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Sexual health in general practice, part 2: Communication in sexual health consultations

Introduction

Partner notification (PN) is a core component of sexually transmitted infection (STI) management (British Association for Sexual Health and HIV [BASHH], 2019). It aims to ensure that sexual contacts of a person diagnosed with an STI are informed, tested and treated where appropriate, reducing reinfection and onward transmission (BASHH, 2019; National Institute for Health and Care Excellence [NICE], 2022). PN is relevant to general practice because patients may present with genital symptoms, STI testing requests, contraception needs, HIV prevention concerns, cervical screening queries, safeguarding issues or broader sexual health concerns (Brook et al., 2020; NICE, 2022; Mawson et al., 2025). Primary care also remains an important setting for sexual and reproductive healthcare, particularly contraception provision, creating opportunities for General Practitioners (GPs) and General Practice Nurses (GPNs) to discuss STI risk, testing and referral for PN support where needed (Office for Health Improvement and Disparities, 2025).

PN refers to the process through which sexual contacts of a person diagnosed with an STI are informed that they may have been exposed and are supported to access testing, treatment and prevention advice (BASHH, 2019). For GPs and GPNs, PN is not simply an administrative process, but a clinical and communicative intervention that requires confidentiality, sensitivity, safeguarding awareness and appropriate referral to specialist sexual health services when required. This issue is particularly important given the continuing burden of sexual ill health in England. In 2024, there were 364,750 new STI diagnoses, including 168,899 cases of chlamydia, 71,802 of gonorrhoea and 13,030 of syphilis (UK Health Security Agency, 2025). Sexual health services also delivered 4,505,785 consultations in 2024, with care provided through face-to-face, online and telephone routes (UK Health Security Agency, 2025). These figures demonstrate both the scale of need and the importance of clear, inclusive and safe communication across different modes of access.

Primary care remains important within sexual and reproductive health provision, particularly in relation to contraception and opportunistic sexual health discussions. Office for Health Improvement and Disparities (2025) reported that contraception is provided across several settings, including primary care, sexual and reproductive health services, hospital outpatient clinics, pharmacies and other retail settings. The same report explains that long-acting

reversible contraception (LARC) includes implants and intrauterine devices, while injectable contraception is reported separately because it relies on timely repeat attendance. In 2023, LARC prescribing excluding injectables by primary care was 25.6 per 1,000, compared with 26.5 per 1,000 in 2022, showing that general practice continues to provide sexual and reproductive healthcare where opportunities may arise to discuss STI risk, testing and PN (Office for Health Improvement and Disparities, 2025). PN is particularly relevant for infections such as chlamydia, gonorrhoea and syphilis, where untreated partners may remain infectious, experience complications or contribute to reinfection of the index patient. Communication in PN is shaped by stigma, embarrassment, confidentiality concerns, clinician confidence, safeguarding responsibilities and service pressures (Brook et al., 2020; Mawson et al., 2025; UK Health Security Agency, 2025). These factors may influence whether patients feel able to share sensitive information, whether clinicians feel confident to discuss PN, and whether contacts can access timely testing and treatment.

This article explores PN in primary care, with emphasis on the role of GPs and GPNs in recognising when PN is needed, explaining its purpose, supporting patients safely and referring to specialist sexual health services where appropriate. It also considers the ethical tensions that arise between confidentiality, patient autonomy, partner welfare and public health responsibility.

Communication difficulties and inequalities in access

Communication difficulties represent a substantial barrier to effective sexual health consultations, with direct implications for equity, safety and quality of care (Brook et al., 2020; Mawson et al., 2025; Solbach et al., 2025). These challenges are not only interactional but structurally embedded, contributing to persistent inequalities in access and outcomes. Patients may experience barriers related to limited English proficiency, hearing impairment, learning disability, cognitive impairment and reduced health literacy. Table 1 outlines common communication difficulties that may affect sexual health consultations, including language barriers, disability, reduced literacy, safeguarding concerns and remote consultation challenges. These barriers can compromise sexual history-taking, informed consent, safeguarding assessment and clinical decision making, particularly where services do not adapt information, interpretation and communication methods to individual needs (Brook et al., 2020; Faculty of Sexual and Reproductive Healthcare [FSRH] and BASHH, 2019; Department of Health and Medical Foundation for HIV and Sexual Health [MedFASH],

2005; UK Health Security Agency, 2021). Current evidence indicates that sexual health remains under-discussed in general practice despite its recognised importance. For instance, Solbach et al. (2025) found that 68.8% of GPs considered sexual health important and 74.5% identified it as part of their role, yet 48.1% reported discussing it less often than medically indicated. Reported barriers included lack of time, language barriers, the presence of relatives, and lack of structured approaches to initiating discussion. Although this study provides useful current quantitative evidence, it is based on self-report and was conducted in Germany, meaning the findings should be applied to UK general practice with caution. Nevertheless, the findings are consistent with earlier UK qualitative work in which GPs and practice nurses described sexual health conversations as difficult, time-consuming and liable to open a “can of worms” (Gott et al., 2004). These studies suggest that less discussion is not simply a matter of individual discomfort, but reflects wider clinical and organisational constraints.

Communication also shapes whether patients feel able to present sexual health concerns. Young people have described embarrassment, concerns about confidentiality and uncertainty about how to request chlamydia testing in general practice (Heritage and Jones, 2008; Hogan et al., 2010; Normansell et al., 2016). These studies are qualitative and therefore cannot quantify the scale of the problem, but their consistency across different settings strengthens their relevance for practice. They suggest that patient silence should not be interpreted as absence of need. Rather, silence may reflect stigma, fear of judgement or uncertainty about whether sexual health is a legitimate reason for consulting. Similar barriers have been described among older adults. Gott and Hinchliff (2003) found that older people may not seek help for sexual problems because they are uncertain whether those concerns are appropriate for primary care. Malta et al. (2020) also identified age-related assumptions within sexual health conversations, suggesting that older adults may be excluded when clinicians assume that sexual health is primarily relevant to younger people. These studies are limited by small samples, but they are clinically important because they challenge ageist assumptions and highlight the need for clinicians to ask sensitively across the life course.

Davenport et al. (2025), in a qualitative study involving people with endometriosis, found that participants reported limited rapport, privacy concerns, invalidation, embarrassment and uncertainty about whether sexual problems were a valid concern for GPs. This study is useful because it foregrounds sexual wellbeing rather than only STI risk. However, it relied on open-ended survey responses and may reflect the views of participants who already had

strong experiences of poor communication. Even so, the findings are consistent with wider evidence that patients often need clinicians to actively legitimise sexual health concerns before disclosure becomes possible. Inequalities are particularly evident for Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and others 9LGBTQ+0 patients, people from minoritised ethnic communities, young people, migrants and those living with socioeconomic deprivation. Studies involving lesbian, gay, bisexual and trans patients show that heteronormative assumptions, misgendering, clinician discomfort and fear of discriminatory responses can deter disclosure and reduce trust (Cant, 2006; Bjorkman and Malterud, 2007; Hinchliff et al., 2005; Mikulak et al., 2021; Carroll et al., 2024). The evidence base is largely qualitative and often drawn from specific groups, but it consistently demonstrates that communication barriers are linked to wider structures of stigma and exclusion rather than isolated consultation errors.

At a system level, service demand further increases the need for effective communication. UK Health Security Agency data show that sexual health services in England delivered 4,505,785 consultations in 2024, with 53.2% conducted face to face, 41.6% online and 5.2% by telephone (UK Health Security Agency, 2025). These data demonstrate the scale and mixed-mode nature of sexual health provision, although they do not directly measure communication quality. Remote and online access may improve convenience for some patients, but it can also reduce opportunities to assess non-verbal clues, privacy, coercion, safeguarding risk and emotional distress. This is particularly relevant where sexual violence, domestic abuse, female genital mutilation, gender identity, exploitation or adolescent vulnerability may be present.

The epidemiological data reinforces the importance of addressing these communication challenges. In England in 2024, there were 364,750 new STI diagnoses, including 168,899 cases of chlamydia, 71,802 of gonorrhoea and 13,030 of syphilis (UK Health Security Agency, 2025). Rates remain highest among young people aged 15 to 24 years, gay, bisexual and other men who have sex with men, and some minority ethnic groups. Surveillance data provide robust population-level evidence, but they cannot explain the consultation-level processes that contribute to delayed presentation, missed prevention opportunities or incomplete risk assessment. This is where qualitative evidence on stigma, trust and disclosure remains particularly useful.

National guidance continues to emphasise the importance of structured communication support, including professional interpreters, adapted communication methods and accessible resources (Department of Health and MedFASH, 2005; FSRH and BASHH, 2019; Brook et al., 2020). Reliance on family members or friends as interpreters is generally inappropriate in sexual health because it may compromise confidentiality, inhibit disclosure and obscure safeguarding concerns. Appropriate support may include telephone interpretation, British Sign Language provision, easy-read materials, visual aids and checking understanding. However, there is limited direct evidence evaluating these interventions specifically within sexual health consultations in general practice. This means their use is best justified through ethical, legal and safety principles, supported by wider evidence from healthcare communication.

Communication before the consultation: clinic access and external messaging

Communication in sexual health begins before direct clinician interaction. The way services are described and accessed through practice websites, appointment systems, waiting room materials, text messaging, digital triage and receptionist encounters influences patient perceptions of legitimacy, safety and relevance (FSRH and BASHH, 2019; Brook et al., 2020; Mawson et al., 2025; Sutcliffe et al., 2011). Table 2 summarises how clinic access, external communication and core consultation skills influence sexual health consultations in general practice. It shows that communication begins before the consultation and continues through the way clinicians introduce, explain and respond to sensitive sexual health concerns. If practice-level communication does not visibly identify sexual health as part of routine primary care, patients may assume that contraception, STI testing, sexual dysfunction, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis following sexual exposure (PEPSE), pregnancy intention, gender identity or sexual violence are outside the scope of general practice. This concern is supported by qualitative evidence showing that patients' expectations and experiences of STI care in general practice may differ, with uncertainty about whether general practice is an appropriate or sufficiently specialised setting for sexual health concerns (Sutcliffe et al., 2011). This matters because patients do not always anticipate being asked about sexual behaviour or sexual risk when presenting with symptoms that appear unrelated. For example, abdominal pain, urinary symptoms, abnormal bleeding, vulval symptoms, rectal symptoms, mood disturbance, medication side effects or relationship difficulties may all require sensitive sexual health enquiry. Brook et al. (2020) recommend structured sexual history taking because it directly informs investigation, diagnosis,

management, PN and safeguarding. However, guidance alone does not ensure implementation, particularly in short consultations where sexual health is not the presenting concern. Clinicians therefore need to explain relevance clearly and early.

Clinic-level messaging can support this process. Guidance from NICE (2007, 2019), the Royal College of General Practitioners (2013), and FSRH and BASHH (2019) emphasises that sexual health should be presented as a routine component of healthcare rather than as a specialist or stigmatised issue. Visible statements about confidentiality, inclusive care and access to STI testing can reduce uncertainty and encourage disclosure. However, the evidence for clinic-level messaging is stronger conceptually than empirically. There are few intervention studies showing that website wording, waiting room posters or digital triage prompts directly improve disclosure or testing outcomes in general practice. Existing evidence more commonly describes access barriers, patient expectations and the need for inclusive service communication, rather than testing specific practice-level interventions (Freeman et al., 2009; FreemanSutcliffe et al., 2011; Mawson et al., 2025). This should not prevent their use, but it indicates a need for local evaluation. Transparency regarding confidentiality and data handling is also critical. Patients must understand how sensitive information will be recorded, who may access it, how test results will be communicated, and when confidentiality may need to be breached for safeguarding reasons. This is particularly important in remote and digital consultations, where privacy cannot be assumed (FSRH and BASHH, 2019; Brook et al., 2020). Without such clarity, patients may withhold information, provide incomplete histories, decline testing or avoid follow-up, particularly where confidentiality, stigma or fear of judgement affect disclosure (Heritage and Jones, 2008; Bjorkman and Malterud, 2007; Mawson et al., 2025). This is especially relevant for young people, LGBTQ+ patients, those experiencing abuse, and patients from small communities where fear of recognition may affect help seeking (Brook et al., 2020; Mawson et al., 2025).

From a systems perspective, clinic-level communication can either facilitate or inhibit sexual health engagement. Practices that use inclusive, accessible and proactive messaging may reduce stigma and support earlier disclosure. Conversely, unclear websites, inaccessible appointment systems, lack of interpreter provision, non-inclusive forms and absence of visible sexual health information may reinforce the perception that sexual health is not welcome in general practice. The evidence remains limited, but the direction of travel is clear: communication about sexual health begins before the consultation and must be designed at practice level, not left only to individual clinicians.

Core communication skills in sexual health consultations

Within the consultation, communication plays an essential role in enabling sexual health concerns to be explored, understood and managed (Brook et al., 2020). Sexual history taking is a structured clinical skill that requires deliberate technique, adaptability and awareness of context (Alsararatee, 2026). A key principle is to begin with open questions, allowing patients to describe their concerns in their own words. Using open questions at the start of the consultation supports a patient-centred approach by allowing patients to describe their concerns in their own words before the clinician moves into more specific sexual health risk assessment (Floyd et al., 1999; Brook et al., 2020). However, open questioning alone is insufficient. In sexual health consultations, clinicians must also actively legitimise the topic, because many patients will not volunteer concerns unless they feel the subject is clinically appropriate and safe to discuss (Alsararatee, 2026).

The transition from general to more sensitive questioning requires careful explanation. Patients in primary care may not immediately understand why sexual history is relevant to their presenting complaint (Brook et al., 2020). Explaining the clinical rationale can help patients understand why sensitive questions are being asked and can support engagement with sexual history-taking. This is consistent with BASHH guidance, which emphasises that sexual history-taking should be purposeful, relevant to the clinical context and adapted to the consultation setting (Brook et al., 2020). This is particularly important where sexual health is clinically relevant but not the presenting concern, such as pelvic pain, recurrent urinary symptoms, genital dermatology, abnormal bleeding, proctitis, contraception review, medication-related sexual dysfunction or mental health assessment. Although this approach is supported by guidance and communication theory, there remains limited high-quality trial evidence showing which exact phrasing works best in practice. Clinical judgement therefore remains essential.

Language use is central to effective communication. Clinicians must balance clinical accuracy with accessible language, avoiding assumptions about sexual orientation, gender identity, relationship structure or sexual practices. Terms such as “partner” rather than “husband” or “wife” may be more inclusive, but inclusive language alone is insufficient unless accompanied by clinical confidence and genuine openness. Studies involving lesbian, gay, bisexual and trans patients show that heteronormative assumptions and misgendering can silence patients and reduce trust (Bjorkman and Malterud, 2007; Mikulak et al., 2021; Carroll

et al., 2024). While these studies are largely qualitative, their findings are consistent and clinically persuasive. Non-verbal communication significantly influences patient experience. Eye contact, posture, tone, facial expression and attentiveness contribute to whether patients feel judged or supported. This is particularly important because sexual health consultations often involve vulnerability, shame or fear of moral judgement (Kelder et al., 2022; Mawson et al., 2025).

Clinician behaviour, including tone, attentiveness, use of language and visible comfort with the topic, can influence whether patients feel able to disclose sensitive sexual health concerns. Trust and continuity are particularly important for people living with HIV, with qualitative evidence from London showing that patients valued GPs who were knowledgeable, non-judgemental and able to provide care beyond HIV specialist services (Keogh et al., 2016). Kelder et al. (2022), in a systematic review of communication practices in sexual health consultations, found that such interactions are often observed by delicacy, hesitation and topic avoidance, meaning that clinicians need to create explicit permission for discussion. In remote consultations, where non-verbal cues may be reduced or absent, clinicians need to compensate through more explicit checking of understanding, privacy and emotional response (FSRH and BASHH, 2019; Brook et al., 2020).

Inclusivity is an essential component of contemporary sexual health communication. GPs and GPNs must be prepared to discuss contraception, fertility intentions, termination of pregnancy, same-sex relationships, transgender health, sexual dysfunction, HIV testing, PrEP, PEPSE, PN, sexual violence, domestic abuse and safeguarding. BASHH and FSRH guidance emphasise the need for non-judgemental and inclusive communication that reflects current sexual health practice (BASHH, 2019; FSRH, 2025). In the context of PN, inclusive communication is particularly important because patients may need to discuss current or previous partners, same-sex partners, multiple partners, casual partners, anonymous contacts or partners where there is a risk of coercion, abuse or retaliation. GPs and GPNs should avoid assumptions about gender, sexuality, relationship structure or the safety of contacting partners. The challenge for general practice is that this breadth of enquiry must often occur within short consultations and competing clinical priorities. Structured approaches are therefore valuable, but they must not become rigid checklists that undermine rapport.

Sexual health enquiry may also need to include broader psychosocial factors, such as alcohol use, recreational drug use, domestic abuse, sexual violence, coercion, safeguarding concerns

and medication-related sexual dysfunction, depending on the clinical context (Cook and Clark, 2005; NICE, 2014). These issues are relevant to PN because they may affect whether patient-led notification is safe or appropriate. Where there are concerns about sexual violence, exploitation, children, young people or vulnerable adults, clinicians should consider safeguarding responsibilities and referral to specialist sexual health or safeguarding services. The Sexual Offences Act 2003 provides the legal framework for sexual offences in England and Wales, including non-consensual sexual offences and offences involving children, where age, consent, exploitation and power imbalance may affect clinical decision making (Crown Prosecution Service, 2026). These considerations also reflect the ethical principles of autonomy, beneficence, non-maleficence and justice, particularly where clinicians must balance patient confidentiality, partner welfare and wider public health responsibilities (Beauchamp and Childress, 2019). Failure to explore these issues may result in missed diagnoses, incomplete risk assessment, unsafe PN or missed opportunities for prevention. However, clinicians should avoid overwhelming patients with rapid or poorly contextualised questioning. The skill lies in combining structure with sensitivity, ensuring that patients understand why questions are being asked and retain a sense of control.

There is also a need to distinguish between risk-focused sexual health communication and broader sexual wellbeing. Traditional sexual history taking often prioritises STI risk, anatomical sites of exposure, contraception and pregnancy risk (Brook et al., 2020; Davenport et al., 2025). While these remain clinically important, they may neglect sexual pain, desire, arousal, orgasm, intimacy, trauma, relationship context and the impact of chronic illness. Davenport et al. (2025) demonstrate this limitation in endometriosis care, where patients often wanted sexual wellbeing to be acknowledged but felt that GPs lacked time, confidence or knowledge to ask about it. Although this evidence comes from a specific patient group, it raises an important broader point: sexual health communication in general practice should not be restricted to infection prevention alone (Davenport et al., 2025; Brook et al., 2020). This variability has implications for patient safety and equity. The variability observed in sexual history-taking across clinicians reflects differences in training, confidence, perceived role boundaries and local service arrangements. This variability has implications for patient safety and equity, and supports the need for communication to be developed, observed and evaluated through patient feedback, structured supervision and continuing professional development. This aligns with current professional standards that emphasise partnership with patients, effective communication and reflective improvement in clinical

practice (GMC, 2024; NICE, 2021; Brook et al., 2020). Conceptualising sexual health communication as a core clinical competency, rather than an optional specialist skill, is therefore essential to improving consistency and quality in general practice.

Conclusion

Communication in sexual health consultations is complex and multifaceted, encompassing service-level messaging, interpersonal skills and adaptive strategies to address communication barriers. For GPs and GPNs, effective communication requires not only technical skill but also awareness of stigma, inequality, safeguarding, confidentiality and inclusivity. The current evidence indicates that sexual health remains under-discussed in general practice, despite high service demand and continuing STI burden. Patients may not raise sexual concerns unless clinicians create explicit, safe and routine opportunities for disclosure. Although much of the evidence is qualitative, small-scale or based on selected patient groups, the consistency of findings across studies is observed. Time pressure, stigma, embarrassment, confidentiality concerns, clinician discomfort, lack of proactive questioning, heteronormative assumptions and poor service visibility repeatedly emerge as barriers. A structured and evidence-based approach to communication is therefore essential to ensure that sexual health consultations are safe, equitable and clinically effective. Embedding these principles within routine general practice has the potential to improve patient engagement, enhance diagnostic accuracy, support prevention, and reduce health inequalities in primary care.

Key points

1. Sexual health remains inconsistently discussed in general practice, despite its relevance to diagnosis, prevention, safeguarding and wider wellbeing.
2. Communication barriers include stigma, embarrassment, confidentiality concerns, clinician discomfort, time pressure, language needs and lack of structured enquiry.
3. Inequalities in access may be greater for young people, LGBTQ+ patients, minoritised ethnic communities, migrants, people with communication needs and those living with socioeconomic disadvantage.
4. Communication begins before the consultation through practice websites, appointment systems, digital triage, waiting room information and receptionist encounters.

5. Sexual health communication should be treated as a core clinical competency for GPs and GPNs, supported by inclusive language, clear explanation, safeguarding awareness and reflective practice.

Reflective questions

1. How routinely do you create opportunities for patients to raise sexual health concerns when the presenting problem is not clearly sexual in nature?
2. Do your questions, language and assumptions make it clear that people of all ages, genders, sexual orientations and relationship structures are welcome to discuss sexual health?
3. How do you check that patients understand why sensitive sexual health questions are being asked?
4. In remote or digital consultations, how do you assess privacy, safety, understanding and the possibility of coercion or safeguarding risk?
5. What changes could your practice make to ensure that sexual health is presented as a routine, accessible and non-judgemental part of general practice care?

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Table 2: Communication in sexual health consultations: clinic access, external communication, and core communication skills

Section	Key point	Relevance to GPs and GPNs	Evidence
Clinic access and external communication or advertising	Communication about sexual health begins before the consultation. How services are described through websites, appointment systems, posters, and leaflets influences whether patients seek help and what they expect when they attend.	In primary care, patients may not expect to be asked about sexual behaviour, contraception, alcohol or drug use, or safeguarding. Clear pre consultation information can reduce anxiety and improve acceptance of sensitive questioning.	Brook et al. (2020)
	Accessible and transparent information can normalise sexual health help seeking and reduce missed opportunities for prevention, diagnosis, and early intervention.	Waiting room materials, practice websites, and digital messaging can frame sexual health as a legitimate part of routine care rather than something exceptional or stigmatised.	NICE (2007); RCGP (2013); NICE (2019)
	Information provided to patients should explain how confidentiality, test results, and safeguarding will be managed across face to face, online, and remote services.	As general practice increasingly uses remote and digital systems, patients need clarity about how sensitive information will be handled across different modes of access.	FSRH and BASHH (2019); GMC (2024c)
Communication skills	Effective communication is central to sexual history taking and is associated with improved patient outcomes and clinical engagement.	GPs and GPNs require communication that facilitates disclosure, supports rapport, and improves diagnostic accuracy in potentially sensitive consultations.	Griffin et al. (2004)
	Sexual health consultations should usually begin with open questions before moving to more focused enquiry.	Open questions allow patients to describe concerns in their own words, which can reveal the presenting agenda before more specific sexual history questions are asked.	Griffin et al. (2004); Floyd et al. (1999)
	Clinicians should explain why sensitive questions are being asked and use clear, respectful, understandable language.	This is especially important in primary care, where patients may not see the immediate relevance of sexual history questions to their presenting complaint.	Wylie (2015); Radcliffe et al. (2012)
	Nonverbal communication, including eye contact, posture, tone, and attentiveness, shapes whether the patient feels safe and not judged.	Sexual health disclosure is often influenced by how the clinician behaves as much as by what is asked.	Epstein et al. (2005)

	Sexual health communication must be inclusive and current, covering issues such as same sex behaviour, contraception, termination of pregnancy, transgender health, HIV testing, PrEP, PEPSE, and chemsex without moral judgement.	GPs and GPNs need confidence and training to address contemporary sexual health issues in a routine, professional, and inclusive way.	Rogstad (2011); Cresswell et al., 2022); Fisher et al. (2020); Brady et al. (2019); BASHH (2019); FSRH (2025)
	Enquiry may also need to include alcohol use, recreational drugs, domestic abuse, sexual violence, and sexual dysfunction where clinically relevant.	In primary care, sexual health concerns may present indirectly through non specific symptoms, recurrent attendance, or psychosocial distress, making broader enquiry clinically necessary.	Cook and Clark (2005); RCP and BASHH (2011); Perry and Hutchinson (2012); NICE (2014); Goldmeier et al. (1997); Sadeghi-Nejad et al. (2010)
	The quality of communication should be evaluated through patient feedback, observation, and structured professional assessment.	This supports the view that sexual history taking is a teachable and assessable clinical skill rather than an informal conversational ability.	Duffy et al. (2004); Epstein et al. (2005)

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