Northern Ireland's most vulnerable groups, as it makes no mention of promoting real change through advocating behavioural change, which is vital for the well being of Northern Ireland's citizens.
- 1.6 Education and public campaigns must recognise that teaching about inappropriate activities amounts to *promoting* that activity. There is significant evidence to show that such education actually leads to an increase in risk-taking behaviour, and there is little improvement in the population's sexual health.
- 1.7 We urge the Sexual Health Promotion Working Group to consider a truly holistic and coordinated approach to sexual health by deliberating on the points raised in this submission.

## **2. The sexually transmitted disease crisis**

- 2.1 During the past twenty years there has been a steady overall increase in the incidence of sexually transmitted diseases in the United Kingdom including HIV.
- 2.2 The prime reason for this has been the growth in promiscuous behaviour evidenced in multi-partnering alongside a significant increase in dangerous sexual practices.
- 2.3 Increased promiscuity has led inevitably to a substantial increase in the need for genito-urinary medical facilities in the National Health Service.
- 2.4 There was a more than three-fold increase between 1964 and 1986 in new attendances at GUM clinics in England. In the last ten years this has doubled to over 1 million a year. The rate of sexually transmitted infections directly attributable to behavioural changes has now reached epidemic proportions.
- 2.5 However, the main thrust of public policy has been the unquestioning acceptance of this risk-taking behaviour and the minimising of the attendant consequences.
- 2.6 It continues to be contended that, provided the necessary preventative steps are taken and the appropriate facilities made available, the basic problem will be largely resolved.
- 2.7 This attitude has been proved totally wrong in practice insofar as the growth in sexually transmitted diseases has coincided with the growth in the provision of advisory and clinical services. It can be argued with considerable validity that the services offered by agencies such as Brook have, in some ways, contributed to the problem rather than solving it.
- 2.8 Pervading cultural influences, powerful commercial interests and enormous peer pressure, particularly on the young have sought to normalise and even promote promiscuity. The influence of the media, with its resolute mocking of monogamy, and a now obsessive emphasis on sexual matters has undoubtedly been formative. The erosion of the marriage-based family has clearly led to a situation in which a growing number of people have a range of sexual partners, with all the attendant, but avoidable, social, emotional and medical problems.
- 2.9 In this situation public policy has, in the main, been reactive rather than pro-active. In a changing culture, government has been drawn into so-called educational processes which often do little other than introduce participants to new and often dangerous sexual practices.
- 2.10 Public bodies, in the face of considerable medical arguments, have been largely obliged to stop speaking of 'safe' sex and now speak of 'safer' sex.

It is however interesting to note that in paragraph 3.5 of the Department of Health's document 'The National Strategy for Sexual health and HIV' it is stated "schools guidance make sure that secondary schools provide young people with information about ...safe sex..."(p.14).

- 2.11** There appears to be a fear of giving factual information about real risks and a refusal to actively promote anything remotely related to the formation of mature, stable and adult human relationships in which restraint, mutual respect and love are major constituents.
- 2.12** The diminution in the value of individual men and women and their relationships has become a major characteristic of contemporary culture. Sex is no longer presented as an intimate and sacred expression of a real covenant between a man and a woman. Instead, largely due to commercial pressures, sex is now presented as a 'recreational activity' totally detached from any long-term or even short-term responsibility. Sadly, this message is even being directed at children and young people in "sex education" literature.
- 2.13** The natural relationship between sexual intercourse and procreation is now largely ignored, particularly by various agencies involved in family planning services, which now see the destruction of human life in the womb as an acceptable form of contraception.
- 2.14** It is often argued that human behaviour cannot be dictated by government. However, the decisions of government undoubtedly influence human behaviour.
- 2.15** It is beyond dispute that the marriage-based family is a public institution and is the basic building block of a civilised society. Yet the marriage-based family is under severe threat, not least from the policies of recent governments. Its erosion and destruction has immense consequences which no politician dare ignore. It is equally beyond dispute that the marriage-based family not only saves huge financial resources which would otherwise be spent on supporting other, largely dysfunctional family structures, but also makes a major contribution to the diminution of sexually transmitted diseases and unwanted pregnancies.
- 2.16** It would therefore seem sensible for government to put far greater emphasis upon the support of the marriage-based family, rather than pursuing the policies of recent years in which married couples have been increasingly penalised and all other forms of co-habitation are presented as equally acceptable.

### **3. The crisis facing children and young people**

- 3.1 In the United Kingdom the youngest children are today subject to enormous pressures implying the necessity and desirability of physical sexual activity. The form and intensity of these pressures amount, some would say, to brainwashing. Deep, lasting and often damaging impressions are being freely inflicted upon the young.
- 3.2 Children are bombarded with images of sex on public hoardings, in broadcasts, in advertisements and particularly in a variety of magazines directed at youth, which at best encourage a grossly distorted and, some would argue, totally irresponsible attitude to sexual relations.
- 3.3 In some sex education programmes children are cruelly introduced to adult sexual practices some of which are utterly grotesque. At a sensitive and impressionable time in their lives they are often given misleading and corrupting information. There are even sex education programmes being offered in schools, which blatantly present sexual activity as a game. Some of the visual material shown to the young is overtly pornographic.
- 3.4 The provision of condoms and contraceptive pills for children who biologically and legally should not be involved in sexual activity is, according to many, a form of child sexual abuse. Children are undoubtedly being encouraged to experiment sexually at a very early age and thus to run enormous emotional and physical risks
- 3.5 Targeted by powerful commercial interests, children and young people are actively encouraged to engage in sex acts. In UK pop concerts a pharmaceutical company actively encouraged teenagers to have sex. A “survival guide” produced by a mobile pharmacy makes the morning after pill available to young people “*in case your contraceptive lets you down in a moment of festival passion*”.
- 3.6 William J. Bennett former United States secretary of education said, “*Sex education has to do with how boys and girls, how men and women, treat each other and themselves. It has to do with how boys and girls, how men and women should treat each other and themselves. Sex education is therefore about character and the formation of character. A sex education course in which issues of right and wrong do not occupy centre stage is an evasion and an irresponsibility.*” If sex is presented as simply a physical or mechanical act devoid of all moral significance to the young and if they accept this teaching, children will be vulnerable to major destructive influences in their lives including sexually transmitted infections (STIs) and unplanned pregnancies.
- 3.7 If contemporary society is prepared to accept, and even encourage child sex, it must be honest enough to accept the dire consequences.

These include the emergence of a large number of parents who are themselves children; a huge growth in teenage abortions and an enormous explosion of sexually transmitted disease especially amongst the young.

- 3.8** The young are largely being kept ignorant of the medical consequences of promiscuity. Most of them are totally unaware of the inadequacy of most contraceptives to give fail-safe protection from disease. Most of them do not know the high failure rate of incorrectly used contraceptives and many of them are totally unaware of the risks of infertility due to STIs and also of the fact that they may have a disease for years without being aware of it.
- 3.9** There is continuing concern that the educational and health services are being used as a vehicle to promote homosexual exploration and activity. Many parents have expressed concern about this. A teaching video project for schools produced by the Avon Health Authority includes a direct invitation for children to try homosexual activity. The same video also has teaching notes suggesting 30% of children are homosexual or have a near relative who is. Not only is this figure without any foundation, but, surprisingly, this NHS trust ignored the fact that the sexual orientation of a person cannot be regarded as fixed before maturity and certainly not at birth. Thus children are being presented with information which is untruthful and which can lead to emotional harm and physical disease. This should be a warning to those responsible for sex education in Northern Ireland.
- 3.10** If we are to protect young girls they need to know that doctors recognise the damage to them from under-age sexual intercourse, contrary to the advice given by some concerned with sexual health. They need to be informed by the warnings given by medical authorities such as the gynaecologist Dame Josephine Barnes who said, *“Not only is there risk of venereal disease and a possible risk of cancer of the cervix later on but there is no doubt that some damage may result.”*

## **4. The special situation in Northern Ireland**

- 4.1** It is recognised that the situation in Northern Ireland differs from the rest of the United Kingdom. For example, there is a stronger influence in the Province on the importance of marriage, family values and Christian morality. We are convinced that the importance given to Christian values and the importance of the marriage-based family protects young people from sexual ill health. This is evidenced in the much lower rates of teenage pregnancies and STIs in Northern Ireland compared with England and Wales.
- 4.2** Levels of sexual ill health in Northern Ireland are high, but not as high as England and Wales.

The teenage pregnancy rate in Northern Ireland in the year 2001 was 28.9 per 1000 girls. This is just over half the rate for England and Wales, which stood at 51.6 per 1000. Although the cases of STIs in Northern Ireland are increasing in line with the figures across the rest of the United Kingdom, the incidences of new diagnoses in the population are still only a fraction compared with the those in England and Wales for most STIs.

## **5. Shortcomings in the proposed strategy for Northern Ireland**

- 5.1** We are particularly concerned that the prevention message of the proposed strategy (chapter 3.2) fails to mention the most important determinants for teenage sexual activity such as family breakdown, poverty, and unemployment. Addressing those issues will have a more profound effect in achieving the goals set out in the strategy than sex education, access to family planning clinics, and the distribution of condoms and the provision of contraceptive services.
- 5.2** There is strong evidence showing that economic welfare, family stability and religion have a positive impact on teenage pregnancies. For example, a stable family with both parents present reduces underage pregnancy. Young people aged 14-17 who live in a two parent family are less likely to have had sexual intercourse than young people living in any other family arrangement. Strengthening religious influences, improving economic welfare, and supporting family stability will be the most effective measures to impact teenage pregnancies. We are concerned that the consultation document recommends access to family planning clinics as an answer to teenage pregnancies. This is not the solution to the problem and there is much evidence to show this:
- 5.3** Access to family planning clinics is likely to increase conception rates, not decrease them. This is demonstrated by the pattern of conception rates at the time of the Gillick ruling which restricted underage family planning in England and Wales, but not in Scotland. In 1984 – the year before the Gillick Ruling – the conception rate in England and Wales was 1.37% higher than the previous year. In 1985, when restrictions were imposed on underage family planning, the conception rates in England and Wales were unchanged, i.e. there was no increase. In the following year, when restrictions had been lifted, but family planning attendances had not recovered to previous levels, conception rates rose by 0.01%. In contrast, conception rates in Scotland – which was not affected by the Gillick ruling – increased by 7.6% (1985) and 5.6% (1986), while conception rates of 16-19 year olds increased by 3.3% and 1.3% respectively. Restricted access to family planning clinics for underage girls did not lead to an increase in conceptions but stopped the year on year increase in underage conceptions.

## **6. The dangers of corrupting ideology in schools**

- 6.1** The consultation document claims that ‘lack of information’ is a problem and that therefore sex education should address this lack of information. Apart from the fact that there is little evidence to show that UK young people – who have the highest teenage pregnancy rate in Europe – are less informed about sexual matters than other young Europeans, we are very concerned that some of the new approaches to sex education are potentially extremely damaging.
- 6.2** There is a very real danger that sex education, divorced from morality, will concentrate interest in the physical sex act. The unintended side effects of much sex education can be a debasing of human relationships and the forcing upon children of ideas and practices which they would rarely otherwise encounter.
- 6.3** Through the process of 'values clarification', pupils are encouraged to develop their own values and reject the values of their parents and the inherited Christian values of society. They are also encouraged to reject the concept of absolute 'right' or 'wrong'. This then inevitably leads to adoption of so-called 'situational ethics' where what is right or wrong is totally dependent on the situation. For example there may be a feeling that it is right to engage in homosexual sex, sex with animals, sex with children or dead people. This feeling would be presented as 'right' under those circumstances which are ‘right for the person concerned’. It is often suggested that the presentation of basic standards should be rejected as ‘moralising’ or ‘preaching’. The rejection of moral absolutes and standards is clearly expressed in the frequently used term ‘informed choices’, which the consultation document also uses.
- 6.4** Much current sex education is critical of both family and marriage. Because one should not discriminate against some pupils whose parents have split up, sex educators rarely teach about marriage as the ideal. Also, it is claimed that the state and not parents should decide what is 'right'. Inevitably much sex education drives a wedge between children and parents.
- 6.5** Current sex education frequently stresses the concept of 'sexual and reproductive rights’, which is a euphemism for access to family planning, contraception and abortion for children without/against parental knowledge and approval. It is not usually taught that along with ‘rights’ go ‘responsibilities’.
- 6.6** A considerable proportion of current sex education uses a mechanistic approach, focussing on the 'mechanics', for example specific contraceptive techniques. There is very little or nothing about marriage, responsibility and the emotional or spiritual adverse effects of premature sexual activity.

It is claimed that sexual ill-health is the consequence of lack of information and therefore young children at an earlier and earlier age need to be taught about sex using explicit material. There is no evidence to support this.

- 6.7 Abstinence, ideally abstinence until marriage, is not usually taught as an option in 'modern' sex education. Children are being misled.

## **7. Condoms and the 'safe sex' myth**

- 7.1 We are deeply concerned that a 'harm-reduction' approach, as in drug education, is being applied to sex education, where it is stated that young people are going to engage in sex anyway whatever we do and we therefore need to teach them how to do it 'safely', i.e. use condoms. This leads to a false sense of security. However, because condoms are not as 'safe' as claimed, this increases the overall risks of sexual activity.
- 7.2 We are aware of cases where contraception (the 'pill') has been given to under-age girls without parental consent and with tragic consequences. For example because the girl herself was not aware of a family history of a clotting disorder, use of the 'pill' rendered her more susceptible to blood clots including deep vein thrombosis, pulmonary embolism and strokes. Recently there has been evidence of the 'Morning After' pill being dispensed to under-age schoolgirls against the recommendations of the manufacturer.
- 7.3 One part of the proposed sexual health strategy will be the distribution of condoms and contraception in family planning clinics and even in schools. We are, however, deeply concerned about any attempts to distribute condoms and other contraceptives at schools with or without parental knowledge or consent. Many parents are strongly opposed to such policies and they do not see the school as having any role in this.
- 7.4 We are particularly concerned about the uncritical promotion and distribution of condoms since this, in our view, implies a tacit approval of sexual activity. Furthermore, condom use gives young people a false sense of security. Many facts about condom use are not widely known.
- 7.5 About 14% of couples using condoms experience a pregnancy in one year due to 'condom failure'. For this reason it is somewhat surprising that many young people think that condoms protect against sexually transmitted infections.
- 7.6 Condoms do *not* give 100% protection against sexually transmitted infections. For example with always (100%) condom use, the risk of contracting HIV is reduced by 85%. There is still a remaining risk of 15% of getting HIV.

Always (100%) condom use reduces the risk of transmission of chlamydia, gonorrhoea and syphilis by about 50%. However, 100% condom use is very rare and there is little evidence to suggest that less than 100% condom use is protective against most STIs. Furthermore, condoms do not protect against the Human Papilloma Virus (HPV - which can cause cervical cancer) since the virus may be in skin which is not covered by a condom. Similarly, genital herpes is not always prevented by condoms either. For this reason, it is surprising that the message still seems that condom use equals safe(r) sex. We consider these messages – that using condoms equals ‘safe sex’ to be deeply misleading and irresponsible.

- 7.7 We are aware of many cases especially of young women who thought that they had only engaged in ‘safe sex’ and still contracted sexually transmitted infections. We are aware of a case of a young woman in her early 30s who nearly died due to cancer of the cervix contracted through the Human Papilloma Virus which was transmitted through sexual contact. We therefore believe that the focus on ‘safe or safer sex’ is misguided.
- 7.8 In view of the above mentioned data on condom ‘safety’ we are deeply concerned at the recently announced commercial deal between the condom producer Durex and the teenage magazine ‘Sugar’ aimed at 13-year olds. In an editorial of the magazine, Durex condoms are being blatantly promoted. We believe this to be grossly irresponsible.
- 7.9 Since many young people are deeply influenced by teenage magazines and also by the media in general which frequently have very explicit sexual contents, we urge the Working Group to exert pressure on the editors and publishers of teenage magazines but also producers of TV programmes and other media with regard to the messages they send to young people.

## **8. Information about dangerous sexual practices**

- 8.1 At a time when Government, the National Health Service and Educational Establishments are working to reduce health risks by addressing life-style factors such as smoking, excess alcohol consumption and drug abuse it is of very grave concern that people are being encouraged to regard unnatural and deviant practices such as anal intercourse, as normal. Sadly they are not being clearly informed of the fact that this is an extremely unhealthy and high-risk activity.
- 8.2 A substantial volume of medical information exists warning of the consequences and risks of alternative sexual practices and a group of medical professionals has spelt these out in a statement published by ‘The Council for Health and Wholeness’.

- 8.3** Rarely in sexual educational material in current use do we see warnings about the serious consequences of anal intercourse. Sometimes it is presented as simply another form of intercourse merely requiring stronger condoms. Sexual health educationists have the responsibility to tell the truth, namely that condoms frequently burst when used in this situation but in any case do not form a 100% reliable barrier to the transmission of the HIV virus.
- 8.4** The manufacturers of both pills and condoms have invested huge sums of money globally in the promotion of their products. Their marketing arms have exercised a ruthless and powerful political influence at a time when so much public attention has been given to the AIDS pandemic. The risks attached to the use of their products have invariably been minimised or ignored.
- 8.5** Huge public resources are currently being devoted to AIDS research and attendant educational programmes. It is not generally known that the lifetime treatment costs for those currently living with HIV in the United Kingdom will, according to sources quoted by the NHS exceed £3billion.
- 8.6** Fears about homophobia should not hide the figures regarding increases in gonorrhoea and syphilis amongst homosexuals, directly attributable to their sexual practices, nor the fact that sex between men remains the major transmission route for HIV in the United Kingdom.

## **9. The true meaning of safe sex**

- 9.1** The only safe sex is sex with a safe partner. There is no such thing as ‘safe sex’ with an unsafe partner. We encourage the Sexual Health Promotion Group to include the only evidence-based definition of “safe sex” – which is – apart from abstinence – *mutual monogamy with an uninfected partner*. The strategy should promote this definition of safe sex. Furthermore, we would strongly encourage the promotion of abstinence until marriage as the ideal and at the heart of the sexual health strategy.
- 9.2** We are disappointed that the consultation document does not mention sex education based on abstinence until marriage as part of the overall strategy. There is increasing evidence on the positive impact that abstinence-based sex education programmes are having in the US, leading to a reduction of teenage pregnancies and sexually transmitted diseases. This is in marked contrast to the UK, where the Chief Medical Officer has claimed, to the astonishment of many Americans, that abstinence-based programmes are ineffective. The latest figures for teenage conceptions and sexually transmitted diseases in England show another increase on last year.

- 9.3** One of the most dramatic examples of sexual health policy based on abstinence until marriage comes from Uganda, a country that unlike the UK, has dramatically reduced STIs, in particular HIV. Among some groups, the reduction of HIV was up to 80%. The main reason for the success in Uganda was the reduction in casual sex/promiscuity rather than the promotion of condoms.
- 9.4** In Uganda, HIV rates fell nationally from 21% to 9.8% between 1991–1998, continuing to fall to 6.4% among pregnant women. The most important factor in this decline is a decrease in non-regular partners by two-thirds. While condom use increased somewhat, the unique factor in Uganda was the steep decline in multiple sexual relationships. Uganda promotes ‘ABC’ as the basis of sex and relationship education: ABC stands for ‘Abstinence (no sex before marriage), Be faithful, or use Condoms’, in that order of emphasis. It is not ‘abstinence only’ or ‘condoms only’. Condoms are needed if ‘A’ or ‘B’ fails! Research has shown that the most important factor of ABC is B – be faithful.

## **10. Conclusion**

- 10.1** While there are many positive points in the proposed strategy, our main concern remains that it is in essence an adaptation of strategies that have been used in England for many years and which have proved to be a total failure. The failure of current English policies is evident in the exponential increase in STIs and the extremely high teenage pregnancy rate in England over the past decades despite teenage pregnancy strategies similar to the ones proposed in the Consultation document. This makes it necessary to look for other ways of tackling the problems.
- 10.2** We are, therefore, very concerned that the NI strategy may adopt the failed English policies. These include earlier and earlier explicit sex education for children, based on ‘informed choice’ and without any moral reference. They also include access to family planning and genito-urinary clinics, and the distribution of contraception. This is likely to happen in schools without parental knowledge or even directly against parental wishes. Young people, including under-age children, are encouraged to attend clinics in order to receive contraception ‘in confidence’ without parental knowledge thereby driving a wedge between children and their parents.
- 10.3** As a Christian community we recognise the importance of a view of human sexuality that is not limited to physical aspects and which recognises the important emotional and spiritual dimension of sexual relationships. Too often, the issue of teenage sexuality is reduced to pure ‘mechanics’.

In dealing with sexual activity focus is too often directed to the adverse physical effects of unwanted pregnancies or sexually transmitted diseases, rather than on the adverse emotional and spiritual consequences of teenage sexual activity. The emotional and spiritual causes and consequences of teenage sexual activity are often ignored and because of this young people are caused unnecessary suffering. There is a real danger of the minority views of pressure groups being imposed, thus exploiting the educational system for social engineering purposes.

- 10.4** A successful sexual health strategy will tackle the underlying problems such as poverty, family breakdown and poor educational achievement. An approach to sexual health based on Christian values, encouraging the role of parents, strengthening families and teaching abstinence until marriage as the best choice young people can make for their lives will have a profoundly positive impact on the sexual health of young people in Northern Ireland.

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*The Maranatha Community is a Christian inter-denominational community which consists of over 11,000 members across the United Kingdom. It has over 1,800 members in Northern Ireland. Many Maranatha members are engaged in the care of children professionally or in a voluntary capacity. They are deeply involved in issues affecting young people, not only regarding sexual health but also matters such as the experience of violence (including paramilitary intimidation), drug abuse, family breakdown, and relationship problems. The Maranatha membership includes Presbyterians, Catholics, Methodists, and members of the Church of Ireland and also Pentecostals and members of new churches.*

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