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Perspective

The need of integrating Sexual Health Care into collaborative primary healthcare system: An STD clinician's perspective

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Abstract

Despite the fact that Sri Lanka has a low HIV prevalence (less than 0.1% among adults) and a relatively stable epidemiological profile, the nation still faces significant challenges in providing comprehensive sexual health care. Through specialized STD clinics, current sexual health services primarily target high-risk populations, stigmatizing and limiting access for people in general. Drawing on effective HIV management frameworks, this article promotes the integration of sexual health services into primary healthcare through a collaborative care model. This approach can help normalize sexual health as a basic human need, lessen stigma, and guarantee that all age groups have equal access to sexual health education, screening, contraception, and prevention services.

Keywords: Sexual health integration, Primary healthcare, Collaborative care, Population health, Stigma reduction

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Introduction

The prevention and treatment of sexually transmitted infections (STIs) is only one component that influences sexual health. The World Health Organization defines sexual health as "a state of physical, emotional, mental, and social well-being in relation to sexuality." Historically, cultural norms, beliefs, and traditional barriers have hindered the development of comprehensive sexual health services in Sri Lanka, especially for young adults and adolescents who are underserved despite establishing up a significant proportion of the population.

Integrating Sexual Health Care into collaborative primary healthcare system

There are a number of serious issues with Sri Lanka's current sexual health service delivery model that require immediate attention. Services primarily target vulnerable and high-risk groups, ignoring the needs of the general public in terms of sexual health and encouraging a bias against certain groups that prevents many from receiving proper care. (3)

There are age-specific service gaps caused by the severe shortage of pediatric, adolescent, and geriatric sexual health specialists, which disproportionately impacts young people by preventing them access to important sexual

health information. (4) The fact that sexual health services are still only available at specialized STD clinics reinforces the stigma and institutional isolation that keep many people from getting the care they need. Public health outcomes are compromised by educational deficiencies caused by a lack of platforms for sexual health education. Furthermore, a lack of effective channels for exchanging sexual health experiences and information results in communication barriers that interfere with the advancement of sexual health acceptance and awareness.

In sexual health, where cultural sensitivities and personal beliefs greatly influence care acceptance, patient-centered care fosters active participation in health decisions while acknowledging individual needs, preferences, and values. In order to achieve common goals, interdisciplinary collaboration requires a multidisciplinary team approach involving doctors, nurses, pharmacists, social workers, and community health workers. In the case of sexual health, this would include general practitioners, sexual health specialists, counselors, and peer educators.

The integration of sexual health services into primary healthcare offers multiple compelling benefits that justify this paradigmatic shift. Stigma reduction occurs by normalizing sexual health as part of routine healthcare, allowing patients to access services without the fear of discrimination that often accompanies visits to specialized STD clinics. (5) Universal access ensures that sexual health services reach all population segments, including those who may not consider themselves at risk but still require preventive care, education, and screening. Cost-effectiveness is achieved by leveraging existing primary healthcare infrastructure, reducing the need for parallel systems and maximizing resource utilization. Early detection and prevention become possible through regular screening and education through primary care, enabling early detection of STIs and implementation of preventive measures.

Through extensive service integration, the suggested framework for Sri Lanka involves integrating sexual health services into the country's current primary healthcare facilities. Pre-exposure prophylaxis (PrEP) for high-risk individuals, STI prevention education, contraceptive counseling and provision, routine sexual health screening during general health check-ups, and HPV and Hepatitis B vaccination services are all included in this. Adolescent services must offer comprehensive sexual education, access to contraception, and confidential counseling; adult services must offer routine screening, family planning, and reproductive health care; geriatric services must address age-related issues and sexual health maintenance; and pediatric sexual health services must focus on age-appropriate education and abuse prevention programs.

Educational integration represents a crucial component of this model, requiring collaboration between primary healthcare centers and educational institutions to provide age-appropriate sexual education curricula, regular health screenings, peer education programs, and teacher training on sexual health topics. Community outreach must extend services beyond clinical settings through community health worker training, public awareness campaigns, religious and community leader engagement, and mobile clinic services for remote areas. Technology integration can enhance service delivery through telemedicine consultations for sexual health concerns, mobile applications for health education and appointment scheduling, electronic health records integration for continuity of care, and online platforms for anonymous queries and counselling. (1)

The expected outcomes and benefits of this integrated approach are substantial and multifaceted. Population health improvements include reduced STI incidence through early detection and treatment via routine screening, improved reproductive health through better access to contraception and family planning services, and enhanced health literacy through comprehensive education programs that improve population understanding of sexual health issues. System-level benefits encompass reduced healthcare costs through a prevention-focused approach that decreases long-term treatment costs for STIs and their complications, improved service efficiency through integration that eliminates duplication and improves

resource utilization, and enhanced quality of care through coordinated care delivery that improves patient satisfaction and health outcomes.

Significant stigma reduction is one of the social effects of normalizing sexual health services, which lessens discrimination and encourages more people to seek help. Youth empowerment happens through comprehensive education and services that empower young people to make informed decisions about their sexual health, while gender equity is advanced through equal access to sexual health services that promote gender equality in healthcare.

Conclusion

The integration of sexual health services into primary healthcare represents a paradigm shift that aligns with global best practices and Sri Lanka's commitment to universal health coverage. By adopting a collaborative care approach, the country can move beyond the current model of targeting only high-risk populations to embrace a comprehensive, population-based strategy that normalizes sexual health as a fundamental human right. This integration offers multiple benefits including reduced stigma, improved access, cost-effectiveness, and better health outcomes across all age groups. While implementation challenges exist, they can be addressed through careful planning, community engagement, and phased implementation.

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