

From Royal Victoria Hospital, Belfast

Date 19th February 2007

Thank you for the excellent consultation document the group has prepared. I am replying on behalf of GUM services. The aim is to highlight the need of SARCs in the context of an integrated sexual health network.

Dr Helen Keane conducted two audits on Alleged Sexual Assault Cases attending GUM clinic in RVH in 1999 and in 2004. I enclose here some of the useful data from GUM.

- Caseloads

1/8/2001 to 31/7/2002	59
1/8/2002 to 31/7/2003	86
1/8/2003 to 31/5/2004	102

- 4/145 (2.8%) cases were male (2001-2002 data)
- 26/145 (18%) were under 16 years old, 68/145 (47%) were 16-24 years old
- 34/145 (23%) were self referral, 53/145 (37%) referred by GP, 26/145 (18%) referred by Rape Crisis, 10/145 (7%) referred by PSNI
- 51/145 (35%) presented within 7 days of alleged assault
- 83/145 (57%) were not on any form of contraceptive at point of alleged assault
- 41/145 (28%) were given Post-coital Contraception post assault by GUM/Care unit/GP
- 56/145 (39%) reported known alleged assailant
- 74/145 (51%) alleged victim reported under influence of alcohol and/or other drugs at time of assault
- From 145 cases, 84 positive GUM diagnoses were made; These include STDs such as Chlamydia infection (16), genital warts (6), acute genital herpes (2), hepatitis B infection (1), trichomoniasis (1), pubic lice (1) and scabies (1)
- 13/145 rapid hepatitis B vaccination were initiated; 2/145 HIV post exposure prophylaxis were initiated

Comments on the consultation document

1.2/1.9 AGREE. An agreed framework for a comprehensive service for victims of sexual violence does not exist and needs to be in place; the strategy requires a collaborative approach to cover all related areas of priorities as outlined.

Page 103 – single holistic SARC – very good idea. Question is where is the best location? A stand alone SARC, even with good network with other sexual health services may be able to provide holistic care; but if wrongly perceived by potential user as a primarily forensic orientated service, could still have the potential to deter user. From GUM data in 1999, up to 50% of our caseloads of victims chose to not involve forensic team/RUC before and after consultation with ourselves.

Page 104 to 116 – with training, uniform and high standard of care, experienced with specific group and need in mind; an integrated sexual health service is needed. The model exists in Sandyford Initiative in Glasgow (<http://www.sandyford.org>). I also understand that some of the successful SARCs in London also locate within similar models.

Sandyford Initiative is a primary care based purpose built site where holistic sexual health services are provided i.e. GUM, Family planning, Women's health, SARC, Youth & children clinic, Gay & Bisexual Men's clinic, Psychosexual counselling, dedicated service for ethnic minority, commercial sex workers; assessment and referral for termination of pregnancy service, HIV service, on site library with appropriate literature, free for all internet access, all existing under one roof. Being under one roof, they feed into each other's resources to provide a patient focused service. They do joint rotational training so that staff have transferable skills across the service. Easily accessible from their website is their annual report – annual budget of £5.2 million, patient turnover over 90000 visits, staffing capacity of 141 Whole-Time-Equivalent, 32 audits reported last year as quality control. The flexibility to capture data on sexual violence from such an integrated service means that data is more likely to be complete.

As a physician, I would highlight again the importance of this holistic patient focus to victims of sexual violence from the medical perspective – there are medical management issues of an emergency nature when dealing with these cases. Emergency decisions may include assessment to risk of pregnancy, risk of infection which includes HIV and viral hepatitis. Preventative measure for these, such as prescription of HIV prophylaxis medications and post coital contraception, have a very narrow window to be effective, often less than 72 hours from the assault. The discrepancy between our numbers and PSNI numbers is extremely worrying considering the large number of diagnoses in our caseloads – STIs that are not promptly managed have serious chronic health consequences and may also be transmitted to future partners.

Sometimes, I feel GUM clinics are very restricted in their flexibility to network into the other services by being within acute hospital trust. I would like to refer the steering group to a report prepared by a regional panel chaired by Dr Paula Kilbane, Chief Executive of EHSSB titled "Improving Access to GUM and Sexual Health Services in Northern Ireland – October 2006"; and the document already cited in your reference awaiting publication – the Sexual Health Promotion Strategy. Within these documents are recommendations to develop an integrated service network for Northern Ireland. Related steering group and Service Delivery Unit should therefore be working together towards such a model.

Please do not hesitate to contact us should you require more details on our audit data.

Thank you.

Yours sincerely

Consultant Physician in Genitourinary Medicine
Royal Victoria Hospital, Belfast