Modern British History, 2024, **35**, 414–434
https://doi.org/10.1093/tcbh/hwae047
Advance access publication 12 June 2024
Article

‘Initially this work was done by doctors, often ineffectively … ’: the History of Sexual Health Advising in twentieth-century England

David Evans [1,*]

[1]University of the West of England, UK
*Corresponding author. University of the West of England, Frenchay Campus, Bristol BS16 1QY, UK.
E-mail: david9.evans@uwe.ac.uk

Abstract

Much has been written about the history of policy and practice on venereal diseases/sexually transmitted infections in twentieth-century England, but one key group of actors has been overlooked: sexual health advisers and their predecessors. From the introduction of venereal disease clinics c. 1918, workers variously titled hospital almoners, health visitors, contact tracers, social workers, and, latterly, sexual health advisers have been involved in a range of interconnected activities including counselling, health education, contact tracing, and seeking defaulters from treatment in the community. Leading medical venereologists have generally expressed strong support for the value of such workers, but throughout the century there has been continuing diversity in the background, employment, training, roles, and responsibilities of those workers. In the last decades of the twentieth century, sexual health advisers sought to professionalize by establishing a professional organization and seeking other professional attributes including certified training and professional registration. Although there appeared to be policy support for such steps, by the early twenty-first century a change of government disappointed such professionalization hopes. The history of sexual health advising provides a unique lens on the challenges facing occupational groups seeking to professionalize within the National Health Service.

Introduction

In recent years, much has been written about the history of policy and practice on venereal diseases (VD)/sexually transmitted infections (STIs) in twentieth-century England, but one key group of actors has tended to be overlooked: sexual health advisers and their predecessors.[1] Sexual health advisers have worked in genitourinary medicine (GUM) services since the early 1980s and more recently in integrated sexual health services.[2] Prior to the 1980s, this work was done by people variously called hospital almoners, contact tracers, medical

---

[1] STIs were referred to as ‘VD’ until the late 1970s when the term was replaced by ‘sexually transmitted diseases (STDs)’. More recently, STI has replaced STD as it is seen to be more accurate (as not all infections cause disease) and less stigmatizing.

[2] The term ‘genitourinary medicine’ replaced ‘venereology’ in the late 1970s and ‘GUM clinic’ replaced previous terms including ‘special clinic’, ‘VD clinic’, and ‘venereal disease treatment centre’.

social workers, and/or health visitors who worked in VD clinics/GUM services or local authorities.[3] The work of sexual health advisers changed over the course of the twentieth century, but key tasks usually included seeing patients with STIs in the clinic, encouraging reattendance for treatment and test of cure, seeking information on sexual contacts, encouraging patients to ask their contacts to attend, providing health education and social support, and then pursuing defaulting patients and non-attending contacts in the community. From the mid-1980s, sexual health advisers also had an important role in providing pre- and post-test HIV counselling and support.

This article makes two key arguments about the history of sexual health advisers in England. First, that sexual health advisers are an important professional group in sexual health services, which has emerged from a complex but previously unexplored process of professional development; it identifies their steps towards professional recognition, the factors which supported professionalization and the challenges they faced. Second, the history of sexual health advising is relevant to understanding the professionalization of non-medical occupational groups in the NHS more widely.[4] It illustrates the precarious and contingent nature of professional projects and the complex interplay among national policy, medical dominance, and the aspiring professionalizing occupational group. In particular, it demonstrates a unique intersection of two other professional projects—those of nursing and medical social work—and the challenges of achieving professional recognition for a new (and relatively small) professionalizing group bridging existing occupations.

This article draws on two usually distinct historiographies: first, the history of twentieth-century British sexual health services and second, the history of the growth of occupational groups seeking to professionalize in the UK National Health Service (NHS). Hanley has recently provided a useful historiographical overview of the literature on twentieth-century British sexual health services.[5] As she argues, sexual health has been the subject of historiographic attention for decades, but it is only recently that historians have contextualized this history within broader concerns about the gendered, racialized, and class-based aspects of health and welfare services. In particular, earlier accounts emphasized the innovative voluntary, confidential, and free to use nature of the VD services established following the Royal Commission on Venereal Diseases from c. 1918.[6] More recently, work has challenged this positive interpretation, arguing that the new services retained stigmatizing and moralizing aspects as well as hidden forms of coercion and surveillance, and that such control was particularly directed at marginalized groups—for example, working-class young women, Black immigrants and gay men.[7] As front-line clinic staff working directly with people with VD/STIs, sexual health advisers, and their predecessors would have played a key role in such surveillance and clinical management. To date, however, they have only

---

[3] Almoners were employed in UK voluntary hospitals from 1895, initially to ensure that those who had the ability to pay would be excluded from the hospitals' charitable provision, but increasingly in the 1920s to assess patients' ability to pay so as to contribute to the costs of their care due to hospitals' increasing financial difficulties. With the advent of the NHS, almoners sought a new social work professional identity. See G. Gosling, 'Gender, Money and Professional Identity: Medical Social Work and the Coming of the British National Health Service', *Women's History Review*, 27 (2018), 310–28.

[4] Occupational groups seeking to professionalize are sometimes referred to as 'semi-professions' but that term is avoided in this article. As Witz has argued, that usage implicitly and patriarchally associates professions with men and semi-professions with women. A. Witz, *Professions and Patriarchy* (London: Routledge, 1992).

[5] A. Hanley, 'Histories of 'A Loathsome Disease': Sexual Health in Modern Britain', *History Compass* 20 (2022), e12716.

[6] D. Evans, 'Tackling the "Hideous Scourge": The Creation of the Venereal Disease Treatment Centres in Early Twentieth Century Britain', *Social History of Medicine* 5 (1992), 413–33; J. Eyler, *Sir Arthur Newsholme and State Medicine 1885-1935* (Cambridge: Cambridge University Press, 1997).

[7] P. Cox, 'Compulsion, Voluntarism, and Venereal Disease: Governing Sexual Health in England after the Contagious Diseases Acts', *Journal of British Studies* 46 (2007), 91–115; S. Caslin, 'Transience, Class and Gender in Interwar Sexual Health Policy: The Case of the Liverpool VD Scheme', *Social History of Medicine* 32 (2019), 544–64; A. Hanley, 'Migration, Racism and Sexual Health in Postwar Britain', *History Workshop Journal* 94 (2022), 202–22.

been referenced occasionally and unsystematically in these historical debates and their specific roles are not examined or contextualized.

The historiography of the development of health professions in the NHS has been dominated by histories of medicine and nursing, with much less attention paid to the growth of numerous 'allied health professions' usually subordinate to medicine.[8] A key concept is that of the professional project, the way in which occupational groups (and in particular medicine) sought to establish their professional status through training, qualifications, registration, and regulation.[9] Within health care, medicine is widely seen as the most successful professional project and nursing is often seen as less successful in establishing itself as a profession in comparison with medicine, with feminist scholars particularly pointing out the gendered basis for the hierarchical relationship between medicine and nursing and other predominantly female occupations.[10] There is no one historiographical overview of other UK health occupations' attempts to professionalize although there are useful introductions to the issues in Nancarrow and Borthwick and Larkin.[11] Accounts exist for the emergence and development of a number of occupational groups, for example, radiographers, paramedics, and genetic counsellors.[12] Of the many health occupations seeking professional status, a few have been largely successful, some partly so, and a small number failed completely. The most successful are those like physiotherapists, radiographers, and dietitians who were recognized as professions supplementary to medicine by the government in 1960 and have gone on to have protected titles, recognized academic qualifications, professional societies, and state registration.[13] Others have failed to gain statutory registration, but have gained voluntary registration with an accredited register overseen by the Professional Standards Authority.[14] A few occupational groups have developed but then disappeared, often amalgamated into other emerging professions. For example, for a time health promotion specialists appeared to be close to professional recognition, with a professional society, academic units and a discrete body of knowledge, but momentum towards registration stalled, and its distinct professional identity disappeared in structural changes following the introduction of the NHS internal market in the early 1990s.[15] Even when successful, professionalization can have unanticipated negative consequences, as Timmons has demonstrated with regard to operating department practitioners (ODPs), where registration ultimately led to the collapse of their professional association.[16]

Several other themes within the professionalization literature are particularly relevant here. First, within medicine there has been useful work on the developing role of women doctors and their struggles to assert their agency and professional identity within broader

---

[8] S. Nancarrow and A. Borthwick, *The Allied Health Professions: A Sociological Perspective* (Bristol: Policy Press, 2021); G. Larkin, 'The Regulation of the Professions Allied to Medicine', in J. Allsop and M. Saks, eds, *Regulating the Health Professions* (London: Sage, 2002), 120–33.

[9] M. Larson, *The Rise of Professionalism: A Sociological Analysis* (Berkeley: University of California Press, 1977); E. Freidson, *Professional Powers: A Study of the Institutionalization of Formal Knowledge* (Chicago: University of Chicago Press, 1986).

[10] Witz, *Professions and Patriarchy*.

[11] Nancarrow and Borthwick, *The Allied Health Professions*; Larkin, 'The Regulation of the Professions Allied to Medicine'.

[12] S. Decker and R. Iphofen, 'Developing the Profession of Radiography: Making Use of Oral History', *Radiography*, 11 (2005), 262–71; L. McCann *et al.*, 'Still Blue-collar After All these Years: An Ethnography of the Professionalization of Emergency Ambulance Work', *Journal of Management Studies*, 50 (2013), 750–76; J. Bangham, 'Making the 'Genetic Counsellor' in the UK, 1980-1995', *Medical Humanities* 49 (2023), 248–59.

[13] *Professions Supplementary to Medicine Act 1960.*

[14] J. Allsop and K. Jones, 'Regulating the Regulators: The Rise of the United Kingdom Professional Standards Authority'. In: J. Chamberlain, M. Dent and M. Saks, eds, *Professional Health Regulation in the Public Interest: International Perspectives* (Bristol: Policy Press, 2018), 93–116.

[15] P. Duncan, 'Failing to Professionalise, Struggling to Specialise: The Rise and Fall of Health Promotion as a Putative Specialism in England, 1980-2000', *Medical History* 57 (2013), 377–96.

[16] ODPs were unwilling to pay both registration and professional association fees leading to the insolvency of the Association of ODPs; Stephen Timmons, 'Professionalization and Its Discontents', *Health* 15 (2010), 337–52.

sexual health services, that is family planning services as well as VD/GUM.[17] Secondly, there is the related development of sexual counselling within family planning services, the LGBTQ+[18] voluntary sector and psycho-sexual nursing.[19] Finally, Gosling has done important work on the transition from almoners to medical social workers with the coming of the NHS.[20] However, neither Gosling nor any other author has looked at sexual health advisers as an example of an occupational group seeking professional status in the NHS, nor the lessons that can be learned from looking at this unique group which spanned clinical and welfare work as an exemplar of the challenges and barriers to professionalization.[21]

In terms of work on the precursors of health advisers, Davidson has examined the history of contact tracing in Scotland from its origins c. 1918 to the advent of HIV in the 1980s.[22] But he was more interested in the politics, policy and legal aspects of contact tracing and has little to say about the workers conducting the contact tracing. Other than noting that they were almoners, health visitors and nurses, he says nothing about their recruitment, training, relationship to doctors or other professionals, or their experiences in doing the job. Parker wrote an ethnographic description of working as health adviser in an English GUM clinic in the 1990s, but hers was a research post rather than a standard service role, and indeed much of her narrative focuses on the conflict she encountered with the clinic's permanent health advisers and her critique of the sexualized culture of the critic.[23] Otherwise Parker, like Davidson, has little to say on the recruitment, training, or professional identity of the health advisers. Hanley and Cox have both highlighted the work of the almoner Dorothy Manchée as illustrative of the coercive role they argue was played by almoners, but neither discussed the profession position of the almoner within the VD clinic.[24] In another paper, Hanley also critiqued VD social workers for derogatory comments about Black patients, but again does not significantly differentiate their role and attitudes from the medical venereologists they were working to.[25]

Kampf has provided one detailed account of similar workers in New Zealand which draws on an in-depth interview with one retired contact tracer active in the 1970s and 1980s as well as a published interview with a New Zealand contact tracer during the Second World War.[26] Issues explored include the lack of training and professional development for contact tracers, the social stigma of working on STIs, the impact on the contact

---

[17] A. Hanley, '"Sex Prejudice" and Professional Identity: Women Doctors and their Patients in Britain's Interwar VD Service', *Journal of Social History* 54 (2020), 569–98; C. Rusterholz, 'English Women Doctors, Contraception and Family Planning in Transnational Perspective (1930s-70s)', *Medical History* 63 (2019), 153–72.

[18] The acronym LGBTQ+ is used here to denote a range of non-heterosexual communities due to the continual change in accepted terminology although the term was not commonly used until late in the period under discussion. I follow Richard McKay and others in using 'homosexual' when referring to usage at the time by the sources being discussed; R. McKay, 'Before HIV'. In: Mark Jackson, ed., *The Routledge History of Disease* (Abingdon: Routledge, 2016).

[19] T. Chettiar, 'Counselling for Connection: Making Queer Relationships during Britain's Sexual Revolution', *Medical Humanities* 49 (2023), 182–92; R. Irwin, 'Recalling the Early Years of Psychosexual Nursing', *Oral History* 39 (2011), 43–52.

[20] Gosling, 'Gender, Money and Professional Identity'.

[21] The only published account of sexual health advising in the UK is a brief account by a practicing sexual health adviser as part of a professional manual: H. Wilson, 'History of Sexual Health Advising'. In: Society of Sexual Health Advisers (SSHA), *Manual for Sexual Health Advisers* (London: SSHA, 2004), 188–93.

[22] R. Davidson, '"Searching for Mary, Glasgow": Contact Tracing for Sexually Transmitted Diseases in Twentieth-century Scotland', *Social History of Medicine* 9 (1996), 195–214; R. Davidson, *Dangerous Liaisons: A Social History of Venereal Disease in Twentieth-Century Scotland* (Amsterdam: Rodopi, 2000).

[23] M. Parker, 'Stuck in GUM: An Ethnography of a Clap Clinic'. In: D. Gellner and E. Hirsch, eds, *Inside Organizations: Anthropologists at Work* (Oxford: Berg, 2001), 137–56.

[24] Cox, 'Compulsion, Voluntarism and Venereal Disease'; Hanley, '"Sex Prejudice" and Professional Identity'.

[25] Hanley, 'Migration, Racism and Sexual Health in Postwar Britain'.

[26] A. Kampf, 'A Little World of Your Own: Stigma, Gender and Narratives of Venereal Disease Contact Tracing', *Health* 12 (2008), 233–50.

tracer's own social life and the risk of violence. Kampf comments on how little has been written on contact tracers by historians of venereal disease; this paper seeks to address that gap in the English context, and tells the story of contact tracers (and their evolution into sexual health advisers) from their advent within VD clinics after 1918 through to the early twenty-first century.

This article is based on documentary analysis of three types of primary material: first, official publications relating to VD/STIs from the UK government, in particular the Ministry of Health and its successor departments, the NHS from its formation in 1948, and local authorities; secondly, articles, reports and letters in medical journals, in particular the *British Journal of Venereal Diseases* (*BJVD*), the *British Medical Journal* (*BMJ*), and *The Lancet*; thirdly, reports by professional bodies, such as Society of Sexual Health Advisers (SSHA), independent think tanks and academics. Searchers for relevant material were conducted using Pub Med, Google Scholar, Gov.uk, the National Archives, the Wellcome Library, the British Library, the SSHA website and Google. References from existing secondary literature on the history of English STI policy and practice were scanned to identify any additional literature relevant to contact tracing and/or sexual health advising. A total of sixty-one primary documents relating to contact tracing/sexual health advising were identified, obtained and read either as hard copy or electronically as pdfs.

The early history of social work in VD clinics

The role that would become the sexual health adviser grew out of the social work role in VD clinics in early twentieth-century England. The establishment of the clinics was a major policy innovation following the Royal Commission on Venereal Diseases 1913–1916, which deplored the prevailing inadequate and stigmatizing patchwork of VD services and recommended a comprehensive medical response to the problem of VD based on recent scientific advances in diagnosis and treatments.[27] A new nationwide network of VD clinics was established from early 1917 following government regulations requiring local councils to establish free and confidential services.[28] The intention was that they should be easily accessible to both men and women and free of the stigma previously associated with the treatment of venereal diseases. The guidance attached to the regulations focused on the medical, diagnostic and treatment services to be provided, and the financing of the services, but did not consider the need for other staffing.[29] In the early days, the key challenges were overcoming the institutional and professional resistance from local councils, hospital management, and medical professionals who in some areas were initially reluctant to set up the services.

The initial guidance did not consider issues of default on treatment or contact tracing, but these soon became matters of concern, particularly default on treatment as with both syphilis and gonorrhoea there were concerns that treatment was onerous and time consuming, and that patients might often default when their symptoms disappeared but they might still be infectious. As early as 1920, of the 105,619 persons treated for syphilis, 39,809 left before completing treatment or before a final check.[30] A particularly influential voice was that of Colonel Lawrence Harrison who was the first Adviser in Venereal Diseases to the Ministry of Health and led the VD clinic at St Thomas' Hospital, who suggested that default by patients was often due to poor medical practice, and that some doctors were negligent in not seeking to persuade male patients to advise their wives to attend to 'avoid the

---

[27] Evans, 'Tackling the "Hideous Scourge"'.

[28] Evans, 'Tackling the "Hideous Scourge"'.

[29] Local Government Board, *Prevention and Treatment of Venereal Diseases: Circular. Councils of Counties and County Boroughs. Common Council of the City of London* (London: Local Government Board, 1916).

[30] Chief Medical Officer of the Ministry of Health, *Annual Report of the Chief Medical Officer, 1920* (London: Ministry of Health, 1921).

risk of causing domestic disturbances'.[31] A government-appointed Committee of Inquiry report in 1923 considered the issue of defaulting in its deliberations on more coercive measures, including compulsory notification, but concluded that this was not warranted.[32] This report was also the first extant mention of the potential role of social workers in advising VD patients, but the report emphasized the 'primary duty' must always be with doctors and that the social worker role was supplementary.[33]

By the mid-1920s, a small number of VD clinics did employ social workers, usually designated hospital almoners. The first published account of such work was given by M.D. Spens, an almoner working in the women's VD clinic at St Thomas Hospital, in 1926.[34] Spens made clear her view that the almoner role must be subordinate to the medical officer. Such acceptance of medical dominance is unsurprising given the higher status of medicine, that almoners were seeking to establish themselves as a profession, that most venereologists were men and almoners women, and that almoners were only appointed to work in the clinics with the consent of the medical officer in charge. Along with encouraging attendance and following up any defaulting patients, Spens identified a role in persuading women to bring their contacts to the clinic, though she phrased this in terms of 'children' and 'older members of the family' rather than sexual contacts. Moreover, the discussion of defaulting and contacts is a relatively small part of her text, with most of it devoted to a claimed wider welfare role of the almoner, regarding emotional support for women 'innocently infected' or practical support for 'women and girls who have made a mistake', including assistance with housing, employment, and training. Such judgemental and gendered distinctions were typical of both the attitudes of the dominant medical offices within the VD clinics and of the social work profession outside the clinics, so it is unsurprising VD almoners shared these wider professional attitudes in the period.

The medical officer in charge of the women's clinic at the Royal Free Hospital, Margaret Rorke, argued that it was 'highly desirable' to have a trained social worker on the staff of a VD clinic and reported that:

> In England in some of the larger clinics we have a Hospital Almoner for this work. If no such person be available or provided, then the social work has to be done by the doctor or the sister, with a corresponding loss of time for the purely medical work. To those asking, what is the use of a social worker in a VD clinic, I would say, she is invaluable.[35]

Rorke then went on to innumerate the various ways the social worker was invaluable, which included enabling the mother to bring in her children for examination, following up defaulters and a broad range of welfare activities. Similar to Spens, she only addressed one aspect of pursuing the male sexual contact: 'she discovers-or tries to-why father will not attend, and gives the anxious mother persuasive arguments to use.'[36] When discussing the 'young girl who has gone wrong' she did not mention seeking to trace her sexual contacts. Notably Rorke's language as a doctor is very similar to Spens' as an almoner in terms of the gendered and judgemental distinction between those deemed innocent and those women perceived to have 'gone wrong.' Moreover, they similarly focus on the almoner's

---

[31] L. W. Harrison, 'The public health services and venereal diseases', *British Journal of Venereal Diseases* 1 (1925), 19.

[32] Anon, 'Inquiry on venereal disease: Report of Lord Trevethin's committee', *British Medical Journal* 1 (1923), 976–9.

[33] Anon, 'Inquiry on venereal disease', 978.

[34] M. D. Spens, *An Almoner's Work in a Women's Venereal Disease Clinic* (London: British Social Hygiene Council, 1926).

[35] M. Rorke, 'The Administrative Aspect of the Venereal Disease Problem', *Journal of State Medicine* 37 (1929), 292.

[36] Rorke, 'The Administrative Aspect', 292–3.

role with women attenders/defaulters much more than with male contacts, reflecting the then common assumption placing responsibility for transmission on women.

The most extensive writing about the role comes from Dorothy Manchée, almoner at St Mary's Hospital Paddington, who produced two books and a number of articles in the 1930s and 1940s about the almoner in the VD service.[37] Like Spens and Rorke, Manchée assumed the almoner would be female, and in her 1939 article similarly focused on work with female patients, though she gave brief attention to work with men. She began by arguing the value of the almoner and seeking to convince the reader (assumed to be a medical venereologist) to employ one. 'One often hears it said that a clinic "manages very well without an almoner"' she stated, suggesting that many VD clinics in the 1930s did indeed go without an almoner, before going on to argue in terms very similar to Spens and Rorke the value the almoner brought both in welfare work and in encouraging attendance by potential defaulters.[38] As with Spens, there is throughout a tone of deference to the dominant medical officer, suggesting again that almoners needed to explicitly accept subordination to be accepted in the clinic.

There is an emphasis on the value of home visiting, but more in terms of establishing trust and rapport, with no mention of contact tracing. Manchée also stressed the importance of almoner training, and details the content of the Institute of Almoners two-year course which included a four-month practical placement with a social work organization and eleven months placement with a hospital almoner. She acknowledged that there might be some unqualified almoners doing work of the highest standard, but warned 'as a general principle the unqualified woman in the V.D. department is an even greater danger than the unqualified teacher.'[39] This call for trained almoners is arguably the first evidence of a professionalizing project for VD social workers.

By the end of the 1930s, the position of social work in VD clinics was clearly quite varied. Some clinics, particularly those for women, had VD almoners, some of whom were certified by the Institute of Almoners and others unqualified. In England, almoners' stated focus was mainly on welfare work with women[40] and on preventing or addressing defaulting on treatment, with little sustained effort on contact tracing, whereas Davidson reports that in Scotland nurse almoners in major VD schemes began to develop informal systems of contact tracing as part of their regular follow-up work.[41] Where almoners were not employed, the pursuit of defaulters might be undertaken by health visitors employed by the local authority medical officer of health (MOH).[42] In other cases, defaulters and contacts were managed by the clinic medical or nursing staff, or not managed at all. One venereologist writing in 1939 believed almoners were useful for visiting female defaulters but not males as 'a lady, no matter how tactful, may inadvertently be responsible for other members of the household getting to know that the son or husband is attending the V.D. centre'.[43] There was no national policy or guidance on either social work in VD services or specifically on addressing defaulting or contact tracing, and therefore no counter to the wide variation in local practice. The work was clearly quite gendered at this point, both in

---

[37] D. Manchée, 'The Almoner in the Venereal Diseases Service', *British Journal of Venereal Diseases* 15 (1939), 275–86; D. Manchée, *Social Service in the Clinics for Venereal Diseases* (London, 1943); D. Manchée, 'The Social Aspect of the Venereal Diseases—1 The Work of the Almoner', *British Journal of Venereal Diseases* 21 (1945), 12–14; D. Manchée, *Textbook for Almoners* (London: Bailliere, Tindall and Cox, 1947).

[38] Manchée, 'The Almoner in the Venereal Diseases Services', 276–8; Notably, Harrison's 1934 proposed model plan for a venereal disease treatment centre did not include a room for an almoner: L. W. Harrison, 'The Design of Venereal Disease Treatment Centres', *British Journal of Venereal Diseases* 10 (1934), 223–2.

[39] Manchée, 'The Almoner in the Venereal Diseases Services', 285.

[40] Unfortunately, we lack women's voices on how they experienced this welfare work and the extent to which it was experienced as supportive, or oppressive as suggested by some authors such as Hanley or Cox.

[41] Davidson, 'Searching for Mary, Glasgow', 198.

[42] J. L. Burn, 'Home Visiting of Defaulting Venereal-disease Patients', *Lancet* 238 (1941), 655–6.

[43] C. H. Wilkie, 'The Prevention of Defaulting from V.D. Treatment Centres', *British Medical Journal* 2 (1939), 806.

terms of being carried out by women almoners or health visitors, and being focused on women attenders and defaulters. There was a strong explicit commitment to confidentiality of service, although as Cox has noted, Manchée demonstrates that there were subtle ways almoners could breach confidentiality in communications with other agencies where they felt it was in the patient's interest.[44]

The Second World War and Defence of the Realm Act 33B

Wars almost always bring an increase in the incidence of STIs and the Second World War was no exception.[45] As rates of infection rose early in the war, the UK initially continued its pre-war policy of non-compulsion for the civilian population.[46] By 1942, however, calls for a more compulsory approach increased from venereologists (in particular in the military), and influentially from allied governments (in particular the USA and Canada) whose troops were stationed in the UK.[47] In response the government introduced Regulation 33B of the Defence of the Realm Act (DORA) in November 1942. Under 33B, if a patient was found by a 'special practitioner' (i.e. a venereologist) to be suffering from venereal disease, the practitioner should inform the local MOH of the name of any person the patient suspected as the source of infection. If the MOH found that two patients named the same person, then the MOH could then require this 'contact' to submit to compulsory examination, and if infected, to treatment. Failure to comply until such time as given a 'clearance certificate' could lead on conviction to three months imprisonment, a fine of £100 or both.

In practice, the explicitly compulsory aspects of 33B were never widely applied or had any significant impact on rates of STI transmission. But the introduction of the regulation, and particularly the collection of data on contacts suspected of being the source of infection did act as a significant spur to the development of notionally non-compulsory contact tracing. In December 1943, the Ministry of Health sent a circular to all local authorities empowering and encouraging them to trace alleged contacts named by one infected person.[48] In a debate in 1945, over the merits of the scheme, Harrison argued that it had led directly to 2,858 contacts being examined, the vast majority of whom were contacted informally as they had only been identified by one patient rather than the two required for compulsory action to be taken.[49] Historians are divided as to what extent there was coercion in practice if not officially in this contact tracing with Cox and Caslin seeing degrees of informal coercion in the scheme whilst Lemar is more sceptical.[50] In any case, as previously, the responsibility for and direction of the contact tracing lay with the MOH and the venereologist in charge of the VD clinic, with the almoner or health visitor conducting the contact tracing subordinate to their medical superior.

Heavily influenced by the example of contact tracing in the USA and by the US Army medical service in the UK, a number of local contact tracing schemes were set up in the UK in the latter years of the war. The most extensively reported was the 'Tyneside Scheme', which was sponsored jointly by two county councils and four county borough councils in the northeast of England and supported by the Ministry of Health. A full-time hospital almoner worked as the 'liaison officer' organizing the scheme, supported by a full-time

---

[44] Cox, 'Compulsion, Voluntarism and Venereal Disease', 115.

[45] L. Hall, '"War Always Brings It On": War, STDs, the Military, and the Civilian Population in Britain, 1850-1950'. In: R. Cooter, M. Harrison and S. Sturdy, eds, *Medicine and Modern Warfare* (Amsterdam: Rodopi, 1999), 205–23.

[46] Ministry of Health, *Venereal Diseases, Circular 1956* (London: Ministry of Health, 1940).

[47] S. M. Laird, 'The Need for Further Powers to Deal with Sources of Infection, Contacts and Defaulters', *British Journal of Venereal Diseases* 18 (1942), 84–93.

[48] Ministry of Health, *Venereal Diseases, Circular 2896* (London: Ministry of Health, 1943).

[49] L. W. Harrison, 'Regulation 33B', *British Journal of Venereal Diseases* 21 (1945), 91.

[50] Cox, 'Compulsion, Voluntarism and Venereal Disease'; Caslin, 'Transience, Class and Gender in Interwar Sexual Health Policy'; S. Lemar, *Venereal Diseases in Adelaide and Edinburgh 1910-1947* (Adelaide: University of Adelaide, 2001).

clerical officer, one full time health visitor, and eight part-time health visitors who combined the contact tracing role with their usual local authority work. Within the field of venereology, the scheme was regarded as successful at the time and when reviewed twenty-seven years later.[51] Unfortunately the various reports on this scheme throw relatively little light on the background, training or professional working of these professionals. In one of her few references to her own role as the liaison officer, Johns described herself as a 'trained hospital almoner with general social experience.'[52] A companion paper in the same issue of the *BJVD* reported that the health visitors were 'not experienced in contact tracing' before the experiment began, but were 'trained and experienced health visitors.'[53] She goes on to argue the desirability of using health visitors for contract tracing and visiting defaulters, due to their knowledge of the district and access to other health records. Given later debates discussed below regarding whether sexual health advisers needed a nursing qualification, it is notable that at this point an almoner was recommending a nursing rather than a social work background for contact tracing.

Both the almoner and the health visitors were female, and appear to have focused largely on female contacts. Writing twenty-seven years later in 1972, the venereologist A.S. Wigfield commented 'the employment of a male health visitor for such work is not, as yet, recommended.'[54] Thus the gendered nature of contact tracing work did not appear to have significantly changed in the half century since it had been initiated in VD clinics.

Several of the contemporary accounts stressed the professional and personal qualities needed for contact tracing:

> The use of health visitors for tracing contacts and visiting defaulters is desirable. Their knowledge of the district and the access which they have to other health records is of assistance. They need to be specially selected for qualities of tact and initiative, and those chosen must be free to make appointments with contacts at any time convenient to the contact.[55]

The most extensive account of the almoner role in the VD clinic was given by Manchée in a further series of articles and books published towards the end of the war. In the same issue of the *BJVD* as Johns' paper, Manchée wrote:

> I believe that the almoner should be qualified and should hold the certificate of the Institute of Hospital Almoners. This is not merely because I happen to do so, but because I am convinced that it is essential for such a woman to be properly trained in the handling of people and in the social aspect of disease … An unqualified woman, however conscientious and anxious to help, can well do untold harm through misdirected zeal; as time elapses and her lack of qualifications prevent her advance, her attitude to life will, of necessity, become narrower if not disappointed. The time is then reached when she defeats her own ends and the patient is left without help.[56]

In the first evidence of tension between the nurse and social worker roles in the VD clinic, Manchée went on to dismiss the ideas of the nurse–almoner as an impossible

---

[51] H. Johns, 'The Social Aspect of the Venereal Diseases—3 Contact Tracing', *British Journal of Venereal Diseases* 21 (1945), 17–21; A. S. Wigfield, '27 Years of Uninterrupted Contact Tracing: The "Tyneside Scheme"' *British Journal of Venereal Diseases* 48 (1972), 37–50. It should be noted however, that these assessments were made by proponents of the scheme rather than independent researchers.

[52] Johns, 'The Social Aspect', 17.

[53] Anon, 'The Social Background of Venereal Disease. A Report on an Experiment in Contact Tracing and an Investigation into Social Conditions. Tyneside Experimental Scheme in Venereal Disease Control October 1943 to March 1944', *British Journal of Venereal Diseases* 21 (1945), 26, 33.

[54] Wigfield, '27 Years', 42.

[55] Anon, 'The Social Background', 33.

[56] Manchée, 'The Social Aspect', 13.

combination of different roles requiring wholly different fields of knowledge and training; similarly, she dismissed the health visitor playing the social work role in the VD clinic due to the entirely different focus of her work. This view directly contradicted previous statements by both venereologists and other almoners, and suggests a lack of consensus on how best to develop this ambiguous and emerging professional role. Further, Manchée counselled against seeing the almoner as primarily a contact tracer, arguing that the almoner had a much wider patient welfare role in the clinic.[57] Manchée quoted approvingly from a recent leading article in *The Lancet*:

> Contact tracing is no part of the duty of the clinic almoner except in so far as she is in a position herself to persuade the patient to take some action to this end. Her role, inter alia, is to help the patient through the difficulties inseparable from what is at best a trying and tedious time, to assist in rehabilitation and to do all she can to prevent default from treatment. Compulsory powers might aid her in dealing with a small refractory minority, but her success or failure otherwise will continue to depend, as it does now, on her personality and her capacity for friendship.[58]

Finally, Manchée also commented on the rapid growth in the number of VD clinics with almoners, from six in February 1943 to twenty-nine in November 1944, but asked 'Is this number to be further increased among the other 165 clinics and what, in the meantime, is happening to the young folk who need an almoner's care?'[59]

From a different perspective, a MOH wrote reiterating the innovative social worker/contact tracer role emerging during the war:

> The social worker in the prevention of venereal diseases is also an important innovation. Nobody is more in need of a confidant and adviser than a man or woman who has fallen foul of venereal infections; and few are capable of being a greater danger to the community. The earliest form of venereal disease social worker arose through the use of the hospital almoner for clinics established at hospitals. In the latest form of this work social workers, usually with nursing experience, are being appointed to Public Health Departments, to visit in their homes persons thought to be suffering from either syphilis or gonorrhoea in an infections state.[60]

Here, we again see the emergence of a hybrid health visitor/social worker professional role, where a nursing qualification is seen as an important criterion in the appointment of VD social workers. However, the notes of a meeting of the Medical Society for the Study of Venereal Diseases (MSSVD) held in November 1944 (at which the Johns and Manchée papers were read), demonstrated that there remained a variety of views amongst both venereologists and almoners over the role of almoners in the VD clinic, and the relative utility of the almoner, the health visitor and the contact tracer in contact tracing.[61] The importance of the initial interview in establishing a positive relationship between the almoner (or other staff) with patients and/or contacts was stressed by several speakers:

> It was important to have the almoner doing the contact tracing, because the first interview was full of pitfalls; if the interviewer had not been trained fully in the art of interviewing,

---

[57] Manchée, 'The Social Aspect', 13–14.

[58] Anon, 'Legislative Control of Venereal Diseases', *Lancet* 244 (1944), 17–18, quoted in Manchée, 'The Social Aspect', 14.

[59] Manchée, 'The Social Aspect', 14.

[60] C. F. Brockington, 'The Social Worker in Public Health', *Health Education* 3 (1945), 118.

[61] Anon, 'Discussion on the Preceding Papers', *British Journal of Venereal Diseases* 21 (1945), 21–26.

> the whole situation could be ruined. If the first interview were successful and the girl realized that the almoner was there to help her, she would not be afraid to go to the clinic.[62]

What type of training and whether it was linked to a formal qualification in either nursing or social work, or informal on-the-job training, is often not specified by such authors. Training leading to a formal qualification is an important part of any professional project but is often absent or unclear in VD discussions in this period. This ambiguity of role and qualifications required reflects the circumstances at the time that nursing already involved formal training and professional registration whilst social work did not always require formal training and was without professional registration.

Contact tracing in the NHS 1948–1970s

The government allowed Regulation 33B to expire on 31 December 1947 and in January 1948 issued a circular to local authorities and the medical officers in charge of each VD clinic encouraging them to continue the voluntary tracing of contacts. The guidance assumed that such tracing would be done by either social workers or health visitors under the supervision of either the MOH or the medical officer in charge of a VD clinic. It also anticipated that such tracing would continue when responsibility for the work passed to the Regional Hospital Boards of the NHS due to commence on the appointed day (5 July 1948) under the *National Health Service Act, 1946*. Other than continuing to focus on confidentiality by advising that the social worker or health visitor should not be told the name of the index patient and that they should avoid 'implying a suspicion of venereal infection … in the hearing of any third person,' no further guidance was given on the role of the contact tracer.[63]

Wartime debates over who was best to fulfil the contact tracing role continued into the post war years. The issues were summarized by the Deputy Chief Medical Officer for England in 1947.

> None will deny, I think, that so far as local contacts go the patient himself is the best tracer, but the contacts are not always local, and anyhow the patient needs encouraging and the contact has to be followed up in many cases, so these social workers are vitally necessary. Should they be health visitors, venereal disease almoners, or who? The general opinion, I believe, and certainly my own, is that the ordinary women officers of the Local Authority, that is, health visitors, school nurses, tuberculosis visitors, or persons combining several of these functions, are the most suitable persons to trace the contacts in the first instance, as their visit to a house excites no particular remark and it is easy for them to make some banal enquiries and wait their opportunity to introduce the subject of venereal disease. But the special training and experience of the venereal disease almoner makes her ideal in most instances for following up defaulters.[64]

The diversity of arrangements continued into the NHS as illustrated by a 1952 British Medical Association survey of physicians in charge of UK VD clinics (Table 1).[65] The survey results make clear that the vast majority of clinics had some sort of social work role, but who carried this out (hospital almoners or nurses, or local authority health visitors) and the degree to which it involved either or both clinic interviews and community visits varied widely.

---

[62] Miss Clark (Almoner, West Surrey) quoted in Anon, 'Discussion of the Preceding Papers', 25.

[63] Ministry of Health, *Venereal Diseases: Expiry of Defence Regulation 33B. Suggested method of continuing to trace sources of infection. Circular 5/48, 5 January 1948* (London: Ministry of Health, 1948).

[64] W. Dalrymple-Champneys, 'The Epidemiological Control of Venereal Disease', *British Journal of Venereal Diseases* 23 (1947), 104.

[65] Anon, 'Social Work in the V.D. Service', *British Journal of Venereal Diseases* 28 (1952), 146.

Table 1. Social work in the VD service.

Question[a]	Answer	
Do you have the services of social workers?	Yes: 133[b]	No: 68
Do they attend clinics and interview patients	Yes: 74	No: 58
Who appoints them?	Hospital	42
	Local authority	85
	Both	5
Are routine visits regarding contact tracing, default, etc., made by health visitors or by social workers engaged on VD work only?	Yes: 144	No: 52
	Health visitors	48
	Social workers	69[c]
	Both	27[c]
Do you consider a social worker is or should be an integral part of a VD clinic?	Yes: 180	No: 20

[a] Replies received from 201 of approximately 290 VD treatment centres in the UK.

[b] This figure (133) includes a number of centres where it is clear that health visitors, hospital almoners, or nursing staff, etc., are acting as social workers, and it seems possible that, although not stated, this is also the position at other centres. Similarly, it is clear that in some cases where a negative answer was given, health visitors or other personnel are to some extent carrying out social work.

[c] These figures (69 and 27) include a number of cases where almoners or nursing or other personnel act as social workers for visiting purposes. In none of the cases, medical officers assist with visiting. It is not clear how many social workers are engaged on VD work only, but it would appear that the number is comparatively small.

Adapted from a table in Anon, 'Social Work in the V.D. Service', *British Journal of Venereal Diseases* 28 (1952), 146.

Other articles in the 1950s and 1960s demonstrate the continued diversity of practice. For example, the venereologist J.A. Burgess in 1963 advocated the scheme operating in the West Riding of Yorkshire for the previous fourteen years where contact tracing was conducted by specially trained social workers employed by the MOH who were also all qualified health visitors.[66] By the early 1960s, the term 'almoner' had disappeared from usage in venereology, along with broader changes in the social work professions that saw the Institute of Almoners change its name to the Institute of Medical Social Workers in 1964. Another illustration of the continued diversity of practice was the report that two major metropolitan clinics, at the London Hospital and St Thomas' Hospital, only appointed full-time VD social workers in 1964, and initially only as a pilot in the face of some scepticism by venereologists: 'many were of the opinion that this type of contact tracing would not be successful.'[67] This is a further demonstration of medical dominance in the VD clinic and the challenges for social workers to develop and sustain their professional role within the clinics.

In 1968, the Ministry of Health published the first revision to the *NHS VD Regulations* since 1948.[68] Accompanying the 1968 *Regulations* was a *Memorandum on Contact Tracing in the Control of Venereal Disease*, which gave the most detailed official guidance to date on the role of the contact tracer.[69] The guidance sought to reflect the continuing diversity in practice. For example, it recognized that the person conducting the initial interview with the patient might be the clinician or 'another "interviewer", who may be a member of the nursing staff, a medical social worker or other officer employed by the hospital, or an employee of the local health authority working at the clinic.'[70] Similarly, the guidance recognized diversity in field work:

---

[66] J. A. Burgess, 'A Contact-tracing Procedure', *British Journal of Venereal Diseases* 39 (1963), 114

[67] B. Muspratt and L. I. Ponting, 'Improved Methods of Contact Tracing', *British Journal of Venereal Diseases* 43 (1967), 204.

[68] Ministry of Health, *National Health Service (Venereal Diseases) Regulations 1968*. Statutory Instrument 1624 (London, 1968).

[69] Ministry of Health, *Memorandum on Contact Tracing in the Control of Venereal Disease* HM(68)84 (London: Ministry of Health, 1968).

[70] Ministry of Health, *Memorandum on Contact Tracing*, 2.

> It may be possible for the "interviewer", who is more usually employed by the local health authority and placed at the clinician's disposal, to undertake contact tracing as well, either because sessions are infrequent or because he or she is alternating with a colleague; there are certain advantages in this arrangement. On the other hand, in some busy clinics, "interviewers" remain in the clinic at all times and pass the information out to "contact tracers" who stay, 'in the field'. Whatever the administrative arrangement personal understanding and confidence between clinician and interviewer is essential.[71]

More details were then given as to the qualities required of both the interviewers and the contact tracers who 'need special qualities whatever their professional background. Both tasks call for tact, patience and, on occasion, courage, and resource. While personal qualities are the primary requirement, many local health authorities consider that qualification as a nurse or as a trained social worker, whilst not essential, has proved an asset.'[72] This was the first official guidance on the employment of VD social workers/contact tracers and it is notable that the document is non-prescriptive on the question of professional qualifications, although gently encouraging of clinics of employing those with nursing or social work qualifications. Contrary to Manchée's earlier arguments, however, the Ministry of Health clearly did see contact tracing as central to the VD social worker's role, suggesting it was officially viewed as straddling clinical and welfare work.

It is also notable that the guidance mentions 'an apparent increase in promiscuity—both heterosexual and homosexual' and 'a recent influx of immigrants' as important epidemiological factors but does not go on to discuss the specific challenges of contact tracing with homosexual men or immigrants. Immigrants, particularly those from the West Indies, with higher rates of VD than the indigenous population were an increasing concern expressed by venereologists from the mid-1950s. But there is no substantive discussion of working with immigrants by social workers in the venereology literature in the 1950s or 1960s, though Hanley has identified an occasional brief stigmatizing reference.[73] Similarly, there are very occasional references by VD social workers to working with homosexual men but no substantive discussion. Thus, there does not appear any evidence in the literature that VD social workers were addressing issues of racism and homophobia as part of their professionalizing project at this date in the late 1960s, though it is of course possible that some VD social workers were engaged in such issues in practice as they began to penetrate the wider social work profession.[74]

Following the 1974 reorganization of the NHS and local authorities, the *National Health Service (Venereal Diseases) Regulations 1974* were issued to replace the 1968 Regulations that had lapsed. The new regulations imposed a similar duty of confidentiality on the new regional and area health authorities to that which had previously applied to regional hospital boards. No new guidance was drafted but the 1968 memorandum on contact tracing was re-circulated despite some sections now being out of date due to the abolition of the MOH role in the 1974 reorganization. Shortly afterwards, however, the Department of Health and Social Security (DHSS) (which had replaced the Ministry of Health in 1968) encouraged the Health Education Council (HEC) to undertake a project investigating the job requirements and training of health workers in special clinics (as VD clinics were then called). This culminated in the substantive 168-page *Handbook on Contact Tracing in Sexually Transmitted Diseases* published in 1980.[75] This Handbook provided detailed advice on all aspects of the interviewer and contact tracing roles,

---

[71] Ministry of Health, *Memorandum on Contact Tracing*, 3.

[72] Ministry of Health, *Memorandum on Contact Tracing*, 3.

[73] Hanley, 'Migration, Racism and Sexual Health'.

[74] M. Lavalette and L. Penketh, 'Introduction: Race, Racism and Social Work'. In: M. Lavalette and L. Penketh, eds, *Race, Racism and Social Work* (Bristol: Policy Press, 2013), 1–16.

[75] HEC, *Handbook on Contact Tracing in Sexually Transmitted Diseases* (London: HEC, 1980).

including record keeping, legal aspects, and a detailed five-phase model of the interview. It included a template job description which made clear the contact tracer's subordinate role to the doctor in charge of the clinic and was non-prescriptive on necessary qualifications: 'Suitable qualifications might include nursing, social work, or experience in a related field.'[76] A survey reported in the handbook indicated the continuing diversity in practice. Of the 192 clinics surveyed, only 133 clinics (employing 147 workers) included someone carrying out contact tracing. Of these 147, 72 were employed as contact tracers, 35 were nurses, 17 health visitors who attended the clinic, 17 health visitors who made visits only, 1 technician and 5 secretaries.[77] The Handbook is also notable for the first extant evidence of discussion of prejudice and how to deal with it in the contact tracing literature. After suggesting the need to understand other cultures, the Handbook went on:

> However, while it is valuable to learn about such groups it is important to remember that generalizations can be misleading. West Indians are not all alike, anymore than are the English, Scots, homosexuals or prostitutes. Attention must always be paid to the individual patient, not his racial or class characteristics. Such attention is given in careful and attentive listening to him in the interview. Contact tracers need to be aware of their own prejudices, whether these relate to race, sex, class or age, and try to prevent these prejudices interfering with their work.[78]

This was of course, a statement of aspiration rather than evidence of what actually went on in practice, but is notable nonetheless as the first explicit recognition within VD social work/contact tracing of the need to consider one's own racial and other prejudices.

At the same time the Handbook was developed, work was undertaken to develop a 5-day residential training course funded by the DHSS which first ran in February 1982.[79] This appears to have been the first comprehensive training programme designed specifically for contact tracers/medical social workers in STIs and represented an important step in the professionalizing project.

Reviewing the state of contact tracing in 1982, the leading venereologist Michael Adler commented:

> Initially this work was performed by doctors, often ineffectively and rarely by trained staff fully integrated into the clinic. The pattern is different now: a recent survey in England and Wales showed that contact tracing was performed by designated non-medical personnel in 77% of clinics, but that in only half of these clinics was someone specifically employed for contact tracing. In the remainder the duties were carried out by nursing staff, already busy, or by health visitors, who either attended clinic sessions as well as carrying out general health visitor duties or did not-attend sessions but could be called upon to do so.[80]

Emergence of the sexual health adviser

The term 'health adviser' first appears in the medical literature in a series of letters in the *BMJ* in 1982 prompted by Adler's article on contact tracing. Adler had not used the term 'health adviser', but several of the correspondents were at pains to add explanatory phrases such as 'contact tracers (now called health advisers in STDs).' The correspondence focused

---

[76] HEC, *Handbook on Contact Tracing*, 121.

[77] HEC, *Handbook on Contact Tracing*, 126–7.

[78] HEC, *Handbook on Contact Tracing*, 76–77

[79] M. W. Adler, 'Contact Tracing', *British Medical Journal* 284 (1982), 1211.

[80] Adler, 'Contact Tracing', 1211.

on Adler's contention that the recruitment of contact tracers from all backgrounds should be encouraged, and that 'even though 60% of contact tracers have a nursing background, this qualification should not be a prerequisite for entry.'[81] The first response from a correspondent who was both a nursing sister and a health adviser argued that 'a nursing background is essential as a part of total patient care.'[82] This argument was then countered by two further correspondents, both representing professional organizations: Dr R.N. Thin, Secretary of the British Federation Against the Venereal Diseases and Patricia White, Secretary of the Society of Health Advisers in Sexually Transmitted Diseases (SHASTD).[83]

The second letter is also notable as this is apparently the first direct appearance in the medical literature of SHASTD. Until the 1970s, there is no evidence of any specific association or society for those engaged in medical social work, interviewing and/or contact tracing in VD clinics. The first refence to such a body came from the venereologist R. D. Cattterall in a 1973 article where he mentions in passing that 'contact tracers and social workers have recently formed an organisation called the Society of Social Workers in Venereology.'[84] After various name changes, this was known by 1982 as SHASTD and from 2004 as the Society of Sexual Health Advisers (SSHA).[85]

The 1970s was a time of increasing specialization in all aspects of the NHS, in medicine, nursing, and in the allied health professions. In 1960, the government had recognized twelve professions supplementary to medicine, which gained statutory registration, but many more non-medical occupational groups were also professionalizing.[86] Professional associations and societies proliferated. Irwin has recounted the history of both the early years of psychosexual nursing and psychosexual counselling in the period, though neither seems to have interacted significantly with sexual health advising in GUM.[87] Similarly, Chettiar has examined the creation of counselling services by and for the LGBTQ+ community in the 1970s, but this equally did not appear to impact health adviser work in the period.[88] It was also a time of increased debate around professionalization within social work, with the introduction of regulation of social work training in 1970, though not registration of individual social workers.[89] This did not, however, appear to impact the continued ambiguous bridging of clinical and social work by health advisers.

In 1984, the venereologist Thin gave an overview of the training and role of health advisers.[90] By that date, the majority of health advisers had attended one of seven 5-day training courses held. The courses covered clinical and epidemiological aspects of STIs, sexuality, interviewing and other interpersonal skills, contact tracing, teamwork, and working with groups. SHASTD held an annual 2-day meeting with papers presented and opportunities for sharing experiences and ideas. A role specification for health advisers was informally accepted by the DHSS including guidance for appointment, contact tracing, record keeping and health education of patients. The guidance on appointment included a minimum age of twenty-five and at least three year's training in some related discipline such as nursing or

---

[81] Adler, 'Contact Tracing', 1211.

[82] J. Hale, 'Contact Tracing', *British Medical Journal* 284 (1982), 1952.

[83] R. N. Thin, 'Contact Tracing', *British Medical Journal* 285 (1982), 291. Patricia White, 'Contact Tracing', *British Medical Journal* 285 (1982), 292.

[84] R. D. Catterall, 'Changing Patterns in the Organization of the Venereal Diseases Service in Great Britain', *British Journal of Venereology* 49 (1973), 126.

[85] SSHA, *The Manual for Sexual Health Advisers* (London, 2004).

[86] *Professions Supplementary to Medicine Act 1960* (cc 60).

[87] Irwin, 'Recalling the Early Years of Psychosexual Nursing'; R. Irwin, '"To Try and Find Out What is Being Done to Whom, By Whom and with What Results": The Creation of Psychosexual Counselling Policy in England, 1972-1979', *Twentieth Century British History* 20 (2009), 173–97.

[88] Chettiar, 'Counselling for Connection'.

[89] J. Manthorpe and C. Purcell, eds, *How Did Social Worker Registration in England Come About?* (London: Policy Institute, King's College London, 2023).

[90] R. N. Thin, 'Health Advisers (Contact Tracers) in Sexually Transmitted Disease', *British Journal of Venereal Diseases* 60 (1984), 269–72.

social studies. Thin concluded that health advising had developed widely in Britain, but noted that a few clinics still lacked full-time cover.[91] Together with a professional association, annual education meetings, an agreed job title, role summary, minimum educational requirements, and appointment process, the development of a recognized training programme appeared to indicate that the project to professionalize sexual health advising was well advanced by the early 1980s.

The impact of HIV/AIDS

It is notable that Thin's article published in 1984 did not mention the advent of HIV/AIDS which had first been recognized in the UK in 1981 and was increasingly being seen in GUM clinics once the HIV antibody test was available in 1984. Health advisers very quickly became identified as the appropriate staff to provide pre- and post-test HIV antibody test counselling in the vast majority of GUM clinics. The advent of HIV antibody testing changed the role of health advisers substantially. Following DHSS guidance, health advisers needed to ensure informed consent, advising patients on the pros and cons of a test which if positive, had profound implications not only for health but also for social relations, insurance, employment, and experiencing stigma and discrimination.

The *Monks Report* on GUM workloads for the Department of Health (DH) in 1988 provides the first detailed overview of health adviser work at the time.[92] Despite the professional developments of the late 1970s and early 1980s, a great deal of diversity remained between clinics. Of the twenty clinics visited by the review team, one did not have a health adviser post, with contact tracing and counselling undertaken by doctors, with the authors commenting 'this was clearly unsatisfactory'.[93] In a set back to the professionalizing project, the previously DHSS-funded residential training was no longer running, and there were no plans for further national training. There was wide variation in role specifications and pay scales and the Handbook for contact tracing needed updating to reflect health advisers' new HIV responsibilities. Health advisers undertook most of the counselling for HIV and other issues, though a 10 per cent minority of clinics were using other staff such as clinical psychologists. Workloads had increased substantially in all clinics due to HIV-related work, but staffing levels for health advisers were not reported to have increased to match, nor did any of the health authorities report plans for increased staffing. There were related issues including a lack of sickness and holiday cover and a lack of appropriate accommodation for counselling. The *Monks Report* made several recommendations regarding health advisers including that every clinic should have at least one health adviser, a certified course should be established, common career structures and pay scales laid down and that the 'professional status of health advisers should be recognized by the Department of Health and health advisers should be represented at District, Region and the Department of Health.'[94]

If the *Monks Report* recommendations had been implemented, then this would have represented a major advance in professionalization. However, given the major reorganization of the NHS the government embarked upon the following year, it is perhaps unsurprising that none of these recommendations were enacted.[95] A further review by the Policy Studies Institute (PSI) commissioned by the DH reported similar issues in 1993 to those identified in the *Monks Report*.[96] The PSI report also gave more comprehensive detail on the

---

[91] Thin, 'Health Advisers (Contact Tracers)', 271.

[92] The DH replaced the DHSS in 1988; DH, *Report of the Working Group to Examiner Workloads in Genito Urinary Medicine Clinics [The Monks Report]* (London: DH, 1988).

[93] DH, *Report of the Working Group*, 12.

[94] DH, *Report of the Working Group*, 14.

[95] R. Robinson and J. Le Grand (eds), *Evaluating the NHS Reforms* (London: King's Fund, 1994).

[96] I. Allen and D. Hogg, *Work Roles and Responsibilities in Genitourinary Medicine Clinics* (London: Policy Studies Institute, 1993).

characteristics, qualifications, training and employment of health advisers. Once again, the main message was the degree of diversity found amongst health advising roles in the twenty clinics visited. Six of the clinics did not have a health adviser in post at the time of the research. Twenty-two health advisers were interviewed in the other fourteen clinics with a variety of educational qualifications, training experiences, grades, salaries, and range of responsibilities. Twelve of the twenty-two had a nursing qualification, but only two had social work qualifications. Eight had other qualifications as varied as health education, hair dressing, librarianship and hotel management. Academic qualifications ranged from GCE 'O' level through to PhD. Fifteen of the health advisers were on the ancillary and clerical grading system, including six of the twelve with nursing qualifications. The other seven were all on the nursing and midwifery grading system, although one of them did not in fact have a nursing qualification. On both systems, health advisers were on a range of grades within the respective scales although overall, those on the nursing scale tended to have higher salaries. Only nine of the twenty-two had attended specific training course to work in GUM, of which seven had attended the 5-day DHSS courses.[97]

Health advisers were generally strongly valued by the doctors in charge of the clinics with 79 per cent saying the clinics could not operate without them. The clinics without health advisers were generally smaller, less busy part-time clinics where the doctors or nursing staff fulfilled the health adviser responsibilities. Some of the doctors and nurses in these clinics thought this was satisfactory, but others thought the clinics would operate more effectively if they also had health advisers. In terms of attitudes towards the qualifications necessary for health advisers, most of the doctors agreed with the majority of health advisers that a range of qualifications were appropriate for health advisers and that a nursing qualification was not necessary but could be helpful. However, four health advisers who were qualified nurses did think that a nursing qualification was necessary. Among (non-health adviser) nurses, over a third thought health advisers needed a nursing qualification but 60 per cent did not.[98]

The PSI report provides the first detailed evidence of the motivations and experiences of health advisers in practice. Reported motivations for working the field were diverse but included being attracted to the counselling role and/or health education, wanting to work with HIV/AIDS patients, the variety of work involved, opportunities for promotion amongst a range of other reasons. In terms of what health advisers saw as their main roles, the majority mentioned health education first, then counselling. Significantly, only thirteen of the twenty-two health advisers said that contact tracing or partner notification was one of their main roles.[99] Related to this finding was an interesting response to a question about responsibility for partner notification, with less health advisers (55 per cent) than doctors (67 per cent) believing this should be active, and with 23 per cent of health advisers thinking it should be entirely up to the patient.[100] The substantial increase of HIV/AIDS work in areas like London meant some health advisers spent 90 per cent or more of their time with HIV/AIDS patients, and thus reduced the time available for the traditional contact tracing responsibility.[101] Despite devoting an entire chapter to health advisers and their roles, the PSI report made no specific recommendations regarding health advisers; rather its recommendations were all generic to GUM clinics as a whole and all staff within them.

By 1993, it was clear that HIV/AIDS was having a huge impact on GUM clinics, not just on health advisers but on doctors, nurses, and other staff as well. Health advisers in the PSI

---

[97] Allen and Hogg, *Work Roles and Responsibilities*, 65–66, 69.

[98] Allen and Hogg, *Work Roles and Responsibilities*, 80–86.

[99] Allen and Hogg, *Work Roles and Responsibilities*, 67–68. In the 1990s, partner notification came to be the preferred term for what had been previously referred to as contact tracing.

[100] Allen and Hogg, *Work Roles and Responsibilities*, 145.

[101] Allen and Hogg, *Work Roles and Responsibilities*, 74.

study reported it as both a positive in terms of a group of patients they wanted to work with, but also a negative in terms of the emotional nature of the work and the greater demands HIV/AIDS patients made compared with those with traditional STIs. For some health advisers in areas of high HIV prevalence, giving positive HIV test results for a condition for which there was no treatment at the time, and which patients were likely to die of, was particularly stressful. Other contemporary studies confirm both the stressful nature of the HIV counselling role and the continued diversity of practice, with health advisers seeing all patients for HIV pre- and post-test counselling in some clinics, doctors only sending HIV-positive patients in others and in some clinics, the doctor only sending patients identified as 'high risk' to the health adviser.[102] Moreover, the HIV/AIDS epidemic impacted the nature of health advising in important ways. First, it brought a number of new recruits into GUM clinics, often with a graduate social science, voluntary sector or counselling background. Secondly, many health advisers attended short courses in AIDS counselling, often provided by a new National AIDS Counselling Training Unit (NACTU), with trainers from both NHS psychology and from LGBTQ+ self-help voluntary sector.[103] Together these developments led to a shift among health advisers from a directive approach mainly focused on the prevention of transmission to a more support-focused non-directive approach to counselling. Thus, despite two major inquiries, the ambiguity between clinical and welfare work of the health adviser role remained largely unresolved.

Following the PSI report there appeared little central policy attention to health advisers' development for some time, until the long-delayed appearance of the *National Strategy for Sexual Health and HIV* in 2001.[104] As part of the ambitious overall strategy for improving sexual health, there were for the first time explicit government commitments that 'the role of sexual health advises is developed and numbers increased' and 'to identify a process for defining the roles and responsibilities of health advisers, including the development of a health advising qualification by 2005.'[105] As part of the action plan to deliver the strategy, the DH committed to investing six million pounds in 2002–2003 in GUM services, primarily in sexual health advising.[106] The DH then commissioned the SSHA to produce and publish the *Manual for Sexual Health Advisers*[107] in 2004 and *Sexual Health Advising—Developing the Workforce* in 2008.[108]

Throughout the 1990s and 2000s, the SHASTD/SSHA continued to work to professionalize health advising and sought to have it recognised as a health profession. The Society continued to hold annual conferences with both practice and research focused presentations, as well as other training events, and to work with the DH whenever possible to promote the development of the occupation as a profession. Aspirations continued to be expressed at the annual conferences for some form of certified training and/or professional registration. By 2008, however, it became clear that the aspiration for a health advising qualification would not be met in any comprehensive way. The 'opportunity' agreed with the DH and the Nursing & Midwifery Council (NMC), and offered in the 2008 SSHA document, was for qualified nurse health advisers to seek registration with the NMC as specialist community public health nurses (SCPHN) on part three of the register 'either by completing a programme of study or by migration via portfolio.'[109] As well as only being

---

[102] D. Silverman, 'The Social Organization of HIV Counselling'. In: P. Aggleton, P. Davies and G. Hart, eds, *AIDS: Individual, Cultural and Policy Dimensions* (Basingstoke: The Falmer Press, 1990).

[103] V. Berridge, *AIDS in the UK: the Making of Policy 1981-1984* (Oxford: Oxford University Press, 1996), 72–73.

[104] DH, *Better Prevention, Better Services, Better Sexual Health: National Strategy for Sexual Health and HIV* (London: DH, 2001).

[105] DH, *Better Prevention, Better Services*, 37, 47.

[106] DH, *Better Prevention, Better Services, Better Sexual Health: National Strategy for Sexual Health and HIV Implementation Action Plan* (London: DH, 2002).

[107] SSHA, *The Manual.*

[108] SSHA, *Sexual Health Advising—Developing the Workforce* (London: SSHA, 2008).

[109] SSHA, *Sexual Health Advising.*

open to health advisers who were already qualified nurses, this was for a limited time period only, with the unrealized expectation that a sexual health adviser pathway would be provided in future by some universities. The only alternative proposed for non-nurse health advisers was to consider seeking registration in future with the UK Public Health Register (UKPHR) as a public health practitioner,[110] a registration which was not then available and would not become so until 2011, and which was intended for practitioners with a population focus not individual patient care.[111] With a change of government in 2010 and another major reorganization of the NHS, the focus of the DH on health adviser professional development seemed to disappear. There was no mention of sexual health advising in any of the UK government's health policy or sexual health documents after 2010.[112]

SSHA continued to seek to professionalise across the 2000s and 2010s, producing sample job descriptions, a *Competency Framework for Sexual Health Advisers and* a *Code of Professional Conduct*.[113] But without any central policy or guidance from the DH, and no certified training, nor nationally agreed role specification or professional registration, there was little reason for NHS employers to deviate from the diverse employment arrangements for sexual health advisers that had long existed in their local STI services.

Conclusions

Sexual health advisers are one of many health occupations, which have sought professional status since the advent of the NHS in 1948, and particularly since the 1970s. They remain a small but critical group of UK health workers in the STI and HIV/AIDS field. There has been virtually no historical exploration of their origins, development, and roles. The principles and practice of sexual health advising in the early twenty-first century are rooted in the development of VD services in the early twentieth century, in particular the role of hospital almoners in VD clinics from the 1920s. There are parallels with other small occupational groups of health workers seeking professional status in the NHS following its establishment in 1948.[114] Increasingly, health advisers sought full professional status by pursuing the attributes of existing professions, in particular, establishing a professional society, seeking certified training and recognition as a registered health profession, and developing professional tools including a competency framework and a code of professional practice.

Except for Duncan's work on health promotion specialists 'failing to professionalise', most historical accounts of allied health professional projects have focused on those occupational groups which have successfully achieved professional recognition.[115] The history of sexual health advisers thus provides a rare account of a professional project which was neither successful in achieving state recognition nor was it a complete failure; the occupation has continued with professional attributes such as a professional society, and it is valued by employers and the dominant medical profession. Overall, the history of sexual health advising is consistent with previous literature on the characteristics and strategies of occupational groups seeking to professionalize, but adds depth to our understanding of the barriers to professionalization and the factors involved in failing to be recognized as a profession which are likely to be relevant to the many other health occupations seeking to professionalize in the English NHS.

[110] SSHA, *Sexual Health Advising*, 7.

[111] UKPHR, *The Value of Practitioner Registration* (Birmingham: UKPHR, 2023).

[112] Secretary of State for Health, *Healthy Lives, Healthy People* (London: The Stationary Office, 2010); DH, *A Framework for Sexual Health Improvement in England* (London: DH, 2013).

[113] SSHA, *Sample Job Descriptions* (London, 2009); SSHA, *Competency Framework for Sexual Health Advisers* (London, 2013). SSHA, A *Code of Professional Conduct* (London: SSHA, 2023).

[114] Nancarrow and Borthwick, *The Allied Health Professions*.

[115] Duncan, 'Failing to Professionalise', 377.

The reasons for success or failure in professional projects are multiple, complex, and contingent on a number of factors. In the case of health advisers, the factors for success included the support of the dominant medical profession, the development of a professional society, and during the period of the Labour government 1997–2010, support from national policy makers. In particular, the dominant medical profession supported health advisers to take on roles in counselling, health education, and contact tracing that doctors did not want to do and did not see themselves as skilled at.

Despite continued efforts from the 1980s onwards, however, health advisers were unsuccessful in obtaining a certified training course or qualification, or achieving registered professional status. Factors working against the professional project included the relatively small size of the health adviser workforce and its location in a marginalized specialty within the NHS. Health advising also lacked an academic base or a unique body of knowledge.[116] Although health advisers very occasionally contributed to research projects in GUM, this was usually in subordinate roles to medical researchers, and there are few, if any, examples of health advisers as principal investigators or lead authors of academic papers. Overall, health advising remained a subordinate occupational group. The advent of HIV/AIDS did appear to give health advisers more autonomy and the opportunity to carve out a more autonomous role in HIV/AIDS counselling, but this was also a contested space with others offering such counselling.[117] Moreover, the advent of HIV did raise some tensions within health advising between their traditional public health focused contact tracing role and the less directive individually focused counselling approach favoured by many in the HIV/AIDS field. Perhaps the most significant obstacle to professional registration was a change of government in 2010 that brought in a new Conservative-dominated administration that believed in market solutions to NHS problems, and that regulation in the NHS should be reduced, not extended.

Over the course of a century, there was a long-term transformation from mixed social work and nursing workforce to predominantly (but not exclusively) nursing health adviser workforce. The challenge of embracing such a multidisciplinary group within one professional project is likely to have been a factor in the ultimate failure to achieve recognition as a registered health profession. Health advisers were bridging clinical and social welfare work, which was key to their value to the dominant medical profession, but also led to ambiguity about their professional status. The mixture of nursing and social work backgrounds in the workforce accentuated this ambiguity. Health advisers with a nursing background would already have been registered with the Nursing & Midwifery Council (or its long-established predecessors) whilst social workers were only required to register with the new General Social Care Council from 2001. The training of nurses and social workers was also very different, leading to different professional cultures, for example, in how directive their approach to counselling might be.

The history of sexual health advising provides a unique lens to the challenges faced by small but important occupational groups of health workers in seeking to be recognized in the NHS as a profession. Despite the best efforts of SSHA, health advising remains a very diverse occupational group without the attributes of a recognized profession. There is no agreed training, qualification, registration, job description, salary scale, or role specification. NHS employers are at liberty to recruit and employ health advisers on different terms and conditions and to play varied roles in different sexual health services. With the exception of rare short-term research projects, there are no health advisers with academic roles and no senior health advisers within NHS structures outside of immediate clinic management roles. The diversity that characterized almoners and health visitors working in VD

---

[116] P. Abbott and L. Meerabeau (eds), 'Professionals, Professionalization and the Caring Professions'. In: *The Sociology of the Caring Professions*, 2nd edn, pp. 1–19 (London: Routledge, 1998).

[117] Silverman, 'The Social Organization of HIV Counselling'.

clinics in the 1920s continues to be reflected in the diversity of health adviser roles and responsibilities into the twenty-first century.

At the time of writing, the English NHS claims that over 350 potential occupational careers are available within its services, but we have only a handful of historical accounts of these various occupational groups emerging as professions and fewer still of occupations trying and failing to professionalize. Thus, there is still a dearth of detailed case studies of individual occupational groups' professional projects to enable wider lessons to be drawn about the overall process of professionalization and the barriers and enabling factors for successfully achieving professional status in a field dominated by the medical profession.

Finally, there are also a number of other issues around sexual health advising that would benefit from further research. In particular, we lack oral histories of the work of sexual health advisers and how they have negotiated the many complexities and dilemmas of their work. For example, we have first-hand accounts from patients of the lived experience of receiving a positive HIV test but we do not have the health adviser's perspective on what it meant to them to give such a diagnosis in the 1980s when it was virtually a death sentence. Hanley and others have written about the stigma, surveillance, and coercion that young working-class women, Black immigrants, and other marginalized communities sometimes experienced in VD/STI services, but VD social workers and health advisers have only appeared intermittently in these accounts. A fuller investigation of the health adviser role in colluding with and/or challenging such discrimination and control would add further depth to these accounts.

Acknowledgements

I am very grateful for the extremely helpful comments and suggestions from four anonymous reviewers who have helped me significantly improve this article. Any remaining errors and omissions are of course entirely my own.

Funding

None declared.

Modern British History, 2024, 35, 414–434
https://doi.org/10.1093/tcbh/hwae047
Article