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PROGRAMME FOR CONSULTATION DAY

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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>BMA</td>
<td>British Medical Association</td>
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<tr>
<td>CMO</td>
<td>Chief Medical Officer</td>
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<tr>
<td>CPA</td>
<td>Crisis Pregnancy Agency</td>
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<tr>
<td>DHSS (UK)</td>
<td>Department of Health and Social Services, UK</td>
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<tr>
<td>DIT</td>
<td>Dublin Institute of Technology</td>
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<tr>
<td>ECAHB</td>
<td>East Coast Area Health Board</td>
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<tr>
<td>ERHA</td>
<td>Eastern Regional Health Authority</td>
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<tr>
<td>(changed on January 1 2005 to Health Service Executive - Eastern Region)</td>
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<tr>
<td>ESRI</td>
<td>Economic and Social Research Institute</td>
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<tr>
<td>GMHP</td>
<td>Gay Men's Health Project</td>
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<td>GUIDE Clinic</td>
<td>Genito-Urinary Infectious Disease Clinic</td>
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<td>GUM</td>
<td>Genito-Urinary Medicine</td>
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<td>HBsAg</td>
<td>Hepatitis B Surface Antigen</td>
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<tr>
<td>HBV</td>
<td>Hepatitis B Virus</td>
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<td>HCV</td>
<td>Hepatitis C Virus</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HPSC</td>
<td>Health Protection Surveillance Centre</td>
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<tr>
<td>HSE</td>
<td>Health Service Executive</td>
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<tr>
<td>ICGP</td>
<td>Irish College of General Practitioners</td>
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<tr>
<td>ID</td>
<td>Infectious Disease</td>
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<tr>
<td>IFPA</td>
<td>Irish Family Planning Association</td>
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<td>ISSP</td>
<td>International Social Survey Project</td>
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<tr>
<td>IVDU/IDU</td>
<td>Intravenous Drug Users - used interchangeably</td>
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<tr>
<td>KAB</td>
<td>Knowledge, Attitude and Behaviour</td>
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<tr>
<td>LCR</td>
<td>Ligase chain reactor</td>
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<td>MSM</td>
<td>Men who have sex with men</td>
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<td>NAHB</td>
<td>Northern Area Health Board</td>
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<tr>
<td>NASC</td>
<td>National AIDS Strategy Committee</td>
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<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<td>NVRL</td>
<td>National Virus Reference Laboratory</td>
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<td>NYCI</td>
<td>National Youth Council of Ireland</td>
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<td>PHLS</td>
<td>Public Health Laboratory Service (UK)</td>
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<td>RSE</td>
<td>Relationship and Sexuality Education</td>
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<td>SAVI</td>
<td>Sexual Abuse and Violence in Ireland</td>
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<tr>
<td>SLÁN</td>
<td>Survey of Lifestyle, Attitudes and Nutrition</td>
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<td>SPHE</td>
<td>Social Personal Health Education</td>
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<td>SSA</td>
<td>Sub-Saharan Africa</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>SWAHB</td>
<td>South Western Area Health Board</td>
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<tr>
<td>UCD</td>
<td>University College Dublin</td>
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<tr>
<td>UK</td>
<td>United Kingdom</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children Educational Fund</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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</table>
Good sexual health is essential for physical and social well-being. There is a clear relationship between sexual ill-health, poverty and social exclusion. Our National Health Strategy, *Quality and Fairness*, has emphasised the importance of good sexual health. It was in response to our National Strategy and the evidence of growing sexual health problems in the East that this Report was produced. It is the work of experts in the field and the result of extensive consultation.

The main aims of this Sexual Health Strategy are to ensure the promotion of sexual health, the prevention and management of infection and the prevention of unintended teen pregnancies.

In recent years sexual activity in teenagers has become a particular cause of concern. Research tells us that many teenagers now become sexually active around the age of 15 years. Unfortunately, all too often alcohol appears to be a major contributory factor. Many of these teenagers are unaware of their risks. They often fail to seek preventative medical interventions. However, user-friendly, accessible services for this age group may not always be readily available.

There are over 1,200 teen pregnancies in the region every year. Although the rates in the region have remained stable in recent years, Irish teen pregnancy rates are among the highest in Europe. Teen pregnancy can be a concern due to the increased likelihood of poor health in both the mother and the baby.

The increase in Sexually Transmitted Infections (STIs) in the East is alarming. These infections now account for over 50% of all notifiable infections in the region. Of particular concern is the alarming rise in Hepatitis B, Syphilis, Chlamydia and Genital Herpes Simplex. HIV also continues to increase. The rising level of infection is reflected in the increasing work-load of clinics in the region.

It is clear that our sexual health service needs to be enhanced and modernised. A much greater emphasis on Primary Health Care is required. There is an urgent need for user-friendly information, enhancement of prevention and health promotion services and the availability of services in the right place, delivered by the right people and at the right time. On-going training for health personnel is a priority.

This Strategy needs an Action Plan. The recommendations need to be costed and implemented within a defined time frame with the ultimate objective of providing an excellent, equitable and efficient sexual health service in the East.
Chapter 1  Introduction

1.1 Background

Sexual health is an important component of public health. It encompasses not just the absence of disease and infections but also well-being, the ability to control fertility and to have children and the ability to enjoy fulfilling relationships free from discrimination. The World Health Organisation defines sexual health as the integration of the physical, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love. Worldwide, Sexually Transmitted Infections (STIs) are among the most common causes of disease and are an increasing cause of ill health. Apart from the initial symptoms and discomfort, they may result in long-term health problems such as infertility, ectopic pregnancies and genital cancers. In Ireland, rising STI rates have increased the level of concern in this area among health professionals, the government and the public.

The promotion of sexual health has become a priority for policy makers and health agencies in recent years. A number of key policy reports have highlighted issues that need to be addressed. The National Health Strategy Quality and Fairness stated that ‘measures will be taken to promote sexual health and safer sexual practice’ and that ‘an action plan for sexual health will be developed’.

The Report of the National AIDS Strategy Committee (2000) recommends that HIV/AIDS should now be dealt with in the wider context of sexual health and other STIs.

The Crisis Pregnancy Agency (CPA), established in 2001, published its strategy in November 2003. The strategy aims to reduce the number of crisis pregnancies and to decrease the number of women who opt for termination, by offering services and support.

The CPA in partnership with the National AIDS Strategy Committee (NASC) has recently commissioned the Economic and Social Research Institute (ESRI) to carry out a study of knowledge, attitudes and behaviours in the area of sexual health for adults and is planning a similar survey for teenagers aged under 18 years.

At health board level, the 2001 'Get-Connected' Report for Adolescent Health recommended that a sexual health strategy be developed in each of the health boards. Since then a number of health boards have produced or are developing sexual health strategy documents.

The UK Department of Health 2001 report The National Strategy for Sexual Health and HIV highlights the relationship between sexual ill-health, poverty and social exclusion. Markers of poor sexual health identified include STIs, ectopic pregnancies, infertility, cervical cancer, unintended pregnancies, abortion, the psychological consequences of sexual abuse and poor educational, social and economic opportunities for teenage mothers.

Rising rates of STIs including HIV infection have been recorded both nationally and internationally since the early 1990s and statistics in the Eastern Region reflect these trends. Recent reports from the UK also indicate a rising trend of 4% per annum in STI rates, a rise that hides considerable variation in the epidemiology of STIs even in the past two years. STIs constitute a particular problem in the Eastern Region. In recent years, STIs have accounted for approximately 50% of the notifications of infectious diseases received by the Director of Public Health in the HSE - Eastern Region. In 2003 there were over 4,700 notifications of STIs in the Eastern Region. A major outbreak of syphilis occurred in the Dublin area during 2000-2003. This mainly affected homosexual and bisexual men and received extensive national media coverage at the time.
A review of the STI services in the Eastern Region in 2000 identified deficiencies in service provision and made recommendations for expansion of and improvements in the services. Some of these recommendations have been acted upon. However, progress has been slow due to lack of funding. The report recommended that in the future development of STI services, consideration should be given to including services for other aspects of sexual health such as opportunistic cervical screening, contraceptive services, psychosexual counselling and sexual health information and advice.

Within the Eastern Region the importance of a strategic approach to sexual health has been highlighted to help address the needs of the population in this region including those groups with special needs e.g. ethnic minorities, young people including third-level students, homeless people and prisoners. In 2002 the Director of Public Health set up a multi-disciplinary working group to develop a strategy and to report back to the management team with a view to implementation at area board level.

1.2 Terms of Reference

In 2002, a Steering Committee was established and given the task of preparing a Sexual Health Strategy for the HSE - Eastern Region.

The key areas to be addressed were:
1. Promotion of sexual health and well-being
2. Prevention of transmission of STIs
3. Prevention of unintended pregnancy with emphasis on teenage pregnancy.

The key outputs of this strategy document are as follows:
1. Review and report on surveillance of STIs in the region
2. Review and report on clinical care and services for those with STIs, teenage pregnancy and contraception
3. Review and report on issues relating to legal consent and adolescents
4. Develop a disease prevention and health promotion strategy for sexual health
5. Set out key recommendations for developing and enhancing services.

The overall aim of this strategy is to have a framework for an integrated approach to sexual health in the region.

The specific objectives of this strategy were:
- Mapping of current services
- Identification of gaps in programmes and services
- Recommendations on future development of services.

Sub-groups of the Steering Group were assigned to work on the following areas:
- Sexual health promotion
- Sexual health services and prevention services
- Consent and legal issues in young people
- Information and surveillance.
1.3 Consultation

The purpose of the consultation process was to obtain the knowledge and opinions of individuals and groups working in the field of sexual health, both locally and nationally, in order to inform the strategy. In September 2003, in order to get detailed feedback concerning access and equity issues, a questionnaire was circulated to a wide variety of health professionals and organisations working in the area of sexual health. Over 45 responses were received. The consultation process also involved a one-day stakeholders forum facilitated by an external consultant. The key themes discussed at the forum were:

1. Promotion of sexual health and well-being
2. Prevention of transmission of STIs

A complete report on the consultation process is provided in Appendix 1. Key points from the process have been incorporated into this report and its recommendations.
Chapter 2  Key Information

2.1  Demography

The Eastern Region has the largest and most densely concentrated population in the country. The population is unique because of its young age profile and high mobility. The most recent census undertaken in 2002 showed that between 1996 and 2002 the population of the Eastern Region increased by 105,502 (8.1%) to 1,401,441. The largest change in population occurred in County Dublin with an increase of 64,577 (+6.1%).

Figure 2.1  Population in HSE - Eastern Region and area health boards, 2002

2.1.1  Age Profile in the Eastern Region

The age profile in the Eastern Region is different from that in other health boards in the country (Figure 2.2). Seventy per cent of residents of the Eastern Region are under the age of 45 years, which is higher than the corresponding proportion in any other health board region. This is mostly accounted for by the large number of people in the 25-44 year age group.

Figure 2.2  Proportions of the population of different ages in health boards

Key messages

- Currently 36% of the total population of the country live in the Eastern Region. Since 1996 the rate of increase in population numbers has been higher than in the rest of the country.
- The population of the Eastern Region is unique due to its young age profile, with 523,879 residents (37%) aged under 25 years.
- In terms of the need for sexual health services, 50% of the population (700,218 males and females) of the region are currently aged between 15 and 44 years and therefore more likely to be at risk from infections and unintended pregnancy.
2.2 Sexual Knowledge, Attitudes and Behaviours in the Eastern Region

2.2.1 National Studies

There is little information available on the sexual attitudes and lifestyles of the Irish population. Available information relates almost exclusively to problems with sexual health or practices, e.g. sexually transmitted diseases and unwanted pregnancy, and therefore is focused on particular groups in the population. During 2004 the first National Study of Sexual Knowledge, Attitudes and Behaviours commissioned by the Department of Health and Children commenced in Ireland. Results are expected in 2005. Although there have not been any extensive surveys of sexual knowledge, attitudes and behaviours, there have been a number of more limited surveys in national studies which looked at particular groups in the population or addressed other areas but which also asked some sexual health questions.

Those studies include:

- SLÁN, Survey of Lifestyle, Attitudes and Nutrition, 2002
- The International Social Survey Project (ISSP), 1994
- Survey of Sexual Abuse and Violence in Ireland (SAVI), 2002
- Vital Statistics Ireland- Survey of Gay and Bisexual Men in Ireland, 2000

**SLÁN - Survey of Lifestyle, Attitudes and Nutrition, 2002**

The National Health and Lifestyle Survey, SLÁN was first undertaken in 1998 and repeated in the summer of 2002. Only a small number of questions related to sexual health and behaviour. Of those who said they were sexually active, 43% of females and 26% of males stated that they always used contraception. The most frequently used method of contraception by women was the contraceptive pill (30%), while men stated that condoms were their most frequently used contraceptive method (60%).

**The International Social Survey Project (ISSP), 1994.**

The ISSP is an international project that collects data on social science issues for research on a regular basis. Data are gathered from 38 countries for comparative purposes. In 1994, member countries, including Ireland, carried out a module on sexual behaviour. The study group interviewed 938 individuals, randomly sampled from a national sampling frame. The questions on sexual practices were given to respondents as a self-completion survey which had a response rate of 53%. Among the sample, 74.2% had sex in the previous five years. 54.7% of men and 64.5% of women had one partner in this period, with 12.3% of men and 7.3% of women having three or more partners over this period. Of those men having sex in the last 12 months, 2.9% had been solely homosexual relationships. Among the women, 3.8% had homosexual relationships over this period. The mean lifetime (since age 18) number of female partners reported by men was 3.9 and 1.8 among women.
Survey of Sexual Abuse & Violence in Ireland (SAVI), 2002

A national prevalence study of 3,120 adults was conducted which looked at sexual violence, post-traumatic stress disorder in those experiencing abuse, the pattern of disclosure of such abuse to others and the attitudes of the public to the disclosure of abuse. Randomly selected participants from the general population were interviewed by telephone.

Results indicate that 42% of women and 28% of men reported some form of sexual abuse in their lifetime. Females were more likely than males to have been subjected to serious sexual crimes. The levels of serious sexual crimes committed against women remained similar from childhood through adulthood. However, the risks for men decreased three-fold from childhood to adult life.

The survey showed that only 7% reported abuse to Gardaí, 5% to medical professionals and 12% to counsellors. The public significantly overestimated the percentage of cases reported to Gardaí (estimated at 34% by women and 16% by men; actual 10% women and 6% men).

Gay and Bisexually Active Men (Vital Statistics Ireland), 2000

A survey of gay and bisexual men in the Republic of Ireland and in Northern Ireland was conducted in 2000. The aims of the research were to provide a snapshot of the sexual lifestyle of gay/bisexual men, and to identify the sexual health and HIV prevention needs of this group. The questionnaires were distributed at Gay Pride events, pubs and clubs and in social groups in rural areas. One thousand five hundred short, self-completion questionnaires were distributed, with a response rate of 95%.

Sixty per cent of respondents said that they had been tested for HIV and overall 3% had tested positive. Testing for HIV was more common in men who live in Dublin although there was no evidence from this study that they were more likely to be positive. Most gay men who acquired HIV were under the age of 40 years. The average number of sexual partners in the last year was five and those who tested HIV positive averaged more partners than the other groups. Most gay men who acquired HIV were under the age of 40 years. The average number of sexual partners in the last year was five and those who tested HIV positive averaged more partners than the other groups. Most gay men (57%) who had more than one sexual partner in the last year had not been for STI screening but men with a large number of partners were more likely to have gone for STI screening. Knowledge about HIV prevention and treatment was erratic.

Survey of Sexual Health Practices among Third Level Students, 2003

A study in Trinity College Dublin (TCD) was carried out using a web-based questionnaire, which was distributed to all 11,500 students. There was a response rate of 21% for all students. Respondents were asked about age, gender, sexual orientation, age of first sex, number of partners, contraception, STI testing. Their mean age was 21 years and 64% were female and 36% male. For further analysis, the researchers looked at Irish students only and, of these, 94% were sexually active. In relation to sexual orientation 96% of females were heterosexual and 89% of men were heterosexual. The most frequent age of first sex was 18 years, with 15% of males and 10% of females reporting age of first sex as 16 years or below.

Just under two thirds of males and 55% of females used condoms as a method of contraception, with 48% of males and 38% of females always using them. The most common reason for not using condoms given by males and females was that they were in a monogamous relationship. The main reason that they used condoms was to prevent pregnancy, not to protect against STIs. Twenty per cent of females had been tested for an STI compared with 14% of males.
2.2.2 Surveys of Adolescents in Ireland

There have been a number of small-scale research projects on young people's sexual knowledge, attitudes and behaviours. These include:

- Survey of Post-Primary Schools in Galway, 1997 (Mac Hale)
- Survey among Young People in Cork, 1996 (Cork Alliance).

Survey of Post-Primary Schools in Galway 1997

A survey was carried out among 2,799 pupils aged 15-18 years attending post-primary schools in the Galway area. The participants were asked questions on sexual behaviour and sex education including sources of information on sex, knowledge about the use of condoms/contraceptives for the prevention of infections, alcohol consumption, drug use and age of first sex. The study reported that 29% of boys and 15% of females had been or were sexually active. The mean age for first sex was 15.5 years.

Survey among Young People in Cork, 1997

The project aimed to collect descriptive data on the knowledge, values and practices of young people in Cork City in the areas of relationships, sexuality, AIDS, alcohol consumption and drug use. The study was carried out among 15-24 year-olds in Cork in 1996. A self-administered questionnaire was distributed to around 800 young people in a range of education settings and youth organisations in the city. Four focus groups were also held - three among early school leavers and one among people from different social backgrounds aged 15 to 25 years. Although a non-random sampling methodology was used, the findings are compatible with those of other studies.

The study reported that condom use decreased and contraceptive pill use increased with age. In the 15-17 year age group 27% of females and 14% of males did not use any contraception during last intercourse while in the 21-24 year age group 19% and 21% of females and males respectively did not use any contraception. The consistent use of contraception decreased with age, particularly in men.

2.2.3 Drug and Alcohol Use

The link between alcohol use and unintentional and unprotected sex has been well documented internationally. A major Irish research project on crisis pregnancy identified alcohol as one of the factors that contributed to the incidence of unwanted pregnancies where drinking resulted in the non-use of condoms. A study among school-going Irish teenagers reported that 35% of the sexually active respondents said that alcohol was an influencing factor for them engaging in sex.

Alcohol use has also been identified as one of the main risk indicators in relation to teenage pregnancy. Unprotected sex gives rise to an increased risk of STIs. Among a group of 32 teenage girls attending a sexually transmitted disease clinic, nearly half reported that they had unprotected intercourse on at least one occasion when drunk. The Rotunda Hospital has reported that girls seen at the sexual assault unit often cannot remember whether they had consensual or non-consensual sex the previous night due to the amount of alcohol consumed.
2.2.4 Information about Groups Vulnerable to Risk-Taking Behaviour

Despite the lack of national comprehensive data, sexual behaviour and attitudes have received much media attention in the past few years. From the current knowledge of behaviour and attitudes, the high-risk groups are young people, especially those under 20 years of age, who are likely to indulge in excessive alcohol intake. Gay men are at increasing risk because of their high-risk behaviour and exposure to infectious diseases such as HIV, Syphilis and Gonorrhoea. Victims of sexual violence are also at risk, not only of STIs and crisis pregnancy, but also of long-term psychological trauma.

Key messages

- Information about knowledge, attitudes and behaviour in relation to sexual health in both teenagers and adults in Ireland and the Eastern Region is limited.
- From the limited information available young people in Ireland become sexually active around the age of 15 years.
- Young people are at high risk of STIs and unintended pregnancies.
- Gay men are at high risk of serious STIs - Syphilis, Gonorrhoea and HIV.
- Alcohol is a major driver of risk-taking behaviour, especially among the young.
- There is a need for greater awareness, within the general population and among special groups, of sexual health risks.
- There is a need for national knowledge, attitude and behaviour studies for young people especially those aged 15-19 years.
2.3 Sexually Transmitted Infections Overview

Until January 2004 fourteen STIs were legally notifiable in Ireland (Table 2.1). Three were denotified in December 2003 with the updating of the list. However this report will contain data applicable to the legislation prior to this period. Hepatitis C, which is mainly bloodborne but is also sexually transmitted, also became notifiable in 2004.

Table 2.1 Notifiable Sexually transmitted Infections in Ireland, 2004

<table>
<thead>
<tr>
<th>Ano-Genital Warts</th>
<th>Denotified December 2003</th>
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<tbody>
<tr>
<td>Candidiasis</td>
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<tr>
<td>Chancroid</td>
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<td>Chlamydia trachomatis</td>
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<td>Genital Herpes simplex</td>
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<td>Gonorrhoea</td>
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<td>Granuloma inguinale</td>
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<td>Hepatitis B</td>
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<td>Hepatitis C</td>
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<tr>
<td>Lymphogranuloma venereum</td>
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<tr>
<td>Molluscum contagiosum</td>
<td>Denotified December 2003</td>
</tr>
<tr>
<td>Non specific urethritis</td>
<td></td>
</tr>
<tr>
<td>Pediculosis Pubis</td>
<td>Denotified December 2003</td>
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<tr>
<td>Trichomoniasis</td>
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</tbody>
</table>

Epidemiological information on STIs comes from a range of sources. Until 2003 aggregate data were collated quarterly based on data received mainly from clinics, GPs and specialised physicians. These data were then sent to the HPSC which produced a quarterly bulletin. Most notifications in the HSE - Eastern Region come from the genito-urinary medicine clinics in St James's and the Mater Misericordiae Hospitals, with the remainder coming from private physicians, GPs and special clinics. As most cases are notified by genito-urinary medicine clinics, they also include cases that live outside the region. This may lead to artificial aberrations in data.

The quarterly aggregated data received from genito-urinary medicine clinics were of limited use for epidemiological purposes as they did not have information on area of residence, age or risk factors. In addition, under-reporting has been a problem.
2.3.1 Annual Trends

Nationally, notifications for STIs have increased steadily each year since 1994, increasing by 6.5% between 2002 and 2003 (the latest year for which national statistics are available). Over 90,000 STIs have been reported nationally since 1991 and the number notified in 2003 was the highest reported in any year on record.\(^\text{19}\) During the 1980s and early 1990s the number of notified cases of STIs in the Eastern Region remained relatively stable. However, since 1995 there has been a steady increase in infections. This trend has also been seen elsewhere in Ireland, Northern Ireland and UK.\(^\text{20}\)

Figure 2.3  Notifications of STIs in Ireland, 1991-2003

Between 1994 and 2003, while numbers increased steadily in the Eastern Region, the increase was less than elsewhere in the country. This is thought to be due to improved services outside the region and also lack of capacity in existing services to deal with outpatient waiting lists.

Table 2.2  Comparison of national and regional notifications for STIs, 2003

<table>
<thead>
<tr>
<th>Sexually Transmitted Infections 2003</th>
<th>National</th>
<th>HSE - Eastern region</th>
<th>HSE - Eastern region % of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ano-Genital Warts</td>
<td>3,981</td>
<td>1,879</td>
<td>47%</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>2,258</td>
<td>1,278</td>
<td>57%</td>
</tr>
<tr>
<td>Genital Herpes Simplex</td>
<td>375</td>
<td>225</td>
<td>60%</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>186</td>
<td>106</td>
<td>56%</td>
</tr>
<tr>
<td>Infectious Hepatitis B</td>
<td>112</td>
<td>58</td>
<td>52%</td>
</tr>
<tr>
<td>Non-Specific Urethritis</td>
<td>2,332</td>
<td>975</td>
<td>42%</td>
</tr>
<tr>
<td>Syphilis</td>
<td>235</td>
<td>170</td>
<td>72%</td>
</tr>
<tr>
<td>Other STIs</td>
<td>1,674</td>
<td>711</td>
<td>42%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11,153</strong></td>
<td><strong>5,402</strong></td>
<td><strong>48%</strong></td>
</tr>
</tbody>
</table>
2.3.2 Age Distribution of Sexually Transmitted Infections

Most new cases of STIs are in young people, particularly those aged between 18 and 34 years. Until 2003 the age details of notified cases were not available for almost three quarters of all notifications in the Eastern Region. Nationally, in the 97% of cases where age was known, those in the 20-29 age group represented the largest age group. In the HSE - Eastern region in 2003 the highest age specific rates per 100,000 population were in those aged between 20 and 24 years (Table 2.3).

<table>
<thead>
<tr>
<th>Sexually Transmitted Infection (STI)</th>
<th>Age group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15-19 yrs</td>
</tr>
<tr>
<td>Ano-Genital Warts</td>
<td>199.9</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>143.8</td>
</tr>
<tr>
<td>Genital Herpes Simplex</td>
<td>13.1</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>7.5</td>
</tr>
<tr>
<td>Non-Specific Urethritis</td>
<td>66.3</td>
</tr>
<tr>
<td>Syphilis</td>
<td>0.9</td>
</tr>
<tr>
<td>Total</td>
<td>513.7</td>
</tr>
</tbody>
</table>

Source: HSE - Eastern Region

2.3.3 Gender Distribution of STIs

Nationally STIs occur slightly more frequently in females than in males. However, in the Eastern Region, since 2000, the number of notified cases was higher in males than in females. The majority of cases of Syphilis are in males whereas the majority of cases of Genital Chlamydia, Hepatitis B, Genital Herpes, Gonorrhoea and Genital Warts are reported in women. There has also been an alarming increase in infections in men who have sex with men.

Figure 2.4 Total number of STI notifications in Eastern Region by gender, 1995-2003
2.3.4 Genital Chlamydia

Genital Chlamydia is the second commonest STI notified to the HSE - Eastern Region. Worldwide, Genital Chlamydia is the most common curable bacterial STI, with an estimated 89 million new cases each year.\textsuperscript{21} Infection is often asymptomatic and, if left untreated, can result in chronic pelvic infection and infertility. Since 1994, the number of new cases notified at regional level increased over 14 fold from 86 to 1,251 in 2003. This increase could be due to a number of factors such as a true increase in prevalence, increased awareness of the condition by health professionals and improved laboratory testing. In 2003, the numbers notified represented an increase of almost 40% from 2002.

Figure 2.5 Number of notifications of Genital Chlamydia in Eastern Region by gender, 1995-2003

Although Chlamydia was traditionally diagnosed more frequently in females than in males, between 1999 and 2002 more men than women were affected. However, this trend was reversed in 2003 when women exceeded men.

In 2003, 67.2% of new cases were aged between 20 and 29 years, with 12.4% aged less than 20 years. In all 79.6% of all new cases (1,278) of Chlamydia infection in 2003 were aged less than 30 years. Provisionally, 1,668 cases were notified in the Eastern Region in 2004, of which 1,141 (80.9%) were aged less than 30 years.

Since Genital Chlamydia is usually asymptomatic, notifications underestimate the true prevalence of infection. There are very limited data on the prevalence in the region and these come from special screening programmes in different health settings. Reported rates vary from 9.5% among clients at an STI clinic in Dublin in 1999 to 5% among antenatal attendees in Dublin in 2004 and 13% among a sample of clients at a Dublin Family Planning Clinic.\textsuperscript{22}

Among men, the prevalence of Genital Chlamydia positivity varied from 3% among a sample of sexually active 17-35 year old male attendees at an orthopaedic outpatient department to 5.4% at a third-level sports complex.\textsuperscript{23} In the United Kingdom, estimates of the prevalence of Genital Chlamydia infection vary from 1% to 29%.
2.3.5 Gonorrhoea

Gonorrhoea can lead to infertility if left untreated in women. Nationally, the incidence of Gonorrhoea increased dramatically in 2001, mainly due to the increase in incidence among men who have sex with men. In the Eastern Region the numbers decreased in both sexes in 2002 and again in 2003 when 79 male and 25 female cases were notified. Information on risk is only available for men who have sex with men; this group remains at high risk. Although information on antibiotic resistant strains is not available regionally at the time of this report, this is an emerging public health problem.

Figure 2.6 Number of notified cases of Gonorrhoea in Eastern Region by gender, 1995-2003

2.3.6 Syphilis

Syphilis is a complex disease. It has two main stages, an early infectious stage and a later non-infectious stage. Worldwide it is an important global health problem, with 12 million new cases each year. If left untreated, patients can go on to develop serious multi-system health problems. The disease is treatable with antibiotics but long-term follow up is essential. It is also a disease of disadvantaged populations and affects those involved in high-risk sexual activities.24

Enhanced surveillance of Syphilis has been conducted in the Department of Public Health since 2000 in collaboration with the Health Protection Surveillance Centre (HPSC). Between January 2000 and December 2003, 803 cases of Syphilis were notified to the HSE - Eastern Region, out of which 485 (60.4%) had enhanced surveillance information. New infections in 2003 occurred equally in both men and women.

Since 2000, there has also been a steady increase in Syphilis in the heterosexual population, both national and non-national (the latter presenting mainly with late Syphilis). A dramatic increase in Syphilis among men who have sex with men began in Dublin in early 2000 and an outbreak control team was convened later that year. Interventions were targeted primarily at men who have sex with men. The outbreak control team carried out on-site testing in clubs, pubs and saunas in order to target interventions and capture further cases. The outbreak peaked in 2001 but has entered an endemic phase since then.25

The enhanced surveillance of Syphilis identified the problem of HIV co-infection in Syphilis cases, highlighting the need for continued vigilance in prevention and awareness in this group.
Figure 2.7  Number of notifications of Syphilis in the Eastern Region by gender, 1995 - 2003

*Excludes known late latent types in 2000-2003

Figure 2.8  Early (infectious) Syphilis cases by sexual orientation (homosexual and bisexual only) and month of diagnosis in HSE - Eastern Region, Jan. 2000 to Dec. 2003.
2.3.7 Hepatitis B

Hepatitis B is one of the commonest causes of liver disease worldwide. Around half of adults with acute infections do not have symptoms. The disease is spread by body fluids including blood. Traditionally thought to be a low-prevalence condition in Ireland, transmission patterns in the Eastern Region have shifted from being mainly blood borne and affecting intravenous drug users (IVDU) to being mainly sexually transmitted, affecting national and non-national heterosexuals.

The number of cases of Hepatitis B notified has increased dramatically since the mid-1990s. In the last two years and especially since the change in disease notifications in January 2004 an even more dramatic increase has become evident. In 2003, 200 Hepatitis B cases were reported to the Department of Public Health in the Eastern Region. These notifications included cases from asylum screening centres, some of whose clients are transferred to other parts of the country. Provisionally, 513 cases were notified in the Eastern Region during 2004, many of which were reported by the National Virus Reference Laboratory (NVRL). Much of the increase in Hepatitis B notifications is from the heterosexual population.

The increase in cases from the heterosexual population is thought to be due to a number of factors including the influx of immigrants and asylum seekers from countries of high endemicity and the increase in cases identified in antenatal and STI clinics. The prevalence of Hepatitis B virus (HBV) carriage among antenatal cases screened increased from 0.25% in 1998 to 0.45% in the first six months of 2000.26

The main sources of notifications are refugee screening centres, maternity hospitals, STI clinics and paediatric units (Table 2.4). Most of the cases reported from STI clinics in 2002 were male. However, cases from other clinics are more evenly distributed between men and women. Most newly diagnosed cases of HBV in 2003 were in young people aged between 20 and 29 years. Under-reporting of HBV is common as demonstrated by the large numbers of HBsAg positive samples tested by the NVRL in comparison to the substantially smaller number reported to the HPSC (553 vs. 342 HBsAg positive cases, 2001).27

Figure 2.9   Hepatitis B virus notifications, Eastern Region and national, 1988 - 2004*

* Case numbers are provisional for 2004
Increasing rates of STIs, injecting drug use, international travel and immigration from countries with high endemicity make it likely that HBV infections will continue to increase.

### 2.3.8 HIV/AIDS

The epidemiology of HIV in Western Europe is reflected in Ireland where heterosexual contact is now the most frequent transmission mode. Heterosexual contact accounted for 44% of all new HIV diagnoses reported in Western Europe in 2002 and for more than 50% in certain countries including Ireland and the United Kingdom.28

Overall in Western Europe in 2002, there were increases in the number of newly diagnosed cases. Within Ireland the incidence of cases of HIV has been rising (Figure 2.10) and the incidence is significantly higher in the Eastern Region than it is in the other regions of the country.

### Table 2.4 Hepatitis B notifications, Eastern Region by clinic, 1999 - 2003

<table>
<thead>
<tr>
<th>Location</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asylum / antenatal and non STI clinics</td>
<td>157</td>
<td>117</td>
<td>102</td>
<td>155</td>
<td>179</td>
</tr>
<tr>
<td>STI clinics</td>
<td>17</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>58</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>174</td>
<td>147</td>
<td>132</td>
<td>185</td>
<td>237</td>
</tr>
</tbody>
</table>

### Figure 2.10  Number of new HIV cases annually, Eastern Region/Ireland, 1996-2003
In 2003 the total number of newly diagnosed HIV cases nationally was 399. This represents a 10% increase in the number of cases diagnosed compared to 2002 (Figure 2.10). Of the cases diagnosed in 2003, a total of 213 (57.8%) were resident in the Eastern Region at the time of diagnosis. Ninety-two per cent of cases with exposure category listed as IVDU lived in the Eastern Region, as did 62% of the heterosexuals and 56% of the men who have sex with men.

Since the mid 1990s the widespread use of highly active antiretroviral therapy in Western Europe has greatly reduced HIV morbidity and mortality. The incidence of AIDS has declined substantially as a result and is less representative of the underlying trends of HIV transmission. The reported number of 17 in the Eastern Region of a national total of 23 in 2004 reflects this. However, the importance of enhanced surveillance to monitor trends cannot be underestimated in order to direct and improve public health interventions.

*Figure 2.11  Number of new HIV cases by exposure category in Ireland, 1995-2003*

Since the mid 1990s the widespread use of highly active antiretroviral therapy in Western Europe has greatly reduced HIV morbidity and mortality. The incidence of AIDS has declined substantially as a result and is less representative of the underlying trends of HIV transmission. The reported number of 17 in the Eastern Region of a national total of 23 in 2004 reflects this. However, the importance of enhanced surveillance to monitor trends cannot be underestimated in order to direct and improve public health interventions.

*Figure 2.12  AIDS reported figures, Eastern Region and National, 1983-2004*
2.3.9 Surveillance and Control of STIs

Control of STIs requires an integrated response from all relevant service providers. Timely and comprehensive information on incidence of diseases, age, gender and risk groups is necessary in order to understand the epidemiology of STIs in Ireland.

While an area of great concern to clinicians is patient confidentiality, notifications from STI clinics are often made without any details of patient name or address thereby limiting the use of these data for surveillance, control and service planning.

The introduction of a standardised notification system for STIs used by all clinicians would improve the quality of the information collected. This system should record data on a variety of socio-demographic variables along with information on risk factors.

Since January 2004 clinicians and laboratories are legally obliged to notify scheduled infectious diseases. Under the Act, data to be notified are decided by the HPSC.

Key messages

- STIs in the Eastern Region have been increasing since the mid-1990s and are reaching epidemic proportions especially for serious diseases such as Syphilis, Gonorrhoea and Genital Herpes.
- Young people and gay men are at high risk from STIs.
- Genital Chlamydia is on the increase, and its prevalence, although not well known nationally, needs to be established by further studies.
- Infectious Syphilis, especially in gay men, has been a major problem in Dublin, with an outbreak peaking in 2001. The epidemic has entered an endemic phase but vigilance needs to be maintained. Co-infection with HIV is a problem in men who have sex with men. There is also an increase in late syphilis in non-nationals.
- The incidence of HIV has been rising and is significantly higher in the Eastern Region than it is in the other regions of the country.
- The number of new HIV diagnoses in the heterosexual exposure category has been increasing over the last decade accounting for the majority of cases in 2003.
- The majority of new cases in the heterosexual exposure category came from areas where HIV is endemic e.g. Sub-Saharan Africa.
- Surveillance of STIs has been inadequate in the region for a variety of reasons, resulting in incomplete reporting, lack of timeliness and missing data on key factors such as residence and risk factors.
- At Regional level stronger collaboration between all relevant parts of the health service has been a major achievement and needs to be given further support in the strategy.
2.4 Pregnancy and Reproductive Health

2.4.1 Birth Rates

The number of births to mothers resident in the Eastern Region has risen continually during the past ten years from 18,373 in 1993 to 22,671 by 2002. This represents an overall increase of 23% (Fig. 2.13) with births in 2002 at their highest in almost 20 years. Based on migration assumptions and no change in fertility, approximate birth projections for the next five years estimate that an additional 7% of births will occur in the Region's three maternity hospitals. With the influx of refugees in recent years it is estimated that approximately 13% of births (approximately 3,000 in 2001) are to non-nationals seeking refugee status. Not infrequently, women from this group arrive in the region in an advanced state of pregnancy with consequent increased risk of birth complications. Although the percentage of births to teenagers has remained stable at approximately 6-7%, the percentage of births to mothers aged 35 years or more has risen by 58% from 1,963 in 1993 to 4,675 in 2001.

These changes reflect trends in maternal demographics seen elsewhere in Europe, with a tendency to childbirth at a later age due to social and career reasons, in addition to the recent trend towards a reduction in family size. Overall, approximately one third of births are to single mothers. This proportion has increased in recent years, again reflecting societal change.

Figure 2.13 Number of births, percentage teenage births and births to mothers aged 35 years and over, 1993-2002, Eastern Region

Source: Crisis Pregnancy Agency 2003
2.4.2 Crisis or Unintended Pregnancy

At present there are no actual figures for crisis pregnancy and proxy indicators are used including abortion figures, adoptions and survey estimates. The figures for women giving Irish addresses at UK abortion clinics have increased substantially over the last two decades. These increases were especially apparent for women aged between 20-24 years. (Table 2.5)

Table 2.5 Abortion trends for Irish women in UK by age category, 1975 to 2002

<table>
<thead>
<tr>
<th></th>
<th>All ages</th>
<th>15 &amp; under</th>
<th>16-19 years</th>
<th>20-24 years</th>
<th>25-29 years</th>
<th>30-34 years</th>
<th>35 &amp; over</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975</td>
<td>1,532</td>
<td>4</td>
<td>227</td>
<td>677</td>
<td>347</td>
<td>158</td>
<td>119</td>
</tr>
<tr>
<td>1980</td>
<td>3,315</td>
<td>16</td>
<td>479</td>
<td>1,379</td>
<td>735</td>
<td>380</td>
<td>326</td>
</tr>
<tr>
<td>1985</td>
<td>3,888</td>
<td>16</td>
<td>558</td>
<td>1,535</td>
<td>828</td>
<td>464</td>
<td>487</td>
</tr>
<tr>
<td>1990</td>
<td>4,064</td>
<td>18</td>
<td>649</td>
<td>1,498</td>
<td>880</td>
<td>503</td>
<td>516</td>
</tr>
<tr>
<td>1995</td>
<td>4,532</td>
<td>25</td>
<td>673</td>
<td>1,763</td>
<td>943</td>
<td>561</td>
<td>567</td>
</tr>
<tr>
<td>2000</td>
<td>6,391</td>
<td>27</td>
<td>857</td>
<td>2,243</td>
<td>1,631</td>
<td>853</td>
<td>780</td>
</tr>
<tr>
<td>2002</td>
<td>6,485</td>
<td>54</td>
<td>842</td>
<td>2,239</td>
<td>1,611</td>
<td>920</td>
<td>819</td>
</tr>
</tbody>
</table>

Source: Crisis Pregnancy Agency and Department of Health and Social Security, UK

The Crisis Pregnancy Agency (CPA) reviewed the range of factors that give rise to crisis pregnancies. At an individual level the most important factors were age, socio-economic status, insufficient knowledge about fertility and contraception, skills, attitudes, intentions and self-esteem. Situational factors are also important, such as use of alcohol, access to and costs of contraception, failure of condoms etc. Respondents to the CPA consultation drew particular attention to the difficulty in accessing contraception especially for emergencies and in rural areas. The influence of peers, family and the media is also important.

Figure 2.14 Births outside of marriage, teenage births (19 years and under) in Ireland and abortions in Irish women in the UK, as a percentage of total births, 1955-2002

Source: Crisis Pregnancy Agency 2003
2.4.3 Teenage Pregnancy

Ireland has one of the highest rates of teenage births in Europe at 8.2 births per 1,000 women. Teenage pregnancy is a public health priority and a challenging issue, which requires an integrated and co-ordinated response at statutory, voluntary and community level. Teenage mothers and their children can suffer adverse health, social and economic consequences although this can be both cause and consequence of teenage parenthood. For society also, unintended early pregnancy can have serious financial and social costs. Teenage pregnancy is often considered to be both a cause and consequence of social exclusion. International research highlights that young people with multiple risk factors are particularly vulnerable, especially those who live in disadvantaged areas.

These risk factors include:

- Poverty/Disadvantage
- Being in care
- Being the daughter of a teenage mother
- Educational problems and low educational achievement
- Not being in further education, training or work at the age of 16
- Sexual abuse
- Mental health problems
- Involvement in crime.

The teenage pregnancy rate, i.e. births in women 19 years and under per 1,000 population has been slowly increasing in the last decade in Ireland, with a flattening out in the increase in the last few years. The Eastern Region has consistently recorded the highest rate of teenage pregnancy in Ireland. However, the teenage pregnancy rate in the Eastern Region has decreased in the last few years.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of teenage births in the Eastern Region (≤19yrs)</th>
<th>Rates of teenage births (/1,000) in the Eastern Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>1,163</td>
<td>20.11</td>
</tr>
<tr>
<td>1994</td>
<td>1,050</td>
<td>18.22</td>
</tr>
<tr>
<td>1995</td>
<td>1,042</td>
<td>18.01</td>
</tr>
<tr>
<td>1996</td>
<td>1,179</td>
<td>20.32</td>
</tr>
<tr>
<td>1997</td>
<td>1,244</td>
<td>21.20</td>
</tr>
<tr>
<td>1998</td>
<td>1,391</td>
<td>23.46</td>
</tr>
<tr>
<td>1999</td>
<td>1,441</td>
<td>24.64</td>
</tr>
<tr>
<td>2000</td>
<td>1,323</td>
<td>23.26</td>
</tr>
<tr>
<td>2001</td>
<td>1,254</td>
<td>23.03</td>
</tr>
<tr>
<td>2002</td>
<td>1,227</td>
<td>23.31</td>
</tr>
</tbody>
</table>
Trends from UNICEF based on 1998 data show that 41% of teenage mothers in Ireland were in households with income in the lowest 20%. These data also show that 73% of Irish teenage mothers did not complete secondary education and that 69% were not in active employment. Of these teenage mothers 42% were without a partner.

Teenage pregnancy is a health concern because teenage parents tend to have poor antenatal health, lower birth weight babies and higher infant mortality rates. These problems arise because the pregnancies may be unplanned and poorly managed.

**Key messages**

- ERHA births increased by 23% between 1993 and 2001.
- Women seeking asylum accounted for over 13% of births (approximately 3,000 in 2001) (20% in some maternity hospitals in 2002/3).
- One third of all births in the region are to single mothers.
- Crisis pregnancies are difficult to measure and are multi-factorial in aetiology.
- Abortion numbers for Irish women in the UK increase every year.
- Teenage abortions among residents of the Eastern Region are also increasing in line with all abortions and represent a significant burden of disease in this population.
- Although they have remained relatively stable, teenage pregnant rates in Ireland remain among the highest in Europe.
**Chapter 3  Sexual Health Promotion**

### 3.1 Introduction

Health promotion is a process of enabling people to increase control over and improve their own health. It goes beyond a focus on individual behavioural change to one that recognises the impact of broader health determinants, such as social, economic, lifestyle, environmental and cultural factors. These are outlined in Figure 3.1.31

**Figure 3.1  Wider determinants of health**

One of the aims of the National Health Promotion Strategy 2000-2005, is to promote sexual health amongst the population.32 The key objectives regarding sexual health stated in the strategy are as follows:

- To **support** school-based programmes designed to develop personal skills such as Relationships and Sexual Education (RSE) and Social, Personal and Health Education (SPHE)
- To **work in partnership** to develop and implement health promotion initiatives which address issues in relation to teenage pregnancies
- To **contribute** to a reduction in crisis pregnancies
- To **work in partnership** to develop and implement strategies aimed at reducing the incidence of STIs
- To **initiate** research into the need for a National Sexual Health Strategy that would encompass the prevention of STIs and crisis pregnancies
- To **support** the implementation of the recommendations of the AIDS Strategy 2000 Report of the National AIDS Strategy Committee (NASC).

Inequalities in health are strikingly evident in the area of sexual health. Information on sexual ill-health in the UK has shown that those most affected are the most disadvantaged in society.5 While comparative Irish figures are not available to the same degree, anecdotally there are many causes for concern, with STIs and crisis pregnancies most likely among marginalised groups (teenagers in inner-city areas, ethnic minorities, men who have sex with men). Certain lifestyle practices such as alcohol misuse are associated with unplanned sexual activity and sexual violence.33, 34 Health promotion is the key towards tackling these health determinants and redressing the inequalities that currently exist.
3.2 Sexual Health Promotion in the Eastern Region

Within the statutory services, the Department of Public Health has a strategic role in terms of guiding health promotion policy in the region. The development and implementation of health promotion initiatives have been the responsibility of the three area health boards. Health Promotion Officers work in the community in education and training activities around sexual health. The Health Promotion Officers for schools support the implementation of the Social and Personal Health Education Programme (SPHE) in schools and are a useful resource for youth agencies. There is also a national network of Health Promotion Officers, who have responsibility for sexual health as part of their remit.

The Women’s Health Unit, although located in the Northern Area Health Board (NAHB), has a regional role. It funds the Teenage Health Initiative (see below) and trains teachers in SPHE, although only in the NAHB. It also provides funding to the Irish Family Planning Association (IFPA) for the development of Black and White information guides and for programmes addressing violence towards women. Many agencies, groups and individuals outside the statutory sector, develop and deliver health promotion on sexual health in the community e.g. drug and alcohol services, gay health networks, and a wide range of health advisors, outreach workers, social workers, youth groups, schools, teachers and parents.

3.3 Strategic Framework for Sexual Health Promotion

Health promotion is generally carried out within the strategic framework of three approaches: population groups, topics and settings. These are inter-linked and need to be considered as an entity and are guided by the Ottawa Charter for health promotion. Within this framework the topic of sexual health is considered in relation to relevant settings and population groups.

3.3.1 Settings
In the settings approach, efforts are concentrated on combining healthy policies, in a healthy environment, with complementary education programmes and initiatives. The relevant settings include schools, colleges, youth sectors, community, workplace and health services.

3.3.1.1 Schools and Colleges
In the context of sexual health, a strategic aim of the National Health Promotion Strategy is to facilitate the implementation of health education and health promotion programmes within the school and college setting.

Through the medium of Social Personal Health Education (SPHE), teachers are key deliverers of education for life programmes. Relationship and sexuality education (RSE) is an integral part of SPHE in primary and secondary schools. The aim is to foster self-esteem and to equip students with effective communication and problem-solving skills. The RSE component of SPHE aims to teach children, within the ethos of their school, about their own development, good self-image, promoting respect for themselves and others, providing them with appropriate information, about friendships, relationships and sexuality so that they can think and act in a caring and responsible way.

All primary-school teachers have received training in both SPHE and RSE. Post-primary teachers have received training in RSE. For post-primary (junior-cycle) level, designated health promotion officers from health boards provide the training for teachers and there is a post-primary (junior cycle) support service available. A curriculum for SPHE at senior cycle post-primary level is being developed by the Department of Education and Science.
Third-level institutions are not included in SPHE programmes. However, some third-level institutions have sexual health policies and provide walk-in student clinics, e.g. Trinity College Dublin and the Dublin Institute of Technology have one-stop sexual health clinics and University College Dublin provides sexual health services as part of its student health service.

With regard to the implementation of SPHE/RSE the number of primary schools delivering the programme in the region is not known. A national survey of primary schools carried out in 2002 found that less than 50% were teaching RSE in all classes. A survey of post-primary schools in 2000 indicated that 41.5% were teaching RSE in all classes and 39.5% in some classes.

Within the Eastern Region, there is no detailed information available on the progress of the SPHE Programme. However, as there has not been full implementation, there are children entering second level without the benefit of the Programme. Some teachers have reported difficulties with the Programme especially when addressing medical issues such as sexually transmitted diseases and contraception. The lack of input from male teachers, the dependence on school principals in the implementation of the programme and the slow take-up of the programme by all boys schools were identified during the preparation of this report as constraints to the effective implementation of the SPHE programme and which need to be resolved.

Youth workers working outside the school system have reported difficulties in using the SPHE programme. There is also the problem of delivering vital health education programmes only in the school setting, when some of the most vulnerable children will be excluded because of early school leaving. The lack of standardisation of training programmes particularly for youth workers with clear evaluation and accountability was particularly noteworthy as only a few isolated programmes meet accredited standards.

3.3.1.2 Youth Sector
The National Health Promotion Strategy\textsuperscript{32} stated that the youth sector represents a forum through which young people, especially those who leave school early, can be offered opportunities to develop their personal skills including those in the area of relationships, sexual health and self esteem. At a national level, through the National Youth Health Programme in partnership with the Department of Health and Children, the Department of Education and Science and the National Youth Council of Ireland, the Programme has taken responsibility for the provision of health promotion training for groups and youth workers on an outreach basis nation-wide, using both a settings and topic approach.

Teenage Health Initiative
The Teenage Health Initiative was established in 1996 as a means of addressing the high level of teenage pregnancy. The course content is broadly similar to the content of the SPHE programme. The initiative is aimed at early school leavers in disadvantaged areas. The overall aim of the intervention programme is the reduction of teenage pregnancies and the delay in onset of sexual activity. The programme focuses on providing youth workers with information, support and skills on health matters around relationships, sexual health and general health issues. Approximately 30 people in the area boards are trained each year in the Eastern Region. An evaluation is planned for 2005.

Teen Parent Support Initiative
The Teen Parent Support Initiative (TSPI) was set up in July 1999. The initiative sought to provide a range of additional support services for teen parents during pregnancy and until their children reached two years of age. It was set up as three pilots: one hospital based, one community based and one voluntary.
National Youth Council Ireland (NYCI)

The National Youth Council has been funded by the Crisis Pregnancy Agency to develop a programme for youth workers, which will cover areas such as self-esteem, healthy relationships, sexual health promotion, crisis pregnancy prevention, contraception and STIs. However, within the Eastern Region a regional approach to the standardisation of training and ongoing mentoring has not been developed. The Health Promoting Youth-Reach Initiative is a general health promotion programme with accreditation from the Youth Council of Ireland. Five areas in the Eastern Region have achieved accreditation.

3.3.1.3 Community
The community as a setting has the potential to reach individuals or population groups that are not associated with the other settings such as older people, members of the Traveller community and ethnic minorities. The aim is to enhance the health of the community, its environment and its people by developing partnerships with all relevant agencies and enlisting the active involvement of the community concerned. In addition to the generic community setting, specific strategies exist for some of the above groups.

3.3.1.4 Workplace
The Health Promotion Strategy 2000-2005 identified the Department of Health and Children as having a prominent role in formulating policy, liaising with health boards and facilitating the dissemination of information on workplace health promotion programmes. Employee Assistance Programmes (EAPs) and occupational health services have a capacity to deliver workplace health promotion programmes addressing lifestyle, relationships, stress management, alcohol use and disease prevention (e.g. screening) in an easily accessible, culturally sensitive, comprehensive manner. There is also a network of health promoting workplaces similar to health promoting hospitals (see below).

3.3.1.5 Health Services
As a workplace the health services come within the section above as a major employer. In addition all health service staff, if well informed, can impact on the overall health of their families and friends. Front-line staff can have a major impact on those they come in contact with through their work. Health Promoting Hospitals is an international movement following lines similar to health promoting schools, colleges and workplaces. A number of hospitals in the Eastern Region belong to the national network of health promoting hospitals. Monthly bulletins highlight important topics such as alcohol use and how to protect against STIs.

3.3.2 Specific Population Groups
The sexual health needs of other groups such as the homeless and disabled must also be addressed. GPs in their submission to the consultation have expressed interest in including STI screening at hostels for the homeless, other hostels and groups of highly vulnerable men and women.

3.3.2.1 Lesbian/Gay/Bisexual

Gay Men's Health Project
The Gay Men's Health Project provides support, sexual health promotion and screening services for men who have sex with men (MSM). Sexual health promotion and education is provided at the project and through outreach services. Services are provided at the project location and through an outreach network.

The Gay Men's Health Project also provides services to all men who have sex with men and those who work in the sex industry. The project provides STI screening and management services, counselling and information and advice.
**HIV Services Network**

The HIV Services Network (HSN) established in 2000 is comprised of individuals or agencies providing HIV and sexual health services throughout Ireland. It receives statutory state health funding and holds two annual conferences/workshops. It has published a Directory of HIV and Sexual Health Services in Ireland details of which are included on its web site [www.hivireland.ie](http://www.hivireland.ie).

**Gay HIV Strategies**

Gay HIV Strategies is a non-governmental national organisation, core-funded by the Department of Health and Children, which works to build the capacity of the gay community to respond to gay disadvantage and marginalisation.

**3.3.2.2 Sex Workers**

Women involved in prostitution can be a hidden group for a variety of reasons.

**Women’s Health Project:**

Outreach workers provide advice on issues such as safer sex, contraception, STIs, and referral to statutory and voluntary agencies. They also carry out street work in order to meet women in their place of work, carry out health promotion and encourage women to attend services based at one dedicated clinic.

**Ruhama Women Project**

This is a community-based voluntary organisation that provides support, training and outreach services to women working in the sex industry.

**3.3.2.3 General Sexual Violence**

There are a number of agencies working in the area of sexual violence. In terms of sexual health promotion and prevention the following are of particular relevance:

**Dublin Rape Crisis Centre**

The Dublin Rape Crisis Centre’s 24-hour help line, staffed by trained counsellors, provides a free, confidential support service for women and men who have been raped and/or sexually abused at any time in their lives, or for anyone who wants to talk about the affects of sexual violence. One-to-one counselling is also available.

**Domestic Violence**

Women’s Aid operates a free-phone help-line and supports women on a one to one basis giving advice, information and support on financial, legal, housing and social welfare matters.
3.4 Feedback from Consultation

As described in Chapter 1, a consultation process was conducted for this strategy. This consisted of inviting written submissions and a one-day consultation forum for those working in the area of sexual health, consumers and special interest groups. The one-day forum was held in November 2003 and was attended by over 50 people from the statutory, private, professional and voluntary sectors. Further details are contained in the consultation report (Appendix 1).

From the written and oral submissions, there was general consensus that the strategy should emphasise promoting sexual health in a positive holistic way rather than having a narrow disease focus. The principle of equity was identified as important in targeting groups who have greatest need of services. Respondents were concerned about the impact of social disadvantage on the lack of priority that individuals at risk give to sexual health matters and on the lack of access to services for these high-risk individuals.

The partnership approach was identified as being the critical component of future developments in the area of sexual health. The principle of confidentiality was considered very important by many of the groups and individuals consulted. Sexual health matters in general require a high level of confidentiality and the relative anonymity of the urban environment cannot be assumed in more rural localities. There are also specific issues which can prevent individuals from accessing the appropriate services due to statutory restrictions on services to young people, an inability to seek services due to personal shame and guilt, fear of authority or illegal residence status. More detailed feedback from the consultation will be given in section 3.5 below and in other relevant sections.

3.5 Consultation and Feedback on Existing Sexual Health Promotion Programmes

Many gaps in the development and implementation of sexual health promotion programmes and services were identified by the working groups and during the consultation process. The current structures were perceived as being excessively focused on negative outcomes such as unplanned pregnancies and STIs.

3.5.1 Information

A dearth of easily accessible information on what services currently exist was identified. As a result it was not possible to carry out a detailed service-mapping exercise within a reasonable timeframe. In the wider society the need for increased awareness and education especially among those who may be sexually active was highlighted. Respondents would like education programmes to be strengthened and public information campaigns to be developed.

3.5.2 Lack of co-ordination

Respondents see current services for sexual health promotion and treatment as lacking co-ordination. Health promotion was seen as a parallel provider of service rather than as a co-ordinated, complementary approach. Too often service providers feel they are competing for scarce resources.

3.5.3 Access

Access and acceptability of services were highlighted as key issues for ethnic and religious minorities and for other marginalised groups. Physical access for disabled persons was in particular identified as an issue. In relation to emergency contraception, restricted access and opening times of clinics especially when it is most needed were cited (e.g. weekend and holiday periods).
3.5.4  Personal Issues
Personal issues such as embarrassment, lack of privacy, confidentiality issues and the effect of tests being recorded on insurance medical forms were key influencers in decisions to seek sexual health services.

3.5.5  Intersectoral collaboration
Respondents noted the importance of groups and individuals other than primary care and hospital based services in providing services such as community-based voluntary organisations, health advisors, outreach workers, drug/alcohol services, social workers, youth groups, schools, teachers and parents.

3.5.6  High-risk groups
In terms of being at special risk, the groups most often prioritised by respondents were youth, ethnic minorities and gay and lesbian groups. These groups are either at higher risk of sexual ill-health or are affected by other factors that make it more difficult to access services.

Priority needs for young people identified by respondents included the following:

- Full range of sexual health services on a drop-in basis
- Youth-friendly setting
- Access to contraception and advice
- STI screening
- Age-appropriate information material
- Services developed in partnership with youth services
- Training of providers
- Confidentiality.

Women, young men (often alone) and unaccompanied children (minors) were considered a priority within the ethnic minorities group. The indigenous Traveller population was also identified as needing culturally sensitive services.

<table>
<thead>
<tr>
<th>Priority needs for ethnic minorities identified:</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Services developed in partnership with ethnic minority communities</td>
</tr>
<tr>
<td>■ Provision of translators and translated information material</td>
</tr>
<tr>
<td>■ Training of service providers</td>
</tr>
<tr>
<td>■ Confidentiality</td>
</tr>
</tbody>
</table>

Other groups recognised as having specific needs were people with disabilities, mental, physical and intellectual; people living with HIV and/or HCV; women and men working in prostitution; victims of child sexual abuse; victims of sexual assault; prisoners; homeless persons; those with alcohol and/or drug problems, middle aged and older persons and holidaymakers.

3.5.7  Evaluation and research
The need for more evaluation and research was stressed in order to understand sexual health issues in Ireland and highlight areas of unmet need. It was also suggested that there was insufficient evaluation of health promotion programmes. There is a need for a reduction of inequalities in sexual health and for performance indicators to monitor progress in meeting set targets.
Key Points from Consultation

- A national framework for promotion of sexual health is a key priority.
- Much greater emphasis on promotion and education campaigns are needed for the region.
- Improved collaboration between sectors is needed for health promotion.
- SPHE and RSE are important programmes in our schools and require greater support from the health services. These programmes specifically should be expanded to include the out-of-school setting and outreach services currently run by area health boards and community/voluntary schemes.
- A formal evaluation of the SPHE programme and how it impacts on the senior cycle should be conducted.
- Information about sexual health is lacking across the whole age and gender spectrum of society.
- There is a need for a series of health campaigns and dissemination of information concerning services, behaviour and attitudes based on evidence and sound research.
- Training should be made available for all health promotion officers and other key health workers in the area of sexual health.
- There should be a broader programme developed for the training of youth workers.
- Patient and client surveys of satisfaction and acceptability of health promotion are needed.
Chapter 4  Prevention and Treatment Services

4.1 Introduction

Sexual health prevention and treatment services include a broad range of health care at different levels, both public and private, throughout the health care system. The main elements include prevention of sexually transmitted infections (STIs) and clinical care for those with STIs, contraception, screening for diseases such as Genital Chlamydia, psychosexual counselling and support, and specialised services for high-risk groups and diseases. Early diagnosis, treatment and prevention are the key components of the clinical services.

4.2 Services for Sexually Transmitted Infections

Community-based services for STIs are underdeveloped in the Eastern Region. Clinics have been almost exclusively based in hospitals in the Eastern Region although this is not the case elsewhere in the country. STI clinics are currently run in St James's Hospital and the Mater Misericordiae Hospital and other satellite clinics.

The increasing incidence of STIs in the past 10 years with the added burden on society and the health services has led to difficulties in providing services for diagnosis, treatment and contact tracing. Also, the Care and Management Subcommittee of the National AIDS Strategy Committee has studied the clinical services in the region and a synopsis of their findings was used to map out the current services.

Support for sexual health is provided in many settings: for example in the family by parents, siblings and extended family, in school by teachers and counsellors and in the community by GPs and practice or specialist nurses. Other services are provided by hospital consultants, laboratories and consultant microbiologists, health advisors and outreach workers, community-based voluntary services, health promotion agencies, and drug/alcohol services, social workers and youth groups.

4.2.1 Hospital-Based STI Services

St James's Hospital Genito-Urinary and Infectious Disease (GUIDE) services

The Genito-Urinary and Infectious Disease (GUIDE) services were combined in 1998 and now provide a range of STI, HIV, Hepatitis C/HIV co-infection and general infectious diseases clinical services. GUIDE also provides services to the Baggot Street Hospital Clinics, Trinity Court Drug Treatment Services and Cherry Orchard Hospital and supports student health services in Trinity College Dublin. A respite ward for HIV patients operates in Cherry Orchard.

Four health advisors are attached to the St James's GUIDE clinic whose role includes the provision of support and education on STIs to patients, treatment, contact tracing and liaison with GPs and family planning centres. GUIDE provides all medicines for the patients free of charge, currently running at a cost of approximately €3-4 million per year.

Outpatient attendances at GUIDE clinics have increased significantly in recent years and currently represents approximately 7.6% of overall attendance to St James's Hospital. In 2002, 7,855 new patients presented to the clinic, compared with 5,891 in 2001. In 2002, 226 new HIV patients were diagnosed in St James's Hospital. The increase in non-EU nationals presenting to the GUIDE clinic has presented particular challenges - language barriers, cultural mores, dispersal of asylum seekers and medico-legal issues. In 2003 there was a four to six-week waiting list for the STI clinics.
Table 4.1 Attendances at St James’s GUIDE clinic, 2001-2004

<table>
<thead>
<tr>
<th>GUIDE clinic</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>5,891</td>
<td>7,855</td>
<td>7,498</td>
<td>6,915</td>
</tr>
<tr>
<td>Return</td>
<td>11,642</td>
<td>11,838</td>
<td>9,840</td>
<td>10,396</td>
</tr>
<tr>
<td>Total</td>
<td>17,533</td>
<td>19,693</td>
<td>17,338</td>
<td>17,311</td>
</tr>
</tbody>
</table>

Source: Monitoring and Evaluation Department, HSE- Eastern Region

Mater Misericordiae Hospital
The Mater Misericordiae Hospital provides an infectious disease service to clients from the Mater Hospital catchment area. Since 2000 there has been a marked shift in patient profile with an increase in non-nationals presenting and especially with the referral of patients from the Rotunda Hospital and Balseskin refugee-screening centre.

Table 4.2 Attendances at Mater ID and STI clinics, 2001-2004

<table>
<thead>
<tr>
<th>ID clinic</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>New patients</td>
<td>327</td>
<td>345</td>
<td>364</td>
<td>335</td>
</tr>
<tr>
<td>Return patients</td>
<td>676</td>
<td>894</td>
<td>1,517</td>
<td>1,541</td>
</tr>
<tr>
<td>STI Clinic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New patients</td>
<td>1,359</td>
<td>836</td>
<td>1,249</td>
<td>1,399</td>
</tr>
<tr>
<td>Return patients</td>
<td>2,044</td>
<td>1,621</td>
<td>1,839</td>
<td>2,065</td>
</tr>
</tbody>
</table>

Source: Monitoring and Evaluation Department, HSE- Eastern Region

The number of non-EU nationals with HIV attending the clinic has increased, with 50-75% of all new cases of HIV from this population.

There is currently no health advisor attached to the STI clinic. HIV testing is not carried out on site and all tests are sent to the National Virus Reference Laboratory. The screening of all STI clinic attendees for Hepatitis B as recommended in the National Immunisation Guidelines is not routinely carried out.

Beaumont Hospital
Beaumont Hospital provides services for those with general infectious diseases and HIV but not for those with STIs.

Table 4.3 Attendances at Beaumont ID clinic, 2000-2004

<table>
<thead>
<tr>
<th>Infectious Disease clinic</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>New patients</td>
<td>112</td>
<td>216</td>
<td>161</td>
<td>121</td>
</tr>
<tr>
<td>Return patients</td>
<td>1,007</td>
<td>1,167</td>
<td>1,382</td>
<td>1,173</td>
</tr>
<tr>
<td>Annual numbers</td>
<td>1,119</td>
<td>1,383</td>
<td>1,543</td>
<td>1,294</td>
</tr>
</tbody>
</table>

Source: Monitoring and Evaluation Department, HSE- Eastern Region
There has been a significant rise in the numbers of HIV patients treated at Beaumont Hospital. They accept all new referrals from the asylum-seeker reception centre in Balseskin and the Rotunda Hospital.

Restrictions were introduced into the service in 2003 due to the increased demands. STI referrals are no longer accepted and pregnant and immuno-compromised patients take priority on the waiting list for treatment.

4.2.2 Special Services in the Community

Gay Men’s Health Project
The Gay Men’s Health Project (GMHP) promotes sexual health among gay, bisexual and other men who have sex with men, through outreach, counselling and STI clinical services. A community-based multidisciplinary project team of medical and support staff provide a range of services including free STI clinical services two evenings a week.

Table 4.4 Attendances at Gay Men’s Health Project

<table>
<thead>
<tr>
<th>Attendance</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>640</td>
<td>649</td>
<td>598</td>
<td>638</td>
</tr>
<tr>
<td>Return</td>
<td>2,984</td>
<td>2,976</td>
<td>2,962</td>
<td>4,080</td>
</tr>
<tr>
<td>Total</td>
<td>3,624</td>
<td>3,625</td>
<td>3,560</td>
<td>4,718</td>
</tr>
</tbody>
</table>

Source: Gay Men’s Health Project

The outreach and counselling services are an important function of the GMHP. As part of the response to a Syphilis outbreak the project’s staff were involved in onsite Syphilis testing in 2002 and 2003. In 2003 there was a significant increase in HIV infection diagnosed among men who have sex with men (25% of whom are non-nationals).

Well-Woman Clinics and Irish Family Planning Association (IFPA)
The Well-Woman clinics and the IFPA both provide STI screening for men and women although the services for men are not widely advertised. Full STI screening is available at the Cathal Brugha Street and Tallaght branch of the IFPA. Two Well-Woman clinics also provide STI screening. As these services are not publicly funded, both organisations charge a consultation fee of approximately 150.

Women’s Health Project (women in prostitution)
The Women’s Health Project was established in 1991, as part of the HIV/AIDS prevention strategy. Since then services have been developed to cater for the increased needs of the clients. The project, based in Baggot Street Hospital, provides an accessible drop-in service, open in the evenings and weekends. A full sexual health screening and counselling service is available including HIV and Hepatitis A, B and C testing, vaccinations, smears, counselling, contraception, pregnancy testing and advice, support, referral and education. Additional services include a methadone and needle exchange programme. All services, including drugs and condoms, are free.
Full STI testing is carried out in an on-site laboratory. In 2003 there were 799 attendances at the drop-in clinics. The outreach service made 677 contacts on the street and 131 contacts in brothels/parlours. There were 87 new clients. There has been a shift in the profile of women who access the service towards an increase in non-national women. Intravenous drug users, who are involved in prostitution, tend not to attend sexual health services.

**Student Health STI Services**

Health centres in third level institutions provide an ideal opportunity to target an at-risk population for the promotion of safe sexual practices and STI screening. Consultations are free or are subsidised by the colleges.

At present two third-level institutions, Trinity College Dublin (TCD) and the Dublin Institute of Technology (DIT), provide a dedicated sexual health service. This includes STI screening and treatment and the provision of contraception. Other colleges incorporate STIs into their clinical services for students.

**Hepatitis B Prevention Services**

Since 1996, the National Immunisation Guidelines for Ireland have recommended Hepatitis B vaccine for those in high-risk groups who are not already immune. Some STI clinics offer screening and immunisation to their clients and their contacts. However, this is not routine in all STI clinics in the Eastern Region. Each notified case of Hepatitis B, whether acute or chronic, should be investigated to identify risk factors for infection and also to identify non-immune contacts so that immunisation can be offered.

Although the specialised services in St James's Hospital carry out contact tracing for people with Hepatitis B infection, generally hospital services do not carry out contact tracing beyond advising the index case about the risks to contacts and the need for those contacts to seek medical advice. Some GPs will attempt to trace and manage contacts but this is on an ad hoc basis and no information is available on the outcomes.

A Hepatitis B Medical Officer in the Department of Public Health has responsibility for following up acute cases and liaising with clinicians in relation to surveillance and immunisation of contacts. This service has only recently been established and requires considerably greater resources than those available currently.

**Genital Chlamydia Screening**

Chlamydia infection is a common curable STI which can result in infertility. As most infections are asymptomatic, screening and case finding is essential in chlamydia control. Register-based screening programmes have been shown to be the most effective measure in Chlamydia control. In Ireland Chlamydia infection is now the second most common notified infection in Ireland after Genital Warts, with almost 2,000 cases notified to the HPSC in 2002. The report of the HPSC working group on Chlamydia screening is due to be published in 2005.

The ERHA Review of STI Services 2000 recommended that the prevention, control, and management of Chlamydia infection be addressed as a matter of urgency.
4.2.3 Primary Care

General practitioners with their practice or specialist nurses have an important role to play in both preventative and treatment services. Prevention is facilitated through general health information, medical advice, and contraceptive advice and provision. Screening, diagnostic and treatment services are also offered through the general practitioners; however all of these services are paid for by the patient.

GPs who participated in the consultation process indicated a need for specialised education and training in providing sexual health services. Resources are needed for the development of a network of GPs with specialist interest and knowledge. This network could provide a range of medical and non-medical services and accept inter-referrals from other GPs.

Barriers to an expansion of primary care to meet the needs of a comprehensive sexual health service at the consultation day were also highlighted:

- GPs may not be confident about managing STIs as, historically, STI management was hospital-based.
- GPs need ongoing training and education so that their sexual health management skills can be updated.
- Issues relating to payment (consultation time, treatment and counselling) were a concern.
- Client barriers such as embarrassment, lack of privacy, confidentiality issues and the effect of tests recorded on insurance medical forms were also raised.
- The lack of community contact tracing was highlighted as an important issue.
- Access to/acceptability of services for ethnic and religious minorities was also raised.

STI Contact Tracing

There is no community-based contact tracing service for STIs in the Eastern Region. Hospital-based contact tracing is only available through the specialised service in St. James’s Hospital. General practitioners do not have the time or resources to carry out comprehensive contact tracing. There is an urgent need to address this as a major risk management issue.

The Review of STI Services 2000 reiterated strongly the need to develop community clinics for prevention, diagnosis, treatment and contact tracing. Contact tracing is considered an essential component in the management of STIs. The review recommended that each hospital STI service should have contact tracing staff and that community contact tracing services should be established.

4.2.4 Laboratories

STI testing in the Eastern Region varies between laboratories. While many laboratories provide testing for the most important STIs, others send all samples to the NVRL, which provides both a diagnostic and confirmatory test service to hospitals and special clinics. Other hospitals send specimens, e.g. for Syphilis testing, to laboratories such as St James’s Hospital laboratory. Resources for screening or diagnosing STIs are not normally earmarked and therefore there are difficulties in identifying a suitable budget to expand diagnostic capability. The HPSC STI Sub-Committee recently completed a special survey of laboratory practices in relation to STI testing and a report is due to be published which should highlight areas to be addressed.
National Virus Reference Laboratory

The National Virus Reference Laboratory (NVRL) provides a comprehensive diagnostic service for the following STIs:

- HIV
- Hepatitis B
- Hepatitis C
- Chlamydia Trachomatis
- Herpes simplex
- Syphilis.

The ERHA Review of STI Services 2000 recommends the development of reference laboratories with molecular techniques for the detection of Chlamydia and that transport systems should be set up for transporting specimens from clinics to laboratories.

4.2.5 Voluntary Agencies and Sexual Health Services

Voluntary agencies focusing on particular cohorts such as the gay community, non-EU nationals or drug users are important to the overall service delivery for patients with HIV or other STIs. These organisations provide advice, education, support and counselling and, in some cases, outreach work, making a very valuable contribution to the overall services. Other projects such as Cairde and the Merchants Quay Project have increased awareness of HIV infection and other STIs among high-risk groups.

4.3 Feedback about STI Services from the Consultation

Participants agreed that services for STIs should incorporate prevention, advice, screening, treatment and follow-up as well as clinical care and diagnosis. While there was not a consensus about the location of services there was agreement that they should be available throughout the region and accessible at an affordable cost. Stakeholders emphasised the need:

- To improve access to services including basic screening.
- To promote safe sex including the wider distribution of free condoms.

Respondents cited as problems long waiting lists for STI clinics and a lack of locally-based services for those living away from the city-based centres.

Lack of hospital services outside Dublin city was identified as a serious problem. Respondents were in agreement that there should be more hospital-based Infectious Disease Consultant led services especially in certain geographical areas such as West Dublin and Wicklow.

Improved co-ordination of services

There was general agreement that sexual health promotion and treatment services need to be planned and developed in a strategic, holistic way with a reorientation to promoting sexual health. Evidence-based needs assessment should ensure that scarce resources are used in the most effective way. The result should be an integrated ‘joined up’ quality service in terms of accessibility, equity, appropriateness, responsiveness to need and client satisfaction.
Access to and acceptability of clinical services

The most commonly perceived access problems were the costs of GP visits, screening tests, procedures, medications and contraception. Access to and acceptability of services were highlighted as key issues for ethnic and religious minorities and for other marginalised groups such as disabled persons.

Personal issues such as embarrassment, lack of privacy, confidentiality issues and the effect of tests being recorded on insurance medical forms were key influencers in decisions whether or not to seek sexual health services.

Participants at the consultation felt that sexual health services should be based in primary care, in line with the National Primary Care Strategy. Suggestions were made to increase access at primary care level by including more services in the GMS scheme and by providing non-medical services (counselling, health advice) free of charge to GMS card-holders. A major concern was the vulnerability of those without GMS entitlement. Views were also expressed that services should be provided in more satellite locations and some out-of-hours services should be encouraged especially for emergency contraception. Other access problems exist for specific groups such as physical access or language/cultural barriers for ethnic minorities.

The new primary care teams and GP partnerships could provide the structures into which enhanced sexual health services could optimally fit. These services could be GP-led with access to nurse practitioners, counselling and other disciplines. Advanced nurse practitioners could be appointed and trained in the area of sexual health:

"The STI service provided by the GUIDE clinic is a comprehensive service, working within a limited capacity. In our experience there is a greater need to develop this service in a primary care setting with ongoing training and supervision from specialists". Respondent

The Review of STI Services 2000 recommended that GPs and other health professionals, who have a special interest in the management of STIs, should be supported and encouraged.

It was recognised that the training of GPs and nurses in sexual health management is important if the services for sexual health are to become more firmly based in primary care. The Primary Care Strategy specifies that continuing professional development programmes should be available to primary care professionals. The Health Boards, in partnership with the Irish College of General Practitioners (ICGP), could provide training in sexual health management.

The Primary Care Strategy also recommends the development of modules of joint training and education for all primary care professionals. Some of these inter-disciplinary training modules have already been established and more will be established in the future. These programmes can create a multi-disciplinary approach to training in the area of sexual health.

Respondents suggested improving linkages between health promotion and treatment services e.g.

- GP links to other service providers
- Health units in youth centres providing education and advice
- Drop-in centres
- SPHE/RSE links with health and social support services
- Integration between public, private and voluntary sectors
- Surveillance systems stretching across the different service providers
- Central resource database available to provide information on services, educational material and referral.
Adapt successful existing paradigms

The existing services for gay men in Ireland were noted to be innovative and many of the services already provide partnership approaches, peer support, outreach, dedicated services and drop-in. The services for gay men were seen by some respondents as a positive model of service provision and were recommended as a model for future service development.

4.4 Family Planning and Contraception Services

Contraceptive services are primarily delivered by general practitioners through general clinics or local family planning clinics.

4.4.1 GPs and Contraception

The range of contraceptive services provided varies between GPs and it can be difficult for a woman to know what types of contraception her GP provides. Intra-referrals should be encouraged between GPs, e.g. for insertion of intrauterine devices, etc.

Issues can arise with regard to prescribing contraception or emergency contraception to those aged under 16 years. An Irish study found that the majority of GPs were willing to give advice to those aged under 16 years and that over 80% would prescribe to these patients in certain circumstances.

In 2004 the Crisis Pregnancy Agency undertook a literature review of contraceptive services, both nationally and internationally. This study identified four main service issues that need to be addressed:

- Training for health professionals: As hormonal contraception is increasingly used, professionals become deskilled in other forms of contraception.\(^{35,36,37}\)
- Remuneration for GPs under the General Medical Scheme is considered inadequate to provide a comprehensive contraceptive service.\(^{37}\)
- Time constraints: This is a particular problem for single-handed GP practices.\(^{38}\)
- Co-ordination of Services with GPs and Family Planning Services.\(^{38}\)

4.4.2 Family Planning Clinics

There are a variety of reasons why women choose to attend a family planning clinic for contraception and women's health issues. Patients with medical cards should have the option of attending a family planning clinic. In the Eastern Region, Well-Woman centres have daily clinics in Coolock, Leeson Street and Pembroke Road. The IFPA has daily walk-in and appointment clinics in Cathal Brugha Street and Tallaght.

4.4.3 Gynaecologists and Maternity Hospitals

Maternity hospitals provide a good opportunity for women to discuss their future methods of contraception. During pregnancy and after delivery are good times to discuss contraception with women. Staff with a full knowledge of all methods of contraception can play a valuable role. The review of STI Services 2000 recommended that closer relationships be fostered between health professionals in gynaecology departments and STI clinics. Liaisons have been formed between the gynaecology department in St James's Hospital and the STI clinics. The Mater Misericordiae Hospital provides STI services for women attending the Rotunda Hospital. However there is a paucity of STI clinics in other hospitals.
4.4.4 Emergency Contraception

The Irish Medicines Board has licensed emergency contraception for use since May 2003. Women require advice on its availability, particularly at weekends, its contra-indications and its efficacy. Access to emergency contraception was raised during the consultation and many respondents felt that availability and cost are barriers to the use of contraception and can lead to unintended pregnancy.

4.5 Contraception - Feedback from the Consultation

The main issues to emerge from the consultation were the lack of accessible family planning and contraception services, especially for those in low-income groups. There was consensus that services have to be made more accessible and that the issue of cost has to be reviewed. Many respondents think that family planning services should be affordable or free either through GPs or family planning clinics. Some respondents proposed the integration of family planning with genito-urinary medicine to provide a stand-alone sexual health clinic.

Staff training and the need to increase knowledge and awareness among service providers were identified as unmet needs during this consultative process. Intercultural training would greatly improve culturally appropriate service delivery to target groups. Specially designed training workshops that would be available to sexual health service providers and support organisations would be very useful and ensure a consistency in training and standards.

Many respondents indicated that free services and contraception should be widely available especially emergency contraception particularly out of hours and on weekends:

“Condoms should be free and should be easily accessible, i.e. not under the nose of a pharmacist. Contraception should be free to all men and women”. Respondent
Key Points

Throughout the region STI services are under-resourced in terms of capital expenditure, human resources, laboratory support and integration.

Hospital services for STIs in the Eastern Region are mainly based in St James's Hospital (70% of activity based on notifications). The Mater Misericordiae Hospital also offers STI services and Beaumont Hospital provides HIV care. There is no standardisation of services (prevention, diagnosis and treatment and contact tracing) offered to patients in the region. Some areas of the region are without services (Kildare, East Coast area, west Dublin, north County Dublin).

Barriers to the development of primary care services to address the needs of patients with STIs must be overcome.

Chlamydia infection is an increasing public health concern. Investment is needed in resources for training and for diagnosis, treatment and contact tracing. Chlamydia testing should be supported though free laboratory services and treatment protocols must be developed.

Contact tracing for STIs including Hepatitis B is currently under-resourced, uncoordinated and fragmented.

Access to family planning clinics and emergency contraception must be improved especially for those on low income.

A partnership approach incorporating service users, service providers, educators and community services needs to be incorporated into the provision of the sexual health services.

Liaison between health professionals in hospital settings needs to be improved.

Consultant-led services need to be provided to patients outside the Dublin region.

GP's should be facilitated in ongoing training and education in the management of STIs. Testing equipment should be made readily available and guidelines developed for the management and treatment of common STIs.

Current STI services capacity must be increased to meet the demand for diagnosis, treatment and partner notification in relation to Chlamydia infection. Prevalence studies in different settings, e.g. general practice, antenatal clinics and STI clinics should be undertaken.

Community-based STI services need to be developed. Contact tracing is an essential component in the prevention of spread of STIs and should be further developed in primary care and community settings.

Consideration should be given to the provision of free family planning services and emergency contraception to those on low income.
4.6  Services for Young People

Responding to the sexual health needs of young people is problematic for a variety of reasons including limited information being available about young people and sexual health. Prior to 2003, information on age was not available for the majority of notifications of STIs received by the Department of Public Health. Under-reporting is common in this age group for a variety of reasons, both professional and legal. There are few services available for young people under 18 years in the country. In the Eastern Region there is a clinic at St James's Hospital for teenagers under 19 years and there is also one in the Southern Health Board for those aged 17 to 25 years.

4.6.1  Adolescents and Issues Relating to Consent

Considerable confusion exists around the area of legal consent and adolescents in Ireland. The constitutional rights of a child under the age of 16 years are exercised by the choice of the parents or a legally recognised guardian. Irish courts place emphasis on the rights of the family and the rights of the parents to decide what is in the best interests of their children. This is based largely on the rights given to the family by Articles 41 and 42 of the Constitution.

Under Section 23 (1) of the Non Fatal Offences against the Person Act 1997, a child becomes an adult for the purposes of consenting to medical or surgical treatment when he/she reaches the age of 16 years. In Britain the legal capacity of a minor to consent to medical treatment is considered on the grounds of maturity rather than chronological age. However, consent to treatment for mental health is 18 years.

The Health (Family Planning) Amendment Acts, 1979-1993 allow condoms to be sold from vending machines in areas frequented by those under the age of seventeen. The access of minors to other methods of contraception is prevented by the general restriction on unmarried minors' consent to any medical treatment.

The age of consent for sexual acts between males and females or between two females is 15 years while for sexual acts between two males the age of consent is 17 years. The legal age for marriage is currently 18 years (Family Law Act, 1995).

In Ireland only adolescents over the age of 16 years can legally consent independently and without parental knowledge to medical treatment. In the absence of parental consent, it is not possible for a child under 16 to give consent for the contraceptive pill or for a test for sexually transmitted diseases, as the law currently stands. This causes a conflict between patient-doctor confidentiality and parental involvement for the healthcare professional.

All health boards follow the Children First Guidelines (1999). However, few boards actually provide written legal guidance for health and social care professionals. Therefore according to the law at present teenagers over 15 years can engage in heterosexual sex but cannot give consent to have diagnostic tests or treatment for infections/diseases they may acquire as a result. Young teenagers who become ill with an STI or who become pregnant need support, advice and treatment. Pregnant teenagers need advice on their options and support before, during and after birth. Health and social care professionals require clarification about what services they can or cannot offer within the legal framework.
Children who might have become pregnant through sexual abuse need to seek appropriate help, without fear. Social services act in loco parentis and bear special responsibilities in relation to sexual issues. Difficult situations arise for medical professionals and social workers in efforts to assist children seeking help (either those in the care of the health board or those at home).

Changes in the legislation are required to provide the necessary safeguards for clinicians, parents and children in need of treatment.

<table>
<thead>
<tr>
<th>Key messages</th>
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<tr>
<td>Health and social care professionals have concerns about the legal dilemmas that surround the area of sexual health and adolescents which interfere with diagnosis, treatment, referral and education programmes.</td>
</tr>
<tr>
<td>Adolescents are at high risk of unintended pregnancy and STIs.</td>
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<tr>
<td>The current legislation places constraints on young people requiring information and access to sexual health services.</td>
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### 4.7 Summary

At consultation it was evident that provision of and access to a full range of comprehensive and quality services for STIs is essential. Services are needed that provide choices for the individual. There are differing views on how this can be achieved. Some suggestions include:

- Moving STI services away from HIV treatment and hospitals
- Restructuring the service
- Expansion of existing services
- Satellite service clinics to target groups in need
- Community-based groups providing sexual health services in primary care on a sessional basis and linked with hospital-based services
- Drop-in services
- Sexual health services available on the medical card for free
- Combining family planning clinic with genito-urinary medicine services and providing a stand-alone sexual health clinic.
5.1 Introduction

In recent years the number of STIs reported in the Eastern Region and the number of people engaging in sexual risk-taking behaviour have increased dramatically. A greater awareness of sexual health promotion has led to greater demand for services relating to sexual health in the region, yet a review of current services highlights inequity in service provision. All of these factors, together with the changing demography of the region, point to the need for the development of a strategy to plan for the future.

From the consultation process and meetings with service providers and care groups, key principles that sexual health services and programmes need to adhere to were identified. The services should be:

- Accessible
- Provided in partnership with patients and carers
- Effective and evidence based
- Focused on patients/users
- Confidential
- Non-judgmental.

The key values identified through the consultation process include:

- Sexual health as a human right
- Respect for values and beliefs of communities and patients
- Equity in the provision of care and prevention services
- Transparency in relation to allocation of resources.

The causes of sexual ill-health are multi-factorial and, therefore, the solutions need a cross-sectoral, multi-agency approach. The economic and social cost of sexual ill-health is a national issue and a concern for all sectors of society. At a national level there are issues that will need to be addressed. An action plan to promote sexual health and safer sexual practices was proposed by the National Health Strategy *Quality and Fairness* in 2001. It is now more urgent than ever that this be progressed. There is also a need for a commitment at the highest level to prioritise sexual health nationally and to lead the process. Other issues of national importance include the training and education of health professionals, the development of patient information and the consideration of dilemmas relating to legal consent for clinical care, treatment and sexual activity in young people.

This report has presented information on current services for the prevention, diagnosis and treatment of STIs in the Eastern Region and has identified gaps in services. The results of the extensive consultation process have also been presented. Within the Eastern Region a strategic approach to sexual health is needed. The following key recommendations are made.
5.2 List of Recommendations

A. Making sexual health a priority at all levels

1. The Eastern Region will prioritise Sexual Health and the development of appropriate services.
A Regional Sexual Health/ HIV Co-ordinator was appointed in December 2004 and is based in the Department of Public Health to drive the implementation of the HSE - Eastern Region Sexual Health Strategy.

2. A Regional Sexual Health Forum with representatives from key stakeholders will be established to develop an action plan and to oversee the implementation of the strategy. The forum will be supported by the Regional Sexual Health/ HIV Co-ordinator.
It is proposed that the Steering Committee for the Strategy be reconvened as the Regional Sexual Health Forum in 2005. This forum will be chaired by a Specialist in Public Health Medicine attached to the Department of Public Health. The initial work of the Forum should focus on:

- Development of the action plan.
- Determination of funding and resources for implementation.
- Ensuring the inclusion of the action plan and resource needs in the HSE Service Plan so that implementation can proceed.

B. Improving information and surveillance

3. A surveillance system for STIs in the Eastern Region should be established in line with recommendations from the National Health Protection Surveillance Centre (HPSC) STI Surveillance Committee.
Notifications for STIs account for almost double all other infectious disease notifications in the Eastern Region. Significant backlogs have developed as a result of pressure on clinical and administrative staff. Priority needs to be given to develop a confidential information and reporting system. This should be based on individual notifications which include vital information on risk factors and a minimum data set with agreed case definitions.

4. Information regarding sexual health should be easily accessible to all and provided in a number of settings to different client groups.
Drop-in Information Centres on sexual health issues for young people should be established in the Region. These centres will be in locations that young people access such as social welfare offices, employment agencies and libraries.

5. Information leaflets and videos on sexual health including HIV/STIs should be distributed to Health Board premises, local community centres, community-based organisations and GPs.
This information needs to be accessible, clear, appropriate, positive and provided in an integrated way with other health promotion initiatives and with partners in the community. The information needs to cover several topic areas highlighted by the consultation process including: rights and entitlements in relation to sexual health, common STIs and how to prevent infections, contraception and unintended pregnancy. Information leaflets will be translated into a number of different languages.

6. A Sexual Health Services Directory should be developed for the Region. This should include up-to-date information on family planning, HIV and STI services at local level and for particular groups.
The Directory will have lists of practitioners who provide relevant services, e.g. services available to particular groups such as gay/bisexual people and asylum seekers.
C. Health promotion/ community development

7. Health Promotion Officers whose remit includes Sexual Health will be designated in the region.

8. Training for Health Promotion in Sexual Health should be supported in the Eastern Region.

9. Community development and partnership organisations should be facilitated by the Sexual Health Forum and Health Promotion Officers in the development of appropriate actions to address the sexual health needs of minority and special groups within the community. The Regional Sexual Health and HIV co-ordinator will liaise and work with these community development and partnership organisations working with ethnic and other minorities and special groups within the community (Dublin Aids Alliance, Cairde) to support training and education programmes.

10. The HSE - Eastern Region supports the full implementation of the SPHE/RSE programmes in all schools in the region. Teachers should be adequately supported by appropriately trained health personnel.

In order to do this further training and development in the sexual health area should be supported. Youth workers employed by the HSE - Eastern Region should be trained to target early school leavers with similar programmes of sexual health promotion.

11. Consumer and patient satisfaction surveys in sexual health services should be funded by the Eastern Region for a variety of settings including STI and family planning clinics.

D. Organisation of services

12. Three levels of Sexual Health Services are recommended:

   **Level 1 Primary Care**

   A number of aspects of sexual health can be dealt with effectively at primary care level e.g. prevention, education, basic STI screening, HIV testing and counselling, Hepatitis testing and immunisation, Chlamydia screening, cervical screening, pregnancy testing, antenatal care and family planning.

   **Level 2 Specialised Clinical Services in primary care, community or specific settings**

   GPs who undertake further training in sexual health management can act as a resource to other GPs who wish to refer the more complex sexual health services which include intrauterine device insertion (IUD), contraceptive implant and vasectomy. This level also includes the provision of services in special settings in the community such as STI screening in family planning clinics and the development of clinics for special groups.

   Sexual health clinics for particular groups should be set up using the model of the Methadone Service or the Gay Men's Health Project. These provide an integrated package of care, which is fully funded, for vulnerable groups in a sympathetic setting.

   **One-Stop Shop Sexual Health Clinics should be piloted in the Eastern Region.**

   **Level 3 Hospital-based/ tertiary referral**

   Level 3 refers to hospital-based consultant-led services. An increase in consultant-led services is needed. A Needs Assessment for Primary Care should be carried out similar to that completed in 2000 for hospital-based services.
13. One Stop Shop Sexual Health Clinics staffed by GPs and other appropriate personnel should be piloted in the Region. These clinics could be staffed with GPs with further training in sexual health and linked with hospital services. The one stop shop clinics with a defined catchment area would provide a range of services including prevention and education services, counselling, STI screening and treatment, cervical screening and family planning services. Same-week appointments and special evening clinics would be part of such a pilot scheme.

14. Health Advisors/Contact tracers should be available at all hospital-based STI clinics. In addition, community based/Health Advisor/ Contact Tracers will be appointed to support sexual health services in primary and community care and specialised clinics. It is acknowledged nationally that there is under-reporting of community notifications for STIs. However, there are no Health Advisors or Contact Tracers in the community to support GPs and specialist physicians at present. A national Directors of Public Health Report on STI Surveillance has proposed that such a system be set up. The health advisors could be attached either to Departments of Public Health or local, hospital-based STI clinics depending on location and availability. An important role would be to improve liaison between the community and the hospitals.

15. The management of more complex STIs including HIV should be delivered by the Specialists in Infectious Disease/Genito-Urinary Medicine services.

16. Referral pathways should be agreed between GPs and hospitals for the treatment and management of complex STIs.

17. Additional Genito-Urinary Consultant Posts should be established in the Region to lead services in hospitals and provide support to satellite clinics and outreach services.

E. Special groups

18. STI clinics established in Student Health Clinics should be further supported and developed. Young people are most at risk of STIs. Third-level institutions providing sexual health services (STI screening, contraception, cervical smear screening, counselling) need additional support for diagnosis, laboratory testing, referral for contact tracing, pharmacy as well as training and education.

19. STI screening for antenatal patients should be piloted in the maternity hospitals. All antenatal patients should be screened and followed up for Hepatitis B.

20. Best practice guidance should be developed at national level for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health and treatment.

21. The legal position for clinicians, health promotion and other healthcare professionals working with young people needs to clarified and a national policy developed.

22. Additional sexual health services targeted specifically at adolescents should be developed at regional level.
F. Training

23. Training and Continuing Medical Education in Sexual Health, including STI and Family Planning management, should be facilitated and supported for GPs and other health professionals. Staff training, knowledge and awareness were identified as an unmet need among service providers, health educators and support organisations. In keeping with the Primary Care Strategy, A New Direction 2001, training and continuing medical education in sexual health should be provided and supported for GPs and other health professionals. Training in sexual health should also be part of the undergraduate and postgraduate training for primary care physicians.

24. At national level, training in sexual health including clinical management of STIs should be part of the undergraduate medical training and postgraduate GP training. The Eastern Region should support a training programme and sponsor training of trainers.

G. Other issues

25. STI clinics should be adequately resourced for the provision of a Hepatitis B immunisation service.

26. In keeping with the National Immunisation Guidelines, all STI attendees should be offered Hepatitis B vaccination if non-immune.

27. Hepatitis B vaccine should be made available in the Eastern Region to GPs and physicians in the community and special settings for those in the high-risk category. All individuals who change sexual partners frequently should be offered Hepatitis B vaccine if non-immune, in particular, men who have sex with men.

28. Screening for Chlamydia is a priority in the Eastern Region. GPs and clinicians who undertake this should be supported through access to laboratory services, medication and community contact tracing.
References


22. Personal communication. Chlamydia NDSC Committee 2004 draft report
23. Powell J. *Chlamydia trachomatis (Otalies) prevalence in men in the MWHB*. 2004
25. Coleman C, Clarke S, Fitzgerald M, Quinlan M. *Syphilis onsite testing in Dublin.* Epi-Insight 2004; 5(7)
Appendix 1 Report of Consultation Process

Introduction
With the establishment of the Regional Steering Committee for Sexual Health in October 2002 two working groups on Health Services and Health Promotion were established. The working groups identified the need for further consultation with those individuals and groups working in the field of sexual health.

Effective consultation is essential to the development of a strategy that is based on needs, and is acceptable and comprehensive. The focus for this consultation was on the development of sexual health prevention and treatment services and health promotion. The outcomes of the consultation were used to inform the sexual health strategy report and will be used to inform the implementation phase. The consultation was carried out in two phases.

Phase 1 Written submissions and questionnaires
The consultation was concerned with three main areas:
1. Promotion of sexual health and well-being
2. Prevention of transmission of sexually transmitted infections

Written submissions and questionnaires
A written questionnaire was designed by the Health Promotion Working Group and agreed by the Regional Steering Committee. The questionnaire was circulated to a wide variety of health professionals and organisations working in the area of sexual health. Over 45 responses were received, including detailed written submissions.

Phase 2 Consultation Day
In November 2003 a consultation day was held in the Chester Beatty Library Dublin Castle, attended by 50 people representing healthcare professionals, voluntary organisations and statutory bodies. The topics discussed included the values and principles of the strategy, information needs, services for sexual health and health promotion. A facilitator was used to present a framework regarding the development of a sexual health strategy. The facilitator also provided a summary of work produced during workshops and presented preliminary feedback on the day. Feedback was given by statutory health and social services both general and specialised, voluntary agencies, special interest groups, non-governmental organisations and healthcare professionals. A limitation of this consultation is that service users were not present for the consultation process although their representatives were. The following topics were explored:

1. Key Values and Principles
2. Information Needs
3. Sexual Health Promotion
4. Sexual Health Services.

As many of the same issues were raised in both the written submissions and the consultation day, the results have been combined and presented together. It is important to note that input from smaller stakeholder groups has been included as well as from larger ones. These smaller groups often have specific needs or a point of view different from the majority and therefore an attempt was made to be as inclusive as possible during the consultation process.
Results
We received a broad-based response from health professionals, statutory health and social services, voluntary agencies, special interest groups, non-governmental organisations (NGO) and associations. Four areas were explored:

- Key Values and Principles of our proposed strategy
- Information Needs for a regional strategy
- Sexual Health Promotion
- Sexual Health Services

Key Values and Principles
There was general consensus that there should be a positive focus on sexual health in the strategy not just defining issues in terms of sexually transmitted diseases or crisis pregnancy. The wider WHO definition of sexual health was preferred which includes physical and mental well being. Services, whether preventive or curative, should be inclusive and culturally sensitive to groups in the population with differing viewpoints and sexual health needs. The principle of equity was important - and the targeting of groups with greater need of services:

"incorporate the right of individuals to a full sexual life not necessarily related to reproduction".

Respondents also stressed the need to place the strategy in the context of the current health reform and other national and regional strategies including the National Health Strategy, Primary Care Strategy, National AIDS Strategy, Crisis Pregnancy Strategy, and Health Promotion Strategy and recent ERHA Ethnic Minorities Strategy.

Partnership approach
The partnership approach was identified as being the critical component of any developments in the area of sexual health. Essentially respondents asked that those affected by services would be involved in the planning and design. Patients, doctors and other healthcare workers, teachers and those working in the community services need to be involved in the provision of sexual health services. The partnership approach extends to the design and delivery of services and is key to reaching groups with special needs in the population. The inclusion of targeted groups in the needs assessment, design and delivery of appropriate services is important to the acceptability of those services to the group. There was a recommendation that the representation in the Steering Committee of interest groups be included in any subsequent implementation committee:

"joint working is crucial, but structures need to be resourced to make this happen with specific plans for how this works".

Confidentiality
The principle of confidentiality is considered very important by many of the groups and individuals consulted. Sexual health matters in general require a high level of confidentiality and the relative anonymity of the urban environment cannot be assumed in more rural localities. There also specific issues which can prevent individuals from accessing the appropriate services due to statutory restrictions on services to young people, an inability to seek services due to fear of authority or illegal residence status.
Equity
Respondents were concerned about the impact of social disadvantage on the priority given to sexual health matters by individuals at risk and on the lack of access to services for many of these. Some respondents suggested that more services be provided free to medical cardholders and also to those with special needs in the population without medical cards (services such as contraception, STI screening, and consultation with GP/nurse). Individuals just above the threshold for a medical card may not prioritise sexual health services for themselves when there are competing and more urgent calls on scarce resources. Therefore on public health grounds greater effort needs to be made to provide user-friendly preventive care.

Prevention and treatment services
Respondents see current services as being fractured and not co-ordinated. The key principles cited here were evidence-based interventions (e.g. evidence-based health promotion and clinical services, which are integrated, planned and coordinated in a more transparent way). Respondents advocated a needs-based approach to provision of services as a fairer system to better treatment and prevention.

Communication and health promotion
Respondents recommended that innovative approaches be used in the design and methodologies including the peer approach, telephone texting and websites. Involving the target group in the design and delivery of health promotion services has been shown to be very effective. The need for more evaluation and research was stressed in order to understand sexual health issues in Ireland and highlight areas of unmet need. In order to increase awareness and public health information a series of campaigns was suggested. A revision of the directory of services and information regarding services was proposed.

Respondents noted the importance of groups and individuals other than primary care and hospital based services in providing services such as community based voluntary organisations, health advisors, outreach workers, drug/alcohol services, social workers, youth groups, schools, teachers and parents.

Comprehensive and quality services
The most important principle was that there should be needs-based access to a full range of comprehensive and quality services with choice for the individual patient. There were different views on how this can be achieved. Some suggestions included:

- Moving STI services away from HIV treatment and hospitals
- Restructuring and expansion of existing services
- Setting up or using existing model of satellite clinics to target groups in need
- Sexual health clinics within primary care on a sessional basis and linked with hospital-based services
- Drop-in information services for young people
- Drop-in sexual health clinics incorporating STI and contraception and or gynaecology
- Making sexual health services available on the medical card and or free to non-GMS holders

The most common access problem was the cost of the visit to the GP, cost of screening tests, procedures, medications and contraception. Also restricting access are waiting lists for STD clinics and lack of access to locally based services. This again can cause a much greater difficulty in those living away from the one or two city-based centres. Other access problems exist for specific groups such as physical access for disabled persons or language or cultural barriers for ethnic minorities.

In relation to emergency contraception, restricted access and opening times of clinics especially when it is most needed were cited (e.g. weekend and holiday periods).
Co-ordination

Services should be co-ordinated. Many respondents expressed a desire for 'joined up' services. Everyone agreed that better coordination and integration within the services would improve the quality and accessibility of services. Co-ordination and co-operation is needed between providers and the levels of care. Too often service providers feel they are competing for scarce resources. Health promotion was seen as a parallel provider of service rather than as a co-ordinated, complementary approach. Respondents wanted clear linkages between services such as:

- GP links to other service providers
- Voluntary organisations and access to information, resources, family planning, specialised health clinics
- Social approach to services in sexual health centres
- SPHE/RSE links with health and social support services
- Integration between public, private and voluntary sectors
- Adequate surveillance systems
- Central resource database available to provide information on services, educational material, and referral
- Health units in youth centres providing education, advice, and services.

As a voluntary sector organisation involved in prevention and education, we consistently must seek out information. For example, the Syphilis epidemic was well underway by the time we were alerted to it. We could focus our prevention work accordingly.

Some services exist currently that employ a partnership approach within and across providers, e.g. services for IVDUs and Gay Men. The respondents thought the following were necessary to meet the needs of the community in relation to services:

- Sexual health clinics/GP practices that offer the broadest possible range of sexual health services
- Family planning
- Full STI screening for vulnerable groups and third-level students on a drop-in basis
- Better information to the public about the range of services
- Better trained health and social care professionals
- Safe-sex awareness, education and health promotion.

Where sexual health services should be delivered

Primary Care services

The majority of participants said that sexual health services should be based more in primary care in line with the National Primary Care Strategy. Suggestions were made to increase access to primary care by including more services in the GMS scheme, providing non-medical services (counselling, health advice) free of charge to GMS holders. A major concern was the vulnerability of those without GMS entitlement (a high proportion of young people who at present have limited access to essential public health services such as pregnancy prevention and STI prevention). Publicly funded services should be provided in more satellite locations and some out-of-hours services should be encouraged especially for emergency contraception.

Primary care should provide general medical care, screening and referral, education, advice, information and support in the area of sexual health. A proposed model was to have community-based groups providing sexual health services with medical primary care on a sessional basis and formal links with hospital-based services. This model could include fully funded drop-in services available in key locations.
GPs who responded indicated a need for specialised education and training for those interested in providing sexual health services. Resources are needed for the development of a network of GPs with specialist interest and knowledge. This network could provide a range of medical and non-medical services and accept inter-referrals from other GPs. There is a need for a system of liaison with other services including voluntary agency providers and hospital services.

Barriers to an expansion of primary care to meet the needs of a comprehensive sexual health service were also highlighted:

- The perception that GPs are not confident about managing STIs as, historically, STI management was hospital-based.
- Respondents stressed that many STIs can be managed in primary care and this would take some of the pressure off the hospital-based services.
- For this to happen GPs need to be trained and have ongoing CME so that their sexual health management skills can be updated.
- The issue of cost, resources, who will pay? where will money come from? was a concern. The cost to the GP and to the patient - consultation time, treatment, tests and counselling - were all cited by respondents.
- Client barriers exist such as embarrassment, lack of privacy, confidentiality issues and the effect of tests being recorded on insurance medical forms
- There is a lack of community contact tracing at present. This could possibly be addressed by a health advisor linked to hospital services or Department of Public Health and who also covers a certain catchments area of GPs.
- Access/acceptability of services for ethnic and religious minorities. There are problems with access for ethnic and religious minorities and other marginalised groups. The cultural differences of special groups need to be addressed in the design of information services and other sexual health services provided to these groups.

The new primary care teams and GP partnerships could provide the structures into which enhanced sexual health services could optimally fit. These clinics could be GP-led with access to nurse practitioner, counselling and other disciplines. Advanced nurse practitioners could be appointed and trained in the area of sexual health. It is also proposed that there will be Primary Care Partnerships and at present there are five in the Eastern Region:

“The STI service provided by the GUIDE clinic is a comprehensive service, working within a limited capacity. In our experience there is a greater need to develop this service in a primary care setting with ongoing training and supervision from specialists”.

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**Hospital-Based Services for Sexually Transmitted Infections**

STI services must include prevention, advice, screening, treatment and follow-up. While there was not a consensus about location of services there was agreement that they should be available throughout the region and accessible at an affordable cost.

Stakeholders emphasised the need to:

- Improve access to services including basic screening
- Promote safe sex including the wider distribution of free condoms

There is a debate among respondents about whether or not health screening should be broad or targeted at certain groups and whether it should be opportunistic or comprehensive:

"Condoms should be free and should be easily accessible, i.e. not under the nose of a pharmacist".

"Contraception should be free to all men and women".

The main points were the need for both self-referral and specialist clinics. Some respondents suggest a model which combines family planning clinic services with genito-urinary medicine services and provides a stand-alone sexual health clinic. Lack of hospital services outside Dublin was identified as a real problem.

There was consensus about the need for more hospital-based Infectious Disease Consultant-led services so as to address the lack of these services in certain geographical areas, e.g. West Dublin, Wicklow.

**Information, education and communication**

Overall there was a demand for a stronger health service approach in the area of health promotion and sexual education. Important concepts were the need to provide age appropriate information to young people, having a positive, realistic approach to sexuality and having a responsive information campaign to address the knowledge gap throughout society. Respondents were unhappy with the lack of resources for health promotion. Better funding and more efficient planning and development of services were called for:

"We find it difficult as an agency to access resources instrumental to promoting sexual health, such as information pamphlets, contraceptives, and family planning information. Our agency would welcome improved co-ordination of service activity between all agencies involved in sexual health promotion, particularly with those most at risk".

**Sexual Education Programmes and Information**

Respondents stressed the important role of the SPHE and RSE programmes in schools. Teacher training provided through Health Promotion Departments ensures the quality and standardisation of these programmes.

The following principles should underpin training: encouraging the delay of sexual intercourse within potentially sexual relationships, increasing the knowledge and practice of safe sex, acknowledging sexuality, sexual orientation, homophobia and sexism, giving support for parents and carers.

In the wider society there is an urgent need for increased awareness and education for everyone especially those who may be sexually active. Respondents would like education programmes to be strengthened. Overall the health service will have to scale up its support to teachers, parents and professionals in this area.
Training of Professional Staff
An important unmet need for staff was the lack of staff training. There is a need to increase knowledge and awareness among health and social care service providers about sexual health issues. Intercultural training would greatly improve culturally appropriate service delivery to target groups. Training of GPs and nurses in sexual health management is an important priority if the services for sexual health are to become integrated into health services.

Target Groups
Stakeholders representing the groups should be involved in needs assessment, provision of services and evaluation. These groups are either at higher risk of problems with sexual health or have other factors that make it harder to access services. The groups most often cited by respondents as being in need of targeted sexual health services were the youth, ethnic minorities and gay and lesbian groups. Other groups recognised as having specific needs for services or specialised services were people with disabilities, mental, physical and intellectual; people living with HIV and/or HCV; women and men working in prostitution; victims of child sexual abuse; victims of sexual assault; prisoners; homeless people; alcohol and/or drug users; older people and holidaymakers.

Youth
Many respondents identified this group as being the most in need of targeted health promotion, prevention and services. The definitions for youth ranged from childhood to young adulthood. This period of adolescence has been extended earlier into childhood and later into the late twenties due to demographic changes in society. Included in this group would be school children, primary, secondary and third level, early school leavers, teenage parents, and young adults. Priority needs for young people include a full range of sexual health services on a drop-in basis, access to contraception and advice, STI screening, age-appropriate information material, services developed in partnership with youth services, training of providers and confidentiality:

“The strategy needs to enable safer sexual negotiation skills by identifying the means through which young men and women may acquire the confidence to assert their own sexual needs, and not be influenced by peer pressure to partake of sexual practices which are unsafe and/or which they may be uncomfortable with”.

Ethnic Minority Groups
Those most vulnerable within the group were women, young men (often alone) and unaccompanied children (minors). The indigenous Traveller population has also been identified as having need of culturally specific services. Priority needs include culturally sensitive services, translators available with translated information material, services developed in partnership with ethnic minority communities, training of providers and confidentiality:

“Booklets produced by the IFPA on contraception and STDs are available in a few languages and prove very useful. More languages would reach a wider audience”.

Gay, Lesbian and Bisexual Health, Men who have Sex with Men
The existing services for this grouping have been innovative in Ireland and many of the services already provide partnership approaches, peer support, outreach, dedicated services and drop-in. The services for this group were mentioned by other groups as providing a positive model of service provision and delivery with dedicated resources.

Gynaecology
Respondents stressed the need for improved linkages between gynaecology and infectious disease clinicians and having combined clinics where possible:

“Our gynaecology service would benefit from improved liaison with specialist consultant services. There needs to be greater awareness of existing agencies and services and how to access them”.

Contraception and Family Planning
The main issues were the lack of accessible family planning and contraception services especially for those on low incomes. There was consensus that services have to be made more accessible and the issue of cost has to be reviewed. Many respondents felt that family planning services should be affordable or free either through GP or family planning clinics. Some respondents proposed the integration of family planning clinics with genito-urinary medicine and providing a stand-alone sexual health clinic.

Unintended Pregnancy
This was an important issue especially for those working with young people and in family planning clinics. Many respondents indicated that free services and contraception should be freely and widely available especially emergency contraception particularly out-of-hours and on weekends.

Prevention may be particularly difficult with teenage pregnancy due to issues of criminality and lack of resources. Avoidance of crisis pregnancy will need to take into account issues of self-esteem, better sex education, listening to teens, and the provision of training to youth and street workers to deal with sexual health issues. Post-abortion check-ups, counselling and contraception advice should be considered as part of any comprehensive sexual health strategy.

Discussion
The consultation was useful because it provided feedback information to the process. The groups and individuals who participated in the consultation were enthusiastic and persuasive advocates for better quality services, improved accessibility of services and resources to expand prevention initiatives. Participants often stressed the need to see sexual health in its widest form, with the emphasis being on a holistic and inclusive view of sexuality. The main issues and groups that require specialised or targeted services were identified during the consultation. Important sexual health issues that affect smaller groups were also articulated.

The consultation was mainly confined to healthcare workers, NGOs and statutory bodies. It did not include patients, consumers, service users or wider members of the public and therefore is not a comprehensive stakeholder consultation. The views primarily reflect healthcare service issues rather than the wider areas of sexuality and reproductive health in society. Some issues that did not arise in this exercise but which are important were violence against women and gynaecological/obstetric services and liaison.

The Steering Committee wish to acknowledge the support and efforts of all those involved in the exercise especially Ms Louise Mullen, Researcher, Department of Public Health, who collated the responses.
Questionnaire circulated in advance of Consultation Day

ERHA Sexual Health Strategy

Consultation questionnaire for key stakeholders in the ERHA region

The ERHA has set up a Steering Committee to prepare a strategy to promote sexual health and safer sexual practices in the Eastern Region. The committee are looking at three main areas:

- Promotion of sexual health and well-being
- Prevention of transmission of sexually transmitted infections
- Prevention of unintended pregnancy.

We would like to hear from those who working in the area of sexual health - prevention and community work, primary care; specialist and hospital services. We aim to have a consultation day on November 13th in Dublin (see details end of this questionnaire).

SECTION A

Key values and principles for an ERHA Sexual Health Strategy:

1. What do you think should be the key values and principles underpinning the ERHA Sexual Health Strategy?

2. Are there specific groups which you feel should be targeted through the ERHA Sexual Health Strategy?

3. Do you see a need for better joint working across different agencies, services or groups, to improve sexual health?
   Please give details:

SECTION B

Sexual Health Promotion:

1. In relation to sexual health promotion, what are the specific issues that the ERHA Strategy should address?

2. Are there specific groups that should be targeted for sexual health promotion?

3. Are there current programmes or initiatives that should be strengthened?
4. Are there programmes or initiatives that should be introduced?

5. How can sexual health promotion be made more effective?

6. Do you know of any models or innovations that demonstrate good practice, which we should build on?

**SECTION C**

**Services To Improve Sexual Health**

1. What are the range of services that need to be available to meet the needs of your population?

2. We are proposing an integrated approach to sexual health services with levels of service ranging from self-management through to specialist service provision.
   Do you agree with this structure?    Yes ☐    No ☐

   If not what structure would you feel is more appropriate?

3. What should the role of the following groups be in providing sexual health services and what would be the practical implications e.g. education, training and resources.
   - Primary Care:
   - Family Planning:
   - Gynaecology:
   - Genito-urinary Medicine:
   - Other groups/individuals that have a role in providing services?

4. Are you aware of examples of models/innovations of service delivery that demonstrate good practice and better outcomes, which we should seek to build on?

**SECTION D**

Any other issues or suggestions relevant to the development of an ERHA Sexual Health Strategy:

Thank you for your help in the development of the ERHA Sexual Health Strategy

*Completed replies should be sent by Wednesday October 8th 2003 to:*
*Dr. Margaret Fitzgerald, Chair,*
*Sexual Health Strategy Committee, ERHA Dr Steevens Hospital, Dublin 8*
*Email: mgt.fitzgerald@erha.ie Fax: 01-6352103*
Programme for Consultation Day

Consultation Day  November 12th 2003  
Eastern Regional Health Authority  
Udaras Slainte Reigiunach An Oirthir

Programme for Consultation Day  
Sexual Health Strategy

Venue: Chester Beatty Library, Dublin Castle  
Date: 13th November 2003

10.00am  Registration & Tea/coffee

Morning Session: Chair, Dr. Margaret Fitzgerald, Specialist in Public Health Medicine

10.45am  Introduction Dr. Marie Laffoy Director of Public Health ERHA

11.00am  Setting the Scene for the ERHA Sexual Health Strategy  
Dr. Margaret Fitzgerald, Specialist in Public Health Medicine

11.30am  Approach to Developing Sexual Health Strategy  
Dr. Lorraine Doherty, Senior Medical Officer DHSS (N. Ireland)

12.00pm  Workshop I  
Values, Principles and Information Needs for Sexual Health

1.00pm  Feedback on Workshop I

1.20pm  Break for Lunch

1.30pm  LUNCH

Afternoon Session: Chair, Dr. Catherine Hayes, Specialist in Public Health Medicine

2.30pm  Sexual Health Promotion / Sexual Health Services  
Dr. Lorraine Doherty, Senior Medical Officer DHSS (N. Ireland)

3.00pm  Workshop II  
Sexual Health Promotion / Sexual Health Services

3.50pm  Feedback from Workshops

4.15pm  Conclusions

4.30pm  Closing
Consultation Day
Sexual Health Strategy

Facilitators

Workshop I
Values, Principles and Information Needs for Sexual Health

- Ms. Stephanie White, CAIRDE
- Mr. Mick Quinlan, Gay Mens Health Project
- Dr. Joe Barry, Specialist in Public Health Medicine

Workshops II
Sexual Health Promotion / Sexual Health Services

- Ms. Sheilagh Reapor Reynolds, Health Promotion Officer, SWAHB
- Dr. Joe Barry, Specialist in Public Health Medicine, ERHA
- Ms. Helen Mc Cormack, Health Promotion Officer, ECAHB

Rapporteurs

Dr Deirdre Mulholland
Ms Louise Mullen
Ms Eimear Brennan

Consultation Day Workshops:

1. Values, Principles and Information Needs
2. Sexual Health Promotion
3. Sexual Health Services
**ERHA SEXUAL HEALTH STRATEGY CONSULTATION WORKSHOP 1**

**Values and principles**
Discuss the values and principle that should underpin the sexual health strategy.

**Information Needs**
List the information requirements for the development of the ERHA sexual health strategy. In particular consider the information requirements in each of the following areas:
- Sexual attitudes and behaviours
- Epidemiology of Sexually Transmitted Infections
- Unintended pregnancies
- Teenage Pregnancies
- Termination of Pregnancy
- Sexual health needs of gay/bisexual men and women
- Sexual health needs of particular ethnic groups
- Sexual health services

**ERHA SEXUAL HEALTH STRATEGY CONSULTATION WORKSHOP 2**

Sexual Health Promotion
Responsibility for Promotion of Sexual Health
Sexual Health Information
Other approaches to sexual health promotion

**ERHA SEXUAL HEALTH STRATEGY CONSULTATION WORKSHOP 3**

**Sexual Health Services**

**Service settings and configurations**
Sexual health services are currently delivered in a range of different settings - Genitourinary Medicine, Family Planning, Primary Care, Obstetrics & Gynaecology, Voluntary Agencies. It is acknowledged that sexual health services are in crisis and improvements are required. Critical issues are access to services, waiting lists and range of services available. Outline:

(i) What solutions are possible to improve sexual health services in the short term? A key consideration in this area is the need to enhance the provision of genitourinary medicine services.

(ii) The strategic vision for the provision of more 'holistic' sexual health services. Under this area consider the possibility of 'one stop shops' and also the use of a range of agencies in the delivery of services.

(iii) How could primary care professionals be more proactively engaged in the delivery of primary care based sexual health services?

**Raising awareness of sexual health services**

**Education and Training of those involved in the provision of sexual health promotion and clinical services**
Consultation Participants

Age Action
AIDS Care Education Training
Barnardos
Berkerley Clinic
Cairde
Central Remedial Clinic
Cherish
Chief Executive, East Coast Area Health Board
Child Health Department, East Coast Area Health Board
Child Health Department, South Western Area Health Board
Community Care Area, Northern Area Health Board
Crisis Pregnancy Agency
Department of Education
Department of Sociology, Trinity College Dublin
Department of Sociology, University College Dublin
Dublin AIDS Alliance
Eastern Regional Health Authority
Gay Health Network
Gay Men's Health Project
GP Unit, South Western Area Health Board
GPs in Ballymun Health Centre - Dr David Gibney
GUIDE Clinic St James's Hospital
Health Promotion (Teenage Health), Northern Area Health Board
Health Promotion Department, Department of Health and Children
Health Promotion Department, South Western Area Health Board
Irish College of General Practitioners
Irish Family Planning Association
National Consultative Committee on Racism and Interculturalism
National Disease Surveillance Centre
National Rehabilitation Hospital
National Youth Council of Ireland
Primary Curriculum Support Programme
Rainbow Clinic, Our Lady's Hospital for Sick Children
Social Inclusion, Northern Area Health Board
Social Work Department, National Maternity Hospital
Social Work Department, Northern Area Health Board
Social Work Department, The Children's University Hospital
Student Health, Dublin Institute of Technology
Student Health, Trinity College Dublin
Student Health, University College Dublin
Students Union, Dublin City University
Teen Counselling Mater Dei
Walkinstown Association for Handicapped
Well Woman Centre
Women's Health Council
Women's Health Project