Sex and health promotion: the need for a new primary care initiative

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SUMMARY. The adverse consequences of sexual behaviour are increasingly important. Half a million new cases of sexually transmitted diseases were reported in England in 1984 and at present there is one legal abortion for every five births. The services provided for the sexually active population are disparate and uncoordinated and it is time for a radical reappraisal of the care and advice they receive. The case is made for a new member of the primary care team, a 'sex education and health promotion nurse', who would ensure that all sexually active men and women are identified and are receiving the sex education and contraceptive services they need, provide pre-conception and fertility advice, run cervical and breast screening programmes, and counsel patients who have AIDS or who have had an abortion.

Introduction

DURING the last few years the adverse consequences of some sexual behaviour have become increasingly important. The consequences of a major epidemic of the acquired immune deficiency syndrome (AIDS) pose a major public health threat and need no further elaboration here. Other sexually transmitted diseases, such as gonorrhoea, non-specific genital infections, genital warts and candidiasis generate considerable morbidity. For example, returns to the Department of Health and Social Security from physicians in genitourinary medicine show that half a million new cases of sexually transmitted disease were reported in England in 1984. These figures take no account of patients treated in primary care. In the long term such infections may manifest themselves as cancer of the cervix; this condition accounted for 1900 deaths in England and Wales in 1984, 10 000 hospitalizations and many thousands of outpatient attendances for colposcopy. The cervical cancer screening programme, which has yet to be implemented in a comprehensive and reliable way,[1] costs more than £40 million per annum.

Unplanned and unwanted pregnancies still occur despite the fact that oral contraception has been widely available for more than 25 years. At present there is one legal abortion for every five births; there were 136 000 abortions in England and Wales in 1984.

In summary, the adverse consequences of sexual activity yield a toll of considerable morbidity and mortality, much of which should be avoidable in a society with well developed education and health services.

Reasons for adverse outcomes of sexual behaviour

It is suggested by some that the sexual freedoms of the contraceptive pill and intrauterine device, with the parallel decline in the use of the condom, account for part of the increase in sexually transmitted diseases. However, the number of therapeutic abortions suggests that contraceptive use has not extended far enough. Screening programmes for cancer of the cervix leave much to be desired. Access to clinic or surgery facilities is most difficult for the less educated and motivated, who are often at higher risk.

In obstetrics there is increasing interest in preconceptual care. At a recent symposium at the City University preconceptual care for diabetics and women suffering recurrent abortion, who already have access to such care and advice, was discussed but no consideration was given to the great majority of women without a history of major pathology who present for the first time in a pregnancy well after organogenesis is complete.

If perinatal mortality rates are to continue to decline we will need to consider how to reduce the antepartum deaths which are not easily amenable to obstetric and neonatal intervention, but which may well be responsive to improvements in social, medical and behavioural factors. For example, in a 10-year review of perinatal mortality in Leicestershire (Clarke M and colleagues. Unpublished report), it has been shown that women delivering macerated stillbirths are more likely to be primiparous, be in a manual occupation, have a husband who is an unskilled manual worker, and have a general practitioner who is not on the obstetric list, than women who have liveborn children.

Taken together this evidence suggests that it is time for a radical reappraisal of the care and advice we provide for sexually active men and women. At present such advice is provided by a pot-pourri of agencies, some public, some private. The maternity services have been established as a separate specialty with their own hospitals or departments, staffed predominantly by midwives, whose main concern is the safe delivery of liveborn infants. This rather narrow definition of obstetrics has probably led to the under-emphasis on preconceptual and postpartum care. One might have hoped that a group such as the radical midwives[3] would espouse a broad, community-based agenda but they also appear to be happy to see the delivery room, or patient's bed at home, as the focus for their radicalism. With no greater insight the Royal College of Midwives are happy with a few consultations with pregnant women starting well after pregnancy is established.[2]

Sex education and health promotion nurse

A major strength of the health service in the UK is the comprehensive system of primary care. Most of the problems and failures listed above could be remedied if a primary care team member were responsible for sex education and health promotion. However, the major role of such an individual would be to ensure that those needing services received them. This could be achieved if all general practices had accurate age–sex registers providing lists of those at risk.

Health visitors and midwives could undertake these tasks. However, the health visitor is charged with infant welfare and is increasingly urged to play a part in the care of the elderly, while the midwife focusses on the pregnancy itself. A new primary health care worker is needed, responsible for reducing morbidity secondary to sexual activity. This 'sex education and health promotion nurse' should have general nursing experience and have attended a short course of between three and six months to equip him or her for the new role. The nurse would have the following responsibilities:

- To ensure the reliability of the practice age–sex register or to help establish such a register so that all names and addresses of fertile women and men are easily available.

- To ensure that all sexually active men and women are provided with the sex education and contraceptive services they need.
- To initiate a programme of preconceptual advice for those wishing to become pregnant.
- To provide advice to women on matters concerned with human fertility, including menstrual disorders and variation.
- To ensure that the cervical cytology programme is available to and taken up by all women at risk, and if necessary to provide a domiciliary service.
- To ensure that the breast cancer screening programme is available to and taken up by the target population or to establish such a programme.

In addition the nurse could counsel patients with AIDS or who have had an abortion, and provide the initial advice for patients complaining of infertility.

Approximately one nurse would be needed for the lists of three general practitioners. The usefulness of such a scheme should be evaluated by experiment, using cervical cytology uptake, requests for termination of pregnancy and treatment for genitourinary disease as outcome measures. In addition, the social acceptability of the scheme would need assessment.

Conclusion

The general practitioner's list and clinical record allow identification of the population at risk. This provides the opportunity to determine which patients are not using the preventive services and to ensure that appropriate services are offered to them. Such ideas are not new, but most recent efforts have been directed towards the reduction of risk factors for cardiovascular disease.[3]

The adverse consequences of sexual behaviour challenge the health services and threaten the public health in many ways. A new initiative needs to be established in general practice with a nurse responsible for providing a comprehensive programme of sex education and health promotion. Anything less is unlikely to achieve the necessary behaviour changes.

References

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