



ROYAL COLLEGE OF  
PHYSICIANS OF IRELAND

**RCPI Policy Group on Sexual Health**  
**Better Sexual Health for Ireland Policy Statement**  
**May 28, 2012**



PHYSICIANS OF IRELAND

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# 1 EXECUTIVE SUMMARY

## RCPI Policy Group on Sexual Health

- 1.1 As part of the Royal College of Physicians of Ireland's (RCPI) aim to play a proactive role in the development of healthcare policy in Ireland, it has convened a number of issue-focused policy groups that allows medical and other experts to meet and discuss healthcare matters of concern to healthcare providers and the general public. These policy groups provide evidence-based position papers that outline the issue(s) and propose steps to address the issue(s).
- 1.2 In keeping with this aim, RCPI established a **Policy Group on Sexual Health** in 2010. Recognising that the breadth and scope of sexual health is vast, extends beyond healthcare and is not without complex societal, cultural and legal implications the policy group agreed to focus its efforts on three critical areas of sexual health:
  - Education
  - Prevention, and
  - A model of care for sexually transmitted infection (STI) services.

## Focus on Sexually Transmitted Infections

- 1.3 The World Health Organisation defines sexual health as *'a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.'* Mace, Bannerman and Burton identified three aspects to sexual health and sexual wellbeing, specifically:
  - A capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethic
  - Freedom from fear, shame, guilt, false beliefs, and other psychological factors inhibiting sexual response and impairing sexual relationship
  - Freedom from organic disorders, diseases, and deficiencies that interfere with sexual and reproductive functions
- 1.4 Sexual health affects our physical and psychological wellbeing, and is fundamental to our health and happiness. Protecting, supporting and restoring sexual health is important, dependent not only on a range of sometimes overlapping healthcare services, such as dedicated STI services, family planning services, and services for victims of sexual violence, but also on an understanding within our society of the diversity of human nature and cultural diversity.
- 1.5 The policy group agreed that the exploration and examination of sexual health in its broader definition would be ambitious and beyond its remit. The policy group was ideally placed to develop a position document addressing some critical areas of sexual



health, namely: (1) the provision of education; (2) the development of preventative strategies, and (3) propose a model of care for STI services.

- 1.6 Three subcommittees were formed by the policy group and these gave rise to this document and the enclosed position statements, the focus of which is to:
  - Provide clear recommendations to address the information and education needs of the public, particularly young people and adolescents and provide clear recommendations to address the training and development needs of healthcare providers
  - Set clear priorities for future preventative strategies
  - Propose a model for service delivery, and legal considerations for same.
- 1.7 Whilst the focus of the position statements has been on STIs, it is the view of the policy group that particular mention must also be made of family planning and sexual violence. Family planning is integral to the sexual health of the nation and must be incorporated into any national health strategy. It is also imperative that the successful service development for men and women who have experienced sexual violence, through a national network of sexual assault treatment units and allied interagency links, continue and be integral in the development and implementation of a national sexual health strategy.

## Better Sexual Health in Ireland

- 1.8 Improving, promoting and protecting our sexual health will have major benefits for the overall health and wellbeing of the nation. The policy group hopes that their work will provide the impetus for engagement with government, key stakeholders and policy makers in developing and implementing a national sexual health strategy in Ireland.
- 1.9 There is a need for a national strategy for the promotion and maintenance of sexual health. Public health policy should acknowledge the inter-relationships between health determinants, health behaviours and health outcomes and in response:
  - The Department of Health leads a coordinated, cross-sectoral approach to addressing public health issues, and
  - That sexual health is acknowledged as an important area to be addressed within a national public health policy.
- 1.10 There is an ideal opportunity with the current work of the Chief Medical Officer on developing the public health policy *Your Health is Your Wealth: A Policy Framework for a Healthier Ireland 2012-2020*. We advocate for the inclusion of sexual health as a key focus in this policy. In conjunction with this, we recommend the inclusion of strategies for tackling the wider determinants of health and recognition of the overlapping contribution of various factors to an individual's overall health. With sexual health, the contribution of alcohol and drug misuse to sexual ill health is recognised and areas of common ground in planning and provision of sexual health and drugs/ alcohol should be recognised by health care providers and planners.

- 1.11 Therefore, the overall recommendation of the RCPI Policy Group on Sexual Health is that government must recognise and acknowledge that there is a need to develop and implement a national sexual health strategy. The successful development and implementation of this strategy requires engagement with health, education, justice and social partners. Recommendations from the education, prevention and service statements are detailed in sections 2, 3 and 4, but can be summarised as follows:

OVERALL RECOMMENDATION	<b>Government must recognise and acknowledge the need to develop and implement a national sexual health strategy, based on engagement with health, education, justice and social partners.</b>
Summary of Key Recommendations – Education, Prevention and Service	<p>Appropriate support and resources for the successful integration of all stakeholders in the prevention of sexual ill health and the promotion of sexual health:</p> <ul style="list-style-type: none"> <li>• It is critical that parents and educators continue to receive appropriate support and resources for the successful implementation and further development of home and school-based sexual health programmes.</li> <li>• There is a need for targeted education programmes for groups known to be at-risk of poor sexual health.</li> <li>• The public must have access to appropriate, accessible information to promote good sexual health.</li> </ul> <p>Recommendations to enable a high quality sexual health service:</p> <ul style="list-style-type: none"> <li>• Effective health education requiring inter-sectoral collaboration between educators and clinicians with relevant agencies, at all levels of statutory, voluntary and community settings.</li> <li>• There is also a need to provide quality education to undergraduates and professionals involved in sexual health services with a robust system for ongoing professional development.</li> <li>• Appropriate support and resources for the successful implementation of interventions known to prevent STIs, e.g. immunisation programmes, contact tracing.</li> <li>• Appropriate support and resources for the successful implementation of accessible services to ensure timely, holistic management of symptomatic and asymptomatic sexually transmitted infections.</li> <li>• An equitable, accessible sexual health service for all, and that the challenges to this service are addressed.</li> <li>• A model of care that ensures people are seen at the right time, at the right place and by the right person, e.g. the ‘Hub and Spoke’ model.</li> </ul>

## 2 EDUCATION: ENABLING INFORMED DECISIONS AND PROMOTING EDUCATION

### Introduction

2.1 Sexual health education is a broadly based community-supported process that requires the full participation of educational, medical, public health, social welfare and legal institutions. It is a process whereby individuals, families and communities are equipped with the information, motivation and behavioural skills needed to enhance sexual health and avoid negative sexual health outcomes.

2.2 All sexual health programmes should be broadly based, integrated and coordinated. Effective sexual health education requires inter-sectoral collaboration between educators and clinicians with relevant agencies, at all levels of statutory, voluntary and community settings. The World Health Organisation defines inter-sectoral collaboration as: *“a recognised relationship between part or parts of the health sector with part or parts of another section which has been formed to take action on an issue to achieve health outcomes in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone”*.

Effective partnerships between the Department of Health, Health Service Executive, NGOs and the Department of Education and Skills can help build collective capacity through identifying common ground in all areas of sexual health education.

2.3 Increasing public awareness and providing information and education on sexual health is required so that people can make informed decisions. A number of sexual health indicators in Ireland have highlighted the need for providing information and education programmes/campaigns; these include the rise of sexually transmitted infections (STIs), the rise of HIV infections, unintended pregnancy rates, psychological consequences of coercion and abuse and the consequences of poor educational, social and economic opportunities for teenage mothers.

2.4 Formal education, and particularly early years education, are protective factors related to better sexual health behaviours and outcomes in later life. However, public education is a continuum and required by all. Specific focus should target those especially at-risk including people who have sex before the age of 17, young adults, women aged between 35 and 55, men who have sex with men (MSMs), and people from lower socio-economic backgrounds. These groups require targeted information campaigns to raise awareness of sexual health.

2.5 Education and training for those who provide services is another critical element of providing a successful sexual health strategy, and needs to cover both generic and specialist skills.

## Considerations for Promoting Sexual Health Education in Schools

- 2.6 Sex education is a lifelong process, but it is most essential during childhood and adolescence. Appropriate sex education is associated with healthier sexual behaviours and sexual outcomes in later life.
- 2.7 Formal education and early years education are protective factors and are linked to improvements in sexual health behaviour and outcomes in later life. Integrated school and youth service based programmes may play a role in changing attitudes, intentions and, to some extent, sexual behaviour.
- 2.8 All schools are required to provide a Social, Personal and Health Education (SPHE)/ Relationship and Sexuality Education (RSE) programme in all classes at post primary level. A comprehensive study carried out in 2007 showed that 41% of schools were implementing the programme very well, 36% moderately and 24% poorly.
- 2.9 Internationally, comprehensive sexual health programmes seem to be more effective if people have access to factual information and skills development to make healthy informed choices. Good quality sex education offers young people the choice of delaying sexual activity and practicing safer sex.
- 2.10 A recent study in the Irish context has highlighted that those who received sex education at home or at school were 1.5 times more likely to use contraception with first heterosexual intercourse. Irish survey data demonstrates that *where* sex education is received is important. Those who received sex education at home and/or at school were over 1.5 times more likely to use contraception the first time they had heterosexual intercourse, compared to those who received sex education outside of the home or school environment.

## Considerations for Promoting Sexual Health Education at Home

- 2.11 Parents play an essential role in the delivery of sexual health education. The importance of parents communicating with children at an early age about relationships and sex, delivering age-appropriate and accurate information to create an environment where children will feel comfortable in discussing the subject as they get older is well documented.

Furthermore, it is well known from existing research that parental monitoring, such as knowing what time adolescents come and go and where they are has a protective effect in terms of sexual health. Low parental monitoring has been found to be associated with early sexual activity, more sexual partners and inconsistent contraceptive use.

- 2.12 The HSE Crisis Pregnancy Programme has created a number of resources to help parents feel comfortable and confident in leading a conversation about relationships and avoid a situation where they are reacting to teenagers' behaviour as they get



older. The Irish Family Planning Association coordinate and facilitate an innovative training programme designed to provide parents with an opportunity to develop skills, knowledge and confidence in talking to their children about relationships and sexuality. The *Speakeasy* programme helps parents communicate with their child from a young age.

- 2.13 There is a need to continue to support schools and parents in the successful development and implementation of SPHE/RSE programmes.

## **Considerations for Professional Education and Training in Sexual Health**

- 2.14 Education and quality training should be standard for all professions involved in the provision of sexual health services. These healthcare providers include: sexual health advisers, health promotion officers, youth workers, teachers, doctors, nurses, social workers, psychologists, among others. It is desirable that each group have opportunities to access high-quality training in sexual health. The inclusion of training in family planning is recommended as standard. As a significant proportion of STIs are asymptomatic, all healthcare providers need to be aware of screening protocols and appropriate testing algorithms for STIs. Otherwise, opportunities for early detection and treatment of STIs will be missed. While most of the focus of this section is on training of medical students/doctors and general practitioners, it is acknowledged that there is a clear need to support other healthcare professionals involved in the management of patients as a multidisciplinary approach to sexual health is critical. In addition, the question of ensuring satisfactory standards of practice and professional competence throughout the services must be addressed. As well as having the required skills and resources, every service must engage in ongoing professional development to ensure that quality sexual health services are maintained.
- 2.15 Educational curricula for health professionals are found to vary greatly internationally. Many authors call for improvements of sexual health education across the spectrum of health professional educational programmes. To-date, no evaluation of the adequacy of the curricula in terms of sexual health education in Ireland's medical schools and postgraduate training bodies has taken place. There is a clear need to establish minimum standards for undergraduate and postgraduate sexual health education.
- 2.16 Undergraduate Medical Education: All healthcare professionals require adequate education and training in sexual health. There is a need to engage with medical educationalists to develop an appropriate curriculum at undergraduate level.
- 2.17 Postgraduate Medical Education: Similarly, for the same reasons detailed for undergraduate medical students, all postgraduates need to develop and maintain a level of skills in sexual health. The Royal College of Physicians of Ireland has incorporated sexual health learning outcomes as part of its core curriculum for Infectious Disease and Genitourinary Medicine (GUM) trainees. In addition, a review

of the curricula of other medical specialties will be required to ensure that sexual health education is provided.

- 2.18 A HSE Area sexual health strategy published in 2005 recommended that sexual health education should be provided in primary care and that, in order to achieve this, primary care providers must be facilitated in on-going training and education in the management of STIs to facilitate patient-focused service delivery.
- 2.19 The Core Curriculum for General Practice training in Ireland, developed by the Irish College of General Practitioners, lists the essential learning goals and is broken down into learning outcomes for specific clinical areas. Learning outcomes include:
- Recognising the role of the General Practitioner in the management of sexual health and STIs
  - Accepting the role of the General Practitioner in adolescent health with particular emphasis on age and consent
  - Accepting the role of the General Practitioner in gay and lesbian healthcare issues
  - Accepting the role of the General Practitioner in the detection of violence and sexual assault
  - Describing the systems of care for conditions in sexual health including the role of primary and secondary care, shared care arrangements, multi-disciplinary teams and patient involvement.

Learning opportunities include hospital placement, General Practitioner placement, day release and private study. An attachment in a sexual health clinic is also highlighted as being beneficial.

- 2.20 Continued Medical Education/Continued Professional Development for General Practitioners: The definition of general practice states that General Practitioners must take responsibility for developing and maintaining their skills, personal balance and values for effective and safe health care (ICGP 2007). Sexual health education for General Practitioners can be provided by a variety of educational activities, including the following: CME small group network meetings, topics at conferences and courses, faculty meetings, clinical meetings, seminars, workshops, e-learning and personal reading. Sexual health can be included as a topic at practice-based meetings.
- 2.21 The Medical Council of Ireland has stated: *'It is the responsibility of each doctor to maintain professional competence in line with the standards. The standards do not however define a curriculum for doctors to pursue, since maintenance of professional competence is a self-directed process relevant to and embedded in each doctor's own practice'*.
- 2.22 Education of Other Health Professionals: Addressing the sexual health education needs of other health professionals is also imperative. In a European Sexual Health study it was found that most people working in sexual health were non-medical health professionals including nurses, midwives, psychologists, physiotherapists, social

workers and others. It could be argued that the issue of sexuality and sexual health education is pertinent to all aspects of holistic healthcare.

- 2.23 **Guidelines:** The use of standardised national guidelines is fundamental to facilitate the delivery of and measure outcomes from high quality healthcare. A system of accreditation and competence assessment should be in place in keeping with current Medical Council and An Bord Altranais guidelines on practice standards.

## Accessing Public Information

- 2.24 Educating the general public can be achieved by use of a variety of sources, relevance and application of which will depend on the target group for education. Utilisation of services, with consequent disease control, is dependent upon visibility to the community, and ease of access. Assessment needs to be made of the relative efficiencies of the various sources, keeping in mind that this may vary according to age group and locality.

## Summary of Key Recommendations

The Education Subcommittee of the RCPI Policy Group on Sexual Health recommends the following key action points arising from this position statement:

### RECOMMENDATIONS ON EDUCATION

1. It is critical that parents and educators continue to receive appropriate support and resources for the successful implementation and further development of home and school-based sexual health programmes.
2. There is a need for targeted education programmes for groups known to be at-risk of poor sexual health.
3. There is a need to provide quality education to undergraduates and professionals involved in sexual health services with a robust system for ongoing professional development.
4. Effective sexual health education requires inter-sectoral collaboration between educators and clinicians within relevant agencies, at all levels of statutory, voluntary and community settings.

### 3 PREVENTION OF SEXUALLY TRANSMITTED INFECTIONS: AN EQUITABLE APPROACH FOR THE PREVENTION OF POOR SEXUAL HEALTH

#### Introduction

- 3.1 Poor sexual health can have physical, psychological, social and economic consequences and it is vital to have a comprehensive strategy in place to reduce these potential sequelae.
- 3.2 Disease prevention is fundamental to any sexual health strategy and the aim of this position statement on prevention is to set out a focused, coordinated and equitable approach for prevention of poor sexual health, with particular emphasis on sexually transmitted infections (STIs).
- 3.3 An inclusive policy on prevention of poor sexual health should emphasise health promotion in terms of other aspects of sexual health, in particular strategies to prevent or respond to sexual violence. While the scope of this position paper does not allow for an expanded and/or in depth review of sexual violence strategies, the policy group directs the reader to published documents for further information. Implementation of existing policies and a sustained commitment to optimising accessible services for survivors of sexual violence is vital to reduce its long-term health effects and is actively supported by the policy group.

#### Considerations for the Prevention of Poor Sexual Health

- 3.4 Prevention of poor sexual health depends on a wide range of factors. These include the availability of appropriate information, skills and services, with health, education, social care and voluntary services all playing vital roles in infectious disease prevention.
- 3.5 Integration between education, health promotion and delivery of both clinical services and public health action is vital to ensure a comprehensive and effective programme of prevention. Explicit funding for such prevention interventions is paramount.
- 3.6 Factors essential to disease prevention include: education; risk reduction vaccination and medication strategies; effective testing, screening and diagnosis and treatment of both symptomatic and asymptomatic cases and sexual contacts.

#### Educational Considerations

- 3.7 Formal education and early years education are protective factors and are linked to improvements in sexual health behaviour and outcomes in later life. Integrated school and youth service based programmes may play a role in changing attitudes, intentions

and, to some extent, sexual behaviour. These considerations are discussed in greater detail in the education policy statement (section 2 of this document).

## **Risk Reduction Vaccination and Medication Strategies**

- 3.8 Hepatitis B (HBV): HBV is transmitted by infected blood or body fluids by sexual intercourse, blood-to-blood contact and perinatal transmission from an infected mother to her child. Persons with chronic HBV can transmit the infection for many years. HBV is 50-100 times more infectious than HIV. A safe and effective vaccine is available for the prevention of HBV. In 1991, the WHO recommended that HBV vaccine be incorporated into all national programmes by 1997.

Universal vaccination within the first year of life is now in place in Ireland since 2008 (for babies born on or after July 1, 2008), but it will be many years before the adolescent and adult population have acquired immunity. The Royal College of Physicians of Ireland's National Immunisation Advisory Committee (NIAC) has recommended HBV vaccination in a number of scenarios/settings. Pre-exposure vaccination should be offered to individuals who change sexual partners frequently, men who have sex with men (MSM), male and female commercial sex workers, attendees at STI clinics and those diagnosed with an STI. Post-exposure vaccination should be offered to those who are sexual contacts of persons with acute or recently identified chronic HBV.

- 3.9 Human Papilloma Virus (HPV): Transient infection with Human papillomaviruses (the virus that causes genital warts) is very common in young sexually active men and women. There are many different types of HPV, some of which are associated with genital warts and some of which cause cervical cancer. The virus is transmitted through sexual contact. Condom use reduces but does not eliminate the risk of sexual transmission of HPV.

In Ireland, there is a safe and effective vaccine available to prevent infection with two of the viral types associated with cervical cancer and two of the types associated with genital warts. The Royal College of Physicians of Ireland's National Immunisation Advisory Committee (NIAC) recommends that all girls should receive the vaccine at the age of 12 years. The first year of the School HPV vaccination programme (2010-2011) had an uptake of 82%. This programme is continuing with first year to sixth year girls. The vaccine may also be given to girls aged 9-12 years at the discretion of the physician and, similarly, to women aged 13-26 years if appropriate to do so. At present, there is not enough information available to know the effect of HPV vaccination on cervical cancer. Therefore, cervical screening, in line with the national cervical screening programme is still recommended for women who have been vaccinated against HPV.



- 3.10 Chlamydia Control Programme: *Chlamydia trachomatis* is one of the most common bacterial sexually transmitted infections worldwide, and since 1995 the number of notifications in this country has risen almost 14-fold.

Chlamydia is a significant public health problem because, if untreated, it may lead to pelvic inflammatory disease, subfertility and poor reproductive health outcomes. A stepwise approach for Chlamydia control is recommended by both the European Centre for Disease Control and by the authors of the recent pilot study in Ireland. This approach includes recommendations in terms of primary prevention, case management and opportunistic testing. The development, implementation and evaluation of such a programme in Ireland should be considered.

- 3.11 Antiretroviral Treatment for HIV Prevention: At present there is no effective vaccine against HIV, but there is good evidence to show that antiretroviral treatment strategies can prevent both HIV transmission and acquisition. For HIV positive individuals effective antiretroviral treatment (ART) can suppress the virus and protect the host immune system.

Recent data demonstrates that when a HIV positive person is on effective ART the risk of their sexual partner acquiring HIV through unprotected sexual intercourse is significantly reduced. Thus, the early treatment of known HIV cases may represent a significant prevention strategy to reduce ongoing HIV transmission.

The success of such a strategy is dependent on people being aware of their HIV status. A lack of awareness of HIV status has consequences for the individual and their sexual partners. The majority of newly diagnosed infections in Ireland during Q1 and Q2, 2011 had evidence of weakened immune system as a consequence of late diagnosis. In Europe, The European Centre for Disease Prevention and Control (ECDC) encourages Member States to develop and scale up HIV testing programmes if there is an epidemiological basis for doing so.

For non-infected people, a short-term course of antiretroviral therapy can be given before (pre exposure prophylaxis) and after (post exposure prophylaxis) as a strategy to prevent HIV acquisition. Risk of exposure/acquisition may be as a consequence of occupation or sexual practices. The decision to proceed with pre- or post-exposure prophylaxis (PrEP or PEP) for HIV must be made on a case by case basis. National guidelines for the use of antiretroviral therapy (ART) following potential exposure of HIV infections are currently under consultation/review.

## **Effective Testing, Screening, Diagnosis and Treatment of Both Symptomatic and Asymptomatic Cases and Sexual Contacts**

- 3.12 The Education Subcommittee of the RCPI Policy Group on Sexual Health has made recommendations for undergraduate and postgraduate education to ensure adequate training in STI diagnosis, treatment and management. These considerations are discussed in greater detail in the education policy statement (section 2 of this document).
- 3.13 Allied to this, the Service Subcommittee of the RCPI Policy Group on Sexual Health has proposed a 'Hub and Spoke' model for an integrated STI service in this country. (See section 4 of this document for the policy statement on service). Availability of trained personnel in conjunction with adequate infrastructure and funding will optimise standards of practice to ensure structured, accessible and affordable STI services.
- 3.14 Patients should be able to access care promptly and laboratory capacity should be sufficient to enable early diagnosis, treatment and thus prevention of onward transmission of STIs. An agreed system of surveillance and data collection must be adhered to.
- 3.15 Identification of both symptomatic and asymptomatic infection is vital to prevent disease transmission, and also to prevent disease sequelae.
- 3.16 All symptomatic men and women should be tested.
- 3.17 Populations to be screened include:
- Opportunistic testing of specific high risk groups (e.g. MSM, people who change their sexual partner frequently, migrants, commercial sex workers). Migrants to the EU and Ireland are generally healthy. However, from a population perspective, migrants bear a disproportionate burden of infectious disease. In Ireland, 60% of new HIV diagnoses are reported in people born outside the country.
  - Antenatal screening for specific infections in pregnant women to allow appropriate treatment and also to prevent sexual and mother to child transmission.
  - All men and women embarking on a new sexual relationship.
- 3.18 Health advisors play a crucial role in partner notification to ensure that sexual contacts of individuals with an STI are offered the opportunity for testing and treatment. Health advisors should also be available to enable patients to understand or manage their particular risk or condition and to offer further advice on prevention of disease transmission or acquisition. There is a need for Regional Health Advisors to support General Practitioners, practice nurses and patients in the community.
- 3.19 Tests should be repeated: if the patient becomes symptomatic or is identified as being at increased risk, prior to a new sexual relationship, and, for specific infections, at the start of any pregnancy, and repeated at 28 and 36 weeks gestation if increased risks.

## Summary of Key Recommendations

The Prevention Subcommittee of the RCPI Policy Group on Sexual Health recommends the following key action points arising from this position statement:

### RECOMMENDATIONS ON PREVENTION

1. The public must have access to appropriate, accessible information to promote good sexual health.
2. Appropriate support and resources for the successful integration of all stakeholders involved in the prevention of sexual ill health and the promotion of sexual health.
3. Appropriate support and resources for the successful implementation of interventions known to prevent sexually transmitted infections, e.g. immunisation programmes, contact tracing.
4. Appropriate support and resources for the successful implementation of accessible services to ensure timely, holistic management of symptomatic and asymptomatic sexually transmitted infections.

## 4 SERVICES FOR SEXUALLY TRANSMITTED INFECTIONS: A NATIONAL INTEGRATED MODEL OF CARE

### Introduction

- 4.1 Sexually transmitted infections (STIs) are currently managed in multiple settings including hospitals, community clinics, private clinics, general practice, student health clinics and family planning clinics. There are parts of the country that are poorly served with STI services.
- 4.2 There is no unifying, national integrated network for management of STIs. A national integrated network for delivery of STI services is necessary to ensure equity of access and quality of service, thereby, ensuring that individuals are seen at the right time and at the right place.

### Models of Care

- 4.3 In developing services, the HSE has embraced the concept of integrated service networks defined recently by World Health Organisation: *“the organisation and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money.”*
- 4.4 The success of such developments is dependent on clear referral protocols and clear bi-directional patient care pathways between community services and hospital services such that individuals are seen at the right time, at the right place and by the right person.
- 4.5 In developing such a network for STI services, there are many existing services and service providers to consider, namely: hospital based STI clinics (run by both public health and genitourinary medicine/infectious diseases specialists); general practice; family planning; student health; private genitourinary medicine/infectious diseases clinics.
- 4.6 Well integrated, accessible hospital and community based services will enable STI services to function as a single seamless service delivery unit, thus ensuring equal access to the right service at the right time.
- 4.7 A proposed model for STI services is that of a **‘Hub and Spoke’ model**. In this model the ‘Hub’ has the expertise and resource to manage the most complex caseload whilst supporting ‘the Spokes’. It is foreseeable that there will be degrees of overlap between different services, for example, within private services there may be the expertise to manage the most complex cases. ‘The Spokes’ have the expertise and resource to manage the less complex caseload. See Figure 1.

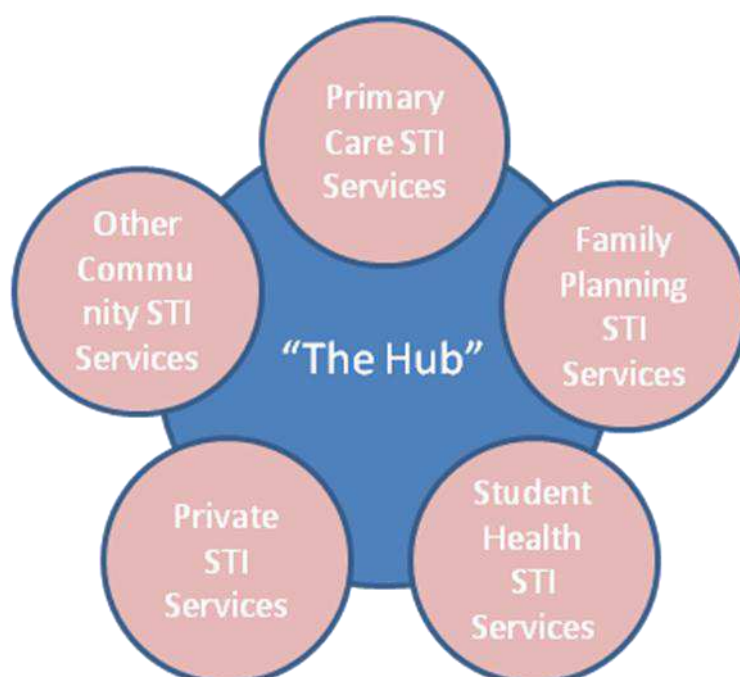


Figure 1: 'Hub and Spoke' model of integrated STI services

- 4.8 It is likely that the Hub would be hospital based, where there is a multidisciplinary team of healthcare professionals and laboratory services available to meet the needs of individuals with more complex sexual health problems.
- 4.9 Based on clearly defined competencies, training, and resources, different services would manage differing degrees of caseload complexity with clearly defined referral pathways between different services, such that the service user experiences a seamless, quality service.
- 4.10 In addition to the 'Hub' and 'Spokes' working together to deliver an integrated service, there is a need for clear co-operation on the development of national management guidelines for diagnosis, delivery of care, disease surveillance and research to direct care development and ongoing professional development.
- 4.11 In considering a model for delivery of STI services, access to these services is crucial and potential barriers to access must be addressed. Easy and timely access to STI services is central to controlling the spread of STIs and of paramount public health importance. STI services need to be accessible to those with symptoms, those identified by contact tracing, and those who perceive that they should be screened. To date, access has been enhanced by the development of a small number of hospital-based free public STI clinics.



- 4.12 Equitable access to laboratory testing for STIs is required. This is not currently available with the example of chlamydia urine testing, which is not available in all HSE areas.
- 4.13 Unlike other services, individuals can self-refer to specialist STI clinics. However, budgetary, social and professional constraints mean that these clinics are often unattractive to attend, and inaccessible in terms of time and location. Access to STI services must not be restricted by a patient's inability (or perceived inability) to pay and the development of an integrated model of care for the provision of STI services must determine how free (or affordable) STI services can be made available for all service users.

### **Access to Services**

- 4.14 Access to services should not be restricted by age, gender, sexual orientation, physical or intellectual ability, or geographical location. In particular within the younger population there is a need to provide appropriate, accessible services to those in need. It must be acknowledged that the provision of STI services to young people (especially those under 16 years of age) can sometimes be challenging in the context of the current legal framework in Ireland. These challenges have a negative impact on equity of access to services for young people and a negative impact on education and research into their sexual health needs.
- 4.15 Even with wide availability of free STI services, some individuals will elect to travel away from their local service in order to retain anonymity. Furthermore, individuals may also elect to attend private STI services. Preferences have been declared for generic health services where sexual health care is only one of the services provided. Thus, individuals receiving these services are not identifiable. The heterogeneity of services required to meet the individual needs within the community must be recognised. Retention of choice for the individual must be considered in the context of establishing widespread STI services and a needs assessment with community engagement on development and provision of services is central to informing the process.
- 4.16 Utilisation of services, with consequent disease control, is dependent upon visibility to the community, and ease of access. Information about STI services must also be readily accessible. People in need obtain information from a variety of sources: word of mouth; GP referrals; the internet; media; directories; helplines; family; friends and teachers. Assessment needs to be made of the relative efficiencies of the various sources, keeping in mind that this may vary according to age group and locality. Notation to indicate competence and accreditation of a given service should be considered when providing information on STI services to service users.

## Legal Framework Considerations

- 4.17 In considering an integrated service network for STIs, the legal framework within which this network must operate requires consideration. In particular, specific consideration is needed with regard to the statutory obligation to report STIs and ethical and legislative aspects of provision of care to young people, those with mental illness and those with intellectual disability need specific consideration.
- 4.18 Under the Infectious Diseases Act, clinicians and laboratory directors have a statutory and a professional obligation to notify all suspected and confirmed cases of infectious diseases, including sexually transmitted and HIV infections, to their respective Department of Public Health.
- 4.19 The information must be provided in a timely manner in line with agreed health information governance standards. The statutory obligation to notify STIs does not mitigate patient confidentiality.
- 4.20 All laboratory-confirmed notifications should be managed through the Computerised Infectious Disease Reporting (CIDR) system. CIDR is a secure, confidential infectious disease reporting system, which has explicit data management and data security protocols. The system is subject to regular external audit and is ISO 27001 accredited.
- 4.21 Surveillance information on STIs in Ireland is an integral part of clinical service development planning and assessment.
- 4.22 In recent times sexual abuse of minors in Ireland has been well documented and the legislature is currently working through the need for a comprehensive legal response. The Criminal Law (Sexual Offences) Act 1993 reflects the legitimate aim of protecting people with intellectual disability from sexual exploitation though it fails to provide sufficient clarity to recognise the rights of persons with an intellectual disability to have a fully-expressed consensual sexual life.
- 4.23 The Oireachtas Joint Committee on the Constitutional Amendment on Children, Reports and consultation papers from the Law Reform Commission on Sexual Offences and the Capacity to Consent, and the Children First Guidance for the Protection and Welfare of Children, are part of this comprehensive approach.
- 4.24 From a sexual health service provider perspective it is important that any barrier placed in the path of a client's access to sexual and reproductive health care services should be heavily scrutinised and should be necessary and proportionate in all the circumstances. The relevant standard, in determining such access, should be the best interests of the individual person concerned. Their evolving capacity to understand the situation and to make decisions concerning access to health care for themselves needs to be recognised.

- 4.25 All people, including young people and people with a disability, deserve recognition of their maturity and their sexual health needs. They should not have to face uncertainty about the confidential aspect of service provision.
- 4.26 Healthcare professionals should be entitled to the protection of the law when they provide services to a young person, which after careful assessment, they deem to be in a young person's best interest. The protection for service providers should be legislatively provided for in terms similar to that of UK legislation, pursuant to the Sexual Offences Act 2003. Under that legislation, health professionals are encouraged to establish a rapport with the young person and support them to make informed decisions.
- 4.27 Health professionals should discuss the emotional and physical implications of sexual activity, including the risks of pregnancy and sexually transmitted infections, whether the relationship is mutually agreed or whether there may be coercion or abuse. A person does not commit an offence if he/she acts for the purpose of:
- Protecting the young person from a sexually transmitted infection or,
  - Protecting the physical safety of the young person, or
  - Preventing the young person from becoming pregnant, or
  - Promoting the young person's emotional well being by the giving of advice.
- 4.28 In all cases, the person must not be causing or encouraging the activity constituting the offence or a child's participation in it. In this regard, draft legislation compiled by the Law Reform Commission in the form of the Health (Children and Consent to Healthcare Treatment) Bill 2011, should be enacted with some minor changes. These should include the protection of sexual health service providers and the deletion of references to exceptional circumstances to provide clarity to young people, healthcare professionals and parents/guardians.
- 4.29 Recommendations made by the Law Reform Commissions in its consultation paper on Sexual Offences and Capacity to Consent should be supported.

## Summary of Key Recommendations

The Service Subcommittee of the RCPI Policy Group on Sexual Health recommends the following key action points arising from this position statement:

### RECOMMENDATIONS ON SERVICE

1. An equitable, accessible sexual health service for all, and that the challenges to this service are addressed.
2. A model of care that ensures people are seen at the right time, at the right place and by the right person, e.g. 'Hub and Spoke' model.

## 5 MEMBERS OF THE RCPI POLICY GROUP ON SEXUAL HEALTH

The **RCPI Policy Group on Sexual Health** was established in 2010 with the aim of publishing position papers on how to achieve better sexual health in Ireland. The policy group is multi-disciplinary in nature with the following membership:

Members	Institution	Role on Policy Group
<b>CO-CHAIRS</b>		
<b>Prof Colm Bergin</b>	St James's Hospital	Co-chair of policy group & member of service subcommittee
<b>Dr Jack Lambert</b>	Mater Misericordiae Hospital & Rotunda Hospital	Co-chair of policy group & lead of education subcommittee
<b>MEMBERS</b>		
<b>Ms Alison Begas</b>	Well Woman Centre	Member, prevention subcommittee
<b>Ms Anita Ghafoor-Butt</b>	Irish Family Planning Association	Member, education subcommittee
<b>Dr Susan Clarke</b>	St James's Hospital	Member, service subcommittee
<b>Ms Claire Coleman</b>	Galway University Hospital	Member, education subcommittee
<b>Dr Dan Corcoran</b>	Cork University Hospital	Member, education subcommittee
<b>Dr Miriam Daly</b>	Irish College of General Practitioners	Member, service subcommittee
<b>Ms Sandra Delamere</b>	St James's Hospital	Member, service subcommittee
<b>Dr Mary Dennehy</b>	Waterford Regional Hospital	Member, education subcommittee
<b>Dr Lucinda Dockeray</b>	Dodder Park Medical Centre	Member, service subcommittee
<b>Dr Maeve Eogan</b>	Rotunda Hospital	Lead, prevention subcommittee
<b>Dr Catherine Fleming</b>	Galway University Hospital	Member, service subcommittee
<b>Dr Derek Freedman</b>	St James's Hospital	Member, service subcommittee
<b>Prof Mary Horgan</b>	Cork University Hospital	Member, service subcommittee
<b>Ms Rachael Howard</b>	Mater Misericordiae Hospital	Member, service subcommittee
<b>Ms Carmel Kelly</b>	South Eastern HSC Trust, Downe Hospital	Member, prevention subcommittee
<b>Dr Fiona Lyons</b>	St James's Hospital	Lead, service subcommittee
<b>Prof Sam McConkey</b>	Beaumont Hospital	Member, prevention subcommittee
<b>Prof Fiona Mulcahy</b>	St James's Hospital	Member, service subcommittee
<b>Dr Austin O'Carroll</b>	Mountjoy Medical Centre	Member, education subcommittee
<b>Dr Emer O'Connell</b>	Faculty of Public Health & Department of Public Health, HSE	Member, education and prevention subcommittees
<b>Dr Darina O'Flanagan</b>	HPSC	Member, prevention subcommittee
<b>Dr Aidan O'Hora</b>	HPSC	Member, education, prevention and service subcommittees
<b>Dr Stephanie O'Keeffe</b>	HSE Crisis Pregnancy Programme	Member, education subcommittee
<b>Dr Say Quah</b>	Royal Victoria Hospital Belfast	Member, prevention subcommittee
<b>Ms Rosie Toner</b>	Irish Family Planning Association	Member, service subcommittee

The policy group also aims to promote sexual health in Ireland through a national awareness campaign '*National Sexual Health Awareness Week*' which will be held in May 2012 to bring together key stakeholders with responsibility for and interest in sexual health education, promotion and wellness in Ireland.

Further information relating to this position paper, National Sexual Health Awareness Week, and the members of the policy group, please contact the Royal College of Physicians of Ireland at [www.rcpi.ie](http://www.rcpi.ie) or at +353 1 8639700.



## 6 REFERENCES

The finalised version of the policy statement and references will be available online at [www.rcpi.ie](http://www.rcpi.ie)



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