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ARTICLE

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Histories of 'a loathsome disease': Sexual health in modern Britain

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Abstract

From Victorian preoccupations with prostitution and degeneration to our present-day problems with antimicrobial resistance and inequalities in access to care, sexual health has been riddled with gendered, racialised, politicised and class-based meanings. Historians writing from within an increasingly diverse collection of subfields have explored how British attitudes towards, and interventions in, sexual health have changed over the past two centuries. In so doing, they have also addressed a wide range of themes in British social life, politics, gender and sexuality. This article surveys this extensive historiography, highlighting important shifts and reflecting on where historians might fruitfully turn next. Inevitably, there are problematic silences in the scholarship. Historians, overwhelmingly reliant on records compiled by health authorities and the state, have tended to write top-down histories of sexual health. The lived experiences of ordinary people, especially those on the margins of society, remain frustratingly elusive. Moreover, the same sorts of inequalities that historically undermined care and denied patients a voice continue to shape health outcomes. As such, this article not only surveys the historiography but also makes the case for the important role that historians can play in supporting positive changes in attitudes towards sexual health and the delivery of healthcare today.

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1 | INTRODUCTION

From Victorian preoccupations with prostitution and degeneration to our present-day battles with antimicrobial resistance (AMR) and inequalities in access to care, sexual health is riddled with meanings beyond the biomedical. Over the last two centuries, sexual health[1] has been many things in Britain: a by-word for social and sexual disorder; a racial poison; a profound threat to the health of the nation and its empire; and an excuse to experiment on vulnerable people, impose draconian legislation and curtail immigration. Yet sexual health, described at the time as 'venereal disease' (VD), simultaneously became ammunition for women fighting the sexual double standards of a patriarchal society. It was the catalyst for significant developments in medical practice. And, perhaps most importantly, sexual health was the impetus for Britain's first system of universal healthcare that was free at the point of use.

The study of sexual health is a relatively small historiographical field. It has not been subject to the same extensive historiographical interpretation and reinterpretation that has characterised other fields. Nonetheless, sexual health has proven itself to be an incredibly versatile historical lens through which to explore a wide range of themes in British social life, politics, gender, health and sexuality. Writing from within an increasingly diverse collection of subfields, historians are mapping the fluid and often-contradictory significance of sexual health in British society. In surveying this dynamic historiography, the article explores important shifts, such as the impact of the cultural turn and the emergence of postcolonial history. It highlights problematic silences, like the dramatic changes in post-war health policy and service provision. And, by highlighting these silences, the article reflects on where historians might fruitfully turn next. Overwhelmingly reliant on records compiled by health authorities and the state, historians have also struggled to write histories that capture the sexual-health experiences of 'ordinary people', especially the experiences of Black and Asian communities. But as we shall see, there is still much that can be done to recover these experiences.

This article is arranged chronologically and thematically, setting out vast changes in sexual-health knowledge, practices and policies. In so doing, the article also maps the important historiographical trends through which those changes have been documented. This thematic arrangement reflects broad divisions in the historiography. Historians of sexual health have tended to focus on discrete themes and time periods. For example, few who have written about the Contagious Diseases (CD) Acts have also turned their attention to the impact of the bacteriological revolution on sexual health. Similarly, few who have written about Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (HIV/AIDS) have also looked at sexual health in the pre-AIDS era. These different areas of sexual-health historiography have developed largely independently of one another. Instead, historians have taken their inspiration from broader scholarly shifts in the histories of medicine, sexuality, gender and postcolonialism.

2 | SEXUALITY AND REGULATIONISM

Sexual health has been a subject of historiographical attention for many decades. But it was not until the cultural turn and the emergence of new historiographical frameworks like the social history of medicine that attention began to move away from studies centred around prominent venereologists and their ground-breaking 'discoveries' (Oriel, 1994; Waugh, 1974). Importantly, this shift coincided with the emergence of AIDS and new waves of feminist activism, resulting in a flurry of rich historiography during the 1980s and early 1990s. With this historiography came new efforts to understand VD not just according to its narrowly defined epidemiology, but also its complex cultural significance and its impact on marginalised and vulnerable groups (Brandt, 1987; Quétel, 1992). Indeed, the 1987 edition of Allan Brandt's *No Magic Bullet* included an entire additional chapter on AIDS in which he made the case for history's important role in understanding the emerging health crisis. Certainly, responses to AIDS in the 1980s

seemed to parallel the state inaction, punitive legal measures, medical uncertainty and public fear and taboos that had long characterised responses to VD. At the same time, feminist historians began mapping the legacies of state and institutional violence against women. Venereal disease became a regular theme within these histories, often appearing via discussion of harmful regulatory mechanisms like the CD Acts and equivalent colonial ordinances (Bland, 1995; Mort, 2000).

Enacted in 1864, and expanded in 1866 and 1869, the CD Acts were intended to curtail the spread of VD among soldiers and sailors. But their principal victims were working-class women. The Acts gave individual police officers complete discretionary power to arrest any woman they suspected of soliciting. Women registered under the Acts as common prostitutes were subjected to periodic examinations and, if thought to be infected, detained in lock hospitals for months of compulsory treatment. Never extended to the entire British Isles, this system operated in specific port cities and garrison towns. The operation of the Acts has been critiqued extensively from a range of disciplinary and geographical perspectives, from coordinated national efforts to repeal them, to their impact on the day-to-day lives of local communities, to their function as biopower wielded over women's bodies by state and institutional authorities (Howell, 2000, 2009; Levine, 2003; O'Brien, 2021; Spongberg, 1997; Walkowitz & Walkowitz, 1973). Judith Walkowitz (1980) argues in her canonical study that, rather than reducing prostitution and disease, the Acts instead became instrumental in creating a professional class of prostitute, making it almost impossible for registered women to extricate themselves from sex work. It is an argument reiterated by Peter Baldwin (2005) in his comprehensive overview of VD controls in Europe; far from seriously attempting to eradicate prostitution, authorities sought to regulate commercial sex and, by extension, curb VD transmission.

The CD Acts were eventually repealed in 1886 after a lengthy and controversial campaign spearheaded by Josephine Butler and the Ladies National Association for the Repeal of the Contagious Diseases Acts. By the end of the century, with changes in public attitudes and medical knowledge, such regulation and surveillance was criticised not only as unethical, but also counterproductive. Bacteriological developments led subsequent generations of doctors to dismiss the cursory clinical practices employed under the Acts as scientifically flawed: women were diagnosed incorrectly and periods of disease latency were misinterpreted as progress towards recovery (Hanley, 2017a, 2017b). Punitive methods to curtail the spread of VD rarely had their desired effect. But this did not stop governments from repeatedly falling back on such methods during national crises (Bingham, 2005; Bland, 1982; Davidson, 1996; Hall, 2000; Harrison, 1995; Lammasniemi, 2017; McCormick, 2012; Woollacot, 1994).

Neither did mounting criticism bring about a rapid repeal of similar colonial legislation. Versions of the Acts remained in force throughout the empire for many decades. Indeed, as Philippa Levine (1996, 2003) shows in her seminal studies of imperial responses to prostitution and VD, the domestic Acts were nowhere near as expansive as their colonial counterparts, which sought not just to protect military strength but also quash supposed sexual disorder among colonised peoples and solidify colonial authority. Writing as a historical geographer, Philip Howell (2000) highlights how regulationism, rather than spreading outwards from Britain to its colonies, was in fact a racialised colonial practice that paved the way for the domestic Acts. Under such colonial ordinances, as Lenore Manderson (1997) notes, 'race structured the institutionalisation and containment of sexual nature by standing both as an apology for various sexual practices and as a legitimation of the state's response' (p. 373).

While some historians (MacPherson, 2001) have emphasised the limitations of colonial authority and the extent to which it was resisted, others (Howell, 2000; Levine, 2003; Varnava, 2020) have called attention to the manifold ways in which superstructures of white prejudice shaped and sustained legislative responses to VD and, by extension, the experiences of colonial subjects. As Levine (2003) notes, historical analysis must account for how the othering of colonised people enabled legislation that created a burden shouldered primarily by impoverished, vulnerable women. The operation of such legislation was shaped by the cultural and political specificities of different colonial spaces. But almost every colonial territory was subject to ordinances that were designed to control the sexuality and mobility of women and girls, constructing them as little more than biomedical threats (Manderson, 1997; Warren, 1990).

3 | EUGENICS, (IN)FERTILITY AND 'RACE SUICIDE'

The CD Acts and their equivalent colonial ordinances were the product of ever-growing fears about the strength of the British race and its ability to maintain imperial power. These fears took on new forms with the advent of eugenics, becoming bound up with ideas about fertility, sexuality, degeneration and 'race motherhood' (Pick, 1989; Robb, 1997; Szreter, 2019). This intersection between eugenics, degeneration and VD has not only received considerable historiographical attention but has also been heavily scrutinised from a range of disciplinary perspectives. For example, this trifecta's sensational (if often-oblique) appearance in literary genres like late-Victorian gothic horror and New Woman fiction has made it a particularly popular subject among literary scholars (Krumm, 1995; May, 1998; Nixon & Servitje, 2018; Pietrzak-Franger, 2018; Prescott & Giorgio, 2005; Showalter, 1985; Smith, 2004), which in turn has shaped the way that historians write about this important historical moment.

By the end of the 19th century, VD was thought to threaten the future of the British race through moral and physical degeneration. As Michael Worboys (2004) observes, it was constructed as a 'racial poison', with syphilis undermining the quality of the race and gonorrhoea affecting its quantity. Moreover, with health authorities acutely aware of the porous boundaries between the imperial metropole and colonial periphery, VD also came to embody the supposed degeneration that accompanied sexual encounters and race-mixing between white colonists and colonised subjects (Howell, 2000; Levine, 2003; Pietrzak-Franger, 2018). As we shall see, this would continue to trouble health authorities well into the 20th century. But it was not just VD's terrible physical impact that instilled fear. Also alarming was the fact that its true prevalence was unknown. Appearing before the Royal Commission on Venereal Diseases (RCVD) in 1914, Dr. T. H. C. Stevenson, Medical Superintendent of Statistics at the General Register Office of England and Wales, lamented the lack of reliable data on transmission and infection rates (RCVD Cd 7475).

The impact of VD on fertility as well as maternal and infant mortality and morbidity makes it a particularly worthwhile focus for historians of demography and reproductive health. Yet the absence of reliable data presents significant challenges and authoritative studies (Soloway, 1995; Szreter, 2002) have consequently paid limited attention to the impact of VD. This has begun to change in recent years (Hanley, 2017c; Szreter & Schürer, 2019) and there is scope for even further investigation. Szreter and Kevin Schürer (2019) have produced persuasive estimates of disease prevalence and the impact of VD on fertility during the Edwardian period. Szreter (2014) estimates that, on the eve of the First World War, the prevalence of syphilis and gonorrhoea among men in their mid-thirties was 7.0%–8.5% and 23.0%–27.5%, respectively. However, he notes that among the more affluent classes, perhaps one in three bachelors were infected with syphilis or gonorrhoea either before or at the time of marriage. Such findings lend credence to the Victorian belief that VD rates were out of control and wreaking havoc on fertility and health, especially among young married women. In turn, this belief fed widespread anxiety about the health, vitality and efficiency of the nation itself.

At the same time that eugenics was engendering new fears about degeneration, it also seemingly offered a means of counteracting that degeneration—something that acquired a new urgency during the Second Boer War (1899–1902) when large numbers of urban-dwelling, working-class recruits were being turned away because they were unfit, many with previously undiagnosed VD (Szreter, 2002). As Joanne Townsend (2018) puts it, 'in light of the recruiting crisis, a link was drawn from the substandard diseased recruit back to the unhealthy child he had been, thence to his sickly infancy, and finally to his mother, never quite well since marriage' (p. 69). Worboys (2004) and Anne Hanley (2017c) have both shown that it was in this period that doctors were becoming increasingly cognisant of, and alarmed by, the dangerous impact of gonorrhoea on women's reproductive health, a fact that was being weaponised in eugenic propaganda (Robb, 1997). But the multiple cultural meanings assigned to the term 'degeneration' allowed the language of degeneracy to be adopted by groups with competing social and political agendas (Arata, 1996; Hanley, 2017c). Equating women's sexual ignorance with innocence, conservatives sought to prevent degeneration by shoring up the sexual double standard by keeping women ignorant of all matters affecting their sexual health. Others, by contrast, called for the demolition of this conspiracy of silence because it threatened the health of women and, by extension, the future health of the nation (Hanley, 2021).

There is still much to be done historiographically on the complex relationship between eugenics, disease, fertility, women's sexuality and Victorian patriarchy. But as a number of historians and literary scholars have already demonstrated, the women's movement radically redefined the parameters of the debate over VD. A diverse group of New Woman writers, suffrage campaigners and women doctors— among the most vocal critics of the sexual double standard—effectively shifted attention away from regulationism. Instead, they emphasised the need to equip women with the knowledge, social capital and political power to protect themselves against diseased husbands (Bland, 1987; A. Richardson, 2003; Woods, 2018; Worboys, 2004).

Victorian and Edwardian women's vulnerability within marriage has become a popular historiographical subject. But the sources available for such studies are limited. The official records and newspaper reporting of cases brought before the Divorce Courts, which historians like Gail Savage (1990) and Angus Ferguson (2016) have expertly explored, offer unusually rich insights into the private tragedies of VD (albeit mostly among the wealthier classes). We see in the reporting of these sensationalised cases, of which Lord and Lady Colin Campbell's 1886 divorce suit is perhaps the most notorious, a clear coding of language around sex and sexual health. Reporters covering the Campbell's case relied on euphemistic terms like 'a loathsome disease' (Anon. 1886) to obliquely tell their readers that Lord Colin Campbell had infected his wife with VD. Such terms were, as Livia Arndal Woods (2018) argues, part of a wider culture in which VD was unmentionable and the conspiracy of silence was allowed to go unchecked. Under the 1857 Matrimonial Causes Act, husbands had only to prove adultery to secure a divorce. Wives had to prove adultery and an additional fault like cruelty, which included the wilful communication of VD. Lady Gertrude Campbell, unquestionably infected by her husband but unable to prove adultery, had to settle for judicial separation.

4 | LAB BENCH AND BEDSIDE

At the same time that women were pushing against the sexual double standard, doctors were mapping the aetiology and pathology of syphilis and gonorrhoea. The half-century before the First World War witnessed enormous changes in the way that VD was understood and treated. But many of these developments were the product of controversial experimentation on vulnerable groups. Although 19th-century medical ethics and malpractice have become well-trodden historiographical fields (Baker, 2013; Lederer, 1997; Maehle, 2016; Price, 2015; Tomkins, 2017), their intersections with VD have received little attention (Benedek, 2005; Sherwood, 2010). Syphilisation—the repeated inoculation of syphilitic matter from one infected person to another—is one of the few exceptions (Dracobly, 2004; Perett, 1977; Sherwood, 1999; Taithe, 1999). Initially a French practice, it was performed in Britain against the backdrop of the CD Acts on working-class patients in the London Lock Hospital. Syphilisation presents historians with an important case study on how doctors understood their ethical responsibilities to patients suffering from diseases that carried enormous stigma (Hanley, 2017b). But other examples are yet to be explored. Historians interested in such research would do well to draw on the wider scholarship on historical medical ethics, as well as important work like Susan Reverby's 2009 study of the notorious Tuskegee syphilis experiments and even contemporary bioethics (Hutchinson & Dhairyawan, 2018) and social science (Kapilashrami, 2019).

Just as syphilisation divided medical opinion, so too did the emergence of laboratory technologies a few decades later. Part of the late-19th century's bacteriological revolution, the identification of the gonococcus in 1879 and the spirochete in 1905, along with a range of diagnostic and therapeutic developments had a revolutionary impact on sexual health (Worboys, 2006, 2010). Writing about the Wassermann reaction and the science of serology that it helped to establish, Ilana Löwy (2004) notes that scientists tended to 'erase all the traces of labour invested in the construction of "scientific facts" and present such facts as if they existed "out there" and were independent of human actions' (p. 513). Early histories of medicine were also guilty of such oversimplification. An important counterexample to this is Ludwik Fleck's 1935 *Genesis and Development of a Scientific Fact*. Although critiqued extensively in recent years, it was among the earliest studies to map what Henk van den Belt (2011) describes as the 'zig-zag course of

development from false initial assumptions via detours and cul-de-sacs' (p. 311). No longer whiggish, histories of medicine now recognise that biomedical innovation is never the work of solitary geniuses but rather the collective effort of entire research communities. But despite the growing historiographical attention to cultures of research and the movement of ideas between them, historians continued implicitly to regard Continental European developments as examples of a universal venereological knowledge, within which the nuances of British research and clinical practice were subsumed (Liebenau, 1990; Löwy, 2004; Witkop, 1999).

Reflecting on Fleck's work, Löwy (2004) noted that 'social processes of fact consolidation usually take place within a scientific community that shares a specific "thought style", which is shaped by a range of cultural variables and that, 'once stabilized, a scientific fact often migrates outside the "thought collective" that produced it' (p. 512). But the development of the Wassermann test—and venereological developments more broadly—were not the product of a single scientific community but multiple ones working within different cultural and political contexts. As Worboys (2004) noted when mapping the 'unsexing' of gonorrhoea's pathology in Britain, such fact consolidation was 'a long process of debate' that relied heavily on local 'sexual politics' (p. 59). Fortunately, there is a growing body of transnational histories situating British venereology within bigger conversations about prevention, research and patient care (Davidson & Hall, 2001; Mazumdar, 2003; Szreter, 2019). To appreciate fully the complexities of British venereology, historians must refocus on the cultural specificities and continuous development of knowledge within research communities as well as the circulation of knowledge between those communities, from the teaching of medical students all the way through to the work of seasoned scientists (Hanley, 2017a; Mazumdar, 2003; Ross & Tomkins, 1997; Szreter, 2014; Worboys, 1992).

The translation of these new technologies into care 'at the bedside' has received comparatively little attention, in large part because historical records of such care are patchy. But then as now, there was a clear lag, sometimes of many years, between the development of a technology or process, and its integration into day-to-day clinical practice (Hanley, 2017a). As Szreter (2014) has shown, not all doctors trusted these new technologies, especially in the absence of corresponding physical symptoms. Nonetheless, as Gayle Davis (2008), Jennifer Wallis (2017) and Hanley (2017a) have demonstrated, technological developments were instrumental in charting new venereological territory, including mapping the complex aetiology of neurosyphilis.

There has been similarly little attention to the dynamics of the doctor–patient relationship, especially among affluent patients. Over the past several decades historians have tried with varying degrees of success to realise Roy Porter's 1985 call for historians of medicine to 'lower the historical gaze to the sufferers' to better understand interactions between sick persons and their doctors (p. 192). But the acute stigma and shame surrounding VD has resulted in a dearth of historical records. Individuals and their families, often aided by doctors, actively suppressed knowledge of their affliction (Hanley, 2021). Alternatively, they forewent mainstream care in favour of 'quack' remedies. Although quack medicine has been linked most often to Britain's less-regulated medical marketplace of the 19th century, Richard McKay (2016) has shown that queer men were seeking quack alternatives well into the 1960s. Syphilis and gonorrhoea were perhaps the diseases most notoriously associated with quackery, yet little focused attention has been given to the relationship between quack doctors and VD sufferers. Neither have historians fully explored the ways in which the language of quackery operated in relation to the emergence of venereology as a field of mainstream medicine.

Suppression and stigma, combined with a prevailing historiographical focus on the mistreatment of women under the CD Acts, has led to a common assumption that doctors were largely unsympathetic (or even hostile) to VD sufferers. But recent scholarship has shown that there was enormous diversity in doctors' relationships with patients. Indeed, the availability and quality of care depended not just on one's wealth and social capital, but also on the attitudes of institutions and attending health workers (Hanley, 2017a). Lloyd (Meadhbh) Houston's study (2021) of the work of Dr. Thomas Kirkpatrick in Ireland reveals not only the immense social and emotional complexities of such relationships. It also shows that patients, even from among the working classes, were able to build up knowledge of sexual health during a period when discussion of VD was widely suppressed, strategically playing on gender and class stereotypes to solicit care.

5 | THE VD SERVICE

Historians are right to point out that British and imperial responses to health challenges were becoming increasingly interventionist and collectivist throughout the late-19th century (Mooney, 2015; Porter, 1999). Yet, with the repeal of the CD Acts, VD bucked this trend. As Pamela Cox (2007) notes, there were exceptions. But with notification and regulation largely rejected as mechanisms for controlling sexual health, Britain entered a 30-year period during which VD was excluded from the state's expanding remit of public-health interventions (Hanley, 2017a).

It was on the principle of utilitarian noncoercion that the state-funded VD Service was established in 1917. Across the interwar years, the VD Service established a nation-wide network of clinics that, at least in theory, provided a confidential service utilising the latest diagnostic and therapeutic technologies. It was an endeavour energetically supported by the British Social Hygiene Council (formerly the National Council for Combatting Venereal Diseases), the organisation tasked with overseeing the accompanying programmes of sexual-health education and propaganda (Boon, 1999, 2005; Evans, 1992; Tomkins, 1993). But in reality, the VD Service was shaped as much by local pressures as by national directives. Given such regional variation, there is understandable disagreement among historians about the extent to which the VD Service employed forms of coercion and moral surveillance more commonly associated with the CD Acts and the wartime Defence of the Realm Act (Caslin, 2019; Davidson, 2000; Hanley, 2020; Moore, 2015).

In 1994, Davidson lamented that there was a frustrating 'lack of regional and local studies of the VD services that provide traction on these issues at the interface between the health authorities and dispensaries and those in society who were venereally infected' (p. 268). With the work of historians like Caslin (2019), Lemar (2006) and Francesca Moore (2015), this gap is slowly being filled. These studies paint a rich, finely grained picture of sexual health at a local level. But comprehensive four-nations surveys of 20th-century sexual health are only just beginning to emerge (Hanley, 2021–2025). Although interwar sexual health has become a popular historiographical focus, the postwar period remains largely undocumented. With the exception of David Evans's work (2001), the integration of the VD Service into the National Health Service (NHS) after 1948 has been largely overlooked. Neither has the VD Service's influence on wider British healthcare reforms been fully considered. Lesley A. Hall (2001) argues that scant thought was given to VD when setting up the NHS. But rather than looking just at the place of VD in postwar health provisions, it would be useful also to examine the extent to which the VD Service's ideological underpinnings shaped the NHS's social and bureaucratic foundations.

6 | POSTWAR SILENCES

Although the growth in sexual-health historiography during the 1980s and early 1990s was due in part to the emergence of AIDS and its particularly devastating impact on queer men, very little of this early work addressed the longer historical legacies of marginalisation and inequality that undermined Lesbian, Gay, Bisexual, Transgender, Queer and Others (LGBTQ+) sexual health. As more recent historiography has noted, this was due in part to silences in the archives. Historians must work hard to find the often-veiled references to disease transmission between men in previous centuries. And although the postwar decades witnessed a significant uptick in the numbers of recorded VD cases among queer men, little attention has been given to these spikes or the cultural and political factors underpinning them.

McKay (2016), one of the few historians to look at these longer histories of queer sexual health, has speculated that the increase in recorded cases among queer men resulted in part from growing confidence among these communities in seeking care and disclosing information about sexual encounters and contacts. But despite growing confidence, well-founded concerns remained that personal information would be disclosed to the authorities. As he notes, queer sexual-health experiences continued to be shaped by state surveillance. An uneasy relationship between sick

persons and the state affected not only the availability of historical records but also created legacies of inequality that continue to be felt today.

These legacies are nowhere more acute than among migrant and minoritised British[2] communities, who remain mistrustful of, and let down by, formal healthcare structures. Far more attention has been given by health researchers and social scientists to contemporary sexual-health challenges among these communities (Aicken et al., 2019; Serrant-Green, 2011). But to properly address such challenges we must also come to terms with the legacies of historical prejudice and inequality. Increasingly, historians are undertaking postcolonial studies of interracial marriage, miscegenation, sexuality, racism and migrant contributions to medicine in postwar Britain (Berridge, 2002; Bivins, 2017; Bland, 2017; Buettner, 2009; Connell, 2017; Simpson, 2018; The Young Historians Project). The racialisation of colonial sexuality, within and beyond the British Empire, has also been scrutinised extensively (Bayliss-Smith, 2019; Doyle, 2013; Drinot, 2020; McCalman & Kippen, 2019; Walther, 2015). But with few exceptions (Bivins, 2015; Hanley, Forthcoming 2017a), the transmission of racist stereotypes to Britain, and their utilisation by nationalist and anti-immigrant groups in debates over sexual health, is something that historians have yet to explore fully. Likewise, the historical role that minoritised communities have played in the delivery of sexual healthcare has received little attention.

Although archives like the Black Cultural Archive have acquired rich collections articulating experiences of HIV/AIDS, minoritised accounts of sexual health in the preceding decades are much harder to find. As with so many other sexual-health histories, locating the voices of ordinary people presents significant challenges. But as Kennetta Hammond Perry (2020) observes, in the case of Black experiences, such silences are not just the result of eccentricities in historical record-keeping or efforts on the part of individuals to suppress knowledge of their own ill-health. Rather, these silences were often part of deliberate institutional processes of expurgation.

Archival silences around personal sexual-health experiences have often been matched by gaps in medical literature. McKay, for example, has mapped the ingenious ways in which queer men navigated such silences, adapting health guidance and developing strategies to protect themselves from VD and state interference. But at the same time, he highlights how awareness among health authorities and queer communities of the dangers of VD transmission in queer sexual encounters was severely limited in the decades before HIV/AIDS. Future scholarship would do well to consider the extent to which VD's impact on other communities was met with similar medical silences and blasé responses. Oral histories will be essential for these sorts of finely grained studies, nuancing experiences according to factors like class, ethnicity, gender and sexuality. Yet there are currently no collections focused on sexual-health experiences or service delivery in the decades before HIV/AIDS.

7 | HIV/AIDS, AMR AND ONGOING CHALLENGES

Compared to the dearth of information on sexual health in earlier decades, there are vast (though not always easily accessible) historical records on HIV/AIDS. It is an abundance that historians have noted in their finely grained studies of AIDS-era sexual health (Cook, 2017; Engleman, 2018; Loughlin & Berridge, 2008; McKay, 2017), ranging from oral histories ('HIV/AIDS Testimonies'; 'Imagining Patient Zero'; Severs, 2020; 'The AIDS Era'), to grassroots activism (Gould, 2009; Severs, 2021), to studies of policy change and health campaigns (Berridge, 1996; Coyle, 2008; Weston, 2019). Although the focus was originally on queer men (Cook, 2019; McKay, 2016, 2017; Severs, 2017), growing collections of archives and scholarship are mapping the historical framing and reframing of HIV/AIDS as affecting other LGBTQ+ groups, health workers and wider society ('HIV in the Family'; 'Invisible Women'; 'The AIDS Era').

Building on this important work, historians must continue their efforts to locate the voices and experiences of those who have been traditionally silenced. Hannah Elizabeth's research (Forthcoming b) goes a long way towards nuancing intersectional experiences of health education, activism, love, sexual encounters and familial relationships. Their work on dental dams (2020c) traces the complex relationships between queer sexuality, HIV/AIDS prevention

and lesbian health activism. In such work we also see how exploring the material culture of sexual health can open up important aspects of these histories. Likewise, we see how frameworks drawn from history of the emotions and the body can help us to understand the devastating impact of VD and HIV/AIDS as well as the way that sexual health became a means of reading and regulating 'deviant' bodies.

Increasingly, queer voices shaped policy conversations, as did a sensitivity to the 'pre-history' of punitive VD preventions. Yet, as Janet Weston and Virginia Berridge show (2018), national and institutional policies remained at odds with liberal health interventions. Elizabeth's work (2020a; 2020b; Forthcoming a) on AIDS-era health promotion and safe-sex practices among adolescents reveals how such resistance played out in British schools. In his famous (1986) *BMJ* leader on HIV/AIDS, Porter described education as 'the crucial weapon' in the state's preventative strategy. But as we see in Elizabeth's work, historical efforts to raise awareness through education became a 'constant battle' for young people asserting their agency and rights. Indeed, it was one of many battles fought over the sexuality of young people in the face of rapid social change, affecting their access to education and health services (Rusterholz, 2021). And these battles still rage, not just over the place of Relationship and Sex Education in schools, but also the autonomy of trans adolescents. It is clear that age—the wellbeing of younger and older populations alike—as a category of analysis in sexual health requires more attention. In this, the work of health researchers (Bourchier et al., 2020; Malta, 2020; Nagington, 2016) has much to offer.

The historical legacies of conservative resistance are still felt. Although HIV in Britain is now a manageable condition, other Sexually Transmitted Infections (STIs) are experiencing a troubling resurgence. In 2019 the House of Commons Health and Social Care Committee reported that falling overall STI rates mask persistent challenges among, for example, young adults, racially minoritised communities and transgender people. Antimicrobial resistance is also fast becoming a serious problem when treating diseases like gonorrhoea (Findlater, 2021; Fitzpatrick, 2015; Gradmann, 2013; Leanord, 2021; Podolsky, 2010, 2015; Spiteri et al., 2019; Unemo et al., 2019). Much more needs to be done to meet trans sexual-health needs (Hibbert et al., 2019; D. Richardson et al., 2020), tackle long-standing health inequalities, overcome structural and cultural barriers to pre-exposure prophylaxis (Nagington & Sandset, 2020; Nakasone et al., 2020) and build more nuanced, less-judgmental understandings of high-risk behaviours like chemsex (Blomquist et al., 2020; Hegazi et al., 2016; Moyle, 2020; Pollard et al., 2017). To overcome such challenges, we must understand their historical legacies. In this, historians would do well to turn to the health and social sciences and build new ways of engaging diverse audiences with the history of sexual health.

8 | CONCLUSIONS

As this article has demonstrated, the historiography of sexual health is rich and diverse. But there is still much that we do not know about Britain's sexual-health histories. The lived experiences of ordinary people, especially on the margins of society, remain frustratingly elusive. Where possible, historians should strive to fill these gaps, such as through collecting oral histories or reading against the grain of existing archives. In this, we would do well to continue thinking creatively and drawing inspiration from across the medical humanities, social sciences and health science for our analytical models and frameworks.

This work is also integral for overcoming sexual-health challenges today. There is still significant stigma around sex and sexual health. Approaching these difficult and sensitive subjects through history offers a distancing mechanism—a safe space to discuss these subjects and explore ways to process personal and potentially traumatic experiences. But understanding the historical legacies that continue to shape services, attitudes, and experiences is also vital for achieving lasting structural change. There are calls, for example, to decolonise sexual health. Doing so requires self-reflective awareness on the part of academics, health workers, policymakers and wider publics of the ways in which knowledge of, and attitudes towards, sexual health has been socially constructed. Tackling persistently high infection rates, especially among minoritised and marginalised communities, means understanding the historical inequalities that still contribute to those high infection rates. To overcome structural barriers to healthcare, we

first need to understand how those barriers were erected and why there is persistent suspicion of formal healthcare among communities who have historically been mistreated by health authorities. Such efforts require multidisciplinary responses and history has important contributions to make.

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ENDNOTES

[1] Across the period covered in this article, the nomenclature of sexual health underwent radical transformations. Throughout the 19th century and for much of the 20th century, the medical term of choice was 'venereal disease'. In lay discussion, a huge variety of colloquialisms were used, ranging from delicate euphemisms to coarser slang. These terms all described a far smaller collection of diseases than we classify as sexual health today. Before the postwar period, it meant syphilis and gonorrhoea. But gradually, sexual health ballooned, becoming its own clinical field and encompassing a variety of other conditions like chlamydia and HIV/AIDS.

[2] The term 'BAME' (referring to Black, Asian and minority ethnic individuals and communities) is still used widely in the UK to describe racially minoritised communities. But this term is problematic and even harmful because it homogenises a range of complex cultural, personal and social factors that affect health experiences and outcomes. As the British Association for Sexual Health and HIV and the Terrence Higgins Trust recently noted, 'despite the collection of detailed ethnicity breakdowns at sexual-health clinics, this is aggregated up to an often-meaningless level in the Public Health England national data'. See BASHH and THT, 'The State of the Nation: Sexually Transmitted Infections in England' (February 2020), 20. www.tht.org.uk/sites/default/files/2020-02/State%20of%20The%20nation%20Report.pdf (Accessed September 2020).

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