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EXECUTIVE SUMMARY

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A range of innovative responses to supporting general practitioners to undertake sexual health have been observed in England, Scotland and the United States, and critically assessed during this study tour. For general practitioners to improve their practice of sexual health, the following criteria need to be met:

- an acknowledgement of the significant role general practitioners play in sexual health;
- an acknowledgement of the desirability of this role;
- a commitment to improving the skills, knowledge and attitudes of general practitioners in sexual health;
- a commitment to involving general practitioners in this process; and
- the need to develop a comprehensive, multi-strategic response to education, support and resourcing for primary care practitioners, including general practitioners.

As demonstrated by the innovative policies and practices observed in England, Scotland and the United States, multi-strategic aspects of supporting, educating and resourcing general practitioners and other primary care practitioners should include:

- national, state and local commitment and strategy development;
- general practice support and development;
- web resourcing and information;
- web education and specialist support, ie moderated discussion boards;
- clinical placements;
- flexible on-site training;
- development of primary care referral clinics;
- general practice visits;
- developing and implementing structured Development Guides;
- development and distribution of STI protocols, ie. through websites;
- nurse support for change management in general practice;
- seminar based didactic training;
- linking into state and national initiatives; and
- Significant partnering with Divisions of General Practice.

The following activities will be undertaken to disseminate the findings of this study tour in New South Wales and beyond:

- specific feedback to the GP/Sexual Health Liaison Officer with the Western Sydney Area Health Service;
- In-services for staff at HIV/Sexual Health Promotion Units;
- In-service for members of Area Workforce Development Groups;
- In-services for staff at Sexual Health Clinics;
- Liaison with Divisions of General Practice to develop approaches for disseminating this information to general practitioners in NSW;
- preparation of an abstract for either the Australian Society for HIV Medicine (ASHM) or the Australasian College of Sexual Health Practitioners (ACSHP) Conference, in 2003 and 2004 respectively;
- specific feedback to ASHM, with their particular interest in HIV and STI on-line education for general practitioners; and
- forwarding the attached Report to the relevant services, individuals and organisations in NSW and beyond.

It should be noted that in this Report where it has been stated that a secondary document or report is attached, then it can be obtained by contacting Greg Ussher at Greg_Ussher@wsahs.nsw.gov.au
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Appendix - Respondents
1. Introduction

This research was undertaken as a result of funding and support provided by the Churchill Foundation of Australia, and Western Sydney Area Health Service.

The initial aim of this Fellowship was “to investigate traditional and contemporary methods of educating general practitioners on sexual health, including web based options.” Although this aim remained substantially intact, from early in the process of conducting interviews it became clear that the question was probably broader. Two key areas of the initial question became broader.

First, “education” quickly became too constraining a concept: many of the programs I investigated framed their approaches in terms of education, support and resourcing. Such an expansion allowed for the investigation of practices which included placements, development plans, GP specific clinics and General Practice environments. Similarly, “general practitioners” was perceived to be constraining: there are a range of clinical professionals working in sexual health primary care, including Practice Nurses, community based organisations with some medical presence, community health physicians and school nurses, and these clinicians were all at times targeted with education, support and resourcing.

It also became clear very early in the process of conducting interviews in England, Scotland and the United States, that the policy and practice sexual health environment was dynamic. The issue of the relationship between Sexual Health Clinics and primary care professionals was being hotly debated, in a range of forums, and these debates were being quickly picked up by the media. A range of media clippings are attached. The question of how to best fine tune the delivery of sexual health services so as to reflect the total service delivery environment was being addressed in a range of national and local policy documents. These are discussed below under National Policies.

The assumption on which this research was based was generally and widely agreed to by respondents. The assumption, with some supporting research, which formed the basis of this research, was that primary care professionals, including general practitioners, conduct a broad range of sexual health interventions, but that they required education, support and resourcing to improve their practice. A secondary assumption was that Area Health Services (in the UK Primary Care Trusts and in the US, Prevention Training Centres) had a role in investing in education, support and resourcing, not only because of efficiencies to be gained, but also because of the multiple entry points such an approach provided for patients seeking sexual health care. This research, then, examined the types of education, support and resourcing offered to primary care professionals, and the commitment, in policy and practice, to fine tuning the balance between specialist and generalist sexual health service delivery.
It should be noted as well that interviews generally began with an agreed broad definition of sexual health, to include management of sexually transmissible infections, including HIV/AIDS, sexual function and dysfunction, family planning and reproductive health.

One of the first opportunities presented by this Fellowship was to attend a seminar on sexual health conducted by Professor Mike Adler, the primary architect of the National Sexual Health Strategy (England), and Dr Jackie Cassell, a researcher at University College London. This seminar, entitled Sexual Health and Primary Care: delivery on the National Strategy and Research Implications, looked specifically at the relationship between specialist and generalist sexual health services, and the role of the National Strategy in fine tuning this relationship.

The seminar made me realize that I have always framed the question as being “GPs do a lot of sexual health, but how can we assist them to do it better?” This is still a part of the question: but the questions about the interface are more complicated. Improved access is not just about education, general practitioners aren’t the only players, and specialist and generalist balancing, is not just about education.

Professor Adler indicated that one of the main drives of the Strategy was to ensure better access to GUM clinics, and to ensure that GPs within Primary Care Trusts played a more direct role in sexual health service provision. One of the key research agendas he proposed was investigating how PCTs, GPs and GUM Clinics could better coordinate service delivery.

Professor Adler also spoke about the current Parliamentary Select Committee, at which one of his colleagues had given evidence suggesting that sexual health in England was in a “crisis” and a “shambles”. This House of Commons Third Report on Sexual Health is discussed below under National Policies.

As a side issue, but a very challenging issue, Professor Adler also felt that we in sexual health need to start to thinking about the consequences of changing technology in the context of GU medicine. For instance, he suggested that in five years there may be technology which enables patients to “go to Boots and pick up a self testing kit for gonorrhea or Chlamydia.” So self-diagnosis becomes part of the equation. One would hope that this did not become as fraught as self treatment.

In the same way that the Seminar indicated to me that the question was not just about education, Shirley Fraser, senior policy analyst with the Public Health Institute in Glasgow, indicated to me that the question was broader than the role of general practitioners only, and included an examination of the role played by all relevant primary care sexual health providers. In Scotland, Shirley pointed out that the Scottish Strategy will not just focus on the role played by GPs, although that will be a significant part of the Strategy. The Strategy will focus on all of those with a role in sexual health primary care. These include:

- GU staff
- Salaried GPs
- Some community based organizations ie Caledonian
- Community pharmacists
- School based nurses
- Practice nurses
- Community nurses funded by NHS

In Scotland, sexual health is perceived as not just a National Health Service (NHS) issue, but as a partnership issue.

2. Contexts

Although this research was clearly designed to examine policy and practices in England, Scotland and the United States, this examination had two other related purposes. From the Churchill perspective, the research was meant to be “of benefit to the Australian community”, and so some dissemination of the ideas generated by the research was presupposed. From the WSAHS perspective, the research was meant to inform the policies and practices of the Area Health Services, and to provide some insight into innovative, and possibly duplicable, programs.

With these two approaches in mind, it needs to be pointed out that there are a range of significant differences in the practice and delivery of sexual health services in Australia, the UK and the US. This is more than terminological: even though a Sexual Health Clinic is a Genito Urinary Medicine (GUM) Clinic in the UK, and an STD Clinic in the US, there are also differences in their operation, modus operandi, and the cultural and political contexts in which they operate.

One of the most stark differences relates to the operation, function and positioning of general practice in the different countries. In England, general practices are often more closely allied with the National Health Service, and within individual Primary Care Trusts, general practitioners are formally encouraged and subsidised to come on board with PCT goals and targets. It is also clear that the stand-alone general practitioner, operating solo, is relatively uncommon: most general practitioners work in large practices, with a Practice Manager and often a Practice Nurse. These arrangements make general practitioners more accessible than in WSAHS, where it would appear there is still a preponderance of stand alone practitioners.

In Southwark, Lambeth and Lewisham, in south east London, for instance, it should be noted that in the 3 PCTS there are roughly 50 practices in each PCT, with roughly 10 GPs in each practice. Patients have to register with a particular GP. There are only about 15 single hand practices. Most large practices have a Practice Nurse, many of whom are interested in sexual health and do particular training.

In Glasgow as well, for instance, the structure of the health service plays a role in determining accessibility to general practitioners. The health service in Scotland is structured in the following way. The Scottish Executive funds NHS Scotland. The NHS
funds 13 NHS boards across the country. Each NHS is made up of ACTS (Acute Care Trusts) and PCTS (Primary Care Trusts). The Sandyford Initiative is funded through PCT. PCTS also support LHCC (Local Health Care Co-operatives), which are collectives of GPs. These appear to be a bit like the WSDGP, but include a broad range of primary health care providers. This ensures that accessing general practitioners, and other relevant primary care providers, is facilitated.

In the United States, I only examined the National Network of STD/HIV Prevention Training Centres (PTCs), with some investigation of the national coordinating and standardising role played by the Centre for Disease Control (CDC), particularly their role in the development of Healthy People 2010 – STDs, and STD Treatment Guidelines.

The Maryland PTC, for instance, covers Maryland, Washington DC, Pennsylvania, Virginia, Delaware, and West Virginia. Most PTCs are funded therefore by region. The California PTC only encompasses California.

Regional PTCs do one of three things:

a. Outreach clinical training (diagnostic, therapeutic and counseling)
b. Teaching behavioural interventions (NYCPTC covers the whole East Coast)
c. Federally funded partner notification

The most recent strategies with PTCs nation wide have been to better utilise resources by standardizing curriculum and developing disease specific modules.

The Maryland PTC primarily conducts:

1. Training for State and Government clinics in the following
   a. Sexual history taking
   b. Performing diagnostic tests
   c. Treatment according to standardized protocols
   d. Counselling
   e. Partner notification
   f. STD management
   g. CDC treatment guidelines

2. Outreach clinical training to non Government workers including GPs, family practitioners, obgyn, adolescent medicine, neurologists and pediatricians.

These structural differences make any direct comparisons difficult. However, it can be noted that the range of national and local GP training coordinating centres in both the US and the UK provide excellent opportunities for sexual health education (the MSSVD and the PTCs are examples). It should also be noted that these bodies are specifically concerned with education, and that initiatives which focus on support and resourcing often operate at a local level (see Programs conducted by Theresa Battison and Vicki Pearce)
As well as these structural differences, there are significant cultural differences. Much prevention activity in the United States focuses on abstinence, and private health insurance means that treatment and care needs to be cognizant of plan and nonplan sexual partners. In England, many PCTs are concentrating prevention energy on Afro-Caribbean communities, and place significant emphasis on socially excluded communities. Not only in different countries, but in different regions of countries, there are significant differences in emphasis in relation to designated priority populations for sexual health promotion. In Scotland, there is a considerable emphasis on the sexual health of young people, including the need to tackle teenage pregnancies. In the United States, African American communities are a major priority population. In England as well, PCTs freely distribute condoms and pregnancy testing kits to all general practices.

3. Sexual health and health inequalities

One of the most significant contexts in which sexual health was interpreted during the research, particularly in England and Scotland, was the relationship between sexual health and broader health inequality. This connection was made repeatedly in interviews, and in most literature, particularly in the House of Commons Third Report on Sexual Health, which is discussed in detail later in this Report. The Third Report does not directly comment on the relationship between sexual health service provision in general practice and health inequalities. In its summary it does however argue that access to specialist sexual health clinical services are restricted for “those whose voices are not heard in society as a whole.”

The Report does not however comment on the possible link between accessing sexual health services through general practitioners and health inequalities. This is a fruitful area for further research. The Third Report quotes Professor Michael Kelly, Director of the Health Development Agency (HDA) as saying that "the inequalities in health repeat themselves as inequalities in sexual health." As well, according to the English Health Department:

“The highest burden is borne by women, gay men, teenagers, young adults and black and ethnic minorities. The rates of gonorrhoea in some inner city black and minority ethnic groups are ten or eleven times higher than in whites. HIV infection also has an unequal impact on some ethnic and other minority groups. Britain's African communities have been particularly badly affected by HIV/AIDS, with high rates among both adults and children. There is some evidence to suggest that chlamydia infection rates are associated with levels of deprivation.”

The Third Report also points out that the risk of unintentionally becoming a teenage mother is ten times higher among girls in social class five (manual unskilled) than in social class one (professional). Children in care and children of teenage mothers are also more likely to become teenage mothers, as are girls of Bangladeshi, Pakistani and Afro-Caribbean origin. Data also suggest that those girls who have higher educational aspirations are more likely to opt for an abortion.
The Third Report also argues that young heterosexuals, men having sex with men and minority ethnic groups are at increased risk. Their figures for 1996-2001, and other sources, support the suggestion that in sexual health there are serious health inequalities:

- 36% of females with genital chlamydial infection were under 20 years of age: among 12 to 15 year old females diagnosed with gonorrhoea, almost a quarter will return with another episode of the disease within a year.
- A majority of diagnoses of gonorrhoea were in men having sex with men.
- The rates of gonorrhoea among some inner city black and ethnic minority groups are ten or eleven times higher than among whites.

In relation to HIV/AIDS, in evidence to the House of Commons Third Report, Dr Peter Weatherburn, Director of SIGMA Research, a specialist sexual health and HIV health promotion research unit affiliated to the University of Portsmouth, described the difficulties associated with providing services for those groups disproportionately affected by HIV and AIDS:

“It is still very much the case that HIV follows the fault lines of society. Marginalised groups are affected by HIV. We mainstream the way we provide services around HIV and HIV prevention but it is still an infection that fundamentally occurs amongst groups that are marginalised from society or otherwise socially excluded.”

The Third Report summarises its section on social inequality and sexual health by stating that “it had heard much from service providers about the difficulties experienced by patients in terms of access, waiting times, and clinic premises and facilities. In light of this evidence it is striking that few, if any, patients complain about the unacceptable conditions under which they seek and receive diagnosis and treatment.” Given the stigma around sexual problems, and given that those groups most affected by sexual ill health tend to be “those whose voices are not heard in society as a whole”, it is clear why patients might feel reluctant or even unable to complain. Further research may indicate that similar issues arise for patients seeking sexual health services from general practitioners.

4. Process

This research utilised three approaches:

- a series of semi-structured interviews;
- a review of relevant literature distributed during interviews; and
- a web search of current policies and programs relating to sexual health.

This research was conducted in England, Scotland and the United States. Some information was investigated in relation to Wales. In the United States, most information relates to the eastern seaboard, with an emphasis on Maryland and New York, and with an emphasis on one national network of prevention services, the National Network of STD/HIV Prevention Training Centres (PTCs).
In all, thirty seven (37) interviews were conducted, with a broad range of respondents. A set of core questions informed all interviews, although individual leads and specific enquiries were followed up as needed. Respondents usually provided me with a range of relevant documentation, all of which has been reviewed, and is available upon request.

Prior to the writing of the Final Report, a web search was undertaken of relevant programs and policies. This was necessary as a recognition of the rapidly changing policy and program environment. For instance, during the course of the research the House of Commons in the United Kingdom released its Third Report on the state of sexual health in England, which had direct comment on the relationship between general practitioners and GU Clinics. As well, the Centre for Disease Control in the United States, only months prior to the research being conducted, released Healthy People 2010 – STDs, which also included comment on the role of general practitioners.

5. National Strategies

Whilst this section will provide some observations on the Sexual Health Strategies of four countries – England, Scotland, Wales and the United States – it will do so primarily from the standpoint of their impact on the provision of services by general practitioners. This will include observations on the policy directives relating to educating, supporting and resourcing general practitioners, or not, and the proposed relationship between Sexual Health Clinics and general practitioners. The Innovative Programs described in chapter 5 of this Report were all developed in the shadow and context of these Strategies.

House of Commons Third Report

Towards the end of my research in England, the House of Commons released its Third Report on sexual health services in England. This received considerable media attention, particularly focusing on Chlamydia and teenage pregnancies.

The Third Report acknowledges that the thrust of the National Sexual Health Strategy (England) had been to devolve far more sexual health services to primary care, either to individual practices, or groups with specialist skills, or managed networks. The Third Report acknowledged that very few of those submitting evidence to the Committee welcomed this unreservedly. Anne Edwards, a clinical director of GUM Oxford, described a local audit of the outcome against national guidelines for 100 patients diagnosed with chlamydial infection outside GU medicine (ie in primary care or family planning). Of those seen for follow up in GU medicine, 80% required re-treating, which Ms Edwards suggested indicated the difficulties of managing STIs effectively in non-specialist settings.

The Third Report also acknowledged the findings of a research report produced in December 2002 by the British HIV Association, the National Association of NHS Providers of AIDS Care and Treatment (PACT) and the Terrence Higgins Trust. Disturbing Symptoms concluded that many PCTs had been unable to implement the work needed to respond to the rising rates of HIV and other STIs, that sexual health services do not have the resources they need to implement Government policy, and that: "there is a
level of dislocation of views between those commissioning services and those providing them."

The Third Report also acknowledges that at the time of the National Sexual Health Strategy (England), the Public Health Minister remarked:

“In the strategy we set out a level one, two and three hierarchy of services, and we envisage many more of certain of the level one services—the diagnosis, the interview, the partner chase, all of that—to be done in the primary care setting.”

The Health Department’s *Commissioning Toolkit* was meant to assist in the achievement of these levels, and included a section on improving support to primary care in its recommended checklists for commissioning. This contained a provision that the views of GPs should be taken into account on the introduction of a shared care scheme. However, The Third Report points out that while primary care, and General Practice in particular, might be a setting conducive to effective screening and management of long term conditions, sexual health has not hitherto been a priority for primary care and in some areas primary care may lack the specialist expertise needed to deliver sexual health services.

The Third Report therefore recognized that the delivery of some sexual health services through primary care has considerable potential in terms of access and continuity of care. However, they were not assured “that General Practitioners will receive sufficient training and support to deliver services effectively, nor that PCTs will provide sufficient encouragement to GPs to offer improved sexual health services.”

In the fine tuning and balancing of the relationship between GU Clinics and general practitioners, between specialists and generalists, the Third Report acknowledged that “sufficient training and support” for general practitioners is fundamental.

**England’s Sexual Health Strategy**

The National Sexual Health Strategy (England) put forward three levels of GP competency in relation to sexual health:

- **Level 1**
  - Sexual history and risk assessment
  - STI testing for women
  - HIV testing and counseling
  - Assessment and referral of men with STI
  - Hep B immunization

- **Level 2**
  - Testing and treating STIs
  - Partner notification
  - Invasive STI testing for men
  - Plus all level 1
- Level 3
  This mainly relates to GUM clinics, all of level 1 and 2
  Plus outreach for STI prevention
  Notification
  Specialised HIV treatment and care
  Specialised infection management, including coordination of partner

Some argued that this attempt at competency levels and goals has to be put in the context of what is happening in general practice. GPs say they can’t meet even level 1 because of time and money constraints: GPs have on average 8000 patients, patients have to register with one GP, and in general they only have 5 minute appointments.

Others also pointed out that across the health areas, there are incentives for targets, which are allied to the NSF (National Service Framework). This framework has 6 levels. Level 1 includes things like cardio etc, and the incentives are good. The cash incentives for level 6, for instance, where sexual health sits, are nil. Hence there is very little incentive for GPs to improve their skills in sexual health.

A senior bureaucrat with the English Health Department, pointed out that after the National Sexual Health Strategy (England), smaller commissioning authorities (PCTs) were introduced, making much of the NSHS framed in old jargon, irrelevant. Plus people had a lot of criticism of the Strategy: it was not bold enough, too dominated by the medical model, had very little on sexual health promotion, did not tackle social inequalities or social exclusion, had little on reproductive health, and its sections related to targets for primary health care were not properly consulted upon. The production of the Strategy had raised expectations in the field, and amongst patients, and some follow up work and clarification was needed to breathe new life into the Strategy.

This follow up work has involved:

- the production of the 27 point Action Plan, which is a crystallisation of the main parts of the NSHS – this is an implementation plan, prepared by the National Implementation Team. (see attached)
- the Commissioning Toolkit, which is a guide for PCTs on how to commission sexual health services (see attached)

There are 308 PCTs across England, and each of them is to have a sexual health lead. In the new PCTs, because sexual health is not an NHS priority, sexual health is often just tacked onto a set of other roles, and the real problem is building commitment and expertise in the PCT. Jane commented that:

“With the PCTs, all you can do is offer a framework… you can’t tell them what to do.”

Some felt that some of the real issues were that most GPs did not “give a bugger” about sexual health, that most PCTs were not prioritising sexual health, and there was little commissioning taking place. There were also a range of data collection issues – no
baseline. Some also felt that there was a huge variation between the rhetoric and the reality – “GPs are basically small business men and sexual health was not able to make them money.”

Others also felt that many GPs were resistant to GU, and to the STIF course, arguing that “many GPs did not want to have their patients managed by specialists.” This was called the “rutting antlers syndrome.”

**Scotland’s Sexual Health Strategy**

During my visit to Glasgow, it became clear that Scotland was in the final stages of developing a Sexual Health Strategy. Respondents argued that both the Welsh and English experiences were informing the development of the Strategy.

A senior bureaucrat charged with leading the development of the Scottish Strategy, suggested that there would be a number of principles in the strategy:

- integration and closer links
- any Scot must have access to at least 2 sexual health services
- confidentiality
- a GP must tell patients what they offer in terms of sexual health, or specifically refer

The evidence in Scotland suggests that 90% of patients go to their GP first for a sexual health issue, and when they are referred, a significant number never follow up the referral.

The Strategy will propose five levels:

- self management, ie websites, peers, everyday knowledge. Acknowledging that the sexual health information people get is normally rubbish, and developing mechanisms to influence this information
- the provision of information and some intervention at generic drop in centres like youth services and community pharmacies and general practitioners, with distribution of condoms and contraception.
- Enhanced GP and FP services, and specific CBOs like Caledonian
- The broad range of GU and FP specialist services, with some specialist GPs
- Specialist HIV services, and inpatient services.

These five levels are not mutually exclusive.

Sexual health promotion is not in the Strategy. The reasoning is that sexual health promotion does not have to be done by experts: it can and should be done by parents, peers, teachers, community pharmacists.
Others felt that the Scottish Strategy could be a missed opportunity. They felt that the Strategy should have addressed, but didn’t:

- Emergency contraception through pharmacies
- A positive sexuality agenda
- Deregulation of Termination of Pregnancy

The strategy will however:

- Put forward Sandyford as a model of excellence
- Fund Sandyford to operate a 24/7 sexual assault unit, with follow up for both men and women.

Yet others felt that the expert group for the Scottish Strategy had learnt from England, and would not therefore attempt to coerce GPs into various levels of service: it would instead concentrate on the enthusiasm of early adopters and their colleagues. Others argued that the Strategy may well be overly clinically focused, with only a “tip of the hat” to sexual health promotion.

**Wales’ Sexual Health Strategy**

The Secretary of the MSSVD pointed out that Wales does not come under England’s NSHS. Wales completed its own strategy in 1999, which mainly focused on prevention. She felt it was a missed opportunity for clinical development. England noticed this focus on prevention, and tended to concentrate on clinical services in England’s NSHS. The Wales Strategy can be found at:

[www.wales.gov.co.uk](http://www.wales.gov.co.uk)

As a result of the Welsh Strategy, however, there has been a major promotional initiative across Wales in relation to sexual health. This has included:

- BBC Wales devoting weeks of programming
- Irving Welsh film – CLAP.
- Chlamydia campaign
- 6x 5 minute short films – “Daisy Chain”
- poster campaign . “Come Clean”

Although this lead to increases in attendances at GU Clinics, there was no strategy in place to tackle these increases, and the Strategy did not concern itself with fine tuning the relationship between GU Clinics and general practitioners.

**United States Sexual Health Strategy**

Although the United States has no National Sexual Health Strategy, certain goals and targets relating to sexual health have been set in the *Healthy People 2010 – STDs*. 
document. Clause 25-18 of this document states that the primary goal in relation to
general practitioners is the following:

“To increase the proportion of primary care providers who treat patients with sexually
transmitted diseases and who manage cases according to regionalized standards.”

The CDC argued that as of 2003, 70% of primary care providers treated patients with
STDs according to CDC STD Treatment Guidelines. The target for 2010 was to improve
this compliance to 90%.

The 2010 Report also states that “because most STD care in the United States is delivered
in the private sector, private health care providers, managed-care organizations, and
health departments need to work together to overcome barriers to rapid and effective
treatment of the nonplan sex partners of health plan members.” This difference between
plan and nonplan sex partners is telling.

Healthy People 2010 also remarks that sexually active teenagers often are reluctant to
obtain STD services, or they may face serious obstacles when trying to obtain them. In
addition, primary care providers often are uncomfortable discussing sexuality and risk
reduction with their patients, thus missing opportunities to counsel and screen young
people for STDs.

Generally however, the approach in the United States has been to acknowledge that
access to high-quality health care is essential for early detection, treatment, and behavior-
change counseling for STDs. Often, groups with the highest rates of STDs are the same
groups in which access to health services is most limited. In the United States, this
limitation relates to (1) lacking access to publicly supported STD clinics (present in only
50 percent of U.S. public health jurisdictions), (2) having no health care coverage, (3)
having coverage that imposes a co-payment or deductible, or (4) having coverage that
excludes the basic preventive health services that help avert STDs or their complications.

A full overview of resources related to sexually transmitted diseases and sexual health, on
a state by state basis can be found at:

http://www.allhealthnet.com/Public+Health/Sexually+Transmitted+Diseases+States/

6. Description of innovative GP/Sexual Health projects

PROGRAM 1 – Theresa Battison

This is an excellent, integrated program, which attempted to tackle head on the support
and resource needs of GPs, and their relationship with GU clinics.

Theresa initially provided a background to why this project was established. It operates in
South East London covering the PCTS of Southwark, Lewisham and Lambeth. In this
region there are 3 GUM clinics:
- Lloyd clinic, Guys Hospital, appointment only
- Lydia clinic, Thomas Hospital walk in service
- Caldercot clinic, Kings Hospital, walk in service

All of these clinics are bursting at the seams. There had been a waiting list of 3 – 4 weeks for the appointment only clinic. Between them, these three clinics diagnose 1/3 of London’s gonorrhea and ¼ of London’s Chlamydia. These 3 PCTS have very large Afro-Caribbean populations and a high transient population.

There are 33 GUM clinics in greater London.

The project has 4 main objectives. These are:

a) Training to GPs
b) Developing protocols for STI management
c) Nurse support for change management in general practice (case finding, case detection, referral enhancement, and implementation support)
d) Development of communication and referral networks (primary care referral clinic)

The project has been running now for 18 months. The program has not been evaluated.

It should also be noted that this project was established before the STIF course and so is only marginally related to the standardized training offered by MSSVD.

a. Training

The project has run STI management courses for GPs. They are about to run the fifth. The courses are run over a 10 week cycle. The course comprises 6 by half day compulsory modules, and then 4 clinical sessions, where the GP sits in on clinical examinations at a GUM clinic. The maximum number of participants has been 16 per course, and each has been full. The courses are open to GPs, practice nurses, midwives and gynaecologists.

There has been no need to promote the course, only the distribution of an initial flier. There is currently a waiting list, and the course is free.

It should be noted that in the 3 PCTS there are roughly 50 practices in each PCT, with roughly 10 GPs in each practice. Patients have to register with a particular GP. There are only about 15 single hand practices. Most large practices have a Practice Nurse, many of whom are interested in sexual health and do the course.

This project ties in with the National Sexual Health Strategy (England), which proposes that GPs operate at a number of levels related to sexual health:

- Level 1
Sexual history and risk assessment
STI testing for women
HIV testing and counseling
Assessment and referral of men with STI
Hep B immunization

- Level 2
  Testing and treating STIs
  Partner notification
  Invasive STI testing for men
  Plus all level 1

- Level 3
  This mainly relates to GUM clinics, all of level 1 and 2
  Plus outreach for STI prevention
  Notification
  Specialised HIV treatment and care
  Specialised infection management, including coordination of partner

It should be noted that MSSVD is the registered training authority for GP progress through level and 2. It is likely however that MSSVD will cooperate with Theresa’s project to run joint courses.

Theresa’s project is coordinated by a Stakeholders Board comprising representatives from the 3 PCTS (through the CEO’s of PCTS), FP Leads, GU Leads, and GPs.

The course is accredited through the London Deanery as part of their PGEA (Post Graduate Education Allowance).

b. Developing Protocols

The SPAG (Steering Planning and Advisory Group) developed clinical protocols (3 pages only) which are to be piloted with GPs. Theresa has developed an audit tool to determine how frequently GPs refer to the protocols. The protocols and audit tool are attached.

c. Nurse support

A nurse attached to the project goes out to practices and assesses their sexual health support needs. She also assesses their current level of STI activity. This nurse practitioner provides advice and clinical shadowing. She will also deliver customised training at the practice. Often these practices have sent GPs to the formal course.

d. Communication referral networks
The key question of this objective was how can we assist in clarifying referral processes between GPs and GUM clinics. The first step was the development of a two way referral tool which encouraged GPs to send a letter of referral, and encouraged GUM clinics to respond.

The second step was the development of the primary care referral clinic. This is conducted by Debbie Holland, as a nurse practitioner. GPs can refer patients with acute STIs or suspected acute STIs only. It has been operating since February 2003. An initial mail-out included a starter pack with a flier, covering letter and referral form (which is attached). The key issue was not to set up a two tier service. Participating GPs were guaranteed that their patients would be seen within 48 hours. The key to the success of this clinic has been its explicitness: many patients were previously unaware as to why they had been referred to a GUM clinic, and the referral form in triplicate encouraged the GP to be upfront with the patient and the GUM clinic. This clinic sees three times as many men as women, and has unearthed a load of pathology. This is a nurse lead service.

**PROGRAM 2 – Vicki Pearce**

This project was highly relevant.

Vicki is employed by Southwark PCT as part of the Clinical Governance Directorate, and is designated as a Primary Care Facilitator. There used to be loads of PCFs across UK, in a range of disciplines, but this changed with the PCTs.

Vicki’s main role is to “support Primary Health care to develop sexual health services, with a focus on improving the Practice environment in relation to sexual health.” There is no real focus on clinical governance. Vicki primarily does:

- training on site, flexibly, with whole practice teams
- practice visits, as requested
- facilitate change through the development plans
- to question best practice in relation to sexual health

The overall aim of the project is to bring GPs in Southwark up to the level 1 standard of the National Sexual Health Strategy (England).

In Southwark there are 49 practices, the majority larger practices with managers and practice nurses, and some single handed practices.

Practices can be funded by PCTs in 2 ways:

- items of service – ie, paid by the actual procedure, ie swab
- Personal Medical Service, where the Practice is given a lump sum by the PCT to work towards objectives or priorities that have been set by the PCT
Southwark PCT has prioritised sexual health as one of its top 3 priorities, and this assists Vicki in being able to argue powerfully with local GPs.

Vicki’s training revolves around nine modules, which can be flexibly, formally and informally, implemented in the actual practice. They are meant to be multidisciplinary. The key modules are:

- emergency contraception
- working with young people
- “visible” confidentiality
- communication, values and attitudes
- practical training on condom distribution and pregnancy testing

The training can be for all people associated with the practice:

- practice managers
- GPs
- Practice nurses
- Health visitors
- District nurses
- School nurses.

The GPs generally perceive Vicki as a support and a resource … not “as a police officer, with a big stick.”

Vicki finds that quick, short focused visits are better than extended visits, and she has to try to get in through all different routes.

The Development Plan is a pivotal document. It sets out goals and objectives for sexual health that can be monitored over a period of time. The Development Plan is framed around the training modules. This is a good idea. It is a way of monitoring the practice environment, and can take hours to complete, and it is often completed with practice nurse, practice manager and GP. The Development Plan is attached.

The Development Plan is also tied into the PCIS – Primary Care Incentive Scheme. This is a national scheme, which is funded through the PCT. The PCT sets priorities for a year. The Practice can choose to opt in, and work towards the achievement of these priorities. One of the priorities for Southwark is sexual health. The practices get recurring money – 5000 pounds a year. Vicki sets the conditions by which they apply, and the Development Plan is the primary tool by which they are monitored. Examples of PCIS in relation to sexual health is that practice agree to:

- develop a condom distribution protocol
- develop a pregnancy testing protocol
- develop procedures for rapid access to emergency contraception
- develop a protocol on visible confidentiality.

Vicki has also found that her presence is a great support to Practice Nurses – she is able to give them a platform and support them to improve sexual health

In relation to level 1 with the National Sexual Health Strategy (England), Vicki argued that we might not want all GPs to reach level 1. Some will never get there, nor want to get there. She argued that often the context (i.e. proximity to other services, including GUM Clinics and other level 1 GPs) meant that not all GPs had to achieve level 1.

PROGRAM 3 – Sandyford Initiative

The Sandyford Initiative is not strictly speaking a program which is primarily concerned with supporting or resourcing general practitioners to undertake sexual health.

As the Director of the Clinic, Dr Alison Bigrigg, pointed out, however, this is not to say that the development of the Sandyford Initiative has not had an impact on the roles undertaken by general practitioners in relation to sexual health. According to Alison, the integration at Sandyford Initiative has helped to influence GPs. Each of the integrated departments has helped to resonate with GPs by coming from different angles (i.e. GU, FP). This is something to keep in mind because she is really talking about critical mass.

Before Sandyford, GPs would say “we can’t do microscopy therefore we can’t do GU”. GUM Clinics would also say, “you can’t do microscopy therefore you can’t do GU”. But now GU and FP can be put together and sold as a package. “We have disturbed the balance”. GPs are now more accepting of diversity in different groups, and partner notification, as processes they are able to negotiate. As Alison remarked, “A “powerful centre” has its own strategic impact.”

Aine Kennedy is a freelance health consultant, who has also been employed as the external evaluator of the Sandyford Initiative. There are 3 aspects to her evaluation:

- A description and a critique;
- Action research based around people, power and involvement; and
- Reflections on the strategic impact of the Sandyford, both external and internal.

The basis of Aine's evaluation is systems theory because the organisation is an attempt at integration, and therefore multifaceted, and there has been a great deal of unraveling involved. Systems theory works on the assumption that “the whole is greater than the sum of its parts”. So Aine wanted to evaluate what impact Sandyford was having on the bigger system. This included the impact on GPs. Aine has used a participatory and collaborative approach based on Peter Reason’s work from the University of Bath.

Aine may not even produce a written report, but hold a full day seminar bringing all external and internal partners together. At this seminar she will share her sense of what has been happening at Sandyford and use the participant’s feedback to collectively
organise the information and fill in the gaps. The whole seminar will be based on the image of the tree. She will ask participants to reflect on Sandyford as a tree and what would be the roots (common values, vision statements), the branches, the leaves (the outputs), fruits (outcomes) the trunk etc. In this way she will attempt to assess the strategic impact, which is really only “seeing the bigger picture”. Aine felt that Sandyford had been extensively and over evaluated.

Aine is very interested in how an organisation develops an identity and suggested *Leadership and the New Science* by Margaret Wheatley. Wheatley argues that people in organisations unite over shared meanings, not objectives or business plans. Aine also felt that Sue Lachlan had the original “social model of health” vision for Sandyford, and argued to Aine that “sexual health was the medium not the message”. Sandyford is really an experiment about the social model of health, and within Sandyford there are varying degrees of understanding and commitment.

In a range of interviews across Glasgow, a broad number of attitudes and opinions were expressed about the role, function and nature of the Sandyford Initiative. One critical issue for the Sandyford Initiative is access. It occupies one site, and yet provides sexual health services for the whole of Glasgow. Alison Bigrigg suggested that this was being acknowledged, and that it was beginning to be addressed. Alison highlighted the new approach: around Glasgow there are 28 FP clinics which operate on “feminist well woman principles”. Alison has now started the debate as to whether they should be left alone because they are well attended or whether they should be remodelled toward mini-Sandyfords. Colin McKillop, the Community Access Officer, will lead the community consultation process. The whole process will probably start at 4 pilot sites.

Colin McKillop felt that the relationship between Sandyford and GPs could be more effective. Dr Peter Berry has been bought on board to improve this interface. The SHAs (Sexual Health Advisers) are also involved in improving this interface through their promotion of Chlamydia Partner Notification services for GPs.

The process of integrating all of the component services at Sandyford has been somewhat problematic, and is certainly not over. The public don’t perceive any differentiation of services: some felt that staff have been the hardest to bring on board because of territory concerns.

One of the major issues confronting Sandyford is that it is the only place in Glasgow for sexual health clinical services, apart from GPs, and this can mean that clients have to travel large distances to access services. No formal evaluation of the service has yet been undertaken. Sandyford is administered by a Management Board which is made up of all the senior directors of the component services.

In relation to the integration at Sandyford, Dr Rak Nandwani felt that the key was a properly managed change process. He felt that individual elements were likely to lose their identity. He used the image of plasticine. When you mix a whole lot of vibrant colours together, they make a brilliant ball of colour originally, but then over time the
colours start to leech into each other, and you end up with this bland mass of grey. Rak felt as well that Sandyford had been important because it repositioned sexual health, revalued it, because of the nature of the building, the location, the partnership with other services, and the lovely reception area.

**PROGRAM 4 – National Network of STD/HIV Prevention Training Centres (PTCs)**

On-line Training Resources

Some members of the National Network of STD/HIV Prevention Training Centers offer online training. Academic credits may be offered for some of these courses.


STD Clinic Practices Manual 2003-2004: Current Diagnosis & Therapy of Sexually Transmitted Diseases, 5th edition, prepared by Bradley Stoner, MD, PhD, Medical Director of the St. Louis STD/HIV Prevention Training Center. This 64-page pdf document serves as a useful reference text for general practitioners.

**Online Chlamydia Training**

The California STD/HIV Prevention Training Center has created an easy to use and fun online chlamydia training course. The course is case-based and interactive.

http://www.stdhivtraining.org/educ/training_module/index.html

**STD/HIV Image Repository**

The Cincinnati STD/HIV PTC has compiled an online image repository as a training aid for practitioners, and has a fee paying tuition based training course on sexually transmitted diseases.

http://www.stdptc.uc.edu/Item9.cfm

**Examination of Vaginal Wet Preps Video (Seattle STD/HIV PTC)**

Provides basic instruction on preparing and examining vaginal wet preps. Requires the free RealPlayer application.

**2002 CDC STD Treatment Guidelines, New Recommendations**

Provides highlights of the new recommendations for the 2002 CDC STD Treatment Guidelines. Available in RealMedia and Windows Media formats.

**The Practitioner’s Handbook for the Management of Sexually Transmitted Disease**

The Practitioner's Handbook is designed to assist practitioners in the optimal management of patients with sexually transmitted diseases (STD) and their partners.

**PROGRAM 5 - Condom and Pregnancy testing distribution**

In England and Scotland, Primary Care Trusts (equivalent to Area Health Services) take a role in distributing condoms and pregnancy testing kits to all general practitioners. This is a free service for general practitioners. Often the PCTs Sexual health promotion unit takes a lead role in this distribution program. In one PCT in Liverpool, this free
distribution was made contingent on attendance at specified sexual health training programs.

PROGRAM 6 – Dr Helen Massill

Helen is a clinical family planning doctor, and has a significant role in commissioning FP and STI services in Southwark. She works in the community health sector, and in the last couple of years as had more success in developing services and partnerships than when she first started in 1993. Helen discussed:

a. background to why things have changed
b. the FP/STI Clinic in the community

a. There are a number of reasons why there have been significant advances in sexual health service provision. It has been recognized that SE London has the highest rates of STIs and teen pregnancies, that Lewisham didn’t have a GUM Clinic at all, that GPs could do a range of quite simple investigations and treatments and that GUM clinics didn’t need to do them all, and most importantly that, the PCT decided to prioritise sexual health as one of its top three health priorities, and so funds became available.

These developments grew as a result of considerable work that was put into developing a strong partnership between FP, GUM, community health and GPs. This happened over a number of years, and laid the groundwork for the PCT to be able to support a viable, happening and effective partnership. It is doubtful that they would have invested funds in a shambles.

b. The community health sector set up a FP/STI Clinic, operating five days a week, and particularly at times when young people could attend. No appointments are necessary, staffed by doctor and nurse and youth worker, and works across five community health centres. This is quite unique in UK, and the evaluation is attached. Targeted outreach is also conducted with:

- young people
- homeless people
- people on probation
- ethnic minorities, afro-caribbean
- children in care

The core function of the community clinics is contraception and STIs. The nurses work as Nurse Suppliers, and under “patient group directions”, or standing orders.

PROGRAM 7 – Dr Jackie Sherrard

The Sexually Transmitted Infection Foundation (STIF) course, conducted by the MSSVD, resulted from conversations between Dr Jackie Sherrard and Dr George
Kinghorn, and were premised on the assumption that most GPs have no post-registration training options in sexual health. They were modeled on the Resuscitation Council training.

The training is standardized and controlled centrally, but conducted locally.

It was piloted twice successfully. In 2002, its first year of full operation, 30 courses were run nationally, and up until May 2003, 32 course have been run locally.

There is some connection between DFFP and STIF – a one day STIF section can be bolted on to the DFFP, but this is not ideal.

The STIF course is meant to be multidisciplinary. The following professionals are targeted:

- general practitioners
- practice nurses
- reception staff
- family planning nurses
- family planning doctors
- health advisers
- people new to GU use it a s a bit of an orientation.

Local areas pay MSSVD 30 pounds per delegate, but they can value add and earn money for themselves. Usually a local GU physician takes the lead, and decides to run the course. People who have undertaken the course can then become facilitators.

The following things are organized centrally:

- manuals for delegates
- manuals for course directors
- manuals for facilitators

Things that are organized locally:

- price fixing
- lunches
- venue
- ongoing contact
- any clinical placements

But the MSSVD also employs a central coordinator, Sue Bird, who keeps track of things, and sends out manuals etc.

There are a maximum of 40 people per 2 day course. All information is based on UK Clinical Guidelines, which are on the MSSVD website.
The main aim is to bring GPs up to the level 1 proposed in the National Sexual Health Strategy.

Sometimes it was difficult bringing local GU physicians on board – some resistance, but as the course has mushroomed, the flow on effect has been noticed.

There is also now an Annual Day for Course Directors to get together.

Future challenges include:

- the development and distribution of a CD rom to all delegates
- building in practical clinical follow up sessions for delegates
- accreditation through the new NHS University
- a period of consolidation for the course, and then review.
- Piloting STIF in Medical Schools for undergraduates – St Marys and Leicester Med schools
- Maybe running a specific training session for trainers or facilitators.

**PROGRAM 8 – Dr Petra Boynton**

The development of a Sex Advice Website for GPs

Petra is hoping to have this new website up and running by August 2003. The website may be funded by a private company called Doctors.org, who normally run on-line training programs for GPs. Their usual format is to pose a case scenario, have the GP sit a test, ask the GP to conduct further prescribed reading, redo the test, and then be accredited. Petra did not see this as a very viable process. She is proposing a website which allows a GP ready and immediate access not only to downloadable information, but also to an interactive space. The website will include:

- How to take a sexual history
- An A to Z – a plain English guide for GPs with the recommendation that they begin their consultation with the patient by saying: “these are some of the words we use… which are you most comfortable with.” There is information on this approach on the plainenglish website: there is also information on developing a website.
- Resources
- Courses
- Interactivity – Petra will choose a Moderated Discussion Board as opposed to a chat room, because with an MDB the moderator can archive questions and answers, and a GP can scroll through to see if their question has been answered. GPs can also ask questions without feeling ignorant. Also bias and prejudice can be moderated out.
The website may well be hosted by Doctors.org, may have pharmaceutical sponsorship, and maybe the GPs will pay to access?

The website will be evaluated over a 12 month period.

**PROGRAM 9 – Dr Petra Boynton**

Petra undertook interesting research on sexual health (mainly sexual dysfunction) with patients in GPs surgeries.

This research involved interviewing 1500 patient across 10 large practices in the north of London. Patients had to be between 18 and 75, and not be obviously mentally or physically very ill. 80% response rate from patients, but most GPs decided not to be involved. Patients were interviewed in GPs waiting rooms. The research began by asking patients to complete the questionnaire on a laptop, but this had an in-built class bias – working class people saw the laptop as an invasion of privacy.

The interviews were accompanied by a search of the patient’s records. GPs were funded for this service. Patients were paid with shopping vouchers for their participation. More men said no to the process than women. The primary focus of the research was sexual function. Outcomes included that 10 to 15% of participants had sexual dysfunction problems. But this was complicated by the fact of the classification system: DSM 4. MAP was commonly prescribed, and there was “not much evidence” of sexually transmissible infections.

This research will be published as Sexual Attitudes and Experiences

**PROGRAM 10 – Dr Jackie Cassell**

Dr Jackie Cassell, Honorary Lecturer, University College London, has undertaken a range of research specifically related to the undertaking of sexual health consultations within general practice, and the relationship between general practice and genitor-urinary medicine. Jackie has conducted research on who is being tested for Chlamydia in general practice, the rate of follow through with patients moving from a first appointment to a second appointment at a GU Clinic, the extent of partner notification undertaken in general practice and referral patterns between general practitioners and GU Clinics. Relevant articles include:


*Kufeji O, Slack R, Cassell JA, Pugh S, Hayward A.*
Who is being tested for genital chlamydia in primary care?
PMID: 12794210 [PubMed - as supplied by publisher]

Cassell JA, Brook MG, Mercer CH, Murphy S, Johnson AM.
Treating sexually transmitted infections in primary care: a missed opportunity?
PMID: 12690136 [PubMed - indexed for MEDLINE]

Cassell JA, Brook MG, Mercer CH, Murphy S, Johnson AM.
Maintaining patient access to GUM clinics: is it compatible with appointments?
PMID: 12576606 [PubMed - indexed for MEDLINE]

PROGRAM 11 – Dr Claudia Estcourt

The National Sexual Health Strategy (England) recognised the Medical Society for the Study of Venereal Diseases (MSSVD) as a training body which has been funded to provide education to GPs so that they can, at this early stage in the Strategy, meet the requirement of Level 1. The MSSVD provides, at a regional level, a highly centralised and standardised 2 day course for general practitioners in various PCTs (Primary Care Trusts). The results have been variable, with some PCTs picking up the MSSVD training, and doing it well and consistently, and some not.

One of the shortfalls with the 2 day course (which is also open to Practice Nurses) is that it does not include any practical teaching on how to examine, or how to do swabs. The course covers however such issues as local and national epidemiology, taking a sexual history, partner notification, practical skills in relation to condoms, local liaison and referral information for GUM Clinics, and most importantly, 8 teaching stations, which relate to a syndromic approach to STI diagnosis and management.

This 2 day training has not been evaluated, and no follow-up training is provided. If follow up training were to be provided, then it would need to include clinical placements.

PROGRAM 12 – Dr Chris Wilkinson

He described the electronic referral system at Kings, where GPs could pose an on-line anonymous scenario, which would be responded to by a specialist physician.(see website)

PROGRAM 13 – Dr Olwyn Williams

Olwyn spoke about the Group of Non-Career Grade (NCG) registrars or doctors, who have formed a group, run education, hold an annual conference and have attached themselves to the MSSVD. This group includes part time hospital doctors and general
practitioners, mostly women (with children, hence the p/t), who have a special interest in sexual health.

As an example, Olwyn pointed out that in England there are 276 GU physicians, but about 572 non-career grade physicians, who have not got the MSSVD qualification. In Wales, there are only 10 GU physicians.

PROGRAM 14 – Rosemary Massouris

This program mainly focused on family planning, and was seen as updating after the DFFP. It is in the more traditional model of education and training, bringing large numbers of participants together, in didactic situations. Rosemary runs four 1 day courses a year for GPs from across England. She was holding a course on Friday 9 May for 250 GPs. The agenda is attached. Rosemary focuses mainly on family planning and contraception.

PROGRAM 15 – Dr Anne Rompalo

This PTC has investigated working with pharmaceutical companies to put on educational sessions. It’s dicey, and they can’t mention any specific drugs and they try to make a win/win situation. Anne quoted how one drug company hired a shelf company called for instance Global Medicine to run their education programs. The promotional literature only said in small print underwritten by Pfizer etc. They had oodles of doctors turn up. Perhaps this idea of distancing the education from the health department needs to be investigated.

PROGRAM 16 – Peter McGrath

The CHBT has a partnership with the NYS Prevention Training Centre. There a small number of courses offered by these organisations which are specific to GPs. These are:

- STD intensive course (3 days)
- STD update for clinicians (1/2 day)
- HIV testing procedures (2 days)

The STD intensive course targets clinicians working in STD, Family Planning or other primary care clinics. It provides a comprehensive presentation of the diagnosis, treatment and syndromal management of bacterial and viral STDs – including an update of currently available STD tests and test performance characteristics. It also provides a review of sexual history taking, examination, and behavioural change counseling of clients with STDs, including HIV. Two of the days provide hands on clinical and laboratory experience in a busy, urban STD clinic, with a clinical preceptor.

This intensive course is run in partnership with the NYCPTC. The CHBT does not offer any web based or distance modules for General Practitioners.
8. Conclusions

This research project was a significant learning opportunity, which also produced information, contacts and resources on a number of innovative programs which educate, support and resource primary care providers on issues related to sexual health.

One particular research opportunity stands out. In the context of Western Sydney, NSW and Australia, more needs to be known about the relationship between sexual health and health inequalities. The House of Commons Third Report on Sexual Health has argued, and cited evidence to suggest, that "the inequalities in health repeat themselves as inequalities in sexual health."

The Third Report has argued this in the context of access to specialist sexual health clinics. Given that general practitioners see most patients with sexual health issues, then the question needs to be asked as to the extent to which socio-economically disadvantaged and excluded people and communities are more likely to be accorded poor sexual health management with general practitioners than other more advantaged people in the Area Health Service. In WSAHS, for instance, comparing the sexual health management of residents of the Hills LGA with the residents of Blacktown/Mt Druitt LGA by their general practitioners could be instructive.

Of the 16 programs examined in varying degrees of detail, 10 stand out as useful and relevant, and possibly duplicable in the context of Western Sydney Area Health Service, or other Area Health Services in NSW.

Helen Massi's description of the development of STI Clinics in Community Health Centres, and particularly the partnership between genito-urinary and family planning services.

The STIF courses conducted by the MSSVD, with their emphasis on central coordination and local delivery.

The research on sexual dysfunction conducted with patients of general practice by Petra Boynton

Petra Boynton’s imminent website: Sex Advice for GPs, with its emphasis on moderated discussion boards (MDBs)

The four aspects of the integrated project conducted by Theresa Battison in south east London. These are:

- Training to GPs
- Developing protocols for STI management
- Nurse support for change management in general practice (case finding, case detection, referral enhancement, and implementation support)
- Development of communication and referral networks (primary care referral clinic)

The four aspects of the project conducted by Vicki Pearce in south east London. These are:

- training on site, flexibly, with whole general practice teams
- general practice visits, as requested
- facilitate change towards sexual health management in general practice through the development plans
- to question and support best practice in relation to sexual health

The integrated model of service delivery showcased by the Sandyford Initiative, and the impact of such integration on the development of sexual health services in general practice.

The on-line resources developed by the National Network of STD/HIV Prevention Training Centres in the United States, particularly the on-line Chlamydia training for primary care practitioners.

The free distribution of condoms and pregnancy testing kits to general practices all over the United Kingdom, and the process in Liverpool where this distribution was used as a mechanism and a tool for attendance at sexual health training.

The research agenda of Dr Jackie Cassell, which includes research into the relationship between general practitioners and GU Clinics, and the nature and extent of sexual health consultation undertaken in general practice.

A range of innovative responses to supporting general practitioners to undertake sexual health have been observed in England, Scotland and the United States, and critically assessed during this study tour. For general practitioners to improve their practice of sexual health, the following criteria need to be met:

- an acknowledgement of the significant role general practitioners play in sexual health;
- an acknowledgement of the desirability of this role;
- a commitment to improving the skills, knowledge and attitudes of general practitioners in sexual health;
- a commitment to involving general practitioners in this process; and
- the need to develop a comprehensive, multi-strategic response to education, support and resourcing for primary care practitioners, including general practitioners.

As demonstrated by the innovative policies and practices observed in England, Scotland and the United States, multi-strategic aspects of supporting, educating and resourcing general practitioners and other primary care practitioners should include:
- national, state and local commitment and strategy development;
- general practice support and development;
- web resourcing and information;
- web education and specialist support, i.e. moderated discussion boards;
- clinical placements;
- flexible on-site training;
- development of primary care referral clinics;
- general practice visits;
- developing and implementing structured Development Guides;
- development and distribution of STI protocols, i.e. through websites;
- nurse support for change management in general practice;
- seminar based didactic training;
- linking into state and national initiatives; and
- Significant partnering with Divisions of General Practice.
APPENDIX

RESPONDENTS

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Family Planning Clinics
Tottenham Court

Brian George
Charge Nurse
HIV Clinic
Mortimer Market
GUM Clinic

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Senior Lecturer
Sexual Health
Queen Mary
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Dr Chris Wilkinson
Consultant in GU.Contraception
Mortimer Market and
Margaret Pyke Centre

Dr Helen Massil
Sexual and Reproductive Health Services
Southwark PCT
Faculty of Family Planning and Reproductive Health

Dr Jackie Cassell
Seminar on National
Sexual Health Strategy and
Primary care practitioners

Dr Jackie Sherrard
GUM Specialist
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Dr Olwyn Williams
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Secretary
Welsh Woman of the Year 2000
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Nurse Competencies and Chlamydia Screening
Sexual Health and Substance Misuse Branch
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Professor Mike Adler
Seminar on National Sexual Health
Strategy
And primary care practitioners.

Rosemary Massouris
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External Evaluator of
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Alastair Pringle
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Scottish Executive and Stonewall
LGBT Inclusion Project

Ali Jarvis
Director
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Dr Alison Bigrigg,
Director
Sandyford Initiative

Colin McKillop
Community Liaison Manager
Sandyford Initiative

Donna Milne
Public Health Institute
Manager of Healthy Respect

Dr Peter Berry
Steve Retson Project/
GP Interface Project
GP

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Shirley Fraser
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