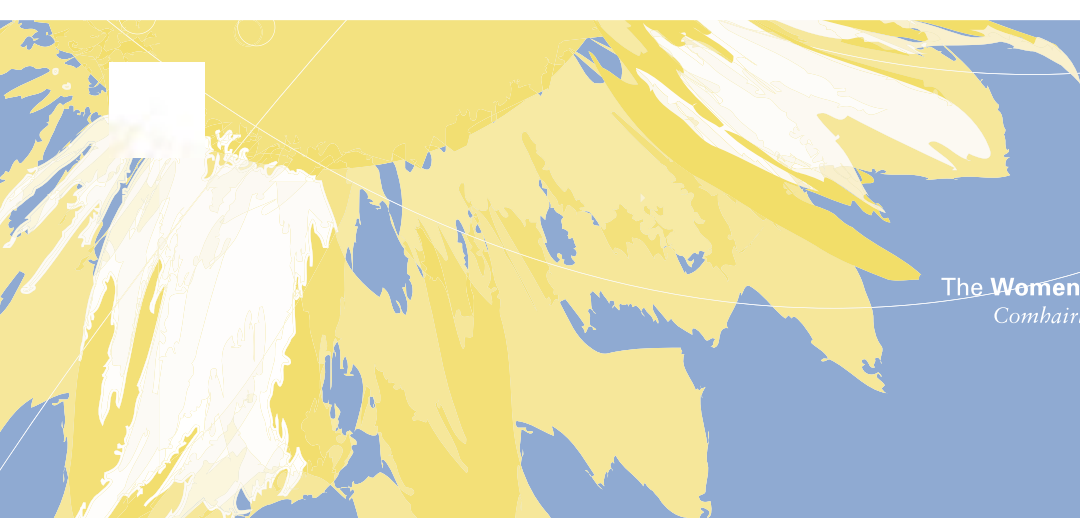


September 2006 **Women & Sexually Transmitted Infections: A Gendered Analysis**



The **Women's** Health Council  
*Comhairle Sbláinte na mBan*



# The Women's Health Council

The Women's Health Council is a statutory body established in 1997 to advise the Minister for Health and Children on all aspects of women's health. Following a recommendation in the *Report of the Second Commission on the Status of Women (1993)*, the national *Plan for Women's Health 1997-1999* was published in 1997. One of the recommendations in the Plan was that a Women's Health Council be set up as 'a centre of expertise on women's health issues, to foster research into women's health, evaluate the success of this Plan in improving women's health and advise the Minister for Health on women's issues generally.'

The mission of the Women's Health Council is to inform and influence the development of health policy to ensure the maximum health and social gain for women in Ireland. Its membership is representative of a wide range of expertise and interest in women's health.

The Women's Health Council has five functions detailed in its Statutory Instruments:

1. Advising the Minister for Health and Children on all aspects of women's health
2. Assisting the development of national and regional policies and strategies designed to increase health gain and social gain for women.
3. Developing expertise on women's health within the health services.
4. Liaising with other relevant international bodies which have similar functions as the Council.
5. Advising other Government Ministers at their request.

The work of the Women's Health Council is guided by three principles:

- Equity based on diversity – the need to develop flexible and accessible services which respond equitably to the diverse needs and situations of women.
- Quality in the provision and delivery of health services to all women throughout their lives.
- Relevance to women's health needs.

In carrying out its statutory functions, the Women's Health Council has adopted the WHO definition of health, a measure reiterated in the Department of Health's 'Quality and Fairness' document (2001). This definition states that:

'Health is a state of complete physical, mental and social well being.'

# Contents

The Women's Health Council	i
Definition	pg 1
Introduction	pg 2
Sexually Transmitted Infections in Ireland	pg 4
Risk Factors	pg 8
The Gendered Nature of STIs	pg 9
Gender and STI Prevention and Screening	pg 12
Sexual Health Policy in Ireland	pg 16
Sexual Health Promotion	pg 18
STI Services	pg 20
Research and Data Collection	pg 23
Conclusions	pg 24
Recommendations	pg 25
References	pg 26
Appendix 1: Sexual Health Policies and Strategies in Ireland	pg 34

# Definition

“Sexually Transmissible Infections are infections which can be passed on from one person to another during sexual contact. They are caused by bacteria, viruses and other microscopic organisms which are present in the blood, semen, body fluids or the pubic area of an infected person.”(Health Promotion Unit, 2005)

Sexually transmitted infections (STIs) pertain to the field of sexual health which is defined by the World Health Organisation as:

*A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.” (2004)*

The many concepts and issues contained in this definition point to the very complex nature of sexual health which incorporates factors ranging from individual sexual behaviours and attitudes to societal factors, such as gender relations and power differentials, education and access to health care. The WHO indeed states that the most significant development of the past decade in sexual health has been the acknowledgement of the “complex social, economic and political forces that influence people’s vulnerability to sexual ill-health” (2004).

# Introduction

The definition of sexual health, of which STIs are a critical component, highlights the complex nature of sexual behaviour and attitudes in any society. Over the past decade, Ireland has experienced dramatic changes in its social, economic and cultural domains. The influence of traditional moral codes based on the teachings of the Catholic Church, which used to underpin Irish society's beliefs in relation to sexuality, has diminished, and more liberal values are now commonplace in relation to sexual relationships, contraception, homosexuality and family formation. This shift has been mainly positive, bringing increased freedom and tolerance in this sensitive aspect of people's lives. However, it has brought challenges, too, especially for young people. They now experience much greater pressure to engage in sex at a younger age when they might not be emotionally ready for it or fully equipped to deal with the possible negative repercussions, such as crisis pregnancy and STIs. Moreover, the importance of gender in this freer sexual culture has not been properly addressed, and double standards in sexual behaviour still persist (Hyde and Howlett, 2004; Murphy-Lawless, Oaks and Brady, 2004). This situation has serious repercussions for the health of both women and men.

While sexual health, as seen earlier, is a broad and multi-faceted concept, the focus of this analysis is on STIs. The incidence of notified STIs<sup>1</sup> in Ireland has increased significantly in recent years, with a 173.8% rise in the general population in the decade between 1994 and 2003 (HPSC, 2005a). Young people are particularly affected and between 2000 and 2004 55.9% of STIs occurred in 20-29 year olds (HPSC, 2005d). While this rise in rates is partly due to increased awareness and screening as well as more sensitive diagnostic methods and improved notification

systems, it still points to a significant upsurge in risky sexual behaviour. Moreover, these statistics represent a 'huge underestimate' of the real incidence of STIs because of the current lack of a comprehensive system of surveillance. In fact, while some primary care practices and laboratories do notify their relevant Departments of Public Health, STI surveillance in Ireland is still mainly clinic-based, and, thus it does not include all screening results (HPSC, 2005d, e).

Ireland is not alone in experiencing this rise in rates of STIs. Similar increases are being documented throughout the European Union (Fenton and Lowndes, 2004), and globally (WHO, 2004). At the European level, this is thought to be due to a combination of societal factors, such as decreases in marriage, delayed childbirth, and population movements, and behavioural factors, such as earlier sexual initiation and worsening high risk behaviours (Fenton and Lowndes, 2004). Because of this situation, many European and non-European governments have in recent years implemented specific sexual health strategies. It is hoped that this report will support and assist the formulation of an Irish sexual health strategy as a matter of urgency.

Gender plays a crucial role in relation to the prevention, screening and treatment of STIs, as in many other health matters. Gender influences sexual attitudes and behaviours (Wong et al., 2004). It also affects the ability and willingness to access information and services in relation to screening and treatment (WHO, 2002a). Hence, it is vital that any policy which aims to improve the sexual health of the population is gender-sensitive and all initiatives in relation to prevention, screening or treatment are targeted at the population in a gender and age appropriate manner.

This report has three main objectives:

- to make the case for the impact of both biology and gender on STIs
- to highlight the fact that women are more vulnerable to STIs because of biological, cultural and socio-economic factors
- to make recommendations for gender sensitive approaches to STIs prevention, screening and treatment.

After a brief overview of the most common STIs for women and men in Ireland, research findings will be presented to illustrate the importance of gender in the realm of sexual health in general, and STIs more specifically. The most relevant health policies will be then explored, especially in relation to health information and promotion, services and current and future screening opportunities. Finally, recommendations will be made in order to safeguard and improve the sexual health of the population in a gender and age appropriate manner.

---

<sup>1</sup> Legally notifiable infectious diseases are regulated through Statutory Instruments. On 1st January 2004, S.S No. 707 of 2003 established a revised list of notifiable diseases and introduced a requirement for laboratory directors to report infectious disease. 11 STIs have since been notifiable in Ireland: ano-genital warts, chancroid, Chlamydia Trachomatis, genital herpes simplex, gonorrhoea, granuloma inguinale, infectious hepatitis B, lymphogranuloma venereum, non-specific urethritis, syphilis and trichomoniasis.

# Sexually Transmitted Infections in Ireland

As already seen, STI rates have been increasing in Ireland over the past ten years. The most recent surveillance report showed that in 2004 10,695 STIs were notified in Ireland, representing a rise of 12.1% on 2003 levels (HPSC, 2005d). Over the last five years, STIs notifications have been quite evenly split across the sexes (NDSC, 2002, 2003, 2004; HPSC, 2005a). Last year, 51% (n=5,458) of the notified STIs were amongst men, and 36.4% (n=3,897) amongst females. Gender data were not reported in 12.5% of notifications, mostly ano-genital warts. It is important, though, to keep in mind, that notifications greatly underestimate the real prevalence of STIs due to the lack of population prevalence studies. Moreover, recent STI epidemics among men who have sex with men and generally high incidence rates among this group might also skew statistics in gender terms. The three most common infections for both women and men in 2004 were ano-genital warts (n=4,174; second most common in both), Chlamydia trachomatis (n=2,803; most common STI in women, third most common in men) and non-specific urethritis (n=2,746; most common STI in men, third most common in women). The sections below will focus on ano-genital warts, Chlamydia and HIV. The first two are the most common STIs in women and the third

deserves special attention because of its potentially fatal consequences.

## ANO-GENITAL WARTS/HPV

Ano-genital warts account for 39% of the total number of STIs notified in 2004, which saw the highest numbers on record. They are the clinically visible manifestation of infection with human papilloma virus (HPV) (HPSC, 2005d). In 2004, males represented 34.8% of cases and females 34.6% (gender not reported for 30.6% of cases). Most strands of the HPV virus are benign. However, infection with HPV types 16 and 18 is known to contribute to invasive cervical cancer (Shepherd et al., 2005). Moreover, the magnitude of the risk association between HPV and cervical cancer is greater than that for smoking and lung cancer (Unger and Barr, 2004). Cervical cancer is the ninth most frequently diagnosed cancer in women in Ireland (WHC & NCRI, 2006). Because of the direct link between HPV and cervical cancer, the possibility of testing for HPV should be considered in conjunction with smear testing when results from the smear test are abnormal. This would not add any extra discomfort or inconvenience to women, as the follow on test would be lab-based, but could identify the women most at risk of developing cancer

**TABLE 1: NUMBER OF NOTIFIED STIS BY GENDER (HPSC, 2005D)**

	Women		Men		Gender Not Known	
STIs Notified	3,897	36.4%	5,458	51%	1,340	12.5%

**TABLE 2: THREE MOST COMMON STIS IN WOMEN AND MEN (HPSC, 2005D)**

	Women	Men
Chlamydia Trachomatis	1,492	1,264
Ano-genital Warts	1,445	1,454
Non-specific Urethritis	550	2,193

in the future (Dublin Well Woman, 2004). Significant advances are also being made in the development of a vaccine for HPV, and the first vaccine has been licensed in the USA in June of this year (Kaiser Network, 2006). However, further clinical trials are due to take place and it is likely that it will not be licensed here until results demonstrate efficacy and safety. Even then, it is vital that women continue to attend for smear tests. A pilot cervical screening project has been going on in the Mid-West since 2000, and a new National Cancer Screening Board will be established tasked with the delivery of a national cervical screening programme among other responsibilities. The establishment of a national cervical screening programme will not be sufficient by itself to prevent cervical cancer.

Until such time as the programme is fully implemented, awareness and prompt treatment of ano-genital warts are therefore necessary to prevent the development of invasive cancer. The Cochrane Collaboration carried out a systematic review of interventions to prevent cervical cancer and found the most effective preventative steps are "educational interventions targeting socially and economically disadvantaged women in which information provision is complemented by sexual negotiation skill development" (Sheperd et al., 2005: 1). Their findings also confirmed the importance of gender and cultural issues in relation to preventative behaviours. These issues will be further explored later in the report.

### CHLAMYDIA TRACHOMATIS

The increase in the notification of Chlamydia trachomatis is the most staggering documented by the Health Protection Surveillance Centre, with a 1,044% rise between 1995 and 2004 and a further increase of 24.1% between 2003 and 2004 (2005d). The figures indicate a slight prevalence of cases by females at 53.2% and males at 45.1% (gender not reported in 1.7% of cases). The dramatic increase not only reflects changes in sexual behaviour but also the more common use of highly sensitive diagnostic

tests (Burckhardt, Warner and Young, 2006). Still, these statistics are likely to be a considerable underestimate of the true incidence of this infection, as *C. trachomatis* remains asymptomatic in up to 70% of women and 75% of men (HPSC, 2005b), who are thus unlikely to present for testing. Untreated Chlamydia in women can cause pelvic inflammatory disease (PID), leading to tubal infertility, tubal (ectopic) pregnancy, and chronic pelvic pain (Oakeshott, 2003). Approximately 40% of women with untreated Chlamydia infections will develop PID, and, of those with PID, up to 20% may become infertile, 18% will experience chronic pelvic pain and 9% will have a life-threatening tubal pregnancy (HPSC, 2005b). In men, untreated infection can cause urethritis, epididymitis, and Reiter's syndrome. Recent evidence also suggests that infection can cause male infertility (LaMontagne et al., 2004). Data available from the Hospital Inpatient Enquiry (HIPE) system for the period 1999 to 2003 shows a 28% increase in the proportion of discharges with a diagnosis of ectopic pregnancy and a 3.2% increase in the proportion of discharges with PID (HPSC, 2005b). While these increases related to hospital inpatient episodes rather than incidence in the population, they still point to a significant rise in these conditions.

Currently, there is no indication of the prevalence of *C. trachomatis* in the Irish population. A systematic review looking at the prevalence of this infection in unscreened asymptomatic women in Europe, based on surveillance data, found rates ranging from 1.7% to 17% depending on setting, context and country (HPSC, 2005b). The GUIDE Clinic in St James' Hospital found a prevalence rate of 9.6% between 1989 and 1999, prior to the recent hike in notification rates (52% of infections in women and 48% men) (Lyons, Mulcahy and Bergin, 2001). Results from the National Maternity Hospital give a prevalence rate of 16% among women younger than 20 years of age attending the antenatal clinics, and a rate of 9% for women younger than 25 years of age attending the colposcopy clinic (Lyons, 2005). The first community screening programme

of men, which took place in the Mid-West, found a prevalence rate of 5.9% (Powell et al., 2004).

Due to the lack of available data, the Scientific Advisory Committee of the Health Protection Surveillance Centre stated that research in this area is urgently required (2005b). In addition, the committee strongly recommended that a study be carried out to evaluate the feasibility, acceptability, likely uptake and effectiveness of screening in various settings in Ireland. Despite the very serious consequences of Chlamydia infection, there is no national strategy for its screening at the moment. The potential benefits as well as the problems involved in implementing this kind of screening will be further analysed later in the report.

### HIV/AIDS<sup>3</sup>

The presence of other STIs increases the likelihood of HIV transmission (Sangani, Rutherford and Wilkinson, 2004). Hence the recorded increase in STIs incidence in Ireland causes further concern in relation to its future impact on HIV figures. In 2004 356 cases of new HIV infection were diagnosed. This represents a 10.8% decrease on 2003 figures (HPSC, 2005a). However, the rate of diagnosed HIV infection went up from 29.6 per million population in 1997 to 89.0 in 2004 (EuroHIV, 2005). While the influx of people from regions significantly affected by the HIV pandemic, such as Sub-Saharan Africa, has probably had an impact on national incidence rates, this increase is still worrying and points to the need for improved health promotion campaigns, prevention and screening, especially amongst the younger age groups, who missed the global awareness campaigns of the 1980s. Moreover, due to the increased ethnic diversity now present in Ireland, any new initiative must also be culturally sensitive, and services must ensure

ease of access for members of ethnic minorities, especially those worst affected.

On a global level, the HIV/AIDS epidemic is affecting women and girls in increasing numbers (UNAIDS, 2005). While unprotected homosexual intercourse and drug injection are still the most common methods of infection in Western Europe, increasing numbers of people are being infected through unprotected heterosexual intercourse. In Ireland heterosexual contact is the most common route to transmission (HPSC, 2005c). In 2004, 192 (53.9%) of newly diagnosed infections occurred in males and 161 (45.2%) in females (gender was unknown in 3 cases). Among females, 72% of newly diagnosed infections were acquired through heterosexual contact. Among males, the most frequent routes of transmission were sex between men (33%) and heterosexual contact (32%) (HPSC, 2005a). Hence, men are still more affected by HIV/AIDS but the proportion of women has been increasing over the last few years from 23.1% in 2000 to 45.2% in 2004 (HPSC, 2005a; EIWH, 2006). The increase in female incidence is partly due to the influx of migrants from heavily affected areas, as already mentioned, but also reflects the introduction of voluntary antenatal testing in 1999, which by 2004 had an uptake of 94.8% (O'Donnell and Cronin, 2006). More than 70% of the women identified as HIV positive in that year were new diagnoses, highlighting the fact that without opportunistic testing these women would have remained unaware of their HIV status and would not have been able to access treatment for themselves and to prevent mother to child transmission.

While the effect of gender on the spread of HIV has been widely documented (UNAIDS, UNFPA and UNIFEM, 2004), most analysis of this aspect focuses on developing

<sup>3</sup> HIV/AIDS is not statutorily notifiable in Ireland. A voluntary anonymous HIV case based reporting system has been in operation since July 2001 (HPSC, 2005e).

countries. Gender inequalities in most aspects of life are indeed much worse in those countries most affected by this pandemic. However, their effect also plays a role in relation to HIV infection in the developed world. As we will see, issues related to empowerment in sexual health and reproductive decisions are intrinsically linked to women's status in society and its many manifestations. All of them play a role in the prevention of HIV infection.

## Risk Factors

For both women and men, general risk factors for STIs include a change in sexual partner, higher number of sexual partners and inconsistent condom use, and, for women, being under 25 years of age (Couldwell, 2005). Surveillance data in Ireland, as seen earlier, also points to the greater rates of STIs incidence in the younger cohorts (20-29 years of age) for both women and men. However, no further data is available on their respective risk factors. Detailed analysis carried out through the National Chlamydia Screening Programme in England showed that risk factors, however, varied by gender. For women, being between 16 and 19 years of age, non-white, and having a new sex partner or more than one sex partner were found to be the most common risk factors. For men, these were being between 20 and 24 years of age and non-white (LaMontagne et al., 2004; National Chlamydia Screening Steering Group, 2004). The reasons behind some of these differences will be explored in the next chapter.

Poverty and social exclusion have also been identified as clearly linked with the risk of STI infection in England (Ellis and Grey, 2004) and the USA (Jones, Ogbara and Braveman, 2004). The UK Department of Health identified the highest burden of STI being borne by women, gay men, teenagers and young adults, and minority ethnic groups (2001). The Irish Contraception and Crisis Pregnancy (ICCP) survey found links between low levels of education and difficulties in talking to a sexual partner about contraception (Rundle et al., 2004). Statistics recently collated by the Well Woman Centres in Dublin also point to a distinct social gradient in chlamydia infection among women with their Coolock centre reporting a 20% chance of positive testing for women under age twenty compared to 14% in the city centre and 4% in an affluent area (2006)

Finally, the role that alcohol plays in risky sexual behaviour also needs to be considered due to Ireland's high consumption level and binge drinking pattern. A recent report shows that Ireland has the highest percentage of male and female binge drinkers in Europe (EIWH, 2006). A systematic review of the link between problematic alcohol

consumption and STIs supported an overall association (Cook and Clark, 2005). The effect of drinking on sexual behaviour has been documented in recent Irish studies as well. The ICCP survey found that almost half of men (45%) and 26% of women agreed that drinking alcohol had contributed to them having sex without using contraception (Rundle et al., 2004). The College Life and Attitudinal National (CLAN) Survey last year reported that binge drinking was also a cause of unprotected sex amongst students (Hope, Dring and Dring, 2005). Research among Irish teenagers also highlighted the role played by alcohol on sexuality, with many participants mentioning a link between intoxication and first penetrative sex (Hyde and Howlett, 2004). It is vital that sexual health promotion campaigns highlight the risks involved in over-consumption and binge drinking. Government initiatives in this area must continue and improve in order to ensure that Irish teenagers and adults consume alcohol in a responsible manner which will not have negative repercussions not only from a sexual perspective but also for their long term physical and mental health.

# The Gendered Nature of STIs

*“Women are much more vulnerable [to STIs] biologically, culturally, socio-economically” (WHO, 2000)*

Women are at greater risk of STIs than men in a number of ways, including their susceptibility to infection and the severity of the sequelae associated with infection (Wong et al., 2004). As will be shown in this report, women’s lower social position in society, and the gender stereotypes that accompany it usually give them less power in sexual relationships and ensure that greater stigma is attached to STIs infection for them.

## BIOLOGICAL VULNERABILITY

STIs, including HIV, are more easily transmitted from men to women than from women to men. For example, the risk of genital herpes transmission from a male to a female partner is 19%, whereas it is 5% for transmission from female to male. After a single episode of sexual intercourse, a woman has a 60% to 90% chance of contracting gonorrhoea from her infected partner, whereas the risk for a man is 20% to 30% (Wong et al., 2004). In general, women are twice as likely to become infected from a variety of sexually transmitted pathogens as men and the efficiency of male to female transmission of HIV is approximately four times higher than female to male transmission (WHO, 2002b). This considerable difference in risk of infection is due to the fact that women’s bodies are physiologically more vulnerable to STIs:

- during and after unprotected intercourse, mucous membranes in the vagina are exposed to infectious fluids for a prolonged period.
- The vagina provides a large mucosal surface for transmission.
- There is more virus in sperm than in vaginal secretions.

- Women experience greater trauma to tissues during intercourse and even more so in the case of forced intercourse.
- Having an STI makes women more vulnerable to HIV. Some STIs cause lesions, making it easier for HIV to enter the body. (Berer, 1997; Aral et al., 2004; Planned Parenthood Federation, 2004; Wong et al., 2004)<sup>4</sup>.

Younger women are at an even greater risk, since the cervix is physiologically less mature and therefore more vulnerable to infection (Planned Parenthood Federation, 2004; Wong et al., 2004). This situation is mirrored by results from STIs statistics from various countries. Available Irish figures do not allow for an age and gender segregated analysis.

As already seen, once infected women face a disproportionate burden of sequelae from STIs. These include PID, chronic pelvic pain, ectopic pregnancy, infertility and cervical cancer. After one episode of PID, 20% of females will suffer chronic pelvic pain, 9% an ectopic pregnancy, and 8% infertility; the risk of infertility doubles after each subsequent episode. PID is the cause of 15% of all infertility (Wong et al., 2004). In men, STIs are now considered to be linked with infertility (LaMontagne et al., 2004), but this is only a very rare complication. Although HPV rarely causes penile and anal cancers in males, females may develop the much more common cervical as well as vaginal and anal cancers. If a pregnant woman is infected, the STI can be transmitted to her newborn, and may result in miscarriage, premature labour, stillbirth, and infant death (Wong et al., 2004).

<sup>4</sup> There is little information on biological susceptibility in males apart from the fact that circumcision reduces the risk of STIs, including infection with HPV (Wong et al., 2004).

### CULTURAL VULNERABILITY

Sociological research into young people's sexuality suggests that sexuality is learnt, learnt differently by males and females, and is heavily influenced by gender relationships, which are influenced by cultural as well as personal factors (Cowan, 2002). Hence sexuality is influenced by gender expectations and the gender-power relationships that exist in society. A gender double standard in relation to sexual behaviour is widely practiced, if not openly accepted. Moreover, there is plenty of evidence to show that this double standard is also internalised by women.

A number of research studies carried out in recent years provide evidence for the persistence of this double standard in Ireland, and especially in adolescents, despite a freer sexual culture than in the past (Inglis, 1998; Mahon, Conlon and Dillon, 1998; Women's Aid, 2001; Hyde and Howlett, 2004; Maycock and Byrne, 2004; Murphy-Lawless, Oaks and Brady, 2004). Two of the issues most relevant to STIs prevention that transpire from the studies above are the fragility of a girl's reputation, which is easily damaged by the perception of 'being easy', and how this issue then limits young women's ability to discuss contraception openly with a sexual partner.

While loss of virginity and sexual experience enhance the reputation of young men, they act in the opposite way for young women, causing them to get a 'reputation' and being labelled as 'slags'. Young women are keenly aware of this double standard, and, while they do not consider it acceptable, they can see no alternative to it, and often support it themselves (Maycock and Byrne, 2004). Boys are also aware of it, and, although they do not necessarily consider it fair, fear of ridicule stops them from opposing it in any significant way.

The need not to appear 'easy' prevents young women from taking the appropriate precautions in relation to

STIs. So while they may avoid pregnancy by using the contraceptive pill, teenage girls are often unable to bring up the topic of condom use for fear of being perceived as too forward or experienced. Moreover, since it is only young women that may be perceived as 'easy', risk of STIs infection is often associated with them but not with young males who might be engaging in similar patterns of sexual activity. This situation makes young men able to control whether a condom will be used, based on their own assessment of the girl's reputation (Hyde and Howlett, 2004). Because of the significant danger of being perceived as 'easy', negotiating safe sex, indeed negotiating sex at all explicitly is, therefore, extremely difficult for young women.

While the double standard in sexuality is mostly beneficial to men, young men have also been found to experience considerable stress in relation to the need to prove their sexual knowledge, experience and prowess. Thus, they are often unable to discuss relationship and sexual health matters within their peer group so not to admit to ignorance and be exposed to derision (Hyde and Howlett, 2004; Maycock and Byrne, 2004).

As women grow older they become better able to cope with the sexual double standard and become less worried by it, and more able to discuss contraceptive precautions (Murphy-Lawless, Oaks and Brady, 2004). However, many of them still find condom negotiation with a partner difficult, confrontational and awkward, and are afraid to insist on it for fear of reactions of the male partners regarding trust and commitment issues (Mahon, Conlon and Dillon, 1998). Thus, the lack of control over condom use, and the underlying gendered dynamics involved in safe sex negotiation, still expose women to a greater risk of STIs infection than men. As outlined in the previous section, this is especially true during adolescence due to physiological immaturity which renders young girls more susceptible to infection.

### SOCIO-ECONOMIC VULNERABILITY

Power is intrinsically linked with sexual activity and reproduction (Evans, 2000). In no society have women reached equal status with men, and their lower socio-economic position and financial dependence also makes them more vulnerable to STIs (Aral et al., 2004). There are many social and economic inequalities which may prevent women of all ages from protecting themselves during sexual activity.

Economic dependency in relationships can make it hard for women to negotiate condom use or leave a relationship that puts them at risk. While women are increasingly joining the labour market in Ireland, and their employment rate has now reached 55.3% (CSO, 2004), due to their caring responsibilities many of them work only on a part-time basis. Women are also overrepresented in clerical and secretarial jobs, which would not attract high remuneration. The Irish social welfare system is still very much based on a male-breadwinner model, which treats the woman as a dependant and gives her no independent entitlement to income support within a household (National Women's Council of Ireland, 2003). Finally, more women are at risk of poverty compared to men (20.4% vs 18.9% in 2004), and, their percentage is increasing rather than decreasing in recent years (CSO, 2005). Disadvantage and social exclusion, as already seen, have been found to be closely linked to STIs infection.

Unequal power relations are also epitomised by coercion and violence in sexual relationships. International studies illustrate that women and girls suffer high levels of sexual violence, which contributes to their vulnerability to STI infection (WHO, 2005). High rates of sexual abuse have also been found in Ireland, with women being more likely to be affected by it in childhood, and throughout their lifetime (McGee et al., 2002). Moreover, females are more likely than males to have been forced into their first sexual encounter (Wong et al., 2004). Research in Northern Ireland found that young women are five times as likely as men to say that they had not wanted to have sex at all the first time they did it (Schubotz, Simpson

and Rolston, 2002). While these results do not necessarily mean that physical coercion had been used, they do point to young women being pressurised into sexual initiation. A study by Woman's Aid conducted in Dublin provides similarly worrying data. While the study does not deal specifically with sexual initiation, it points to the fact that young women reported far more incidents of adolescent non-consensual sex and assault, with the majority of perpetrators being over 18 and known to them (Women's Aid, 2001).

# Gender & STI Prevention and Screening

While the following section focuses mainly on heterosexual relationships, it is important to keep in mind that a different sexual orientation is by no means preventative in terms of sexual health and STIs. In fact, gay men are often targeted in STI campaigns and services as they experience significantly high incidence rates. On the other hand, lesbian women are often completely forgotten in sexual health discourse under the false assumption that they may not be at risk. Recent studies, however, have found that lesbian women are indeed at risk of contracting STIs not only from any previous heterosexual contact but also through their current relationships (Bailey *et al.*, 2004; Marrazzo, Coffey and Bingham, 2005). Around one in five women who have never had heterosexual intercourse have HPV and 10% of women with exclusively female partners have a history of STIs (Hughes and Evan, 2003). Despite these prevalence rates, lesbians are still less likely to be screened for cervical cancer (McNair, 2003). Hence, any new sexual health strategy must include the health needs of all women, regardless of their sexual orientation. Since, there is a dearth of information on the sexual health and health care experiences of lesbian women in Ireland, research in this area should also be funded.

## SEXUAL HEALTH EDUCATION

Education is one of the best ways to prevent the spread of STIs. For this reason, many countries include a sexual health module in the school curriculum. The 'Relationships and Sexuality Education' (RSE) programme was developed in Ireland in 1996 and in 2003 it became a mandatory part of the broader 'Social, Personal and Health Education' (SPHE) programme to be offered in all primary and post-primary schools (Crisis Pregnancy Agency, 2003; Health Promotion Unit, 2006). An official review of RSE carried out in 2000 found very low implementation rates across the country. At primary level, only 19% of schools surveyed had fully implemented the programme. The post-primary

level situation was better, at 41.5%, but still far from full implementation (Morgan, 2000)<sup>5</sup>. From a gendered perspective, the review also found quite substantial differences in the provision of 'comprehensive relationship and sexuality programme in senior classes'; this was twice as likely to occur in girls' schools than in boys', with gender-mixed schools scoring in between. This difference was found to be linked with traditions and beliefs about the differing needs of boys and girls in relation to sexuality. Similar findings were also reported in a later report on the implementation of SPHE at Junior Cycle (Geary and Mannix McNamara, 2003).

Recent Irish studies have also highlighted young students' dissatisfaction with the current programme (Hyde and Howlett, 2004; Maycock and Byrne, 2004; Murphy-Lawless, Oaks and Brady, 2004). School-based education was generally described as inadequate and too focused on the biological aspects of sexuality rather than focusing on the broader emotional, moral and social issues linked to relationships. Both boys and girls felt that they lack information about STIs in their school programmes, as well as the knowledge to recognise them in themselves and others (Hyde and Howlett, 2004).

However, gender differences were also reported on the appraisal of current provision in schools and the desired improvements to be made to it. While young women suggested the inclusion of more contextual and emotional aspects of sexuality, young men wanted more coverage of the physical dimensions of sex relating to technique and performance (Hyde and Howlett, 2004). In a follow-up analysis of these results, Hyde *et al.* found that performance anxiety was an overbearing feature of how young men viewed sex, believing that males rather than females should lead, direct and know how to act in sexual encounters (2005). The authors pointed out that

<sup>5</sup> A more recent review commissioned by the Department of Education and Science and the Crisis Pregnancy Agency is due to be published later on this year, and will indicate that a third of schools across the State are still doing little to implement RSE (Donnellan, 2005).

by endorsing a sexual model of male dominance, these young men helped to entrench gender inequalities that were harmful to young women but also to them. This model provides only one valid definition of masculinity, which negates the existence of vulnerability and the development of a positive identity that does not depend on sexual capacity or prowess. Thus, in order to rectify the situation, the authors called for models of sexual education that, while catering for the needs of young men and women, also play a role in challenging the established gender stereotyped notions of sexuality and power in relationships.

### CONTRACEPTION

Despite the fact that STI prevention can, at the moment, be accomplished only with the use of a male-controlled protection such as condoms, women are generally expected to carry the burden of responsibility for contraceptive choices within relationships (McMahon et al., 2004)<sup>6</sup>. Irish research shows that once a relationship is established, female-controlled contraceptive methods, such as the pill, the coil, or hormonal implants, are adopted as the preferred methods of contraception. Responsibility for contraception then becomes part of the woman's role rather than being shared by the two partners (Murphy-Lawless, Oaks and Brady, 2004). This situation stems from the gendered assumption of proper roles, but is also linked to a number of other factors, such as the implicit agreement to trust and commitment that unprotected sex implies, and the desire to render the sexual act spontaneous and unencumbered by interruption. Moreover, in Ireland, the shift to the pill as a contraceptive method also highlights the fact that fear of pregnancy overshadows fear of STIs for the vast majority of women, the pill being a safer contraceptive for this purpose and being female-controlled (Murphy-Lawless, Oaks and Brady, 2004). Young Irish men have also been found to be

more focused on pregnancy rather than STI prevention (Nicholson, 2004). For the same reason, the pill is also the preferred contraceptive choice of many young women not in established relationships, as it is more likely to protect them from the risk of pregnancy and does not require negotiation with the male partner. However, this choice leaves women more exposed to STI infection.

Because of their contraceptive choices and responsibilities and their reproductive role, women are also more used to accessing medical services, as, unlike male-controlled contraceptives, female-controlled ones cannot be obtained without a visit to a general practitioner. This situation has now created a vicious circle of contraceptive responsibility that is beneficial to neither female nor male sexual health. Men, in fact, often find it very difficult to talk about their sexual health and their initial perception is that their problem is being dismissed (Gregoire, 1999). Nicholson, in the first comprehensive Irish study on men's health, found that men feel marginalised by the health services (2004). The same study found that one in three men have difficulty in talking to their GPs about suspected symptoms of STIs (as well as relationship problems and impotence).

### SCREENING

The tendency to focus on women in relation to STIs is even more marked in relation to preventive screening. This approach is not justified by best practice or even evidence, but by cost and convenience, as women, who attend medical services more frequently, are more easily reached. The development of the National Chlamydia Screening Programme in England and Wales exemplifies this approach. The UK Chief Medical Officer's expert advisory group concluded that, in addition to testing symptomatic patients and those at higher risk of infection, the evidence available nationally supported the screening

<sup>6</sup> While the female condom, which also protects from both pregnancy and STIs, is now available, its uptake in western countries has been low (Hoffman et al., 2004), and the situation is no different in Ireland. Its acceptability is also significantly lower than that of the male condom (Kulczycki et al., 2004).

of the general population. However, instead of attempting to target the population as needed, the group proposed that the screening should be offered in an opportunistic basis to sexually active women only<sup>7</sup> (1998). Following the publication of this recommendation, sexual health professionals contested that opportunistically screening women only would further minimise men's responsibility for sexual and reproductive health and continue to foster gender inequalities in this area (Duncan and Hart, 1999; Hart, Duncan and Fenton, 2002). Opposition to this plan emphasised the fact that targeting women disadvantages them in terms of being subject to surveillance of their sexual behaviour, the possibility of being labelled and blamed as a consequence of a positive result, and the denial of men's contribution in STI infection. Moreover, it also pointed out that by ignoring men, the programme missed an opportunity to engage with them and proactively promote their sexual and general health (Duncan and Hart, 1999).

While *The national health strategy for sexual health and HIV* (2001) still referred to opportunistic screening for women only, in light of the above criticism, its *Implementation Plan* (2002) outlined the introduction of an opportunistic national Chlamydia screening programme targeting primarily women who access services, but also promoting greater uptake of testing among men<sup>8</sup>. In 2004, the first full annual report from the programme was published. Opportunistic screening had found Chlamydia positivity among people under 25 years of age of 10.1% in women and 13.3% in men in 2003-04 (National Chlamydia Screening Steering Group, 2004). These figures dropped slightly to 10.9% and 11.9% respectively in 2004-2005 (National Chlamydia Screening Steering Group, 2005). While the number of men tested is still relatively low (1,172 men screened compared to 15,241 women in 2004; 7,595 men compared to 53,103 women in 2005), these results fully justify the need to proactively include men in this process.

In order to access men, the programme included "pee in a pot" days at places outside traditional health care settings, including young persons' drop-ins, colleges, military bases, prisons and health promotion events. It is clear that more will need to be done in order to increase the number of men covered by the programme, but at least progress is being made in this regard. Countries which have had screening programmes for two decades now, such as Sweden and the USA, and which initially experienced a drop in incidence, are now experiencing a new rise in diagnosed numbers. One of the explanations offered for this occurrence has been the failure to include men comprehensively in the screening programme, resulting in a circulating pool of untreated asymptomatic infection (Low and Egger, 2002).

The first community Chlamydia screening of men to take place in Ireland, which was carried out in the Mid Western region and targeted males aged 17 to 35 years of age, found a prevalence of 5.9% (Powell et al., 2004). This rate, again, shows that any general screening programme would need to include men. It is, therefore, hoped that the proposed national Chlamydia screening programme (HPSC, 2005b) will take on board the study above as well as the lessons learnt from abroad and develop a programme which will attempt to capture both men and women.

<sup>7</sup> The criteria for screening was being under 25 years of age, or over 25 years with a new partner, or to have had two or more partners in the past year.

<sup>8</sup> Similar issues are currently being debated in Australia in relation to the implementation of their National Sexually Transmissible Infections Strategy 2005-2008 (Commonwealth of Australia, 2005). While the strategy highlights the need to develop "a Chlamydia screening pilot targeting sexually active young adults", the Ministerial official position suggests that the pilot program will target women aged 18-30 years only (Mindel and Kippax, 2005).

### **PARTNER NOTIFICATION**

Following on from screening, the issue of partner notification is particularly sensitive from a gendered perspective. Partner notification is essential to the control of STIs (Low et al., 2006); it prevents re-infection and reduces the spread of STIs (Mathew et al., 2001). As women are still more likely to be screened opportunistically, they are also the most likely to have to tell a partner about a positive result. A qualitative analysis of the psychosocial impact of a positive diagnosis of Chlamydia in Glasgow found that all women involved in the study experienced feelings that ranged from mild self-disgust to distress (Duncan et al., 2001). These feelings were caused by the association of STIs with stereotypical notions of contamination and delinquency. Moreover, the women also experienced considerable anxiety at having to disclose the result to their male partners and the potential negative repercussions arising from this disclosure. It is therefore important that women are given the necessary supports in order to communicate screening results in a way that does not assign blame to them, but includes the role that male partners play in infection. Moreover, a more balanced approach to testing itself will redress the burden of blame currently present, so that women's depiction as the sole carriers of infection is minimised.

In summary, better sexual health in the population will only be achieved by strategies that clearly understand and tackle the existing sexual ideology. They should always be implemented in a way that reduces gender inequalities in this field rather than reinforces them. Women benefit from prevention strategies that address gender roles, the power differential between the sexes, financial dependence on men, and the persistence of violence against women in its many forms. Moreover, cost and convenience cannot be used as justifications for implementing screening programmes that will inevitably intensify inequitable consequences for women in terms of surveillance,

labelling and blame. By proactively including men in screening programmes, women would also be less likely to become re-infected, which would reduce the significant treatment costs, making this option more effective even from an economic point of view. Finally, including men in sexual health campaigns would ultimately benefit their health, too, giving them an opportunity to discuss any other health matters concerning them.

# Sexual Health Policy in Ireland

Until recently the area of sexual health has been largely ignored in the health policy arena. Sexuality had been mainly regulated through the moral imperatives of the Catholic Church (Inglis, 1998; Hug, 1999). Only in the last few decades, with amendments to legalise contraceptives and the threat imposed by the HIV/AIDS epidemic, the need to consider sexual attitudes and behaviour from a population health perspective has gained recognition. However, due to the restrictive abortion laws in Ireland, most public and government attention has been focused on the issue of crisis pregnancy. This emphasis, while partly justified, has had the negative effect of compartmentalising the various aspects of sexual health rather than leading to a comprehensive and holistic approach. Moreover, despite the importance of gender in relation to sexual health, as highlighted in the previous section, no gender considerations transpire from the various relevant national policies. While regional strategies fare better in this regard, much still needs to be done in order to attain a sexual health policy that is adequately gender and age sensitive (see Appendix I for detailed analysis).

It is now expected that the first national sexual health strategy will be published in the near future and various initiatives are now in train to inform its formulation<sup>9</sup>. In order to inform this document, an extensive survey on the sexual knowledge, attitudes and behaviours of the Irish population has been carried out and is due for publication in the autumn<sup>10</sup>. In order to lay the foundations of the forthcoming strategy, the HSE is also funding a number of pilot projects<sup>11</sup>. These include: a mapping exercise in relation to best practice in the provision and delivery of sexual health services for young people within primary care; the agreement of a service framework for sexual health services including sexual health promotion; the provision of culturally appropriate information in STI clinics; and supporting marginalized parents in their role as sex

educators through information and training.<sup>12</sup> It is thus hoped that the new strategy will incorporate all the information and learning from the national survey and the pilot projects. Moreover, it is also very encouraging to see that the HSE is committed to gender mainstreaming its services (see Appendix 1). The sexual health strategy would be a most appropriate area to start from.

Finally, the first men's health policy is also due to be published later this year. In light of the historical over-emphasis on women as responsible for contraception and infection, it is vital that the Department take this opportunity to ensure that men's contribution in this area is also highlighted. Drawing attention to the role that men can play in safeguarding their own sexual health and that of their partners will ultimately prove beneficial for the population as a whole. Moreover, it will also help to rebalance the current gender inequity in this sphere.

## LEGISLATION

One last issue that cannot be overlooked in relation to STIs is the legal age of consent for sexual intercourse and medical treatment. At the moment, these are not the same. In the context of sexual intercourse, the recently passed Criminal Law (Sexual Offences) Act 2006 established 17 years of age as the age of consent for both girls and boys. On the other hand, under Section 23 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 s/he reaches the age of 16 years. The above situation is unsatisfactory and has the potential of limiting young people's access to appropriate sexual health services. Moreover, under the recent Sexual Offences legislation boys younger than 17 who engage in sexual intercourse have been technically criminalised. While it is unlikely that prosecutions would be pursued when sexual activity is consensual, this provision

<sup>9</sup> Personal communication with Olive McGovern, Health Promotion Unit, 21.03.06.

<sup>10</sup> Personal communication with Olive McGovern, Health Promotion Unit, 21.03.06. For further information see Layte, Fullerton and McGee (2003)

is bound to deter young boys from accessing sexual health services as well as taking parental responsibility in the case of a resulting pregnancy.

Recent research points to a decrease in the age of sexual initiation, with average age of first sex being 15.5 years (Crisis Pregnancy Agency, 2005). Forty percent of young men and 16% of young women are now becoming sexually active prior to the legal age of consent, and these percentages are rising. During an Oireachtas committee presentation, Dr. Clarke, consultant in the GUIDE Clinic, stated that her unit in St. James faced a “legal nightmare” in cases where children presented with STIs (Parliamentary Debates, 2006). Legally the clinic is obliged to report to the Gardaí all cases of children under the age of 16 engaging in sexual activity, while at the same time trying to encourage all patients with symptoms to present for treatment. It is of paramount importance that young people are protected against exploitative sexual experiences, but the current policy and legislative situation is not adequate to cater adequately for their sexual health needs in cases of consensual sex. The current situation might not only make them reluctant to access the contraception and STIs services they require, but also discourage them from disclosing exploitative sexual experience for the fear of being criminalised.

The HSE Eastern Region *Sexual Health Strategy* (2005) points out that few HSE areas have provided their health and social care professionals with written legal guidance to overcome the legal discrepancy. At the moment, these professionals are unsure about what services they can and cannot offer. This lack of clarity on the issue puts both service providers and service users at a considerable disadvantage and, in the case of service users, could have a serious negative effect on their wellbeing.

---

<sup>11</sup> Personal communication with Janet Gaynor, Health Promotion, HSE West, 22.03.06.

<sup>12</sup> For example see the Cluedup and Spunout websites: <http://www.cluedup.ie>, <http://www.spunout.ie>.

# Sexual Health Promotion

The WHO identifies five domains for sexual health promotions: health, education, political, economic and legal (2004), highlighting the fact that sexual health is a very complex issue and intrinsically linked with many other facets of one's life. For each of these domains, six underlying key principles are also outlined:

- Awareness of the importance of gender and gender-related power dynamics in influencing sexual health;
- Recognition of, and respect for, diversity;
- Promotion of respect of the rights of individuals;
- Participation of all, including the most vulnerable and marginalised, in activities to promote sexual health;
- Awareness of the need to address both risk and vulnerability; and
- Working with social norms to create an environment that supports sexual health.

A systematic review of the effectiveness of non-clinical interventions carried out in Britain (Ellis and Grey, 2004) also found 'sufficient level'<sup>13</sup> evidence to conclude that interventions are more likely to be effective if they include the following features:

- Use of theoretical models in developing interventions
- Targeted and tailored (in terms of age, gender, culture, etc), making use of needs assessment or formative research
- Provision of basic, accurate information through clear, unambiguous messages
- Use of behavioural skills training, including self-efficacy.

Multi-component interventions, i.e. those that address a range of personal and structural determinants of risk simultaneously, were also found to be the most efficient.

## SEX EDUCATION

The same review also found sufficient evidence to conclude that school based education can be effective in reducing adolescent sexual risk behaviour (Ellis and Grey, 2004). Other studies have also shown that initiating prevention when teenagers are still sexually naïve, before patterns of risky sexual behaviour are firmly established, is likely to be more effective than trying to change established behaviours in older adults (Cowan, 2002). Moreover, there is little evidence to support the view that sex education (either abstinence or sexuality based) encourages sexual experimentation or increased sexual activity. Not only that, but school-based education has been found to be more effective when sex positive, that is, if education does not focus solely on delaying or abstaining from sex (Weaver, Smith and Kippax, 2005).

As seen earlier, the current RSE programme in Ireland needs to be considerably improved, but also it needs to ensure that the information provided is not gender-biased but caters for the knowledge needs of students in a gender-balanced and sensitive manner. Similar programmes must also be provided in appropriate community settings for early school leavers.

---

<sup>13</sup> Defined as clear evidence/conclusions from at least one Category 1 review, with no conflicting conclusions between Category 1 reviews. Category 1 reviews were those that were deemed systematic, transparent, analytically sound and relevant.

## INFORMATION

Information on STI and sexual health in general should also be available to young people outside of the school environment. International and Irish studies show that patterns of information seeking are also affected by gender (Schubotz, Simpson and Rolston, 2002; Murphy-Lawless, Oaks and Brady, 2004; SSHA, 2004). Young women often discuss matters related to relationships and sexual health among their peer group and are more at ease asking questions about these matters to their parents, especially their mothers. Moreover, due to young women's greater contact with health professional, these also represent a source of information for them. Young men, on the other hand, find discussing these issues much more problematic, as they are afraid to be considered ignorant and inexperienced by their peers, and are less likely to voice their concerns with their parents. As a consequence, they are more likely to seek information through impersonal media, such as the TV, but especially nowadays on the internet.

Helplines also have a vital role to play in providing advice as their anonymity encourages people to seek help. Ireland has a Drugs/HIV Helpline, which also receives queries in relation to STIs. Statistics from all calls between 2002 to 2004 where caller gender is known show that 45% of callers were male<sup>14</sup>. However, 60% of calls related to HIV and sexual health were from males ringing with personal concerns. This compares sharply with the calls about substance use over the same period where only 21% of calls were from males ringing about themselves. This indicates the appeal of anonymous helpline services for males when addressing their sexual health concerns. The Helpline is currently open from Monday to Friday from 10am to 5pm. These hours need to be extended in order to increase its accessibility to a broad range of users. Its availability should also be more broadly advertised so that

more people become aware of its existence and are able to use it to obtain information.

Hence, any information strategy needs to be aware of the gender specific information seeking behaviour of young people and try to cater for them. In relation to young men, especially, a greater effort should be made to provide information in an innovative unthreatening way, such as through specific health promotion events in the community.

---

<sup>14</sup> Personal communication with Aileen Dooley, Helpline Manager, 06.04.2006

## STI Services

Common barriers to accessing information and prevention services in the UK have been found to be: stigma, discrimination, poverty and social exclusion, language, access problems, low level of awareness and, especially for young people, fears about confidentiality (Department of Health, 2001). These issues are likely to be also relevant to the Irish setting and need to be addressed if STI incidence and prevalence rates are to decrease. While we do not have information on the barriers for the general population, data from Transition Year Fora in the Eastern Region, identified four major barriers in terms of accessing health services. These were knowledge, cost, confidentiality and geographical location (Prendiville, 2003). Students stated that they simply did not have the knowledge about the services that were available to them and were unsure of where they could find out such information. They felt tied by their lack of knowledge and money to using mainstream health care. They raised issues of how to use such services without either asking their parents for their medical card or money to pay the fees. They felt that their confidentiality would be compromised by using the same health services as their parents. Similar issues were also identified during a consultation with young people in the North West (North Western Health Board, 2004).

While the ability to access information might increase with age, and fear of breach of confidentiality subside past the age of sexual consent, the issue of cost persists as an issue even in research carried out amongst older women (Murphy-Lawless, Oaks and Brady, 2004). Condoms in Ireland are amongst the most expensive in Europe (Department of Health and Children, 2000a) and they are currently taxed at 21%, the highest rate of VAT (IFPA, 2006). The current cost is prohibitive for many young people and those on lower incomes. Also in terms of screening and treatment, cost can be a problem. While some STI clinics linked to hospitals are free, such as the GUIDE Clinic in Dublin, the prices of a visit to the GP can deter many people who do not qualify for a medical card. If the current rise in STIs is to be reversed, community sexual health clinics must be able to deliver free or subsidised health care and contraception, including condoms,

especially in more disadvantaged areas. The availability of free condoms would also attract young men, who, as we have seen, are particularly hard to reach by sexual health services.

Geographical availability is also limited in Ireland. Many people and particularly teenagers prefer not to use their usual or family GP for sexual health matters due to embarrassment or fear of breach of confidentiality. However, specialised sexual health services are scarce outside of the main urban centres. Because of the persistent issues of high costs and poor accessibility, family planning services were mentioned as an area of concern by the UN Committee on the Elimination of Discrimination Against Women at Ireland's last review (2005). They called on the government to strengthen family planning services, ensuring availability to all women and men, young adults and teenagers.

From a gender perspective, different types of services have also targeted women and men differently and sometimes in contradictory ways. For instance, family planning services have focused less on the needs of men, while STI clinics have been less sensitive to the needs of women (Wong et al., 2004). Men often perceive family planning services to be for 'women only', and women whose partners accompany them to these clinics often find themselves excluded or marginalised from the consultation process. Moreover, the old fashioned name of 'family planning' clinic has now become unattractive even to young women, who, for the most part, are not planning to start a family and do not perceive their services as relevant (Murphy-Lawless, Oaks and Brady, 2004). Therefore, sexual health clinics, covering contraception, STIs, sexual dysfunction and any other relevant health issue, should be established nation-wide and presented in such a way to appeal to both men and women in gender balanced way. The new Primary Care Centre in Ballymun, which opened in March 2006, has followed this model and includes a sexual health clinic (Inside Government Magazine, 2006). It is hoped that with the implementation of the Primary Care Strategy more such units will become available throughout Ireland.

## PRIMARY CARE

As illustrated by the example above, primary care has an important role to play in relation to STIs. The *Report on HIV/STI Services* (Department of Health and Children, 2005a) states that despite the fact that GPs have a valuable role to play in certain aspects of the delivery of STI services, they generally prefer to refer patients to a specialist centre. This attitude is reflected in an English study which found that GPs and practice nurses do not address sexual health issues proactively with patients as they feel that they would be opening a 'can of worms' due to their sensitivity and complexity (Gott et al., 2004). One of the recommendations from this study is the need for training in this area. The increased need for training in sexual health and especially STIs was also reported among Irish GPs in a study conducted in 2004 by the Irish College of General Practitioners (Ni Riain et al., 2006). Only 54.3% of the GPs surveyed provided a STIs service and the management of STIs was the most popular area for further training, ranked in the top three preferences by more than two thirds of GPs (68%). Moreover, most of the participants agreed that there are barriers to STIs service provision at primary care level. These included: lengthy consultation time, extensive form filling, the necessary turn around time for laboratories, cost to the patient, and lack of cooperation from local specialist service providers. They suggested protocols for liaising with laboratories and specialist clinics should be put in place to improve the current situation. The Care and Management Sub-Committee of the National AIDS Strategy also proposed the adoption of a 'hub and spoke' approach whereby a GP practice could link with a hospital clinic in order to provide efficient comprehensive care. The hospital clinic could then provide practical support in terms of staff and laboratory facilities (Department of Health and Children, 2005a). This set-up would also reduce the pressure on the number of people attending hospital services for routine type of problems that could be satisfactorily dealt with by a GP. Similar recommendations were also made by the GPs surveyed by the HSPC in their recent report on STIs Surveillance (2005e).

Another interesting matter arising from the ICGP study is that practices with a female healthcare professional (either GP or practice nurse) are significantly more likely to provide STIs services and Chlamydia testing than those without. No reasons are given for this finding, but the study by Gott et al. mentioned above found that GPs and practice nurse found it particularly difficult to discuss sexual health matters with patients of the opposite sex. The link between the presence of female staff and the provision of STIs services again points to greater ease that women have in discussing these matters regardless of whether they are service providers or patients. Hence, another aspect of the training to be delivered would be to ensure that male GPs and nurses also become involved in this aspect of service provision and male patients are also asked about their sexual health during consultations.

In relation to other services, especially STIs clinics, the Care and Management Sub-Committee recommended increasing consultant and support services for the all regions and especially the HSE Eastern Region, where STIs incidence rates are highest. They advised that at least one Health Advisor should be available per STIs clinic and the Nurse Practitioner's role should be expanded. They proposed the expansion of laboratory services and an in-depth evaluation of the facilities needed to meet the expanding needs of STIs services. Finally, they suggested that satellite clinics should be developed in a number of locations. The HPSC report also highlighted that no STI clinic is currently in place in the HSE-Midland region or in the HSE-North Eastern Region and this inequity in access should be addressed as a matter of priority (2005e).

## SCREENING

The gender aspects of current screening practices were analysed in detail previously. Here the case will be made for the need to investigate the provision of an asymptomatic Chlamydia screening programme in Ireland. Screening has been described as critical to reducing the hidden STI epidemic (Wong et al., 2004). In their recent report, the Scientific Advisory Committee of the Health Protection Surveillance Centre recommended that

prevalence studies in STIs clinics, general practice, family planning clinics, student health services and antenatal clinics in Ireland, among different age, gender and socio-economic groups should be carried out as a matter of urgency. Furthermore, they strongly recommended that the feasibility, acceptability, likely uptake and effectiveness of screening in various settings in Ireland should be examined as a matter of priority, including the issue of best practice for partner notification and follow up (HPSC, 2005b).

A literature review of screening studies found screening to be cost effective at prevalence of 3.1-10.0% (Honey et al., 2002). The prevalence study advocated by the Scientific Advisory Committee would provide the information required to establish the best screening strategy to be adopted. Considering the results of the localised surveys above, it is clear that some sort of screening seems to be required in Ireland. What the best approach would be, again, could only be determined in light of more in-depth information and consultation with service providers. However, it is crucial that any type of screening programme does not unfairly target women. As already seen, this approach only entrenches existing gender inequalities in the realm of sexual health without providing any long term benefits to the sexual health of the population. Moreover, strict guidelines need to be formulated in terms of who should be targeted for screening. These should be based solely on epidemiological evidence rather than ease of access or any other consideration not reflected in the risk factors of the infection. For Chlamydia, the most commonly cited risk factors are young age (younger than 25) and recent change in sexual partner (HPSC, 2005b). Studies in the USA have shown that despite the presence of national guidelines specifying age as the screening criterion for STIs, screening rates were influenced more by the type

of visit (private or public, and preventative or treatment), race and clinic specialty rather than age (Huppert et al., 2005). It is argued that these screening practices might account for some of the racial disparities in STIs in the USA. Hence, guidelines must be adhered to in order to ensure comprehensive coverage of the target population as well as prevent unfair focus on particular groups of people as 'carriers of disease'.

#### **PARTNER NOTIFICATION**

The Canadian STI Guidelines remind service providers that "they have not treated an STD patient until [they] have ensured management of the partner" (Health Canada, 1998)<sup>15</sup>. In fact, partner notification is key to the reduction of STI infection and especially the re-infection of the primary patient. As seen earlier, gender power imbalances play an important role in this dynamic, and women are often afraid to communicate a positive test result to a partner for fear of being blamed of promiscuity. For this reason, service providers should develop a system of partner notification which does not blame the person but provide a broad range of possible causes for infection as well as highlight the fact that some infections can remain dormant for many years. A review of evidence found that provider referral, i.e. when it is the provider who contacts the relevant current and previous partners to alert them to the need to attend for screening, is more effective than patient referral (Ellis and Grey, 2004). A Cochrane review of strategies for partner notification also found moderately strong evidence that provider referral alone, or choice between patient and provider referral, when compared with patient referral alone increases the rate of partners presenting for medical evaluations (Mathew et al., 2001). The review also found that verbal health education provided by a nurse along with patient-centred counselling results in small increases in the rate of partners treated.

---

<sup>15</sup> Worryingly Irish GPs participating in a focus group organised by the HSPC in 2004 expressed the view that GPs do not routinely engage in partner notification and considered it outside the scope of general practice (HPSC, 2005e).

# Research & Data Collection

Any strategy to combat the rise of STIs in Ireland and effectively promote sexual health needs to be based on strong qualitative and quantitative evidence. At the moment, data available in many of the relevant areas is scant and this situation needs to be rectified. The forthcoming publication of the first Irish survey of attitudes, knowledge and behaviour in sexual health will be a great asset in providing up to date information across gender, age groups and socio-economic circumstances. The adoption of a longitudinal Community Health Survey, with a specific section dedicated to sexual health, would also provide much needed information on this topic across the population (Hansen et al., 2004). Any new research project of this kind must also include gender sensitive analysis of the data. Qualitative research must also be undertaken in order to document and understand the gender dynamics which underpin all aspects of sexual health, from information seeking, to contraceptive behaviour to access to treatment.

It is paramount that greater resources are also put into the documenting of prevalence rates of STIs in Ireland. At the moment, only incidence rates are available, and, as many STIs are asymptomatic, these represent a considerable underestimation of the total burden of disease in the population. Moreover, current surveillance systems are still underdeveloped with many GP practices and laboratories not feeding into the national surveillance system. The Health Protection Surveillance Centre report on *Surveillance of STIs* (2005e) made a number of specific recommendations to improve the situation in this area, such as the need for the collection of person or case-based reports including demographic, clinical and risk factor information to inform prevention and treatment strategies; the standardisation of the notification process for all hospital and general practice clinics as well as laboratories; and the need to expand and develop services especially at primary level.

In order to tackle the current gender imbalance in prevention methods, research into female controlled contraception must also be promoted. While female

condoms are now available, their uptake has been low due to poor levels of acceptability among both women and men. Hence, more needs to be done to develop this promising new barrier method, which as the potential of enabling women to take greater control over their own protection from infection. The development of effective microbicides would also offer women considerable benefits by allowing them to protect themselves without needing the cooperation of their partner. Microbicides delivered in long-acting or sustained release formulations could be applied many hours or even days prior to sexual relations so that they would not interfere with sex (DCI, 2004). Various clinical trials are now underway, with scientists currently testing many substances for this purpose. The first study to show the activity of a microbicide after application in humans provided very promising results (Aidsmap, 2005). Finally, research into the production of an HPV vaccine must also continue.

## Conclusions

Sexual health is a very important aspect in everyone's life. In order to attain optimal sexual health, all relevant aspects of it must be appropriately catered for. While sexual health comprises many different facets, this report focused specifically on STIs. Recent years have seen an unprecedented rise in infection rates in Ireland, causing concern but not triggering the necessary policy and service initiatives required to combat it. While STIs can affect everyone, some sections of the population, especially those affected by poverty and social exclusion, have been found to be at particular risk. Biologically, women are at a disadvantage in relation to susceptibility to infection. Moreover, international research has shown that both sexual health in general, and STI infection, are also inextricably linked with gender. Gender inequalities play a significant role in the ability of women to negotiate safe sex practices and protect themselves from STIs. National discourses linked with Ireland's restrictive abortion laws have caused the issue of crisis pregnancy to overshadow sexual health promotion in general. Both women and men are primarily focused on using contraception that will prevent pregnancy rather than protect them from STIs. Cultural models that assign the responsibility of contraception to women have fostered a social environment in which men are not expected or encouraged to engage with sexual health promotion. This approach places an unfair burden of responsibility on women, but also entrenches men's fear and unease at dealing with their sexual health and other health matters.

Statistics on sexually transmitted infections in Ireland, as mentioned, have increased at staggering rates. However, gender ratios are approximately even. This, though, seems to point more to the higher incidence amongst men who have sex with men, rather than provide an accurate picture of STI prevalence in Ireland by gender.

Following on from this analysis, the Women's Health Council strongly advocates the adoption of a gender sensitive approach to sexual health in general and STI prevention and screening in particular. While the forthcoming national sexual health strategy is eagerly

awaited, this will not be as effective as hoped if it fails to incorporate the basic understanding that gender, just like age, socio-economic status, and ethnicity, for instance, is a key determinant of health. The forthcoming national survey on sexual knowledge, attitudes, and behaviours will provide evidence as to whether internationally documented gender differences also prevail in Ireland. Smaller research studies carried out to date strongly support this proposition. Hence, any measure or initiative stemming from the strategy must be gender sensitive in order to be effective in the long term. Measures that target women only have shown not to be successful, as they do not address the gender power relations, nor impact on men's own sexual health behaviour. Recognition that men have a 'crucial' role to play in sexual health promotion was first suggested at the International Conference on Population and Development in Cairo (United Nations, 1994). Since then efforts to involve men in sexual health have intensified in many parts of the world, but are still limited in Ireland.

Ultimately, the achievement of gender equality in other areas of their lives, such as employment, education and social care, will empower women to demand gender equality in sexual health. Until then, it is vital that policy makers and service providers counterbalance women's greater susceptibility not by putting an unfair burden on them, but by ensuring that all sexually active men and women take responsibility for their sexual health behaviours.

# Recommendations

## POLICY & LEGISLATION

- A national sexual health strategy to be published and implemented as a matter of urgency. This strategy should be evidence-based, gender- and culturally-sensitive.
- Revised legal and practical guidelines to be issued in relation to age of sexual and medical consent to ensure ease of access to services by teenagers.
- Gender equality in sexual health and all other aspects of life to be promoted by policy makers and service providers.

## PREVENTION

- Sex education programmes to be delivered in a comprehensive, gender-sensitive way in schools and community centres.
- Information on sexual health and sexual health services to be available in many easily accessible forms through service providers, community centre, helplines and internet websites.

## SERVICES

- Provision of sexual health services at primary level to be expanded and linked with specialist and laboratory services in an integrated approach.
- Cost for all services and contraception to be reduced.

## RESEARCH & DATA COLLECTION

- A prevalence study of STIs in Ireland to be conducted to inform needed screening programmes.
- Research into effective sexual health promotion strategies to be conducted.
- Financial and practical support for research into female-controlled contraceptive methods to be delivered by government.

## References

- Aidsmap (2005) *Microbicide gel can prevent HIV and herpes infection of human cells*.  
<http://www.aidsmap.com/en/news/C14928FA-B490-48A6-A5F0-D3B967609719.asp>  
accessed on 09.12.2005.
- Aral, S. O., Hawkes, S., Biddlecom, A. and Padian, N. (2004) 'Disproportionate Impact of Sexually Transmitted Diseases on Women'. *Emerging Infectious Diseases*, 10 (11).  
[www.cdc.gov/ncidod/vol110no11/04-0623\\_02.htm](http://www.cdc.gov/ncidod/vol110no11/04-0623_02.htm)
- Bailey, J. V., Farquhar, C., Owen, C. and Mangtani, P. (2004) 'Sexually transmitted infections in women who have sex with women'. *Sexually transmitted infections*, 80, Pg. 244-246.  
<http://sti.bmjournals.com/cgi/context/full/80/3/244>
- Berer, M. (1997) 'Dual Protection: making sex safer for women' In *Beyond Acceptability: users' perspectives on contraception*. (Eds, Sundari Ravindran, T. K., Berer, M. and Cottingham, J.). London: Reproductive Health Matters for the World Health Organisation.
- Burckhardt, F., Warner, P. and Young, H. (2006) 'What is the impact of change in diagnostic test method on surveillance data trends in *Chlamydia trachomatis* infection?' *Sexually Transmitted Infections*, 82, pg. 24-30.
- CEDAW Committee (2005) *Concluding Comments: Ireland*. New York: United Nations.  
<http://www.un.org/womenwatch/daw/cedaw/cedaw33/conclude/ireland/0545060E.pdf>
- CMO Expert Advisory Group (1998) *Main report of the CMO's expert advisory group on Chlamydia trachomatis*. London: Department of Health.
- Commonwealth of Australia (2005) *National Sexually Transmitted Infections Strategy 2005-2008*. Canberra.
- Cook, R. L. and Clark, D. B. (2005) 'Is there an association between alcohol consumption and sexually transmitted diseases? A systematic review'. *Sexually Transmitted Infections*, 32 (3), pg. 156-164.
- Couldwell, D. L. (2005) 'Management of unprotected sexual encounters'.  
*Medical Journal of Australia*, 183 (10), pg. 525-528.
- Cowan, F. M. (2002) 'Adolescent reproductive health interventions'.  
*Sexually Transmitted Infections*, 78, pg 315-318.
- Crisis Pregnancy Agency (2003) *Strategy to address the issue of crisis pregnancy 2004-2006*. Dublin: Crisis Pregnancy Agency.  
[http://www.crisispregnancy.ie/pub/CPA-Strategy\\_doc.pdf](http://www.crisispregnancy.ie/pub/CPA-Strategy_doc.pdf)

Crisis Pregnancy Agency (2005) *Research on Teenage Sexuality*. Vol.1, Issue 1.  
<http://www.crisispregnancy.ie/pub/realparents.pdf>

CSO (2004) *Women and Men in Ireland*. Dublin: The Stationery Office.  
[http://www.cso.ie/releasespublications/documents/other\\_releases/2004/womenandmeninireland2004.pdf](http://www.cso.ie/releasespublications/documents/other_releases/2004/womenandmeninireland2004.pdf)

CSO (2005) *EU Survey on Income and Living Conditions 2004*. Dublin: Central Statistics Office.

DCI (2004) *New preventive technologies: providing new options to stop the spread of HIV/AIDS*. Dublin: Development Cooperation Ireland.

Delamere, S., King, A., Clark, S. and Mulcahy, F. (2003) *Evaluation of STI Diagnosis at a Young Persons Clinic*. Dublin: GUIDE Clinic, St. James's Hospital.

Department of Health (2001) *Better prevention. Better services. Better sexual health. The national strategy for sexual health and HIV*. London: Department of Health.

Department of Health (2002) *The national strategy for sexual health and HIV implementation action plan*. London: Department of Health.

Department of Health and Children (1997) *A Plan for Women's Health 1997-1999*. Dublin: The Stationery Office.

Department of Health and Children (2000a) *Aids Strategy 2000: Report of the National AIDS Strategy Committee*. Dublin: The Stationery Office.  
[http://www.dohc.ie/publications/aids\\_strategy\\_2000.html](http://www.dohc.ie/publications/aids_strategy_2000.html)

Department of Health and Children (2000b) *The National Health Promotion Strategy 2000-2005*. Dublin: The Stationery Office.  
[http://www.dohc.ie/publications/national\\_health\\_promotion\\_strategy.html](http://www.dohc.ie/publications/national_health_promotion_strategy.html)

Department of Health and Children (2001a) *Primary care - A new direction*. Dublin: The Stationery Office.  
[http://www.dohc.ie/publications/primary\\_care\\_a\\_new\\_direction.html](http://www.dohc.ie/publications/primary_care_a_new_direction.html)

Department of Health and Children (2001b) *Quality and Fairness - A health system for you*. Dublin: Stationery Office.  
<http://www.doh.ie/pdfdocs/strategy.pdf>

Department of Health and Children (2004) *Review of the National Health Promotion Strategy*. Dublin: Department of Health and Children.  
[http://www.healthpromotion.ie/uploaded\\_docs/HPU\\_Strategy\\_review.pdf](http://www.healthpromotion.ie/uploaded_docs/HPU_Strategy_review.pdf)

Department of Health and Children (2005a) *Report by the Care and Management Sub-Committee of the National AIDS Strategy Committee on HIV/STI services in Ireland*.

Dublin: Department of Health and Children.

[http://www.dohc.ie/publications/care\\_and\\_management\\_sub\\_committee.html](http://www.dohc.ie/publications/care_and_management_sub_committee.html)

Department of Health and Children (2005b) *Statement of Strategy 2005-2007*. Dublin: Department of Health and Children.

[http://www.dohc.ie/publications/statement\\_of\\_strategy\\_2005\\_2007.html](http://www.dohc.ie/publications/statement_of_strategy_2005_2007.html)

Donnellan, E. (2005) 'Study finds third of schools poor at sex education'. *Irish Times*. 13th September 2005

<http://www.ireland.com/newspaper/ireland/2005/0923/3382478951HM8SEXEDUCATION.html>

Dublin Well Woman (2004) *HPV Prevalence Study*. Dublin: Dublin Well Woman & Royal College of Surgeons in Ireland.

[http://www.wellwomancentre.ie/docs/HPV\\_Research\\_Summary.pdf](http://www.wellwomancentre.ie/docs/HPV_Research_Summary.pdf)

Dublin Well Woman Centre (2006) *Annual Report 2005*. Dublin: Dublin Well Woman Centre.

Duncan, B. and Hart, G. (1999) 'Sexuality and health: the hidden costs of screening for Chlamydia trachomatis'. *British Medical Journal*, 318, pg. 931-933.

<http://bmj.com/cgi/content/full/318/7188/931>

Duncan, B., Hart, G., Scoular, A. and Bigrigg, A. (2001) 'Qualitative analysis of psychosocial impact of diagnosis of Chlamydia trachomatis: implications for screening'. *British Medical Journal*, 322, pg. 195-199.

<http://bmj.com/cgi/content/full/322/7280/195>

EIWH (2006) *Women's Health in Europe*. Dublin: European Institute of Women's Health. [http://www.eurohealth.ie/pdf/WomenshealthinEurope\\_FINALpdf.pdf](http://www.eurohealth.ie/pdf/WomenshealthinEurope_FINALpdf.pdf)

Ellis, S. and Grey, A. (2004) *Prevention of sexually transmitted infections (STIs): a review of reviews into the effectiveness of non-clinical interventions*. London: NHS Health Development Agency.

[www.hda.nhs.uk/evidence](http://www.hda.nhs.uk/evidence)

EuroHIV (2005) *HIV/AIDS Surveillance in Europe. End-year report 2004*. Saint-Maurice: Institut de veille sanitaire. No 71. [http://www.eurohiv.org/reports/report\\_71/pdf/report\\_eurohiv\\_71.pdf](http://www.eurohiv.org/reports/report_71/pdf/report_eurohiv_71.pdf)

Evans, A. (2000) 'Power and negotiation: young women's choices about sex and contraception'. *Journal of Population Research*, Nov.

[http://www.findarticles.com/articles/mi\\_m0PCG/is\\_2\\_17/ai\\_105657390/print](http://www.findarticles.com/articles/mi_m0PCG/is_2_17/ai_105657390/print)

Fenton, K. A. and Lowndes, C. M. (2004) 'Recent trends in the epidemiology of sexually transmitted infections in the European Union'. *Sexually Transmitted Infections*, 80, pg. 255-263.

<http://sextrans.bmjournals.com/cgi/content/full/80/4/255>

Geary, T. and Mannix McNamara, P. (2003) *Implementation of Social, Personal and Health Education at Junior Cycle*. Limerick: University of Limerick. Report Commissioned by the SPHE Support Service.

<http://www.sphe.ie/review1.pdf>

Gott, M., Galena, E., Hinchliff, S. and Elford, H. (2004) "'Opening a can of worms": GP and practice nurses barriers to talking about sexual health in primary care'. *Family Practice*, 21 (5), pg. 528-536.

Gregoire, A. (1999) 'ABC of sexual health: assessing and managing male sexual problems'. *British Medical Journal*, 318, pg. 315-317.

<http://bmj.com/cgi/content/full/318/7179/315>

Hansen, L., Mann, J., McMahon, S. and Wong, T. (2004) 'Sexual Health'. *BMC Women's Health*, 4 (Suppl 1).

<http://www.biomedcentral.com/1472-6874/4/S1/S24>

Hart, G., Duncan, B. and Fenton, K. A. (2002) 'Chlamydia screening and sexual health'. *Sexually Transmitted Infections*, 78, pg. 396-397.

<http://sti.bmjournals.com/cgi/content/full/78/6/396>

Health Canada (1998) *Highlights 1998 Edition of the Canadian STD Guidelines*. Ottawa: Health Canada.

<http://www.phac-aspc.gc.ca/publicat/std-mts98hls/pdf/std98hte.pdf>

Health Promotion Unit (2005) *STIs - Sexually Transmitted Infections. What? Who? How? Help!* Dublin: Health Promotion Unit.

Health Promotion Unit (2006) *Sexual Health Promotion*.

[http://www.healthpromotion.ie/topics/sexua\\_health\\_promotion/?print=1](http://www.healthpromotion.ie/topics/sexua_health_promotion/?print=1)  
accessed on 09.01.2006.

Health Service Executive (2005a) *Corporate Plan 2005-2008*. Naas: Health Service Executive.

<http://www.hse.ie/en/Publications/HSEPublications/FiletoUpload,2602,en.pdf>

Health Service Executive (2005b) *National Service Plan 2006*. Naas: Health Service Executive.

<http://www.hse.ie/en/Publications/HSEPublications/FiletoUpload,2829,en.pdf>

Health Service Executive (2005c) *Sexual Health Strategy: promoting sexual health and well-being in the Midland Area*. Naas: Health Service Executive.

Hoffman, S., Mantell, J., Exner, T. and Stein, Z. (2004) 'The future of the female condom'. *International Family Planning Perspectives*, 30 (3), pg. 139-145.

Honey, E., Augood, C., Templeton, A., Russell, I., Paavonen, J., Mardh, P.-A., Stary, A. and Stray-Perdersen, B. (2002) 'Cost effectiveness of screening for *Chlamydia trachomatis*: a review of published studies'. *Sexually Transmitted Infections*, 78, pg. 406-412.

<http://sextrans.bmjournals.com/cgi/content/full/78/9/406>

Hope, A., Dring, C. and Dring, J. (2005) *College Lifestyle and Attitudinal National (CLAN) Survey*. Dublin: Health Promotion Unit.

HPSC (2005a) *Annual Report 2004*. Dublin: Health Protection Surveillance Centre.

HPSC (2005b) *The Need for Chlamydia Screening in Ireland*. Dublin: Health Protection Surveillance Centre.

<http://www.ndsc.ie/A-Z/HepatitisHIVAIDSandSTIs/SexuallyTransmittedInfections/Chlamydia/Publications/File,1392,en.pdf>

HPSC (2005c) *Newly diagnosed HIV infections in Ireland. Quarter 3 & 4 2004 and Annual Summary 2004*.

Dublin: Health Surveillance Protection Centre.

<http://www.hpsc.ie/A-Z/HepatitisHIVAIDSandSTIs/HIVandAIDS/Publications/2004/File,1128,en.pdf>

HPSC (2005d) *Sexually Transmitted Infections 2004 - Annual Summary Report*. Dublin: Health Protection Surveillance Centre.

HPSC (2005e) *Surveillance of STIs: a report by the Scientific Advisory Committee of the HPSC*. Dublin: Health Protection Surveillance Centre.

HSE Eastern Region (2005) *The Sexual Health Strategy*. Dublin: HSE Eastern Region.

Hug, C. (1999) *The politics of sexual morality in Ireland*. London: Palgrave Macmillan.

Hughes, C. and Evan, A. (2003) 'Health needs of women who have sex with women'. *British Medical Journal*, 327, pg. 939-940.

<http://bmj.com/cgi/content/full/327/7421/939>

Huppert, J. S., Goodman, E., Khoury, J. and Slap, G. (2005) 'Sexually transmitted infection testing and screening in hospital-based primary care visits by women'. *Obstetrics and Gynecology*, 108 (2), pg. 390-396.

Hyde, A. and Howlett, E. (2004) *Understanding teenage sexuality in Ireland*. Dublin: Crisis Pregnancy Agency.

<http://www.crisispregnancy.ie/pub/No.9-Reportinterior.pdf>

Hyde, A., Howlett, E., Drennan, J. and Brady, D. (2005) 'Masculinities and young men's sex education needs in Ireland: problematising client-centred health promotion approaches.' *Health Promotion International*, 20 (4), pg. 334-340.

IFPA (2006) *Family Planning Association Call for Reduction in Condom Tax*. Press Release.  
<http://www.ifpa.ie/news/index.php?mr=118>

Inglis, T. (1998) *Lessons in Irish Sexuality*. Dublin: University College Dublin Press.

Inside Government Magazine (2006) 'HSE to open new innovative Ballymun Primary Care Centre.' *Inside Government Magazine*, (February), pg. 28.

Jones, C. P., Ogbara, T. and Braveman, P. (2004) 'Disparities in infectious diseases among women in developed countries.' *Emerging Infectious Diseases*, 10 (11).  
[http://www.cdc.gov/ncidod/EID/vol10no11/04-0624\\_08.htm](http://www.cdc.gov/ncidod/EID/vol10no11/04-0624_08.htm)

Kaiser Network (2006) *FDA announces approval of HPV vaccine Gardasil*.  
[http://www.kaisernetwork.org/daily\\_reports/print\\_report.cfm?DR\\_ID=37807&dr\\_cat=2](http://www.kaisernetwork.org/daily_reports/print_report.cfm?DR_ID=37807&dr_cat=2) accessed on 12.06.2006.

Kulczycki, A., Kim, D., Duerr, A., Jamieson, D. J. and Macaluso, M. (2004) 'The acceptability of the female and male condom: a randomised crossover trial.' *Perspectives on Sexual and Reproductive Health*, 24 (3), pg. 114-119.  
<http://www.guttmacher.org/pubs/journals/3611404.pdf>

LaMontagne, D. S., Fenton, K. A., Randall, S., Anderson, S. and Carter, P. (2004) 'Establishing the National Chlamydia Screening Programme in England: results from the first full year of screening.' *Sexually Transmitted Infections*, 80, pg. 335-341.  
<http://sti.bmjournals.com/cgi/content/full/80/5/335>

Layte, R., Fullerton, D. and McGee, H. (2003) *Scoping Study for National Survey of Knowledge, Attitudes and Behaviours*. Unpublished Document. Dublin: Economic and Social Research Institute.

Low, N. and Egger, M. (2002) 'What should we do about screening for genital chlamydia?' *International Journal of Epidemiology*, 31, pg. 891-893.  
<http://ije.oxfordjournals.org/cgi/reprint/31/5/891>

Low, N., McCarthy, A., Roberts, T. E., Huengsberg, M., Sandford, E., Sterne, J. A. C., Macleod, M., Salisbury, C., Pye, K., Holloway, A., Morcom, A., Patel, R., Robinson, S. M., Horner, P., Barton, P. M. and Egger, M. (2006) 'Partner notification of chlamydia infection in primary care: randomised controlled trial and analysis of resource use.' *British Medical Journal*, 332, pg. 14-19.  
<http://bmj.com/cgi/content/full/332/7532/14>

Lyons, F. (2005) *Chlamydia screening: the international experience*.

[http://www.icgp.ie/assets/56/0C5C6564-7DE1-4D8F-BF8773E2DC6FF541\\_document/Chlamydia%20-%20WH%20Conf%20June%202005.pdf](http://www.icgp.ie/assets/56/0C5C6564-7DE1-4D8F-BF8773E2DC6FF541_document/Chlamydia%20-%20WH%20Conf%20June%202005.pdf) accessed on 15.03.2006.

Lyons, F., Mulcahy, F. and Bergin, C. (2001) 'Screening for Genital Chlamydia trachomatis Infection in Women'. *EPI-Insight*, 2 (1), pg. 2-3.

<http://www.ndsc.ie/EPI-Insight/Volume22001/File,637,en.pdf>

Mahon, E., Conlon, C. and Dillon, L. (1998) *Women and Crisis Pregnancy. A Report Presented to the Department of Health and Children*. Dublin: The Stationery Office.

Marrazzo, J. M., Coffey, P. and Bingham, A. (2005) 'Sexual practices, risk perception and knowledge of sexually transmitted disease risk among lesbian and bisexual women'. *Perspectives on Sexual and Reproductive Health*, 31 (1), pg. 6-12.

Mathew, C., Coetzee, N., Zwarenstein, M., Lombard, C., Guttmacher, S., Oxman, S. and Schmid, G. (2001) *Strategies for partner notification for sexually transmitted diseases (Review)*. The Cochrane Database of Systematic Reviews. Issue 4. Art. No.: CD002843. DOI:10.1002/14651858.CD002843.

Maycock, P. and Byrne, T. (2004) *A study of sexual health issues, attitudes and behaviours: the views of early school leavers*. Dublin: Crisis Pregnancy Agency.

<http://www.crisispregnancy.ie/pub/No.8-Reportinterior.pdf>

McGee, H., Garavan, R., de Barra, M., Byrne, J. and Conroy, R. (2002) *The SAVI Report: a national study of Irish experiences, beliefs and attitudes concerning sexual violence*. Dublin: The Dublin Rape Crisis Centre.

McMahon, S., Hansen, L., Mann, J., Sevigny, C., Wong, T. and Roache, M. (2004) 'Contraception'. *BMC Women's Health*, 4 (Suppl 1), S25.

<http://www.biomedcentral.com/1472-6874/4/S1/S25>

McNair, R. P. (2003) 'Lesbian health inequalities: a cultural minority issue for health professionals'. *Medical Journal of Australia*, 183 (10), Pg. 502-503.

Mindel, A. and Kippax, S. (2005) 'A nationally sexually transmissible infections strategy: the need for an all-embracing approach'. *Medical Journal of Australia*, 183 (10), pg. 502-503.

Morgan, M. (2000) *Relationships and Sexuality Education. An Evaluation and Review of Implementation*. Dublin: The Stationery Office.

Murphy-Lawless, J., Oaks, L. and Brady, C. (2004) *Understanding how sexually active women think about fertility, sex and motherhood*. Dublin: Crisis Pregnancy Agency.

<http://www.crisispregnancy.ie/pub/Rep6.pdf>

National Chlamydia Screening Steering Group (2004) *First steps. Annual report of the National Chlamydia Screening Programme in England, 2003/04*. London: Department of Health.

National Chlamydia Screening Steering Group (2005) *Looking back, moving forward. Annual report of the NCSP in England, 2004/05*. London: Department of Health.

National Consultative Committee on Health Promotion (1999) *Youth as a Resource*. Dublin: Department of Health and Children.

National Women's Council of Ireland (2003) *A Woman's Model for Social Welfare Reform*. Dublin: National Women's Council of Ireland.

<http://www.nwci.ie/documents/swr.doc>

NDSC (2002) *Annual Report 2001*. Dublin: National Disease Surveillance Centre.

<http://www.ndsc.ie/AboutHPSC/AnnualReports/File,519,en.pdf>

NDSC (2003) *Annual Report 2002*. Dublin: National Disease Surveillance Centre.

<http://www.ndsc.ie/AboutHPSC/AnnualReports/File,518,en.pdf>

NDSC (2004) *Annual Report 2003*. Dublin: National Disease Surveillance Centre.

<http://www.ndsc.ie/AboutHPSC/AnnualReports/File,952,en.pdf>

Ni Riain, A., Galimberti, R., Burke, S., Collins, C. and Dillon, M. (2006) *Women's Health Services in General Practice: 2004*. Dublin: The Irish College of General Practitioners.

Nicholson, N. (2004) *Getting Inside Men's Health*. Kilkenny: South Eastern Health Board.

North Western Health Board (2004) A little bit of respect. *Sexual Health: a consultation with young people, parents and professionals in the North West*. Ballyshannon: Health Promotion Department. North Western Health Board.

Oakeshott, P. (2003) 'Vaginal discharge and sexually transmitted infections' In *Women's Health*. Fifth Edition (Eds, Waller, D. and McPherson, A.). Oxford: Oxford University Press.

O'Donnell, K. and Cronin, M. (2006) 'Voluntary Antenatal HIV Testing in Ireland: 2002 to 2004'. *EPI-Insight*, 7 (5), pg. 4.

Parliamentary Debates (2006) *Sexually Transmitted Diseases: presentation*.

<http://debates.oireachtas.ie/DDebate.aspx?F=HEJ20060406.xml&Node=H2> accessed on 12.04.2006.

Planned Parenthood Federation (2004) *Sexual and Reproductive Health Counselling Guidelines*. Ottawa: Planned Parenthood Federation of Canada.

Powell, J., O'Connor, C., Ó hIarlaithe, M., Saunders, J. and de Freitas, J. (2004) 'Chlamydia trachomatis prevalence in men in the mid-west of Ireland.' *Sexually Transmitted Infections*, 80, pg. 349-353.  
<http://sti.bmjournals.com/cgi/content/full/80/5/349>

Prendiville, J. (2003) *A review of the literature into the need for and effectiveness of young people's sexual health services*. Cork: Southern Health Board.

Rundle, R., Leigh, C., McGee, H. and Layte, R. (2004) *Irish Contraception and Crisis Pregnancy (ICCP) Study: a survey of the general population*. Dublin: Crisis Pregnancy Agency.  
<http://www.crisispregnancy.ie/pub/Repseven.pdf>

Sangani, P., Rutherford, G. and Wilkinson, D. (2004) *Population-based interventions for reducing sexually transmitted infections, including HIV infection*. The Cochrane Database of Systematic Reviews 2004, Issue 3. Art. No.: CD001220.pub2. DOI:10.1002/14651858.CD001220.pub2.

Schubotz, D., Simpson, A. and Rolston, B. (2002) *Towards Better Sexual Health: a survey of sexual attitudes and lifestyles of young people in Northern Ireland*. Family Planning Association: London.

Shepherd, J., Weston, R., Peersman, G. and Napuli, I. Z. (2005) 'Interventions for encouraging sexual lifestyles and behaviours intended to prevent cervical cancer.' *The Cochrane Database of Systematic Reviews*, Issue 4 (Art.No.: CD001035. DOI: 10.1002/14651858.CD001035).

Southern Health Board (2001) *Strategy to Promote Sexual Health 2001-2011*. Cork: Southern Health Board.  
<http://www.hse.ie/en/Publications/HSEPublications/FiletoUpload,2829,en.pdf>

SSHA (2004) *The Manual of Sexual Health Advisers*. London: Society of Sexual Health Advisers. [http://www.ssha.info/public/manual/ha\\_manual\\_2004\\_complete.pdf](http://www.ssha.info/public/manual/ha_manual_2004_complete.pdf)

UNAIDS (2005) *AIDS epidemic update: December 2005*. Geneva: UNAIDS.  
[http://www.unaids.org/epi/2005/doc/EPIupdate2005\\_pdf\\_en/epi-update2005\\_en.pdf](http://www.unaids.org/epi/2005/doc/EPIupdate2005_pdf_en/epi-update2005_en.pdf)

UNAIDS, UNFPA and UNIFEM (2004) *Women and HIV/AIDS: confronting the crisis*. New York: UNAIDS, UNFPA, UNIFEM.  
[http://genderandaids.org/downloads/conference/308\\_filename\\_women\\_aids1.pdf](http://genderandaids.org/downloads/conference/308_filename_women_aids1.pdf)

Unger, E. R. and Barr, E. (2004) 'Human papillomavirus and cervical cancer.' *Emerging Infectious Diseases*, 10 (11).  
[www.cdc.gov/ncidod/vol110no11/04-0623\\_09.htm](http://www.cdc.gov/ncidod/vol110no11/04-0623_09.htm)

United Nations (1994) *International Conference on Population and Development*.  
<http://www.un.org/popin/icpd2.htm> accessed on 27.07.2005.

Weaver, H., Smith, G. and Kippax, S. (2005) 'School-based sex education policies and indicators of sexual health among young people: a comparison of the Netherlands, France, Australia and the United States.' *Sex Education: Sexuality, Society and Learning*, 5 (2), pg. 171-178.

WHC & NCRI (2006) *Women and Cancer in Ireland 1994-2001*. Cork: The Women's Health Council and the National Cancer Registry.  
<http://www.whc.ie/publications/WomenCancer.pdf>

WHO (2000) *Women and sexually transmitted infections*.  
<http://www.who.int/mediacentre/factsheets/fs249/en/print.html> accessed on 03.03.2006.

WHO (2002a) *Mainstreaming gender equity in health: the need to move forward*. Copenhagen: World Health Organisation.

WHO (2002b) *Programming for male involvement in reproductive health. Report of the meeting of WHO Regional Advisers in Reproductive Health WHO/PAHO, Washington, USA. 5-7 September 2001*. Geneva: World Health Organisation.

WHO (2004) 'Sexual Health - a new focus for WHO'.  
*Progress in Reproductive Health Research*, 67.  
<http://www.who.int/reproductive-health/hrp/progress/67.pdf>

WHO (2005) *WHO multi-country study on women's health and domestic violence against women: summary report of initial results on prevalence, health outcomes and women's responses*. Geneva: World Health Organisation.

Women's Aid (2001) *Teenage Intolerance: the hidden lives of young Irish people*. Dublin: Women's Aid.

Wong, T., Sigh, A., Mann, J., Hansen, L. and McMahon, S. (2004) *Gender Differences in Bacterial STIs in Canada*. Ottawa: Women's Health Surveillance Report.  
[www.phac-aspc.gc.ca/publicat/whsr-rssf/chap\\_25\\_e.html](http://www.phac-aspc.gc.ca/publicat/whsr-rssf/chap_25_e.html)

# Appendix 1: Sexual Health Policies and Strategies in Ireland

## NATIONAL POLICIES – DEPARTMENT OF HEALTH AND CHILDREN

The publication of *A Plan for Women's Health 1997-1999* (Department of Health and Children, 1997) was the first specific policy looking at taking gender considerations into account in health policy in Ireland. In the section dedicated to 'Family Planning and Reproductive Health', the document identified the need to 'improve availability of family planning services' to 'contribute to women's overall well-being by enabling them to make informed choices about their sexuality and fertility'. Family planning services should provide information and advice on sexually transmitted diseases and their impact on women's reproductive health. In order to do so, the Department would review the implementation of the family planning guidelines to ensure that services are being provided as recommended.

A few years later, the Department focused on the health needs of young people and especially young people at risk by publishing *Youth as a Resource* (National Consultative Committee on Health Promotion, 1999). This document was based on nationwide consultation process. Sexual health was identified by the participants as one of the most important things in their lives. Girls mainly worried about avoiding pregnancy whereas for boys information on sexual issues was the more pressing issue. In general, young people emphasised the need for provision of anonymous, accessible and youth friendly information and services on sexual health issues with particular reference to greater accessibility to contraception. The recommendations reiterated this need. One other recommendation, which has gender resonance, was the call to promote the importance of the role of men in the development of healthier families and communities.

The *National Health Promotion Strategy 2000-2005* highlighted sexual health as a key health area (Department of Health and Children, 2000b). Objectives under the strategic aim of promoting sexual health and safer sexual practices amongst the population included: support for RSE and SPHE programmes in schools, work in

partnership to develop and implement health promotion initiatives which address the issues in relation to teenage pregnancies, contribution to a reduction in the number of crisis pregnancies, work in partnership to develop and implement strategies aimed at reducing the incidence of STIs, initiation of research into the needs for a national sexual health strategy which would encompass the prevention of STIs and crisis pregnancies, and support for the implementation of the AIDS strategy. While the strategy had specific objectives for women and men's health, none of them were linked specifically to sexual health. The review of this strategy identified sexual health as an area where further progress is needed (Department of Health and Children, 2004). In addition, it recommended the collection of Irish data to provide baseline information to inform the development of effective programmes on sexual health promotion.

In the same year as the National Health Promotion Strategy, the *AIDS Strategy 2000* was also published (Department of Health and Children, 2000a). The document stressed the need for HIV/AIDS awareness to be delivered in the context of the broader areas of sexual health and STIs. However, despite identifying a significant increase in both the number and proportion of HIV cases associated with heterosexual activity, pointing out that the majority of these were women and that women become infected at a younger age, the strategy did not highlight the need for gender sensitive policies as an objective. The strategy also recommended that a national Sexual Knowledge Attitudes and Behaviours study be carried out in line with other European countries in order to inform policy and service provision.

The national health strategy, *Quality and Fairness* (Department of Health and Children, 2001b), mentioned sexual health under Objective 2: the promotion of health and wellbeing is intensified. Action 16 of this objective states that 'measures will be taken to promote sexual health and safe sexual practices'. In order to achieve this, an action plan was to be prepared by the Department of Health and Children by the end of 2003, the SPHE

programme would continue to be implemented in schools and the AIDS Strategy 2000 would be fully implemented. The only relevant gender considerations in the document were the need to address the issues of crisis pregnancy<sup>16</sup> and cervical screening for women, and the need to combat domestic violence against both women and men.

While the primary care strategy *Primary Care: A New Direction* (Department of Health and Children, 2001a) did not specifically deal with sexual health, health education was listed as one of the essential competencies of any primary care team.

*The Report on HIV/STI Services in Ireland* (Department of Health and Children, 2005a) dealt mainly with service provision and highlighted the need to increase staffing and funding for most services dealing with HIV/STIs. It recommended increased involvement of GP practices in the care of STI patients linking in with hospital clinics mirroring the objective of the Primary Care Strategy. It also drew attention to the need of a national Chlamydia screening programme, and in this regard, supported the UK approach to targeting women rather than the sexually active population according to the recognised risk factors.

Despite its ongoing failure to deliver a national sexual health policy since 2003, the Department's *Statement of Strategy 2005-2007* did not list this as an objective (2005b). However, it did commit to continue to develop policy in relation to HIV/AIDS in line with the recommendations of the National AIDS Strategy Committee. While this Statement did stress the role of the determinants of health, it did not explicitly mention gender as one that requires specific attention.

## NATIONAL STRATEGIES – HEALTH SERVICE EXECUTIVE

The health reform process has now added another level of strategic thinking to service delivery through the establishment of the Health Service Executive (HSE). In its *Corporate Plan 2005-2008*, the HSE identified sexual health under two goals: developing a population health approach to all levels of the delivery system, and empowering individuals and communities in the maintenance of their own health through health promotion (2005a). In order to achieve the first goal, the HSE sets out to reduce the threats to public health to management and prevention of communicable diseases, including sexually transmitted ones. In order to do so it aims to further develop protocols and guidelines for prevention, surveillance and control. Under the second goal it lists the review of existing sexual health strategies, further below, and the development of a national one. While the plan takes a population health approach, no gender considerations are present in it. It is then encouraging that the *National Service Plan* for 2006 reiterates the two goals above for the current year, but also adds another one, which will be key in order to the achievement of a gender sensitive sexual health strategy: working 'in partnership with the Women's Health Council to develop approaches to gender mainstreaming for planning and delivery of all services' (Health Service Executive, 2005b).

---

<sup>16</sup> Positioning crisis pregnancy as a health issue only for women provides a clear example of the underlying gendered framework that defines responsibility for reproductive health matters as a woman issue.

## REGIONAL POLICIES<sup>17</sup>

The Southern Health Board was the first administrative health area to produce a sexual health strategy in 2001. Its *Strategy to Promote Sexual Health 2001-2011* provides a comprehensive approach to this health area, highlights some gender issues, such as differences in age of first intercourse, use of contraception, types of sexual dysfunctions and genital cancers, and finally makes recommendations calling for gender sensitive measures in all aspects of sexual health service delivery (Southern Health Board, 2001). This document draws particular attention to the barriers that men encounter in the realm of sexual health, such as when accessing family planning services and information. Thus it calls for the development of gender specific sexual health programmes targeting men.

Following and extensive consultation in 2003, the HSE Eastern Region published its sexual health strategy in 2005. The *Sexual Health Strategy* does cover the gender distribution of STIs and highlights a number of specific population groups which require special attention, such as lesbian/bisexual women, and women in prostitution, as well the issue of sexual violence (HSE Eastern Region, 2005). However, the only gender sensitive recommendation calls for the screening for STIs of women attending antenatal clinic, again reinforcing rather than rebalancing the negative link between women and STIs.

In the same year, the HSE also published a sexual health strategy for the Midland Area, based on the deliberations of a working group previously appointed by the Midland Health Board (Health Service Executive, 2005c). This document contains a number of specific actions to reduce STIs through prevention, screening and treatment including: increase the awareness of knowledge of STIs and how they are acquired, increase availability and access

to screening services and address associated stigma and encourage people to seek treatment. Moreover, it also advocates the seeking of funding for the establishment of a specialised STI screening and treatment service in the Midland, as currently patients have to attend services in either the eastern or western region of the HSE. While it does acknowledge that women are generally more willing than men to seek advice and/or obtain treatment, it does not recommend that this situation should be challenged and rectified.



---

<sup>17</sup> With the abolition of the Health Boards and the establishment of the HSE, the operational status of these policies is unclear, but they still represent some valid examples of strategic thinking in this area.

The **Women's Health Council**  
*Comhairle Sbláinte na mBan*



The Women's Health Council  
Block D, Abbey Court,  
Irish Life Centre,  
Abbey Street Lower,  
Dublin 1.

Tel +353 1878 3777  
Fax +353 1878 3710  
E-mail [info@whc.ie](mailto:info@whc.ie)

[www.whc.ie](http://www.whc.ie)