Better prevention

Better services

Better sexual health

The national strategy for sexual health and HIV
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The last thirty years has seen an unprecedented shift in this country in attitudes towards sex and sexuality.
The reasons for these changes are complex and wide-ranging.

There have been success stories in the way new and emerging threats to sexual health have been tackled. The control of HIV in England through providing people with information about risks, open access to Genito-Urinary Medicine (GUM) clinics and measures such as needle exchange schemes have resulted in us having one of the lowest rates of HIV in Western Europe. The availability of a broad range of contraceptive methods provided free by the NHS has given many women and men the opportunity to plan their families.

Despite these advances, there can be no room for complacency, as there are serious challenges to be met. There are an increasing number of people living with HIV, the rates of sexually transmitted infections have increased significantly in recent years, and there is a high rate of unintended pregnancies. Evidence suggests that many people lack the information they want and need to make informed choices that will affect their sexual health. There is a clear relationship between sexual ill health, poverty and social exclusion. The quality of service provision remains varied across the country. For all these reasons it is time to re-examine traditional approaches to the way problems associated with sexual health are addressed.

This sexual health and HIV strategy has been drawn up with experts and service users across the country, in line with the principles set out in the NHS Plan. It is part of a nationwide programme of investment and reform, to modernise services around the needs of patients and service users, tackle inequalities, and ensure that the NHS works to prevent ill health as well as treating problems once they arise.

Yvette Cooper
Parliamentary Under Secretary of State for Public Health
July 2001

This strategy has been developed by involving a range of stakeholders including service users, members of target groups and professionals in the field. A list of members of the strategy steering group is at appendix 1.

The criteria for all national public consultations is set out in appendix 2.

We would welcome views on this document. Any comments should be sent to:

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by 21 December 2001 at the latest, please.
Summary

This is the first national Strategy for sexual health and HIV. It is a Strategy that will modernise sexual health and HIV services in this country. It addresses the rising prevalence of sexually transmitted infections (STIs) and of HIV.

The consequences of poor sexual health can be serious. Unintended pregnancies and STIs can have a long lasting impact on people's lives. The number of visits to genito-urinary medicine (GUM) clinics has doubled over the last decade and now stands at over a million a year.

There is a clear relationship between sexual ill health, poverty and social exclusion. There is an unequal impact of HIV on gay men and on certain minority ethnic groups. For too long there have been significant variations in the quality of sexual health services across the country. This is not acceptable. This is a Strategy that addresses the need to raise standards of services in line with the principles set out in the NHS Plan.

HIV remains a life-threatening condition. There is still no cure. The introduction of drug therapies has improved the lifespan of people infected with HIV. But this has presented fresh and difficult challenges for those involved in their treatment, support and care. This is a Strategy that acknowledges and addresses the complex issues associated with HIV.

This Strategy aims to:

- reduce the transmission of HIV and STIs;
- reduce the prevalence of undiagnosed HIV and STIs;
- reduce unintended pregnancy rates;
- improve health and social care for people living with HIV; and
- reduce the stigma associated with HIV and STIs.

All this adds up to a Strategy that proposes:

- providing clear information so that people can take informed decisions about preventing STIs, including HIV;
- ensuring there is a sound evidence base for effective local HIV/STI prevention;
- setting a target to reduce the number of newly acquired HIV infections;
- developing managed networks for HIV and sexual health services, with a broader role for those working in primary care settings and with providers collaborating to plan services jointly so that they deliver a more comprehensive service to patients;
- evaluating the benefits of more integrated sexual health services, including pilots of one-stop clinics, primary care youth services and primary care teams with a special interest in sexual health;
beginning a programme of screening for Chlamydia for targeted groups in 2002;

• stressing the importance of open access to GUM services and, over time, improving access for urgent appointments;

• ensuring a range of contraceptive services are provided for those that need them;

• addressing the disparities that exist in abortion services across the country;

• increasing the offer of testing for HIV and setting a target to reduce the number of undiagnosed infections, thereby ensuring earlier access to treatment for those infected and limiting further transmission of the virus;

• increasing the offer of hepatitis B vaccine;

• setting standards for the treatment of STIs and for the treatment, support and social care of people living with HIV;

• setting priorities for future research to improve the evidence base of good practice in sexual health and HIV; and

• addressing the training and development needs of the workforce across the whole range of sexual health and HIV services.

The NHS Plan highlights the need for patients to have a real say in the NHS and sets out action that is needed to make that happen. Building on that, this Strategy emphasises that the planning and provision of services benefit from involving service users and their representatives. Voluntary organisations have a crucial role to play too, particularly in the HIV field. Commissioners will therefore develop effective partnerships with voluntary organisations, service users and their representatives.

The Strategy is ambitious and comprehensive, and it requires a ten-year commitment to deliver what it proposes. As a start we will invest an extra £47.5 million over the next two years to support a range of initiatives set out in this document. If the strategy succeeds it will have contributed to reducing health inequalities. It will have set in place modern, efficient and patient-centred services, accompanied by a reduction in the burden of sexual ill health and HIV.

This Strategy will be strengthened through public consultation on its proposals over the coming months. The final Strategy will demonstrate that the Government has listened to the views of service users, their representatives and the wider public, as well as other stakeholders such as service providers and health professionals.
1 Sexual health in England today – setting the scene

Sexual health is an important part of physical and mental health. Sexual health problems in England have grown in recent years. More HIV infections are being diagnosed and sexually transmitted infections are rising. England has the highest teenage birth rates in Western Europe.

Introduction

1.1 Our sexual health affects our physical and psychological wellbeing and is central to some of the most important and lasting relationships in our lives. It follows that protecting, supporting and restoring sexual health is important.

1.2 The Government’s strategy for sexual health and HIV proposes a comprehensive and holistic model:

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 fulfilment with access to information and services to avoid the risk of unintended pregnancy, illness or disease.

The problems

1.3 Rising infection rates, the arrival of the HIV epidemic in the 1980s, evidence of increased risk taking and – often – poor control of infections, have all helped to raise the level of concern among health professionals, the Government and the public. The most common conditions now are Chlamydia, non-specific urethritis and wart virus infections, but almost all sexually transmitted infections (STIs) are becoming more common.

1.4 The number of visits to Departments of genito-urinary medicine (GUM) in England has doubled over the last decade and now stands at over a million a year [figure 1]. Diagnoses of genital Chlamydia also almost doubled during the 1990s, with a particularly marked increase in men and women aged under 20. Recent surveys of women indicate Chlamydia infection rates of up to 12% and there are more reports of outbreaks of syphilis. The number of HIV infections newly diagnosed in 2000 was the highest since reporting began [figure 2].


3 CDSC ‘Increased transmission of syphilis in Brighton and Greater Manchester among men who have sex with men’: Communicable Disease Report Weekly 27 October 2000: Vol. 10 (43) 383-6

Figure 1

Number* of newly reported HIV infections in England by year of diagnosis (data to end March 2001)

Figure 2

Number* of newly reported HIV infections in England by year of diagnosis (data to end March 2001)

*Numbers, particularly for recent years, will rise as further reports are received. [Source: AIDS/HIV Quarterly Surveillance Tables]

1.5 Many sexual infections have long-term effects on health. Some genital wart infections are associated with cervical cancer, as is Chlamydia4. Left untreated, Chlamydia can result in pelvic inflammatory disease which can lead to ectopic pregnancy and infertility5.

Consequences of poor sexual health

- Pelvic inflammatory disease, which can cause ectopic pregnancies and infertility
- HIV
- Cervical and other genital cancers
- Hepatitis, chronic liver disease and liver cancer
- Recurrent genital herpes
- Bacterial vaginosis and premature delivery
- Unintended pregnancies and abortions
- Psychological consequences of sexual coercion and abuse
- Poor educational, social and economic opportunities for teenage mothers

International comparisons

1.6 England is not unique – other European countries have similar problems. France, the Netherlands, Sweden and Switzerland have all reported increases in gonorrhoea between 1995 and 1999, particularly among men having sex with men. The same group has also suffered outbreaks of syphilis.

1.7 Despite the rise in newly diagnosed infections, HIV prevalence in England has stayed low compared with some other Western European countries. This reflects prompt action on a number of fronts: health promotion, needle exchange schemes and other harm minimisation initiatives, screening of blood and clinical interventions, the availability of open-access GUM clinics and careful surveillance and analysis of trends.

HIV

1.8 An estimated 30,000 people are living with HIV in the United Kingdom, of whom a third are undiagnosed. There is still no cure. There probably won’t be a highly effective vaccine for at least five years. About 400 people a year die as a result of their HIV infection. The year 2000 saw the largest annual number of newly diagnosed HIV infections since the start of the epidemic, and for the second year running the number of new infections acquired through heterosexual sex outnumbered those acquired through homosexual sex. However, three quarters of these heterosexual infections were probably acquired abroad, which means that sex between men remains the major transmission route for HIV in this country. HIV prevalence by the end of 2003 is expected to be 40% higher than the 1999 level.

1.9 Combination therapy has improved the lifespan of people living with HIV. Better survival rates combined with the growing numbers of new infections, mean that the number of people living with HIV is rising. Recently, there have been increasing concerns about resistant HIV strains and their sexual

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6 Nicoll A, Hamers F F: Emerging trends in HIV, gonorrhoea and syphilis in Western Europe (in press/personal communication)
7 AIDS and HIV Infection in the United Kingdom: monthly report. CDR 2000, 10 (50), 453–4
transmission. All of these present some real challenges for long term clinical treatment, care and social support, as well as for prevention of further transmission.

1.10 HIV therapies are complex, expensive and extremely demanding on the patient. The human costs for people living with HIV are high. Many cannot work, and others can still suffer ill-informed prejudice and discrimination. Children with HIV have an especially difficult time – as well as the effects on their own health they may face losing one or both of their parents prematurely.

Sexual behaviour & knowledge

1.11 Studies suggest there has been an increase in risky sexual behaviour, and that there is still ignorance about the possible consequences. The average age at which people start having sex is now 17. Forty years ago it was 21 for women and 20 for men. Between a third and a half of teenagers do not use contraception at first intercourse. Over a quarter of 14–15 year olds think that the contraceptive pill protects against infection. In 1999 most people questioned in a national study did not know what Chlamydia was.

1.12 A 1999 survey of gay men showed that 58% of those under 20 did not always use a condom. A recent study indicated that 44% of HIV positive men had anal sex with a new partner in the last month, of whom 40% reported no or inconsistent condom use.

Teenage pregnancy and unintended pregnancy

1.13 Sexual health is not just about disease. Ignorance and risky behaviour can also have profound social consequences.

1.14 Planning parenthood, understanding contraception and the age of first intercourse can all have an important impact on individuals and communities. England's teenage birth rates are the highest in Western Europe – treble those in France and six times those in the Netherlands.

1.15 In 1999 there were nearly 174,000 abortions performed in England and Wales. Abortion rates are highest for women in their twenties.

References:

9 Health Education Authority, Young People and Health, HEA 1999
12 Imrie J, Davis MD, Black S, Hart GJ, Davidson OR, Williams IG, Stephenson JM. "Meeting the sexual health needs of HIV-seropositive gay men in a pre-requisite to developing the next generation of prevention strategies". (Oral presentation) 14th Meeting of the International Society for Sexually Transmitted Diseases Research (ISSTDR) and International Congress of Sexually Transmitted Infections, Berlin Germany. 24-27 June 2001
Inequality

1.16 Sexual ill health is not equally distributed among the population. The highest burden is borne by women, gay men, teenagers, young adults and black and minority ethnic groups. 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.

1.17 There is a strong link between social deprivation and STIs, abortions and teenage conceptions [see figure 4]. Unintended pregnancies increase the risk of poor social, economic and health prospects for both mother and child. Girls from the poorest backgrounds are ten times more likely to become teenage mothers than girls from wealthier backgrounds.

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16 Communicable Disease Report, AIDS & HIV infection in the UK: monthly report; 26 April 2001: Vol. 11, No.17
Inequity of current service provision

1.18 As well as the inequalities in sexual health itself, there are significant variations in the way sexual health services are provided [see figure 5], including health promotion and HIV prevention. This affects the quality and range of services as well as access to them. For example, the percentage of abortions funded by the NHS varies between 46% and 96% in different health authorities, and there is no evidence that this relates to variation in need.

Rates of First Contacts at Family Planning Clinics per 1000 women aged 20-24 years
1.19 Pressure on sexual health services has led to unacceptable delays in accessing services. A recent survey of GUM clinics found delays of up to a week for urgent appointments and four weeks for routine appointments\(^7\). The effectiveness of joint working within and between organisations is also too variable.

1.20 These inequities are no longer tolerable. The NHS Plan signalled the Government’s determination to tackle unjustified variations and raise standards permanently, and that applies to sexual health and HIV services as much as to any other.

Costs

1.21 Poor sexual health costs the country a lot of money. Preventing poor sexual health has significant potential not just for better health, but for the better use of finite resources. 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\(^8\), and the monetary value of preventing a single onward transmission is estimated to be somewhere between £\(\frac{1}{2}\) and 1 million in terms of individual health benefits and treatment costs. We can also reduce dramatically the costs associated with preventable infertility.

Conclusion

1.22 Improving sexual health in England will have major benefits for overall health and wellbeing, and for NHS resources. The NHS provides a comprehensive range of sexual health services – including GUM clinics, community family planning clinics and services in primary care – but too often they are fragmented, poorly advertised and too narrowly focused. Access is a problem in some parts of the country. In rural areas especially, long journeys and patchy provision often restrict access to services. Information on sexual health is often out of date or simply not available.

1.23 The problems are real, but they are not a cause for pessimism. For the first time, this strategy sets out a programme that begins to put things right. It strengthens programmes that prevent sexual health problems, and it sets out important new measures for improving people’s understanding of the issues, for better planning of services and for better provision of treatment.

\(^{17}\) Djuretic T et al, Genito-urinary Medicine services in the United Kingdom are failing to meet the current demand (in press)

\(^{18}\) Beck EJ et al, for the NPMS-HHC Steering Group. “Reduced HIV disease progression and mortality due to CART in English NPMS-HCC clinics”. 13th International AIDS Conference, Durban, South Africa, 9-14 July 2000: Poster TuPeC3331
2 Aims and principles

This strategy applies the values and principles of the NHS Plan to sexual health. It sets out to redesign services around the people who use them and aims to:

- improve services, information and support for all who need them;
- reduce inequalities in sexual health; and
- improve health, sexual health and well being.

Introduction

2.1 This strategy’s fundamental aim is to improve England’s sexual health. We need to foster a culture of positive sexual health by making sure that everyone gets the information they need – without stigma, fear or embarrassment – so that they can take informed decisions to prevent STIs, including HIV, and about services.

2.2 The strategy recognises that sexual health is important throughout life, and that people’s needs for information and demands for services vary according to their age, way of life and sexual orientation.

Principles

2.3 The NHS Plan\textsuperscript{19} set out a sustained programme of investment and reform designed to deliver faster, better quality and more patient-centred care. This strategy takes the Plan’s principles and applies them to sexual health and HIV services.

2.4 This means:

- **Shaping services around patients, their families and their carers** – the strategy focuses services more closely on people and gives patients’ representatives and the public a bigger say in planning future developments.

- **Working with others** – partnership at all levels is central to the strategy’s success: between health and social care agencies, Government departments, prisons, voluntary organisations and private service providers as well as with patients and citizens.

- **Keeping people healthy and reducing health inequalities** – the strategy sets out new ways to plan, fund and deliver sexual health promotion and HIV prevention services and tackle inequalities.

\textsuperscript{19} Department of Health: The NHS Plan, A plan for investment, a plan for reform: CM4818, Stationery Office July 2000:
ISBN 0101481829
Aims and principles

• **Providing a comprehensive service** – sexual health services can be patchy and poorly co-ordinated. The strategy describes effective models for services and sets new standards for fair access.

• **Responding to the different needs of different populations** – the strategy shows that services should meet the needs of local communities, and identifies where service developments are needed most.

• **Continuously improving services** – this strategy acknowledges the need for standards for sexual health and HIV services and for the agencies providing them. It sets out underpinning programmes of professional education, training, information and research to support continuous improvement in quality.

• **Respecting confidentiality and providing open access to information about services, treatment and performance** – the sensitivity of sexual health issues makes confidentiality and ease of access to information especially important.

2.5 Turning those principles into practice will mean:

• that everyone has better access to good services and information on sexual health;

• that services are focused on people;

• that key groups get the resources and developments they need;

• fewer undiagnosed infections;

• lower rates of unintended pregnancies;

• better health and social care for people living with HIV; and

• reducing the stigma associated with HIV and STIs.
3 Better prevention

Introduction

3.1 Preventing poor sexual health depends on everyone having the information, skills and services that they need. Skilled professionals in health, education, social care and voluntary services play vital roles in HIV and STI prevention and raise awareness of sexual health and help people to get the information and services they need. In particular, their work has made a significant contribution to maintaining the low prevalence of HIV in England.

3.2 Attitudes to sex and sexuality have changed significantly and rapidly. In general, people – especially younger people – are more open about sex and more tolerant of homosexuality. Nevertheless, many still find the subject difficult to talk about or offensive, and discrimination persists.

3.3 Discrimination should never be tolerated. It should not be allowed to stop prevention messages getting across, nor to deter people from using testing services, or stop people accessing good quality information on sexual health relevant to their personal need.

Information for the public

3.4 Information on sexual health is often uncoordinated or poorly targeted. It is not consistently accessible and doesn’t make enough use of new media and technology. There is a lack of accurate sexual health information relevant to young people (among others). Information on STIs, contraception and services is often out of date or not available at all. Even key groups often lack basic information about services – one survey found that a fifth of gay men didn’t know that GUM clinics were open access.

3.5 Action giving young people better information has already started. The Teenage Pregnancy Strategy, Sure Start Plus, the Healthy Schools initiative and the Department for Education and Skills’ revised Sex and Relationship Education Guidance are all helping to expand young people’s knowledge of and understanding of sexual health and relationships. In particular the schools guidance makes sure that secondary schools provide young people with information about different types of contraception, safe sex and how they can access local sources of further advice and treatment.

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21 Teenage Pregnancy, Report by the Social Exclusion Unit, ISBN: 0-10-143422
22 Sex and Relationship Education Guidance, ISBN 184185 144 2
3.6 The strategy builds on that by making better information available to people of all ages. It also reflects the five action areas of the Ottawa Charter for Health Promotion\textsuperscript{23}.

- **Building healthy public policy that promotes sexual health at local and national levels and addresses inequalities** – the strategy sets out a range of public health measures to reduce the spread of HIV and other STIs;

- **Creating environments that are supportive of sexual health** – the strategy emphasises the importance of sexual ill-health and the need to reduce stigma associated with HIV and STIs;

- **Developing personal and social skills regarding sex, sexuality and sexual health** – the better information and knowledge that the strategy encourages will help people to develop skills and make informed choices;

- **Ensuring that all services, which promote sexual health, build upon the evidence base and develop professionals’ skills, knowledge and positive attitudes through education and training** – better professional education and training are central to the strategy, and it describes a programme of action for more evidence-based practice.

- **Strengthening community action in setting priorities, making decisions, planning strategies and implementing them to achieve better sexual health** – the strategy sets out targeted work aimed at reducing inequalities in sexual health and encourages more involvement of local people.

### HIV prevention

3.7 Information on sexual health can help to prevent HIV, but there are aspects of HIV prevention, that need to be addressed specifically. The growing number of STIs is an indication of the level of unsafe sex and the potential for HIV transmission – especially among some higher risk groups\textsuperscript{24}. The number of HIV infections diagnosed in heterosexuals has risen, and African communities have been disproportionately affected. There is continuing transmission among gay men. There remains a low but steady rate of infection in injecting drug misusers.

3.8 Better treatment has reduced the death rate associated with HIV, but it is still a serious, lifelong and life-threatening infection. HIV prevention is, and must stay, a priority – especially for the higher risk groups. It remains important to diagnose and treat pregnant women to stop the virus transmitting from mother to child (see chapter 4).

3.9 England may have a relatively low HIV prevalence, but there are no grounds for complacency. The number of new diagnoses of HIV infection in 2000 is the highest on record. This is not necessarily all bad news as we may be reducing the pool of undiagnosed infection. Part of the increase appears to be due to implementation of the antenatal HIV screening policy, with more than double the number of HIV diagnosis reports giving “antenatal” as the reason for testing in 2000 compared with 1999. However, it is vital to maintain and strengthen prevention efforts.

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\textsuperscript{23} Ottawa Charter for Health Promotion: WHO, Geneva 1986

\textsuperscript{24} CDSC ‘Increased transmission of syphilis in Brighton and Greater Manchester among men’: Communicable Disease Report Weekly, 27 October 2000: Vol. 10 (43) 3836
Objectives and targets

3.10 The key aims of HIV prevention are:

• to reduce the number of newly acquired HIV infections;

• to reduce the levels of unsafe sex (measured, for example, by rates of STIs including rectal gonorrhoea); and

• to raise awareness of services.

3.11 The strategy sets a national target for reducing newly acquired HIV infections and gonorrhoea infections. The target will help to assess the effectiveness of both national and local health promotion and sexual health service activities.

3.12 The target is to reduce by 25% the number of newly acquired HIV infections and gonorrhoea infections by the end of 2007.

3.13 To achieve these objectives the Department will:

• continue to give a high priority to HIV prevention for gay men that the Community HIV and AIDS Prevention strategy (CHAPS) currently delivers. Making it Count is the CHAPS collaborative framework for reducing HIV infection and should become the model for locally commissioned HIV prevention for gay men;

• develop, in collaboration with London health authorities, the National AIDS Trust and the African HIV Policy Network, a strategic framework for local commissioners and providers of HIV prevention for African communities;

• improve outreach services for people with undiagnosed HIV, particularly in targeted groups;

• set a target for reducing the number of people with undiagnosed HIV infection (see chapter 4);

• make sure HIV treatment and care services play a key role in HIV prevention by maintaining the sexual health of people living with HIV, diagnosing and treating STIs, reducing the transmission of HIV and providing information and advice (see chapter 4);

• make sure that services for people living with HIV help them to deal confidently with issues around disclosure, condom use and safer sex, so they can maintain their own health and reduce transmission. As a first step the Health Development Agency and Terrence Higgins Trust have produced a resource guide for professionals, on HIV and sexual health promotion for people with HIV;

• require health authorities to continue to provide needle exchange schemes for injecting drug misusers who are vulnerable to HIV and other blood borne viruses, and to promote the schemes in appropriate venues; and

• develop national information campaigns targeted at young injecting drug misusers and those who are already HIV positive and hepatitis B or hepatitis C infected. The Government’s ten-year Drug Strategy and Second Annual Plan sets interim targets which support efforts to reduce the transmission of HIV and other blood borne viruses. The target for injecting drug misusers and needle sharing is to reduce the numbers in treatment who report injecting and numbers of those who report sharing by 2002.
3.14 The Department will also:

- Ensure that guidance on infection control measures in clinical settings is kept under review;
- support the Prison Service’s strategy for preventing the spread of communicable diseases in prison, offering harm minimisation information and treatment of substance misusers and;
- take into account emerging findings on vaccines and microbicides (see chapter 6).

Role of mass media

3.15 Action to prevent sexual ill-health works best when it is multi-faceted. National information campaigns can provide a backdrop for more targeted local prevention work. Effective communications can inform and change attitudes and give people properly informed choice. An evaluation of safer sex campaigns in Holland showed attitudes and intentions towards safer sex were affected positively but that the effect was lost when the intervention ended25.

3.16 To be effective information needs to be based on evidence and credible with target audiences. The evidence is that simply telling people not to engage in behaviours that put them at risk tends to be ineffective26. Informed by a review of the research on how media campaigns can provide information to help people take informed decisions, the Department will develop a new information campaign for the general population in 2002 on preventing STIs (including HIV) and unintended pregnancies.

3.17 The Department will co-ordinate information campaigns for the population as a whole with initiatives like the Teenage Pregnancy Unit’s campaign, and make sure they are properly evaluated. The Department will also ensure that professional groups know about new work in good time so that they can plan supporting local initiatives.

Evidence base

3.18 The evidence base for HIV and STI prevention is still dispersed and unsystematic. Although there is more agreement on the definition of success, what count as acceptable and effective interventions hasn’t been agreed.27

3.19 Effective commissioning of HIV/STI prevention needs up to date evidence of what and how different interventions work. The Department has commissioned the Health Development Agency to draw together the available evidence, assess what works and make clear recommendations on future approaches by the end of 2002. The Department will use that work to set the direction for local prevention activity.

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27 Hickson F et al, Making it Count, a collaborative planning framework to reduce the incidence of HIV infection during sex with men. Second edition, September 2000. Sigma Research
Co-ordinated provision of local sexual health information and HIV/STI prevention

3.20 Local co-ordination of sexual health information is vital and most effective when agencies work together in groups\(^{28}\). Local planners and providers need to co-ordinate sexual health information and HIV/STI prevention, based on a local needs assessment as well as national priorities. Effective information gets to people where they are and addresses their specific concerns and needs, so people such as social workers and youth workers need to be involved.

3.21 Local multi-agency groups (see chapter 5) will co-ordinate sexual health information and prevention in line with the Health Improvement Programme. The groups must include representation from a specialist sexual health promotion/HIV prevention team and should make sure local activities are evidence based and are evaluated.

Sexual health information for specific groups

3.22 Some groups need targeted sexual health information and HIV/STI prevention because they are at higher risk, are particularly vulnerable or have particular access requirements. Strategies need to be developed to respond to the specific information and prevention needs of local populations. They should assess the needs of:

- young people, and especially those in, or leaving care;
- black and minority ethnic groups;
- gay and bisexual men;
- injecting drug misusers;
- adults and children living with HIV and other people affected by HIV;
- sex workers; and
- people in prisons and youth offending establishments.

3.23 In targeting these groups commissioners and providers need to work together to overcome the common barriers to accessing information and prevention services. These include stigma, discrimination, poverty and social exclusion, language, access problems, low awareness and concerns about confidentiality.

3.24 There is a range of service and health promotion initiatives that can help, including staff training on discrimination, outreach health promotion and targeting hard to reach or stigmatised groups.

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Female genital mutilation

3.25 Female genital mutilation (FGM) – sometimes known as female circumcision – is illegal, unacceptable, and a violation of the human rights of the young girls (usually aged between four and ten) who suffer it. All procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs, whether for cultural or other non-therapeutic reasons, have been illegal in the UK since 1985.

3.26 Wherever there are people from cultures with a tradition of FGM there is a need to raise the awareness and skills of health, education and social services professionals. Local services need to support community initiatives aimed at stopping this practice. The Department will work with the FORWARD organisation to mobilise professionals from various disciplines to meet the needs of women and girls affected by FGM.

Helplines

3.27 The anonymity of telephone helplines can encourage people to seek help or advice on their sexual health. NHS Direct (0845 46 47) provides advice 24 hours a day including comprehensive information on local services and emergency contraception. The development of NHS Direct Online and NHS Direct information points in public places will also help people to find the information need. The Department will make sure that there are clear links between NHS Direct, specialist helplines and local providers, and that NHS Direct provides accurate information and advice. The Department will constantly review the helplines’ decision support systems and ensure adequate training is available.

3.28 The National AIDS Helpline (0800 567123) and Contraceptive Education Service Helpline (0845 310 1334) deal with almost 300,000 telephone enquiries a year and provide confidential advice and information on all aspects of HIV, AIDS, STIs and contraception.

3.29 The Department will review the specifications for the National AIDS Helpline and the Contraceptive Education Service to make sure they respond to the needs of key groups and population as a whole. The review will include the outcome of an independent evaluation of both services, which will report in 2001, and involved consultation with health promotion agencies, health professionals, and voluntary groups including those representing people living with HIV.

3.30 The Department will develop wide ranging information provision, giving people choices in the way they can access information, including telephone lines, digital TV and the Internet as well as leaflets and posters where appropriate.

3.31 The Department will continue to support helplines providing services specifically for young people such as Sexwise (0800 282930).

Information and support for professionals

3.32 Everyone providing sexual health information and HIV prevention needs better access to up to date information\(^\text{29}\). The Department will work with the Health Development Agency to develop and disseminate the information and evidence professionals need, including good examples of best practice (see paragraph 3.20).

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\(^{29}\) SASH Consultation of the Sexual Health Strategy
3.33 The Government supports life-long learning and continuing professional development. Staff delivering sexual health promotion must have access to flexible, multi-professional education and training. Good training will help them to develop their interpersonal and communication skills and their cultural competence, values and attitudes as well as their clinical and technical ability. More action is set out in chapter 6.

The Department of Health is including sexual health information in its Practice Development toolkit available for all health visitors and school nurses. This helps to ensure a greater provision of sexual health information and HIV/STI prevention through services. Professionals consulted in the course of developing this strategy said this was a vital area for improvement if HIV and STI prevention was to be more effective.

3.34 Professionals across a range of services, including primary care, can play an important part in providing consistent and integrated information. The Department will set clear standards for sexual health information and HIV/STI prevention at all levels of service provision. These standards will help professionals to:

• give advice and support on safer sex practice;
• provide good information on sexual health services; and
• recognise relevant factors, such as alcohol use, drug misuse, homelessness, social exclusion and poor self-image.

3.35 People who work with vulnerable groups (for example, supporting children at risk, people with learning disabilities) need to help them develop the knowledge and skills to protect their sexual health. The Department will ensure provision of specific training for staff, in skills development, as part of the dissemination of the new guidance due out shortly on promoting health for looked after children.

Questions:

• Is the target proposed for reducing the number of newly acquired HIV infections the right one?
• Is there a better description than “safer sex” in the provision of information to people about preventing STIs, including HIV?
• What are the most effective interventions for HIV and STI prevention?
• How can the increasingly diverse range of communications media be best exploited for providing the public with the information they need?
### Action and targets

**The Government will:**

- 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.

**Commissioners, service providers and health professionals should:**

- Focus sexual health promotion and HIV prevention on identified local need, set targets in line with national priorities and monitor progress as appropriate to local populations.
- Support all staff to develop their skills through work-based and other dedicated education and training programmes, in line with national priorities.
- Ensure prevention is integral to service delivery.
- Co-ordinate local information campaigns with national information campaigns and ensure they meet good practice benchmarks.
- Work towards achieving a target to reduce the number of newly acquired HIV infections.
5 Better commissioning

Introduction

5.1 The effective implementation of this strategy hinges on good local planning and commissioning of services. Good planning helps to make sure that:

- medical, nursing and other health and social care staff can work together in new ways and across traditional boundaries;
- HIV and STI prevention is more consistent and effective; and
- both commissioners and providers broaden their focus and work in partnership.

Effective commissioning

5.2 The job of commissioning the various components of sexual health and HIV services is carried out currently at different levels and by different organisations. From April 2002 PCTs will be able to commission sexual health services. Specialised services for HIV treatment and care will need to be strategically planned at the appropriate level. (The definition of specialised HIV treatment and care will be published in autumn 2001.)

5.3 The Department will publish a good practice “tool kit” for commissioning the three levels of care described in chapter 4, and every commissioning organisation must be able to show that they have applied these principles of effective commissioning of sexual health and HIV services:

- using a multi-agency and multi-disciplinary steering group to develop and implement a local action plan;
- understanding local needs and identifying priority population groups;
- linking to the wider policy context;
- working in partnership with other agencies and with users;
- being centred transparently on community and patient;
identifying current resources, including those that need development; and

• setting clear local targets for monitoring the development, implementation and outcomes of plans.

Local multi-agency commissioning groups

5.4 Local stakeholders, including all the organisations responsible for commissioning services, should agree a sexual health and HIV plan. A local multi-agency group should be set up to inform, implement and monitor this planning.

5.5 The size of the group will have to strike a balance between inclusiveness (of, for example, commissioning organisations like local authorities and PCTs as well as other stakeholders) and practicality. The group should be a function of existing primary care partnership groups where they have been established and build on local teenage pregnancy strategies. A lead commissioner should co-ordinate the group and the local action plan.

5.6 Assessments of the local need for services should:

• identify sexual health needs;

• highlight gaps in services or high levels of need; and

• take account of the wider, underlying determinants of health.

5.7 The groups should use improvements to data collection and information on service activity and good practice (see chapter 6) to inform planning for specific communities. They should also make sure that their plan relates to the wider policy context by reflecting the local Health Improvement Programmes and the views of local Modernisation Boards. Plans should highlight links with specific national and local initiatives. PCTs’, local authorities’ and health authorities’ plans should also reflect the specialised commissioning plan for HIV treatment and care.

Working in partnership

5.8 Effective partnerships should be at the root of all commissioning of sexual health services. Commissioning plans should incorporate agreed aims and priorities, based on agreed local values and principles, which should reflect those set out nationally. There should be evidence of an effective process for involving stakeholders.

5.9 Partnerships should include voluntary organisations, service users and others who represent users and potential users. It can be difficult for some voluntary or community organisations to contribute because of limited staff and resources, but smaller organisations should be encouraged to collaborate to make their voices heard. We will support development programmes that help to build capacity in the voluntary sector.
Empowering patients and communities

5.10 The Government wants patients and the public to play a big part in reshaping services at local level. Patient Forums and the new Patient Advocate and Liaison Service will be a good source of input, but the local multi-agency groups should involve users in different ways to make sure they hear the full diversity of views. The groups should help their staff to develop the skills they need to take account of cultural complexities in their discussions with users.

Identifying resources

5.11 Commissioners should identify the current level of investment in sexual health services and HIV, the cost effectiveness of those services and any gaps in resources. Local planning will need to match capacity to need, priorities and targets and set out the resources necessary for meeting the targets.

Local targets

5.12 Local targets should be based on an assessment of need and an understanding of local services – but they should also fit with the aims and objectives of this strategy. This means that local targets should:

• tackle inequalities;
• help to overcome local barriers to change;
• be based on the service standards;
• be measurable and achievable; and
• reflect a clear process for involving those working in sexual health in setting the targets.

Targeted groups

5.13 The multi-agency groups should ensure that local strategies address the needs of targeted groups. The local needs assessment must identify groups that need targeted information or services as well as identifying barriers to access. Commissioning plans for HIV prevention must specifically address the groups that this strategy recognises as a priority.

Commissioning for services and prevention

5.14 Commissioners should reflect the aims of this strategy in their local plans. They should:

• reflect the three levels of services, concentrating on the interface between service levels to ensure smooth referrals;
• make sure that there are clear open access arrangements, including for people who seek care from GUM services outside their own area;
• identify action to meet the needs of targeted groups;
• include prevention of HIV and STIs in all service agreements and investment plans;
• give local people access to information on services in a variety of ways;
• lead the development of managed networks for HIV services and for sexual health services; and
• define and monitor service standards for providers.

5.15 HIV prevention plans should:
• show how resources will be used to target priority groups;
• set local targets;
• indicate the outcomes to be achieved; and
• describe the monitoring and evaluation process.

**Commissioning social care services for people living with HIV**

5.16 Commissioners of social care services for people living with HIV should base their planning on the same principles, including the involvement of users and good working partnerships between the statutory and voluntary sectors. The flexibility offered by the Health Act 1999 has created new opportunities to pool budgets and develop integrated provision and lead commissioning arrangements. Commissioners should exploit these mechanisms to build seamless social care services that can respond quickly to changing needs.

5.17 Social services departments should also consider the needs of people living with HIV in other relevant services, like those funded from the Carers Grant, and plan for services that encourage social inclusion.

**Questions:**

• Are the proposed principles for the effective commissioning of sexual health and HIV services the right ones?
• How easy will it be to set up multi-agency commissioning groups as a function of existing local partnership groups?
**Action and targets**

**Commissioners should:**

- Establish a local multi-agency group, involving local stakeholders and commissioning organisations, and identifying a lead commissioner. This should build on existing arrangements and the agreed local teenage pregnancy strategy.
- Ensure a multi-agency plan is developed, agreed and specified in the Health Improvement Programme.
- Work to reduce inequalities by ensuring local resources are targeted to high need groups as nationally specified and as identified in needs assessments.
- Work in partnership with the range of stakeholders.
- Ensure the diversity of user views is reflected in planning and monitoring by using a range of involvement mechanisms, including specifically involving people living with HIV.
- Set and monitor performance indicators for sexual health and HIV in line with national targets, using transparent mechanisms to evaluate the development, implementation and outcomes of plans.