HOUSE OF COMMONS

Women and Equalities Committee

Oral evidence: Prevalence of STIs among young people, HC 463

Wednesday 24 January 2024

Ordered by the House of Commons to be published on 24 January 2024.

Watch the meeting

Members present: Caroline Nokes (Chair); Dr Lisa Cameron; Carolyn Harris; Kim Johnson.

Questions 1 - 61

Witnesses

I: Dame Rachel de Souza, Children's Commissioner for England; Professor Sir Chris Whitty, Chief Medical Officer for England, Department of Health and Social Care; Dr Claire Dewsnap, President, British Association for Sexual Health and HIV (BASHH).

Examination of witnesses

Witnesses: Dame Rachel de Souza, Professor Sir Chris Whitty and Dr Claire Dewsnap.

Q1 **Chair:** Good afternoon, and welcome to this afternoon's session of the Women and Equalities Committee and our work on the prevalence of STIs among young people. I thank our three witnesses this afternoon, Professor Sir Chris Whitty, Dr Claire Dewsnap and Dame Rachel de Souza. As usual, members of the Committee will ask you questions in turn. If a question has not been directed to you but you wish to contribute, please indicate and I will bring you in as soon as possible. All the witnesses have confirmed that they are happy for me to use their first names.

I will come to Chris first. Can you briefly set out what the main trends are in the prevalence of STIs and why that is causing concerns?

Professor Whitty: Thank you. Why don't I make some comments about the numbers and general trends, and I am sure Claire will want to come in with more detail? There is some good news and some bad news, in terms of sexually transmitted infections in younger people, but also across all age groups.

Let us start off with the good news: because of the remarkable success of HPV vaccination—we might want to come on to this in greater detail—there has been a steady decrease over time in venereal and genital warts, which is very good news. Alongside that, and slightly later in time, we'll see, and will continue to see, a substantial reduction in women who get cervical cancer, in men who get penile and anal cancers, and some throat cancers. That is an astonishing improvement. We now need to make sure we keep those rates of vaccination up, and it might be worth talking about that later on in the session, if you would find that useful, because HPV is a really important sexually transmitted infection.

Alongside that, there is broadly good news with HIV. Things have improved quite significantly over the last decades, but there has been some levelling off more recently, and that probably should be recognised. The third area where I think things on the whole have become slightly better is herpes simplex. There has been a bit of a decrease in that over time.

Unfortunately, there is a but to this. As has been very clearly laid out in the newspapers over the weekend, and rightly so, there has been a very substantial increase both in the last year—some of that is due to the pandemic; short perturbations because people were not being diagnosed, and maybe changing behaviours—and also long-term trends where there have been significant increases, the sharpest being in gonorrhoea and the second in chlamydia, but there are also increases in syphilis and a variety of other infections.

I will pass over to Claire, because she has to live this every day, but before I do, I want to put in a few numbers to get some sense of scale. The overall number of chlamydia cases that are diagnosed a year—there is a big caveat because large numbers of people carry these infections without knowing about them and do not have symptoms, so the sense is this is at the bottom end of the range—is around 199,000, with around 82,500 cases of gonorrhoea. I am rounding these numbers just to give some idea. There were around 26,000 cases of genital warts, but that number is going down. Herpes simplex has roughly the same kinds of numbers, and syphilis is down at about 8,500. Syphilis is a very dangerous disease, which has long-term consequences if not treated.

All these diseases have long-term implications if they are not treated, but there are two reasons to treat. First, it stops or substantially reduces the chances of going on to get genital complications or fertility issues. There might be general complications—for example, syphilis can cause very serious disease. Secondly, it protects. If someone is treated early, it protects their partner but also other people they may have sexual relationships with and the wider community. So it is really important that people are treated—ideally, they do not get infections in the first place, but if they do—to stop onward transmission.

The final point I would make before handing over to Claire is it is very important that we do not see this as in any way stigmatising. These are very common diseases. They spread around very easily. Lots of people get them who have incredibly conventional sexual and romantic lives, and this should simply be seen as one of the routes of transmission, just like oral or respiratory, by which people can get potentially very serious infections.

Q2 **Chair:** Can I ask you a question about HIV diagnosis? We have seen a downward trend in men but a 26% increase in heterosexual women in 2022. Is stigma driving that? That might be a question for Claire.

Professor Whitty: One thing I will say before Claire comes in is that the last three years have been a bit complicated, because people have both changed their behaviours but also diagnostic rates have gone down during covid, in my view. Both of those need to be taken into account, but I will hand over to Claire.

Dr Dewsnap: It is complicated, but the long and the short of it is, areas where there is a high density of gay and bisexual men—who would have previously had lots of programmes directed at them in terms of access to PrEP and other prevention methods, and treatment and care for HIV—have been addressed with lots of incredible programmes. The wider geographical areas where you are quite correctly seeing these rises—in particular, among black African women or women of black Caribbean ethnic origin—are much more likely to be outside big conurbations like Manchester, Brighton and London, which have already seen lots of improvement, having attracted investment in the field of prevention due to their previous higher rates. Women are now really disadvantaged, and

not only do they have higher rates of new diagnosis of HIV but they are also presenting significantly later, meaning we are not testing them early enough. That is really critical and there is massive inequality. You see this both geographically but also socioeconomically and in terms of racially minoritised communities.

Q3 **Chair:** Thank you. Chris, you touched on the serious health implications that can result. Are we also seeing an uptake in teenage pregnancy and abortion rates?

Professor Whitty: The long-term trend in terms of teenage pregnancy and under-age abortion rates has actually been downwards and quite markedly so, which is a great tribute to large numbers of people working particularly in the education sector but also elsewhere. Again, there has been a bit of perturbation in the numbers over the last two or three years and it is quite difficult to tell how much is due to reporting issues around covid. My view is the overall trend has remained very low on this, but we should not be complacent, as this could go backwards at any point if we do not put a lot of emphasis on it.

If it will be useful, I will find out the numbers, but we have seen extraordinary improvements in this area. This is not because people are having pregnancies and then having an abortion—because the abortion rates have also gone down in this age group—but because they are not getting pregnant in the first place, which is absolutely critical.

Q4 **Chair:** Is that a success of pregnancy prevention measures—so long-acting contraception which is protecting against pregnancy but not against STIs?

Professor Whitty: That is correct, in broad terms. I do not expect people have had big changes in sexual behaviour, but it has not led to translation through to pregnancies.

Dr Dewsnap: I would add that the slight problem you have with pregnancy rates is that there is always a delay—it is a bit more like the Titanic than STIs are. STIs are the canary in the mine, so pregnancy rates are going to move slower. Teenage pregnancy rates have stabilised; they went down and now they are stable. But if you look at the pregnancy rates in 24 to 30-year-old women, the termination and repeat termination rates are higher, and that is because programmes have not specifically been directed at those women; they have specifically been directed at young people, including LARC. In many services now, including primary care, they will only deliver LARC to young people.

While I recognise that this Committee is particularly concerned with the sexual health of young women and young people generally, those 18-year-olds become 25-year-olds, and they cannot then access the care they could 10 years ago. Those pregnancy rates are really worrying, and the recurrent termination rate, in particular, is going up, not least because there is fragmentation across the system. Sexual health services

and most contraception are commissioned by local authorities. Women's termination care and gynae services are commissioned by the CGC, and now the ICBs, and other bits of care are commissioned by NHS England, but those bits of the system are not currently speaking to each other, which is quite worrying.

Q5 **Chair:** Is there an easy way to make those bits of the system speak to each other?

Dr Dewsnap: To me, this is all about accountability. Somebody needs to be overseeing those different bits of the system. At the moment, as far as I can see, the only body that oversees the sexual health contract, which provides the vast majority of contraception and STI care, is the local authority itself. It is basically marking its own homework, because no other bit of the system is saying, "We're not able to deliver termination care. How can we work together as a system to do it?" That could easily be a structural issue rather than any other influence.

Q6 **Chair:** Rachel, you were nodding your head on the question about long-acting contraception. Did you want to add anything to that?

Dame Rachel de Souza: It is really good that pregnancy rates are down, but when I read that total new STIs among 13 to 19-year-olds rose between 2021 and 2022, and last year there were 385 diagnoses of STIs, that is one a day, in 13 to 14-year-olds, and 56,000-plus among 15 to 19-year-olds, that is 155 per day, clearly, if pregnancy rates are going down, we are not having a positive impact on STIs. The gonorrhoea stats are three times what they were the year before.

Chair: Thank you. We are going to come back to young people very shortly, but Kim, I would like to bring you in, please.

Q7 **Kim Johnson:** Thanks, Chair, and good afternoon, panel. I have a couple of questions on antibiotic resistance—so for Chris and Claire. To what extent is antibiotic resistance a concern in tackling the spread of gonorrhoea? I will go to Chris first on that point.

Professor Whitty: You have absolutely zeroed in on the infection where the biggest worry is. In the UK and internationally, gonorrhoea is one of the most highly drug-resistant organisms we have. We are now down to a very limited number of antibiotics which can be used. Previously, we would have had a much wider range. Fortunately, this has not translated into drug resistance for most of the other antibiotic-treatable sexually transmitted infections, at least not to this level, but we are in deep trouble at the moment, and we need some new antibiotics or some new way of approaching it.

Dr Dewsnap: The thing that worries me most about this is that with gonorrhoea and mycoplasma genitalia, which is another STI that has very high rates of antibiotic resistance, the most resistance is seen particularly in people of black African or black Caribbean ethnic origin and also young people and MSM. So the three groups that we are most worried about

being able to tackle infections in are more likely to have drug resistance on board. We are also finding it very difficult to access resistance testing for mycoplasma genitalia. The system itself is not set up as well as it could be for us to monitor that resistance and to act appropriately. We also need research trials to develop new drugs, because we are on our last antibiotic for gonorrhoea, and if it suddenly starts becoming more resistant to that antibiotic we are going to have a real problem.

Q8 **Kim Johnson:** What would be the long-term effects of somebody not being treated effectively with the antibiotics?

Dr Dewsnap: All you have to do is look back to 1930 and you will know. Twenty out of a million people died of syphilis in 1920 and that was part of the reason for the STI and venereal disease Act. People can die of gonorrhoea. Babies can be born with blindness. People get long-term consequences from heart infections. They can get encephalitis, a brain infection. Syphilis itself is very damaging. If you are born with syphilis you are likely to go on to have a life of disability, and that disability is often not even recognised because it can be low-level. There are major consequences and also lots of impacts on pregnancy. Again, this is all unequally impacted across the sector, so not everybody is as likely to be poorly treated and poorly identified with gonorrhoea, chlamydia and syphilis. That is important.

Professor Whitty: I completely agree with Claire, but just to be clear, at this point we are much less concerned about drug resistance in syphilis. Syphilis is a very dangerous disease with multiple complications; gonorrhoea is the biggest in terms of antibiotic resistance. It does not have quite the same level of risk as syphilis if it is untreated, but it still has a lot of potential risks, including pelvic inflammatory disease in women and a variety of other things. So this is not a trivial but a very serious infection.

Q9 **Kim Johnson:** In 2022, the UKHSA report noted increases in less-frequently-reported STIs such as LGV and Shigella. Are less frequently reported STIs becoming a concern, and are particular groups affected? You have just touched on that, Claire, so could you pick up on some those points, please?

Dr Dewsnap: We are really worried about LGV. For those of you who are not sure, it is a chlamydial infection, but it is a particular type of chlamydia which is more likely to have long-term consequences. It often presents to secondary care, which is part of the problem. It can present with diarrhoea. It can present with long-term consequences, such as enlarged genitals through lymph node enlargement and fissures, so long-term health complications. Similarly, Shigella may not present to sexual health services, so a lot of the infections that we would normally code for—therefore, you can see the data in this report—are not coded for in a hospital setting. If people do not present to us and are not referred directly to a sexual health service, we would not necessarily be aware that they have had the infection.

Importantly, we cannot then implement prevention messages for the future. They are often just identified as an infection, treated, and then it is, "On your way," whereas we would implement other practices like talking to them about safe sex and perhaps advising more condom sex, giving them a way into PrEP, HIV testing and generally education around regular testing for STIs. That is an important part of what we do to prevent other infections.

Q10 **Kim Johnson:** In terms of the antibiotics, do these diseases have the same kinds of issues that you have related to gonorrhoea?

Dr Dewsnap: LGV is a chlamydial infection. We do not see much resistance in chlamydia, so it is fairly easy to treat, but Shigella has been identified in this country as being multi-drug-resistant. That could be problematic for people, especially if it were to take hold in a particular community. As we saw with monkeypox, or Mpox, last year, infections spread across global boundaries and communities, so there is nowhere to be safe around those infections. We need to identify them early, test for them and make sure that we resistance test so people get the right antibiotic.

Professor Whitty: Can I add one thing on Shigella? Most people who catch Shigella do not do so sexually. It is caught by a variety of different routes. If someone has heard that someone has had a Shigella infection, it does not necessarily mean it is sexual. There is a lot of it around. There is a big problem, exactly as Claire says.

Q11 **Kim Johnson:** I think Rachel raised the point earlier about the number of young people, including 13-year-olds, contracting STIs. What is the prevalence in this group in terms of syphilis and gonorrhoea? Are younger people contracting gonorrhoea and syphilis, and what are the long-term health effects on those young people?

Dr Dewsnap: Gonorrhoea has gone up the most in heterosexual women. The groups that are most affected are young people but also gay and bisexual men, people from socially deprived backgrounds, and racially minoritised communities. So young people are very vulnerable to gonorrhoea, and rates are increasing. Syphilis is as well but to a slightly lesser degree. We see more of an increase in the 20-somethings than in younger women, but younger women are still getting it, and that in itself is a relatively new thing. We now see more syphilis than we have since 1948, and a lot of the presentations in clinics and potentially in other settings like primary and secondary care, are things that we have not seen for 50 or 60 years, which is deeply worrying.

Professor Whitty: If I could add two points to build on what Claire just said: in younger people, girls and women tend to be more affected than boys and men. So the rates are higher in the youngest, and then that reverses once you get to about 30, and after that the rates are higher in men. There is a gender difference in this, which is slightly different between the different diseases, but overall that is true.

To get a sense of scale on this, the Royal Commission on Venereal Diseases, as it was called in the 1910s, estimated that over 10% of the population of London and the other metropolitan areas had syphilis. That gives you some idea of how high the rates can go if treatment and prevention are not available.

Q12 **Chair:** Chris, you referred earlier—I do not know if this is going to come up later but in case it does not—to vaccination programmes and the importance of the HPV vaccination. Are there any other vaccinations coming down the tracks or already in existence? If so, what should we be looking to vaccinate against next?

Professor Whitty: Let us start off with the one that is extraordinarily effective, which is the HPV vaccine. We know that if all girls, and now boys, are vaccinated at a young enough age—around the age of 12 or 13—then 97-ish per cent will be individually protected, and at a population level this will probably be just shy of 90%. They protect one another by the fact that both sexes are included, and this will, in due course, get rid of almost all the herpes-driven cancers that go this way, which are principally cervical cancer but a number of others, and genital warts. HPV vaccination is the most important one we really must get on top of.

On gonorrhoea, if you give people meningitis B vaccines—meningococcus is a distant cousin of gonococcus in terms of its biology—that has about, for the sake of argument, a 30% to 40% protection against gonorrhoea as well. It is not complete. It is nothing like, for example, a covid or an HPV vaccine, and it probably will not last for very long, because we know you can get gonorrhoea repeatedly, so that implies protection is not going to be long-lasting. It is not for everybody by any means, but for people who are at high risk, it is a useful thing to be considering.

There is a gonorrhoea-specific vaccine that is being trialled at the moment. We will see where that goes to, but for other reasons we hope to do better than the 30% to 40% that we have on the current vaccines. In terms of other sexually transmitted infections we have talked about, there are lots of things in research stages, but, unless Claire wants to disagree on this, I would say we are five to 10 years away from widespread deployments. Gonorrhoea is the one where the biggest potential for vaccination lies in the short term.

Dr Dewsnap: The only thing I would add to that is the Mpox vaccine for which we did an outbreak management of a rollout, and now there are recommendations to have a wider rollout in particular risk groups. There is the gonorrhoea vaccine that Chris talks about, but also potentially DoxyPEP. That is not a vaccine, but it is an antibiotic which is probably coming down the line, which we can use in certain groups and is particularly good at reducing chlamydia and syphilis infections.

Q13 **Chair:** Is there a steady take-up of the HPV vaccine?

Professor Whitty: It took quite a hit during covid, largely because the vaccine is delivered through schools, and it is beginning to creep up again. The most recent data came out yesterday but take-up is still significantly down on what it was in the youngest age groups and what it was pre-pandemic. We need to work hard to get that back up again because we have the potential to almost eliminate cervical cancer in this country. It would be tragic to let that slip through our fingers because of operational problems or because people have concerns.

We really need to make clear that this is an incredibly effective vaccine against a very unpleasant set of diseases—not just one disease—and with a very good side effect profile. It is something that any girl and boy should be encouraged to take up.

Q14 **Chair:** Is it only a problem with the catch-up programme?

Professor Whitty: Take-up before the pandemic was actually very good, and I do think we will get back there, but we have a cohort of people who would normally have had it through the schooling system who have missed out. We need to take account of that.

Dr Dewsnap: Sexual health services would really like to be able to provide catch-up for the women who present to them. We are currently only commissioned to deliver the vaccine for MSM, and we have been doing that for five or six years. Boys are now getting the vaccine through school, but before that sexual health services delivered it. We see many women who have missed out on the vaccine, and we cannot give it to them. If you could change that, it would be a really great thing we could do.

Q15 **Chair:** That is a really solid recommendation, because while you can catch up with men, at the moment, you cannot catch up with women.

Dr Dewsnap: There are also students who are new to this country and have access to NHS services because of their visas. They often stay and are productive but because they are having sex with other people in this country, they should be offered the vaccine as well.

Professor Whitty: I am very supportive of that, but—and there is a big but on this—because the HPV viruses are so infectious and so widespread, most people are infected at a very early stage in their sexual life. The effectiveness of the vaccine goes down quite quickly once people become sexually active. I absolutely agree we should have a catch-up, because it is much better to be vaccinated than not, but a vaccination at 25 is not as effective as a vaccination at 13.

As far as possible, we should get people before they are sexually active, and then they will have complete protection. So while I completely agree with you, I am just saying, they are not a 1:1 ratio.

Dr Dewsnap: That is absolutely right, but evidence is now coming out that shows people who have already acquired the wart virus, and

probably already have high-risk HPV which might lead to cancers, are treated effectively by giving them the vaccine. Now, this is early data—it is cohort studies—but potentially somebody who has already acquired that high-risk virus may get rid of it quicker because they have been vaccinated. We do not really know that for certain yet, but it is worth seeing where it goes.

In the meantime, as Chris said, we should continue to vaccinate people in schools, and catch up where that has not happened.

Q16 **Dr Cameron:** My questions are about the demand on services. Dr Dewsnap, how are sexual health services coping with increased demands? We understand that more people are possibly being diverted to home testing. Are these kits as reliable as those undertaken at the clinic? Would in-person consultations be available to those who need or wish to have them?

Dr Dewsnap: It is really complicated. I do not like to use the word "crisis", we are very close to a crisis. I do not know if the Committee is aware, but we have done our own surveys, and the Terrence Higgins Trust just did an incredible mystery shopper survey where it asked a group of people to phone around sexual health services. Only 50% of services in that mystery shopper review were able to offer a face-to-face appointment to the caller, and that was worse in rural areas and worse for young people.

Access is not good enough; there is no doubt about that, and there is no doubt that this is a result of reduced funding. We have had a real terms funding reduction of about £150 million over the last 10 years going to all sexual health services, and because the vast majority of our budget goes on staff, ultimately there are fewer staff in clinics. Something like 80% of my budget is spent on staff, so if I have to reduce the budget by 10%, I am going to reduce staff. There is no doubt that has happened.

Q17 **Dr Cameron:** What concerns would you have about people not being able to access face-to-face when they want it?

Dr Dewsnap: It is really tricky. If you are talking about young people, there is a lot of evidence showing that young people have more difficulty accessing online testing, not least because, for example, if you order an online test, it has to come to your home address, most of the time. If you do not want a parent to know that you are testing, or someone you are living with—for example, someone you are already in a relationship with—you would not want the test to come to your home address. That is the only way of doing it at the moment. You also have to give a mobile number. So there is an issue of security and personal confidentiality around ordering it to your home.

In addition, there are digital disparities, and that is worse across socially and economically deprived groups. It is worse in rural areas, so you are less likely to get an online test in a rural area. Some of the problem is

around the slightly different funding for geographically wide areas with lower populations. They are going to have less funds for an online test.

The last thing I would say, and this worries me a lot, is that only 50% of young people online identified as safeguarding risks are eventually able to be contacted. So if you go online as a young person and put something in your screening questionnaire that says, "I am a safeguarding risk," there is only a 50% chance you will ever be contacted about that safeguarding risk. That is extremely worrying.

What needs to be remembered is that online tests are great, and we want more people to have them, but that cannot be at the expense of a face-to-face service, because young people will always lose out.

Q18 **Dr Cameron:** So they need the option and people may be falling through the net. Dame Rachel, you wanted to come in?

Dame Rachel de Souza: I feel so passionate about this. One of the ways we were so successful in the past in these areas was that children could just walk in. Often, they would be signposted by a school nurse, who was a trusted adult in the school and would send them off for a test. We now have 35% fewer school nurses than 10 years ago, and you cannot just walk in. Children are telling me all the time that they are not able to get access, they are not able to get appointments. Just think: you are one of this massively rising tide of children, girls with gonorrhoea, you are feeling unwell, and you try to get an appointment, but you cannot get one. It settles down, so you leave it, then five years later, you have serious trouble when it flares up again.

Children do not access services in the same way as adults. They are not going to sit and wait and take something two weeks later. They need instant access; that is what does it.

Claire will confirm that those services have been decimated, and the children who need help are not able to access it. Children in rural areas, children with disabilities and SEND, asylum-seeking children, children from certain ethnic minority groups and in particular LGBT children have spoken to me about it. So I am deeply worried and even more worried after talking to Claire.

Q19 **Dr Cameron:** Thank you, that has been extremely helpful.

Are there particular areas in the UK where you think young people are finding it harder to access screening? In relation to services being somewhat fragmented in terms of sexual health service commissioning, how would that impact upon access as well?

Dr Dewsnap: Rural areas are significantly more disadvantaged. If your child lives in a rural area, they are going to find it harder to get into an appointment, whether online or face-to-face, and that is worrying. There are particular local authorities where the rates of STIs have gone up—you can access that data online—and while some of those challenges are

around funding, others are around structure and the fragmentation of services.

One of my main worries about fragmentation in our local authorities' commissioning for sexual health services is that there is not really any challenge to those commissioners if things are getting worse, because it is owned by the local authority. I hope that politicians within local authorities are challenging the situation, but we have not seen any evidence of that. What we have seen is repeated calls for further funding, when actually we need to be honest about where we could be doing better.

The other problem with tendering is that it massively undermines the workforce, and we have seen that categorically since tendering began 10 years ago. The backstory is that you have to go to tendering because of the value of these contracts—within a local authority, you are required to do it. As a result, workforces have been absolutely decimated, including GUM trainees. I am a GUM doctor. Our ability to recruit people into our specialty has fallen off a cliff, and the same has happened in contraception and reproductive health as a specialty. We also have a massive turnover in nursing staff, so we spend a long time training staff. All these things have an enormous impact on access.

As Rachel said, it is much harder for young people to get access to those services because they do not want to sit about. One of the major consequences of the reduction in budgets has been a reduction in drop-in services. They are particularly challenging to deliver because you do not know what your capacity needs to be. You need to have enough staff to deal with an onslaught if you get it, but you do not want staff sat around not doing very much if activity is going up and down. It is an easy thing to cut back. What we know is that only 10% of services now have a drop-in available for all. About 25% of services have a drop-in for young people, and most of those are for under-18s rather than under-24s. And the under-24 age group, as a group, moves together.

Q20 **Dr Cameron:** I feel like having evidence of good practice in drop-in services is something that is really required.

Dr Dewsnap: My ask to this Committee is that you recommend a strategy because it all has to be underpinned. If we are in a setting of tight resources, you have to make decisions about what you are going to spend money on and that can only really come from a strategy. We are not expecting you to suddenly lavish us with all the funds that we would ever need, but we do need more funding, and we actually need a strategy that decides where we are going to put our resources.

Young people would obviously be a really important part of that because they are at the beginning of their sexual lives, they need the knowledge and they also need the access to the service. So that is really important.

Q21 **Dr Cameron:** Did anyone else want to add to that?

Dame Rachel de Souza: Just two things. One is to reiterate Claire's point that this is often a child's first engagement with health, how they look after themselves and how they go forward into adult life. It is a really important engagement, and we should try to reduce as many barriers as possible.

In addition, yes, a strategy is vital, but we can be proactive. Rather than sitting at drop-ins waiting to see if under-18s come in, we should get into schools, get into colleges, and engage in that way. There are lots of things that can be done, and again it needs an evidence base and proper thinking, but it is critical. A child that goes knocking on an unfamiliar door in absolute terror because they think they have an STI needs embracing, dealing with, and supported to be able to overcome that through the system, not barrier after barrier or maybe, if they are lucky, a bit of online advice. It is really serious.

Q22 **Dr Cameron:** Is there any evidence of good practice that you could describe?

Dr Dewsnap: There is a lot of good practice. Some depends on the variation in resources that people are able to put into different parts of their work and the need to focus on risk groups. If you work in a setting where 80% of your clients and service users are men who have sex with men, then that is where you might focus your resources. There are many services that focus quite heavily on young people. We have lots of good practice that we could signpost you to, but it is really difficult because we are now making choices about what we offer, and that is going to continue in this current environment.

Q23 **Dr Cameron:** I am interested in technological advances in health, and I believe it was reported that an STI diagnostic tampon has been developed. To what extent is there scope for advances in screening kits and technological advancements that might have an impact on diagnosis and treatment, moving forward?

Dr Dewsnap: The testing we have is excellent, so there is currently no gap in the market for different tests. If you order a test online you get a swab. For a man that is just a urine sample, and for a woman it is a self-taken swab, so you can do it yourself in the bathroom. I do not know many women that would prefer to use a tampon than a swab that is there for 10 seconds. It is an unnecessary initiative.

Where we need to focus is access and changing the inequality of that access. Both young women and fully adult women absolutely know what they want; it is being able to get it right now that is the problem. I do not think the testing tampon will make a difference, if I am honest. It might turn out to be a flash in the pan.

Dr Cameron: Thank you, that is helpful.

Q24 **Chair:** Can I just take you back to postal testing and the delivery of testing kits? Is there any model whereby you could use the Amazon

Locker method?

Dr Dewsnap: There is. That could work, and some clinics may already do that, but it is certainly not widespread. Around 90% of services have an online offer but it is limited, often by cost. These tests are sometimes quite expensive, especially if you are with an external provider.

So, yes, it is absolutely possible that we could get around people not wanting it to come to their home. What may be better, however, is for people to be able to have tests local to their service, and that outreach which we used to be able to do—so not a permanent clinic around every corner, because obviously that is not sustainable, but pop-up clinics in different places.

We used to do buses that went around towns and cities, and they would be at the youth club on a Thursday and at the town centre on a Friday. Those things are really welcomed, and the evidence that has been gathered is that young people quite like those services.

So in terms of online services, there are other things we could do, but there are also other ways to get to young people.

Q25 **Chair:** Some questions I am going to ask are specifically around young people, barriers and stigma. What stigma, if any, did the bus service create, or was it a mechanism to break down stigma? I am firing that at you Claire, but Chris or Rachel may also want to comment on it.

Dr Dewsnap: My experience of young people is that they tend to be less stigmatised about STIs in this current environment than those of my age in the sense that they are learning information from social media. It might not always be the right information, but they are learning it, so we did not really see any opposition.

The problem is that, for young people, one model that will not fit everybody. The evidence shows that different models are required in different areas. So, for example, if you wanted to open up an outreach setting in Lambeth, you might have a completely different concern or worry than if you are opening somewhere in Lincoln. Services need to be locally derived, and it is fine that we get a mixed economy of different offers.

Q26 **Chair:** Rachel, I want to ask you about how young people are accessing information. Claire has just referred to social media. What are the positives of that? What are the dangers?

Dame Rachel de Souza: It is interesting. In 2022, my office did a nationally representative survey of 3,000 young people and asked them where they learned about sex education, and what they learned at school. Only 55% of children said they had learned about relationships as part of their PSHE lessons. They were all worried that they had not learned enough about adult sexual relationships, enough about STIs, and they were also worried about unplanned teenage pregnancies. Many of

them said their PSHE teaching at school was so poor that they learned most of it online. There was a great quote, "I learnt all my actual sex education that wasn't basic biology from unreliable sources because school failed to provide it." I have hundreds, tens of hundreds, of quotes like that.

The problem is, because we are talking about STIs, if you are learning about sex from TikTok and you are watching porn, nobody uses a condom. Young people are getting inaccurate information from unreliable sources rather than from where they should be getting it, which is really excellent RSE teaching. I have a lot to say about that.

Q27 **Chair:** Carolyn is going to ask you an awful lot about RSHE teaching. I just wanted to get a picture of what the levels of knowledge are, where the gaps are. Why are we seeing a spike in STIs when many of us in this room—probably not Lisa, she is younger than me—will have lived through public awareness campaigns and understood the importance of condoms in the 1980s. Has that knowledge diminished?

Dame Rachel de Souza: Yes, and it feels quite different out there. If you add up all the kids I have talked to over three years, it is 1 million children. Two and a half years ago, kids were worrying about mental health and getting back to school. This time, I went to pretty much every part of the country talking to children, and they were talking about the need for reliable knowledge about sex and relationships. There was a lovely girl in Exeter, doing her A-levels. I will never forget her telling me, "Until this year, I thought that I wasn't normal, that my body wasn't normal, and I've lived with that for years until I actually got to do A-levels, because I never got a lesson that showed me what I should look like, and I was seeing stuff online."

I cannot tell you how many children are coming forward and talking to me about this, which just underlines why we need better sex education. It is certainly a postcode lottery whether you are going to be taught about contraception or whether contraception, in terms of free condoms, is going to be available for you. Schools offer very differential support and teaching on this.

I agree with Claire: I do not see stigma in the children, what I see is a desire for knowledge. Every single school I went to, every area of this country and every youth club, mental health ward, prison—everywhere I went—the kids wanted to know more about this. In my nationally representative surveys they want to know more about this: they want to know how to keep themselves healthy, to know that they are normal, to know how to be adults and what adult relationships are like. We are letting them down.

Q28 **Chair:** Are there any differences between ethnic minority groups? Is there the same level of enthusiasm to learn and understand?

Dame Rachel de Souza: We are analysing our latest 350, so we will be able to tell you more, but we certainly found LGBT-identified young people wanted to know even more and were more confused. We found that was pretty much the case across ethnic groups and across genders, expressed in different ways, but there was an absolute desire for better advice.

When I asked them, "What do you want the next Prime Minister to do?" One of the top answers was, "Give us better PSHE lessons." That is how serious it is.

Q29 **Kim Johnson:** I have a couple of questions on prevention. Rachel, you have already touched on the fact that a lot of young people access information online, particularly pornography, and we have heard quite a lot of that in terms of some inquiries this Committee has done. I wanted to know whether young people could access information online about prevention, because you talked about young people knocking on the door and asking for help, but a lot of that is about education and training and knowing, isn't it? Are there sites where young people can go that say, "This is an STI; these are the symptoms; this is what you need to do?" Online can be good and evil in terms of how young people access information.

Dame Rachel de Souza: Absolutely, I do not know if there are any—

Dr Dewsnap: There was a brilliant site called Sexwise led by the Department of Health and Social Care, and that was really well used. It is in stasis at the moment and there are conversations happening. There is also a sexual health telephone line commissioned by the Department of Health and Social Care that people can phone. That is really well used by young people, and it provides a lot of accurate information. So there is information out there.

What you are really talking about here, though, is the gap left by school nurses not being available. This is really critical because it is the first step for young people into having their thoughts legitimised, and then they can go on to that next step, even if that next step is two years later when they have had time to process, which it sometimes is. Children, young people, progress at different rates, and sometimes that first conversation is really important.

Q30 **Kim Johnson:** You have all alluded to the fact that the last 14 years of austerity have had a major impact on public sector services in the round really, but also in terms of youth services. In a previous life, I was a youth worker. I used to have a lot of informal conversations with young people, triage young people, have those conversations, and a lot of that does not exist at the moment.

Dame Rachel de Souza: What children and young people tell me is that they want to speak to trusted adults to gain this information, or to talk about their concerns. That is often at school or youth services and then,

from there, they are pointed to the right places. You are not going to be teaching yourself online about gonorrhoea until you think you might have it, unfortunately. That is the problem with teenagers. That is why PSHE and RSE, the really good education, and then the school nurse, the teacher, the youth worker—to be able to have the conversation—is so important, even though it is really important we also have great information online.

Q31 **Chair:** Rachel, can I just ask: do you have anything that backs up that statement? I would love to see a stat around people not searching online for gonorrhoea until you think you have it.

Dame Rachel de Souza: Let us have a look; I will have a look for it.

Chair: Thank you.

Dame Rachel de Souza: We will write to you if we find anything.

Chair: If you could just write in, that would be really useful.

Q32 **Kim Johnson:** You also mentioned the transmission of sexually transmitted disease, and the fact that young people watch pornography sites where condoms are not used. I just wanted to know about the prevalence of the use of condoms. Are you seeing high levels, and do we have areas in the country where you can access free condoms?

Dr Dewsnap: Condoms used to be a really key part of our prevention mechanisms, but condom budgets have gone down. Basically, in most services, the condom budgets have been halved, so that means you can get about half as many condoms for free. Obviously, condoms are not super-cheap, especially for young people who do not have much disposable cash. We should be focusing on improving those condom budgets if we are going to improve anything, and they have been sacrificed so we can have face-to-face services and online testing.

Q33 **Kim Johnson:** Chris, in terms of public health, what campaigns are the Government involved in at the moment when looking to address the prevalence and the increase in STIs?

Professor Whitty: In reality, most of the sexual health education and campaigning is actually done either locally or through schools. That is the way services are currently commissioned. There is an important question about whether the NHS as a body could do more. If you go to the NHS, you get very good, accurate information but, in the main, it is reactive rather than proactive. Where that would be most useful is in what Claire was talking about—in rural areas, places where it is harder to access services elsewhere. There is still a place for national services, but the great majority of the information is done locally, except when there is a major thing like, for example, when the Mpox outbreak happened, and that will be led nationally.

Q34 **Kim Johnson:** In your opinion, what public health campaigns can be

most effective?

Professor Whitty: In terms of sexually transmitted infections, the first thing to do is to normalise them because the danger is people think only bad people and people who are not like their friends get sexually transmitted infections, rather than just to say, "Look, this is just a normal thing that happens a lot in lots of different places."

In the context of schools, the second thing we need to do is help parents to see sexually transmitted infection information not as something which is a threat, and which will make it more likely their children and their peers will behave in ways they do not want them to, but rather as a safeguard against them being exploited by people who are not caring for them, and it is an opportunity really to talk things through. We really need to make that positive case for people who are understandably nervous on this.

Beyond that, we need to be quite careful not to push a fear narrative on this. There was a point, for example, at the beginning of HIV, where we had to do that; it was the right thing to do. People of the older generation will remember the "Don't Die of Ignorance" campaign. That was necessary at a point when 100% of the people who caught the infection were dying. It was an appalling situation that I saw when I was a junior doctor; huge numbers of young adults dying. However, we are in a very different situation now and we need to avoid that and see it much more as something we normalise, as just an ordinary part of life that is a particularly high risk early on when you initiate your sexual life and tend to have more partners. That is why young people are the ones we really need to concentrate on.

Q35 **Kim Johnson:** In terms of our reduced concern in terms of HIV, have we seen the prevalence in STIs, and does that go back to a requirement for greater and better campaigns?

Professor Whitty: We will see what Claire says, but my view is that part of the increase in STIs in the GBMSM community is because people, rightly, have a lower concern about HIV than they would have had 10 or 20 years ago, and that is for two reasons. First, if you get HIV, the risks are lower, but part of the success of HIV has been, because treatment is so effective, people essentially are not going to transmit on if they are on treatment, and effectively on treatment. The risks are lower and people know that because the GBMSM community has very good information by and large, but it needs constant work to maintain that. As a result of that, people are taking fewer precautions than they probably would previously have done and that is just the reality.

To be clear, I do not think that is the whole answer and, as Claire rightly said, if we take the gonorrhoea rates in the last year, they have, in fact, gone up faster in the heterosexual community than they have in the GBMSM community. I would not want to say this is the whole story, but it

is something that has changed, and we need to respond to that change. Claire, do you agree with that?

Dr Dewsnap: Yes, when surveyed, the GBMSM community say they are less worried about HIV, but they are now more worried about STIs than they have ever been. One of the caveats with the rates of gonorrhoea in GBMSM going up is that, because a lot of those groups are on PrEP, they are actually doing more frequent testing. We are also testing pharyngeal samples, which we did not routinely always do. Basically, we are doing a lot more throat samples and you can carry gonorrhoea in the throat. We are probably picking up more infections than we did before because we are doing more testing and we are testing different sites. That is the caveat with GBMSM but, as a whole, what we are seeing reported is people less able to use condoms when they are having sex for a variety of reasons or choosing not to, and that is the thing we should really be focusing on in terms of messages.

Just coming back to Rachel's point, what the evidence shows internationally on sexual and reproductive health education is that the more comprehensive age-appropriate SRE people get, the later sexual debut is, and the less information people have, the earlier sexual debut is. There is a prevention in delivering SRE at the right age and there is no wrong age to be delivering the right age sex education. Obviously, Rachel knows more about that than I do, but my headline is that there is no bad news to be given about SRE.

Kim Johnson: They are all my questions and it is a really nice segue way into—

Q36 **Chair:** Can I just chip in a minute? I want to understand what we have learned about effective public health campaigns—whether it is in the GBMSM community or anywhere else—that could be translated into effective public health campaigns that can help young people.

Professor Whitty: You go first, and I will follow on.

Dr Dewsnap: Yes. On stigma and stigmatising, the tombstone that everybody remembers from the '80s did change people's sexual behaviour for a period of time, but it did stigmatise people who were sexually active gay men, and that trauma still lives with those people. People from the '80s still talk about how they were traumatised. I understand why that happened. I was not around at the time, but it had the desired impact. Whether, in the long term that was the right thing or not, we will never know, but we know stigmatising types of sex, sexualities or genders does not help people in terms of their choice.

What we are trying to do here is give people information and not put up barriers. To me, this is about co-produced, person-designed messages. We want young black women to be designing the messages they want. We want young gay men to be designing the messages they want. We want all young people engaged in SRE to be designing the messages. It is

not for us as 50-year-olds to be designing those messages because, let us face it, we are going to be out of touch. Basically, we should be doing true co-produced messages that are properly designed to give people information and lead them on to the gateway of other information if that is what they want.

Professor Whitty: I completely agree with that. To add to that, if you make it sound as if STIs are always things that happen to other people, then don't be surprised if people aren't worried about them, don't take precautions, and don't recognise them when they occur. You have to make people understand this can happen to anybody. It is a normal thing that can happen to anybody. You can have a loving partner and he or she can have passed something on to you; they were unaware they had it, lots of sexually transmitted infections are asymptomatic, it just happens. I completely agree with this necessity to not stigmatise because that always implies it is not nice people sitting next to me in the mosque, in the schoolroom, in the university lecture hall; this is bad people who do bad things. That is not actually the way we should see it at all. That is the first thing.

The second thing is we do have to double down on the basics. Reinforcing the importance of condoms or other barrier methods, in addition to other things, is really important as we see this increase in rate, particularly in younger people, because we are seeing this very rapid increase. There are certain things we can provide a technological solution to. We talked about HPV; we talked about Mpox. There are some things we can do that for but, for lots of things, it is about difficult and long-term behaviour change. People have to get used to it at a very early stage and normalise it before they really start their sexual debut. However, it is not easy to do. Sexual behaviour is a private affair; it is a complex affair. It has a lot of overlays: social, religious, moral. There are many different aspects to it and, as Claire was saying, we have to design the messages in a way that works for multiple different communities. To think a single set of messages is going to work for all the communities is clearly incorrect, and schools have a huge part to play.

Q37 **Chair:** Do we know why the Sexwise site is down?

Dr Dewsnap: I do, and I would be happy to talk about this outside of the meeting because I am not sure it is for discussing in this Committee, but it is solvable.

Q38 **Chair:** Should there be something to replace it?

Dr Dewsnap: Yes, definitely. It was very well regarded, it was really well accessed and, while I respect that NHS England's website is correct, it is not service-user friendly. There is no doubt about that in terms of the information, whereas Sexwise absolutely was.

Q39 **Chair:** Apologies, I am going to get all parochial. The Youth in Romsey project tells me young people do not access websites, they only use apps.

Is it available as an app?

Dr Dewsnap: Yes, it was available as an app and, actually, there were lots of links to other things in it, so that was useful. I would be interested to speak to the Youth in Romsey group because we find lots of young people actually google their sexual health service, and then they get links from there. One of the things BASHH has been trying to do is move into that 21st century space and actually do some TikToks about this because if you cannot beat them, join them. We should be on TikTok; there is no harm in doing that. I speak to my own children. They get messages on TikTok all the time, and they check with me, "Is this correct?" And I look it up and tell them it is not correct, or it is correct. We need to move into those spaces if that is where they are getting it.

Q40 **Chair:** Carolyn and I have both done a ton of work around destigmatising the menopause. If you were to look at someone like Nighat Arif, the TikTok doctor—

Dr Dewsnap: Yes, she is great.

Chair: That is a tiny part of the solution, isn't it? Carolyn?

Q41 **Carolyn Harris:** Thank you, Chair. Good afternoon, everyone. Sex education in schools is one of those subjects that always invokes a reaction, and not always a good reaction. Rachel, do you think current sex education in schools is adequate? I think I know the answer.

Dame Rachel de Souza: Let me just frame this. Over the last seven years, the last Ofsted chief did an in-depth curriculum review, a deep evaluation with recommendations for every single subject, but not RSE. In fact, the only comment I could find was in last year's annual report. There was a comment under personal development saying it was not good enough. It is almost as if there was no consideration that RSE has domain-specific knowledge that children need to learn, like about STIs. It is often seen as a discussion class. There is a level at which, because Ofsted has not done the judgment of it, I cannot give you an answer. I met the new HMCI earlier this week. I said, "We need to completely review this. You have all that evidence from all the EIF inspections. We genuinely need to know, with evidence, how well this has been taught."

What I hear from children in properly undertaken nationally representative surveys, and from what I see as a former headteacher—a teacher for 32 years—is it is often taught by non-specialists; it is often timetabled last because the curriculum is crowded. Children talk about the teachers being embarrassed and not knowing the subject well enough and, certainly from my work with children, the vote is definitely no, it is not taught well enough.

There are examples of fantastic practice where there are specialist PSHE teachers, but if you look at the British education system, since compulsory elementary schooling in, what, 1890 or whatever, all our Education Acts have highlighted children's SMSC: spiritual, moral, social,

and cultural development. We are not just an academic factory; we are developing young people for the future; we are concerned about their pastoral wellbeing. In 2017, we got really good RSE statutory guidance, but I am afraid the subject has not been prioritised or taught as well as it could be, partly because of accountability issues, partly because of what you are judged on as a headteacher, partly because of curriculum crowding—am I going to have a history teacher or a PSHE teacher?—and partly because of a nervousness about teaching it. I remember teaching sex education to my form for the first time as a 23-year-old first-year teacher; it is difficult. We need better training as well. All those issues come into play.

Q42 **Carolyn Harris:** That to me says that teachers are not equipped well enough, they do not have the right resource. Teachers can teach anything if they have the resource to be able to do that, but is the resource out there to allow them to deliver proficient RSHE lessons on these particular subjects? These kids are our future; we cannot allow them to continue to not know about these things.

Dame Rachel de Souza: There are highly qualified PSHE teachers; there is the PSHE Association; there are materials. Unfortunately, one of the things that has started to happen is—because of the use of non-specialist teachers and perhaps a lack of surefootedness from heads and others about how to teach this—that there has been a lot of use of external companies to come in and do the job. Now, I am really concerned about that because, as a former headteacher, the emotional development and the personal development of the children I care for is absolutely critical, and I would want to oversee this with parents, with the children, and with my staff to make sure this was done well. I am concerned. There are materials, but we could do better.

I would love to see education and the NHS come together, create a set of materials, particularly around STIs, and get them on the Oak National Academy website so everyone could share them for free and parents could see them. There are so many things we could do that are really straightforward, where it is domain-specific knowledge, like around STIs and other things. Too often, PSHE lessons are ill-informed chats, discussions, and the children certainly feel slightly, "Well, that was useless." I have a page of quotes here to share with you on that.

Q43 **Carolyn Harris:** If you are reliant on an outside company, you are reliant on their material, which might not necessarily be the messaging that you as the headteacher, or the teacher, want. This is where we have seen a lot of parents have been upset and distressed about the fact that the information—

Dame Rachel de Souza: Honestly, when you do RSHE well, when you develop a curriculum, as we said, you can co-construct it with your children, but you develop a curriculum with specialists so it fits the ethos of your school. You do it with your parents; your parents are invited in to see it. The vast majority of parents in my 32-year career in education

were happy, grateful and, actually, able then to have the discussions they needed to have at home at the right time. It is a partnership. We need to be equipping our children with knowledge about adult life. They are crying out for knowledge about it.

It is so interesting. I was in a school the other day, talking to the boys, and they were saying, "We have had three years of lessons on consent. Consent's really important, it's really important, but what we want to know is, actually, how would we have a relationship as an adult?" They were really heartfelt questions. We could do so much better here. If you are putting all your PSHE and RSE teaching out to a commercial company, I find it hard to see how a headteacher who has that duty to look after the ethos of the school and develop the children could do that. It is okay to use a bit, but—

Q44 **Carolyn Harris:** Any thoughts on that, Claire?

Dr Dewsnap: Yes, there is also some real benefit in local partnership with health and education because you are forming those links. We used to have some structures where we would go into a school, maybe only once a month, but we would have regular conversations with the school nurse. We would be seen as not abnormal and they would know what we looked like. Kids were not thinking, "Oh my God, who are those weird people who sit in those clinics?" There is something to be said about developing those working relationships, and the school nurse being able to pick the phone up and say, "Look, I've just spoken to this young girl and I'm worried about her." Those things have been lost a bit because the extra stuff that was done at the edges has been squished out of the picture.

Dame Rachel de Souza: That is where you can bring in your safeguarding lead, who can reassure parents about materials and you can pick things up. There is so much positive about those local partnerships. But it is also about owning this curriculum as much as you own English or history. It is our duty as heads to do it; we are there to develop the entire child. It is really important.

Dr Dewsnap: The other thing is that silo thinking that is happening across the NHS now and across other public sector things. There is the prevention work that is being done by school nurses that is then picked up by outreach; that saves money for the NHS. Instead of people ending up on wards or in A&E departments, they are seen before all those problems happen. Spending on that bit of the pathway is cost-effective.

Q45 **Carolyn Harris:** I spent many months following your entire list of instructions; you were the professor for me. Any thoughts on that?

Professor Whitty: This is one I am definitely going to bow to Rachel and Claire on; it is something they have both had a lot of experience of doing. But I agree completely with what they have said.

Q46 **Carolyn Harris:** It stops at 16; should it go on until 18?

Dame Rachel de Souza: Life goes on, doesn't it? Post-16, you probably want to do RSE teaching slightly differently, but I think good colleges do, and find ways to do it. I have run free school sixth forms in maths and science and made sure that we had excellent RSE in there. It does not stop, does it?

Dr Dewsnap: It should definitely go on to 18. Also, the variation in people maturing is so huge. I think about this a lot when I see my children with their friends. The variation between one 13-year-old and another 13-year-old, and for that matter a 17-year-old and another 17-year-old—in terms of how engaged they are with their own sexuality, or them as they are beginning to be a sexual being, and as their knowledge grows—is very variable. It should go on to 18, if possible. We do lots of linking in with universities; as people go on to universities or further education, they can link in from there. Yes, I would like it to go on because of the variation in how receptive kids are at that age. Some kids will not be receptive at 15.

Professor Whitty: I agree, and people tend to need to have a refresher on STIs later on, because often the first time they come across them is when they or a friend have one. It will often not be at school; it will be a bit later in their lives. There is a strong argument for having that information, by whatever route.

Q47 **Carolyn Harris:** Rachel, do you have specific concerns around SEND kids? Kids with special needs, deaf children—are they missing out on the education, and is the prevalence of STIs alarming to you guys?

Dame Rachel de Souza: Yes. I have my list of groups of children that I am really concerned about. We have talked about rural children, children with disabilities and SEND. I talked about asylum-seeking children, children who are not getting good RSE, frankly, because that is a great protective factor in terms of teaching them about what they need to know—but definitely children from disabled and SEND backgrounds. Again, we talk to them about it and what works. Good RSE works for them, too.

Dr Dewsnap: Young people with disabilities are more likely to get STIs and to not have them diagnosed early. Access to face-to-face services and online services can also be more challenging for people with disabilities, whether those are physical or mental disabilities, or learning difficulties. It is an area of worry, and there are some really good resources on how to handle offering services to people with disabilities around the country. That information is there and the intelligence is there; we just need to share that and make sure that it happens.

Q48 **Carolyn Harris:** Is there good practice that could be shared? Is there any reason why it is not being shared?

Dr Dewsnap: Again, what is happening at the moment is, because services are under so much pressure, we are all focusing on what is

coming through the front door. The front door is opening and closing, and we are just looking directly at that. We are not thinking about the things that have not yet happened, and we are not thinking about the things that we could be doing better. A lot of those things around the edges that people might see as nice to have, but are in fact essential for lots of groups, are not currently happening universally. It is a worry, yes.

Dame Rachel de Souza: I would just say that school nurses are amazing in this area. They are amazing both in terms of picking up vulnerable groups, supporting them, and because they are local and can work closely with teachers, they are in that environment. They are a godsend in every school. They really, really are.

Dr Dewsnap: And they can support young people to get into services. We have a lot of support from good school nurses who will ring us and say, "Well, this child has really severe ADHD," and, for example, "They'll need to come and not sit in the main waiting room; they'll need to be sat in a private room or taken straight through to clinic." All those things can make accessing sexual health face-to-face care a lot better. We get that information before they even come, when it is good. When it is not good, a young person arrives at the service and thinks, "I can't deal with this," and leaves. We are putting up barriers, in that sense.

Dame Rachel de Souza: I said it before, but there has been a 35% drop in school nurses over the last 10 years. It is a real tragedy; they are gold dust. Anything we could do about increasing the number of school nurses would be amazing.

Q49 **Carolyn Harris:** If we were to say to you, "We're the conduit to the Government; are the Government doing a good job? Do they need to do more? Are they reliant on schools too much?", what would you say? What is it that the Government should do to help this situation?

Dame Rachel de Souza: Did you want to do health and I will do education?

Professor Whitty: You start off.

Dame Rachel de Souza: I would encourage Government to prioritise the subject of RSE. It is really important and it has not been prioritised. In fact, there is an RSE review on at the moment, but rather than the quality of teaching—the teaching basics 101, the STIs, the domain knowledge—we find ourselves sometimes having Westminster debates. They are about things that do matter, but they are very interesting to hear rather than what kids actually need. So prioritise RSE and think about materials—that would be helpful. We have Oak National Academy; the Government have funded it massively. Let us get our shared materials on there to help other schools share best practice.

I think it is about qualified PSHE teachers, and I really think schools should be prioritising this—I am not going to let them off the hook. I was

a head myself; it is an important part of being a headteacher. We should not be buying this in from elsewhere; it is fundamental to children's lives. Children look to us in schools with trust, to be the trusted adults who help them with this. So it is about prioritising PSHE teaching in schools.

I know heads will say, "Funding cuts, accountability," meaning that this subject gets squeezed out. We just have to put our foot down. The figures about STIs today should encourage everybody to get this back on the agenda. I want Ofsted to play its part. If Ofsted measures it and is concerned about it, headteachers will do it. The fact there was not a review on this subject sends a very strong message. This should be central. I strongly feel that they should be focusing on this, too.

Dr Dewsnap: I would like four things. There are things that this Government have done really well: PrEP has been an incredibly important innovation, widening access to the HPV vaccine, the opt-out testing for HIV has been good. What has not been good is the moving of sexual health services into local authorities, which has effectively resulted in us being sidelined. It is actually really cheap to deliver. I was looking at these figures today: effectively, every consultation in England today costs £1.10. That is how many consultations we are doing, and we have seen a 13% rise over the last year. We are cost-effective services; we are not hugely expensive. I would like the loss of funding to be returned. The loss of funding is about £150 million, which, in the scheme of things, seems like a really small amount for reversal of these figures.

The next thing I would like them to do is stop tendering services. I do not know how you do that. The mechanism might be to move us back to NHS commissioning—I don't know—but tendering of services destabilises. Every time a service is tendered, we lose experienced nurses and doctors and support workers, and we have to then retrain. We effectively go back in our effectiveness and productivity for 18 months while we retrain. Then, two years later, we go back out to tender again. We are constantly having to retrain staff, and these are not skills that you learn overnight—so stop tendering.

I would like to invest in the workforce. BASHH has developed a workforce plan. If NHS England could have a little look at that—again, it is really cheap in the scheme of things—we would like that. This should all be underpinned by a sexual health strategy, so that we know with the resources that we have, where we should be spending them. Those are things we should do.

Professor Whitty: I will steer clear of the money side because I have always thought that is a job for Ministers rather than for me. But I completely agree: the resources have gone down in this area—that is a statement of fact—and rates have gone up. That is probably worth bearing in mind.

There are some areas where we just need to double down on what we are doing well. I agree with PrEP. We need to test out what DoxyPEP's role is; we have not talked about that, but that is an important area. We absolutely need to make sure that the HPV vaccination strategy is working. We need to look at some other newer techniques, but we also need to go back to re-promoting condom use, making sure that is available to people via multiple routes.

I would firmly reinforce the point that people need lots of routes into sexually transmitted infection services. What works for one person absolutely will not work for another. Online is very good for some people, but it is absolutely the wrong approach for others. Face-to-face is essential for some, more tricky for others, and it varies by area of the country. Most of the STI concentration, though, is in the big conurbations; it is not evenly spread across the country. We can concentrate our efforts principally in the places where there are large concentrations of younger people such as London, Manchester, big university towns, and other areas where you have high concentrations.

Thirdly on strategy, I am very sympathetic to this personally, whether we call it a strategy or whether we do a rethink. But if you look back at the last eight or 10 years, a lot of things have changed. Some new things have come in—we have just talked about those—and we have had one important new outbreak, which was the Mpox outbreak of 2022, which is completely different. Some of our thinking about various areas has been changed and challenged by the covid pandemic, even though that is a respiratory route of transmission. So I think we should do a proper rethink.

We need to get the timing of that right, but the principle that we should say, "Okay, lots of things have changed; let's rethink this, not throw out stuff that's good," makes a lot of sense to me. I am very supportive of what Claire said on that. That is probably enough for one session, but I think between us those are quite a few things that we all would agree on. I would not disagree with any of the other things people have said.

Q50 **Carolyn Harris:** Something just came to my mind: we see a lot of campaigns and a lot of attention on period poverty, but we have a bit of a problem with condom poverty, haven't we? There is somebody out there somewhere, surely, who would want to do a campaign on getting the condom manufacturers to be generous and give condoms to food banks, to be proactive in giving condoms out, because it is obviously going to be of great help to the nation.

Dr Dewsnap: People do use them if they are available for free, and people still ask for them. In many clinics, unfortunately—as horrific as this sounds—we ration how many we give.

Q51 **Carolyn Harris*:*** That is like tampons, is it not? We should not be rationing an essential.

Dr Dewsnap: I completely agree with Chris's point about condom use. One of the things that we need to think about—this is perhaps outside this Committee's remit—is how we talk about sex. It should be about sexual wellbeing, not just about sickness because the evidence shows that if you talk about someone's wellbeing and make it person-centred, they are more likely to engage with the messages. That is the shift that needs to happen. It is obviously not going to happen overnight because lots of the information we still use is from 10, 15 years ago. We could move that forward.

Q52 **Chair:** I have a whole sweep-up here. Last week I was at LifeLab at Southampton General Hospital with an amazing man, Professor Keith Godfrey. We talked about the programme that it does with young people, "Me, my health and my children's health", which focuses on sexual wellbeing. Of course, there will not be any future children if you have caught a condition that renders you infertile, will there? I wonder whether there should be more roll-out of programmes like that, encouraging teenagers to think about their own wellbeing. That is probably heinously expensive though.

Dr Dewsnap: I don't know that it is. Again, when you look at places that have focused on sexual wellbeing as the point of discussion, not just how not to get an STI, that has been well received. If you look at some Nordic countries, that is the route they went down, and it delays people having sex. They are also more able to talk about things like consent and bodily autonomy. It is not just about impacting on STI rates; it is about people's general sexual wellbeing. Of course, it is part of natural human instinct to be a sexual being, whether you are having it at the moment or you are not. It is in our instincts to have sex, and we need to make it a point of mental wellbeing. If you have that focus for young people, it also removes some the barriers we have talked about.

Dame Rachel de Souza: We have to recognise the incredibly low base we are coming from in terms of education in these areas in school, if what children are telling me is to be believed.

Q53 **Chair:** Turning to that incredibly low base, I just want to get this on the record with a straight "Yes" from you, Rachel. As part of the National Oak Academy, you would like to see pages of resources on sexual wellbeing and health for every school in the country to be able to download for free.

Dame Rachel de Souza: Absolutely—for free. And it would be great if the NHS was partnered in that where there were relevant domain-specific things, for example on STIs, so the information was accurate—absolutely. And have the best practice from teachers across the country who can share it, because that is how Oak started.

Q54 **Chair:** Claire, I think you said earlier—can I just clarify this—that there was no downside to better sexual health education?

Dr Dewsnap: There is no downside.

Q55 **Chair:** And we have evidence?

Dr Dewsnap: We have evidence for that.

Q56 **Chair:** Thank you. Finally, I am going to turn to you, Chris, and ask for some science on this. Do the rates of infection merit, in your view, a public health campaign targeted specifically at young people?

Professor Whitty: They certainly merit targeting at young people—I think that very strongly—but it should not necessarily be a national campaign, because the drivers of this are very different in different communities. A national campaign, like all things, would be a broadcast that would not hit any of the key groups. What we need to do is work with Claire and other colleagues to work out how we get to the communities who are the biggest risk, and target messages to those. To me, that seems the right approach to this.

Q57 **Chair:** I was at an event earlier today talking about HIV and women. I am not entirely clear on this stat, and I hope one of you can pick it up. Is the incidence of HIV going up in 15 to 34-year-olds?

Dr Dewsnap: In women.

Q58 **Chair**: In women? I wondered whether it was specifically women.

Dr Dewsnap: And you are more likely to be a woman of black or Caribbean ethnic origin if you are newly diagnosed with HIV. Black women are more likely to be affected than white women in that age group.

Q59 **Chair:** So targeted campaigns need to be specifically focused on age groups, on demographics, on ethnicity. It needs to be segmented.

Dr Dewsnap: Targeted campaigns co-produced by those communities—that is what we are being asked for.

Q60 **Chair:** We had that message earlier—that campaigns need to be co-produced, don't they?

Dr Dewsnap: The problem is that you sit in a service, and you do not necessarily know how to get into those groups. The other thing that needs to be said briefly is that women of those groups are accessing sexual reproductive health services, but they are often just presenting to contraception appointments. In those contraception appointments they are not being asked for an STI screen, and they are not being given an HIV test.

Q61 **Chair:** Yes, and in that same meeting, there was a conversation about, 15 years ago, a fun and engaging chlamydia screening programme. Should we go back to something like that? If women are presenting for contraception appointments and there is no screening, should there be?

Dr Dewsnap: Yes. We need to work with the Faculty of Sexual and Reproductive Healthcare, which we are already doing, because a lot of

that work is delivered by a slightly different specialty than mine. Some is done by my specialty, but some is done by the FSRH people. We need to work with them and we need to work with GPs to make sure those tests are happening, but a campaign would be great. You still have to get the health professionals to do it, though. The biggest barrier is health professionals in those settings: people are not offering the test. That is partly because of stigma—again, people are seen as being not those kinds of people. We hear that comment from many parts of the health sector. Part of our campaign is to influence the health sector, as well as to influence people accessing services.

Chair: Thank you very much. If any of you have anything more you wish to add, can I ask that you do so in writing. We are no longer quorate with Carolyn out of the room, so I am going to bring the meeting to an end. Thank you.