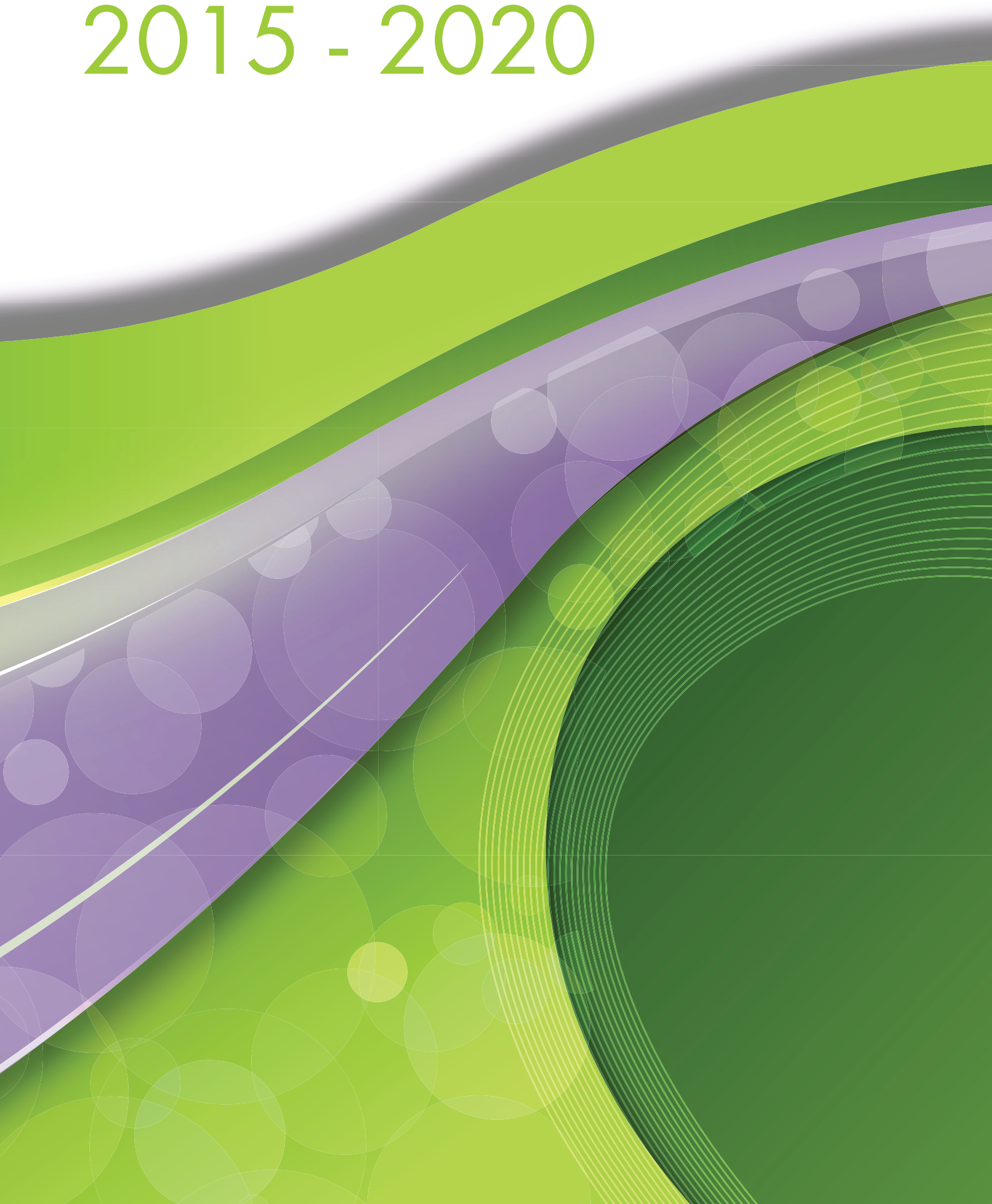
NATIONAL SEXUAL HEALTH STRATEGY

2015 - 2020



National Sexual Health Strategy

2015 - 2020

And
Action Plan 2015 - 2016

October 2015

The action plan sets out the main actions to be taken in 2015 and 2016 to commence implementation of the National Sexual Health Strategy for Ireland 2015–2020

hi Healthy Ireland

An Roinn Sláinte
DEPARTMENT OF HEALTH

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Ministerial Foreword

Our vision is:

that everyone in Ireland experiences positive sexual health and wellbeing and has access to high quality sexual health information, education and services throughout life.

I am publishing a two year action plan with the National Sexual Health Strategy to ensure that an immediate start is made on putting the Strategy into action. We want to promote a mature, non-judgemental attitude to sexual health and to remove stigma associated with sexual health issues in the provision of education, information and services. The immediate focus is on improving the structures needed to provide a quality sexual health service. It also aims to improve and increase training to teachers, youth workers and healthcare professionals who provide services and information to the public.

Now is the right time to publish and commence the implementation of a National Sexual Health Strategy. The increase in sexually transmitted infections in Ireland has raised concern among healthcare professionals, the government and the public. Chlamydia has increased from 6.8 per 100,000 in 1995 to 136.5 per 100,000 in 2013. Likewise gonorrhoea increased from 2.5 in 1995 to 28.2 in 2013 per 100,000. Recent data indicate that HIV infection rates are rising again particularly among younger men who have sex with men (MSM) and this is of concern. This Strategy aims to target 'at risk' groups for specific interventions.

In the past, sex and sexual health were taboo subjects. In truth, sex is a normal part of everyday life and essential to our survival as a species. It is also good for our physical and mental health and for healthy relationships.

The Strategy takes a life course approach, which is a key underpinning concept in the Healthy Ireland Framework, under which this Strategy will be implemented. It acknowledges the importance of developing a healthy attitude to sexuality in young people and of building on that foundation for positive sexual health and wellbeing into adulthood and older age.

It is significant that the Strategy places strong emphasis on access to information and education. High quality sexual health education promotes positive mental and physical wellbeing. Education and access to information is important throughout life, particularly for 'at risk' and vulnerable groups.

I would like to thank all those involved in the development of this Strategy. In particular I would like to acknowledge the contribution and effort of key NGOs to this Strategy and sexual health services generally.

Leo Varadkar, T.D. Minister for Health

Abbreviations

Acronym	Full term
AIDS	Acquired immunodeficiency syndrome
CIDR	Computerised infectious disease reporting system
CPD	Continuous professional development
DCYA	Department of Children and Youth Affairs
DES	Department of Education and Skills
DoH	Department of Health
ECDC	European Centre for Disease Prevention and Control
HAART	Highly active antiretroviral therapy
HBV	Hepatitis B virus
HIQA	Health Information and Quality Authority
HIV	Human immunodeficiency virus
HPSC	Health Protection Surveillance Centre
HPV	Human papillomavirus
HSE	Health Service Executive
HSE SH&CPP	HSE Sexual Health and Crisis Pregnancy Programme
ICGP	Irish College of General Practitioners
LARC	Long-acting reversible contraceptives
LGBT	Lesbian, gay, bisexual and transgender
MRL	Microbiological reference laboratory
MSM	Men who have sex with men
NASC	National AIDS Strategy Committee
NCCA	National Council for Curriculum and Assessment
NGOs	Non-governmental organisations
PDST	Professional Development Service for Teachers
PEP	Post-exposure prophylaxis
RSE	Relationship and sexuality education programme
SAVI	Sexual abuse and violence in Ireland (see The SAVI report)
SES	Socio-economic status
SPHE	Social, personal and health education
STI(s)	Sexually transmitted infection(s)
TasP	Treatment as prevention

UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Glossary of Terms

Antenatal: Antenatal or prenatal refers to the time before birth.

Antimicrobial resistance: Antimicrobial resistance is resistance of a microorganism to an antimicrobial medicine to which it was originally sensitive. Resistant organisms are able to withstand attack by antimicrobial medicines such as antibiotics, antifungals, antivirals and antimalarial so that standard treatment becomes ineffective and infections persist, increasing the risk of spread to others.

Antiretroviral therapy: Antiretroviral drugs and therapies are used in the treatment of retroviruses, primarily human immunodeficiency virus (HIV).

Contraception: Contraception is the use of artificial or other methods to prevent pregnancy as a consequence of sexual intercourse.

Concealed pregnancy: Concealed pregnancy is a situation where a woman presents for antenatal care past 20 weeks' gestation, without having availed of antenatal care or without disclosing the pregnancy to her social network.[1]

Crisis pregnancy: Irish legislation defines a crisis pregnancy as a pregnancy which is neither planned nor desired by the woman concerned and which represents a personal crisis for her.

Diagnostic: The term diagnostic refers to the decision reached by diagnosis of a disease.

Epidemiological: From the word epidemiology – the branch of medicine that deals with the study of causes, distribution and control of disease in populations.

Health inequalities: A difference in health status or in the distribution of health determinants between different population groups.

Healthy Ireland Framework: A national framework for action to improve the health and wellbeing of the Irish population, published March 2013. (Full title: *Healthy Ireland – A Framework for Improved Health and Wellbeing 2013–2025*)

Health promotion: Health promotion is the process of enabling people to increase control over their health and its determinants, and thereby improve it. It is a core activity of public health and contributes to tackling communicable and non-communicable diseases and other threats to health.

Healthy public policy: Healthy public policy is characterised by an explicit concern for health in all areas of public policy, with the main aim of creating a supportive environment to enable people to lead healthy lives.

Health technology assessment: Health technology assessment is a form of research that generates information about the clinical and cost effectiveness of health technologies.

Life course approach: An approach suggesting that the health outcomes of individuals and the community depend on the interaction of multiple protective and risk factors throughout people's lives. This approach provides a comprehensive vision of health and

[1] Conlon, C. (2006) *Concealed Pregnancy: A case-study approach from an Irish setting*, Crisis Pregnancy Agency, Report No. 15, available at http://crisispregnancy.ie/wp-content/uploads/2012/05/15.-Concealed-pregnancy-a-case-study-approach-form-an-Irish-setting.pdf.

its determinants, which calls for the development of health services centred on the needs of its users in each stage of their lives.

Men who have sex with men (MSM): MSM refers to men who have sex with men irrespective of whether the men involved self-identify as gay or bisexual and regardless of whether or not they also have sex with people of the opposite sex.

Pathogen: A pathogen is a biological agent that causes disease or illness to its host.

Partner notification and contact tracing: Partner notification is a voluntary process by which sexual contacts of people with a sexually transmitted infection (STI) are notified of their exposure. The terms partner notification and contact tracing have been used interchangeably, but partner notification is the more commonly used term.

Positive prevention: Positive prevention refers to a set of strategies that aim to help people with HIV live longer and healthier lives. Positive prevention encompasses strategies to protect sexual and reproductive health and delay HIV progression. It also includes individual health promotion, access to HIV and sexual and reproductive services, community participation, advocacy and policy change.

Post exposure prophylaxis: Post-exposure prophylaxis (PEP) is a preventive treatment initiated after pathogen exposure to prevent infection. HIV PEP is a short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure.

Reference laboratory: A reference laboratory provides detailed analysis of microbial agents causing ill health, their susceptibility pattern or the epidemiological type. A reference laboratory may also undertake analyses of samples that have wider public health implications. This investigation of organisms increases the speed, precision and certainty by which the sources and means of the spread of an infection can be identified and can therefore direct the appropriate public health control measures. As reference laboratories receive specimens from multiple regions, they can be instrumental in the initial detection of outbreaks. Reference laboratories also undertake research and are involved in international networks for information exchange and method improvement.

Risk: Certain behaviours (not group membership) may place individuals in situations where they may be exposed to negative health outcomes.

Screening: Screening is the application of tests to people who are, or are presumed to be, healthy for the purposes of diagnosing potential ill health.

Sexual dysfunction: Sexual dysfunction is a difficulty experienced by an individual or a couple during any stage of sexual activity.

Sexuality: Sexuality is a central aspect of being human and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction.[2]

Sexual health: Sexual health is a state of physical, emotional, mental and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual

[2] WHO (2006) *Defining sexual health: Report of a technical consultation on sexual health*, 28-31 January 2002, Geneva, available at http://www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf

relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.[3]

Sexual orientation: Sexual orientation ranges along a continuum, from exclusive sexual attraction to the opposite sex through to exclusive attraction to the same sex. People can identify their sexual orientation as heterosexual, lesbian, gay or bisexual. Some people may also engage in sexual behaviour that differs from their stated sexual orientation; an example here would be a man who identifies as heterosexual but engages in sex with other men.

Sexually transmitted infections: Sexually transmitted infections are spread primarily through person-to-person sexual contact. The most common conditions they cause are gonorrhoea, chlamydial infection, syphilis, trichomoniasis, chancroid, genital herpes, genital warts, human immunodeficiency virus (HIV) infection and hepatitis B infection.

Social determinants of health: The social determinants of health are the circumstances in which people are born, grow, live, work and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies and politics.

Testing: Testing differs from screening in that it does not refer to national programmes, but rather refers to testing people for ill health or the potential for ill health on request, opportunistically or because the healthcare worker believes there is a risk.

Treatment as prevention (TasP): Since the advent of combination antiretroviral therapy, it has been noted that people with suppressed or low HIV viral loads are less likely to transmit HIV than people not using antiretroviral therapy. Treatment of people with HIV as a prevention method is emerging as an effective strategy in stopping or slowing the spread of HIV.

Vaccination: Vaccination is the administration of a modified pathogen that stimulates the immune system's response, creating protective antibodies to confer protection against that pathogen in the future.

[3] WHO (2006) *Defining sexual health: Report of a technical consultation on sexual health,* 28-31 January 2002, Geneva, available at http://www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf

Introduction to the National Sexual Health Strategy

This National Sexual Health Strategy is Ireland's first national framework for sexual health and wellbeing. It has been developed in response to a recommendation of the National AIDS Strategy Committee (NASC) on the need to establish clear leadership within the health sector around the area of sexual health.

This **Strategy** reflects the many changes Ireland has experienced over the past 30 or so years regarding sexual behaviour and sexuality. This includes developments in Ireland's legislative framework, the requirement to provide school-based sexual health education and, more broadly, society's changing attitudes to sex and sexuality.

This Strategy is being published in the context of major reforms of the health service in its approach to the health and wellbeing of the population. *Healthy Ireland – A Framework for Improved Health and Wellbeing 2013–2025* recognises that many factors outside of the healthcare sector influence health.[4] The ability to reach and maintain good health is shaped not only by individual lifestyle factors and genetics, but also by the environment within which we live. The Healthy Ireland Framework aims to address these factors and support the aims of the National Sexual Health Strategy in a wider context.

It is therefore appropriate that this Strategy is among the first national strategies to be produced within the Healthy Ireland Framework. The National Sexual Health Strategy closely follows the guiding principles for implementation of the Healthy Ireland Framework. These are: better governance and leadership; better use of people and resources; better partnerships; better systems for healthcare; better use of evidence; better measurement and evaluation; and better programme management.

This Strategy will build upon the work and experience of many service providers, including the HSE who have provided sexual health services on behalf of the State over many years. However, it will also work to deliver enhanced care pathways, which will be integrated across the new structures within the HSE. In particular, this will include the hospital groups, community healthcare organisations and primary care services, in order to ensure the delivery of an integrated service model that will treat patients at the most appropriate level in the health service, across a range of services from GPs to specialist provision.

The National Sexual Health Strategy was produced by working groups under a Steering Group that represented a wide range of expertise and stakeholders in the area of sexual health policy and service delivery. The objective of the Steering Group was:

> **to produce a cohesive policy that would clearly define the structures and governance arrangements for sexual health services, which in turn would result in improved sexual health outcomes at population level.**

The Strategy contains 71 recommendations that address a wide spectrum of sexual health services, from surveillance and prevention, to treatment, counselling and supports, to education and professional development. It signals a change in sexual health services from current provision, which has its origins in regional responses to specific sexual health

[4] For simplicity, this framework is referred to as the Healthy Ireland Framework throughout this report.

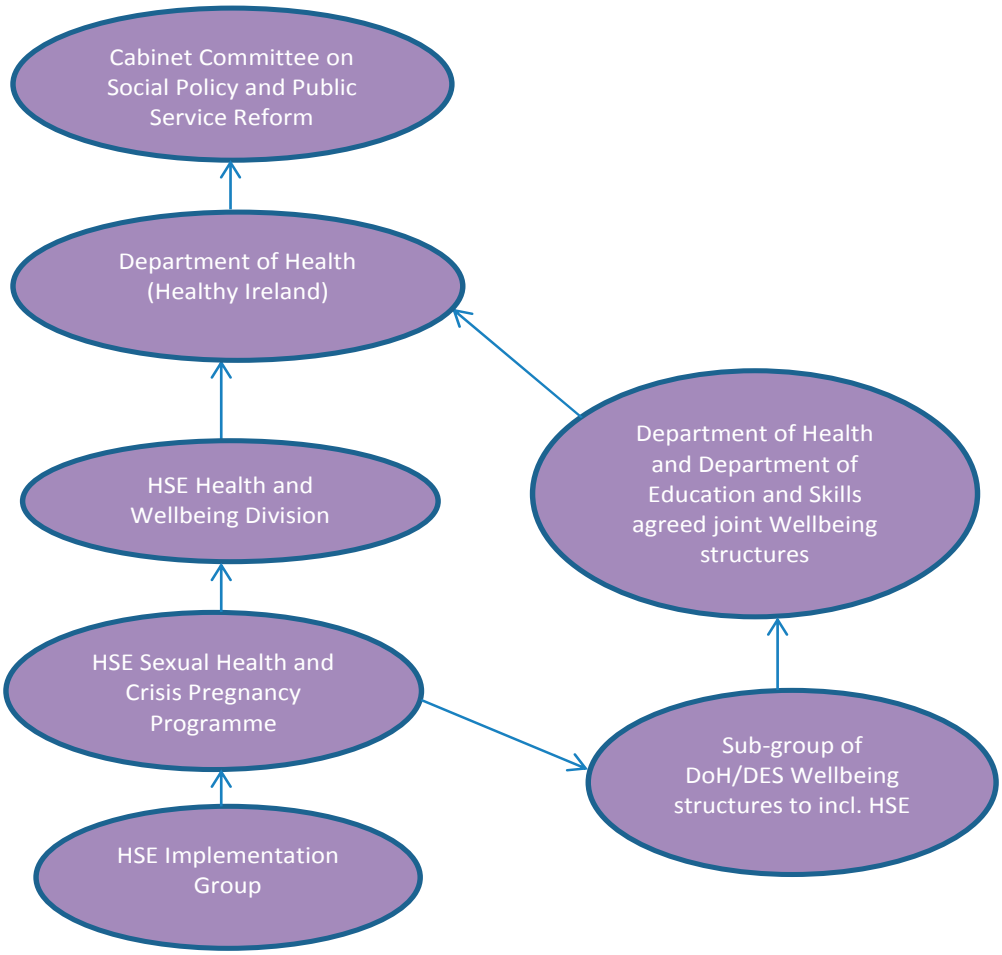
issues, to a national strategy to provide high quality sexual health services to the whole population as required.

One of the recommendations in the Strategy is to '*develop and manage a detailed implementation plan to deliver goals and actions, working across departments and in partnership with statutory and non-statutory agencies/bodies and NGOs*'.

The Minister for Health, in line with this recommendation, directed the Department of Health to develop a detailed **action plan** to translate the recommendations in the Strategy into actions with a focus on identifying priorities that can be commenced in the short term. This action plan identifies priority recommendations from the Strategy and specific actions required to implement them that can be commenced in 2015 or 2016. It sets out a governance structure to ensure that the cross-sectoral and cross-departmental nature of the work can be managed efficiently. It also contains specific actions to support parents in engaging with their children on sexual health issues, and includes actions that aim to improve the experience of young people in relation to sexual health education in the education system by providing better training and resources for teachers and youth workers.

Successful implementation of this action plan will ensure that the structures for the ongoing development of sexual health services are in place. The cooperation provided by all stakeholders in developing the Strategy augurs well for implementation.

Reporting and governance structure



Governance

The Health and Wellbeing Programme in the Department of Health will be responsible for monitoring the implementation of the Sexual Health Strategy 2015–2020 and the Action Plan 2015–2016 and reporting to the Minister and the Cabinet Committee on Social Policy and Public Service Reform on its progress.

The HSE Sexual Health and Crisis Pregnancy Programme (SHCPP) will be responsible for leading the implementation of the majority of actions specified in the action plan of this Strategy. In order to support this, the SHCPP will establish a HSE implementation group to support the implementation of the actions identified in this Strategy. Service users and non-statutory service providers will be represented on this group. A new Clinical Lead for Sexual Health will work with the SHCPP. In addition, an existing advisory group will be invited to provide advice and recommendations to the HSE Programme on a regular basis. This advisory group, already well established, will be expanded to include the membership of organisations and individuals that can provide a wide range of viewpoints and expertise on sexual health.

Appropriate joint working structures will be established to monitor implementation of actions within the Education sector structures.

In addition, the existing cross-sectoral collaboration between the Department of Health and the Department of Children and Youth Affairs will ensure an alignment between the Healthy Ireland Framework and *Better Outcomes Brighter Futures: The national policy framework for children and young people 2014–2020*, in terms of delivering on the commitments of both frameworks as they relate to prioritising the health and wellbeing of children and young people.

Sexual Health Action Plan for 2015–2016

Priority actions

	Action	Timescale	Outcome	Lead Agency
	Clinical services			
1.	Complete a mapping exercise of existing clinical sexual health services (contraceptive, sexually transmitted infection (STI) and laboratory services) to inform an assessment of service need including the capacity of laboratory services required to support STI diagnostic services.	2015	Mapping document complete. Service needs assessment complete.	HSE SHCPP
2.	Conduct a review to inform a decision to formally designate and resource an appropriate laboratory or laboratories as a national reference laboratory/laboratories for STIs.	2016	Review completed. Options identified and costed. Decision to be made on a designated national reference laboratory for STIs.	HSE SHCPP
3.	Prioritise, develop and implement guidance to support clinical decision making for STI testing, screening and treatment and on the appropriate use of antiretroviral therapy in HIV prevention. This guidance should be developed in line with the National Clinical Effectiveness Committee (NCEC) National Standards for Clinical Practice Guidance (for publication in 2015). Assess, develop and implement guidance on STI and HIV testing in various settings to improve access and ease of testing and to include guidance on home based testing and the use of point of care HIV testing. STI services to participate in clinical audit as an ongoing quality improvement approach.	2015–2020	Working group established and guidance developed and implemented.	HSE SHCPP
4.	Department of Health to give policy consideration to extend HPV vaccine to adolescent boys and potential at-risk groups (eg MSM).	2016	Policy decision taken on extension of HPV vaccination programme based on HIQA Health Technology Assessment.	DoH

5.	Relocate the Gay Men's Health Service to fit-for-purpose accommodation, which will facilitate enhanced access to services for men who have sex with men (MSM).	2015–2016	Services provided in an appropriate setting.	HSE
Education: Supporting parents, teachers and youth workers				
6.	Develop and disseminate guidelines and advice to parents of children aged under 10 years on sexuality, sexual development and growing up.	2016	A high quality information and advice resource available to parents/carers.	HCPP
7.	Conduct a review of sexual health and relationships training and other non-clinical supports currently funded by the HSE with a view to establishing a coordinated and strategic approach to training and other supports.	2015	Review complete. Recommendations developed in consultation with stakeholders to establish a more coordinated approach.	HSE SHCPP
8.	Establish a HSE foundation programme in sexual health promotion as a national sexual health training programme.	2015–2020	At least 100 people trained annually.	HSE SHCPP
9.	Evaluate the implementation of the relationship and sexuality education (RSE) programmes in post-primary schools and centres delivering the Youthreach programme with input from teachers, principals, young people and other stakeholders to identify a set of initiatives that will improve the quality of RSE programmes delivered in schools and in centres delivering the Youthreach Programme.	2015	Quantitative report complete. Qualitative interviews complete and set of actions agreed.	Partnership of DoH; DES and HSE SHCPP
10.	RSE in-service training in 2015–2016 will be scheduled based on demand. All Schools will be made aware of the availability of RSE in-service training.	2015/16	A range of RSE training courses will be provided by the PDST in 2015–2016.	DES
11.	Track, through the Lifeskills survey, the number of schools using quality RSE resources, such as B4uDecide resource materials for the Junior Cycle and the TRUST Resource for Senior Cycle, as part of their RSE programmes; work towards increasing the number of schools using	2015	Questions included in 2015 survey to provide baseline figures. B4uDecide resource materials to be re-developed in partnership	DES HSE SHCPP

	these resources; and evaluate and update resources as required.		between HSE and DES.	
12.	DES support services will prioritise the development of web-based supports, which will facilitate access for all teachers in all schools to curricular support material for RSE.	2016	Web-based support material will be developed and made available to all Teachers on www.pdst.ie.	DES
Communication and information				
13.	Coordinate sexual health communications work of the HSE and non-statutory organisations to ensure joint resources are used in the most effective manner.	2015–2020	Communications plan agreed and rolled-out for 2015 and 2016.	HSE SHCPP
14.	Continue to deliver the 'Johnny's got you covered' national sexual health campaign to encourage young adults to use condoms every time they have sex; evaluate the campaign annually to ensure its effectiveness; and re-develop when required.	2015–2020	Maintain high awareness levels of over 70% for the campaign. Complete external evaluation in 2015 and 2016.	HSE SHCPP
15.	Publish MISI (MSM Internet Survey Ireland) 2015 survey report and implement dissemination plan.	2016	Survey results published in 2016.	HPSC
Governance and structures				
16.	Establish the appropriate governance structures to oversee the implementation of the Strategy within the Department of Health. Establish a HSE implementation group, with service user and service provider representation, with responsibility for developing and implementing a sexual health action plan up to 2020.	2015 2015	Structures established. HSE implementation group established.	DoH HSE
17.	Reconfigure the HSE Crisis Pregnancy Programme as the HSE Sexual Health and Crisis Pregnancy Programme and appoint a Clinical Lead for Sexual Health.	2015	Clinical Lead appointed. HSE CPP name changed to HSE SH&CPP.	SHCPP
18.	Appoint an advisory group that will provide advice to the HSE Sexual Health Programme on implementation.	2015	Advisory group expanded.	SHCPP

Action plan for 2017–2020: The HSE implementation group will draft a further action plan for approval of the Minister for Health for the period 2017–2020, setting out actions to complete implementation of the Strategy.

Executive Summary

Introduction

This National Sexual Health Strategy is Ireland's first national framework for sexual health and wellbeing. It has been developed in response to a recommendation by the National AIDS Strategy Committee (NASC) on the need to establish clear leadership within the health sector around the area of sexual health. In the past, regional sexual health strategies have been implemented in specific regions and national strategies have been implemented to address specific sexual health issues. However, this is the first time a nationally coordinated, strategic framework has been developed to address sexual health and wellbeing.

Healthy Ireland Framework

This Strategy is being published in the context of major reforms of the health service in our approach to the health and wellbeing of the population. *Healthy Ireland – A Framework for Improved Health and Wellbeing 2013–2025* recognises that many factors outside the healthcare sector influence health.[5] The ability to reach and maintain good health is shaped not only by individual lifestyle factors and genetics, but also by the environment in which we live. The Healthy Ireland Framework aims to address these factors and to support the aims of the National Sexual Health Strategy in a wider context.

What is sexual health?

The World Health Organization (WHO) has defined sexual health as:

> 'a state of physical, emotional, mental and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence'.[6]

Vision

The strategic vision of this Strategy is

that everyone in Ireland experiences positive sexual health and wellbeing. To achieve this vision, this Strategy aims to:

> *improve sexual health and wellbeing and reduce negative sexual health outcomes by ensuring that everyone living in Ireland has access to high quality sexual health information, education and services throughout their lives.*

Three goals

This vision will be addressed through three goals.

> **Goal 1 – Sexual health promotion, education and prevention:** Everyone living in Ireland will receive comprehensive and age-appropriate sexual health education and/or information and will have access to appropriate prevention and promotion services.

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[5] For simplicity, this framework is referred to as the Healthy Ireland Framework throughout this report.
[6] See http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/

Goal 2 – Sexual health services: Equitable, accessible and high quality sexual health services that are targeted and tailored to need will be available to everyone.

Goal 3 – Sexual health intelligence: Robust and high quality sexual health information will be generated to underpin policy, practice, service planning and strategic monitoring.

The Strategy recognises the diversity of sexual identities in Ireland and supports all expressions of sexual identity through positive sexual health and wellbeing outcomes.

This Strategy makes a total of 71 recommendations under these goals, which are presented in chapters three to six of this report, and collated in Appendix 2.

Sexual health in Ireland

Ireland has experienced many changes over the past 30 or so years regarding sexual behaviour and sexuality, including developments in Ireland's legislative framework, the requirement to provide school-based sexual health education and, more broadly, society's changing attitudes to sex, sexuality and contraception. Legislative changes throughout this period in relation to sexual health and relationships have contributed to improvements in sexual health and wellbeing. Further changes and improvements are likely in the coming years. However, sexually transmitted infections (STIs) and crisis pregnancy are still significant public health issues. While Irish society is now more open about sex and sexuality, it has been shown that embarrassment in talking about sex and contraception is a barrier to delivering education and information.

Sexually transmitted infections

There is concern over the general upward trend in STI notifications, which in the period 1995–2013 saw increases from 3,361 to 12,753. In 2013, 344 people were newly diagnosed with HIV in Ireland, a rate of 7.5 per 100,000 head of population. The Health Protection Surveillance Centre (HPSC) report that the greatest burden of STIs falls among those aged under 25 years and among men who have sex with men (MSM).

Crisis pregnancy

Over one-third (35%) of women who have had experience of pregnancy have had a crisis pregnancy. Crisis pregnancy is defined in Irish legislation 'as a pregnancy which is neither planned nor desired by the woman concerned and which represents a personal crisis for her'. The rate of teenage pregnancy has declined from 20 births per 1,000 females aged 15–19 years in 2000 to 12 per 1,000 in 2012.

Sexual health promotion, education and prevention

The Strategy's goal for sexual health promotion, education and prevention is:

> Everyone living in Ireland will receive comprehensive and age-appropriate sexual health education and/or information and will have access to appropriate prevention and promotion services.

The aims of sexual health promotion, education and prevention initiatives are: to encourage the development of a healthy sexuality throughout life; to enhance people's lives and relationships; to reduce negative outcomes such as STIs and crisis pregnancies; and to create an environment that supports sexual health and wellbeing.

Sexual health promotion, education and prevention strategies work to address a range of issues such as challenging stigma and discrimination, promoting healthy attitudes and values, and challenging perceptions of risk. Interventions include: relationship and sexuality education; public health campaigns; condom distribution; targeted outreach; counselling and support; testing; vaccination; and medication programmes. In schools, the relationship and sexuality education (RSE) programme has been a required component of the curriculum at primary and post-primary level since 1996, and in 2003 was integrated into the broader Social Personal and Health Education (SPHE) programme.

In recognition of the role played by healthcare and other professionals in sexual health promotion and improvement, the development of professional skills and competencies is an integral component of achieving the Strategy goals.

Recommendations of this chapter of the Strategy address:

- the development of a culture of support, encompassing education in and outside of the school, education in the home and among sexual health practitioners;
- sexual health among adults;
- interventions for 'at risk' or vulnerable groups;
- training for relevant professionals; and
- prevention of STIs through clinical interventions, such as HIV testing and partner notification.

Sexual health services

The Strategy's goal regarding sexual health services is:

> Equitable, accessible and high quality sexual health services, which are targeted and tailored to need, will be available to everyone.

Sexual health services to the public include: clinical services for the diagnosis and management of STIs; contraception services/family planning services; counselling; information and support services; community outreach services for sexual health promotion; education and information; support; and crisis pregnancy management. There is a need to **map** existing services in order to provide a clear picture of the array, quality, efficiency, accessibility and availability of clinical services and to carry out a needs assessment for services to inform the implementation of this Strategy.

A '**hub and spoke**' model of care for the delivery of sexual health services is proposed. In this model, the 'hub' has the the expertise and resources to manage the most complex caseload in supporting the 'spokes', while the 'spokes' have the expertise and resources to manage a less complex caseload.

Communications **technology** and laboratory services are key supports that need further development in order to support sexual health services.

Recommendations regarding sexual health services address:

- Principles for sexual health services outlined above;
- a mapping exercise of existing services;
- the 'hub and spoke' model of care; and
- communications technology and laboratory services.

Sexual health intelligence

The Strategy's goal for sexual health intelligence is:

> Robust and high quality sexual health information will be generated to underpin policy, practice, service planning and strategic monitoring.

Sexual health Intelligence is the development and use of knowledge to support decision making to improve the health of the population. It supports good decision-making for better health and health outcomes by using an evidence base. The development of evidence-based analyses, to inform key strategic and operational decision-making, will be prioritised and supported and will underpin all strategic actions in line with the Healthy Ireland Framework. The ongoing monitoring of the implementation plan and reporting on progress will also be facilitated by the Healthy Ireland Outcomes Framework.

There is a need to continue to use and build on the established evidence base as a means of understanding emerging trends related to sexual health. In line with this, it is proposed to ensure that robust and high quality sexual health information is generated to underpin policy, practice, service planning and strategic monitoring.

Many other needs present in the field of sexual health intelligence: strengthening of surveillance; an agreed national core database for STI notifications; national reference laboratory facilities; and to strengthen the capacity for surveillance of antimicrobial resistance.

Recommendations regarding sexual health intelligence address:

- Information on knowledge, attitudes and behaviours;
- International clinical and behavioural indicators;
- Information on HIV and STIs;
- The need for an agreed national core dataset for STI notifications;
- The need for capacity for surveillance of antimicrobial resistance;
- Crisis pregnancy indicators;
- Knowledge transfer and exchange;
- Baseline information on sexual health services; and
- Effective strategic monitoring.

Strategy implementation

The Strategy will be delivered and monitored under the existing governance arrangements in place for the Healthy Ireland Framework. The Health and Wellbeing Division of the HSE will be responsible for leading the implementation of the majority of actions specified in the action plan of this Strategy. To support this, a National Clinical Lead and National Programme Lead will be appointed. The Division will also be supported by government departments, statutory and non-statutory bodies/agencies, professional bodies and NGOs as appropriate.

The **National Clinical Lead** for sexual health services will be responsible for ensuring standardised and effective sexual health services as outlined in the Sexual Health Strategy.

The **National Programme Lead** will have responsibility for the development of an implementation plan and for leading on actions in the implementation plan in conjunction with the National Implementation Group.

These two key roles will support the delivery of the goals of the Strategy. Both leads will work cross-divisionally within the HSE and with external partners as required to enhance

the delivery of sexual health services and to provide leadership for the Strategy's agenda. This will involve the Health and Wellbeing division of the HSE, other divisions and health structures, and external key stakeholders. In doing so, they will focus attention on agreed actions and coordinate sexual health strategy priorities within the HSE.

The Department of Health, through the governance structures of the Healthy Ireland Framework, will be responsible for oversight of the Strategy and for monitoring its outcomes and reporting to the Minister and the Cabinet Committee on Social Policy and Public Sector Reform.

National Sexual Health Strategy 2015–2020

Part 1: Context and background

1. Background

This National Sexual Health Strategy is a framework for the sexual health and wellbeing of the Irish population. This is the first time a nationally coordinated approach has been developed to address sexual health and wellbeing. Ireland has previously developed regional sexual health strategies and national strategies to address specific sexual health issues.

This Strategy's vision is that everyone in Ireland experiences positive sexual health and wellbeing, and has access to high quality sexual health information, education and services throughout their life. This Strategy acknowledges the importance of developing healthy attitudes to sexuality throughout childhood and adolescence and builds on that foundation for positive sexual health and wellbeing into adulthood and older age.

This working definition of sexual health was developed by the World Health Organization (WHO) through a consultative process with international experts:

> 'Sexual health is a state of physical, emotional, mental and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.'[7]

The aims of this Strategy are:

- to improve sexual health and wellbeing; and
- to reduce negative sexual health outcomes.

These aims will be addressed by the following overarching goals:

- Everyone living in Ireland will receive comprehensive and age-appropriate sexual health information and/or education and will have access to appropriate promotion and prevention services;
- Equitable, accessible and quality driven sexual health services, which are targeted and tailored to need, will be available to everyone; and,
- Robust and high quality sexual health intelligence will be generated to underpin policy, practice, service planning and strategic monitoring.

The three major domains involved in delivering the goals are:

- promotion, education and prevention;
- services; and
- health intelligence.

[7] WHO (2006) *Defining sexual health: Report of a technical consultation on sexual health,* 28-31 January 2002, Geneva, available at http://www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf

1.1 Determinants of health

The WHO recognises that social determinants of health impact on sexual health and that these can create health inequalities.[8] Social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies and politics. They include, for example, social status, education, gender, cultural and societal values, health-related behaviours and age. Sexual health determinants can act as enablers and barriers to sexual health and wellbeing.

This Strategy addresses the sexual health needs of the general population, recognising that an individual's sexual health can be adversely affected by personal circumstances and identity as well as by their economic, social and cultural circumstances. To be truly effective, this Strategy is targeted, tailored to the relevant epidemiological, economic, social and cultural contexts of the communities being addressed, with a particular emphasis on individuals with the greatest need.

This Strategy recognises the diversity of sexual identities in Ireland and supports all expressions of sexual identity through positive sexual health and wellbeing outcomes. It acknowledges that sexual orientation ranges along a continuum, from exclusive sexual attraction to the opposite sex through to exclusive attraction to the same sex, and that while many people identify as heterosexual, lesbian, gay or bisexual, some people may also engage in sexual behaviour that differs from their stated sexual orientation; for example, a man who identifies as heterosexual but engages in sex with other men.

1.2 Policy context and framework

This Strategy is being published in the context of major reforms of the health service and in its approach to the health and wellbeing of the population.

In 2012, *Future Health – A Strategic Framework for Reform of the Health Service 2012–2015* was launched and outlines the health service reforms up to the year 2015. *Future Health* identifies four pillars of reform:

- health and wellbeing;
- service reform;
- structural reform; and
- financial reform.

The Health and Wellbeing pillar ensures a focus on maintaining health and wellbeing and prevention of ill health, rather than just treating illness, and recognises a whole-of-government and whole-of-society approach to addressing health and wellbeing issues.

Healthy Ireland – A Framework for Improved Health and Wellbeing 2013–2025 (Healthy Ireland) was launched in March 2013. It outlines several guiding principles for implementation, including better governance and leadership, better partnerships, better use of people and resources and better measurement and evaluation.

The leadership, governance and coordination required to deliver the overarching goals for sexual health set out in this Strategy will be in line with both the Future Health Framework

[8] Malarcher, S. (2010) *Social Determinants of sexual and reproductive health: Informing future research and programme implementation*, World Health Organization, Geneva, available at http://whqlibdoc.who.int/publications/2010/9789241599528_eng.pdf

and the Healthy Ireland Framework and through their emerging structures and mechanisms for implementation.

The Health and Wellbeing Division of the HSE will take responsibility for leading the implementation of this Strategy, supported by the Department of Health and operating within the parameters of the Healthy Ireland Framework. Structures will be put in place to support the delivery of the strategic goals by:

- providing leadership for sexual health and wellbeing;
- developing, delivering and monitoring the implementation plan; and
- facilitating and coordinating cross-sectoral working for sexual health and wellbeing.

2. Sexual Health in Ireland

Ireland has experienced many changes in sexual behaviour and sexuality in recent decades. This chapter provides an overview of relevant developments in policy and legislation. It reviews research and epidemiological data relating to sexual behaviour and attitudes, sexually transmitted infections (STIs), the human immunodeficiency virus (HIV), crisis and teenage pregnancies, and presents data on sexual violence. Throughout, a focus is placed on at-risk or vulnerable groups. This chapter also describes some of Ireland's relationship and sexuality education initiatives.

2.1 Legislation and policy development

Ireland's changing sexual health landscape is evidenced by changes in legislation and policy over recent decades, for example legislation on contraceptive supply and information and same-sex sexual activity.

In 1979, the Health (Family Planning) Act facilitated the supply of contraception for family planning purposes or medical reasons by prescription in Ireland. In 1985, condoms and spermicides were made available without prescription to those over 18 years (lowered to 17 years in 1992) through pharmacies, hospitals, GP clinics and family planning clinics. A further amendment to the Health (Family Planning) Act in 1993 enabled condoms to be sold and supplied with almost no restrictions. In 2002, the Irish Medicines Board granted a licence for the first dedicated emergency contraception product on a prescription-only basis. In 2011, emergency hormonal contraception became available without prescription in pharmacies.

In 1988, the European Court of Human Rights held that certain provisions of the Offences against the Person Act 1861 and the Criminal Law Amendments Act 1885 were in breach of Article 8 of the European Convention on Human Rights. On foot of this ruling the Criminal Law (Sexual Offences) Act 1993 was introduced. It repealed sections of the above Acts, which in effect decriminalised homosexual acts between consenting males over the age of 17 years.

In 1995, the Regulation of Information (Services outside the State for the Termination of Pregnancies) Act allowed physicians, advisory agencies and counsellors to provide information on abortion services abroad on request, alongside information on parenting and adoption, in the context of one-to-one counselling. The Department of Health and Children established the Crisis Pregnancy Agency in 2001 to prepare and implement a strategy to address the issue of crisis pregnancy in Ireland.

In 2013, the Protection of Life During Pregnancy Act was passed. This regulates access to lawful termination of pregnancy in cases where there is a real and substantial risk to the life, as distinct from the health, of the pregnant woman, which may only be averted by such a medical procedure.

Other significant legal and regulatory developments include:

- The Infectious Diseases (Amendment) Regulation 2011, which provided that HIV became legally notifiable; and
- The Criminal Law (Sexual Offences) Act 2006, which makes it a criminal offence to engage or attempt to engage in a 'sexual act' with a child (i.e. someone under the age of 17 years).

Recent changes in legislation, such as the introduction of divorce in 1996 and the Civil Registration Act 2004, are also relevant. In 2010, the Civil Partnerships Act granted extensive rights and responsibilities to lesbian and gay couples that were previously only available to married couples. By June 2014, a total of 1,467 civil partnerships had taken place in Ireland. The Civil Partnerships Act also accords certain rights to long-term cohabiting couples who have not entered into a civil partnership.

2.2 Sexual behaviour and attitudes

The majority of adults in Ireland are sexually active, and enjoy healthy sexual relations with people of the same or different sex.

Sexual activity

The majority of young people in Ireland have sex for the first time between the ages of 17 and 19 years.[9] However 37% of men and 26% of women aged between 18 and 25 years report having had sex before 17 years. Younger adults are more likely than older adults to report that they had sexual intercourse at a younger age. They are also more likely to report having had more sexual partners than older adults.

A small research study with 41 early school leavers found that 58.5% of the young people were sexually active. The average age of first sex was 13.5 years, with 54% reporting that no contraception was used at this time and it was unplanned sex.[10]

Risk reduction behaviour

Almost four-fifths (78%) of adults report using contraception consistently, but consistency of use decreases with increasing age.[7] Younger adults use contraception more consistently than older adults. However, young people who have sex before 17 years are 52% less likely to use contraception for their first sexual experience than those who have first sex aged 17 years and over. The most commonly used contraceptives amongst adults in Ireland are the contraceptive pill and condoms. The use of long-acting reversible contraceptives (LARCs) has increased in recent years across all age groups. The LARC methods include intrauterine systems, intrauterine devices and subdermal implants.

Attitudes and culture

Attitudes to sex and sexuality have altered over the past few decades; Irish society is now more open about these issues. However, embarrassment in talking about sex and contraception remains a barrier to delivering education and information and accessing services.[7]

The general climate created as a result of sex and sexuality not being openly discussed can contribute to concealed pregnancy, non-disclosure of HIV status and late HIV and STI diagnosis. It may also contribute to people with sexual health problems – such as a HIV-positive diagnosis, an STI, crisis pregnancy or sexual difficulties – fearing stigma and discrimination to the degree that it discourages them from accessing medical help or

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[9] McBride, O. Morgan, K. and McGee, H. (2012) *Irish contraception and crisis pregnancy study 2010 (ICCP–2010): A survey of the general population*, Crisis Pregnancy Programme, Report No. 24. (This is the key source for this subsection, unless otherwise stated.)

[10] Mayock, P. and Byrne, T. (2004) *A study of sexual health issues, attitudes and behaviours: The views of early school leavers*, Crisis Pregnancy Agency, Report No. 8, available at http://crisispregnancy.ie/wp-content/uploads/2012/05/8.-a-study-of-sexual-health-issues-attitudes-and-behaviours-the-views-of-early-school-leavers.pdf.

counselling support. Embarrassment can be a barrier to accessing information and assistance with sexual health issues such as sexual dysfunction. There also remains a stigma with regard to sexual health issues and sexual orientation for some people. This embarrassment and stigma can lead to a reluctance by individuals to seek help, while healthcare professionals may not raise sexual health as an issue for the same reason (or because they are focussed on another health issue). These issues can be compounded by physical illnesses such as cancer, which can impact body image and fertility and, alongside medication, can also affect sexual function. While recent years have seen an increase in information on public attitudes to many areas of sexual health and behaviour, further information is needed in the areas of health promotion, prevention, education and services.

The sexualisation of culture and the premature sexualisation of children is an area that requires further exploration.[11] According to research by UNICEF, one in five adolescents reported receiving information about sex from pornography.[12]

[11] See 'Bailey review reports' (2013) for UK evidence on this issue, available at http://www.education.gov.uk/childrenandyoungpeople/healthandwellbeing/a0074315/bailey-review In addition, in Ireland the Department of Children and Youth Affairs has commissioned research in this regard; see 'DYCA/IRC Co-funded Research Scheme', available at http://www.dcya.gov.ie/viewdoc.asp?fn=/documents/Research/CommericalSexualisationAbstract.htm

[12] UNICEF (2011) *Changing the future: Experiencing adolescence in contemporary Ireland: Sexual health and behaviour*, UNICEF, available at http://www.unicef.ie/Downloads/UNICEF_Change_the_Future_A5_Report-Sexual_Health__Behaviour-Web.pdf.

2.3 Epidemiology of STIs and HIV

STIs

There has been a general upward trend in STI notifications since 1995, though during this timeframe methods of data collection and recording have improved considerably.[13] In the period 1995–2013, STI notifications increased from 3,361 to 12,753, equating to 92.7 per 100,000 per population to 277.9 per 100,000. The table below shows the rates of STI notifications in 1995 and 2013.

STI notifications, 1995 and 2013

STI	1995		2013		
	Notifications (n.)	Per 100,000	Notifications (n.)	Per 100,000	Median age
Chlamydia trachomatis	245	6.8	6,262	136.5	25
Gonorrhoea	91	2.5	1,294	28.2	26
Herpes simplex (genital)	198	5.5	1,136	24.8	29
Syphilis	11	0.3	576	12.6	36
Ano-genital warts	1,972	54.4	2,133	46.5	N/A
Non-specific urethritis	781	21.5	1,272	27.7	N/A
Trichomoniasis	60	1.7	75	1.6	33
Lymphogranuloma venereum	0	0	5	0.1	31
Chancroid	3	0.1	0	0	N/A

Source: Summary of STIs in Ireland 2013, Health Protection Surveillance Centre (HPSC)

The HPSC report that the greatest burden of STIs falls among those aged under 25 years and among men who have sex with men (MSM). Chlamydia trachomatis is the most commonly reported STI, followed by ano-genital warts and genital herpes. Young people are most affected by STIs, accounting for approximately 70% of notifications each year. The rise in gonorrhoea notifications since 2010 is cause for concern, particularly in view of the development of antimicrobial resistance.

HIV

In 1992, the Irish government responded to the HIV crisis by establishing the National AIDS Strategy Committee (NASC). This Committee and its subgroups comprised a wide range of stakeholders from government departments and non-governmental

[13] Health Protection Surveillance Centre (2014) *Summary of STIs in Ireland 2013*, available at www.hpsc.ie (This is the key source for this subsection, unless otherwise stated.)

organisations (NGOs). They continued to meet until 2012 (at which point the development of this Strategy was underway).

Between the early 1980s and end 2014, a total of 7,353 people were newly diagnosed with HIV in Ireland.[14] The year 2014 saw 377 newly diagnosed cases of HIV reported. This marked an 11% increase from 2013. The highest proportion of these new HIV diagnoses occurred among MSM. This proportion has been increasing overall since 2004 (it was 48.5% in 2014). Of the newly diagnosed cases of HIV, almost 50% had a late diagnosis, which is associated with poorer health outcomes and a greater chance of onward transmission.

2.4 Crisis pregnancy and teenage pregnancy

Irish legislation defines a crisis pregnancy as 'a pregnancy which is neither planned nor desired by the woman concerned and which represents a personal crisis for her'. This definition is understood to include the experiences of women for whom a planned pregnancy develops into a crisis over time due to a change in circumstances.[15] A teenage pregnancy is not necessarily a crisis pregnancy, with many young people welcoming planned and unplanned pregnancies.

Crisis pregnancy

A 2012 study on crisis pregnancy found:

- Approximately one-third of women (35%) with experience of pregnancy have experienced a crisis pregnancy, while one-fifth of men (21%) whose partners were pregnant have experienced a crisis pregnancy;
- Two reasons most commonly given for a pregnancy being defined as a crisis were a pregnancy not being planned or the woman thinking she was too young to have a child at that time;
- Among women who experienced a crisis pregnancy, the majority outcome was parenthood (62%) while over one-fifth (21%) had an abortion and the remainder of pregnancies ended in miscarriage.[16]

Since 2001 the number of women giving Irish addresses at British abortion clinics has decreased from 6,673 to 3,679 in 2013. This suggests a 45% decrease in the number of women travelling to Britain for abortion over the period.[17] In 2005, the Netherlands was identified as a principal European state destination for women from Ireland seeking an abortion, but again, this figure has decreased, from 461 women in 2006 to 12 in 2013.

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[14] HSE-HPSC (June 2015) *HIV in Ireland: 2014 Report,* available at http://www.hpsc.ie/A-Z/HIVSTIs/HIVandAIDS/SurveillanceReports/File,15208,en.pdf (This is the key source for this subsection, unless otherwise stated.)

[15] Crisis Pregnancy Agency (Establishment) Order 2001 (S.I. No. 446 of 2001).

[16] McBride, O., Morgan, K. and McGee, H. (2012) *Irish contraception and crisis pregnancy study 2010 (ICCP–2010): A survey of the general population*, Crisis Pregnancy Programme, Report No. 24.

[17] HSE (2013) 'Number of women giving Irish addresses at UK abortion clinics decreases for eleventh year in a row according to UK Department of Health, 11 July 2013, available at http://www.crisispregnancy.ie/news/number-of-women-giving-irish-addresses-at-uk-abortion-clinics-decreases-for-eleventh-year-in-a-row-according-to-uk-department-of-health/.

Teenage pregnancy

The teenage birth rate has declined, from 20 births per 1,000 females aged 15–19 years in 2001 to 10 births per 1,000 females aged 15–19 years in 2013.[18] There were 1,381 teenage births in 2013. This represents a decrease of 55% between 2001 and 2013.

2.5 At-risk and vulnerable groups

Many public health issues have common root causes. Poor health outcomes and behaviours often present disproportionately (or 'cluster') for certain populations. While sexually active people of all ages are at risk of contracting an STI or experiencing a crisis pregnancy (if fertile), certain groups are at greater risk than others.

Those at increased risk of not using contraception at first sexual intercourse: Men, people with a pre-Leaving Certificate education, people in lower socio-economic status (SES) groups and people with a sexual debut before age 17.[19]

Those at increased risk of experiencing a crisis pregnancy: Younger women, women with a pre-Leaving Certificate education.[20]

Those at increased risk of STIs and HIV: Gay and bisexual men and MSM – men who have sex with men who do not identify as gay or bisexual.

Some people may be in greater need of sexual health supports for a range of reasons.[21] These may include those who self-identify as lesbian, gay, bisexual or transgender (LGBT).

Vulnerable groups

There are a number of vulnerable groups that require targeted support to improve their sexual health and wellbeing. These include people with a migrant background, people with an intellectual disability, and young people in care.

Research with people with a **migrant background** has found that knowledge and information about sexual health and crisis pregnancy prevention services was poor, and experiences of accessing sexual and reproductive health services limited, in comparison with other young women in the same age group. The main barriers to accessing and participating in sexual and reproductive health services were linked to cultural and religious backgrounds, their pre-migration experiences, the impact of the legal status on access to health services, costs and language and communication issues.[22]

Research finds that sexual healthcare and engaging in sexual relationships for those with **intellectual disabilities** is complicated by legal and technical issues surrounding capacity to consent, both to medical treatment (including contraception) and to sexual

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[18] HSE (2013) 'HSE welcomes decline in teenage births', 31 May 2013, available at http://www.crisispregnancy.ie/news/hse-welcomes-decline-in-teenage-births/. (This is the key source for this subsection, unless otherwise stated.)

[19] McBride, O., Morgan, K. and McGee, H. (2012) *Irish contraception and crisis pregnancy study 2010 (ICCP–2010): A survey of the general population*, Crisis Pregnancy Programme, Report No. 24.

[20] McBride, O., Morgan, K. and McGee, H. (2012) *Irish contraception and crisis pregnancy study 2010 (ICCP–2010): A survey of the general population*, Crisis Pregnancy Programme, Report No. 24.

[21] McGee, H. Rundle, K. Donnelly, C. and Layte, R. (2008) *The Irish study of sexual health and relationships*, *Sub-Report 2: Sexual health challenges and service provision*, Department of Health and Children and Crisis Pregnancy Agency, available at http://crisispregnancy.ie/wp-content/uploads/2012/05/ISSHR-sub-report-2.pdf.

[22] Conlon, C, O'Connor, J and Ní Chatháin, S (2012) *Attitudes to fertility, sexual health and motherhood amongst a sample of non-Irish national minority ethnic women living in Ireland*, Crisis Pregnancy Programme, Report No. 25, available at http://crisispregnancy.ie/wp-content/uploads/2012/06/migrant-women-report.pdf

intercourse.[23] Negative attitudes to sexual activity among people with intellectual disabilities, a desire to legally and physically protect people with intellectual disabilities from exploitation and a lack of specialised care to support participation in decision-making can compromise the level of sexual health support received.

2.6 Relationship and sexuality education for young people

Sex education at home

Parental involvement in sex education can have a positive impact on the subsequent behaviour of young people, encouraging later sexual initiation, higher prevalence of protective behaviours and greater confidence in negotiating sexual relationships.[24] Adults who received sex education in home and/or in school were 1.5 times more likely to use contraception the first time they had heterosexual intercourse than adults who received sex education outside of the home or school environment.[25] In 2010, however, fewer parents (70%) reported that they or their partner had talked to their children (12–18 years) about sex compared to the 2003 figure (82%).[26]

Sex education in schools

The relationship and sexuality education (RSE) programme has been a required component of the curriculum at primary and post-primary level since 1996. In 2003, RSE was integrated into a broader health education programme called Social Personal and Health Education (SPHE).

A Department of Education and Skills (DES) Lifeskills survey, conducted in 2012, indicated that among respondents, 97% of primary and 95% of post-primary schools either have an RSE policy in place or are in the process of developing one. Almost all schools indicated that they were delivering each element of the RSE programme. Schools draw upon the expertise of external agents, particularly the HSE, for the delivery of some aspects of the RSE programme.[27] It is expected that the data from the 2015 Lifeskills survey will be published before the end of 2015. They will provide an update on the position in schools since 2012. There are varied experiences of RSE in schools and some young people have indicated that they want more RSE classes and better quality teaching.[28] However, recent

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[23] O'Connor, J (undated) *Literature review on provision of appropriate and accessible support to people with an intellectual disability who are experiencing a crisis pregnancy*, National Disability Authority and Crisis Pregnancy Agency, available at http://nda.ie/nda-files/People-with-Intellectual-Disability-Crisis-Pregnancy-Report.pdf.

[24] Layte, R., McGee, H., Quail, A., Rundle, K., Cousins, G., Donnelly, C. et al. (2006) *The Irish study of sexual health and relationships*, Crisis Pregnancy Agency and Department of Health and Children, available at http://www.ucd.ie/issda/static/documentation/esri/isshr-report.pdf.

[25] McBride, O. Morgan, K. and McGee, H. (2012) *Irish contraception and crisis pregnancy study 2010 (ICCP–2010): A survey of the general population*, Crisis Pregnancy Programme, Report No.24.

[26] McBride, O. Morgan, K. and McGee, H. (2012) *Irish contraception and crisis pregnancy study 2010 (ICCP–2010): A survey of the general population*, Crisis Pregnancy Programme, Report No.24.

[27] Department of Education and Skills (2014) *Results of Department of Education and Skills 'Lifeskills' survey 2012*, available at http://www.education.ie/en/Publications/Education-Reports/Results-of-the-Department-of-Education-and-Skills-%E2%80%98Lifeskills%E2%80%99-Survey-2012.pdf

[28] Dáil na NÓg (2010) *Life skills matter – Not just points*, Office of the Minister for Children and Youth Affairs, available at http://dcya.gov.ie/documents/publications/Life_Skills_Matter.pdf.

research suggests that the quality and reach of relationship and sexuality education in schools is improving.[29]

Sex education in out-of-school settings

Out-of-school settings refers to the alternative paths to education and training taken by early school leavers. It also refers to other youth organisations and groups who may have a remit or opportunity to provide relationship and sexuality education. Services in out-of-school settings play an important role in providing relationship and sexuality education, delivering comprehensive programmes in line with good practice guidelines.

In addition, many targeted outreach programmes exist in Ireland providing sexual health support and information in a more informal setting than a school. National public health campaigns such as *Think Contraception* also facilitate access to information for sexually active people of all ages, but particularly young people.

2.7 Sexual violence

In March 2010, the Government launched the *National Strategy on Domestic, Sexual and Gender-based Violence, 2010–2014*. This was a five-year strategy that aimed to provide a framework for a sustainable intervention to prevent and effectively respond to domestic, sexual and gender-based violence. In this context, the HSE also published its own complementary *HSE Policy on Domestic, Sexual and Gender-based Violence*, in line with the national strategy. Due to these policy initiatives, this Strategy does not deal directly with sexual violence but recognises the need for coordination across these areas. A second National Strategy on Domestic, Sexual and Gender-based Violence is currently being developed by the Department of Justice and Equality.

There are 6 HSE Sexual Assault Treatment Units located around Ireland. All of these strive to provide a 24 hour, 7 days a week service to men and women over the age of 14 years who have experienced sexual violence. These Units provide services in line with the *Rape/Sexual Assault: National Guidelines on Referral and Forensic Clinical Examinations in Ireland (3rd Edition 2014)*[30].

The SAVI report (2002) revealed that one in five women and one in 10 men have experienced contact sexual assaults as adults, and that one-third of women and one-quarter of men have experienced some level of sexual abuse in childhood.[31] In 2011, 2,308 survivors of sexual violence attended Rape Crisis Centres for counselling and support. Of these, 88% were female and 12% were male. In 2011, 7% of female survivors of rape became pregnant (n. 90).[32]

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[29] McBride, O. Morgan, K. and McGee, H. (2012) *Irish contraception and crisis pregnancy study 2010 (ICCP–2010): A survey of the general population*, Crisis Pregnancy Programme, Report No. 24.

[30] National SATU Guidelines Development Group. Rape/Sexual Assault: National Guidelines on Referral and Forensic Clinical Examination in Ireland. 3rd edition; 2014. Available at www.hse.ie/satu.

[31] McGee, H., Garavan, R., de Barra, M., Byrne, J. and Conroy, R. (2002) *The SAVI report: Sexual abuse and violence in Ireland*, Liffey Press in association with Dublin Rape Crisis Centre, available at http://www.oneinfour.ie/content/resources/savi.pdf.

[32] Rape Crisis Network Ireland (2012) *2011 national rape crisis statistics*, available at http://www.rcni.ie/uploads/RCNIARNationalStatistics2011.pdf. The Rape Crisis Network manages an anonymised database for 15 of the 16 Rape Crisis Centres in Ireland.

National Sexual Health Strategy 2015–2020

Part 2: Goals and recommendations

3. Sexual Health Promotion, Education and Prevention

Goal: Everyone living in Ireland will receive comprehensive and age-appropriate sexual health education and/or information and will have access to appropriate prevention and promotion services.

The promotion of sexual health and wellbeing is about enabling people to improve their sexual health and to increase their control over it. These outcomes require a combination of sexual health education and healthy public policy aimed at creating a supportive environment for sexual wellbeing. The aims of sexual health promotion, education and prevention initiatives are:

- to encourage the development of a healthy sexuality throughout life;
- to enhance people's lives and relationships;
- to reduce negative outcomes such as STIs and crisis pregnancies; and
- to support the creation of a cultural and legislative environment in which sexual health and wellbeing can flourish.

Sexual health promotion, education and prevention strategies work to address a range of issues such as challenging stigma and discrimination, promoting healthy attitudes and values, and challenging perception of risk. Interventions include: relationship and sexuality education; public health campaigns; condom distribution; targeted outreach; counselling and support; testing; vaccination; and medication programmes.

As health and other professionals have a role in sexual health promotion and improvement, the development of professional skills and competencies is an integral component of achieving the Strategy goals.

3.1 Developing a supportive cultural environment for sexual health and wellbeing

Many factors are associated with both sexual health inequalities and sexual wellbeing. These include social and economic status, general education, gender, sexual orientation, cultural background, mental and physical health and wellbeing, age, disability, family background, and issues such as alcohol and substance misuse. Health and social inequalities that affect health outcomes in general also affect sexual health outcomes. In order to address these inequalities, this Strategy adopts a targeted approach and works within the Healthy Ireland Framework.

Legislative and ethical issues compound the problems of responding to individual sexual health needs. The legislative framework for the provision of sexual health services to particular groups, such as young people, people with intellectual disabilities and people in care, can be complex. All relevant organisations and individuals should have an awareness of the legislation and regulations relating to sexual health particularly those relating to issues of consent, child protection, sexual abuse and intellectual disability.

While attitudes to sexuality have changed, barriers still exist in relation to open communication about sex and sexuality. This can present problems for the healthy sexual development of children and young people, particularly if parents and teachers experience difficulty in communicating about sex and sexuality. In addition to the need for effective relationship and sexuality education for children and young people, many older adults may not have received sex education as children and may not perceive themselves to be at risk of negative consequences of unprotected sexual activities.

As mentioned, the general climate created as a result of sex and sexuality not being openly discussed can also result in issues such as concealed pregnancy and late HIV/STI diagnosis. The fear of stigma and discrimination may also result in non-disclosure of HIV status, and people not accessing medical help and counselling support. Lesbian, gay, bisexual and transgender people (LGBT) and those who have sex with people of the same sex without self-identifying as lesbian, gay or bisexual may have added difficulties in expressing their sexuality and in accessing appropriate care and support.

Many of the recommendations in this Strategy aim to promote a positive cultural change regarding open communication about relationships and sexual health. Specific recommendations are outlined below.

Recommendations: A supportive cultural environment for sexual health and wellbeing

	Recommendations	Partners
3.1	Promote an environment of openness to reduce the negative impact of stigma relating to sexual health and wellbeing.	HSE, DoH, NGOs
3.2	Develop guidelines on the implications of the legislative environment relating to the provision of sexual health services.	HSE, relevant professional bodies, NGOs
3.3	Develop a communications strategy to highlight developments and priorities in sexual health both through research findings and progress on strategic actions.	HSE, DoH, DCYA, DES, NGOs

3.2 Sex education for children and young people

Early exposure to high quality sexuality education promotes positive mental and physical wellbeing, as well as an individual's ability to develop appropriate competencies and skills, to avoid sexual exploitation and abuse and to achieve healthy sexual development.

The sexual health education of children is the responsibility of parents in the first instance and is supported through RSE in primary and post-primary schools and by youth organisations and NGOs. The State has a responsibility to ensure that children and young people receive comprehensive relationship and sexuality education in order to help them attain the knowledge, understanding, attitudes and skills required for healthy sexual expression. A partnership approach between parents, statutory and non-statutory organisations is also required to address the sexual health information needs of children and young people to support sexual health and wellbeing.

Children and young people receive messages from a range of sources about sexuality and relationships at a time when they may be going through significant psychological, emotional and physical change. They require support in filtering these messages and an awareness of where to access correct and trustworthy information. Public policy deliberation on the early sexualisation of children and young people, and their exposure to pornography, based on research evidence and expert opinion, is required. The driving concerns here are child health, wellbeing and safety.

The relationship between alcohol and risky sexual behaviours is not clear cut. While excessive alcohol consumption by young people may be a factor in risk taking, there are many other factors to be considered and the relationship may not be causal. Other factors that influence sexual risk taking when alcohol has been consumed include the nature of

the relationship and/or if the individuals involved had contemplated and prepared for a sexual encounter. However, alcohol, in lowering inhibitions, may reduce perception of risk, which can result in earlier sexual debut, unplanned, unprotected and regretted sexual activities and increased risk of sexual exploitation.

The role of parents

Children and young people learn directly and indirectly from their parents and other significant adults. Their experiences, impressions and observations form the foundation of future sexual attitudes and decisions. As parents are the primary educators of their children, they have responsibility for providing them with the information, education and support necessary to prepare them for a lifetime of positive sexual health and wellbeing. The contribution of the education system in this regard complements rather than replaces the role of parents. As not all parents feel competent to provide good quality sex education to their children, provision should be made to support them in their role.

The role of schools

As children grow, school settings become important to their healthy development. It is important for promoting sexual health and wellbeing that relationship and sexuality education is accessible to all pupils at both primary and post-primary level. Government education policy contains an ongoing commitment to providing relationship and sexuality education and associated skills and competencies at all school levels to children and young people in Ireland.

The role of out-of-school settings

Opportunities can arise in non-formal education settings for conversations about sex, less structured than those that occur in the school setting. Those working in out-of-school settings should therefore be resourced to promote positive sexual health and wellbeing and respond to crisis situations.

Recommendations: Children and young people

	Recommendations	Partners
3.4	Ensure that all young people will have continued access, and knowledge of how to access, age-appropriate sources of trustworthy and accurate information and support on relationships and sexual health.	DCYA, DES, HSE, NGOs, Youthreach
3.5	Support all children and young people in addressing issues that impact on sexual wellbeing such as stigma, homophobia, gender, ability/disability, mental health, alcohol and drugs.	Parent organisations, DCYA, DES, HSE, NGOs
3.6	Develop and promote accessible and appropriate information, resources and supports for parents to enable them to communicate effectively about relationships and sexuality.	HSE, DCYA, NGOs, parent organisations

3.7	Address the impact of early sexualisation and pornography and support parents to address issues arising from early sexualisation.	Parent organisations, DCYA, DES, HSE, NGOs
3.8	Evaluate State-funded relationship and sexuality education programmes, within available resources, with input from stakeholders.	DES, DoH, HSE, children and young people representatives, NGOs
3.9	Continue to provide teachers with appropriate training within available resources to equip them to deliver relationship and sexuality education programmes.	DES, DCYA, HSE, DoH
3.10	Continue to provide to all young people who have left school with information on how and where to access sexual health services appropriate to their needs.	HSE, NGOs, Youthreach
3.11	Outreach programmes to inform and support young people in out-of-school settings will address sexual health needs.	NGOs, sexual health service providers, HSE
3.12	Provide organisations working with young people in out-of-school settings with support and sexual health training to ensure they provide high quality advice, resources and services.	HSE, Youthreach, NGOs, other health professionals

3.3 Sexual health among adults

Patterns that develop in late adolescence and young adulthood, particularly the context in which they experience first sex, can have a significant impact on sexual health and wellbeing. Attitudes to sex, sexuality and relationships continue to develop into adulthood and can be influenced by family, peer groups, wider society, the media and, for some people, pornography.

Many adults only become aware of their sexual health needs when faced with issues that impact on their relationships and/or their sexual activity. Sexual health and wellbeing are impacted by a range of issues, such as negative attitudes and experiences of one's own or other's sexuality, unhealthy sexual relationships, experience of STIs, crisis pregnancy, sexual difficulties and dysfunction and the stigma attached to all of these experiences. Access to sexual health services providing testing, counselling and advice on sexual issues can help people overcome difficulties they face, irrespective of age.

Education and information to promote sexual health and wellbeing and safe practices should be accessible through specialist, core health and community service providers. Education and information should be accessible, non-judgemental, targeted, de-stigmatising and positive. Social marketing campaigns aimed at preventing crisis pregnancy and STIs should be maintained and reviewed in order to include a broader focus on sexual health and wellbeing for adults.

Older age may bring advantages and disadvantages to sexual health and sexuality and many older adults continue to enjoy sexual activity. However, it must also be

acknowledged that later adulthood may bring additional challenges to sexual wellbeing, such as illness, changes in sexual functioning and expression, changing relationship and family structures and the loss of partners and peers. This Strategy supports the healthy sexuality of older adults through promoting positive awareness of the issue, empowering older people to communicate with their health and community professionals and enabling health and community professionals to acknowledge and address sexual health and wellbeing with their older client group.

Recommendations: Adults

	Recommendations	Partners
3.13	Provide all adults with information aimed at reducing negative sexual health outcomes and promoting sexual wellbeing, throughout life.	HSE, NGOs
3.14	Provide accessible crisis pregnancy supports, STI/HIV testing and other supports and counselling for all sexually active adults.	HSE, NGOs
3.15	Include broader sexual health information in public health campaigns and information resources.	HSE, NGOs

3.4 At-risk and vulnerable groups

There are groups of people who are at particular risk of and/or are vulnerable to experiencing negative sexual health outcomes. These groups therefore require specific interventions to attain and maintain sexual health. At-risk and vulnerable groups are not necessarily mutually exclusive. Current research suggests that they include: early school leavers or those at risk of becoming so; people living in disadvantaged communities; young people in care or aftercare; people with disabilities or mental health problems; sex workers; prisoners; young adults; LGBT people; and MSM - men who may or may not identify as gay or bisexual. This is not a comprehensive list of those who may be 'at risk' and/or vulnerable; others will be identified and targeted during the lifetime of the Strategy.

The following interventions, all of which have been a cornerstone of HIV prevention, will continue to play a key role in reducing negative sexual health outcomes: positive prevention; the promotion of testing; the promotion of access to condoms; and targeted education and outreach initiatives.

Recommendations: At-risk and vulnerable groups

	Recommendations	Partners
3.16	Develop an evidence-informed response to targeting those most at risk of negative sexual health outcomes.	HSE
3.17	Ensure that all campaigns and interventions targeting those most at risk of negative sexual health outcomes will be inclusive with regard to the diversity of sexual experiences and identities.	HSE, NGOs
3.18	Develop and maintain positive prevention, access to condoms, testing, targeted education and outreach.	HSE, NGOs

3.19	Identify and establish links with other relevant strategies, particularly those relating to vulnerable and at-risk groups, to ensure their sexual health needs are addressed.	HSE, NGOs

3.5 Professional training

High quality training for relevant professionals is a crucial element of promoting sexual health and wellbeing and reducing negative sexual health outcomes. This includes both those who work specifically in the area of sexual health and those who can incorporate sexual health issues into their core work. In addition to meeting the need for improved knowledge and skills, training should include an exploration of participants' own attitudes and values in relation to sexual health issues. This will help prepare professionals to deal supportively with clients whose lives, life stage or beliefs may be different to their own. As the personal discomfort of professionals can be a barrier to raising sexual health issues with clients, such training should also seek to normalise communication about sexual health, thereby increasing comfort levels in relation to the topic.

Recommendations: Professional training

	Recommendations	Partners
3.20	Develop programmes for those working with vulnerable and at-risk groups to train them to recognise and respond appropriately to the sexual health needs of their clients, recognising and addressing the barriers to accessing services faced by many at-risk groups.	HSE, sexual health service providers, NGOs, other health and non-health professionals, undergraduate and postgraduate training bodies
3.21	Incorporate training on sexual health for professionals who deliver sexual health education and prevention activities or who can incorporate sexual health into their core work as part of continuing professional development.	HSE, undergraduate and postgraduate training bodies, professional bodies, NGOs
3.22	Provide training to health professionals on how to recognise the ways in which other health problems may impact on sexual health and to support them in raising sexual health issues with their clients across all age groups.	HSE, undergraduate and postgraduate training bodies, professional bodies, NGOs

3.6 Prevention through clinical interventions

Opportunities for education, prevention and health promotion initiatives arise during interactions between healthcare workers and clients. Medical interventions such as vaccines, testing, screening and treatment also help eliminate or reduce onward transmission of STIs and HIV.

Prevention through vaccination

In 2008, universal vaccination against the Hepatitis B Virus (HBV) within the first year of life was introduced, but it will be many years before the adolescent and adult population have acquired immunity. People who attend STI clinics or access primary care are offered the HBV vaccination if they belong to a high-risk group. Vaccination will be offered to those who are sexual contacts of persons with acute or recently identified chronic HBV.

In 2010, a human papilloma virus (HPV) vaccination was introduced for adolescent girls in Ireland. This vaccine targets two of the HPV types associated with cervical cancer and two of the HPV types associated with genital warts. This programme will be considered for expansion to other target groups.

Prevention through HIV screening and testing

Awareness of HIV status and antiretroviral therapy is essential to the prevention of morbidity and mortality associated with HIV and in the prevention of new infections. People at risk of HIV should be made aware of the benefits of knowing their HIV status, encouraged to test for HIV and to avail of antiretroviral therapy as appropriate. For many years attendees at STI services in Ireland have routinely been offered HIV testing. In 1999, routine opt-out antenatal testing for HIV was introduced in Ireland.

The European Centre for Disease Prevention and Control (ECDC) encourages Member States to develop and scale up HIV testing programmes if there is an epidemiological basis for doing so.[33] Current research is considering routine, opt-out HIV testing in various clinical settings (including hospitals in Dublin). Furthermore, advances in HIV testing provide increased opportunities for testing in non-clinical settings and should be assessed in the Irish context. In addition to service users being targeted for HIV testing, service providers should have appropriate information and guidelines on HIV testing in various settings.

HIV status disclosure to sexual partners is considered an important public health goal by both the WHO and UNAIDS as it can motivate testing, change risk behaviours and ultimately decrease HIV transmission. For the individual with a HIV diagnosis, disclosure can have a range of positive benefits such as opportunities for social support and implementation of HIV risk reduction with partners. Disclosure can also have potentially negative implications associated with stigma, such as rejection and discrimination. Both the individual's decision to disclose and actions to reduce stigma and discrimination should be supported.

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[33]European Centre for Disease Prevention and Control (2010) *HIV testing: Increasing uptake and effectiveness in the European Union* Stockholm, ECDC, available at http://ecdc.europa.eu/en/publications/publications/101129_gui_hiv_testing.pdf.

[34] Myron, S., Cohen, M.D., Chen, Y., McCauley, M., Gamble, T., Hosseinipour, M. et al. (2011), 'Prevention of HIV-1 infection with early antiretroviral therapy', *New England Journal of Medicine*, Vol. 365, No. 6, pp. 493–505.

HIV prevention through antiretroviral therapy

Highly-active antiretroviral therapy (HAART) has revolutionised HIV treatment.There is no effective HIV vaccine but antiretroviral treatment strategies can prevent HIV transmission and acquisition. Recent data demonstrate that when a person living with HIV is on effective HAART, the risk of their sexual partner(s) acquiring HIV through unprotected sexual intercourse is significantly reduced.[34] Thus, the early treatment of known HIV cases may contribute towards reducing HIV transmission. Treatment as Prevention (TasP) will be assessed and implemented as appropriate as part of this Strategy.

Furthermore, following exposure to HIV, there is a 72-hour period when it is possible to provide post-exposure prophylaxis (PEP) to protect against transmission. The decision to proceed with HIV PEP should be made in line with recently published national guidelines.[35] Further work to implement the national guidelines for post-exposure prophylaxis is recommended under this Strategy.

Prevention through STI screening

Research commissioned by the HPSC determined that it is currently not cost effective to implement opportunistic screening for chlamydia.[36] This research made recommendations including the development of a step-by-step approach to chlamydia and STI screening in Ireland. In line with ECDC guidance, this would involve initially focusing on primary prevention and progressing towards case management interventions.[37] Further assessment will be made of the effectiveness of screening for chlamydia and other STIs in various settings with the subsequent development and implementation of STI screening guidelines.

Prevention through partner notification

Partner notification and contact tracing of individuals exposed, or potentially exposed, to STIs plays an integral role in the control of STIs, both at individual and population levels. This is particularly important in the avoidance of clusters or outbreaks. An assessment should be undertaken of partner notification procedures for potentially exposed individuals to include the effectiveness of current methodologies, including community-based facilities and IT-based procedures.

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[35]HSE, 'EMI Toolkit: Guidelines for the emergency management of injuries', available at www.emitoolkit.ie.

[36]Chlamydia Screening Steering Group (2012) *Chlamydia screening in Ireland: A pilot study of opportunistic screen for genital chlamydia trachomatis infection in Ireland (2007–2009)*, Health Protection Surveillance Centre and the Health Research Board, available at http://www.hpsc.ie/hpsc/A-Z/HIVSTIs/SexuallyTransmittedInfections/Chlamydia/Publications/File,13423,en.pdf.

[37] For example: diagnostic services, partner notification services.

Recommendations: Prevention through clinical interventions

	Recommendations	Partners
3.23	Implement the Hepatitis B vaccination programme in line with national immunisation guidelines.	DoH, HSE, relevant professional bodies
3.24	Maintain and promote the HPV vaccination programme for adolescent girls in line with national immunisation guidelines.	DoH, HSE, relevant professional bodies
3.25	Assess the effectiveness (including cost effectiveness) of extending the HPV vaccine to other groups and develop appropriate guidelines.	HIQA, DoH, HSE, relevant professional bodies
3.26	Assess the acceptability and effectiveness (including cost effectiveness) of testing for HIV and other STIs in various settings.	HSE, ICGP, sexual health service providers, NGOs, relevant professional bodies, HIQA
3.27	Develop and implement HIV and STI testing guidelines.	DoH, HSE, HIQA, NGOs, relevant professional bodies
3.28	Actions to support HIV disclosure and reduce stigma and discrimination will be supported.	DoH, HSE, sexual health service providers, NGOs
3.29	Develop and implement guidelines for the appropriate use of antiretroviral therapy in HIV prevention.	HSE, relevant professional bodies
3.30	Implement the recently developed national guidelines for potential exposure to blood borne viruses (see www.emitoolkit.ie).	HSE
3.31	Assess options and implement a plan to improve partner notification and contact tracing.	HSE, sexual health service providers, NGOs

4. Sexual Health Services

Goal: Equitable, accessible and high quality sexual health services, which are targeted and tailored to need, will be available to everyone.

Sexual health services to the public include:

- clinical services for the diagnosis and management of STIs;
- contraception services/family planning services;
- counselling, information and support services;
- community outreach services for sexual health promotion;
- education/information and support; and
- crisis pregnancy management.

These services are currently provided in community (including community outreach) and hospital-based clinical and non-clinical settings, by a mix of public, private and NGO services. Some work with particular groups, such as MSM or young people.

Many excellent sexual health services already exist in Ireland, providing a wide range of services. Notwithstanding this, there is no clear picture of the array, quality, efficiency, accessibility and availability of services around the country. A mapping exercise of existing services and needs assessment for services is required to inform the implementation of this Strategy and ensure that the overarching goal is achieved.

4.1 A vision for sexual health services

The vision for sexual health services is:

> accessible, high quality sexual health services for everyone, appropriate to people's needs and targeted and tailored to the relevant epidemiological, economic, social and cultural contexts of the community that services are being provided in and for, with an emphasis on those groups in greatest need.

The sexual health service needs of many people are not complex and sexual health services should and will be delivered to the individual in the least complex, most efficient way. However, some people are at greater risk of sexual ill health. Furthermore, those at risk of sexual ill health may not recognise this increased risk. In addition, some individuals will elect to travel away from their local service in order to protect their anonymity or may choose to attend private services. Individual choice and preference should be acknowledged in the further development of sexual health services.

4.2 Principles for sexual health services

Equitable, accessible and targeted services

Ready availability of and timely access to sexual health services are central to improving and maintaining sexual health and reducing negative sexual health outcomes. In addition to providing universal access to services at a local level through primary care structures and NGOs, services will also need to be targeted towards people in greatest need of help, support and at greatest risk of sexual ill health.

In promoting a more active approach to sexual health and wellbeing, service users and potential service users should be well informed of when, how and where to access sexual health services. Service use is dependent upon service visibility in the community, and ease of and timeliness of access. Information about sexual health services must be readily

accessible. People obtain information from a variety of sources: word of mouth; GP referrals; the internet; media; directories; helplines; family; peers; friends; and teachers. Thus, consideration of the best methods for accessing whole communities as well as specific groups will form part of future health promotion and service plans. Furthermore, service users can feel confident about service quality through the introduction of publicly available competence and accreditation for sexual health services and service providers.

Recommendations: Accessible services

	Recommendations	Partners
4.1	Provide universal access to sexual health services for all service users and prospective service users.	HSE, sexual health service providers, NGOs
4.2	Target services for those at greatest risk of sexual ill health.	HSE, sexual health service providers, NGOs
4.3	Ensure service users (and prospective service users) are aware of how, when and where to access sexual health services.	HSE, sexual health service providers, service user groups, NGOs
4.4	Ensure service users (and prospective service users) have access to information on the quality of services.	HSE, sexual health service providers, NGOs, relevant professional bodies

Safe, high quality and efficient services

For the first time, a National Clinical Lead and National Programme Lead will be assigned, with support from a national advisory group. Together, they will be responsible for, among other duties, commissioning and/or managing all sexual health services to ensure delivery of a safe, high quality and efficient service for all clients.

The National Clinical Lead for sexual health services will be responsible for ensuring standardised and effective sexual health services as outlined in this Strategy. In order to fulfil these priorities and key result areas there is a need to enhance partnership working and ensure that joined-up work plans are agreed with Health Promotion and Improvement, Public Health and across the health service. This will enable the coordination and standardisation of STI prevention activity, the removal of any duplication of effort and the development of shared working commitments to reduce costs and improve the impacts of our collective efforts in the area of sexual health promotion. The National Clinical Lead will work cross-divisionally within the HSE and with external partners as required to enhance the practice and delivery of sexual health services.

The Programme Lead will have responsibility for the development of an implementation plan and for leading on its stated actions in conjunction with the National Implementation Group. The Programme Lead has responsibility for creating a sense of shared ownership by fostering strong engagement among members of the National Implementation Group and will provide leadership for the agenda within the Health and Wellbeing division of the HSE, across other divisions/health structures, and externally with key stakeholders. They will focus attention on agreed actions and coordinate sexual health strategy priorities within the HSE.

Protocols for the management and delivery of sexual health services addressing STIs, crisis pregnancy and contraception will be developed and implemented. These will be evidence-based and reflect good practice with agreed mechanisms for updating these protocols and dissemination to service providers.

Quality standards for services will be developed and agreed in line with the *National Standards for Safer, Better Healthcare* (2012) and will be updated as appropriate over the lifetime of the Strategy.[38] Quality improvement and quality assurance tools will be implemented in line with the Europe-wide Joint Action on Quality and Quality Action. National sexual health service performance indicators and mechanisms for their assessment will be developed and implemented.

The future development and incorporation of good practice will be facilitated through outputs from ongoing sexual health intelligence, thus ensuring that sexual health services continue to respond to service user need.

Sexual health service providers will engage in continuing professional development (CPD) appropriate to the type of service they provide and compliant with their relevant professional body. At present, counselling is neither regulated nor considered a named profession under the Health and Social Care Professionals Act 2005. The absence of regulation will be critically examined in the development of CPD for counselling service providers.

Recommendations: Safe, high quality and efficient services

	Recommendations	Partners
4.5	Appoint a national lead and national expert/advisory group to oversee governance of sexual health services.	HSE
4.6	Develop and implement protocols for the management of sexual health services and agree processes for updating and reviewing them.	HSE, HIQA, representative professional bodies, NGOs
4.7	Develop and implement national quality standards and key performance indicators for sexual health services.	HSE, HIQA, representative professional bodies, NGOs
4.8	Agree mechanisms for the transfer and sharing of information from sexual health intelligence to service providers to allow for appropriate responses to identified areas of need.	HSE, HIQA, representative professional bodies, NGOs
4.9	Work with relevant professional bodies to develop and implement CPD criteria for service providers in sexual health services.	HSE, HIQA, representative professional bodies, NGOs

[38] HIQA (2012) *National standards for safer, better healthcare*, available at www.hiqa.ie/system/files/Safer-Better-Healthcare-Standards.pdf.

Integrated services

The HSE has adopted the WHO definition of integrated service networks:

> *'the organisation and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money'.*

Sexual health services will be delivered in an integrated way, ensuring that individuals have access to a high quality, supportive and non-stigmatising service throughout life. The successful development of an integrated network of sexual health services requires collaboration and cooperation between services.

Based on clearly defined competencies, skill mix, training, and resources, different services will manage differing degrees of caseload complexity with clearly defined referral pathways between different services.

Service user pathways and referral pathways should be formalised (where already in existence), developed and delivered to ensure that the service user experiences a seamless, high quality service.

Recommendations: Integrated services

	Recommendations	Partners
4.10	Determine and develop (as necessary) the required competencies and resources for delivery of sexual health services.	HSE, relevant professional bodies, NGOs
4.11	Formalise existing and, as appropriate, develop new service user pathways for bidirectional referral between sexual health services.	HSE, relevant professional bodies, NGOs

4.3 Developing a model of care for sexual health services

Identifying service needs

A pilot study to assess the feasibility of chlamydia screening in Ireland revealed that service users want accessible, free, confidential, non-stigmatising services in primary care settings with normalisation of STI testing.[39] Further work in 2012 identified that nine of the 26 counties in Ireland have no public, non-fee paying STI services. Priority should be given to the undertaking of a formal, comprehensive needs assessment and mapping exercise to identify the status of existing sexual health services and to identify the current gaps.

[39] Chlamydia Screening Steering Group (2012) *Chlamydia screening in Ireland: A pilot study of opportunistic screen for genital chlamydia trachomatis infection in Ireland (2007–2009)*, Health Protection Surveillance Centre and the Health Research Board, available at http://www.hpsc.ie/hpsc/A-Z/HIVSTIs/SexuallyTransmittedInfections/Chlamydia/Publications/File,13423,en.pdf.

Recommendations: Identifying needs for sexual health services

	Recommendations	Partners
4.12	Complete a needs assessment of all sexual health service requirements.	HSE, sexual health service providers, NGOs
4.13	Complete a mapping exercise of existing sexual health services.	HSE, sexual health service providers, NGOs

Meeting service needs

The outcomes of the needs assessment and mapping exercise will be used to inform a model of care for the delivery of sexual health services. A 'hub and spoke' model of care is proposed. In this model, the 'hub' has the expertise and resources to manage the most complex caseload in supporting the 'spokes', while the 'spokes' have the expertise and resources to manage a less complex caseload. The 'hub(s) and spokes' will work together with agreed bidirectional referral pathways to ensure that services are delivered in a patient-focused way that is safe, of high quality, efficient and effective. The aim is that the majority of services will be accessible locally and this should be developed, where appropriate, according to service user need, through capacity and competency building in primary care settings. The needs assessment and mapping exercise will also identify the required capacity and competency for delivery of specialised sexual health services. This capacity and competency should ensure that all service users (and prospective service users) have equitable access to specialised services as required.

Recommendations: Meeting sexual health service needs

	Recommendations	Partners
4.14	Develop and implement a 'hub and spoke' model of care for sexual health services.	HSE, sexual health service providers, NGOs
4.15	Develop capacity for sexual health services within primary care settings.	HSE, sexual health service providers, NGOs
4.16	Develop required capacity for specialised sexual health services.	HSE, sexual health service providers, NGOs

4.4 Supporting sexual health services

Communications technology

Technology has been used to improve efficiency and quality of communication between providers and between providers and users in other jurisdictions in relation to sexual health, and also within other health and non-health sectors in Ireland. Communication between services and service users can be enhanced through, for example, use of text messaging in arranging appointments, providing results and web-based partner notification.

Communication between services should be improved; for example by the efficient, effective, safe transfer of data from STI services to data collection bodies in line with regulatory requirements for disease notification. These advances will be explored in the further development of sexual health services in Ireland with a view to improving efficiency and enhancing communication between services and service users, and also communication between services.

Recommendation: Technology in sexual health services

	Recommendation	Partners
4.17	Assess technologies that are used in delivery of sexual health services and in communication between providers and users and between providers in other health and non-health related sectors.	HSE, sexual health service providers, NGOs

Laboratory services

In 2013, the Microbiological Reference Laboratory (MRL) Group provided the HSE with information on current microbiological reference laboratory services in Ireland, including informal and temporary services. They also identified how to best structure services to ensure that a reference laboratory is in place for pathogen typing. While some types of pathogen testing require a centralised service, others require a service level agreement with other sectors in Ireland and internationally. Independent reference laboratories may not be required; rather, existing laboratories and expertise may provide a more cost effective use of technology and staffing. The MRL Group noted that there are considerable gaps in the epidemiological and laboratory data on STIs in Ireland.

Reference laboratories for STIs are necessary to ensure that there is:

- appropriate monitoring of STI diagnosis advances;
- adequate monitoring of antimicrobial resistance in STIs;
- quality control in STI diagnostics;
- participation in European and international STI pathogen research/surveillance; and
- support for primary diagnostic laboratory services.

Reference laboratories may also undertake analyses of samples that have wider public health implications.

Building on the MRL Group's work, an assessment of laboratory diagnostic services for STIs should be undertaken and provision made for appropriate diagnostics with acceptable turnaround times for all services providing STI services, including general practice.

Recommendations: Laboratory services

	Recommendations	Partners
4.18	Building on existing work, undertake a mapping exercise and needs assessment to identify the capacity of laboratory services required to support STI diagnostic services.	HSE, laboratory services, relevant professional bodies
4.19	Formally designate and resource appropriate laboratories as national reference laboratories for STIs based on this assessment exercise.	HSE, laboratory services

5. Sexual Health Intelligence

Goal: Robust and high quality sexual health information will be generated to underpin policy, practice, service planning and strategic monitoring.

Health intelligence is the development and use of knowledge to support decision-making to improve the health of the population. Health intelligence supports good decision-making for better health and health outcomes by using an evidence base. The development of evidence-based analyses, to inform key strategic and operational decision-making, will be prioritised and supported and will underpin all strategic actions in line with the Healthy Ireland Framework.

To monitor population health and strategically plan for current and future needs, sexual health data needs to be:

- systematically collected;
- timely;
- accurate;
- detailed;
- standardised; and
- representative.

High quality sexual health data are also needed to evaluate the effectiveness of services and interventions, and to make international comparisons.

5.1 Information on knowledge, attitudes and behaviours

In recent years, investment in research has led to an established evidence base regarding public knowledge, attitudes and behaviours in relation to sexual health in Ireland. This has helped to identify risk factors contributing to sexual ill health and protective factors contributing to positive sexual health and wellbeing among different population groups. Large-scale surveys have provided reliable nationally representative data, establishing baseline measures to monitor trends in sexual knowledge, attitudes and behaviours over time. Qualitative research studies have provided in-depth analyses in relation to sexual and reproductive issues.

It is critical that the established evidence base continues to be used and built on as a means of understanding emerging trends relating to sexual health. Key areas requiring exploration will be prioritised. This will be informed by a baseline description of research activity to date, and based on an assessment of need. Indicators measuring trends in sexual knowledge, attitudes and behaviours over time will be agreed and maintained in order to reliably report on trends in the sexual health of the population. It is important that under-researched populations are included in order to understand behaviours and attitudes throughout life. For example, research should include young people under 18 years and those aged 65 years and over.

Research expertise and capacity lies with professionals from varying disciplines and a high level of expertise in the area of sexual health has been established. However, uncertainty around ongoing funding can impact on sustaining expertise. Sexual health research and funding streams will be supported and directed where necessary to ensure best possible investment. Strategic prioritisation and partnership approaches between funding organisations will achieve greater value for investment.

Recommendations: Knowledge, attitudes and behaviours

	Recommendations	Partners
5.1	Continue to build on the existing evidence base to understand emerging trends relating to crisis pregnancy and sexual health and undertake new research initiatives to address knowledge gaps.	DoH, HSE, other government departments and statutory organisations, NGOs, academic institutions
5.2	Develop and support cross-sectoral partnership approaches to the commissioning of research, in order to achieve greater value for investment.	DoH, HSE, other government departments and statutory organisations, NGOs
5.3	Prioritise sexual health research as a public health priority and ensure research funding streams are maintained and that capacity and infrastructure are supported, sustained and improved.	DoH, HSE, academic and research institutions
5.4	Incorporate sexual health indicators into relevant national health and wellbeing surveys.	DoH, HSE, academic institutions

5.2 International clinical and behavioural indicators

A set of clinical and behavioural indicators are required in line with the ECDC framework as national markers of sexual health status.[40] These will be used to measure progress and service impacts, to enable monitoring of service performance, to detect changes over time and to make comparisons internationally. Some countries have well developed behavioural surveillance systems, where high quality information is produced on a regular and planned basis. Ireland needs to work towards a similar system. It is essential that the appropriate mechanisms and resources are in place to support the systematic collection and reporting of this information.

Recommendations: Sexual health indicators

	Recommendations	Partners
5.5	Agree a set of clinical and behavioural sexual health indicators.	DoH, HSE
5.6	Undertake a baseline description of surveillance and research activity to inform the development of appropriate, standardised, clinical and behavioural indicators.	DoH, HSE, other Government departments, statutory organisations, NGOs, academic institutions, research bodies

5.3 Information on HIV and STIs

Surveillance is the ongoing systematic collection, collation, analysis and dissemination of information on HIV and STIs. It is an essential component of effective sexual health promotion, prevention and control of STIs. Systematically collected HIV/STI surveillance information is needed to estimate the population burden of disease, to develop STI prevention programmes and monitor their effectiveness, and to assess determinants of

[40] The ECDC is developing a framework for the implementation of behavioural surveillance and second generation surveillance related to STI/HIV in Europe.

transmission. Surveillance is essential to providing an evidence-informed and high quality service to the population.

The principal current regulations requiring notification of infectious disease are contained in the Infectious Diseases Regulations 1981 (S.I. No. 390 of 1981). The Infectious Disease (Amendment) (No.3) Regulations 2003 (S.I. No. 707 of 2003) mandates clinicians and laboratory directors to notify the Medical Officer of Health of incident cases of infectious diseases. The HPSC regularly publishes statistics on STI notifications.

Surveillance of STIs has improved considerably. This is due to the work of clinicians, public health departments and the HPSC. It is also largely due to the inclusion of STIs in the national computerised infectious disease reporting system (CIDR) in 2013. Timely information is now available on laboratory diagnosed STIs. Information on sexual orientation is not available from laboratory sources, so further development work to enable clinic-based behavioural data on sexual orientation for inclusion in CIDR is needed. Capacity for surveillance is not uniform across all health settings; there is a need to build capacity and embed a culture that recognises that a sustainable commitment to surveillance of STIs is an essential component of sexual health services.

The need for an agreed national core dataset for STI notifications

A core dataset of case-based information that includes an identifier, age or date of birth, gender, county of residence, country of birth, diagnosis and sexual orientation is required. This would allow interventions and services to be targeted at particular population groups and areas in greatest need. The identifier would ideally be a nationally agreed unique patient identifier; however in the absence of this, the use of named patient information in the confidential CIDR system as an interim measure is necessary. This dataset is currently not being provided across all locations. This situation has led to individual patients sometimes being reported twice, thereby providing an inaccurate picture of the situation, and also preventing identification of multiple STIs for the same person.

The need for capacity for surveillance of antimicrobial resistance

Given the emergence and spread of antimicrobial resistance to gonorrhoea, the need for national reference laboratory facilities and epidemiological capacity for surveillance of antimicrobial resistance in STI pathogens is recognised as a priority.

Second generation sexual health surveillance

Second generation surveillance combines biological and behavioural sexual health indicators.[41] As mentioned above, Ireland needs to work towards having a well-developed behavioural surveillance system. Behavioural surveillance, in combination with biological surveillance, will provide the health intelligence to support health promotion and prevention activities in a targeted way, maximising the use of data to improve sexual health outcomes across the population.

[41] Second generation surveillance (SGS) refers to surveillance that combines both the monitoring of biological (new cases of HIV/AIDS and STIs) and behavioural indicators (e.g. sexual behaviour, use of protection). This approach is important both in informing policy development and in evaluating its outcome. See: ECDC (2009) *Mapping of HIV/STI behavioural surveillance in Europe*, ECDC, Stockholm, available at http://ecdc.europa.eu/en/publications/publications/0909_ter_mapping_of_hiv_sti_behavioural_surveillance_in_europe.pdf.

Recommendations: Information on HIV and STIs – Surveillance

	Recommendations	Partners
5.7	Implement a core dataset of case-based information for STI notifications.	DoH, HSE, other government departments
5.8	Support, sustain and improve surveillance infrastructure and capacity, including the development of capacity to gather behavioural data systematically from sexual health service providers in CIDR.	DoH, HSE, other government departments
5.9	Develop and embed a culture of commitment to surveillance of STIs within sexual health services.	DoH, HSE, clinicians
5.10	Provide facilities for national reference laboratory and epidemiological capacity for surveillance of antimicrobial resistance in STI pathogens as a priority. (See actions 4.18 and 4.19.)	DoH, HSE
5.11	Following the development of appropriate, standardised, clinical and behavioural indicators, establish second generation sexual health surveillance in line with international requirements, combining biological and behavioural sexual health indicators.	DoH, HSE

5.4 Crisis pregnancy indicators

Currently, there is annual and systematic monitoring of the number of women giving an Irish address when travelling to other jurisdictions for an abortion, and of the number of births in Ireland to women under 20.[42] It is important that key indicators related to crisis pregnancy continue to be measured, interpreted and reported; this enables the monitoring of trends, services and initiatives and allows for international comparison. It is important that new and emerging behavioural trends relating to crisis pregnancy are monitored as they arise.

Recommendation: Crisis pregnancy indicators

	Recommendation	Partners
5.12	Systematically monitor crisis pregnancy indicators and emergent trends related to crisis pregnancy nationally and internationally.	HSE

5.5 Knowledge transfer and exchange

Sexual health information is currently under-utilised in policy development and service planning. In order to get full value from investment in research and surveillance, use of current information sources must be maximised to enable effective knowledge transfer. It should also be recognised that knowledge transfer is a two-way flow of information between stakeholders, and that it flows bottom–up and top–down. Steps to address this issue will be aligned with dissemination and knowledge transfer activities outlined in the Healthy Ireland Framework.

[42] While teenage births are not necessarily interpreted as a crisis by the mother, traditionally the teenage birth rate has been used as an indicator of crisis pregnancy.

Recommendations: Knowledge transfer and exchange

	Recommendations	Partners
5.13	Deliver effective knowledge transfer and exchange to maximise use of investment to date.	DoH, HSE, other government departments and statutory organisations, NGOs, academic institutions
5.14	Identify and build on linkages with international initiatives to support information sharing.	DoH, HSE, other government departments and statutory organisations, academic institutions

5.6 Information on sexual health services

Baseline information on sexual health services will become available as part of the mapping exercise that will be completed for this Strategy's implementation plan. In order to inform good practice in sexual health service provision and effective resource allocation, information on the following will be required, on an ongoing, real-time basis:

- the availability of services (preventative and treatment);
- the profile and number of service users; and
- the outcomes and quality of the services provided in relation to financial allocation.

Therefore, the monitoring of sexual health services and their outcomes form part of a health intelligence remit. While some services in the area of sexual health have effective monitoring in place, many do not. Monitoring of services will provide a better understanding of what is available, to whom it is available, where it is available, and at what cost. It will contribute to the development of indicators and targets and will also provide information regarding barriers to service access and the effective targeting of services. The development of evaluation frameworks for services will provide guidance to develop, deliver and manage effective service evaluations to enhance the quality of service information.

Recommendations: Information on sexual health services

	Recommendations	Partners
5.15	Develop a monitoring programme for sexual health services to inform service targeting and to provide information on quality and outcomes of service provision in relation to financial allocation.	DoH, HSE, HIQA, sexual health service providers
5.16	Examine models to support effective evaluations to improve service delivery and development.	DoH, HSE, sexual health service providers, NGOs

5.7 Effective strategic monitoring

Strategic monitoring refers to ongoing systems for monitoring, with feedback loops to ensure that this Strategy's governance process and implementation plan reflect awareness of what is taking place on the ground, enabling changes to be made efficiently and effectively, where necessary. This will also facilitate innovation; not all initiatives can be evidence-based and some will need to be based on partial information as it arises and instead will be evidence informed. Key indicators will be identified to support implementation planning and allow for the ongoing monitoring of strategic progress. The ongoing monitoring of the implementation plan and reporting on progress will be facilitated by the Healthy Ireland Outcomes Framework.

Service providers will be encouraged to participate in evaluations and up-skilling opportunities will be provided for professionals to generate sexual health intelligence.

Recommendation: Effective strategic monitoring

	Recommendation	Partners
5.17	Develop high quality data monitoring systems to ensure reliable and accurate reporting data, which will support the monitoring of strategic delivery. This may lead to up-skilling opportunities for some professionals.	HSE, DoH, other government departments and statutory organisations, NGOs, academic institutions, clinical services

6. Strategy Implementation

The Health and Wellbeing Division of the HSE, supported by government departments, statutory and non-statutory bodies, professional bodies and NGOs as appropriate, will lead the implementation of this Strategy through the appointment of two posts – a National Clinical Lead and a National Programme Lead – and the establishment of a HSE implementation group with service user and non-statutory service provider representation. The group will comprise a small team, and may be supported by additional groups of experts on specific issues. It is envisaged that it will be accountable for developing an implementation plan for this Strategy, managing its rollout and ensuring better governance and coordination to improve sexual health outcomes in Ireland.

The National Clinical Lead for sexual health services will be responsible for ensuring standardised and effective sexual health services as outlined in this Strategy. The National Programme Lead will have responsibility for the development of an implementation plan and for leading on actions in the implementation plan, in conjunction with the national implementation group. These two key roles will support the delivery of the goals of the Strategy by working cross-divisionally within the HSE and with external partners as required to enhance the practice and delivery of sexual health services, as well as providing leadership for the agenda within the Health and Wellbeing Division of the HSE, across other divisions and health structures, and externally with key stakeholders. They will also focus attention on agreed actions and coordinate sexual health strategy priorities within the HSE.

Under the auspices of the Healthy Ireland Framework, a range of specific sexual health indicators will be used to monitor and evaluate outcomes.43 Indicators for quality and standards in sexual health services will be developed, and will be factored in when developing the implementation plan. This work will be informed by the principles of equity, accessibility and quality with regard to sexual health and wellbeing throughout life.

Coordination: Within the sector, across sectors, on the island and internationally

The implementation of the Strategy will require coordination both within and between the three key identified areas: promotion, education and prevention; services; and health intelligence. This will include improved communication and sharing of knowledge. It will also include improved coordination in the way data are collected and recorded to ensure standardisation for research purposes, both within Ireland and for data compatibility with European partners. The relationships between sexual health and other strategies or policies in health and education, as well as other sectors, will form part of the implementation plan. This approach will be taken in order to maximise potential synergies, while operating within the existing legislative framework.

There is a need to consider the cross-border relationship with Northern Ireland. Cross-border cooperation in the area of sexual health is already underway, providing economies of scale and improved effectiveness. Work to facilitate cooperation with Northern Ireland

[43] A model similar to the UK scorecard will be considered. For information on this model, see Public Health England, 'Key indicators' available at http://www.apho.org.uk/resource/view.aspx?RID=83256

partners will continue to ensure cross-border initiatives and cooperation in provision of services and promotion activity.

Recommendations: Implementation and coordination

	Recommendation	Partners
6.1	Appoint a national lead and a national expert group for sexual health.	HSE Health and Wellbeing Division
6.2	Develop and manage a detailed implementation plan to deliver goals and actions, working across departments and in partnership with statutory and non-statutory agencies/bodies and NGOs.	HSE Health and Wellbeing Division, DoH, DES, DCYA, HPSC, NGOs, professional bodies
6.3	Develop an independent monitoring and evaluation process for the implementation plan.	HSE Health and Wellbeing Division, national lead on sexual health and supporting expert group
6.4	Identify opportunities and act to improve coordination and communication to maximise synergies within the sexual health sector, as well as across sectors.	HSE Health and Wellbeing Division, national lead on sexual health and supporting expert group

Appendix 1: National Sexual Health Strategy Steering Group

Members of the Strategy steering group

Name	Organisation
Geraldine Luddy (Chair)	Social Inclusion Unit, Department of Health
Alan Bell / Caroline Greene (Secretariat)	Social Inclusion Unit, Department of Health
Colette Bonner	Health Protection Policy Unit, Department of Health
Tiernan Brady	HIV Services Network
Noëlle Cotter	Institute of Public Health in Ireland
Miriam Daly	Irish College of General Practitioners
Sandra Delamere	Irish Association of Nurse and Midwife Managers
Seán Denyer (replaced Olive McGovern)	Department of Children and Youth Affairs
John Devlin	Health Promotion Policy Unit, Department of Health
Nazih Eldin	Health Promotion, Health Service Executive
Alessandra Fantini	Social Inclusion Unit, Department of Health
Catherine Fleming	Royal College of Physicians in Ireland
Tony Gaynor	Department of Education and Skills
Derval Igoe (replaced Aidan O'Hora)	Health Protection Surveillance Centre
Kevin Kelleher	Health Protection, Health Service Executive
Fiona Lyons	Royal College of Physicians in Ireland
Tim McCarthy	Social Inclusion Unit, Department of Health
Owen Metcalfe	Institute of Public Health in Ireland
Deirdre Seery	Sexual Health Centre Cork

Terms of reference of the steering group

The steering group will oversee the drafting of a National Sexual Health Strategy, which will take the form of a strategic action plan that will outline Government policy in relation to sexual health. The Strategy will provide a strategic direction for the delivery of sexual health services and will be submitted to Government at the end of 2012. The plan will

focus on improving sexual health and wellbeing in addition to addressing the surveillance, testing, treatment and prevention of HIV and STIs, crisis pregnancy, and sexual health education and promotion. The Strategy will be in line with the forthcoming Health and Wellbeing Framework.

The aims of the steering group are to produce a cohesive policy which will clearly define the structures and governance arrangements for sexual health services which in turn will result in improved sexual health outcomes at population level.

Members of the education and prevention working group

Name	Organisation
Nazih Eldin (Chair)	Health Promotion, Health Service Executive
Michael Barron	BeLonG To
Josephine Clancy	Limerick Regional Hospital
Claire Coleman	Health Service Executive
Noëlle Cotter	Institute of Public Health in Ireland
Sandra Delamere	Irish Association of Nurse and Midwife Managers
Susan Donlon	Dublin AIDS Alliance/Gay Health Network
Janet Gaynor	Health Service Executive
Tony Gaynor	Department of Education and Skills
Moira Germaine	Health Service Executive
Jack Lambert	Mater Hospital
Linda Latham	Health Service Executive
Maire Morrissey	Squashy Couch
Tim McCarthy	Social Inclusion Unit, Department of Health
Elizabeth Ann McKevitt	Health Service Executive
Seán Denyer (replaced Olive McGovern)	Department of Children and Youth Affairs
Orla McGowan	HSE Crisis Pregnancy Programme
Diane Nurse	Health Service Executive
Sarah O'Brien	Health Service Executive
Siobhán O'Higgins	National University of Ireland, Galway and AIDS WEST

Anna Quigley	Dublin AIDS Alliance
Deirdre Seery	Sexual Health Centre Cork
Frances Shearer	SPHE Support Service

Members of the health intelligence working group

Name	Organisation
Aidan O'Hora (Chair) (resigned July 2012)	Health Protection Surveillance Centre
Tim McCarthy (Chair) (August 2012-July 2013)	Social Inclusion Unit, Department of Health
Joe Barry	Department of Public Health, TCD
John Brazil	Health Protection Surveillance Centre
Patricia Clarke	Health Research Board
Noëlle Cotter	Institute of Public Health in Ireland
Grainne Courtney	GUIDE Clinic, St. James's Hospital
Síle Dooley	GUIDE Clinic, St. James's Hospital
Sarah Doyle	Health Service Executive
Deirdre Fullerton	Insights Health and Social Research
Agnes Higgins	School of Nursing & Midwifery, Trinity College Dublin
Derval Igoe	Health Protection Surveillance Centre
Hannah McGee	Royal College of Surgeons in Ireland
Maeve O'Brien	Crisis Pregnancy Programme, Health Service Executive
Emer O'Connell	Health Service Executive
Deirdre Seery	Sexual Health Centre Cork
Thomas Strong	Gay Health Network

Members of the sexual health services working group

Name	Organisation
Kevin Kelleher (Chair)	Health Promotion, Health Service Executive
Alison Begas	Dublin Well Woman
Tiernan Brady	Gay and Lesbian Equality Network
Noëlle Cotter	Institute of Public Health in Ireland
Miriam Daly	Irish College of General Practitioners
Sherie de Burgh	One Family
Sandra Delamere	Irish Association of Nurse and Midwife Managers
Mary Dennehy	STI Clinic Waterford
Roisin Doogue	Irish Practice Nurses Association
Catriona Henchion	Irish Family Planning Association
Rachel Howard	Catherine McAuley Research Centre
Shay Keating	Drug Treatment Centre Board
Glenn Keating	BeLonG To
Mary Kelly	Academy of Medical Laboratory Scientists
Linda Latham	Women's Health Services, Health Service Executive
Fiona Lyons	St James's Hospital
Tim McCarthy	Social Inclusion Unit, Department of Health
Margaret Morris	Treoir
Liz Murphy	Cork University Hospital
Diane Nurse	Health Service Executive
Kate O'Flaherty	Pharmaceutical Society of Ireland
Lysander Preston	Positive Now
Mick Quinlan	Gay Men's Health Service
Sarah Ryan	Crisis Pregnancy Programme, Health Service Executive
Deirdre Seery	Sexual Health Centre Cork

Members of the National Sexual Health Strategy writing group

Name	Organisation
Tim McCarthy (Chair)	Social Inclusion Unit, Department of Health
Noëlle Cotter	Institute of Public Health in Ireland
Seán Denyer (replaced Olive McGovern)	Department of Children and Youth Affairs
Moira Germaine	Health Service Executive
Fiona Lyons	St James's Hospital
Elizabeth Ann McKevitt	Health Service Executive
Maeve O'Brien	Crisis Pregnancy Programme, Health Service Executive
Deirdre Seery	Sexual Health Centre Cork

Appendix 2: Strategy Recommendations

Sexual Health Promotion, Education and Prevention

Number	Recommendation	Partners
	A supportive cultural environment	
3.1	Promote an environment of openness to reduce the negative impact of stigma relating to sexual health and wellbeing.	HSE, DoH, NGOs
3.2	Develop guidelines on the implications of the legislative environment relating to the provision of sexual health services.	HSE, relevant professional bodies, NGOs
3.3	Develop a communications strategy to highlight developments and priorities in sexual health both through research findings and progress on strategic actions.	HSE, DoH, DCYA, DES, NGOs
	Children and young people	
3.4	Ensure that all young people will have continued access, and knowledge of how to access, age-appropriate sources of trustworthy and accurate information and support on relationships and sexual health.	DCYA, DES, HSE, NGOs, Youthreach
3.5	Support all children and young people in addressing issues that impact on sexual wellbeing such as stigma, homophobia, gender, ability/disability, mental health, alcohol and drugs.	Parent organisations, DCYA, DES, HSE, NGOs
3.6	Develop and promote accessible and appropriate information, resources and supports for parents to enable them to communicate effectively about relationships and sexuality.	HSE, DCYA, NGOs, parent organisations
3.7	Address the impact of early sexualisation and pornography and support parents to addresses issues arising from early sexualisation.	Parent organisations, DCYA, DES, HSE, NGOs
3.8	Evaluate State-funded relationship and sexuality education programmes, within available resources, with input from stakeholders.	DES, DoH, HSE, children and young people representatives, NGOs
3.9	Continue to provide teachers with appropriate training within available resources to equip them to deliver relationship and sexuality education programmes.	DES, DCYA, HSE, DoH
3.10	Continue to provide to all young people who have left school with information on how and where to access sexual health services appropriate to their needs.	HSE, NGOs, Youthreach
3.11	Outreach programmes to inform and support young people in out-of-school settings will be proactive in addressing sexual health needs.	NGOs, sexual health service providers, HSE
3.12	Provide organisations working with young people in out-of-school settings with support and sexual health training to ensure they provide high quality advice, resources and services.	HSE, Youthreach, NGOs, other health professionals

Adults		
3.13	Provide all adults with information aimed at reducing negative sexual health outcomes and promoting sexual wellbeing, throughout life.	HSE, NGOs
3.14	Provide accessible crisis pregnancy supports, STI/HIV testing and other supports and counselling for all sexually active adults.	HSE, NGOs
3.15	Include broader sexual health information in public health campaigns and information resources.	HSE, NGOs
At-risk and vulnerable groups		
3.16	Develop an evidence-informed response to targeting those most at risk of negative sexual health outcomes.	HSE
3.17	Ensure that all campaigns and interventions targeting those most at risk of negative sexual health outcomes will be inclusive with regard to the diversity of sexual experiences and identities.	HSE, NGOs
3.18	Develop and maintain positive prevention, access to condoms, testing, targeted education and outreach.	HSE, NGOs
3.19	Identify and establish links with other relevant strategies, particularly those relating to vulnerable and at-risk groups, to ensure their sexual health needs are addressed.	HSE, NGOs
Professional training		
3.20	Develop programmes for those working with vulnerable and at-risk groups to train them to recognise and respond appropriately to the sexual health needs of their clients, recognising and addressing the barriers to accessing services faced by many at-risk groups.	HSE, sexual health service providers, NGOs, other health and non-health professionals, undergraduate and postgraduate training bodies
3.21	Incorporate training on sexual health for professionals who deliver sexual health education and prevention activities or who can incorporate sexual health into their core work as part of continuing professional development.	HSE, undergraduate and postgraduate training bodies, professional bodies, NGOs
3.22	Provide training to health professionals on how to recognise the ways in which other health problems may impact on sexual health and to support them in raising sexual health issues with their clients across all age groups.	HSE, undergraduate and postgraduate training bodies, professional bodies, NGOs
Prevention through clinical interventions		
3.23	Implement the Hepatitis B vaccination programme in line with national immunisation guidelines.	DoH, HSE, relevant professional bodies
3.24	Maintain and promote the HPV vaccination programme for adolescent girls in line with national immunisation guidelines.	DoH, HSE, relevant professional bodies

3.25	Assess the effectiveness (including cost effectiveness) of extending the HPV vaccine to other groups and develop appropriate guidelines.	HIQA, DoH, HSE, relevant professional bodies
3.26	Assess the acceptability and effectiveness (including cost effectiveness) of testing for HIV and other STIs in various settings.	HSE, ICGP, sexual health service providers, NGOs, relevant professional bodies, HIQA
3.27	Develop and implement HIV and STI testing guidelines.	DoH, HSE, HIQA, NGOs, relevant professional bodies
3.28	Support actions to facilitate HIV disclosure and reduce stigma and discrimination.	DoH, HSE, sexual health service providers, NGOs
3.29	Develop and implement guidelines for the appropriate use of antiretroviral therapy in HIV prevention.	HSE, relevant professional bodies
3.30	Implement the recently developed national guidelines for potential exposure to blood borne viruses (see www.emitoolkit.ie).	HSE
3.31	Assess options and implement a plan to improve partner notification and contact tracing.	HSE, sexual health service providers, NGOs

Sexual Health Services

Number	Recommendation	Partners
	Accessible services	
4.1	Provide universal access to sexual health services for all service users and prospective service users.	HSE, sexual health service providers, NGOs
4.2	Target services for those at greatest risk of sexual ill health.	HSE, sexual health service providers, NGOs
4.3	Ensure service users (and prospective service users) are aware of how, when and where to access sexual health services.	HSE, sexual health service providers, service user groups, NGOs
4.4	Ensure service users (and prospective service users) have access to information on the quality of services.	HSE, sexual health service providers, NGOs, relevant professional bodies

Safe, high quality and efficient services		
4.5	Appoint a national lead and national expert/advisory group to oversee governance of sexual health services.	HSE
4.6	Develop and implement protocols for the management of sexual health services and agree processes for updating and reviewing them.	HSE, HIQA, representative professional bodies, NGOs
4.7	Develop and implement national quality standards and key performance indicators for sexual health services.	HSE, HIQA, representative professional bodies, NGOs
4.8	Agree mechanisms for the transfer and sharing of information from sexual health intelligence to service providers to allow for appropriate responses to identified areas of need.	HSE, HIQA, representative professional bodies, NGOs
4.9	Work with relevant professional bodies to develop and implement CPD criteria for service providers in sexual health services.	HSE, HIQA, representative professional bodies, NGOs
Integrated services		
4.10	Determine and develop (as necessary) the required competencies and resources for delivery of sexual health services.	HSE, relevant professional bodies, NGOs
4.11	Formalise existing and, as appropriate, develop new service user pathways for bidirectional referral between sexual health services.	HSE, relevant professional bodies, NGOs
Identifying needs for sexual health services		
4.12	Complete a needs assessment of all sexual health service requirements.	HSE, sexual health service providers, NGOs
4.13	Complete a mapping exercise of existing sexual health services.	HSE, sexual health service providers, NGOs
Meeting sexual health service needs		
4.14	Develop and implement a 'hub and spoke' model of care for sexual health services.	HSE, sexual health service providers, NGOs
4.15	Develop capacity for sexual health services within primary care settings.	HSE, sexual health service providers, NGOs
4.16	Develop required capacity for specialised sexual health services.	HSE, sexual health service providers, NGOs
Technology in sexual health services		
4.17	Assess technologies that are used in delivery of sexual health services and in communication between providers and users and between providers in other health and non-health related sectors.	HSE, sexual health service providers, NGOs

Laboratory services		
4.18	Building on existing work, undertake a mapping exercise and needs assessment to identify the capacity of laboratory services required to support STI diagnostic services.	HSE, laboratory services, relevant professional bodies
4.19	Formally designate and resource appropriate laboratories as national reference laboratories for STIs based on this assessment exercise.	HSE, laboratory services

Sexual Health Intelligence

Number	Knowledge, attitudes and behaviour	Partners
5.1	Continue to build on the existing evidence base to understand emerging trends relating to crisis pregnancy and sexual health and undertake new research initiatives to address knowledge gaps.	DoH, HSE, other government departments and statutory organisations, NGOs, academic institutions
5.2	Develop and support cross-sectoral partnership approaches to the commissioning of research, in order to achieve greater value for investment.	DoH, HSE, other government departments and statutory organisations, NGOs
5.3	Prioritise sexual health research as a public health priority and ensure research funding streams are maintained and that capacity and infrastructure are supported, sustained and improved.	DoH, HSE, academic and research institutions
5.4	Incorporate sexual health indicators into relevant national health and wellbeing surveys.	DoH, HSE, academic institutions
Sexual health indicators		
5.5	Agree a set of clinical and behavioural sexual health indicators.	DoH, HSE
5.6	Undertake a baseline description of surveillance and research activity to inform the development of appropriate, standardised, clinical and behavioural indicators.	DoH, HSE, other government departments, statutory organisations, NGOs, academic institutions, research bodies
Information on HIV and STIs – Surveillance		
5.7	Implement a core dataset of case-based information for STI notifications.	DoH, HSE, other Government departments

5.8	Support, sustain and improve surveillance infrastructure and capacity, including the development of capacity to gather behavioural data systematically from sexual health service providers in CIDR.	DoH, HSE, other government departments
5.9	Develop and embed a culture of commitment to surveillance of STIs within sexual health services.	DoH, HSE, clinicians
5.10	Provide facilities for national reference laboratory and epidemiological capacity for surveillance of antimicrobial resistance in STI pathogens as a priority. (See actions 4.18 and 4.19.)	DoH, HSE
5.11	Following the development of appropriate, standardised, clinical and behavioural indicators, establish second generation sexual health surveillance in line with international requirements, combining biological and behavioural sexual health indicators.	DoH, HSE
Crisis pregnancy indicators		
5.12	Systematically monitor crisis pregnancy indicators and emergent trends related to crisis pregnancy nationally and internationally.	HSE
Knowledge transfer and exchange plan		
5.13	Deliver effective knowledge transfer and exchange to maximise use of investment to date.	DoH, HSE, other government departments and statutory organisations, NGOs, academic institutions
5.14	Identify and build on linkages with international initiatives to support information sharing.	DoH, HSE, other government departments and statutory organisations, academic institutions
Information on sexual health services		
5.15	Develop a monitoring programme for sexual health services to inform service targeting as well as to provide information on quality and outcomes of service provision in relation to financial allocation.	DoH, HSE, HIQA, sexual health service providers
5.16	Examine models to support effective evaluations to improve service delivery and development.	DoH, HSE, sexual health service providers, NGOs
Effective strategic monitoring		
5.17	Develop high quality data monitoring systems to ensure reliable and accurate reporting data, which will support the monitoring of strategic delivery. This may lead to up-skilling opportunities for some professionals.	HSE, DoH, other government departments and statutory organisations, NGOs, academic institutions, clinical services

Number	Recommendation	Partners
	Implementation and coordination	
6.1	Appoint a national lead and a national expert group for sexual health.	HSE Health and Wellbeing Division
6.2	Develop and manage a detailed implementation plan to deliver goals and actions, working across departments and in partnership with statutory and non-statutory agencies/bodies and NGOs.	HSE Health and Wellbeing Division, DoH, DES, DCYA, HPSC, NGOs, professional bodies
6.3	Develop an independent monitoring and evaluation process for the implementation plan.	HSE Health and Wellbeing Division, national lead on sexual health and supporting expert group
6.4	Identify opportunities and act to improve coordination and communication to maximise synergies within the sexual health sector, as well as across sectors.	HSE Health and Wellbeing Division, national lead on sexual health and supporting expert group

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