Race, ethnicity, and sexual health

Can sexual health programmes be directed without stereotyping

S Studying and interpreting the relation between race, ethnicity, and health often invites debate and controversy. Research in this area is rapidly expanding, driven by a desire to explore variations in health and to understand the aetiology of diseases. However, concerns have been raised about the ways in which race and ethnicity are defined and used in epidemiological research. Some have questioned the motives behind research in ethnicity; with hindsight, it is often unclear who, besides the researcher, benefits from the results. Methodological errors in some studies, chief of which is non-adjustment for confounding by socioeconomic variables, have led to erroneous conclusions or to findings of limited generalisability. To this end, guidelines for improving the use of ethnicity in research and mechanisms to avoid common pitfalls have been published.[1] [2]

In this week's *BMJ*, Raj Bhopal takes a critical look at research in race and ethnicity (p 1751).[3] He challenges researchers to "move from repetitive demonstration of disease variations" towards "assessing needs and inequality, and guiding practical action." Alongside this article are a series of papers that demonstrate or comment on ethnic differences in the incidence of sexually transmitted diseases, including HIV infection and AIDS.[4-7] The studies also highlight the difficulties in carrying out such research. But to what extent has Bhopal's challenge been met by researchers and practitioners in sexual health? How should these findings impact on the provision of services to reduce inequity?

Surveillance data for HIV infection and AIDS and other sexually transmitted diseases show variations in incidence across ethnic groups.[8-10] In the United States, higher rates of sexually transmitted diseases have been described among some minority racial groups compared with white people. The most recent epidemic of syphilis was located largely among African Americans living in poverty.[11] Heterosexually acquired HIV infection in the United States is now increasing in all ethnic groups, with the highest infection rates occurring in young women in ethnic minorities (Rosenberg et al. (Abstract Tu C572.) XI International conference on AIDS, Vancouver, July 7-12, 1996).In Britain, apart from some data for HIV infection and AIDS, the absence of ethnicity in routine surveillance has limited our ability to explore ethnic differences.[12] Descriptive surveys undertaken in sexually transmitted disease clinics, though convenient, can provide only limited information that has limited generalisability.

Comparisons between clinics are limited by poor comparability of patient data, diagnostic criteria, and ethnic categories. Where minority populations are more or less likely than white people to make use of sexually transmitted disease clinics (from which surveillance reports are completed), reporting bias may also contribute to differential rates.

Recent studies have looked at the distribution of sexually transmitted infections diagnosed in sexually transmitted disease clinics in relation to the local population. Studies in south east London (p 1719)[4] and in Leeds (p 1715)[5] suggest that being of a black ethnic group is associated with a higher risk of acquiring gonorrhoea as judged by incidence rates, even after controlling for socioeconomic status. The differences in disease incidence suggested between racial groups are alarming, although the inability to differentiate between some ethnic groups, particularly between black African and black Caribbean, by the authors' own admission, limits the usefulness of the findings in ethnically diverse areas such as London. This highlights the problem emphasised by DeCock and Low (p 1747),[6] that without standardised collection of interpretable data on ethnicity, opportunities for surveillance to inform action on public health are lost.

How ethnicity relates to health is unclear

Bhopal chastises the research community for undertaking "black box epidemiology" in which the emphasis is placed on describing associations without due regard to the underlying mechanisms by which they occur.[3] How ethnicity relates to sexual health remains unclear. There are no known biological reasons to explain why racial or ethnic factors alone should alter the risk for sexually transmitted diseases. Race and ethnicity may be markers that are associated with fundamental determinants of health such as poverty and seeking health care.[12] A person's cultural background can have a strong influence on his or her sexual attitudes and behaviours,[13] sexual mixing patterns, and choices of partner. For example, people tend to have partners within their own ethnic group (a form of assortative mixing),[14] and, in the presence of raised levels of undetected sexually transmitted diseases, assortative mixing may make ethnicity an important determinant of incidence of sexually transmitted diseases, further disadvantaging some communities. Conversely, other communities may seem to be protected: for example, Asians have lower incidences

of AIDS and sexually transmitted diseases.[8] [10] Variations in the quality, availability, delivery, and use of services proved to be effective in preventing sexually transmitted diseases (such as screening and contact tracing) may also contribute.

Implications for public health

The public health implications are numerous. Sexual health remains a national priority and a major problem.[7] Objectives have been set in the government's Health of the Nation strategy to reduce the incidence of HIV infection and other sexually transmitted diseases, with specific targets related to gonorrhoea and teenage conceptions.[15] Citing various national data, including the incidence of gonorrhoea in 1995,[16] Adler (p 1743) expresses concern at the poor progress in this area over the past five years.[7] Suggestions that, within this, some groups may be more severely affected—such as gay men, teenage women, and certain ethnic minorities—are worrying. It is imperative that a balance is created between aiming control strategies at the general population and meeting the needs of those at higher risk.

How might these findings be useful in guiding national policy on sexual health? Both studies suggest that black groups are at higher risk of acquiring gonorrhoea,[4] [5] and surveillance reports show black Africans to be at high risk of heterosexually acquired AIDS.[8] However, it is crucial to consider also the proportion of the total of infections occurring in different groups, the population attributable risk. In south east London, where black groups comprise nearly 20% of the local population,[17] 63% of people with gonorrhoea were black, while in Leeds the comparable figure was 27%. The only available national gonorrhea dataset with ethnic data, that from the PHLS Gonococcal Reference Unit, indicates that being a black Caribbean confers higher risk but that most gonococcal infections were among white people.[10] Given the uneven geographic distribution of ethnic minorities, appropriate policies and initiatives must be tailored to the needs of local communities.

How should the sexual health services respond? What these observational data cannot answer is whether the underlying differences lie predominantly in different lifestyles, in patterns of health seeking behaviour, or in the quality of services provided. Ethnic differences in consulting behaviours have been documented.[18] [19] If high risk ethnic minority communities have poor access to sexual health services, then infections will persist within these groups, with the burden of the resultant sequelae. Such inequity demands concerted action by public health practitioners, providers of sexual health services, and specialists in health promotion to ensure that their services are sensitive to the needs of their local communities and are able to respond effectively. Not all ethnic minority communities are at high risk, and some are at lower risk than the ethnic majority,[8] [10] a point seldom given any attention. Nevertheless, many will have specific needs that should be addressed to improve access and acceptability of services.

Involving the most affected communities in the planning and implementation of programmes is essential. As Bhopal advocates,[3] this requires establishing partnerships between ethnic minority and ethnic majority scientists and the continued involvement of organisations based in ethnic minority communities. Continued support should be given to these organisations to carry out initiatives promoting sexual health. Culturally sensitive and innovative approaches to preventing disease are critical, and services will need to be targeted effectively without stigmatising affected communities.

Gonorrhoea is curable, and HIV infection is increasingly treatable. Both are preventable. Acknowledging ethnic disparities in rates of HIV infection and other sexually transmitted diseases is one of the first steps in empowering affected communities to organise and focus on this problem. However, openness to ethnic differences should not be a license for stereotyping and exploitation, and, in this regard, the media carry a particular responsibility. Polarised and dogmatic approaches are more likely to exacerbate than alleviate current problems.

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Disillusioned doctors

Need a better balance between service commitment and education.

The exodus of young doctors from the NHS has been exaggerated,[1] but British medicine has nothing to be complacent about. Disillusionment and discontent among doctors seems widespread and, as shown in this week's journal, is by no means confined to the juniors. Growing concern about the service's inability to care adequately for patients is causing frustration and even despair among senior doctors. This is perhaps reflected in early retirement, which is becoming common among both hospital consultants (especially those without merit awards) and general practitioners. Surveys of junior doctors who have left or are contemplating leaving medicine now rank the unattractive lifestyle of consultants as a major factor in their decision. In general practice the same concern about lifestyle is adversely affecting recruitment to general practitioner training schemes.

Objective measurement of the misery index may be lacking and anecdote more evident than hard data, but recent discussions at the Royal Society of Medicine made it clear that there is an iceberg of discontent that cannot be ignored. Over the past year there have been 3300 calls to the BMA's helpline, mostly from doctors between the ages of 21 and 25 years, and although less than 100 have left their jobs many were experiencing difficulties. The causes of discontent are familiar. Despite the New Deal, long hours on call remain a major problem. Dr Elisabeth Paice, dean of postgraduate medical and dental education for North Thames, reported on a recent questionnaire survey of nearly 3000 junior doctors in the North Thames Region. This found that the commonest working pattern was 72 hours a week, and over a 36 hour period on call half got four to five hours sleep or less. Paradoxically, in the specialties where the hours had been substantially reduced a down side was emerging with doctors complaining of isolation, lack of peer support, too little teaching, and insufficient hands on experience.

Poor working and living conditions continue to take their toll—understaffed wards, faulty equipment, dirty on call rooms, trivial night calls, no hot food. The list is long and unedifying. The large volume of "inappropriate" work that junior doctors do, including time consuming bureaucratic and administrative chores, is particularly disliked. Poor personal support from senior doctors, little career guidance, inadequate supervision, patchy, old fashioned, didactic teaching, insufficient protected time, stressful working patterns with increased patient turnover, poorly structured training programmes, and too few flexible and part time training opportunities contribute to the misery. Loss of autonomy, erosion of professional values and integrity, and the tendency, said Dr Isobel Allen, of the Policy Studies Institute in London, "for management to treat doctors as technical monkeys" compound it. Add to this the fact that many doctors are inhibited from drawing attention to their concerns for fear of being labelled weak or inadequate, and that the recognition and support of "sick" doctors is poor, and it is not difficult to see why some doctors regret their career choice.

Solving these problems requires creative thought and a change in culture. Shift work is here to stay and, although efficient rostas help, doctors need to be taught new skills. "Interdisciplinary team skills, communication skills, computer skills to facilitate good documentation, and transfer skills to ensure continuity of care are essential," said Dr John Parboosingh, associate director of the Royal College of Physicians and Surgeons of Canada. "Doctors must also be taught to manage change and accept that power is a privilege not a right; that their role is not necessarily to head teams but to be influential members of them." Senior doctors should do more to ensure that postgraduate training was made an enjoyable learning experience for junior doctors not a period to be endured before reaching consultant status. These changes were seen as more important than improving rates of pay although there was a call for better rates for overtime work.

Improving the learning experience of trainees is dependant on getting a better balance between service commitment and education. The latter must be seen as fundamentally important, and, in addition to ring marking more time, consultants teaching skills had to be improved, said Dr John Biggs, postgraduate dean at Cabridge University. "Unlike GP trainers, hospital consultants are not paid to teach, nor are they given protected time to learn teaching skills. The government should give trusts funds specifically for education." Teaching, mentoring, appraisal, and computing skills should become core skills that all consultants acquire, not optional extras. In addition, it was suggested, the accreditation committees of the Royal colleges could and should act more decisively. Not infrequently the inspectors who prepare detailed reports of senior house officer posts found them to be inadequate, but the colleges seldom withdrew recognition of these posts.

Making the consultant job more desirable and rewarding is another challenge, but one that looks increasingly unachievable unless urgent steps are taken to improve services to patients. Last week, representatives of Britain's senior hospital doctors declared that the hospital service is failing its patients and is seriously underfunded (p 1768). Meanwhile, consultant morale continues to plummet. In an open letter to Britain's secretary of state for health (p 1756), two senior hospital consultants document some of the causes behind the growing frustration and despair—increasing numbers of patients attending accident and emergency departments, emergency admissions squeezing out elective referrals, elderly patients blocking acute beds because of inadequate provision in the community, supervision of trainees in theatre and outpatients reducing the number of operating sessions and patients seen.[2] The authors describe strategic measures they and their colleagues have taken, but they conclude that, "with the best of intentions we can-

not sustain current services with even less than current resources; we cannot maintain morale without light at the end of the tunnel." These calls for action can no longer be ignored.

Additional funding should be accompanied by other steps. One way forward is to be much more imaginative about continued professional development. Consultant contracts should be much more flexible and allow doctors the freedom to pursue different career tracks, clinical, teaching, managerial, or research, depending on their preference and ability. Portfolio careers and career changes should be seen as positive developments. Full time, life time service at the

clinical coal face may no longer be in either the profession's or the patients' interest.

It is of course easy to point to problems and only a little harder to suggest solutions. The difficulty comes in effecting change. This requires good leadership which, as several speakers at the meeting emphasised, must come from the profession.

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Supporting diversity in primary care

If autonomy improves general practitioners' morale, nobody has a long term interest in taking it away

The accumulating evidence clearly shows that general practitioners are able to perform a wide variety of clinical activities effectively. Recent examples include success in managing asthma[1] and diabetes,[2] which can be set alongside earlier evidence in areas such as managing hypertension and community obstetrics.[3] Primary care's proved effectiveness and ease of access are a powerful combination, and planners and health authorities are now looking for new ways to transfer work from secondary to primary care to everyone's advantage. Examples of work that is initiated in secondary care but which is being shifted to primary care include routine follow up for breast cancer[4] and earlier discharge from hospital after day surgery.[5] However, picking out such examples obscures the true picture of a richly varied and rapidly changing landscape. For instance, a colleague was recently asked to discuss transferring responsibility for routine examination of newborn infants in his area from specialist paediatricians to general practice (G Young, personal communication), and in my own area general practitioners have been asked to take on preoperative counselling for vasectomy.

General practitioners' willingness to take on more clinical activity stems from a desire to provide better care for patients and a more rewarding professional life for themselves, but it creates an unstable primary care environment. Secondary care providers and policy makers quickly spot the opportunity to shift work away from apparently more expensive secondary care centres. Although there is little concrete evidence of a substantial increase in workload,[6] general practitioners themselves can easily feel that they are being "dumped on." Whatever its real extent, it is likely that this has contributed to falling morale and even an air of surliness among some general practitioners.

In this week's *BMJ*, Gruer and colleagues describe a scheme for treating opiate users in Glasgow that seems to offer one way out of this problem (p 1730).[7] The key elements in the scheme were: recognition that the work fell outside the scope of general medical services, an

undertaking from the general practitioners participating to attend regular education, an agreement to adhere to shared treatment policies, some minimal data collection to review their performance, and payment for the work involved. In addition, there were facilities for specialist support. At present, the scheme's success can be judged only by the increasing numbers of general practitioners participating, an increasing proportion of prescriptions issued as part of it, and a high proportion of prescriptions dispensed daily. Only one doctor is reported to have left the scheme. A similar pilot scheme involving the management of patients with long term mental illness in primary care is currently being explored in south London (T P Burns, personal communication).

Given the superficial similarities, it is instructive to compare this approach with that of the ill fated health promotion clinics which appeared with the 1990 contract. They failed, possibly because they were too easily exploited in the absence of strictly controlled quality standards, but also because central control dictated that all practices should work in the same way regardless of the point from which they were starting. In the scheme reported by Gruer et al the background was of doctors already dealing with opiate users but wanting more support and a more coherent method for handling the problem. In other words, the scheme was devised partly by the doctors themselves in response to a clearly expressed local need.

Beyond offering a model for better care of the increasing number of opiate misusers in Britain, can such schemes be applied to other clinical areas and help solve the general question? At least three difficulties arise. Firstly, funding more varied and larger scale schemes, where work is shifted from one sector to another, is likely to be more complicated to organise than small scale developments such as the one described by Gruer et al. Secondly, there is conflict between the ordered world of health policy and the ungovernable variety of general practice. Policy makers have a legitimate desire to move whole services entirely from one sector to another. This is not simply an administrator's ingrained yearning for order in a

chaotic world. It is only by shifting substantial volumes of work that any savings can be made to fund provision for the work to be done elsewhere. General practitioners have little desire or incentive to be managed in this way. They want to be free to pursue particular interests and to move at their own speed. A plea for preserving such variety is not an anarchist's desire for maintaining chaos: if such control over their own work does have a bearing on general practitioners' morale then nobody has a long term interest in taking it away from them. Thirdly, and most importantly, many would count it a disaster to break up general practice into a series of discrete and definable parts. The strength of general practice is in providing comprehensive, holistic, and continuous care.[8] [9] Any move to price the individual components would eventually detract from the whole.

This is the dilemma. Further expansion of general practice is possible and desired by all the stakeholders. However, there is a limit to what can be accomplished under current funding arrangements. Whether or not we are close to the limit, as many general practitioners claim, is irrelevant: we know the limit exists. There has to be a method of rewarding the different levels of activity that practices wish to undertake or, at the very least, of providing staffing that makes developments neutral in cost to the general practitioners themselves. It is sobering that this problem is no nearer solution than when it was first identified in 1954.[10] It would be destructive to take a narrow definition of "general medical services" in order to allow doctors to bid voluntarily for what is left out. It has also been suggested that remunerating services outside the core by fee for item of service is wasteful.[6] Quite apart from any effect it might have on doctors' own attitudes, it is bewildering to anybody not directly concerned with general practice remuneration.

One solution may be to develop an idea first suggested by Morrell when the 1990 contract was first introduced.[11] Under this scheme practices would be free to arrive at their own definitions of general medical services and to negotiate the appropriate mix of payment for medical and other services. Such a scheme could be used flexibly to reward practices undertaking a broad range of extended services, to fund innovations, and to recompense those practices that were able to mount a convincing argument that they were responding to particular local needs. It would be a messy solution and would be unlikely to be popular with planners, but it may be the only way of supporting healthy, organic development of general practice.

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Fighting malaria

A new campaign for the next millenium

In the centenary year of Ronald Ross's discovery that malaria was transmitted by anopheline mosquitoes, it is reasonable to ask why we are still so far from controlling this dreaded disease. Malariologists were quick to apply the fruits of his discovery, reducing vector populations by eliminating breeding sites and later advocating application of cheap effective insecticides to reduce transmission in areas of high population density. Extraordinary progress was made, and malaria was eradicated from many countries. Such was the optimism that many believed it would be possible to eradicate malaria with the technology and knowledge available in the mid 1950s. Unfortunately, little impact was made in rural areas of the most severely affected countries in sub-Saharan Africa.

Today, malaria is a public health problem in more than 90 countries, inhabited by 40% of the world's population, and is responsible for up to 500 million clinical episodes and 2.7 million deaths a year, predominantly in young children in sub-Saharan Africa.[1] Some successful control programmes have broken down because of cost and organisational reasons but also because of the emergence of resistance to dicophane (DDT). Malaria has returned in epidemic proportions in many countries, causing high morbidity and high mortality in people of all ages. Increased international travel, migration, and civil unrest have led to increased mortality in non-immune people, and global climate change has the potential to aggravate the problem further. Resistance to both first and second line antimalarial drugs has limited the options available for preventing or treating malaria.

In recognition of the need for a renewed approach to malaria, international consultations culminated in a

global malarial control strategy presented at a conference of health ministers in 1992.[2] This strategy incorporated a major change in direction, which highlighted malaria control (in contrast to eradication) as an integral part of national health development. It also acknowledged that different approaches were required for areas with different characteristics of endemicity and transmission. The strategy emphasised the need to improve local capabilities for assessing and responding to specific problems, because universal approaches had not been successful. Within two years, most of the severely affected countries had made a political commitment to increased activities in malaria control through key elements of disease management, implementation of selective preventive measures, early recognition of epidemics, and building of local capacity.

The global strategy recognised that there was no universal solution for malaria control and that research was a high priority.[3] Advances were needed on several fronts, including epidemiological information systems, vector control, and intersectoral collaboration. Priorities for research included development of vaccines and new antimalarial drugs. First reports of an efficacious antierythrocytic stage vaccine appeared almost 10 years ago,[4] and demonstration of 30% protection against first infection in children in Tanzania[5] is being followed by tests of efficacy of vaccination in the first year of life. Studies in the Gambia[6] and Thailand[7] have not demonstrated efficacy. Recent exciting experiments suggest that it is possible to provide at least short term sterile immunity directed against sporozoites if an appropriate immune response can be generated.[8] Vaccines would be powerful additions to existing control measures,[9] such as insecticide treated bed nets, which have been shown in certain settings to reduce childhood mortality by 15-30%.[10]

The lamentable lack of research funding for a disease of such global importance is highlighted in a study by the Wellcome Trust's unit for Policy Research in Science and Medicine (PRISM).[11] This reports that total global expenditure on malaria research in 1993 was only about $84m, compared with more than $900m for HIV and AIDS and $127m-158m for asthma. Expenditure per fatal case was $42 for malaria compared with $789 for asthma. Over half of the funding for malaria research came from the United States, despite the fact that American contributions fell from more than $60m in 1985 to about $35m in 1994, largely as a result of a decrease in the annual contribution of the United States Agency for International Development. Meanwhile, the amount of money coming from Britain has increased to about $15m, with grants from the Wellcome Trust exceeding $10m in 1994.

It was beyond the scope of the report to recommend how the most promising areas of research, such as parasite genetics and biology, should be pursued, but clearly the most important factor is to provide sustained support that will attract and retain the best investigators for careers in malariology. The Wellcome Trust is to be commended for providing such support in Britain and for recent efforts to enhance global output by expanding funding support for institutions outside Britain. However, expenditure through researchers in non-endemic areas should be complemented by support to develop research capability in endemic areas. The World Health Organisation can play an important part in coordinating the efforts of the many funding agencies. Despite the limited funds available, it would be inappropriate for future research to become too focused on specific areas as the direction from which the most beneficial advances will come is unpredictable. With restricted funding, DNA vaccines[12] would not have been a priority and antisporozoite vaccines[8] might well have been abandoned.

The malaria problem is too great to be overcome with the meagre resources traditionally devoted to health. Solutions demand that its control should become a national and international priority. The appearance of malaria on the agenda of the annual summit of the Organisation of African Unity is a demonstration of political commitment to acknowledge the problem, and the World Bank's substantial increase in support for health projects in recognition of the economic benefits that will follow is of great symbolic and practical importance. With political commitment and sufficient resources, people can be trained to apply what is known and tackle the major current obstacles. The landmark meeting of scientists in Dakar, Senegal, earlier this year to discuss a long term strategy for malaria control[13] was an important initiative that could signal a new wave in an integrated campaign for the new millenium.

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