Sex, health, and society: ensuring an integrated response

Earlier this month, the President of the UK Faculty of Public Health, John Ashton, made the unsurprising claim that adolescents have sex. He went on to propose that the age of consent for sex be reduced to 15 years, and he called for a public debate about the issue. Within 24 hours the Government and Opposition leaders had all condemned him. But it was hard to know if they were condemning him because of what he had to say about the age of consent or because of their unwillingness to engage in a public discussion about adolescent sexual behaviour. Once again, Britain seemed unable to have a mature debate, informed by evidence, about sexual health. The publication of six papers from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3) in today’s Lancet aims to provide that firm platform of evidence for a better public, indeed political, debate about sexual health in Britain today.

The first two surveys, Natsal-1 and Natsal-2, took place in 1990–91 and 1999–2001, respectively, and the studies have been a vital resource for scientists, clinicians, and policy makers. Natsal data have informed the creation of transmission models of HIV and sexually transmitted infections (STIs); guidance on legislative reform regarding the age of homosexual consent; planning of contraceptive and HIV and STI services; and development of national public health strategies, such as the national chlamydia screening programme, the teenage pregnancy strategy, and the HPV vaccination programme. These data have been used in print, broadcast media, and on sexual health service websites, providing a reliable and authoritative source of data for the public.

Natsal-3 surveyed 15,162 men and women in 2010–12. It provides updates on prevalence estimates of well-known adverse outcomes of sexual behaviour in the population, such as STIs and unplanned pregnancy, but includes, for the first time, data from people up to 74 years of age, responses to more general health questions, and a focus on the quality of sexual experiences. Also, the first British prevalence figures of non-volitional sex are reported. These additions have allowed the authors to examine changes in sexual lifestyle over time, and to better study the relationship between general physical and sexual health.

These issues are important because Natsal-3 data provide the most reliable evidence (and case) for establishing integrated sexual health services. Yet, from April, 2013, the provision of these services was divided between three organisations. Local authorities will be responsible for STI testing and treatment, teenage pregnancy and specialist services, HIV prevention, and the promotion of sexual health. Clinical commissioning groups will provide abortion, sterilisation, vasectomy, and gynaecological services. And NHS England will be responsible for contraceptive services through general practitioners, HIV treatment and care, cervical screening, sexual health in prisons, and sexual assault referral centres. As a result, sexual health services have been fragmented and made unprecedentedly complex, with huge variations in their provision across the country. There is concern that the diverse sexual health needs identified in this series of Natsal papers may not be fully addressed by the service reforms introduced by the Coalition Government this year.

There is another anxiety. Sexual health has a social context. Poor sexual health is not evenly distributed across society. It is linked closely to deprivation and is associated with particular disadvantaged groups within the population. Some of these populations face stigma and discrimination, reducing their access to sexual health services. Any response to the challenges set out in these Natsal papers will require attention to the social determinants of sexual health, as well as to clinical need.

There is also a global dimension to this work. Natsal’s findings provide a better understanding for the role of sex in people’s lives. The authors argue for a holistic approach to sexual health and the need to move away from disease-focused biomedical framework to a broader concept of wellbeing. Indeed, as the discussions for the post-2015 development agenda also shift away from disease and towards wellbeing, there is an opportunity to bring out the positive contribution of sex in the global wellbeing agenda. Sex is a dimension of every person’s life everywhere.

In conclusion, we call on the UK Government to initiate an urgent review of sexual health services. It is essential that integrated sexual health services are fully achieved to meet the public need set out clearly by the Natsal investigators. The depth and breadth of our understanding of sexual health, shown by their work, indicates that the present arrangements for delivering sexual health services may be severely deficient.

The Lancet