

Reviewing the National Sexual Health and HIV Strategy

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Background

The English *National Strategy for Sexual Health and HIV* (2001)¹ was a landmark in raising sexual health as a national issue. The Sexual Health Independent Advisory Group commissioned a review of the strategy's progress, *Progress and Priorities – Working Together for High Quality Sexual Health*,² which was published in July 2008. The review highlights the need to build on what has been done to maintain the profile for sexual health through local and national leadership, effective partnerships across health and social care, effective commissioning, prevention and further modernisation of service delivery. Importantly, it clearly raises the profile of contraception and abortion as priorities in sexual health care. In this commentary we aim to summarise some of the main issues presented in relation to contraceptive service provision in the review.

Progress in sexual health

The original strategy attempted to straddle the range of issues relating to sexual and reproductive health care (SRH) and HIV. It was an important lever for placing sexual health on a national agenda, further strengthened by the government White Paper, *Choosing Health*.³ The introduction of national targets for a reduction in the number of conceptions in under-18-year-olds, 48-hour access to genitourinary medicine (GUM) services and increasing access to abortion before 10 weeks became a major driver for achievements in these areas of sexual health. We have seen teenage conception rates decrease by 13.3% from baseline, 98.9% of GUM appointments are offered within 48 hours of contacting the service,⁴ and access to abortion within 10 weeks has increased from 51% to 68%.⁵ We now have an English Chlamydia Screening Programme, and although to date only two primary care trusts (PCTs) have achieved the 15% target for proportion of the population screened, all have a functioning programme.

However, lack of detailed attention to contraception and abortion in the original document, compounded by a lack of contraception-specific targets, left this area without a route map for service development. In addition, funds pledged to support the implementation of *Choosing Health* did not find their way directly into services as promised,⁶ and disinvestments resulted in service closures as contraception failed to take its place in local priority setting.^{7,8}

Need for contraception

Delays in childbearing and a shifting population age structure have meant that while the rate of increase in conceptions is an issue across all reproductive ages, it has been greatest in the over 40-year-old age group. Unmet

need for contraception is seen clearly through rising abortion rates across all age groups. In spite of the fact that 85% of people of childbearing age report using contraception,⁹ there appears to be a wide discrepancy between these perceptions and effective use.

The strategy review clearly identifies the need to prioritise community contraceptive services. Nonetheless, ensuring that this is translated into effective action will be a major challenge in the face of rising unmet need for contraception, changing National Health Service (NHS) policy and structure, as well as technological advance and behavioural change.

Changing policy landscape

Since 2001 there have been substantial developments in health policy. From April 2008, a statutory duty was placed on local authorities alongside PCTs to carry out a *Joint Strategic Needs Assessment*,¹⁰ the results of which will be used to inform Local Area Agreements, forming the basis of joint local health strategy. While partnership working has been central to the Teenage Pregnancy Strategy, this has been less comprehensively explored within other areas of sexual health, and it is imperative for the health sector to engage more meaningfully if it is to sustain levels of local priority. Given a lack of contraception-specific targets this is particularly pertinent. There is a need to highlight the essential role of services in contributing to achievement of sexual health targets within local strategic partnerships. Equally – as recommended by the review – there is a need to identify and explore links with other areas of health improvement that might hold priority within local health strategy such as drug and alcohol use and high-risk sexual behaviour.

Policy has shifted towards placing clients at the centre of their care and to increasing convenience and accessibility by shifting care out of hospitals into the community. The value of prevention is also increasingly recognised. SRH is uniquely placed as a specialty within the community and with a purpose in prevention, compliant with the new closer-to-home, client-focused, holistic agenda. However, while this presents an opportunity, PCTs have consistently failed to prioritise sexual health prevention in their resource allocation processes.

Commissioning and market reforms

Payment by results (PbR) was intended to promote competition, increase activity and improve quality. PbR tariffs are available for GUM and hospital abortions, but not for other elements of sexual health care. The abortion tariff excludes post-abortion contraception and pre-abortion assessment, disassociating abortion from contraceptive care. The strategy review recommends that PbR be implemented more widely. Based on reference costs, the GUM tariffs are crude, poorly implemented and hinder the provision of holistic sexual health care. Whilst there are examples of local tariffs being developed, as a result of a lack of prioritisation it is unlikely that a national tariff will be in place before 2010, and this has an impact on the ability to de-host. The Department of Health should ensure the development of meaningful tariffs that apply across both acute and community providers. However, this delay does give providers time to review their information technology infrastructure to ensure readiness for this system of financing.

J Fam Plann Reprod Health Care 2008; **34**(4): 211–212

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Leadership and levels of public health and commissioning expertise across sexual health are variable. Many PCTs have not had sexual health leads or commissioners with sufficient time, experience or authority. Driving the strategy forward is often left to committed local champions who are key, but who should not have to function in isolation. PCTs must ensure that commissioning, public health and provider networks are supported to ensure local implementation of the strategy.

Many commissioners have not appreciated the breadth of care and the role of community services in the provision of training, clinical governance, specialist care and access for harder-to-reach groups. Offering a range of elements of sexual health care, community services play an important part in achieving national targets such as chlamydia screening, cervical screening, abortion referrals and 48-hour GUM access; and would be important for a contraceptive target were it to be introduced.⁶

Service delivery

There is a lack of consistency in the contraceptive advice that clients receive at the point of access, and often a lack of knowledge at PCT level about what is actually being provided. Market reforms have resulted in the creation of a wider range of potential service providers where quality can vary and competition may supersede collaboration. Strategic planning is required to ensure that the configuration of services commissioned reflects need, ensures high quality and allows individual clients to move seamlessly within networks. Today's commissioners require expertise to ensure that services are placed in the hands of providers able to deliver high-quality services to required outcomes. This includes the recognition of training needs to ensure that the workforce is competent to deliver the full range of services. To increase access to Level 1 and long-acting reversible contraception (LARC)¹¹ training for non-specialist doctors the theory component of the Diploma of the Faculty of Sexual and Reproductive Healthcare (DFSRRH) is being developed in an online format. For nurses, however, in spite of role expansion with more specialist nurses trained in sexually transmitted infection (STI) management and insertion of both implants and intrauterine devices, achievement of a training standard has been slower and should be a priority, utilising established programmes such as the DFSRRH.

General practitioners (GPs) provide 80% of non-specialist contraceptive care, although only one-third of GPs are currently able to offer the full range of contraceptive choice including LARC.¹² There is a lack of incentive through the Quality and Outcomes Framework for GPs to provide non-essential sexual health services; this needs addressing to encourage increased provision of LARC and STI management in general practice. Local Enhanced Service agreements are being increasingly explored and bring training requirements, service specification and auditable service standards within the contract. However, there is still wide variation and an ongoing lack of consensus as to whether all GPs should be required to deliver a basic minimum service and what this should comprise, or whether this should be left in the hands of a smaller number of interested GPs and practice nurses complemented by provision across a geographical network of specialist providers.

Pharmacists are the main provider of condoms and emergency contraception and the new pharmacy White Paper, *Pharmacy in England – Building on Strengths, Delivering the Future*,¹³ signals an increasing role for pharmacists in the provision of basic-level sexual health services. This complies with the demedicalisation agenda

and as yet has been not fully exploited, particularly in STI testing and access to abortion.

Research

In parallel with service developments, expansion and wider dissemination of the evidence base in contraception and abortion is also needed. The original strategy focused almost entirely on increasing research outputs for STIs and HIV, and the majority of the funded studies that followed reflected this emphasis. In addition, there has been no academic career structure for clinicians in SRH, which leaves the specialty heavily reliant on service-based input for development of its evidence base and research needs. A change in focus of the strategy and recognition of the specialty of SRH will bring with it new opportunities for developments in academic training.

Moving forward

Now is a time of unprecedented change in the NHS and for sexual and reproductive health care. The focus is shifting further towards improving service user experience and choice, and more investment in health and well-being, with stronger commissioning of services. The sexual health strategy channelled energy and progress into sexual health that had not previously been seen and much has been achieved. The recent strategy review² highlights the need to now focus on those areas that were less well addressed previously such as contraception. This national recognition of the importance of contraceptive care is significant; however, making the revised national strategy lead to change that benefits users will be as much about getting contraception and abortion onto local agendas and about local service innovation as any greater national drive.

Statements on funding and competing interests

Funding None identified.

Competing interests None identified.

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