from mainstream provision, and be prioritised for support based on an objective case of health need, and outcomes secured. This should result in services becoming more sensitive to the needs of their local populations.

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Health of the nation

Sexual health—health of the nation

M W Adler

A decade later—a further failure

The Health of the Nation: a strategy for health in England (HoN), published in 1992, identified HIV/AIDS and sexual health as one of five priority areas with specific objectives and/or targets being set.[1] The incidence of HIV infection was to be reduced with no targets set, however, with a specific target to reduce the incidence of gonorrhoea among men and women aged 15–64 years by at least 20% by 1995 (from 61 new cases per 100 000 of the population to less than 49), and to reduce the rate of conceptions among females under 16 by at least 50% by the year 2000 (from 9.5 per 1000 among 13–15 year olds to no more than 4.8). Five years on from the publication of HoN, it was pointed out that even though the gonorrhoea target had been achieved, most other sexually transmitted infections had increased since publication.[2] Additionally, pregnancy rates had not decreased. By 2002, a full decade after HoN, little improvement has occurred, and in most instances, if anything, the nation's sexual health has declined.

GONORRHOEA

By 1997 the target of 49 new cases of gonorrhoea per 100 000 had been achieved. However, latest figures indicate an increase in both male and female cases of gonorrhoea in England between 1997 and 2001.[3] There was a 84% increase in the number of cases in men from 8418 to 15 475, and in females of 67% from 3981 to 6641, with an overall increase for both sexes of 78% (fig 1). This represents an increase in the rate per 100 000 for both sexes of 76% (from 25 in 1997 to 44 in 2001). The incidence of gonorrhoea has increased in homosexual men, as have other STIs, and this is particularly marked in London. In the year 2001, 22% of gonorrhoea diagnoses in males were seen in homosexual men, and in London this was higher at 28%.

CHLAMYDIA

Chlamydial infection is now the commonest curable bacterial STI seen in England. In the year 2001, 67 403 cases of chlamydial infection were diagnosed in departments of genitourinary medicine (GUM), 29 154 in males and 38 249 in females. This represents an increase of 73% in the past 5 years (fig 2). This condition is most commonly seen in young people; the peak age in men is between 20–24 and between 16–19 in women. Screening surveys carried outside normal STD clinic environments also show high levels in antenatal and gynaecology clinics, general practice, family planning and termination of pregnancy clinics; prevalences ranging from 4.5 to 16%.[4] The two pilot studies of chlamydia screening carried out in the Wirral and Portsmouth reported that 10% of women under 25 years of age attending health services and being screened were infected with chlamydia.

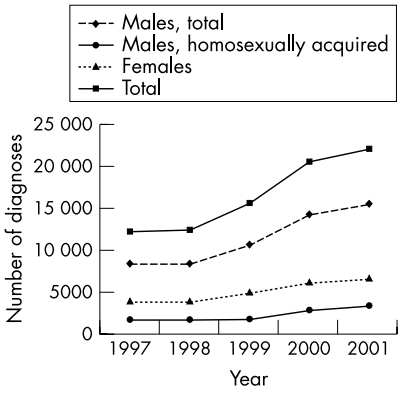

Figure 1 Diagnoses of uncomplicated gonorrhoea by sex, England, 1997–2001.

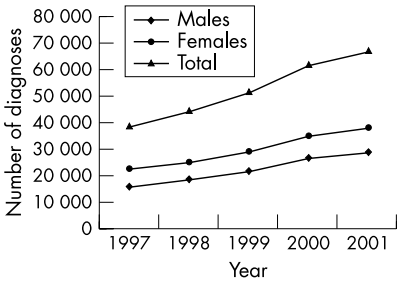

Figure 2 Diagnoses of uncomplicated chlamydia by sex, England, 1997–2001.

OTHER STIs

Anogenital warts are still the commonest viral condition seen in departments of GUM in England with 62 222 new cases in 2001. The increase since 1997 is 6%, less than for gonorrhoea and chlamydia. There were 17 056 cases of genital herpes in 2001, an increase of 13% in the past 5 years. Infectious syphilis is now rare in England; however, there has been an increase of 374% in the past 5 years to a current level of 697 cases diagnosed in 2001, the increase in the past 12 months alone has been 116%. Additionally, a number of outbreaks of syphilis have been reported throughout the country.[5]

HIV/AIDS

The advent of highly active antiretroviral agents in 1995 has had a profound effect on the progression from HIV to AIDS and subsequent death. The number of new HIV diagnoses has increased dramatically, which means that the prevalent pool of infected individuals is increasing with implications for treatment costs and dangers of onward transmission. The increase in prevalent cases is expected to reach 33 930 by 2005, an average of nearly 10% per year since 2000 (23 017 cases), and a doubling between 1997 and 2005.[6]

The majority of cases of HIV infection and AIDS that have occurred in England have been seen in homosexual men, 54% and 84% of the total respectively. Despite this, heterosexual transmission is becoming increasingly important. In 2001 we saw the largest annual total of new diagnoses of HIV (4419) since the start of reporting in 1982, 55% of these were as a result of sex between men and women. Additionally, 79% of new diagnoses made in heterosexuals were in individuals who had acquired their infection abroad, mainly (71%) in Africa.

CONCEPTION RATES AND UNWANTED PREGNANCY

The high rate of teenage conceptions caused considerable concern in the mid 1990s, resulting in the Social Exclusion

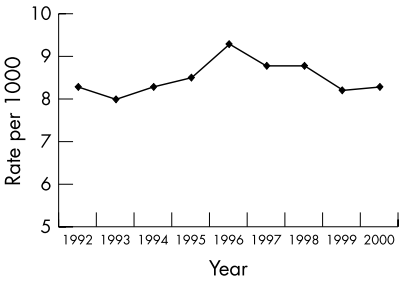

Figure 3 Under 16 years of age conception rates per 1000, England 1992–2000.

Report and the setting up of the Teenage Pregnancy Unit within the Department of Health (DoH) in 1999.[7] Despite this, the rate in under 16 year old women remains unchanged from 1992, the year of the HoN, and at 8.3 per 1000 in the year 2000 is far short of the target originally set for that year of 4.8 (fig 3).

THE CONTEXT/WHAT ELSE IS HAPPENING?

It is important to put these trends in STIs, HIV, and pregnancy into a context of what changes have occurred in sexual behaviour and service provision within the United Kingdom.

Sexual behaviour

The recently published National Study of Sexual Behaviour and Lifestyles (NATSAL) has given an indication of the changes that have occurred between 1990 and 2000.[8 9] For example, the survey indicates that half of teenagers have sex before the age of 17 years, and that the age of first intercourse has decreased over the 10 years. Additionally, the number of lifetime partners has increased, particularly among females, and the number of individuals involved in concurrent sexual relationships has also increased. It is encouraging that condom use has gone up, but probably not enough to offset the increase in sexual partners. A number of other studies indicate increases in high risk sexual behaviour among homosexual men.[10 11]

Service pressures

The increases in infections, pregnancies, and high risk sexual behaviour puts considerable demands on the existing services for STIs and HIV, contraception, abortion, and health promotion.

Clinics for STIs/departments of genitourinary medicine (GUM) have seen a substantial rise in attendances. There has been a doubling in attendances in departments of GUM within England in the past 10 years, now reaching 1.1 million per annum (fig 4). The details of the burden and increases in different diseases have been mentioned earlier, with considerable increases over the past 5 years of diagnoses of chlamydia (73%), gonorrhoea (78%), and syphilis (374%). As a consequence, departments of GUM have found it hard to deliver immediate high quality, open access, and self referral services. Immediate access allows for prompt treatment, avoidance of complications, potential onward transmission, and rapid identification and treatment of sexual partners. The Monks Report of 1988 which looked at GUM workload and infrastructure set a target for patients with a new problem to be seen within 48 hours.[12] All the evidence indicates that patients are waiting for increasingly longer periods before obtaining an appointment. The length of waiting times has increased within the United Kingdom from 5 days for males and 6 days for females in 2001 to 12 and 14 days respectively by 2002. These national data do not highlight the particular problems seen in large urban centres, where in some instances patients have to wait over a month for the next available appointment. Additionally, recent surveys indicate that considerable improvements are needed to clinic infrastructure, that one third of clinics operate 3 days a week or less, that the Royal College of Physicians' recommendations on consultant expansion in GUM is under target by 70% resulting in trainees not having consultant posts to apply for (Medical Society for the Study of Venereal Diseases and Association for Genitourinary Medicine. Modernising genitourinary medicine services in England and Wales, personal communication).[13–15] Clearly all of this is totally unsatisfactory in terms of being able to control sexually transmitted infections and HIV.

Contraception is an important aspect of sexual health in relation to avoiding both unwanted pregnancies and potential sexually transmitted infections. Unfortunately, "the accessibility and range of contraceptive methods available including NHS funded sterilisation vary widely."[16] In addition, the service is fragmented and of variable quality. Currently, 20% of NHS contraception prescribing takes place in community clinics, with the remaining 80% occurring in primary care. Mandatory training is not required for general practitioners providing contraceptive care, but they can be paid on an item for service basis without regard to the quality of service offered.[17] This hit and miss approach is not ideal for maintaining standards, accessibility of a wide range of contraceptive methods, and tailoring services to users.

As with contraceptive services, there are wide variations in access to abortion services and methods available. The percentage of NHS funded abortions ranges between 46% and 96% in different parts of the country and women can wait up to 6 weeks.[18] These delays militate against

Summary points

- All sexually transmitted infections have increased in the past 5 years, particularly gonorrhoea (78%), chlamydia (73%), and syphilis (374%)
- Prevalent cases of HIV are expected to double between 1997 and 2005
- Teenage pregnancy rates have remained unchanged since 1992
- Changes in sexual behaviour over the past 10 years (decrease in the age of first intercourse, increase in lifetime partners and concurrent relationships, and decrease in safe sex practices among homosexual men) and pressure on GUM services and delays in access will drive the epidemic of STIs
- There is a progressive decline in the nation's sexual health resulting in a public health crisis which will only be resolved by political and financial commitment

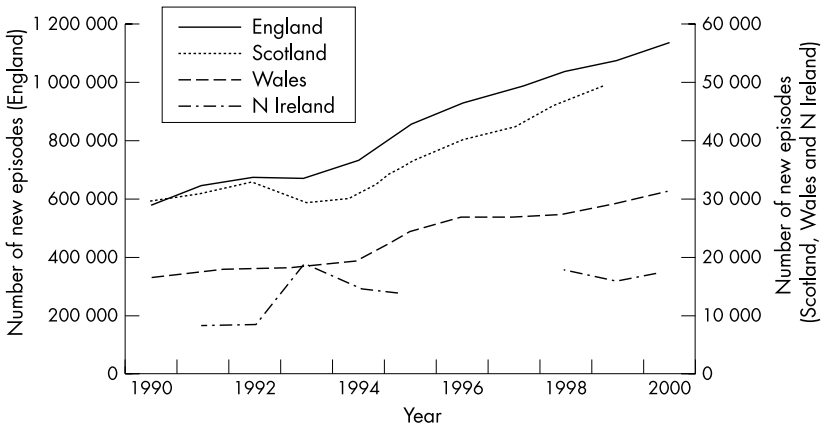

Figure 4 All diagnoses and workload at GUM clinics by country: 1990–2000. (Data are currently unavailable from Scotland for 2000 and from Northern Ireland for 1990, 1996, 1997.)

obtaining an abortion on request and without complications. The current services for terminations fall far short of the Royal College of Obstetricians and Gynaecologists' recommendations.[19]

CONCLUSIONS

The past decade has seen a continuing and considerable deterioration in the nation's sexual health. All infections have increased alarmingly, teenage pregnancies are yet to decrease, and changes in sexual behaviour regardless of sexual orientation can only continue to drive this situation. It is no exaggeration that we now face a public health crisis in relation to sexual health. The recently published sexual health and HIV strategy for England attempts to outline a plan for better prevention and services.[15] Only £47.5 million has been allocated over the next 2 years, not enough to tackle even one aspect of the strategy—namely, the roll out of a national screening programme for chlamydia. Concern has been expressed that the allocated resource "is manifestly insufficient."[20] Sexual health is not an NHS or political priority. Until it becomes so we will witness further failure upon further failure.

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ECHO

Softly, softly does it in promoting sexual health in off street sex workers

Please visit the Sexually Transmitted Infections website [www.stijournal.com] for link to this full article.

Valuable lessons are to be learnt in promoting sexual health to women who work "off street" in saunas, massage parlours, and other premises, according to an outreach project doing just that in north west England.

Gaining access is a major hurdle and takes a time and patience. Total honesty about the project and its aims—assessing the needs of this group and offering women health advice—and clear communication are essential. The starting point may be nothing more than delivering condoms to the door. For women who work in their own homes it may entail meetings on neutral territory—in nearby parks or car parks—until rapport and trust are built up.

The caseworker's attitude and demeanour are crucial—a focus on improving the women's sexual health, no underlying attempt to lure them away from the work; an unquestioning acceptance of the work; and respect for the women and willingness to learn from and build on their knowledge.

So far, since the project started in December 1999 the caseworker has achieved unfettered access to four massage parlours and 10 women in their homes. In all, 135 women are contacted regularly and are given contraceptive supplies and advice on sexual health and relevant local services; 21 have been immunised against hepatitis B.

Off street sex workers are a neglected group, yet are estimated to be three times more numerous than their on street counterparts, and they indulge in more high risk behaviours, especially unprotected penetrative sex.

▲ *Journal of Epidemiology and Community Health* 2002;**56**:903–904.