

Private Sexual Behavior, Public Opinion, and Public Health Policy Related to Sexually Transmitted Diseases: A US–British Comparison

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Introduction

The transmission of sexually transmitted diseases (STDs) in populations is determined by the interaction among the biological properties of the infecting organisms, the behavioral characteristics of the population, and the effectiveness of control programs.¹ Until recently, little attention has been paid to the distribution of sexual behavior in populations; with the emerging HIV epidemic, however, national studies have been conducted in Europe,^{2–5} the United States,^{6–11} and several developing countries.¹²

Studies in the developed world have been more remarkable for their findings of similarity than for their findings of differences in sexual behavior,¹³ yet there are important differences in the epidemiology of STDs, including HIV, among countries with superficially similar patterns of sexual behavior. The 1994 US gonorrhea rate per 100 000 population 15 to 64 years of age, for example, was 246, while in Britain the rate was only 33. In Britain, the number of reported cases of *Chlamydia trachomatis* in 1994 was 3-fold higher than that of gonorrhea, while the United States reported almost equal numbers of *C trachomatis* and gonorrhea cases.^{14,15} The 1996 incidence of AIDS in Britain was 24 per million population,¹⁶ while in the United States it was 256 per million population,^{17,18} despite the fact that HIV was probably introduced into Britain shortly after it was introduced into the United States.¹⁹

The incidence of HIV is estimated to have peaked in Britain between 1982 and 1984 with an intense epidemic in homosexual men and a limited spread to injection drug users. Probably as a result of behavior change, a declining incidence followed; thus, the prevalence observed in Britain has never reached the intensity of high-risk populations in the United States. In the

United States, no such peak occurred early in the epidemic. Regarding the known transmission mechanisms of all AIDS cases as of 1996, 50% of US and 59% of British cases involved transmission between men who have sex with men, 26% of US and 10% of British cases involved injection drug users (with another 6% in the United States and 2% in Britain involving both of the preceding 2 groups), and 9% of US and 20% of British cases involved heterosexual contacts.^{17,18,20}

Britain operates a national network of free, open-access STD clinics responsible for STD reporting. These clinics are thought to treat the majority of STDs and are known to be used by all sectors of the population.²¹ Underreporting in Britain is unlikely to be the explanation for the observed differences in incidence, which probably reflect differences in sexual behavior patterns and in STD control programs. In this paper, we compare patterns of sexual behavior in the United States and Britain, drawing on data from recent national probability sample surveys, and we suggest how sexual behavior and opinions in the 2 countries may have influenced public health policy and behavior regarding STDs.

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This paper was accepted January 15, 1998.

ABSTRACT

Objectives. The purpose of this study was to characterize sexual behavior and opinions about sex in the United States and Britain; implications are discussed for effective public health policy regarding sexually transmitted diseases (STDs) in the United States.

Methods. Large-scale national probability surveys conducted in the 2 countries detailed sexual behavior, opinions, and the prevalence of STDs.

Results. In comparison with that of Britain, the US population has greater variability in sexual behavior, less tolerant opinions about sexual behavior, and a higher STD prevalence and lower condom usage among men.

Conclusions. The survey data show compelling evidence from both countries of a strong association between number of sex partners and STD risk. In the United States relative to Britain, there is both greater dispersion in sexual behavior and a greater incidence of unconditional opposition to certain sexual practices. The former implies a need for strong public health policy to address the risks of STDs, but the latter implies strong opposition to that policy. This disjuncture between public health need and feasibility may contribute to the high US rate of STDs. (*Am J Public Health.* 1998;88:749–754)

Methods

Britain

Between May 1990 and December 1991, a sample of 18 876 adults in England, Wales, and Scotland was interviewed. Households were randomly selected from the Post Office Small Users Postcode address file. One member of each household between 16 and 59 years of age was selected; data were collected via face-to-face interviews and self-completion questionnaires. Respondents were not offered financial payment for participating, and the overall response rate was 65%. The final sample broadly represented the demographic characteristics of Great Britain's population.^{2,22,23}

United States

Between February and August 1992, a sample of 3432 adults in the United States was interviewed. These individuals were selected from a stratified, clustered national sample of households, with random selection of one English-speaking household member 18 to 59 years of age. Blacks and Hispanics were oversampled. The overall response rate was 79%. Forty-six percent of respondents were paid a nominal fee of \$10 to \$25, 41% were paid no fee, and the remainder were paid a fee exceeding \$25; no indication was found of any effect of these payments on the answers provided. The face-to-face interview lasted, on average, 90 minutes and included several self-administered components and memory aids. The data set is known as the National Health and Social Life Survey.^{9,24}

Comparison

This comparative analysis involved British respondents 18 to 59 years old and excluded the US oversamples; all tables report weighted statistics adjusted for household size. Although the 2 surveys were conducted independently with different protocols, the general character of the information obtained was similar and facilitated cross-national comparisons. There is little evidence from these data or elsewhere of a response bias in sexual behavior surveys (see publications reporting these data and Biggar and Melbye²⁵). Statistical analysis was restricted to comparison of proportions in which there were minimal differences in question wording; Mantel-Haenszel chi-square statistics are reported for significance tests of cross-country differences (separately by gender).

TABLE 1—Number of Heterosexual Partners within the Previous Year, by Age and Gender: Great Britain and United States

Age, y	Gender	Country	No. Partners, %				Base
			0	1	2-4	5+	
18-24	Men	GB	19.4	51.5	25.2	3.9	1565
		US	17.7	46.4	27.1	8.7	289
	Women	GB	14.3	70.0	14.9	0.8	1747
		US	13.0	59.7	20.7	6.6	302
25-34	Men	GB	8.6	76.8	12.7	1.9	2102
		US	11.4	67.7	17.5	3.4	443
	Women	GB	6.7	86.8	6.2	0.3	2798
		US	7.9	85.1	6.0	1.0	490
35-44	Men	GB	6.8	84.1	8.3	0.8	1974
		US	6.5	78.7	13.5	1.3	378
	Women	GB	7.4	88.4	4.1	0.1	2483
		US	10.4	84.3	4.9	0.3	479
45-59	Men	GB	10.8	83.9	5.4	0.1	2031
		US	11.1	83.3	5.0	0.6	355
	Women	GB	19.3	78.8	1.8	0.0	2583
		US	22.8	74.8	2.3	0.1	416
All	Men	GB	11.0	75.4	12.2	1.5	7673
		US	11.3	70.1	15.4	3.2	1466
	Women	GB	11.7	82.0	6.1	0.3	9611
		US	13.2	77.8	7.4	1.6	1687

Note. GB = Great Britain; US = United States.

The data on STDs were derived differently in the 2 surveys. In the British survey, respondents were asked whether they had attended an STD clinic, irrespective of a positive diagnosis. In the US study, respondents were asked whether they had been diagnosed specifically with any of 9 STDs (see Table 4). The lack of correspondence between the questions used in the 2 surveys makes direct comparisons difficult. Use of STD clinic attendance rather than diagnosis of an STD as the indicator may lead to an overestimate of prevalence for Britain relative to the United States, but it also may result in an underestimate since some conditions may be treated in other settings in Britain (e.g., general practice, student health services, or family planning clinics). The comparisons for the 2 countries were therefore inexact.

Results

Sexual Behavior

Number of partners. Tables 1 and 2 show the distribution of numbers of opposite-sex partners by age, gender, and country for the previous year and over the adult lifetime. A relatively high proportion of the youngest and oldest age groups reported no sex partner in the previous year. There was a strong decline in the proportion having 2 or more sex partners with increasing age in both countries. Consistently fewer women

than men and fewer respondents in Great Britain than in the United States reported having 2 or more sex partners (cross-country $\chi^2 = 23.2$, $P < .001$, for men and 16.9, $P < .001$, for women). In all age groups, British respondents were more likely to have only 1 partner, and women were more likely than men to report 1 partner.

Questions about lifetime number of opposite-sex partners were asked differently in the 2 surveys reported in Table 2: US respondents reported the number of partners since 18 years of age, while British respondents reported the number of partners over their lifetime. Many of the patterns seen in Table 1 were also observed for lifetime partners. The number of partners increased with age as partners were accumulated. For both genders in most age groups, larger proportions in the United States had both no partner and more than 20 partners. As found in other studies, men reported substantially more partners over their lifetime than did women.^{9,26,27}

Sexual practices. Table 3 shows the percentages reporting different sexual behaviors. The top panel shows the percentages of the British and US samples who first had intercourse before the age of 18 years. In both countries and in all age groups, men were more likely than women to be sexually active before 18 years of age, and younger cohorts were more likely than older ones, especially women. The second panel shows the percentages who reported

TABLE 2—Number of Heterosexual Partners over Lifetime (Great Britain) or since Age 18 (United States), by Age and Gender

Age, y	Gender	Country	No. Partners, %						Base
			0	1	2-4	5-10	11-20	21+	
18-24	Men	GB	12.0	16.6	32.8	24.2	9.8	4.7	1562
		US	15.8	21.5	28.5	20.2	8.9	5.1	279
	Women	GB	10.7	29.8	37.8	17.9	2.0	0.8	1747
		US	10.3	27.1	40.8	18.1	2.6	1.1	285
25-34	Men	GB	3.1	15.0	27.4	29.1	15.0	10.3	2098
		US	5.7	16.1	23.8	27.4	13.9	13.1	422
	Women	GB	2.1	30.8	40.7	20.4	4.6	1.3	2795
		US	4.6	29.1	37.3	21.4	5.0	2.5	464
35-44	Men	GB	1.9	20.5	27.8	26.5	14.4	8.9	1966
		US	1.2	16.0	20.4	34.4	13.7	14.4	361
	Women	GB	0.7	40.7	36.2	16.9	3.5	1.9	2476
		US	3.5	31.0	34.3	22.0	5.8	3.4	450
45-59	Men	GB	1.5	30.5	31.5	21.0	9.0	6.5	2021
		US	2.0	22.2	21.9	24.7	12.1	17.0	312
	Women	GB	1.5	57.7	29.6	8.8	1.8	0.6	2576
		US	4.9	41.7	31.1	16.9	3.2	2.2	389
All	Men	GB	4.2	20.8	29.7	25.3	12.2	7.8	7673
		US	5.7	18.6	23.4	27.2	12.4	12.7	1374
	Women	GB	3.2	40.4	36.0	15.9	3.3	1.2	9595
		US	5.4	32.4	35.6	19.9	4.4	2.4	1587

Note. GB = Great Britain; US = United States.

not having had sexual intercourse before their first marriage. The patterns were again quite similar across the 2 countries, except in the youngest age group, based on a small sample for the United States (all numbers are based on 30 or more cases). In both countries, the percentages who were virgins at marriage have declined across the decades, more steeply in Britain than in the United States, and the rates are typically higher for women.

The third and fourth panels show the percentages reporting a same-gender sex partner in the previous year or over their lifetime (United States: since age 18). In the previous year, the rate of reported homosexual experience was higher in the United States than in Britain (for men, $\chi^2 = 14.3$, $P < .001$; for women, $\chi^2 = 13.2$, $P < .001$), and the annual rate was highest in the 25- to 34-year age group for men in both countries and for women in the United States. Lifetime rates differed within a few percentage points in both the United States and Britain for each age and gender group.

The fifth panel shows similar proportions reporting extramarital sex in the previous year in Britain and the United States: overall, about 5% of men and 2% of women. There were differences among age groups, but these differences should be interpreted with caution, especially for the youngest US age groups (based on relatively few cases).

The sixth and seventh panels show rates of oral and anal sex, excluding from the denominator individuals who had no sex partner within the year. The reported rates of

oral sex were slightly higher for men than for women and tended to be higher for British respondents under age 35 and for US respondents over that age. Overall, the differences were small and were significant only for women ($\chi^2 = 0.6$, $P < .50$, for men; $\chi^2 = 5.5$, $P < .025$, for women). In both genders, the rates were decidedly lower for those more than 45 years of age. For anal sex, there was a lower rate at older ages in Britain, but a more erratic pattern in the United States. There was no clear difference in the reported rate by gender, but there was a consistently higher rate in the United States than in Britain ($\chi^2 = 8.2$, $P < .01$, for men; $\chi^2 = 7.1$, $P < .01$, for women).

The bottom panel of Table 3 shows condom use the previous time the respondent had vaginal intercourse. Reported use was significantly higher among British than US men ($\chi^2 = 15.8$, $P < .001$) but not consistently so for women ($\chi^2 = 3.6$, $P < .10$). This country difference was particularly marked for men more than 35 years of age. There was a pronounced age difference in both countries, with younger men and women reporting higher rates of condom use. As noted earlier, these groups also have more partners, so their risks are correspondingly greater.

Disease Risks

The first panel of Table 4 shows rates in the previous year, by gender and age, of visiting an STD clinic in Britain or of having an STD in the United States. The rates

were roughly comparable in the 2 countries and were relatively similar for men and women (although note, again, that the questions asked on this matter differed substantially). The second panel of Table 4 shows US rates of having an STD and British rates of attending an STD clinic (lifetime), and there were pronounced differences by country. The US rates were 2 or 3 times as high as those in Britain for men and even greater for women, and differences were present in every age group. Overall, British men had a rate near 8% and US men had a rate nearly twice as high, 15%. For women, the overall rate in Britain was near 6%, and the rate in the United States was 16%. The far higher US rates mirrored the higher rates reported in official surveillance data (cited earlier).

The third and fourth panels of Table 4 show a clear positive relationship between number of sexual partners and likelihood of contracting an STD. This strong relationship was seen in both the US and British data, in both genders, and in both the short term (third panel) and over the lifetime (fourth panel).

Opinions

Table 5 shows that there were great differences between the 2 countries in opinions about sexual behavior regarding premarital, extramarital, and homosexual sex. The British were much more tolerant of premarital sex in all age groups, and there was far greater tolerance among younger generations in both nations. There was less

TABLE 3—Sexual Behavior, by Age and Gender: United States and Great Britain

Gender	Country	Age, y, %				All
		18–24	25–34	35–44	45–59	
Sex before age 18						
Men	GB	65.2	60.0	46.9	31.8	
	US	69.2	55.4	53.3	42.9	
Women	GB	63.3	48.0	33.7	15.3	
	US	59.5	52.4	39.2	29.7	
Virgin at first marriage						
Men	GB	0.0	4.1	7.5	15.0	
	US	22.2	11.9	13.0	18.8	
Women	GB	3.9	6.8	14.7	39.2	
	US	17.9	17.0	24.7	44.4	
Same-gender partners within past year						
Men	GB	1.4	1.5	0.8	0.7	1.1
	US	2.9	3.9	1.9	0.4	2.4
Women	GB	0.7	0.6	0.2	0.1	0.4
	US	0.1	2.4	0.8	0.4	1.0
Same-gender partners over lifetime (GB) or since age 18 (US)						
Men	GB	3.1	3.7	5.0	3.2	3.8
	US	4.4	6.8	2.0	1.7	3.9
Women	GB	1.6	2.0	2.1	1.3	1.8
	US	0.2	3.7	3.5	2.8	2.8
Extramarital sex in past year						
Men	GB	3.9	5.1	5.4	3.7	4.7
	US	5.4	4.8	5.0	4.6	4.8
Women	GB	1.5	2.1	2.4	1.1	1.9
	US	8.5	1.2	0.8	1.2	1.6
Oral sex in past year						
Men	GB	85.8	84.1	73.0	46.5	71.6
	US	73.1	76.2	76.2	58.4	71.3
Women	GB	81.5	78.6	64.0	37.1	65.2
	US	78.8	76.2	68.7	49.8	68.7
Anal sex in past year						
Men	GB	10.0	7.2	6.6	5.6	7.2
	US	7.2	10.5	13.0	5.9	9.4
Women	GB	10.0	7.1	5.2	5.3	6.7
	US	9.3	10.2	8.9	5.3	8.6
Condom use in last heterosexual event						
Men	GB	37.0	24.0	19.6	13.6	22.5
	US	33.1	24.0	10.9	4.8	17.5
Women	GB	22.9	18.9	16.2	12.4	17.1
	US	29.1	16.2	14.0	4.5	15.3

Note. GB = Great Britain; US = United States.

tolerance of extramarital sex than of premarital sex in both countries, and there was less difference in opinion about extramarital sex between Britain and the United States; there was little difference by age in opinions about extramarital sex.

The questions on homosexual sex were asked differently in the 2 surveys. In the United States, no distinction was made between sex between men and sex between women, whereas separate questions were asked in Britain. The results show that both genders in each age group in Britain were more tolerant of homosexual behavior than those in the United States. In fact, Table 6 shows a remarkable consistency. In all 4 age groups within each country, the tolerance ranking was the same (premarital,

homosexual, extramarital), and within each of the 24 age-gender comparisons, the British exhibited greater tolerance.

Discussion

Because Britain and the United States are similar in social structure, legal system, and language, it is not surprising that the 2 nations have many similarities in their populations' sexual behavior. At the same time, there are profound differences between the 2 countries in geographic dispersion, religious affiliation, and the homogeneity of the populations' race/ethnicity (i.e., in Britain, about 5% of the population is non-White, and in the United States, about 25%

is non-White or Hispanic in origin). Thus, it is also not surprising that sexual behavior is not identical in the 2 countries.

While many studies have reported patterns of sexual behavior similar to those seen in Tables 1 through 3,^{28–30} few have made comparisons across countries.¹³ We discuss 2 public health issues resulting from the comparison, one reinforced by the similarity between the 2 countries and the other emerging from their differences.

The first of these 2 public health implications is clear and compelling. There is strong evidence in Table 4 (third and fourth panels) that risk of contracting an STD is closely associated with number of sexual partners. In Britain and the United States, this evidence is consistent with the epidemiology of sexually transmitted infections. The magnitude of the risk change is dramatic as the number of sex partners rises. There is suggestive evidence in Table 3 that in both countries, those at greater risk of disease (younger men and women) are more likely to use condoms.

The second public health issue relates to a greater disjunction in the United States than in Britain between the need for policy intervention and the social resolve to effect it. Consider the following 3 differences between Britain and the United States. First, there is greater dispersion in sexual behavior in the United States than in Britain; in particular, larger proportions of the US population are found in both tails of the distributions of many sexual behaviors. For example, in most age groups, larger proportions in the United States than in Britain report both having no sex partner and having 5 or more partners in the previous year, and larger proportions report both being virgins at their first marriage and having intercourse before age 18. Second, Table 5 shows that a larger proportion of the US population, in every gender-age group, holds unconditional or absolute opinions against extramarital sex, nonmarital sex, and homosexuality. Third, the United States has substantially higher rates of STDs, as evidenced in Table 4 and described in official surveillance statistics.

We suggest that this final difference is partially explained by the interaction of the other two. The greater dispersion in sexual behavior in the United States would, in itself, make the formulation of effective and efficient public health policy more difficult. A public health effort to address a risk faced by one segment of the population would have little direct value to another segment whose behavior was different and who correctly considered that risk of remote relevance to themselves. As Catania et al.¹⁰ suggest, perhaps 85% of US adults 18 to 49

TABLE 4—Previous-Year and Lifetime Incidence of Sexually Transmitted Diseases (STDs), by Age, Gender, and Number of Partners: Great Britain (Visited an STD Clinic) and United States (Diagnosed as Having 1 of 9 STDs)

Gender and Country	Age, y				All	
	18–24	25–34	35–44	45–59		
Previous year, %						
Men						
GB	1.5	1.2	0.7	0.2	0.9	
US	3.7	1.2	0.3	0.4	1.3	
Women						
GB	1.6	1.3	0.1	0.1	0.7	
US	5.2	1.6	1.1	0.3	1.8	
Lifetime, %						
Men						
GB	5.2	11.7	10.5	5.3	8.4	
US	9.2	16.3	18.4	14.3	15.0	
Women						
GB	5.3	8.2	6.4	2.6	5.7	
US	16.3	18.2	17.9	10.8	16.0	
Previous year, %						
Male or female partners, no.						
	0	1	2	3	4+	
Men						
GB	0.1	0.5	2.0	3.6	8.8	
US	0.0	0.6	0.8	6.5	6.0	
Women						
GB	0.3	0.6	2.9	7.4	3.7	
US	0.2	1.2	3.4	4.8	17.2	
Lifetime, %						
Male or female partners, no.						
	0	1	2–4	5–10	11–20	21+
Men						
GB	0.5	1.1	3.2	8.8	18.7	29.8
US	0.0	3.2	5.4	13.7	27.6	38.2
Women						
GB	0.3	1.3	4.3	12.3	28.7	47.6
US	0.1	4.7	12.0	31.5	47.6	50.6

Note. The 9 STDs separately asked about in the US survey were gonorrhea, syphilis, genital herpes, chlamydia, genital warts, hepatitis B, HIV, pelvic inflammatory disease (women only), and nongonococcal urethritis (men only). GB = Great Britain; US = United States.

years of age have “no risk” or very little risk of HIV, while the other 15% have varying risks that are, in some cases, quite substantial. Efforts such as the Centers for Disease Control and Prevention’s “prevention marketing initiative”³¹ stress the marketing strategy of segmenting audiences and targeting specific messages. These appropriate marketing techniques encounter resistance, however, when one segment of society holds strong, absolute opinions that the behavior creating public health risk is itself inappropriate and unacceptable.

Thus, these 2 facts—the greater diversity of sexual behavior and the greater degree of absolute opinion about improper sexual behavior—make it much more difficult to mount an effective public health effort in the United States than in Britain. The strong, unconditional opinions in the United States about sexual behavior suggest

the basis for serious resistance to a public health policy that promotes safer sexual behavior: a sizable portion of the population considers much of that behavior unacceptable and inappropriate, not primarily risky. Exacerbating this situation, these strong censorious attitudes may also inhibit health-seeking behavior by individuals reluctant to disclose their condition, even to physicians. Absence of aggressive public health messages and actions may reinforce this reluctance.

One can see the dilemma within almost any population subgroup (e.g., compare percentages in Tables 1, 2, and 4 for US and British young men). The proportion having 5 or more partners within the previous year in the United States is more than twice as high as in Britain, and yet the rate at which they consider premarital sex “always wrong” is nearly 4 times as high as in

Britain. These are different men; there is simply greater dispersion in both sexual behavior and opinion in the United States. Thus, the dilemma for public health officials is how to address the needs of the distribution at 1 tail (i.e., the young men with many partners) without clashing with the majority of the same young men who believe that this behavior is wrong and should not be accommodated. And these opinions are not casual: analysis of British data indicates that those with premarital, extramarital, or homosexual experience have more tolerant attitudes toward these behaviors than do others, and conversely.^{2(p245)}

The dilemma is greater in the United States than in Britain because both extreme views and extreme behaviors are more prevalent in the former, which creates public ambivalence in the United States about policies regarding safe sex and probably also affects private health-seeking behavior. This has surely contributed to the “public health tragedy” described by Vermund³² in characterizing “our society’s failure to encourage and even to permit aggressive, widespread marketing of condoms in the national media.”

That ambivalence is also seen in the public health responses to HIV/AIDS in the 2 countries. In the mid-1980s (when the total number of AIDS cases was about 500), Britain conducted a national household leaflet drop about the transmission of HIV, produced a series of advertising campaigns on prime-time television, and introduced needle exchange programs, particularly in London. Successive secretaries of state for health maintained a high profile on the public health importance of AIDS. In addition, Britain has a national network of open-access STD clinics for diagnosis and treatment and a national health service available free at the time of need and used by all sectors of the population.

The contrast in the United States is sobering. Illustrative of the highly contested character of US public health initiatives is the protracted struggle over the content of Surgeon General Koop’s message sent as a public health warning to every household in the country about the threat posed by the AIDS epidemic. The measure was proposed in the mid-1980s (when the total number of AIDS cases exceeded 20 000); a pamphlet was drafted and readied for distribution at a cost of some \$25 million only to require a redraft at the last minute with a stronger statement about sexual abstinence. The message was finally sent out in spring 1988, as the number of AIDS cases approached 100 000.

Although both countries were slow to see the necessity of condom advertising,

TABLE 5—Opinions about Sexual Behavior (Agreement with Statement, %), by Age and Gender: United States and Great Britain

Gender and Country	Age, y, %				All
	18–24	25–34	35–44	45–59	
Premarital sex is "always wrong" or "almost always wrong"					
Men					
GB	4.7	5.2	7.6	14.0	8.1
US	17.8	19.1	25.1	37.5	24.8
Women					
GB	4.8	5.9	9.2	21.0	10.7
US	20.7	28.2	33.4	46.3	32.7
Extramarital sex is "always wrong" or "almost always wrong"					
Men					
GB	79.4	75.2	72.5	79.2	76.4
US	92.6	89.7	87.5	86.2	88.9
Women					
GB	84.3	83.2	78.6	84.6	82.6
US	95.8	94.3	92.1	92.5	93.5
Homosexual sex is "always wrong" or "almost always wrong"					
Men					
GB (2 men)	66.4	62.1	64.8	75.6	67.4
GB (2 women)	59.6	55.8	58.7	69.8	61.1
US	71.9	70.7	76.3	80.5	74.7
Women					
GB (2 men)	49.6	48.9	52.0	62.7	53.6
GB (2 women)	52.0	49.8	52.4	63.8	54.7
US	65.7	66.8	69.7	74.3	69.3

Note. GB = Great Britain; US = United States.

British HIV/AIDS public education was characterized by early and energetic efforts to raise awareness of the epidemic; in the United States, even circumspect advertising about condoms did not appear on television until 1995. In terms of the spread of AIDS among injection drug users, Britain conducted an experiment regarding the efficacy of a needle exchange program and quickly approved a program. Despite generally positive results in these experiments, implementation of similar programs in the United States is still limited to scattered sites under highly controlled supervision. A ban against the use of US federal funds for needle exchange programs continues.

The legacy of failure to mount an effective US public health campaign about sex and HIV may well have contributed to the higher rate of that disease in the United States than in Britain. We do not claim to have shown a causal link between the combination of greater dispersion in sexual behavior and unconditional opinions about sexual behavior in the United States leading to a weaker public health stance. Yet, our comparisons are consistent with this linkage, and we suggest that it deserves further investigation. There is great public resistance in the United States to addressing forthrightly the risks of having many sexual partners and of engaging in risky sexual practices. That resistance results in large part from the strong opinions that such

behavior is preemptively unacceptable, not that it is risky. Our public health may be the high price we pay for our public opinion. □

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