

STIs & Teenage pregnancy

**A submission to
The National Institute for
Clinical Excellence
on its draft guidance for
Interventions to prevent
Sexually Transmitted Infections
and reduce under-18 conceptions**

**by The Maranatha Community and the
Council for Health and Wholeness**

March 2006

Preface

THIS DOCUMENT

This document has been prepared in response to the invitation for written submissions by the National Institute for Health and Clinical Excellence.

This submission is addressed to the National Institute for Health and Clinical Excellence, MidCity Place, 71 High Holborn, London, WC1V 6NA. Tel: 020 7067 5800; Fax: 020 7067 5801; Email: nice@nice.org.uk; Web: <http://www.nice.org.uk>

THE MARANATHA COMMUNITY

The Maranatha Community is a Christian movement with many thousands of members throughout the country active in all the main churches. Its membership includes a substantial number of people involved in the health and caring professions and in a wide range of voluntary work. Since its formation 24 years ago, it has been deeply involved in work amongst children and young people, people with drug and alcohol problems, the elderly, the disabled and the disadvantaged. It has taken the initiative in a broad range of projects directly contributing to the health of the nation and it also has extensive international experience.

The Maranatha Community
UK Office, 102 Irlam Road, Flixton, Manchester M41 6JT. Tel: 0161 748 4858
Fax: 0161 747 9192; Email: info@maranathacommunity.org.uk; Web:
www.maranathacommunity.org.uk
The Maranatha Community Trust is a registered charity number 327627.
The Leader and co-founder of the Community is Mr. Dennis Wrigley.

THE COUNCIL FOR HEALTH AND WHOLENESS

The Council is a multi-disciplinary body embracing doctors drawn from a variety of specialist disciplines, nurses and various medical auxiliaries, counsellors, chaplains and others. It has close links with the healing ministry of the Christian church and is involved in a broad range of research projects.

The Council for Health and Wholeness is based in the offices of the Maranatha Community.
Its medical co-ordinators are Dr. Hans-Christian Raabe & Dr. Linda Stalley.

Comments

- 1. As noted in the draft guidance, Sexually transmitted infections in the UK are out of control with an epidemic of Chlamydia, Gonorrhoea, Syphilis, HIV and other STIs.**

There has been a massive increase of sexually transmitted diseases (STIs) in the UK over the past years. Diagnoses of gonorrhoea and chlamydia have all more than doubled between 1995 and 2004. Syphilis cases rose by a staggering 1500%. Cases of HIV and AIDS are set to rise almost 10 per cent a year and have more than doubled between 1993 and 2002. There has been a record numbers of HIV infections in 2001, with 5393 newly diagnosed cases. This was the highest number of new diagnoses recorded in a single year since the beginning of the AIDS epidemic. (*Draft NICE guidance; MW Adler, Sexual health – health of the nation. Sexually Transmitted Infections 2003; 79: 85-87; Written answer; Sexual Health; Miss Melanie Johnson: Sexually Transmitted Disease data for England; as at 28 November 2003*)

- 2. There has been a massive increase in sexual promiscuity as measured by the number of lifetime sexual partners, a significant increase in risky sexual behaviour and a trend to earlier sexual intercourse. The key to reducing STIs will be addressing the underlying cause for the epidemic of STIs, which is mainly the steep increase in promiscuity.**

The number of lifetime sexual partners had increased from 8.6 to 12.7 for men and from 3.7 to 6.5 for women over the past 10 years. Britons also have sex at an earlier age now. For over 55s the average age of losing their virginity was 19, within the 25-34 age group it was 16 and among the 16-24 year olds it is only 15. Over the past 10 years, there has been a “considerably higher rate of new partner acquisition among those younger than 25 years and those not cohabiting or married. These strong age effects are reflected in the substantially higher incidence of STIs in those younger than 25 years, compared with older people.” (*The Observer, “Sex uncovered, result of a poll of 1027 adults aged 16 or over”, 27 October 2002; Johnson AM et al. ‘Sexual behaviour in Britain: partnerships, practices, and HIV risk behaviours’, National Survey of Sexual Attitudes and Lifestyles; Natsal 2000; Lancet 2001: 358; 1835-42.*)

- 3. There has been a doubling in GU clinic attendances over the past 10 years. A record attendance at GU clinics has failed to stop the dramatic increase in STIs. To increase access to GU services even further is unlikely to stop the epidemic of STIs.**

Between 1991 and 2001, attendances at GU (genito-urinary medicine) clinics in England, Wales & Northern Ireland rose from 669,291 to 1,332,910. In 2004, there were 1.5 million appointments at GUM clinics. At the same time, there has been a dramatic increase in all STIs. The government’s drive to further increase access to GU clinics will therefore not stop the epidemic of STIs. (*Draft NICE guidance; Sexually Transmitted infections in the UK: new episodes seen at Genitourinary Medicine Clinics, 1991 – 2001; Public Health Laboratory*)

- 4. The most important risk factor for contracting an STI is the number of lifetime partners, not whether a person does or does not use condoms. The benefits of increased condom use were more than offset by increased number of sexual partners.**

A small increase in condom use has been observed over the past 10 years in the National Survey of Sexual Attitudes and Lifestyles. This survey concludes that, due to the increase in risky sexual behaviour the *'benefits of condom use were offset by increases in reported partners'*. To rely on condoms without emphasis on reducing casual sex – as the government seems to be doing – will not stop the epidemic of STIs. (Johnson AM et al.; Natsal 2000; Lancet 2001: 358; 1835-42. The Medical Institute for Sexual Health: Sex, condoms and STI's – what we now know. 2002)

- 5. Messages aimed at promoting 'safe(r) sex' alone, by aiming to increase condom use have failed and will continue to fail if they do not reduce casual sex at the same time.**

There is a strong positive correlation between increased condom use at first sexual intercourse and increased teenage pregnancy. If the traditional approach – to encourage increased uptake of condoms – were effective, an increased use of condoms would be associated with a decrease in unwanted pregnancies. However, this is not the case since condom distribution may be associated with increased sexual activity and condom use may give a false sense of security, which increases sexual risk-taking and casual sex. Finally, condom distribution does not ensure condom use: In a recent survey, $\frac{3}{4}$ of male students reported having sex without condom when they felt one should have been used to protect against pregnancy or infection. (Williams ES. Contraceptive failure may be a major factor in teenage pregnancy. British Medical Journal 1995; 311: 806-7. United States Agency for International Development: The 'ABCs' of HIV prevention. 'ABC' Expert Technical Meeting September 17, 2002. Warner L. Condom access does not ensure condom use: you've got to be putting me on. Sexually Transmitted Infections 2002; 78: 225.)

- 6. There is no such thing as 'safe sex' relying only on condoms. The overwhelming majority of the population does not use condoms consistently. Inconsistent (i.e. less than 100%) use of condoms does not decrease the transmission of STIs. The true meaning of 'safe sex' is mutual monogamy between uninfected partners. The draft NICE guidance does not promote this definition of 'safe sex' but instead relies on condoms, which are not as 'safe' as has been claimed.**

There is no such thing as 'safe sex' - there is however only sex between safe partners. The National Institutes of Health, USA and The Medical Institute examined condom effectiveness for STIs. There is good evidence that "always condom use, i.e. 100% of times" reduced the risk of especially HIV transmission. However, even with 100% condom use, there is already less protection against the transmission of gonorrhoea, syphilis and chlamydia

transmission. There is insufficient evidence that condoms were effective in reducing transmission of many other non-HIV STIs including human papilloma virus, which is associated with cervical cancer. Unfortunately, the draft NICE guidance does not recommend mentioning condom failure rates. The large majority of people do not use condoms consistently. Consistent condom use is observed in only 24% of men and 18% of women in the UK. Even a doubling of consistent condom use would still mean that less than half of the population would use condoms consistently. However, inconsistent condom use (i.e. less than 100% of times) has not been shown to reduce the risk of transmission of most STIs. 14% of couples experience an unintended pregnancy during the first year of “typical” use of condoms for contraception. It is surprising to note that – while everyone is aware that condoms may break or slip, resulting possibly in an unwanted pregnancy – the assumption is still that condom use equals “safe sex. (*National Institutes of Health. Workshop summary: Scientific evidence on condom effectiveness for sexually transmitted disease prevention; 2000. The Medical Institute for Sexual Health: Sex, condoms and STI's – what we now know. 2002. Johnson AM et al. Natsal 2000; Lancet 2001: 358; 1835-42.*)

7. A country that, unlike the UK, has dramatically reduced STIs, in particular HIV, is Uganda. 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 rather than the promotion of condoms.

In Uganda, HIV prevalence declined nationally from 21% to 9.8% between 1991 and 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 65% during 1989-95. While Condom use doubled (to ever-use of condoms of 23% in Uganda which is still lower than neighbouring countries) and delay of sexual debut also increased, the unique factor in Uganda, compared to other African countries, was the steep decline in multiple sexual relationships. Reduction in number of partners has a greater effect on preventing HIV infections than either condom use or treatment of STIs. Other countries in east and southern Africa that have committed greater resources and have implemented many elements of global policy, condom provision, treatment of STDs, media programmes, testing and counselling have seen HIV prevalence increase throughout the 1990s. Many of these countries have made progress in important areas e.g. South Africa has the highest rate of condom use and Botswana is advanced in terms of treatment, but they have not seen the same decline in HIV infection that is seen in Uganda. (*United States Agency for International Development, 'The 'ABCs' of HIV prevention', 'ABC' Expert Technical Meeting September 17, 2002 (available from www.usaid.gov/pop_health/aids/Publications); United States Agency for International Development: 'The 'ABCs' of HIV prevention' Press release January 2003. Green EC, 'Sexual partner reduction and HIV infection', *Sexually Transmitted Infections* 2000; 76: p145. Dr Daniel Low-Beer and Rand L Stoneburner, 'Behaviour and communication change in reducing HIV: is Uganda unique?' *African Journal of AIDS Research* 2003, 2(1): 9–21.*

8. **Uganda promotes ‘ABC’ as the basis of sex and relationship education: ABC stands for ‘Abstinence, 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’ fail. Rather than relying on failed policies such as the distribution of condoms without emphasising partner reduction or abstinence, Uganda adopted a successful campaign at modifying behaviour, mainly aimed at reducing casual sex. The subsequent fall in HIV cases has been dramatic.**

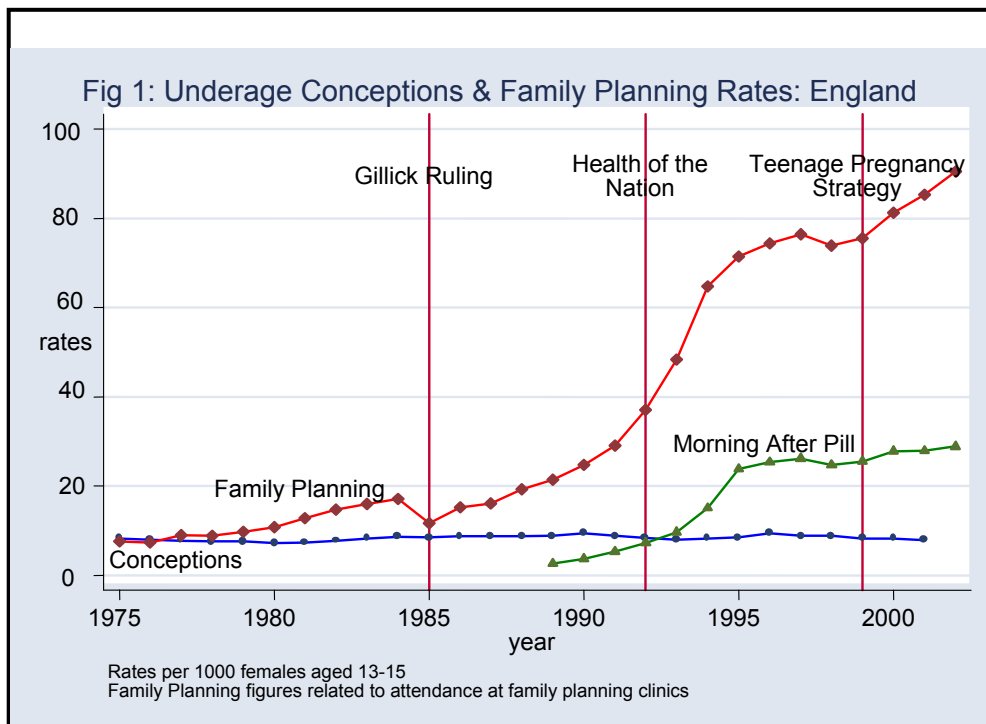
“Recent data from Uganda and other countries where HIV prevalence has been reduced or stabilized suggest that an “ABC”-based approach can alter patterns of personal behaviour ... Successful prevention programs in places like Uganda, Senegal, and Jamaica have employed a multi-pronged approach to behaviour change, involving promotion of abstinence or delayed onset of sexual debut and fidelity/partner reduction, along with condom use especially for higher risk sexual encounters. By finding common ground among diverse political, religious, public health, and other constituencies, such an approach can facilitate a more concerted and unified prevention effort.” (United States Agency for International Development: The ‘ABCs’ of HIV prevention. Press release January 2003)

9. **While we are aware of cultural differences, we urge the government to learn from the success of Uganda’s balanced ‘ABC’ approach to sexual health and urge this approach to be at least mentioned in the draft NICE guidance and adopted throughout the UK. A public health campaign aimed at modifying behaviour, with a predominant emphasis on reduction of casual sex, is the only measure that will stop the epidemic of STIs in the UK. To combat STIs with the currently adopted strategy – as proposed in the NICE guidance – is likely to be unsuccessful.**

The current UK policy on sexual health is based on the National Strategy for Sexual Health and HIV, (Department of Health 2001) and the Teenage Pregnancy Strategy in 1999. The government has been attempting to tackle high teenage pregnancy rates and increasing rates of STIs in the UK. The aim is to halve teenage pregnancy rates by 2010. The Teenage Pregnancy Strategy policy initiatives are very similar to those introduced by the Conservative Government in 1992 with the aim of halving the underage pregnancy rate by the year 2000. The National Strategy for Sexual Health nor the draft NICE guidance does not promote the only evidence-based definition of safe sex, which is (apart from abstinence) mutual monogamy among uninfected partners. Neither the National Strategy nor the draft NICE guidance mention the word marriage, even though the majority of the population – 83% – still considers monogamy and marriage as the preferred form of relationship. Reduction in casual sex does not even feature in the National Strategy for sexual health and HIV nor the draft NICE guidance. This guidance is therefore doomed to fail, since it does not address the underlying problem, the dramatic increase in casual sex. *(In a recent poll 83% of respondents aged 16 or over believed that monogamy is desirable. Source: The Observer, ‘Sex uncovered’, 27 October 2002; National Strategy for Sexual Health and HIV, Department of Health, 2001)*

10. The graph below shows that there has essentially been very little or no impact of increased access to family planning clinics on underage conceptions. It is of interest to note, that, despite a massive increase in family planning clinic attendances, underage conceptions have remained unchanged. The previous Conservative government tried to reduce underage conceptions with the 'Health of the Nation' programme in 1992, which contained very similar policy measures to the currently adopted teenage pregnancy strategy. This programme failed to reach its target, to halve teenage pregnancies by the year 2000. Since this previous programme failed to significantly reduce teenage pregnancies, it is very likely that the currently adopted strategy – as recommended by the NICE guidance - will not make much difference either.

(Graph reproduced with permission from Prof David Paton's presentation 'Teenage Sexual health: an economic approach' at the consultation meeting 'The Sexual Health of the Nation', Attlee Suite, Portcullis House, House of Commons, Westminster, 12th November 2003)



March 2006