Consultation to support the new National Sexual Health Strategy, 2024

Introduction: the National Sexual Health Strategy 2015 – 2020

The first *National Sexual Health Strategy 2015 – 2020*, took a life course approach, acknowledging the importance of healthy attitudes to sexuality in young people and of building on that foundation during adulthood and into older age. The Department of Health and HSE are now redrafting the Strategy, retaining the successful basis of the previous Strategy but also developing this further.

The new Strategy will include many of the positive developments of recent years, such as free contraception, through the free contraception scheme and National Condom Distribution service, free pre-exposure prophylaxis for HIV and free home STI testing, and linking in with other key policy areas such as LGBTI+, women's and men's health. Information, education, communications and research are other key areas that contributed to the success of the first Strategy and will be strengthened further in the second.

The new Strategy will strive to further improve supports for sexual health and wellbeing, while reducing negative sexual health outcomes and supporting healthy attitudes to sexuality throughout the life-course. Implementation of the new Strategy will be led by the HSE. Refreshing the NSHS is of key importance given the introduction of many new services since 2015, and the rise in Ireland's population, both in terms of numbers and diversity.

Stakeholder feedback sought, supports for sexual health

With many thanks to many of you for your response to previous stakeholder engagement events that informed the Review of the NSHS (held in 2021), we are now looking to update these in advance of delivering the new Strategy.

We would be grateful for information regarding your views on current sexual health supports and any additional considerations that arise under your remit that you would like us to consider.

This information will be used to inform drafting of the second National Sexual Health Strategy and to inform implementation, future outreach, informational supports and service planning.

We include 4 questions below, should you wish to submit feedback, we would be grateful if this could be returned to Fiona Mansergh Fiona_Mansergh@health.gov.ie and Jenna Scott jenna_scott@health.gov.ie by close of business on 28th March, 2024.

Questions:

1. **Have additional supports provided during the lifetime of the previous Strategy (2015-2022) been helpful and easily accessible?** *Examples include (but are not limited to) information and education supports, the free contraception scheme, the National Condom Distribution Scheme, PrEP and free home STI testing.*

Please note all RCNI answers are through the lens of sexual violence perpetration and survivors, we do not have expertise on wider SH matters.

The advances in reviewing and updating the curriculum have been significant but do need continual review to keep up with rapid cultural and technological changes.
The Sexual wellbeing and B4Udecide websites are excellent resources along with the Real U training.

We have some notes re the contents of same as we noted these while reviewing for this submission (for more see Q4 answer below). These notes raise points of principle/approach that might form key considerations for the development of the next strategy. Eg the extent to which SH needs to be informed by the reality of SV, predatory behaviour and a significantly victimised population (lifetime prevalence of SV for Women is 52% and 28% for men – CSO SVS 2022). Our responses in Q4 points to significant areas where sexual violence impact has not been integrated but is likely to have significant impacts on the efficacy of supports. eg SH behaviour advice is often constructed on an assumption of an SV-free world but applied in a far from ideal world to a significantly traumatised, terrorised and groomed population with the resultant limitations or unpredicted responses from users.

2. **Do you feel that there are significant gaps or capacity deficits in the provision of free or subsidised Sexual Health services? If so, what are these (in order of priority).**

Reflecting on how SV trauma impacts on service user behaviour, capacity and access, should the next strategy specifically undertake a review or proofing exercise on how SV trauma impacts SH behaviours including accessing services? Such a review would make recommendations leading to an action plan on improving sexual violence survivors' sexual health overall.

It should be noted that generic trauma-informed actions are often insufficient or not be fit for purpose for SV survivors. The particular implications, social context and emotional impacts of SV may need specific attention.

Any actions for developments in SH services needs to cross-reference with the DSGBV Zero Tolerance strategy and in particular the Prevention and Protection Pillars. It has been a peculiarity of Ireland's policy landscape that SH and SV have been so separate – there are developing models in other jurisdictions that provide SH responses specifically targeted to sexual violence survivors. A needs assessment for same should be developed with a timeline for implementing actions arising.

3. **In your view, what are the most significant challenges that people experience in terms of SH and wellbeing – please also feel free to suggest potential avenues of support for these challenges?**

In relation to SV survivors:
We do know that SV impacts in significant ways on how people access and experience services. Survivors of SV may not access immediate medical care after an assault and indeed become avoidant of SH care in the medium and long term. A survey of survivors in England and Wales in 2019 found that half said they had not attended Cervical Smear screenings because of their trauma, a quarter said they had put the test off with only 14.5% saying they had attended the screening when invited. How Survivors of Sexual Violence May Feel About Screening (jostrust.org.uk)
We also know that survivors have significantly higher levels of uptake of a range of health services and indeed may, conversely to SH avoidance, be 'over-tested' See SAVI, & C Kelleher. In addition, a common coping strategy for survivors is to engage in sexual behaviours that may negatively impact their sexual health as a response to the SV trauma.

For these reasons a SV proofing of SH service provision is important to ensure this cohort can access the SH services they require.

4. Are there any additional points you would like to make or areas you would like to see supported by the next version of the National Sexual Health Strategy?

The prevention of sexual violence needs to consciously and critically address culture, systems and norms that perpetuate the conditions which facilitate sexual violence. This means challenging victim blaming, minimisation and denial.

The fact that Sexual Health has for many years been seen as distinct to sexual violence holds risks. RCNI very much recognise the efforts that have been made to ensure cross-over relevance and efficacy despite this policy separation and indeed are grateful to have been consulted in supporting the HSE in particular in developing their plans and content some of which we critique below. Nevertheless, there are numerous instances of 'rape culture' constructs that reappear and are replicated. These more easily re-assert themselves in spaces that attempt to be SV-'neutral' or 'blind'. We set out some examples below. It is for this reason that we recommend that the SH Strategy explicitly engages with the facts of sexual violence throughout the strategy.

Examples of rape culture reinforcing language used in the Sexual Wellbeing website (many of the same issues are repeated on B4UDecide):

Age of Consent section:

'This is sometimes called the "Romeo and Juliet Defence". This means that if a person has been charged with an offence of engaging in a sexual act with a child who is 15 or 16 years of age he or she can put forward a defence but only if all of these conditions apply:'

We would strongly recommend removing the reference to 'Romeo and Juliet'. This language is harmful to the increasing numbers of young people who are raped by their peers as it sets and reinforces a cultural expectation that sexual acts between children are romantic, harmless and consensual. Peer on peer sexual violence is often deeply confusing for a teenager to name as they are highly susceptible to manipulation, peer pressure and gaslighting. This terms reinforcing these ambiguities and weaponizes romance against the teenage victim.

We would also recommend underlining or Bolding the 'all' at the end of the sentence.

Consent Practice section:

Giving Consent

The first section is largely silent on predatory behaviour and largely frames consent and any problems as a miscommunication between good actors. This is unhelpful given what we know of the prevalence of sexual violence – indeed one could argue it is gaslighting of survivors.

RCNI recommends adding the line at the end of this section on 'Giving consent'

'If someone is not respecting your boundaries this is predatory behaviour. They are not entitled to negotiate your boundaries and you do not owe them any explanation. You should prioritise your safety when someone displays this behaviour.

Getting Consent:

'Many people think they know if their partner is consenting to sex by their behaviour, but in reality the only sure way to know is if you talk about it and they agree to have sex.'

This is not correct under the law (which does not require consent to be verbal) and not good advice (again it assumes good actors and secondly it assumes a non-SV-traumatised population). It is not trauma informed. People may, for a variety of reasons, agree to sex verbally who have not in fact consented. Survivors of SV risk assess based on their experience and learned behaviours from the abuse/s they were subjected to previously and the responses they received afterwards. Their best option may therefore be compliance. This is not consent.

The website does recognise this, to a point, where it later contradicts the opening advice with this statement:

'Even if someone verbally agrees to sex but their body language is signalling something else, you should stop and check in with them.'

The rest of the advice is generally good but there needs to be an acknowledgment of trauma and its impact here. This is a significant issue. In Ireland today 65% of 18-24 year olds have already experienced some form of sexual violence (CSO SVS 2022). The objective of simplifying the message on consent practice and being sexual violence 'blind' with the objective of engaging the widest audience, may be alienating and doing a disservice to survivors of SV, who are in fact the majority audience for 18 –24 year olds.

Contact Information:

The information in this form can be submitted without providing a name and contact details, however, should you wish to provide contact details for use in the case of follow-up and information regarding any future initiatives, please feel free to do so below. If you would be interested in participating in a future stakeholder consultation group, on behalf of your organisation, please feel free to indicate availability below. Details are yet to be finalised, but it is likely that such group(s) will

meet once to twice per annum with the primary purpose of updating policy leads on matters arising in the communities that you serve, as the Strategy is implemented.

Name: Cliona Saidlear
Contact details (email, phone): director@rcni.ie
Position: Executive Director
Organisation: RCNI
Availability for Stakeholder Group (TBC): yes/no

Note on Stakeholder Group:

Details are still to be confirmed, but it is envisaged that a Stakeholder Group would meet twice per year to discuss ongoing, new and emerging issues that may arise in the context of sexual health service provision and Strategy implementation. Essentially, the Group will function as a forum that will enable listening and stakeholder engagement, keeping everyone informed and up-to-date and enabling information sharing and problem-solving.

Disclaimer:

We are very grateful for submission of feedback, which will be considered as soon as possible. All feedback and suggestions will be considered and prioritised at our discretion in terms of future planning and inclusion in future policy and initiatives. Given requirements for senior level and/or Government approval, for any Government Department, State Agency or public body to publish a policy or strategy, or to provide funding for any initiatives, we cannot offer any assurance that any specific proposals will be supported or included.