

SEXUAL HEALTH WORKING PARTY,DEPARTMENT OF HEALTH [Queensland]

Dear Sir / Madam,

In our first Working party meeting Dr. Dunne and myself were asked to comment on some concerns with the current provision of sexual health services in Queensland from a research point of view. During our discussions, the following areas of major concern have arisen.

1) CONDOM INEFFECTIVENESS AGAINST THE SPECTRUM OF STI's.

Collation of the international medical literature on the subject suggests that on a case / control basis there have been 16 cases of HIV 508 in heterosexual "always" condom users, as against 394 in 1300 "never" condom users in 19 published studies.^{1,2,3,4,5} Meta-analysis suggests that whilst this provides unequivocal evidence of the efficacy of condoms against heterosexual HIV transmission ($P < 0.0000001$), the degree of protection offered is only 6-fold, with a relative risk reduction to 0.16 (95% C.I. 0.10-0.27). These collated data would suggest that condoms are fairly effective against HIV, and their use should definitely be encouraged for this purpose particularly in sexual contacts involving recognized high risk groups, but that it is unrealistically optimistic to promote them as a universal panacea or as an impenetrable barrier at the individual level.^{6,7}

However when one considers the generality of STI's seen in Australian STD clinics, a very different picture emerges. Figures for the Brisbane Adelaide St. STD clinic for calendar year 1997 are given below, but published figures for other states and in fact New Zealand are directly comparable. Condoms are not thought to be effective against our commonest STI's including Genital Warts and Herpes, and NSU (for which latter disease formal study is difficult in the absence of an accurate diagnostic test). The Wart virus is particularly pertinent to our discussion. 380 Women died from cervical cancer in 1995, the most recent year for which data is available, compared to 24 female deaths in 1997 from AIDS, and a total of 311 people dying in Australia from HIV disease.⁸ In other words HPV has usurped HIV as our most lethal STI, obviously as a result of the recent introduction of Highly Active Anti-retroviral Therapy (HAART). The literature on condom efficacy against chlamydia transmission is conflicting with only the occasional isolated positive report,^{9,10} but if one discounts the three conflicting reports from Gothenburg Sweden,^{11,12} and papers with obvious technical

STI's TREATED IN THE BRISBANE STD CLINIC¹³

DISORDER	PATIENTS %
GENITAL WARTS	22.10%
NSU	18.50%
CHLAMYDIA	16.90%
B VAGINOSIS	8.00%
HCV	7.30%
MOLLUSCUM	6.70%
LICE	6.70%
GONORRHOEA	4.40%
HBV	1.90%
TRICHOMONAS	1.60%
SCABIES	1.50%
SYPHILIS	1.50%
HIV - NEW	1.10%

PROSTATITIS	1.10%
HAV	0.30%
HDV	0.30%
REITER'S	0.20%
CHANCROID	0.00%
DONOVANOSIS	0.00%

errors such as non-significant P-values,¹⁴ or inadequate reporting of data,¹⁵ in fact most statistical reports, including some from Australia,¹⁶ do not suggest that condoms are effective against transmission of this disorder,^{17,18,19,20,21,22,23,24,25,26,27} or may actually increase transmission either alone²⁸ or in combination with oral contraceptives.²⁹ Condoms are not thought to be protective against other STI's including Hepatitis A, lice, scabies, Candida, Molluscum Contagiosum, or Donovanosis. Published reports do not support the view that condoms are useful against Hepatitis B, C or D. Literature is divided on the efficacy of condoms against trichomonas. Condoms are thought to reduce the risk of Syphilis transmission, but will not be effective when the chancre is not covered by the condom, as in many female cases where the primary chancre is commonly labial, or where the lesion is pubic, scrotal, abdominal or on the lips around the mouth. Similarly the rash of secondary Syphilis is generalized throughout the body surface and is highly infectious on contact.

These data would suggest that condoms could properly be said to be highly effective against only Gonorrhoea and HIV disease, which together account for 5.5% of the STI's documented to occur at our largest Queensland STD clinic. This suggests that they will be inactive, or only weakly active against 94.5% of Queensland STI's, which not only suggests a very different public health policy from the one currently in vogue, but also suggests that the present condom based campaign may actually be responsible to some degree for the present explosion of STI's in Australia. Nor is such a position idiosyncratic to Queensland. Professor Basil Donovan, current President of the Australian College of Venereologists, has written about this fact some years ago,³⁰ and indeed his words are worth quoting here. Indeed recent publications from the Federal Department of Health again under Professor Donovan's chairmanship, are essentially in accordance with the observations made here.³¹

“It is possible that this narrow focus [on HIV/AIDS] has contributed to a net deterioration in the sexual health of the Australian community.”
[Emphasis in the Original]³²

In fact the situation is somewhat worse than this because correlational studies suggest that in fact condom sales³³ have a very high level of correlation with the best data series of the incidence of Warts and Herpes 1973-1994 in the country,³⁴ significant at P= 0.000077 and 0.0277 respectively. Similar exercises can be performed for other STI's. The correlation of condom sales with adjusted age standardized incidence of Cervical Precancer is 0.00000768, based on the reports of the Victorian Cytology Registry.³⁵ Whilst correlational data alone is recognized not to be sufficient evidence of causal association, very high order significance levels, together with plausible basic science rationale certainly do command serious academic consideration at the very least, and are consistent with Professor Donovan's commentaries as mentioned. (NOTE: This committee could usefully request the official condom sales data from Ansell in Melbourne, as I have not had any meaningful response to repeated written and telephoned requests in the last three months.)

A further difficulty faced by safe sex practices is that it is well known that many sexual practices occur on Friday and Saturday nights when patients are not infrequently affected by alcohol or drugs, or in the context of certain drug related events such as dance parties. These substances are known to materially impede the performance of any delicate techniques such as the correct and consistent application of condoms.

2) FAILURE TO DEMONSTRATE HARMLESSNESS OF “HARM REDUCTION”

The most widely quoted series in the country which suggests that a decade of harm reduction instruction has had no effect on the sexual behaviours of teens and young adults, is taken from the regular annual survey of first year psychology students at Macquarie University. Whilst this is not a terribly representative group, this dataset now does

have the advantage that a decade of information relating to sexual behaviours has been gathered. It has recently been published,³⁶ and will soon be released in updated form.³⁷ This data relates to the period 1988-1997 which in fact is the period after the public relations “media blitz” on condoms, so that in fact true historical comparator data is not available. In fact this dataset shows highly significant trends to a ***rising incidence of sexual behaviours in 18-19 year olds***, even amongst a socially relatively advantaged group. For vaginal sexual behaviour, and for any sexual behaviour, ***the P-Values for trend are significant <0.001 and <0.0001 respectively.***

3) FAILURE OF “HARM REDUCTION” IN LONG TERM STUDIES.

The exact research base upon which harm reduction rests is unclear. Only a handful of countries have embraced these policies, and these would include Switzerland and Netherlands. It is understood that the phrase harm reduction was first reported from Amsterdam, and accompanied the introduction of needle exchanges to reduce Hepatitis B transmission in 1984. The following year, with the discovery of the AIDS epidemic strategies were quickly modified to adapt to HIV prevention. Early Dutch reports were encouraging,³⁸ but the initial enthusiasm was quickly dampened by subsequent reports only two years later of the dramatic failure of these strategies both in IVDU^{39,40} and in homosexual males.⁴¹ However given that the initial drop in HIV incidence 1986-1998 which was reported in both risk categories actually more probably reflected a passage from prevalence estimates to incidence estimates with the introduction of the first diagnostic tests, it would appear that the Dutch experience indeed does not constitute meaningful evidence for harm minimization.

Similar evidence has now accrued from Australia with the documented failure of Safe sex Practices in high risk males in Sydney,⁴² including higher rates of Gonorrhoea in risk groups in Adelaide^{43,44} and Melbourne⁴⁵ and indeed are reflected in the national gonorrhoea rates.⁴⁶ The Gonorrhoea data, which form a surrogate marker for safe sex, show a dramatic decline in the number of reported cases in Australia 1982-1990 from 12806 to 1919, but then a 2.2-fold rise to 4331 cases in 1997. Similarly the reported proportion of cases of new HIV infections in Australia in recognized high risk groups appears to be declining through the 1990's,⁴⁷ reflecting the steady if slowed passage of HIV infection into the general community, notwithstanding vigorous harm minimization techniques in many localities. Similarly the efficacy of the introduction of Needle Exchanges in Australia has been dramatically brought into question by a major review from Sydney, which showed that for the first week of its introduction, the syringe program reduced the frequency of heroine usage, but after that time there was a statistically significant risk in illicit heroine use in both the study and the supposed control clinic in the same city.⁴⁸

The above comments should not be viewed with a superficial understanding only. Despite the difficulties of formal arguments for causality in social and health sciences, it may well be that so-called harm minimization techniques have served Australia well at the beginning of the HIV epidemic, and have significantly slowed our Australian epidemic at least in its initial decade. However there is now incontrovertible evidence of widespread failure, fatigue and simple boredom with the message of safer sex, and continued risky sexual practices right across Australian communities despite the obvious effective and thorough penetration of the safe sex message, which is of such proportions as to require health policy making bodies to take into serious consideration the fact that although these messages are ‘heard,’ there is increasing evidence that they are not well “heeded,” in a manner in which in another situation, a microorganism may become resistant to continued exposure to the constant levels of antibacterial pharmaceuticals.

4) LACK OF EFFECTIVENESS OF SEX ED COURSES.

Whilst it is not commonly realized outside the sex ed world, in fact there is a plethora of research, emanating from the two Australian National Centers for HIV Social Research at Latrobe and Macquarie Universities,^{49,50,51} and elsewhere^{52,53} that in fact ***sex educational courses do not predictably improve safer sex behaviours of condom utilization***, and Professors Kippax and Rosenthal now assume this ***non-relationship as axiomatic.***⁵⁴ In view of all these problems, one might well ask “*What is the way forward?*”

SOLUTION

5) PRIMACY OF “GROUP ETHOS” AND “CULTURAL NORMS” MODEL

The National Centres for HIV Social Research chaired by Kippax and Rosenthal have consistently emphasized what might be referred to as the primacy of the cultural norms for sexual practices and behaviours. Whilst their groups consistently fail to demonstrate any improvement in condom usage rates with supposedly educational materials, they do propose that there may be a more indirect effect through the establishment of peer pressure, and subcultural norms. In the case of these research groups, who are naturally concerned primarily with HIV, the reference is usually to the establishment of safe sex practices.

However on the broader context of sexual and reproductive health for the cross section of the Australian community, the technical shortcomings of condom-based public health programs is now obvious to the discerning and informed reviewer. Harm minimization based programs appear to have a natural “fatigue time” which has now been exceeded. Public Health Policy Makers will need to urgently come to grips with this major phenomenon if they are properly to prepare our community for the next millenium of sexual health challenges – of which a good number appear to continually emerge.

What are the alternatives? One major and very useful modification of the present status which could very usefully be made, and it may well be that this is a timely opportunity, is to publicize some of the more obvious facts which have been discussed in the above remarks so that people in general, and young people in particular are more fully informed about their health risks, and the real safety limitations of the currently popular practices.

The major obvious alternative would be a return to a traditional morality and family values and a promotion of exclusive marriage as the sexual social and cultural norm. In this respect the present state of medical and scientific knowledge is very much in line with traditional Western values. Although this would not appear to be the forum for a full exposition of the benefits of traditional heterosexual marriage as detailed in the voluminous research literature on this subject, there is good evidence of the benefits of marriage for both men and women to longevity,⁵⁵ happiness,⁵⁶ illness incidence and recovery, breast cancer,⁵⁷ child raising,⁵⁸ financial well being,^{59,60} and welfare dependency,⁶¹ unemployment,⁶² accommodation and housing,⁶³ protection from illicit drugs,⁶⁴ most crimes^{65,66} including domestic violence⁶⁷ child sexual abuse⁶⁸ and homicide,⁶⁹ mental illness including suicide,^{70,71} and STI's^{72,73,74} including cervical malignant disorders,⁷⁵ and enjoyment and satisfaction with sexual function.⁷⁶ Such an approach would also address the major issue occurring now in Australia with an inexorably rising illegitimacy rate, reported recently from ABS as 26%. This is serious as sociological experts have suggested that 25% may well be the safety limit at which the criminality delinquency and rebellion so well described in single parent families begins to become non-sustainable for the general culture.⁷⁷

Furthermore, in the specifically Australian literature the following health advantages have been documented as being conferred by marriage, almost all at the P<0.001 level.⁷⁸ This work is from Colin Mathers, writing for the Australian Institute of Health and Welfare in the Commonwealth Department of Health and Human Services.

- 1) Death,
- 2) Avoidable Deaths,
- 3) Years of Life Lost,
- 4) Ill Health,
- 5) Handicap and Severe Handicap,
- 6) Disability,
- 7) Chronic Illness,
- 8) Unhappiness,
- 9) Reduced Activity,
- 10) Mental Illness,
- 11) Emotional Disorders,
- 12) Suicide,
- 13) Coronary Disease,

- 14) Stroke,
- 15) Cancer,
- 16) Tobacco and Alcohol Use,
- 17) MVA's,
- 18) Bronchitis, Pneumonia,
- 19) Diabetes,
- 20) Lung Cancer,
- 21) Injury and major organ failure associated with death including failure of:
 - 22) Respiratory,
 - 23) Circulatory,
 - 24) Neurologic,
 - 25) Endocrine/metabolic,
 - 26) Genitourinary and
 - 27) Gastrointestinal systems.

None of this should be misunderstood to imply a judgmental or condemnatory attitude to non-traditional lifestyle choices. People of all types and characteristics deserve to co-exist side by side in a pluralistic and free society. Nor is this to deny the need for special programs targetted to localized subcultures felt to be at elevate risk on documented behavioural grounds. However neither is it true that the freedoms of numerically limited special needs groups should be allowed to fetter widely accepted scientific truths, nor to censor important health messages, which in the final analysis must ultimately be directed at the wider community. The importance of the Human Papilla Virus (HPV) to Australian Public Health which, other from the Pap Smear campaign, would appear to have received virtually no attention in the Public forum; and the established superiority of traditional marriage to any other relationship style across a wide range of research documented criteria, would be major illustrations. However there are many other points pertinent to young people's reproductive health which have also not been meaningfully addressed. These might include the role of prolonged hormonal contraception in increasing the risk of Breast Cancer particularly in teenagers; 30 studies showing almost uniformly an increase in the incidence of Breast Cancer induced by abortion; the interaction between female reproductive and the oncogenic effect of HPV; the increased incidence of many STI's including HIV in patients taking oral contraceptives etc.

CONCLUSION.

In summary, Queensland does need an urgent review of its sexual health program, and the R.A.C.G.P. would be more than happy to work with government agencies to develop and improve presently available clinical and educational services. Compelling Australian data presented above strongly suggest, and our medical leaders concur, that not only is the present approach not working, but continued efforts in the so-called "comprehensive" and "harm minimization" models are not only a *significant and possibly major force driving the current deterioration in sexual and psychological health or our young people*, but suggests that a return to a more *time honoured, robust and character based approach* such has been proven successful in international fora⁷⁹ to be effective against the plethora of behaviourally based psychosocial disorders presently plaguing our youth, may in fact be *timely and appropriate*, and *represent an option which Queensland should urgently explore.*

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