ISSUE 06

SEXUAL HEALTH NEWS

WELCOME TO ISSUE 6, SPRING 2018

A fresh approach to Sexual Health Education for the Deaf Community see page 20 for further information.

FEATURES INSIDE THIS ISSUE

Seirbhís Sláinte Níos Fearr á Forbairt | Building a Better Health Service

GENERAL NEWSLETTER INFORMATION

CONTENTS

Design & Print

Murphy Print & Graphic Design Ltd
Woodlands Industrial Estate
Park Road
Killarney
Co. Kerry

Welcome

by Tracey Tobin,
Sexual Health News Co-Editor,
Health Promotion & Improvement HSE
South East

Welcome to Issue 6, Sexual Health News (SHN) magazine; it gives us great pleasure to be able to present **Issue 6** of Sexual Health News bringing us in to our third year of this rewarding process. Martin & I are delighted to have such a varied array of topics and areas of work described by dedicated health and community professionals working within sexual health promotion. The work of the magazine editorial team is made easier with your help and contributions.

This issue again offers the opportunity to highlight some significant topics in this work such as Quitting Smoking is Good for your Sex Life; How Entwined are Sexual Health and Mental Health?; The Need to Improve Partner Notification in Ireland and the EU and Capturing the Experience of Vaginismus for Irish Couples; and an innovative programme for the Deaf community. This issue also includes details of a broad section of sexual health training programmes across the country.

As always, **please** do consider contributing to Issue 7 due out in the Autumn 2018, it's a great way to share our work and to keep informed in what's happening within sexual health promotion in Ireland.

Tracey

Call for Submissions

Issue 7 – Autumn 2018, *closing date for receipt of submissions 31st July 2018*

If you have any feedback on the newsletter or would like to contribute to the next edition please contact:
Martin Grogan at martin.grogan@hse.ie or Tracey Tobin at tracy.tobin@hse.ie

Editorial Team

Sexual Health News is funded by HSE Sexual Health & Crisis Pregnancy Programme

Childrens First Legislation commenced on 11th December 2017

by Louise Monaghan National Youth Council of Ireland

The Children First Legislation (2015) and accompanying National Guidance outline *'the obligations of relevant services to prevent, as far as practicable, deliberate harm or abuse to the children availing of their services. While it is not possible to remove all risk, organisations should put in place policies and procedures to manage and reduce risk to the greatest possible extent'.* (Children First 2017)

In this regard, relevant services are required to have a Child Safeguarding Statement (Section 11) within 3 months of commencement and therefore must be fully compliant with the Act by 11th March 2018.

Since 11th December 2017, certain staff have been identified as mandated persons. Mandated persons are people who have contact with children and/or families and who, because of their qualifications, training and/or employment role, are in a key position to help protect children from harm. Mandated persons include professionals working with children in the education, health, justice, counsellors, youth and childcare sectors. Mandated persons have two main legal obligations under the Children First Act 2015.

These are:

1. To report the harm of children above a defined threshold to Tusla;
2. To assist Tusla, if requested, in assessing a concern which has been the subject of a mandated report.

Roles & Responsibilities for organisations

The Provider is the individual with overall responsibility for the organisation, this may be the CEO, the Chairperson of a board of management, owner/operator

The Designated Liaison Person acts as a resource, and is responsible for ensuring that reporting procedures within your organisation are followed

The Relevant Person is the first point of contact in respect of the organisation's Child Safeguarding Statement

The Mandated Person includes certain categories of professionals who have a legal obligation under Children First Act 2015 to report the harm of children to Tusla and to assist Tusla , if requested, in assessing a concern which has been the subject of a mandated report

Other staff and volunteers are responsible for reporting reasonable grounds of concern to their DLP/Tusla

Mandated persons should be aware that the legal obligations under the Children First Act to report mandated concerns rest with them and not with the Designated Liaison Person.

Many employers consider a failure to report a child protection concern to be a disciplinary matter. Employers are encouraged to include references to obligations in relation to mandated reporting in codes of conduct and contracts of employment for relevant persons.

For further information:

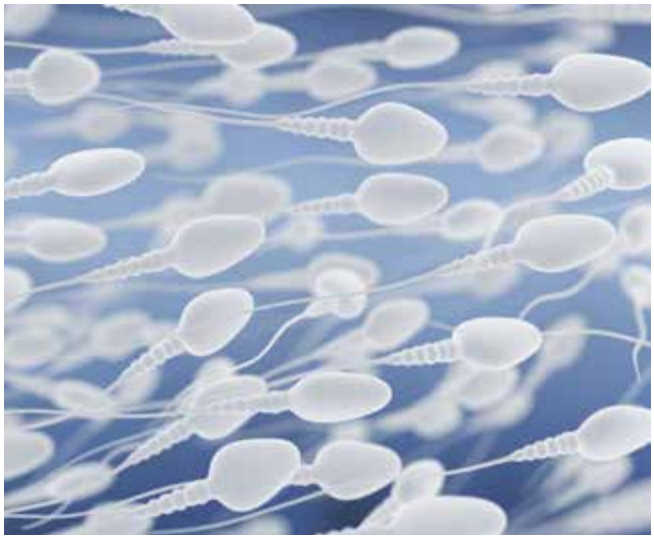
The Department of Children & Youth Affairs and Tusla have developed a suite of resources to support the implementation of the Act. **www.tusla.ie**

A free, online child welfare and protection e-learning programme module has been prepared by Tusla and is available to anyone. **www.tusla.ie**

"An Introduction to Children First" is mandatory for all HSE Staff irrespective of role or grade, **www.hseland.ie**

Comprehensive Study Shows an Ongoing Decline in Sperm Counts of Western Men

Review of a paper by Tracey Tobin Health Promotion Officer



The first systematic review and meta-analysis of the trends in sperm count has found that, among men from North America, Europe & Australia the sperm concentration has declined over 50% in less than 40 years.

The researchers examined 7500 studies in total and used meta-regression analysis on 185 studies published between 1973 and 2011. They found a 52.4% decline in sperm concentration and a 59.3% decline in total sperm count among men from North America, Europe, Australia & New Zealand. Contrastingly there was no significant decline seen in South America, Asia & Africa however fewer studies have been conducted.

Sperm count is considered of importance for various reasons. It is particularly related to male fecundity (the ability to produce offspring frequently) and is crucial for semen analysis in the investigation of male infertility, a condition which appears to be on the increase. Although the study does not provide the evidence on the causes of the declines of sperm count, it suggests they are reasonably associated with multiple environmental and lifestyle influences both prenatally and in adult life.

The downward trend in relation to sperm count shows no evidence of levelling off, with an increasing portion of men having sperm counts below 40 million/ml. This is of significant concern because of its association with decreased conception and with male ill-health.

Dr. Hagai Levine, the lead author describes this study as an urgent wake-up call for researchers and health care providers with regards to the necessity of investigating the causes of the sharp drop in sperm count, bearing in mind its importance for male fertility and human health.

Temporal trends in sperm count: a systematic review and meta-regression analysis.

Hagai Levine, Neils Jørgensen, Anderson Martini-Andrade, Jaime Mendiola, Dan Weksler-Derri, Irina Mindlis, Rachel Pinotti, Shanna H Swan.

Human Reproduction Update, Volume 23, Issue 6, 1 November 2017, pages 646-659
Http://doi.org/10.1093/humupd/dmx022

Gender Identity Skills Training (GIST)

by Vanessa Lacey, Health and Education Manager, TENI

Transgender Equality Network Ireland (TENI) have partnered with the Health Service Executive (HSE) since 2011; consulting on developing healthcare pathway's for the trans community and developing and delivering training to health professionals. Between 2014 and 2015 TENI have delivered approximately one hundred and twenty days of professional training.

In December 2015 this partnership organised a Transgender Healthcare Conference, which included both national and international expertise and was attended by three hundred and eighty five health professionals. It was the feedback from this conference that motivated TENI to develop a training that would meet the growing needs and interests of those working with trans people and their families in Ireland. In 2017 a funding application was submitted to Social Inclusion in CHO 5; the application was successful. The aim was to develop a 'higher-level' of training for health professionals.

There is interest in further training for frontline clinicians due to increased referral rates of transgender youth to services and an emerging evidence-based practice in this area especially in an Irish context. Some of the Irish key partners involved in the development of this programme are:

- Dr Aileen Murtagh, Consultant Child & Adolescent Psychiatrist, St Patricks Mental Health Service Dublin
- Dr Anne Kehoe, Clinical Psychologist, Dublin North City & County CAMHS, Blanchardstown & Castleknock CAMHS
- Angela Joy, Regional Senior Community Participation Coordinator, for Social Inclusion in CHO 5.

On an International level, two of the most influential experts (Psychology) in Europe, if not globally were:

- Dr Natasha Prescott (Gender Identity Development Service, UK) and
- Dr Thomas Steensma (Centre of Expertise on Gender Dysphoria, VUmc Amsterdam),

These both contributed to the development of the training and presented modules as part of the initial 2 days in 2017. Gender Identity Skills Training (GIST) was the agreed name of the training. The course began in earnest on 30th November and December 1st.

The three-day course consists of:

Day 1

- Psychological Assessment & Counselling of Children and Adolescents (Dr. Steensma)
- Endocrine Society clinical practice guidelines 2017
- Discussion of diagnostic criteria and current DSM-V criteria for Gender Dysphoria,
- Co-occurring mental health issues (Dr. Kehoe & Dr. Murtagh) Common comorbid conditions were highlighted
- Outcomes (Dr Steensma & Vanessa Lacey, TENI). Research on outcomes was presented, including factors influencing persistence and desistence. Development of resilience was considered
- Practical aspects of working with gender variant youth (Dr. Prescott). As children and young people referred to specialist gender services comprise a heterogeneous group that present with a diversity of experiences, needs and wishes.

Day 2:

- Physical Interventions (Dr. Susan O Connell, Paediatric Endocrinologist, UHC).
- Transitions (Dr. Steensma, Vanessa Lacey & Catherine Cross, TENI). Social, medical, surgical and legal transitions.
- Service Provision (Dr. Anne Kehoe) Current service provision in Ireland for young people.
- Fertility & Sexual Health (Dr Aileen Murtagh & Siobhan O'Dea, GMHS). This module on the fertility implications of cross-sex hormones and sexual health matters of Trans people including relationships.

Day 3:

Focused on case discussion, where participants' had an opportunity to discuss current dilemmas in clinical practice; this was facilitated by Dr Natasha Prescott from GIDS, UK.

The course was funded in CHO 5 and priority was given to clinicians that worked within this region. There was however some exceptions, where links had been made with clinicians in other regions and who had developed special interests in this area of work. The course focused initially on Psychiatry and Psychology, as their roles are at the forefront regarding referrals and assessments of children and adolescents experiencing these issues. External evaluation of GIST is currently being researched and findings due shortly. The future direction of GIST will be based on this evaluation. This may include extension of training programme to professionals working with transgender adults.

Our aim was to develop capacity in health professionals, enabling them with the skills to confidently work with children and young people with complex gender identities. It was an exciting year working with some of the most inspiring experts in the area of transgender healthcare and research. It was enlightening to have had the opportunity to present with the key professionals in this area.

Overall, it was heartening that, between us, we have potentially developed capacity within this area of expertise, whilst reducing costs going forward.

Pictured at the event (below, from left to right) were: Front – Dr. Aileen Murtagh (Consultant Child & Adolescent Psychiatrist, St Patrick's University Hospital, Dublin), Angela Joy (LGBTI Health Lead, CHO 5 Social Inclusion), Catherine Cross (Education and Family Support Officer, TENI) and Dr. Anne Kehoe (Dublin North City & County Child & Adolescent Mental Health Services). Back – Vanessa Lacey (Health & Education Manager, TENI), Dr. Thomas Steensma (Clinical Psychologist, Centre of Expertise for Gender Dysphoria, Amsterdam, Holland) and Dr Natasha Prescott (Clinical Psychologist, Gender Identity Development Service, Tavistock Centre, London, UK).

RESOURCES

This section of the newsletter provides an update of new materials that the reader may find helpful in their respective roles. If there are any new resources, factsheets, infographics or booklets you are aware of please let the Sexual Health News team know. And we can include details of these in the next edition.

National Cancer Control Programme publishes a Sexual Wellbeing Guide for Women

Issued by: HSE National Press Office

The National Cancer Control Programme (NCCP) has launched a new guide for women who have completed treatment for breast cancer or pelvic cancer, which deals with questions women may have about their sexuality or sexual health following their treatment. Titled *"Sexual Wellbeing after Breast or Pelvic Cancer Treatment – A Guide for Women"*, this booklet was designed by expert healthcare professionals.

Having cancer may affect your relationships with your family, friends and colleagues, and it is natural to need some time to adjust. You may experience emotional and physical changes during and after cancer treatment which may cause sexual problems - such as body image, mood, energy levels and sexual desire. But while cancer treatment may affect your sexuality, your sex life doesn't have to end. This guide gives details of treatments that may help to improve sexual wellbeing and encourages women to be their own strongest resource. It includes advice on how to talk to your partner about your sexual wellbeing, how to create physical and emotional intimacy, and what to do if you are not in a sexual relationship but would like to be.

This guide is a companion to the previously published *"Information for Men on Sexual Wellbeing after Pelvic Cancer Treatment"*, which has been widely used by men to understand the sexual changes caused by cancer treatment.

As part of the National Cancer Strategy 2017-2026, the NCCP are continually working on projects such as these to improve the experience and care for cancer survivors. With cancer survivorship numbers increasing significantly, optimising peoples' quality of life is a particular focus. The goal for many cancer survivors will be to return to as normal a life as possible. A key objective of survivorship care is to empower patients to achieve their best possible health outcomes while living with and beyond a diagnosis of cancer.

Louise Mullen is NCCP National Programme Manager for Cancer Survivorship:

> *"Patients, healthcare professionals and advocacy groups will tell you time and time again that patients feel adrift and as if they have 'fallen off a cliff' after their active treatment for cancer is complete. Patients need support at this time to regain a sense of control over their lives, rebuild their sense of health and wellbeing and have expert advice, assessment and treatment for any consequences of treatment which may be physical, psychological and or social."*

For more information about the National Cancer Control Programme please visit:
www.hse.ie/cancer

Capturing the Experience of Vaginismus for Irish Couples: A Dublin City University Study

by Maria McEvoy (pictured), Dr. Rosaleen McElvaney and Dr. Rita Glover

What is Vaginismus?

Vaginismus is an "involuntary contraction of the pelvic floor muscle group leading to painful and/or impossible vaginal penetration" (Heinemann, Atallah & Rosenbaum, 2016, p.147). One of the difficulties in understanding vaginismus lies in how to define the problem. Most medical definitions such as the one above concentrate on the spasming of the vaginal muscles when intercourse is attempted but this focuses on the physical aspect of the difficulty to the exclusion of other aspects. Whereas the physical definition sees vaginismus as a sexual dysfunction, in psychological terms it can be recast as a functional spasm that is protecting the woman from anticipated harm. The perception of harm can stem from actual experiences of attempted painful intercourse or from the anticipation that a sexual encounter will be painful. This anticipation can come from the messages about sex that the woman has received growing up. For example, sex can be represented as 'dirty' and something that 'nice girls don't do.' One study of vaginismus in the UK found that women with vaginismus were more likely to use negative adjectives to describe sex, e.g. dangerous, painful, frightening, undignified, disgusting, animal-like (Ward & Ogden, 1994). The factors that contribute to vaginismus can be thought of as a spectrum from physical to psychological to relational and cultural and a different blend of factors will contribute in a unique way to each couple experiencing it. The inability to have a sexual relationship has a profound impact on how the woman feels about herself, on her partner and on their relationship (Ward & Ogden, 1994).

Developing an Understanding of Vaginismus

Vaginismus has been estimated to be the second most prevalent female sexual difficulty presenting at clinics in Northern Ireland (Roy, 2002). No recent statistics exist for the Republic of Ireland but clinical surveys thirty years ago estimated that vaginismus affected 5 in every 1,000 marriages (Barnes, 1986). A study in Dublin City University (DCU) is the first known study in Ireland to try to capture the experience of couples where vaginismus is a concern, and their experiences of seeking help. The study also seeks to capture professionals' experiences of working with couples where vaginismus has been diagnosed. The aim is to gain a better understanding of vaginismus and from this to build a conceptual model that captures the experiences of couples and what it is like to seek help in modern day Ireland.

Why Does Vaginismus Occur?

Thirty years ago, Irish studies identified vaginismus as a 'psychosexual experience' rather than a psychosexual dysfunction (Barnes, 1986). One of the key contributing factors in Ireland at that time was deemed to be the Catholic ultra-conservative orthodox religious messages about sex and sexuality that linked sexual behaviours with guilt and frequently led to sexual difficulties. Ireland was identified as being unique in Europe in terms of its staunch opposition to divorce and contraception. However, rates of vaginismus have also been identified in countries with predominantly Orthodox Christian, Jewish and Islamic faiths (Heinemann et al, 2016). It is not the specifics of the religious messages that appear to make a difference; rather it is how strictly these rules are enforced. Ireland nevertheless was seen as unique in terms of its conservative attitude towards sexual matters and the reluctance of the Irish people to discuss anything to do with sex (O'Sullivan, 1979; Barnes, 1986).

Barnes' (1986) in his study of vaginismus in Ireland described how mothers socialised their female children from birth, encouraging a sense of self in these girls that prioritised the importance of responding to the demands of others. This, Barnes claimed, included a passive sexuality, and sex was portrayed as unimportant or dirty. This socialisation or conditioning by mothers was found to be subtle and well-intentioned but manipulative insofar as it reinforced a high level of control over daughters. Fathers were often identified as peripheral figures in the family (Barnes, 1986) or as violent frightening figures in households where alcohol abuse was a feature (O'Sullivan, 1979). Consequently, the girls sought out men who were gentle and would not force them into sexual intimacy. Although relationship factors were rarely considered to be responsible for vaginismus, they were always considered to have played a part in its maintenance (O'Sullivan, 1979). Thus, relationships could last a significant amount of time in the absence of sexual intercourse and even in the absence of communication about the difficulty.

Continued on page 10

Continued from page 9

In modern day Ireland, little is known about the factors that contribute to vaginismus in couple relationships. However, preliminary findings by the DCU study suggest that some of the factors identified thirty years ago continue to be important today. Interviews with professionals who work with women with vaginismus suggest that conservative religious messages still feature in the developmental histories of women seeking help. Sex is either not talked about or frightening messages are conveyed that appear to be designed to control the sexuality of daughters emphasising that girls should stay away from boys, that girls' reputations can be damaged and lives ruined by pregnancy. In particular, it is suggested that these messages may have been transmitted from mother to daughter. The silence surrounding sexual matters may pervade the household and beyond so that the women are unable to speak to sisters or best friends about sexual concerns. This difficulty may have been compounded by the lack of sex education in Irish schools until recent years beyond what might have been covered in biology class, neglecting any education on the emotional or relationship aspects of sex. It is suggested that an Irish culture of silence has surrounded the discussion of sexual matters that may have left those with sexual difficulties feeling ashamed and isolated.

The current study seeks to start a conversation about vaginismus in Ireland. We are currently seeking to interview couples who have experienced vaginismus and professionals who have experiences working with couples where vaginismus has been a concern.

For further information, please contact Maria McEvoy at the following:

Facebook: https://www.facebook.com/groups/146160606150136/
Linked in: www.linkedin.com/in/maria-mcevoy-aa91a5134
Research Gate: www.researchgate.net/profile/Maria_Mcevoy
Email: maria.mcevoy26@mail.dcu.ie
Twitter: https://twitter.com/IrishVaginismus
Tel: +353 (0) 874019690

The following organisations provide support for couples currently experiencing difficulty:

Accord	**Tel:** 01 - 5053112	**Email:** info@accord.ie
College of Sexual and Relationship Therapists	**Tel:** 020 - 8543 2707	**Email:** info@cosrt.org.uk
Dublin Well Woman Centre	**Tel:** 01 - 8749243	**Email:** info@wellwomancentre.ie
Healthy Living Centre Dublin City University	**Tel:** 01 - 7007171	**Email:** hlc@dcu.ie
Institute of Psychosexual Medicine	**Tel:** 020 - 75800631	**Email:** admin@ipm.org.uk
Relate Northern Ireland	**Tel:** 028 - 90323454	**Email:** office@relateni.org

References

Barnes, J. (1986). Primary vaginismus (part 1): Social and clinical features. Irish Medical Journal 79(3): 59-62.

Barnes, J. (1986). Primary vaginismus (part 2): Aetiological factors. Irish Medical Journal 79(3): 62-65.

Heinemann, J., Attallah, S. & Rosenbaum, T. (2016). The impact of culture and ethnicity on sexuality and sexual function. Current Sexual Health Reports, 8: 144-150.

O'Sullivan, K. (1979). Observations on vaginismus in Irish women. Archives of General Psychiatry 36(7): 824-826.

Roy, J. (2002). A survey of Relate psychosexual therapy clients, January to March 2002. Sexual & Relationship Therapy 19(2): 155-166.

Ward, E. and J. Ogden (1994). Experiencing vaginismus: Sufferers' beliefs about causes and effects. Sexual and Marital Therapy 9(1): 33-45.

How Entwined are Sexual Health and Mental Health? A Literature Review from the Donegal Sexual Health Forum

by Dr Sarah O'Brien, SpR Public Health Medicine, Dr Caroline Mason Mohan, Consultant in Public Health Medicine

The WHO defines health as 'a state of physical, mental and social wellbeing and not merely the absence of disease or infirmity'. Its definition of sexual health includes all aspects of health, including emotional wellbeing, and states that it needs '..a positive and respectful approach to sexuality and sexual relationships..' It advises that to improve sexual health, interventions should be implemented across five domains: laws, policies and human rights; education; society and culture; economics; and health systems. The National Sexual Health Strategy is an important step towards achieving this holistic approach. The progress so far on implementation of the actions has already improved the sexual health of the Irish population.

In 2017, the Donegal Sexual Health Forum, an interagency group of people with an interest in promoting positive sexual health particularly for young people, wanted to develop positive messages about sexual health to support their work. The narrative around sexual health has continued to focus on the negative effects of sexual activity, suggesting that sexual behaviour is harmful, particularly to adolescents, and is to be avoided. It rarely explores the positive effect of good sexual health on overall wellbeing and in particular, on mental and emotional health. The WHO previously stated there is 'No Health without Mental Health'. The Forum thought it would be useful to highlight that good sexual health is as essential to mental health as any other type of health. They commissioned a systematic literature review to identify if there was any evidence that linked good sexual health to good mental health.

The literature review has highlighted a number of areas where there is a close relationship between sexual and mental health: For example:

1. Adolescence is an important time for developing a sense of self and this is influenced by level of confidence in ones sexuality. Young women continue to have societal pressures to conform to traditional ideas of femininity and conversely peer pressure to engage in sexual relationships, which can affect mental health. Young men have reported stress and anxiety related to their sexual performance and how this reflects on their masculinity.

2. Poor mental health can lead to earlier and riskier sexual behaviour but also the consequences of this poor sexual health has been found to impact on mental health.

3. The vast majority of young people who identify as LGBT experience homophobic bullying, which has been shown to impact on their mental health with high levels of depression, anxiety, alcohol and substance misuse and high rates of suicide reported in this group. They also report negative experiences with healthcare, which can lead to them avoiding using services, which restricts their access to health information and impacts negatively on their health.

4. Older people who are sexually active report a higher quality of life and are less likely to report depressive symptoms.

Overwhelmingly the evidence is focused on poor health: how to have good health is hard to identify. The literature does suggest that sexual health should be seen as part of a normal biological, psychological and social developmental journey that lasts through the life course. This requires a more normative and positive approach to sexual health by society and those delivering sexual health interventions.

Overall, the review shows how sexual health and mental health are interlinked across the life-course and underpins how important it is to consider the mental health effects of not promoting sexual health. Although the literature is limited, this review has given food for thought for the Donegal Sexual Health Forum to inform its future work and for member organisations to develop more holistic messages for young people.

Dr Sarah O'Brien, SpR Public Health Medicine, Dr Caroline Mason Mohan, Consultant in Public Health Medicine (and chair of DSHF), Dept of Public Health Medicine, Health and Wellbeing Division, HSE West (Donegal, Sligo, Leitrim). On behalf of the Donegal Sexual Health Forum
For a full copy of the literature review contact patricia.diver@hse.ie

The Need to Improve Partner Notification in Ireland and the EU

by Shannon Glaspy,
UCD University College Dublin Medical School

Partner notification (PN), the act of informing a patients' sexual contacts of their exposure and inviting those partners to attend for testing, has multiple public health benefits (European Centre of Disease Prevention & Control ECDC, 2013). Not only does it help prevent re-infection for the index patient, but is also contributes to increased linkage to care through the referral of at-risk individuals that many benefit from testing and services. Not only does partner notification allow testing for the specified infection, but it also enables identifying other co-infections.

For example, if a patient is identified as having syphilis and they bring their partner in for testing, the partner may be identified as having syphilis and another infection. Partner notification helps identify and treat these co-infections to reduce horizontal and vertical transmission. Additionally, partner notification can help vulnerable populations that are prone to multiple co-infections.

There are different ways to approach PN, typically defined by who is responsible for informing the partner: patient referral denotes the patient will notify partners themselves, provider referral denotes the health provider will notify partners either anonymously or not, and contract referral denotes the patient is given a timeframe in which to notify the partner otherwise the health provider will step in and do so.

According to the ECDC (2013), patient referral is the preferred method in Europe for all STIs. To contact partners, there are many different methods and mediums that can be employed. While in the past partner notification was limited to phone calls, letters and face-to-face meetings, new technologies present a multitude of opportunities for contact. Beyond emails and SMS, there is an increasing number of web-based partner notification tools arising.

Many research studies indicate the importance of partner notification in ending the cycle of transmission (Dalal, 2017). The WHO (2016) recommends that 'voluntary assisted partner notification services should be offered as part of a comprehensive care package'. To improve the uptake of partner notification services, the WHO stresses the need for supportive policies and offering patient multiple options to undertake partner notification.

Other research highlights the importance of offering partner notification services periodically throughout care and treatment, as a patient's ability and/or interest to notify partners may change over time (Johnson, 2017).

Across Europe, legal requirements for partner notification for HIV and STIs show high variability, demonstrating the importance of a country's social, political and cultural context on the topic. The WHO recommends revising any mandatory or coercive PN practices, as mandatory laws and policies can act as barriers to those in need of treatment services, while also acknowledging that assisted partner notification can lead to increased linkage to care.

In Ireland, partner notification is not compulsory for any STI or HIV, but instead is a voluntary decision to be made by the patient. Low rates of partner notification persist due to, among other barriers, a lack of resources and time for health care providers to counsel patients on the benefits of PN, approaches to notifying partners and to assist patients in tracking down contacts when necessary. Specific key populations such as MSM, migrants, homeless and PWID are at increased risk and require more resource intensive partner notification efforts.

Currently, guidelines on partner notification vary greatly by area and healthcare setting across the EU. In Ireland, there are no national guidelines advising on the process and no standards as to how partner notification should be done, resulting in potential gaps of identification and treatment. Instead, Ireland follows the BASHH (2012) and SSHA (2015) guidelines for partner notification standards.

These recommend that partner notification for HIV and STIs be carried out, yet lack any uniform method or tool to do so. Every local department decides how to carry out partner notification on their own terms. This results in no central monitoring of partner notification and no way to ensure that the necessary partners have been notified, reducing the ability to control infection. With a lack of a national database and a lack of resources to devote time to partner notification, the possibility of reaching vulnerable at-risk patients is minimal.

Across Europe, there are calls to increase partner notification efforts across healthcare settings, including general practitioners and others in the efforts previously left to STI clinics.

The ECDC notes there is a need to improve policy maker awareness regarding the importance of partner notification, to highlight the need for more resources. Additionally, the ECDC recommends developing and disseminating guidelines on PN that encompass a range of approaches (ECDC, 2013).

The EU joint action project INTEGRATE has the potential to help, as it aims to integrate care across STIs, HIV, viral hepatitis and TB. One component of the project is dedicated to partner notification, amalgamating a range of PN approaches for implementation that can be adapted to different contexts, population groups and healthcare settings.

Through mapping partner notification strategies and tools from one to another disease area, INTEGRATE aims to adapt existing best practice partner notification tools, resulting in an applicable resource for health providers to navigate partner notification.

Integrate

References

Dalal, S., Johnson, C., Fonner, V., Kennedy, C. E., Siegfried, N., Figueroa, C., & Baggaley R. 2017, "Improving HIV test uptake and case finding with assisted partner notification services", AIDS, vol. 31, no. 13, pp. 1867-1876.

ECDC, 2013. "Public health benefits of partner notification for sexually transmitted infections and HIV", Stockholm. European Centre for Disease Prevention and Control.

Johnson, C.C., Kennedy, C., Fonner, V., Siegfried, N., Figueroa, C., Dalal, S., Sands, A. & Baggaley, R. 2017, "Examining the effects of HIV self-testing compared to standard HIV testing services: a systematic review and meta-analysis", Journal of the International AIDS Society, vol. 20, no. 1, pp. Z1-n/a.

WHO, 2016, "HIV self-testing and partner notification: supplement to consolidated guidelines on HIV testing services", Bulletin of the World Health Organization, vol. 94, no. 12, pp. 864.

BASHH, 2012. "Statement on Partner Notification for Sexually Transmissible Infection"

SSHA, 2015. "Guidance on Partner Notification"

HIV Ireland Training Dates
Upcoming Training and Education Events - HIV Ireland

STIs, Condoms and Safer Sex – Thursday 19th April
HIV and Hepatitis C – Thursday 17th May
Let's Talk About…HIV in Ireland – Friday 15th June

All of these training and education events take place at HIV Ireland, 70 Eccles Street, Dublin 7. More information on all of our training and education programmes can be viewed at www.hivireland.ie where bookings can also be made.

Other courses include, HIV and STIs, HIV, Stigma, and Discrimination, HIV: an overview for Counsellors

---

Sexually Transmitted Disease Training

STIF CORE: 12th May 2018
STIF PLUS: 13th May 2018
The Catherine Mc Auley Centre, 21 Nelson Street, Dublin 7

The aim of the course is to equip participants with the basic knowledge, skills and attitudes for the effective management of sexually transmitted infections (STIs) outside the GUM setting. For further information please visit http://www.bashh.org

This is a multi-disciplinary course and applications are invited from, Doctors and nurses working in general practice, family planning and reproductive health, GUM, health advisers, secondary care clinicians who may encounter patients with STIs (e.g. O&G, A&E, rheumatology and ophthalmology), pharmacists, school nurses.

For Further information and Application contact the course organiser:
Gordana Avramovic Tel: 01 716 4562 Email: gavramovic@mater.ie

---

Contraception Foundation Course for Midwives and Nurses
The Irish Family Planning Association

The Irish Family Planning Association runs a Contraception Foundation Course for Midwives and Nurses annually, which has been approved for Continuing Education Units (CEUs) by the Nursing and Midwifery Board.

This course for nurses and mid-wives is a 2 day course including a half day of practical workshops. It aims to cover all methods of Contraception as well as providing information on Menopause, Cervical Screening, Sexually Transmitted Infections and other sexual health related issues.

The 2018 course will be run in the latter half of 2018, if you are interested in receiving notice of the actual dates, please send an email to reception@ifpa.ie

A Series of Masterclasses - Supporting an unplanned pregnancy

For: Health Professionals, teachers, youth workers and others who might encounter someone with an unplanned pregnancy in the course of their work

Do you encounter clients with an unplanned pregnancy? If so the HSE Sexual Health and Crisis Pregnancy Programme in conjunction with the Department of Adult and Community Education, National University of Ireland Maynooth has developed the following Masterclasses which may be of interest to you.

They will be held over the period April to June 2018 in Maynooth University.
Masterclass 1: Crisis Pregnancy Counselling skills for professionals
Friday 27th April 2018, 10am – 4.30pm John Hume Building, Maynooth University

Masterclass 2: Termination: Dealing with Complex Issues
Friday 11th May 2018, 10am – 4.30pm John Hume Building, Maynooth University

Masterclass 3: Understanding Fatal Fetal Abnormality as a Crisis Pregnancy
Friday 15th June 2018, 10am – 4.30pm John Hume Building, Maynooth University

Masterclass 4: Law and Crisis Pregnancy Counselling
Friday 22nd June 2018, 10am – 4.30pm John Hume Building, Maynooth University

The aim of these Masterclasses is to create an opportunity for professionals to gain more in-depth knowledge and skills to resource them in managing the challenges that can present around supporting women, their partners and families around unplanned pregnancy. The Masterclasses will provide a supportive and informative space for dialogue and reflection to help strengthen professionals' work in the broad field of crisis pregnancy. These Masterclasses further support the work of the HSE Sexual Health and Crisis Pregnancy Programme in the area of quality and standards development in the broad field of supporting clients with unplanned pregnancy.

Note: CPD points to be confirmed closer to the time. The fee is €30.00 per Masterclass - non-refundable (including a light lunch). Facilitator Anne McCarthy, Department of Adult and Community Education, Maynooth University

Further information on these Masterclasses and a copy of the application form are available at crisispregnancy.ie under the 'Highlights' section. A brochure and application form is also contact Breda Gibney at Department of Adult and Community Education, Tel 01 7083752 or Email: breda.gibney@mu.ie

---

Foundation Programme in Sexual Health Promotion Training – How and Why it Works

The Foundation Programme in Sexual Health Promotion (FPSHP) is one of the key deliverables of the National Sexual Health Strategy 2015-2020 and it runs throughout the country in 9 different locations annually.

Although the FPSHP operates from the perspective of positive sexual health promotion, it is also mindful of the evidenced need for increased risk reduction around issues causing sexual ill-health. A national study of sexual health and relationships (Layte et al., 2006) found that the average age of first intercourse has dropped to 17 for the 18- 24 year-olds surveyed, while the 35-39 year old averages were 18 for men and 19 for women. The same report discovered that 21% of women who had experienced a pregnancy in their lives described at least one of those pregnancies as a 'crisis pregnancy and 15% of these crisis pregnancies ended in abortion. In relation to STIs, according to the Health Protection Surveillance Centre (HPSC), there has been overall an increasing trend in STI notifications from 1995 to 2015, in particular in relation to men who have sex with men (MSM). Quarter 1 2016 shows a 10% increase compared to 2015.

The FPSHP programme seeks to support the findings of the WHO / PAHO report (2000), which calls for the integration of sexual health into existing public health programmes. Those suffering from a chronic illness (e.g. types of cancer, renal failure, hypertension or diabetes) often experience changes in their intimate physical and emotional relationships and the healthcare personnel with whom they are most in contact, may be crucial in providing support.

Continued on page 16

Continued from page 15

In addition, research indicates that core services around physical disability (Couldrick, 2008), intellectual disability (Eastgate, 2008) and mental health (Higgins et al., 2006a), also have a significant role to play in promoting sexual health to their clients. Several reports (Higgins et al., 2006b; Ho & Fernández, 2006) indicate that nurses, by virtue of their close relationships with clients, are particularly well placed to promote sexual health but need appropriate training and support to enable them to do so. (Northern Ireland (N.I) Govt., 2008; WHO, 2006).

The FPSHP offers a safe environment where health, education and community professionals can expand their knowledge of what constitutes sexual health, explore their values and attitudes and how these may impact on the service to clients, and develop sexual health promotion skills for use in their core work. In 2013 The Foundation Programme in Sexual Health Promotion was evaluated by Professor Agnes Higgins and her team at the School of Nursing and Midwifery in Trinity College Dublin (TCD) see: http://www.lenus.ie/hse/handle/10147/313441).

In total, 97 surveys from past participants were returned, representing a 49% response rate.

35 managers returned their surveys representing a 35% response rate.

Findings showed that all stakeholder groups (participants, managers and facilitators) were highly satisfied with the aspects explored in the study, including content, facilitation and follow up supports, as well as its impact on the sexual health promotion work of the participants. There was clear evidence that the programme had a positive impact on capacity building at an individual and organisational level, improving past participants' confidence and competence in communicating about sexual matters, and knowledge of the field.

The majority of participants (61%) who completed the survey reported that they were already engaged in sexual health promotion activities before the programme and 70% did so after they attendee the programme. The main impact of the programme however was the on the expansion and diversity of the activities of the participants. All of the 19 sexual health promotion activities presented to the past participants showed increases after participation, with some activities showing a dramatic increase. Raising awareness (+41%) and providing sexual health education to staff within the organisation (+31%) were activities that seemed to be impacted upon most by participating in the course. Furthermore, significant expansion was reported in: using group settings in sexual health promotion (+23%), developing services within the organisation (+26%), developing written materials on sexual health promotion

(+28%), as well as engaging with further education and training (+30%). In terms of capacity building, the findings from the managers and facilitators supported those of the past participants, as they also reported a greater level of impact at the individual and organisational level.

The follow up supports and communication (Sexual Health Newsletter, email bulletins, library resources and follow up days) were seen by all stakeholders as instrumental in generating and nurturing a sustained impact at the individual and organisational levels, with managers particularly welcoming the support and advice they received. The managers, in turn, had supported participation in the programme, which highlights their key role in capacity building and the importance of ongoing communication with them before, during and after the programme.

The FPSHP continues to be rigorously evaluated and monitored. In 2017 Ignite Research has been recruited to compile data using on-line evaluation tools which were previously created by TCD. These tools are completed by participants prior to course commencement, on course completion and at a six month interval following course completion. The current data is again being compiled to ensure that the capacity building element of this course is being actively maintained and delivered upon by course participants.

Findings from these reports will be available in the third quarter of 2018.

For information about the FPSHP nationally, please email the National Coordinator, Catherine Byrne at catherine.byrne2@hse.ie

Recent Graduates of the National Foundation Programme in Sexual Health Promotion (FPSHP)

Dates for your diary

APRIL	JUNE	AUGUST
23rd – 29th **World Immunisation Week WHO**	11th – 17th **International Men's Health Awareness Week**	1st -7th **World Breast Feeding Week**

**The above information is supplied by the Health Promotion & Improvement Library and Information Service Health & Well-being Events 2017.*

Foundation Programmes in Sexual Health Promotion (FPSHP) 2018

As always the FPSHP ten-day training programme operates in various locations throughout Ireland; the courses are normally run in the autumn or spring of each year; this will be the same for 2018. For further information on FPSHP courses close to you please contact:

Ardee, Co. Louth

February: 26th & 27th
March: 20th & 21st
April: 16th & 17th
May: 14th & 15th
June: 11th & 12th

Contact: Olivia McGeough
Tel: 041 6860716 **Email:** olivia.mcgeough@hse.ie

Midlands

Dates to be confirmed

Contact: Margaret Whittaker,
Health Promotion & Improvement
Tel: 057 93 57800 **Email:** margaret.whittaker@hse.ie

Donegal

Autumn 2018 dates to be confirmed

Contact: Lisa O'Hagan, Health Promotion Officer
Tel: 074 91 04693 **Email:** lisa.ohagan@hse.ie

Dungarvan, Co. Waterford

Autumn 2018

September: 18th & 19th
October: 16th & 17th
November: 6th & 7th
November: 27th & 28th
December: 11th & 12th

Contact: Tracey Tobin, Health Promotion Officer
Tel: 087 9028590 **Email:** tracy.tobin@hse.ie

Limerick

October: 9th & 10th
November: 6th & 7th
December: 4th & 5th
January: 8th & 9th 2019
February: 5th & 6th 2019

Contact: Mairead Kelly, Promotion Officer
Tel: 061 483257 **Email:** maireada.kelly@hse.ie

Cork

September: 25th & 26th
October: 23rd & 24th
November: 13th & 14th
December: 11th &12th
January: 23rd & 24th 2019

Contact: Martin Grogan
Tel: 021 4921665 **Email:** Martin.grogan@hse.ie

Mayo

September: 19th & 20th
October: 17th & 18th
November: 21st & 22nd
December: 12th & 13th
January: 23rd & 24th 2019

Contact: Thelma Birrane
Tel: 094 9042589 **Email:** Thelma.birrane@hse.ie

For general information of the FPSHP please contact
Catherine Byrne National
Coordinator of the Foundation Programme
in Sexual Health Promotion
Tel: 021 4921674 or
Email: catherine.byrne2@hse.ie

The features section is made possible by the following authors giving of their time and expertise in their respective fields; for any queries or further information on the features in this section please contact the relevant author.

2017 Sexual Offences Act

by Catherine O'Sullivan
Lecturer, School of Law,
University College Cork UCC

The *Criminal Law (Sexual Offences) Act 2017* has introduced a number of important reforms to sexual offences that seek to protect young people and those who lack the capacity to consent to sexual relations from exploitation. For those who work with young people or with those who are mentally ill or intellectually disabled, these changes are significant. There are now three age of consent offences to be found in the *Criminal Law (Sexual Offences) Act 2006*, as amended by the *2017 Act*. All three criminalise persons who engage in or attempt to engage in sexual acts with children. Where the child is under the age of 15, section 2 applies and the maximum penalty is life imprisonment. Where the child is under the age of 17, section 3 applies and the penalty varies depending on whether the convicted person is a "person in authority" or not. Where the convicted person is a "person in authority" the maximum penalty is 15 years, it is 7 if they are not. Section 3A is a new offence that was inserted into the *2006 Act* by the *2017 Act*. This provision makes it an offence for a person in authority to engage or attempt to engage in a sexual act with anyone aged 17-years. In other words, section 3A creates a new higher age of consent that is specific to persons who hold or held a position of authority over a child.

Those who were familiar with the definition given to "person in authority" in the *2006 Act* should note that the definition has been expanded slightly by section 15 of the *2017 Act*. In essence though, a person in authority is anyone who is or was in a position of power over the child, and that includes all forms of parents (birth-, step-, foster- and current or past partners of a parent of the child) and anyone who is or has been responsible for the education, training, care or welfare of the child. The next important change introduced by the *2017 Act* is a peer-exemption provision. The amended *2006 Act* now provides that if someone is accused of an offence with a child who is aged 15 or older, the younger child's consent will be recognised as a defence to the charge as long as the accused is no more than 2 years older than the child, was not a person in authority and was not in an intimidatory or exploitative relationship with the child.

The final important reform to the *2006 Act* is that a person accused of a section 2, 3 or 3A offence can no longer claim that they were honestly mistaken about the age of the child as a defence to the charge. The defendant must now prove that they were *reasonably* mistaken that the child had attained the age of 15 or 17 or 18, depending on the offence charged. The way that an accused would do this is to show that a reasonable person would have come to the same conclusion as they did. This makes it much more difficult for an accused party to access the mistaken belief defence and is accordingly a welcome development in terms of protecting children. The *2017 Act* also deletes section 5 of the *Criminal Law (Sexual Offences) Act 1993* which criminalised sexual intercourse, buggery and acts of "gross indecency" between two men with a new offence of acts of "gross indecency" between two men engaging in or inviting, inciting, counselling or inducing a protected person to engage in a sexual act. Section 21 provides that it is presumed that the accused person knew or was reckless as to complainant's status as a protected person. Protected person is given a functional test, *i.e.* defined as someone who is incapable of understanding the nature or reasonably foreseeable consequences of the sexual act, of evaluating whether to engage in that act, or is unable to communicate his/her consent to that act.

The most important difference between this offence and the old one is that a greater range of sexual acts is now covered by the offence. Specifically, it includes sexual activities that would previously have had to be prosecuted under sexual assault, aggravated sexual assault and rape under section 4. This change makes it easier to prosecute an accused person because the prosecution no longer has to prove that the protected person did not consent. There have been a number of high profile cases where, due to the difficulties the complainant had in communicating what happened to them or because they were not regarded as a credible witness because of their impairment, it was difficult to prove this threshold beyond a reasonable doubt.

Finally, the *2017 Act* also introduces a new offence where a person in authority engages in or invites, incites, counsels or induces a relevant person to engage in a sexual act. Section 22 defines a "person in authority" as someone who is employed to educate, care for, supervise, train or treat a relevant person. A "relevant person" is someone who has a mental or intellectual disability or has a mental illness that is of "such a nature or degree as to severely restrict the ability of the person to guard himself or herself against serious exploitation." The consent of the relevant person is no defence. The accused however can raise the defence of mistaken belief, but like under the age of consent provisions, s/he must prove that the mistake was a reasonable one. In reality though it seems very unlikely that this mistake could be raised that often, in light of the definition given to "person in authority."

A Fresh Approach to Sexual Health Education for the Deaf Community

Foundation Programme of Sexual Health Promotion (FPSHP) colleagues Declan Boyle, Gerard Holmes and Catherine Caraher.

DeafHear is an organisation that provides personal support to Deaf and Hard of Hearing people and their families through the family support, family therapy, mental health and deafness services. The services are free and strictly confidential and are provided through the communication of choice i.e. Irish sign language, speech, lip-reading etc.

Following training in the Foundation Programme of Sexual Health Promotion (FPSHP) colleagues Declan Boyle (Social Worker in Letterkenny), Gerard Holmes (Community Resource Worker) and Catherine Caraher (Social Worker in Dundalk) decided to offer aspects of this training to DeafHear service users. This was the first time DeafHear had delivered such a programme in Irish Sign language to profoundly deaf sign language users.

Why did you engage with FPSHP course?

Catherine: *I did the FPSHP course in 2016/17 in Ardee, as I was interested in developing my own knowledge and skill set in working with people with regards to sexual health promotion and awareness. Throughout, my time as a social worker there have been a number of occasions when I have supported individuals and families in accessing medical and counselling services in relation to sexual health issues. This was primarily because information provided in the mainstream wasn't always accessible to Deaf and Hard of Hearing people in the same manner as hearing members of the community.*

Declan: *Gerard and I completed the FPSHP course in Letterkenny, we were working with a group of Deaf Adults and through discussions came to realise that Deaf People simply do not have access to information on sexual health. I realised that the gap in knowledge in relation sexual health for deaf people compared with their hearing counterparts was significant. I also realised that I needed to upskill in this area and felt the FPSHP course would allow us to begin to address this knowledge provision deficit with our group and with the individuals we meet in our day to day work.*

Gerard: *I work with DeafHear.ie providing services to those that are Deaf and Hard of Hearing. Working with Deaf Adult group, the English language, even everyday words, is a continuous barrier for them to comprehend. I wanted to know what's out there that can be of help to our service users. As a Deaf user and provider, I thought I knew a lot but realised I didn't, and I wondered how to provide such a course for other Deaf service users and translate it into Irish Sign Language.*

What did you get from the FPSHP course?

Catherine: *The course was invaluable, not only did it provide me with statistical and factual information on sexual health issues, such as STI's, contraception and the Law (Irish context). It enhanced my capacity to incorporate sexual health promotion into my work on a larger scale. The course challenged my personal comfort levels and attitudes to discussing sexual health issues, by addressing my own views and beliefs with regards to sexual health and lifestyle. In doing this I am confident that in working with service users I am able to provide objective advice and support.*

Declan: *I really learned so much from this course in terms of Sexual Health Promotion but also much more than that. I feel as if the course helped me to refine skills that I used every day with service users, especially in terms of dealing with "difficult topics".*

Gerard: *The course provided, what in short, was a real eye opener for me. It has given me much needed confidence and skills to be able to deliver our course effectively. It has also given me an insight of what I have learnt from it and how I could transfer it into Irish sign language. I have also used some visual aid items from the sexual health promotion library.*

What type of programme?

Catherine: *The choice to offer a programme on sexual health promotion for Deaf ISL users was based on the current lack of resources in sex education for young profoundly deaf sign language users with many having little or no knowledge of sexual health safety awareness or access to information in a language they can understand. For example, in a UK documentary named "Snapshot: dicing with sex" a group of young deaf people are shown cards with different words on them. All the young people recognise the words, Facebook, Wii and YouTube, but the words syphilis, genital warts and hepatitis are all met with expressionless reactions. This documentary highlighted that a significant number of vulnerable young deaf sign language users lives are being put at "extreme risk" when it comes to sex education because their communication needs are not being met. Unfortunately, we were unable to locate research that was specific to Ireland and so we decided to utilise elements of the DEAFAX programme from the UK and incorporate the law and stats available from the Health Promotion Unit for the Irish context.*

In terms of language, each of the programme presenters are skilled ISL users and able to present the residential programme in ISL the preferred language of participants. In order to ensure that the programme would be completed in time and for additional support an interpreter was used on occasion for some of the more complex parts of the programme.

In terms of the learning needs of our group, it was agreed that by starting with traditional learning activities that involve dialogue, discussion and questioning that too much emphasis on such activities can be difficult for deaf and hearing impaired learners to engage in.

Information can be more accessible by:

- Using pictures and visual prompts that reinforce the language and content
- Avoiding unnecessarily complex language in tasks or instructions
- Pre-teaching new vocabulary with signs if required
- Using interactive whiteboards and VLEs to capture notes from teaching sessions and make available to learners afterwards
- Incorporating activities that allow responses other than writing (eg use of images and videos)

Why residential?

Gerard: *Previous Residential Workshops have shown to work well with deaf service users and represent good value for money in relation to providing interpreter services. This meant that Deaf service users had the luxury of time to comprehend and understand what was presented and after processing the information to come back and ask questions relevant for them.*

Over the three day we covered topics including:

- Language-Exploring Deaf and Hearing language of Sexual Health & Relationships
- What is Sexual Health and how does it impact our lives?
- Sexual Health Flower
- Sex Education/Contraception
- Legal Issues
- Exploring Healthy Relationships

Feedback and planning

Declan: *Feedback from the participants was beyond our expectations; it was very positive, participants felt they have learnt so much over the three days and wanted more. Evaluating the course allowed us to consider future planning. At the beginning of the course none of the participants were aware of the Emergency Contraceptive Pill and upon completion of the course were now aware of it and how to access it. This is a strong indicator of the value of continuing this work with deaf service users across Ireland. Participants also commented on how much they had learned about the language of sexual health and in particular how expressive and exhaustive hearing language is in relation to the topic. We feel that this is only the beginning and want to expand on the work complete, nationally as a service provider and also within our areas.*

DeafHear as an organisation are looking at the possibility of providing the course to deaf teenagers during the summer camp as feedback indicate that people felt they should have access to this information at a much younger age. All of the presenters feel that the individual service users that have attended the course are now more forthcoming in asking for support in relation to their sexual health. For example since the course several attendees have requested appointments at the G.U.M. clinic or asked for more information on how to access contraception. We again feel this is a strong indicator of how beneficial the course was for attendees.

Quitting Smoking is Good for your Sexual Health

by Anna Burns,
Senior Health Promotion Officer for Tobacco Control
HSE South

Contrary to the popular image of the post-coital cigarette being a pleasurable part of a sexual encounter (image of Betty Blue/Don Draper?) smoking a cigarette or a rollie has negative impacts on your sexual health. Many studies have found a link between smoking and difficulties having or maintaining an erection. Being a vasoconstrictor that tightens blood vessels and restricts blood flow, the nicotine you are addicted to as a smoker, has been shown to cause damage to arteries and as a consequence to blood flow. Since erectile function is dependent on blood flow, it is safe to assume that erectile dysfunction can be related to smoking. Studies have confirmed this. In women, blood flow also plays a part in sexual arousal and could equally be negatively affected by smoking (though research is scant in this area).

First hand smoke

Smokers expose themselves to the "tar" in cigarettes, as well as the nicotine they are addicted to. This tar (containing 7,000 or so chemicals) has detrimental effects on reproductive health as well as cardiovascular and overall health. We all know that smoking is bad for health and causes lung cancer, but do we know that men's fertility as well as sexual potency can decline?

For women are we aware that, particularly if using oral contraceptives, cardiovascular disease risk increases? There is also an impact on female fertility, risk of cervical cancer, early menopause and increased risk of bone fractures.

Second hand smoke

Second hand smoke is not sexy. Billowing across the room in that Hollywood illusion of satisfaction comes 85% of the cancer-causing chemicals your way. As a sexual partner is this sexy? Second-hand smoke exposure heightens the risk of developing cardiovascular disease, coronary artery disease, and a multitude of cancers and exacerbates conditions such as asthma.

Third hand smoke

Particles or residue that land on soft furnishings after tobacco has been smoked can cling to clothes, hair, bedding, carpets, curtains and even the dust in a house and are also cancer-causing. Not only are you exposed to these particles as a smoker or partner of a smoker but so too are others in the environment (such as small children in particular, who very often spend time on the floor).

Post-partum, breast-feeding mums who smoke are advised to disrobe after going out for a cigarette, wash their hands, face and neck, in order not to expose their new-borns to third hand smoke particles that do harm.

Quitting is sexy

The impact of not smoking on sexual health runs throughout the life course; as people mature and consider reproducing, the affect on fertility in both men & women; for an infant not to be born prematurely or of low birth weight, quitting smoking can help reduce all of these risk factors. Post-menopause the bone health as well as risk of cancer and cardiovascular risk all diminish when smokers quit. As mentioned, for men the risk of erectile dysfunction diminishes as well as risk of cancer and cardiovascular complications when smokers quit. It is not a leap to say that being in good health can only improve sexual health in men and women.

How do I quit?

Quitting is not easy. Smoking is a disease. The nicotine craved as a smoker is considered to the third most addictive chemical for our brain (following heroin and cocaine, in descending order). With support and medication smokers can quit.

Smokers are four times more likely to quit with the support of a trained counsellor and with the use of medications (such as nicotine replacement therapy – patch, losenge, gum, inhaler, spraymist). Talk to your doctor. Get advice from your pharmacist. You can quit and we can help.

Talk to the Quit Team

CALL US: 1800 201 203
EMAIL US: support@quit.ie
FREE TEXT US QUIT TO: 50100
TWEET US: @HSEQuitTeam

A New Era for Adoption Law in Ireland

by Beatrice Cronin
Information & Policy Officer TREOIR

The Adoption (Amendment) Act 2017 (hereinafter the 2017 Act) came into effect on 19 October 2017. It changes various parts of the Adoption Act 2010, which governs how all adoptions in Ireland are carried out. This innovative piece of legislation intends to better reflect the complex realities of modern family life. The following is a summary of the main changes brought forward by the 2017 Act.

Child-Centred Approach

The 2017 Act gives legislative effect to the Thirty-first Amendment of the Constitution (Children) Act 2012 through its prioritisation of the best interests of the child and its promotion of the voice of the child. It provides that the best interests of the child is the paramount consideration in relation to any matter, application or proceedings under the Adoption Act 2010.

In determining what is in the child's best interests, the Authority or the court shall have regard to all of the factors or circumstances that it considers relevant to the child concerned. A non-exhaustive list of those factors and circumstances is specifically enumerated to enable to focus on various aspects of the child's present and future well-being when determining his/her best interests. In addition, the 2017 Act provides that the views of the child shall be ascertained by the Adoption Authority or by the court and shall be given due weight, having regard to the age and maturity of the child.

Children Who May be Adopted

All children are now treated equally in terms of eligibility for adoption. The 2017 Act increases the age limit for adoption from 7 to 18. In addition, the fact that a child was previously adopted or born to married parents is no longer an automatic restriction. Under the new legislation, married parents may place a child for adoption, on a voluntary basis, in circumstances where both parents place the child for adoption and where both parents consent to the making of the adoption order.

Eligibility to Adopt Extended

The 2017 Act makes specific provision for joint adoption by civil partners and cohabitants. Cohabitants must have resided together for at least three years in order to be eligible to adopt a child. This requirement aims to ensure that children are adopted into stable environments. Eligibility to adopt is only one aspect of the matter and the detailed criteria on suitability remain in place.

Step Parent Adoption

Step-parents can now apply to adopt their partner's child without the partner, who is already the biological parent of the child, also applying to adopt the child. In addition, the 2017 Act widens the interpretation of "step-parent" to include the civil partner of a parent of the child; a cohabitant in a cohabiting couple where the other cohabitant is a parent of the child; and the spouse of a parent of the child. It also requires that, where the applicant is a step-parent of the child, the child has a home with the child's parent and that step parent, for a continuous period of not less than 2 years at the date of the application for the adoption order.

Non-Voluntary Adoption Revised Criteria

The 2017 Act introduces a lower threshold test for involuntary adoption. Before authorising the Adoption Authority to make an adoption order in respect of a child without parental consent, the High Court shall be satisfied that the parents of the child have failed in their duty towards the child for a continuous period of at least 36 months immediately preceding the time of the making of the application, and that there is no reasonable prospect that the parents will be able to care for the child in a manner that will not prejudicially affect his or her safety or welfare.

In addition, the length of time that the child has been in the custody of the adoption applicants has been increased from 12 to 18 months in order to ensure that the child has had a home with the adoption applicants for a significant period of time. This provision allows a greater prospect of stability for some children in long-term foster care where it is unlikely that they will return to live with their parents through the process of adoption by their carers.

Continued on page 24

Continued from page 23

Consent to Adoption

The Adoption Act 2010 requires that for an adoption to take place full, free and informed consent must be obtained from the natural mother of the child; any guardian of the child and any other person having charge of or control of the child immediately before the child is placed for adoption. The High Court may authorize the Adoption Authority to dispense with the consent of a person whose consent to the making of the adoption order is necessary where satisfied that it is in the best interests of the child.

The 2017 Act amends the definition of a guardian to take account of changes introduced by the Children and Family Relationships Act 2015, in particular, unmarried fathers who become legal guardians automatically if meeting certain cohabitation criteria, and non-parental guardians appointed by the court with specific right to place the child(ren) for adoption and consent to the adoption of the child(ren).

Consultation of Relevant Non-Guardians

The 2017 Act introduces the definition of "relevant non-guardian" which encompass certain interested parties to an adoption who are not guardians - and consequently are not required to give consent to the adoption process - but have a right to be consulted in relation to the adoption.

A relevant non-guardian means, in relation to a child:

- a father of a child who is not a guardian of the child;
- a person who has been appointed the guardian of a child but who has not been granted certain rights of guardianship;
- a person appointed by the court to be a temporary guardian of a child; and
- a parent of a donor-conceived child who is not a guardian of the child.

On receipt of an application for an adoption order, the Adoption Authority is to take such steps as are reasonably practicable to ensure that every relevant non-guardian of the child is consulted in relation to the adoption. In addition, the 2017 Act provides that where any relevant non-guardian objects to the proposed placement of the child for adoption, the placement will be deferred for not less than 21 days for the purpose of affording the relevant non-guardian an opportunity to make an application to court to become a legal guardian.

These provisions ensure that non-guardian parents - the natural father and the parent under donor-assisted human reproduction procedures including second female parents -, non-parental guardians without the right to place the child for adoption and temporary guardians are consulted in relation to an adoption. Although they are not required to give consent over the adoption, their inclusion in the category of relevant non-guardians reflects that they are an interested party in the child's life whose opinion on the proposed adoption must be consulted.

Reasonable Support to Birth Parents

The 2017 Act inserts a requirement that the Child and Family Agency must satisfied that every reasonable effort has been made to support the parents of a child before that child can be adopted without the consent of the birth parents.

Open and Semi-open Adoption

The 2017 Act mandates that, not later than 10 months after the passing of the 2017 Act, the Minister (Children and Youth Affairs) shall initiate a review and consultation in respect of the potential introduction of open or semi-open adoption in Ireland.

Beatrice Cronin is a qualified barrister and an Information and Policy Officer with Treoir, the National Federation of Services for Unmarried Parents and their Children.

Sexual Health Needs of Women who have Sex with Women (WSW)

by Laura Louise Condell Dublin Lesbian Line (DLL) Coordinator

Since the 1980's, with the first HIV epidemic, the sexual health needs of MSM have been the main focus of healthcare in the LGBTI+ community. While services and supports were necessary to respond to this crisis, the sexual health needs of lesbian and bisexual women were not, and still are not considered.

For Men who have sex with men (MSM) there are national sexual health campaigns and access to free STI testing, condoms and counselling. WSW in Ireland are largely unaware and often misinformed about their sexual health needs. There are no specialised services, which mean that WSW are often met with stigma, ignorance or misinformation when trying to access general sexual health services. There is no access to dental dams for the general population of WSW, unless people import them. There is no specific data on sexual health needs of WSW in Ireland. While the services for MSM are absolutely essential, the comparison illustrates a stark disparity between the availability of services for MSM and WSW.

There are many reasons why there are no specific sexual health services for WSW. Ireland's historical attitudes to female sexuality, along with misinformation and assumptions about the sexual practices of WSW have contributed hugely to the invisibility of WSW's sexuality. While MSM have often been hypersexualised in the media, WSW's sexuality has been erased from conversation, policy and services.

Many women who have engaged with DLL have talked about the stigma they have experienced amongst health professionals regarding their sexual health. WSW have been told that they do not need STI or smear tests because they cannot get STI's or cervical cancer if their sexual partner is female. Women who identify as either lesbian or bisexual as well as trans or non-binary face a whole additional plethora of barriers to access to services, and are impacted not just by stigma surrounding their sexuality but in the ignorance and judgements regarding their gender identity.

Over the last four years DLL have seen a change in WSW's willingness to engage with their sexual health. Almost 10 years ago, DLL ran a campaign called 'Smears for Queers' which was not received well. In the context of the time, this was understandable; this was before long before the referendum, and when it was still legal in certain professions to not hire, or fire, someone based on their sexual orientation. WSW often experience homophobia through sexual harassment or violence and felt the campaign as another attack on their privacy and sexuality. DLL persisted with sexual health promotion and over the last few years have piloted various ways of introducing the topic of sexual health to WSW with great success, for example through workshops and information sessions on everything from consent to DIY dental dams.

However, we realise that supports and services need to extend beyond our small organisation. Medical staff and service providers need to be educated on WSW's health needs. National research on LGBTI+ female sexual health needs to be conducted. Women of our community need to be able to access accurate information, support and services to educate themselves and protect their health.

I attended the HSE's Foundation Programme in Sexual Health Promotion which has given me renewed inspiration to make this happen. I learned a lot on this course but also felt a strong enthusiasm from service providers in other sectors to support WSW's sexual health needs. DLL are aiming to hold a community event this summer which will bring together health professionals, interested parties and the community, to look at how we can make this a reality.

Please email info@dublinlesbianline.ie or sign up to our mailing list on our website for more information. www.dublinlesbianline.ie

Speakeasy Plus – sexual health training for those working in the Intellectual Disability sector

by Lisa O'Hagan
Health Promotion Officer

Fourteen HSE staff, from a variety of services supporting the Intellectual Disability client group, participated in Donegal's first ever 'Speakeasy Plus for Professionals' training course, delivered by the Irish Family Planning Association (IFPA) in partnership with HSE Health Promotion and Improvement. The training arose from a need repeatedly identified during the national Foundation Programme in Sexual Health Promotion (FPSHP), which is delivered in Donegal by HSE Health Promotion and Improvement and the Donegal Women's Centre.

Speakeasy Plus is a 4-day comprehensive capacity-building sexual-health training programme that professionals in the Intellectual Disability sector have increasingly sought to enable them to better address their clients' educational needs in the area of sexual health and sexuality.

Participants were able to explore relevant topics such as healthy relationships, consent, puberty, saying no, and safe and unsafe touch, in a way that would enable them to address these essential areas with their service users. Participants also had the opportunity to discuss the importance of organisational policy in relation to promoting sexual health with this client group.

Through an end evaluation, many of the participants commented on the added benefit of networking with other professionals in the same sector who are also in close geographical proximity, and highlighted the potential to meet post-training for planning purposes.

Feedback from the course was positive in terms of learning, practice and sharing:

"I would feel more confident in conversation with parents, if issues or concerns arose and would now have a network of people to contact and discuss. I now know where to get the necessary resources."

"One of the most enjoyable, informative courses I have completed…I now feel equipped to deliver sexual health education to the service users who require it."

"My expectations [of the course] were most definitely exceeded. I really learned so much over the 4 days and feel that I now have a support group within my own peers to raise awareness of sexual health in relation to Intellectual Disability."

For further information contact: reception@ifpa.ie for more information on Speakeasy Plus

Sexual Health Brainteasers

by Tracey Tobin HSE Health Promotion and Improvement

History of Sex in Ireland

3	4	5	2	2	5	7	6	2	8	1	1	0
4	6	1	3	5	7	8	8	2	1	9	9	6
9	1	9	3	5	2	9	4	6	9	7	8	0
6	7	8	0	7	1	3	6	7	0	3	1	1
8	2	3	7	6	9	1	7	9	3	0	3	2
1	1	6	6	2	3	6	1	9	2	0	8	3
6	9	9	4	5	4	1	9	9	1	3	3	7
2	0	0	0	9	6	1	1	0	3	9	6	5
4	6	3	2	4	7	5	2	0	6	3	7	2
7	3	9	9	6	6	1	6	5	0	3	4	0
0	7	6	2	9	9	7	9	6	9	7	2	1
4	0	9	5	8	1	4	2	3	1	9	9	5

- Age of consent for Sexual Activity (17)
- Gender Recognition Act (2015)
- HPV Programme Commenced (2010)
- The year age of consent increase for girls from 16 – 17yrs (1935)
- Condoms went on sale in Dublin Virgin Megastore, Shops were not allowed to sell condoms by Law (1991)
- Homosexuality was formally decriminalised in Ireland (1993)
- Homosexuality was formally decriminalised in Northern Ireland (1982)
- Homosexuality was formally decriminalised in England, Wales & Scotland (1967)
- Divorce referendum resulted in the ban being lifted (1995)
- % voted yes in divorce referendum (50.3)
- First Pride Parade in Dublin (1983)
- % voted yes in Marriage Equality referendum (62)
- Civil service Marriage bar lifted (1973)
- 23 year Ban on Playboy Magazine lifted (1996)
- Number of countries Homosexuality remains Illegal (74)
- Breast screening programme commenced (2000)

Foundation Programme in Sexual Health Promotion (FPSHP)

A comprehensive training programme for health, education, youth & community service providers who wish to develop their confidence, skills and knowledge in the area of sexual health promotion.

Programme Aim

To enhance participants' capacity to incorporate sexual health promotion into their work through the development of their comfort levels, confidence, knowledge and skills in relation to sexual health.

Content

This programme will look at sexual health promotion holistically throughout the human life-course.

This will be covered under the following headings:

- Sexual Health Promotion in the Irish Context
- Sexual Health, A Life-Course Approach
- Contraception and STIs
- Self Esteem & Sexual Health
- Sexual Diversity
- Sex, Society and Culture
- Irish Law and Sexual Health
- Power and Sex
- Working Safely around Sexual Health
- Project Planning and Needs Assessment
- Facilitating Workshops on Sexual Health

Certification

This course is certified by the HSE Health Promotion & Improvement and endorsed by:

- An NMBI Category 1 Approved for Registered Nurses and Midwives
- Irish Association Social Workers - Accredited for CPD points, see IASW CPD policy for further details
- Irish Association Counselling and Psychotherapy - 60 hours attended

Application Process

The application process is a 2 step process:

- Step 1: Application Form
- Step 2: Telephone interview

The duration of the course is 10 days; these 10 days are split into five 2 day modules, typically facilitated over a four to five month duration.

Training days run from: 9.30am to 4.30pm

The course fee is currently covered by Health Promotion and Improvement.

FPSHP 2018 course locations & facilitator contact email details:

Ardee, Co. Louth
Olivia McGeough
Tel: 041 686 0716
Email: olivia.mcgeough@hse.ie

Midlands
Margaret Whittaker
Tel: 057 935 7800
Email: margaret.whittaker@hse.ie

Donegal
Lisa O'Hagan
Tel: 074 910 4693
Email: lisa.ohagan@hse.ie

Dungarvan, Co. Waterford
Tracey Tobin
Tel: 087 902 8590
Email: tracy.tobin@hse.ie

Limerick
Mairead Kelly
Tel: 061 483257
Email: maireada.kelly@hse.ie

Cork
Martin Grogan
Tel: 021 492 1665
Email: Martin.grogan@hse.ie

Mayo
Thelma Birrane
Tel: 094 904 2589
Email: Thelma.birrane@hse.ie

For general information of the FPSHP please contact Catherine Byrne National Coordinator of the Foundation Programme in Sexual Health Promotion

Tel 021 492 1674 or
Email:catherine.byrne2@hse.ie

Sláinte Ghnéis &
Clár um Thoirchis Ghéarchéime
Sexual Health &
Crisis Pregnancy Programme