

**INDEPENDENT ADVISORY GROUP ON
SEXUAL HEALTH AND HIV**

**Response to the
Health Select Committee
Report on Sexual Health**

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The Independent Advisory Group (IAG) on Sexual Health and HIV was established in 2003 as part of the Implementation Action Plan for the National Strategy for Sexual Health and HIV. The IAG was set up to monitor progress and advise Government on implementation of the Strategy, including any further action necessary to achieve the Strategy's aims. The IAG meets quarterly, and is due to produce its first Annual Report in Summer 2004.

I. Introduction

The Government's National Strategy for Sexual Health and HIV defines sexual health as follows:

“Sexual health is an important part of physical and mental health. It is a key part of our identity as human beings together with the fundamental human rights to privacy, a family life and living free from discrimination. Essential elements of good sexual health are equitable relationships and sexual fulfillment with access to information and services to avoid the risk of unintended pregnancy, illness or disease.”

The IAG would like to pay tribute to the work that the Government has achieved to date in drawing up the National Strategy for Sexual Health and HIV [**Recommendation 1**], and in drawing up the Action Plan for the Strategy. In particular, we welcome the important steps which have already been taken to implement the Strategy, including: the identification of sexual health and HIV leads within Primary Care Trusts (PCTs); the publication of the Sexual Health and HIV Commissioning Toolkit; the start of the chlamydia screening programme; the development of HIV treatment standards; and the launch of the 'Sex Lottery' national information campaign.

We hope that the Government will now build on this work to ensure that sexual health and HIV are treated as key health priorities, with concomitant priority given to investment in education, information, and the provision of services. In addition to prioritising sexual health within Local Delivery Plans and the Planning and Priorities Framework, we believe that the Government should explore the option of introducing one or more detailed Public Service Agreement (PSA) targets, for example on sexually transmitted infections (STIs), HIV or chlamydia, to ensure that due prioritisation is given to improving these areas of sexual health.

The IAG would also like to pay tribute to the valuable work of the Health Select Committee in producing its Report on Sexual Health. We greatly welcome the Report and endorse its recommendations. The IAG is keen that the recommendations contained in the Report are carried forward and implemented, and, to this end, we have prepared this response to provide further recommendations to complement the Report.

We recognise that the Select Committee was not able to cover all relevant areas fully in its Report, and that there have also been significant developments since the Committee collected its evidence and published its Report. In this response, therefore, we not only respond to the Committee's recommendations and the Government's response to these, but also address some of the broader issues affecting sexual health, including:

- Access to Services
- Capacity – including facilities, staffing and training
- Commissioning and Prioritisation – particularly at primary care level
- Funding
- Prevention
- Education and Sexual Health Promotion
- Patient Voice

We have structured this report so that our comments on and reference to the Select Committee's recommendations are clearly referenced by recommendation number (taken from the Report's Conclusions and Recommendations section), inserted in bold in the text. Any references to the Government Response to the Select Committee's Report are footnoted. For the purposes of this report we will mainly use the term sexual health as incorporating HIV, however HIV on its own is used where specific reference is being made.

The IAG endorses the Government's holistic definition of sexual health, and would like to see an holistic approach being taken at both a local and national strategic level. It is crucial that sexual health services are joined up, and that a person's whole sexual well-being is taken into consideration when they present for advice or treatment about a specific area. In this context, sexual dysfunction should be an integral part of the Strategy.

Sexual health is often marginalised as an issue for specific groups – for example young people, gay men, or particular ethnic communities. However, it must be acknowledged that sexual health is an integral part of every person's overall health and well-being – regardless of age, ethnicity, gender, sexual orientation, disability, or religion. Evidence shows, for example, that rates of sexually transmitted infections (STIs) are increasing in all age groups, and that over one-third (36%) of all new cases of HIV in the UK are in the 35-44 age group, compared to just 7% in the under-25s age group¹.

Moreover, it must be recognised that the greatest current threat to sexual well-being – STIs – takes the form of transmittable infections. As we have seen, the rate of these infections has grown considerably in recent years, and if this epidemic is not tackled, the rate of infections will keep growing exponentially. Since the Strategy was published in the summer of 2001 there has been a significant increase of 15% in attendances at departments of Genitourinary Medicine (GUM) in England, Wales and Northern Ireland. Particular increases have been seen since that time in syphilis (63%), chlamydia (14%), and gonorrhoea (9%)².

The causal link between chlamydia and infertility means that, unless this epidemic is addressed, the rate of infertility could rise rapidly in the near future. It has been shown that screening for chlamydia decreases cases of pelvic inflammatory disease (PID) – a significant cause of infertility – by 64%. In this context, investment in chlamydia screening and prevention now may help to forestall a huge rise in the costs of infertility treatment in the future. Overall, as STIs rise there will be an increase in the longer term harm to public health and the cost to society, and better preventative action coupled with improved access to services would be able to moderate this very considerably.

A common feature in sexual health is the effect that the stigma attached to the issue has on people requiring services for HIV, STIs and abortion. This can be a major impediment to self-referral and places an additional responsibility on commissioners to ensure not only easy access to services but also that the services are relevant and supportive.

2. Access to Services

Lengthy waiting times are common across all sexual health services, particularly for GUM. The Select Committee Report drew attention to median waiting times for first appointments in such clinics of 12 days for men and 10 days for women. The Committee also heard evidence of situations where 400 people a week were turned away from a clinic in Bristol. We would like to highlight similar access problems faced by abortion and community based contraceptive services, where pressure due to increasing demand cannot be measured through monitoring waiting times, as most are drop-in services.

¹ Taylor Nelson Sofres, 2003

² Health Protection Agency, 2003

It is clear that current staffing levels and service provision is insufficient to meet rising demand. Moreover, long waiting times in these areas can have disastrous results – the person who remains sexually active with an STI while waiting for an appointment at a GUM clinic, for example, or a woman denied the opportunity of a medical abortion through having to wait too long for a referral from her GP.

The IAG strongly believes that sexual health services need to be consistently prioritised to enable fast, efficient access to all who need them. We strongly endorse the Report's recommendation that the Government takes urgent steps to ensure that access to high quality sexual health services is prioritised and resourced **[Recommendation 48]**.

We would also like to highlight the point made in the Government's response, that: "Poor sexual health continues to disproportionately affect those who are often already vulnerable or socially excluded"³. It is also the case that access to information and services is more limited for people who are already disadvantaged, and we urge that, in addressing access to sexual health services overall, access for these groups is also ensured.

2.1 Abortion

The IAG supports the recommendations made by the Report. The IAG feels very strongly that it is unsatisfactory that many women have to wait three weeks or more for an abortion **[Recommendation 7]**, and we endorse the Report's recommendation that the Government should promote a model of open-access for termination of pregnancy **[Recommendation 32]**.

The current legal framework builds bureaucracy and delay into the referral system, combined with the proportion of GPs expressing some degree of conscientious objection who are able to delay or refuse access to further advice or services.

National campaigns to inform and educate women that abortion is a legal and positive option in the event of an unintended pregnancy would be a valuable means of emphasising the overall benefits of improved sexual health. We also endorse the use of a national helpline to provide advice and counselling to women who are uncertain about what to do about a pregnancy, and who are unable to access such advice locally. However, this must be a helpline specifically designed for this remit, rather than existing helplines such as **fpa's** Sexual Health Direct which are primarily designed for information-giving and initial advice. Information about services and direct booking is best provided at a local level, and the IAG believes that it may be more cost effective to investigate establishing these services locally.

Any response should be designed to improve access for women as early as possible in their pregnancy. Direct referral with an information component to ensure that women are aware of how to access services would improve matters considerably, although the bottom line remains a change in legislation. Although access to abortion at the earliest possible gestation should remain a priority, there are concerns surrounding later term procedures and the choices available to women presenting after the 13th week of pregnancy, in particular the training of doctors to perform these procedures. In 2001, almost 70% of abortions after 13 weeks were performed outside the NHS, therefore we would like to see collaborative working between the NHS and non-NHS sectors for women presenting after the 13th week of pregnancy in order to improve the care pathways and their experience.

³ Government Response to the Health Select Committee's Third Report of Session 2002-03 on Sexual Health, p1

2.2 STI services

Health Protection Agency (HPA) data shows that there were 1.5 million attendances at GUM clinics in England, Wales and Northern Ireland in 2002, a 15% increase on 2001. This rapid escalation of infections has led to very considerable pressures on existing services, and the Select Committee received evidence of waiting times which currently extend up to six weeks, which we believe is unacceptable.

In this context, we strongly support the 48-hour primary care target as the maximum acceptable delay for any patient requesting STI specialist services **[Recommendation 13]**. We welcome the Government's agreement that "access to GUM services within 48 hours is an appropriate aim"⁴, and in order to achieve this aim we believe that this target should be included within Local Delivery Plans, performance managed by Strategic Health Authorities, and fully implemented within two years.

Some Community Family Planning services have successfully integrated STI services – both diagnosis and management – and in order to optimise access we would like to ensure that access to these services is provided not only via GUM services but also via contraceptive services within the 'one stop shop' model.

2.3 HIV services

The IAG welcomes the Select Committee's endorsement of the recognition that the Government gives to the voluntary sector in providing services for people with HIV **[Recommendation 24]**. We also believe that the focus given to the diagnosis of people with STIs **[Recommendation 16]** should consider the role that community based organisations can play in the diagnosis and support for people with HIV.

The attention given in the Select Committee Report to the continuing misinformation on migration and HIV is a helpful contribution to the debate **[Recommendation 18]**. This is a complex issue and we would support an open and transparent examination of it that is not only cross-governmental but also involves specialist groups who can provide additional expertise.

2.4 Emergency contraception

We welcome the fact that the Government approved the pharmacy provision of emergency contraception in 2001, and that since this time emergency contraception has been available to buy over-the-counter, as well as being freely available on prescription from doctors and family planning clinics.

However, in order to ensure that women are given due information and advice in a confidential setting when they access emergency contraception through pharmacies, we would like to see a review and, where necessary, modernisation of the premises from where pharmacists provide emergency contraception.

3. Capacity

3.1 Abortion

The IAG welcomes the recommendation that greater use should be made of early medical abortion, which is currently an under-utilised alternative to surgical procedure **[Recommendation 33]**.

⁴ Government Response, p10

The IAG also proposes further areas which should be addressed in addition to those recommended by the Select Committee:

- Investigation of alternative service delivery models – highlighting early medical abortion – to increase access via non hospital service delivery sites.
- Raising awareness and disseminating information about developments of abortion procedures, including Manual Vacuum Aspiration (MVA) and use of conscious sedation as an alternative to general anaesthesia, through additional research.
- Advocacy targeted at relevant Royal Colleges – the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of General Practitioners (RCGP) in particular – to raise awareness of the need for training in abortion procedures.
- Integration of early abortion into Sexual Reproductive Health (SRH) provision, in particular forging greater linkages with family planning services.
- Further consideration to be given to testing for HIV prior to abortion – this is now felt to be extremely important due to the high HIV positivity rates among women presenting for abortion, and would parallel the testing already offered to women in antenatal clinics who are continuing with their pregnancy.

Although investment may be required to make the necessary advances in service delivery, access and overall, this would be offset by the introduction of lower cost models for services in the medium to long-term.

3.2 Contraceptive services

The Select Committee Report indicates the inadequate level of investment in contraceptive services **[Recommendation 29]**, which impacts negatively on the level of staffing. The Faculty of Family Planning recommends that all contraceptive services should have a medical consultant lead, and that there should be one whole time equivalent (WTE) consultant per 125,000 population. This means that there should be 450 WTE consultants in the UK, which is significantly more than the 70 WTE consultants there are at present. This has serious implications for the quality of patient care and clinical governance.

We recommend that retiring SCMOs and Associate Specialists be replaced by a Consultant lead so that no contraceptive service functions without a lead.

3.3 GUM services

We agree that many clinic premises are of “an unacceptable standard” **[Recommendation 14]**. We strongly recommend that Strategic Health Authorities and PCTs be encouraged to take responsibility for a two-year programme of multidisciplinary clinic reviews to assess service capacity, staffing, premises, supporting infrastructure, and modernisation. This programme will need strong leadership from the Department of Health. As well as strong leadership, capital resources will need to be made available for the modernisation programme. We recommend that findings from individual clinics be collated by Department of Health and a national report be published. To this end we very much welcome SoS for Health’s announcement of a further £15m to improve GUM services by modernising premises and facilities within clinics, which we understand will be available from April this year.

We feel it is essential that no consultant work alone, and we recommend the further development of clinical networks and optimal clinical governance by sharing additional consultant posts across adjacent clinics **[Recommendation 12]**. In meeting this aim we welcome the development of a specific standard

for the development of managed networks, which the Medical Foundation for AIDS and Sexual Health is undertaking on behalf of the Department of Health⁵.

3.4 Sexual dysfunction

The scant mention of sexual dysfunction in the Strategy and the Implementation Plan is of major concern to us, and we agree that sexual dysfunction should be included within the wider Sexual Health Strategy [**Recommendation 34**]. Sexual dysfunction, a cause of much suffering for patients, is common, under-reported, poorly managed, and services are often under-funded.

In order to allow for the most appropriate use of resources it is essential that best practice guidelines for the identification, assessment and management of psychosexual problems and sexual dysfunction are established. This should be supported by the provision of training so that a wider range of practitioners can recognise and assess individuals with these problems. There also needs to be a better understanding of the level of service need so that there can be more consistent commissioning and less variation of provision across England. Commissioning and provision of services may be best achieved across a number of PCTs co-ordinated by a Strategic Health Authority, as this would help to streamline service provision.

The IAG endorses the view of the Select Committee that the current policy for the provision of anti-impotence treatments is contrary to the principles of the NHS and should be reviewed. We support the more liberal prescribing of appropriate medication and call for additional resources to enhance service, both in primary care and in specialist services. The IAG also feels that the broader discussion of sexual dysfunction as outlined above will put the issue of anti-impotence treatments in context and allow the availability of care for all sexual dysfunction and psychosexual problems to be addressed.

These recommendations should all form part of the overall Implementation Plan of the Strategy. This should ensure that progress can be monitored and that establishing consistent sexual dysfunction care across England is facilitated by the mechanisms being developed to allow implementation of other aspects of the Strategy.

3.5 Professional training

The recommendations of the Report will only be delivered in full and to the necessary standards if all those involved in delivering sexual health services and in sexual health promotion have relevant and high quality training [**Recommendations 22 and 23**]. This includes training in communications skills, values and attitudes, and in working with young people and more marginalised groups in the community.

There is currently a training strategy accompanying the Strategy Action Plan which will bring together clinicians and non-clinicians with training roles to agree quality standards and form an ongoing Standing Group on Sexual Health Training. Agreement needs to be reached with the clinical training organisations that training in the non-clinical aspects of sexual health work – such as values, attitudes and anti-discriminatory practice in delivering services – should be integral to all training for this work.

We welcome and endorse the Government's assertion that "We can only deliver high quality sexual health services if staff are appropriately trained so that they are well placed to respond to all patient needs"⁶, and we urge that a fully comprehensive sexual health training strategy is developed as a matter of urgency.

⁵ Government Response, p17

⁶ Government Response, p4

The great diversity, quality and content of training courses in STIs, HIV care, contraception and psychosexual medicine continues to be problematic. The Strategy should pave the way to greater consistency and consensus but this is slow to emerge. Validation and accreditation for courses is also required. There is now an excellent model for the training of primary care workers in the management of drug misuse in general practice and there is no reason why this cannot be reproduced for sexual health.

We also endorse the work that is being done by the Royal College of Nursing to provide training on sexual health, including the development of a distance learning programme for nurses, and discussions with the Faculty of Family Planning on joint training around areas such as contraception. Nurses are in an ideal position to deliver the aims of the Strategy, and we are keen to see further opportunities opened up to enable them to do so, including encouraging skill mix with nurse competencies.

3.6 HIV services

There is concern that the removal of dedicated funding for treatment and prevention in recent years will place at risk the investment in services over the past 20 years. The IAG is particularly concerned that there should be a commitment to ongoing funding, not one-off, to ensure the availability of appropriate treatment and care for all those eligible.

The need to ensure that disinvestment does not become a major problem places greater onus on the reformed AIDS Control Act. The revised report format should include clear questions on resource use, including additional funds granted to specialist services, and the Department of Health should publish a review report on these returns on an annual basis.

4. Commissioning and Prioritisation

In the Government's Response to the Select Committee report, we welcome the statement that: "The clear message is that we expect PCTs to be addressing issues around waiting times and investing appropriately in these services. We would expect to see this appropriately reflected in Strategic Health Authorities' Local Delivery Plans (LDPs), in turn feeding through to PCTs"⁷.

However, it is clear from the evidence gathered by the Select Committee that sexual health is often downgraded and deprioritised across services, and that PCTs are not currently treating sexual health as a priority area. Indeed, a recent survey of Strategic Health Authorities' LDPs showed that the NHS, at a local level, plans to give little attention to tackling the rapidly growing HIV and STI epidemics. It also plans to show little attention to improving contraception and abortion services. Out of 24 LDPs the review showed that: teenage pregnancy was mentioned in fifteen plans; sexual health was mentioned in ten plans; HIV was mentioned in seven plans; STIs were mentioned in two plans; and abortion and contraception services were not mentioned in any of the LDPs reviewed⁸.

We welcome the commitment that the Chief Medical Officer (CMO) and Chief Nursing Officer (CNO) will seek to achieve greater priority for sexual health and HIV within the current NHS Planning and Priorities Framework (PPF) for 2003-2006⁹, but we urge that specific targets around sexual health and HIV should be included in the next PPF. It is crucial that sexual health and HIV are seen as a priority in order to provide adequate and effective services, and the IAG is keen to work with the Government to ensure that this is fully incorporated within the next PPF.

⁷ Government Response, p6

⁸ *Review of Strategic Health Authority Local Delivery Plans (August 2003)* – Terrence Higgins Trust, fpa and Brook

⁹ Government Response, p6

Sexual health and HIV should also be included in all LDPs [**Recommendation 21**], and we recommend that there should be an explicit role for Strategic Health Authorities in ensuring implementation of this recommendation. We also endorse the Committee's recommendation that sexual health and HIV should be a National Service Framework (NSF) [**Recommendation 49**]. We recognise that the Government is not prepared to introduce such a NSF at this stage, which in any case would be a long-term development. However, we urge the Government to rectify the missed opportunity whereby sexual health has been left out of the current PPF, and hope that the Government will consider the development of a NSF in the future.

We welcome the fact that ministers "wish to see an additional indicator for sexual health in the star rating system for PCTs", and that "they have therefore asked officials to work with CHAI (The Commission for Healthcare Audit and Inspection) to determine the most effective indicator"¹⁰. We urge that CHAI should take a leading role in ensuring that sexual health is an integral part of public health and has priority in the NHS, and should fully inspect the quality and delivery of sexual health provision.

4.1 Contraceptive services

The Select Committee Report notes that "contraception just seems to have disappeared" in relation to the published aims of the Strategy for Sexual Health and HIV. The IAG backs this statement – the NHS is facing serious difficulties in contraceptive service provision similar to those which we are currently experiencing with STI prevention, treatment and care.

There is a clear gap between the intentions of the Strategy with regard to contraception and the reality of the fragile network of community contraceptive clinics and largely unconsidered contraceptive provision in primary care. The Strategy must be effective at PCT level if it is to achieve its aims, and must be afforded political prioritisation in order for this to happen.

Specifically, we believe that the Government should take steps to prioritise both sexual health overall and contraceptive services as a specific area. We urge the Government to define and implement a specific workplan to support the improvement of contraceptive service delivery at PCT level. It should also be recognised that specialist contraceptive service provision complements contraceptive service in primary care, and some contraceptive services have successfully integrated basic STI diagnosis, thereby increasing access to sexual health care at a community level.

4.2 Primary Care Trusts

PCTs have many delivery priorities, and sexual health and HIV is rarely on the list. The abolition of Health Authorities (HAs) and the creation of PCTs in England, the loss of ring-fenced funding and HA-held budgets has resulted in dissipation and further fragmentation of skilled commissioners in sexual health and HIV.

We support the inclusion of sexual health and HIV in Local Delivery Plans, but do not believe that the 'Reducing Inequalities' section of the 2003-2006 PPF is sufficient to improve access to sexual health services¹¹. Strategic Health Authorities, especially those outside London, appear to have already de-prioritised sexual health, as shown by the recent review of Local Delivery Plans. PCT sexual health leads come from disparate backgrounds, have varying degrees of time, skill and support to fulfil their role as expected in the implementation of the Strategy, and often have an impossible task to keep sexual health on their PCT's agenda.

¹⁰ Government Response, p10

¹¹ Government Response, p6

In the Government's Response to the Select Committee Report it is made clear that: "Under Shifting the Balance of Power, the emphasis is to move away from centralised control and target setting"¹². However, this "greater local flexibility in allocating budgets and determining local priorities"¹³ is still tied up with the targets and priorities set nationally, particularly those in NSFs and the PPF. In the context where PCTs inevitably do not have sufficient resources to meet all local priorities fully, those – such as sexual health – which do not have national targets attached to them invariably suffer in terms of prioritisation and investment.

We strongly support the formation of consortia to provide expertise, direction and impetus to drive the improvement of local services **[Recommendation 25]**. These consortia could also provide a useful means of spreading best practice between PCTs.

Well formulated and targeted sexual health promotion works and we support the recommendations to ensure specific funding to support and maintain local specialist health promotion services, and for PCTs to be held to account for this **[Recommendation 36]**.

4.3 New GMS contract

We agree with the Select Committee Report that GPs can play an important role in the management of HIV and testing in undiagnosed individuals **[Recommendation 22]**. In our view there is also a need for clear guidelines on how integrated or parallel care will operate between GPs and specialist centres. We recognise the importance of this development but we also see the barriers for patients and doctors in discussing lifestyle and risks. In order to meet Level 1 and 2 requirements – for HIV and other sexual health areas – GPs and their teams need education, training and support, all of which require adequate funding **[Recommendations 28 and 30]**.

Since the publication of the Select Committee Report significant progress has been made in the development of the new General Medical Services (GMS) contract. The IAG would like to use this opportunity to endorse the view of the RCGP Task Group for Sex, Drugs and HIV that it is disappointing to see that all of sexual health (other than contraception) has been placed in Nationally Enhanced Services. We see sexual health as a core part of a person's well-being, the care of which should not be placed into an opt-in service. We echo the Task Group's concern that contraception is again being separated from other aspects of sexual health, allowing for potential bad practice. The new GMS contract also fragments sexual health services in a way that is at variance with the levels of service within the National Strategy.

We do not believe that sexual health should be put in the category of a National Enhanced Service. Under the new contract GPs need to react to all medical complaints that may present to them, but we fear that by placing sexual health in the more specialist category of an enhanced service we will allow the less skilled or aware practitioner to continue to practise poor and potentially indefensible medicine **[Recommendations 28 and 30]**.

There is a significant problem with unmet need in sexual health in primary care attenders, and the only way to address this is to improve the quality of care and opportunistic approaches within primary care as a whole – to look at sexual health outside of a general primary care context is simply inappropriate.

¹² Government Response, p12

¹³ Government Response, p16

5. Funding

In the Government Response to the Select Committee Report we welcome the announcement of an additional £11 million to be allocated to sexual health this year: £5 million to GUM services, £5 million to facilitate the introduction of a more reliable, non-invasive chlamydia test, and £1 million to contraceptive services. We are also encouraged that “the Government does recognise the need for additional targeted investment in areas where there are the most pressing sexual health problems”¹⁴.

However, we are concerned that even this additional investment is not enough to tackle current needs in sexual health. Specifically, the new funding has been announced as non-recurrent, and we do hope that this can be addressed. As far as GUM clinics are concerned, the need is for additional staffing to increase capacity – whereas non-recurrent funding is very difficult, often impossible, to translate into sustainable capacity increases. The rapid replacement of sub-optimal chlamydia testing methodologies by nucleic acid amplification tests (NAATs) will be very difficult to achieve unless laboratories can be assured that the new monies will be made recurrent – either by the Department of Health, or by PCTs (with appropriate guidance).

5.1 GUM services

We support the recommendation that the Government make long-term planning and funding commitments to expand the numbers of consultants in Genitourinary Medicine [**Recommendation 8**]. We also recommend an accelerated timetable to make good the identified shortfall of 180 WTE consultant posts in England. This will require increases in the numbers of centrally funded specialist registrar training posts.

We also agree with the need to increase the numbers of nurses, health advisors, and other essential members of the multidisciplinary GUM clinic team [**Recommendation 10**].

We agree with the Select Committee Report that there is a need for £22-30 million of additional revenue per annum to increase GUM service capacity, and for mechanisms to ensure that additional resource reaches its intended target [**Recommendation 9**].

We continue to see money for sexual health and HIV treatment being diverted in hospital trusts. HIV drugs must be adequately and separately funded with an expectation that robust financial accounting be normal practice [**Recommendation 11**].

5.2 HIV services

GUM clinics remain the principal provider of specialist HIV care in England. There is widespread scepticism about the ability of many individual PCTs to understand the complexities of HIV commissioning and the very large sums of additional resource involved. The expected 6500 newly diagnosed HIV patients in 2002 will necessitate around £100 million per annum in additional resource for treatment and care. We believe that local consortia of adjacent PCTs will be necessary to ensure that additional resource for HIV patients is assured without detriment to other services, especially specialist STI services.

We believe that there needs to be Department of Health commitment to support the infrastructure and social support required to ensure cost-efficient use of HIV treatment, and guidance to PCTs on doing so. We would also like to see commitment to ongoing funding, not one-off, to ensure availability of appropriate treatment and care for all those eligible.

Consideration should also be given to funding for a programme of modernisation in the delivery of sexual health services in the acute, voluntary and community sectors.

6. Prevention

6.1 Chlamydia screening

We endorse the recommendations for urgent implementation of chlamydia screening **[Recommendation 15]**, and we believe that there should be an explicit aim for this screening programme to reach national rollout within the next three years. This should routinely be offered to women having a first smear and aged less than 25 years attending all family planning, termination of pregnancy, infertility and GUM clinics, as well as in primary care, and be available for screening men. With the successful initiation of the 10-site roll out, much of the infrastructure required for central coordination and implementation are now in place, and every effort should be made to expedite roll-out across England.

Moreover, chlamydia screening must be seen in the wider context of its causal effect on other medical conditions, most notably pelvic inflammatory disease (PID), which can cause infertility. The National Institute for Clinical Excellence recently recommended free IVF treatment on the NHS, but that has not been accompanied by any reference to the rising rates of chlamydia, despite the identified causal link between chlamydia and infertility. Evidence shows that screening for chlamydia decreases cases of PID by 64 per cent. Investment now could help to forestall a huge rise in the costs of infertility treatment in the future.

We acknowledge the need for innovation in chlamydia screening **[Recommendation 16]**. However, we believe that it is important that this is locally driven, linked to local chlamydia prevention and control efforts, and properly evaluated. We recommend that sites selected in the chlamydia screening roll-out should be encouraged to implement innovative programmes to supplement their screening activities. We also recommend that models of good practice and innovation be disseminated widely, in particular to those areas where screening is taking place. The Department of Health should, through the national chlamydia screening steering group, form a focus for collating and disseminating these examples of good practice.

We are concerned that Department of Health pump-priming funds should not be seen as the only means of starting chlamydia screening at local NHS sites. PCTs should be encouraged to commence screening with the roll-out programme. In so doing, the Department of Health funding should be viewed as a means to enhance and augment local programmes.

We fully endorse the Select Committee's opinion that the widespread use of suboptimal tests for chlamydia diagnosis is "scandalous and is highly vulnerable to damages claims made by patients" **[Recommendation 17]**. We strongly urge their urgent replacement by NAATs for chlamydia throughout England. The Health Protection Agency (HPA) has also endorsed this recommendation, and we welcome the fact that the CMO has now written to PCT Chief Executives highlighting the concerns about the use of the sub-optimal test for chlamydia and seeking bids for funding to ensure that all major laboratories in each region of England use NAATs. The use of chlamydia NAATs will also allow wider screening of young men, especially outside the traditional clinic setting.

We would also go further – we feel that it is essential that clear guidance be given by the CMO in the implementation of NAATs for diagnostic purposes and ways in which the new technology may be implemented. In addition, we recommend that, rather than all laboratories investing in NAAT technology immediately, this be done in a phased approach which takes into account regional diagnostic capacity and expertise and the development and functioning of Pathology Networks. The Regional Microbiologists may play a key role in this regard.

6.2 Male screening

We agree with the need to target men in all chlamydia prevention and control efforts [**Recommendation 16**]. We note that men will be screened as part of the chlamydia screening roll-out programme in GUM, family planning and youth clinic sites. We also endorse the piloting in York of chlamydia screening in secondary schools to reach both young men and women¹⁵, and hope that this will be rolled out more widely if it proves to be successful.

Nevertheless, opportunities for screening in prisons, youth offender institutions, educational establishments, occupational screening and in non-traditional settings may be missed. We suggest that chlamydia screening in prisons and remand centres be included in sites being selected as part of the chlamydia screening roll-out programme.

We also recommend that the Medical Research Council Sexual Health and HIV Research Committee be encouraged to consider funding demonstration projects for the effectiveness and cost-effectiveness of chlamydia screening in men to inform the expansion of this intervention.

7. Education and Sexual Health Promotion

Much of the formerly ring-fenced budget previously split between HIV prevention/sexual health promotion and treatment is now being swallowed up by the costs of more expensive HIV treatments [**Recommendation 36**]. The lack of specific funding for sexual health promotion is a continuing problem and will make it difficult for some of the goals set in the Select Committee Report to be delivered.

In this context, there is currently no 'lever and driver' for sexual health promotion. In many areas sexual health promotion teams are being disbanded and broken up into a number of PCTs, with the critical mass of expertise being dissipated and lost. This is inevitably going to have a deleterious effect on sexual health promotion and HIV prevention at local levels.

This is extremely short-sighted because if we are not working 'upstream' (i.e. in prevention), then the costs of work 'downstream' (i.e. in treatment and care) will continue to soar. Prevention really is better than cure – not just in terms of health economics but also in relation to the reduction of human misery.

It is therefore vitally important that significant emphasis is given to education and health promotion as well as to the provision of clinical services. Guidance should be given to PCTs to ensure that sexual health promotion is included in LDPs and that both the Commissioning and Sexual Health Promotion Toolkits should be used to ensure quality in these areas of activity.

7.1 Target audiences

7.1.1 Young people

We fully endorse the recommendation that sex and relationships education (SRE) becomes a core part of the National Curriculum, to be delivered within the broader framework of personal social and health education (PSHE) along with citizenship [**Recommendation 40**]. We support the recommendations from the Teenage Pregnancy Independent Advisory Group¹⁶ that PSHE should become compulsory at all

¹⁵ Government Response, p21

¹⁶ Teenage Pregnancy Independent Advisory Group Annual Reports 2001 and 2003

Key Stages in the Curriculum, and that every secondary school in the country should have a specialist PSHE teacher by 2006. We also recommend that PSHE has a statutory status within the curriculum, as we are concerned about the efficacy of relying on SRE as an optional component of PSHE. The IAG pledges to alert the Government to both good and bad practice in this area.

Children have a right to SRE and PSHE, and both are entirely necessary for producing responsible and competent citizens. In this context, we recommend that the right of parents to opt their child out of SRE elements of PSHE on any grounds including those of faith or religion should be explicitly ended.

PSHE and SRE programmes need to provide the opportunity for young people to gain practical skills e.g. in dealing with pressure, in assertiveness, in negotiating and in saying 'no' [**Recommendations 37 and 38**]. Alongside informational input and advice and support on accessing local services, this is vital if young people are to put into practice the knowledge they are gaining.

Research continues to tell us that young people are not aware of HIV and AIDS in the way that they were in the mid to late 1990s. To address this there needs to be a concerted effort to include discussion of HIV and AIDS in the PSHE curriculum, and also across the curriculum more broadly in terms of global issues e.g. in development studies, geography, and economics.

All PSHE programmes should also pay attention to the needs of lesbian, gay and bisexual (LGB) young people and should ensure that diverse sexuality is reflected in the whole of the SRE programme. In addition, where citizenship programmes address issues of diversity and equal opportunities, LGB issues should be addressed alongside other forms of diversity [**Recommendation 43**].

Research continues to tell us about the parlous state of affairs in schools and youth settings around homophobic bullying, and the rates of suicide, attempted suicide and self-harm among young LGB people should be a cause for grave concern. All schools should therefore specifically include homophobic bullying and harassment in their Bullying and Equal Opportunities Policies. Visible work to make it clear that homophobia is as unacceptable in schools as racism should be made at all levels. Where necessary this may require training for staff and governors to ensure they feel competent and comfortable in handling these matters.

Reported cases of rape and sexual assaults grow in number while prosecutions for these decline. It is therefore suggested that schools and informal youth settings address education work on these issues. This may be within SRE, as a way of exploring what is and is not acceptable in relationships, or within other parts of the curriculum dealing with violence – including domestic violence – and safety. Even better would be for it to be in both.

While agreeing with the Select Committee on the importance of peer education as an effective approach with young people [**Recommendation 45**], we would want to express a concern that this should be done in responsible ways, since it is a powerful tool which, mishandled, has the potential to be extremely damaging for young people. A set of quality standards for peer education in SRE should therefore be developed. All those developing peer education projects in formal and informal educational settings should be required to work to these guidelines to safeguard young people, facilitators, and the integrity of this delicate but undeniably effective work.

The IAG welcomes the reference in the Green Paper 'Every Child Matters' to the importance of sexual health for children and young people, and we will do all we can to help ensure that sexual health is properly dealt with alongside all of the other children and young people's issues.

7.1.2 Young people with learning disabilities

The needs of children and young people with learning disabilities for supportive, appropriate and person-centred SRE are the same as for any other young people, but all too often this is an overlooked and forgotten group. Children and young people with learning disabilities have as much right to be sexual as other children and adults, and their need for SRE is if anything even greater given that their disability makes them especially vulnerable to abuse or sexually exploitative relationships.

All of the above points relevant to young people generally should therefore also apply to Special Schools for those with learning disabilities, and for specialist provision in workplaces, Further Education colleges and Connexions. They should also apply to work with parents of children and young people with learning disabilities. In particular, importance should be placed on building a skills base with this group in assertiveness and saying no to pressure.

7.1.3 Parents

We advocate more programmes supporting parents' role in talking with their children about sex and other sensitive issues **[Recommendations 44 and 45]**. In particular, we suggest the community-based approach such as that taken by SpeakEasy (fpa), and the peer education approach such as that taken by Parent to Parent (Centre for HIV and Sexual Health). These are especially effective in that they build capacity in communities, draw on parents' own skills, and have been positively evaluated as enabling parents to gain greater confidence in this area.

7.1.4 Schools

As we know, there is often difficulty with young people in schools getting access to in-depth appropriate information on sexual health **[Recommendation 39]**. One way of tackling this and ensuring access is universal would be to make the Teenage Pregnancy Unit's 'R U Thinking?' available via website and CD-ROM to every school and IT department. In this way, with supportive information to staff on enabling students to be able to find and work with these materials, all students and pupils could be assured of good, safe and comprehensive information.

If there is to be greater multi-agency work in schools in delivering and contributing to PSHE programmes – and we would support this approach – there needs to be clarity about the roles of each agency and in particular about confidentiality protocols **[Recommendation 41]**. For example, there is confusion about the role of Connexions Personal Advisers (PAs) on confidentiality and this needs clarifying and strengthening so this role does not cut across or undermine sensitive work being done by staff from other agencies working with young people.

All PAs should be trained, skilled and confident to deal with young people and children who may disclose abuse. But they, and all of those working within school settings, also need to be aware of the Fraser Guidelines and work in a way which is not inconsistent with these when addressing issues of consensual sexual activity between young people.

7.2 Specific subject areas

7.2.1 Abortion

Alongside the provision of faster access to abortion, there should be a comprehensive support for awareness raising programmes and education about abortion. For example, information about local sexual health services should always include information about accessing abortion services. The SRE elements of

PSHE should include education about choice, and awareness campaigns on sexual health should address issues of abortion as a choice.

Only in this way will we begin to change the culture of taboo and silence which surrounds abortion. 'Talking About Choice' – the education programme led by the charity Education For Choice – provides an excellent model for this.

7.2.2 HIV

The proposal that PCTs should support a range of interventions through their own health promotion activity and community based agencies is welcomed. PCTs should also be given guidance which includes details of proven health promotion strategies for behavioural change and the targeting of these to communities at greatest risk within their HIV prevention programmes [**Recommendation 35**].

The changing pattern of the epidemic highlights the need for dedicated training for professional groups like social workers and administrative staff working in GP practices and other relevant settings.

People with HIV should also be explicitly prioritised as a target group for sexual health promotion, and should have rapid access to a full range of sexual healthcare including STI screening, contraception provision and prevention advice.

8. Patient Voice

If we are to shape our services to best suit our patients' needs then the voice of the service users must be heard [**Recommendation 2**]. There are many working examples of user involvement in service design and delivery despite stigma and marginalisation.

We agree that it is just as important to develop local and national mechanisms to obtain feedback from patients attending GUM clinics for STIs as it is for HIV patients. Moreover, patients must be allowed to choose to access HIV and sexual health services from outside their PCT area if they wish, as well as have local choices of service providers [**Recommendation 27**]. The wish to remain anonymous is a major issue in sexual health and HIV care.

The nature of abortion means there are no vocal user groups. However, independent providers are geared up to carry out surveys and this could be utilised to get women's views on what they want from services.

There must also be appropriate support mechanisms in place for people living with HIV/AIDS, in order to ensure that they are able to engage in patient participation structures and to have their voices heard.

There are not currently mechanisms in place to register patient voice about contraceptive services, and we believe that this is a critical area in which patient views of both primary and community level provision are needed to ensure that these services meet their needs.

We welcome the recent commencement in post of the new Director for Patients and the Public, Harry Cayton, whose role will be to champion the voice of patients, carers and the public throughout the NHS and in the Department of Health. We urge that the needs and voices of patients accessing sexual health services are fully included within this remit, in particular for services where their sensitive nature means that individual patients themselves may not speak up.

9. Conclusion

The IAG welcomes the emphasis that the Government is beginning to place on sexual health and HIV. In particular we recognise the valuable work achieved to date in producing the first National Strategy for Sexual Health and HIV, drawing up the Implementation Action Plan for the Strategy, and the important steps which have already been taken to implement the Strategy.

However, as the Select Committee Report so clearly demonstrated, much work remains to be done to improve the sexual health of the population across the board. The Committee highlighted six key factors which it believed were the principal causes of the current situation **[Recommendation 47]**:

- 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.

The IAG agrees that all of these factors must be addressed if we are going to drive the sexual health agenda forward. In particular, we believe that sexual health and HIV must be explicitly prioritised at both a local and national level – and, as part of this prioritisation, allocated further resources – in order to achieve the wholesale upgrading of services which is necessary to guarantee a significant improvement in sexual health in this country.

