House of Commons
Health Committee

Sexual Health

Third Report of Session 2002–03

Volume I

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Third Report of Session 2002–03

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Footnotes

In the footnotes of this Report, references to oral evidence are indicated by 'Q' followed by the question number. References to written evidence are indicated ion the form 'Ev' followed by the page number.

Contents

Report

		Page
	Summary	**5**
1	**Introduction**	**7**
2	**What is sexual health?**	**10**
	Definitions	10
	Sexual health and health inequalities	10
	Sexually Transmitted Infections	12
	Chlamydia	*13*
	Gonorrhoea	*13*
	Syphilis	*13*
	Genital Warts	*14*
	Genital Herpes	*14*
	HIV/AIDS	*14*
	Other Conditions	*15*
	Co-infection issues	15
	Unintended pregnancy and teenage pregnancy	16
	Sexual dysfunction	16
3	**What is the current situation?**	**17**
	Trends in Sexually Transmitted Infections	17
	Trends in HIV/AIDS	20
	Trends in teenage pregnancy	22
	Trends in unintended pregnancy	24
4	**What underlies these trends?**	**25**
5	**How has the Government responded to the problems identified?**	**28**
	Targets	30
6	**Treatment and service provision**	**32**
	STI services	32
	Consultant numbers	*32*
	Access to, and pressures on, services	*34*
	Premises	*38*
	Chlamydia Screening	*39*
	HIV/AIDS services	43
	Treatment	*43*
	Services	*43*
	Funding treatment and service provision for HIV and AIDS	*46*
	The Strategy and HIV services	*49*
	Contribution of primary care	*50*
	Contribution of Social Care	*51*
	Contribution of Voluntary Care	*52*

The impact of the *Strategy* on the organisation of service delivery: general issues 54
Commissioning of services *54*
Services in Primary Care *56*

7 Family planning and abortion services 58
Current arrangements for commissioning and delivering 58
What impact will the *Strategy* have? 60
Lack of priority given by the *Strategy* to contraception 60
Lack of priority at a PCT level 61
Access to services 62
Clinical quality and audit 63
Abortion services 64

8 Sexual dysfunction treatment and services 65
Anti-impotence treatments 65
Other issues of dysfunction *66*

9 Prevention and sexual health promotion 68
Getting the message across—a national information campaign 69
Evidence-based practice 70
The wider impact of health promotion 71
Securing the status and position of health 72

10 Relationships and sex education 75
What do young people know about sex and sexual health? 75
Is relationships and sex education necessary or appropriate? 76
Best practice in relationships and sex education 78
Relationships and sex education in 2003 79
Does this assessment match with that of current and recent school pupils? 80
Lack of priority 82
Lack of experienced teachers 83
The wrong focus 84
Meeting the needs of both boys and girls 85
What age? 86
Parents 87
Improving sexual health 88

11 Conclusions 91
The cultural context of changing sexual behaviour 91
Giving priority to sexual health 92

Conclusions and recommendations 95

List of abbreviations used in the report 105

Appendix 106

Formal Minutes 108

Witnesses 109

List of written evidence 111

List of unprinted written evidence 114

Volume II, Oral and written evidence, HC 69-II

Summary

England is currently witnessing a rapid decline in its sexual health. Around one in ten sexually active young women (and many men) are infected with chlamydia. Syphilis rates have increased by 500% in the last six years and those for gonorrhoea have doubled. Rates of teenage pregnancy are the highest in Europe. Sexual dysfunction is a largely silent problem within society.

Sexual health services appear ill-equipped to deal with the crisis that confronts them. Median waiting times to services are currently around 10-12 days and some services are turning hundreds of people away each week. We call for a target of 48 hours for patients to be able to access genito-urinary medicine, for the Government urgently to review staffing levels and for it to ensure that genito-urinary medicine needs are properly addressed. Genito-urinary medicine clinics are often dilapidated so we ask trusts to give priority to improving them. Although the Government's *Sexual Health Strategy* calls for more sexual health commissioning to be delegated to Primary Care Trusts we received little evidence to suggest PCTs were ready to take on these responsibilities. We also call for improvements in access to sexual dysfunction treatments and services.

Chlamydia screening has been piloted at two sites; the results were so worrying that we recommend the immediate introduction of a chlamydia screening programme nationally in a range of settings. We also urge the abandonment of the most widely used test, which produces far too many false-negative results, in favour of more sophisticated tests generally used elsewhere.

HIV continues to be the most important communicable disease in the UK. As the dramatic impact of the awareness campaigns of the 1980s has faded, worrying new trends in the infection and its transmission have emerged. Combination therapies for HIV have radically improved the health and lifestyles of people living with the infection but poor adherence to treatments promotes the development and transmission of resistant strains of HIV. Although gay men remain at greatest risk of acquiring the infection, the number of people who have acquired the infection heterosexually has risen. Currently, the majority of these heterosexual infections were not acquired in England, but abroad, predominantly in sub-Saharan Africa. This new trend has intensified the stigma around HIV, as marginalised groups in society, such as minority ethnic communities, bear a disproportionate burden of infection.

As mortality rates for HIV have decreased, the number of people living with HIV has risen. Not only are there now more HIV patients than ever before, but there are more infections to be diagnosed—an estimated 6,500 new diagnoses in 2002. This report gives an indication of how specialist HIV service providers, alongside other sexual health service providers, have been struggling to meet increasing demand for counselling, testing and treatment. We examine the implications of the *Strategy* for HIV services, in the context of recent fundamental changes to the way in which HIV services are co-ordinated: the end of dedicated or 'ring-fenced' funding for HIV services, and the transition to PCT-led commissioning arrangements. Our recommendations draw attention to serious concerns that the spiralling cost of HIV drugs will continue to deplete the resources needed by clinical and support services for sexual health, and that the vital prevention, health

promotion and evidence-gathering work undertaken in the community and voluntary sector could be lost if PCTs withdraw funding.

The Government's teenage pregnancy strategy, now in its fourth year of implementation, is cited by many as an example of good practice in taking a well researched, multi-faceted approach to health promotion to tackle a specific issue with young people. However, we heard that sexual health services are not meeting the needs of young people, and they are also being failed by an education system which persistently delivers 'too little, too late', often placing a mistaken emphasis on sex at the expense of young people's wider concerns about relationships. We therefore recommend that sex and relationships education is made a statutory part of the National Curriculum, supported by dedicated professionals who are able to meet the needs of young men as well as young women. The Government should also explore the possibility of improving young people's access to health services through providing specialist advice facilities.

The Government's sexual health strategy states that the prevention of unplanned pregnancy by NHS contraception services probably saves the NHS over £2.5 billion a year already. Despite this, in 2001 over 176,000 women underwent abortions, and the evidence we heard pointed to persistent deprioritisation of contraceptive services, with one of our witnesses pointing out that contraception appeared to have totally 'disappeared' from the Government's sexual health strategy. As well as a pressing need to rectify this priority imbalance, the report emphasises the importance of ensuring, through the GP contract, that GPs offer the same high standards of contraceptive care found in dedicated family planning clinics. The report also recommends that, within the current legal framework, practical steps are taken to improve access to safe, early abortions on the NHS for those who meet the legal criteria.

We conclude that the crisis in sexual health of the nation arises from:

- A failure of local NHS organisations to recognise and deal with this major public health problem
- A lack of political pressure and leadership over many years
- The absence of a patient voice
- A lack of resources
- A lack of central direction to suggest that this is a key priority
- An absence of performance management

We recommend that the Government should take urgent steps to ensure that access to high quality services is provided. The best way of achieving this would be a dedicated National Service Framework, but in the interim the Government should tackle sexual health as a public health priority at a strategic health authority level.

We have been appalled by the crisis in sexual health we have heard about and witnessed during our inquiry. We do not use the word 'crisis' lightly but in this case it is appropriate. This is a major public health issue and the problems identified in this report must be addressed immediately.

1 Introduction

"The evidence is quite plain—outbreaks of gonorrhoea and syphilis locally—high levels of teenage pregnancy and chlamydia. How much more evidence is needed to convince those who can make changes that the sexual health of the population is deteriorating? I was able to offer a better Sexually Transmitted Infections service to local people when I took up my post ten years ago."

Helen Lacey

One rather demoralised full time (100% NHS) consultant in Genito-urinary medicine.[1]

1. No area of public health in England has suffered a more dramatic and widespread decline in recent years than sexual health. Around one in ten sexually active young women (and many men) in England are infected with chlamydia, a sexually transmitted infection which, if left untreated, can lead to infertility. Syphilis, which had appeared to be disappearing from the population in England, has witnessed a 500% increase in the last six years. Gonorrhoea rates have also spiralled, almost doubling in the same period. HIV diagnoses, on one estimate, exceeded 6,000 cases in the last year, the highest recorded in England.

2. What confronts these armies of disease is one of the poorest-resourced, most stretched and least well-staffed areas of the NHS. One after another of the memoranda we received attested to the pressures faced by genito-urinary medicine (GUM). We were told that long waiting lists had replaced open access; that where open access remained in place hundreds of patients a week were now turned away; we were also told that premises were often dilapidated and unwelcoming; it was repeatedly suggested to us that moves to devolve more treatment to primary care would be unlikely to succeed, given the other competing pressures on services. Although in our visits we saw some excellent facilities and work being done on sexual health, these accounts of pressures were amply borne out by visits we undertook to major GUM clinics, where staff were expected to work in the most rudimentary conditions. Waiting lists stretched to eight weeks in the case of Manchester, while at Bristol, where the appointment system had been abandoned in favour of telephone bookings made on the day, some 400 people are being turned away each week. Those who are successful are treated in a Portacabin, a building which has been condemned.

3. As well as this burden of disease, Britain has the unwelcome distinction of recording the highest rates of teenage pregnancy in Europe, lagging behind only the USA in world rates amongst industrialised nations.[2] Indeed, rates of teenage pregnancy in the UK are around five times as high as those found in the Netherlands, Sweden, Switzerland or Italy.

4. Data from the National Survey of Attitudes and Lifestyles (see below, paragraph 70) suggest that the explosion in sexually transmitted infections has been facilitated by far-reaching changes in sexual behaviour over the last ten years, with both men and women reporting higher numbers of partners, and earlier ages at first sexual intercourse, together with increases in unsafe sexual practices.

1 Ev 330

2 International Planned Parenthood Foundation, European Network, *Annual Report 2001*, (Brussels, 2002), p 6

5. It was in the context of these most worrying and depressing trends for STIs, HIV/AIDS and unwanted pregnancy that the Department of Health (the Department) in July 2001 published England's first ever strategy to tackle sexual health, *Better Prevention, Better Services, Better Sexual Health: The National Strategy for Sexual Health and HIV* (the *Strategy*). Our inquiry took as its basis an analysis of that strategy. **While we have some reservations about some of the detail in the *Strategy* (and indeed about areas where there is scant detail) we regard as entirely commendable the decision of the Government to produce the *Strategy*. We would like to see measures going well beyond what it proposes, but would want to acknowledge that the *Strategy* represents an excellent starting point and a foundation which can be developed.**

6. We announced our intention to hold this inquiry on 30 April 2002 with the following terms of reference:

> The Committee will examine the effectiveness of the Government's strategy for sexual health in the context of the consultation document *Better Prevention, Better Services, Better Sexual Health: The National Strategy for Sexual Health and HIV*.

7. Our advisers in this inquiry were Professor Michael Adler, Royal Free and University College Medical School, Dr Anton Pozniak, Chelsea and Westminster Hospital and Helen Christophers, an independent consultant in sexual health promotion. We are lucky to enjoy the services of many excellent advisers but we would particularly like to record our gratitude to members of this team who made a tremendous input into our work, putting in many hours of service and always providing high quality advice in a technically demanding, sometimes emotive area.

8. We heard from 67 witnesses in the course of ten evidence sessions, between 26 June 2002 and 23 January 2003. These comprised Hazel Blears MP, Minister for Public Health and officials in the Department of Health; the Parliamentary Under Secretary of State for Young People and Learning, Department for Education and Skills (DfES), Mr Stephen Twigg, MP; clinicians with specialist knowledge in this area within primary and secondary care; family planning service providers; the Communicable Disease Surveillance Centre of the Public Health Laboratory Service (PHLS); other experts in the epidemiology of STIs and HIV/AIDS; various patient groups and charities; experts in sex and relationships education; Dr Muir Gray, Programme Director of the National Electronic Screening Library; the Family Education Trust; and, most importantly, a number of young people aged 15 to 21. We are grateful to all our witnesses for their evidence.

9. We received over 160 written submissions and these were invaluable to us in our work. Those submitting ranged from GUM consultants, to academic institutions, charities, members of the public, lobbying groups, Royal Colleges and pharmaceutical companies. These memoranda formed a valuable resource for us and we would like to thank those submitting evidence for the many thoughtful contributions we received.

10. In the course of our inquiry we undertook three visits within the United Kingdom. In November 2002 we visited Manchester and Bolton. At Manchester Royal Infirmary we met GUM consultants and other clinical staff, and public health and Strategic Health Authority representatives. We visited the Brook Advisory Centre in Manchester, where we heard about sexual health services for young people and about the financial difficulties encountered by those trying to provide such services through the voluntary sector. Health promotion specialists based at Bolton Primary Care Trust shared with us examples of best practice with regard to the

promotion of sexual health through targeted intervention and outreach work with off-street sex workers. We also met representatives from Manchester Young People's Council who talked to us about Sex and Relationships Education in schools and about their concerns relating to sexual health issues and the media. A note on this meeting is appended to our report.

11. In December 2002 we visited the Lighthouse King's Centre in Camberwell, London. We heard about the model of integrated care developed by the Caldecot Centre (King's Hospital GUM clinic) and by the Terrence Higgins Trust to provide sexual health services and a wide range of other support services to those living with and those affected by HIV.

12. In February 2003 we visited Bristol, Paignton and Exeter. We heard from staff at the South Bristol NHS Walk-in Centre and met clinical and managerial leads at the premises of the Milne Centre for Sexual Health, Bristol Royal Infirmary. In Exeter we heard from single-handed clinicians who provide services for large populations in rural areas in the South West of England, and from representatives of the A PAUSE Sex and Relationships Education project. At Paignton Community College we saw the Teenage Information Centre-Teenage Advice Centre or Tic Tac project. We met the health and youth work professionals who staff the Centre (a self-contained bungalow on the site of the college), representatives of the college management, and students at the college.

13. Since sexual health is also an area where there is EU competence, because it is an aspect of public health, we visited Brussels in July 2002 to hold discussions with Health Commissioner David Byrne and his officials. We also met representatives of the International Planned Parenthood Foundation Network. These meetings helped us to gain a better understanding of the European context of our inquiry. We were able to see just how poorly England fared in terms of teenage pregnancy rates. However, we also learned that STIs were rapidly rising across most of Europe; and in addition it was impressed on us that the relatively recent rapid growth in figures for HIV/AIDS in Central and Eastern Europe would be likely to have an impact on Western European countries in the near future.

14. In December 2002 we visited Sweden and the Netherlands. In Sweden we held meetings with representatives from Youth Health Centres and the staff of Rudbeck Upper Secondary school in Stockholm, the Swedish Institute for Infectious Disease Control, National Institute for Public Health, the Sexual Health Clinic at South Stockholm General Hospital, the Swedish Social Ministry and the Health and Welfare Committee at the Swedish Parliament. In the Netherlands we held meetings with representatives from the International Affairs Department, Ministry of Health, Welfare and Sport, the staff of AMOC clinic for sex workers, the HIV Foundation, the Municipal Health Centre, the Institute for Prostitution Studies, the Prevention and Health division of the Netherlands Institute of Applied Geo-science, and the Netherlands Institute for Health Promotion and Disease Prevention. These meetings provided an opportunity for us to see at first hand the different approaches to sexual health taken by two socio-economically comparable countries, and in particular to see examples of good practice in terms of sexual health services for young people and of infectious disease control. However, our visits to Sweden and the Netherlands also showed us that the public health problems caused by sexual ill health are increasing rapidly even in countries where such good practice is found.

2 What is sexual health?

Definitions

15. Sexual health goes well beyond the medical model of the treatment of disease. The World Health Organization definition of sexual health captures this point:

> Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.[3]

16. Nevertheless, our inquiry was prompted by concerns expressed to us about the mounting levels of disease and the persistently high levels of unwanted pregnancy. We have attempted to look at the wider antecedents of these problems by exploring issues of sex education and lifestyle in young people. We have also paid some attention to the issue of sexual dysfunction, though we are aware that this neglected problem would merit an inquiry in itself.

Sexual health and health inequalities

17. As Professor Michael Kelly, Director of the Health Development Agency (HDA), pointed out, "the inequalities in health repeat themselves as inequalities in sexual health."[4] According to the Department:

> The highest burden is borne by women, gay men, teenagers, young adults and black and ethnic minorities. The rates of gonorrhoea in some inner city black and minority ethnic groups are ten or eleven times higher than in whites. HIV infection also has an unequal impact on some ethnic and other minority groups. Britain's African communities have been particularly badly affected by HIV/AIDS, with high rates among both adults and children. There is some evidence to suggest that chlamydia infection rates are associated with levels of deprivation.[5]

18. Research using the Office for National Statistics Longitudinal study has shown that the risk of unintentionally becoming a teenage mother is ten times higher among girls in social class five (manual unskilled) than in social class one (professional). Children in care and children of teenage mothers are also more likely to become teenage mothers, as are girls of Bangladeshi, Pakistani and Afro-Caribbean origin. Data also suggest that those girls who have higher educational aspirations are more likely to opt for an abortion.[6]

19. While little research has been carried out into the relationship between unintended pregnancy and social or ethnic grouping in older women as opposed to teenagers, statistics

3 See www.who.int.
4 Q 432
5 *Strategy*, p 9
6 Q 432 (Professor Mike Kelly, Health Development Agency)

about abortion show that unintended or unwanted pregnancy affects the full age-range of women, although it is most common in the 20-25 age group.

20. The PHLS offers a similar analysis: young heterosexuals, men having sex with men and minority ethnic groups are at increased risk. Their figures for 1996–2001, and other sources, support the suggestion that in sexual health there are serious health inequalities:

- 42% of females with gonorrhoea and 36% of females with genital chlamydial infection were under 20 years of age: among 12 to 15 year old females diagnosed with gonorrhoea, almost a quarter will return with another episode of the disease within a year.
- 22% of diagnoses of gonorrhoea were in men having sex with men.
- The rates of gonorrhoea among some inner city black and ethnic minority groups are ten or eleven times higher than among whites.[7]

21. Dr Peter Weatherburn, Director of SIGMA Research, a specialist sexual health and HIV health promotion research unit affiliated to the University of Portsmouth, described the difficulties associated with providing services for those groups disproportionately affected by HIV and AIDS:

> It is still very much the case that HIV follows the fault lines of society. Marginalised groups are affected by HIV. We mainstream the way we provide services around HIV and HIV prevention but it is still an infection that fundamentally occurs amongst groups that are marginalised from society or otherwise socially excluded.[8]

22. As Mr Nick Partridge of the Terrence Higgins Trust pointed out, these marginalised groups—those living in poverty, those who have been prisoners or young offenders, sex workers, those from ethnic minority communities, those who feel that their sexuality excludes them from their family or community — often have complex needs in clinical and social care settings, but do not access the health and social care system.[9]

23. Although the general demand for HIV/AIDS services in rural areas tends to be lower than that in urban centres, the needs of those people who are HIV positive may be all the greater. We received written evidence from Ruth Webb, an HIV positive mother of two living in West Sussex who had encountered great difficulties in gaining access to health advisers, community nurses and consultants. Mrs Webb also provided evidence of the stigma and myths still associated with HIV:

> I quote a well-educated gentleman speaking to me recently, whilst unaware of my HIV positive status: "we're immune in this country, so we don't have to worry about HIV. The only people who have it were infected somewhere else."[10]

24. In oral evidence to us, HIV/AIDS service providers expressed concern that people outside the urban centres where prevalence of HIV is high, might suffer through late diagnosis or

7 Ev 58-59; www.phls.co.uk;*Strategy,* p 9
8 Q 358
9 Q 366
10 Ev 400

through lack of local services. Dr Simon Barton, Clinical Director of HIV and Genito-urinary Medicine at the Chelsea & Westminster Hospital, told us that:

> The message that HIV needs to be considered in the diagnosis of somebody who goes into a district general hospital with a fever and pneumonia is an essential message which we need to keep getting across ... that is why we need better networks of care where every unit, wherever people are, is linked in to obtain specialist access, information and help.[11]

25. Dr Belinda Stanley from North Cumbria Acute Hospitals NHS Trust identified a general problem with services in low-prevalence, rural areas: "patients' reluctance to complain in rural areas because of associated stigma may give an inaccurate impression of satisfaction with the service being tendered."[12]

26. HIV compounds health inequalities for people who may already feel socially excluded. It also creates health inequalities for those living in areas where prevalence of stigma is higher than prevalence of HIV itself and where access to services and support is difficult.

27. Throughout this inquiry we heard much from service providers about the difficulties experienced by patients in terms of access, waiting times, and clinic premises and facilities. In light of this evidence it is striking that few, if any, patients complain about the unacceptable conditions under which they seek and receive diagnosis and treatment. **Given the stigma around sexual problems, and given that those groups most affected by sexual ill health tend to be those whose voices are not heard in society as a whole, we can appreciate why patients might feel reluctant or even unable to complain. Primary Care Trusts need to make themselves aware of the patient's experience of sexual health services and work to improve this experience. Patient forums may be a route through which this could be undertaken.**

Sexually Transmitted Infections

28. Sexually transmitted infections (STIs) are infections whose primary route of transmission is through sexual contact. STIs can be caused mainly by bacteria, viruses or protozoa.[13] They now represent a major public health problem and are among the commonest forms of illness, even death in the world today with far reaching social and economic consequences, particularly in the developing world. STIs cause considerable reproductive morbidity and poor health outcomes, including pelvic inflammatory disease (PID), infertility, ectopic pregnancy, neonatal disorders, cervical cancer and death, and about 12% of women with untreated chlamydia develop infertility after a first episode of acute infection rising to 70% after three different episodes.[14] As well as the physical impact of the diseases there is also "significant psychological morbidity"[15] caused to patients, together with social problems arising from stigmatisation. The general level of social stigma attaching to these conditions makes people reluctant to come forward for treatment and demands high levels of privacy and confidentiality in treatment services.

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11 Q 669

12 Ev 395

13 Most sources now refer to STIs rather than STDs (Sexually Transmitted Diseases) or venereology.

14 See www.phls.co.uk : Chlamydia— general information

15 Ev 324 (Dr Beng Goh, GUM physician for North East Thames Association for GUM)

Chlamydia

29. Chlamydia is the commonest bacterial STI in the UK. It is often undiagnosed since it is asymptomatic in 70% of infected women and 50% of infected men.[16] In women chlamydia may cause inflammation of the cervix, abnormal vaginal discharge, pain in the pelvic region, intermenstrual bleeding and burning sensations on urination (dysuria). If left untreated chlamydia in women can lead to PID, ectopic pregnancy[17] and infertility. Chlamydia can cause conjunctivitis in adults; babies born to infected mothers can develop conjunctivitis or pneumonia soon after birth. Symptoms in men include difficulties in urination, discharges from the penis, itchiness and tenderness.[18] The duration of the infection if untreated may be a year or more. Testing for chlamydial infection is by means of urethral samples in men and women, or cervical samples, urine samples or self-administered vulval swabs in women. Treatment is by antibiotics, and all partners should be seen and treated if infected.

30. Levels of awareness of chlamydia are low with one recent survey suggesting that almost three quarters of those aged 16-24 had never heard of the disease.[19]

Gonorrhoea

31. This is an infection caused by the bacterium *Neisseria gonorrhoeae*. Gonorrhoea is similar in its clinical presentation to chlamydia. In men gonorrhoea causes pain on urination and a penile (urethral) discharge, but may occur without symptoms. In women it normally produces only mild symptoms or no symptoms. In women gonorrhoea may spread to the fallopian tubes and can cause PID. If left untreated this condition may lead to scarring of the fallopian tubes, ectopic pregnancy and infertility. Rectal infection in men and women may lead to painful bowel movements, blood in the faeces, anal itching and discharge. Gonococcal infection can be transmitted during birth and cause conjunctivitis in babies. Although antibiotic treatment usually leads to a complete cure there is increasing concern about the development of antibiotic resistant strains of the bacterium.

Syphilis

32. Syphilis is caused by the bacterium *Treponema pallidum*. It has traditionally been classified into early infectious and later non-infectious stages. Early syphilis has two stages, primary and secondary. The incubation period for primary syphilis is approximately 9-90 days after sexual exposure. In the primary stage, lesions appear at the site of inoculation, which is normally the genital area. The lesion starts as a red spot which breaks down into an ulcer or chancre, which is often painless and unnoticed by patients. A secondary stage appears four to eight weeks after infection. The most common manifestation is a widespread red rash on the trunk, palms, leg, soles, face and genitalia. Again, some individuals will not be aware of symptoms. If primary and secondary stage syphilis are not treated about two thirds of patients will develop late effects of the disease, tertiary syphilis. About 10% will develop infection of the central nervous system, a

16 Chief Medical Officer's Advisory Expert Advisory Group on Chlamydia trachomatis, 1998 (hereafter EAG Report)

17 Chlamydia has been estimated to account for 40% of ectopic pregnancies, a condition which is the leading cause of maternal death in pregnancy in industrialised countries during the first three months of pregnancy (EAG Report).

18 This and other information on the pathology of STIs is sourced from *Sexually Transmitted Infections*, BMA Board of Science and Education, February 2002, together with material prepared for the Committee by Professor Michael Adler and Dr Anton Pozniak, advisers to this inquiry.

19 Cited in EAG Report.

further 10% of the heart and 15% lesions of the skin and bone. These severe complications may lead to disability and even death. Syphilis in pregnant women often leads to miscarriage or stillbirth; live babies born to syphilitic mothers may show signs of congenital syphilis. Treatment is by antibiotics and long-term follow up is essential to ensure that the infection has cleared.

Genital Warts

33. These are the commonest of all viral STIs and are almost always transmitted by sexual contact. They constitute an infection of the skin and mucous membranes caused by the human papilloma virus (HPV). Small lumps with irregular surfaces are found on the penis, scrotum, anus, rectum, vulva, vagina, cervix or in the mouth. Often these are small and not easily detected. They can cause itching and irritation. The commonest types of genital wart rarely lead to complications but the virus types HPV-16 and HPV-18 are associated with the subsequent development of cancer of the cervix. Flat warts on the cervix are not usually apparent to the naked eye. However, they are detected in smear tests. Treatment of genital warts is by the application of chemical paint to the wart or freezing of the wart. Some treatments can be applied at home while others require a health worker.

Genital Herpes

34. This is a common infection caused by the herpes simplex virus type 2 or type 1 (the usual cause of cold sores). Genital HSV 1 herpes is commonly acquired through oral genital contact; type 2 typically affects the genital area and is most frequently a result of penetrative intercourse. Symptoms include small blisters in the genital area which rapidly break down to leave painful ulcers. Other symptoms include pain or difficulty in passing urine. Some patients may develop headache and fever. The virus can be spread by skin to skin contact at any time when there are blisters or other symptoms. A first episode of herpes during late pregnancy is potentially dangerous to the baby during labour. Herpes is a life-long chronic condition which cannot be cured; but the severity of infections, and likelihood of recurrent infections, can be decreased by the use of antiviral drugs taken daily in small doses.

HIV/AIDS

35. Human Immunodeficiency Virus or HIV belongs to a group of viruses called retroviruses. Viruses infect cells by copying their genetic material into the genetic material of the human cells. HIV prevents the immune system from working properly by infecting CD4 cells (also known as helper T-cells) which coordinate the immune system's fight against infection. CD4 cells are a type of lymphocyte (a white blood cell) that helps to identify, attack and destroy specific bacteria, fungi, and other germs that infect the body. They help regulate the production of antibodies.

36. In general, HIV infection is detected by an HIV antibody test. The first test to be conducted, usually on blood, but possibly on saliva, is an ELISA (enzyme linked immunosorbent assay) test which uses an enzyme to detect the presence of antibodies. Since this test can sometimes be positive even when someone is not infected—a 'false positive'—a second enzyme test called the Western Blot is carried out. This test yields more detailed results but is not used exclusively because the ELISA test can be done much sooner after infection with HIV than the Western Blot test. There are also a number of tests which can look for the virus or parts of the virus itself, for damage to the immune system, or for other aspects of the body's response to the effects of the

virus. The diagnosis of AIDS is only made when a patient develops an opportunistic infection or cancer which indicates the presence of severe underlying immune deficiency. Such opportunistic infections or cancers are usually diagnosed after a patient has been diagnosed as HIV positive. However some patients learn of their HIV positive status only when they become seriously ill with one of the opportunistic infections or cancers and present at hospital.

37. The major modes of transmission of HIV are through sexual transmission, vertical transmission (mother to child), and through blood and blood products including the use of contaminated needles by intravenous drug users. Once the virus has infected a human being there are three phases of HIV infection: Primary HIV infection; the long term (chronic) asymptomatic phase; and overt AIDS.

38. Primary HIV infection is a transient condition appearing two to four weeks after virus exposure. Although it can occur without symptoms, 40–90% of patients develop a symptomatic illness, which is flu-like but sometimes associated with rashes and more severe symptoms. Patients may be unwell for up to two weeks. During this period of time the patient may not have produced sufficient HIV antibodies to become HIV positive on the tests routinely used. Patients become HIV antibody positive from six weeks to six months (usually from six to twelve weeks) after exposure.

39. Primary HIV infection is then followed by a long phase during which neither signs nor symptoms of illness are present. This is the long term (chronic) asymptomatic phase. The median length of time of this phase is around ten years. The patient is HIV positive but the levels of virus in the blood and the number of CD4 cells tend to be relatively stable and only change slowly over this period of time. As the immune system is slowly impaired the number of cells which help protect the patient from various disease entities and the CD4 cell count starts to drop below 200 cells per ml. At this point the risk of developing life-threatening opportunistic infections or tumours increases rapidly, and the patient may pass into the overt AIDS stage. These opportunistic infections and tumours, which would not normally arise in people whose immune systems are intact, are often called AIDS-defining illnesses.

Other Conditions

40. Among a wide variety of other conditions presenting to clinics and requiring specialist investigation and treatment are urinary tract infection, dermatological and psycho-sexual problems and infections caused by fungi such as vaginal candida (thrush). In addition, the viruses hepatitis B can be sexually transmitted, though not normally by vaginal intercourse; hepatitis A and C are rarely sexually transmitted.[20]

Co-infection issues

41. It is now recognised there is a synergy between most STIs and HIV (particularly ulcerative and inflammatory conditions). The understanding that both HIV transmission and acquisition are enhanced by the presence of STIs has resulted in the development of overarching control programmes for sexual health which include both HIV and STIs.

20 British Medical Association, *Sexually Transmitted Infections*, (2002) p 6

42. Co-infection with STIs and HIV is now common, and can create difficulties in treatment. Up to 50% of homosexual men diagnosed with infectious syphilis in London are HIV positive, and co-infection with HIV and tuberculosis (including multiple drug resistant strains) is becoming more prevalent, particularly in those from ethnic minorities.[21] This may help to explain the disproportionate burden of HIV in settings where the prevalence of STIs is high. Data from the Unlinked Anonymous HIV Sero-Prevalence Survey show a marked increase in the proportion of known HIV positive homosexual men diagnosed with acute STIs. This highlights concern that HIV positive individuals can play "an active and often substantial role" in the transmission of STIs and in the growth of syphilis outbreaks in particular.[22]

Unintended pregnancy and teenage pregnancy

43. The *Strategy* states that "Sexual health is not just about disease. Ignorance and risky behaviour can also have profound social consequences."[23] Teenage pregnancy is frequently (although not always) unintended,[24] is generally perceived as a problem, and has well documented links with ill health, low educational levels and ongoing poverty. The focus in recent years on the issue of teenage pregnancy has tended to divert attention from the broader but equally problematic issue of unintended or unwanted pregnancy across all age groups. Ian Jones, Chief Executive of the British Pregnancy Advisory Service told us that in 2000, some 79% of women having abortions were not in fact teenagers.[25] Unintended pregnancy at any age can have high social and economic costs and may result in abortion which can have adverse health effects for the patient, as well as being costly for the NHS.

Sexual dysfunction

44. Any type of sexual dysfunction is distressing and can affect either sex at any age. Most commonly, men are concerned about premature ejaculation, failure to obtain or maintain an erection and lack of libido. Women's concerns are less widely publicised but cover problems such as sexual disinterest and failure to achieve orgasm. The pharmaceutical company Lilly UK cite US research data to suggest that up to 30% of the population will experience some form of sexual dysfunction and that as many as a third of men suffer from some form of erectile dysfunction.[26] Specialist services are scarce and have tended to focus on erectile dysfunction. The psychological distress caused by sexual dysfunction can be profound and the extent of this problem, we believe, needs to be recognised more openly.

21 Ev 389 (The Specialty Societies for Genitourinary Medicine)

22 Unlinked Anonymous Surveys Steering Group. Prevalence of HIV and hepatitis infections in the United Kingdom. London: Department of Health, 2001

23 *Strategy*, p 8

24 K Kiernan, "Transition to parenthood: Young mothers, young fathers—associated factors and later life experiences", Welfare State Programme, Discussion Paper WSP/113, London School of Economics, 1995

25 Q176

26 Ev 331

3 What is the current situation?

Trends in Sexually Transmitted Infections

45. The last decade has witnessed a dramatic rise in diagnoses of all major diseases. One in ten of the UK population have at some time had an STI.[27] A summary of trends from the Public Health Laboratory Service (PHLS), which reveals that diagnoses of chlamydia, gonorrhea and syphilis have more than doubled over the past six years, presents a stark picture.[28] Annual diagnoses of gonorrhea increased by 86% from just under 12,000 to just over 22,000 cases between 1996 and 2001; chlamydia increased by 108% (from around 32,000 to 67,000 cases) and infectious syphilis by 500% (116 to 696 cases).

46. The table below gives the trends over the last six years; figures in the first six columns give actual numbers, with percentage increases appearing in the final two columns:

Summary of selected conditions by sex: England 1996–2001.

Condition		1996	1997	1998	1999	2000	2001	2000-2001	1996-2001
Syphilis (primary and secondary)	Total males	84	98	87	156	247	598	143%	612%
	of which homo-sexually acquired	20	18	23	52	119	341	187%	1605%
	Total females	32	49	44	55	75	98	31%	206%
	Total	**116**	**147**	**131**	**211**	**322**	**696**	**116%**	**500%**
Gonorrhoea (uncomplicated)	Total males	7,911	8,418	8,446	10,677	14,290	15,476	8%	96%
	of which homo-sexually acquired	1,683	1,779	1,677	1,812	2,867	3,435	20%	104%
	Total females	3,977	3,981	4,089	4,880	6,225	6,642	7%	67%
	Total	**11,888**	**12,399**	**12,535**	**15,557**	**20,515**	**22,118**	**8%**	**86%**

27 Ev 346 (Medical Research Council)

28 www.phls.co.uk.

Condition		1996	1997	1998	1999	2000	2001	2000-2001	1996-2001
Chlamydia (uncomplicated)	Total males	13,946	16,180	18,937	21,808	26,632	29,166	10%	109%
	of which homo-sexually acquired	275	353	454	621	962	1,343	40%	388%
	Total females	18,526	22,659	24,975	29,196	34,815	38,248	10%	106%
	Total	**32,472**	**38,839**	**43,912**	**51,004**	**61,447**	**67,414**	**10%**	**108%**
Herpes (first attack)	Total males	5,755	5,597	6,140	6,039	6,190	6,492	5%	13%
	of which homo-sexually acquired	384	334	301	338	384	397	3%	3%
	Total females	9,453	9,482	9,675	9,852	9,976	1,0558	6%	12%
	Total	**15,208**	**15,079**	**15,815**	**15,891**	**16,166**	**17,050**	**6%**	**12%**
Genital Warts (first attack)	Total males	27,133	30,239	30,782	31,908	32,067	32,636	2%	20%
	of which homo-sexually acquired	1,290	1,472	1,501	1,565	1,673	1,761	5%	37%
	Total females	27,583	28,472	28,899	29,322	28,711	29,568	3%	7%
	Total	**54,696**	**58,711**	**59,681**	**61,230**	**60,778**	**62,204**	**2%**	**14%**
All Diagnoses	Total males	202,465	216,916	228,963	242,087	260,899	276,342	6%	36%
	of which homo-sexually acquired	12,778	12,957	12,464	13,223	15,740	18,739	19%	47%
	Total females	249,438	264,976	277,945	291,703	309,173	329,719	7%	32%
	Total	**451,903**	**481,892**	**506,908**	**533,790**	**570,072**	**606,061**	**6%**	**34%**

Source: PHLS

47. The general trends are startling enough, but in certain areas rises have been even greater. Brighton GUM/HIV clinic, for example, recorded an increase of 318% in chlamydia in the last four years and an increase of over 700% in recorded cases of syphilis, this in an area with high HIV/AIDS; the Department of GUM at Mayday University Hospital, Thornton Heath witnessed

a doubling in diagnoses of gonorrhoea and chlamydia between 1999 and 2001; the Wolverton clinic in Kingston has had to cope with a 400% increase in chlamydia in the past six years alongside an increase of 77% in HIV diagnoses.[29] The huge increase in syphilis is actually concentrated in a small number of 'hotspots' but these areas also have high rates of other STIs and HIV, placing heavy burdens on staff locally.

48. The presentation of these and similar data in the written memoranda is consistently that of 'an explosion' in sexually transmitted infection. However, a caveat was raised by Dr Kevin Fenton of the Communicable Disease Surveillance Centre at the PHLS. He pointed out that when the public first became aware of the HIV pandemic this triggered a substantial decline in the numbers and rates of both bacterial and viral STIs so that the figures for 1994—which tends to be around the base year used by those submitting evidence—represented "a nadir or bottoming out of STI incidence" with figures for the early 1990s seeing "some of the lowest rates and numbers for sexually transmitted infections".[30]

49. It is also worth bearing in mind that the UK is not alone in witnessing a recent dramatic rise in the rates of sexually transmitted diseases. Although good quality data are not available for all countries, gonorrhoea rates in France rose by 92% in 1998. In Sweden, gonorrhoea rates show a rise of 154% from 1995-2000. Notable rises have occurred in gonorrhoea amongst men having sex with men in studies in Greece, the Netherlands, Sweden and Switzerland. Syphilis outbreaks have recently been reported in the Netherlands, Ireland, France and Norway.[31]

50. The figures for sexual ill health compiled by the PHLS, which form the basis of much of our analysis, are not in fact comprehensive. They relate only to people attending departments of genito-urinary medicine. Screening surveys outside normal GUM clinic environments also show high levels of chlamydia in antenatal and gynaecology clinics, general practice, family planning and termination of pregnancy clinics, ranging from 4.5% to 16%. We were also told that STIs within the armed forces are separately recorded and not forwarded to the PHLS.[32] **We recommend that the Army Medical Services forwards to the Public Health Laboratory Services its figures for STIs. We also recommend that the PHLS looks at how a more comprehensive surveillance system can be developed to cover all areas of sexual health and possible service providers. This will give a more complete picture of trends, prevalence and service utilisation.**

51. Finally, and most importantly, the official figures for diagnoses will greatly understate the overall burden of diseases since many sexually transmitted infections are asymptomatic.

29 Ev 309; Ev 351; Ev 336

30 Q 250

31 Angus Nicholl and Francoise F Hamers, "Are trends in HIV, gonorrhoea and syphilis worsening in western Europe?", BMJ, vol. 324 (2002), pp 1324-27

32 Ev 309 (Dr James Bingham, Civilian Consultant Adviser in GU Medicine to the Armed Forces)

Trends in HIV/AIDS

52. According to the PHLS Communicable Disease Surveillance Centre:

> HIV continues to be the most important communicable disease in the UK. It is an infection associated with serious morbidity, high costs of treatment and care, significant mortality and, since it affects mainly younger adults, high number of potential years lost.[33]

53. Cumulatively, by the end of December 2002, 45,625 people in the UK had been diagnosed HIV positive with sexual transmission as the probable route of infection. Of these people, 42,764 were diagnosed in England. Reported deaths in HIV-infected patients numbered 11,219 in England and 11,982 in the UK as a whole, as reported by the end of December 2002.

54. In England at the end of 2001, an estimated 12,900 adults were living with an undiagnosed HIV infection, 4,200 infected through sex between men, 8,300 infected heterosexually and 400 infected through intravenous drug use.[34]

55. Since the widespread introduction of combination therapy in 1996, mortality rates have decreased: in England in 1995 there were 1,285 reported deaths in HIV patients with sexual transmission as the probable route of infection, compared with 188 in 2002. However, the numbers of new diagnoses in England have been increasing: there were 2,147 new diagnoses in 1995 and 3,158 in 2001.[35] For 2002, reports of new diagnoses of HIV in the UK (all routes of transmission) number 4,200. After adjustment for delayed reports, PHLS estimates that there will have been 6,500 new diagnoses for 2002 – the highest ever number of new diagnoses in a single year.[36]

56. It is projected that the number of people living in the UK with diagnosed HIV will have increased by 47% between 2000 and 2005. Advances in diagnosis and treatment have meant that although HIV is often perceived to be a condition which affects younger people, nearly 11% of people with AIDS are now aged 50 or over.[37]

57. Cumulatively, the majority of HIV infections reported to the Communicable Diseases Surveillance Centre in the UK have occurred in gay men. This group remains at greatest risk of acquiring HIV infection within the UK and the PHLS estimates that there will have been about 1,800 new infection reports in 2002. Despite general levels of awareness of the risks for HIV acquisition about a quarter of HIV infected men who have sex with men have not had their infection diagnosed.

33 Ev 59

34 PHLS, *HIV and AIDS in the UK in 2001. An Update: November 2002*. Estimates of the total number of undiagnosed HIV infections in the population are based on figures derived from the Unlinked Anonymous Prevalence Monitoring Programme. The programme monitors undiagnosed HIV infection in homosexual and bisexual men and in heterosexual men and women attending GUM clinics, in injecting drug users attending specialist treatment and support agencies or GUM clinics, and also in pregnant women or women having a termination of pregnancy. Each year material left over from more than 600,000 diagnostic samples taken for other purposes is irreversibly unlinked from patient identifying information and then tested for HIV infection.

35 Ibid.

36 Ibid. The delay in reporting newly diagnosed cases is taken into account when assessing the extent of the epidemic. Within a given year, only two-thirds of the reports for that year become available. A year later 95% of the reports will be available.

37 *Age Concern England, Opening Doors: working with older lesbians and gay men – a resource pack*, 2001

58. It is estimated that nearly half of all HIV infections acquired heterosexually are currently undiagnosed. Many people remain undiagnosed until testing is prompted by HIV-related symptoms late in the course of illness. With the rise in the numbers of those who acquired their infections heterosexually there has been an increase in the number of women diagnosed. The male:female ratio for all new infections diagnosed in 1985–86 was approximately 14:1 whereas in 2000–01 it was about 1.7:1.[38]

59. Most of those people diagnosed in the UK who have acquired infection heterosexually were not infected in this country. In answering our questions on heterosexual infection abroad, Dr Vicki King, a microbiologist in the Communicable Diseases branch of the Department of Health, confirmed this.[39] In the late 1980s and early 1990s the majority of the African infections were acquired in East Africa but more recently the impact of the HIV epidemic in South Eastern Africa has been greater.

60. Since the mid 1990s there has been an increase in the recorded number of births to HIV infected women from approximately 130 in 1994 to over 300 in 2000. Dr Ade Fakoya told us that between 1 in 150 and 1 in 250 pregnant women seen at Newham General Hospital are HIV positive.[40] This may reflect an improvement in antenatal diagnosis rates, following the success of a Department of Health initiative which directed that all pregnant women should be offered and recommended an HIV test along with other antenatal screening tests, with the aim of reducing the number of babies with HIV acquired from an infected mother during pregnancy, birth or through breastfeeding.[41] In Inner London, the Government target of diagnosing 80% of infections before birth has been met, and diagnosis rates in Outer London and in other regions are rising.[42] Treatment for HIV, caesarean section and avoidance of breastfeeding, can reduce the risk of transmission from mother to baby from 1 in 4 to less than 1 in 50.

61. In the *Strategy* the Department highlighted the need for research and for a strong evidence base with regard to health promotion, and planning services for HIV/AIDS and STIs. In addition to the funds allocated to the Medical Research Council for AIDS (and in turn to the National Sexual Attitudes and Lifestyles Survey), the Department of Health has directed the Health Development Agency to draw together the available evidence on trends in HIV/STI prevention. The Department will then use this evidence to inform prevention work at local level.[43]

62. **We welcome the recognition of the importance of research and evidence with regard to the provision of HIV/STI prevention. We recommend that the Government continues to support the Health Development Agency in developing an evidence base in the long term and that the Department ask the Medical Research Council to commission further research in this area of sexual health.**

63. **In respect of the monitoring of trends in both STIs and HIV/AIDS we would like to pay tribute to the work of the Public Health Laboratory Service. Their monitoring ensures that**

38 PHLS, HIV and AIDS: epidemiological data, http://www.phls.co.uk/topics_az

39 Ev 13-14

40 Q 631

41 Department of Health, Health Service Circular HSC 1999/183

42 CDR Weekly Bulletin, vol 12 no.17, April 2002

43 *Strategy*, para 3.18-3.19

the UK has the best data in the world, and this in turn gives great credibility to their research. It would be most regrettable if the absorption of the PHLS within the new Health Protection Agency were in any way adversely to affect its work. In particular, we would be alarmed if the close networks developed between the regional and local laboratories and clinicians and epidemiologists were to be impaired as a consequence of the move to NHS management of the laboratories.

Trends in teenage pregnancy

64. The UK currently has the highest rate of teenage pregnancy in Europe (almost five times higher than the Netherlands), and in the developed world is second only to the United States. The table shows the number of births to women aged below 20 per 1,000 women aged 15 to 19. Data are for 1998, the most recent year for which comparable information is available from all countries:

Country	Teenage birth rate (per 1000 women aged 15-19)
Korea	2.9
Japan	4.6
Switzerland	5.5
The Netherlands	6.2
Sweden	6.5
Italy	6.6
Spain	7.9
Denmark	9.1
Finland	9.2
France	9.3
Luxembourg	9.7
Belgium	9.9
Greece	11.9
Norway	12.4
Germany	13.1
Austria	14.0
Czech Republic	16.4
Australia	19.4
Ireland	19.7
Poland	19.7

Country	Teenage birth rate (per 1000 women aged 15-19)
Canada	20.2
Portugal	21.2
Iceland	24.7
Hungary	26.5
Slovak Republic	26.9
New Zealand	29.9
UK	30.8
USA	52.1

Source: A League Table of Teenage Births in Rich Nations, UNICEF, July 2001

65. In the year 2000, there were almost 98,000 conceptions to teenage girls, aged under 20, in England and Wales—61% of these led to a maternity and 39% to abortions. There were 8,000 conceptions among girls under the age of 16, less than a tenth of the total number of conceptions to teenagers. Of these conceptions, almost 400 were to girls under the age of 14, 160 of which led to maternities.

66. Historical data show that despite the overall trend towards later childbearing, after fluctuating in the 1970s the proportion of teenage girls becoming pregnant rose significantly in the 1980s. By 1990 there were 68 conceptions per 1,000 women aged 15 to 19 in England and Wales; in 1999 the rate was slightly lower at 63. The Government has chosen particularly to target pregnancies in girls under 18. In 1999 the rate of conceptions to teenagers under 18 was 45 conceptions per 1,000 women aged 15 to 17 years. This rate has remained within the range of 42 to 48 conceptions for the last ten years.

Year	Conceptions under 16		Conceptions under 18	
	Number	Rate[44]	Number	Rate
1992	6,747	8.3	35,165	43.2
1993	6,802	8.0	33,495	42.1
1994	7,290	8.3	33,794	41.6
1995	7,484	8.5	35,371	41.6
1996	8,213	9.4	40,558	45.9
1997	7,707	8.9	40,463	45.8
1998	7,855	8.9	41,089	47.0
1999	7,408	8.2	39,247	45.3
2000	7,620	8.3	38,700	43.9
2001[45]	7,396	7.9	38,439	42.3

Source: Office for National Statistics

44 Rate per 1,000 women aged 13-15 and 15-17 respectively using revised population estimates (in light of the 2001 Census).

45 Provisional figures.

67. These statistics reveal that in England and Wales conceptions for under 16s fell by 4.5% between 2000–01; the corresponding figures for under 18s show conception rates fell by 3% in the same period. Since 1998, the year before the launch of the Government's teenage pregnancy strategy, conceptions for under 16s have fallen by 10%, and for under 18s by 9%, demonstrating the steady success of the teenage pregnancy strategy in its aim to halve teenage pregnancy rates by 2009.[46]

Trends in unintended pregnancy

68. It is difficult to measure rates of unintended pregnancy objectively, and there are no national statistics which do this, although the BPAS estimates that 50% of pregnancies are unplanned.[47] Abortion rates, which have been rising steadily since the early 1970s, give an indication of rates of unwanted pregnancy, although of course they may be influenced by cultural and legal factors as well.

69. Statistics show that abortion rates in England and Wales have almost quadrupled in the thirty years since abortion was legalised, increasing from 49,829 in 1969 to 173,701 in 1999. There has been a relatively steady increase during that time, but the rate appears to have stabilised in recent years at approximately 175,000 per annum, or 16.9/1000 women aged 15–44. Internationally, the abortion rate in England and Wales is well over double that in the Netherlands (6/1000 women aged 15 44), although not as high as Sweden (18.8/1000) or the US (25.9/1000). In the UK rates are highest amongst women in their twenties, making up 48.9% of all abortions, as opposed to 21% for under twenties and 30.3% for women of 30 and over. But unplanned pregnancy is not a problem confined to young, single women without families. According to the BPAS, approximately 20% of women having abortions are married, 46% already have one or more children, and 28% have had a previous abortion.[48]

46 Department of Health Press Release, 2003/0086, 27 February 2003

47 British Pregnancy Advisory Service, Abortion Facts and Statistics, www.bpas.org.uk

48 Ibid.

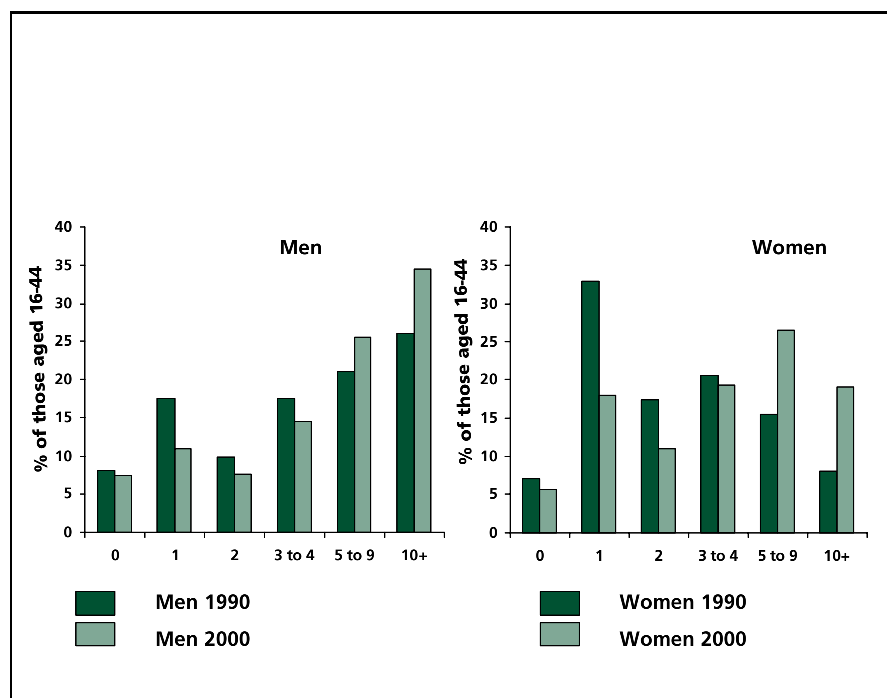
4 What underlies these trends?

70. The National Survey of Sexual Attitudes and Lifestyles (NATSAL) is a ten-yearly survey of sexual behaviour patterns, the most recent edition of which (2000) was published in December 2001. The survey interviewed 11,161 respondents (4,762 men, 6,399 women) and revealed the following key behavioural trends:

- For men and women the numbers of sexual partners has increased. The mean number of partners in a lifetime rose from 1990 to 2000 from 8.6 to 12.7 partners for men and from 3.7 to 6.5 for women.
- The proportion of men and women having more than one partner at the same time, which increases the probability of an infection being passed on to more than one person, has also increased. Some 9% of women and 14.6% of men were in such relationships in 2000, as opposed to 5.4% and 11.4% respectively in 1990.
- Average age at first intercourse has fallen for women and men from 17 years to 16 years.
- The proportion of men in Britain who had ever had a homosexual partner increased from 3.6% in 1990 to 5.4% in 2000.
- The number of men paying for heterosexual or homosexual sex has more than doubled, from 2.1% in 1990 to 4.3% in 2000.
- Whereas in 1990 7% of men and 6.5% of women had had anal sex in the past year these figures had risen to 12.3% and 11.3% in 2000.
- Although overall use of condoms is up, the overall figures for high risk behaviour, which is defined as "Two or more heterosexual and homosexual partners, past year and inconsistent condom use in past 4 weeks" show rises of 13.6% to 15.4% in men and 7.1% to 10.1% in women between 1990 and 2000.[49]

49 See Q 327

Percentage distribution of heterosexual partners: lifetime, by gender, 1990 and 2000



National Survey of Sexual Attitudes and Lifestyles, 2000

Changes in sexual behaviour

	1990—Men	2000—Men	1990—Women	2000—Women
Average number of heterosexual partners, lifetime	8.6	12.7	3.7	6.5
Percentage of heterosexual people who had had anal sex in the past year	7%	12.3%	6.5%	11.3%
Consistent condom use	18.3%	24.4%	14.9%	18.0%
'Unsafe sex' in the past year	13.6%	15.4%	7.1%	10.1%

Data source: NATSAL

71. Among 16-24 year olds the prevalence of first intercourse before age 16 was higher in single parent families, amongst those whose parents were manual workers and those whose main source of information about sex was not school. Eight per cent of those aged 16-24 reported peer pressure as the main reason for having sex and 8.5% put drunkenness as the main reason. Many of our witnesses described the UK today as an "increasingly sexualised" society, and anecdotal evidence from young people to the Committee bore out these social changes – as one young

woman put it, “snogging is not a big thing any more ... [young people] need to go that one step further and that is a really big issue.”[50]

72. Changing attitudes and sexual habits are, however, only one part of a far more complex picture. The risks posed by frequent intercourse and frequent partner change can be reduced (though not entirely eliminated) by the use of condoms to prevent STIs, and other contraceptives to prevent unwanted conceptions, but people need appropriate education and information to promote safer sexual practices. For the British Medical Association (BMA), an area of serious concern was the “lack of representation of sexually transmitted infections as a significant health problem in the media.”[51] Dr Kevin Fenton of the PHLS also described the problems of an increasingly sexualised society which lacked awareness of the dangers associated with this: “you are getting these messages to start having sex earlier and having multiple partnerships; but you are not having ... messages to say ‘use a condom’ or telling them to reduce the number of partnerships.”[52] In addition to information people also need confidence and good negotiating as well as technical skills to put safer sex messages into practice. On top of this, people need quick and easy access to high quality healthcare services to provide them with information, preventatives (whether condoms or other forms of contraception), and diagnosis and treatment of STIs.

50 Q 917
51 Q 266
52 Q 340

5 How has the Government responded to the problems identified?

73. The Government's *National Strategy for Sexual Health and HIV*, first published in 2001 as a consultation document, is divided into four broad themes, covering:

Better prevention, including public information campaigns, targeted sexual health information, helplines and information and support for professionals;

Better services, based around a new model setting out three different levels of service provision that should be available within each PCT area, with specific targets for improvements in several areas of service provision;

Better commissioning, including the establishment of local multi-agency commissioning panels;

Supporting change, including measures to improve information, research and training in the field of sexual health.

74. Currently, sexual health services are delivered in a variety of different settings. Genito-urinary Medicine (GUM) services, for people with suspected STIs and HIV, are run as self-referral clinics usually attached to acute hospitals. Contraceptive services are provided both by GPs and by community based specialist-family planning clinics, which again operate on a self-referral basis. Termination of pregnancy services, where they are provided on the NHS, are provided within the obstetrics and gynaecology units of acute hospitals, and women seeking a termination of pregnancy must be referred there either by their GP, or from a family planning clinic. Although some family planning clinics offer screening tests for chlamydia, and some GUM clinics are co-located with family planning clinics, the disciplines of GUM and family planning have evolved separately from different branches of medicine (urology; and obstetrics and gynaecology respectively), and services in the two branches of sexual health remain largely distinct.

75. The *Strategy's* plan to improve sexual health services in the NHS introduces a new model of integrated working based on three levels:

Level 1 services will be provided in GP surgeries, although the *Strategy* concedes that not every GP is able to provide these services at present.

Level 2 covers many of the services currently provided in specialist GUM and specialist family planning clinics, and the *Strategy* proposes that these should be provided by

primary care teams with a special interest in sexual health, or local family planning and GUM clinics working in conjunction with General Practitioners.

At **Level 3**, the top tier of sexual health service provision, the *Strategy* envisages that specialist clinical teams will deliver the more specialist aspects of care that need to be provided across more than one PCT.

76. The services that will be provided at each level include the following:

Level 1	**Level 2**	**Level 3**
Sexual history and risk assessment	Invasive sexually transmitted infection testing for men	Specialist genito-urinary medicine
Contraceptive information and services	Testing and treating sexually transmitted infections	Specialised HIV services
STI testing for women	Partner notification	Highly specialised contraception for people with complex medical conditions
Assessment and referral of men with STI symptoms	Insertion of IUDs and contraceptive implants	Local co-ordination and back up for sexual assault
HIV testing and counselling	Vasectomy	Termination of pregnancy services
Cervical cytology screening and referral		Services for people with psychological and sexual problems
Pregnancy testing and referral		Outreach for sexually transmitted infection prevention
Hepatitis B immunisation		Outreach contraception services
		Specialised infections management, including co-ordination of partner notification

Data source: National Strategy for Sexual Health and HIV

Targets

77. The *Strategy* includes four targets. These are:

- To reduce by 25% the number of newly acquired HIV infections and gonorrhoea infections by 2007.
- By the end of 2004, all GUM clinic attendees should be offered an HIV test on their first screening for sexually transmitted infections (and subsequently according to risk) with a view to:
  - increasing the uptake of the test by those offered it to 40% by the end of 2004 and to 60% by the end of 2007;
  - reducing by 50% by the end of 2007 the number of previously undiagnosed HIV infected people attending GUM clinics who remain unaware of their infection after their visit.
- By the end of 2003, all homosexual and bisexual men attending GUM clinics should be offered hepatitis B immunisation at their first visit;
  - expected uptake of the first dose of the vaccine, in those not previously immunised, to reach 80% by the end of 2004 and 90% by the end of 2006;
  - expected uptake of the three doses of vaccine, in those not previously immunised, within one of the recommended regimens to reach 50% by the end of 2004 and 70% by the end of 2006.
- From 2005, commissioners should ensure that women who meet the legal requirements have access to an abortion within 3 weeks of the first appointment with the GP or other referring doctor.

As the *Strategy* does not have National Service Framework status, these targets are not included in the Priorities and Planning Framework around which PCTs base their annual agreements, and progress against these targets will not be measured as part of the NHS performance management system.[53]

78. A great many service providers welcomed the arrival of the *Strategy*, and endorsed its general aims. They were pleased to see that in 'joining up' HIV/AIDS with broader sexual health issues, the *Strategy* presented a strong case for prioritising sexual health on the grounds of public health. For some participants in the Department's consultation, the breadth of the *Strategy* was its strongest aspect. In written evidence to us Dr Simon Barton, Clinical Director of HIV and Genito-urinary Medicine at the Chelsea & Westminster Hospital, said it was essential that:

> sexual health and HIV, united together in a national strategy, would be identified for primary care trusts and strategic health authorities as areas of health care requiring

53 National Service Frameworks set national standards and define service models for a service or care group, put in place strategies to support implementation and establish performance milestones against which progress can be measured. Established NSFs comprise cancer, paediatric intensive care, mental health, coronary heart disease, diabetes and older people: NSFs in preparation are: renal services; children's services, long-term conditions focusing on neurological conditions and the involvement of the pharmaceutical industry. The Department has suggested that there will only normally be one new framework a year (www.doh.gov.uk).

> prioritisation on public health grounds, as well as ensuring that they developed an integrated approach between HIV and sexual health services on a network basis.[54]

79. However, much concern was expressed about whether overstretched services would be able to implement the *Strategy*. Consultant Physician Janette Clarke's response is representative of the evidence we received:

> The Sexual Health Strategy offers a vision of comprehensive open access service for HIV, sexual infection and contraception services. I sincerely hope that we can work towards the vision but would plead that patients need services in the interim.[55]

80. Dr Barton told us that he and his colleagues responded to the *Strategy* with enthusiasm in July 2001:

> Although the publication of the *Strategy* had been delayed for several months, we were optimistic that the consultation period which ended on 21 December 2001 would be followed swiftly by clarifications of the *Strategy* and the implementation action plan and identification of the resources to achieve this. Unfortunately, since the end of the consultation period, we are unaware of any formal response from the Department. This is particularly disappointing and has contributed to losing the momentum, which had been gained in the production and consultation period of the *Strategy*.[56]

81. In June 2002 the Department announced that owing to the overall support for the aims and interventions proposed in the *Strategy*, the *Strategy* itself would not be revised in light of the response to consultation. Instead, the Department published an *Implementation Action Plan* for the *Strategy*, which included a response to the key points raised by the consultation.

82. **Although we support the Government's drive to improve sexual health services via the *Strategy*, without wholesale advances in sexual health provision these targets will be tokenistic.**

83. **The *Strategy* specifies that from 2005, commissioners should ensure that women who meet the legal requirements have access to an abortion within three weeks of the first appointment with the GP or other referring doctor. In our view, three weeks is too long for people to wait in these circumstances.**

54 Ev 421

55 Ev 316

56 Ev 421

6 Treatment and service provision

84. Sexual health care is provided in many parts of the NHS including general practice and family planning. Since 1917 specialist services have been established for the management of sexually transmitted infections.[57] In the UK, a network of over 250 GUM clinics, led by consultant physicians, deals with the clinical management of STIs; most of the HIV seen within the UK is managed within departments of GU medicine.[58] These are normally attached to main hospitals. Patients can attend a clinic anywhere in the country. GUM clinics not only handle the treatment of conditions but are also instrumental in notifying the partners of those affected, using specially trained health advisers, and have some responsibility for recording epidemiological data on particular diseases.

STI services

Consultant numbers

85. Consultants in GUM undertake an initial training in general medicine and gynaecology before four years of specialist training.[59] According to the latest Royal College of Physicians (RCP) survey, there are around 238 whole time equivalent GUM consultants in England.[60] Dr Janet Wilson, Chair of the Specialist Advisory Committee in Genito-urinary Medicine and a GUM consultant at Leeds General Hospital suggested that not enough consultant posts were being created for the specialists who were being trained, a point echoed in our visit to Manchester.[61] Dr George Kinghorn, immediate past president of the Medical Society for the Study of Venereal Disease, and a GUM consultant in Sheffield, told us that there were currently about 120 specialist registrars in training and that their training period was around four years, giving an output of consultants of about 30 per year.[62] He thought that to get up to the figure of one consultant per 119,000 population, the ratio recommended by the RCP, would require an extra 173 consultants for England.

86. Evidence submitted to us points to numerous parts of the country where the consultant: population ratio falls well below the RCP guidelines. In addition, there are many locations, even outside rural areas, where services are scant or non-existent. GUM consultants in North Cheshire told us of a ratio of 1:325,000 in the North Cheshire/Wirral area.[63] The figure of 1:300,000 is cited in South Buckinghamshire.[64] Dr Helen Lacy, a GUM consultant in the North West claimed that a ratio of 1:400,000 prevailed in her area.[65] The Head of the GUM service at Newcastle General Hospital told us that there was no GUM service in all Northumberland and

57 Ev 387 (Specialty Societies for Genito-urinary Medicine)
58 Ev 387
59 Ev 388 (Specialty Societies for Genito-urinary Medicine)
60 Q 518
61 Ev 401
62 Q 519
63 Ev 352 (Dr Ranjani Rani and Dr V Smith)
64 Ev 377 (Dr Graz Luzzi)
65 Ev 330 (Dr Helen Lacey)

Gateshead.[66] Dr Mark Fitzgerald described himself as a single-handed consultant covering the whole of Somerset from two clinics.[67]

87. There clearly are shortages of trained staff but some caution may be required here. The shortages in GUM consultants identified by the RCP form only part of a pattern of a general dearth in consultants. The percentage shortfalls for several other specialties are much higher: while a 96% increase is needed in GUM medicine to bring it up to the recommended ratio, an increase of 265% is sought in clinical neurophysiology, of 306% in rehabilitation medicine and of 812% in audiological medicine. Further, the estimates of what were needed were supplied to the RCP by the specialties themselves.[68]

88. We put this point to Dr Kinghorn. He told us that, so far as he was aware, the RCP's estimates of what was an acceptable ratio of consultants to the population were not in dispute. Moreover, in weighing up the competing claims of GUM against, for example, neurology in arguing for an increase in numbers, Dr Kinghorn suggested his patients had an infectious disease which they could pass on to others; there was a "public health imperative".[69] The Department would appear to have accepted the claims of GU medicine, given the increase it has made in the number of those now in training.[70] The Public Health Minister, Hazel Blears MP, told us that there would be a net increase of 35 Specialist Registrars qualified to be consultants in the next two years. However, staffing figures from the RCP indicate that no consultant jobs currently exist for these 35 specialist registrars, who have completed their training.

89. The Department itself has no direct control over the creation of posts which is a matter for determination within local health economies, where the need for additional posts in one area has to be weighed up in the context of many competing demands. But as our visit to Bristol made clear, when we met the Trust Chair and Acting Chief Executive, sexual health is not a first priority for trusts: waiting times for other specialties was cited as the key priority. On our visit to Manchester we were told that there would be no new posts for newly qualified consultants and that in fact they had recently lost a post. Dr Pat Munday, a GUM physician in Watford, described what had happened in her clinic. In January 2001 year on year attendances had increased by 35%; evening sessions were "overwhelmed" and staff demoralised. A bid for a new consultant was rejected, an outreach service was abandoned and clinic closures, on an ad hoc basis, were introduced. Trusts were prioritising other service areas and it was suggested that the sexual health budget should be cut by £200,000.[71] We were shocked that such an obvious public health priority is being accorded so low a priority.

90. **We are concerned that there are not enough available consultant posts to be filled by appropriately trained specialist registrars. Given the shortfall of 90% in consultant numbers as against the recommendations of the Royal College of Physicians, the increase in workload and the problems of access, this is unsustainable. We recommend that the Government urgently review the staffing requirements and the need for an expansion of consultant posts in GUM. We also recommend that the Government makes clear that the additional money**

66 Ev 363 (Richard Pattman)

67 Ev 321

68 *Consultant Physicians Working for Patients: The duties, responsibilities and practice of physicians*, 2nd ed, Royal College of Physicians, November 2001, p 27

69 Q 541

70 Q 520

71 Ev 161; Q557

granted to GUM services will be given on a recurrent basis so as to encourage the creation of additional posts.

91. **It is not easy for us to judge how much recurrent funding would be needed to have a real impact on the numbers. However, we note the estimates submitted by Dr Kinghorn that, given an average cost for a completed new patient episode of £150-200, and assuming an additional 150,000 episodes per annum (allowing for increases prompted by the Government's publicity campaign) an additional revenue commitment of £22-30 million per annum will be required.**[72] **While any increase in funding needs to be fully justified and accounted for, in the context of the current disastrous impact on public health of the nation's poor sexual health, these figures do not strike us as excessive. It should be stressed that there is not just a shortage of consultants: nurses with expertise and training in this area, health advisers and laboratory technicians are all needed and these should not be left behind in any increase in funding, a point we develop below.**

92. **There has been evidence that money intended for HIV treatment, but not ring-fenced, has sometimes been diverted, so we would like the mechanisms to be in place to ensure that any additional funding that is granted to specialist GUM/HIV services is allocated specifically to these services.**

93. The Specialty Societies for Genito-urinary Medicine pointed out that around one third of consultants currently operate in single-handed practices which is unsatisfactory in terms of clinical governance. Single-handed practice also places unreasonable demands on staff or patients in terms of taking holiday leave or having the opportunity to pursue further training; finally it limits the amount of training and continuous professional development which can take place.

94. The Minister acknowledged that the high proportion of single-handed consultants in this area was a concern. She told us that the Department was trying to set up some clinical networks so that consultants could co-operate more closely, support training initiatives and generally help one another. This is a policy also outlined in the *Strategy*.

95. **It is far from ideal for services to be managed by single-handed consultants. It is difficult for single-handed consultants to find a consultant locum to cover holidays and study leave. At this point we would accept that it will not be possible for every clinic to have more than one whole time equivalent consultant. However, more than one consultant can provide the service within each clinic so long as there are shared consultant appointments within clinical networks.**

Access to, and pressures on, services

96. Shortages of consultants, and the rapid recent escalation of infections, have led to very considerable pressures on existing services. Between 1991 and 2001, new episodes seen at GUM clinics in England, Wales and Northern Ireland rose from 669,291 to 1,332,910. Clinic workload increased by 155% and diagnoses by 61%. Between 2000 and 2001 alone the figure for episodes at clinics rose by over 10%. As well as a rise in numbers, as Dr Kinghorn pointed out, there has

72 Ev 392

been an increase in the complexity of the workload, since GUM is the major provider for HIV treatment and care.[73]

97. The impression from a survey of the memoranda we have received is of a crisis overwhelming the service. Dr Sarah Gill, a GUM physician at Paddington told us: "I have never seen the extraordinary intensity of patient numbers as witnessed in the last six months or so. The Department feels like a war zone or Accident & Emergency; there is a queue of patients up to 40 deep most mornings."[74] As she put it: "nobody wants to end up in the 'clap clinic' let alone when you have to wait up to four hours to discuss your most intimate of problems, with a harassed doctor who is still worrying about the last patient hurried out of the room in a bid to try to relieve the already heaving waiting room." Services at Airedale Hospital in West Yorkshire were described by one clinician as "fallen in to pieces due to lack of resources".[75] For another consultant in Rochdale and Bury, specialist services were "understaffed, under-resourced ... overburdened and demoralised".[76] Dr Jillian Pritchard, a consultant in Chertsey in Surrey said that local services were "swamped".[77] Dr Colm O' Mahoney, a single-handed consultant in Chester reported he had "never seen a service become so demoralized and overwhelmed" with staff pushed to the limits. He drew our attention to the fact that the 300 or so consultants in GUM were totally dedicated to the NHS, with fewer than 4% being engaged in private practice.[78]

98. Until recently many GUM clinics operated a walk-in service. This picture has changed out of recognition and the situation is rapidly deteriorating. A consultant at St Mary's Hospital London, told us that six out of eight GUM clinics in the North West London sector had had to abandon open access in the last 18 months.[79] Dr Beng Goh, the Association for Genito-urinary Medicine representative for the North Thames area, said that clinics with walk-in services were "inundated", which was hardly surprising when some clinics were operating six week waiting times.[80] The PHLS told us that the median waiting time for a first appointment for men in GUM clinics was now 12 days and for women 10 days. The figures as recently as the year 2000 were six and five days respectively. Moreover, some areas have experienced even greater increases in workload. The Courtyard Clinic at St George's Hospital, Tooting suggested it had witnessed a growth in attendances from 22,500 in 1995 to 36,500 in 2001, an increase of 62% in workload:

> Our walk-in clinics are currently working to full capacity. Indeed, our clinics have been unable to operate an 'open access' service for the last 18 months, and as a result we have been limiting patients by triage according to clinical need and staffing. This has meant turning away many clients with potentially serious sexually transmitted infections and asking them to either go elsewhere or try to re-attend the following day.[81]

99. Dr G A McCarthy, a GUM consultant at the Wolverton Centre in Kingston, London, emphasised the scale of the problem: "We only open up the appointments clinic a week in advance but these are usually booked up within an hour of opening." She estimated that about a

73 Q 514
74 Ev 322
75 Ev 349 (Dr K C Mohanty).
76 Ev 330 (Helen Lacey)
77 Ev 364
78 Ev 355
79 Ev 326 (Dr Linda Green)
80 Ev 324
81 Ev 392

hundred people a week had to be turned away. In Manchester we were told that waits of up to six or eight weeks were not uncommon and similar figures crop up throughout written evidence.[82] Yet Manchester has had a recent outbreak of syphilis and records high rates of chlamydia, gonorrhea and HIV.

100. In many centres, a system of appointments has had to be abandoned in favour of a service where patients phone in on the morning. We were told that the Archway Clinic in London had now introduced such a system: all of the available male appointments were booked within 15 minutes, and the female ones were booked in half that time.[83] On our visit to Bristol, where a similar system was in place, around 400 patients a week were currently being turned away.

101. The consequences of such long waiting periods in this area are not hard to predict. As the PHLS put it:

> The delay in access time to curative service is important in STI transmission as this increases the duration of infectiousness (since the individual remains untreated for longer) and increases the probability of disease transmission.[84]

102. The Specialty Societies for Genito-urinary Medicine similarly noted a worrying trend, whereby problems of access directly exacerbated the problem: “Many clinics are reporting increases in the number and proportion of complicated cases, consistent with deteriorating access.” Persons at increased risk fail to obtain timely treatment and may continue to spread their infection. This is not merely anecdotal evidence. Dr Fenton of the PHLS cited American and British studies which suggested that around 30% of individuals continue to have sexual intercourse despite being symptomatic.[85] This is particularly worrying in areas experiencing sudden outbreaks (for example, the syphilis outbreaks in Greater Manchester, London and Brighton). Dr Fenton gave an example of the potential negative consequences of delays in access to GU, the case of a patient suffering primary syphilis. This person might be put on a waiting list, find that his or her initial sore or chancre spontaneously resolves, and mistakenly believe that he or she is no longer ill.[86] The patient might then choose not to seek further medical intervention, thus facilitating the onset of secondary syphilis.

103. Such delays are also likely to compound health inequalities. As Dr Kinghorn pointed out: “Those who are less articulate, those for whom English is not their first language and those who are young, are likely to have longer delays.” Dr Kinghorn also pointed out that delays in access “tend to adversely affect those who are in greatest need, particularly young people, those from ethnic minorities and those from deprived backgrounds.”[87] Those who were less articulate or for whom English was not a first language would be less likely to be able to negotiate their way around the system and get seen earlier.[88]

82 Q 1046
83 Q 524
84 Ev 61
85 Q 304
86 Q 304
87 Q 524
88 Q 526

104. The Royal College of Physicians sets out a template for best practice in this area:

> Patients suspecting an acute STI should be seen on the day they present to a clinic, or on the next occasion the clinic is open. Most departments hold clinics at least four days per week and should have dedicated premises.
>
> Clinics should be in good quality easily accessible premises. There should be a relaxed atmosphere to assist confidential discussion of sexually related conditions. Interviewing rooms should be sound attenuated and examination rooms should afford privacy.

105. Our evidence suggests that such best practice is currently far from widespread. A consultant in Chesterfield/Sheffield, told us that, in his clinic, unless a patient clearly had an infection they would have to wait up to four weeks. In his opinion patients needed to be seen within two days if the spread of infection was to be controlled.[89] Dr Kinghorn indicated that over a third of clinics were unable to see patients for three weeks or more.[90] He pointed out that General Practitioners were aiming for a target of seeing patients in 48 hours, and felt that the standards for the treatment of a communicable disease ought not to be any less.[91] A Department of Health working party and subsequent report (The Monks Report, 1988) set out a standard of seeing a patient on the day they present or the next day and this was adopted as Government policy in 1990.[92] However, it is now clear that the initial Department of Health target is not being met.

106. Many clinics are now introducing nurse triage or are attempting to triage over the phone. However, as Dr Jillian Pritchard pointed out, triage is difficult since many patients are asymptomatic but could still have an urgent problem.[93] While a number of clinics maintained that they were now making maximum use of nurses to alleviate the burden, the Royal College of Nursing thought that the under-use of nurses represented a real "lost opportunity". Nurses would be well placed to go out into the community and operate outreach schemes. Nurses, in the view of the College, could also be used more in schools to promote good sexual health.[94]

107. Such are the pressures of work that those consultants in place appear to have little time left over for training and development of staff. Jackie Rogers, a lead nurse for sexual health services for two PCTs based in the Hastings area, said that the pressures on clinical time meant that there was no time left for teaching, meetings or clinical networks.[95]

108. The Department told us it was committed to developing a new indicator around waiting times for GUM services.[96] The Public Health Minister said she would be "disappointed" if the additional £5 million allocated to GUM medicine this year did not go some way to relieving these pressures, though she conceded this would be undermined if the figures for infection were to continue to rise dramatically.[97] She cited the development of a waiting times indicator as a means of monitoring the effect of the investment of the new money on waiting times.

89 Ev 322 (Dr P A Fraser)

90 Q 524

91 Q 525.

92 Q 525; *Report on the Working Group to Examine Workloads on Genito-urinary Medicine Clinics*, (November, 1988)

93 Ev 364

94 Ev 365

95 Q 538

96 Q 24

97 Q 1060

109. It seems to us a matter of grave concern that patients in some cases are waiting eight weeks to see a consultant, during which time a substantial proportion will remain sexually active.

110. **We welcome the fact that the Department is developing a waiting times indicator as a means of monitoring the effect of its recent investment on access to clinics. However, this will merely duplicate existing activity since the Public Health Laboratory Service and the Specialty Societies for Genito-urinary Medicine already monitor waiting times, and evidence of the extent of the problem is not wanting. So we are unconvinced that this measure alone will do much to address what amounts to a public health crisis. We recommend that there should be a presumption that anyone wishing to access genito-urinary medicine should be able to do so on the day of, or day after, presentation to a clinic. If a target of 48 hours to see a GP is appropriate then a target of 48 hours for the treatment of what is potentially a communicable disease is essential. Without such standards of access the very delays in accessing treatment will inevitably cause further disease and that in turn will contribute to the pressures on services. It is also essential that if clinics do not allow patients to book an appointment more than 48 hours in advance, this does not conceal the problem of patients who are not able to make an appointment.**

Premises

111. Premises where GUM clinics operate are also frequently a target for criticism in the memoranda. We visited The Milne Centre, a GUM clinic serving Bristol, where services were conducted in a Portacabin condemned as a fire risk. The Wolverton Clinic in Kingston, we are told, lacked sinks in some clinical rooms. Dr K C Mohanty, a consultant in West Yorkshire described the standard of his clinic at the Airedale General as being "less than that of a developing country". Services had actually deteriorated over the last ten years with the withdrawal of a lab technician who used to read test slides.[98] Pressure on departments also jeopardised patients' chances of being seen in appropriate levels of privacy.[99]

112. The Specialty Societies for Genito-urinary Medicine estimated that around 20% of clinics were located in Portacabins and that refurbishments and extensions were needed for about 80% of clinics; the total cost for carrying this work out was estimated to be between £152-248 million, depending on the level of work.[100] This is a consequence of historic under-funding of services. Dr Munday told us that she believed that specialties that used routine outpatients tended to be upgraded every ten years or so but that GUM was outside this system and had to bid separately, giving the potential for neglect.[101]

113. On our visit to the Milne Centre, we were struck by the extent to which the poor quality of the building had a deleterious effect on the ability of staff to work efficiently. Members of staff had constantly to shepherd patients from one end of the building to the other; urine samples had to be transported via the waiting room; patients enjoyed little or no privacy; staff were boxed up in tiny rooms; consultation areas were out of date and unwelcoming; the small waiting rooms meant that patients had to wait outside on occasions when these were full. Whilst the dedication and commitment of the staff were still very evident, their conditions of work—and the

98 Ev 349

99 Ev 390 (The Specialty Society for Genito-urinary Medicine)

100 Q 591

101 Q 590

environment in which highly vulnerable patients were expected to discuss intimate and sensitive matters—were unacceptable.

114. Our visit to Manchester similarly revealed poor working conditions and an environment that was generally unwelcoming, not least to the young people who are likely to be the main users of services. We were told that, typically, GUM clinics are out of the public eye, tucked away in inaccessible parts of hospitals. They are not easily accessible to young people, as some of our witnesses, who were researching accessibility, pointed out:

> (*Erica Buist)* The best description I could get was, "It's behind Boots". It was not behind Boots, but then of course there was a winding path you have to go down with everyone looking at you ...
>
> (*Sarah Nicholls)* The GUM clinic in Wakefield, I had already been there twice before, but I had always gone by car, but this time I had to catch the bus because I was going from college and I could not find it ... I walked to the hospital and they had someone on work experience behind reception and by this point I was bright red. I was not really that bothered, but I thought 'Oh no! People are looking at me now', so I walked in and said 'Can you tell me where the GUM clinic is?' and he said 'I don't know'. There was nobody else around, so he had to ring a nurse to come and get me and escort me round ..."[102]

115. We asked the Minister whether the state of premises in GUM was acceptable and she acknowledged that they were "not good enough".[103] However, she was confident that, with the Government having embarked on "the biggest hospital building programme ever known in the NHS", over the next few years there would be "significant improvements".[104]

116. **We note the very poor condition of many of the premises in which genito-urinary medicine is being carried out. Many strike us as being of an unacceptable standard and significantly below the general standard within the health service, as a consequence of the low status of this branch of medicine over the years. We believe that the very condition of the buildings makes them less attractive to patients and staff, less efficient, and less conducive to the necessary levels of privacy. Below we make recommendations about extending the range of settings in which GUM should take place, drawing particular attention to the advantages of the creation of a network of school-based clinics. However, we would urge the Minister to ensure trusts give due priority to the demands of GUM to compensate for the historic levels of under-investment. Unless sexual health is given higher priority within the health service we see no immediate prospects of widespread improvement.**

Chlamydia Screening

117. The *Strategy* specified chlamydia screening as an area needing development. As already noted, chlamydia is now the commonest sexually transmitted infection. The fact that in the majority of cases chlamydia is asymptomatic means that its prevalence is only likely to be reduced through screening.

102 Q 892
103 Q 1057
104 Q 1058

118. The Chief Medical Officer's Expert Advisory Group on Chlamydia argued that specific target populations should be screened in a variety of healthcare settings. Screening should be offered to all GUM clinic attenders, in the view of the Group, as well as to all women seeking termination of pregnancy and their partners, and to asymptomatic sexually active women aged under 25 (especially teenagers and especially those who have had two or more partners in a year or a recent partner change). The preferred settings for testing, in the view of the Group, were General Practice and Family Planning Clinics. Referral for treatment should then be made to GUM clinics (although the Group acknowledged that some individuals would be unwilling to attend). Training would be required for GPs "who will have to decide whether or not to raise the issue of testing for a sexually transmitted infection when the patient is presenting for an unrelated condition".[105] Professor Anne Johnson of the Department of Population Sciences at the Royal Free Hospital listed antenatal clinics, abortion clinics, primary care and possibly the contraception service as potential settings for clinics, and in particular drew attention to the difficulty in capturing chlamydia in the male population, given the limitations of partner tracing and the fact that men would not access most of the obvious settings. In the absence of a widespread screening programme she anticipated that chlamydia would continue to present a "major public health burden".[106]

119. A pilot study to assess the impact of opportunistic screening for chlamydial infection has been completed at two sites, Portsmouth and the Wirral. This was funded by the Department and co-ordinated by the PHLS. The study also looked at the feasibility of opportunistic screening in a range of primary and secondary healthcare settings.[107] In a written answer to Sandra Gidley MP, the Public Health Minister, Hazel Blears MP said:

> The pilots showed that this form of screening was acceptable to the target group and the professionals with 75% uptake among those offered screening and 95% of those diagnosed returning for treatment. The national strategy for sexual health and HIV commits to beginning a programme of opportunistic screening for chlamydia for targeted groups in 2002. The first 10 screening sites are currently being selected, and will be approved shortly. The pace of the roll-out of the programme across the country will depend on the availability of resources, trained staff and equipment, and cannot be precisely predicted at this stage.[108]

120. Approximately 17,000 women were tested, equivalent to about 45% of the sexually active female population aged under 25 years in the area concerned. The results suggested that between 10% and 11% of women aged under 25 and attending healthcare services may be infected with chlamydia, with the highest rates being recorded in youth clinics where 17% were found to be positive.[109]

121. Dr Jean Tobin, a consultant in GUM and one of the managers of the chlamydia screening pilot, told us that the results of the pilot were so striking she would have preferred the Department to proceed straight away to a national roll-out of the screening programme:

105 EAG Report

106 Q 277

107 See J Catchpole et al, "Evidence based health policy report: screening for genital chlamydial infection", *BMJ*, 2000, 321:629-31

108 HC Deb, 19 June 2002, col. 437W

109 Q281; Ev 58

> It is going to take a while to roll out the programme, anyway, but I would much rather that than just another ten sites and expanding very slowly afterwards, because an awful lot of people are going to be able to get an asymptomatic infection during that time.[110]

122. Dr Kinghorn told us that the GUM specialty found it "very difficult to understand why we are rolling out in dribs and drabs."[111] Professor Anne Johnson argued that "a population based strategy" was needed since chlamydia was so widespread in society. However, Dr Muir Gray, Programme Director for the National Electronic Screening Programme which is involved in advising on the programme, suggested that targeted testing of the high risk population was what was needed. He did not support a call for an immediate national roll out until national standards for testing, quality assurance of testing, information giving and communication had been established.[112] He thought it was important that the results of a follow-up reinfection study were known before proceeding to a national roll out. A different view was taken by Dr Gwenda Hughes, for the Communicable Disease Surveillance Centre of the PHLS, who told us she did not believe that the benefits arising from refining the screening programme, in the light of the reinfection study, constituted sufficient reason for any delay in the screening programme, given the quantity of untreated infection in the community.[113]

123. **We do not think that it is necessary to wait for the results of the reinfection study before introducing nationally the chlamydia screening programme. Any additional information that the reinfection study provides is, in our view, likely only to lead to modifications in the programme rather than fundamental reforms. Accordingly we recommend that the NHS must, as a matter of urgency, move to provide such screening in all family planning clinics, infertility clinics, termination of pregnancy clinics and GUM clinics and for women having their first cervical smears. We also believe that GPs should routinely offer testing to those aged under 25 years without attempting to second-guess patients' sexual behaviour.**

124. Dr Gray told us that he thought that the best way of tracing and treating chlamydia in males was via contact tracing through female contacts. We are not convinced that this will be sufficient. We gather that the preliminary findings of the reinfection study suggest a high degree of reinfection in the community. Men are less likely than women to access any of the settings where it is suggested that screening can take place. Given the fact that chlamydia is usually asymptomatic in men, this poses real problems.

125. **We recommend that the Department explores the possibility of offering screening and advice on STIs, including chlamydia, to men outside traditional health service settings. Imaginative solutions will be needed if the male population is to be engaged. School based services such as that offered by the Tic Tac project offer one possible avenue for advice, testing and referral (see below, paragraph 312). We would also like screening to be offered via community outreach schemes, for example targeting night clubs or sports clubs, especially in areas where high prevalence rates are recorded. We also recommend that the Government should assess the possibility of a much wider screening campaign, including a national screening day or series of regional screening days, promoted through a campaign of**

110 Q 283

111 Q 587

112 Q 739

113 Q 288

hard-hitting messages. Such a campaign should be introduced in an attempt to have a real impact on chlamydia in the wider population.

The test for chlamydia

126. Testing for chlamydial infection is by means of urethral samples in men and women, or cervical samples, urine samples or self-administered vulval swabs in women. Several of the memoranda draw attention to the greater accuracy and sensitivity of the newer molecular amplification test, such as the polymerase chain reaction (PCR) test, and to the fact that, for cost reasons, this is not always available.[114] In oral evidence, Dr Tobin suggested that only 10% of clinics used the PCR test, and that the enzyme immuno-assay (EIA) tests in common use would have missed 30% of women and 46% of men.[115] Dr Kinghorn estimated that fewer than 5% of GPs had the PCR test available to them.[116]

127. We were astonished to learn from Dr Kinghorn that even the chlamydia screening pilot sites, which had provided a stark picture of the extent of chlamydia in the population using the more accurate PCR test, had had to revert to the sub-optimal test following the completion of the pilots:

> In Portsmouth, following the completion of their study—and they had very strong evidence for using the molecular test—they had to go back to using the suboptimal test on the patients they are looking after. That to me is wicked. It is a situation which prevails across the country. There should be no argument. The evidence from everywhere says very clearly that this molecular test is so much better.[117]

128. Professor Johnson pointed out that there were potential long-term cost savings in the use of the more sensitive test if PID and infertility were reduced as a consequence of its introduction, given the very high costs of infertility treatment.[118] The Public Health Minister acknowledged that urine tests were "very acceptable" to patients, though she also felt that the self-swab test, whilst invasive, also had high levels of acceptability.[119]

129. **We believe it is scandalous that a sub-optimal test, with an accuracy rate markedly below the best tests, is still widely in use in England for the detection of chlamydia. Indeed, we believe that health providers would be highly vulnerable to damages claims made by patients who had received a false negative diagnosis and had thus not had treatment for chlamydia infection. We believe that the Department of Health should issue firm guidance to the effect that the sub-optimal EIA test should be withdrawn in favour of the molecular amplification test as soon as possible. In some cases we realise that laboratory services would not be able to cope with sudden transition to these types of tests. Nevertheless, the examples of the Netherlands and Sweden, which we visited and which had long since abandoned EIA testing, convince us that it must be possible to move to the optimal test and we believe this should be an urgent priority.**

114 See eg Ev 349 (Dr T R Moss); Ev 354 (Nottingham City Hospital)

115 Q 280. The PCR test amplifies a fragment of DNA, and will detect even a single chlamydial cell in a sample.

116 Q 574

117 Q 572

118 Q 279

119 Q 1079

HIV/AIDS services

Treatment

130. The development of new and improved treatments both for the underlying HIV infection and the opportunistic infections has significantly altered the way in which HIV and AIDS affects a person's health and lifestyle. Since 1995, substantial reductions in death rates among HIV-positive people have been reported in many industrialised countries where infected people have access to the latest therapies. Early use of a combination of therapies (such as the triple combination or triple cocktail which makes it more difficult for resistance to develop), before HIV-related symptoms develop, may reduce an individual's risk of developing an AIDS-defining illness. Furthermore, many people with very advanced disease, including those with a prior AIDS diagnosis, have experienced remarkable recoveries in physical health.

131. It has been said that in some cases the latest combination therapy, Highly Active Antiretroviral Treatment (HAART), can be so powerful as to transform AIDS from an invariably fatal illness into a chronic condition. However, a 95% adherence rate to a drug regimen is required for HAART to have optimum effect.[120] Poor adherence can lead to the development and transmission of resistant strains of HIV and about 25% of new HIV cases are now found to be resistant to one or more of the treatment agents. As Ruth Lowbury, Director of the Medical Foundation for AIDS and Sexual Health (MEDFASH) told us:

> We must not forget that HIV care comprises more than just the drugs. If people are given the drugs without the support they need to adhere to treatment, to get the social support which enables them to manage what can be a very difficult life keeping on these drug regimes, the treatments themselves will not be so effective.[121]

Services

132. As the main provider of HIV diagnosis and treatment, genito-urinary medicine services are integral to HIV care, and several witnesses told us of the need for a comprehensive sexual health service which catered to the various prevention, health promotion and care needs of individual patients. According to Dr Simon Barton, issues such as co-infection:

> raise a lot of questions about how we link together the sexual health and HIV care of individuals. Many of us feel that people with HIV are a target group for better sexual health management and prevention ... in our own and many other units, people are working to provide regular sexual health screening of people attending for their HIV treatment follow-up. So they do not have to go to queue separately and make an appointment a week hence at their local sexual health clinic.[122]

133. The Royal College of Physicians, in conjunction with specialists and specialty committees, has set out its views of the conditions necessary for effective safe delivery of HIV/AIDS services.[123] Recommended conditions of service for HIV infection include:

120 Ev 323 (Glaxo Smith Kline)

121 Q 681

122 Qq 653-54

123 RCP, *Consultant Physicians Working for Patients,* 2nd ed. 2001, pp 130-40.

- a patient newly diagnosed with HIV infection should have an appointment for initial assessment within a week
- at the first visit a full history should be taken, physical examination performed, and an STI screen should be offered if not previously done
- dietitians, physiotherapists and pharmacists should take part in all aspects of care, and patients should have access to community services and patient support groups
- regular outpatient follow-up with monitoring of immunological and virological parameters
- when complications occur patients should receive care in dedicated beds staffed by specially trained nurses
- longer appointment times are required for these patients than those with STI.

134. The RCP directs that consultants seeing HIV infected patients require the support of junior medical staff who need additional training and that there should also be receptionists, nurses and health advisers. Ideally, where dedicated HIV clinics are held, the RCP states that other healthcare professionals should be available including pharmacists, dieticians and clinical psychologists. In the view of the RCP, HIV clinic nurses are also key members of the clinical team. They develop specialised skills in assessing the wide range of clinical and other problems that patients experience, and may be trained to assist with or to undertake a wide range of medical procedures. They may also help patients by providing a link between services in the hospital and in the community.[124]

135. The RCP recommends that all clinics should have one or more health advisers on duty throughout all clinic sessions. Health advisers help patients to change risk-taking behaviour and to adhere to their treatment. They assist patients with partner notification, provide ongoing support and monitor patients' response to treatment. In doing this work, they help to prevent onward transmission of drug-resistant strains of HIV. It was suggested to us that health advisers could play a particularly important role in supporting those with HIV. Consultants who provide HIV treatment and care for patients may find it difficult to discuss risk-taking behaviour and STIs. Dr Barton told us:

> it can be difficult when you have known people for a long time to raise the whole issue of sex and potentially having unsafe sex in a consultation where you have been talking about HIV … this is the reason for the multi-disciplinary team, having health advisers, counsellors, nurses, all working together.[125]

136. However, some HIV clinics do not have access to any support services at all. In Cornwall, HIV services are centralised in Truro where no dedicated nursing time is allocated to them. Repeated attempts by consultants to obtain basic dedicated support services such as dietetics and pharmacy for HIV patients have foundered and there is no community liaison nurse for such

124 Ibid.

125 Q 654

patients. Service providers in Cornwall pointed out that while they struggled to fund basic support services the drug budget for HIV treatment "continues to rise inexorably".[126]

137. Much of the evidence we have received strongly suggests that a great many clinics would struggle to meet even a few of the conditions of service set down by the RCP because there are now so many patients to be tested, diagnosed and treated. For example, it is recommended that a consultant should see five to nine patients in a three hour session but we heard from Dr Ade Fakoya who saw on average 15 patients per clinic and from Dr Simon Barton who reported that he usually saw 18 to 20 patients.[127]

138. Dr Paul Lister, Network Lead Clinician of South West London HIV & GUM Clinical Services Network, told us that between 1996 and 2000 South West London Clinics experienced an increase of over 75% in the number of HIV positive patients under care.[128] Royal Liverpool and Broadgreen University Hospitals reported that during 2001–02 the GUM department had witnessed a continued increase in the number of patients with HIV infection, the highest increase arising from patients from ethnic minority groups and asylum seekers or refugees who often needed costly translation services. There had been no corresponding increase in funding for HIV care and management, except in terms of an attempt to meet spiralling drug costs.[129]

139. Evidence from Homerton University NHS Trust in Hackney testified to the fact that some patients wanting to access HIV services were now being turned away owing to increased disease-prevalence and demand. Dr Mayura Nathan from that trust told us that targeted research was needed into the patterns of transmission of HIV and other STIs, to detect new waves of transmission at a local level. However, given the discrepancy between the disproportionate burden of HIV and STIs which affects East London and the resources available for services, the potential for any kind of research or monitoring work (beyond the requirements of the AIDS Control Act 1987 which requires some data collection) is limited.[130]

140. Dr Alan Tang of Royal Berkshire Hospital, Reading (Royal Berkshire & Battle Hospitals NHS Trust) told us that "new cases of HIV arrive at the rate of one a week", that the HIV caseload at his clinic had nearly doubled in two years and that it was projected to expand by another 60% by 2005. Dr Tang reported that such new cases arose almost exclusively from patients of African descent, including refugees and asylum seekers, and that the cost of HIV treatment for an (already overspending) trust had risen accordingly.[131]

141. Language barriers and cultural differences can make counselling and treatment difficult. Given the massive benefits to health and lifestyle of early diagnosis and treatment, it can be demoralising and distressing for service providers to see patients presenting in the advanced stages of disease. Discussing the growing number of asylum seekers presenting with HIV positive status, Dr T R Moss of Doncaster and Bassetlaw Hospitals, told us:

> The cost of providing antiretroviral drugs and clinical services, as well as all of the other needs of a sudden, unexpected, and unplanned influx of patients who often have very

126 Ev 318 (Dr Frances Keane)
127 Q 699
128 Ev 378
129 Ev 368
130 Ev 350-51
131 Ev 398

> advanced disease, is now a major concern within this specialty. The situation has reached a crisis which requires central intervention if we are to provide the care and compassion that these people require.[132]

142. The marked rise in the number of infections found in people arriving from abroad, and the consequential impact on access to services, is a major cause for concern. We note that this concern has in some cases taken the form of calls for mandatory testing of groups such as refugees and asylum seekers entering the country.[133] We sought the views of service providers on the issue of mandatory testing. We heard of their concern for people whose HIV goes undiagnosed, and for those people who might become infected as a consequence of this; and of their commitment to treat and care for each individual who presents at their clinics. Dr Ade Fakoya told us:

> The view that people have of asylum seekers in the media and in the community is very different from the view of asylum seekers whom we see within the clinic. The majority are women; we have a number of women who have presented in the last year who have either been raped overseas or have been raped as asylum seekers in this country. The youngest person I deal with is 14 and she is pregnant at the moment. We have had ten in the last year under twenty.[134]

143. Dr Fakoya's view was that mandatory testing would drive the HIV epidemic underground by generating stigma and fear, leading to a decline rather than an increase in rates of diagnosis. Dr Barton told us that anyone who is to have an HIV test should be able to give informed consent, as part of the necessary preparation for a diagnosis.

144. **We are concerned by the trends in HIV and support the Government in its aim to reduce the prevalence of undiagnosed HIV and in turn to safeguard public health. Early diagnosis of HIV not only reduces the chances of it spreading within the community but it also greatly improves outcomes for those infected. On the basis of the evidence we have heard, however, we do not believe mandatory testing of asylum seekers, refugees, immigrants, visitors newly arrived in this country, and returning residents, to be an effective way of achieving the Government's aim. We recommend that HIV testing for newly arrived people should be voluntary, but should have as its clear objective the promotion of full disclosure of any relevant medical history and should also aim to facilitate appropriate and culturally-sensitive counselling before and after testing for HIV.**

145. We welcome the Government's commitment to an expansion of the roles played by nurses and by health advisers in caring for HIV patients. However, unless resources are also allocated to increasing the capacity of HIV clinics and care teams in general, HIV patients will have to wait longer for shorter consultations.

Funding treatment and service provision for HIV and AIDS

146. According to the National Association of NHS Providers of AIDS Care and Treatment (PACT), the cost of managing a patient with HIV in the UK is £15,000 per patient per annum.

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132 Ev 350

133 *See BMJ*, 2003, 326:342 (8 February); Anthony Browne, "The Secret Threat to British Lives", *The Spectator*, 25 January 2003

134 Q 659

The total cost of treatment and care in 2002–03 will be £345 million, with the expectation of further diagnoses at an additional cost of £30 million. The Medical Foundation for AIDS and Sexual Health (MEDFASH) cited estimates suggesting that by 2007 the cumulative lifetime treatment costs for those known to be infected with HIV will exceed £5 billion. MEDFASH set this figure alongside the *Strategy*'s assessment of the cost/benefit of preventing a single case of HIV at £0.5 million, and concluded that preventing half the current annual new infections would provide a cost/benefit of £1 billion.[135]

147. Some £165 million was allocated for treatment and care in 2001–02 and current estimates are that providers are under-funded by around £3,000-5,000 per patient per year after their patients have been diagnosed.[136] This situation is likely to be exacerbated by the 6,500 newly diagnosed HIV cases in 2002. HIV drug therapy is the biggest cost pressure on budget allocation for treatment and care. Persistent under-funding, combined with spiralling drug costs and the emergence of many new drugs on to the market, means that clinicians struggle to prescribe the appropriate therapies for their patients and that funds needed for other sexual health services may be diverted to pay for HIV drugs. Dr Barton told us that:

> There needs to be more sophisticated planning between those whose responsibility is to plan the funding and those who know what drugs are coming through ... other than being mentioned in documents as being valuable, they do not have the Department of Health stamp on, so when we take them because they are nationally agreed by all the clinicians and it has been mentioned, but where is the stamp on the front saying this is what must be supported? If you prescribe along these guidelines you have to find money from the budget.[137]

148. **We recognise that the field of HIV therapy is one which develops quickly and we appreciate that any guidelines on the use of HIV drugs might require frequent revision. However, we recommend that the National Institute for Clinical Excellence (NICE) should undertake an appraisal of treatments for HIV patients so that service providers and commissioners can collaborate and plan to make available the most effective treatment.**

149. We asked the Public Health Minister whether, in light of increasing costs, prescription of HIV drugs would be rationed. She told us that "there are no plans to ration access to clinical treatment."[138] We are reassured by the Minister's statement but we remain concerned that a shortfall with regard to monies for HIV drugs will divert funds from other areas of HIV and GUM treatment and care. **Adequate funding for HIV drug therapy constitutes the only means of ensuring that HIV patients have access to the most appropriate drugs and that the other aspects of the sexual health service can be maintained and developed according to patients' needs.**

150. Until recently, funding for HIV services was 'ring-fenced' from the rest of a health authority's budget. The Department has provided steady-state funding for specialised services for 2002–03 and PCTs have been obliged to honour the service agreements of their parent local health authorities, but as PCTs gain financial independence they will be able to allocate funding

135 Ev 356; Ev 194
136 Ev 356
137 Q 683
138 Q 1100

according to their own priorities and HIV monies will be mainstreamed. PCTs are now expected to fund services for HIV patients through mainstream allocations.

151. Those involved in providing HIV services have had to respond to NHS-wide reform and to the end of ring-fenced funding for HIV treatment and care. Ruth Lowbury for MEDFASH told us of the concerns held by many health professionals with regard to the place of HIV in the mainstream and in the priorities of PCTs:

> On the one hand the traditional ring-fencing and funding of HIV for treatment and prevention has been removed and at almost the same time there has been a complete restructuring of the NHS in terms of commissioning arrangements. The people who understood what was being done with the ring-fenced money are no longer necessarily there, at the same time as the ring-fencing has been removed ... a lot of expertise has been lost ... there has to be something which will encourage PCTs, commissioners within PCTs, to take on HIV and sexual health, to recognise it as a priority.[139]

152. PACT told us that London was "not ready for the transition to PCT-funded HIV services", and identified a general problem with the new commissioning structure in that much commissioning expertise is concentrated in Strategic Health Authorities which do not have financial responsibility.[140]

153. The Department has acknowledged the concern that the end of ring-fenced funding for HIV treatment and prevention would be detrimental to HIV/AIDS service provision and we were assured that investment in HIV treatment and prevention would be monitored through performance management mechanisms and through the Service and Financial Framework (SAF) which requires PCTs to make statements on their expenditure and investment plans. According to the Department, the evidence suggests that investment levels have been maintained, if not increased.[141]

154. However, as Mr. Nick Partridge of Terrence Higgins Trust told us, concerns remain about funding for HIV/AIDS services as sexual health is not on the list of twenty 'must dos' in the SAF round. Without this status, and without a National Service Framework "HIV and sexual health ... has very little to encourage chief executives of primary care trusts to ensure that sexual health and HIV need is met and that good competent people are placed to work collaboratively."[142]

155. The Planning and Priorities Framework replaces the Service and Financial Framework. As part of the new Framework, PCTs are required to produce Local Delivery Plans detailing how local organisations will meet local and national priorities and targets within available resources over three years. The Planning and Priorities Framework sets out 13 areas to be included in Local Delivery Plans. Sexual health is not named as one of these 13 areas.

156. The Public Health Minister sought to reassure us that sexual health and HIV would be regarded as a priority area, despite their omission from Local Delivery Plans. She told us that sexual health would feature in areas such as 'Reducing Health Inequalities':

139 Q 671
140 Ev 356
141 Ev 20
142 Ev 108

> there is nothing more important to Government than tackling health inequalities, and therefore that again will aid people at local level to make this an important area of work by saying that it contributes to our push on inequalities.[143]

157. This, the Minister told us, was "one of a number of levers in place to make sure that sexual health services become a more important issue at local level through PCTs."[144] She added that the requirements of the AIDS (Control) Act 1987, which directs health authorities to make annual reports about HIV/AIDS, was to be revised to accommodate a "monitoring system". This would "give us more detail about where the money is actually being spent, and more importantly, rather than just the money, we will be concentrating on the outcomes to see what difference it has made to patients and to communities."[145]

158. **Now that funding for HIV services has been mainstreamed, and that commissioning is PCT-led, sexual health and HIV should be a priority at local level on grounds of public health. However, sexual health and HIV service providers have told us that they need help to persuade commissioners to allocate resources to an area which remains stigmatised, particularly in rural areas where prevalence of HIV is low. We are not convinced that the current arrangements will ensure that sexual health will be treated as a sufficiently urgent priority. Given that sexual health has no National Service Framework, and until NICE guidelines are introduced, we recommend that sexual health and HIV be included in Local Delivery Plans.**

The Strategy and HIV services

159. The *Strategy* aims to reduce undiagnosed HIV and to improve health and social care for people living with HIV by developing managed networks for HIV and sexual health services, and by shaping services around patients, their families and their carers.[146] These managed networks would provide a range of open access services with clear referral pathways, staffed by professionals who would themselves have access to support, training, and opportunities for continuing professional development.[147] The *Implementation Action Plan* states that the Department has prioritised the training and development needs of the sexual health workforce.[148]

160. The *Strategy* set targets for reducing undiagnosed HIV:

- by the end of 2004, all GUM clinic attendees should be offered an HIV test on their first screening for sexually transmitted infections (and subsequently according to risk) with a view to:
    - increasing the uptake of the test by those offered it to 40% by the end of 2004 and to 60% by the end of 2007

143 Q 1065
144 Q 1090
145 Q 1065
146 *Strategy*, p 3
147 *Strategy*, p 36
148 *Implementation Action Plan* para 1.6 (viii)

- reducing by 50% by the end of 2007 the number of previously undiagnosed HIV infected people attending GUM clinics who remain unaware of their infection after their visit.

161. As part of the *Strategy* the Department undertook to:

- develop the role, and increase numbers of, health advisers
- establish service networks for HIV, backed up by standards and guidelines
- set standards to promote good practice, including improving information and access to services
- set broad standards for the delivery of social care and support for people living with and affected by HIV.

Contribution of primary care

162. With regard to HIV and sexual health services, under the new three-level model of working for sexual health service provision, General Practice should offer discussion of sexual history and risk assessment, and HIV testing and counselling. The *Commissioning Toolkit* states:

> Training to support these components will be part of existing training structures such as undergraduate and basic professional training and will be expected to be present in the majority of services to which patients may self refer, such as primary care services and self-referral sexual health services (contraception and GUM).[149]

163. Some of the evidence we received highlighted the potential for wider access to HIV testing through making it available in the primary care setting. Ruth Lowbury told us that:

> In all our communities there is a stigma about HIV... Many people will feel quite nervous or reluctant to go and seek HIV testing in a centre which can be identified as a centre for sexually transmitted infections. It is very important that services for testing are accessible in a range of settings, including primary care and perhaps more community-based organisations as well.[150]

164. With enhanced awareness of the signs and symptoms of HIV on the part of primary care service providers, more of the thousands of people who remain unaware of their HIV status could be tested and diagnosed. Ruth Lowbury went on to outline an enhanced role for GPs:

> They may be able to co-ordinate or enable people to access other types of care such as social care, such as mental health care, where the provision is often locally based and the GP has contacts and has the ability to access those services in a way which somebody based in a specialist treatment centre, possibly quite a distance away, may not be able to do.[151]

165. However, a number of those submitting evidence told us that the majority of people with HIV/AIDS did not use their GP but instead visited specialist centres for a full range of primary

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149 *Effective Commissioning of Sexual Health and HIV Services*, p 29

150 Q 667

151 Q 716

medical care. They worried that GP services were already stretched beyond capacity and also that some family doctors might have limited experience of people with HIV/AIDS. As the Medical Foundation for AIDS and Sexual Health (MEDFASH) told us:

> Increasing the availability of sexual health services in primary care is a way of increasing access for those who are unable, or prefer not, to use GUM clinics. However, the pressures on primary care are well-known and waiting times to see GPs for all health care needs are often too long. Sexual health competes with a long list of other health concerns in primary care, and many GPs would currently see the diagnosis and management of STIs as solely the role of specialist services.[152]

166. The Terrence Higgins Trust and PatientView conducted a survey which found that GPs were reporting problems collaborating with specialist HIV services and also understanding the complex issues around confidentiality and HIV.[153] The *Commissioning Toolkit* acknowledges that “primary care practices will need to negotiate a pace of change with PCTs to aim towards providing the full range of Level 1 elements.”[154]

167. **We recognise that GPs and other primary care providers have an important role to play in the diagnosis and support of people with HIV as well as in their general medical treatment. HIV is a chronic condition. Dealing with chronic conditions is traditionally an area of strength for primary care. We therefore welcome moves to give primary care more of a role in the management of HIV/AIDS. However we are not convinced that the rebalancing of care provision is being sufficiently well supported. Accordingly, we recommend that these service providers be supported through training and through involvement in service networks. We also believe that it is crucial that the expertise currently residing within GUM is not diluted as a consequence of any move to primary care. So we would encourage any measures which promote close interaction between the expertise now found in secondary and tertiary services and that in primary care.**

Contribution of Social Care

168. The Association of Directors of Social Services (ADSS) argued that “Discharging patients with an AIDS diagnosis without the right support structures in place defeats the objectives of responding to the crisis in waiting lists in the NHS, and of good patient care.”[155] The health visitors and social workers who provide support structures for people who have been diagnosed with HIV/AIDS are integral to the success and cost-effectiveness of HIV treatment. However, we have heard that support for people with HIV from the social services is not what it once was. As Ms Heather Wilson, Senior Health Adviser at Barnet General Hospital told us:

> Health advisers traditionally have had to take responsibility for co-ordinating the social care of the HIV-positive patients and it often involves a lot of direct advocacy work ... it used to be that everywhere you looked there were specialist social workers, but nowadays ... some boroughs will provide them and others will not.[156]

152 Ev 194

153 Ev 95

154 *Effective Commissioning of Sexual Health and HIV Services* p 29

155 Ev 307

156 Q 707

169. The ADSS attributed some of the £200 million overspend in social services to a rise in the numbers of children affected by HIV/AIDS coming into care and we heard evidence from a clinical specialist nurse in HIV that some social work teams might be ill-equipped to manage care for children affected by HIV:

> those teams are not really used to dealing with patients with HIV and their complex problems ... they did help with respite care for the child, but they could not really understand the difficulties that the mother was having with starting therapy for her HIV... it was not that they were not caring. It was just that they did not have the knowledge ... professionals have to be able to look at a family as a whole and at the moment that is not really happening.[157]

170. The AIDS Support Grant was introduced in 1989–90 to encourage the development of strategic plans within local authorities to respond to HIV infection and of operational plans for the provision of services for people living with and affected by HIV and AIDS. Since 1994–95 funding has been allocated on the basis of live AIDS cases resident in each local authority area receiving HIV treatment in NHS facilities but the Department has begun a review of the AIDS Support Grant and the allocation formula:

> The success of combination therapies in delaying the progress of HIV, and the increasing numbers of women and children from black and minority ethnic groups requiring help and support have led to changes in the package of social care provided by social work departments and others. Dispersal of asylum seekers to areas outside London is beginning to have an impact on the planning and provision of care and support in areas where formerly few required care.[158]

171. This statement seems to endorse the view of the British Association of Social Workers that here was still need for a "central drive" on HIV/AIDS.[159]

172. **We recommend that the Government should support the co-ordination of training for all social workers who have contact with those living with and affected by HIV, and also support the creation of posts for specialist social workers, who we believe could play an important role in developing and maintaining HIV service networks in high- and low-prevalence areas.**

Contribution of Voluntary Care

173. The Department recognises the vital role played by the voluntary sector in working with people affected by HIV/AIDS to providing care and support. It looks to the voluntary sector as a model for innovative and flexible service provision and has undertaken to develop "better strategic arrangements for commissioning voluntary sector services".[160]

174. The Public Health Minister told us:

157 Qq 706-7 (Ms Christina Green)

158 *Effective Commissioning of Sexual Health and HIV Services* p.24

159 Ev 380

160 *Strategy*, p 34

> Clearly the voluntary sector at local level will be important but we also think the voluntary sector nationally is very important here in terms of the funding we allocate to the Terrence Higgins Trust, the National AIDS Trust, and particularly the work around African communities increasingly ... funding will still be continued at national level to make sure the very important work that those national voluntary organisations are doing is able to continue.[161]

175. We heard from Mr Simon Collins, who has worked in the voluntary sector for five years. His voluntary organisation, HIV i-base provides publications to healthcare professionals, a monthly bulletin for doctors, and a range of patient guides; as well as a treatment support telephone line for patients and links to European treatment networks for patient access. We asked Mr Collins about funding for this work:

> It is a very good question. It is very hand to mouth. Although our organisation has been running for several years, there is no money in the bank at the end of the month and it is very difficult to identify a central fund which links to the NHS given the services we provide.[162]

176. The Terrence Higgins Trust reported that voluntary sector HIV services were "struggling to meet client need" and that uptake of its own services had increased by up to 500% in some areas.[163] Mr. Nick Partridge of the Trust warned us of potential risks to voluntary organisations providing HIV/AIDS services posed by the restructuring of health authorities into PCTs. He compared the restructuring to the disaggregation of county councils and as an example of the potential effect on voluntary HIV/AIDS services, told us that when Avon County Council disaggregated into three unitary councils, one of the new councils decided that it did not wish to allocate monies to Terrence Higgins Trust West and so funding for that unit was cut by 25%.[164]

177. Evidence from Mr Collins and Ms Lowbury reinforced our worries about the risks to voluntary sector services posed by the end of ring-fencing and by the devolution of commissioning powers to PCTs:

> If you are losing any specialist commissioning which included support for voluntary organisations then there is a concern as to whether those organisations which used to receive that funding will continue.[165]

And: –

> with so many different commissioners, potentially if the commissioning is devolved to PCT level, one voluntary organisation which maybe provides services across an area equivalent to a strategic health authority or more is going to have so many different commissioners to negotiate the contracts with that they could spend all their time negotiating contracts.[166]

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161 Q 1095
162 Q 627
163 Ev 95
164 Q 368
165 Q 694
166 Q 694

178. **We welcome the Government's acknowledgement of the voluntary sector contribution to HIV services. We have received a great deal of evidence to suggest that the voluntary sector can reach many HIV-positive people who will not access statutory services. We recommend that the Government reciprocate the support it receives from voluntary groups in terms of practical work and policy guidance by supporting voluntary work at both national and local level. It would be counter-productive if the *Strategy* led to any diminution in the funding given to these bodies. Some HIV services (such as targeted prevention work) can only be provided by organisations which are very closely in touch with their communities and these services must be adequately resourced.**

The impact of the S*trategy* on the organisation of service delivery: general issues

Commissioning of services

179. The thrust of the *Strategy* is that far more services will be devolved to primary care, either to individual practices, or groups with specialist skills, or managed networks. Very few of those submitting evidence welcomed this unreservedly. Anne Edwards, a clinical director of GUM Oxford, described a local audit of the outcome against national guidelines for 100 patients diagnosed with chlamydial infection outside GU medicine (ie in primary care or family planning). Of those seen for follow up in GU medicine, 80% required re-treating, which Ms Edwards suggested indicated the difficulties of managing STIs effectively in non-specialist settings.[167] King's College NHS Trust, which we visited, saw some potential benefits in the management of HIV patients in primary care, but remarked that their clinic was attended by patients who had telephoned local practices having been told there was a two to three week wait for a GP appointment.

180. The additional constraints of confidentiality associated with sexually transmitted diseases was another commonly expressed cause for concern. The Herpes Virus Association suggested that the provision of services at primary level would be inappropriate since "many patients fear that they could be recognized by others when they attend the STI session or that the STI clinic records might be accessed by others in the health centre."[168]

181. The National AIDS Trust saw no signs of the development of commissioning via consortia and felt that the new model of working might easily lead to fragmentation of services.[169] When we visited Manchester, we were told that three separate PCTs were responsible for 'leading' on sexual health.

182. Following the NHS reforms introduced by *Shifting the Balance of Power*, responsibility for commissioning of sexual health treatment and care was devolved to PCTs.[170] Owing to the stigma attached to sexual health issues, many people who seek access to sexual health services do so outside their own area of residence. This creates difficulty in terms of PCT commissioning and service provision. In June 2002 we asked Department of Health officials how PCTs would be reimbursed for treating patients resident in other areas. At that time we were told that there was

167 Ev 321

168 Ev 163

169 Ev 89

170 See www.doh.gov.uk/shiftingthebalance

no definitive answer to our question.[171] In January 2003 we asked Public Health Minister this same question. Her reply was:

> It is obviously for PCTs themselves to sort out a mechanism for how they are going to reimburse each other for treatments provided ... every PCT is responsible for the cost to its residents so there needs to be a local mechanism agreed as to how those costs can be apportioned ... It is not a matter for the centre to dictate how they should do that but we will be giving them support to enable them to get robust mechanisms in place.[172]

183. The Department recommends that PCTs use networks and consortia arrangements in order to plan and purchase sexual health services. The Department asked each PCT to identify a sexual health lead person who would oversee the commissioning process.

184. We note the findings of a research report produced in December 2002 by the British HIV Association, the National Association of NHS Providers of AIDS Care and Treatment (PACT) and the Terrence Higgins Trust. *Disturbing Symptoms* concluded that many PCTs have been unable to implement the work needed to respond to the rising rates of HIV and other STIs, that sexual health services do not have the resources they need to implement Government policy, and that: "there is a level of dislocation of views between those commissioning services and those providing them."[173]

185. The survey found that one in four of the PCTs which responded have not included sexual health and HIV in their Service and Financial Frameworks, and registered concern that PCTs might restrict open-access GUM services by only paying for services provided locally. In response to these findings, the Public Health Minister told us that "significant progress" had been made since the survey had been carried out. She reported that 286 PCTs now had sexual health leads and that there were currently "only eighteen outstanding".[174]

186. Many of the sexual health service providers who spoke to us emphasised the importance of networks and consortia working in terms of service provision, and went on to call for commissioners to participate in these networks. Ruth Lowbury, of MEDFASH was one such service provider:

> it is very important for networks to be set up in such a way that there is an identified lead person, so that somebody has the responsibility for taking it forward, so that commissioners can play a key role, either in terms of leading the network, or ensuring that the network lead is there ... Resources are needed, maybe not major resources, but enough to allow people to get together to get the time to work it out, to get the time to attend meetings.[175]

187. Ms Lowbury's evidence gives some indication of the pressure exerted on service providers in terms of time and resources, as they seek to fulfil their clinical commitments and also to develop and maintain networks.

171 Qq 88-89

172 Q 1097

173 BHIVA, PACT, Terence Higgins Trust,. *Disturbing Symptoms: how Primary Care Trusts are responding to the challenges of sexual health and HIV, and how specialist clinicians view the resulting changes,* Terence Higgins Trust, 2002, p 2

174 Q 1093

175 Qq 701-2

188. **We recommend that commissioners participate in sexual health service networks, and that they should be accountable to service providers through transparent commissioning processes. Consortia are essential to the establishment of comprehensive service networks, particularly in rural areas. We believe that the Department must require Strategic Health Authorities to ensure that preliminary development of consortia is taking place, based on regional commissioning groups such as are in place for cancer services, so as to give a definite impetus to the development of networks.**

189. The Department has issued a *Commissioning Toolkit* for commissioners in PCTs and local authorities, as recommended best practice guidance for sexual health services.[176] The Department has also commissioned work to develop and publish standards for service delivery across a broad range of sexual health treatment and care services (including partner notification).[177] The *Toolkit* states that primary care-led commissioning is now where "influence on the direction, quality and quantity of sexual health provision will be determined."[178]

190. **We welcome the guidance provided by the Department of Health in issuing the Commissioning Toolkit and also recommend that the standards developed by MEDFASH and The Specialty Societies in Genito-urinary medicine should be used by Strategic Health Authorities in managing the performance of trusts.**

191. **We remain concerned that patient choice with regard to HIV and sexual health services will be limited should PCTs decide against paying for patients to use services outside the PCT area. We recommend that the Government, after consultation with commissioners and service providers, should issue further guidance and ensure funding arrangements which enable patients to access sexual health services away from their home PCT area if they wish, in line with the recommendations of the Monks Report.**

Services in Primary Care

192. Together with *Shifting the Balance of Power*, the *National Strategy for Sexual Health and HIV* also promotes devolution of some aspects of sexual health service delivery to primary care. The Public Health Minister told us:

> In the strategy we set out a level one, two and three hierarchy of services, and we envisage many more of certain of the level one services—the diagnosis, the interview, the partner chase, all of that—to be done in the primary care setting.[179]

193. The *Commissioning Toolkit* includes a section on improving support to primary care in its recommended checklists for commissioning. This contains a provision that the views of GPs should be taken into account on the introduction of a shared care scheme. However, while primary care, and General Practice in particular, might be a setting conducive to effective screening and management of long term conditions, sexual health has not hitherto been a

176 Department of Health, E*ffective commissioning of sexual health and HIV services: a sexual health and HIV Commissioning Toolkit for Primary Care Trusts and Local Authorities,* January, 2003

177 MEDFASH has been commissioned by the Department to develop recommended standards for sexual health services and to facilitate the development of sexual health networks.MEDFASH has already developed new standards for NHS HIV services, which are available to download.These standards will soon be finalised and published. See http://medfash.org.uk/publications.

178 *Effective Commissioning*, p.10

179 Q 1046

priority for primary care and in some areas primary care may lack the specialist expertise needed to deliver sexual health services.

194. The *Commissioning Toolkit* states that: "Anonymity and confidentiality are key indicators for successful access and uptake of services, and for respecting people's rights to dignity and privacy."[180] However, confidentiality in General Practice remains a worry for many patients with sexual health problems, and particularly with regard to HIV testing.

195. **We recognise that the delivery of some sexual health services through primary care has considerable potential in terms of access and continuity of care. However, we have not been assured that General Practitioners will receive sufficient training and support to deliver services effectively, nor that PCTs will provide sufficient encouragement to GPs to offer improved sexual health services. These may be matters which could be addressed through the new GP contract.**

180 *Commissioning Toolkit*, p.14

7 Family planning and abortion services

196. The *Strategy* describes unintended pregnancies and abortion as "a consequence of poor sexual health", and one of its five aims is to "reduce unintended pregnancies".[181] Unintended pregnancy is influenced by a wide range of social and behavioural factors, many which are difficult to map, measure and change. However, inadequate provision of NHS services, whether it be in terms of awkward location, inconvenient opening hours, insufficient choice of provider or method or long waits for appointments, may prevent people of all ages from accessing contraceptive advice and supplies, and therefore contribute to increased numbers of unintended pregnancies and thus abortions.

Current arrangements for commissioning and delivering

197. The provision of contraceptive services is currently divided between GPs, who provide approximately 80% of care, and specialist community family planning clinics, which provide the remaining 20%. According to Dr Connie Smith, Consultant in Family Planning and Reproductive Health Care and Co-Director, Westside Contraceptive Services, Westminster PCT, the current inequitable distribution of community contraceptive provision has developed from the legacy of the clinics taken into the NHS from the voluntary sector Family Planning Association in 1974:

> The development of community contraceptive services since then has been determined largely by the work of diverse local champions (including clinicians, service managers, public health physicians) and the interest (or otherwise) of local NHS commissioners. This has resulted in variations producing inequalities in the range, quality and accessibility of service provision across England. The pattern of services does not seem to reflect the pattern of need.[182]

198. Community family planning clinics are staffed by specialist doctors (usually consultants, staff-grade doctors or associate specialists) and nurses, and are funded directly from PCTs, who pay salaries according to sessions worked, as in a hospital clinic. Although GPs are not required to undergo mandatory training in contraceptive and reproductive health, they have strong financial incentives to provide contraceptive services regardless of ability and experience, as they receive fee-for-service payments each time they give contraceptive advice.

199. Termination of pregnancy services, where they are available on the NHS, are provided within the obstetrics and gynaecology units of acute hospitals, and women seeking a termination must be referred there either by their GP, or from a family planning clinic. Like community family planning services, NHS abortion services are also subject to significant variation throughout the country. It has been estimated that the percentage of abortions funded by the NHS varies between 46% and 96% in different health authorities. According to the Department, women can wait up to four or five weeks for an abortion in some parts of the country, and the British Pregnancy Advisory Service estimate that waiting times may in fact be up to six weeks in some cases. This can have particularly serious implications for pregnant teenagers, who tend to

181 *Strategy*, p 3; p 7

182 Ev 374

seek professional advice later than older women. The availability of medical abortion, which can be used early on in pregnancy and avoids the need for anaesthesia and surgery, also varies.

200. With regard to services surrounding unintended pregnancy, the three levels of care proposed by the *Strategy* will constitute the following:

Level 1 (for example GP practices)—pregnancy testing and referral; contraceptive information and services

Level 2 (for example primary care teams with a specialist interest in sexual health) – more complex contraceptive services, such as IUD insertion and implant insertion

Level 3 (specialist teams spanning more than one PCT, for example GUM clinics) – outreach contraception, highly specialised contraception, and abortion services.

201. The *Sexual Health Strategy Implementation Plan*, while promising service standards for treatment of HIV and other STIs and psychosexual problems, does not mention similar standards for contraceptive or abortion services. Instead, it says that "best practice guidance will be published for other sexual health services, including reproductive health services, and services provided in primary care settings."[183] The *Implementation Plan* does include a section on 'Improving Contraceptive Services', which lists the following measures:

- *Commissioning Toolkit* to provide advice on nurse-prescribing and on ensuring sufficient open-access provision
- Research on effectiveness of free or low-cost condom schemes
- Good practice guidance for pharmacists providing emergency contraception
- By 2006, NICE will have published guidelines on specific types of long-acting contraception.[184]

202. The *Commissioning Toolkit*, published by the Department in February 2003, devotes several pages to a comprehensive description of best practice in delivering contraceptive services, including ensuring a full choice of methods are available, and that contraceptive advice is complemented by easy referral for pregnancy testing, psychosexual problems, STIs, and immediate access to cervical screening. However, it is not clear whether these are standards for Level 1 or Level 2 service providers to aspire towards. Although the *Toolkit* specifies that there should be sufficient daytime and evening open-access contraceptive service provision, it does not give maximum waiting time targets, specifying only 'same day attendance'.

203. The *Strategy* states that abortion services should be developed to provide NHS-funded abortions in line with the Royal College of Obstetrics and Gynaecology guidelines, which recommend:

183 *The National Strategy for Sexual Health and HIV - Implementation action plan*, p 13
184 Ibid, p 14

- A central booking service allowing direct access to services
- Termination within three weeks
- Ideally, a choice of methods
- Counselling
- Prevention of infection strategy
- Contraceptive provision
- Follow-up.

204. Moreover, the *Strategy* specifies that from 2005, PCTs must ensure that women who meet the legal requirements have access to an abortion within three weeks of the first appointment with the GP or other referring doctor. The *Implementation Plan* contains a section on abortion focused solely on improving access and achieving the waiting time target set by the *Strategy*. No mention is given in the Standards section to clinical standards for abortion provision, although these guidelines have already been developed by the Royal College of Obstetricians and Gynaecologists.

What impact will the *Strategy* have?

205. Dr Kate Guthrie, Community Gynaecologist, Hull & East Riding Community NHS Trust described the current separation of contraceptive provision from GUM services as "a ridiculous divide",[185] and most of the other witnesses were supportive in theory of more joined up services. However, Anne Weyman, Chief Executive of the Family Planning Association (FPA), a voluntary organisation which provides advice and community family planning services, argued that the *Strategy* itself "is not always integrated across the different areas".[186] Dr Sarah Randall, a consultant in Contraception and Reproductive Health from St Mary's Hospital Portsmouth, also suggested that increasing the remit of community clinics to absorb more STI work in addition to contraceptive provision would increase workload in an unsustainable way, and that community specialists would require more time and funding to equip primary care for its new role in the *Strategy*. The FPA pointed out that although "the new tiered model outlined by the Strategy is designed to promote clarity and consistency for users and providers, the practical implementation presents problems". The FPA flagged up the need for standards at each level to be comprehensively outlined, as well as relationships between levels, and argued that the *Strategy* failed to take account of the many providers that had not yet acquired the range of services commensurate with Level 1. Our witnesses also identified several major problems related to the *Strategy* and its implementation.

Lack of priority given by the *Strategy* to contraception

206. The Public Health Minister told us that although "we want to try and reduce unintended pregnancies across the board" she made "no apology for focusing on teenage parents and young

185 Q194
186 Q138

people because the evidence is overwhelming that multi pregnancies in the very early years affect people's life chances right the way through." She went on to qualify this, saying:

> I think it is important, however, that older women as well in their 20s, 30s and 40s have access to really good contraceptive facilities. There is a need to make sure that people have the whole range of contraception—not just simply the contraceptive pill—and good advice about what is suitable for them. So I think contraception needs to be highlighted too.[187]

207. The *Strategy* claims that implementing the *NHS Plan*'s principles in the field of sexual health will mean "lower rates of unintended pregnancies".[188] However, the *Strategy* gives no detail at all on how the leap from the broad, service-wide reforms outlined in the *NHS Plan* to actually securing improved outcomes in unintended pregnancy rates, will be made. Indeed, the lack of specific actions, targets or guidance in this area emerged as a key concern in this inquiry. Although the *Commissioning Toolkit* devotes a section to describing elements of a best practice contraception service, doubts remain over whether or not this is likely to have any impact on the actual priority afforded to contraceptive services by PCTs. Dr Guthrie said that in her view contraceptive services were "progressively becoming the 'poor cousin' in terms of health care provision",[189] and this sentiment of exclusion and deprioritisation was echoed in the reactions of several other service providers to the *Strategy*:

> It is interesting that in the five aims which are noted in the *Strategy* the word contraception is not actually mentioned. Four of the aims are to do with HIV and STIs and one is to do with abortion. Contraception just seems to have disappeared.[190]

Lack of priority at a PCT level

208. While provision of specialist GUM and HIV/AIDS services at secondary and tertiary referral centres is generally accepted as an appropriate model of care, many specialist contraceptive providers feel threatened by what they regard as a widely-held view that specialist contraceptive clinics are not necessarily needed because GPs also provide contraceptive services.[191] Several memoranda from clinicians working in specialist community services suggest that their work is sometimes seen as a duplication of the services on offer by GPs, but all go on to point to the continuing importance of specialist community clinics, arguing that many GPs do not provide contraceptive services, and those that do may not have the expertise to offer a full range of methods. While GPs may be local and convenient for the majority of people, community clinics provide contraceptive services on an open-access basis, which reduces the bureaucracy that often attends registering with a GP and securing an appointment. Community clinics services are also of particular use for people not registered with a local GP, people whose GPs do not offer contraception, or who only offer a limited range, those with special difficulties in their use of contraception, and of course those who for personal or cultural reasons will not consult their GPs about such a potentially sensitive subject.

187 Q 112

188 *Strategy*, p13

189 Q172

190 Q139 (Dr Sarah Randall, Family Planning Specialist)

191 See eg Q145

209. Anne Weyman for the FPA told us:

> We had a lot of discussion at the last session of the Committee about the problems that are facing other areas of the service, particularly the treatment of sexually-transmitted infections. Contraceptive services are in exactly the same position and under the same pressures. They are often the soft option for cutting expenditure when there is a need to cut expenditure at the local level.[192]

210. In common with service providers in the fields of GUM and HIV/AIDS, providers of contraceptive and abortion services were also highly concerned about whether, without additional ringfenced funding or NSF status, the *Strategy* would really have "teeth".[193] Anne Weyman, speaking in her capacity as a PCT board member, argued that "the reality for the PCTs is that these issues are not high priority issues. Teenage pregnancy is on the list but the rest of it is not and there is the question of what is meant by sexual health."[194]

211. **According to the Government, the prevention of unplanned pregnancy by NHS contraception services probably saves the NHS over £2.5 billion a year already. Despite this, we have received compelling accounts of disinvestment in these vital services, and the fact that contraceptive services are not even included within the Strategy's five aims is further evidence of this creeping deprioritisation. We recommend that the Government takes immediate steps to rectify this priority imbalance.**

Access to services

212. Continuing demand for community family planning services is certainly evident from the concerns voiced by many witnesses from the family planning sector which have striking parallels with those put forward by GUM and HIV/AIDS service providers. Anne Weyman expressed her concern that contraceptive services were 'overloaded', and Dr Sarah Randall, reinforced this view:

> It has been a disaster in a lot of areas where clinics have closed. Those that have been left open have increased demands. Certainly around my area you have some clinics which are totally swamped. They have got perhaps four clinic [sessions] trying to deal with what was originally a week's worth of clinics foreshortened.[195]

213. Dr Randall also told us that while GUM services which are run on an appointment basis have this increased demand reflected by their increased waiting lists, in family planning services most are still run on a non-appointment drop-in basis, with staff simply having to stay until all the patients have been seen. This means that although services are stretched, instead of increases in demand being exposed by increased waiting lists, they are masked by staff goodwill.

214. Several of our witnesses expressed concern that access problems were likely to be compounded by an impending shortage of specialist consultants and senior medical staff in this area. Dr Randall argued that this may stem from the fact that, unlike GPs and GUM consultants, there is no clearly defined career path for doctors wishing to specialise in contraception and

192 Q 145
193 Qq 139–40
194 Q 218
195 Q 170

sexual health. Doctors who specialise in sexual and reproductive health are first required to follow a specialist training in general obstetrics and gynaecology. Historical workforce issues have resulted in a shortage of junior doctors in Obstetrics and Gynaecology, meaning that there are fewer trainees to divide between the five sub-specialties, of which sexual and reproductive health is one. Priority is obviously given to ensuring cover in high-intensity acute areas of the specialty such as labour wards, so most junior doctors in Obstetrics and Gynaecology do not get a chance to do community-based work in sexual and reproductive health. This has a knock-on effect on recruitment to senior posts, as fewer juniors are attracted to specialise in this area, having no previous experience in it. Disparities between sessional pay rates for GPs and specialist community doctors (GPs receive £130 for a three hour session while a clinic doctor is paid only £68) may be exacerbating difficulties with recruitment and retention.

Clinical quality and audit

215. Another concern raised with us is that although General Practitioners and their teams provide the majority of NHS contraceptive care, they are not required to undergo mandatory training in this area. The FPA points out that many GPs do not offer the full thirteen methods of contraception, or provide free condoms, and this is not always made clear to patients.[196] GPs are not required to undergo mandatory training in this area, but they have strong financial incentives to provide contraceptive services regardless of ability and experience, and they receive fee-for-service payments not related to quality. The FPA argued that this must be recognised and addressed in the new GP contract.

216. The problem of training was acknowledged by Dr Ford, a GP with a special interest in sexual health:

> Primary care cannot take on this role if there are not well supported specialist services to work in local and regional networks. We do not have a consistent training programme. As a medical student, I got no training around sexual health. I have done some obviously but it is not given emphasis in undergraduate and postgraduate training.[197]

217. **If General Practitioners are to deliver Level 1 and Level 2 services to a high standard, the Government must ensure that the GP contract addresses issues of quality in relation to provision of contraceptive and other sexual health services, as well as giving GPs incentives to undergo further training in this area. The Government should also work with the relevant bodies to ensure that sexual health is given appropriate emphasis both in undergraduate medical training and in postgraduate education for trainee GPs.**

218. **Many memoranda also point out that there is a serious shortage of national information currently available about the organisation and provision of contraceptive services. According to Dr Smith, a review of contraceptive services was carried out by the Department at a regional level ten years ago, but the results were never analysed or used to obtain a national picture due to lack of Department of Health capacity. Very little data are available about GP provision of contraceptive services. We recognise the importance of the collection of relevant**

196 The 13 methods of contraception that the FPA recommend should be available are the combined pill, the progestogen-only pill, contraceptive implants, contraceptive injections, interuterine devices, interuterine systems (which deliver a hormone locally), male condoms, female condoms, natural family planning methods, diaphragm, cap, sterilisation and emergency contraception.

197 Q 567

information for the planning and delivery of services. We therefore recommend that steps are taken to standardise information collection in the field of sexual health, both for specialist service providers and general practitioners.

Abortion services

219. While many witnesses and pro-choice lobby-groups have welcomed the inclusion of a measurable target to improve access to abortion services, the FPA argued that "the *Strategy*'s inclusion of a headline target to provide women with an abortion within three weeks of referral will only exacerbate problems caused by an increasing national shortage of consultants, access to GP referral, and inadequate information provision. Women's access is also obstructed by the over-bureaucratic procedure—services must be reformed to facilitate self-referral, and early abortions."[198] The FPA's proposed solution to this was a change in the law to allow an enhanced role for non-medical health professionals in abortion provision, and to allow more freedom in terms of the settings in which abortions may be carried out. The BPAS went further in arguing that the law should be fundamentally reformed to allow women access to abortion on request within the first 12 weeks of pregnancy.

220. **With improved access to better contraception services as part of the implementation of the *Strategy*, we would hope to see a reduction in the number of unwanted pregnancies, leading to a decrease in the use of the abortion service. For those women who do seek access to the service, we believe that certain improvements should be made. We recognise the difficulties that would beset attempts to reform current laws relating to abortion. However, we support the FPA's view that access targets are meaningless without attendant measures to cut through the bureaucracy surrounding referral for termination of pregnancy. We believe, therefore, that the Government should, within the current legal framework which includes the approval of two doctors, promote a model of open-access for termination of pregnancy, based within Level 3 services, and accessed through a national advice line.**

221. **We heard compelling evidence that for women who need to undergo an abortion, early medical abortion is a preferable option to surgery, as it carries significantly reduced risk of complications, and can be less distressing. The fact that early medical abortion does not involve any type of surgical process means that, with appropriate training and backup, it could be carried out by nurses rather than solely by doctors, and in community settings rather than solely in acute hospitals. However, at present early medical abortions constitute only a very small proportion of the total abortions carried out. We believe that allowing women access to early medical abortion in a wider range of healthcare settings would help reduce the number of late abortions which may occur as a result of long waits for surgery, and would also be a more cost-effective use of NHS resources. We therefore recommend that the Government should consider this option.**

198 Ev 31

8 Sexual dysfunction treatment and services

222. The *Strategy* has very little to say about sexual dysfunction. Under the chapter "Better services" there are two paragraphs devoted to "psychological and sexual problems". The Department pledges to develop "consistent standards of care to ensure that all ... sectors manage their patients appropriately". The Department also says it will encourage the development of training to allow a wide range of practitioners to recognise and assess sexual health problems such as impotence.[199]

Anti-impotence treatments

223. The debate on the priority that the Government attaches to sexual dysfunction intensified during the controversy over the charges for the new impotence drug sildenafil (whose trade name is Viagra). Sildenafil was one of the first drugs to bring the concept of rationing the provision of expensive treatments on the NHS to prominence. Following its launch in 1998, the Government, along with health service managers and doctors, feared that the NHS would be swamped by requests for the drug from otherwise healthy people wanting to improve their sex lives. Despite a High Court ruling in May 1999 against the Government's interim restrictions, access to sildenafil (and a range of other anti-impotence treatments) on the NHS has been limited under regulations which came into force in July 1999. Men who have been treated for prostate cancer or kidney failure, those with severe spinal injuries, diabetes, multiple sclerosis, spina bifida, polio, Parkinson's disease or single gene neurological disease are eligible for anti-impotence drugs. Men who are impotent through psychological causes, and whose impotence causes them "severe distress", are eligible only in exceptional circumstances, after a specialist assessment. The Impotence Association estimate that only 10% of the estimated 2.3 million men suffering from erectile dysfunction in the UK receive treatment for it. GPs can prescribe such drugs privately, but the cost to a patient of six Viagra tablets can be around £75.

224. The controversy surrounding the availability of sildenafil has greatly raised awareness of sexual dysfunction. However, grey areas persist over how far erectile dysfunction through psychological causes should be viewed as a medical problem. 'Recreational' use of the drug has been widely reported, and there is a thriving black market for the drug, particularly on the internet and in London bars and clubs.

225. We asked the Public Health Minister how she responded to a consultation that the Government had carried out in which 98% of those who responded had said that access to anti-impotence drugs should be widened. We also asked whether she had examined any research on the potential savings accruing in terms of a reduction in the costs of treating depression if such preparations were more widely available.

226. She acknowledged that this was "quite a difficult area of policy making when decisions were originally adopted ... we have certain circumstances in which the products are available but we take into account the priorities and pressures that are on the National Health Service and have

199 *Strategy*, p 28

made the decision accordingly."[200] She told us she was not aware of any cost-benefit analysis in this area of the type we had described.

Other issues of dysfunction

227. The controversy over sildenafil has perhaps served to mask the wider issues relating to sexual dysfunction. Dr Pat Munday felt this was a very serious problem. Her work had convinced her that:

> there is an enormous amount of sexual dysfunction which is under the surface and which we as clinicians in general practice and in GU medicine constantly see and we see the consequences of that. In women it is much more tenuous and difficult to identify because it tends to present with medico-organic type problems whereas in men it tends to present with pure erectile dysfunction ... It is because of the cost which attaches to erectile dysfunction that there has been some anxiety about it. But it is only a small part of the whole sexual dysfunction agenda.[201]

228. Jackie Rogers, a clinical nurse specialist in GUM, told us that sexual dysfunction therapy was very time consuming and expensive. Most therapists would see a patient for an hour and would have contact with them over a long period of time. While a few clinics had taken on therapists they were generally regarded as a "luxury".[202] Chris Ford confirmed that a therapist in a PCT adjoining hers had a year's waiting list, obliging her to muddle through with whatever advice she could give. If GUM services were the Cinderella of the NHS, then, in her view, services for sexual dysfunction represented "the Cinderella of Cinderella services".[203] The resources around dysfunction were "almost non-existent" in her area.

229. For the Department, Cathy Hamlyn, Head of Sexual Health and Substance Abuse, affirmed that the Action Plan contained a clear commitment to the development of psycho-sexual services, that include sexual dysfunction".[204] There is scant mention of sexual dysfunction in the *Strategy* and our evidence suggests that the Action Plan commitment is not yet a reality for those people suffering from serious sexual dysfunction.

230. **We fully accept that any Government has to balance competing priorities and pressures in respect of public expenditure. We do, however, find it indicative of the priority accorded to sexual health, and sexual dysfunction services in particular, that access to anti-impotence services and drugs is so restricted. Effectively, the Government is dealing with this more as a lifestyle issue than a health issue, and that seems to us to be wrong. It is simply not appropriate that so many men and women with a clear medical and psychological need are not having access to these treatments, leading to a situation where only those who can afford it are likely to use them. This seems to us contrary to the fundamental principles of the NHS. We therefore recommend that access to anti-impotence treatments should be reviewed. We also think it would be helpful if the Department commissioned research to establish the costs and benefits of a more liberal prescribing regime, given the likely savings which might accrue**

200 Q 1108
201 Q 619
202 Q 621
203 Q 621
204 Q 7

in areas such as the treatment of depression, infertility, and dealing with the consequences of marital breakdown. Given the lack of development of sexual dysfunction services, and the fact that social pressures are such that those suffering will often be shy and unwilling to articulate their case, we call on the Department to include sexual dysfunction within the wider sexual health strategy.

9 Prevention and sexual health promotion

231. There is no doubt that the prevention of sexual health problems, whether unintentional pregnancy or sexually transmitted infections, is a far preferable alternative to attempting to deal with their consequences. In addition to the short and long term physical and psychological morbidity (and mortality) associated with sexually transmitted infections and unintended pregnancies, the cost of treating these problems is very high, as the *Strategy* acknowledges:

> The prevention of unplanned pregnancy by NHS contraception services probably saves the NHS over £2.5 billion a year already. The average lifetime treatment costs for an HIV positive individual is calculated to be between £135,000 and £181,000 and the monetary value of preventing a single onward transmission is estimated to be somewhere between £0.5 and 1 million in terms of individual health benefits and treatment costs.[205]

232. Following its introductory aims and principles, the *National Strategy for Sexual Health and HIV* opens with a chapter devoted to 'Better Prevention'. Included under this heading are subsections on information for the public, HIV prevention, the role of mass media, the evidence base on prevention, and sexual health information for specific groups. Within this section, the Government pledges to:

- Develop a new safer sex information campaign for the general population.
- Ensure national helplines on HIV and safer sex are more responsive to people's information needs.
- Use the work commissioned from the Health Development Agency to provide an evidence base for local HIV/STI prevention.
- Exploit the wide range of media available for providing information on sexual health.
- Set a target to reduce the number of newly acquired HIV infections.
- Develop, with London health authorities and others, a strategic framework for HIV prevention for African communities.

233. The Government's proposed target is to reduce by 25% the number of newly acquired HIV infections and gonorrhoea infections by 2007. This is the only target included in the *Strategy* in respect of health promotion and prevention. Many of those giving evidence to us criticised the *Strategy* for presenting a 'medical model' of sexual health, overly focused on the detection and treatment of these problems rather than on their prevention and on more positive promotion of good sexual health. Nick Springham, Health Improvement and Commissioning Manager at Newcastle PCT, argued that "sex and sexuality need to be normalised. They are a fundamental part of what it is to be human. They are neither smutty nor dirty. They are not clinical issues but social issues."[206] Chris Ford, a North London GP, agreed:

205 *Strategy*, p 11

206 Ev 135

> One of the slight problems with the *Strategy* was that it was very much pushing a medical model rather than, "Sex is fun, most of us have it, it is a very positive experience", and that should be pushed in terms of education around sex, how to have good sex, and sexual health for all. If you look at every other European country, sex is regarded as normal and is talked about in a healthy, open way.[207]

234. The *Strategy*'s section on preventative services aims to cover a very broad and complex subject, but pays little attention to the practical difficulties of securing 'better prevention' in sexual health.

Getting the message across—a national information campaign

235. In the mid 1980s, the hard-hitting government 'Icebergs' campaign resulted in a leaflet on HIV and AIDS landing on the doormat of every household in the country. While our witnesses differed in their evaluations of the campaign's success, its reach and impact seem to have been large judging from the fact that it is clearly still well-remembered nearly twenty years on by those exposed to it. According to Professor Johnston, the campaign was a success, but its message has not been repeated, leading to an ebbing of public consciousness about these issues:

> In the late 1980s, we saw plummeting rates of gonorrhea and other infections in this country. That was a result of concerns about the AIDS epidemic in the early 1980s. During that time, we were experiencing major education campaigns targeted at those at greatest risk, primarily gay men in the early 1980s, but also more generally, in the general population ... However, with all prevention activity, this is not a one shot thing. You cannot just have a prevention campaign in the 1980s and think the problem has gone away. We have perhaps to some extent lost our focus in understanding that we have to continue these health education messages but change them in a way that is appropriate to the cultural attitudes and mores of the year 2000, not the year 1982.[208]

207 Q 554
208 Q 268

236. Data published by OFSTED support the theory of decreasing levels of awareness about HIV and AIDS amongst young people:

Changes in young people's perceptions of HIV and AIDS

Year	Proportion of young people 'concerned' or 'very concerned' about HIV/ AIDS (males aged 12-13)	Proportion of young people 'concerned' or 'very concerned' about HIV/ AIDS (females aged 12-13)	Proportion of young people 'concerned' or 'very concerned' about HIV/ AIDS (males aged 14-15)	Proportion of young people 'concerned' or 'very concerned' about HIV/ AIDS (females aged 14-15)
1993	20%	23%	27%	34%
1994	19%	22%	21%	29%
1995	16%	18%	21%	27%
1996	14%	17%	19%	25%
1997	8%	10%	13%	17%
1998	9%	10%	12%	13%
1999	8%	10%	8%	12%
2000	10%	14%	12%	16%

Data source: Schools Health Education

Evidence-based practice

237. As Professor Johnson pointed out, we are living in a changing society, and "prevention messages need to be as up-to-date with the epidemiology as vaccines are up-to-date with the technology"[209]. The national information campaign promised by the *Strategy* came to fruition in Autumn 2002, with the launch of the 'Sex Lottery' campaign aimed primarily at the 18-30 age group. It is too early to attempt to evaluate the campaign's success, but responses from our witnesses were generally positive. The Health Development Agency (HDA) has a key role in reviewing evidence on sexual health promotion and prevention initiatives, and working with the Department to disseminate information to professionals, including examples of best practice, aims we support wholeheartedly. However, the HDA is amongst many to argue that "the strategy seems to place a greater emphasis on the absence of disease than on the promotion of well-being", and that "more attention needs to be paid to the role of sexual health promotion".[210] The HDA also recommended that, as part of the drive to reduce inequalities in sexual health, the Government needs to work with other departments to ensure consistent cross-government policy, in, for example, allowing access to condoms in prisons.[211]

238. The HDA's written evidence gave interesting interim positions on the three pieces of work they are currently carrying out regarding best practice in prevention of teenage pregnancy, STI

209 Q 313
210 Ev 119
211 Ibid.

prevention, and HIV prevention.[212] The HDA also identified considerable gaps in the sexual health promotion evidence base:

> The review-level evidence tells us nothing regarding the effectiveness of HIV prevention interventions targeting African communities or people with HIV, both priority populations for the UK. We also know very little about the impact of socio-political actions on the wider determinants of sexual risk behaviour – for instance about how attitudes towards gay men can affect their self-esteem and in turn their sexual behaviour; or how discrimination affects access to services … We also know very little about the relative impact of interventions according to socio-economic status, and how to reduce inequalities in sexual health.[213]

The wider impact of health promotion

239. As well as actually getting information across, experts argue that there is real value in national campaigns such as those detailed above in that they serve to 'legitimise' further efforts at a local level:

> If you are a head teacher and you want to decide whether to put a condom machine in your school, the fact that there is a government ad currently running on condom use may just make you feel that your efforts may be legitimate. If you run a garage and are wondering whether to put condoms on the counter, the fact that the government is currently running a condom campaign in magazines or on the radio might make you feel that your efforts are legitimate. We must not forget the legitimating effect of mass media campaigns.[214]

240. However, according to some of our witnesses, including Dr Sarah Randall, a family planning specialist from Portsmouth, there is still a long way to go in terms of normalising sex and sexual health:

> There was a campaign some time ago about trying to advertise emergency contraception, a concept where you might have little stickers in public conveniences for that. An awful lot of district councils said 'Oh, no, we cannot have that'. It is all back to this business that we cannot talk about sex openly, sex does not happen.[215]

241. As pointed out by the Sex Education Forum, information alone is not enough to change behaviour patterns: "The acquisition of knowledge about contraception is of limited or little use to a young person without education which helps them to develop the social and personal skills to obtain contraceptives, negotiate their use with a partner and use them properly."[216] In the view of Nick Springham, factual information needed to be linked to accessible services, and to be supported by practical help in accessing those services and resources, as well as help in improving confidence, assertiveness and negotiating skills:

212 Ev 120-22

213 Ev 122

214 Q 453 (Kaye Wellings)

215 Q157

216 Ev 125

> People also need the skills to be able to use that information and the understanding to be able to use that information. To just tell people, "Don't do this or do that or do the other" we know that is an important first step but not very effective. Most people in this country know that smoking is bad for you but we know there are a lot of people who continue to smoke. The skills around sexual health could be having the assertiveness to be able to make the choices that they want to make, whether that is saying "no" or whether that is saying "yes but" or "yes if".[217]

242. Many of our witnesses agreed that this sort of sexual health promotion should be an integral part of every child's school education, but although much good work has been set in train by the Government's Teenage Pregnancy Strategy, this subject is conspicuously absent from the *Strategy*. The subject of sex education for young people is discussed in more detail in the next section.

243. **Sexual health promotion offers a long term solution to many of the sexual health problems which challenge society. It is clear from the evidence we have received that awareness-raising activity and information campaigns are important but they will not on their own bring about sustained behaviour change, particularly amongst those marginalised individuals, groups and communities most vulnerable to HIV and other sexually transmitted infections. We recognise the importance of targeted community–based initiatives, peer education programmes and outreach work and would urge PCTs to ensure these range of interventions are a central part of local HIV prevention and sexual health promotion programmes.**

Securing the status and position of health

244. Preventative measures and health promotion services intuitively appear particularly well-suited to being driven by primary care services, which are uniquely well-placed to tailor preventative interventions closely to local health needs. However, the recent reconfiguration of the NHS seems to have raised considerable anxiety about whether, without a National Service Framework, PCTs will retain the expertise and the motivation to give sufficient priority and investment to preventative services in the area of sexual health. We are concerned that many professionals argued that the only way to get sexual health services improved was through a National Service Framework. Given the public health and cost benefit aspects of sexual health we would expect professionals, trusts and PCTs to be able to provide adequate sexual health and sexual health promotion facilities without further central directives. We are having in this Report to recommend such further central directives but feel that the Department should try to learn why this group of patients has not been properly served by many local NHS services.

245. Historically, responsibility for sexual health promotion and preventative measures at a local level has rested within the public health function of local health authorities, and was usually funded through spending allocations ringfenced for HIV prevention. The implementation of the Teenage Pregnancy Strategy, led by local co-ordinators working across health and social services, was also funded separately. Responsibility for the commissioning and organisation of health promotion and public health services has now shifted to PCTs, with the role of new Strategic Health Authorities still little-understood. All PCTs have a Director of Public Health, but not all

217 Q 422

have the resources or expertise to establish dedicated sexual health promotion teams, and with the transition from 95 Health Authorities to 303 PCTs, there are considerable worries about dilution of expertise, as voiced by Nick Springham, Health Improvement and Commissioning Manager at Newcastle PCT:

> Newcastle and North Tyneside are now two separate PCT's, having been previously a single Health Authority District. However, we have maintained one Health Promotion Department working across the two PCT areas. This service is currently hosted by Newcastle PCT. There was some discussion about splitting the service in two, in order to better serve the individual PCT areas. However, it was felt that if this were to happen, expertise developed across Newcastle and North Tyneside would be lost to one or other of the PCTs. Consequently, we have maintained the service across the districts. This is working well, but I have concerns that in some areas in the country a valuable and scare resource has been watered down by the fragmentation of the old Health Authority-wide Health Promotion services into separate PCTs.[218]

246. Eve Asante-Mensah, Chair of North Manchester PCT, supported this concern:

> As health authorities were dis-established a lot of staff were displaced and did not come into PCTs and they have left with an awful lot of experience and history about both sexual health and HIV promotion and prevention particularly. As a PCT, or Central Manchester Primary Care Trust, we have had quite a deficit in terms of commissioning sexual health, we have not had the experience and the expertise there.[219]

247. The main changes proposed to the delivery of sexual health services set out in the *Strategy* consist of their reorganisation into a three-level model. The only place prevention services are explicitly mentioned in this model is at level three (specialist service provision) which may include outreach STI prevention services. Although contraceptive services are available at both level one and level two, very little specific guidance is given on providing services which help prevent as well as deal with unintended pregnancies and STIs.

248. In terms of commissioning, again the *Strategy* focuses almost exclusively on the commissioning of services to detect and treat sexual health problems rather than to promote sexual health and prevent problems arising in the first place. Mr Springham argued:

> It is most important that [the *Commissioning Toolkit*] gives clear guidance on the importance of commissioning sexual health promotion services. Pressure to achieve clinical targets might result in sexual health promotion being marginalised. Fighting for funds to work 'upstream' is difficult at the best of times. The *Toolkit* needs to set out the importance of this area of work, with clear standards. Many commission managers do not necessarily have the background and experience in the field. They are often more experienced in commissioning clinical services rather than community support, education and health promotion activities.[220]

249. The *Commissioning Toolkit* acknowledges the unique difficulties faced by commissioners trying to balance demands for diagnostic and treatment services against their own responsibility

218 Ev 133
219 Q 406
220 Ev 135

for public health and preventative interventions, and to this end promises a dedicated health promotion toolkit "aiming to inform commissioners of a wide selection of comprehensive evidence based health promotion methods and good practice."[221]

250. **We welcome the Department of Health's efforts to produce and disseminate a health promotion toolkit to support commissioners. In relation to sexual health, this should specify that all those providing services in any area of sexual health, including GPs, GUM clinics, family planning clinics, and termination of pregnancy services, should provide a full sexual health risk assessment and sexual health promotion advice to all patients, as clinically appropriate. We feel that health promotion services in the field of sexual health are absolutely vital, but are also one of the services most at risk of being marginalised and deprioritised, given that demand for preventative services is never articulated as vociferously by patients as demand for treatment, and that targeted funding which has been available over the past decade has been subsumed into mainstream allocations. There is a compelling rationale for continued investment in health promotion and prevention. If a healthier nation is to be created, sexual health promotion needs the support and capacity to make a difference. Resources need to be identified to maintain specialist health promotion services, which provide training and advice to health professionals and lead on community-based initiatives with target groups. PCTs should be held to account for the commissioning of targeted HIV prevention and sexual health promotion, both in terms of resource input and effectiveness measures.**

221 *Commissioning Toolkit*, p 36

10 Relationships and sex education

251. The Social Exclusion Unit's 1999 report on teenage pregnancy gave a resonant description of the mixed messages which besiege young people growing up today:

> As one teenager put it to the Unit, it sometimes seems as if sex is compulsory but contraception is illegal. One part of the adult world bombards teenagers with sexually explicit messages and an implicit message that sexual activity is the norm. Another part, including many parents and most public institutions, is at best embarrassed and at worst silent, hoping that if sex isn't talked about, it won't happen. The net result is not less sex, but less protected sex.[222]

252. This is not merely conjecture – NATSAL shows that only 50% of young people used a condom the first time they had sex. As well as impacting upon rates of teenage pregnancy, less protected sex is also, as the statistics show, having a dramatic impact on sexually transmitted infections amongst young people. Given the obvious and specific need in this part of the population, we were surprised that although the *Strategy* does identify "young people, and particularly those leaving care" as a group in need of specific and targeted information, it makes no reference to sex and relationships education in schools[223], and does little to exploit the considerable progress in this area following the launch of the Teenage Pregnancy Strategy.

253. With the NATSAL showing that young people are becoming sexually active at an earlier age, it has never been more crucial to ensure that they are properly equipped with the information and skills they need to negotiate the highly sexualised adult world that confronts them, and schools should be an important part of this education. However, the practice of school-based sex education is far more complex than the well intentioned principle. How should sex education be delivered and by whom? At what age should it begin, and how should it be weighed against other pressing educational priorities? Most crucially, perhaps, what information, skills and messages need to be conveyed? Although there are few immediate solutions, the evidence we have taken from teachers, educationalists, and, most importantly of all, from young people, has identified serious shortcomings in this area.

What do young people know about sex and sexual health?

254. Dr Chris Ford, a North London GP with a special interest in sexual health, described her amazement at the lack of knowledge about sexual health displayed by young people, despite their being both sexually active and in contact with health services:

> The number of young people I see who have never heard of chlamydia and who go to wherever and get contraception; they get the contraceptive pill but no information is given to them on how to stay sexually healthy and what problems they might get into.[224]

222 *Teenage Pregnancy*, Social Exclusion Unit, *1999*, p 7

223 We have reluctantly stuck to the term "sex and relationships education" in this section where our witnesses or others have used that term. In our view, the term "relationships and sex education" would be preferable, in that it accords appropriate priority in the sequence to relationships over sex and we use that term elsewhere.

224 Q 545

255. Research evidence supports this. In a survey conducted by the HEA, over a quarter of 4,000 14 to 15 year olds surveyed thought that the pill protected against STIs.[225]

256. Nor was young people's lack of knowledge limited to the relatively complex subject of sexually transmitted infections; it extended even to a lack of knowledge of the basic facts of life. Gemma Minty, a 16-year-old from Wigan and a member of the Wigan Borough-wide Youth Council, gave a telling example:

> A few weeks ago, one of my friends told me that her little sister became involved in foreplay and, after that, she came running into her room crying her eyes out thinking that she was pregnant. To say that she was a 14–15 year old girl, it is pretty ridiculous that she did not know the basic facts around sex, foreplay and things like that.[226]

257. One in ten of the 13-16 year old girls taking part in a survey organised by the Health Promotion Research Trust had not had any information about periods prior to the onset of menstruation.[227]

Is relationships and sex education necessary or appropriate?

258. Some recent research has argued that providing young people with information about sex actually encourages early and potentially unsafe behaviour in children and young people who would not otherwise have considered it.[228] This idea has been seized upon enthusiastically by the UK tabloid media (although it seems not to have reduced the focus on sex prevalent elsewhere in their pages). In theory, an increased awareness of sex might serve to normalise the idea of sexual activity way before most young people would have engaged in it. According to OFSTED, there may already be inaccurate perceptions amongst young people about levels of sexuality, perpetuated by the fact that in much of the media directed towards young people, "the underlying, but inaccurate, message is sometimes seen to be that all young people are sexually active," despite the fact that only one third of young people in the UK have sex before they are 16.

259. While it did not go as far as blaming it for the current poor state of young people's sexual health, the Family Education Trust argued that sex education, however good, could only have an impact "at the margins". Robert Whelan, the Trust's Director, told us:

> In the present debate about sexual health and teenage pregnancy much too much weight is being attached to what can be achieved by sex education ... it cannot begin to compare with the influence of the media, advertising, Internet, peer pressure ... I do not think there is a magic programme for sex education that we can devise that is going to solve the huge cultural problems we are facing, which are the sexualisation of the culture and the increasing pressure on young people to be sexually active at early ages.[229]

225 *Teenage Pregnancy*, p 37

226 Q 952

227 S Prendergast, *This is the time to grow up; Girls' experiences of menstruation in school*, Health Promotion Research Trust, 1992; *Young People and Health*, Health Education Authority, 1999

228 Prof Paton et al, *Journal of Health Economics*, 4 March 2002

229 Qq 762, 781

260. The Family Education Trust also told us that they felt that today's sexual health problems could not be attributed to lack of knowledge amongst young people, arguing that:

> Young people are not getting pregnant because they think that babies are delivered by Mr Stork under the gooseberry bush. People have a pretty good idea now of the processes you have to go through to produce a baby.[230]

261. However, no research has borne out the theory that educating young people about sex encourages earlier sexual activity. In fact most research to date actually shows that high quality sex education can delay rather than bring forward the age of first intercourse and, when linked to access to contraceptive services, can help to prevent negative health outcomes such as unintended pregnancy [231] In addition to this, recent research has also shown that sex education programmes can improve young people's knowledge about sexual health and relationships, increase their personal and social skills, and can have a positive impact on the quality of their relationships, as well as increase advice and information seeking from friends, parents and other sources.[232]

262. The Family Education Trust are among many who argue that young people should be given a clear message to delay sex and, if they are already sexually active, to abstain. It is generally assumed that the later the age at which young people begin to have sex, the more careful and responsible they are likely to be, therefore reducing the likelihood of adverse sexual health outcomes, such as unwanted pregnancy or STIs. Dr Stammers argued:

> Clearly the younger a teenager is the more difficult it is for them to use contraception appropriately ... when you are 14 there is not usually the emotional maturity to negotiate in the heat of the moment the putting into practice of the rules that you may already know.

263. The assertion that older teenagers may be able to look after their sexual health more effectively is supported by some international statistics—for example, according to research carried out by Durex in 2001, Netherlands, which has the lowest rate of teenage pregnancy in Europe, also has a later average age of first sexual intercourse than England (17.2 years as opposed to 16 years in England). According to data cited in the Teenage Pregnancy Strategy, the Netherlands also has a correspondingly high rate of reported condom use at first sexual intercourse (85%, as opposed to 50% in England).[233]

264. The United States has the highest teenage pregnancy rate amongst the industrialised nations, and rising rates of STIs amongst young people, and has invested very heavily in recent years in campaigns specifically aimed at promoting abstinence amongst young people as a means of tackling these problems. In its memorandum, the Family Education Trust argued that:

> The most realistic approach to reducing the spread of STIs amongst young people is to encourage the postponement of the onset of sexual relationships, or their discontinuation if they have already begun at a young age. We regret that the Government's national

230 Q 790

231 *Effective Health Care Bulletin,* Centre for Review and Dissemination (CRD), York 1997

232 DiCenso et al, "Interventions to reduce unintended pregnancies among adolescents: systematic review of randomised controlled trials", *BMJ* 2002;324:1426.

233 Teenage Pregnancy, Social Exclusion Unit, 1999, Table 1, p 29

> strategy for sexual health and HIV and its teenage pregnancy strategy appear to attach little or no importance to this[234].

265. Dr Stammers told us that in his view, young people's "sexual desires develop much earlier than sometimes the ability to restrain them without appropriate help". However, Gill Frances of the National Children's Bureau argued strongly that rather than delivering a single 'top-down' message to them to abstain, those trying to influence young people's behaviour must demonstrate a genuine commitment to work with them:

> It is not about telling them ... it is about whoever is going to deliver the sex education, whether it be parents or carers or social workers or teachers, actually engaging with young people and saying "What do you want?" It is about consulting with them and getting young people to participate.[235]

266. A recent systematic review of interventions to reduce unintended pregnancies amongst adolescents has in fact found that the programmes which primarily aimed to promote abstinence from sex until marriage either had no effect or negative outcomes including, in one case, increasing the numbers of pregnancies to the sexual partners of young men who received the programme.[236]

267. **Our evidence from young people, which we discuss more fully below, suggests that even basic factual knowledge about sex and sexual health cannot be assumed, and we believe that providing young people with accurate and appropriate information through school relationships and sex education programmes is an essential building block for securing improved sexual health both for this and for future generations. We see no benefit in preventative approaches based primarily around promoting abstinence. However, the fact that many young people who have not had sex believe they are in a minority, and equally that a significant proportion of them regret their first sexual experience, suggests that they would benefit from more support in deciding when is the right time for them in respect of the management of relationships, and support to resist external pressures to have sex, which is why we firmly support the location of sex education within the broader emotional and social framework of sex and relationships education (SRE).**

Best practice in relationships and sex education

268. The Sex Education Forum, an umbrella organisation researching and promoting best practice in sex and relationships education which is based at the National Children's Bureau, describes sex and relationships education as having three interdependent components – the acquisition of information, the development of skills and the formation of positive beliefs, values and attitudes. As described above, the acquisition of knowledge about contraception is of limited or little use to a young person without education which helps them to develop the social and personal skills to obtain contraceptives, negotiate their use with a partner and use them properly. The Sex Education Forum defines the purpose of sex and relationships education as supporting

234 Ev 234

235 Q 788

236 "Interventions to reduce unintended pregnancies among adolescents: systematic review of randomised controlled trials", DiCenso et al, BMJ 2002;324:1426.

children and young people in managing adolescence and preparing them for adult life in which they can:

- Develop positive values and a moral framework that will guide their decisions, judgements and behaviour.
- Have the confidence and self-esteem to value themselves and others.
- Behave responsibly within sexual and personal relationships.
- Communicate effectively.
- Have sufficient information and skills to protect themselves and their partner from unintended/unwanted conceptions, sexually transmitted infections including HIV.
- Neither exploit nor be exploited.
- Access confidential advice and support.

269. According to the Sex Education Forum, besides information, children and young people need to learn about and to practise personal and social skills which will help them to develop and maintain relationships, to take responsibility for their own and other's sexual health, to access support and help and to make informed choices and decisions regarding their sexual health and emotional well-being. These life skills include managing emotions and relationships confidently and effectively, developing independence in thought and action and defending values as well as decision-making and skills for negotiating with friends and partners.[237]

270. But how far does what is currently provided in schools live up to this ideal and, more importantly, how far does it meet the actual needs of young people?

Relationships and sex education in 2003

271. The basic biology of sex and relationship education has a statutory framework as part of the science element of the National Curriculum. By Key Stage 3 (ages 11 to 14), a child should have learnt about how babies are made, and the changes that they will go through at puberty. By Key Stage 4 (ages14 to16), a young teenager should have learnt in more detail about the process of conception, and how hormonal methods of contraception such as the pill work to prevent it. The theory of some sexually transmitted infections should also be referred to as young people learn, as part of the National Curriculum in science, about viruses and how they are transmitted, although it is not clear to us that the connection between viruses and STIs is clearly made in schools.

272. These basic biological facts appear as isolated elements of sexual health which are covered in passing. These, along with the many other issues of relevance to sexual health, including the social and emotional aspects of sexual relationships, are intended to be interwoven within a dedicated framework of 'Sex and Relationships Education' (SRE), which sits within the Personal Social and Health Education (PSHE) curriculum. Guidance on SRE was issued by the DfES in

237 Ev 226

2000.[238] This guidance specifies that at primary school, children should be taught about puberty and menstruation, and at secondary school about contraception, abortion, and STIs including HIV and AIDS, all against a backdrop of education about relationships. It also contains useful sections about involving parents, and using peers, health workers and other professionals to help deliver SRE.

273. However, beyond the very broad distinction between primary (age 5-11) and secondary (age 11-16) education, the guidance does not specify at what ages children should receive different elements of SRE. This guidance is not statutory, as SRE beyond what is covered in science is not part of the national curriculum. This means that the Board of Governors have considerable discretion as to how it is implemented in individual schools. SRE may be covered within a school's OFSTED inspection, but in practice this may mean no more than checking the school's policy or discussing it with a teacher.

274. A recent inspection of the provision of SRE by the Office for Standards in Education (OFSTED) demonstrated that provision in this area is still patchy and inconsistent and highlighted the need for development of provision which deals with relationships, emotional issues and the development of young people's social and personal skills.[239] Amongst the particular reasons identified for this are:

- The weak position of PSHE and Citizenship in the school curriculum.
- Weaknesses in initial and in-service teacher training, and a lack of development of specialist teams of teachers for sex and relationships education.
- The absence of clear learning objectives for sex and relationships education and subsequently poor monitoring of provision and assessment of pupils' learning.
- Weaknesses in consultation processes with parents and pupils which may undermine teachers' confidence about teaching about sex and relationships particularly in relation to subjects and issues which are perceived to be sensitive.

275. **In view of the clear inadequacy of provision relating to the context in which sexual behaviour takes place, we feel that a much greater emphasis on the importance of handling relationships would contribute to an improvement in sexual health. We therefore recommend that DfES give further consideration to whether existing guidance on the relationships aspect of SRE emphasises sufficiently the importance of this area.**

Does this assessment match with that of current and recent school pupils?

276. Asked to award a grade to the sex education they had received in school, three young people from the Wigan Borough-Wide Youth Council gave their schools 3/10, 5/10, and 1/10.[240] Natalie Stuart, a 17-year-old from the Swindon area, described how sex education was swamped in the wider PSHE curriculum: "We did PSHE and that was mainly about drugs. I can just remember doing drugs all the time; I cannot actually remember much about sex." Sex and relationships

238 *Sex and Relationships Education Guidance*, Department for Education and Skills, July 2000

239 *Sex and Relationships Education in schools*, OFSTED, April 2002

240 Q 985, Q 987

education also needs to be engaging and relevant for young people, rather than the "couple of out-of-date videos from about ten years ago" described by Lorna Webley, and Tara Hall, two 16-year-olds from Wakefield.[241]

277. The first results from the Teenage Pregnancy Strategy evaluation reveal that over 90% of young men and women surveyed reported receiving SRE at school. Two thirds had fewer than 10 lessons. Whilst the young people indicated general satisfaction with the quality of education about sex and risk reduction they were less satisfied with advice or coverage in respect of sexual feelings, emotions and relationships.

278. Young people are interested in sex and will pick up information from other sources if it is not available in schools. Natalie Stuart told us that for her, information about STIs came from an FPA booklet passed on by friends: "It was called Love Stings and it is about someone who went to a party and he had sex with a girl and then he ended up getting something and he had to go and have a test, and that always stuck with me."[242] However, not all experiences involve such reliable sources of information. Sarah Nicholls told us that she got most of her sex education from her peer group, "word of mouth from friends."[243] Emma Henderson, a member of the National Youth Parliament, who has carried out research in Buckinghamshire, argued that "one of the things that has come through is that most people get their information from friends in school or magazines".[244] The same piece of research indicated that up to 92.6% of young people in Buckinghamshire did not know of any agencies where they could seek support or advice about sexual health issues. The Wakefield Peer Research project had similar findings, and as a result recommended that contact numbers for sexual health services should be included in every young person's school planner.[245]

279. Young people are also keen to obtain sexual health information through new media which they use every day. Another of the Wakefield group's findings was that large numbers of young people favoured a text message service for sexual health: "One young lad said, 'I can text to see how my football team is doing, so why can't I text to get advice on sex?'". However, we also heard that the internet, around which many sexual health services for young people are based, is not proving as useful as it could be, because young people cannot guarantee privacy at home, and find that computers in schools and colleges will not let them access any website with the word 'sex' in its content. We put this problem to Stephen Twigg MP, the Parliamentary Under Secretary of State for Young People and Learning, Department for Education and Skills (DfES), who told us that "Schools should consider the appropriateness of any filtering process they apply. Most do recognise that a blanket approach to filtering on websites which contain words such as sex might mean that some educational sites are filtered out".[246]

280. New technology can also help young people to learn about sexual health and the consequences of unprotected sex in a much more practical way than textbooks or lectures. Anna Eagle and Natalie Stuart, two teenage mums from the Swindon area, told the Committee how prior to the birth of their babies they had had the opportunity to learn from 'electronic babies',

241 Q 834
242 Q 994
243 Q 832
244 Q 846
245 Q 859
246 Ev 418

dolls which are programmed to cry at certain times to simulate the demands of a new born baby. Both young women (and the partner of one of the women) felt that they learned a lot from the experience, and felt it would have been helpful to have had access to this at school before they became pregnant.

281. **We recommend that the Department for Education and Skills and the Department of Health work together to compile a resource for schools detailing websites with high-quality information on sexual health which should be exempted from any filters schools may apply to their I.T. systems. DfES should also consider making 'electronic babies' more widely available in schools. The possibility of a text-messaging advice service should also be investigated.**

Lack of priority

282. We have heard strong evidence that sex education in schools is frequently starved of time and resources in order to accommodate subjects which are accorded a higher priority by schools because of their National Curriculum status. The Manchester Young People's Council described SRE lessons which were essentially used as 'free periods' in which to complete coursework. Sarah Nicholls also described sex and relationships education as being squeezed into the timetable, rather than having a place in its own right, and the negative consequences of this lack of priority:

> I can only remember having, like, three sex education lessons and we did not really get anything done because it was, "Oh, we're having sex education instead of geography", so everyone was saying, "Hooray!", and nothing ever got done unfortunately.[247]

283. The Sex Education Forum felt very strongly on this issue, arguing that "PHSE cannot go any further unless it is statutory ... unless you make it statutory it is going to be patchy, inconsistent and equivalent to a postcode lottery".[248] Lindsay Abbott, a deputy headteacher from Slough, was equally unequivocal in her support for the inclusion of SRE as part of the National Curriculum.[249]

284. We found that Stephen Twigg MP agreed with our other witnesses on the subject of priority: "I do not get a sense mostly that there is any resistance to [teaching SRE] in schools. It is often that it is not given sufficient priority, but schools do want to do their best."[250]

285. This issue was flagged up by the Independent Advisory Group on Teenage Pregnancy, a group set up by the Department to oversee the implementation of the Teenage Pregnancy Strategy. The First Report of the Group recommended in 2001 that SRE should become part of the National Curriculum. However, although we learned that another element of PHSE, Citizenship, has recently been introduced as part of the core National Curriculum,[251] Mr Twigg told us that his department were "very sceptical" about extending National Curriculum status to SRE, as "the whole direction of policy in terms of the national curriculum ... is away from compulsory elements in secondary."[252] Mr Twigg went on to argue that in future "loosening the

247 Q 835
248 Q 461
249 Q 482
250 Q 1122
251 Q 1139
252 Q 1132

school curriculum might give more scope within school timetable" for SRE. We are not, however, convinced that this will afford SRE the priority it needs.[253]

286. **We strongly recommend that SRE becomes a core part of the National Curriculum, to be delivered within the broader framework of PSHE along with citizenship. We want to see education on relationships and sex given a high priority since the short and long term consequences of poor sexual health for young people, including unplanned pregnancy and parenthood as well as disease, can be so serious.**

Lack of experienced teachers

287. Currently, SRE lessons are given by teachers whose expertise lies in an entirely different subject. Delivering SRE requires a fairly large specialist knowledge base, without which it is impossible to meet pupils' needs, as David Morris from Wigan described:

> When you saw a video, it would give you brief details about sex education and things, but if you had any questions, the teacher did not have the experience or the training to answer the questions, so you never knew.[254]

288. Teachers also need the skill to lead children and young people of all ages through what can be highly sensitive, emotive and confusing issues, where a teacher's ability to discuss things confidently and without embarrassment is paramount:

> I can remember things like, we would be sat in there and the teacher would explain about a certain thing and then a boy would shout out, "Oh, yeah, you know all about that", or something like that, and you are all blocked off then. You do not want to know any more. You do not want to say anything. You feel embarrassed.[255]

289. To young people, the problem with lack of expertise seems obvious. As Erica Buist put it:

> We have English teachers to teach English, but we do not have sex education teachers to teach sex education, yet surely that has a bigger impact on our lives, so it is really not doing the job properly to have an English or geography teacher teaching sex education.[256]

290. Although there is an increasing amount of high quality guidance on SRE available for teachers, this is unlikely to equip them with the skills they need. This is clearly as acute a problem for teachers as it is for pupils. Lindsay Abbott described an ongoing battle to encourage teachers at her school to embrace SRE, resulting in slow but definite progress: "they feel a bit more comfortable in the classroom now about teaching it ... they come out of the lesson saying 'I did not go quite so red today, or 'it was a lot better today.'"[257]

291. However, expecting unqualified and possibly unwilling teachers to tackle such complex and sensitive issues without adequate training and support, is, as Gill Frances put it, "unfair on the children and deeply unfair on the teachers", and will undoubtedly have a negative impact on

253 Q 1124

254 Q 835

255 Q 1024 (Natalie Stuart)

256 Q 880

257 Q 480

morale as well as standards within schools.[258] The DfES is currently piloting an SRE accreditation scheme aimed at teachers with SRE responsibilities who are in their third to fifth year of practice. However, SRE is not currently covered by initial teacher training, reinforcing the impression that it is simply an add-on rather than an integral part of every young person's education. Stephen Twigg MP agreed with us that if SRE were to become compulsory, then this would probably lead to better initial training in teacher training colleges.[259]

292. **While investing SRE with National Curriculum status will improve its standing, we believe that the key to improving educational standards in SRE lies in providing each school with well-trained, capable and enthusiastic SRE teachers. We recommend that the Department for Education and Skills reviews the way in which teachers are trained and SRE is managed in schools, ensuring that SRE is taught by teachers with specialist knowledge and expertise in the subject. We recognise the difficulties of scale that might attend ensuring that each primary and secondary school has a dedicated SRE teacher, but we believe that these logistical difficulties could be overcome through creative local arrangements, such as pooling a teacher or teachers across a consortium of schools within a local authority. DfES should also ensure that schools have access to, and make good use of, support from a range of individuals and agencies—such as nurses, GPs, health promotion specialists, peer educators and youth workers—when planning and teaching SRE.**

The wrong focus

293. Many of the young people who gave evidence to us also felt that they and their peers were not receiving important messages about sexual health. A common problem not addressed by sex education was that for many young women, concern about pregnancy takes precedence over concern about STIs:

> A number of people are aware of the pill and think that, if you are on the pill, you are protected against STIs. They are taking the pill for absolutely ages thinking they are fine and they may not be. They just do not know enough about it.[260]

294. Sarah Nicholls described a similar lack of emphasis given to the most common STIs amongst young people:

> I remember the only lesson we had on sexual health, there was nothing about chlamydia or syphilis or anything like that, but it was a leaflet passed around the class about AIDS and HIV which then got taken back to the form teacher at the end of the lesson to use in next week's lesson with a different group.[261]

295. Homosexuality is another key issue that many young people felt was not receiving adequate coverage, a problem ascribed by Jay Bailey, a 16 year old student from Wigan, to the ramifications of Section 28 of the Local Government Act 1988. Although Stephen Twigg was very clear that Section 28 did not constitute a bar to teaching young people about homosexuality, Lindsay Abbott reported that many teachers found Section 28 made covering these issues more

258 Q 797
259 Q 1133
260 Q 906
261 Q 884

difficult.[262] As Sarah Nicholls pointed out, this is at odds with the move towards inclusiveness in many other forms of educations: "in RE you do not just get taught Christianity, but you get taught Buddhism and everything, so why not get taught about everything in sex education?"[263] Gemma Minty, a 16 year old student from Wigan, described the consequences of excluding homosexuality from sex education very eloquently:

> I think that first of all you need to break down the barrier between young gay, lesbian and bisexual people and straight people because at the moment the barrier is so high. You can see kids running round and saying, "Oh, your shoes are gay", without them actually knowing the meaning of the word "gay". If they were taught from an early age that some people ... have two Dads or two Mums, then the barriers would gently fall and then perhaps sex education could be more open, you could explore the alternative ways of having sex.[264]

Meeting the needs of both boys and girls

296. Our witnesses were not always in agreement about the merits of single-sex SRE. Although it may allow certain issues to be covered with less embarrassment, as Simon Blake argued, young men and women ultimately need to learn how to negotiate sex and relationships together, and single sex SRE can impose artificial barriers. As Sarah Nicholls told us, "the young ladies should be allowed to get just as much sex education and information on what goes on with a boy as they should with themselves because at the end of the day they are both coming together to have sex, so they need to know what is being offered in both parts."[265]

297. However, a more frequent complaint from our two panels of young people was that young men's needs were not met by sex education that was usually very female orientated. This is a particular issue given that, according to our witnesses, young men may actually be more vulnerable to peer pressure than young women. Natalie Stuart was the first to raise this:

> I think there is more pressure on boys sometimes, because boys, even if they are friends, they sit there and make fun of them, but girls obviously,—with Anna I would not start saying, "Oh, go on, go on", and force her into it if I am her real friend, but boys do even if they are friends, do they not?[266]

298. This view was supported by David Morris:

> For men image is a very big thing. If you are part of a group of males and they have all done it, then obviously they are going to really intimidate you and really put you out and try their hardest to make you an outcast, so therefore you think, "They have done it. I have got to do it or else therefore I am not part of the gang." It is male image. You have got to be the man as such.[267]

262 Q 501
263 Q 883
264 Q 978
265 Q 883
266 Q 1020
267 Q1026

299. **The Department for Education and Skills is currently engaged in work with the National Children's Bureau on guidelines specifically aimed at how to best engage boys and young men in schools-based sex education. We recommend that this guidance forms a specific plank of the National Curriculum on SRE, as clearly young men's needs have hitherto not been adequately addressed, despite the fact that they represent half the problem and half the solution to improving young people's sexual health. We were also struck by the fact that during the course of this inquiry, the vast majority of the people we met and took evidence from who were involved in sex and relationships education, and sexual health promotion for young people were female. One of the young men who came to give us evidence gave lack of specific male input as a key problem in the delivery of relationships and sex education for young men, and this is clearly a difficult problem that needs to be addressed. While we understand that it may not be practical for every school to provide both a male and a female teacher for SRE, schools must ensure that young men have access to SRE delivered by males, perhaps through using male peer educators, community workers and health professionals.**

What age?

300. The age at which sex and relationships education should begin is controversial. It is clearly vital that each subject to do with sex and relationships is covered at an age which is appropriate to children's differing needs, so that it does not intrude on or complicate other areas of a child's social development. Research carried out by the Health Development Agency suggests that SRE programmes are most effective when they start before young people become sexually active.[268] However, without exception the young people from whom we took evidence felt that the sex education they received had started too late:

> When I was in primary school, it was more like puberty sex education where you got shown how to use a Tampax. So it started there and then we had nothing and it started again at 14
>
> It was too late?
>
> Yes, it was because we already knew it all anyway.[269]

301. Rachel Ward went on to argue that "the basics of sex should be taught in the last year of primary school, but that it should go into more detail around about the age of 13."

302. Lindsay Abbott described the comprehensive SRE programme she delivered in Slough, spanning each year in secondary school, covering contraception from the age of 12-13, and STIs from the age of 13-14:

> In Year 7 we look at why you are different and it is okay to be different. We start them off in the room and they are all different sizes, they have all got different shoe sizes and you are all different inside and we do a whole package on relationship. Then in Year 7 we look at puberty and I teach that separately because the kids feel more comfortable about that in Year 8 we go on to talk about contraception and that is where I would show them the

268 Ev 121

269 Qq 949-50

> contraception available, they would talk about them in classrooms, and still stick to relationships. In Year 9 we do HIV and sexually transmitted infections. We look at the media as well throughout Years 7, 8 and 9. In Year 10 we look back at relationships and the beginnings of the family unit. In Year 11 I look at actually having the family and how much it costs.[270]

303. **It is imperative that all school-based relationships and sex education gives young people the opportunity to learn and think about the broader aspects of sex and sexual health, including emotions, relationships and families, and including the existence of different family structures. It is also vital that young people have a good understanding of the facts surrounding sexual health *before* they need them. Current guidance states that all primary aged children need to know about how a baby is born and about puberty before they experience the onset of physical changes; and that secondary school pupils should understand human sexuality, be aware of their own sexuality and know about contraception, sexually transmitted infections and HIV. We have seen little evidence through this inquiry that the SRE guidance is being implemented in a consistent way, especially in relation to more sensitive areas such as sexual feelings and emotions, sexual orientation and HIV and AIDS. We therefore recommend that the Department for Education and Skills establishes mechanisms (until such a time when SRE has National Curriculum status) both to monitor the implementation of the guidance and to assess the extent to which relationships and sex education, which addresses the needs of young people, is being delivered by primary and secondary schools.**

Parents

304. Closely linked to the age at which sex and relationships education should start is the issue of the appropriate role of parents in sex and relationships education. While all the adults who gave evidence on this subject felt that parents should be supported and encouraged to talk to their children about sex and relationships themselves, the young people felt strongly that their privacy should be respected at all times. As one of them trenchantly put it: "It is not a subject to be shared. The parents would not expect to share their sexual lives with their children, so why should the children be expected to share theirs with their parents?"[271]

305. Currently, parents have a right to withdraw their children from SRE if they wish. Although only a tiny minority exercise this right, the young people we took evidence from felt very strongly that although parents should be aware of what was contained in SRE programmes so they could support their children at home, young people's entitlement to SRE should not be compromised by their parents.[272] **We welcome the efforts currently being undertaken by the Department of Health and the Department for Education and Skills with regard to helping parents talk to their children about sex, as we feel that this type of engagement has a vital role to play in ensuring young people receive rounded sex education.**

270 Qq 475-77

271 Q 869 (Erica Buist)

272 Qq 874-75

Improving sexual health

306. The *Implementation Action Plan* gives considerably more information on sex education than the *Strategy*. According to the *Implementation Action Plan:*

> "A new emphasis will be given to STIs and HIV as part of the work already underway to improve education about sex and relationships and tackle teenage pregnancy. Effective teaching should enable young people to understand human sexuality, build self-esteem and understand the reasons for delaying sexual activity. Further work will include in particular:

- Practical guidance for teachers including lesson plans and case studies through the new PSHE website;
- Guidance on initial teacher training within the new Teacher Training Agency handbook;
- National roll out of the pilot scheme to accredit SRE teachers, and a new pilot training scheme for school nurses and others involved in delivering SRE in schools;
- Partnership work through the National Healthy School Standard to improve the quality of SRE in schools, and through Connexions to ensure young people are referred to appropriate services;
- Consideration of options for promoting better support on sex and relationships issues within Further Education;
- Better support for parents in talking to their children about sex and relationships through the Involving Parents in Prevention teenage pregnancy initiative."

307. We endorse these efforts, although, as discussed above, we do not feel they will go far enough towards guaranteeing quality and priority in SRE without national curriculum status. In addition to these measures, we have learnt about many innovative approaches to SRE throughout the country during the course of this inquiry. Many of the young people we took evidence from had worked with their peers to promote sexual health, and felt that having sex education delivered by young people their own age, in a language and style they could relate to, had been very successful. However, we are also aware that training a new group of young people to act as peer educators every year might be expensive. **We strongly support the use of peer educators, and recommend that the Department for Education and Skills and the Department of Health should work together to continue to promote this approach in all schools, although we believe this should be a supplement to rather than a replacement of formal schools-based relationships and sex education.**

308. Young people also placed great value on the input of healthcare professionals to their SRE, often finding it was easier to talk about sensitive subjects in complete confidence to someone they would not be seeing on a regular basis. As well as getting information first hand from 'the experts', we heard that this approach could also serve to familiarise young people with staff from local clinics, making them feel more confident about finding, negotiating and using health services. However, links between schools and services do not always work together to meet young people's needs, and we heard evidence from one young person that due to difficulties with

location and opening times, the only time young people could access a clinic for emergency contraception was by taking time off school, which could lead to real difficulties.

309. When we visited Sweden in December 2002, we saw an extension of this approach, with each secondary school having a designated Youth Clinic. All pupils in the Ninth Grade (aged 14-15) visit their Youth Clinic, to familiarise themselves with where it is, meet its staff, and learn about what services are on offer. Education is often delivered jointly by youth clinics and schools. In England, there is no equivalent dedicated NHS provision for young people. As against the 200 youth clinics in Sweden, a country with a population under nine million, there are 17 Brook clinics offering services exclusively to young people in the UK, with its population close to 60 million. However, we feel that models such as the Tic Tac project, in Paignton, Devon, have the potential to offer even more accessible advice and services for young people without expensive reconfiguration of health services.

310. Tic Tac (The Teenage Information and Advice Centre) was launched in February 1998 in Paignton Community College, a comprehensive secondary school with 2,000 pupils. The Centre is housed in a small building within the school grounds but separate from the main school building, and has a 'drop in' lounge area where young people can pick up information and leaflets, or simply sit and relax. The Tic-Tac co-ordinator is always on hand to chat to young people, and is a familiar and trusted figure. The session is staffed by a health professional every day of the week, and young people approach the co-ordinator privately and arrange to see a doctor, nurse or health visitor, all of whom are able to offer confidential advice. Users of the service are given firm assurances that discussions with the health professionals based at the Tic Tac project will not be disclosed to their teachers, parents or peers. We were also told by young people that there was no stigma attached to going to the Centre, even although it was on the school site and visible to teachers and other pupils, because rather than being a specific sexual health clinic, the Centre functions as a general advice centre where pupils can go for information about a wide range of issues, including general health, diet, fitness, stress, bullying, or just for a cup of tea and a chat.

311. The project appears to have struck a unique balance between being extremely accessible, without being so clearly linked to the school that young people feel it is too closely connected with either their teachers or parents. The Centre operates alongside the school-based sex and relationships education programme, and reports that peaks in demand for the Centre often directly follow coverage of complex issues in SRE which pupils then want to know more about. Although the health professionals who staff the Centre will give contraceptive and sexual health advice and an initial supply of contraceptives, as well as emergency contraceptives, all the health professionals strive to make the Centre a gateway to other local services rather than an end in itself, an approach they say has worked well.

312. **The Tic Tac project in Paignton, clearly an example of best practice in meeting, in a confidential manner, young people's sexual health needs, has been heavily driven by local enthusiasm and leadership, which has helped steer it through continuous funding uncertainties as well as negative publicity. It is seen as an integral part of raising educational standards in the school. However, we also heard of several examples of other schools which were keen to adopt the model, but which were obstructed by school governors. We believe that the Government should actively promote this model of joint service provision and education for young people, and make dedicated funding available to establish an appropriate number of such services within each local authority area. Although we recognise**

that it may not be practicable to have such a service attached to every school site, arrangements should be made between smaller schools to establish shared facilities or to devise links with dedicated clinics. We would also urge the Department to pilot a youth clinic along the lines of those we visited in Sweden: these may be more effective in reaching those not attending school.

11 Conclusions

The cultural context of changing sexual behaviour

313. Dr Kate Guthrie, a family planning specialist, spoke for many of our witnesses with her stark statement that "the British are very bad at sex altogether".[273] According to Dr Guthrie, sexual health has become "a medical problem, but it is only medical because we mop up. It is really a cultural and attitudinal problem." Cathy Hamlyn, head of the sexual health unit at the Department of Health, clearly supported this view: "We are stiff upper lipped. We can't talk easily about sex in this country. But we are also a little coy and giggly about sex. I sometimes call this the Benny Hill culture – a culture where we are not very open about things."[274]

314. As constituency MPs, the information we receive in our surgeries and in letters from our constituents can provide a useful barometer of key problems with our local health services. However, the fact that despite sexual health services reaching crisis point in some areas sexual health problems are rarely, if ever, brought to our attention by individuals illustrates the culture of embarrassment and secrecy that still surround sexual health in this country.

315. Attempting to change cultures and attitudes that are deeply entrenched in the national psyche may seem a fruitless aim. However, we were encouraged to hear the view of Gill Frances, Policy Director at the National Children's Bureau, who argued that the Netherlands is now starting to reap the benefits of sexual health interventions put in place thirty years ago, as the young people of the early 1970s have now had their own children and are passing on a new set of values, where sex and sexual health are openly discussed, to today's young people.

316. Responsibility for influencing societal attitudes goes well beyond the sphere of Government. In this context, we note that the BMA in their oral evidence said that their "main area of concern" was the "lack of significant representation of sexually transmitted infections as a significant health problem in the media". They called on the Broadcasting Standards Commission to survey this area and make representations to broadcasters to assist here.[275] Nick Partridge, for the Terrence Higgins Trust, pointed out it was wrong to lump the media together in describing its coverage of HIV/AIDS. He paid tribute, for example, to the educative impact of the Mark Fowler story line in *Eastenders*, on which the Trust had been consulted, and to the role of the Deirdre column in *The Sun*. But he also noted the confusion and mixed messages prevalent in the media, particularly denigrating "knee-jerk reactions" to stories relating to sex education in schools.[276] We ourselves witnessed at close hand the capacity of the British media to trivialise and smirk at issues relating to sex education: it struck us as depressing and distasteful that, when we took evidence from young people aged 15 to 21, who showed real courage in coming before a Parliamentary Committee and gave thought-provoking and well-articulated

273 Q146

274 Http://news.bbc.co.uk/1/hi/health/2125610.stm

275 Q266

276 Q356

evidence, this was largely reported by newspapers' diary columnists. Predictably enough, their aim was to ridicule the evidence we received and the young people who presented it.[277]

317. While we do think the media has a vital role to play and we also acknowledge the key importance of societal pressures we would not like to conclude our report without drawing attention to the responsibilities individuals must take for their own health. Drawing from the NATSAL, the PHLS point to "substantial increases in high-risk sexual behaviours in the British population", ranging from increases in the numbers of partners over a lifetime, to a higher rate of concurrent partnerships, to an increase in the proportion of gay men reporting unprotected sex.[278] To some extent we have to acknowledge that individuals are making choices, some of which are irresponsible, in that they lay not only themselves but others to risk of harm.

Giving priority to sexual health

318. We began our report by noting the crisis in the nation's sexual health. Nothing in the evidence we have received convinces us that sexual health is yet accorded the priority it deserves. We have looked at failings in treatment service; problems of access to service; poor premises; insufficient numbers of clinicians working in this area; weaknesses in health prevention strategies; and sex education still leaving much to be desired. We were very struck by the fact that we received no evidence either from regional directors of public health, or from directors of public health in Strategic Health Authorities, suggesting that a key layer in the strategic management process is currently neglecting the issue of sexual health.

319. **The crisis in sexual health services seems to us a consequence of several factors:**

- **A failure of local NHS organisations to recognise and deal with this major public health problem**
- **A lack of political pressure and leadership over many years**
- **The absence of a patient voice**
- **A lack of resources**
- **A lack of central direction to suggest that this is a key priority**
- **An absence of performance management**

320. During the course of this inquiry, it has become clear that sexual health services in the NHS are not equipped to cope with the rising demand for their services sparked by changing sexual behaviour and an epidemic in sexually transmitted infections. Equally concerning is the fact that in both acute trusts and Primary Care Trusts, even in areas of huge sexual health need, development of sexual health services is being pushed off the agenda by other issues, such as waiting times for elective surgery, where organisations' performance against explicit targets is closely monitored by the Department.

277 See for example Simon Hoggart, "Fixed Smiles greet the sex revelations of Sarah", *The Guardian*, 17 January 2003; Frank Johnson, "Commons Sketch", *Daily Telegraph*, 17 January 2003; Simon Carr, "Let's not talk about sex and geography", *The Independent*, 17 January 2003.

278 Ev 57

321. NHS organisations have their performance managed in a number of different ways. NHS Trusts are subject to the star rating system, which gives an annual assessment of their performance on nine key targets, 28 wider performance indicators, and Commission for Health Improvement clinical governance reviews. National targets such as waiting times are also monitored by the Department in-year via Strategic Health Authorities. PCTs now produce 3-year Local Delivery Plans setting out how national targets in six areas will be met in their own areas, which are agreed and managed by the overseeing SHA. The targets against which both Trusts and Primary Care Trusts are managed come from a variety of places. Most general targets surrounding access to care originate from the NHS Plan, while the more detailed targets surrounding access to care and quality of care in particular clinical areas are set out in National Service Frameworks.

322. The Government has invested significant priority in the issue of waiting times for NHS services, which it argues is the issue of greatest importance to patients. When treating life-threatening conditions or transmissible infections, gaining diagnosis and treatment as quickly as possible is obviously paramount. This is something that has come out very strongly in our evidence. The Government has put in place a broad range of targets surrounding waiting times, which cover almost every entry point to the NHS: by 2004, patients should have to wait no longer than 48 hours for initial assessment by a GP. If they have urgent problems which require immediate attention in a hospital, their maximum wait at an Accident and Emergency department should be one and a quarter hours. By 2005, if patients require a specialist outpatient appointment for a chronic problem which does not require immediate action, they should be given an appointment within a maximum of three months, and a non-emergency surgery appointment within a maximum of six months. However, access to sexual health clinics remains one area which is not covered by any of these very comprehensive targets.

323. Despite a considerable investment by the Government in targets to improve access to care and to improve health, sexual health is an area which seems to have fallen completely through the net. We understand the concerns of NHS organisations who feel that innovation is oppressed by the imposition of large numbers of centrally managed performance targets, which may not reflect local priorities, and for many organisations the recommendation of further central measures to improve the delivery of sexual health services may be unwelcome. However, at the moment we are in a position where so much NHS activity is currently subject to targets and performance management that those areas where urgent action is needed but which lack central performance management are in serious danger of being deprioritised. **We therefore recommend that the Government takes urgent steps to ensure that access to high-quality sexual health services is prioritised and resourced.**

324. **The best way of achieving this would be the launch of a dedicated National Service Framework for sexual health and we recommend that this be done. We understand, however, that the development of an NSF can take a number of years. Therefore, as an interim step we recommend that the Department should insist that sexual health is tackled, as a public health priority, at a strategic health authority level by adding it to the *Planning and Priorities Framework 2003–06*. The Department should set in place a rapid and urgent review of sexual health need, services, sexual health promotion, and treatment. This will need to be done jointly with SHAs and PCTs. To ensure that SHAs fully embrace this new responsibility, SHA Directors of Public Health should be responsible for the delivery of a 48-hour access**

target within their patch within two years, which should be supported by specific targets relating to reductions in the numbers of cases of the major sexually transmitted diseases.

325. **We are well aware of the danger of prescribing an NSF as the necessary panacea for any particular problem in the health service. There are numerous competing demands for priority and resources within the health service. However, the dramatic and spiralling decline in the nation's sexual health, the fact that this decline impacts most seriously on the most disadvantaged in society, and the danger that if nothing is done there will be a further deterioration with profound consequences convinces us that this is an area desperately in need of prioritisation. Further, we believe that the process of drawing up an NSF in this area could be expedited. The *Strategy* and its supporting documents already provide a very substantial basis, meaning that the development timescale could be condensed considerably. The Medical Foundation for AIDS and Sexual Health work on standards and networks could be woven into an NSF. If this option were pursued, in our view, the NSF should contain a maximum access target of 48 hours for access to a GUM or specialist family planning clinic, and be supported by specific targets relating to an eventual reduction in the number of cases of the major sexually transmitted diseases. As with other NSF targets, these should form part of PCT local delivery plans.**

326. Each onward transmission of HIV costs the health service hundreds of thousands of pounds and individual countless hours of anxiety, if not serious illness; each case of chlamydia in a young woman has the potential to trigger infertility; each unwanted teenage pregnancy has the potential to damage the life-chances of the parents and children involved. It would be profoundly depressing if a successor Health Committee was to address these issues in ten years' time, only to find evidence of a further deterioration of sexual health in this country. **We have been appalled by the crisis in sexual health we have heard about and witnessed during our inquiry. We do not use the word 'crisis' lightly but in this case it is appropriate. This is a major public health issue and the problems identified in this Report must be addressed immediately.**

Conclusions and recommendations

1. While we have some reservations about some of the detail in the Strategy (and indeed about areas where there is scant detail) we regard as entirely commendable the decision of the Government to produce the Strategy. We would like to see measures going well beyond what it proposes, but would want to acknowledge that the Strategy represents an excellent starting point and a foundation which can be developed. (Paragraph 5)

2. Given the stigma around sexual problems, and given that those groups most affected by sexual ill health tend to be those whose voices are not heard in society as a whole, we can appreciate why patients might feel reluctant or even unable to complain. Primary Care Trusts need to make themselves aware of the patient's experience of sexual health services and work to improve this experience. Patient forums may be a route through which this could be undertaken. (Paragraph 27)

3. We recommend that the Army Medical Services forwards to the Public Health Laboratory Services its figures for STIs. We also recommend that the PHLS looks at how a more comprehensive surveillance system can be developed to cover all areas of sexual health and possible service providers. This will give a more complete picture of trends, prevalence and service utilisation. (Paragraph 50)

4. We welcome the recognition of the importance of research and evidence with regard to the provision of HIV/STI prevention. We recommend that the Government continues to support the Health Development Agency in developing an evidence base in the long term and that the Department ask the Medical Research Council to commission further research in this area of sexual health. (Paragraph 62)

5. In respect of the monitoring of trends in both STIs and HIV/AIDS we would like to pay tribute to the work of the Public Health Laboratory Service. Their monitoring ensures that the UK has the best data in the world, and this in turn gives great credibility to their research. It would be most regrettable if the absorption of the PHLS within the new Health Protection Agency were in any way adversely to affect its work. In particular, we would be alarmed if the close networks developed between the regional and local laboratories and clinicians and epidemiologists were to be impaired as a consequence of the move to NHS management of the laboratories (Paragraph 63)

6. Although we support the Government's drive to improve sexual health services via the Strategy, without wholesale advances in sexual health provision these targets will be tokenistic. (Paragraph 82)

7. The Strategy specifies that from 2005, commissioners should ensure that women who meet the legal requirements have access to an abortion within three weeks of the first appointment with the GP or other referring doctor. In our view, three weeks is too long for people to wait in these circumstances. (Paragraph 83)

8. We are concerned that there are not enough available consultant posts to be filled by appropriately trained specialist registrars. Given the shortfall of 90% in consultant numbers as against the recommendations of the Royal College of Physicians, the increase in workload and the problems of access, this is unsustainable. We recommend that the

Government urgently review the staffing requirements and the need for an expansion of consultant posts in GUM. We also recommend that the Government makes clear that the additional money granted to GUM services will be given on a recurrent basis so as to encourage the creation of additional posts. (Paragraph 90)

9. It is not easy for us to judge how much recurrent funding would be needed to have a real impact on the numbers. However, we note the estimates submitted by Dr Kinghorn that, given an average cost for a completed new patient episode of £150-200, and assuming an additional 150,000 episodes per annum (allowing for increases prompted by the Government's publicity campaign) an additional revenue commitment of £22-30 million per annum will be required. (Paragraph 91)

10. While any increase in funding needs to be fully justified and accounted for, in the context of the current disastrous impact on public health of the nation's poor sexual health, these figures do not strike us as excessive. It should be stressed that there is not just a shortage of consultants: nurses with expertise and training in this area, health advisers and laboratory technicians are all needed and these should not be left behind in any increase in funding, a point we develop below. (Paragraph 91)

11. There has been evidence that money intended for HIV treatment, but not ring-fenced, has sometimes been diverted, so we would like the mechanisms to be in place to ensure that any additional funding that is granted to specialist GUM/HIV services is allocated specifically to these services. (Paragraph 92)

12. It is far from ideal for services to be managed by single-handed consultants. It is difficult for single-handed consultants to find a consultant locum to cover holidays and study leave. At this point we would accept that it will not be possible for every clinic to have more than one whole time equivalent consultant. However, more than one consultant can provide the service within each clinic so long as there are shared consultant appointments within clinical networks. (Paragraph 95)

13. We welcome the fact that the Department is developing a waiting times indicator as a means of monitoring the effect of its recent investment on access to clinics. However, this will merely duplicate existing activity since the Public Health Laboratory Service and the Specialty Societies for Genito-urinary Medicine already monitor waiting times, and evidence of the extent of the problem is not wanting. So we are unconvinced that this measure alone will do much to address what amounts to a public health crisis. We recommend that there should be a presumption that anyone wishing to access genito-urinary medicine should be able to do so on the day of, or day after, presentation to a clinic. If a target of 48 hours to see a GP is appropriate then a target of 48 hours for the treatment of what is potentially a communicable disease is essential. Without such standards of access the very delays in accessing treatment will inevitably cause further disease and that in turn will contribute to the pressures on services. It is also essential that if clinics do not allow patients to book an appointment more than 48 hours in advance, this does not conceal the problem of patients who are not able to make an appointment. (Paragraph 110)

14. We note the very poor condition of many of the premises in which genito-urinary medicine is being carried out. Many strike us as being of an unacceptable standard and

significantly below the general standard within the health service, as a consequence of the low status of this branch of medicine over the years. We believe that the very condition of the buildings makes them less attractive to patients and staff, less efficient, and less conducive to the necessary levels of privacy. Below we make recommendations about extending the range of settings in which GUM should take place, drawing particular attention to the advantages of the creation of a network of school-based clinics. However, we would urge the Minister to ensure trusts give due priority to the demands of GUM to compensate for the historic levels of under-investment. Unless sexual health is given higher priority within the health service we see no immediate prospects of widespread improvement. (Paragraph 116)

15. We do not think that it is necessary to wait for the results of the reinfection study before introducing nationally the chlamydia screening programme. Any additional information that the reinfection study provides is, in our view, likely only to lead to modifications in the programme rather than fundamental reforms. Accordingly we recommend that the NHS must, as a matter of urgency, move to provide such screening in all family planning clinics, infertility clinics, termination of pregnancy clinics and GUM clinics and for women having their first cervical smears. We also believe that GPs should routinely offer testing to those aged under 25 years without attempting to second-guess patients' sexual behaviour. (Paragraph 123)

16. We recommend that the Department explores the possibility of offering screening and advice on STIs, including chlamydia, to men outside traditional health service settings. Imaginative solutions will be needed if the male population is to be engaged. School based services such as that offered by the Tic Tac project offer one possible avenue for advice, testing and referral (see below, paragraph 312). We would also like screening to be offered via community outreach schemes, for example targeting night clubs or sports clubs, especially in areas where high prevalence rates are recorded. We also recommend that the Government should assess the possibility of a much wider screening campaign, including a national screening day or series of regional screening days, promoted through a campaign of hard-hitting messages. Such a campaign should be introduced in an attempt to have a real impact on chlamydia in the wider population. (Paragraph 125)

17. We believe it is scandalous that a sub-optimal test, with an accuracy rate markedly below the best tests, is still widely in use in England for the detection of chlamydia. Indeed, we believe that health providers would be highly vulnerable to damages claims made by patients who had received a false negative diagnosis and had thus not had treatment for chlamydia infection. We believe that the Department of Health should issue firm guidance to the effect that the sub-optimal EIA test should be withdrawn in favour of the molecular amplification test as soon as possible. In some cases we realise that laboratory services would not be able to cope with sudden transition to these types of tests. Nevertheless, the examples of the Netherlands and Sweden, which we visited and which had long since abandoned EIA testing, convince us that it must be possible to move to the optimal test and we believe this should be an urgent priority. (Paragraph 129)

18. We are concerned by the trends in HIV and support the Government in its aim to reduce the prevalence of undiagnosed HIV and in turn to safeguard public health. Early diagnosis of HIV not only reduces the chances of it spreading within the community but it also greatly improves outcomes for those infected. On the basis of the evidence we have heard,

however, we do not believe mandatory testing of asylum seekers, refugees, immigrants, visitors newly arrived in this country, and returning residents, to be an effective way of achieving the Government's aim. We recommend that HIV testing for newly arrived people should be voluntary, but should have as its clear objective the promotion of full disclosure of any relevant medical history and should also aim to facilitate appropriate and culturally-sensitive counselling before and after testing for HIV. (Paragraph 144)

19. We recognise that the field of HIV therapy is one which develops quickly and we appreciate that any guidelines on the use of HIV drugs might require frequent revision. However, we recommend that the National Institute for Clinical Excellence (NICE) should undertake an appraisal of treatments for HIV patients so that service providers and commissioners can collaborate and plan to make available the most effective treatment. (Paragraph 148)

20. Adequate funding for HIV drug therapy constitutes the only means of ensuring that HIV patients have access to the most appropriate drugs and that the other aspects of the sexual health service can be maintained and developed according to patients' needs. (Paragraph 149)

21. Now that funding for HIV services has been mainstreamed, and that commissioning is PCT-led, sexual health and HIV should be a priority at local level on grounds of public health. However, sexual health and HIV service providers have told us that they need help to persuade commissioners to allocate resources to an area which remains stigmatised, particularly in rural areas where prevalence of HIV is low. We are not convinced that the current arrangements will ensure that sexual health will be treated as a sufficiently urgent priority. Given that sexual health has no National Service Framework, and until NICE guidelines are introduced, we recommend that sexual health and HIV be included in Local Delivery Plans. (Paragraph 158)

22. We recognise that GPs and other primary care providers have an important role to play in the diagnosis and support of people with HIV as well as in their general medical treatment. HIV is a chronic condition. Dealing with chronic conditions is traditionally an area of strength for primary care. We therefore welcome moves to give primary care more of a role in the management of HIV/AIDS. However we are not convinced that the rebalancing of care provision is being sufficiently well supported. Accordingly, we recommend that these service providers be supported through training and through involvement in service networks. We also believe that it is crucial that the expertise currently residing within GUM is not diluted as a consequence of any move to primary care. So we would encourage any measures which promote close interaction between the expertise now found in secondary and tertiary services and that in primary care. (Paragraph 167)

23. We recommend that the Government should support the co-ordination of training for all social workers who have contact with those living with and affected by HIV, and also support the creation of posts for specialist social workers, who we believe could play an important role in developing and maintaining HIV service networks in high- and low-prevalence areas. (Paragraph 172)

24. We welcome the Government's acknowledgement of the voluntary sector contribution to HIV services. We have received a great deal of evidence to suggest that the voluntary

sector can reach many HIV-positive people who will not access statutory services. We recommend that the Government reciprocate the support it receives from voluntary groups in terms of practical work and policy guidance by supporting voluntary work at both national and local level. It would be counter-productive if the Strategy led to any diminution in the funding given to these bodies. Some HIV services (such as targeted prevention work) can only be provided by organisations which are very closely in touch with their communities and these services must be adequately resourced. (Paragraph 178)

25. We recommend that commissioners participate in sexual health service networks, and that they should be accountable to service providers through transparent commissioning processes. Consortia are essential to the establishment of comprehensive service networks, particularly in rural areas. We believe that the Department must require Strategic Health Authorities to ensure that preliminary development of consortia is taking place, based on regional commissioning groups such as are in place for cancer services, so as to give a definite impetus to the development of networks. (Paragraph 188)

26. We welcome the guidance provided by the Department of Health in issuing the Commissioning Toolkit and also recommend that the standards developed by MEDFASH and The Specialty Societies in Genito-urinary medicine should be used by Strategic Health Authorities in managing the performance of trusts. (Paragraph 190)

27. We remain concerned that patient choice with regard to HIV and sexual health services will be limited should PCTs decide against paying for patients to use services outside the PCT area. We recommend that the Government, after consultation with commissioners and service providers, should issue further guidance and ensure funding arrangements which enable patients to access sexual health services away from their home PCT area if they wish, in line with the recommendations of the Monks Report. (Paragraph 191)

28. We recognise that the delivery of some sexual health services through primary care has considerable potential in terms of access and continuity of care. However, we have not been assured that General Practitioners will receive sufficient training and support to deliver services effectively, nor that PCTs will provide sufficient encouragement to GPs to offer improved sexual health services. These may be matters which could be addressed through the new GP contract. (Paragraph 195)

29. According to the Government, the prevention of unplanned pregnancy by NHS contraception services probably saves the NHS over £2.5 billion a year already. Despite this, we have received compelling accounts of disinvestment in these vital services, and the fact that contraceptive services are not even included within the Strategy’s five aims is further evidence of this creeping deprioritisation. We recommend that the Government takes immediate steps to rectify this priority imbalance. (Paragraph 211)

30. If General Practitioners are to deliver Level 1 and Level 2 services to a high standard, the Government must ensure that the GP contract addresses issues of quality in relation to provision of contraceptive and other sexual health services, as well as giving GPs incentives to undergo further training in this area. The Government should also work with the relevant bodies to ensure that sexual health is given appropriate emphasis both in undergraduate medical training and in postgraduate education for trainee GPs. (Paragraph 217)

31. Many memoranda also point out that there is a serious shortage of national information currently available about the organisation and provision of contraceptive services. According to Dr Smith, a review of contraceptive services was carried out by the Department at a regional level ten years ago, but the results were never analysed or used to obtain a national picture due to lack of Department of Health capacity. Very little data are available about GP provision of contraceptive services. We recognise the importance of the collection of relevant information for the planning and delivery of services. We therefore recommend that steps are taken to standardise information collection in the field of sexual health, both for specialist service providers and general practitioners. (Paragraph 218)

32. With improved access to better contraception services as part of the implementation of the Strategy, we would hope to see a reduction in the number of unwanted pregnancies, leading to a decrease in the use of the abortion service. For those women who do seek access to the service, we believe that certain improvements should be made. We recognise the difficulties that would beset attempts to reform current laws relating to abortion. However, we support the FPA's view that access targets are meaningless without attendant measures to cut through the bureaucracy surrounding referral for termination of pregnancy. We believe, therefore, that the Government should, within the current legal framework which includes the approval of two doctors, promote a model of open-access for termination of pregnancy, based within Level 3 services, and accessed through a national advice line. (Paragraph 220)

33. We heard compelling evidence that for women who need to undergo an abortion, early medical abortion is a preferable option to surgery, as it carries significantly reduced risk of complications, and can be less distressing. The fact that early medical abortion does not involve any type of surgical process means that, with appropriate training and backup, it could be carried out by nurses rather than solely by doctors, and in community settings rather than solely in acute hospitals. However, at present early medical abortions constitute only a very small proportion of the total abortions carried out. We believe that allowing women access to early medical abortion in a wider range of healthcare settings would help reduce the number of late abortions which may occur as a result of long waits for surgery, and would also be a more cost-effective use of NHS resources. We therefore recommend that the Government should consider this option. (Paragraph 221)

34. We fully accept that any Government has to balance competing priorities and pressures in respect of public expenditure. We do, however, find it indicative of the priority accorded to sexual health, and sexual dysfunction services in particular, that access to anti-impotence services and drugs is so restricted. Effectively, the Government is dealing with this more as a lifestyle issue than a health issue, and that seems to us to be wrong. It is simply not appropriate that so many men and women with a clear medical and psychological need are not having access to these treatments, leading to a situation where only those who can afford it are likely to use them. This seems to us contrary to the fundamental principles of the NHS. We therefore recommend that access to anti-impotence treatments should be reviewed. We also think it would be helpful if the Department commissioned research to establish the costs and benefits of a more liberal prescribing regime, given the likely savings which might accrue in areas such as the treatment of depression, infertility, and dealing with the consequences of marital breakdown. Given the lack of development of sexual dysfunction services, and the fact that

social pressures are such that those suffering will often be shy and unwilling to articulate their case, we call on the Department to include sexual dysfunction within the wider sexual health strategy. (Paragraph 230)

35. Sexual health promotion offers a long term solution to many of the sexual health problems which challenge society. It is clear from the evidence we have received that awareness-raising activity and information campaigns are important but they will not on their own bring about sustained behaviour change, particularly amongst those marginalised individuals, groups and communities most vulnerable to HIV and other sexually transmitted infections. We recognise the importance of targeted community–based initiatives, peer education programmes and outreach work and would urge PCTs to ensure these range of interventions are a central part of local HIV prevention and sexual health promotion programmes. (Paragraph 243)

36. We welcome the Department of Health's efforts to produce and disseminate a health promotion toolkit to support commissioners. In relation to sexual health, this should specify that all those providing services in any area of sexual health, including GPs, GUM clinics, family planning clinics, and termination of pregnancy services, should provide a full sexual health risk assessment and sexual health promotion advice to all patients, as clinically appropriate. We feel that health promotion services in the field of sexual health are absolutely vital, but are also one of the services most at risk of being marginalised and deprioritised, given that demand for preventative services is never articulated as vociferously by patients as demand for treatment, and that targeted funding which has been available over the past decade has been subsumed into mainstream allocations. There is a compelling rationale for continued investment in health promotion and prevention. If a healthier nation is to be created, sexual health promotion needs the support and capacity to make a difference. Resources need to be identified to maintain specialist health promotion services, which provide training and advice to health professionals and lead on community-based initiatives with target groups. PCTs should be held to account for the commissioning of targeted HIV prevention and sexual health promotion, both in terms of resource input and effectiveness measures. (Paragraph 250)

37. Our evidence from young people, which we discuss more fully below, suggests that even basic factual knowledge about sex and sexual health cannot be assumed, and we believe that providing young people with accurate and appropriate information through school relationships and sex education programmes is an essential building block for securing improved sexual health both for this and for future generations. We see no benefit in preventative approaches based primarily around promoting abstinence. However, the fact that many young people who have not had sex believe they are in a minority, and equally that a significant proportion of them regret their first sexual experience, suggests that they would benefit from more support in deciding when is the right time for them in respect of the management of relationships, and support to resist external pressures to have sex, which is why we firmly support the location of sex education within the broader emotional and social framework of sex and relationships education (SRE). (Paragraph 267)

38. In view of the clear inadequacy of provision relating to the context in which sexual behaviour takes place, we feel that a much greater emphasis on the importance of handling relationships would contribute to an improvement in sexual health. We therefore recommend that DfES give further consideration to whether existing guidance on the

relationships aspect of SRE emphasises sufficiently the importance of this area. (Paragraph 275)

39. We recommend that the Department for Education and Skills and the Department of Health work together to compile a resource for schools detailing websites with high-quality information on sexual health which should be exempted from any filters schools may apply to their I.T. systems. DfES should also consider making 'electronic babies' more widely available in schools. The possibility of a text-messaging advice service should also be investigated. (Paragraph 281)

40. We strongly recommend that SRE becomes a core part of the National Curriculum, to be delivered within the broader framework of PHSE along with citizenship. We want to see education on relationships and sex given a high priority since the short and long term consequences of poor sexual health for young people, including unplanned pregnancy and parenthood as well as disease, can be so serious. (Paragraph 286)

41. While investing SRE with National Curriculum status will improve its standing, we believe that the key to improving educational standards in SRE lies in providing each school with well-trained, capable and enthusiastic SRE teachers. We recommend that the Department for Education and Skills reviews the way in which teachers are trained and SRE is managed in schools, ensuring that SRE is taught by teachers with specialist knowledge and expertise in the subject. We recognise the difficulties of scale that might attend ensuring that each primary and secondary school has a dedicated SRE teacher, but we believe that these logistical difficulties could be overcome through creative local arrangements, such as pooling a teacher or teachers across a consortium of schools within a local authority. DfES should also ensure that schools have access to, and make good use of, support from a range of individuals and agencies—such as nurses, GPs, health promotion specialists, peer educators and youth workers—when planning and teaching SRE. (Paragraph 292)

42. The Department for Education and Skills is currently engaged in work with the National Children's Bureau on guidelines specifically aimed at how to best engage boys and young men in schools-based sex education. We recommend that this guidance forms a specific plank of the National Curriculum on SRE, as clearly young men's needs have hitherto not been adequately addressed, despite the fact that they represent half the problem and half the solution to improving young people's sexual health. We were also struck by the fact that during the course of this inquiry, the vast majority of the people we met and took evidence from who were involved in sex and relationships education, and sexual health promotion for young people were female. One of the young men who came to give us evidence gave lack of specific male input as a key problem in the delivery of relationships and sex education for young men, and this is clearly a difficult problem that needs to be addressed. While we understand that it may not be practical for every school to provide both a male and a female teacher for SRE, schools must ensure that young men have access to SRE delivered by males, perhaps through using male peer educators, community workers and health professionals. (Paragraph 299)

43. It is imperative that all school-based relationships and sex education gives young people the opportunity to learn and think about the broader aspects of sex and sexual health, including emotions, relationships and families, and including the existence of different

family structures. It is also vital that young people have a good understanding of the facts surrounding sexual health *before* they need them. Current guidance states that all primary aged children need to know about how a baby is born and about puberty before they experience the onset of physical changes; and that secondary school pupils should understand human sexuality, be aware of their own sexuality and know about contraception, sexually transmitted infections and HIV. We have seen little evidence through this inquiry that the SRE guidance is being implemented in a consistent way, especially in relation to more sensitive areas such as sexual feelings and emotions, sexual orientation and HIV and AIDS. We therefore recommend that the Department for Education and Skills establishes mechanisms (until such a time when SRE has National Curriculum status) both to monitor the implementation of the guidance and to assess the extent to which relationships and sex education, which addresses the needs of young people, is being delivered by primary and secondary schools. (Paragraph 303)

44. We welcome the efforts currently being undertaken by the Department of Health and the Department for Education and Skills with regard to helping parents talk to their children about sex, as we feel that this type of engagement has a vital role to play in ensuring young people receive rounded sex education. (Paragraph 305)

45. We strongly support the use of peer educators, and recommend that the Department for Education and Skills and the Department of Health should work together to continue to promote this approach in all schools, although we believe this should be a supplement to rather than a replacement of formal schools-based relationships and sex education. (Paragraph 307)

46. The Tic Tac project in Paignton, clearly an example of best practice in meeting, in a confidential manner, young people's sexual health needs, has been heavily driven by local enthusiasm and leadership, which has helped steer it through continuous funding uncertainties as well as negative publicity. It is seen as an integral part of raising educational standards in the school. However, we also heard of several examples of other schools which were keen to adopt the model, but which were obstructed by school governors. We believe that the Government should actively promote this model of joint service provision and education for young people, and make dedicated funding available to establish an appropriate number of such services within each local authority area. Although we recognise that it may not be practicable to have such a service attached to every school site, arrangements should be made between smaller schools to establish shared facilities or to devise links with dedicated clinics. We would also urge the Department to pilot a youth clinic along the lines of those we visited in Sweden: these may be more effective in reaching those not attending school. (Paragraph 312)

47. The crisis in sexual health services seems to us a consequence of several factors:

- A failure of local NHS organisations to recognise and deal with this major public health problem
- A lack of political pressure and leadership over many years
- The absence of a patient voice
- A lack of resources

- A lack of central direction to suggest that this is a key priority
- An absence of performance management. (Paragraph 319)

48. We therefore recommend that the Government takes urgent steps to ensure that access to high-quality sexual health services is prioritised and resourced. (Paragraph 323)

49. The best way of achieving this would be the launch of a dedicated National Service Framework for sexual health and we recommend that this be done. We understand, however, that the development of an NSF can take a number of years. Therefore, as an interim step we recommend that the Department should insist that sexual health is tackled, as a public health priority, at a strategic health authority level by adding it to the Planning and Priorities Framework 2003–06. The Department should set in place a rapid and urgent review of sexual health need, services, sexual health promotion, and treatment. This will need to be done jointly with SHAs and PCTs. To ensure that SHAs fully embrace this new responsibility, SHA Directors of Public Health should be responsible for the delivery of a 48-hour access target within their patch within two years, which should be supported by specific targets relating to reductions in the numbers of cases of the major sexually transmitted diseases. (Paragraph 324)

50. We are well aware of the danger of prescribing an NSF as the necessary panacea for any particular problem in the health service. There are numerous competing demands for priority and resources within the health service. However, the dramatic and spiralling decline in the nation's sexual health, the fact that this decline impacts most seriously on the most disadvantaged in society, and the danger that if nothing is done there will be a further deterioration with profound consequences convinces us that this is an area desperately in need of prioritisation. Further, we believe that the process of drawing up an NSF in this area could be expedited. The *Strategy* and its supporting documents already provide a very substantial basis, meaning that the development timescale could be condensed considerably. The Medical Foundation for AIDS and Sexual Health work on standards and networks could be woven into an NSF. If this option were pursued, in our view, the NSF should contain a maximum access target of 48 hours for access to a GUM or specialist family planning clinic, and be supported by specific targets relating to an eventual reduction in the number of cases of the major sexually transmitted diseases. As with other NSF targets, these should form part of PCT local delivery plans. (Paragraph 325)

51. We have been appalled by the crisis in sexual health we have heard about and witnessed during our inquiry. We do not use the word 'crisis' lightly but in this case it is appropriate. This is a major public health issue and the problems identified in this Report must be addressed immediately. (Paragraph 326)

List of abbreviations used in the report

AIDS	Acquired Immune Deficiency Syndrome
BHIVA	British HIV Association
BMA	British Medical Association
BMJ	British Medical Journal
BPAS	British Pregnancy Advisory Service
DfES	Department for Education and Skills
EIA	Enzyme immuno-assay test
FET	Family Education Trust
FPA	Family Planning Association
GU	Genito-Urinary
GUM	Genito-Urinary Medicine
HAART	Highly Active Antiretroviral Treatment
HDA	Health Development Agency
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
MEDFASH	Medical Foundation for AIDS and Sexual Health
NATSAL	National Survey of Sexual Attitudes and Lifestyles
NICE	National Institute for Clinical Excellence
NSF	National Service Framework
OFSTED	Officie for Standards in Education
PACT	National Association of NHS Providers of AIDS Care and Treatment
PCR	Polymerase Chain Reaction test
PCT	Primary Care Trust
PHLS	Public Health Laboratory Service (now the Health Protection Agency)
PID	Pelvic Inflammatory Disease
PSHE	Personal, Social and Health Education
RCP	Royal College of Physicians
SAFF	Service and Financial Framework
SRE	Sex and Relationships Education
STI	Sexually Transmitted Infection
Strategy	*National Strategy for Sexual Health and HIV*

Appendix

Visit to Manchester Young People's Council

Friday 15 November 2002

As part of its inquiry into sexual health, the Committee met with six representatives of the Manchester Young People's Council to discuss their experiences of and views on sex education and sexual health promotion.

Experiences of sex education in school

Young people's experiences of sex education in school varied widely. Most reported that the subject of sex education was split, with the factual, physical elements of the topic covered in science lessons, and social and emotional issues addressed in Personal Health and Social Education (PHSE) lessons, which were generally taught by form tutors rather than specialist teachers. The group were all in agreement that talking to their parents about sex was embarrassing. Several of the group had not had any school sex education prior to secondary school.

The group felt that having sex education in single-sex classes led to more openness and less embarrassment. One council member described a positive experience of sex education at his single-sex school during Year 9 (aged 13-14). A whole term of lessons was devoted to sex and relationships issues, led by a PHSE teacher who was not embarrassed or afraid of talking about delicate issues. This inspired confidence in the students who took the subject seriously and made good use of the facility provided to ask the teacher anonymous written questions.

However, several people felt that the position of sex education within the school curriculum was weak. The lack of exams meant that it was not classed as a 'real' or 'respected' subject by pupils or by teachers, with PHSE sessions frequently used by students as 'free periods' in which to complete coursework for other subjects. One member of the Council described her school's attempts at sex education as a 'fashion statement', a brief token effort driven by an urge to keep up with initiatives in neighbouring schools, which was soon forgotten.

Attitudes towards sex and sexual health

The group felt that an attitude of 'it won't happen to me' was widespread amongst people their age. Amongst girls, pregnancy was seen as a bigger fear than that of sexually transmitted infections, which were largely viewed as illnesses which could be easily treated, as opposed to having a child, which is a life-changing event.

When asked about the impact of peer pressure on sexual behaviour, the group reported that the concept of getting drunk and 'getting off with as many people as possible' is now such an accepted part of youth culture, for girls as well as boys, that young people are unlikely to have the opportunity to reflect on whether they are making the right decisions for themselves. The idea of direct 'peer pressure' is simply no longer relevant, with young people assuming that sexual activity from an early age is the norm, although of course young people may be subconsciously put under pressure by wider cultural influences.

Service provision

Some schools promoted an active awareness of sexual health services to their pupils, with posters for Brook advisory centres on display and visits from Brook sexual health nurses forming part of the sex education programme. It was generally felt that going to a GP with sexual health concerns would be harder than a clinic targeted at young people, because of perceptions that staff would be older, and may also have contact with their parents.

However, a few of the council members felt that the services provided by youth clinics were not necessarily striking the right balance either. One member described going to a clinic for advice and having large quantities of free condoms pushed on her without any supporting advice and guidance. There was a feeling that this type of approach promoted sex inappropriately, making it seem 'too easy, too casual' and risked normalising promiscuity among young people without paying enough attention to the emotional support that might be needed when making important decisions about sex and sexual health.

Beyond sex education

The group felt strongly that although sex education could be improved, the impact of school sex education on young peoples' sexual behaviour would always be limited in the face of other influences. Alcohol and the media were identified as two key factors in influencing sexual behaviour. The group described some teen movies as promoting sex in an inappropriate way (for example 'American Pie' and 'Road Trip'), and the teenage soap opera 'Dawson's Creek' was mentioned as providing a more positive take on teenage sexuality. The group also discussed a creeping sexualisation of society, with younger and younger children wearing 'sexy' clothes, and childhood being eroded. Adverts promoting the message that 'not everyone is having sex' had been positively received by the group.

Possible future options

Sex education typically centres around negotiating sexual encounters within established relationships. However, according to the representatives from Manchester Young People's Council, young people are now having many more transient sexual experiences outside traditional relationships which sex education does little to prepare them for.

Unsubtle 'scaremongering' tactics (the group described teenage mothers, drug users, and prison inmates visiting them in school) were not seen by the group as effective deterrents. One option suggested by the group was to train up 'peer advocates' within each school year to act as a source of information and guidance to fellow students.

Formal Minutes

Thursday 22 May 2003

Members present:

Mr David Hinchliffe, in the Chair

Julia Drown
Sandra Gidley
Dr Doug Naysmith
Dr Richard Taylor

The Committee deliberated.

Draft Report (*Sexual Health*), proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 326 read and agreed to.

Summary agreed to.

An Appendix (Visit to Manchester Young People's Council)—(*The Chairman*)—brought up, read and agreed to.

Resolved, That the Report be the Third Report of the Committee to the House.

Ordered, That the provisions of Standing Order No. 134 (Select Committees (Reports)) be applied to the Report.

Several papers were ordered to be appended to the Minutes of Evidence.—(*The Chairman*.)

Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House.—(*The Chairman*.)

[Adjourned till Tuesday 3 June at Four o'clock.

Witnesses

Wednesday 26 June 2002 *Page*

Ms Cathy Hamlyn, Head, Sexual Health and Substance Misuse, **Dr Vicki King**, Head, Blood and Healthcare Associated Infections Unit, **Ms Ruth Stanier**, Deputy Head, Sexual Health and Susbtance Misuse, **Ms Kay Orton**, Team Leader, HIV and Health Promotion, and **Ms Andrea Duncan**, Acting Team Leader, Sexual Health, Department of Health Ev 8

Wednesday 10 July 2002

Anne Weyman, Chief Executive, Family Planning Association, **Dr Sarah Randall**, Family Planning Specialist, St Mary's Hospital, Portsmouth, **Dr Kate Guthrie**, Community Gynaecologist, Hull & East Riding Community NHS Trust, **Jane Thomas,** Director, National Collaborating Centre for Women's and Children's Health, Royal College of Obstetricians & Gynaecologists, **Mr Ian Jones**, Chief Executive, British Pregnancy Advisory Service and **Liz Davies**, Director of UK Operations, Marie Stopes International Ev 39

Wednesday 17 July 2002

Dr Kevin Fenton and **Dr Gwenda Hughes**, Communicable Disease Surveillance Centre, Public Health Laboratory Service, **Professor Anne Johnson**, Department of Population Sciences, Royal Free Hospital, **Dr Jackie Cassell**, British Medical Association, **Dr Jean Tobin**, Consultant in Genitourinary Medicine, St Mary's Hospital, Portsmouth Ev 72

Tuesday 23 July 2002

Dr Barry Evans, Communicable Disease Surveillance Centre, Public Health Laboratory Service, **Mr Nick Partridge**, Chief Executive, Terrence Higgins Trust, **Mr Joseph O'Reilly**, Deputy Chief Executive, National Aids Trust, **Dr Peter Weatherburn**, Director, SIGMA Research, **Dr Alec Miners,** Health Economist, Brunel University, **Mr John Imrie**, Senior Research Fellow, Royal Free and University College Medical School Ev 101

Monday 18 November 2002

Mr Nick Springham, Health Improvement and Commissioning Manager, Newcastle Primary Care Trust, **Ms Evelyn Asante-Mensah**, Chief Executive, Black Health Agency, **Professor Mike Kelly**, Director, Research and Information, Health Development Agency, **Ms Kaye Wellings**, Director, Sexual Health Programme, Health Promotion Research Unit, London School of Hygiene and Tropical Medicine, **Mr Simon Blake,** Assistant Director, Children's Personal Development Unit, National children's Bureau, and **Mrs Lindsay Abbott**, Deputy Head Teacher, Slough and Eton Church of England School Ev 141

Thursday 28 November 2002

Dr George Kinghorn, immediate past president, Medical Society for the Study of Venereal Diseases, and Clinical Director of the Genito-urinary Medicine Department, Royal Hallamshire Hospital, Sheffield**, Dr Pat Munday**, Consultant Physician in genitor-urinary medicine, Watford General Hospital, **Dr Chris Ford**, practising GP and Chair, Royal College of General Practitioners Sex, Drugs and HIV Task Group, **Ms Marian Nicholson**, Chair, Herpes Viruses Association, **Mr Graham Taylor**, lead commissioner for sexual health and HIV care, Brighton and Hove City Primary Care Trust, and **Mrs Jackie Rogers**, clinical nurse specialist in genito-urinary medicine, Ore Clinic, Hastings — Ev 172

Thursday 12 December 2002

Dr Simon Barton, Consultant Physician, Chelsea and Westminster Healthcare NHS Trust, **Mr Simon Collins**, Representative, HIV i-Base, **Mrs Ruth Lowbury**, Director, Medical Foundation for AIDS and Sexual Health, **Dr Ade Fakoya**, Consultant Physician, Newham Healthcare NHS Trust, **Ms Chrissie Green**, Clinical Nurse Specialist, West Middlesex University Hospital and **Ms Heather Wilson**, Senior Health Adviser, Barnet General Hospital — Ev 200

Thursday 9 January 2003

Dr Muir Gray, Programme Director, National Electronic Screening Library, **Dr Trevor Stammers**, Trustee, and **Mr Robert Whelan**, Director, The Family Education Trust; and **Ms Gill Frances**, Director, Children's Development, National Children's Bureau — Ev 235

Thursday 16 January 2003

Ms Lorna Webley, **Ms Tara Hall, Ms Sarah Nicholls** and **Mr David Morris,** Wakefield Peer Group Research Project**, Ms Emma Henderson** and **Ms Erica Buist,** National Youth Parliament. — Ev 248

Ms Natalie Stuart, and **Ms Anna Eagle**, Young Mums-to-be project, Swindon, **Mr Jay Bailey, Ms Gemma Minty, Ms Rachael Ward**, and **Mr Scott Williams**, Wigan Borough-wide Youth Council — Ev 262

Thursday 23 January 2003

Ms Hazel Blears MP, Parliamentary Under-Secretary of State for Public Health, Department of Health, and **Mr Stephen Twigg MP**, Parliamentary Under-Secretary of State, Department for Education and Skills — Ev 273

List of written evidence

1	Dr Sara Randall	Ev. 29
2	British Pregnancy Advisory Service	Ev. 33
3	Marie Stopes International	Ev. 37
4	Royal College of Obstetricians and Gynaecologists	Ev. 38
5	PHLS Communicable Disease Surveillance Centre	Ev. 56
6	National Aids Trust	Ev. 88
7	Sigma Research	Ev. 92
8	Terrence Higgins Trust	Ev. 94
9	Alec Miners	Ev. 96
10	John Imrie	Ev. 97
11	Health Development Agency	Ev 117
12	Sex Education Forum	Ev. 123
13	Black Health Agency	Ev. 131
14	Newcastle Primary Care Trust	Ev. 133
15	Mrs Lindsay Abbott	Ev. 135
16	Dr Pat Munday	Ev. 160
17	Herpes Viruses Association	Ev. 162
18	Mr Graham Taylor	Ev. 165
19	Dr Chris Ford	Ev. 169
20	Chelsea and Westminster Healthcare NHS Trust	Ev. 191
21	Medical Foundation for AIDS and Sexual Health	Ev. 192
22	Sex Education Forum	Ev. 225
23	Family Education Trust	Ev. 233
24	Abbott Laboratories	Ev 305
25	Association of Directors of Social Service	Ev 306
26	Professor Mark Bellis	Ev 307
27	Dr James Bingham	Ev 308
28	Brighton GUM/HIV Clinic	Ev 309
29	Dr Gary Brook	Ev 311
30	Centre for HIV and Sexual Health	Ev 312
31	Dr Janette Clarke	Ev 314
32	Dr Elizabeth Claydon	Ev 316
33	Dr Frances Keane	Ev 317
34	Richard Curtin	Ev 318
35	Dr Anne Edwards	Ev 320
36	Dr Peter Fisk	Ev 321
37	Dr Mark FitzGerald	Ev 321
38	Dr P Fraser	Ev 322
39	Dr Sarah Gill	Ev 322
40	GlaxoSmithKline	Ev 323
41	Dr Beng Goh	Ev 324
42	Dr B Goorney	Ev 325

43	Dr Linda Green	Ev 326
44	Dr Janima Harvey	Ev 328
45	Dr E Carlin	Ev 329
46	Dr Helen Lacy	Ev 330
47	Lilly UK	Ev 330
48	The London Directors of Public Health	Ev 335
49	Dr G McCarthy	Ev 336
50	Dr Paul McCrory	Ev 339
51	Medical Foundation for AIDS	Ev 342
52	Medical Research Council	Ev 345
53	Dr K Mohanty	Ev 349
54	Dr T Moss	Ev 349
55	Dr Mayura Nathan	Ev 350
56	Mayday University Hospital, Thornton Heath	Ev 351
57	Dr Ranjana Rani	Ev 352
58	Directorate, Sexual Health Nottingham City Hospital	Ev 353
59	Dr Colm O'Mahony	Ev 355
60	PACT	Ev 356
61	Pan London HIV/AIDS Providers Consortium	Ev 357
62	Mr Richard Pattman	Ev 363
63	Dr Jillian Pritchard	Ev 363
64	Royal College of Nursing of the United Kingdom	Ev 364
65	Dr Peter Carey	Ev 367
66	Dr Connie Smith	Ev 372
67	Dr Graz Luzzi	Ev 377
68	Dr Paul Lister	Ev 377
69	Special Interest Group HIV & Sexual Health	Ev 379
70	The Speciality Societies for Genitourinary Medicine	Ev 387
71	The Courtyard Clinic, St George Hospital, Tooting	Ev 392
72	St Mary's Hospital, London HIV Department	Ev 393
73	Dr Belinda Stanley	Ev 394
74	Dr Alan Tang	Ev 397
75	Dr Nicholas Theobald	Ev 398
76	Simon Wright	Ev 400
77	Mrs Ruth Webb	Ev 400
78	Dr Janet Wilson	Ev 401
79	London Communicable Disease Control Group	Ev 401
80	Pfizer Limited	Ev 408
81	All-Party Parliamentary Pro-Choice Group	Ev 409
82	Jane Thomas	Ev 411
83	Jean Tobin	Ev 411
84	Wirral Brook Advisory Centre	Ev 412
85	London School of Hygiene and Tropical Medicine	Ev 414
86	Christina Green	Ev 418
87	Stephen Twigg MP, Parliamentary Under-Secretary of State for Schools	Ev 418

88	Brook et al	Ev 419
89	Youth Participation, Wigan	Ev 420
90	Dr Simon Barton	Ev 421
91	National AIDS Trust	Ev 422

List of unprinted written evidence

Additional papers have been received from the following and have been reported to the House but to save printing costs they have not been printed and copies have been placed in the House of Commons Library where they may be inspected by members. Other copies are in the Record Office, House of Lords and are available to the public for inspection. Requests for inspection should be addressed to the Record Office, House of Lords, London SW1. (Tel 020 7219 3074) hours of inspection are from 9:30am to 5:00pm on Mondays to Fridays.

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Dr J Willcox
Young Minds
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Miss Rose Kearns
Mrs C S Smith
Anthony Dignan
Mrs E Hill
Leonie Walker
Mrs Anne Brennan
Mrs Rita Brennan
Mr J M Callaway
Mr P Runciman
Derby City Council
Rev. Beth Gardner
Simon Collins

Reports from the Health Committee since 2001

The following reports have been produced by the Committee since the start of the 2001 Parliament. The reference number of the Government's response to the Report is printed in brackets after the HC printing number.

Session 2002–03

First Report	The Work of the Health Committee	HC 261
Second Report	Foundation Trusts	HC 395

Session 2001–02

First Report	The Role of the Private Sector in the NHS	HC 308 (*Reply Cm 5567*)
Second Report	National Institute for Clinical Excellence	HC 515 (*Reply Cm 5611*)
Third Report	Delayed Discharges	HC 617 (*Reply Cm 5645*)