

ICPD +10: Sexual and reproductive health and rights in the UK in 2004

At the 1994 International Conference on Population and Development (ICPD) in Cairo, the 179 countries represented adopted a 20-year Programme of Action which emphasised the integral links between population and development, and which focused on individuals' needs and rights in sexual and reproductive health. 10 years on, at the mid-point of the Programme of Action, it is time to consider the challenges remaining and the progress still needed in the UK in key areas.

In recent years, greater attention has been paid to sexual health in the UK at a national policy level. Both the Teenage Pregnancy Strategy (1999) and the National Strategy for Sexual Health and HIV (2001) have highlighted the problems in sexual health and outlined programmes to address the issues in England. The Strategic Framework for Promoting Sexual Health in Wales was launched in 2000, and similar strategies are also being developed in Scotland and Northern Ireland. This is an encouraging development, but there is still a long way to go – the level of funding for sexual health services has not yet matched the rhetoric of prioritisation, and in 2003 a parliamentary committee described the “crisis” in sexual health in the UK¹. In this report we detail the progress to date in key areas from the Programme of Action, and outline the challenges remaining in order to meet ICPD goals by 2015.

Chapter IV: Gender equality, equity, and empowerment of women

- **The girl child:** *“Governments are urged to prohibit female genital mutilation wherever it exists and to give vigorous support to efforts among non-governmental and community organisations and religious institutions to eliminate such practices”*
- The Female Genital Mutilation Act 2003 came into force in March 2004 and strengthened existing legislation against the practice of FGM carried out both in this country and in other countries on citizens or residents of the UK. This was a welcome development and a strong statement in law that the practice of FGM is totally unacceptable.
- However, the strong legal message sent out by this Act is not being matched by strong actions at a local level. In order to eliminate this practice in the UK there needs to be greater commitment by Government to funding work with practising communities to inform, educate and change behaviour.
- **Male responsibilities and participation:** *“Special efforts should be made to emphasise men’s shared responsibility and promote their active involvement in sexual and reproductive behaviour”*
 - There is a growing recognition of the need to engage men in taking joint responsibility for sexual and reproductive health and behaviour, and there have been a number of initiatives which have pioneered ways of doing this.
 - However, this recognition has been slow to move into mainstream practice, where sexual and reproductive health is still commonly perceived as being a “women’s issue”. Although the number of men attending family planning clinics in England nearly doubled between 1992-3 and 2002-3, up to 93,000 men in 2002-3, this is still only a very small percentage compared with around 1.2 million women attending in the same year².
 - There are many ways in which reproductive health services such as family planning clinics

actively discourage the involvement of boys and men through their publicity, their image in the community, the attitudes of staff, or even through the lack of a suitable waiting area.

- Boys also report that they find sex and relationships education (SRE) in schools not relevant to them as it focuses almost exclusively on female reproduction or on negative aspects of sex such as sexually transmitted infections or unwanted pregnancies.

Chapter VII: Reproductive rights and reproductive health

- **Reproductive rights and reproductive health:** *“The right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law”*
- Access to abortion services has improved in recent years: in 2003 80% of abortions in England and Wales were NHS-funded (compared with 67% in 1994), and the vast majority (87%) were carried out under 13 weeks³; in Scotland, in 2003 99% of abortions were NHS-funded, and 92% were carried out within 13 weeks⁴.
- However, within Britain access to NHS abortion varies considerably according to where an individual lives. 2002 figures show that while in some Primary Care Trust (PCT) areas almost all abortions are NHS funded, in others less than two thirds are. There is also significant geographical variation in terms of waiting times for abortion services. 2002 figures show that there are particular variations between PCTs in the number of NHS-funded abortions which take place under 10 weeks, which range from as low as 9% to as high as 75% in some areas⁵.
- Having taken the decision to end a pregnancy, all women should be able to access abortion services promptly and without delay. There should be a target waiting time of 72 hours for abortion, with one week as a minimum

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standard. In addition, while women should have the right to choose and pay for an abortion privately, all women who want to do so should be able to access abortion services funded by the NHS. As a minimum, at least 90% of abortions should be paid for by the NHS.

- Women who choose to have an abortion must also have a choice of method. In 2002 only 14% of abortions in England and Wales were medical abortions⁶, compared with nearly 50% in Scotland⁷. There is an over-reliance on surgical methods using general anaesthetic rather than medical or early surgical (using local anaesthetic) methods. There needs to be greater development of both medical and early surgical methods, with all women offered a choice of methods where appropriate.
 - The primary abortion legislation enshrined in the Abortion Act 1967 has never been extended to Northern Ireland – this makes it extremely difficult for women there to get a legal abortion. Women in Northern Ireland are therefore denied the choice in fertility control extended to their counterparts in England, Wales and Scotland, and for this reason many women from Northern Ireland have to travel to England to pay for an abortion privately. It is an urgent priority to look at extending abortion legislation to Northern Ireland to enable women there to have the same reproductive rights as in the rest of the UK.
 - **Family planning:** *“To ensure that comprehensive and factual information and a full range of reproductive health-care services, including family planning, are accessible, affordable, acceptable and convenient to all users”*
 - Up to 80% of contraceptive advice and care is accessed through general practice. It is therefore encouraging that in the new General Medical Services (GMS) Contract, which came into operation in April 2004, practices which provide contraception are required to provide advice on the full range of methods.
 - However, helping women and men make a contraceptive choice about which they can feel confident requires professionals to have
 - **Sexually transmitted infections (STIs) and prevention of HIV:** *“Reproductive health programmes should increase their efforts to prevent, detect and treat STIs and other reproductive tract infections, especially at the primary health-care level...information, education and counselling for responsible sexual behaviour and effective prevention of sexually transmitted diseases, including HIV, should become integral components of all reproductive and sexual health services”*
 - The Government and health agencies are beginning to recognise the urgent need to tackle the rising rates of STIs, including HIV, and to address this. Most significantly, an opportunistic screening programme for
- up-to-date and objective information on the choices that are available. There is a need to provide full information and training to all medical professionals who advise on contraception, particularly GPs and practice nurses, and this should be updated regularly to take into account new methods as they are developed.
- Evidence shows that contraceptive services have been consistently deprioritised at a commissioning level. PCTs and Strategic Health Authorities must ensure that contraceptive services are fully funded and resourced, and should also undertake comprehensive data collection to evaluate and monitor service provision.
 - There must be greater investment in community family planning clinics to extend choice, particularly to improve access to methods such as implants and intrauterine devices (IUDs) which require specialist expertise for insertion and removal.
 - At a national level, more must be done to recruit both nurses and doctors into family planning services to ensure that there is sufficient staffing for future maintenance and development of these vital services. There is particular scope to increase the role of nurses in the provision of contraception, for example through development of nurse prescribing and nurse-led services.

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chlamydia is being rolled out and will be operational across England by 2008. This will primarily target young women, but will also promote greater uptake of testing among men.

- However, the scale of the problem requires a more urgent approach to implementation of the chlamydia screening programme, which we believe should be rolled out by the end of 2005.
- There needs to be much greater investment in GUM services in order to provide fast and effective treatment services. Waiting times currently average 10-12 days and can be up to six weeks⁸. It is crucial to implement a 48-hour target for waiting times in GUM clinics to speed up access to testing and treatment.
- There must also be further development of STI and HIV services in primary care, and much greater integration of testing and treatment within existing services such as general practices and family planning clinics.
- **Human sexuality and gender relations:** *“To promote adequate development of responsible sexuality, permitting relations of equity and mutual respect between the genders and contributing to improving the quality of life of individuals”*
 - In 2000, the age of consent in England, Wales and Scotland was finally equalised for both men and women (heterosexual and homosexual) at 16. In Northern Ireland the age of consent is equal for all at 17. This legislative change has sent out a clear message of equity between the genders and between those of different sexual orientation. New workplace anti-discrimination laws, making it unlawful to discriminate against workers on the basis of sexual orientation, are also part of a package of measures to promote equality.
 - However, there remains a need for SRE to include a comprehensive exploration of gender and sexual orientation, to help people of all ages to develop the knowledge, skills and attitudes to enable them to negotiate positive and mutually respectful relationships.
- **Adolescents:** *“Information and services should be made available to adolescents to help them understand their sexuality and protect them from unwanted pregnancies, sexually transmitted diseases and subsequent risk of infertility”*
- Government policy has recognised the importance of making information and services available to young people. Specifically, the Teenage Pregnancy Strategy (launched in 1999) is a cross-government programme which aims to reduce under-18 conceptions and increase the participation of young parents in education, training and work. There has also been a recent media campaign called ‘The Sex Lottery’ aimed at 18-30 year olds, which raises awareness of STIs and stresses the importance of safer sex.
- However, despite these initiatives, many young people do not receive the sexual health information and services they need. SRE in the UK is currently inadequate for young people’s needs, and is criticised for being ‘too little, too late, and too biological’. All young people have the right to high quality SRE from nursery school onwards, and this should be compulsory in schools within the framework of Personal Social and Health Education (PSHE).
- Sexual health services for young people should be built around the expressed needs of young people and underpinned by an understanding of the impact of sexuality and gender on their sexual and social identity and behaviour. Links between schools and health services should be encouraged, including providing holistic health provision on secondary school sites to meet young people’s needs. Provision should include advice and support about the availability of contraception, screening for STIs (particularly chlamydia) and other services for young people.
- *“Services must safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent, respecting cultural values and religious beliefs”*
- All young people are entitled to confidential services when seeking advice about sex,

relationships and sexual health. New Government guidance issued in 2004 clarifies and reinforces the right of under-16s to confidential advice and treatment – including for contraceptive and abortion services – as long as a medical professional is satisfied that the young person is able and competent to make that decision for themselves⁹.

- However, the Children Bill may jeopardise young people's rights in the UK, as it proposes to extend professionals' responsibilities to record and share information about young people's use of services.
- As a principle, professionals should not share information on young people's contact with sexual health services or where young people are known to be having sexual relationships. Information-sharing should only take place when there are serious child protection issues, especially in relation to young children, or if they have the young person's consent.
- Research with young people shows that they will not seek advice or disclose personal problems to any professional unless they are reassured about the confidentiality of the discussion. It is therefore crucial that these services are confidential and that young people perceive them as such.
- *"Programmes should involve and train all who are in a position to provide guidance to adolescents concerning responsible sexual and reproductive behaviour, particularly parents and families, and also communities, religious institutions, schools, the mass media and peer groups"*
- There has been increasing emphasis on supporting parents in Government initiatives, which recognise that the role of parents and carers in meeting young people's information, emotional and physical needs is crucial. The Government has also recognised the need to train teachers to deliver SRE, and in 2003 started to roll out a programme of professional development for teachers of PSHE which includes a specialist module for SRE.

- However, parents and carers report that they are given very little help in talking to their children about sex. Parents need to have improved support, information and advice to enable them to talk more easily with their children about sex and sexuality.
- It is urgent that training is extended more rapidly to teachers which will enable them to deliver young people's entitlement to SRE, and we believe that by 2006 there should be at least one specialist PSHE teacher in all secondary schools.

Chapter VIII: Health, morbidity and mortality

- **HIV and AIDS:** *"Programmes to reduce the spread of HIV infection should give high priority to information, education and communication campaigns to raise awareness and emphasise behavioural change. Sex education and information should be provided to both those infected and those not infected, and especially to adolescents"*
- The Government commissioned new 'Recommended standards for NHS HIV services', launched in 2003, which provide a framework for planning and commissioning services.
- However, diagnoses of HIV are increasing: there have been sharp increases in heterosexual diagnoses, particularly among recent migrants from Africa, and it is also estimated that about a third of people with HIV in the UK are unaware of their condition¹⁰.
- The early HIV/AIDS public health campaigns of the 1980s had a profound and significant impact. However, there have not been similar campaigns since that time, which has meant that a new generation of young people have grown up without those messages, and the messages are fading even for those who remember the campaigns.
- There is an urgent need to address public information needs about the risks of HIV in the UK, and to raise awareness of the need for testing among at-risk communities to reduce the levels of undiagnosed HIV.

Chapter XI: Population, development and education

- **Population information, education and communication:** *“Information, education and communication efforts should raise awareness through public education campaigns on priority issues [including]: reproductive health and rights; family planning; sexually transmitted diseases, including HIV/AIDS; responsible sexual behaviour; and teenage pregnancy”*
- The majority of information, education and communication efforts around sexual health are based at a local level. The main national government-funded campaigns on sexual health in recent years have been The Sex Lottery campaign, and a series of campaigns run by the Teenage Pregnancy Unit.
- The lack of national public health campaigns on STIs, HIV and safer sex since the 1980s has undoubtedly contributed to the lack of awareness about these issues among the population as a whole. Local campaigns are insufficient and there is widespread ignorance of the key issues in sexual health.
- It is vitally important that this situation is addressed by rapid improvements in SRE and the re-introduction of national public information campaigns about all aspects of sexual health.

- 1 House of Commons Health Select Committee, *Report on Sexual Health*, June 2003.
- 2 *NHS contraceptive services*, England: 2002-03, Department of Health, Statistical Bulletin 2003/15, 2003.
- 3 Government Statistical Service, *Abortion Statistics, England and Wales: 2003*, first release, 2004.
- 4 isdScotland, *Abortion Statistics Scotland: 2003*, 2003.
- 5 Government Statistical Service, *Abortion Statistics, England and Wales: 2002*, Bulletin 2003/23, 2003.
- 6 *ibid.*
- 7 isdScotland, as above.
- 8 House of Commons Health Select Committee, as above.
- 9 *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*, Department of Health, 2004.
- 10 Annual Report of the Chief Medical Officer 2003, *Health Check – On the State of the Public Health*, Department of Health, 2004.

fpa (Family Planning Association) is the UK’s leading sexual health charity working to improve the sexual health and reproductive rights of all people throughout the UK. **fpa** wants to see a society with positive and open attitudes to sex, in which everybody enjoys sexual health and where sexual and reproductive rights are respected.



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