Feedback on the National Sexual Health Strategy (NSHS) consultation, 2024

10th May 2024

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Feedback from the Irish Family Planning Association
10th May 2024

We provide feedback and recommendations in relation to the questions within the table below. We have focused on seven broad topics, which are organised in the context of the most relevant question for each. Under each heading we make a number of recommendations.

Under question 2: regarding gaps or capacity deficits in the provision of free or subsidised sexual health services, we address:

I. Contraception
Recommendations 1 and 2

II. Abortion care
Recommendations 3 to 7

III. Specialist pregnancy counselling
Recommendations 8 to 12

IV. Primary health care provision of sexual and reproductive healthcare
Recommendations 13 to 16

Under question 3 regarding challenges, we address:

V. Equity in access to healthcare
Recommendations 17 to 20

VI: Data collection
Recommendation 21

Under question 4 regarding additional points, we address:

VII. Female genital mutilation
Recommendations 22 to 28

The IFPA's comments encompass a wide range of issues pertaining to the right to health, including legal, policy and operational aspects of healthcare. We view these as interdependent and indivisible. All of our comments should therefore be considered of equal priority.

Questions:
Thinking of supports that you provide, including through any public-facing services:

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.*

Positive measures

The introduction of abortion care has been transformative for women, with a high proportion of the need for abortion care met within community primary healthcare services. It is critical that abortion care is integrated into the new NSHS. The ongoing support for "crisis pregnancy counselling" services has been of immense benefit to women and girls who avail of abortion care. The SHCPP review of the service was a very welcome and timely exercise and raised many relevant issues and recommendations.

The free contraception scheme has removed the cost of contraception from a large cohort of women and girls of reproductive age, thereby expanding choices and supporting bodily autonomy. The inclusion of long-acting reversible contraceptives in the scheme has ensured that those who wish to use contraception can avail of the method that is best and most effective for them, at their stage of life, rather than having to accept a method based on affordability. The planned extension of the scheme up to age 35 is very welcome.

The introduction of enhanced services for complex menopause cases is also very welcome. The information supports provided by the HSE have been excellent.

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).**

Note: all issues outlined below are of equal priority.

I. Contraception

With the free scheme introduced in 2022 the state recognised that access to contraception is so obviously a public good that the state, rather than the user, should bear the cost. In the IFPA's view, the limitation of the scheme to defined age-groups is inherently inequitable, as many women and girls for whom an unintended pregnancy would be a significant crisis are excluded from the scheme and therefore at higher risk. The ineligibility of those under 17 is particularly problematic, as they are unlikely to be able to pay for contraception and a pregnancy is highly likely to adversely affect these young people's well-being, education and career prospects in multiple ways and increase their vulnerability to ongoing disadvantage.

The findings of the Irish Health Behaviour in School-aged Children (HBSC) Study, 2022 underscore the need for expansion of the scheme to younger teenagers. The report found a decrease among 15- to 17-year-olds who report using a condom and an increase in those who report using no contraception at last sexual intercourse. Overall, 25% of 15 to 17-year-olds reported that they have ever had sexual intercourse, which remains broadly unchanged from

2018 (25%). However, of those who reported having had sex; 34% said that they or their partner used no contraception at last sexual intercourse, an increase of 22% from 2018.[1]

While a budgetary allocation has been made for the inclusion of 16-year-olds, the Minister has said that he has been advised that legislation is needed to extend the free scheme to younger age groups.[2] However, no legislative proposals have yet been published. We understand that such legislation would resolve the unclear legal status of prescribing contraception to under 17s and the fact that the law is silent on whether under 16s are capable of consenting to medical treatment, or need the consent of their parents. Action to address these issues was recommended by the Law Reform Commission in 2011.

The stated position in the current HSE National Consent Policy is that the key consideration in prescribing contraception to minors is the best interests of the child. Young people's health should be a national priority. The UN Committee on the Rights of the Child has repeatedly criticised the State for failing to ensure young people's rights to access sexual and reproductive healthcare.

Recommendation 1
The introduction of legislation to resolve the legal barrier to extension of the scheme to under-17s must be a priority for the NSHS.

For those who are eligible, the scheme is working extremely well, however there are issues with supplies of non-hormonal intra-uterine devices: there is currently only one copper coil (Ballerine) available within the scheme.

Recommendation 2
The NSHS should include an action to ensure availability of a full range of quality modern methods, including non-hormonal devices, to women and girls who are eligible under the scheme.

II. Abortion care

Legislators acknowledged in 2018 that there was no domestic evidence on abortion care in Ireland. They therefore made the appropriate decision to include a review clause in the Health (Regulation of Termination of Pregnancy) Act 2018. The comprehensive, evidence-based review of abortion published in 2023 (the O'Shea Report) highlighted a range of gaps in the provision of abortion under the current legislative framework. The O'Shea report is informed by the abortion care guidance of the World Health Organization (2022) and draws on the 2022 HSE Unplanned Pregnancy and Abortion Care (UnPAC) study.[3]

While there have been improvements in many operational aspects of abortion services in the past year – e.g. 17 of the 19 maternity hospitals now providing care – significant barriers to equitable and accessible abortion services remain. These barriers include ongoing

[1] Irish Health Behaviour in School-aged Children (HBSC) Study, 2022 (published 2 May 2024) https://www.universityofgalway.ie/media/healthpromotionresearchcentre/hbscdocs/nationalreports/HBSC-2022-National-Report.pdf
[2] Dáil debates Wednesday, 6 July 2022: Health (Miscellaneous Provisions) (No. 2) Bill 2022: Committee and Remaining Stages https://www.kildarestreet.com/debates/?id=2022-07-06a.243&s=contraception+16+year+olds+speaker%3A359#g254
[3] Unplanned Pregnancy and Abortion Care (UnPAC) Study https://www.sexualwellbeing.ie/for-professionals/research/research-reports/unpac.pdf

criminalisation, the mandatory 3-day wait, inadequate data collection, uneven geographical coverage, and narrow rigid legal criteria for abortion access after 12-weeks; including the 28-day clause for fatal foetal anomalies. These obstacles have resulted in women and pregnant people being denied timely reproductive health care and, in many cases, being forced to travel abroad.

Recommendation 3
The NSHS should include a range of actions to ensure implementation of the operational recommendations of the 2023 O'Shea report.

The NSHS should also include the following actions related to the key legislative reforms proposed in the report:

Recommendation 4
Full decriminalisation of abortion in line with World Health Organisation (WHO) guidance to remove the chilling effect on healthcare providers, ensuring that they can use their clinical judgment to care for people without fear of prosecution.

Recommendation 5
Remove the medically unnecessary mandatory three-day wait period to ensure timely access to abortion care.

Recommendation 6
Review the 12-weeks gestational limit to ensure women and pregnant people are not timing out of care and forced to travel abroad for essential reproductive healthcare.

Recommendation 7
Moreover, to support the operational recommendations, the NSHS should include recruitment of a HSE Primary Care Lead for Termination of Pregnancy to address current gaps in training, guidance, and data collection in relation to abortion care at the community level.

III. Specialist pregnancy counselling

The review of "crisis pregnancy" counselling services in Ireland undertaken in 2023, four years after the introduction of abortion care in Ireland was very timely. As the review noted, the term "crisis pregnancy" is outdated and comes from a time when abortion care was illegal and stigmatised. The term may be associated with an erroneous view that the role of pregnancy counselling is support with decision-making. The term does not encompass the range of emotional and psychosexual needs that arise in practice within the service (e.g. infertility, tokophobia, post-natal depression, gender-based violence). The limitations of the terminology have implications for the ability of service provision to provide care that is truly needs-led.

Moreover, section 4(i) of the regulation that established the mandate of the SHCPP (formerly known as the Crisis Pregnancy Agency)[4] must be reframed. The regulation defines the functions as:

[4] S.I. No. 446/2001 Crisis Pregnancy Agency (Establishment) Order, 2001. Available at: https://www.irishstatutebook.ie/eli/2001/si/446/

(a) To reduce the number of crisis pregnancies by the provision of information, advice and contraceptive services.
(b) To *reduce the number of women with crisis pregnancies who opt for abortion* by offering services and supports which make other options more attractive.
(c) To provide counselling services, medical services and such other health services for the purpose of providing support, after crisis pregnancy as may be deemed appropriate by the Crisis Pregnancy Programme.

Paragraph (b) reflects the legal position imposed by pre-2018 legislation and by article 40.3.3 of the Constitution and is at odds with current public policy in relation to abortion care, which is now part of mainstream healthcare and available from GPs. All three stated functions are out of alignment with contemporary understanding of access to reproductive healthcare as essential to women's health, well-being and bodily autonomy.

Recommendation 8
The NSHS should include actions to promote and support the service currently termed "crisis pregnancy counselling" as part of an overall strategy to integrate all aspects of abortion care into mainstream healthcare. We recommend the term "specialist pregnancy counselling" and that reference be made to "unintended pregnancy" and "pregnancy that has become a crisis".

Recommendation 9
The NSHS should reframe the role of the SHCPP within the wider context of sexual and reproductive health and the terminology should be revised to reflect this, including by the removal of the language in relation to reducing the number of women with crisis pregnancies who opt for abortion and reframing the functions of the SHCPP in terms of fulfilling rights and supporting choices with regard to abortion and contraception.

Specialist pregnancy counselling is an area of mental health that requires significant expertise. Complex cases frequently require engagement with other healthcare professionals, including GPs, and within hospital settings, medical social workers, midwives and perinatal mental health teams. However, there are no formal referral pathways from specialist pregnancy counselling into hospital perinatal care.

Recommendation 10
Introduce measures, including referral pathways, to ensure integration of specialist pregnancy counselling services into maternity and pregnancy care more generally.

Recommendation 11
Support the ongoing development of skills within the sector through the provision of advanced training by appropriately experienced practitioners of pregnancy counselling.

Recommendation 12
Take measures to combat the activities of disingenuous/rogue agencies, including by promoting legitimate counselling services and by accelerating the process of regulation of counselling through Corú.

IV. Primary healthcare provision of SRH

The World Health Organisation promotes the vision of universal health coverage (UHC), i.e. that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship.[5] To deliver on this promise, countries need to have strong, efficient and equitable primary health care systems which can ensure that SRH needs are identified, prioritized and addressed in an integrated way within the community; that there is a robust and equipped health and care workforce; and that all sectors of society contribute to confronting the environmental and socio-economic factors that affect health and well-being.

In the IFPA's view, the provision of sexual and reproductive healthcare (SRH) at the community level should be a priority of the NSHS. Currently, many people have no option but to travel long distances within Ireland to access hospital or other specialist services to avail of SRH that could be better provided at local primary healthcare facilities. The burden of the geographical inequity in relation to distribution of services falls most heavily on those who are disadvantaged.

There is a need for more centres across Ireland that can provide the full range of SRH services, as well as training and capacity building, and support policy development. Such centres should provide accessible referral pathways from GP services for complex cases which may be overly burdensome within a busy general practice.

Recommendation 13
In order to support the capacity of general practice and to foster the development of specialist skills in sexual and reproductive healthcare (SRH) throughout primary care, the NSHS should include an action to identify and resource leading primary health care specialist providers of SRH in each of the healthcare regions.

As emphasised in the UNPAC report, there is currently an over-reliance on the goodwill of champions of particular areas of SRH to provide training and to deal with more complex cases and provide peer support. These champions frequently provide such supports on their own time and access training at their own expense. This is not sustainable for quality, ongoing health-service development. There is a need to foster the development of a community of practice, promote research and innovation. In this context, while the role of doctors is emphasised in the 2018 act and the model of care for early medical abortion, the expansion of the roles of nurses and midwives within abortion care provision would enhance the capacity of primary healthcare providers of the service.

Recommendation 14
Initiate a faculty of sexual and reproductive health. Such an institution should be tasked to ensure that Ireland has sufficient numbers of providers who are trained in the provision of care for both routine and complex contraception, menopause and abortion care, as well as other areas of SRH.

Recommendation 15
Provide subsidised training and education in key areas of SRH, including abortion, contraception and menopause.

[5] Universal Health Coverage (UHC), https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)

Recommendation 16
Enhance the role of nurses by providing advanced training in SRH for nurses and midwives.

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?

V. Equity in access to healthcare

Equity in healthcare access is a major challenge, related both to out-of-pocket costs of healthcare and the difficulty of accessing a GP in contexts where GMS lists are full. National or population-based programmes are necessary but not sufficient to ensure equitable access.

The recently published 2024 UNFPA State of World Population report, *Interwoven Lives, Threads of Hope: ending inequalities in sexual and reproductive health and rights*[6] outlines the impacts of multiple, intersecting forms of discrimination on the most marginalised and vulnerable in all societies. The report makes clear that barriers to health care fall fastest for those who are more affluent, educated and privileged. The groups that have benefitted the most from population-based programmes are those that had the fewest barriers to begin with.

The development of a quality assessment framework aligned with the principles of the right to health, and taking into account the social determinants of health, as outlined in international human rights law, would support the identification of actions to promote equity across the health service. (See final question for more on this point.)

The cost barrier in relation to menopause care
The existing structures for menopause care offer an encouraging example: however, these services are inadequate to meet the demand for menopause care and there is a need for training of GPs to enhance their capacity to deal with moderately complex cases. Moreover, the cost of hormone replacement therapy is onerous for many women and subject to the same gender inequity with regard to the burden of cost as contraception.

Recommendation 17
Take appropriate steps to introduce a free scheme for access to hormone replacement therapy, along the lines of the free contraceptive scheme.

The cost barrier in relation to vasectomy care
Access to vasectomy under the GMS should also be improved to enhance the reproductive options available to men and also to decrease the health and financial burden on those women who may be using contraception not because of choice, but due to the high cost of vasectomy.

Recommendation 18
Immediately increase the number of GMS providers of vasectomy and take steps to introduce a free scheme for access to vasectomy.

[6] *Interwoven Lives, Threads of Hope: ending inequalities in sexual and reproductive health and rights. UNFPA 2024. Available at: https://www.unfpa.org/sites/default/files/pub-pdf/swp2024-english-240327-web.pdf*

Promoting equity

Monitoring the implementation of the right to the highest attainable standard of health care is a critical aspect of addressing inequalities. The NSHS should adopt an ambitious and visionary human rights based approach: 2024 marks 30 years since the International Conference on Population and Development (ICPD) took place in Cairo in 1994. The ICPD's landmark Programme of Action (PoA), adopted by 179 governments, including Ireland, recognised the importance of sexual and reproductive health and rights as critical to health and wellbeing. Ireland's statement at the UN gathering which marked this milestone made a renewed commitment to advance the ICPD agenda.[7]

A human rights based approach to the NSHS should make reference to the norms of international human rights law, the guidance standards of the World Health Organisation, including its abortion care guidance. It should be aligned to the most up to date definition of sexual and reproductive health and rights, namely, that proposed by the 2018 Guttmacher Lancet Commission, which in turn draws on numerous international and regional agreements, and on international human rights treaties and principles, and reflects an emerging consensus on the services and interventions needed to address the sexual and reproductive health needs and bodily autonomy of all individuals.[8]

Recommendation 19

In line with a human rights-based approach, the Sustainable Development Goals and the associated goal of universal health coverage, the NSHS should include actions to promote access to healthcare and the realisation of the rights of those furthest behind, i.e. those who experience multiple and intersecting forms of discrimination and disadvantage.

Recommendation 20

Development of a quality assessment framework aligned with the principles of the right to health as outlined in international human rights law, and taking into account the social determinants of health, which support the identification of actions to promote equity across the health service.

VI. Data-gathering

A 2024 report by UNFPA, the UN agency for sexual and reproductive health, makes clear that too few countries are collecting data on sexual and reproductive health needs and barriers; fewer still are disaggregating data by factors known to contribute to neglect, discrimination and marginalization, factors including culture, ethnicity, "race", caste, language, religion, disability status, HIV/AIDS status, migration status, sexual orientation and gender identity.[9]

Without a proper system of data collection at national level in relation to abortion, contraception, FGM and other areas of SRH, Ireland lacks a robust evidence base which can

[7] National Statement by Ireland at 57th session of the Commission on Population and Development: https://www.ireland.ie/en/un/newyork/news-and-speeches/speeches-archive/57th-session-of-the-commission-on-population-and-development-national-statement/

[8] Guttmacher-Lancet Commission on sexual and reproductive health and rights https://www.guttmacher.org/guttmacher-lancet-commission/accelerate-progress-executive-summary

[9] *Interwoven Lives, Threads of Hope: ending inequalities in sexual and reproductive health and rights. UNFPA 2024. Available at: https://www.unfpa.org/sites/default/files/pub-pdf/swp2024-english-240327-web.pdf*

support monitoring of the successes and shortcomings of these critical services and hamper the development of future initiatives. We have raised this issue in relation to abortion care, pregnancy counselling and contraception (previous sections) and with regard to the provision of treatment for women who are subjected to FGM (below).

Recommendation 21
A system for national data collection across all areas of SRH should be developed in light of current service needs, informed by the social determinants of health, and capable of capturing data relevant to national service planning and design, including, but not limited to asylum status, use of interpreters, socio-economic factors, experience of gender-based violence, disability.

Are there any additional points you would like to make or areas you would like to see supported through a subsequent National Sexual Health Strategy?

VII. Female genital mutilation (FGM)

FGM is the cutting, injuring or closing of the external female genitalia, or other injury to the female genital organs, for no medical reasons. FGM is a human rights violation and a form of gender-based violence, most commonly carried out on young girls between infancy and age 15. It has no health benefits. It can cause excruciating pain and severe bleeding in the immediate aftermath and often leads to long-term physical and psychological issues, including infection, infertility and post-traumatic stress disorder. Many girls and women who have been cut also face childbearing complications, including postpartum haemorrhage, stillbirth and infant mortality.

It has been estimated that 10,000 women and girls living in Ireland have experienced FGM. Since 2014, the IFPA has been operating Ireland's only dedicated expert primary healthcare service for the treatment of women who have been subjected to the extremely harmful practice of FGM. This is funded by the HSE. The service includes a referral pathway to secondary care (Rotunda Hospital) for surgical assessment and intervention (deinfibulation). Since 2022, the IFPA has seen an unprecedented increase in demand for our service: in 2023, we provided 241 FGM appointments (medical and psychological). This represents a 338% increase on 2021 appointments (55). The increase in client numbers has been accompanied by an increase in complexity as most women presenting to the service are newly arrived asylum seekers. Uncertain legal status, limited or no English and the absence of family and community support networks mean that FGM clients are a highly vulnerable population, who experience particular difficulties as they try to navigate the unfamiliar health, social protection, public transport and international protection systems in Ireland.

A single service is not sufficient to meet the needs of this large and highly vulnerable population. The NSHS should include dedicated actions to address the increasing demand for treatment from women and girls who have been subjected to female genital mutilation (FGM). We recommend a range of measures below to address the deficit in care provision for those who have been subjected to FGM.

Recommendation 22
Appoint a national clinical lead for FGM treatment services in primary care to provide guidance and support for appropriate service expansion around the country.

Recommendation 23
Develop a new funding model aimed at GPs who specialise in women's health, in addition to women's health and family planning clinics, i.e. healthcare providers who already possess a skillset relevant to the care of women who have experienced FGM.

Recommendation 24
Provide training for providers of treatment to those who have been subjected to FGM in the clinical aspects, but also areas of cultural competence and cultural awareness.

Recommendation 25
Develop clear referral pathways to psychological supports for healthcare providers who care FGM survivors. In the IFPA's extensive experience, there is significant demand for counselling, including psychosexual therapy, amongst FGM survivors.

Recommendation 26
Develop national clinical guidelines for FGM treatment in primary care and therapeutic guidelines for working with FGM survivors (however such development should not be a precondition to service expansion).

Recommendation 27
Establish FGM contact points in all 19 maternity hospitals, as recommended in the 2019 Guidance for hospital management of FGM.[10] This should be prioritised: the IFPA is only aware of two hospitals (Rotunda, CUMH) where an FGM referral pathway exists.

Need for multiagency and multisectoral strategy development and governance.
Responsibility to address FGM cuts across the health, social care, social protection and justice sectors. There is a need for a whole-of-government approach. However, to date, efforts to tackle the practice in Ireland have been led for the most part by NGOs. The State has largely confined its role to the enforcement of the Criminal Justice (Female Genital Mutilation) Act 2012 and providing financial support to NGOs and multilateral agencies to work on FGM both at home and abroad. Policy formation and implementation are fragmented and there is no over-arching accountability structure to ensure an effective and coordinated response to FGM by the diverse State bodies, agencies and government departments that have a role in addressing this harmful practice.

Recommendation 28
Establish a government-led interagency committee, with representation from key government departments, State agencies, NGOs and women and men from affected communities. This committee should be tasked with responsibility for the development of a national-level framework or strategy with appropriate resourcing, including funding, to combat FGM across key areas.

[10] National Clinical Guideline: Management of Female Genital Mutilation (FGM). Published by: Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland and the Clinical Strategy and Programmes Division, Health Service Executive. Available at: https://www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/clinical-guidelines/management-of-female-genital-mutilation-2019-.pdf

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.

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Organisation: Irish Family Planning Association
Availability for Stakeholder Group (TBC): Yes

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.