

Sexual Health in the 21st Century – by Nigel Scott

The current problem

The last two years have seen renewed interest in the subject of sexual health and the new epidemic threat posed by many STIs. Clinics are full to bursting. Seven hour waits at walk in centres are the norm. Appointment times are often two weeks rather than the 'gold standard' of less than two days.

There are several reasons for the increase in the spread of STIs. The 80s AIDS campaign and the accompanying increase in condom use led to a measurable reduction in STI transmission. This is now a distant memory and many sexually active adults are unaware that it ever occurred. The days when most people only had one or two sexual partners in a lifetime have long gone. Young people of both sexes now start having sex younger and have many more partners than their parents did. Meanwhile, many middle aged people, newly separated or divorced, are embarking on new relationships. The increase in sexual activity and teenage pregnancy has not been accompanied by adequate sex education in schools or high profile safe sex advertising campaigns.

Recent activity by government

The government's Sexual Health Strategy was published in December 2001, following a consultation led by Professor Michael Adler of the GUM department at University College Hospital, London. This was followed by the formation of an advisory body, the Independent Advisory Group on Sexual Health and HIV, to monitor progress in service improvement and advise the Minister of Public Health. Meanwhile, this year the House of Commons Health Select Committee carried out its own investigation and members were shocked by the inadequate state of our sexual health services. The resulting report was more comprehensive and more damning than the government's Strategy that preceded it.

The House of Commons report generated much needed publicity, highlighting the crisis.

Extensive media coverage has followed but there has been little in the way of increased resources. GU consultants will renew their campaign for adequate patient services and better working conditions. But as we all know, every speciality is campaigning for increased resources and many other disease areas have a powerful patient voice which will always carry more weight than the special pleading of professionals.

The dermatology example

In the last few years, dermatology has faced similar problems. Demand for referrals is rising and the need to meet skin cancer screening targets has compounded matters for consultants, forcing them to give other dermatology patients a lower priority and lengthening waiting times. The British Association of Dermatologists is a respected professional body but has little experience in rolling up its sleeves and negotiating with Whitehall. Fortunately an enterprising alliance of patient charities has been able to take up the challenge. The Skin Care Campaign is an umbrella group, supported by thirty four patient charities, large and small. It has a small staff with PR backup and close links with the All Party Parliamentary Group on Skin. Its recent publication of a ten year plan for improvement in dermatology services has been enthusiastically received by the Department of Health.

Problems in translating this approach to GU

This model could be one for GUM campaigners to follow but there are problems with this approach. There are very few patient-led charities in sexual health. Apart from those in the AIDS/HIV community there is only the Herpes Viruses Association. As non HIV patients account for up to 98% of clinic visitors, this is a significant omission. There are two reasons for this lack of patient support:

- Most STIs are not persistent and can usually be eliminated by antibiotics so long term support for patients is not needed

- Because of society's prudery, most GU patients are unwilling even to admit that they have attended a clinic so are less likely to seek extra information than, say, a diabetes patient.

GU patients are renowned for not complaining about poor service – they just go away and many do not come back. Professor Adler was quoted in the Observer recently on the subject of a seminar he delivered to the Health Select Committee: *'After it [MPs] told me, "We never knew it was like this. We've never had a letter from a patient complaining about STIs, "to which the only obvious response was, "Well, you wouldn't, would you?"'*

So assembling a patient coalition to campaign for better services is not going to be easy, but there are other patient focused organisations who could perhaps be persuaded to come on board.

What is the agenda?

Currently PCTs have no targets and no obligation to provide adequate sexual health services. [Editor: Since 2004, the 48 hour access target has been brought in.] Decisions are made locally and trusts face many competing claims for scarce resources. So 'short-termism' rules – the resources to make dramatic, or even modest improvements to facilities are simply not there.

Adequate provision is expensive but the cost of failing to improve services could be even more expensive. More patients would be untreated and would spread their infections further and asymptomatic cases of infections like chlamydia would not be picked up. Ten years down the line, the cost of IVF treatment required as a consequence of untreated chlamydia is many times the cost of screening and treatment now.

A starting point would be to commission research and discover how the next generation of clinic attendees - teenagers at school - would like to see services delivered. This would have the added benefit of educating them about the STI risks they are about to encounter.

Suggestions for the future

Currently, there is a certain stigma to attending a sexual health clinic, compounded by the fact that services are often hidden in hospital basements. For sexual health to become mainstream there needs to be a change in the way people perceive/look after their sexual health. Regular check-ups by the sexually active need to become the norm. Having a sexual health screening will need to be as routine as a visit to the dentist or optician. This is the only way we will check the spread of asymptomatic infections.

Increased educational resources and high profile publicity campaigns will be required in order to secure this step change in behaviour.

Clinics will need to be enlarged and modernised; perhaps even relocated. After all, GUM services are largely a matter of primary care for most patients. Most clinics are only located in hospital complexes for historical reasons and there is no reason why they should stay there. Perhaps a national service should be re-established, with independent funding, no longer competing with other specialties for a slice of the cake, independent of PCTs and with town centre/high street shop locations – bringing the service to the users and reducing the stigma. After all, if regular check-ups are the norm, no one will assume that all those who enter a clinic have an STI.

We need a ten year plan to achieve this and we need it now. Aspirations and fine words will not give our society the service it needs. A clear, costed, step by step approach is the answer. A coalition to press for these changes is urgently needed.

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Officers of other patient focused organisations who would like to investigate the feasibility of launching an umbrella organisation to lobby for improvements in sexual health services should contact Nigel Scott on 020 7607 9661 or email: nigel@herpes.org.uk