Globalization has had a profound impact on many aspects of health, particularly sexual health. Increasing international mobility has resulted in greater potential exposure of overseas travellers to sexually transmitted diseases (STDs) and human immunodeficiency virus (HIV). There has been increased migration of people from resource poor or transitional economies where there is a higher prevalence of STDs and HIV. There has also been growing diversity in the sex industry in the UK, in part as a result of a recent influx of migrant workers, often in association with sex trafficking. These changes present unique challenges in the delivery of effective sexual health care. The aim of this series of three articles is to highlight some of the topical issues in sexual health of relevance to an occupational health physician.

A high proportion of travellers have sex while abroad, and may be at particular risk of acquiring a sexually transmitted infection, as a result of greater levels of unsafe sexual behaviour with new partners. The first article examines the impact of travel on sexual health and provides an outline of the pre-travel advice and sexual health assessment of the returning traveller. Hamlyn et al. [1] review the epidemiology of sexual risk behaviours among travellers. They examine strategies to minimize exposure to STDs and blood-borne viruses in specific high-risk groups, including the young, gay men, sex tourists, military personnel and expatriates. The additional risks of occupationally acquired HIV infection faced by health care workers and elective medical students working in endemic areas are also highlighted.

In the second article, Spice [2] describes the changing demography and diversity of the sex industry in the UK. This includes the increasing use of Internet and mobile phone technologies, the growth of sex trafficking and the influx of workers from the transitional economies of Eastern Europe and Russia. In one recent survey based in London, less than a quarter of sex workers were from the UK. Sex workers are themselves increasingly diverse including transgender, male commercial sex workers and the nature of their work. The workplace is also diverse, ranging from traditional street workers to work in off-street premises such as massage parlours and increasingly private addresses. Spice reviews the main health challenges in sex workers (STDs, violence, drug use and mental health) and the different types of services available, including outreach and drop-in clinics and harm reduction strategies.

Although there has been a reduction in occupational needlestick injuries with the increasing adoption of safer ‘sharp’ technology such as sheathed and retractable needles, there remains a problem of underreporting and poor knowledge of procedures to follow in the event of an incident. The third article [3] reviews the current evidence for use of occupational HIV post-exposure prophylaxis, and current approaches to risk assessment and management. The evaluation of the source patient where possible has become increasingly important because of the significant rate of HIV drug resistance among HIV-1-infected patients receiving antiretroviral therapy. The drug regimens are often poorly tolerated, and Hamlyn summarizes the key adverse events of which the supervising physician should be aware.

Common to all three areas are the challenges in research methodology. In the absence of any large prospective randomized controlled trials, evidence for the efficacy of occupational post-exposure prophylaxis is based on a single-case control study of occupational exposure to HIV in 33 infected health care workers. This is in addition to data from animal primate models and exposure to simian immunodeficiency virus, which may not be generalizable to humans because of exposure to a different virus to HIV, and differences in drug metabolism and dosing between animals and humans. For example, in studying the sexual health of travellers, most studies have been cross-sectional and descriptive rather than prospective and analytical, have lacked control groups and are confounded by recall bias of sexual behaviours. Furthermore, travellers are a heterogeneous population making targeted interventions difficult; and STDs may be diagnosed some time after travel, so it may be difficult to link an infection with a risk exposure while travelling. Research into commercial sex work is similarly hampered by small and unrepresentative study populations due to problems gaining access and trust among sex workers. As a result, researchers are
reliant on individuals attending sexual health clinics voluntarily, who may be poorly representative of the local commercial sex worker population, particularly the more vulnerable groups. There is also likely to be a reporting bias in response to questionnaires or structured interviews on topics such as condom use and drug habits. Finally, sex workers represent an unstable population both temporally and geographically, which means prospective studies are difficult to conduct without the loss of significant numbers of subjects, which may bias the findings.

References