Sexually transmitted infections: condom distribution schemes

NICE National Institute for Health and Care Excellence

Consultation on draft guideline – deadline for comments 5pm on 16/09/16 **email:** SHcondoms@nice.org.uk

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Organisation name – Stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):	Christian Medical Fellowship
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	or the **appendices**	for comments on the whole document	for comments on the whole document	Do not paste other tables into this table, because your comments could get lost – type directly into this table.
Example 1 Example 2 Example 3	Full Full Full	16 16 16	45 45 45	We are concerned that this recommendation may imply that …….. Question 1: This recommendation will be a challenging change in practice because ……. Question 3: Our trust has had experience of implementing this approach and would be willing to submit its experiences to the NICE shared learning database. Contact……
1	Short	General		CMF is, of course, in favour of measures that will reduce the transmission rate of STIs. However, we question the validity of the orthodoxy which claims that the key to achieving this goal is more and better-targeted condom provision. Our contention is that evidence suggests condom distribution without behaviour change has had little effect to date, and that to do more of the same is unlikely to produce a different outcome and may even lead to an increase in teen pregnancy. A rigorous new study (2016) by a pair of Notre Dame economists found that school districts that instituted condom distribution programs in the early 1990s saw significant increases in the teen-fertility rate.[1] That increase was only partially offset in settings where counselling was provided alongside condoms. The same study also found that sexually transmitted diseases (STDs) increased in counties with condom-distribution programs, suggesting that condom-distribution programs encourage sexual risk taking. The researchers suggest that risk-taking may be offset by counselling programmes: 'Because counselling programs commonly promote abstinence and other safe sexual practices, counselling might discourage risky sexual activity that otherwise would be condoned by the presence of condoms in schools' (p19) We advocate a shift in focus from policies aimed at reducing the risks associated with sexual activity to those which are aimed more directly at reducing the level of sexual activity. CMF's view is that we cannot deal effectively with teenage sex and its legacy of sexually transmitted disease without challenging the widely promoted idea that teenage relationships are incomplete without sex. Teenagers need help and support in crossing the border between childhood and adulthood - affirmation from peers, family and friends, accurate information about sex and its consequences and assurance that virginity is good and that saying 'No' is OK

[1] http://www3.nd.edu/~kbuckles/condoms.pdf

2	Short	5	8-10	The priority that local sexual health clinics appear to work to is 'safe sex' rather than 'fulfilling relationships'. We do not believe it is inevitable that young people 'will have sex anyway'. Better, surely, to encourage long-term satisfaction rather than immediate gratification, and having the courage to postpone sexual debut rather than succumb to cultural and peer pressures. Towards this goal, the importance of parental and media influences should not be underestimated. Teenagers are more likely to save sex when their parents communicate the importance of doing so.[2] Much evidence points to the effectiveness of maternal involvement in sex education, but the presence of a father is also an important factor in teenagers saving sex until adulthood.[3] Health professionals should ignore the role of parents only as a last resort, not as standard procedure. The Bailey Review findings on the commercialisation and sexualisation of childhood in our culture, and the role of the media in promoting it, are also relevant here.[4] A key factor in the Ugandan success in reducing HIV rates so dramatically during the 1990s was a community wide, mass media communication of messages to achieve the desired outcomes of abstinence and being faithful, in addition to condom use.[5] The Learning and Teaching Scotland (2010) resource[6] highlighted that, '*while important, combining sexual health services and education does not, alone, effect real change. Action is also needed that focuses on improving self-esteem, motivation and achievement. Having a sense of a positive future is argued to play a critical part in achieving positive sexual health and well-being. Parental, family and media influences are also important'.*
3	Short	5	general	CMF does not support condom distribution schemes to young people but, if they are to occur, then multicomponent schemes are preferable, linking distribution with education and information that emphasize the 'save sex' message and its benefits, not simply the 'safe sex' message. The latter is in any case a misleading term. Sex is not 'safe'

[2] Dilorio C, Kelley M, Hochenberry-Eaton M. Communication about sexual issues: mothers, fathers and friends. *J Adolesc Health* 1999;24:181-9.
[3] McNeely C, Shew ML, Beuhring T, Sieving R, Miller BC, Blum RW. Mother's influence on the timing of first sex among 14 and 15 year-olds. *J Adolesc Health* 2002;31:256-65.
[4] https://www.gov.uk/government/news/bailey-review-of-the-commercialisation-and-sexualisation-of-childhood-final-report-published
[5] Joseph Roundtree Foundation. *"Planned" teenage pregnancy* 2006 www.jrf.org.uk/bookshop/eBooks/9781861348753.pdf.
[6] SPICe Briefing Teenage Pregnancy 22 January 2013. http://scottish.parliament.uk/ResearchBriefingsAndFactsheets/S4/SB_13-03.pdf

				when it is dependent on condoms that may sometimes be faulty and are always dependent on correct use.[7] It is not safe when condoms do not protect against HPV, HSV or chlamydia.[8] [9] Indeed the term may give young people a false sense of security such as to put them at greater, not lesser, risk. It is not 'safe' when the likely emotional and psychological costs are factored in. Information about the risks of intercourse under the influence of drugs or alcohol should be included. Sex in such settings is much more likely to result in unplanned pregnancy or transmission of STIs.[10] [11]
4	Short	5	general	In a recent survey of almost 5,000 15 year olds in NI, 14% were sexually active. But those 15 year olds themselves, when asked, considered that 60%-70% would be sexually active. Education of young people should let them know that not everyone of their age is sexually active and that those who are often regret it.[12] This will lend courage to those young people whose deepest instincts are to save sex for later but who feel intimidated by the thought that 'everyone is doing it' and that they can't afford to be different. The importance of empowering young people by teaching techniques to resist pressure is not highlighted in the guidance as an area that requires equality with providing information on contraception and STIs. In our view, this needs to be remedied. There are numerous organisations providing high quality sex education that recognises the importance of 'saved' sex (ideally saved for marriage, but at the very least for a committed loving relationship) as well as 'safer' sex (which usually equates to using a condom). Their websites[13] contain links to a wealth of resources which when combined give a truly comprehensive sex education package.
5	Short	5	12	Assessment of competence must be more than a box-ticking exercise by those whose priority is simply to ensure safe sex.

[7] 9.Fu H et al. *Fam Plann Persp* 1999; 31:56-63
[8] 20.www.naid.nih.gov/dmid/stds/ condomreport.pdf
[9] 23.Wald A et al. *JAMA* 2001; 285:3100-6
[10][10] Deardorff J et al. Early puberty and adolescent pregnancy: the influence of alcohol use. *Pediatrics* 2005; 116:1451-6
[11] Yan A et al. STD-/HIV-related sexual risk behaviors and substance use among U.S. rural adolescents. *Journal of the National Medical Association* 2007; 99:1386-94
[12] Dickson N et al. First sexual intercourse: age, coercion, and later regrets reported by birth cohort. *BMJ* 1998; 316:29-33
[13] www.loveforlife.org.uk; www.evaluate.org.uk; www.oasisuk.org/article.aspx?menuid=865; www.lovewise.org.uk; www.lifeuk.org./education/relationships; www.challengeteamuk.org; www.damaris.org/savingsex; http://www.love2last.org.uk/

				Intercourse with an under-aged girl is still a criminal offence, notwithstanding Home Office advice.[14] Consideration should be given to whether a 13 year old girl has sufficient emotional and psychological maturity to consent. Evidence exists suggesting sex experience before confidentiality, empathy and trust have been established can hinder and may destroy the possibility of a solid permanent relationship.[15] Sabia found a link exists between early experience of sex and depression in teenage girls.[16] Routine provision of condoms cannot be in the best interests of young teenagers.
6	Short	6	2	Parental involvement should normally be sought, and invariably so where younger teens are involved. Fraser guidelines permit proceeding without parental knowledge, but Lord Fraser also stated in his ruling that: 'Any important medical treatment of a child under 16 would normally only be carried out with the parents' approval' and it should be: '…most unusual for a doctor to advise a child without the knowledge and consent of parents on contraceptive matters.' [17] DH guidance states that: 'The duty of confidentiality is not absolute. Where a health professional believes that there is a risk to the health, safety or welfare of a young person or others which is so serious as to outweigh the young person's right to privacy, they should follow locally agreed child protection protocols.'[18]
6	Short	5	14	Information about contraception should be given in the context of lessons about mutual worth, respect for self and others, freedom from peer pressures and the courage to resist cultural trends and make one's own decisions in line with one's most deeply held instincts. The likely emotional cost of saying yes to sex early in a relationship only for it all to 'end in tears' should be considered. Contraception cannot protect the heart! Regret at surrendering cheaply something of such worth is ubiquitous. A number of research studies have shown that teenagers often regret the age when they started having intercourse, and over 40% of teenagers in the UK give peer pressure as the reason for first intercourse.[19] *Sex education should focus on values, not simply on technicalities*.

[14] Home Office, Children and Families: *Safer from Sexual Crime* – The Sexual Offences Act 2003, London: Home Office Communications Directorate, 2004.
Read more at http://www.fpa.org.uk/factsheets/law-on-sex#fupXTiyb1kEwl7B8.99
[15] Calderone, M, quoted in Collins R. A physician's view of college sex. *JAMA* 1975; 232:392
[16] Sabia J, Rees D. The effect of adolescent virginity status on psychological well-being. *Journal of Health Economics* 2008; 27:1368-1381
[17] *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402 (HL). bit.ly/2aYvtBH
[18] *Best Practice Guidance For Doctors And Other Health Professionals On The Provision Of Advice And Treatment To Young People Under 16 On Contraception*, Sexual And Reproductive Health, DH, Gateway Reference Number 3382, 29 July 2004. bit.ly/2ayXnOM
[19] *'Teenage Sex'*, Trevor Stammers, CMF File 37, 2008.
http://www.cmf.org.uk/publications/content.asp?context=article&id=2184

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				There is considerable evidence that simply increasing the availability of contraception to teenagers without accompanying education on the importance of saving or delaying sex leads to more sexually transmitted infections (and unplanned pregnancies) rather than fewer.[20] [21] Paton found that where there was an emergency birth control scheme operating, STI rates for under 16s increased by 12%. Young people aged 16-24 were the most affected group, accounting for 50-65% of all newly-diagnosed STIs in the UK in 2007.[22] Easier access to condoms reduces the perceived cost of sexual activity and makes it more likely (at least for some teenagers) that they will engage in sexual activity. This phenomenon, sometimes known as 'risk compensation',[23] results in an increase in the very thing it is trying to prevent and in this context will trend towards an increase in rates of STIs.
7	Short	5	27	It must be made clear that condoms do not effectively protect from the risk of chlamydia, herpes and HPV, even when used consistently and competently. In one study, among clients with known exposure, 13.3% of consistent condom users were diagnosed with *C trachomatis* infection compared to 34.4% of inconsistent condom users.[24] The figures are worse for HPV and Herpes, condoms providing little or no protection.

Insert extra rows as needed

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[20] http://www3.nd.edu/~kbuckles/condoms.pdf
[21] Paton D. Random behaviour or rational choice? Family planning, teenage pregnancy and sexually transmitted infections. *Sex Education* 2006;6:281-308
[22] http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1216022460726
[23] http://en.wikipedia.org/wiki/Risk_compensation
[24] Niccolai L et al. Condom effectiveness for prevention of Chlamydia trachomatis infection. *Sex Transm Infect*. 2005 Aug; 81(4): 323–325.

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