RCOG and FSRH joint consultation response: proposal for revised NCSP policy

25 February 2020

The Royal College of Obstetricians and Gynaecologists (RCOG) and the Faculty of Sexual and Reproductive Healthcare (FSRH) welcome the opportunity to respond to the public consultation on the proposal for a revised National Chlamydia Screening Programme (NCSP) policy by Public Health England (PHE).

The RCOG works to improve health care for women everywhere, by setting standards for clinical practice, providing doctors with training and lifelong learning, and advocating for women's health care globally. We now have over 14,000 members worldwide. Our members look after more than half of the population (51%) at some point in their lives.

FSRH is the largest UK multidisciplinary professional membership organisation representing more than 15,000 doctors and nurses working at the frontline of sexual and reproductive healthcare (SRH). Our goal is to ensure that high standards in SRH care are achieved and maintained through appropriate funding/commissioning and a highly-skilled workforce, to ensure the population can access services which realise our Vision for high-quality and holistic SRH across the lifecourse.

Questions

Based on the scientific evidence it is recommended that the primary focus of the National Chlamydia Screening Programme should be to improve population health outcomes by reducing the harms of untreated chlamydia.

This is a change to the current primary focus of chlamydia prevention and control through early detection and treatment. [More detail can be found in the Peer Review Panel's Report section 1.1]

10. Do you support this change in focus of the programme?*

Yes/No/**Not sure**

11. Please give reasons for your answer

The Royal College of Obstetricians and Gynaecologists (RCOG) and the Faculty of Sexual and Reproductive Healthcare (FSRH) support the goal of preventing the adverse consequences of untreated chlamydia. We note the peer review panel report finding that there is no strong empirical evidence that screening of women and men has resulted in a fall in prevalence. As such, we understand why the consultation proposes that prevention of harm from untreated chlamydia infection is likely to be a more measurable and appropriate goal than prevention of ongoing transmission.

However, despite our support for a change that focusses on improved health outcomes rather than transmission, we believe that the NCSP should aim to improve outcomes for everyone affected by chlamydia, not only women. RCOG and FSRH are concerned that the suggested change in primary focus may inadvertently bias public perception that chlamydia is a sexually transmitted infection (STI) primarily affecting and transmitted by women, effectively discouraging men from taking responsibility for their own sexual and reproductive health.

We agree that health promotion should be offered to people requesting or being offered a chlamydia test. This should include using varied materials. Whilst many people like to access health information digitally, some people prefer more traditional formats, and the NCSP should support patient choice concerning how individuals with different needs prefer to access health information. Careful thought needs to be given to how to promote healthy sexual and reproductive health behaviours for all people, including those with one or more protected characteristics, from disadvantaged backgrounds, marginalised communities, those with disabilities, visual impairments or language barriers or those living in institutionalised settings.

Overall, RCOG and FSRH are unconvinced that the programme should change its focus away from screening men and women in order to diagnose and treat infection and prevent onward transmission. We call on Public Health England (PHE) to focus the NCSP on health outcomes, but not at the expense of shifting responsibility for sexual and reproductive health away from men, creating unhelpful myths about STI transmission and further stigmatising women's health.

12. Do you have any concerns about the proposed change in the primary focus of the programme?

Yes/No/Not sure

13. Please give reasons for your answer

Shifting responsibility and stigma to women

RCOG and FSRH are concerned that the proposed change inadvertently implies that good sexual and reproductive health is the sole responsibility of women rather than men. We are concerned that this effectively misappropriates the risk of STIs as a 'women's issue', whereas responsibility for sexual and reproductive health should be equal.

RCOG and FSRH support efforts to reduce the harm that untreated chlamydia infections can cause in women, but are concerned that the removal of opportunistic screening for men might imply that men do not need to be concerned about testing or the sequelae stemming from their untreated infection. As noted in the evidence pack, it has been estimated that 2% of men with asymptomatic chlamydia develop epididymitis; and that decreased sperm counts and decreased sperm motility are commonly seen in cases of acute epididymitis, which is associated with increased levels of male infertility. These are far from being negligible consequences to men's sexual and reproductive health, which can be avoided by effectively testing men opportunistically for chlamydia.

Opportunistic screening of men was originally included in the NCSP programme because it was deemed necessary to highlight men's role in preventing onward transmission, encouraging both women's and men's ownership of their sexual and reproductive health. NSCP's "Men Too" Strategy from 2007 aimed to raise awareness of the importance of screening men, both for their own sexual and reproductive health and to contribute to preventing reproductive morbidity in women, which we believe is a key focus the NSCP should retain.

There is a marked difference in health-seeking behaviours between genders when it comes to sexual and reproductive health. Young men may be less likely than women to seek testing[1]. Guidance for commissioners and providers issued in 2009 by the NCSP to target access to young men highlighted evidence that young men often lack knowledge about chlamydia and screening for the infection. It also found that young men associated chlamydia with 'dirtiness' and 'shame'; and felt pressure to present themselves as 'sexually successful' rather than 'sexually responsible' as well as to demonstrate risk taking behaviours[2].

On the other hand, the two surveys carried out by PHE in 2014 and 2015, as noted in the evidence pack, showed that chlamydia screening had a positive impact on awareness and health-seeking behaviours: '[*t]esting had a normalising and destigmatising effect, in terms of making young adults more likely to think that testing was normal and approved of in their peer group*'. The surveys also found that chlamydia screening resulted in changes to their subsequent knowledge, healthcare-seeking or sexual behaviour. Screening provides an opportunity to deliver safer sex messages to young adults with higher risk of poor sexual health outcomes. As outlined in the evidence pack, the '*findings suggest that chlamydia screening has a wider effect on young adults' sexual health beyond diagnosis and treatment alone*'[3].

In a context when men already lack knowledge of chlamydia and screening and hold stigmatised views, it is easy to conclude that the wider benefits of screening in relation to normalising, destigmatising and changing knowledge and attitudes to chlamydia and health-seeking behaviours will be lost if men are not offered opportunistic screening any longer.

Finally, rates of chlamydia are increasing in HIV-diagnosed men who have sex with men (MSM); between 2014 and 2018 there was a 61% rise in incidence from 11,760 to 18,892, evidencing the need for men to be offered opportunistic testing.

Cuts to services and the role of SRH

RCOG and FSRH are worried that this proposed change in focus will encourage local authorities, who are already under severe budget constraints, to make further cuts to sexual and reproductive healthcare (SRH) services. This would be damaging given that SRH services have already been hard hit by cuts to Public Health budgets. Two thirds of local councils have cut their SRH budget since 2016/17. More than 8 million women of reproductive age now live in an area where the local council has reduced the SRH budget[4]. Cuts have taken place in a context of increasing demand, which has risen by 13% since 2013. The Local Government Association (LGA) has warned that sexual health services are now at a "tipping point"[5].

[1] Andersen, B. et al. (2002) Population-based strategies for outreach screening of urogenital Chlamydia trachomatis infections: a randomised, controlled trial. *Journal of Infectious Diseases*, 185:252-258. Available at: https://www.ncbi.nlm.nih.gov/pubmed/11807700

[2] NCSP & NHS 2009. *Involving Young Men in Chlamydia Screening. A Practical Guide*. Available at: https://www.gov.uk/government/collections/national-chlamydia-screening-programme-ncsp

[3] PHE 2019. *National Chlamydia Screening Programme. External Peer Review: evidence pack*. Available at: https://www.gov.uk/government/consultations/national-chlamydia-screening-programme-policy-update

[4] AGC 2018. *Cuts to contraceptive care deepen as new data reveal half of councils closed sites providing contraception since 2015 – September 2018*. [pdf] Available at: http://theagc.org.uk/our-work/

[5] LGA 2017. Sexual health services at tipping point warn councils. *Local Government Association*. [online]. Available at: https://www.local.gov.uk/about/news/sexual-health-services-tipping-point-warn-councils

RCOG and FSRH strongly believe that SRH services are uniquely positioned to provide a holistic approach to chlamydia prevention and treatment as well as health promotion and reduction in transmissions through education. SRH services are open access, confidential and see a large number of young people, a group disproportionately affected by chlamydia. The provision of opportunistic chlamydia testing in those who attend for contraception at SRH services provides a unique opportunity in line with the new focus of the NCSP. Hence, in order to safeguard the provision of these vital services, RCOG and FSRH call on PHE to support SRH services to continue to deliver holistic care including chlamydia testing, treatment, health promotion and education.

Furthermore, we believe there needs to be a stronger focus by the NCSP on education programmes to ensure that young people understand the importance of using barrier contraception to prevent STI transmission. The focus must be on emphasising to young people the positive impacts of taking healthy decisions and ownership of their sexual and reproductive health. It is crucial that this is aimed at young people of any gender, to create a shared responsibility for healthy behaviours, mutual respect and wise choices when it comes to sex and relationships.

14. Would you be concerned if the primary focus did not change?

Yes/No/Not sure

15. Please give reasons for your answer

We support the current practice of screening both men and women and the health promotion and education programme which has supported this policy to date. However, we agree that there has not been a significant reduction in chlamydia prevalence despite this work and that the programme needs review and reform.

However, as previously stated, RCOG and FSRH have key concerns that the proposed change to exclude men from opportunistic screening will have damaging effects on health equality. We would like to see a change in policy that enables both men and women to equally understand the importance of screening to prevent onward transmission and poor health outcomes and does not negatively bias one gender to carry this responsibility.

Most of the harm caused by untreated chlamydia is in women. To achieve a reduction in the harms of untreated chlamydia, it is recommended that the following three changes are implemented:

(i) focus chlamydia screening on young women. This means that chlamydia screening outside of specialist sexual health services should only be proactively offered to young women (not young men)* [More detail can be found in the Peer Review Panel's Report section 2.1 and 2.2]

****Young men should still be offered tests if they are identified as partners, if they have symptoms or if they are undergoing other sexual health screening.***

and

(ii) increase the chance of diagnosing infection early (in order to minimise the duration of infection) by offering screening to young women at all contraceptive interventions and promoting testing at partner change (or annually if no partner change) [More detail can be found in the Peer Review Panel's Report section 3.1 and 4.1]

and

(iii) optimise the management of those diagnosed with chlamydia (this means more rapid treatment, greater number of partners tested and treated, and greater proportion retested after treatment). [More detail can be found in the Peer Review Panel's Report section 2.3, 4.2 and 5.1]

16. Regarding (i) focus chlamydia screening on young women. This means that chlamydia screening outside of specialist sexual health services should only be proactively offered to young women (not young men)

Yes/**No**/Not sure

17. Please give reasons for your answer

As outlined in our previous answers, the RCOG and FSRH strongly reject this proposal that would negatively affect both men, who would not be routinely screened, and women, as they would be targeted unfairly. Furthermore, we believe that a lack of evidence into the consequences of untreated chlamydia and sequelae in men does not render these issues non-existent or invisible; it only means there is not enough evidence on them. As noted in the evidence-pack, epididymitis, orchitis and epididymo-orchitis have not been routinely monitored, and we believe that a lack of evidence should not warrant a change of policy of this magnitude to the NCSP programme.

18. Do you have any concerns about this proposed recommendation?

Yes/No/Not sure

19. Please give reasons for your answer

The RCOG and FSRH are concerned at the consequences of this proposal, namely the implication that good sexual and reproductive health is the responsibility of women, rather than men. We support efforts to reduce harm in women and prevent poor health outcomes, but this should not come at the cost of health equality. The removal of opportunistic screening for men provides a potentially dangerous message that men do not need to consider their sexual and reproductive health as important. This may negatively impact men's health-seeking behaviours and create stigma between genders.

As outlined previously, RCOG and FSRH are concerned that this change in focus may drive further cost-cutting policies at local authority level, risking the sustainability of SRH services further. While we appreciate that funding for health interventions is not infinite, the negative consequences of these proposals are too great to account for any potential financial savings.

20. Would you be concerned if this proposed recommendation was not implemented?

Yes/**No**/Not sure

21. Please give reasons for your answer

We support the goal of preventing the adverse consequences of untreated chlamydia. We note the peer review panel report finding that there is no strong empirical evidence that screening of women and men has resulted in a fall in prevalence. As such, we understand why the consultation proposes that prevention of harm from untreated chlamydia infection is likely to be a more measurable and appropriate goal than prevention of ongoing transmission.

However, despite our support for a change that focusses on improved health outcomes rather than transmission, we believe that the programme should aim to improve outcomes for everyone affected by chlamydia, not only women. RCOG and FSRH are concerned that the suggested change in primary focus may inadvertently bias public perception that chlamydia is an STI primarily affecting and transmitted by women, effectively discouraging men from taking responsibility for their own sexual and reproductive health.

22. Regarding (ii) increase the chance of diagnosing infection early (in order to minimise the duration of infection) by offering screening to young women at all contraceptive interventions and promoting testing at partner change (or annually if no partner change) [More detail can be found in the Peer Review Panel's Report section 3.1 and 4.1]

Do you support this proposed recommendation?

Yes/**No**/Not sure

23. Please give reasons for your answer

RCOG and FSRH do not support annual screening for chlamydia. We support screening if it is considered there is a risk of infection. We support patient choice in that service users, no matter the gender, should have the right to request chlamydia screening if they feel it necessary. Screening can also be requested following a consultation with an SRH healthcare professional who will conduct a risk assessment with the service user and support the individual to make the best choice for themselves.

However, we support the aim of increasing early detection. Therefore, we agree that screening should be offered to women at contraceptive interventions and services offering contraceptive care, such as SRH services, as well as via all the methods identified in section 3.1 of the peer review panel report. We would argue that this should be available to all women who would benefit from testing, not just 'young women' as stated in question 22, and following an STI risk assessment.

We support efforts to improve online testing. We know that many people feel embarrassed and ashamed when it comes to seeking sexual and reproductive healthcare and treatment. Self-taken tests remove the need for an intimate examination for both men and women and improves access to screening and early diagnosis.

24. Do you have any concerns about this proposed recommendation?

Yes/No/Not sure

25. Please give reasons for your answer

Please see previous answers. We remain concerned that the change in focus serves to reinforce stigma and shame around women's sexual and reproductive health and removes the right for men to also seek sexual and reproductive healthcare and advice.

26. Would you be concerned if this proposed recommendation was not implemented?

Yes/No/**Not sure**

27. Please give reasons for your answer

We support aims to increase early diagnosis and treatment and to reduce poor health outcomes. As stated previously, we do not support annual screening for chlamydia. We support screening if it is considered there is a risk of infection. We support patient choice in that service users, no matter the gender, should have the right to request chlamydia screening if they feel it necessary. Screening can also be requested following a consultation with an SRH healthcare professional who will conduct a risk assessment with the service user and support the individual to make the best choice for themselves.

28. Regarding (iii) optimise the management of those diagnosed with chlamydia (this means more rapid treatment, greater number of partners tested and treated, and greater proportion retested after treatment) [More detail can be found in the Peer Review Panel's Report section 2.3, 4.2 and 5.1]

Do you support this proposed recommendation?

Yes/No/**Not sure**

29. Please give reasons for your answer

RCOG and FSRH agree with these proposals, including proposal 4.2 that suggests everyone who tests positive for chlamydia should be encouraged to have a re-test at three months. Yet this proposed recommendation would need greater financial support to be implemented. Optimising the management of those diagnosed with chlamydia through more testing and re-testing, more rapid time to treatment etc requires more staff and increased investment in services that are currently overstretched and already operating beyond capacity.

As we have outlined, SRH services have been hard hit by cuts to Public Health budgets. Two thirds of local councils have cut their SRH budget since 2016/17. More than 8 million women of reproductive age now live in an area where the local council has reduced the SRH budget[6]. Cuts have taken place in a context of increasing demand, which has risen by 13% since 2013. Therefore, RCOG and FSRH call for more investment to SRH services as a condition to implement this recommendation.

30. Do you have any concerns about this proposed recommendation?

Yes/No/Not sure

31. Please give reasons for your answer

We broadly support recommendation 5.1 on time to results and treatment ("Test results should be available within 7 days, and treatment within another 7 days") provided there is sufficient investment in the system. We question whether this is a realistic ambition, given the significant change in timescales from six weeks to two weeks. Is there sufficient capacity in the existing workforce and infrastructure to achieve this goal and, if not, has the necessary investment been secured? Additionally, the timescales to results and treatment need to be clarified.

[6] AGC 2018. *Cuts to contraceptive care deepen as new data reveal half of councils closed sites providing contraception since 2015 – September 2018*. [pdf] Available at: http://theagc.org.uk/our-work/

32. Would you be concerned if this proposed recommendation was not implemented?

Yes/No/**Not sure**

33. Please give reasons for your answer

As noted in the peer review panel report, minimising duration of infection in women provides better fertility outcomes. Therefore, we support measures to reduce current result and treatment times. We also support enhanced partner notification with the necessary support for individuals notified of infection. However, we support optimising the management of those diagnosed with chlamydia provided that there is increased investment in service and staff capacity. We call for more investment to SRH services as a condition to implement this recommendation.

34. Do you believe there would be any unintended consequences of the proposed changes?

Yes/No/Not sure

35. Please outline potential unintended consequences of the proposed changes, detailing any evidence/ experience related to your concerns and how they might be addressed.

FSRH and RCOG are concerned that these proposals:

1. Negatively and disproportionately impact women, shifting responsibility for sexual and reproductive health away from men, creating unhelpful myths about STI transmission and further stigmatising women's health;
2. Remove the right for men to have sexual and reproductive health tests routinely offered and negatively impact their health-seeking behaviours;
3. Could overburden already stretched SRH services if implemented with no additional funding and investment in capacity;
4. Remove the focus from health education, especially amongst young people, who are disproportionately affected by chlamydia;
5. Create sexual and reproductive health inequalities amongst men and women.

36. If the proposed changes were adopted what specific guidance, tools and communications materials would be helpful to support implementation?

RCOG and FSRH do not support the adoption of these proposed changes.

37. Any other comments?

FSRH and RCOG would welcome the opportunity to meet with NCSP to discuss our concerns further.

For further information please contact Camila Azevedo, External Affairs Manager, at externalaffairsmanager@fsrh.org / 02037945309