Written evidence from Prof David Evans

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This submission is on evidence from a senior sexual health and HIV educationalist (Professor), with three decades of professional practice in the education of nurses, midwives and allied health professions. In 2015, I was asked to give a presentation to the All-Party Parliamentary Group on Sexual and Reproductive Health (HoL), entitled: “Sexual health matters for nurses: meeting client needs through professional multi-disciplinary education and training”.

Over the past three decades I have noticed dramatic changes in nursing education, related to clinical practice, at both pre-and post-graduate levels. The changes, not always for the better, reflect the whole remit as outlined in your ‘Scope of Inquiry’. I shall briefly mention a number of your themes, from an educational perspective, the impact on clinical services, and vice versa. (Using your headings)

- Recent trends

The 2001 (DH) National Strategy for Sexual Health and HIV, preceded by the 1999 (SEU) Teenage Pregnancy Report put money where it was needed. As a result, teenage pregnancies have now come down, in England, to their lowest levels since 1969, and services were able to address and cope with clients presenting with sexual infections and HIV, more urgently and appropriately than the current status quo.

Wider sexual health issues, and occasional targeted initiatives, were also funded and more suitable to client need, e.g. from cervical cytology awareness and uptake (especially after the jade Goody case); HPV vaccination for females (although, controversially, not, then, for males); Chlamydia testing and treatment, especially through new and novel approaches (e.g. the internet); condom provision and campaigns for equal and comprehensive Sex and Relationship Education (SRE or RSE) in schools.

Nurses and other health care professionals play a vital role in all of these services. Education at some Universities and Professional Organisations (e.g. The RCN; BASHH; BHIVA; GUNA; Institute for Psychosexual Medicine, NHIVNA; BHIVA), supported by voluntary sector charities (e.g. Terrence Higgins Trust; fpa, Brook, etc.), raised awareness of sexual health needs; supplied the service provision, and provided / enhanced commensurate education. And yet, now (2018), as acknowledge in Lord Willis’ Report (2015), funding / sponsorship for nurses’ specialist education is cut dramatically, resulting in fewer nurses able to undertake foundation or specialist courses in all aspects of sexual
health. Nurses are getting little or no study time to undertake such courses; yet their clinical services are seeing higher client numbers with decreasing staff.

The result: when nurses attend any of our sexual health, reproductive, cytology, STI, health promotion or HIV courses, they often have to pay the fees themselves and do the courses in their own annual leave or ‘days off’. This is evidenced with cohorts demonstrating increasing tiredness, over-worked, stressed and demoralised professionals. Many qualified nurses, as post graduate / post registration students, debrief and say how they don’t know how much longer their services can cope with demand and lack of staff. The Government cut-backs are counter-intuitive; cutting services when numbers of infections – including many asymptomatic and hard to treat infections – are increasing. Contraception; emergency contraception; abortion; STIs; all have an impact not just for today, but well on into a person’s future. The cut-backs are making many nurses feel negatively challenged when confronted with service requirements of recent trends, and their education – especially for promoting safer sex, sexual health and well-being - takes a ‘back seat’, because they are required to ‘fight fire with fire’, i.e. provide reactive, rather than prophylactic / proactive services.

- **Prevention**

This has been touched upon, above. Whether nurses are working in specific out-reach services; working as School Nurses; Practice Nurses; Prison Health, Mental Health, SARCs or in secondary care services, many experience such demands on their services and time that effective sexual health promotion comes secondary to clinical reaction. Many nurses who would benefit from sexual health promotion learning (e.g. specific university courses) find they will not have the time for it, nor the funding, especially if their role is other, e.g. “Practice Nurse”, then a manger may say that sexual health is not specifically in their remit, despite them experiencing clinical need of it.

- **The commissioning and delivery of sexual health services, including contraception services**

Nurses addressing a client’s ‘sexual health’ approach this from 3 key perspectives: i) as part of the client’s holistic health and well-being, no matter what age; orientation; ability; health condition, etc.; ii) as something secondary to, or effected by another condition, e.g. diabetes; cancer; learning disabilities; physical conditions and disabilities, etc.; and iii) the specifics or sub-specialities of ‘sexual health’, understood as contraception & reproductive health; sexual infections & HIV; psychosexual counselling; abortion; etc.

The commissioning of these services tends to be reductionistic, and focused on the last key domain, above, e.g. contraception / GUM / HIV / abortion. The commissioning appears devoid or proactive sexual health promotion; psychosexual care; stigma interventions.

**Commissioning:**
- **Demand**
Nurses working in sexual health services routinely report how demand far outstretches provision, when services are not adequately matching the need. This leads to increasing waiting-times for clients, and the dangers of attendant on-ward transmission of infections, or unplanned conceptions. The demand in the holistic domain (i) above, and that secondary to other client conditions (ii) above, is often under-reported and totally under-addressed. For example, Practice Nurses unable to have the time to discuss the impact on sexual well-being of diabetes or cancer; or working with older people and time to talk about sexual dysfunctions; or provide / refer for condoms at Travel Consultations.

New ways of working, for example, with PrEP, for all those who have personal need for it, is hindered by the current abysmal funding debacle, permitting it only for such a limited number of core recipients. This strategy misses out on PrEP for various invisibilised groups, such as those who would not come forward to PrEP trials (including many sub-Saharan African women, and other women, disproportionately absent from the current ‘research’ initiative). Also, nurses are able to be commissioned in so many other ways, as long as funding for education and services permit, e.g. those working in Nurse-Led / Outreach PrEP and other services, enabled by Independent Prescribing qualifications or trained to administer via Patient Group Directions.

- **Access**
  Having such reducing clinical services across the country has the knock-on effect of pushing unintended consequences of condomless sex (sexual infections and unplanned conceptions) on to other people’s services and budgets. A wide range of increased primary health promotion initiatives could help individuals avoid later unintended consequences of unsafe sex, and therefore have a positive impact on requirements to access other services. *Without primary prevention, of course, access to remedial services will increase.*

- **Funding**
  Funding for clinical services is increasingly problematic, forcing the services to become overstretched, unsustainable, potentially unsafe and professionally unethical (NMC 2015). **This is a national crisis**, especially with so many unintended consequences of sex totally preventable!

Funding for professional education for nurses and allied professionals is also woefully inadequate (Willis, 2015). One of my on-line courses at the University of Greenwich, formerly of the Royal College of Nursing, had 304 students enrolled in one term, about 8 years ago. Now I struggle to get six people on it! Most complain that they simply cannot afford to pay for courses themselves, on their inadequate nursing salary; many complain their employers will not fund the courses, nor give the nurses protected study leave in which to undertake the learning. The end result is that generalist nurses will have little or no knowledge or skills in the wider, holistic domain of sexual health; specialist nurses in sexual health will struggle to enhance their learning, skills and career development with an absence of specialist study provision.
Action at national and local level to improve sexual health and sexual health services – the role of Government, NHS England, Public Health England and local authorities

The action required: put adequate money to match the human need! Whether this is in preventative services; education for wider uptake of condoms; sexual health promotion; and, by default, adequate funding of nurses to be suitably educated and qualified to address these roles in primary prevention, secondary treatment, care, and further prevention.

Further reading


Greenaway, Sir David (ND) Shape of Training Final Report, Cited at: https://www.shapeoftraining.co.uk/reviewsofar/1788.asp


Willis, LORD (2015), Raising the Bar Shape of Caring: A Review of the Future Education and Training of Registered Nurses and Care Assistants, Health Education England and the