



Sexual Health Services in Ireland:

A Survey of General Practice

January 2018

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Glossary

CPD	Continuing professional development
GMS	General Medical Services
GP	General practitioner
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HIV point of care testing	HIV testing at or near the time and place of patient care
HSE	Health Service Executive
HSV	Herpes simplex virus
HVS	High vaginal swab
ICGP	Irish College of General Practitioners
IUD	Intrauterine device
LARC	Long-acting reversible contraception (e.g. intrauterine systems/devices, subdermal implants)
NAAT	Nucleic acid amplification technique
NGO	Non-governmental organisation
Partner notification	Notifying the sexual partner(s) of a person who has been newly diagnosed with an STI (known as the 'index case') that they may have been exposed to the infection, sometimes referred to as contact tracing
PCR	Polymerase chain reaction
PSI	Progesterone subdermal implant
Public STI service	Publicly funded STI clinic providing sexual health testing and treatment at no cost to patients
SHCPP	Sexual Health and Crisis Pregnancy Programme
STI	Sexually transmitted infection
STIF	STI Foundation, an education programme launched by the British Association for Sexual Health and HIV – BASHH in 2002

Foreword

Understanding the nature and extent of Ireland's current sexual health service provision was identified as a priority need in the National Sexual Health Strategy 2015–2020. In response, the Health Service Executive (HSE) Sexual Health and Crisis Pregnancy Programme (SHCPP) led a process to gather the necessary information from relevant service providers, including sexually transmitted infection (STI) and contraception services, general practitioners (GPs), student health clinics, and laboratories involved in STI diagnostics.

This report presents information about the current provision of sexual health services by general practices across the country. It gives an overview of the STI testing and treatment and contraception services in general practices and highlights some important issues experienced in general practice in relation to the provision of such services. It also contributes useful information on how GPs can be supported to increase their practice in this area.

This report is one in a series setting out current sexual health service provision. The information presented in this series is extremely useful in supporting my role as national Clinical Lead for Sexual Health. It will be used to inform a broader needs assessment for sexual health and the development of an implementation plan of priority actions by the SHCPP in the coming years. These actions will address one of the overarching goals of the sexual health strategy: 'equitable, accessible and high quality sexual health services, which are targeted and tailored to need, will be available to everyone'.

Thanks to everyone involved in the project, including Dr Miriam Daly, Dr Claire Collins and Marie O'Shea of the Irish College of General Practitioners for gathering the information from ICGP members and preparing this report; Dr Fionnuala Cooney and Dr Áine McNamara, Public Health; Helen Barry, formerly Department of Clinical Microbiology, St James's Hospital, Dublin and now with the Academy of Clinical Science and Laboratory Medicine; Moira Germaine, Health Promotion and Improvement; and Dr Declan McKeown, Health Intelligence. Thanks to my colleagues in the SHCPP: Helen Deely, Programme Head for supporting this piece of work; and Maeve O'Brien, Research and Policy Officer and Caroline Hurley, Project Manager at the SHCPP for their invaluable contribution in coordinating and completing this project. Thanks to Ignite research for its support in gathering the data from the services.

Finally, thank you to all the GPs who responded to the survey. These contributions have been invaluable in producing a national picture of service provision and in helping to support the plan to improve service provision into the future.

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1. About this report

1.1 Introduction

This report provides information on the provision of sexually transmitted infection (STI) testing and treatment services and contraception services by general practitioners (GPs) in Ireland. The information has been provided by those GPs who responded to an electronic questionnaire on STI testing and treatment and contraception services, which was circulated by the Irish College of General Practitioners (ICGP) to its membership at the end of 2015.

This report is part of a broader project that aims to document current provision of STI testing and treatment services, laboratories providing STI diagnostic services, and contraception services nationally. The objectives of the overall project are to:

- Gather, collate and report data on provision of STI and contraception service provision nationally in relation to geographic location, public access and service availability and services provided.
- Generate maps providing a visual description of the spatial distribution of public STI services nationally in line with population data and weighting for age and deprivation related risk
- Identify areas for action and report gaps in service provision to inform a sexual health needs assessment. The sexual health needs assessment will inform future service planning and resourcing.

1.2 Rationale

The National Sexual Health Strategy 2015–2020¹ is the national framework for the sexual health and wellbeing of the Irish population. It sets out to improve the coordination of services so as to enhance sexual health and wellbeing and to reduce negative sexual health outcomes. A key goal of the strategy is ‘that equitable, accessible and high quality sexual health services, which are targeted and tailored to need, will be available to everyone’. The strategy also aims to reduce levels of crisis pregnancy by improving access to contraception services.

Priority actions under the strategy are the delivery of a mapping exercise of existing sexual health services (recommendation 4.13) and completion of a sexual health needs assessment (recommendation 4.12). These actions are in line with the World Health Organisation’s action plan for sexual and reproductive health for Europe,² which encourages each country to carry out a situation analysis of existing sexual and reproductive health programmes and services, with particular attention to defining the needs and expectations of vulnerable populations such as those living in poverty and at risk of social exclusion.

To date there has been no systematic documentation of sexual health services in Ireland as regards geographic location, access and availability of STI and contraception services to the public and availability of STI testing diagnostic services.

¹ Department of Health, 2015.

² World Health Organisation, 2016.

1.3 Knowledge of current service provision

A mix of public, private and non-governmental organisations (NGOs) provide sexual health services in Ireland. They are based in primary care, community and hospital settings.

Regular testing for people who are sexually active, particularly those with multiple or short-term partners, is an important preventative approach to HIV and STIs. STIs are assessed, tested for and managed in a variety of settings nationally, including general practice, family planning clinics, student health services and dedicated STI clinics (including clinics for young people, for men who have sex with men or for women affected by prostitution). Some service providers have access to in-house laboratory services, while others must refer samples to external laboratories for diagnosis.

The public STI services, which receive direct public funding, are provided at no cost to patients. Public STI services are not funded from a single budget; some receive funding from primary care, some from public health and some from the acute hospitals division. This heterogeneity in funding reflects the organic way in which services evolved over time, in response to local need and local leadership around the country in securing local resources and establishing public STI services. STI services offered by NGOs and student health clinics are usually provided to patients either free or at a subsidised cost, depending on the service. Private STI services are provided at a cost to the patient. The majority of laboratory services used by clinics and primary care are publicly funded.

In general practice, private patients pay for consultations and for testing and treatment for STIs. Medical card holders and GP visit card holders do not pay for consultations with GPs but there are no specific provisions for STI testing and treatment or vaccinations under the current General Medical Services (GMS) contract between the Health Service Executive (HSE) and GPs. There are arrangements for cryotherapy of skin lesions and counselling. At the end of 2015, 37.4% of the population had a medical card.³

Awareness about safer sex, contraception and easy and equitable access to services increase consistent use of contraception and protection and thus reduces negative sexual health outcomes such as HIV, STIs and unplanned pregnancies. Contraception services, including emergency contraception, are currently available in healthcare settings such as general practice, family planning clinics and retail pharmacies. A medical doctor's prescription is required for most types of hormonal contraception and for long-acting reversible contraception (LARC). Prescriptions for all forms of LARC apart from the copper coil are covered under the medical card. Under the current GMS contract there is provision for insertion and monitoring of LARC, removal of LARC and counselling in relation to fitting of a diaphragm.⁴ The following contraception services are covered for patients who hold a medical card under the GMS scheme: visit to the GP, visit to the GP for contraception and insertion/removal of an intrauterine device (IUD) or subdermal implant.

Condoms are available in commercial settings across the country. In 2015 the HSE Sexual Health and Crisis Pregnancy Programme (SHCPP) set up the National Condom Distribution Service to support statutory agencies/bodies and NGOs to supply condoms at no cost to respective patients and service users, including information on condom usage and safer sex.

³ Department of Health, 2016.

⁴ Health Professional Regulations, see www.irishstatutebook.ie/eli/2016/si/233/made/en/pdf.

Concerns about current sexual health services provision include:

- Health professionals working in the sexual health area are encountering increasing numbers of STIs, including localised outbreaks.⁵ Some services find it difficult to cope with local demand.
- 15% of women in a general population survey (2012) reported embarrassment, cost and difficulty in accessing local services, as factors inhibiting them in accessing contraception. Over half of those who experienced a crisis pregnancy did not use contraception at the time of conception.⁶
- There is no information on how well services are resourced and how well the population is served. There may be inequity in service provision.

1.4 Approach to gathering information

A multidisciplinary Project Working Group was established to oversee the delivery of this project.⁷ An early decision was taken to include all types of STI testing services and contraception services (public, private including GPs, and NGOs) and all laboratories providing STI diagnostic services within the scope of the mapping exercise. It was important to include laboratories because having access to diagnostics is integral to a service's ability to function fully.

In defining STIs, the study focused on the most common infections: chlamydia, gonorrhoea, genital warts, trichomonas, syphilis, genital herpes and pelvic inflammatory disease. Services were not asked about their management of HBV, HCV or HIV but were asked about their testing practices for these infections.

Questionnaire and data collection

A research company was commissioned to provide support with the design and development of an online data collection tool and to manage the data collection. The company used online survey software to script the questionnaire, which was designed in three standalone sections for the different respondent groups: one section for GPs, one for laboratories and one for sexual health services (comprising public, private and NGO STI and contraception services and student health clinics). The online tool routed respondents automatically to the appropriate section of the questionnaire based on their response to the first question about the type of service they provide.

The research company worked with the ICGP to generate unique links for each practice in which ICGP members work (n=1,567). The ICGP then emailed those practices with the questionnaire. The questionnaire was issued in October 2015, with one reminder two weeks later.

Meanwhile, the Project Working Group compiled the database of laboratories and sexual health services, including a named contact for each site. The research company sent a unique link to the questionnaire, along with a cover letter explaining the requirements of the study, to each email address in the database (73 sexual health services; 39 laboratories) in December 2015.

⁵ Health Protection Surveillance Centre, 2017.

⁶ McBride et al, 2012

⁷ For membership, please see Appendix 1.

Responses received

When the responses were reviewed, it emerged that there was some cross-over between the sexual health services and GP sections of the questionnaire. Seven of the 59 responses received for the sexual health services part of the questionnaire were from ICGP members who had self-identified as sexual health services rather than as GPs. Four of these seven services were removed from the sexual health services database because the practice had already responded or did not provide the level of information required by the study for inclusion. In addition, two respondents that had been identified by the Project Working Group as sexual health services self-identified as GPs and completed the GP section of the questionnaire. Their information was therefore collated with the GP data.

A total of 1,567 questionnaires were emailed to individual GP practices and 266 GP practices completed the survey, representing a response rate of 17%. This response rate includes the seven GPs who identified as sexual health services. Excluding those seven services and including the two sexual health services that self-identified as GPs gives a total of 261 valid GP responses.

Surveys of GPs frequently result in lower response rates when compared with surveys of the general population or of other medical professionals. The response rate to this survey (17%) is consistent with other international and Irish GP surveys. Low response rates are generally attributed to perceived lack of relevance and a high survey demand on GPs.⁸

1.5 About this report

This report relies entirely on the information provided by 259 GP respondents plus two sexual health services that self-identified as GPs. Therefore, 261 responses are presented in this report.

The information presented in this report may be affected by:

- The low response rate of 17% – insufficient information was gathered to meet the core aim of the project to accurately and systematically document the current provision of STI testing and treatment and contraception services provided by GPs across the country.
- A level of selection bias – those who responded are likely to have participated in the survey because they have a particular interest in delivering STI and contraception services.
- Missing responses – the number of responses (n) per question fluctuates slightly throughout the report due to the number of GPs responding or not responding to a given question. The n is given for each analysis in this report, which sets out to present the views of those who responded and does not intend to generalise to the total population of GPs in Ireland.

Issues with the response rate did not allow for the findings to be generalisable to the total GP population. However, based on some of the characteristics of those who responded, such as type of practice, the respondents are considered to be broadly representative of GP practices across the country. GP services from every county except Leitrim are represented.

⁸ See Cook et al., 2009; Moore et al., 1999; McAvoy and Kaner, 1996.

It needs to be considered also that there may have been changes to GP services since the information was collected in late 2015.

Notwithstanding these limitations, the information gathered does provide important data in relation to aspects of STI and contraception service delivery in general practice and serves to meet the project's objective of identifying and reporting gaps in service provision in order to inform the development of a sexual health needs assessment. Therefore, the information collected is presented in the form of a survey of GPs.

Although the report cannot be considered representative of all GPs in Ireland, it provides a very good overview of the STI testing and treatment and contraception services in 261 general practices across the country and highlights some important issues experienced in general practice in relation to such service provision. It also furnishes useful information on how GPs can be supported to increase their practice in this area.

The information gathered is presented in the remainder of this report. Chapter 2 gives an overview of the sexual health services provided by those GPs who responded and of the barriers they reported to service provision. Chapter 3 summarises the key points revealed by the data. Chapter 4 then sets out clear areas for action in relation to sexual health services in general practice for the HSE SHCPP and colleagues to consider in response to the information gathered.

2. Overview of GP-provided STI and contraception services

2.1 Respondent profile

This section briefly sets out the demographics of the 261 respondents and provides information about their practices.

The profile of those GPs who completed the questionnaire is broadly representative of the GP population in the Republic of Ireland in terms of single/group practice and GMS list.⁹ Single-handed practices constituted 23.9% of all respondents (see Figure 1), which is consistent with the overall ICGP membership population.¹⁰

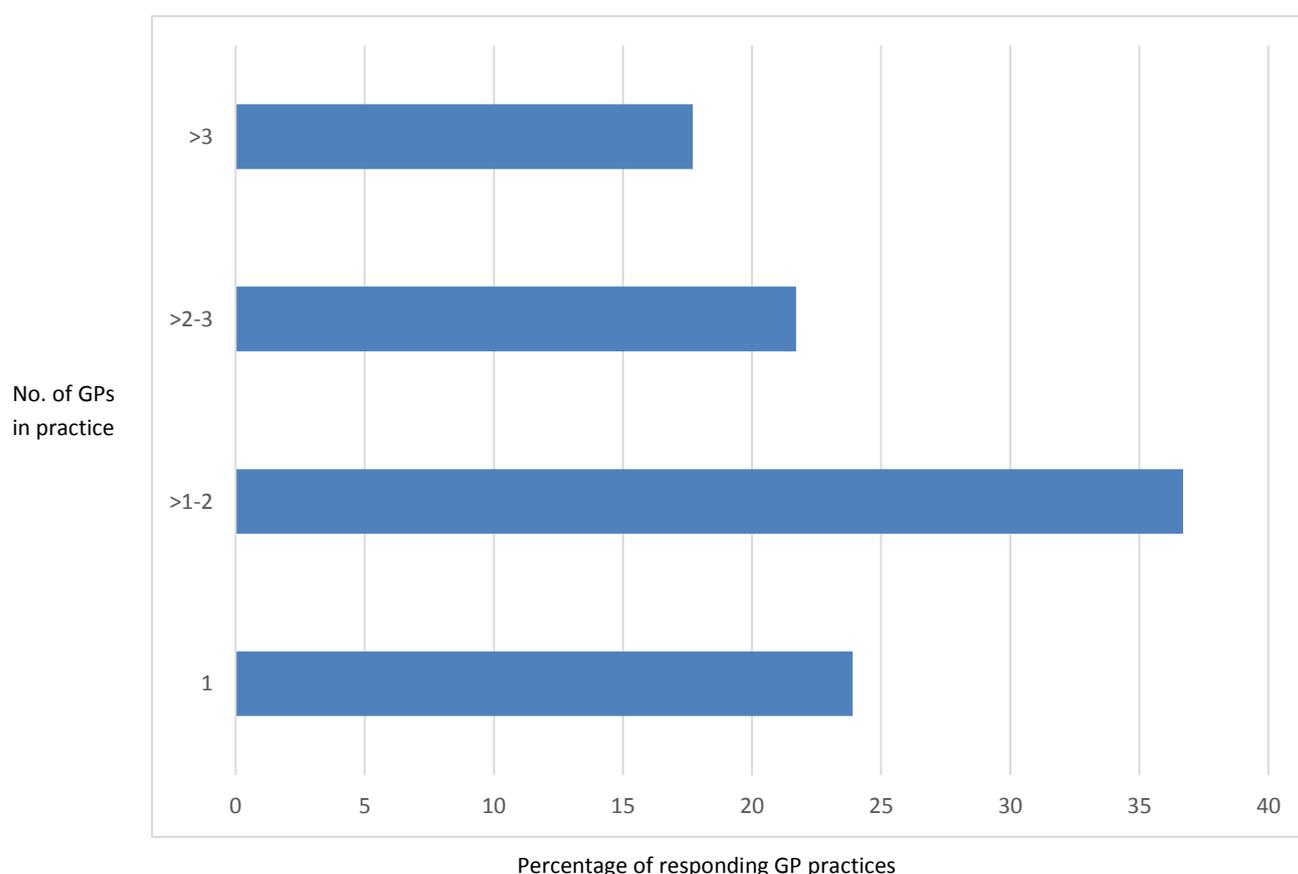


Figure 1: Whole Time Equivalent GPs in practice (n=261)

Nearly 60% of responding practices have at least one practice nurse in situ. This figure is lower than the finding of a recent survey of the structure of general practice in Ireland, which reported that 82% of practices nationally have a practice nurse.¹¹

The vast majority of respondents (93.9%, 214 practices) have a GMS list. This finding closely resembles that of a recent GP study, which identified that 89% of practices have a GMS list.¹²

⁹ See Byrne et al., 2010; O'Shea and Collins, 2016.

¹⁰ ICGP, 2015.

¹¹ O'Kelly et al., 2016.

Every county (except Leitrim) in the Republic of Ireland is represented by the survey respondents (see Figure 2). The highest number of responding practices are in Dublin (29%), Cork (13.5%), Galway (8.5%) and Limerick (8.1%).

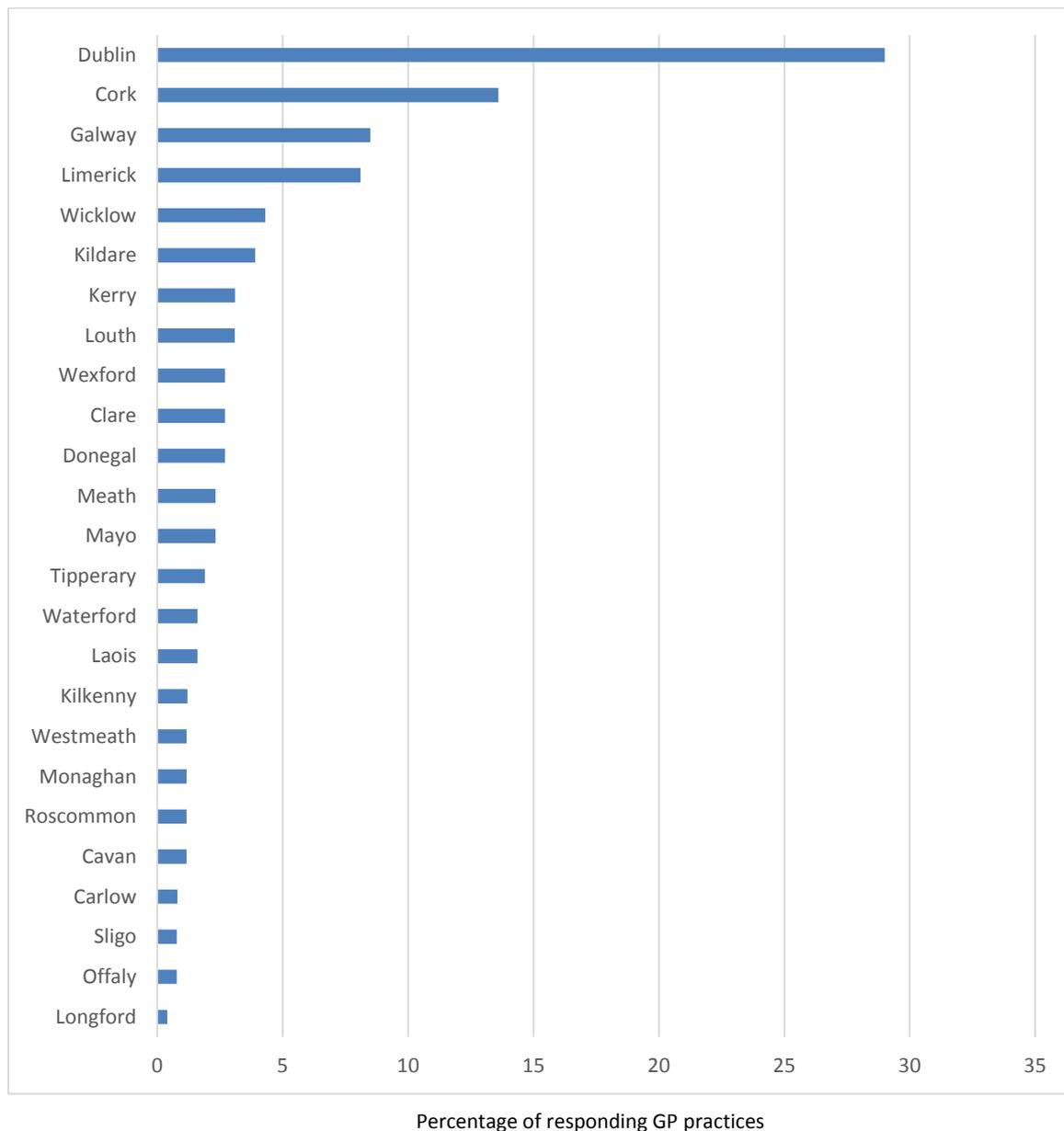


Figure 2: Location of practice by county (n=258)

2.2 STI and contraception services provided

STI testing and treatment services

GPs were asked to indicate whether the practice in which they work provides STI testing and treatment and contraception services to patients. Regarding STI testing and treatment, 93% of responding practices (243 out of 261) always or sometimes provide STI testing and treatment. Seventeen respondents do not provide STI testing or treatment in their practice (see Figure 3).

¹² O’Kelly et al., 2016.

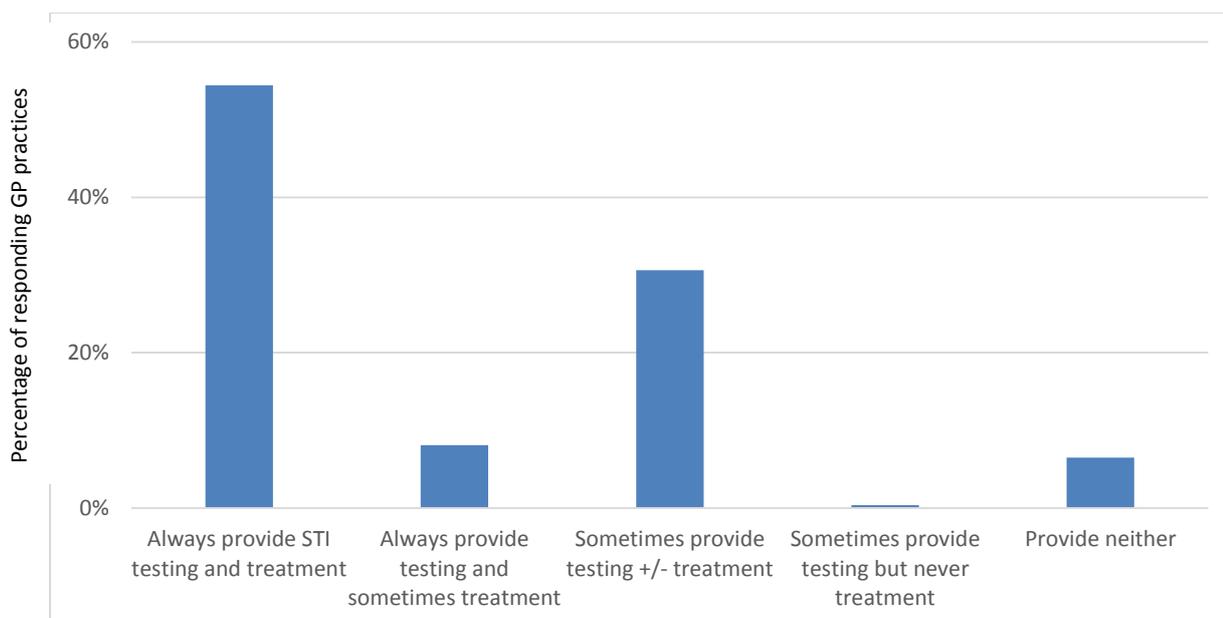


Figure 3: STI services provided (n=261)

Contraception services

Regarding contraception, the vast majority of responding practices (99.2%) provide contraception services. Indeed, just two of the 261 responding practices do not provide contraception services.

2.3 Service availability

For patients presenting with symptoms or signs of an STI, the majority of GP practices open between Monday and Friday for the clinical assessment and testing of symptomatic patients (see Table 1).

In relation to STI blood testing and STI swabs, the availability of these services is marginally lower on both Mondays and Fridays compared with mid-week days.

Only small numbers of services provide clinical assessment and testing of symptomatic patients, and STI blood testing and/or swabs, over the weekend.

	Mon	Tue	Wed	Thurs	Fri	Sat	Sun
Clinical assessment and testing of symptomatic patients	212 (88.7%)	216 (90.4%)	214 (89.5%)	216 (90.4%)	196 (82.0%)	18 (7.5%)	5 (2.1%)
STI blood testing	188 (78.7%)	206 (86.2%)	197 (82.4%)	202 (84.5%)	157 (65.7%)	10 (4.2%)	4 (1.7%)
STI swabs	185 (77.4%)	208 (87.0%)	193 (80.8%)	202 (84.5%)	161 (67.4%)	12 (5.0%)	4 (1.7%)

Table 1: Days of service availability for patients presenting with symptoms or signs of an STI (n=239)

2.4 STI samples

Of the respondents who undertake STI testing, very high proportions reported that they routinely send blood samples to test for HIV, HBV, HCV and syphilis for patients presenting for STI testing or for evaluation of STI symptoms (see Table 2).

GPs routinely send blood to test for:	n	%
HIV	187	89.0
HBV	185	88.1
Syphilis	178	84.8
HCV	166	79.0

Table 2: Patients presenting for STI testing or for evaluation of STI symptoms – routine bloods (n=210)

For patients presenting for STI testing or for evaluation of STI symptoms, samples are most commonly sent for chlamydia (96.7%) and gonorrhoea (93.3%) and high vaginal swabs (HVS) for gram stain and culture (90%) (see Table 3). Samples for trichomonas are least routinely sent (57.6%).

GPs routinely send sample to test for:	n	%
Chlamydia	203	96.7
Gonorrhoea	196	93.3
HVS for gram stain and culture	189	90.0
Trichomonas	121	57.6

Table 3: Patients presenting for STI testing or for evaluation of STI symptoms – routine samples (n=210)

Only two-fifths (39.7%) of those respondents who always or sometimes undertake STI testing routinely send swabs for PCR (polymerase chain reaction) testing for herpes simplex virus (HSV) for patients presenting with symptoms of genital herpes (n=83/209).

Practices that do not routinely send swabs for HSV PCR were asked to identify the main reasons why (see Figure 4). Almost two in three respondents (63.5%, n=80/126) do not have access to the required swabs, while 15.1% (n=19/126) have no mechanism to transport swabs to laboratory services. One in ten practices do not send swabs because they do not think of it.

The 14 practices that responded 'other' offered insights into why they do not send swabs for HSV: six GPs opt to confirm a clinical or visual diagnosis without taking a swab, four refer patients onwards for treatment, two were unaware that they should send a swab, one reported that the laboratory services in the area would not process such swabs and one highlighted the difficulty in accessing the relevant swabs.

Overall, 97% of practices who undertake STI testing do not offer HIV point of care testing.

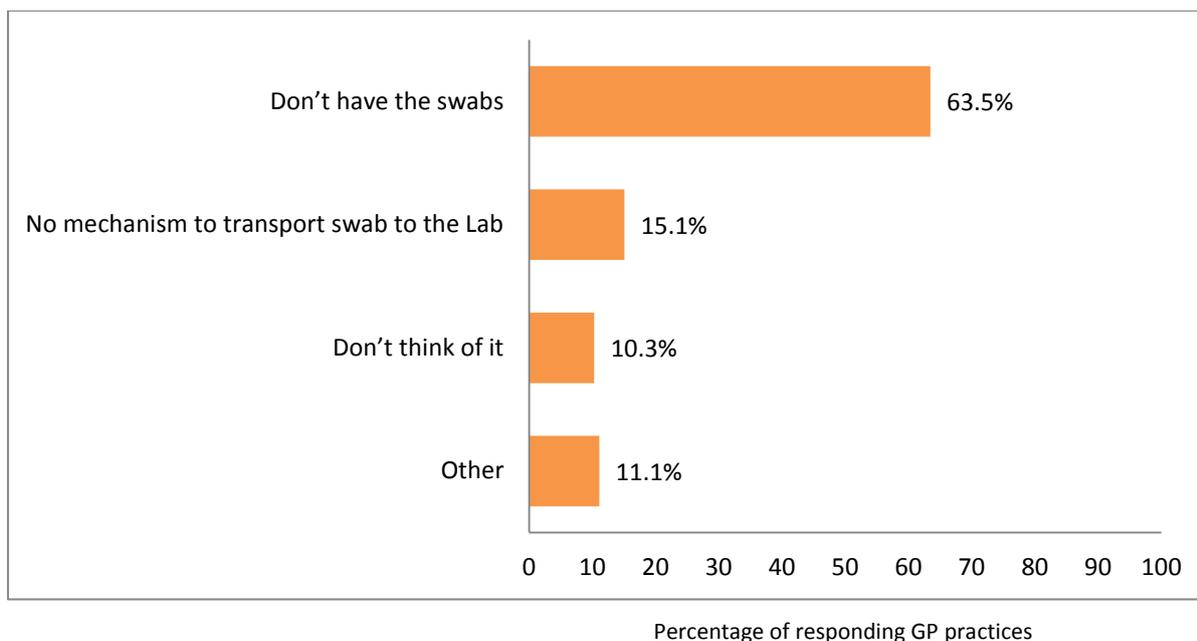


Figure 4: Main reason for not sending a swab for HSV PCR (n=126)

2.5 Access to laboratory services

The vast majority of GPs who responded to the question, 92.2% (189 of 205 practices), reported that their local hospital laboratory accepts STI samples. However, 6.3% are required to send STI samples to other laboratories as their local hospital laboratory does not accept them. These 13 practices are located in Clare, Cork, Dublin, Louth, Wexford and Wicklow, and the laboratories they send samples to include the National Virus Reference Laboratory in Dublin, Cork University Hospital, St James's Hospital in Dublin, University Hospital Limerick and University Hospital Waterford. Three respondents (1.5%) do not know whether their local hospital laboratory accepts STI samples.

GPs were asked to identify the types of STI sample accepted by their local laboratory. Urine and swabs for chlamydia NAAT (nucleic acid amplification technique) and combined chlamydia and gonorrhoea NAAT are accepted in the majority of cases (see Table 4).

Slightly more than 71% of respondents reported that their local laboratories accept STI samples for *Neisseria gonorrhoea* culture; 6.6% of respondents stated that their local laboratories do not accept them; and 22.1% of respondents do not know. A much smaller proportion of respondents (38.9%) indicated that their local laboratory accepts samples for *Neisseria gonorrhoea* antimicrobial susceptibility testing and half of practices ticked 'don't know'.

When asked if their local laboratory accepts trichomonas vaginalis microscopy delayed wet preparation samples, 43.2% of respondents confirmed that their local laboratory does accept such samples, but 46% ticked 'don't know'. Even more respondents (51.4%) ticked 'don't know' when asked whether their local laboratory accepts samples for HSV NAAT; 36.3% confirmed that their local laboratory accepts these samples.

More than 98% of respondents indicated that HVS samples for culture and sensitivity are accepted by their local laboratory, and 92.4% reported that HVS samples for gram stain and comment on vaginal flora are accepted by their local laboratory.

STI samples local laboratories accept	Yes	No	Don't know	n
Chlamydia NAAT				
Urine	145 (79.7%)	24 (13.2%)	13 (7.1%)	182
Swabs	155 (85.6%)	14 (7.7%)	12 (6.6%)	181
Combined chlamydia and gonorrhoea NAAT				
Urine	111 (65.3%)	29 (17.1%)	30 (17.6%)	170
Swabs	133 (74.3%)	20 (11.2%)	26 (14.5%)	179
Neisseria gonorrhoea culture	129 (71.3%)	12 (6.6%)	40 (22.1%)	181
Neisseria gonorrhoea antimicrobial susceptibility testing	68 (38.9%)	19 (10.9%)	88 (50.3%)	175
Trichomonas vaginalis microscopy delayed wet preparation	76 (43.2%)	19 (10.8%)	81 (46.0%)	176
HSV NAAT	65 (36.3%)	22 (12.3%)	92 (51.4%)	179
HVS for culture and sensitivity	184 (98.4%)	0 (0%)	3 (1.6%)	187
HVS for gram stain and comment on vaginal flora	170 (92.4%)	3 (1.6%)	11 (6.0%)	184

Table 4: STI samples accepted by local laboratory

2.6 Accessing STI testing kits

Respondents were asked about the ease of accessing STI testing kits (see Table 5).

Approximately half of respondents never have problems accessing testing kits for chlamydia or chlamydia/gonorrhoea; however, three out of ten always or sometimes experience problems with the supply of these kits.

Testing kits for HSV appear to be the most difficult to access, with nearly half of respondents always or sometimes experiencing issues. Only 15.8% reported never having problems with the supply of these kits.

Any problems securing a supply of STI testing kits for the following?	Always	Sometimes	Never	Not applicable	Don't know	n
Testing kits for chlamydia (NAAT)	12 (6.0%)	45 (22.5%)	113 (56.5%)	15 (7.5%)	15 (7.5%)	200
Testing kits for chlamydia/gonorrhoea	16 (7.9%)	48 (23.6%)	99 (48.8%)	13 (6.4%)	27 (13.3%)	203
Testing kits for HSV	51 (25.2%)	46 (22.8%)	32 (15.8%)	13 (6.4%)	60 (29.7%)	202

Table 5: Problems securing a supply of STI testing kits

2.7 Management of diagnosed STIs

Practices that offer their patients STI treatment (n=208) were asked how they typically treat and/or manage six common conditions (see Figure 5).

Chlamydia

Nearly 68% of responding practices manage cases of chlamydia to completion in-house; 17.3% initiate treatment and then refer cases forward; and 12% reported that cases of chlamydia are referred forward for contact tracing only.

Gonorrhoea

Almost 23% of responding practices manage cases of gonorrhoea to completion in-house; 42.5% of practices initiate treatment for gonorrhoea and then refer cases on; and 29% of practices always refer cases on.

Genital warts

Over 48% of responding practices manage cases of genital warts to completion in-house; 28.8% initiate treatment and then refer cases on; and 16.5% usually refer on. Fewer than 3% of practices refer cases forward for contact tracing only.

Trichomonas vaginalis

Almost 68% of responding practices entirely manage cases of trichomonas vaginalis to completion in-house; 17.3% initiate treatment and then refer cases forward; 1.9% refer for contact tracing only; and 13% usually refer on cases.

Genital herpes

Nearly 60% of responding practices completely treat and manage cases of genital herpes in-house; 28.4% initiate treatment and then refer forward for management; 2.4% refer on for contact tracing only; and 9.6% usually refer on cases.

Pelvic inflammatory disease

Over half (51.9%) of responding practices initiate treatment of pelvic inflammatory disease and then refer cases forward for management; 34.1% usually refer cases forward for both treatment and management; and 13.5% manage cases to completion in-house.

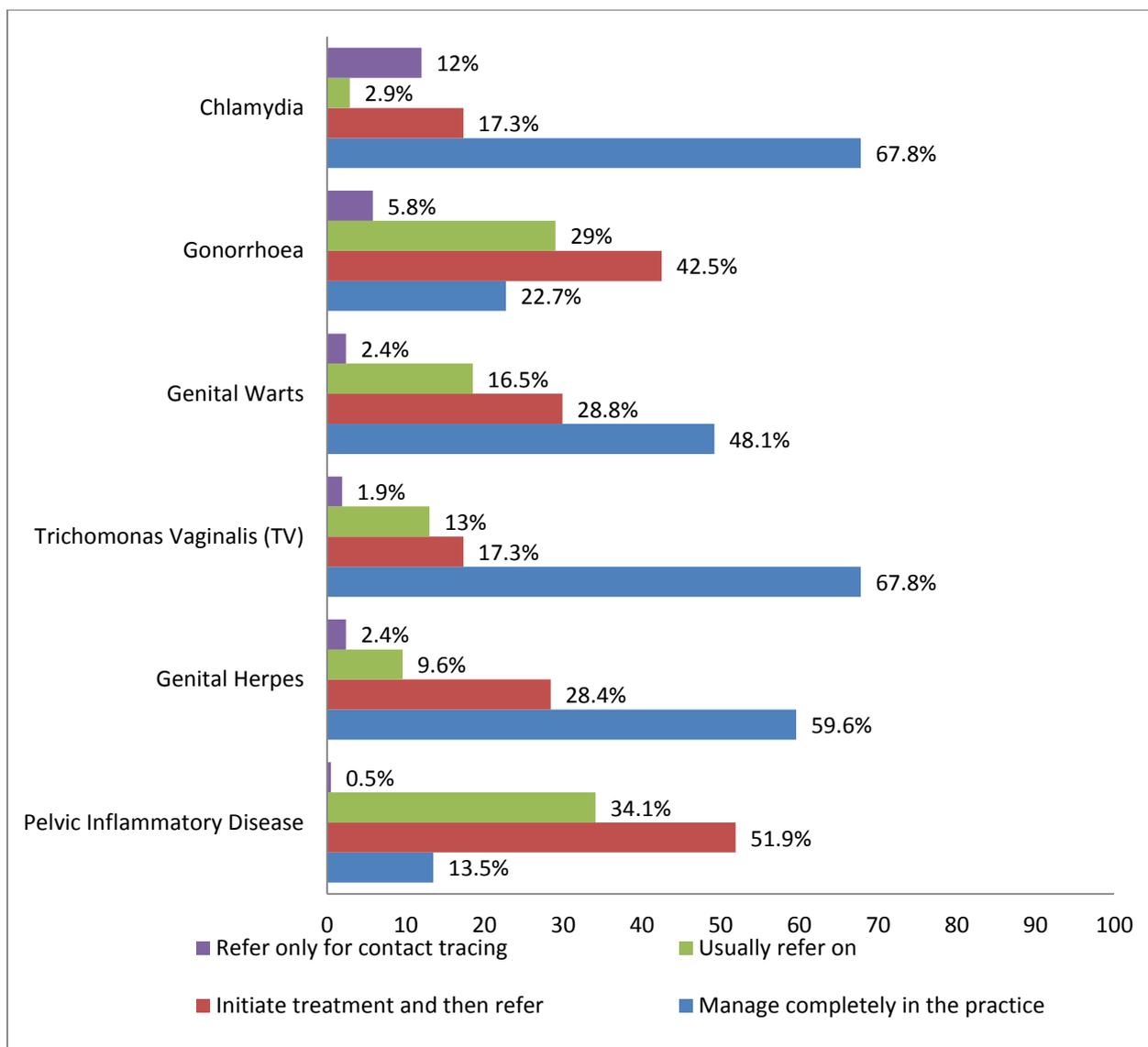


Figure 5: How practices typically treat/manage STIs (n=208)

2.8 Partner notification

Overall, 44.2% of responding practices always or sometimes provide partner notification. Of the practices that do offer partner notification, GPs most commonly provide this service, with practice nurses notifying partners in slightly more than one-quarter of cases (see Figure 6). In one instance the GP and practice nurse work in tandem to provide the service. In three cases the respondent indicated that partner notification is left to the patient.

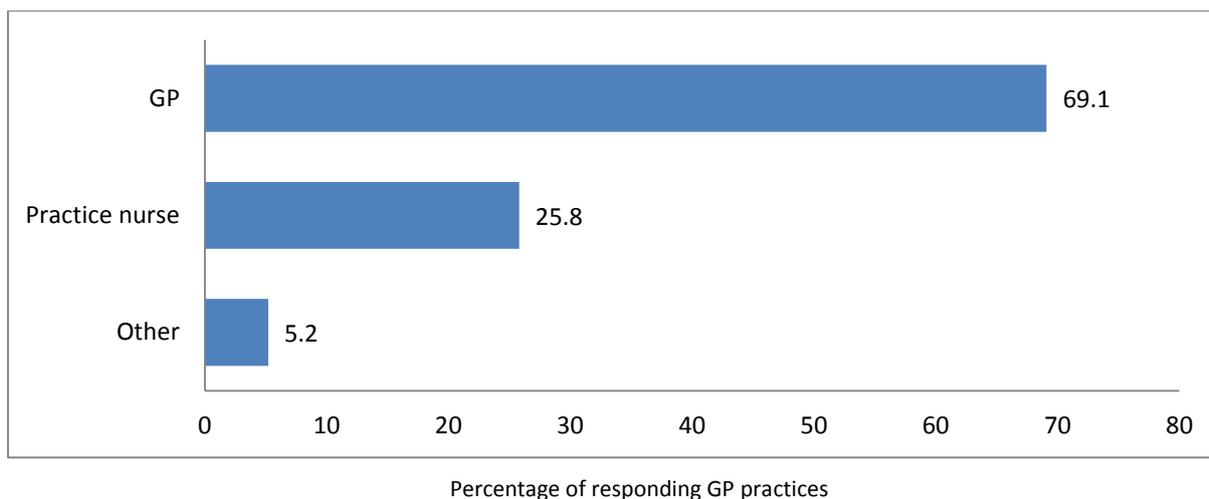


Figure 6: Practice-based professional who provides partner notification for STIs (n=91)

2.9 Barriers to providing STI testing

Respondents were asked to identify which three of seven predefined factors (see Figure 7) are the main barriers to offering patients STI tests at their practice. The most frequently selected responses were: ‘not covered by GMS contract’ (47.4%), ‘time constraints’ (32.9%) and ‘no courier to lab available’ (31.8%). One in four respondents indicated that ‘patient finance constraints’ are a barrier to offering STI testing. Fewer than 11% of respondents reported no barriers to offering STI tests.

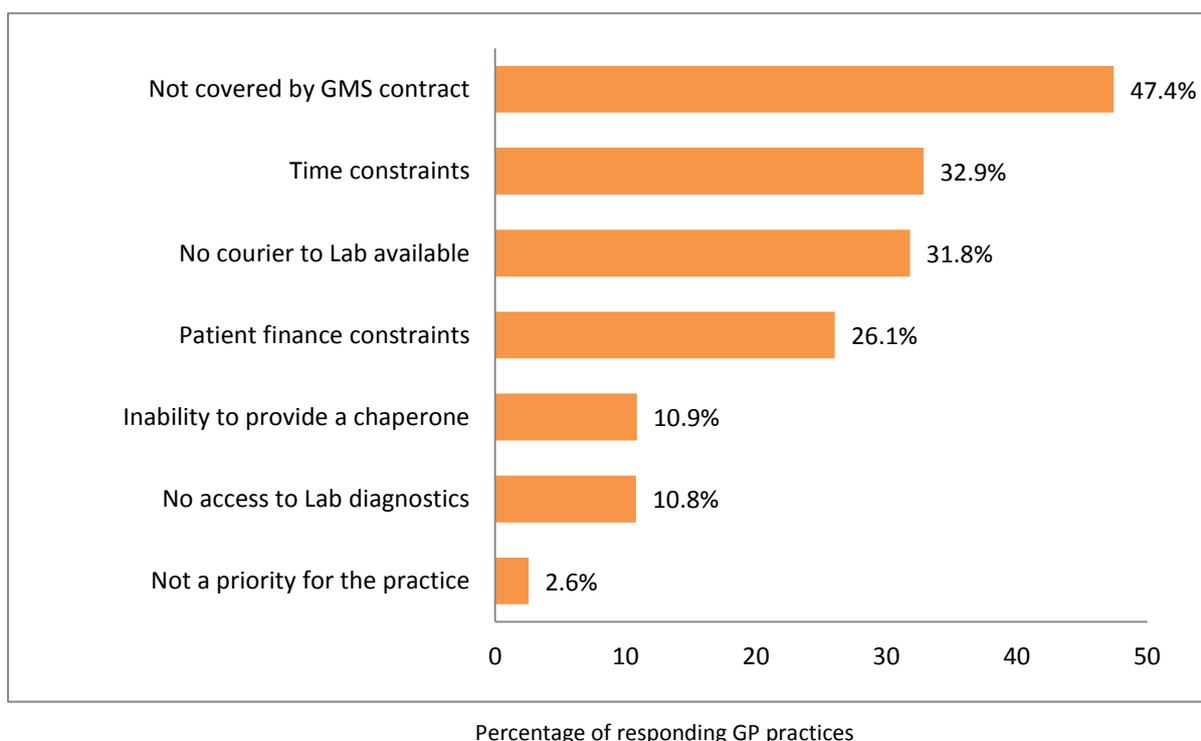


Figure 7: Main barriers to offering STI tests at practice – even if screening is always provided (n=206)¹³

¹³ n represents 206 respondents who ranked the top three barriers to offering STI tests. The bar chart presents the ranked barriers at an aggregate level.

2.10 STI training and CPD education

Of the 243 respondents (93%) who always or sometimes undertake STI testing and/or treatment in their practice, just over half (123 practices) reported that at least one member of staff in the practice has completed some form of STI training or education session in the past five years.

Of those 123 practices, 41% (50) have at least one staff member who has completed the ICGP STI e-learning course and 46% (56) have a member of staff who has completed an STI Foundation (STIF) course. Seventeen practices (14%) have at least one staff member who has completed other forms of relevant education or attended information-sharing sessions. These other forms included: Continuing Medical Education (CME) meetings, Diploma in Women's Health, Certificate in Contraception, Sexual Assault Treatment Unit courses, ICGP summer school updates and membership of the Faculty of Sexual and Reproductive Health, UK.

2.11 Long-acting reversible contraception (LARC)

GPs were asked if the practice where they work provides LARC, specifically the insertion and removal of intrauterine devices and subdermal implants.

Intrauterine devices (IUDs)

Seven in ten respondents (n=153/217) reported that IUDs are inserted at their practice (see Figure 8).

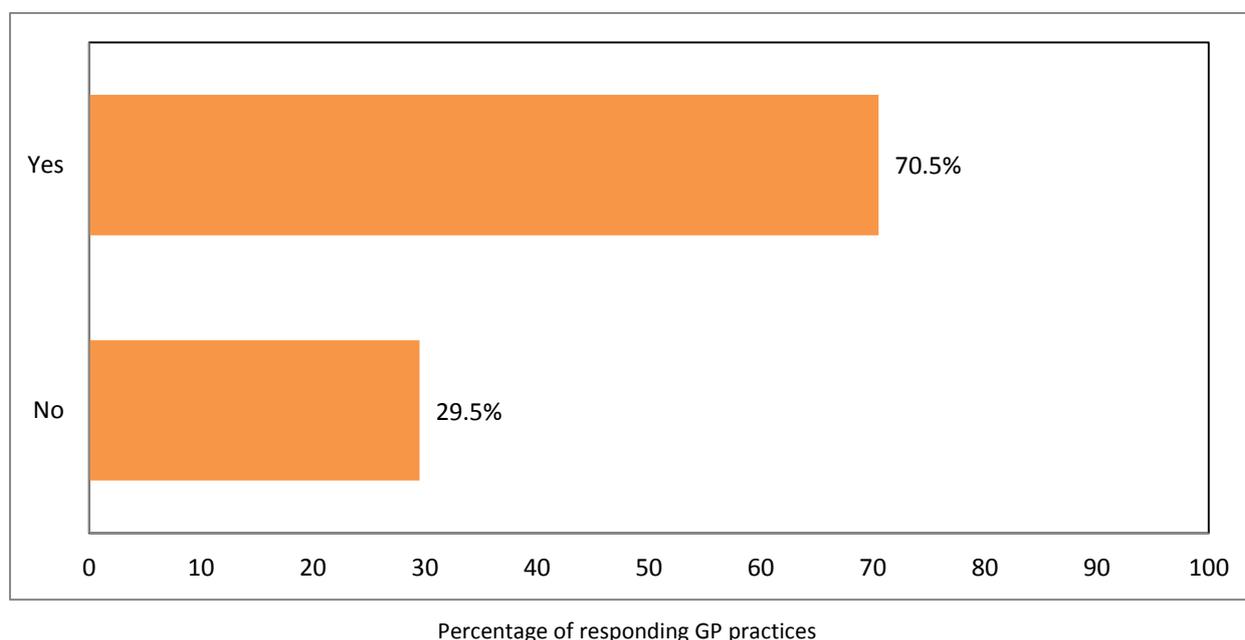


Figure 8: Are IUDs inserted in the practice? (n=217)

Of those respondents who perform IUD insertions, 151 practices (98.7%) provide Levonorgestrel IUDs (Mirena and Jaydess) for contraception; insertions of Copper Coil are provided by over half of practices for long-term contraception and by more than one-quarter for emergency contraception (see Figure 9).

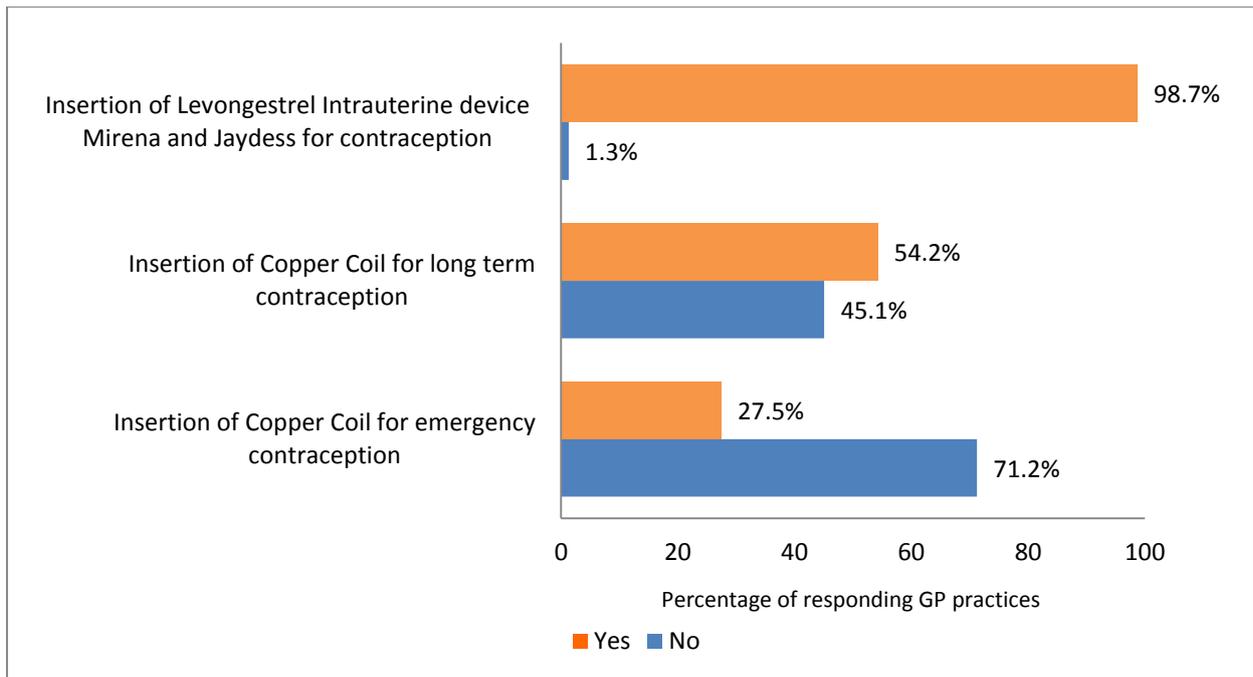


Figure 9: IUD services provided (n=153)

Of those respondents who perform IUD insertions, 83% (127 practices) accept referrals from other GPs who do not offer this service. Private patients are more likely than GMS patients to be accepted for such referrals (n=108) (see Figure 10).

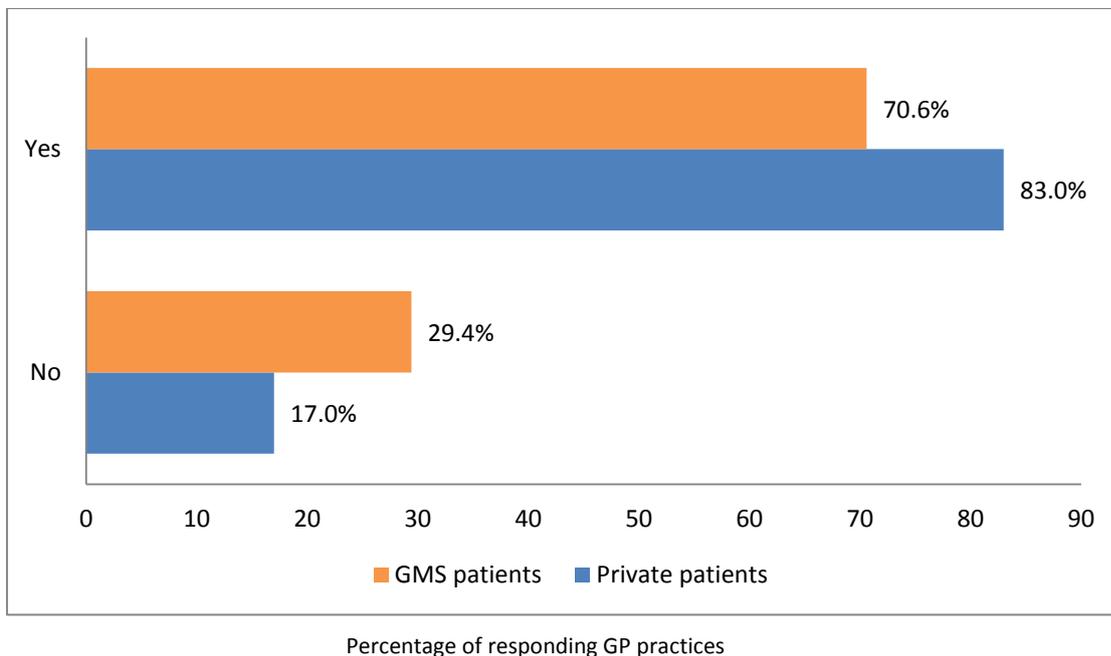


Figure 10: Does practice accept referrals from other practices for insertion of IUDs? (n=153)

All respondents (whether they insert IUDs or not) were asked to rank the top three barriers to offering IUD insertion in their practice (see Figure 11). More than half selected a 'lack of knowledge/skills', followed by 'inadequate remuneration' (40%), 'time and/or scheduling

constraints' (37.6%), 'no demand' (30.8%) and 'patient finance constraints' (27.4%). Overall, 38 respondents (17.5%) reported no barriers to offering IUD insertion in their practice.

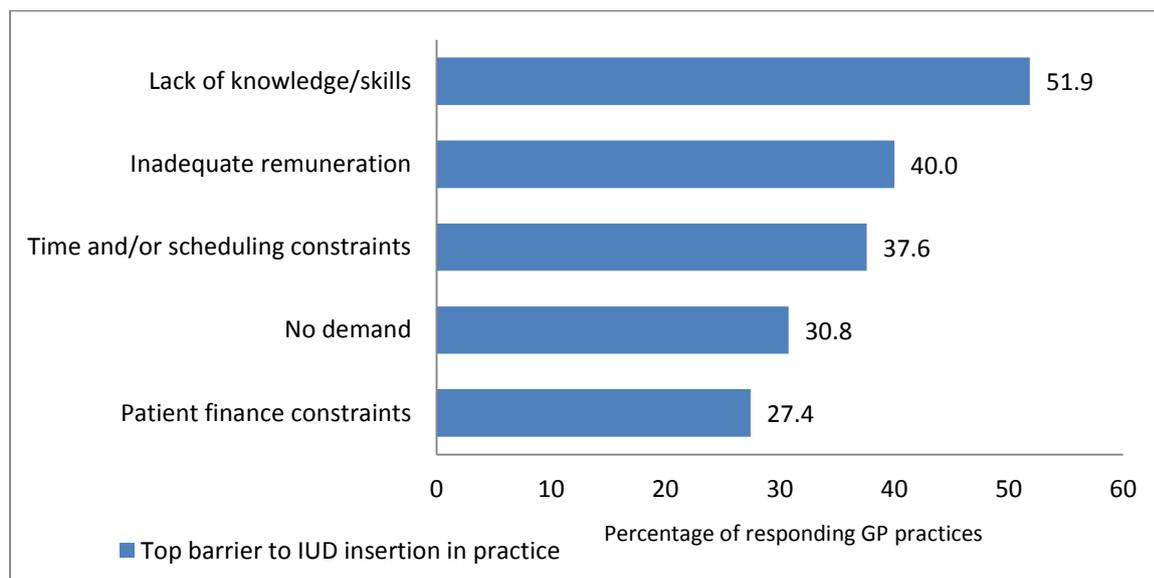


Figure 11: Main barriers to offering IUD insertion at practice (n=217)¹⁴

Of the 64 responding practices who indicated that they do not offer IUD insertion, the vast majority (60 practices) refer patients to another practice for insertion of IUDs where available (see Figure 12).

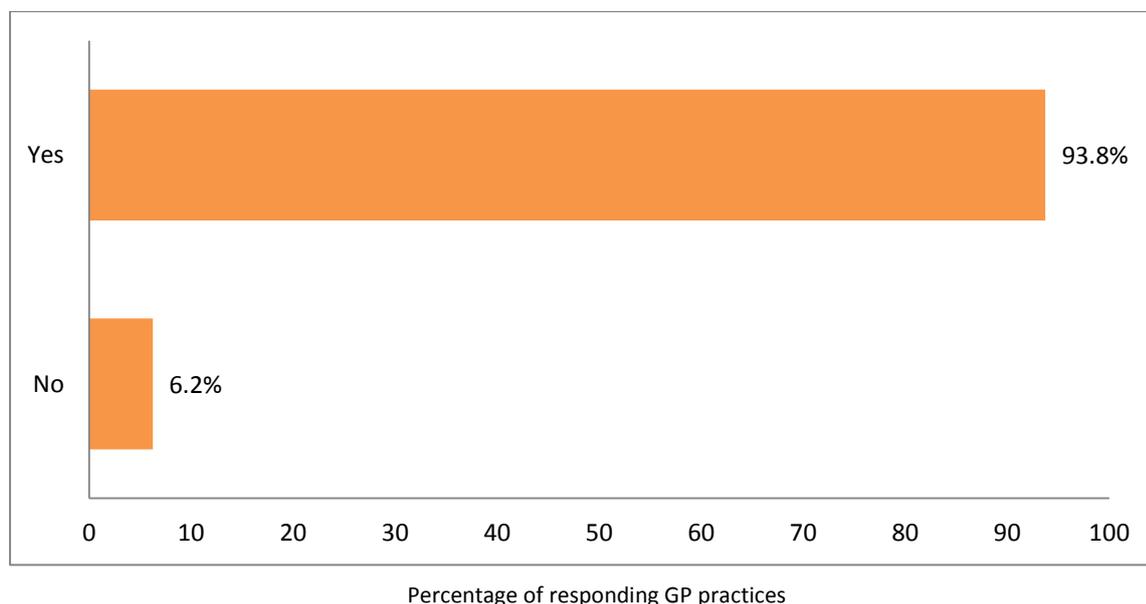


Figure 12: Does practice refer patients to another practice for insertion of IUDs? (n=64)

Subdermal implants

Overall, 81.9% (n=177/216) of responding practices insert and remove progesterone subdermal implants (PSIs); 39 practices (18.1%) do not offer this service (see Figure 13).

¹⁴ n represents 217 respondents who ranked the top three barriers to offering IUD insertion. The bar chart presents the ranked barriers at an aggregate level.

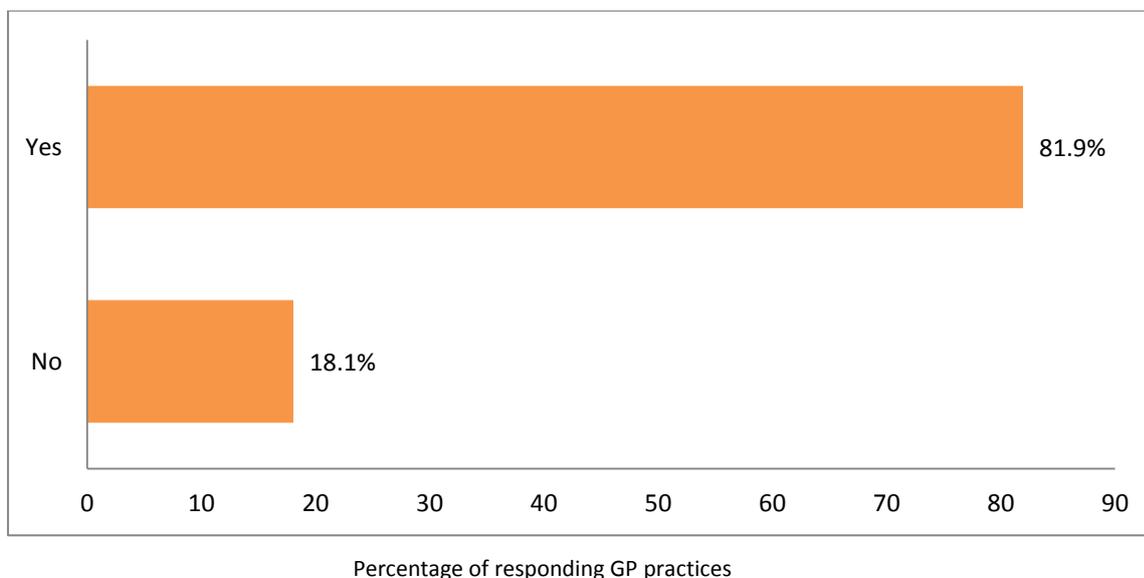


Figure 13: Are PSIs inserted and removed in practice? (n=216)

Respondents were asked to rank the top three barriers to inserting PSIs in their practice (see Figure 14). More than half selected ‘patient finance constraints’, 45.6% selected ‘lack of knowledge/skills’, 32.2% ‘no demand’, 32.1% ‘inadequate remuneration’ and 31.1% ‘time and/or scheduling constraints’. One-quarter of respondents (n=54/216 practices) indicated there are no barriers to PSI insertion in their practice.

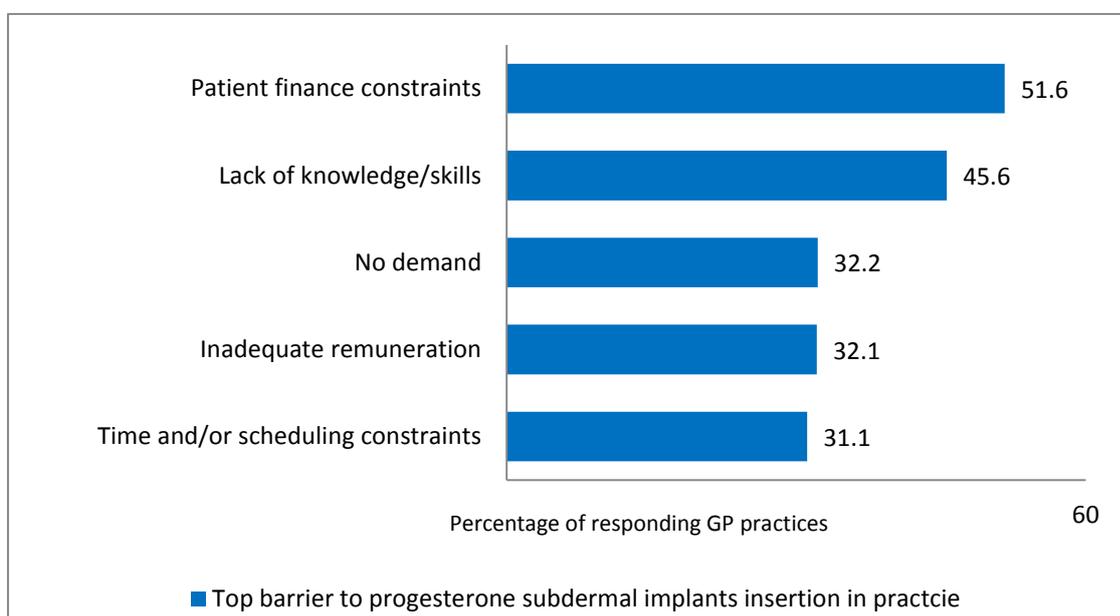


Figure 14: Barriers to offering PSI insertion in practice (n=216)¹⁵

Of the 39 responding practices who do not provide PSI insertions, 29 (74%) refer patients to another practice.

¹⁵ n represents 216 respondents who ranked the top three barriers to offering IUD insertion. The bar chart presents the ranked barriers at an aggregate level.

3. Summary of findings

3.1 Introduction

Whilst the information gathered in this survey provides important data in relation to aspects of the provision of STI testing and treatment services and contraception services by the responding GPs, the response rate precludes a comprehensive mapping of sexual health services in general practice in Ireland and a representative sample was not achieved. Furthermore, any review of the findings needs to take into account the likelihood that those practices which responded to the invitation to participate in the survey may have done so because they have a particular interest in sexual health and contraception.

Notwithstanding the limitations, the information provided meets one of the overall project's objectives, specifically to identify and report gaps in service provision to support the development of a sexual health needs assessment.

This report shows that STI and contraception service provision is very high among responding GP practices across the country, one-quarter of which are single-handed practices. Only 0.8% of respondents reported that they do not provide contraception services and just 6.5% provide neither 'STI testing' nor 'STI testing and treatment services'. The data suggest that the STI and contraception needs of the vast majority of patients attending these GP practices are currently met within one GP service but areas for improvement have been identified.

3.2 STI services in general practice

Two-hundred and forty-three responding practices (93%) reported that they provide STI testing or STI testing and treatment. Of those, the majority reported appropriate serological testing for patients attending for asymptomatic or symptomatic STI testing. However, one in ten or more of respondents do not routinely offer testing for HIV, HBV or syphilis in this circumstance.

Testing rates for chlamydia and gonorrhoea are very high and access to appropriate tests in local laboratories is generally good. Routine testing rates for chlamydia and gonorrhoea are fittingly high at 96.7% and 93.3% respectively. The majority of responding practices have access to NAAT chlamydia and gonorrhoea testing at a local laboratory. Whilst gonorrhoea culture testing is also available to the majority of respondents (71.3%), antimicrobial susceptibility testing was reported as being available to 38.9% of respondents with 50.3% not knowing whether or not they had access. Gonorrhoea culture and antimicrobial susceptibility testing are integral to the management of gonorrhoea and, wherever possible, sampling for culture and antimicrobial testing should be undertaken prior to treatment. Of note, almost 23% of respondents manage gonorrhoea to completion within their practice, without referring patients on to other services for further management.

Two-fifths of respondents routinely send a swab for HSV in patients presenting with symptoms of genital herpes. When asked about the reasons for not sending a swab in this circumstance, over three-quarters of respondents cited operational barriers, specifically not having access to swabs (63.5%) or not having a mechanism to transport swabs to the laboratory (15.1%). One in ten

respondents do not think about taking a swab and a small number reported that it is not indicated where a diagnosis of genital herpes can be made clinically. Of note, the majority (59.6%) of respondents manage cases of genital herpes to completion within their practice.

Partner notification is important in preventing onward transmission of STIs and 44.2% of responding practices always or sometimes provide a partner notification service. Of note, one in eight respondents refer patients with chlamydia to other services specifically for partner notification only.

Half of responding practices that offer STI services have a member of staff who has completed some form of STI training or education in the preceding five years. The ICGP e-learning and STIF courses were completed by staff within 41% and 46% of responding practices where staff completed STI training in the previous 5 years.

The main barriers to providing STI services in general practice relate to financial issues, specifically 'not covered by GMS contract' and 'patient finance constraints'. Operational challenges around STI testing are also experienced by GPs as key barriers, specifically 'no courier to lab available' and 'no access to lab diagnostics'.

3.3 LARC services in general practice

The vast majority of responding practices offer contraception services, with high proportions providing insertion of IUDs and PSIs. Furthermore, the majority of such practices accept referrals from other GPs for IUD insertions, although this is more likely to be done for private than for GMS patients. The main barriers identified by GPs for the insertion and management of IUDs are 'lack of knowledge/skills' (51.9% of responding GPs), 'inadequate remuneration' (40%) and 'time and/or scheduling constraints' (37.6%). The main barriers identified among all responding GPs regarding the insertion of subdermal implants are 'patient finance constraints' and 'lack of knowledge/skills'.

4. Areas for action

STI services

- Make guidelines on STI testing and management and HIV testing available to GPs in Ireland.
 - Develop a sexual health website in consultation with relevant stakeholders that will incorporate a clinical information and guidelines section on the assessment and management of genital conditions.
 - Responsibility for the content for the HSE antibiotic prescribing website section on genital infections now rests with the Clinical Lead for Sexual Health and will be updated.
 - Both of these resources will provide accessible and accurate information to GPs.
- Take measures to improve awareness and access to STI laboratory diagnostics, including availability of appropriate testing kits and transport of specimens for GPs throughout Ireland.
- Ensure that up-to-date education and information resources are readily available to GPs throughout Ireland and that GPs are aware of their availability.
 - Develop a sexual health website that includes a section on education and training in relation to STIs, which will signpost GPs to education and training resources.
 - The ICGP STI e-learning module will be updated before the end of 2017.
- Identify and propose solutions to the financial barriers (specifically the GMS contract and lack of affordability for patients) to the provision of STI services in general practice.
 - The output from the sexual health needs assessment will include recommendations in relation to the availability of STI testing and treatment to GMS patients under the GP contract and recommendations to improve affordability for non-GMS patients attending general practice.
- Support GPs in the provision of STI services, including an efficient mechanism for partner notification within general practice.
 - The SHCPP is planning a review of partner notification in 2017.
- Develop standards for delivery of STI testing, assessment and management appropriate to general practice
 - Standards should address the following areas: access; clinical assessment; diagnostics; clinical management; information governance; clinical governance; appropriately trained staff; links to other services and patient and public engagement
- Monitoring, evaluation and audit
 - Identify priority monitoring, evaluation and audit areas in line with standards
 - Encourage general practices seeing patients for STI testing, assessment and management to participate in monitoring, evaluation and audit and facilitate this process

Contraception services

- Address the identified barriers to the provision of a full contraception service across all general practices, namely skills, remuneration and time constraints.
 - Continue to provide a suite of education for GPs in contraception, including contraception workshops, training in procedures and contraception e-learning courses.
 - The ICGP LARC e-learning module is currently available and a contraception e-learning module will be completed by end of 2017.
 - The output from the sexual health needs assessment will include recommendations in relation to improving the affordability of contraception for non-GMS patients attending general practice and the identified barriers with the existing GP contract for GMS patients.

Information integration

- Review this report in conjunction with the sexual health services and laboratory services reports to identify gaps and areas for synergy in the provision of equitable, accessible STI and contraception services in Ireland.

Needs assessment

- Use the results of this survey to inform the work of the sexual health needs assessment in the development of recommendations and an action plan.

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Appendix 1: Project Working Group

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