Sex and Relationship Education

A Review

Presented to
Rt. Hon Beverley Hughes MP
and Mr Jim Knight MP, Ministers of State, Department of Children, Schools and Families

The Council for Health and Wholeness

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A. THIS DOCUMENT

This review has been prepared in the light of public consideration of sex relationship education (SRE). It is presented to Rt. Hon Beverley Hughes MP and Mr Jim Knight MP, Ministers of State, Department of Children, Schools and Families.

B. THE COUNCIL FOR HEALTH AND WHOLENESS

The Council for Health and Wholeness is a body dedicated to researching health related issues. It has initiated a broad range of projects which directly contribute to the health of the nation. It has extensive international experience. The Council comprises professionals in the fields of science, healthcare and it carries out a wide-ranging programme of research. It is associated with the Maranatha Community

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1. Introduction

The Council for Health and Wholeness welcomes the current review of sex and relationship education (SRE) as a timely opportunity to reconsider the current national approach to sexual health in general and sex and relationship education in schools in particular. We believe, in the light of substantial evidence, that there is now an urgent need for a radical change of public policy in this field.

2. Background

2.1 There has been a dramatic increase in sexually transmitted infections (STIs).
In the past decade many STIs – such as Chlamydia or HIV – have more than doubled. Syphilis has increased by more than 1,800% over the same period of time. STIs are essentially out of control in the UK with rates of most STIs continuing to increase.

2.2 The driving force behind this massive increase is dangerous and irresponsible sexual behaviour.
This includes a significant increase in the number of sexual partners, overlapping sexual relationships, anal sex, homosexual sex, etc.

2.3 Despite many initiatives the UK has still the highest teenage pregnancy rate in Western Europe.
The UK is extremely unlikely to achieve the Government's target of a 50% reduction in teenage pregnancies by 2010. (For some further data on STIs and teenage pregnancy please see appendix 1)

2.4 The combination of STIs being out of control paired with a stubbornly high teenage pregnancy rate proves that the currently adopted approach to sexual health and sex education is not working.
Indeed, we are of the opinion, that – rather than helping the nation's sexual health – the current approach to sexual health and sex education has been part of the problem. Despite decades of "value-free" sex education, free contraception including free condom distribution, free and confidential access to sexual health services STIs are now out of control. However, the only "answer" this government has is "more of the same" approach without a concerted attempt at behavioural modification.

2.5 The medical analogy to this approach would be perhaps not too dissimilar to the following: a doctor prescribes a certain medication to his patient in the well intentioned but erroneous belief that this medication will help the patient get better. Instead, the patient gets worse and the doctor doubles the dose.
Not surprisingly, the patient gets even worse, however, despite this, the doctor further increases the dosage. In the above analogy, the doctor is the government, giving the "patient" (ie the nation) a prescription for sexual health. Despite constantly increasing the "dose" of the current prescription (ie the current approach to sexual health) the nation's sexual health has deteriorated dramatically. Has not the time come for a radical rethink of the current strategy?

3. Critique of the current approach

3.1 The poor sexual health of the nation is the result of a wrong understanding of human sexuality.
The seeds for this wrong understanding have been sown through the "sexual revolutionaries", persons such as Alfred Kinsey, Marie Stopes and others.

The approach to sexual health and sex education relies on principles such as the rejection of moral absolutes through the principle of "informed choice", aiming to separate children from their parents, the rejection of the concept of marriage, the rejection of abstinence-based sex education and an over-reliance on condoms.

3.2 "Sexual revolutionaries", such as Marie Stopes are key in understanding this.

She started the "family planning" movement and was a eugenicist – even though this is not readily acknowledged by the organisation that now bears her name. "Family planning" therefore is a movement that started out of eugenic thinking, to stop the "lower castes" from procreating and to create a brave new world of eugenically clean individuals. (For background information on Marie Stopes please see Appendix 2)

3.3 Alfred Kinsey is probably one of the key figures who prepared the ground for the "sexual revolution".

His publications, starting with his *Sexual Behavior in the Human Male* (1948), caused shockwaves as he claimed to have found very high levels of premarital sex, marital unfaithfulness, promiscuity, frequent contacts with prostitutes etc among the general population. There are major concerns about his "research" including unrepresentative sampling populations, and "research" that can only be called paedophile activity. (For more information on Alfred Kinsey please see Appendix 3)

3.4 Situational ethics have replaced absolute moral standards.

The philosophical preparation for the currently adopted value-free approach to sex education has been done by secular humanists such as Joseph Fletcher who developed situational ethics. This approach, also called "values clarification", is based on the concept that there is no right or wrong, that it all depends on the circumstances and that, as long as any behaviour is done out of love, it is ethical. This approach would allow, under the "right" circumstances, essentially any sexual activity, such as promiscuity, group sex, sado-masochism, paedophilia or even zoophilia (having sex with animals), as long as it is done "out of love". Even cursory reading of typical sex education manuals for teachers show that this philosophy has deeply influenced the current teaching of sex education (For more information on "situational ethics" please see Appendix 4)

3.5 Condoms and "safe(r) sex" have created confusion.

The only form of truly safe sex is *mutual monogamy with an uninfected partner*, which is the principle behind the idea of marriage. One of the cornerstones of the current sexual health approach has been equating using condoms with safe(r) sex. [In this context, it is not immediately clear what the meaning of "safer" sex is – does this mean, even "safer" than "safe"?] Many of those involved in the provision of sexual health education seem to have an almost magical faith in condoms and the use of condoms is equated with safe(r) sex. However it is clear that condom-use does not equal "safe(r) sex".

3.6 Condom failure has been underestimated.

While "always" condom use is quite effective at preventing transmission of HIV, condoms are relatively ineffective at protecting against most non-HIV STIs including the most commonly found STIs, such as chlamydia, genital warts, genital herpes, etc. We find it surprising to note that – while everyone knows that condoms can fail in preventing a pregnancy (a typical "failure rate" for pregnancy of around 13% or more for consistent use is being quoted) it does not appear to be common knowledge that condoms are not very effective in preventing the transmission especially of non-HIV STIs. At best, regular use of condoms delays the acquisition of a STI: having regular sex with an infected partner while using condoms leads to a delay in acquisition of STIs but not to complete protection from being infected. International evidence shows that countries, such as Uganda, that

have placed main emphasis on partner reduction, sexual faithfulness rather than primary condom promotion have a much greater success in combating HIV than countries where the main emphasis has been condom promotion. (For further information on condoms please see Appendix 5)

3.7 Children are being separated from their parents.

One facet of the current approach to sex education is the attempt to drive a wedge between parents and their children. For the past decades, underage girls (and boys) have had access to confidential (or secretive) "family planning" services that allow teenagers to get the pill, condoms and terminations without parental knowledge or consent. The Department of Health insists that this approach is necessary, in order to reduce teenage pregnancies. However, analysis of data regarding parental notification before terminations showed that – as a result of parental notification – termination rates came down and teenage pregnancies either remained the same or fell. (For an analysis of data regarding parental consent for underage terminations please see appendix 6) Similarly, the time of the **"Gillick ruling" – which restricted access for underage girls to attend family planning clinics did not lead to an increase in underage conceptions but rather to a halt in the year-on year increase in underage conceptions.** (For further information about the implications of the Gillick ruling please see section 2.7 of appendix 6).

We find it ironic that – on the one hand, parents are encourage to talk with their children about sex, however on the other hand, the government encourages secrecy by allowing underage children full access to confidential sexual health services, including abortion.

3.8 Marriage has been devalued.

While there had been a commitment to marriage in the original SRE guidance we note that this commitment has been weakened in subsequent publications, such as the Department of Health's "National strategy for sexual health and HIV" (2001), which does not even mention marriage(or abstinence)once.

Analysis of sex educational material seems to show that sex educational material seems to teach that all forms of living together, (whether cohabitation, single parenthood, same-sex "parents" or marriage) are equally valid. However, this contradicts scientific data on the many positive health benefits of marriage which are present both for the individual level as well as for society as a whole. Conversely, marriage breakdown has many adverse effects – including an increased risk of teenage pregnancy in girls from broken families. (For further information about marriage see appendix 7) Recent analysis of Dutch data shows that **the lower teenage pregnancy rate in Holland has probably more to do with social factors such as much less family breakdown, less single parent families and less childhood poverty than with sex education.** (For some more information on the Dutch approach please see appendix 8)

3.9 Abstinence has not been seriously considered.

We deplore that, unlike in the original SRE guidance, sexual abstinence as a positive choice does not appear to be taught or given priority to the extent this would be desirable. The above mentioned "National Strategy for sexual health and HIV" fails to mention abstinence even as an option. Many underage girls later regret having sex early. There is a greater vulnerability of younger girls for STIs and this makes a powerful case for delaying sexual activity, ideally until marriage. A recent review finds that "abstinence plus" sex education shows a positive impact on risk behaviour regarding the risk of contracting HIV. The studies analysed presented abstinence as the most effective choice in HIV prevention, however also mentioned condom use. The average age of participants in the programmes was 14 years (range 11 to 19 years). This age group is much older than what has been suggested here, i.e. to start compulsory sex education in primary schools already. (For further information about abstinence please see appendix 9, for some data on the lack of effectiveness of current sex education programmes please see appendix 11)

3.10 Risky and irresponsible sexual behaviour has been encouraged.

What has been driving the relentless rise in STIs over the past decades has been a dramatic increase in risky sexual behaviour, such as sexual promiscuity, overlapping sexual relationships with several partners, anal sex, and homosexual sexual activity and others. The latter is associated with a significantly increased risk of acquisition of STIs, but it is politically very incorrect to say so. (For some evidence on the health risks of homosexual sexual activity please see appendix 10). "Risky" sexual behaviour is not just "not using a condom". In our view "risky" sexual behaviour is any sexual behaviour that puts the person at risk of acquiring a sexually transmitted infection. Not surprisingly, the answer to a problem driven by risky sexual behaviour is the modification of this behaviour with special emphasis on faithfulness or abstinence. However, for reasons not clear to us, it is considered not acceptable to point this out to the individuals concerned and the nation as a whole as this is deemed to be "moralising".

3.11 A comparison with Anti-smoking campaigns is significant.

Let us contrast this with the –generally accepted – and successful public health approach to smoking aimed at behaviour modification. It has been well established that smoking is associated with a great many diseases. Doctors are strongly encouraged to establish smoking status and to offer smoking cessation advice. Indeed, the new GP contract gives strong financial incentives for this. Cigarette packs contain strongly worded health warnings, and recently, pubs and restaurants have become smoke-free. Recent data on smoking are encouraging as fewer people smoke, fewer young people start smoking and more smokers quit. A recent 2-year anti-smoking campaign appears to have contributed to 1 million smokers quitting smoking. However, no-one says that these successes are "moralising" and therefore unacceptable, even though they aim to modify personal behaviour which could be considered a personal choice.

Let us contrast the success of anti-smoking campaigns with the current approach to sexual health. There is a clearly established link between sexual promiscuity/risky sexual behaviour and the risk of acquiring one or several STIs, similarly to the clearly established link between smoking and lung cancer. National campaigns to try to stop a risky activity – smoking - are being launched, however no national campaign to stop another risky activity - sexual promiscuity – is being started. The reasons for this discrepancy are not clear to us. (We accept that there have been some programmes, but their main focus on using condoms is misguided for reasons explained earlier.)

3.12 Inadequate attention has been devoted to behaviour modification.

There are successful campaigns that have shown that behaviour modification with focus on reducing promiscuity, increasing faithfulness and emphasising abstinence can lead to a dramatic reduction in STIs. One of the more remarkable examples of this has been Uganda, where a national campaign (often described as "ABC" – abstain, be faithful or – if neither is possible – use a condom) has led to a 70% reduction in the incidence of HIV during the 1990s. It appears that the most significant factor in the dramatic reduction of HIV in Uganda was factor "B" – "be faithful". Condom use played only a minor role in the Ugandan success. This contrasts with a more than 100% increase of many STIs in the UK over the same period of time. (For more information about behavioural modification and the example of Uganda please see appendix 10)

3.13 There is very little evidence to in any way support the effectiveness of plans to extend sex education, to make it compulsory or to extend it to primary schools.

In view of the widespread concerns about the explicit and graphic nature of current sex education material coupled with the lack of evidence to support this approach, we are gravely concerned that the Government seems to be intent on introducing statutory sex education into schools and compulsory sex education into primary schools. (For some evidence on the lack of effectiveness of the current approach to sex education and some examples on explicit and graphic sex education used in schools please see appendix 11)

4. Conclusions

4.1 The currently adopted approach to sexual health is at best a failure or at worst a major contributing factor to the nation's poor sexual health.

4.2 Despite the obvious failures of the currently adopted approach the Government's strategy seems to be based on "more of the same", i.e "value-free" sex- education, confidential access to contraception, disproportionate faith in condoms and rejection of the importance of marriage and faithfulness. Scientific evidence including epidemiological data on sexually transmitted diseases and teenage conceptions does not support that this approach is effective.

4.3 A new approach is needed based on

a) Challenging the ideological basis of the current approach to sexual health.

b) Encouraging behavioural modification, bearing in mind the lessons leant by the successful examples of Uganda's fight against HIV or anti-smoking campaigns.

c) Promoting sexual abstinence, ideally until marriage.

d) Teaching marriage as the ideal basis for family.

Appendix 1
Recent data on the sexual health of the nation with reference to the sexual health of young people.

While the Government claims some modest successes in reducing teenage pregnancy rates, the overall picture of the sexual health of young people is quite bleak and essentially deteriorating. The figures of sexually transmitted infections (STIs) are – in our view – a better marker of overall sexual health than teenage pregnancy data. STI data reflect more widely on the sexual health of the nation, including men and women, older and younger people etc, whereas teenage pregnancy rates only describe one variable of the sexual health (pregnancies) of a subgroup of the population (underage girls).

Over the past decades, there have been dramatic increases of most sexually transmitted infections (STIs) with some STIs – such as chlamydia – more than doubling over the past decade. New HIV diagnoses have also more than doubled among the general population and trebled among young people. The most dramatic increases have been observed in the new diagnoses of Syphilis, where there has been a more than 1,800% increase in Syphilis among the general population and a more than 6,000% increase among homosexual men.

1.1 Data on sexually transmitted diseases

There has been a dramatic deterioration of the nation's sexual health over the past decade as the following table shows:

	Percent increase from 1998 to 2007 (UK data)
Syphilis, primary and secondary – total males	2,561%
Syphilis, primary and secondary – homosexual males	6,261%
Syphilis, primary and secondary – total females	482%
Syphilis, primary and secondary – TOTAL	1828%
Gonorrhoea – total males	45%
Gonorrhoea – total homosexual males	115%
Gonorrhoea – total females	35%
Gonorrhoea – TOTAL	42%
Chlamydia – total males	189%
Chlamydia – homosexual males	632%
Chlamydia – total females	121%
Chlamydia – TOTAL	150%
All new STI diagnoses – total males	61%
All new STI diagnoses – homosexual males	115%
All new STI diagnoses – total females	66%
All new STI diagnoses – TOTAL	63%

("homosexual males" means acquired through male homosexual activity;
source: Selected STI diagnoses made at GUM clinics in the UK: 1998 – 2007; Health Protection Agency)

1.2 Sexual health of young people especially poor.

Young people (aged 16-24 years old) are the age group most at risk of being diagnosed with a sexually transmitted infection, accounting for 65% of all chlamydia, 50% of genital warts and 50% of gonorrhoea infections diagnosed in genitourinary medicine clinics across the UK in 2007.

The most common sexually transmitted infection in young people is **genital chlamydia**. The National Chlamydia Screening Programme in England is performed in under 25 year olds in 2007 and found that 9.5% of screens of women and 8.4% of men were positive for chlamydia. A further 79,557 diagnoses of genital chlamydia infection were

made among young people in genitourinary medicine clinics in the UK in 2007, (a rate of 1,102 per 100,000 16-24 year olds), a rise of 7% on 2006.
Genital warts were the second most commonly diagnosed sexually transmitted infection among young people in genitourinary medicine clinics, with 49,250 cases diagnosed in 2007 (682 per 100,000), a 8% rise on 2006.
Since 1998, diagnosis rates of almost all STIs among young people attending genitourinary medicine clinics have risen in the UK. The **rate of chlamydia diagnoses has more than doubled**, from 447 per 100,000 in 1998 to 1,102 per 100,000 in 2007. Although rates of **gonorrhoea** have declined in recent years from the peak in 2002 (186 per 100,000), to 130 per 100,000 in 2007, rates are still **a third higher than in 1998** (96 per 100,000).
In 2007, there were 702 new diagnoses **of HIV** among young people (10 per 100,000), which is still nearly **three times the number reported in 1998** (258).
For infections such as chlamydia, genital herpes and HIV, these rates are an underestimate as asymptomatic infections can remain undiagnosed.
Young people are the group most at risk of being diagnosed with a sexually transmitted infection (other than HIV). Young people represent only 12% of the population, but account for nearly half of all STIs diagnosed in genitourinary medicine clinics across the UK in 2007.
Homosexual men. There have been worrying increases in the number of younger men diagnosed with STIs in the past decade, with more than a **doubling of diagnoses of HIV** (from 128 in 1998 to 281 in 2007) and a **threefold increase of gonorrhoea** (339 to 1001) – increases similar to that observed in older men who have sex with men.
(source: Sexually Transmitted Infections and Young People in the United Kingdom: 2008 Report. Health Protection Agency. July 2008.)

1.3 Teenage pregnancy data
In June 1999, the Social Exclusion Unit (SEU) launched the national Teenage Pregnancy Strategy with the aim of reducing the number of teenage conceptions. Having children at an early age can damage young women's health and well-being and limit their education, career and economic prospects. Although young people can be competent and loving parents, children born to teenage parents are much more likely to experience a range of negative outcomes in childhood and later life than children born to older parents.
The Teenage Pregnancy Strategy set out two targets: to reduce the under-18 conception rate by 50%, and to increase the proportion of teenage mothers in education, employment or training to 60%, both by 2010.
The national strategy has had some modest "success" – both the under-18 and under-16 conception rates have fallen around 13% since the 1998 baseline, however it is very clear that the Government will not achieve the target of a 50% reduction of the under-18 conception rate by 2010 set by the Teenage Pregnancy Strategy.
In our city - Manchester – the data have been quite poor. Manchester has the third highest under-18 conception rate in England. The under-18 conception rate has risen since the 1998 baseline. The rate increased from 61.3 per 1000 (540 conceptions) in 1998 to 71.9 per 1000 (591 conceptions) in 2005, an increase of 17.3%. Taking provisional figures from 2006 into account, the under-18 conception rate for Manchester has still increased by 9.3% since the 1998 baseline, from 61.3 per 1000 to 67.0 per 1000 in 2006. (source: Office for National Statistics and Teenage Pregnancy Unit)

1.4 Some data on sexual behaviour.
Recent trends indicate a dramatic increase in risky sexual behaviour, which is in our opinion the key factor driving the epidemic of STIs:

- There has been a more than 50% increase in risky sexual behaviour over the past decade from 1990 to 2000: There have been increases in the number of homosexual and heterosexual partners, an increase in concurrent (i.e. "overlapping" partnerships), increase in oral-genital contact and heterosexual anal sex. 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. (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.)
- While an increase in condom use has been observed over the past 10 years, this was offset by increases in reported partners according to the Natsal 2000 survey.
- 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." according to the Natsal survey.
- There has been a very significant increase in attendances to Genito-urinary medicine (GUM) clinics with the number of attendances at GUM clinics doubling over the last decade (Department of Health. The national strategy for sexual health and HIV. 2001).

Appendix 2
Some information about Marie Stopes, founder of the Family Planning movement and one of the "sexual revolutionaries".

2.1 Marie Stopes (1880–1958, died of breast cancer) was a highly intelligent woman (she took and passed three degrees, in the same year), author, feminist and campaigner for women's rights. She started the family planning movement. The organisation that bears her name, Marie Stopes International, works in 40 countries across the world and is one of the largest providers of family planning and abortion services outside the National Health Service in the UK.

2.2 Married Love – an explicit sex manual

Her book *Married Love*, which was written after a disastrous first marriage was, as one of the first sex manuals using very explicit language, quite controversial and influential. The book sold 2,000 copies within a fortnight and over a million in total *Married Love* was also published in America, but it was promptly banned.

She writes about marriage, *"Far too often, marriage puts an end to woman's intellectual life. Marriage can never reach its full stature until women possess as much intellectual freedom and freedom of opportunity within it as do their partners."* She was, however, cautious about openly expressing her liberal views on sex outside marriage.

2.3 Family planning movement and the "sexual revolution"

Stopes opened the UK's first family planning clinic in North London in 1921. The clinic offered a free service to married women and also gathered data about contraception. The opening of the clinic created a very significant social change of the 20th century, where women could take control over their fertility, thereby separating sex from procreation. Marie Stopes was involved in the formation of the Family Planning Association in 1939. Marie Stopes was at the forefront of the sexual revolution through cultivating the myth of sexual ignorance. People – according to her teaching – were ignorant in sexual matters, hence the need to "educate" about sex, using explicit language. This notion forms the root of the sex education movement and the basis of "value-free" sex education applied in schools today. In our view, this approach is one of the key causes of the poor sexual health especially among UK adolescents, including high teenage pregnancy and abortion rates.

2.4 Marie Stopes, family planning and eugenics

Stopes was also a prominent campaigner for the implementation of policies inspired by eugenics. Britain's first family planning clinic reflected her eugenicist views, encouraging the lower classes to have fewer children. In her *Radiant Motherhood* (1920) she called for the *"sterilization of those totally unfit for parenthood (to) be made an immediate possibility, indeed made compulsory."* Even more controversially, her *The Control of Parenthood* (1920) declared that *"utopia could be reached in my life time, had I the power to issue inviolable edicts ... (I would legislate compulsory sterilization of the insane, feeble-minded) ... revolutionaries ... half-castes."* Stopes even cut her son Harry out of her will for marrying a near-sighted woman named Mary Eyre Wallis. Stopes wrote, *"She has an inherited disease of the eyes, which not only makes her wear hideous glasses so that it is horrid to look at her, but the awful curse will carry on and I have the horror of our line being so contaminated and little children with the misery of glasses ... Mary and Harry are quite callous about both the wrong to their children, the wrong to my family and the eugenic crime."* Following Stopes' death in 1958, a large part of her personal fortune went to the Eugenics Society.

Appendix 3
Dr Alfred Kinsey and the sexual revolution.

Alfred Kinsey (1894 -1956) was appointed assistant professor of zoology at Indiana University in 1920. From the late 1930s, his area of interest increasingly moved towards sexuality research. From 1947 on, he led the institute, which later became the Kinsey Institute at Indiana University.

3.1 The sexual revolution – based on problematic research

It is widely accepted that two of the key publications starting the sexual revolution were Dr Alfred Kinsey's *Sexual Behavior in the Human Male* (1948) and *Sexual Behavior in the Human Female* (1953). The "findings" in these books were dramatic. It was claimed by him that 67-98% of males (depending on socio-economic level) and about 50% of females had sexual intercourse prior to marriage, and that 69% of men have had sex with a prostitute. He claims that 50% of husbands have had extramarital intercourse at least once. He claimed that 11% of married men had engaged in anal intercourse, and 46% of men had both homosexual and heterosexual experiences. He claims that in 37% of males there has been at least one same-sex experience to orgasm and that 10% of males in the sample were predominantly homosexual between the ages of 16 and 55.

In the female report it was claimed that premarital sexual intercourse was beneficial for women. Particularly worrying are his assertions about childhood sexuality. He claims to have found that children are sexual beings, even from infancy and that they could and should have pleasurable and beneficial sexual interaction with adult 'partners' who could lead them into the proper techniques of fulfilling sexual activity.

The findings of Kinsey have been seriously questioned and for example the prevalences found for the above conditions or observations using reliable methodologies are usually far lower. There are grave concerns about his research methodology. Researchers re-examining his original data arrive at lower prevalence rates and serious questions have been raised on his sampling methods. As one example of this, as mentioned above, Kinsey claimed that 10% of the male population were predominantly homosexual. Dr Gebhard, who – after Kinsey – was the second director of the Kinsey Institute used the same data published by Kinsey. Gebhard however estimated the incidence of female homosexuality at 1.5% or less and male homosexuality at 4%. (Gebhard P. Incidence of overt homosexuality in the US and Western Europe. In JM Livingood, ed. National Institute of Mental Health Task Force on Homosexuality: Final report and background papers. Washington DC 1972. pp 22-29.)

One possible reason for the high prevalences for certain sexual behaviours found by Kinsey was that he used a disproportionately high percentage of sex offenders, prisoners and prostitutes for his samples that were supposed to be representative of the population.

3.2 Kinsey's "research" methodology and paedophilia.

Kinsey's research on childhood sexuality is based on fraudulent claims – he states that the information on the orgasmic response of children was gained through nine men. In reality, the data were gathered by only one man. Kinsey claims that some of these men were 'technically trained persons', whatever that means. The only way this data could have been collected was through paedophile activity. This is confirmed in a statement by John Bancroft, who is the director of the Kinsey Institute (on website Kinsey institute http://www.indiana.edu/~kinsey accessed 9.9.02 – emphasis ours):

"The focus of the attacks [on Kinsey] was data presented in Tables 31 through 34 in ***the*** **Male** ***volume, reporting various aspects of orgasm observed in pre-adolescent boys ranging in age from 2 months to 15 years****. Having commented on the extent to which adults had recalled orgasmic experiences from their own childhoods, Kinsey pointed out that such recall might well be vague or inaccurate...*

Whereas he had some information of this kind from parents and teachers simply observing children, ***he obtained more from men who had been sexually involved with young boys and who had in the process observed their orgasms****. Having therefore made it clear that he was referring to adults who had been involved in illegal sexual interactions with children, he went on to say,* ***"nine of our adult male subjects have observed such orgasm. Some of these adults are technically trained persons*** *who have kept diaries or other records which they have put at our disposal; and from them we have secured information on 317 pre-adolescents who were either observed in self-masturbation, or were observed in contacts with other boys or older adults."*

Tables 31-34 are based on these 317 boys; Table 32 gives details of the speed of orgasm (timed with a second hand or stopwatch), whereas Tables 33 and 34 give details about multiple orgasms. Thus, an understandable concern was raised: How could such information be obtained in a sufficiently systematic manner to allow tabulation of the findings? Hence the allegations that either Kinsey or members of the Institute staff made these observations, or that they trained child molesters to make observations for them.

I decided to check on the sources of this information and ***found that, without any doubt, all of the information reported in Tables 31-34 came from the carefully documented records of <u>one</u> man****. From 1917 until the time that Kinsey interviewed him in the mid-1940s, this man had kept notes on a vast array of sexual experiences, involving not only children but adults of both sexes. Kinsey was clearly impressed by the systematic way he kept his records, and regarded them as of considerable scientific interest. Clearly,* ***his description in the book of the source of this data was misleading, in that he implied that it had come from several men rather than one****, although it is likely that information elsewhere in this chapter, on the descriptions of different types of orgasm, was obtained in part from some of these other nine men. I do not know why Kinsey was unclear on this point; it was obviously not to conceal the origin of the information from criminal sexual involvement with children, because that was already quite clear. Maybe it was to conceal the single source, which otherwise might have attracted attention to this one man with possible demands for his identification (demands which have now occurred even though he is long dead). It would be typical of Kinsey to be more concerned about protecting the anonymity of his research subjects (and convincing the reader of the scientific value of the information) than protecting himself from the allegations that eventually followed.*

Kinsey, with his primary interest in variability, was also intrigued by the various ways in which orgasm was experienced. In the Male *volume, he combines evidence provided from the above source on 196 pre-adolescent boys with descriptions obtained from adults or their partners to produce a* ***list of six different types of orgasm. Two of these types involve signs which in other circumstances would be regarded as distress, such as sobbing or crying or hypersensitivity around orgasm which results in "violent attempts to avoid climax****, although they derive pleasure from the situation...[and] quickly return to complete the experience, or have a second experience." As these descriptions were applied to pre-adolescent boys as well as adults, they have been taken by some to indicate that these children were being tortured. It would never have occurred to Kinsey that responses associated with orgasm, whether in a child or an adult would be interpreted in that way, as he clearly saw the orgasm as the culmination of pleasurable stimulation."*

Further reading: Judith Reisman, Edward Eichel. Kinsey, Sex and Fraud. Huntington House, Lafayette. 1990.

Appendix 4 – situational ethics, values clarification and "informed choice"

4.1 Situational ethics and secular humanism.

The modern approach to sex education is essentially based on principles laid down by secular humanism. In ethics, the humanist approach is characterised by the rejection of absolutes, such as right and wrong. Instead, situational ethics is promoted. In sex education this may mean to state: *"you have to make up your own mind …what your standards are going to be… There just aren't any rules, you do whatever strikes your fancy."* (Dr Graham Cole, quoted in Chambers C. The SIECUS circle; A Humanist Revolution. Belmont, Massachusetts. 1977; p 21)

In humanist approach, ethics based on traditional Judeo-Christian values have been replaced by situational ethics.

Furthermore, the humanist principles of sex education encompass seeing man as essentially an animal evolved in keeping with Darwin's theory. Sex education is based on situational ethics, sets the child against the parent and parental authority, aims to alienate children from the moral values of their parents and has a negative outlook on the traditional family. It uses material that many would consider pornographic. Birth control is treated as to prepare youth for world population control.

This means in the area of sex education that adultery, promiscuity, masturbation, pre-marital sex, essentially any sexual "technique", and homosexuality can be seen as "right" under the "right" circumstances (C Chambers, p 37) The "right" to birth control, abortion and divorce is proclaimed. Sex education is also tied to family planning and population limitation and policy.

The rejection of "right" and "wrong" leads to a technique used in sex education called "values clarification" or "informed choice". The following presentation given on this subject explains the significance of this.

4.2 Values clarification and sex education: should either be part of the curriculum?

(this is based on a presentation given by Nick Seaton, Chairman of the Campaign for Real Education, in a Parliamentary Consultation, House of Commons, Westminster 14.06.2004)

Sex education tends to dwell on the techniques and pleasures of sex – why are the consequences usually played down? Haven't we got it all wrong?

Surely, we send children to go to school to learn English, Maths, Science, History, Geography and so on. They do not go to school to learn how to enjoy so-called safe sex. Sex education, as it has developed, should not be a compulsory part of the curriculum.

The Human Rights Act 1998 says that: *'In the exercise of any functions which it assumes in relation to education and to teaching, the State shall respect the right of parents to ensure such education and teaching in conformity with their own religious and philosophical convictions.'*

If parents knew the full details of what is being taught to their children in sex education lessons, there would be a national rebellion.

Wouldn't it be better, if teachers were responsible only for teaching genuine subjects, and parents were encouraged to fulfil their responsibilities, instead of being told that the state will do their job? There should be no objection to a teacher taking aside any youngster they suspect may be in danger, or need advice, but <u>we cannot trust the system as it is</u>. At the very least, instead of opting their child out of sex education, parents should have to opt their child in. But even that, I fear, would be subverted by the establishment.

Let's stop expecting teachers to be pseudo-parents and social workers and turn them back into professional teachers of subjects! What grounds are there for thinking this?

Psychologists tell us that pre-pubescent children go through a **latency period**. In *Towards Maturity* (BHL, 1988), Dr Louise Eickhoff explains that during a child's latency period, anything to do with their torso below the belt, their private parts, is taboo – they don't want to know. This is nature's way of protecting children from harm. Dr Eickhoff also explains that interfering with the latency period interferes with a child's natural development which, in turn, may create a propensity to homosexuality.

School sex education ignores all that.

Then there's the problem of **values clarification**, on which sex education is based. There are two predominant methods of explicitly teaching values: values transference and values clarification.

Values transference is where responsible adults such as parents and teachers transfer their values from one generation to the next – that is the traditional, time-honoured method.
Values clarification is where young people are offered a range of moral options (or moral dilemmas) from which they are taught to make their own 'informed choices'. There are no right or wrong choices – all that matters is that the choice is freely made.
Values clarification claims to be **non-judgmental**, though, of course, non-judgmentalism is itself a value judgement. Values clarification encourages children to react against the values of their elders and find their own moral code. Without any moral guidance, children make choices based on their feelings. Powerful peer pressure, freed from adult control, ensures that absolutes become relative, and 'shared' values (developed in circle-time and other group-work) sink to the lowest common denominator.
Official documents rarely include the term 'values clarification', but it can easily be recognised by the phrase ***'informed choice'***. Everything to do with Sex Education and all Personal, Social and Health Education – and Citizenship – is based on values clarification. Informed choice is officially recommended for children as young as 7 years old.

Here are a few examples to explain these fears:
The popular ***The Primary School Sex and Relationship Education Pack***, written by Julian Cohan and published by Healthwise, states
Under 'What is Sex and Relationship Education?' it says: *'This is to stress that Sex and Relationship Education needs to go beyond provision of biological information and to focus on clarifying attitudes and values…'* It then quotes *Sex and Relationship Guidance, 2000*, published by the Department for Education and Skills: '[SRE] is about the teaching of sex, sexuality and sexual health.'
Then, hoping to bypass Parliament's decision to allow the governors of primary schools to decide whether or not to teach SRE, it is emphasised that: 'The Department recommends that all primary schools should have a sex and relationship education programme…'
Under '***Aims and objectives of SRE'***, the Healthwise Pack says: *"In the past, some people have set aims for SRE such as 'promoting marriage', 'dissuading children from having sex before marriage', 'stopping young people from having sex', 'telling children what is right or wrong'. Such aims are not achievable, inappropriate for schools and are often more to do with propaganda than education."* Later, the document mentions overcoming children's embarrassment. It also claims that 1 in 20 of us are probably homosexual.
All this is in accordance with the National Curriculum and official government guidance.
Indeed, a booklet published by the Qualifications and Curriculum Authority called ***Personal, Social and Health Education and Citizenship:*** *Planning, teaching and assessing the curriculum for pupils with learning difficulties* says 11-year-old pupils should '*make informed, positive decisions about their own relationships', 'experiment with risk-taking through drama and role play', 'discuss masterbation (spelt wrongly) and privacy, using outline drawings.'* Please note, we are talking about 11-year-old children with learning difficulties here.
There are some outline drawings from the Healthwise pack on the screen, which you'll see are 'mainly for Key Stage 2' – that's 7 to 11 year olds. Healthwise also suggests telling 7 to 11 year-olds that sexual intercourse *'can be very enjoyable and exciting'*. The couple *'both have a lovely feeling all over their bodies'*. Afterwards they *'feel good about what they have shared.'* Masturbation, too, can be *'very exciting'*. It's *'a healthy thing for young people to do'*. If you were a youngster, probably from a broken family, without much parental love (and getting free condoms), wouldn't you want to enjoy such experiences as soon as possible, and begrudge anyone who suggested you should delay or abstain?
Some years ago, a Swiss psychologist sent us a paper he had written about death education, which is promoted by supporters of euthanasia. (Death education also appears in our National Curriculum, but not under that name.) Dr Nestor explains the importance of taboos to a person's psychological well-being. Once taboos are destroyed, a de-sensitised child, or adult, is open to anything.
All these explicit images and instructions de-sensitise children (and their teachers) and break down natural taboos. It could be argued that they are pornographic and serious breaches of children's privacy. We have to face it, sex education in schools is controlled by people with a sinister agenda. It seems to me that some sex education is similar to the grooming process used to prepare children to become victims of paedophiles, which is why sex educationists needed to request exemption from prosecution under the Sexual Offences Act. To my mind, most sex education is itself a form of child abuse. It destroys the innocence of childhood. It is anti-family and goes against the principle that teachers should act *in loco parentis*.

Sex educationists must know what they are doing is wrong and that parents wouldn't approve. Some *Health Education Guidelines* from Birmingham LEA (1992) give the game away and I quote: *'Parents' meetings may be held for many reasons. For example: to quell opposition to new and sensitive developments.'* Why, if what they are doing is honest and right, should health educationists need to 'quell' parental opposition?
We now know without any doubt that school sex education in its present form isn't working. It's time to do away with it!

Appendix 5
Condoms, "safe(r) sex" and contraceptive failure.

The currently adopted approach to sexual health places a disproportionately great emphasis on condom use. In our view this almost blind faith in condoms is based more on ideology rather than fact and is quite misguided.

5.1 ***"After repeated failure, the altar of safe sex needs to be dismantled in favour of credible public health policy****."*

The British Medical Journal recently had a "Head to head" debate about whether condoms are the "answer to rising rates of non-HIV Sexually transmitted infections". In our view, Dr Stephen Genuis hit the nail on the head by the following statement:

"Condoms cannot be the definitive answer to sexually transmitted infection because they provide insufficient protection against transmission of many common diseases. "Skin to skin" and "skin to sore" infections such as human papillomavirus, herpes simplex virus, syphilis, lymphomagranuloma venereum, or chancroid often transmit despite barrier protection. Although condoms prevent contact between the skin of the penis and the vaginal mucosa, intercourse generally involves skin to skin contact in the external genital area; the condom gives limited protection against pathogens found throughout the external genital tract. The most common sexually transmitted pathogens, human papillomavirus and herpes simplex virus, are often dispersed on infected genitalia and transmit through skin to skin contact.

The main problem with condoms is that average people, particularly aroused youth, do not use them consistently.

A recent study found that less than 8% of couples discordant for herpes used condoms for each sex act, despite ongoing counselling. Even among stable, adult couples who were HIV discordant and received extensive ongoing counselling about HIV risk and condom use, only 48.4% used condoms consistently. Irregular use of condoms will not provide sustained protection against sexually transmitted infection.

The relentless rise of sexually transmitted infection in the face of unprecedented education about and promotion of condoms is testament to the lack of success of this approach. In numerous large studies, concerted efforts to promote use of condoms has consistently failed to control rates of sexually transmitted infection—even in countries with advanced sex education programmes such as Canada, Sweden, and Switzerland.

In my home province of Alberta, rates of chlamydia and gonorrhoea have tripled since 1998 despite ubiquitous "safer sex" education. The ongoing assertion that condoms are "the" answer to this escalating pandemic reminds me of Einstein's words, "The definition of insanity is doing the same thing over and over again and expecting different results." Political correctness and ideological interests need to be usurped by sound science. After repeated failure, the altar of safe sex needs to be dismantled in favour of credible public health policy." (Head to Head: Stephen J Genuis, Are condoms the answer to rising rates of non-HIV sexually transmitted infection? No; BMJ 2008;336:185)

Even the authors of the BMJ paper that claimed that *"condoms are the answer to rising non-HIV sexually transmitted infections"* had to admit that *"clinical studies have shown inconsistent protective effects for most sexually transmitted infections other than HIV",* even though, according to the authors *"much of this can be attributed to limitations in study design."* The authors conclude their paper with – what in our view – is a strong endorsement of the Ugandan "ABC" message, which places main emphasis on abstinence and partner reduction:

"Like any prevention tool (such as seat belts, airbags, smoking cessation programmes, virginity pledges) condoms are not 100% effective. Preventing sexually transmitted infection, just as with other health conditions, requires incremental, partially effective steps to produce collectively effective (but not perfect) prevention programmes. (…) Accurate messages about condoms must build on a wide range of risk avoidance and risk reduction approaches. These approaches include delayed initiation of sexual intercourse, mutual faithfulness, and selection of low risk partners. Together with condoms, these reinforcing epidemiologic truisms have been labelled both now and in the past as an ABC strategy: abstinence, be faithful to one partner, and use condoms.

Moreover, a full alphabet of prevention strategies is needed for an optimal effect on HIV transmission, as well as other sexually transmitted infections. Condoms have a pivotal role in this larger armamentarium of strategies. What does this mean for clinicians who counsel patients about sexual health? Firstly, people who abstain from intercourse or who are uninfected and mutually monogamous eliminate the risk of infection entirely. Secondly, people who choose to be sexually active can be reassured that condom use reduces the risk of most infections. Thirdly, condoms, like any other prevention tool, work only when used properly— consistent and correct use is essential for optimal risk reduction." (Steiner MJ, Cates W, Are condoms the answer to rising rates of non-HIV sexually transmitted infection? Yes; BMJ 2008;336:184)

5.2 *Condoms reduce, but do not eliminate risk*

When consistently and correctly used, condoms reduce vaginal HIV transmission by up to 95% but for other infections such as HPV the reduction is virtually zero and for many common STIs such as chlamydia reduction is more around 50-60%. This means that an individual who uses condoms in order to protect himself/herself from acquiring a non-HIV STI probably only delays the acquisition of the STI rather than preventing catching an STI in the first place. A dramatic example of this is described in the testimony by Rachel Groom – see below.

(Richters J et al. HIV transmission among gay men. *AIDS* 2003; 17 2269-2271;
Mann JR Stine CC Vessey J The role of disease-specific infectivity and number of disease exposures on long-term effectiveness of the latex condom Sex Trans Dis 2002 29 344-49
Cates W The condom forgiveness factor: the positive spin Sex Trans Dis 2002 29 350-52
Kirby D Making condoms available in schools West J Med 2000 172 149-151
National Institutes of Health Scientific Evidence on Condom Effectiveness for STD Prevention 2000 www.niaid.nih.gov/dmid/stds/condomreport.pdf
Stephenson JM, Imrie J, Sutton SR. Rigorous trials of sexual behaviour interventions in STD/HIV prevention: what can we learn from them? *AIDS* 2000; 14 (supp 3) S115-S124
Hosker H Have we given the wrong message about condoms? British J Sex Med Nov/Dec 1997 p4
Williams ES Contraceptive failure may be a major factor in teenage pregnancy BMJ 1995; 311:80)

5.3 *"Safe(r) sex" and condoms*

- **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. Current UK policy does not promote this definition of 'safe sex' but instead relies on condoms, which are not as 'safe' as has been claimed.
- **There needs to be a re-definition of the meaning of "safe sex". 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. While there is good evidence that "always condom use, i.e. 100% of times" reduced the risk of HIV, gonorrhoea, syphilis and chlamydia transmission, there is insufficient evidence that condoms were effective in reducing transmission of many other STIs including human papilloma virus, which is associated with cervical cancer, genital warts, herpes simplex, and others.
- **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.)

5.4 Contraceptive failure, not failure to access contraceptive services, is a major factor in teenage pregnancies

One of they key principles of the current sexual health strategy is to improve access to contraceptive services. The assumption is that improved access will reduce unwanted pregnancies. Evidence does not support this assumption.

- In a University of Exeter analysis of 147 **teenagers with unplanned pregnancies, 80% stated that they were using some form of contraception, usually condoms and/or the contraceptive pill.** Also, 81% of pregnant teenagers were aware of emergency contraception. This shows that the major factor in unwanted pregnancies is contraceptive failure, not the lack of contraceptive awareness. (Pearson VAH et al. Pregnant teenagers' knowledge and use of emergency contraception. British Medical Journal. 1995; 310: 1644)
- A survey of 2,000 **women who sought an abortion through the British Pregnancy Advisory Service found that 59% had used some form of contraception, which had failed**. Most said, that they had used a condom (38%) but 17% said they had used the pill. It is concluded that *"contraception cannot be relied on to prevent pregnancy in the UK because too many men and women misunderstand the instructions on condom and pill packaging, make mistakes or simply get carried away and forget to use it."* (Boseley S. Contraception fails to prevent pregnancies. The Guardian; 13 October 1999.)
- **The proposed strategy makes the recommendation to increase the use of contraception, including condoms. The assumption here is that the increased use of contraception, including condoms reduces unwanted pregnancies. This is however not the case.** The Director of Public Health medicine for Croydon examined the correlation between condom use at first sexual intercourse and teenage pregnancy. He found a highly significant ($p<0.001$) strongly positive correlation, i.e. unwanted pregnancies rise with increasing use of condoms. (Williams ES. Contraceptive failure may be a major factor in teenage pregnancy. British Medical Journal 1995; 311: 806-7.) 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. One of the major factors in unwanted pregnancies is contraceptive failure, not the lack of contraceptive knowledge and availability.
- A review on the prevention of teenage pregnancy by Exeter University states that *"Since effective contraception does prevent conception, the absence of available contraception is associated with higher than average rates of teenage pregnancy; but* ***expanding current services has neither decreased rates consistently nor improved effective contraceptive use by young teenagers****."* (Mellanby AR. Preventing teenage pregnancy. Archives of Disease in Childhood 1997; 77: 459-62)

5.5 Rachel Groom – Sex Education Testimony

The following is a dramatic testimony how the currently adopted approach focusing on "safe sex" fails our young people. Even though Rachel had only had "safe sex", she eventually contracted cervical cancer and died in 2006, aged only 34.

On the 1st February 2002 I was diagnosed with cervical cancer. This was as a direct result of contracting an STD called the Human Papilloma Virus (HPV). I was 29 years old and only had five sexual relationships all with long term partners. I couldn't understand how I had developed a life threatening disease like cancer from an STD, especially as I have <u>never</u> had casual sex or a casual relationship. As far as I was concerned I had always practiced 'safe sex.'

Once diagnosed, I had to endure copious tests, scans and biopsies to establish whether the cancer had spread, and if so where. Thankfully it hadn't spread from the cervix and I immediately started a course of chemotherapy.
Unfortunately the chemotherapy was ineffective and I was told that the tumour had now become inoperable as it was starting to grow towards my bladder; combination treatment (chemotherapy and radiotherapy) was my only option. My survival rate had now plummeted from 90% to 60%.

Thankfully my wonderful family insisted on a second opinion from a leading gynaecological surgeon at The Royal Marsden Hospital, London. After an examination it was confirmed that the tumour was operable after all. Two weeks later I was in the operating theatre undergoing a 5 ½ hr operation to remove my womb, cervix, fallopian tubes plus the top of my vagina. The surgeon also moved my ovaries away from my pelvic area and position then under my ribs. This was to prevent me going into the menopause if I needed radiotherapy treatment at a later stage. I am now unable to have children and have regular check ups to

ensure the cancer has not returned. Even after two years I am still aware that it can return. All this has been a result of contracting a so called 'common' STD, I had never even heard of. Being angered by my ordeal I took it upon myself to research why I wasn't aware of this virus. It became apparent that not only was there a serious lack of awareness of HPV, Britain also had the highest rate of underage pregnancies in Western Europe with an alarming increase in STD's, abortion and the use of the morning after pill and oral contraception in young teenagers.

Teenagers need to know that unprotected sex, multiple partners, oral contraception, abortion and the morning after pill can have long term physical and psychological consequences. It can increase the risk of both cervical and breast cancer, deep vein thrombosis and depression. Teenagers need to be more aware of their responsibilities, and the whole of society has a role to play. Parents, schools, health professionals, media and government all need to play their part in getting the message across. Current thinking seems to be myopic and not forward thinking. Rather than just giving out condoms and oral contraception, the risks above should be clearly explained. We need to adopt a more overreaching approach to sex education incorporating the consequences of the decisions we make. The current approach to sex education adopted by educationalists, media and contemporaries appears to encourage teenagers to experiment with sex early. Knowing there is a 'get out clause' for any eventuality means that they do not have to take responsibility.

We all need to accept that a 'quick fix' (safe sex!!) never actually works in the long term. The rapid increase in STD's needs to be dealt with now and proves that the 'safe sex' approach appears not to be working. Teenagers need to be aware of just how serious today's situation is. The cervix is most vulnerable to unprotected sex before age of 20 or before the first full term pregnancy. Up to this point teenagers should be encouraged to abstain from sex, reducing the number of underage pregnancies and teenagers contracting STD's. This will produce a healthier generation of adults and prevent unnecessary loss of life and infertility in women, not to mention fewer mental scars and regret!!

I may have been lucky enough to have lived through my ordeal but it has cost me the lives of my children. Let's not let 'lack of awareness', take the lives of any more of our children's children!!

(Testimony given at a Parliamentary consultation on sex education, House of Commons, 15.06.2004)

[Post script: Sadly, Rachel has since died of metastatic cervical cancer]

Appendix 6
Parental notification and abortion - abortion rates and teenage pregnancy rates
The impact of the Gillick ruling on underage conceptions

6.1 Introduction and Summary

6.1.1 In this appendix we would like to focus on the issue of **parental notification for access to abortion for underage girls**. **The question is whether or not parental notification increases or decreases teenage pregnancy with all its adverse health outcomes.** This is in the context of the current teenage pregnancy strategy, which allows confidential (or secretive) access to terminations for underage girls without parental consent or knowledge.

6.1.2 This area is important to consider, as the **current approach towards sexual health** favours this approach: **confidential, free access to sexual health services**, including contraception and abortion as this is considered to reduce teenage pregnancies. However the available evidence shows that – far from achieving its stated objective, **this approach is likely to make matters, worse, ie increase teenage pregnancies.** The reasons for this – for some surprising – statement are explained further below.

6.1.3 **Teenage pregnancy has been associated with a number of adverse health outcomes.** For the child this includes increased risks of premature birth, low birth weight, an increased perinatal mortality, increased risk of sudden infant death syndrome and hospitalisation due to accidental injuries, an increased risk of experiencing abuse, poor housing, poor nutrition and later risk of school drop-out with subsequent risk of living in poverty. For the mother, adverse health outcomes include hypertension, anaemia, placental abruption, premature birth, depression, poor nutrition, poor housing, poverty and increased reliance on state welfare.[1]

6.1.4 In an effort to reduce teenage pregnancies – it is widely known that the UK has the highest teenage pregnancy rate in Western Europe – the Department of Health issued a revised guidance[2] essentially requiring doctors in almost all circumstances to refer under-16-year-olds for abortions without parental consent, if certain criteria are met.

6.1.5 Some would consider parental notification as a moderate restriction in access to abortion. This submission tries to answer the question: **What is the evidence on the impact of a moderate limitation in access to abortion because of parental notification on:**
a) access to abortion/abortion rates and
b) on teenage pregnancy?

6.1.6 The Department of Health seems convinced that easy access to abortion – in this context without parental involvement – can reduce teenage pregnancies. However, very recent scientific evidence does not support this assumption. Evidence from across the world and especially from the analysis of parental involvement laws in the US shows very clearly that parental **involvement laws do *not* increase teenage pregnancies. Indeed, the introduction of parental notification *reduces* teenage abortion rates by 10-20%, while teenage pregnancy rates remains *unchanged or even decrease slightly* as a result of introducing parental involvement requirements.**

6.1.7 This is in keeping with the UK experience at the **time of the Gillick ruling, which in 1985 restricted access to family planning services for under-16-year-olds in England (obviously a far greater restriction than just parental involvement). In 1985 and 1986, there was a halt in the year-on-year increase in underage pregnancies**, but not in pregnancy rates for over-16-year-olds, who were not affected by this ruling and

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[1] Preventing and reducing the adverse effects of unintended teenage pregnancies. Effective Health Care. February 1997. University of York.

[2] Press release and guidance on http://www.ffprhc.org.uk/admin/uploads/under16s.pdf; issued 30. July 2004. This guidance has been – unsuccessfully – challenged in the High Court by Sue Axon, a mother of five, in January 2006.

therefore could still attend family planning clinics. Scotland, which was not affected by this ruling, had an increase in pregnancy rates both in under and over-16-year-olds during this time.

6.1.8 **In view of these findings, there needs to be a reassessment of the UK policy of essentially unrestricted access for underage girls for abortions. The current policy aimed at reducing teenage pregnancies has clearly failed, and is not evidence-based.**

6.2 Parental involvement in abortion decisions for underage girls. What is the situation in other countries and the international evidence?

6.2.1 A recent analysis of relevant studies on this issue is found in LEVINE, P, *Sex and consequences. Abortion, public policy and the economics of fertility. Princeton University Press 2004.* (It is important to point out that one of the commendations for this book comes from the chair of the International Planned Parenthood Council, Alexander Sanger. This publication therefore cannot be dismissed as "pro-life")

6.2.2 The main approach used by Prof Levine, an economist, is that **availability of abortion may be viewed in some ways a form of insurance**. If an individual has car insurance and his or her car is stolen or has an accident, the insurance will help pay for it to be replaced or repaired. However, **if the insurance provides complete protection, it may bring about** behavioural **changes for those who purchase it in that it may lead to riskier behaviour**. Similarly, widespread and easy availability of abortion will have the opposite effect of what is intended: rather than decreasing teenage pregnancies it may actually have no effect or even increase teenage pregnancies due to increased risk-taking: If 'things go wrong' and abortion is easily available, one can always have an abortion. He writes:

*'…**The availability of abortion shares some of the features of a standard economic treatment of insurance.** The primary feature of **abortion is that it provides protection from downside risk** in the form of giving birth to a child that is unintended... If this form of insurance is available at very low cost, **it may lead to changes in behaviour that increase the likelihood of it being needed.**'* [In other words, it may increase sexual activity.] (Levine, ibid., p. 3)

6.2.3 **Abortion availability can be considered as a form or insurance against an unwanted birth**: *'When an abortion is very costly, a woman will choose to have an unwanted birth rather than* have *an abortion if she becomes pregnant. If its cost falls, the greater access [to abortion] will enable women to abort that pregnancy, protecting them from the downside risk of having a child that they do not want. But if its cost continues to fall further so that abortion is available at relatively little cost (in all dimensions – not just monetarily) then the primary impact will be on the likelihood of pregnancy. Couples will take fewer steps to avoid a pregnancy since these activities are costly as well, any may become more costly than an abortion.'* (ibid., p. 186)

6.2.4 This theoretical framework (abortion essentially being an "insurance") provides specific predictions of behavioural changes that would result in response to changes in abortion policy. If a very restrictive abortion policy is in place, relatively few women may choose to have an abortion. If abortion policies were made less restrictive, women may choose to abort a pregnancy rather than give birth to an unwanted child. **As abortion becomes more readily available, couples may choose, essentially, to use abortion instead of contraception, leading to an increase in pregnancy rates.** International data supports these assumptions.

6.3 Parental involvement laws in the US

6.3.1 **Background**

Parental involvement laws can either require minors, typically under the age of 18, to obtain consent from their parent or guardian before an abortion can be performed, or they can require minors simply to notify their parent or guardian of their intention to have an abortion. At present, the majority of US states (33) have parental involvement laws in place, with these laws becoming more common over time (ibid. p17-18).

6.3.2. It is interesting to point out that in the US, unlike the UK, **over the past decades the teenage pregnancies have fallen significantly as the number of states enacting parental involvement laws has increased**, as the following table shows:

US Teen birth rate (Birth per 1000 females aged between 15 and 19)[3]

	1960	1970	1980	1990	2000	2005
Teenage birth rate per 1000 girls aged 15-19	89.1	68.3	53.0	51.9	47.7	40.4

Obviously, the enactment of parental involvement laws is only one of several factors affecting teenage pregnancies, and association is not causation.

6.3.3 US **court rulings**

There have been a number of US court rulings in this area including two US Supreme Court rulings on this issue. Both held that parental involvement with judicial bypass is constitutional: (*Ohio v Akron Centre for Reproductive Health 1990; Hodgson v. Minnesota 1990)*

6.4 Data on the impact of parental involvement laws in the US

6.4.1. Overall, there is evidence that **parental involvement laws reduce abortion rates of minors by 10-20%. There is no evidence of a concomitant increase in the rate of underage births, and teenage pregnancies either were unchanged (according to the majority of studies), or even declined.** (Levine, ibid. p. 120)

6.4.2. Levine summarises the available studies on this subject and finds that all studies investigating the impact of parental involvement laws come to the above mentioned conclusion (ibid p. 116ff):

6.4.3. *Rogers et al 1991* – Minnesota parental involvement laws led to reduction in underage abortion but there was no impact on birth rates.[4]
Ohsfeld and Gohman 1994 – examined state level data for 1984, 1985 and 1988. As a result of parental involvement laws, both abortion rates and pregnancy rates of 15 to 17-year-olds fell in relation to those of older women in response to parental involvement law.
Joyce and Kaestner 1996 – investigated the effects of parental involvement laws in Tennessee and South Carolina and found no effect of policy on abortion or births.
Matthews et al 1997 – investigated the impact of Medicaid funding restrictions and parental consent laws in 1978-88. These changes either reduced both abortion rate and birth rate or had no significant effect on either.
Ellertson 1997 – investigated the effect of parental involvement laws in three states compared with non-minors. Found that in-state abortion rates for minors fell, but that this may be attributable to increased travel out of state. No evidence of change in birth rate.[5]
Levine 2003 – used state-level data from 1985-96. Parental involvement laws reduced the likelihood of abortion for teens but not for older women, and had no effect on birth rates. Reduction in pregnancies resulted from increased use of contraception.

6.4.4. Using Medicaid restrictions as the policy mechanism of interest, Levine et al[6] find that **states restricting Medicaid funding for abortion during the years 1977-1988 witnessed a decrease in their pregnancy rates on the order of 7.7 percent**. This too implies that **increasing abortion access increases the incidence of unprotected sex**. Interestingly, Levine et al find that **this effect seems to be driven mostly by**

[3] Child trend fact sheets - June 2007; on www.childtrends.org.
[4] Rogers JL, Boruch RF, Stoms GB, DeMoya D. Impact of the Minnesota Parental Notification Law on abortion and birth. Am J Public Health. 1991 Mar;81(3):294-8.
[5] Ellertson C. Mandatory parental involvement in minors' abortions: effects of the laws in Minnesota, Missouri, and Indiana. Am J Public Health. 1997 Aug;87(8):1367-74.
[6] Phillip B. Levine, Amy B. Trainor, and David J. Zimmerman (1996), The Effect of Medicaid Abortion Funding Restrictions on Abortions, Pregnancies, and Births. Journal of Health Economics, 15: 555-578.

behaviour among those in the 15-24 age range, implying that the behaviour of young people is the most sensitive to changes in abortion access.

6.4.5. **The overall impact of Medicaid funding restrictions for abortion was obviously a more drastic** measure than 'just' parental involvement. This leads to an overall 3-5% reduction in abortion rate but there is no evidence of increase in birth rates, and some studies found that birth rates actually declined (ibid. p 115ff). This further supports the hypothesis that abortion acts as an 'insurance' for when things 'go wrong' and that therefore, to reduce the access to abortion seems to have a somewhat beneficial effect on sexual behaviour, with less risk-taking.

6.4.6. An overview over the published evidence is given by Paton. [7] This shows that **essentially all studies, especially those of higher quality, revealed that as a result of parental notification requirements, teen abortion rates fall and teenage pregnancy rates either stay unchanged or fall**. (See table.)

6.5 Studies Evaluating the Impact of Parental Involvement for Abortion Services

Note: "-ve" implies that parental involvement led to a reduction in rates.

Study	Context	Impact on teen abortion rates	Impact on teen birth rates	Impact on teen pregnancy rates
	Stronger evidence			
Haas-Wilson (1996)	Impact of laws on abortion rates amongst minors across States & over time.	-ve & significant	n/a	n/a
Kane & Staiger (1996)	Impact of laws on teenage birth rates across States & over time.	n/a	either no impact or –ve	n/a
Levine (2000; 2003; 2004)	Impact of laws on teenage abortion & birth rates across States & over time.	-ve & significant	-ve but insignificant	-ve & significant
Cartoof & Klerman (1986)	Impact of Massachussets law on abortions rates amongst teenagers.	no impact	n/a	n/a
Rogers et al (1995)	Impact of Minnesota law on abortion & birth rates to minors.	-ve & significant	no impact	-ve & significant
Henshaw (1995)	Impact of Mississippi law on abortion rates to minors.	-ve but insignificant	n/a	n/a
Ellertson (1997)	Impact of laws in three States on birth & abortion rates to minors relative to older teenagers.	-ve or no change	no impact, -ve impact for some specifications	n/a
Joyce & Kaestner (1996)	Impact of laws in two States on abortion & birth rates relative to older teenagers.	-ve & significant	+ve & significant	
Joyce & Kaestner (2001)	Impact of laws in two States on abortion rates.	no significant effect	n/a	n/a
Ohsfeldt & Gohmann (1994)	Impact of laws on abortion & pregnancy rates amongst minors across States & over time	-ve & significant	-ve & significant	-ve & significant

[7] Paton D. Parental Consent and Teenage Pregnancy, February 2005

Altman-Palm & Tremblay (1998)	Effect of laws across States & over time on abortion & pregnancy rates amongst 15-17 year olds.	-ve & significant	-ve & significant	-ve & significant
Gennetian (1999)	Impact of laws on unwanted births across States & over time measured by 'supply' of children for adoption	n/a	-ve & significant	n/a
Wolfe et al (2001)	Impact of laws on probability of births across States over time.	n/a	-ve but insignificant	n/a
	Weaker evidence			
Bitler & Zavodny (2001)	Impact of laws on abortion rates for all women across States & over time.	-ve & significant	n/a	n/a
New (2004)	Impact of laws on abortion rates for all women across States & over time.	-ve but insignificant	n/a	n/a
Matthews et al (1997)	Impact of laws on abortion rates for all women across States & over time.	-ve & significant; -ve but insignificant in some	-ve & significant, +ve but insignificant in some	n/a
Blank et al (1996; 1994)	Impact laws on abortion rates for all women across States & over time.	-ve or no change	n/a	n/a
Tomal (1999)	Cross-section impact laws on abortion & pregnancy rates amongst adolescents.	-ve & significant	+ve & significant	n/a (table cont'd)

6.6 International data on parental involvement

6.6.1. As the UK has the highest teenage pregnancy rate in western Europe, it might be worth while analysing the international situation regarding provision of abortion services for underage girls. An analysis of international regulations regarding parental notification shows the following:

Western Europe	**Parental involvement**	**Remarks**	**Teenage Birth rate per 1000 women aged 15-19**[8]
Austria	No		12
Belgium	No		8
Denmark	Yes		7
Finland	No		7
France	Yes		9
Germany	No		11
Greece	Yes		10
Ireland	No	Abortion legal only to save mother's life	16
Italy	Yes		6
Netherlands	Yes		4

[8] Age Specific Fertility Rate (15-19 years) 2000-2005; http://www.childinfo.org/eddb/fertility/dbadol.htm

Norway	Yes		10
Portugal	n/a	Abortion very limited (rape, maternal health, foetal deformities)	17
Spain	n/a	Abortion very limited (rape, maternal health, foetal deformities)	6
Sweden	No		5
Switzerland	n/a	Abortion very limited (woman's life threatened)	5
UK	No		24
Eastern Europe			
Albania	No		16
Bulgaria	No		41
Czech Republic	Yes		17
Hungary	Yes		21
Poland	Yes	Abortion very limited (rape, maternal health, foetal deformities)	16
Romania	No		37
Slovak Republic	Yes		24
Other countries			
Canada	No		19
Japan	No		4

6.6.2. The above table shows that there is a wide variety of scenarios: some Western European countries with a low teenage pregnancy rate – such as the Netherlands, Demark, France, Greece and Italy – require parental consent, whereas some other Western European countries with a low teenage pregnancy rate do not require parental consent, such as Belgium, Finland, Germany and Sweden. It might be worth while to comment specifically on two countries in this table: Germany and the Netherlands, countries that have fairly low teenage pregnancy rates and abortion rates.

6.6.3. **Germany** has one of the lowest birth and abortion rates in Europe. Birth rates for 15 to 19-year-olds in Germany are 11/1000 girls (compared to 24/1000 in the UK)[9], with one of the lowest abortion rates, both for adults and, especially, for teenagers in Europe. Before an abortion takes place, there is mandatory counselling which is geared towards preserving the life of the foetus. There is also a mandatory waiting period before the abortion can take place. Health insurance may not cover the complete costs of abortion, leaving the woman to pay a proportion of the cost of the procedure. This is in effect a restriction on abortion access.

6.6.4. In the **Netherlands,** which has the lowest teenage pregnancy rate in Europe (birth rate of 4/1000 girls aged 15-19; UK: 24/1000) there is parental involvement before abortion can take place. The Netherlands has often been held up as an example on how to achieve good sexual health among adolescents.

6.6.5. Summarising the international evidence, based mainly on the Eastern European experience but also on that of Western Europe and Canada, it becomes clear that to change from a liberal to a severely restricted abortion environment – for example as in Poland where abortion access was significantly restricted from 1993 onwards to cases of rape, foetal defects or to save the mother's life – leads to an increase in births, presumably due to an increase in unwanted births.

[9] ibid. http://www.childinfo.org/eddb/fertility/dbadol.htm

6.6.6. More moderate restrictions do not appear to increase birth rates: ***'Moderate restrictions on abortion within a legal abortion environment reduce pregnancies'.*** (Levine, ibid. 156f) I would argue that parental notification is such a 'moderate restriction' within a legal environment. The international evidence therefore is that this leads either to no change or a reduction in teenage pregnancies.

6.7 The "Gillick experiment"

6.7.1. **UK data during the time of the 'Gillick ruling' shows that restricting access to contraceptive services for under age girls did not lead to increased teenage pregnancies**. The Department of Health guidance aims to reduce barriers for underage girls to access contraceptive services. The assumption is that increased access to family planning (or other sexual health) clinics will reduce unwanted pregnancies. There is overall very little evidence showing that access to family planning clinics reduces teenage pregnancy rates. There is, however, evidence from the UK to suggest that the opposite effect, i.e. an increase in unwanted pregnancies may occur with increased access to family planning clinics.

6.7.2. A relevant "social experiment" has been 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 for underage girls 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 to 19-year-olds increased by 3.3% and 1.3% respectively. [10]

6.7.3. In conclusion, the **1985 Gillick ruling, which restricted access for under 16 year olds to family planning services in England and Wales, was associated with a halt in the year-on-year increase in underage pregnancies for two years. This contrasts with Scotland, where under 16-year-olds could attend family planning clinics. The underage pregnancy rate increased at the same time in Scotland.** (Paton D. ibid.)

6.7.4. Historically, a **1% increase in family planning attendances** is associated with a **short-term increase of 0.1% in** the **rate of underage conceptions**. In the **long term**, the estimated **impact is about twice this value**. David Paton concludes: *"… I am unable to find any evidence that provision of family planning has reduced conception or abortion rates. Indeed, there is some evidence that family planning provision has been associated with an increase in conception rates for under-sixteens in the UK."* (Paton D. ibid.)

[10] Paton D. The economics of family planning and underage conceptions. Journal of Health Economics 2002. 21: 27-45.

6.8 Conclusions

6.8.1 **The UK has the highest teenage pregnancy rate in Western Europe, six times the rate of the Netherlands, nearly five times the rate of Sweden, four times the rate of Spain or Italy and twice the rate of Germany. Despite a number of initiatives, the UK teenage pregnancy rate has remained essentially unchanged over the past three decades.**

6.8.2 **Teenage pregnancies are associated with a number of serious adverse health effects both on the child and the mother. There is an urgent need to reduce teenage pregnancies.**

6.8.3 **One strand of the UK teenage pregnancy strategy consists of confidential access to abortion for underage girls, presumably with the intent of reducing underage pregnancies.**

6.8.4. **There is no evidence-base for this policy. Indeed, the best available evidence shows that parental notification in underage conceptions reduces underage abortions by 10-20%, while teenage pregnancy rates either are reduced by a few percent or – at worst – remain unchanged.**

6.8.5 The current teenage pregnancy strategy is not evidence-based and needs a significant change in view of scientific evidence.

6.8.6 There is strong evidence to recommend parental consent for underage abortions.

Appendix 7
The positive contribution of marriage to public health and the adverse effects of marriage breakdown

The currently adopted approach to sex education considers marriage to be only one of many equally valid family arrangements.

For example, the Healthwise Primary School Sex Education pack suggests the following activity: As part of SRE, different family constellations should be discussed as being equally valid and acceptable. In this sex education pack intended for primary schools, beginning with key stage one, the teacher is encouraged to discuss different family arrangements, for example married or unmarried parents, single parents, lesbian, gay and bisexual parents, grandparents etc. Teachers are instructed that *'it is important not to try to 'promote' a particular type of home life as the norm or superior'* (Julian Cohen. Primary School Sex and Relationships Education Pack, Healthwise 2001; p. 22)

Similarly, the Staffordshire guidance on SRE states:

"In the past some people have set aims for SRE such as 'promoting marriage', 'dissuading young people from having sex before marriage', 'stopping young people from having sex', 'telling young people what is right or wrong' etc. Such aims are not achievable, inappropriate for schools and are often more to do with propaganda than education. "

However, there is a wealth of evidence linking marriage to many positive health outcomes, both for the individual and for society as a whole. Conversely, marriage breakdown is associated with a huge number of adverse outcomes, including increased risk of teenage pregnancy for the children experiencing family breakdown. It is therefore important that sex and relationship education takes this into account.

7.1 Marriage : Its positive contribution to public health

7.1.1 Health benefits of marriage

There is evidence of married people's better physical health, longevity (length of life), psychological health, and happiness. Married individuals fare better than the never married, who in turn generally fare better than the divorced, separated and widowed. The divorced/separated/widowed seem to be at particularly high risk of mortality. Those who were never married face somewhat lower risks of death in any given period, and the married have the lowest risk of all the groups.

Marriage may be protective for several reasons. First, it may reduce stress and stress-related illness (perhaps as a result of greater social integration). Second, marriage may encourage healthy types of behaviour, and discourage risky or unhealthy ones (drinking, substance abuse, etc). A spouse also makes it more likely that the individual receives adequate care in times of illness. Finally, marriage may increase material well-being, not only by increasing family income, but also as a result of economies of scale from pooling resources and the specialisation of household tasks.

7.1.2 Marriage reduces mortality. The excess mortality of men who are not married is similar to the excess mortality by smoking.

That mortality rates are lower for married individuals has long been known. An international analysis shows that the relationship holds in 16 developed countries. (Hu, Y., Mortality differentials by marital status. 1990; Demography 27, 233-250.) Analysing data from the British Household Panel Survey, which is a nationally representative sample of more than 5,000 British households, containing over 10,000 adults, Gardner and Oswald find that marriage is found to be associated with substantially lower rates of mortality, for both men and women. After controlling for health status, a married male is predicted to be -6.1 percent less likely to die over the period 1993 to 2000. The excess mortality of the unmarried is here similar to that of a smoker (5.8 percent). For women, being a smoker increases the risk of death by 5.1 percent, while being married reduces the risk of mortality by -2.9 percent.

The paper concludes that marriage has a much more important effect on longevity than income does. For men, the effect is positive and substantial. It almost exactly offsets the large (negative) consequences of smoking. For women, the effect is approximately half the size of the smoking effect. (J. Gardner, A. Oswald, Department of Economics, Warwick University: Is it Money or Marriage that Keeps People Alive? August 2002.)

7.1.3 Health benefits of marriage appear to be limited to marriage. Cohabitation does not confer the same degree of benefit than marriage.

Formal marriage itself seems to matter. In the few studies that compare marriage and cohabitation, the results tend to show a beneficial effect from being married.

There are a number of differences between marriages and non-married partnerships. The level of commitment may be different. Cohabiters seem more likely to have lower quality and unstable relationships, and are more likely to have lower socio-economic status (Brown SL "The Effect of Union Type on Psychological Wellbeing: Depression Cohabitants Versus Marrieds" Journal of Health and Social Behaviour. 2000; p.241-255).

Cohabiters are shown to be the group with the highest alcohol abuse. Compared to married people, cohabiters reported 25% more alcohol problems, which was in turn insignificantly different from the figure for the unmarried. This was especially strong for males. Cohabiting men had significantly the highest levels of alcohol problems.

Cohabiting provided no benefits in terms of depression or alcohol abuse, which suggests that the benefits from marriage do not originate solely from having someone with whom to live. (Chris M. Wilson and Andrew J. Oswald: How Does Marriage Affect Physical and Psychological Health? A Survey of the Longitudinal Evidence. January 2002)

7.1.4 Mental health benefits from marriage. Marriage is associated with greater happiness, less depression, less alcohol abuse and less smoking.

An US study and found marriage to be the best predictor of happiness after controlling for education, age, gender and race. (Gove WR et al "Does Marriage Have Positive Effects on the Psychological Wellbeing of the Individual" Journal of Health and Social Behaviour 1983; 122-131)

A more recent study considered 17 developed nations. Controls for gender, age, health, financial situation, children, education, religion, national marriage and divorce rates, GDP, and income distribution measures are included. They found financial situation to be the best predictor of happiness, followed by health, followed by marital status. The married turn out to be happier than those who cohabit, who are themselves happier than single individuals. (Stack S & Eshleman JR "Marital Status and Happiness: A 17 Nation Study" Journal of Marriage and the Family 1998; 527-536)

Marriage gives a beneficial effect in terms of reducing alcohol abuse especially for men and reducing depression for both men and women. (A.V. Horwitz et al "Becoming Married and Mental Health. Journal of Marriage and the Family. 1996; p.895-907)

Remarried appear to have less beneficial effects in terms of anxiety and substance abuse. Thus second and third marriages appear to give less protection to individuals than first marriages.

In a paper by Chris M. Wilson and Andrew J. Oswald: How Does Marriage Affect Physical and Psychological Health? A Survey of the Longitudinal Evidence. (January 2002) the authors summarise the research evidence showing the beneficial effect of marriage:

- Marriage makes people less likely to suffer depression and psychological problems.
- Marriage makes people live longer.
- Marriage makes people healthier.

The authors state: "Married people live longer and are healthier. This fact has been found many times and in many countries. The sociological reasons for this may be that married couples may gain financially.

Second, marriage may bring increased emotional and instrumental support. Third, marriage may change lifestyles because of some kind of guardian effect, where healthy activities are increased and risky behaviours reduced. For example, married individuals drink and smoke less, suggestive of a guardian effect. Also, married people were less likely to die from 'social causes' of death such as accidents, suicide and cirrhosis of the liver."

7.2 Family Breakdown – Its negative contribution to public health

7.2.1 Children from broken families are poorer and more likely to be homeless.

- Children living in lone-parent households are twice as likely to be in the bottom 40% of household income distribution compared with children living in two-parent households (75% versus 40%). (Households Below Average Income 1994/95-2000/01, Department for Work and Pensions (2002), p. 50.)
- Young adults from disrupted families are 1.7 times more likely to have experienced homelessness (6.2% compared with 3.6%). (Kiernan (September 1997), 'The legacy of parental divorce: social, economic and family experiences in adulthood', p. 21.)

7.2.2. Children from broken families have more ill health and higher mortality.

- It has been estimated that parental divorce increases children's risk of developing health problems by 50%. (Mauldon, J. (1990), 'The effects of marital disruption on children's health', Demography 27, pp. 431–46.)
- Children living in lone-parent households were 1.8 times as likely to have psychosomatic health symptoms and illness such as pains, headaches, stomach aches, and feeling sick. (Cockett and Tripp (1994), The Exeter Family Study: Family Breakdown and Its Impact on Children, p. 21.)
- A Swedish study found that children of single parent families were 30% more likely to die over the 16-year study period. After controlling for poverty, children from single-parent families were: 56% more likely to show signs of mental illness, and 26% more likely to rate their health as poor. (Lundbert, O. (1993), 'The impact of childhood living conditions on illness and mortality in adulthood', Social Science and Medicine 36, pp. 1047–52.)

7.2.3. Children from broken families are more likely to have emotional or mental problems

- After controlling for other demographic factors, children in lone-parent households are 2.5 times as likely to be sometimes or often unhappy. (Cockett and Tripp (1994), The Exeter Family Study: Family Breakdown and Its Impact on Children, p. 19.)
- Among children aged five to fifteen years in Great Britain, those from lone-parent families were twice as likely to have a mental health problem as those from intact two-parent families (16% versus 8%). (Meltzer, H., et al. (2000), Mental Health of Children and Adolescents in Great Britain, London: The Stationery Office.)
- A major longitudinal study of 1,400 American families found that 20%–25% of children of divorce showed lasting signs of depression, impulsivity (risk-taking), irresponsibility, or antisocial behaviour compared with 10% of children in intact two-parent families. (Hetherington, M. (2002), For Better or Worse: Divorce Reconsidered, New York: W. W. Norton.)
- One study, which followed 100 children of divorce through 25 years, found that, while the divorced parents may have felt liberated, many of their children suffered emotionally. (Wallerstein, J. et al (2002), The Unexpected Legacy of Divorce: A 25 Year Landmark Study, London: Fusion Press.)

7.2.4. Children from broken families have more problems at school, including increased risk of truancy, being excluded from school and are more likely to leave school with no qualifications.

- Children from lone-parent families are more likely to score poorly on tests of reading, mathematics, and thinking skills. (Elliott, J. and Richards, M. (1985), 'Parental divorce and the life chances of children', Family Law, 1991, pp. 481–484; and Wadsworth, J., Burnell, I., Taylor, B., and Butler, N. (1985), 'The influence of family type on children's behaviour and development at five years', Journal of Child Psychology and Psychiatry 26, pp. 245–254.)
- After controlling for social class, level of parental supervision, attachment to family, whether peers and siblings were in trouble with the police and standard of work at school, boys in lone-parent households were still 2.7 times more likely to truant than those from two-natural-parent households. (Graham, J. and Bowling, B. (1995), Young People and Crime, London: Home Office, p. 120.)
- Children living with a lone mother are three times more likely than those in two-parent families to be excluded from school (15.6% versus 4.8%). (Youth Survey 2001: Research Study Conducted for the Youth Justice Board (January–March 2001)
- Sixteen-year-olds from lone-parent households are twice as likely to leave school with no qualifications as those from intact families. Most studies have found that most or all of this increased risk occurs because lone-parent families generally are poorer, which in itself has a strong association with poor educational outcomes. (Ely, West, Sweeting and Richards (2000), 'Teenage Family Life, Life chances, lifestyles and health', pp. 1–30.)

7.2.5. Children from broken families are at greater risk of suffering physical, emotional, or sexual abuse and to run away from home.

- Data from the National Society for the Prevention of Cruelty to Children (NSPCC) show that young people are five times more likely to have experienced physical abuse and emotional maltreatment if they grew up in a lone-parent family, compared with children in two-birth-parent families. (Cawson, P. (2002), Child Maltreatment in the Family, London: NSPCC.)
- All studies of child-abuse victims which look at family type identify the step-family as representing the highest risk to children – with the risk of fatal abuse being 100 times higher than in two biological-parent families according to international experts Daly and Wilson, drawing on US data from 1976. (Daly, M. and Wilson, M. (1988), Homicide, New York: Aldine de Gruyter.)
- Analysis of 35 cases of fatal abuse which were the subject of public inquiries between 1968 and 1987 showed a risk for children living with their mother and an unrelated man which was over 70 times higher than it would have been for a child with two married biological parents. (Whelan, R. (1994), Broken Homes and Battered Children, Oxford: Family Education Trust.)
- Children from lone-parent families are twice as likely to run away from home as those from two-birth-parent families (14% compared to 7%). (Rees, G. and Rutherford, C. (2001), Home Run: Families and Young Runaways, London: The Children's Society.)

7.2.6. Children from broken families have more problems with sexual health, including earlier intercourse, increased risk of contracting an STIs and becoming teenage parent.

- Children from lone-parent households were more likely to have had intercourse before the age of 16 when compared with children from two-natural-parent households. Boys were 1.8 times as likely and girls were 1.5 times as likely After controlling for socio-economic status, level of communication with parents, educational levels and age at menarche for girls, the comparative odds of underage sex actually increased to 2.29 for boys and 1.65 for girls. Girls from lone-parent households were 1.6 times as likely to become mothers before the age of 18. (Wellings, K., Nanchanahal, K., MacDowall, W., et al. (2001), 'Sexual behaviour in Britain: Early heterosexual experience', The Lancet 358, pp. 1843–50.)
- In a sample of young women who had had intercourse before age 18, those from lone-parent households were 1.4 times as likely to have had a sexually transmitted infection by age 24 (14.3% versus 10.2%). Controlling for other factors slightly increased the comparative odds to 1.53. (Wellings, K., et al. (2001), 'Sexual behaviour in Britain: Early heterosexual experience', pp. 1843–50.)
- Analysis of data from the National Child Development Study (NCDS) indicated that women whose parents had divorced were twice as likely to become teenage mothers as those from intact families (25% versus 14%). After controlling for childhood poverty and behavioural and educational problems, the odds for teenage motherhood and early fatherhood were reduced to 1.4. This means that children of divorce were still 40% more likely to become parents early, even after considering other family background factors. (Kiernan, K. (September 1997), 'The legacy of parental divorce: Social, economic and family experiences in adulthood', London: Centre for Analysis of Social Exclusion, London School of Economics, pp 26–27.)

7.2.7. Children from broken families are more likely to smoke, to drink and to take drugs

- In a sample of teenagers living in the West of Scotland, 15-year-olds from lone-parent households were twice as likely to be smokers as those from two-birth-parent homes (29% compared to 15%). After controlling for poverty, they were still 50% more likely to smoke. (Sweeting, H., et al. (1998), 'Teenage family life, lifestyles and life chances. International Journal of Law, Policy and the Family 12, pp. 15–46.)
- In the West of Scotland, 18-year-old girls from lone-parent households were twice as likely to drink heavily as those from intact two-birthparent homes (17.6% compared to 9.2%). (Sweeting, et al (1998), 'Teenage Family life, lifestyles and life chances', pp. 15–46.)
- Parental divorce during childhood increased the odds of young adults engaging in heavy and/or problem drinking. The link was weak when measured at age 23, but was strong by age 33. (Hope, S., et al. (1998), 'The relationship between parental separation in childhood and problem drinking in adulthood', Addiction; 93: pp. 505–514.)
- At age 15, boys from lone-parent households were twice as likely as those from intact two-birthparent households to have taken any drugs (22.4% compared with 10.8%). Girls from lone-parent homes were 25% more likely to have taken drugs by the age of 15 (8.2% compared with 6.5%) and 70% more likely to have taken drugs by age 18 (33.3% compared with 19.6%). After controlling for poverty, teenagers from lone-parent homes were still 50% more likely to take drugs. (Sweeting, et al (1998), 'Teenage Family life, lifestyles and life chances', pp. 15–46.)

7.2.8. Children from broken families are more likely to be involved in criminal activity and more likely to be incarcerated.

- Children aged 11 to 16 years were 25% more likely to have offended in the last year if they lived in lone-parent families. (Youth Survey 2001: Research Study Conducted for the Youth Justice Board (January–March 2001)
- Although 20% of all dependent children live in lone-parent families, 70% of young offenders identified by Youth Offending Teams come from lone-parent families. (Review 2001/2002: Building on Success, Youth Justice Board, London: The Stationery Office (July 2002).
- American studies have shown that boys from one-parent homes were twice as likely as those from two-birth-parent families to be incarcerated by the time they reached their early 30s. (Harper, C. and McLanahan, S. (August 1998), 'Father absence and youth incarceration', San Francisco: paper presented at the annual meetings of the American Sociological Association.)

7.2.9. The direct costs of family breakdown are in the region of £15 billion per annum. This figure doubles when taking indirect costs of family breakdown into account.

- Earlier research has quantified the costs of family breakdown in the range £4 billion to £10 billion. This report concludes that these previous estimates significantly understate the actual cost of family breakdown, and estimates that the direct annual costs are nearer to £15 billion, and rising. With indirect costs, the total is much more, quite possibly double that. The direct costs of family breakdown cost each of the UK's 26.2 million tax payers an average of £11 per week. Direct costs of £15 billion equate with about one third of government expenditure on education, just over a quarter of what it spends on the NHS, or almost exactly the combined totals it spends on industry, agriculture and employment, or on housing and the environment. Public money spent tackling the social problems caused by family breakdown could otherwise fund creative social projects which strengthen family life and national unity.
- Some of the costs of family breakdown are readily identifiable. The largest is the cost of welfare support and payments for children and parents, amounting to £8.5 billion. There are other less obvious costs, such as Legal Aid; the running costs of the Child Support Agency, special needs schools (disproportionately used by children from broken families), and child psychology services; some of the costs of the criminal justice system, remand centres and prisons; plus additional costs of health due to family breakdown. These can be estimated. Quantifying the lost potential as a result of family breakdown is infinitely more difficult. (The Cost of Family Breakdown; Family Matters Institute, commissioned by the Lords and Commons Family and Child Protection Group; 2000)

Appendix 8
Analysis of Dutch data regarding teenage pregnancy

The Netherlands are often praised as an example of "enlightened" approach to sex education. It is claimed, that, as a result of this approach to sex education, Holland has a much lower teenage pregnancy rate than the UK and that – if only the "Dutch approach" were to be adopted in the UK, teenage pregnancy rates were to fall. However, closer analysis of the Dutch situation shows that this is not the case.
The following is based on a presentation given by Dr Joost van Loon, Centre for Research in Culture and Communication, The Nottingham Trent University, presented in a Parliamentary Consultation, House of Commons, 15.06.2004. (We understand that since this paper has been given, there has been a significant increase in STIs and underage conceptions in the Netherlands.)

Summary points

8.1 **Since the early 1970s the Netherlands have had consistently lower Teenage Pregnancy Rates than the UK.** Whereas in the Netherlands, the TPR continued to drop until the 1990s, the drop in the UK stopped in the late 1970s and has been fluctuating ever since (see figure 1; also see Garssen (2004: CBS, 2002: Singh and Darroch, 2000; UNICEF, 2001; Van Loon, 2003).

8.2 **Since the early 1990s, however the Dutch TPR has been increasing; particularly due to increasing numbers of abortions (teenage parenthood rates remain low). Also STI rates have increased sharply, particularly Chlamydia, HPV and more recently HIV.** This is in spite of high levels of contraception use (Garssen, 2004; Haks and Van der Laar, 2001; Jongeren Informatie Punt, 2002; NISSO, 2000; Rademakers, 2002; Van der Laar et al, 2001; Van der Laar et al, 2002; Van Loon, 2003; on the ineffectiveness of contraception see Oettinger, 1999; Paton, 2002; Pearson et al, 1995; Ranjit et al, 2001; on the situation of STIs in the UK, see Fenton et al, 2001; Johnson et al, 2001; Public Health Laboratory Service, 2001; Wellings et al, 2001).

8.3 **The low TPR in the Netherlands cannot be attributed to the success of sex education; the main drop took place well before sex education was introduced into schools; only in 1993 was it, for the first time in history, a compulsory element of secondary schooling** (as part of the biology of human reproduction). Research conducted at Dutch schools confirms this. There is an enormous variety of didactic approaches and teaching methods depending on the cultural climate of the school (which is a reflection of its direct socio-cultural environment). At secondary level, there is a strong biological-scientific focus (rather than a socio-emotional one) (Van Loon, 2003; on the relative ineffectiveness of sex education see Di Censo, 2002; Kirby, 1997 and Kirby et al, 2001; Wight, 1997; Winn et al, 1995).

8.4 **Contrary to what is sometimes claimed in UK media, use of specialised sexual health expertise in schools (either in the form of invited speakers or specialised material) is not widespread**. Almost all material at the primary schools I researched has been developed by the teachers themselves. All secondary schools I visited followed a standard biology textbook at secondary level. When asking teachers about their experiences at other schools, the report a similar picture. Additionally, there is no contraceptive provision at schools. The pill is not even a standard item on many medical insurance policies. (see Paans, 2002; Van Loon, 2003)

8.5 **Similar to the UK, Dutch sexual health expertise have voiced repeated complaints about the moral conservativism of parents and teachers, which they see as contributing to the proliferation of 'mixed messages'.** For them, the Netherlands are not as liberal and tolerant as their image abroad suggests (see Paans, 2002; Wolvers, 2004; and the relative stability of sexual morality in the Netherlands, see Kraaykamp, 2002).

8.6 **Unlike the UK, however, the Netherlands do not have a widespread and geographically entrenched structure of social exclusion**. Poverty is concentrated in relatively small urban areas; where problems regarding teenage sexual health are much worse than in the rest of the country and resemble those in the UK. (On poverty in the Netherlands, see Erwich and Uunk, 2002; Thijssen, 2001; on the relationship between poverty and sexual risk behaviour see Billy et al, 1994).

8.7 **The most significant difference between the UK and the Netherlands I encountered, is the position of the family. The Netherlands are significantly more traditional than the UK. The divorce rates are lower and there are far fewer single parent families – a child in the UK has a five times higher chance to grow up in a single parent family than in the NL, and is almost twice as likely to be born outside of marriage** (see table 2 and figure 3). Finally, there are significantly fewer 'working families' (both partners in FT jobs) and far more integrated family life. (Komter and Vollebergh, 2002; Paul et al, 2002; ONS, 2001: 18; Schulze, 1999; SCP, 1997; 2000; 2001: 175; Van Loon, 2003; for the effects of family breakdown on teenage sexual risk behaviour see Demo, D. and Acock, A., 1988; Garish, 1998; Whitbeck et al, 1997)

8.8 **There are huge cultural differences between Dutch and British teenagers as far as their attitudes towards sex and sexuality are concerned**. According to research by Roger Ingham (1998), there are far greater levels of mutual respect between Dutch teenagers who claim to enter into sexual relationships on the basis of love; whereas in the UK it is conquest and opportunism (for boys) or peer pressure (for boys and girls). (See Ingham, 1998; and Ingham and Kirkland, 1997; Chambers et al, 2003; Thompson and Holland; 1998; Tincknell et all, 2003)

8.9 **In conclusion:**

8.9.1. **The Netherlands can not be used as a justification for the current Teenage Pregnancy Strategy in the UK.** It does not have a more liberal sexual morality, it does not provide easier access to contraception; it does not have a more advanced programme of sex education; and it is not immune from the adverse consequences of the sexualisation of society (as rising unwanted pregnancies and STI rates among Dutch teenagers testify).

8.9.2. **However, the Netherlands can be used as an explanation of why the problems are much worse in the UK:** the latter's geographically entrenched structures of socio-economic inequality and the significantly greater extent of the erosion of the family give 'sexual health' a fairly low priority among British teenagers, who have a lot less to lose than their Dutch counterparts (not only in a material or economic sense, but also in a socio-emotional and relational one).

8.9.3. **If one wants to use the Netherlands as a beacon for a more effective strategy to improve teenage sexual health in the UK than the primary focus should be on strengthening the family and on breaking down the structural obstacles for socio-economic mobility.**

Figure 1:Teenage Pregnancy Rates in the UK and The Netherlands 1960-1996 (source: Kane and Wellings, 1999: 47 and 65)

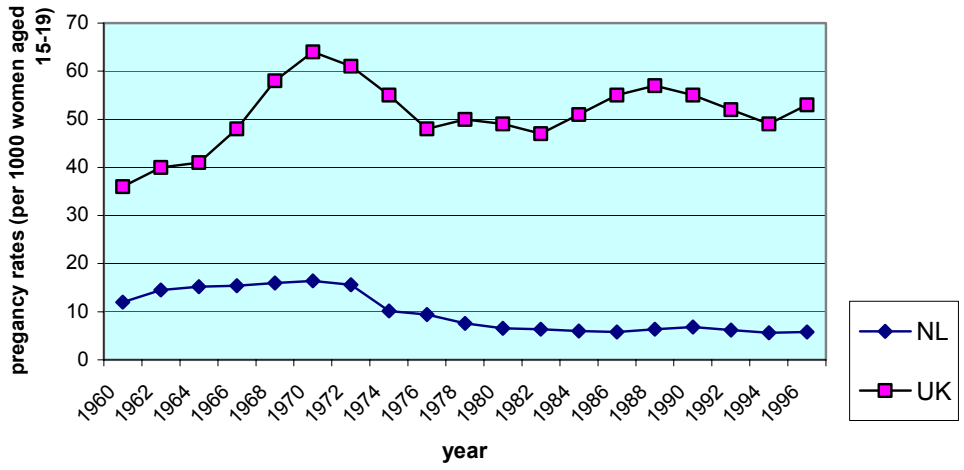
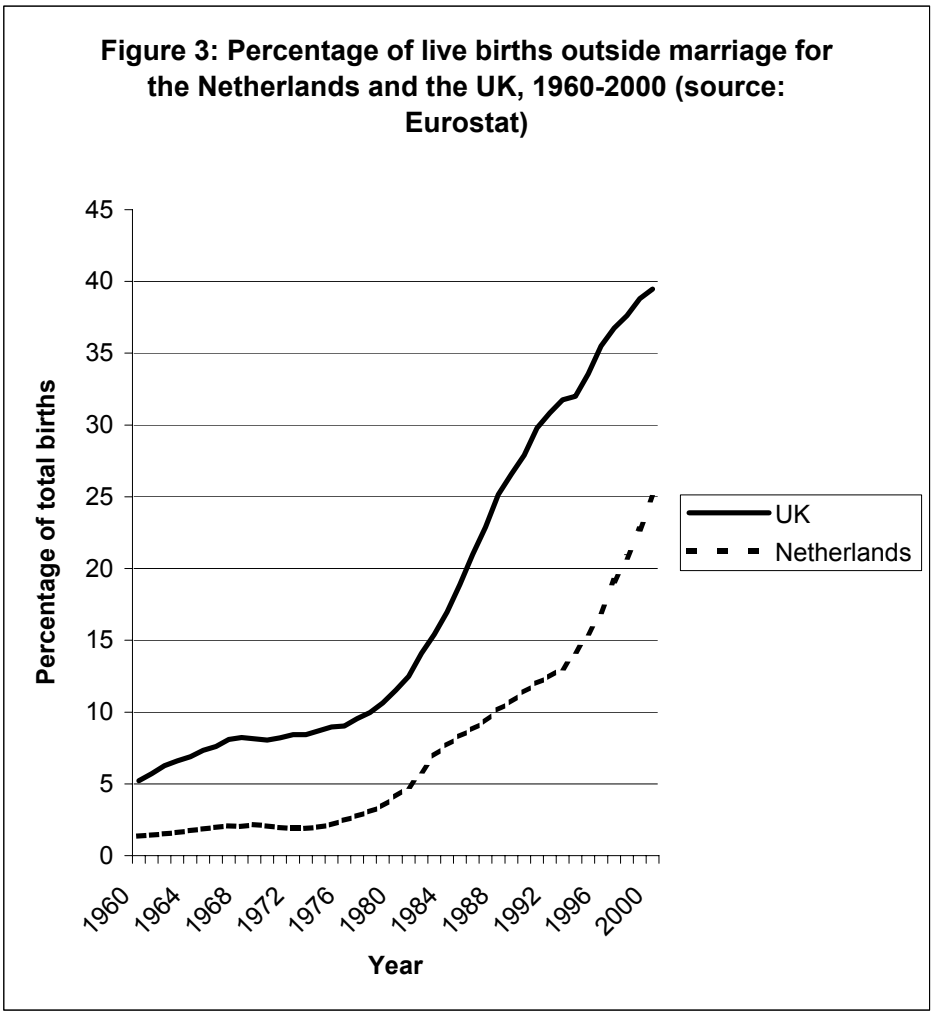


Table 2 Household types in the Netherlands and the United Kingdom (1996 and 2000)

	The Netherlands	United Kingdom
Average size (1996)	2.4	2.4
Households of more than 5 persons (% of all households)	7.7%	6.2%
Complex households (% of all households e.g. extended families)	0.6%	3.5%
Single parent families (as % of all families with children) in 1996	7.4%	19.7%
Single parent families (as % of all families with children) in 2000	5.7%	26.0%

(Source: ECHP, 1996; cited in SCP, 2001: 175; CBS (2002), http://statline.cbs.nl; and ONS, 2001: 10-11).



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For a more detailed discussion of the aforementioned points, see J. Van Loon (2003) *Deconstructing the Dutch Utopia. Sex Education and Teenage Pregnancy in the Netherlands.* London: Family Education Trust.

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Appendix 9

Abstinence, behavioural modification with special reference to Uganda

The "usual" response by the sexual health establishment is to dismiss abstinence-based approaches towards sex. (Blake, S. and Frances, G. *Just say no to abstinence education*, National Children's Bureau, 2001); However, in our view this is incorrect and there has been recent evidence to the contrary.

9.1 Abstinence-plus programs for HIV prevention can reduce risk behaviour

Programmes that above all aim to encourage sexual abstinence while also encouraging and teaching safe(r) sex strategies for those who are sexually active can reduce short- and long-term HIV risk behaviour among young people in high-income countries.

Abstinence-plus programmes start from the premise that sexual abstinence is the best way to prevent infection, but recognises that some people will continue to be sexually active and therefore also helps to enable effective use of condoms.

In addition to teaching condom skills, abstinence-plus programmes commonly teach about communication with partners, and transmission of HIV and other sexually transmitted infections.

A recent Cochrane review analysed the effectiveness of abstinence-plus programmes in high-income countries. Researchers found 39 studies involving over 37,000 North American young people. Mean participant ages for individual trials ranged from 11.3 to 19.3 years, with a median of 14.0 years across trials. The age group taught therefore was secondary school children, not primary school children as has been suggested in the UK. Every intervention program promoted sexual abstinence and condom use for HIV prevention, presenting abstinence as the most effective choice

In 23 studies there was a significant increase in protective behaviour. None of the studies reported any adverse effects; contrary to criticisms against abstinence-plus programmes, participants did not become more sexually active after completing the interventions. In a number of the studies analysed, positive outcomes such as reduced number of sexual partners, delayed sexual initiation, incidence and frequency of sex, and reduced teenage pregnancy rates. Data on the incidence of STIs was not significant. "In a previous Cochrane review we concluded that abstinence-only programs have no effect in high-income countries, which makes the finding that abstinence-plus programs can influence behaviour even more striking," says lead researcher Dr Don Operario who works at the Department of Social Policy and Social Work at the University of Oxford, UK. "This is an opportunity for the HIV prevention and public health communities to harness the potential benefits of comprehensive sexual health education such as abstinence-plus programmes." (Source: Underhill K, Operario D, Montgomery P (2007) Systematic review of abstinence-plus HIV prevention programs in high-income countries. PLoS Med 4(9): e275. doi:10.1371/journal.pmed.0040275)

9.2 Uganda

"Uganda provides the clearest example that human immunodeficiency virus (HIV) is preventable if populations are mobilized to avoid risk. Despite limited resources, Uganda has shown a 70% decline in HIV prevalence since the early 1990s, linked to a 60%reduction in casual sex. The response in Uganda appears to be distinctively associated with communication about acquired immunodeficiency syndrome (AIDS) through social networks. Despite substantial condom use and promotion of biomedical approaches, other African countries have shown neither similar behavioural responses nor HIV prevalence declines of the same scale. The Ugandan success is equivalent to a vaccine of 80% effectiveness. Its replication will require changes in global HIV/AIDS intervention policies and their evaluation." (Rand L. Stoneburner and Daniel Low-Beer; SCIENCE; 30.04.2004)

9.2.1 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 1991–1998, 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 under 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.)

9.2.2. 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)

9.2.3. 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 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 will continue to fail.

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 does not promote the only evidence-based definition of safe sex, which is (apart from abstinence) mutual monogamy among uninfected partners. The National Strategy does not even 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. The National Strategy 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; (www.doh.gov.uk/nshs/bettersexualhealth.pdf)

Appendix 10 Health risks of the homosexual lifestyle.

What follows is in no way condemnatory of "homosexuals" but written out of concern that – perhaps out of "politically correct" considerations – the obvious is not stated, i.e. that the "gay lifestyle" is associated with a much higher risk of contracting sexually transmitted infections. In appendix 1 we quoted figures from the Health Protection Agency which showed that there has been a much higher increase in acquisition for all STIs through male homosexual contact than through heterosexual contact.

Health risks of the homosexual lifestyle

The media and the gay movement portray the homosexual lifestyle as happy, healthy and fulfilled. However, the homosexual lifestyle is associated with a large number of very serious physical and emotional health consequences. A high proportion of homosexual men engage in a destructive lifestyle, for example contracting HIV/AIDS, or other STIs and develop addictions to drugs or alcohol. There is a higher burden of depression, attempted or completed suicide among the "gay population".

10.1 Higher rates of sexual promiscuity

- **The reason for the increased prevalence and incidence of STIs among the "gay population" have to do with increased sexual promiscuity among many gays**. Many – especially male – homosexual relationships are of short duration and even those homosexuals who are in a 'committed' relationship appear to have a significant number of outside sexual partners, far more than heterosexual individuals.
- **In a recent survey in the UK, homosexual men reported on average 27 sexual partners over the past five years.** This contrasts with 'only' four sexual partners on average among those men who reported having no homosexual sex. Not surprisingly, homosexual men and women are at least four times as likely to be diagnosed with a sexually transmitted disease over the past five years compared to heterosexual men and women. (Kevin A. Fenton, et al. Reported Sexually Transmitted Disease Clinic Attendance and Sexually Transmitted Infections in Britain: The Journal of Infectious Diseases 2005; 191: S127–38.)
- **Another study of homosexual men shows that more than 75% of homosexual men admitted to having sex with more than 100 different males in their lifetime:** approximately 15% claimed to have had 100-249 sex partners, 17% claimed 250-499, 15% claimed 500-999 and 28% claimed more than 1,000 lifetime sexual partners. (Bell AP, Weinberg MS. Homosexualities. New York 1978).
- Promiscuity among lesbian women is less extreme, but is still higher than among heterosexual women. Many 'lesbian' women also have sex with men. Lesbian women were more than 4 times as likely to have had more than 50 lifetime male partners than heterosexual women. (Fethers K et al. Sexually transmitted infections and risk behaviours in women who have sex with women. Sexually Transmitted Infections 2000; 76: 345-9.)
- High **rates of promiscuity are observed even within 'committed' gay relationships.** In a Dutch study, the average range of duration of a male homosexual relationship was between 9 months to just over 2 years. On average, these relationships lasted only 17 months. Even though the homosexual men claimed to be in a stable relationship, they had an additional 5-10 outside sexual partners, on average seven. Those who were not in a 'committed' relationship had, on average, 22 sexual partners per year, with a range of 17-28 outside partners. (Xiridou M, et al. The contribution of steady and casual partnerships to the incidence of HIV infection among homosexual men in Amsterdam. AIDS. 2003; 17: 1029-38.)
- In **an online survey among nearly 8,000 homosexuals, 71% of same-sex relationships lasted less than eight years.** Only 9% of all same-sex relationships lasted longer than 16 years. (2003-2004 Gay & Lesbian Consumer Online Census; www.glcensus.org)
- It **may be worthwhile looking at the following quote by a gay author to understand more the nature of many homosexual relationships and perhaps the reason for the high promiscuity.**

  'Most heterosexual relationships are built by, first of all, the meeting relating to the reality of one another. Next comes seeing the person again, getting to know the person. You go though all these levels, until finally it has grown into a relationship that, in order to find a greater closeness, moves into the beautiful sexual areas. You stay together the night, you make it, and next day you explore all the levels of the relationship you've already built up. The base is there. In the gay world, we begin by mumbling a few words to each other, if that. Suddenly, we're making sex. Then we just as suddenly split to the next person. You see, we've begun with the intimacy without ever having gone through any tenderness or gentleness. I think this is the reason why so few lasting homosexual relationships exist.' (from an interview with John Rechy in Gay News, 1976; quoted in Higgins, P.: A queer reader. Fourth Estate, London 1993.; p.226)

10.2 Homosexual promiscuity – some quotes from homosexual men and women.

It may be helpful to look at some quotes from gay men and women to better understand why the homosexual lifestyle is usually associated with very high levels of promiscuity and short duration of even 'committed' relationships. The following quotes were all taken from publications by gay authors, mostly from the "Gay Report" by "gay researchers Jay and Young, ie not from some "homophobic" publication (source: Jay K & Young A.: The Gay Report. Summit Books, New York. 1977)

- *'I feel frustrated and angry that sex is expected so soon in gay relationships. Gay people seem to feel drawn, hop into bed the first night they talk or discover each other, share a lot, get suddenly close, then days or weeks later lose interest and move on to their next affair… Sometimes I feel that we're all caught in a destructive but self-perpetuating system.*' (Gay man quoted in Jay K & Young A.: The Gay Report. Summit Books, New York. 1977; p. 168)
- *'I feel that many lesbians I know place too great an emphasis on sex. I find that in the women's' community (largely lesbian community) of which I was a part for several years… was an alienating, pervasive preoccupation with 'smashing' monogamy, sleeping with lots of people, general talk about sex. …The community I'm talking about has group orgies all the time. Everyone is sleeping with everyone else …'* (Lesbian woman, quoted in the Gay Report, p. 168f).
- *'I think that far too much emphasis is placed on sex in a gay male lifestyle, but it seems directly related to this unaccepting society at large and a proliferation of hang-ups from childhood conditioning. Sex very easily becomes the almighty panacea for many gay men's problems, anxieties, whatever, but I believe that we are really only using sex to satisfy the need for love and affection from other men and as a substitution for these things it is lacking.'* (Lesbian woman, quoted in the Gay Report, - p. 169)
- *'I feel that one of the saddest things about homosexual experience if that so often the act of sex is a frantic race to orgasm rather than an expression of deep emotion.'* (Gay man – quoted in the Gay Report, p. 173)
- *'I like sex both with and without emotion. It is a lot 'safer' and less painful psychologically to 'make it' without emotional contact. This is my most frequent type of sexual contact. I just meet someone, we get it on, and I split to someone else. If I get involved with an emotional exchange, it seems inevitable that I will have to contact that place deep within the personality which is totally empty, unsure, and void.*' (Gay man, quoted in the Gay Report, p 175)
- *I believe my estimate of 4,000 sex partners to be very accurate. I have been actively gay since I was 13 (31 years ago). An average of 2-3 new partners a week is not excessive, especially when one considers that I will have 10-12 partners during one night at the baths.'* (Gay man, quoted in the Gay Report, p. 250)
- *'I have never stayed in a relationship longer than two years in my whole life (except for the time when I was with my first lover from the age 18 to about 28). I am 45 now.'* (Gay man, quoted in George, Kenneth D: Keeping Mr Right. Alyson Publications, Los Angeles, p. 3)

10.3 Highly risky sexual practices such as anal sex are very common among practising homosexuals

- **The majority of homosexual men (63%) has engaged in anal sex over the past year, and 40% have engaged over the past four weeks, often without condom and even, if they know that they are HIV positive.** (Mercer CH et al. Increasing prevalence of male homosexual partnerships and practices in Britain 1990-2000. AIDS. 2004; 18: 1453-8) This contrasts to about 12% or less of the heterosexual population that has engaged in anal sex over the past year. (Anne M Johnson, et al. Sexual behaviour in Britain: partnerships, practices, and HIV risk behaviours. Lancet 2001; 358: 1835–42.)
- **A large number of diseases are associated with anal intercourse, many of which are rare or even unknown in the heterosexual population** such as: anal cancer, Chlamydia trachomatis, Cryptosporidium, Giardia lamblia, Herpes simplex virus, HIV, Human papilloma virus, Isospora belli, Microsporidia, Gonorrhoea, Syphilis, Hepatitis B and C and others.
- **There is a significant increase in the risk of contracting HIV when engaging in anal sex. Young homosexual men aged 15-22, who ever had anal sex had a fivefold increased risk of contracting HIV than those who never engaged in anal sex.** (Valleroy L, et al. HIV prevalence and associated risks in young men who have sex with men. JAMA. 2000; 284: 198-204.)

- **The term 'barebacking' refers to intentional unsafe anal sex. In a study of HIV-positive gay men, the majority of participants (84%) reported engaging in barebacking in the past three months, and 43% of the men reported recent bareback sex with a partner who most likely is not infected with HIV, therefore putting another man at risk of contracting HIV.** (Halkitis PN. Intentional unsafe sex (barebacking) among HIV-positive gay men who seek sexual partners on the Internet. AIDS Care. 2003; 15: 367-78.)
- **While many homosexuals are aware of HIV risk, a large number are unaware of the increased risk of contracting non-HIV STDs, many of which have serious complications or may not be curable.** (K-Y lubricant and the National Lesbian and Gay Health Association survey) While 'always' condom use reduces the risk of contracting HIV by about 85%, Condoms, even when used 100% of the time, fail to give adequate levels of protection against many non-HIV STDs such as Syphilis, Gonorrhoea, Chlamydia, Herpes, Genital Warts and others. The only true safe sex is, apart from abstinence, mutual monogamy with an uninfected partner. (Sex, Condoms, and STDs: What We Now Know. Medical Institute for Sexual Health. 2002)

10.5 Those engaging in a homosexual lifestyle have a disproportionally high number of sexually transmitted diseases

- **The rates of acquisition of various sexually transmitted diseases for homosexual men is far higher than for heterosexual men. A recent study found that homosexual men were on average 46 times as likely to be diagnosed with HIV and more than 56 times as likely to be diagnosed with syphilis than heterosexual men**. Gay men were nearly three times as likely to have a first attack of genital herpes, twice as likely to have first diagnosis of genital warts and 1.5 times as likely to have new diagnosis of Chlamydia. All of those STDs have increased substantially over the past five years. (Macdonald N. et al. Recent trends in diagnoses of HIV and other sexually transmitted infections in England and Wales among men who have sex with men. Sex Transm Infect. 2004; 80: 492-7.)
- **Over 80% of all new HIV diagnoses in the UK are among homosexual or bisexual men**. (Brown AE, et al. Recent trends in HIV and other STIs in the United Kingdom: data to the end of 2002. Sex Transm Infect. 2004; 80: 159-66.)
- **The recently observed dramatic increases in syphilis in many large cities such as London, Manchester and Brighton are in the majority observed in homosexual men, many of whom are also HIV positive.** (Fenton K., Hughes G. Sexual Behaviour in Britain. Clin Med 2003; 3: 199–202.)
- **The UK, Canadian and US blood transfusion services recognises the disproportionally high risk of male homosexuality, banning men who ever had sex with a man from donating blood**. This ban has been in place in the US since 1977. In the US, those male blood donors, who reported having sex with other men once or more over the past 5 years, were at least 5-7 times as likely than those who had no homosexual sex, to have an abnormal screening test, such as a positive HIV, hepatitis, syphilis or other test. (Sanchez AM, et al. The impact of male-to-male sexual experience on risk profiles of blood donors. Transfusion. 2005; 45: 404-13.)

10.6 Homosexual lifestyle reduces life expectancy by many years

- **In a Vancouver study, published in 1997, life expectancy at age 20 years for gay and bisexual men was found to be 8 to 20 years less than for all men aged 20.** The reduction in life expectancy would be similar to the life expectancy of men in Canada in 1871. The main reasons for this reduction was AIDS. The average life expectancy for a 20 year old homosexual or bisexual man was calculated to be between only 34 to 46 years. (Hogg RS et al. Modelling the impact of HIV disease on mortality in gay and bisexual men. International Journal of Epidemiology.1997; 26: 657-61.)
- A repeat of this study a few years later showed only a modest improvement in life expectancy due to improved HIV treatment. **A 20 year old homosexual or bisexual man can expect to live, on average, only until age 41. This contrasts to an average life expectancy for all 20 year old men (including homosexual and bisexual) reaching 56 years of age.** A homosexual/bisexual 20 year old man loses on average nearly 10 years of his life due to AIDS, despite having access to specialist HIV treatment. Overall, he loses a minimum of 15 years life expectancy compared to the average male. (Wood E, et al. Modern antiretroviral therapy improves life expectancy of gay and bisexual males in Vancouver's West End. Can J Public Health. 2000; 91: 125-8.)

Appendix 11 Effectiveness of current sexual health education Some examples of currently used sex education material.

11.1 There is little evidence to support the claim by the Government that the current approach to sex education is effective.

- Even though it is claimed that *"evidence shows that quality SRE had a direct impact on reducing teenage pregnancy rates"* (Press release, Review of Sex and Relationship Education Delivery, 25.02.08) this statement is in fact incorrect regarding the type of sex education endorsed by the government. Most studies on sex education programmes in schools examine intermediate outcomes only, such as pupil satisfaction or reported condom use. As a result "success" is claimed, whereas more robust outcome measures such as teenage conceptions or STIs show no improvement.
- For example, the teacher delivered sex education programme (SHARE) found no significant difference between the intervention and control groups in conceptions. Indeed, the conceptions and terminations in the sex education programme were slightly higher in the intervention group as compared to the control group, however the difference was not significant (conceptions per 1000 pupils: 300 SHARE v 274 control group; or terminations: 127 SHARE v 112 control group) However the most important implication of this research is that neither the SHARE approach nor the standard approach to sex education appeared to reduce conceptions or terminations. (M Henderson, et al. Impact of a theoretically based sex education programme (SHARE) delivered by teachers on NHS registered conceptions and terminations: BMJ 2007;334;133)
- Most studies on sex education programmes in schools examine self-reported variables such as condom use. This often facilitates premature false claims of success, whereas more robust outcome measures such as rates of terminations, unplanned conceptions, and sexually transmitted infections show no benefit.
- One positive exception to this is a Chilean abstinence-based programme at a girls' high school in Santiago, Chile. Researchers used clinical data on pregnancies to show that the intervention, the abstinence-cantered programme TeenStar, reduced teenage conceptions by over 80% over a four-year period. (Cabezon C, et al. Adolescent pregnancy prevention: an abstinence-centered randomized controlled intervention in a Chilean public high school. J Adolesc Health 2005;36:64-9.) Again, we need to emphasise that the current UK strategy for sexual health doesn't even mention abstinence as an option. (National Strategy for Sexual Health and HIV, Department of Health, 2001)

11.2 Sex education based on "abstinence-only" versus "abstinence-plus" approaches

- A recent systematic review of **"abstinence-only"** programmes in high-income countries that "exclusively encourage abstinence from sex do not seem to affect the risk of HIV infection in high income countries, as measured by self reported biological and behavioural outcomes." (Kristen Underhill, et al. Sexual abstinence only programmes to prevent HIV infection in high income countries: systematic review. BMJ 2007;335:248)
- This however contrasts with a subsequent review looking at **"abstinence-plus"** programs for HIV prevention. This was based on programmes that above all aim to encourage sexual abstinence while also encouraging and teaching safe(r) sex strategies for those who are sexually active. Abstinence-plus programmes start from the premise that sexual abstinence is the best way to prevent infection, but recognises that some people will continue to be sexually active and therefore also helps to enable effective use of condoms. In addition to teaching condom skills, abstinence-plus programmes commonly teach about communication with partners, and transmission of HIV and other sexually transmitted infections.
- A recent **Cochrane review analysed the effectiveness of abstinence-plus programmes in high-income countries**. Researchers found 39 studies involving over 37,000 North American young people. Mean participant ages for individual trials ranged from 11.3 to 19.3 years, with a median of 14.0 years across trials. The age group taught therefore was secondary school children, not primary school children as has been suggested in the UK. Every intervention program promoted sexual abstinence and condom use for HIV prevention, presenting abstinence as the most effective choice
- In 23 studies there was a significant increase in protective behaviour. None of the studies reported any adverse effects; contrary to criticisms against abstinence-plus programmes, participants did not become more sexually active after completing the interventions. In a number of the studies analysed, positive outcomes such as reduced number of sexual partners, delayed sexual initiation, incidence and frequency of sex, and reduced teenage pregnancies were noted. Data on the incidence of STIs was not significant. "In a previous Cochrane review we concluded that abstinence-only programs have no effect in high-income countries, which makes the finding that abstinence-plus programs can influence behaviour even more striking," says lead researcher Dr Don Operario who works at the Department of Social Policy and Social Work at the University of Oxford, UK. "This is an opportunity for the HIV prevention and public health communities to harness the potential benefits

of comprehensive sexual health education such as abstinence-plus programmes." (Source: Underhill K, Operario D, Montgomery P (2007) Systematic review of abstinence-plus HIV prevention programs in high-income countries. PLoS Med 4(9): e275. doi:10.1371/journal.pmed.0040275) Again, we need to emphasise that the current UK strategy for sexual health does not even mention abstinence as an option. (National Strategy for Sexual Health and HIV, Department of Health, 2001)

11.3 Some actual examples of explicit sex education material used in schools.
There are widespread concerns that some sex education material used in schools is inappropriately explicit, graphic and pornographic.

- Sex education at Notre Dame Girls' School in Plymouth included **role-playing of homosexuals, bi-sexuals and AIDS sufferers.** A parent protested "They are destroying our children's innocence. Why does a child need to know what it feels like to be a prostitute? Why does she need to **role-play a married man who is homosexual and HIV positive**?" Devon County Council has said that it regarded the school's sex education policy as an example of 'good practice'.(Daily Telegraph 16/05/1997)

- **A teaching guide suggesting that children as young as 11 should be encouraged to discuss graphic sexual acts** is on an approved Scottish Executive reading list. 'Taking Sex Seriously' recommends that teachers devote a one hour lesson to thinking about "all the different sexual activities that two people can do together". The booklet suggests **sadomasochism, group sex and unnatural sexual practices as suitable subjects for discussion**. The teaching pack published by 'Healthwise', appears on a list of approved resources produced for the Executive by 'Learning and Teaching Scotland' set up in July 2000 to advise Ministers on the school curriculum. Tino Ferri, National Executive Officer of the NAS/UWUT Teaching Union said "This sort of material encourages diversion in our schools. Children are impressionable and if they are taught this sort of thing at school there is the danger that they will copy it. This is encouraging deviancy among our children and is morally bankrupt. This booklet should be scrapped immediately before any damage is done. Many parents would view this as political correctness gone crazy". (The Scotsman 29/03/2001)

- The educational correspondent of the Daily Telegraph, John Clare writes on the issue of **sex education for 12-year olds** quoting a teacher: *"If you think what follows is awkward for a family newspaper, consider what it's like for me, a middle-aged English teacher, who is required to teach "personal, social and health education" to 12-year-olds at a secondary school in Sussex. I'm instructed to base one lesson on a list of 10 statements that the pupils have to rate on a scale of one to 10 "with 10 being really serious".* The statements include: ***"My friend has given her boyfriend a blow-job; my friend has snogged her female friend; my friend snogged his male friend; my friend has had unprotected oral sex; my friend has had unprotected anal sex; my friend had her friend's older brother come on to her and force her into having sex."*** *……*
The approved materials for another lesson require the pupils to match a list of words and phrases with the correct definition. Among these are: ***"Mutual masturbation – people use their hands to stimulate the other person; dam – latex sheet to cover female genitals in oral sex; finger cot – latex finger glove to cover finger in digital sex; digital sex – when a finger penetrates the vagina or anus; orgasm – the climax of sexual activity."***
The official aim is to teach pupils "as they develop a sense of sexual identity" that there are "different sexual orientations" and "different cultural norms in society today in sexual relationships". Quite apart from the fact that I wasn't trained to teach any of this, and feel extremely uncomfortable doing it, should I really be required to introduce 12-year-olds to "a range of sexual lifestyles"? - John Clare's answer: "No. I would very much like to hear from other teachers required to teach similar lessons, and from parents of 12-year-olds about whether this is what they want their children to be taught." (John Clare, "Any questions?", Daily Telegraph, 16/11/2005)

- Parents **are kept in the dark about the content of 'personal education'**. In a subsequent article John Clare wrote: ***" No issue I have raised in the Any Questions column over the past nine years has angered so many readers quite as much as last week's item on 12-year-olds being taught about anal, oral and digital sex****. Parents and grandparents wrote in droves to say how horrified, appalled disgusted and outraged they were. Almost without exception, they demanded to know where the lesson materials my correspondent described had originated, who had authorised them and how widely they were being used. They also wanted to know how to discover what their own children were being taught in the name of "personal, social and health education" (PSHE) and what they could do if they did not approve. In seeking the answers, I have come to three stark conclusions.*
First, the use of these crude and explicit materials is apparently widespread*. Second, the school where*

my correspondent was required to use them has not told parents precisely what their 12-year-olds are being taught. And, third, parents everywhere have virtually no hope of discovering the content of their children's sex education lessons. (…) So are my readers and I being paranoid? I don't think so. (…) ***"If you teach children to have sex, they will,"*** *wrote Coleen Goodman.* ***"The number of teenage pregnancies [now the highest in Western Europe] has risen sharply since the Government started 'educating' our children in this way." "If I were to allude to these topics with this age group,"*** *said Stephen Lally, a youth worker,* ***"I would expect to be arrested; this is tantamount to child sex abuse."*** *And, from Mr R E Winmill: "What has the teaching profession been doing these last years as this tawdry orthodoxy has been gaining ground? Where has been the outcry to say, "Enough - this is taking things too far?"* (John Clare, Daily Telegraph, 23/11/2005)

- Horrified mothers shown just the first 15 minutes of a sex education series "Living and Growing" by Channel 4 condemned it as "virtually pornographic" and begged teachers not to use. Officials want to use it in primary schools by September. Parents say that it would encourage sexual experimentation. **Five-year-olds are shown illustrations of a naked man and women and asked to label parts of their bodies, including the clitoris. A film for slightly older children shows an animation of a couple having sex. It then discusses masturbation, gay and lesbian relationships and the purpose of condoms.** Thousands of packs of this course have been sold. Julie Anne Luisis, whose five-year-old daughter Charlotte attends the Cambell Infant School in Dagenham said it would encourage younger children to experiment. She said "Some parents were virtually in tears". Michelle Heggarty, a mother of three said "They should not be taught sex education at that age". Another mother said "I have seen the video and it is virtually pornographic. Whoever said it was OK to educate children needs their head examined". Parents were reduced to tears at a preview screening at the school. (Daily Mail 19/07/2003)

- The Family Planning Association has produced a teachers' guide on sex education (produced with lottery money), and it includes a booklet for girls which includes illustrations of masturbation. That guide called '**Girls Out Loud' has been widely criticised and the guide which is aimed at 12-16 year old girls encourages discussions about possible planks of society which include "everyone has the right to use pornography" and "there is no age of consent for sex, alcohol or driving"; "regardless of age, contraception is free and widely available" and "abortion services are free and widely available".** The FPA establishes "exercises" for girls to consider including three different societies. In the first people are expected to remain virgins until they have a settled relationship but "it is quite normal for a marriage to end because one partner is not able to have children". The second society is "very open about sexuality and it is quite normal for people to have same-sex relationships". In the third society "to help people stay in married relationships sex techniques are seen as a normal part of learning and are an option at school from 15 years onwards". The guide stresses "support for young gay, lesbian and bisexual people". It says children should be asked "how can we make society more inclusive". An accompanying booklet for the same age group called "4 Girls" tells girls "to realise that all women can enjoy sex with the right partner at the right time". It describes how "you can masturbate alone or with a partner" and even includes a cartoon on the subject. The FPA has received nearly £1.5m from the National Lottery, but was also given a further £250,000 by the National Family and Parenting Institute (NFFPI), a quango headed by Alistair Campbell's partner and Cheri Blair's former media aid, Fiona Miller. (Daily Mail 15/11/2004).

- The Brook Advisory Centres, which have for many years been handing out contraceptives and dubious **'sex education' materials to children as young as 12**, has now republished its 1991 sex manual for children entitled **'Say Yes, Say No, Say Maybe?'** It has to be said, firstly, that this publication is of a coarseness and obscenity which could hardly fail to be corrupting: one section of it is **entitled 'The Good Grope Guide'** the contents of which combine specific and graphic instructions with a leering and smutty tone, the purpose of which is clearly to rid sexual activity of any notion that it should be approached with caution and respect. Its foundress, **Lady Brook, said "I despair about sex education these days. I don't believe in all this peculiar stuff they teach now, the homosexuality, the unnatural acts…we don't need to tell young people all the extras. They should be told about love and the facts of life, not all this sex, sex, sex"**. "There is – and has been for a generation and more a deliberate and concerted targeting of our children by activists in the health care and education establishments. **In the words of one family planning activist (back in the 70's), "if we do not get into sex education, children will simply follow the morays of their parents**". One of their clear aims has thus been to exclude parents from any concern with their children's sexual and moral education. Another has been to make children sexually aware – and active – at a much younger age than they have been in the past. Lady Brook herself once triumphantly announced the aims of her brave new world. "It is now the privilege of the parental state to take major decisions – objective,

unemotional, the state weighs up what is best for the child". The state supports and funds bodies like the Brook Advisory Services, to the tune of some £4 million. (The Catholic Herald 17/11/2000)

- An **enhanced sex education programme for teenagers has proved no better than conventional teaching in cutting unwanted pregnancies or abortions**, a detailed research study has discovered. The teaching system called **'Share' – (Sexual Health and Relationships: Safe, Happy and Responsible) included group work, role-play and games. The teenagers were shown how to use condoms and access sexual health services and were given leaflets on sexual health**. The programme and research were devised and supported by the Medical Research Council (MRC) and the Education Board of Scotland (now Health Scotland). Dr. Marion Henderson, the MRC researcher who led the study, said the results were disappointing – "it may be that we have already seen the limits of what sex education can achieve and need to look wider at parenting and the culture in which children grow up". "**This is one of the first studies in the world that has used objective data. Unfortunately it shows that the pregnancy and abortion rates in the girls who were taught using the enhanced programme were no different from rates in the control group given conventional school sex education**". Valerie Riches, founder President of Family and Youth Concern, which promotes family values, said **"We are constantly told that children need more and more sex education and what this shows us is that it is ineffective.** This a crushing blow to the whole sex education campaign". Dr. Daniel White, who led the overall study at the Glasgow based MRC unit said "It was difficult for the 'Share' programme to reduce conceptions or abortions as these are so strongly influenced by socio-economic factors". (Daily Telegrap 21/11/2006)