Warts and All

In the past six years, sexually transmitted infections have risen by up to 870 per cent. But how does one talk to young people about sex?

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Earlier this month, a selection of the world's most famous pop stars gathered in Edinburgh for the MTV Europe Music Awards, the usual three-hour love-in with Justin Timberlake, Christina Aguilera, the White Stripes and the Darkness. The show finished at 11pm, and then there were the parties to attend, and by the time many of the artists and their entourages and their fans made it back to the city's packed hotels the dawn was breaking over the castle and a few staff from MTV had added an unusual feature to their hotel room door handles. A new, dangling cardboard sign carried a picture of a condom and the phrase Weapon of Mass Protection. Goodness knows what the music people made of it at that time of the morning. If they were like almost everyone else, they would have turned the sign over, to the message that read Do Not Disturb, and fallen into sleep, or perhaps into the arms of another.

The sign was part of a wider campaign called Staying Alive and was primarily a message about HIV, new cases of which are being recorded in the UK at a disturbing rate. But it was also intended as a warning about other sexually transmitted infections (STIs), diseases which we often regard as belonging to another age and which are increasing at a rate almost beyond comprehension. The 6,000 young people at the MTV show and the hundreds of thousands who watched the live broadcast and the repeat on Channel 4 would probably all be at least vaguely aware of Aids, but few would know much about syphilis, gonorrhoea, chlamydia, non-specific urethritis or herpes, unless, of course, they knew about them from personal experience. It is likely that several people in the audience had one or more of these infections, many without knowing it, and would pass them on as they would a newly burned CD. Unlike HIV, the traditional STIs are not often life-threatening, although untreated complications can be destructive. And unlike HIV, they did not have pop stars queuing up to talk about their dangers, or to take part in benefit concerts to raise money for patient services. As in the Dark Ages, contracting an STI is not something one talks about readily, or without some embarrassment, even to one's GP. Which is still a major part of the problem and a significant reason why we now have a greater prevalence than at any time since the Second World War.

The latest figures from the Public Health Laboratory Service show an increase of 870 per cent in the number of cases of syphilis between 1996 and 2002. In the same period, chlamydia rose by 139 per cent, gonorrhoea by 106 per cent, genital warts by 17 per cent and herpes by 16 per cent (these statistics are only for

England, Wales and Northern Ireland, as the most recent data for Scotland is not available). The total number of cases in 2002 was 858,646, compared to 482,815 in 1996. The proportion of men and women is roughly equal, with 28,210 cases acquired homosexually. By far the largest increase of the diagnoses occurred in people below the age of 25. The number of women aged between 16 and 19 infected with chlamydia rose from 5,876 in 1996 to 15,617 in 2002; the reported number of cases among men between 20 and 24 went up from 4,869 to 13,517. Infections in those below the age of 16 more than doubled, making up more than five per cent of the total caseload last year, for the first time. None of this would matter very much if their symptoms were all apparent and mild and their effects insignificant. But the effects of untreated chlamydia can lead to pelvic inflammatory disease, ectopic pregnancy and infertility. About 12 per cent of women with untreated chlamydia develop infertility after one acute infection, increasing to about 70 per cent after three episodes. And then there is the mental stress involved even with the less severe infections, which for some young people can prove overwhelming.

There are clinics to treat these cases throughout the UK, but none is busier than the Mortimer Market Centre near Tottenham Court Road in London. This is probably the largest STI clinic in Europe, and the facilities and service are first-class, but even here the staff are struggling to cope. There are too many patients, too few staff, and too little time. Above all, there is too little money to improve things.

On the fourth floor, Professor Michael Adler works in a small rectangular office (the building is part of the Royal Free and University College Medical School). He has the usual pictures of his daughters and wife on display and an Arsenal pennant next to cards celebrating his 63rd birthday. But most of his desk and shelf space has been colonised by the literature of STIs, all the attendant issues of treatment, screening, confidentiality, prevention and education.

Adler has been in the sexual-health business for several decades and witnessed some of the first cases of Aids in this country. Ten years ago he told me of the prejudice faced when his first patient was hospitalised, of how 'You couldn't get the domestic staff to go in, you couldn't get the porters to go in. We treated people extremely badly. It was like medicine 600 years ago.'

Since then, our attitudes and understanding towards those with HIV have improved markedly. But there have not been similar advances with the more traditional STIs. 'HIV was originally dealt with in terms of being a threat to everyone,' Adler told me recently. 'Therefore it had a political drive. But the traditional STIs are not seen as a threat to everyone - they're seen as a threat to "those dirty people" or promiscuous young people. It can be disposed of.'

Professor Adler has several explanations as to why the cases have risen so much. There has been a reduction in the age at which people first have intercourse. There has been an increase in the number of partners and an increase in people having more than one partner at a time. Because of HIV, people have forgotten about the other infections; because spending on HIV education and condom promotion has declined since the early 1990s, there has been an assumption that the threat is over, with a resultant increase in unprotected sex; because of the medical advances of the mid-90s, many regard HIV as a treatable chronic

condition and some have relinquished condom use.
And then there are the more fundamental issues. 'We're more liberal than we were towards homosexuality and sexual behaviour in general,' Adler observed, 'but we still have a real ambivalence towards it all. There is an ambivalence about good sex education, about good services for STIs and for contraception or abortion. The thinking is that once you provide any of those you encourage absolutely rampant fornication.' But the current situation hasn't worked at all - alongside the decline in sexual health, we still have the highest rate of teenage pregnancy in western Europe.
Adler's comments are based on his own experience with patients and healthcare managers, and on the findings of what is called Natsal, the second National Survey of Sexual Attitudes and Lifestyles. This research was first conducted in 1990 and 10 years later a comparative study was conducted and published at the end of 2001. More than 11,000 men and women between the ages of 16 and 44 were interviewed and the results are the most reliable indication of changing sexual practices in Britain. The latest survey found an increase in condom use, but this benefit was offset by rises in the number of partners and risky sexual behaviour. In the five years to 2000, the average number of heterosexual partners was 3.8 for men and 2.4 for women; 2.6 per cent of both men and women reported homosexual relationships; and 4.3 per cent of men said they had paid for sex. In the decade as a whole, 26 per cent of women aged 16-19 years had intercourse before they were 16 (an increase on the previous decade), although an early age of first intercourse did not appear to have an effect on rates of STIs. But all these figures are underlined by one finding: there is a great inequality throughout the country. There is a direct correlation between the incidence of teenage pregnancy/STIs and social deprivation, early departure from schooling and a lack of sex education.
The results of the 1990 Natsal survey were used to design a revised response to HIV and teenage pregnancies, and the findings of the 2000 survey should have already provided a framework for a wider response to the current epidemic of the more traditional STIs. But there is another more recent document that goes directly to the heart of the problem, the report of the parliamentary Health Select Committee on sexual health published this June. This runs to hundreds of pages and makes startling and damning reading.
The all-party committee convened in June 2002 under the chairmanship of David Hinchcliffe, the Labour MP for Wakefield. Over seven months it heard from 67 witnesses, including government ministers, specialist clinicians, health educators and a group of young people, and the committee travelled to several countries and to several clinics in Britain. The feedback was universal: our system is failing. This came as a shock to the MPs. Before hearing from their witnesses, the committee attended a seminar given by Professor Adler. 'After it they told me, "We never knew it was like this. We've never had a letter from a patient complaining about STIs," to which the only obvious response was, "Well, you wouldn't, would you?"'
A year later the MPs were very eager to reveal how much they'd learnt. 'We have been appalled by the crisis in sexual health we have heard about and witnessed during our inquiry,' they said. 'We do not use the ⁰ ª word "crisis" lightly, but in

this case it is appropriate. This is a major public health issue and the problems identified must be addressed immediately.'

Their report was the most unstinting parliamentary indictment of any sector of the health service published in recent memory. It described waiting lists in Manchester of two months and in Bristol it found services being offered from a condemned Portakabin with fleas in the carpet and 400 people turned away each week. (Not long after the committee's visit it was closed down to deal with rats.) The report found genito-urinary medicine to be poorly resourced, under-staffed and demoralised. Frequently it heard from doctors who claimed they could have offered a far superior service 10 years ago.

The doctors I contacted all said that the report got it exactly right. In Sheffield, Dr George Kinghorn, the clinical director for Communicable Diseases at the Royal Hallamshire Hospital, said that his workload had more than doubled in the past 10 years, and that up until two or three years ago his clinic would always see patients within two days. Now it's 10 days at least. 'We never turn people away if they have an urgent problem. However, younger and less privileged members of society and ethnic minorities are less able to negotiate immediate access.'

At the General Infirmary in Leeds, Dr Jan Clarke told me that at present her waiting times were almost five weeks for men and seven weeks for women. 'You try to adapt working practices and use staff imaginatively, but after a while you hit saturation point.' Many of her patients are students at the university and she is encouraged that some are visiting her clinic for checkups, even though they may be asymptomatic; she suspects that more would visit were it not for the lengthy waiting lists. But there is another trend. 'We see a lot of people who had education about HIV when they were at school and they have never met anyone with HIV, so they don't see it as a personal risk and so may not use protection. However, chlamydia is very much a personal risk if they are sexually active.

'My own interest is in young people,' says Clarke, 'and for them, sexual-health clinics are one of the main front doors of the health service. You walk in through casualty, but also through GU. Some of our patients are making their first independent health visit, and if they get an unsatisfactory experience with an STI it colours their whole attitude towards the health service.'

Before political correctness, of course, they used to be called STDs (sexually transmitted diseases), and before that VD (venereal disease), and sometimes the pox (syphilis) or the clap (gonorrhoea). Venereal disease was probably first recorded in England in 1430, when Stow's Survey of London noted the brothels on the banks of the Thames at Southwark. A register was kept by the Bishop of Winchester, who maintained that 'no stewholder keep no woman wythynne his house that hath any sickness or brouning [burning]'. The name 'syphilis' sprung from the imagination of the Veronese physician Jerome Fracastor, who in 1530 wrote a poem in Latin describing the fate of the shepherd Syphilus, who failed to worship the Sun God and was punished with venereal disease and the public humiliation that accompanied it. But the disease that raged throughout Europe in the 16th century was still primarily known as the pox, characterised by sores covering the entire body before death proved a mercy. Sexual contact was believed to be only one cause and abstinence was not considered a worthwhile option. Medical treatment consisted primarily of blood-letting, although for a

while mercury treatments were also popular. In the 19th century, venereal disease accounted for more fatalities in the armed forces than conflict and sanitary commissions were established to offer advice to servicemen and government ministers, including the suggestion that all prostitutes be examined or incarcerated. At the outbreak of the First World War, an article in the Lancet described the process by which groups of women would line up in a room with their mouths open, to be examined by two doctors who 'ply their repellent task perfunctorily' using 'one spatula for all, wiping it hastily on a soiled towel from time to time'. The women then sat on chairs for a cursory vaginal inspection. The reporter observed one of the physicians 'examine 25 or 30 girls without changing, washing or wiping the rubber fingers he wore... the inspections consumed 15 to 30 seconds each'.

Some relief came in the form of Paul Erlich's 'magic bullet' of Salvarsan, a complex and toxic ointment requiring expensive weekly applications, but it was the mass production of penicillin at the end of the 1940s that made venereal disease a manageable ailment (gonorrhoea and lesser infections had by now been distinguished from syphilis). For many in Britain, VD then became what Andre Gide referred to as 'a tax on pleasure'. In the haze of swinging London, a visit to the clap clinic, with all its backstreet horrors, was an initiation into adulthood. A gay man once told me that for him the greatest aspect of sexual liberation was not Stonewall or any act of political or social reform, but the fact that a new treatment for one STD was newly available in tablet form: 'No more excruciating bum-numbing injections.'

Tragically, it was this freedom of sexual expression that allowed HIV to claim such a foothold in the early 1980s. Aids heaped social condemnation on the afflicted - a sense that they had it coming and deserved it - but the concept of the 'wages of sin' had a deep historical precedent. The medical historian Elizabeth Fee has observed how in the 16th century, with the old feudal order being disrupted economically, politically and socially, 'restless young men were challenging the traditional constraints imposed by family, church and state. Those threatened by the social changes may have viewed the new disease as divine punishment for sexual and social deviance.'

These days, most clinicians treat their patients with a little more sympathy; the leaflets in the waiting rooms offer no social judgment and a lot of information. Syphilis is caused by a bacteria, and can be treated with antibiotics. Red spots usually appear in the genital area between a week and three months after sexual exposure and develop into small ulcers that are often painless and can go unnoticed. A red rash may then cover much of the body, and if this secondary stage is untreated far more serious effects may occur. About 10 per cent of those with tertiary syphilis will suffer an infection of the central nervous system and another 10 per cent an infection of the heart.

Gonorrhoea may cause pain while urinating and a white discharge in men, while in women the pain may be milder or undetectable. Untreated, the bacteria may scar the fallopian tubes and possibly cause ectopic pregnancy and infertility. Until recently it was believed that antibiotics were almost fully effective in treatment, but new resistant strains have emerged.

Genital herpes may be transmitted by oral contact as well as intercourse and

show in the form of small blisters and painful ulcers, and sometimes flu-like symptoms. Infection may spread by skin-to-skin contact when blisters are present and is a life-long chronic condition kept under control by daily antiviral drugs.

Genital warts are the most common of all viral STIs, and may be found in the mouth as well as the genital areas. Long-term complications are rare and treatment is by the application of a chemical ointment or a freezing process. As with all of these infections, all recent sexual partners should also be examined.

Chlamydia is asymptomatic in half of infected men and 70 per cent of infected women, and frequently goes undiagnosed throughout its duration of a year or more. In addition to the effects on women outlined previously, babies born to infected mothers may develop pneumonia soon after birth. In men, symptoms may be similar to gonorrhoea. Testing is simple and only briefly uncomfortable, usually by urethral or cervical samples, and treatment is with antibiotics. The Health Select Committee found that awareness of chlamydia is generally low, with one survey reporting that almost three-quarters of those aged between 16 and 24 had never heard of it.

Even at the end of 2003 it is not easy to find people who are happy to talk about contracting any of these maladies. It is only coincidence that the letters STI form the beginning of the word stigmatism, but it is still this feature and the fear of disapprobation and association with promiscuity that keeps a common problem hidden and encourages its spread.

This magazine recently placed an advertisement in The Guardian asking for people who would be willing to talk in confidence about their experience of STIs. Four people responded (all men, possibly because the ad appeared on the motoring page). Gaetan had contracted non-specific urethritis, a mild inflammation that clears up with antibiotics, and had a story of some ignorance and disapproval by his GP, but exemplary treatment at a genito-urinary clinic. John spoke of a painful two-week wait in Birmingham to be seen for chlamydia: 'They were perfectly friendly, but they said they were booked up and I felt it was my fault for not getting in touch with them when I first suspected something.' Colin had a more detailed account of several months of treatment for genital warts, discovered not long after starting a new relationship in Manchester. 'Some of it was one-to-one care and some weeks I was being examined by 12 medical students. In general I found it quite humiliating.

I would go with my partner every two weeks and I didn't feel very supported by anyone. We just blamed each other and the relationship broke up. We would see the same faces going to the hospital on the bus every time and everyone was avoiding eye contact. I was keen to say something like, "So what have you got then?", but we just sat there in silence.'

These are lone voices and they only have first names. This is an unsatisfactory way to handle a serious dilemma. 'One of the things about sexually transmitted diseases is that you don't get champions of them,' Lisa Power told me last month, at the offices of the Terrence Higgins Trust in Ladbroke Grove. 'You do not get people banding together in syphilis support groups or forming gonorrhoea helplines. It's relatively easily curable and highly embarrassing socially and if you've got the clap you go to a clinic and keep your mouth shut. That's why sex-

health services are always the poor relations in the NHS.'
Power is head of policy, campaigns and research at an organisation that formed 21 years ago to support those stricken with Aids, and she has been instrumental in improving the lives of those affected and at risk. She has witnessed the remarkable gestation of the epidemic: the fear among gay men; the campaigns that stated that everyone was at equal risk; the dramatic rise in deaths in the late 80s; and the equally dramatic impact of new treatments in the mid-to-late 90s. These days, about 400 people die from HIV-related causes each year in the UK, which has led to a belief that the epidemic is almost over. But the figures for new infections with HIV suggest the opposite. The Health Protection Agency, the more pointed new name of the Public Health Laboratory Service, estimates that the total number of new diagnoses for 2002 will be more than 6,000, the largest number ever in the UK, and an increase of 25 per cent over the previous year. About one-third of cases are the result of sex between men, and two-thirds the result of sex between men and women. About half are among the black African or Caribbean population. The total number of people presently living with HIV in the UK is estimated at 75,000.
The Trust long ago extended its work from HIV to deal with all STIs. Lisa Power saw the beneficial effects that condom promotion had on all transmissions, but she says we are now seeing the effects of what happens when the worst is assumed to be over. Sexual health and HIV was a key target at the Department of Health in the mid-to-late 80s, but it was de-prioritised a decade later. This made sense at the time, as the rate of HIV had not grown at the rate that had been expected in the UK and there was no clear indication that STIs were rising at the rate that they were subsequently discovered to have reached.
The dilemma is simple: sexual health is one of those issues that becomes a national priority as soon as you take your eye off it. The responsibility for the provision of healthcare in Britain has changed significantly in recent years, devolving from central government to localised primary care trusts (PCTs). The PCTs have strict priorities and targets to meet and sexual health has not been high on the agenda. Last year they commenced a three-year plan at which the issues of HIV and STIs were not mentioned. The government's response to the damning Health Committee report did express some concern about this, but NHS planners will not issue a new strategy for PCTs until 2005. 'The government keeps indicating to primary care trusts that it's important,' Power told me, 'but we've heard several times from people that you don't get sacked for failing to sort out sexual health locally, but you do get sacked for failing to sort out your waiting lists for cancer or heart disease.'
In the meantime, people will not stop having sex. As waiting lists at GUM clinics lengthen, infections will spread further. As the incidence of chlamydia increases, a huge bill is being stored up for future infertility treatment. And there are yet graver concerns, as there is growing evidence that traditional STIs and HIV feed off each other: patients infected with a number of untreated STIs are more at risk of being infected with HIV.
There are some signs of movement. This year the government has made £11m available for clinical services and improvements in chlamydia screening (the select committee recommended £22m-30m). This breaks down to between only

£30,000 and £100,000 per clinic and the few I contacted doubted whether it would make much impact on services or waiting lists. The Department of Health has launched a campaign aimed at teenagers based on the 'It Could Be You' message of the Lottery. There are ironic adverts on the radio and lucky numbers on the website: 25 - the number of different types of STIs; four - the number of STIs that are incurable; eight - the amount of STIs that have no symptoms. You can pull the handle on a virtual one-armed bandit and win big: 'Jackpot! You've got genital herpes,' a caption says. 'Causes painful sores... no known cure.' Pull the lever again and you can get syphilis, or take part in Scratch My Box, a scratchcard game in which you win chlamydia. There is a 'hide' box you can click to bring up a fake desktop screen to save embarrassment in case someone unsympathetic sneaks up. The site links to a directory of clinics and advocates condoms. It's a start.

Among all the people who have devoted their careers to improving our sexual health, there is one overwhelming emotion: frustration. So much of this problem is preventable. At the Terrence Higgins Trust in the mid-90s they used to talk enthusiastically about working themselves out of a job, but you don't hear that very much any more. Instead, Lisa Power and Michael Adler and the GUM consultants throughout the country talk about the need for greater prioritisation, more frankness, and better education in schools. At MTV, Georgia Franklin, head of the Staying Alive team, talks about her hopes of achieving greater awareness from a concert hosted next week by Nelson Mandela and Beyonce, and the problems encountered when trying to take the highly effective MTV brand of safe-sex message into sixth forms ('I would have to write to every parent of every child in every school').

We live in a strange climate, where the sex life of Prince Charles is afforded more significance than our own and where the government is nervous about upsetting the moral code of newspaper columnists. At the busiest clinic in Britain, Michael Adler and his colleagues continue to see a vast backlog of nervous patients. 'I feel very strongly that society has a responsibility to prepare people for a healthy sexual life,' Adler says. 'We're not doing that. I'm absolutely convinced that we have to make sexual-health education a statutory part of the national curriculum. You have to empower people. But we're just faffing around at the moment, while all the evidence suggests that if you give people a good sexual education it actually delays the age of first intercourse, delays pregnancy, and allows people to develop negotiation skills. People learn to respect each other regarding negotiations over sex, with far less coercion.'

Adler says that staff morale is extremely poor. 'People can't continue to go on acting as an assembly line and cutting corners, because quality is affected and professional pride is affected. I feel fairly miserable about it all.' He doubted whether matters would improve much until the issue becomes a political imperative again. 'We see a little more money trickling through, but it's not going to solve the issues, which are colossal. It's never been as bad as this and I'm not quite sure how we do break through this now.'

Once, Britain led the way in these areas. It took a few years, but when the UK started to tackle Aids seriously in 1986 it was with conviction and foresight that we set the standard in Europe. It was politically dangerous and ethically

controversial, but many lives were saved. We have a lot to learn from our own past, but we know how to do this.

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