The Association of Directors of Public Health
Policy Position: Sexual Health

Key Messages

- Sexual health is about wellbeing, not just services. Education and preventative actions to build resilience are as important as the provision of high quality sexual and reproductive health services.
- A whole system approach is needed to bring together reproductive health, sexual health and human immunodeficiency virus (HIV), encompassing commissioning, strategic planning, service provision, prevention, and health promotion.
- Sexual health commissioning and service provision should embrace technologies and digital services that are evidence-based. This requires training, funding, and evaluation.

ADPH Recommendations

National

Long term planning: Governments across the four nations should have in place a long-term, funded Sexual and Reproductive Health Strategy which sets out a collective vision to promote good sexual health for all.

Investment in public health must be increased across the four nations. In England, the Public Health Grant needs £0.9 billion more a year to reverse years of funding cuts.[1] Appropriate funding for pre-exposure prophylaxis (PreP) is essential if the Government is to meet its goal of zero new cases of HIV by 2030.

A whole system approach: Sexual and reproductive health services should be integrated encompassing commissioning, strategic planning, service provision and health promotion to reduce fragmentation and empower individuals.

Prevention: Genitourinary medicine (GUM), HIV and contraceptive services in England should be integrated to prevent sexually transmitted infections (STI), and to promote contraceptive choice, regular asymptomatic testing, and early identification. Sexual education programmes also play an important role in prevention.

Health inequalities: Strategies must be in place to improve sexual and reproductive health services access and uptake especially for hard-to-reach groups. It is necessary to address cultural and behavioural influences on health choices such as the stigma associated with STIs.

New technology: National bodies should prioritise support for innovative technologies and digital services, building on successes such as self-sampling HIV testing. This requires adequate training and funding.

Workforce: Retention of GU (genitourinary) trained and primary care staff, and an expansion of the workforce to include diverse skillsets is necessary to continue the provision of innovative services and technologies, and to meet the growing demand on services.

Recommendations of 'Sexual health, reproductive health and HIV: commissioning review' should be fully implemented in England: This involves revising commissioning guidance, facilitating sexual health networks, developing a Practice Improvement framework and enhancing commissioning support tools.[2]

Local

All providers and commissioners/service planners should work together locally to promote a whole systems approach to:

- Develop models for integrated commissioning, and service provision
- Seamless, affordable service pathways
- Strong area based networks and partnerships
- Address barriers to primary care
- Promote system led improvement

Local public health authorities[1] (eg Integrated Care Boards in England) should work together to deliver an integrated approach to sexual and reproductive health in their local area. A named lead and a central workforce strategy will provide accountability.

Practice Improvement approaches: commissioners and public health leads should utilise Practice Improvement tools and encourage the sharing of good practices to improve services.[3] [4]

Background

In England in 2022, there was an 13.4% increase in sexual health screens performed by sexual health services, as well as a 23.8% increase in new STI diagnoses , compared to 2021, with gonorrhoea diagnoses increasing by 50.3% in this period, to the highest level since records began.[5] In Scotland, a 49% increase of diagnoses of gonorrhoea was recorded between 2019 and 2022, despite levels of testing in sexual health clinics not yet fully recovering to pre-pandemic levels.[6] In Wales, chlamydia and gonorrhoea diagnoses were at a 10-year high in 2022, with a 22% and 127% increase respectively for the 2021-2022 period.[7] In addition, HIV diagnoses among those who were previously diagnosed outside of the UK have increased in all the four nations.[8] [9] Resources are needed to support those living with HIV who have moved to the UK.

The Covid-19 pandemic influenced access to testing and changes related to sexual and healthcare seeking behaviours. The introduction of postal testing schemes has substantially increased the number of STI tests undertaken and has affected sexual health service attendance in some nations.[10] The outbreak of Monkeypox in 2022 also led to additional pressure on sexual health services. Additional resources and planning are required for services to recover from the impact of the pandemics.

Inequalities exist in people's access to sexual health service and their outcomes. People of Black ethnicity had the highest rate of STI diagnoses of all ethnic groups in 2021. Those in the most deprived areas also experience higher rates.[11] Gay, bisexual and other men who have sex with other men (GBMSM) are disproportionately affected by HIV infection – making up 41% of new HIV diagnoses in 2019.[12] Similarly, 81% of new syphilis and 66% of new gonorrhoea diagnoses in men in 2019 were in GBMSM.[13] Inequalities exist in the rates of blood borne viruses (BBV). In Scotland, Hepatitis C is strongly patterned with levels of deprivation – diagnoses are highest in the most deprived.[14]

Although the UK ranks highest in Europe for Government policies on access to contraceptive supplies, family planning counselling and the provision of online information on contraception[15], inequalities exist

[1] By local public health authorities we mean bodies with statutory local responsibility for public health functions (eg upper tier local authorities in England, Health Boards in Scotland and Wales, Public Health Service in Northern Ireland). These differ across the UK, Crown Dependencies, and associated territories. We have published a separate headline explainer on public health in each of these systems.

within the four nations. In England, areas with the fewest ethnic minorities spend more than four times as much on contraception prescriptions as those with the largest ethnic minority populations, indicating inequalities in access to contraception.[16]

Policy Context

The English Government has committed to publishing an updated Sexual and Reproductive Health and HIV: Strategic Action Plan, however it has been delayed. In 2021, the English Government published the Towards Zero: the HIV Action Plan for England – 2022 to 2025 which set out how it will achieve an 80% reduction in new HIV infections by 2025.[17] In 2022, it published the Women's Health Strategy for England which covers areas such as menstrual health, gynaecological conditions, fertility, pregnancy, pregnancy loss, and post-natal support.[18]

The Scottish Government published the Reset and Rebuild – sexual health and blood born virus services: recovery plan in 2021 to review the impacts of Covid-19 on Sexual Health and Blood Borne Virus (SHBBV) services and people that use them, ahead of the review of the SHBBV Framework.[19] The Women's Health Plan 2021-24 was published by the Scottish Government to layout actions to improve women's health inequalities, and includes details on priorities for contraception, abortion, sexual health and pre-pregnancy.[20]

A review of sexual health services in Wales took place in 2018. The report acknowledges the significant contribution of sexual and reproductive health (SRH) services in Wales. The report does however highlight inconsistencies in SRH service provision across Wales, including services provided by primary care, and accessibility to abortion services.[21] Since then, the Chief Medical Officer for Wales has put a call to public health colleagues for the implementation of the recommendations highlighted in the review.[22] A HIV action Plan for Wales 2023-2026 has also been implemented, which aims to eliminate all new HIV infections in Wales and achieve a zero tolerance for HIV-related stigma by 2030.[23]

In Northern Ireland, an addendum to their Sexual Health Promotion Strategy and Action Plan (2008- 2013) was published in 2015. The Department of Health are currently working on a refreshed Action Plan.[24]

ADPH Position

A whole system approach to sexual health, HIV, and reproductive health

A whole system approach to prevention is crucial to reduce the prevalence of STI and will require collaborative work between local partners such as primary care, community pharmacies, schools, youth services, substance misuse services, and Voluntary and Community Sector (VCS) organisations. It is important to bring together reproductive health, sexual health, and HIV, encompassing commissioning, strategic planning, service provision, prevention, and health promotion. GUM, HIV and contraceptive services should also be integrated to promote contraceptive choice and early identification. Attempts to tackle these issues in isolation will lead to silo working. It is crucial that services have a built-in evaluation framework to monitor how well services are working and whether they are reaching key underrepresented communities. Local public health authorities are well positioned to provide system leadership on SRH services to meet the needs of the local population.

Health outcomes for individuals can be improved through integrated care pathways and preventative

interventions targeting those most at risk.[25] There should be clear links into pathways for services such as early pregnancy assessment, abortion services, and health visiting. GPs provide routine and post-partum contraception and are also the preferred provider of long-acting contraception in women. They are well placed to have discussions on sexual health and offer STI testing (eg routine blood tests for HIV).

More public health funding needed for SRH services

Investment in public health must be increased across the four nations. Public health needs to be funded sustainably and adequately in line with local population health need. Failure to invest in vital preventive services can lead to a rise in STI and widening health inequalities. It will also reduce the capacity of treatment services to respond to unforeseen challenges such as Monkeypox. In England, local authorities' (LA) public health funding has suffered a 26% cut (in real terms on a per person basis) since 2015/16. SRH services were one of three of the largest planned areas of spend at £0.6bn, however this funding faced a 23% cut, which is one of the largest reductions in spending between 2015/16 and 2022/23.[26] Although DsPH have been acting to manage these cuts they have reached the limit of available efficiencies.

Limited resources may result in the collective risk of being off track on our efforts on HIV elimination and the prioritisation of treatment services over contraception. There should be standards for commissioners and providers to ensure equal access to both services, catering both planned as well as emergency/acute attendances. GU services especially require more funding and sufficient staffing as they are dealing with increased complexity and disease complication.

In England, a clearer national approach should be introduced to fund out of area activity for both GUM and contraception with payment systems that support accountability and reduced administrative processes. A review of current fees paid for the provision of Long-Acting Reversible Contraception (LARC) commissioned to GPs in local areas is needed to ensure that it is fully funded nationally.

Rising abortion rates

The number of abortions in England and Wales in January to June 2022 increased by 17% compared with the same period in 2021.[27] There are a variety of reasons why abortion is on the rise. The ongoing cost of living crisis means that women across all socio-economic groups are less able to cope with the emotional and financial pressures of continuing a pregnancy. Long-Acting Reversible Contraception (LARC) is also becoming more difficult to access, with longer GP wait times due to stretched NHS services and with SRH services only commissioning to offer LARC to 'sexually active' women. Underfunding, spanning years, has also affected LAs' ability to provide services when attendance at sexual health services has sky rocketed.[28] Reproductive choice is essential for giving control and autonomy to women which means choices of contraception, abortion method, location, and timing should all be prioritised in care.

Building resilience and preventing future harm

Sexual health programmes should not just be about treating illness, but also about building resilience and preventing future harm through health promotion, effective preventative programmes, education, and good access to SRH services.[29] Preventative interventions should build personal resilience and self-esteem and should promote healthy and informed choices.[30] People across the life course should be empowered to have healthy sexual and emotional relationships.

Cuts to outreach services that target high-risk groups such as sex workers and men who have sex with men, sexual health advice, promotion and prevention services leave these services and vulnerable populations increasingly exposed. Outreach in schools is available through school nursing teams and public health can

add fundamental messages on good relationships and encouraging people to make healthy choices. However, school nurse numbers have been reducing in recent years; the number of school nurses in England has fallen by approximately 30% since 2010, from 2,959 in July 2010 to 2,061 in July 2019.[31] Outreach services should be adequately resourced with a comprehensive workforce plan.

Policies should reflect changing population needs

As sexual behaviours and relationships are constantly changing, SRH policy needs to reflect the huge shift in the dynamic of sexual health. The evolving epidemiology of older adults and the ageing population of the UK should be reflected in policy and services to adapt to the increased demand amongst this age group. Between 2017 and 2019, the number of over-65s who had a common STI increased 20%, with the largest proportional increase in gonorrhoea and chlamydia.[32] The proliferation of dating apps is widely speculated to contribute to the spike in STIs reported across all age groups. One such group to be affected by this is GBMSM and evidence suggests the practice of chemsex, particularly amongst GBMSM, has led to an increase in attendance at sexual health clinics.[33] As technological advances create greater access to such applications, people can easily increase their number of sexual partners. National public health authorities[2] should prepare for the emergence of new STIs and respond to a spike in STI diagnoses and SRH clinic attendance. Congenital syphilis, monkeypox and antimicrobial resistant infections are all emerging threats to SRH services which the current system is not prepared for. Updated strategies and protocols ensure the system is dynamic and responsive to public needs.

Relationship, Sex and Health Education (RSHE) in schools

Children and young people need to be taught to look after their own sexual health, free of stigma and judgement to empower them to integrate their sexuality into their lives and make positive decisions. RSHE in schools supports young people to understand relationships, consent, and issues around abusive relationships, and allows them to develop the confidence to negotiate safe sexual relationships.[34] It should help people to be confident about the type of intimacy they want, have autonomy over their identity and how it relates to others. Broader work should also be done alongside RSHE, such as educating young people about the safe use of social media, mental health, and emotional resilience.[35] There should be more educational programmes for younger ages to achieve a life course approach, and a partnership between schools, parents and networks should be developed to support this. It is important that sex and reproductive education is coupled with timely access to confidential advice and dedicated young people's contraceptive services.

In England, years after the Government introduced statutory RSHE, only 40% of young people rated their lessons as 'good' or 'very good'. Students reported that they do not learn enough about today's most pressing issues, including pornography, LGBTQ+ relevant information and healthy relationships.[36] To deliver high quality RSHE that responds to the needs of children and young people and enables them to make informed decisions about their health and wellbeing, the teaching of these subjects and materials used should be factual, evidence based and age appropriate.

Commissioning for outcomes

The commissioning, planning and delivery of services should focus on reducing inequalities and delivering

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better sexual health outcomes covering effectiveness, safety, and individual experience of care. It is important that services cater for the needs of people of all genders and sexual orientation and at all life stages. Service users should be at the centre of co-designing services and be part of continuous feedback to and from service providers.[37] This needs to be balanced with the responsibilities of commissioners and planners to meet needs, promote prevention, and balance budgets.

At a local level, practice improvement approaches are crucial to increase the quality of services. For example, the local HIV, reproductive health, and sexual health self-assessment tool provides a baseline for improvement. [38] [39] The Local Government Association also provides case studies of innovative programmes in collaboration with LAs.[40] Robust quality outcome measures should be developed to enable the assessment of the impact of interventions across a population. National public health authorities also play an important role in supporting commissioners with guidance and tools.

Commissioning of PrEP should be carried out in a joined-up and fair manner

PrEP is an HIV prevention tool which has the potential to transform the course of the epidemic and ensure that individuals vulnerable to HIV acquisition remain HIV negative. It should be used in the context of a holistic package of measures, including the provision of condoms and support for those at risk. ADPH supports increased access to PReP from a broader range of settings as access and PreP equity remains an issue. The UK Health Security Agency (UKHSA) confirmed that HIV PreP is only largely benefitting gay, bisexual and other MSM. Research is needed on ways to increase the uptake of these groups through digital means and delivery in the community. The focus of PrEP commissioning in the future should be how it is accessed by groups with lower uptake, such as women and people from ethnic minority backgrounds.

The national roll out of PrEP has meant significant constraints on capacity in some areas. For example, in some larger urban clinics, PrEP appointments have displaced general GU treatment and care. The PrEP offer has also caused a significant increase in testing which has led to budgets being put under even greater pressure. In England, the cost of providing PrEP should lie with NHS England, as it has been in Wales since 2017. Transferring this responsibility to LAs would create a new and unfunded burden at a time when public health budgets are already being cut. PrEP funding should be aligned with other drugs to reduce fragmentation. Developing provision through community pharmacies and GPs will widen access.

Workforce and training

SRH service innovation is not possible without a robust and sustainable workforce infrastructure. Training, peer learning and support should take place in primary and secondary care across all sexual health services. Retention of staff within GUM services and primary care settings needs to be prioritised to ensure services can keep up with increasing service user attendance and demand.

In England, a review of the specialty training programme is needed to reflect the diverse range of providers and integrated SRH services now in place across the country. Currently GU registrars do not rotate to clinics run by non-NHS organisations even though many LAs commission their SHS from such groups. This means registrars' experience is limited and it may make the non-NHS consultant posts less attractive.

About ADPH

The Association of Directors of Public Health (ADPH) is the representative body for Directors of Public Health (DsPH) in the UK. It represents the professional views of all DsPH as the local leaders for the nation's health.

The Association has a heritage dating back over 160 years and is a collaborative organisation, working in partnership with others to strengthen the voice for public health. It seeks to improve and protect the health of the population through collating and presenting the views of DsPH; advising on public health policy and legislation at a local, regional, national and international level; facilitating a support network for DsPH; and providing opportunities for DsPH to develop professional practice.

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