
Introduction to Sexual Health

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Kathy French

Sexual health is defined by the fpa, formally the Family Planning Association as:

the capacity and freedom to enjoy and express sexuality without the fear of exploitation, oppression, physical or emotional harm (fpa, 2005).

Sexual health is not simply the epidemiology of sexually acquired infections (SAIs) but wider, encompassing contraception, teenage pregnancy, HIV infection, gynaecology, menopause, sexual assault, male and female sexuality and reproduction. Sexual health discourses are many and we are drawn to these by either elements of the media with messages to inform us that young people are 'out of control' in terms of their sexual activity or by the publication of rates of SAIs, abortions and conception.

These messages frequently highlight the fact that when most people talk of 'sexual health', they actually refer to it when things go wrong: to sexual problems and/or illnesses (Wilson and McAndrew, 2000).

That said, it is a positive step to hear sexual health mentioned at all because anything to do with sexual health has often been a taboo, silenced or invisibilised, something not to be discussed in public. More recently and for various reasons, publications in journals have been calling for nurses and other healthcare professionals to talk to their client groups about sex. Reasons for

this action include the need to reduce the high rates of SAIs, HIV infections and teenage pregnancies. It is frequently argued that the rates of infection and teenage pregnancy in the United Kingdom are much higher than that of the rest of Western Europe and action is needed to address these serious but preventable conditions. Despite these calls, it is important to note that not all nurses are equipped with the language and skills to address the sexual health needs of their client groups. Many professionals have had limited or, in some cases, no input during their training in matters of sexual health and if nurses do not have the language to help them, it is no wonder the issue never gets raised. Problems around the language of sex and how it is 'medicalised' and 'pathologised' are rife within health care. The client group may use terms such as 'down there' when the professionals may use vagina and the same applies to male anatomy with the lay population talking about 'manhood' and the professionals talking about penis or reproductive organ. Others, both clients and professionals, may adopt the language of silence and not refer to anything sexual at all. The client believing that the professional will be shocked if they ask a question relating to sexual health and the professional simply burying their head in the sand and thinking this needs to be talked about 'elsewhere', both leading to much confusion all around. Nurses and others often speak of holistic care but may not see the 'personal' issue of sexual health in this way. For example, a man in the medical ward who has had a heart attack may be very concerned about when to resume sexual activity, a valid request, after recovery or a woman who has had a hysterectomy or breast removed, all linked to how they are as sexual beings and the body image.

There has been, however, some major changes over the past few years with sexual health being discussed openly and with drivers put in place to improve sexual health for the population. For example, in July 2001 the Department of Health (DH) (England) published the first-ever sexual health strategy with the key aims to:

- Reduce the transmission of HIV and STIs (sexually transmitted infections)
- Reduce the relevance of undiagnosed HIV and STIs

- Reduce unintended pregnancy rates
- Improve health and social care for people living with HIV
- Reduce the stigma associated with HIV and STIs (DH, 2001).

The English strategy followed the Welsh Assembly Strategy that was published in 2000 and the Scottish Executive followed with theirs in 2003. A sexual health promotion strategy for Northern Ireland is expected soon. This has been delayed by the dissolved government in Northern Ireland.

High rates of SAIs continue to be reported in the United Kingdom, especially among young people, homosexual men and some ethnic minority populations (Miles, 2006). It is also estimated that some 63,500 adults are now living with HIV in the United Kingdom and this figure may be much higher as many individuals may not be aware of their status (French, 2007). The Chief Medical Officer (CMO) and the Chief Nursing Officer (CNO) asked in September 2007 for HIV tests to be more readily available, in effect to 'normalise' HIV tests with the aim to diagnose more people before they reach a much advanced phase in their condition when treatment options are less effective.

Teenage pregnancy rates have been a concern for the UK government as well as those of other countries for quiet some time and was first highlighted as a problem in the Health of the Nation document in 1992. The Teenage Pregnancy Strategy published in 1999 set key targets to halve teenage conceptions by 2010 (DH, 1999). Whilst teenage pregnancy rates are declining overall, there are areas where rates continue to rise, mainly where social deprivation and where lack of opportunity exist for young people.

The cost of poor sexual health could be reduced if young people were informed about sexuality, contraception and preventive measures to reduce the risk of SAIs and HIV. Frequently parents, policy makers and public opinion believe that if they withhold information from young people, this will deter them from becoming sexually active. It is estimated that in the United Kingdom alone the average cost of contraception for a young person under 18 years is around £18, whereas the cost of abortion and maternity services is nearly £750 for each unwanted pregnancy (DH, 2000). This figure does not take into account the emotional cost to the young woman and her family.

Sexual health has been highlighted in several helpful publications which address this public health issue, for example the Select Committee Report (SCR) (2003) commented on the poor sexual health of the nation and recognised the importance of targeted community-based initiatives, peer education programmes and outreach work. It was suggested by the SCR that Primary Care Trusts (PCTs) should ensure a range of interventions as a central part of any local HIV and sexual health prevention procedure (HCHC, 2003). Prior to that publication the Medical Foundation for AIDS and Sexual Health (MedFash), part of the British Medical Association (BMA), published standards for HIV/AIDS in 2002 and these standards offered recommended guidance for commissioners, providers and people living with HIV to help them plan, develop and audit HIV services. In 2005, MedFash also published recommended standards for the wider sexual health which outlined recommended waiting times for all areas of sexual health and these have been used to improve standards nationally. In 2007, we saw the publication of the Standards for HIV Clinical Care, a collaborate partnership between the Royal College of Physicians (RCP), British Infection Society (BIS) and British Association for Sexual Health and HIV (BASHH) and initiated by the British HIV Association (BHIVA). This document sets standards of care for HIV, regardless of the service where care is provided and provides guidance on the patient journey, record keeping, commissioning, training, networks and audit. Such is the interest in sexual health that the DH in partnership with others published *Recommended quality standards for sexual health training – striving for excellence in sexual health training* in 2005. The aim of that document was to ensure that anyone providing sexual health training adhered to those standards.

Sexual health was one of the five priority areas for improving public health in the government's public health White Paper, *Choosing Health: Making Healthy Choices Easier* (DH, 2004). Sexual health is included in Local Delivery Plans (LDPs) ensuring that it has a priority at a local level and that funding is protected. Unfortunately in some areas, funds allocated for sexual health do not always reach the intended target and the funding diverted to other areas at a time when financial budgets need to be balanced, again leaving sexual health in some areas a neglected state. Sexual health and the stigma attached to it renders it an area of health

care which has been neglected over the years but the present government and those in power in Wales and Scotland have taken major steps in recognising the problem and provided funding to address the imbalance and making sexual health a public health priority. The fact remains that SAIs, including HIV infection, teenage pregnancies and abortions are on the whole preventable conditions. The provision of sexual health services and health promotion which meets the needs of the population is vital to address the issue. Sexual risk taking is often linked to the use of drugs and alcohol amongst young people and although many of them may be very knowledgeable about preventative measures, this can change under the influence of other circumstances. The Independent Advisory Group (IAG) for sexual health published a report on the impact of drugs and alcohol and recommended that any work on drugs, alcohol and sexual health should be linked together when addressing preventable measures for all three (IAG, 2007).

Baroness Joyce Gould who chairs the IAG at the DH and a wonderful advocate for sexual health states that:

...good sexual health matters. It is a crucial ingredient in the overall good health of the nation. If we are to see a downward trend in the level of STIs and HIV, we have to ensure that money is ring fenced; that there is targeted intervention, targeted health promotion and early testing; and that we increase awareness of the dangers of unprotected sex (Baroness Gould of Potternewton, House of Lords, December 2006).

Nurses can be a force in challenging the stigma associated with sexual health as highlighted by Evans (2004) when he stated that:

nurses can never be immune to the influences of these sexual stigmas because they, too, are part of the culture and societies from which these stigmas emanate (Evans, 2001).

Sexual health nursing is experiencing a time of long-overdue attention and growth and this is not a minute too soon with many nurses extending their roles within the speciality. The first-ever competency standards were published by the Royal College of Nursing in collaboration with all the key nursing bodies (GUNA, NANCSSH), the fpa, and in consultation with the Faculty of Sexual and Reproductive Healthcare (FSRH) and BASHH in 2003. These have been updated in 2007 and they assist nurses to progress from novice to expert, following a career trajectory (RCN, 2007). Unlike

doctors, nurses do not have the same structure to help them move up the ladder in their chosen field of practice. Nurses can leave the acute sector and go into general practice and be expected to deliver on sexual health, which is totally unfair to nurses and clients. Major advances have been made by nurses in the field of sexual health, many are able to screen for SAIs, prescribe the medications needed, assess contraception needs and prescribe/supply or administer the chosen method. Other nurses specialise in abortion care, HIV or genitourinary medicine (GUM) services. There are a growing number of consultant nurses within the speciality and these leaders are taking the service forward. For example, one large service provider in Inner London (Mortimer Market, Camden PCT) has a consultant nurse as their Director of Services, something unheard of 5 years ago. Another nurse in London has set up a nurse-led hepatitis B vaccination service; this service visits gay bars and has led to an increase in the number of those at risk getting vaccinated against hepatitis B. Other nurses have set up services in prisons, schools, clubs and anywhere where the population go to socialise. There are so many such examples of nurses leading in sexual health, not simply in London but across the United Kingdom. Sexual health nursing is a rewarding option and allowing students to experience some time in sexual health during their training would go some way in helping them for their future in nursing regardless of their chosen speciality. Sexual health nursing is also part of both the Nursing Standard and Nursing Times Annual Awards, where nurses who have developed innovative ways of delivering sexual health are recognised for their contribution and this places sexual health equally as important as other spheres of nursing but this would not have happened even 5 years ago, such is the change in sexual health nursing.

Nurse prescribing has been one of the greatest advancement for nurses and has created opportunities for nurses to be able to provide the full package of care to their clients and facilitate the running of nurse-led services. Nurses who have not undertaken the Nurse Independent Prescribing (NIP) modules can supply and administer medications using a Patient Group Direction (PGD). For definition of a PGD see Chapter 5.

In terms of preregistration programmes in sexual health, it would appear that this is a hit-and-miss experience for students at

some Higher Education Institutes (HEIs); some students reporting a total lack of input on sexual health, whereas others provide excellent opportunities to study sexual health and access clinical placements for their students. This must be the way forward as students should not be allowed to be trained/educated as nurses if they do not understand and respect the religion, sexual orientation and cultural beliefs of their client group as well as the understanding as to why sexual health should be no different to other aspects of care. Sexual health is part of what is termed the 'holistic' approach and affects the lives of clients/patients, be they in an orthopaedic ward, medical ward or those having a kidney or liver transplant. If students do not get access to training, they will not be able to address the sexual health needs of their client group and this is unfair to students and patients alike. Patients expect nurses and those caring for them to be able to 'know' about sexual health or at least to be able to listen and refer them to the specialist areas. Without the training the culture of 'silence' will continue and nurses will not have the language to help those they care for in their daily lives.

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