HIV and AIDS
Education and Prevention Plan
2008 - 2012

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The Education and Prevention Sub-Committee
of the National AIDS Strategy Committee

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Foreword

I am very pleased to be associated with the launch of the HIV and AIDS Education and Prevention Plan 2008 – 2012, prepared by the Education and Prevention Sub-Committee of the National AIDS Strategy Committee.

HIV is a preventable illness. The challenge for the future must be to aim at reducing the number of people who become infected with HIV in the first instance. This can only be achieved through organisations working in partnership and delivering services based on the best available evidence. This report sets out key areas for action and I hope that it will assist those who plan, manage and deliver services in their efforts to prevent people becoming infected with HIV.

The importance of listening to and learning from people living with HIV is essential to effective HIV and AIDS education and prevention. This is a guiding principle of this action plan and I strongly urge those implementing this plan to maintain a commitment to hearing the voices of those living with HIV.

The Education and Prevention Sub-Committee's work in delivering the first *Irish Study of Sexual Health and Relationships* (ISSHR) has provided a strong foundation for all future HIV and AIDS education and prevention activity. The data contribute to an informed understanding of the factors related to the broad spectrum of sexual behaviour and practice. The study allows us to develop a greater insight into the contribution that individual behaviours, appropriate service development and education and prevention activities can make to securing good sexual health and avoiding negative outcomes. It also underlines the need to develop appropriate responses in relation to sexual health inequalities, sexual practices and behaviours, sex education and lifelong learning, and service development and planning.

Finally, I want to thank all those who gave freely of their time to complete this report: the Sub-Committee members, the National University of Ireland, Galway, and participants at the National Consultation Day – all have contributed their expertise, on-the-ground knowledge and enthusiasm to ensure that this report can have meaning to those planning and delivering services.

Ireland's integrated response to HIV to date has proved effective – it is my hope we can maintain and build on this into the future.

Mary Wallace, TD
Minister for Health Promotion and Food Safety

Message from the Chairperson

I am very pleased to present this HIV and AIDS Education and Prevention Plan for the period 2008 – 2012.

This plan sets out the way forward for HIV and AIDS education and prevention in Ireland for the next 4 years. It follows on from the Education and Prevention recommendations contained in the *AIDS 2000* report. It has been informed by a review of the evidence of international best practice, current research findings, epidemiological trends and feedback from a National Consultation Day. This plan is intended to direct service development and prioritise resources for HIV and AIDS education and prevention. It is our intention to ensure that while there is a population focus on HIV and AIDS education and prevention, there also needs to be a focus on the more vulnerable 'at risk' groups.

One of the cornerstones in the development of this plan was the importance of basing any actions on what is known and proven to be effective in HIV and AIDS education and prevention. An up-to-date review of the evidence of international best practice is included and this will be of great benefit to all those involved in the planning and delivery of HIV and AIDS education and prevention programmes and initiatives.

Working in partnership is essential for the success of HIV and AIDS education and prevention. The value of working together as a group in true partnership and in giving back what you take out is demonstrated in this plan: statutory agencies, non-governmental organisations and individuals have been working together in partnership to develop this plan and are now equally committed to ensuring it has the greatest possible impact on implementation.

I would like to thank the members of the Education and Prevention Sub-Committee for all their hard work in writing this plan. I would also like to thank Siobhán O'Higgins and Professor Margaret Barry from the National University of Ireland, Galway, who carried out the review, those who participated in the National Consultation Day and all those involved in the drafting and re-drafting of this plan.

I believe that the initiatives and actions included within the HIV and AIDS Education and Prevention Plan will benefit the lives of many and will ensure that all of us with a responsibility to protect and promote health are directed by the best available evidence. I look forward to guiding the implementation of this plan in the coming years.

Dr. Nazih Eldin
Chairperson
Education and Prevention Sub-Committee
of the National AIDS Strategy Committee

Acknowledgements

Membership of the Education and Prevention Sub-Committee since 2000 includes the following individuals as representatives of key stakeholders in HIV and AIDS Education and Prevention:

Current Members
Dr. Nazih Eldin – *Chairperson*
Ms. Frances Shearer – Department of Education and Science
Ms. Deirdre Seery – Sexual Health Centre, Cork
Mr. Mick Quinlan – Gay Men's Health Service, Health Service Executive
Ms. Leonie O'Neill – Social Inclusion, Health Service Executive
Ms. Janet Gaynor – Health Promotion, Health Service Executive
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Mr. Philip Watt – National Consultative Committee on Racism and Interculturalism
Mr. Ciarán McKinney – Gay HIV Strategies
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Ms. Ann Nolan – Dublin AIDS Alliance
Mr. Rick Lines – Irish Penal Law Reform Trust

Mr. Tom O'Connor, Ms. Marie Kinsella and Ms. Anne Corr – Department of Health and Children – provided Secretariat to the Sub-Committee.

The review of international best practice in HIV and AIDS education and prevention informing this plan was researched and written by Siobhán O'Higgins and Professor Margaret Barry, supported by Nicola Ballintyne, at the Health Promotion Research Centre, Department of Health Promotion, National University of Ireland, Galway.

A large number of stakeholder groups and organisations attended the National Consultation Day and contributed their views and expertise to ensure that the recommendations set out in this plan are linked to current and emerging implementation priorities.

Abbreviations

AIDS	acquired immunodeficiency syndrome
EU	European Union
GHN	Gay Health Network
GIPA	Greater involvement of People living with HIV and AIDS
GLEN	Gay and Lesbian Equality Network
GMHP	Gay Men's Health Project
GMHS	Gay Men's Health Service
GP	General Practitioner
GUM	genito-urinary medicine
HAART	highly active antiretroviral therapy
HCV	Hepatitis C virus
HDA	Health Development Agency, UK
HIV	human immunodeficiency virus
HPSC	Health Protection Surveillance Centre
HPU	Health Promotion Unit
HPV	human papillomaviruses
HSE	Health Service Executive
HSN	HIV Services Network
IDU	injecting drug user
ISSHR	Irish Study of Sexual Health and Relationships
LGBT	lesbian, gay, bisexual and transgender
LDTF	Local Drugs Task Force
MDT	mandatory drug testing
MSM	men who have sex with men
MTCT	mother-to-child transmission
NAS	National AIDS Strategy
NASC	National AIDS Strategy Committee
NCCRI	National Consultative Committee on Racism and Interculturalism
NEP	needle exchange programme
NESF	National Economic and Social Forum
NGO	non-governmental organisation
NSP	needle and syringe exchange programme
PLHIV	people living with HIV
PLWHA	people living with HIV and AIDS
PNEP	prison needle exchange programme
RCT	randomised controlled trials
RSE	Relationships and Sexuality Education
SPHE	Social, Personal and Health Education
STI	sexually transmitted infection
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNGASS	United Nations General Assembly Special Session
VCT	voluntary counselling and HIV testing
WHO	World Health Organization

Introduction

Although AIDS remains a complex and incurable disease, it is preventable. International publications clearly highlight that the AIDS epidemic can only be reversed if effective HIV prevention measures are intensified in scale and scope. As the UNAIDS Policy Position Paper of July 2005, entitled *Intensifying HIV Prevention*, stated: '*In response to the urgent need for action to reduce the growing numbers of new HIV infections, the board [of UNAIDS] strongly endorsed a new policy approach to intensify HIV prevention efforts. This policy position paper outlines essential principles, policy and programmatic actions that are needed to get ahead of the HIV epidemic*' (UNAIDS, 2005). While AIDS-related morbidity and mortality have improved in many high-income countries due to the availability of antiretroviral treatment, the rate of new infections continues to increase, posing a threat to the whole AIDS response.

The underlying dynamics of the HIV/AIDS epidemic need to be addressed and this entails intensifying the implementation of HIV prevention measures. Safer sex is the single most effective method of preventing HIV transmission. It is estimated that comprehensive HIV prevention initiatives could reduce up to 63% of new HIV infections expected to occur up to 2010 (Stover *et al,* 2002). HIV prevention, if adequately resourced, can have a major impact on halting and reversing the spread of HIV/AIDS and can also impact on reducing sexually transmitted infections (STIs) and improving sexual health.

In Ireland, the available epidemiology data indicate that the issues related to the increase in HIV and AIDS are similar to those experienced elsewhere in the European Union and other highly industrialised countries.

This report presents a 4-year plan for HIV and AIDS Education and Prevention in Ireland for the period 2008 – 2012. In developing this plan, the Education and Prevention Sub-Committee of the National AIDS Strategy Committee commissioned the National University of Ireland, Galway, to provide a review of:

- international publications and policy developments;
- the current situation in Ireland in terms of epidemiology, trends and structures;
- evidence of best practice in HIV and AIDS prevention and education.

Structure of report

Chapter 1 of this report explores the international context of HIV and AIDS prevention, outlining key international Declarations of Commitment and policy developments. A number of national strategy documents from a selection of high-income countries are reviewed in relation to the core principles and key actions guiding their national-level responses to HIV and AIDS prevention.

Chapter 2 considers the current situation in Ireland, starting with an overview of the epidemiology of HIV and AIDS in the country. A summary of findings is then presented on the progress achieved on the 19 recommendations made to the Education and Prevention Sub-Committee after the National AIDS Strategy Committee's report of 2000. The findings of key studies are examined in order to illustrate the situation in Ireland regarding sexual knowledge, attitudes and behaviours, and sex education. Finally, the current structures in operation to support the implementation of this HIV/AIDS Education and Prevention Plan are examined.

Chapter 3 sets out the way forward for HIV and AIDS education and prevention in Ireland, with key priorities discussed and a detailed Action Plan given for implementation in 6 key areas over a 4-year timeframe (2008-2012).

In an effort to inform the practice of those involved in the planning and delivery of HIV and AIDS education and prevention programmes and initiatives, **Appendix 1** focuses on a review of evidence-based international best practice in relation to HIV and AIDS prevention and education, including a range of effective intervention approaches that address the needs of particular population groups. **Appendix 2** provides an overview of issues emerging from the National Consultation Day held with the main stakeholders (Dublin, November 2006) and highlights key issues for the future in the fight against HIV/AIDS.

An extensive **Bibliography** of national and international literature is included in the report.

Chapter 1
Review of International Commitments and Priorities

This chapter provides an overview of the key international policy developments on global HIV prevention, including a selective review of national level strategies. The key principles and priority actions highlighted in these documents are outlined since they provide the basis on which to develop effective policy and action in the Irish context.

International Declarations of Commitment on HIV and AIDS

In June 2001, Heads of State and Representatives of Governments met at the United Nations General Assembly 26th Special Session, to review and address, as a matter of urgency, the problem of HIV/AIDS in all its aspects. Their aim was also to secure a global commitment to enhancing coordination and intensification of national, regional and international efforts to combat the pandemic in a comprehensive manner. This UN meeting was a landmark in global efforts to respond to the AIDS crisis and its theme of '*Global crisis requiring global action*' served to underline the need for urgent attention. Recognising that the global HIV/AIDS epidemic, through its devastating scale and impact, constitutes a global emergency and one of the most formidable challenges to human life and dignity, the UN Special Session also served to remind the world that there was hope. With sufficient will and resources, communities and countries could change the epidemic's deadly course.

The **Declaration of Commitment on HIV/AIDS 2001** (*Global crisis – global action*) was issued at that UN General Assembly meeting, with 189 Member States committing themselves to an urgent, coordinated, comprehensive and sustained response to the HIV and AIDS epidemic, building on the experience and lessons learned over the past 20 years (UN, 2001). The Declaration established the agenda for a global response to the ongoing AIDS epidemic and created a blueprint for national and international strategies to halt and begin to reverse the global epidemic. Time-bound targets were set for the delivery of effective HIV prevention, treatment, care and support.

The need to intensify HIV prevention efforts at global, national and regional levels has been reiterated in international agreements since 2001, with commitments to accelerate the implementation of the UN Declaration of Commitment 2001 and to reach the targets set by that agreement:

- the **Dublin Declaration** (February 2004) on Partnership to fight HIV/AIDS in Europe and Central Asia;
- the **Vilnius Declaration** (September 2004) on Measures to strengthen Responses to HIV/AIDS in the European Union and in Neighbouring Countries;
- the **Bremen Declaration** (March 2007) on Responsibility and Partnership – Together Against HIV/AIDS.

The **UNAIDS Policy Position Paper 2005** sought to energise and mobilise an intensification of HIV prevention, with the aim of ensuring universal access to HIV prevention and treatment (UNAIDS, 2005). The paper outlined the rationale for intensifying HIV prevention and the key actions that must be central to the HIV-prevention response, including the core principles underlying these actions and the scaling up of HIV prevention at country level. Twenty-five years into the epidemic, it was declared that the global response needs to be strategic, recognising the need for long-term commitment and capacity-building, using evidence-informed strategies to address the structural drivers of the epidemic. It was necessary to move away from responses that are episodic and based on crisis management; as the **UNAIDS 2006 Report** stated, '*AIDS is exceptional and the response to AIDS must be equally exceptional*' (UNAIDS, 2006).

Resulting from this, the UN General Assembly Special Session in 2006 reviewed the 2001 Declaration and issued the **Political Declaration on HIV/AIDS 2006,** reaffirming the global commitment and stating that '*the prevention of HIV infection must be the mainstay of national, regional and international response to the pandemic*' (UN, 2006).

At EU level, the **EU Communication** on *Combating HIV/AIDS within the European Union and in the Neighbouring Countries, 2006-2009* set out the main lines of action until 2009 (European Commission, 2005). The **World Health Organization's 2006 Report** on HIV and AIDS in Europe urged that the lessons learned internationally be applied to the '*accelerating incidence of HIV in*

eastern Europe [which] poses one of the region's most important public health challenges today' (WHO, 2006a). The European Centre for Disease Prevention and Control (www.ecdc.eu.int) has included HIV and AIDS as part of its brief and is actively engaged with Member States in setting priorities for action.

National strategies on HIV and AIDS

To inform the development of this new HIV and AIDS Education and Prevention Plan for Ireland, six existing national strategies, representative of industrialised high-income countries, were reviewed. This examination showed that although all the jurisdictions communicate through English, their contextual realities, although remarkably similar in some instances, were unique in others. The national strategies reviewed were:

- **Australia (2005)** *National HIV/AIDS Strategy: Revitalising Australia's Response 2005-2008* (Department of Health and Ageing, 2005).
- **Canada (2003 and 2005)** *2003-2004 HIV/AIDS Work Plan: Canadian Strategy on HIV/AIDS* and *Leading together: Canada takes action on HIV/AIDS (2005-2010)* (Canadian Public Health Association, 2003 and 2005).
- **New Zealand (2001)** *Sexual and Reproductive Health Strategy – Phase One* (Ministry of Health, New Zealand, 2001).
- **Scotland (2005)** *Respect and Responsibility: Strategy and Action Plan for Improving Sexual Health* (Scottish Government Publications, 2005).
- **England (2001)** *Better prevention, Better services, Better sexual health: The National Strategy for Sexual Health and HIV* (Department of Health, UK, 2001).
- **Wales (2000)** *A Strategic Framework for promoting Sexual Health in Wales* (National Assembly for Wales, 2000).

Based on the review of international policy documents and selected national strategies, a number of key principles and priority actions have been identified and accepted as core for inclusion in all effective HIV and AIDS prevention plans (*see below*). Although the principles are held in common, the national strategies have a range of priority actions, depending on whether their focus is on responding to HIV and AIDS, or taking a broader view of the sexual health of the general population. The Canadian and Australian strategies, for example, both focus on HIV and AIDS, while those from England, Scotland, Wales and New Zealand include preventing sexual ill-health and focus on the broader context of sexual health and its influences.

Principles of effective HIV and AIDS prevention

National strategies and international bodies like UNAIDS and WHO agree that all HIV prevention efforts and programmes must have the following as their fundamental basis:

- The promotion, protection and respect of **human rights**, including gender equality.
- **Differentiated and locally adapted** to the relevant epidemiological, economic, social and cultural contexts in which they are implemented.
- **Evidence-informed,** based on what is known and proven to be effective, and investment to expand the evidence base should be strengthened.
- **Comprehensive in scope,** using the full range of policy and programmatic interventions known to be effective.

- HIV prevention is for life; therefore both delivery of existing interventions, as well as research and development of new technologies, require a **long-term and sustained effort**, recognising that results will only be seen over the longer term and need to be maintained.
- HIV prevention programming must be at a **coverage, scale and intensity** that is enough to make a critical difference.
- **Community participation** of those for whom HIV prevention programmes are planned is critical for their impact.

These principles are discussed in further detail below.

Human rights and social justice

All HIV prevention efforts and programmes must have as their fundamental basis the promotion, protection and respect of human rights, including gender equality. The creation of an enabling environment is underpinned by the principles of social justice; human rights; promoting respect and responsibility; accessibility; recognising the diversity of moral, cultural and ethical views; equity; participation; and empowerment. In order to prevent the transmission of HIV and to improve care, both the behaviours that put people at risk (i.e. unsafe sex and sharing syringes) and the broader social determinants of health must be addressed. Social factors, unequal power relationships and poverty also impact on the ability of people living with HIV and AIDS to maintain their health or make healthy choices.

Equally, HIV epidemics thrive on stigma and discrimination. The Australian, Canadian and English national strategies on HIV/AIDS (*see above*) explicitly make reference to reducing stigma and discrimination experienced by those living with HIV and AIDS. Combating stigma and discrimination is clearly a large part of a non-partisan approach. The UN Political Declaration on HIV/AIDS 2006 commits governments to '*intensify efforts to enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against people living with HIV and members of vulnerable groups*' (UN, 2006, p. 4).

Meaningful and active participation by people with HIV and communities at risk

The early and comprehensive involvement of members of priority communities/groups is essential for effective implementation of HIV prevention programmes (UNAIDS, 2005). Community participation of those for whom the programmes are planned is critical for their impact. Similarly, involving people living with HIV in the design, implementation and evaluation of prevention strategies will ensure that interventions address their distinct prevention needs.

Improving the lives of those living with HIV and AIDS features prominently in the English, Canadian and Australian national strategies. Within an environment based on the ideals of social justice, meaningful and active participation by people with HIV and communities at risk will ensure that:

- the stigma and discrimination associated with HIV is reduced;
- there is prevention of further transmission;
- care and living conditions will be improved.

Evidence-based practice and research

The Canadian national strategy states that '*to stop the epidemic, our programs must be better tomorrow than they are today*'**.** Any effective response to HIV and AIDS needs strategic planning based on good quality science and surveillance, as well as respect for the local cultural norms and values (WHO, 2007). HIV prevention is for life; therefore both delivery of existing interventions, as well as research and development of new technologies, require a long-term and sustained effort, recognising that results will only be seen over the longer term and need to be maintained (UNAIDS, 2005). The English national strategy stresses that '*effective commissioning of HIV and AIDS prevention needs up-to-date evidence of what and how different interventions work*'.

HIV prevention actions must be evidence-informed, based on what is known and proven to be effective. There is a need for greater investment in expanding and strengthening the evidence base so that it can be translated into effective policy and practice. Research plays a critical role in providing an evidence base in order to inform interventions and policy decisions. It also produces data that will contribute to greater understanding of how HIV affects individuals and communities, while also ensuring that the epidemic can be tracked and monitored. The English national strategy explores the areas where more research is necessary; these include exploring the link between drugs, sex, alcohol and the identification of effective interventions.

Comprehensive provision

HIV prevention programmes must be of a coverage, scale and intensity that can make a critical difference (UNAIDS, 2005). The national strategies reviewed all adhere to health promotion principles and utilise harm-reduction strategies in order to reduce the transmission, personal and social impact, and loss of quality of life caused by ill-health. To achieve this, the following actions are emphasized:

Interventions need to be targeted and tailored

HIV prevention programmes must be differentiated and locally adapted to the relevant epidemiological, economic, social and cultural contexts in which they are implemented (UNAIDS, 2005). The theme of participation and social justice is reflected in the principle of making all programmes and services appropriate to the cultural norms in relation to gender, age, ethnicity, disability and population groups. There is huge diversity within communities and groups when it comes to issues like substance abuse, relationships, sex and sexual orientation. Strategies need to recognise the key role that cultural norms and beliefs may play in supporting prevention efforts, as well as the potential they have to fuel HIV transmission (UNAIDS, 2005). There is also a need to promote greater gender equality and address gender norms and relations in order to reduce the vulnerability of women and girls, involving men and boys in this effort. Actions need to support the mobilisation of community-based responses throughout the continuum of prevention, care and treatment. Both the Australian and Scottish national strategies also stress the importance of creating sexual health services that people can relate to and afford.

Integrated service provision

The international and national strategies agree that the most effective integrated HIV prevention programmes should operate at all five levels listed in the Ottawa Charter, namely – building healthy public policy; creating supportive environments; strengthening community action; developing personal skills; and re-orienting health services (WHO, 1986).

The UNAIDS Policy Position Paper (2005) highlights the necessity of **supporting the mobilisation of community-based responses** throughout the continuum of prevention, care and treatment. The themes of integrating and coordinating services are common across all the national strategies reviewed. For example, the Welsh national Action Plan states that '*environments will be created in which service providers can work in collaboration and integration*'.

Development of workforce in sexual health
There is a recognised need to develop a skilled and confident workforce in the area of sexual health. Development and capacity-building of the workforce underpins most strategies in relation to both generic and specialist services. The English national strategy, for example, sets out a list of principles to continuously improve services and recommends '*programmes of professional education, training, information and research to support continuous improvement in quality*'.

Services responsive to changing needs
The need for a sustained response where prevention and treatment of HIV are linked and require long-term programmes and services is apparent in the national strategies reviewed. Monitoring and evaluation of the programmes and services is advised, so that learning from experience is incorporated to ensure their continual improvement. The Canadian national strategy makes the following points on creating effective sustainable and sustained services:

- prevention information must be delivered many times in many different ways;
- prevention programmes must be adaptable to new knowledge and changing needs;
- prevention programmes must be developed for and by people living with HIV and AIDS as part of life-long disease management;
- treatment programmes must respond to the needs of people with HIV and AIDS.

Shared responsibility
The Dublin Declaration 2004, the Bremen Declaration 2007 and the UN Political Declaration 2006 reiterated and reinforced the need for a shared responsibility in HIV prevention efforts and the need to work through partnership approaches involving all levels of civil society – the State, people living with HIV and AIDS, as well as private/corporate bodies – in order to mobilise all levels of a society's resources in the fight against HIV and AIDS. In addition, there must be strong partnerships between international and national governments. The Canadian national strategy emphasizes the need for '*partnerships between jurisdictions, within the healthcare system and with other sectors beyond health that have an impact on HIV, like social services, education, housing and justice*'.

Priority Actions for HIV prevention

The following priority actions to intensify programmes of education and prevention on HIV and AIDS are cited in the UNAIDS Policy Position Paper 2005:

1. Ensure that human rights are promoted, protected and respected, and that measures are taken to eliminate discrimination and combat stigma.
2. Build and maintain leadership from all sections of society, including governments, affected communities, non-governmental organisations, faith-based organisations, the education sector, media, the private sector and trade unions.
3. Involve people living with HIV in the design, implementation and evaluation of prevention strategies, addressing the distinct prevention needs.
4. Address cultural norms and beliefs, recognising both the key role they may play in supporting prevention efforts and the potential they have to fuel HIV transmission.
5. Promote gender equality and address gender norms and relations to reduce the vulnerability of women and girls, involving men and boys in this effort.
6. Promote widespread knowledge and awareness of how HIV is transmitted and how infection can be averted.

7. Promote the links between HIV prevention and sexual and reproductive health.
8. Support the mobilisation of community-based responses throughout the continuum of prevention, care and treatment.
9. Promote programmes targeted at HIV prevention needs of key affected groups and populations.
10. Mobilise and strengthen financial and human and institutional capacity across all sectors, particularly in health and education.
11. Review and reform legal frameworks to remove barriers to effective, evidence-based HIV prevention, combat stigma and discrimination, and protect the rights of people living with HIV or vulnerable or at risk to HIV.
12. Ensure that sufficient investments are made in the research and development of, and advocacy for, new prevention technologies.

Raising public awareness

Promotion of widespread knowledge and awareness of how HIV is transmitted and how infection can be averted is a common priority action area in all the national strategies reviewed. Within every jurisdiction, issues arise on how to communicate such messages in different languages to the diverse cultures that exist within each society. The Australian strategy stresses that current education and prevention messages need to be refocused to address the increase in HIV and sexually transmitted infections. The Canadian strategy aims to ensure that public misconceptions are dispelled and continued funding for HIV and AIDS prevention and education is secured; it also states that a community that is made aware of the link between the determinants of health and HIV is more likely to support social justice-based services and programmes. The English strategy aims '*to ensure information gets to people where they are, where they need it and when they need it*' and states that national campaigns can provide the backdrop for more targeted local prevention.

People's sexual behaviours can be impacted upon, both positively and negatively, by '*community attitudes, social and cultural values, social support and media representations*', as the New Zealand strategy states. In order to ensure that the programmes remain relevant and reinforce safer practices, the delivery of educational and prevention messages and programmes must take account of the changing nature of communities, society and HIV itself.

Leadership

In its *Overview of HIV Prevention,* the international AIDS charity AVERT (www.avert.org) states: '*To be successful, a comprehensive HIV prevention programme needs strong political leadership. This means politicians and leaders in all sectors must speak out openly about AIDS and not shy away from difficult issues like sex, sexuality and drug use.*'

The national strategies examined indicate that in order to create social environments supportive of safer sex and injecting practices, each jurisdiction needs to foster continuing debate and discussions on its common values in relation to the complex issues of sexuality, risky behaviours and motivation.

Sexual health education

Sexual health education features strongly in most of the national strategies reviewed. School programmes on sexual education are viewed as being integral to building and promoting skills with young people. Programmes involving the development of personal and social skills (e.g. assertiveness, self-identity, self-esteem and relationship-building) should begin at nursery and primary school level,

according to the Scottish national strategy. The value of continuing to provide high-quality information is stressed, particularly messages about delaying the commencement of sexual activity, preparedness for the first sexual encounter and targeted messages about safer sex. The New Zealand national strategy highlights education in schools as a key area for action, emphasizing that programmes should '*promote positive sexuality and sexual health … and should comprise of alternative ways to express relationships*'. It also states that educational initiatives should begin at a younger age and target young people with disabilities. Parents and teachers, as primary educators, have a key role and responsibility, and are acknowledged as requiring support in the delivery of such programmes.

Harm-minimisation approaches

Countries that implement needle exchange programmes at an early stage in the drug-using cycle and provide other complementary services (e.g. cleaning equipment and counselling interventions) have significantly reduced the transmission of HIV by people who inject drugs. Early interventions have '*the potential to radically change the course of HIV disease in Canada and around the world*', according to the Canadian national strategy. All the strategies reviewed stress that the success of needle and syringe programmes can limit the potential impact of HIV and AIDS in the population groups of injecting drug users (IDUs) and prisoners.

The Australian national strategy states that condoms '*have been repeatedly demonstrated to be the cheapest, most readily accessible, safe and practical way to prevent sexual transmission of HIV and some other STIs*'. The provision of condoms is advocated by all national strategies. In relation to service provision for IDUs, the focus has been on their 'single identity' as drug users and may have ignored the sexual aspects of their lives.

Comprehensive prevention

Responses to the HIV/AIDS epidemic need to be comprehensive, using programmes that include peer-led initiatives as well as community-based prevention interventions. Intensifying prevention efforts is directly linked to strengthening diagnosis, treatment, care and support, as well as addressing secondary prevention issues. In order to achieve this, the national strategies reviewed are mapping the services and programmes available in order to ensure that delivery is enhanced and intensified.

Addressing the social factors driving the epidemic

Social inequities fuel the HIV/AIDS epidemic. Legislation designed to protect the rights of people living with HIV and to raise awareness of human rights' issues are stressed in the Canadian national strategy, which states that effective prevention responses '*recognise and address the broad determinants of health that make people vulnerable to HIV and to disease progression*'. Similarly, the Australian strategy believes that sustaining a supportive social, legal and policy environment will encourage people living with HIV and AIDS and affected communities to:

- support and promote education and prevention;
- respond to education;
- access voluntary testing and treatment services;
- participate effectively in all levels of the response.

Priority population groups

To ensure HIV and AIDS education and prevention efforts are targeted to meet the needs of key affected groups and populations, UNAIDS and many other national strategies identify priority population groups. (It is important to note that it is not membership or identification with these groups that is, of itself, a high risk and also that these groups are not necessarily homogeneous and may hold their own 'at risk' sub-groups.) These priority population groups are:

- young people;
- women;
- injecting drug users (IDUs);
- men;
- men who have sex with men (MSM);
- female and male sex workers;
- prisoners;
- people living with HIV and AIDS;
- people from countries where HIV is endemic;
- children affected by HIV and AIDS.

Successful approaches for changing individual behaviour and for peer-led interventions (which are relevant for all these population groups) usually involve the following key elements:

- increasing participants' ability to communicate effectively about sex;
- facilitating participants to increase their skills in using condoms;
- personalising risk;
- getting participants to accept that avoiding risks is a social norm and then reinforcing and supporting this message in order to sustain risk-reducing behaviours;
- at individual level, interventions need context-specific information and skills.

Young people

According to Monash and Maly (2006), '*The HIV epidemic varies greatly in different regions of the world, but in each of these epidemics young people are at the centre, both in terms of new infections as well as being the greatest potential force for change if they can be reached with the right interventions*'.

Nearly half of the new HIV infections worldwide occur in young people, aged 15-24 (UNAIDS, 2005). In Ireland, between the years 2000 and 2004, 67% of STIs occurred in under-30 year-olds (HPSC, 2005b). Research has found that the strongest predictor of present and intended future sexual behaviours is past sexual behaviour (Docherty, 2002). Preparing young people for their first sexual encounter has been found to delay the onset of sexual activity and also to be crucial for safer sex practices. Young people are clearly a suitable group for tailored and targeted interventions, which need to be sensitive to the participants' age-related cognitive, emotional and sexual development. Gender issues are crucial among young people as they attempt to assert themselves in their new adult roles. Gender expectations and gender power relationships influence sexuality and act as barriers to safer sex practices. Studies have shown that the patterns of young people seeking information are also gender-specific (Women's Health Council, 2006).

WHO (2001) listed prerequisites for interventions with young people and stressed the important role of school-based approaches. It is widely acknowledged that school and teachers can have an enormous influence on shaping young people's emotional development and behaviour (Atkinson and Hornby, 2002). Ellis and Grey (2004) conclude that school-based sex education can be effective in reducing sexual risk behaviour; there was also promising review-level evidence that sex education does not increase sexual activity and that it is more effective if begun before the onset of sexual activity.

Swann *et al* (2003) found strong evidence for the effectiveness of interventions aimed at preventing teen pregnancy that linked school-based sex education to contraceptive services. No strong evidence has been found for the effectiveness of abstinence-only approaches in preventing pregnancy. Santelli *et al* (2006) stated that the fall in teen pregnancy in the USA is mostly due to increased contraceptive use, not abstinence-focused sexuality education. The Crisis Pregnancy Agency in Ireland (2004) found little evidence to support the view that abstinence programmes delay initiation of sexual intercourse or reduce sexual risk behaviours.

Pedlow and Carey (2003) found that certain factors impact on the effectiveness of sex education programmes. These include the extent to which the programme focuses on specific skills for reducing sexual risk behaviours; the duration and intensity of the programme; and what kind of training is available for facilitators. Johnson *et al* (2003) observed that intensive behavioural interventions reduced sexual HIV risk because they increased skills acquisition, sexual communications and condom use, as well as delaying the onset of sexual activity and decreasing the number of sexual partners. Cowan (2002) suggests that young people's sexuality is learned and that learning is influenced by cultural as well as personal factors.

Marston and King (2006) reviewed 268 international qualitative studies of young people's sexual behaviour, published over a period of 14 years (1990-2004). Their report explored why – even where condoms were freely available (accessibility), information was imparted and understood (knowledge) and the necessary skills developed and practised (self-efficacy) – young people still chose not to practise safer sex. Seven key themes emerged from their analysis:

- young people assess potential sexual partners as 'clean' or 'unclean';
- sexual partners have an important influence on behaviour in general;
- condoms are stigmatised and associated with lack of trust;
- gender stereotypes are crucial in determining social expectations and, in turn, behaviour;
- there are penalties and rewards for sex from society;
- reputations and social displays of sexual activity, or inactivity, are important;
- social expectations hamper communications about sex.

These findings by Marston and King (2006) illustrate the critical role of social influence on behaviour, especially among young people. This indicates that interventions that provide information and condoms without addressing the social factors will only tackle part of the problem.

Women

The United Nations Population Fund in its *State of the World Population 2005* commented on the position of women and HIV (UNFPA, 2005): '*The ability of women to protect themselves against HIV is often restricted by imbalances in decision-making power, gender-based violence, economic insecurity and harmful practices … Young women are at especially high risk. Those who are poor, female and young often have the least power and opportunity to protect themselves.*'

The vulnerability of women to HIV infection can be categorised in two main areas, where socio-cultural factors interplay with physiological factors to place women at increased risk:

- Women often have little choice or power to negotiate safer sexual practices due to gender inequity, economic vulnerability and cultural practices and norms that favour male sexuality and power. These factors may also contribute to barriers to effective care and support for women, as well as increasing their susceptibility to HIV infection.
- Two physiological factors increase women's vulnerability in terms of sexual transmission of HIV:
  - the sensitive nature of the mucosal lining of the vagina and cervix, combined with its large surface area;
  - the large concentration of HIV virus present in infected male semen (as compared to female secretions).

Pregnancy confers additional risk, with women having the burden of worry about transmitting the virus to their children.

Studies have found that the fragility of a girl's reputation can limit young women's ability to discuss contraception openly with a sexual partner (Murphy-Lawless *et al*, 2004; Women's Health Council, 2006). Raising the issue of condoms means potentially entering the contentious domains of trust and fidelity; the male condom has become synonymous with disease, infidelity and casual sex (Marston and King, 2006; Layte *et al*, 2006). Interventions that directly empower women can have a major public health impact by challenging socio-cultural practices, which may contribute to risky sexual behaviour. Shepherd *et al* (1999) found that increased knowledge strengthened women's desire to protect themselves and communicate this to their partners.

Interventions have relevance to all women, regardless of their sexual orientation. Lesbian women are an almost forgotten group in the discourse on HIV prevention. Their gender automatically confers some risk. Recent studies indicate that lesbian women may be at risk not only from any previous heterosexual relationships, but also through their current homosexual relationships (Bailey *et al*, 2004; Marrazzo *et al*, 2005). Hughes and Evans (2003) found that about 1 in 5 women who have never had heterosexual intercourse have human papillomaviruses (HPVs, causing, for example, genital warts or leading to cervical cancer) and 10% of lesbian women have a history of STIs. The most efficacious interventions specifically targeted at women are tailored to their unique issues and circumstances, and focused on the relationship and negotiation skills necessary to enact condom use with a partner (Mize *et al*, 2002; Exner *et al,* 2003).

Injecting drug users

Injecting is an even more effective way of spreading HIV than sexual intercourse. In most developed countries, including Ireland, the second most common transmission route for HIV is among men and women who inject drugs. Injecting drug use is illegal in most countries and so it is difficult to know exactly how many people inject drugs and how many share their equipment. Some of those who use injection drugs may then avoid prevention and treatment programmes. The sexual partners of people who inject drugs are at high risk, even if they do not inject. Practices for reducing the risk of blood-borne transmission, in order of efficacy, can be listed as:

- stop injecting drug use – change to other methods of taking the drug (e.g. ingesting);
- use sterile needles every time: needle exchange programmes have been found to be cost-effective and not to increase drug use, while opportunistic sexual health promotion can occur with individuals when exchanging needles;
- do not share injecting equipment;
- clean equipment between uses.

Injecting drug users (IDUs) need to develop skills in reducing two types of risk behaviours – drug-related and sex-related (Lyles and Des Jarlais, 1998). Studies have established that needle exchange programmes are extremely effective interventions to reduce HIV transmission among IDUs (WHO *et al,* 2004). Community-based outreach programmes have also been used as an adjunct to needle exchange programmes, providing sexual health promotion together with information on safer injecting practices and the location and times of needle exchanges. These risk-reduction initiatives are obviously more effective when they meet broader health and social needs (Canadian Public Health Association, 2003; Sorensen and Copeland, 2000).

Men

Globally, cases of heterosexual transmission of HIV continue to increase. Given that the most effective prevention behaviour is the consistent use of condoms, targeting prevention interventions for heterosexual men (who have direct volitional control over putting condoms on) would appear to be an efficient use of resources. Despite this, there is a dearth of literature on interventions with this 'forgotten group' (Seal and Ehrhardt, 2004). Interventions among men in their workplaces or men in the Army have indicated the possibility of reducing the burden of sexual risk in the general population (Elwy *et al*, 2002). HIV risk-reduction programmes can lead to safer sexual practices if the interventions are grounded in a good understanding of men's sexuality and if they focus on how to make safer sex effective in the context of men's lives (Exner *et al*, 1999).

Men who have sex with men

Ellis *et al* (2003), in their review assessing the effectiveness of interventions to reduce the risk of sexual transmission, observe that *'even within what seems to be a relatively homogeneous population group – gay men – there are wide variations in culture that contribute to HIV risk*'. The UNAIDS Policy Position Paper (2005) states: *'The term "men who have sex with men" describes a behaviour rather than a specific group of people. It includes self-identified gay, bisexual, transgendered or heterosexual. Men who have sex with men are often married, particularly where discriminatory laws or social stigma of male sexual relations exist.*'

Interventions for men who have sex with men (MSM) should be placed within the broader context of men's lives, address the wider determinants of health and need to take place within supportive environments and public policies (Ellis *et al*, 2003). Studies have highlighted that MSM are adversely affected by internalised homophobia and experiences of discrimination (Wong and So-Kum Tang, 2004; Zea *et al,* 2003; Folch *et al*, 2006). Risk behaviour is being influenced by psychological factors that include, according to Kelly (2004) *'an individual's perceptions about peer and sexual partner norms regarding safer sex, attitudes toward safer sex practices, strength of risk-reduction behaviour change intentions, perceived personal vulnerability for contracting HIV and self-efficacy or confidence in being able to enact safer sex practices, as well as situational and relationship factors*'.

The determinants of sexual safety among MSM do not appear to centre on lack of knowledge about AIDS and risk reduction. Young gay men perceive AIDS as a problem for older people and therefore may feel safe having unprotected sex with other young men. Docherty (2002) found that younger men (under 20) who were experiencing their first exposure to a homosexual lifestyle were most at risk of learning unsafe sexual behaviours from older sexual partners.

Hays *et al* (2003) found that interventions among MSM need:

- to clarify misconceptions about safer sex;
- to increase the enjoyment of safer sex;
- to build communication skills for negotiating safer sex;
- to address interpersonal issues that may interfere with safer sex.

Sex workers

Interventions that focus on changing behaviour among commercial sex workers and their clients are important strategies to reduce HIV transmission. Sex workers who work 'on the street' have been identified as being most at risk of HIV transmission (Alexander, 1992; Kondagunta *et al*, 2006), as well as finding themselves in circumstances where they are vulnerable to high levels of violence and exploitation.

Ellis *et al* (2003) conclude that interventions delivered at community level (particularly peer-led) can be effective in influencing the sexual risk behaviours of commercial sex workers. Miller *et al* (1998) found positive results from a peer opinion leader (POL) model intervention with male commercial sex workers. The Scarlet Alliance National Training Project in Australia gives accreditation for peer-educators working among street sex workers. In Thailand, the '100% Condom Programme' instituted changes in the behaviour of sex workers and was implemented in partnership with brothel-owners, police and public health clinics (Exner *et al*, 2003). The programme, which was initiated in 1991, resulted in a 90% increase in effective condom use and a 75% decrease in STI rates among sex workers. The intervention directly empowered women to insist on condom use with their commercial partners.

Prisoners

While in prison, prisoners' human rights must be respected under both national and international legislation. Prisoners need protection from contracting diseases and, if infected, from any form of discrimination. Efforts to prevent infections in prisons are beneficial for inmates, staff and the wider public (WHO, 2005; UNODC *et al*, 2006). Studies in the 1980s found indications that extensive HIV transmission could occur in prisons and had the potential to affect the wider community: '*The opportunity to prevent infectious disease, including HIV, in both prisons and the community is a significant and frequently unrecognised element of public health protection*' (Huntington *et al,* 2006). The cost of treating chronic infections such as HIV and Hepatitis C virus (HCV) is significant (Schackman *et al,* 2006; Wright and Katz, 2006). To protect prisoners (and hence to protect the general population) from blood-borne infections, HIV and HCV preventative measures must be available in prisons, at least to the same extent as they are in the community.

The common use of drugs in prisons increases the risk of blood-borne infections (European Monitoring Centre for Drugs and Drug Addition, 2002). Although IDU prisoners may be injecting less frequently than when outside prison, each injection is far more risky due to the scarcity of injecting equipment and hence the greater prevalence of sharing syringes. There is the additional concern that due to the illegality of intravenous drug use, there are high incarceration rates among IDUs, many of whom will tend to spend a proportion of their lives in prison (Wood *et al*, 2005b; O'Sullivan *et al,* 2003; Caplinskiene *et al,* 2003; Hagan and Thiede, 2003; Allwright *et al*, 2000).

Since the early 1990s, community needle and syringe programmes (NSPs) within the prison system in Europe have been evaluated and found to reduce the spread of HIV among IDUs, without increasing drug injecting (Stark *et al,* 2006; Ksobiech *et al*, 2005; Stover and Nelles, 2003; Dolan *et al,* 2002; WHO, 2005).

Reviews evaluating the provision of sterile injecting equipment in prisons have found that such needle exchange programmes:

- reduce the incidence of blood-borne infections;
- reduce sharing of injecting equipment;
- reduce other injecting-related health problems, such as vein damage and abscesses;
- reduce fatal and non-fatal overdoses;

- do not increase drug use or drug injecting;
- improve health;
- increase referral into drug treatment;
- do not lead to safety or security problems, or prison violence.

Other harm-reduction measures include the provision of appropriate drug treatment, given that increased access to substitution therapies can reduce the demand for drugs and consequently reduce risk. Dillon (2001) notes that prison can be a place where people opt to achieve a drug-free status and recommends that a full range of services should be available, including abstinence-based rehabilitation models which afford prisoners a full range of choices.

Policy decisions can either limit or increase access to risk-reduction interventions, such as the distribution of sterile needles and condoms. As Justice Kirby of the High Court of Australia (2006) stated: '*We owe it to all the prisoners and we owe it to the community to protect people from infection while they are incarcerated. This requires radical steps before it is too late. The infection of a person who is in the custody of society, because that person does not have access to ready means of self-protection and because society has preferred to turn the other way, is unpalatable … As a community, we must take all proper steps to protect prison officers and prisoners alike. By protecting them, we protect society.*'

People living with HIV – secondary prevention

The widespread use of antiretroviral treatment (ART) in industrialised countries has dramatically decreased the AIDS mortality and incidence, resulting in more people living for many years with an infectious life-threatening disease. Hart *et al* (2004) strongly urge that outreach workers be adequately trained and supervised in order to meet the challenges faced by this highly socio-economically and culturally diverse group. Individuals and groups may not perceive that they have a responsibility to practise safer sex if the risks are seen as negligible. According to the US Centers for Disease Control and Prevention (CDC), the majority of new HIV infections are the direct result of unprotected sex among serodiscordant individuals (i.e. where one partner is HIV-positive and the other is HIV-negative) (Patterson and Semple, 2003). It is a fundamental right to know one's HIV sero-status (Sweat, 1998), yet substantial numbers of people remain ignorant of this. Supports for HIV-positive people to encourage and empower disclosure are necessary and cost-effective.

The issue of disclosure is extremely sensitive, requiring not only self-efficacy but well-developed communication and negotiation skills. Ellis and Grey (2004) conclude that partner notification is an effective means of detecting infections. They state that there is a need to understand the consequences of partner notification for infected people and their partners. When voluntary testing is accompanied by pre- and post-test counselling, it can be both an effective early intervention (i.e. linking people who are infected with care and treatment) and an effective prevention strategy (i.e. by giving those who practise unsafe sexual or drug behaviour information and support for behavioural changes) (Ellis *et al*, 2003). USA studies suggest that over 70% of HIV-positive people may remain sexually active and a substantial percentage continue to engage in unprotected sex (Crepaz and Marks, 2002).

People from countries where HIV is endemic

In much of Africa and many countries in the Caribbean, HIV is endemic and is a highly stigmatised disease among people coming from these countries. Such attitudes tend to keep people silent and isolated, thus allowing the virus to spread. Global mobility and integration of diverse cultures within different societies has also increased. Eastern European countries, such as Estonia, the Russian Federation and Ukraine, have an estimated HIV prevalence greater than 1% (WHO, 2006a). People from these countries are now part of the population in Ireland and therefore prevention planning must also aim to meet the needs of these groups.

The spread of HIV is fuelled by factors such as:

- the stigma associated with HIV;
- challenges due to recent immigration, e.g. settlement issues, poverty, financial dependence, racism, stigma;
- cultural attitudes;
- lack of support from the broader community;
- lack of comprehensive, coordinated and targeted prevention efforts;
- fear that disclosure of HIV status will affect migration status and application process.

Children affected by AIDS

The terms 'children affected by AIDS' and 'affected children' are used to refer to:

- children and young people under 18 years of age with HIV or AIDS;
- orphans who have lost one or both parents due to AIDS;
- vulnerable children whose survival, well-being or development is threatened or impacted by HIV and AIDS.

Globally, an estimated 15.2 million children under 18 years of age have lost one or both parents to AIDS and countless others are affected in other ways (UNAIDS, 2006). In 2006, the UN Political Declaration on HIV/AIDS pledged nations to '*addressing as a priority the vulnerabilities faced by children affected by and living with HIV*'. Due to the stigma and discrimination around HIV and AIDS, many of the young people affected may remain hidden. UNICEF's 2006 report, *Child protection and children affected by AIDS*, notes that children affected by HIV and AIDS have many vulnerabilities. All actions to address the vulnerabilities and protection risks of 'affected children' will, of necessity, happen within the globally agreed human rights' framework set forth in the UN Convention on the Rights of the Child (UN, 1989) and other human rights' instruments. As the UNICEF (2006) report stated: '*Putting this framework into practice requires an increased focus on the capacities, systems and structures needed for protection and recognition of children's resilience, as well as the importance of their participation.*' In Ireland, this approach has been central to the work of the Office of the Minister for Children and Youth Affairs.

Summary

This chapter has set out some of the main issues for consideration in developing an Irish plan for HIV and AIDS education and prevention. Key principles that have informed strategy development in other countries are examined, followed by an overview of priority action areas and population groups. The evidence of effectiveness, where available, has been interlinked, thereby providing the evidence base for the later Action Plan set out in Chapter 3 of this report.

Chapter 2
The context for developing a HIV and AIDS Education and Prevention Plan in Ireland

This chapter provides an overview and update of the issues relevant to the Irish situation for HIV and AIDS education and prevention. The current epidemiology for HIV, AIDS and sexually transmitted infections (STIs) is presented to place the scale of the problem in Ireland in context. It is important to note that while Ireland has successfully managed to keep overall figures for HIV and AIDS relatively low, within some risk groups the figures remain a cause for concern and the dramatic increase in STIs, particularly among young people, is a worrying trend.

An overview of key research reports is presented to provide an insight into the current sexual behaviours of both the general population and a number of high risk sub groups. This information is essential to inform the development of future policy and programme interventions.

Finally, an update is provided on the National AIDS Strategy Committee (NASC) as the key organisational mechanism with responsibility for the implementation of national policy relevant to HIV and AIDS. An overview of progress on the implementation of the 19 recommendations made to the Education and Prevention Sub Committee in the NASC's *AIDS 2000* report is presented in order to establish the current situation and identify key gaps.

Epidemiology of AIDS, HIV and STIs in Ireland

The data on the epidemiology of HIV, AIDS and STIs in Ireland are taken from surveillance reports of the Health Protection Surveillance Centre (HPSC), part of the Health Service Executive (HSE).*

HIV

By the end of 2006, there was a total of 4,419 HIV diagnoses in Ireland, with 337 cases occurring in that year alone. For all HIV cases, the most probable route of transmission is via heterosexual intercourse (38%), followed by IDUs (30%) and then MSM (22%) (*see Figure 1*). It must be noted that changing patterns of drug use may be contributing to an increased prevalence of risky injecting behaviour.

Figure 1
HIV-infected patients in Ireland, by probable route of transmission (cumulative to end December 2006)

Cumulative Total	Number	%
Heterosexual	1,665	38
Injecting drug user (IDU)	1,327	30
Men who have sex with men (MSM)	968	22
Haemophiliac	107	2
Children	88	2
Prisoner*	39	1
Blood donor*	30	1
Transfusion recipient	13	0.3
Occupational and Needlestick**	8	0.2
Haemophiliac contact*	4	0.1
Other	13	0.3
Unknown	157	3
Total	4,419	100

* Categorised by site rather than risk reason, category no longer in use.
** 'Needlestick' means an injury to someone from an injection needle.

Although the current epidemiological evidence suggests that HIV incidence and prevalence are low among young people, the data indicate that the potential exists for the spread of HIV among young Irish people. Those young people at risk of HIV are not just those 'at risk' groups normally cited in reports (e.g. disadvantaged, early school-leavers, young offenders, drug misusers) – they are the general young heterosexual population whose sexual behaviours are significantly different to any group of young people in other generations.

In 2006, there were 337 newly diagnosed cases; this figure is a 6% increase on the 2005 figure of 318. This represents a change from a more general decline in new cases which had been seen since the 2003 peak of 399. Among MSM, an increase of 45.6% was found. Table 1 shows the new cases in 2006, broken down by gender and probable route of HIV transmission. Information on probable route of transmission (risk group) was unavailable for 25 of the newly diagnosed cases (7.4%).

* It should be noted that there is a large percentage of unknown variables within the cohorts identified and thus the figures should be interpreted with caution since they are by no means comprehensive due to both significant underreporting and delays. This surveillance information, however, is essential to inform and direct HIV and AIDS education and prevention efforts.

Table 1
Newly diagnosed HIV infections in Ireland, by probable route of HIV transmission and gender (2006)

Probable route of HIV transmission	Gender Number (%)			
	Male	Female	Unknown	Total
Heterosexual	74 (44%)	95 (56%)		169 (50%)
Injecting drug users (IDUs)	41 (72%)	16 (28%)		57 (17%)
Men who have sex with men (MSM)	83 (100%)	–	–	83 (25%)
Mother-to-child transmission (MTCT)	2 (67%)	1 (33%)	–	3 (0.8%)
Other	3 (100%)		–	3 (0.8%)
Unknown	9 (41%)	11 (50%)	2 (9%)	22 (6.4%)
Total	**212 (62.9%)**	**123 (36.5%)**	**2 (0.6%)**	**337 (100%)**

Most of the newly diagnosed cases (76%) were **aged between 20 and 40 years;** the mean age at HIV diagnosis was 34 years. The mean age at HIV diagnosis was 32.2 years for IDUs, 34.1 years for heterosexuals and 36.3 years for MSM. The mean age at HIV diagnosis was 30.8 years in females and 35.9 years in males, a difference of 5.1 years.

Information on **geographic origin** was unavailable for 22 (7%) of the newly diagnosed cases in 2006. Of the 337 cases diagnosed in 2006, 125 were born in Ireland, 109 were born in sub-Saharan Africa and 20 were born in other countries in Western Europe. Of the 169 cases acquired through heterosexual contact, 104 were born in sub-Saharan Africa (63 female and 41 male) and 33 were born in Ireland (17 female and 16 male).

Information on **area of residence** was unavailable for 18% of the new cases diagnosed in 2006. Of the remainder, 180 (53%) were resident in the Eastern Region (i.e. Dublin, Kildare and Wicklow) and 97 (29%) were resident in the rest of the country at the time of HIV diagnosis.

Information on **stage of infection** was unavailable for 17% of the newly diagnosed cases in 2006. Of the 279 cases where stage of infection was known, 60% were asymptomatic at the time of HIV diagnosis and 8% were diagnosed with AIDS at the same time as HIV diagnosis (i.e. diagnosed 'late'). In order to avail of the best opportunities for early intervention and treatment, it is vital for both the individual and the community that HIV is diagnosed as soon as possible.

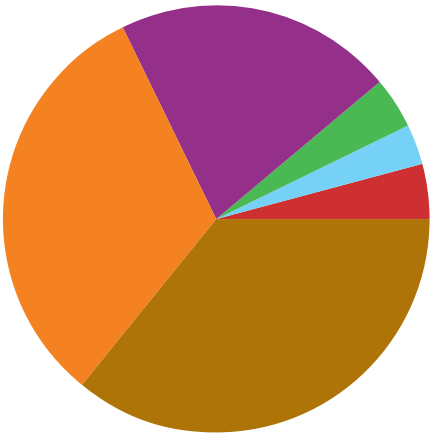
All the **HIV-infected babies** in Ireland in 2006 were born to women from countries where HIV is endemic. Offering pregnant women HIV testing and counselling has been effective in identifying HIV-positive women and providing appropriate treatment. Accurate monitoring of HIV prevalence among pregnant women provides a useful tool to evaluate the effectiveness of national antenatal HIV-screening programmes (HPSC, 2007a).

AIDS

By the end of December 2006, there was a total of 909 cases of AIDS in Ireland reported to the HPSC and 397 deaths among AIDS cases. The incidence of AIDS in Ireland increased steadily from 2000 to 2005, but decreased in 2006. In 2005 (to end Quarter 3), IDUs represented the largest group (36%), followed by MSM (32%) and then heterosexuals (21%) (*see Figure 2*).

In the 1990s, most AIDS cases were among IDUs: there was a peak in 1993 with 38 new cases and since then there has been a steady decline, to 6 in 2004 (*see Figure 3*). The number of AIDS cases among MSM peaked in 1994 with 31 new cases and has declined to 4 in 2004. There has been a steady increase since 2001 in the number of AIDS cases among heterosexuals, rising to 26 new cases in 2004.

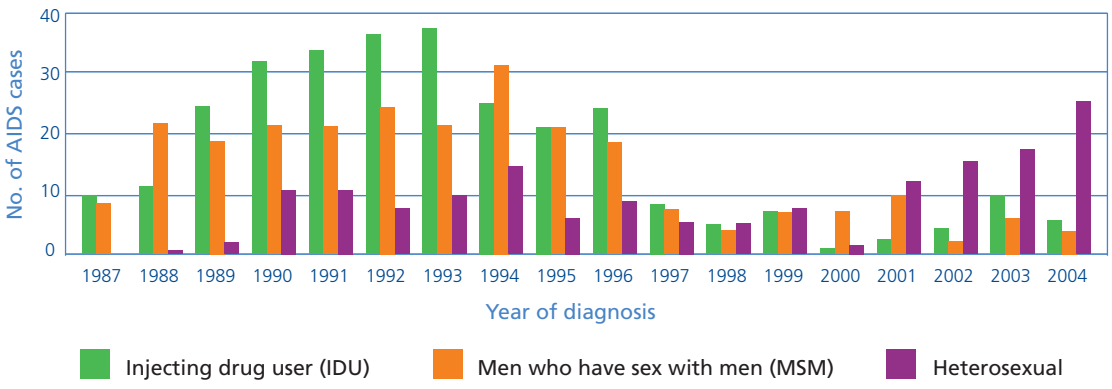
Figure 2
Cumulative total of AIDS cases diagnosed, by probable route of transmission (to end Quarter 3 2005)



Probable route of transmission	%
Injecting drug user (IDU)	36
Men who have sex with men (MSM)	32
Heterosexual contact	21
Haemophiliac	4
Children	3
IDU and MSM	1
Transfusion recipient	1
Other/unknown	2

Source: HPSC (2005a)

Figure 3
AIDS cases in Ireland, by year of diagnosis (1987-2004) and probable route of transmission



Source: HPSC (2005a)

Sexually transmitted infections

The sexually transmitted infections (STIs) of gonorrhoea, Chlamydia, non-specific urethritis, genital herpes and genital warts are all increasing in Ireland, while the numbers of cases of Syphilis and Hepatitis B have decreased. The age group presenting with most STI infections are 20-29 year-olds. The rise in STIs is of concern since 90% of new HIV infections may be attributable to STIs as co-factors in the early stages of an HIV epidemic (Robinson *et al,* 1997). The presence of an STI facilitates both the transmission and acquisition of HIV. There has been a dramatic increase in annual notifications of STIs – with 2,588 in 1994 rising to 10,695 in 2004.

Research update

Cultural norms, attitudes, beliefs and sexual practices are all important factors influencing HIV transmission. HIV prevention approaches need to be tailored to address these factors since they can play a significant role in either facilitating or inhibiting the implementation of effective intervention strategies. With the changing cultural context in Ireland, a number of important national studies have been published in recent years and have added to the knowledge base on current sexual attitudes, knowledge and behaviours among Irish adults. An overview of the key findings from these studies is presented below, with particular reference to their relevance for HIV education and prevention strategies.

Irish Study of Sexual Health and Relationships

The *Irish Study of Sexual Health and Relationships* (ISSHR) by Layte *et al* (2006) examined sexual knowledge, attitudes and behaviour in Ireland. The survey was conducted by telephone interviews with 7,441 participants, aged 18-64 years. Nine key themes were explored with the participants:

- attitudes to sexual issues (e.g. sex before marriage, abortion);
- sex education (e.g. own experiences, what should be taught);
- sexual knowledge (e.g. HIV, Chlamydia, current needs);
- first sexual intercourse (e.g. age, contraception, willingness);
- sexual attraction and identity (e.g. heterosexual/homosexual/bisexual);
- sexual partnerships (e.g. lifetime, last 5 years, last year);
- contraception and protection (e.g. use of condoms);
- sexually transmitted infections (e.g. experience, testing);
- crisis pregnancy (e.g. experience, outcomes).

The following is a brief overview of some of the findings.

Sexual identity

2.7% of men and 1.2% of women described their sexual identity as homosexual or bisexual. Somewhat more (5.3% of men and 5.8% of women) reported some same sex attraction, with 7.1% of men and 4.7% of women having one or more homosexual experiences in their lives (4.4% of men and 1.4% of women reporting genital same-sex experience). All of these behaviours were more likely in younger participants.

Sex education
Most younger people under 25 years of age (88% of males and 93% of females) received sex education, but only about half found it 'helpful' (42% of males and 34% of females aged 18-24 reported it was 'unhelpful').

Age at first vaginal sex
The median age of first vaginal intercourse was lower in younger groups: 22 years for men and 23 years for women currently aged 60-64. For both males and females aged under 25, the median age was 17. One-fifth of males (21%) and 12% of females experienced their first sexual intercourse before the age of 17 (30% males and 25% females aged 18-24). While most people felt their first sexual experience happened at 'about the right time', 14% of men and 19% of women felt they should have waited longer. This was more likely to be reported by those under 25 years of age.

Use of contraception and protection
Use of contraception varied by age. 93% of males and 94% of females aged 18-24 who did not want to become pregnant used contraception at their last sexual experience, compared to 81% of men and 82% of women aged 35-44. Use of contraception at the time of first sexual intercourse was more common in recent years.

Crisis pregnancy
One-fifth of women (21%) who had ever been pregnant had experienced a crisis pregnancy, with younger women more likely to report pregnancies as 'crisis'. Overall, 13% of all women had experienced a crisis pregnancy and 4% had had an abortion.

Sexually transmitted infections (STIs)
The ISSHR found that only 3.4% of men and 1.8% of women had been diagnosed with an STI. However, testing for STIs was also relatively low (9.4% of men and 8.3% of women) and these test levels may underestimate STI prevalence in Ireland. Sex before the age of 17 was associated with both increased risk of crisis pregnancy and diagnosis with an STI. One woman and 6.4% of men reported ever having paid for sex. Men with higher numbers of 'unpaid' female sexual partners were also more likely to have paid for sex.

Risky sexual behaviours
The ISSHR found that:

- the first sexual experience among the younger age group is more likely to be with a casual partner;
- younger age groups are more likely to practise anal sex and have concurrent sexual relationships;
- use of commercial sex workers is highest among young men, aged 18-34;
- younger age groups are more likely to use contraception for their first sexual intercourse and to use both contraception and protection subsequently (this may reflect greater awareness of safer sex messages among younger age groups);
- approximately 90% of the respondents who supported sex education favoured it being taught in schools.

Risk-reduction practices
The ISSHR highlights that the disadvantaged and vulnerable members of Irish society are most at risk of sexual ill-health. In particular, lower levels of education and social class were found to be associated with lower levels of sexual knowledge and poorer parent-child communication on matters sexual.

The ISSHR found that 10% of younger people do not use contraception and 10% fail to use condoms. A substantial minority of respondents (26% of men and 31% of women) reported that they did not use contraception and protection the last time they had sexual intercourse. Of those whose last sexual intercourse was with someone they did not know beforehand, 22% of men and 29% of women did not use a condom. A principal reason why both men and women did not use contraception and protection during their most recent sexual intercourse was a lack of planning and preparation. The other major reason cited was intoxication from alcohol and/or illegal drugs. The cost of contraception and protection was found to be an issue for 20% of respondents (i.e. those in low-income groups and/or in receipt of direct provision).

The ISSHR found that being able to negotiate safe sex practices is crucial and aspects of self-efficacy need to be combined with attitudes about risk in order to encourage the consistent use of protection. Trust in stable relationships affects the level of condom use: this applied to 14% of those who did not know their partner before they had sex. Earlier studies had found links between low levels of education and difficulties in talking to a sexual partner about contraception (Rundle *el al*, 2004).

Real Lives – All-Ireland Gay Men's Sex Surveys

The 2006 report *Real Lives: Findings from the All-Ireland Gay Men's Sex Surveys, 2003 and 2004* found that there has been a reduction in the number of men who have sex with men (MSM) having HIV tests, with men under 20 years of age least likely to have been tested (Devine *et al*, 2006). The report shows that between 2000 and 2005, 438 MSM were diagnosed with HIV – a 71% increase since 2000. The HIV test history generally matched men's current belief in their HIV status, although 50% of the respondents who said they were definitely HIV-negative had never been tested.

The findings indicate a high level of risky sexual behaviour, with 50% of men stating they had taken part in unprotected anal intercourse. This may be due to a number of factors, including assumptions of HIV negativity; trust; relationship status; coercion; ignorance of risk; and lack of access to condoms or water-based lubrication. The study found that for most of the indicators, men living in the Republic outside of Dublin experienced the highest level of unmet need in relation to '*level of knowledge on HIV transmission, testing and treatment; access to condom and lubricant; social inclusion and an extensive social network; sexual assertiveness; and access and confidence in health prevention and treatment service*'. Being younger also exacerbated the level of need, while the oldest age group expressed loneliness.

The *Real Lives* study highlights that gay men are not a homogeneous group and suggests that HIV prevention programmes should focus particularly on younger men and those with lower levels of education. Increased knowledge is likely to influence both sexual and HIV-testing behaviours, so it is important to widen education and access to programmes relating to HIV testing.

Research from the Crisis Pregnancy Agency on RSE

Projects commissioned by the Crisis Pregnancy Agency (CPA) have provided a suite of new research findings in recent years that have informed policy-makers and educators. A 2007 survey explored the implementation of the Relationships and Sexuality Education Programme being delivered in schools throughout the Irish education system. Entitled *Relationships and Sexuality Education (RSE) in the context of Social, Personal and Health Education (SPHE): An assessment of the challenges to full implementation of the programme in post-primary schools,* the study was commissioned by the Department of Education and Science and the Crisis Pregnancy Agency (Mayock *et al*, 2007).

The RSE Programme was originally envisaged and designed as a holistic programme to be taught by school teachers in the context of SPHE. The 2007 research found that RSE is broadly supported by teachers, parents and students. 41% of schools were found to be high implementers of RSE and 36% to be moderate implementers, while 23% of schools were found to be implementing RSE poorly. The research shows that levels of implementation at Junior Cycle have improved since the 2002 survey carried out by the University of Limerick, with 81% of schools teaching RSE as part of SPHE in First and Second Years (Geary and McNamara, 2003). This is probably related to the fact that since September 2003 schools have been required to timetable one class of SPHE a week, or its equivalent, up to Third Year. At Senior Cycle level, many schools are not implementing the RSE programme fully and in some cases are not implementing it at all.

The students interviewed for the CPA's 2007 study saw RSE as being selectively addressed by schools and felt that the topics of contraception, safe sex, condom use and sexual orientation were not dealt with effectively by teachers. Where these topics were addressed, it was generally in Senior Cycle and the students felt that they should be introduced at Junior Cycle level. Both teachers and students expressed the need for up-to-date teaching resources, especially for Senior Cycle. While parents were supportive of the RSE Programme generally, many felt that they were not well informed about it.

National AIDS Strategy Committee

The National AIDS Strategy Committee (NASC), established in 1991 and chaired by the Minister of State at the Department of Health and Children, is the key mechanism through which all relevant sectors are engaged at policy level in matters related to HIV and AIDS. The NASC and its three sub-committees – on Surveillance, Care and Management, and Education and Prevention – are supported by the Department of Health and Children and have representation from key State agencies, statutory partners, NGOs and civil society groups. To date, the NASC has published two reports to inform the development of policy and services on HIV and AIDS (NASC, 1992 and 2000).

Key stakeholders in HIV and AIDS Education and Prevention Policy

The delivery of policy related to HIV and AIDS is a cross-Government responsibility. However, a number of key stakeholders have been identified as central to the education and prevention response. These are:

- **Department of Health and Children** is responsible for setting and monitoring policy for HIV and AIDS prevention. It also provides executive support for the ongoing work of the NASC and its sub-committees.
- **Health Service Executive** (HSE), as the primary health service delivery agent, is responsible for the delivery of all health and social services throughout the country. In the present context, HSE has responsibility for the provision of HIV and AIDS-related services at regional and local levels. The Health Protection Surveillance Centre (HPSC) of the Population Health Directorate has responsibility for STI, HIV and AIDS surveillance. HSE is the core funding provider for many civil society groups active in the field of HIV and AIDS prevention, drug services and sexual health. HSE and its related bodies are represented throughout the NASC structures.
- **Department of Education and Science** is represented on the NASC and the Education and Prevention Sub-Committee as a key partner in HIV and AIDS prevention. It is responsible for ensuring the delivery of the Relationships and Sexuality Education (RSE) Programme in schools, which is taught in the context of Social, Personal and Health Education (SPHE).
- **Department of Justice, Equality and Law Reform** has responsibility for the development of the legislative context and also sets policy in certain key settings, such as prisons.

- **Civil society organisations** are non-profit organised groups, clubs and associations that operate independently from Government and the State. Examples include Dublin AIDS Alliance, Gay and Lesbian Equality Network (GLEN) and the Sexual Health Centre, Cork. UNAIDS advocates the full participation of civil society as a necessity in order to bring about effective outcomes and legitimate targets. Because civil society organisations are providers of support, education and prevention services, they are pivotal in assessing the feasibility of measures and targets. The NASC is strongly committed to the widespread representation of these civil society groups in its deliberations. Particular efforts have been made to ensure that people living with HIV are facilitated to participate in the policy-making process, since they, together with representatives from the most 'at risk' population groups, have particular insights into the effectiveness and appropriateness of interventions for HIV and AIDS.

Education and Prevention Sub-Committee

The Education and Prevention Sub-Committee of the NASC has representatives from the following bodies:

- Department of Health and Children;
- Health Service Executive;
- Department of Education and Science;
- people living with HIV;
- civil society groups, including Dublin AIDS Alliance, Gay HIV Strategies and the Sexual Health Centre, Cork;
- Irish Prison Service;
- National Consultative Committee on Racism and Interculturalism.

The approach taken by the Education and Prevention Sub-Committee involves:

- working in partnership with all sectors, including civil society and people living with HIV;
- developing policy and making recommendations over the lifetime of the AIDS Strategy;
- prioritising research and reviewing evidence in order to inform policy and practice;
- linking closely with the other sub-committees of the NASC to ensure a synergy between their work.

The Education and Prevention Sub-Committee meets approximately six times a year and reports regularly to the NASC. While it does not hold a budget itself, the sub-committee has secured funding for some major projects and also provides a strong link to other areas of sexual health and drugs strategy.

Progress Review on Recommendations in NASC 2000 Report

AIDS 2000: Report of the National AIDS Strategy Committee (NASC) was published in 2000. It included 19 recommendations for the Education and Prevention Sub-Committee. The sub-committee has since reviewed progress on the implementation of these recommendations (*see below*), with the joint aims of informing the development of the present HIV and AIDS Education and Prevention Plan 2008-2012 and of highlighting good practice and important gaps in activity since 2000.

The detail provided in the review was not intended to be fully comprehensive, but creates a clear sense of the extent of work underway among stakeholder groups. An overview of this information has been collated and some of the activities are summarised below. Although there has been considerable progress in some areas, there remains substantial room for improvement in others. It must also be said that, in the period since 2000, much progress has been made beyond the level of the 19 recommendations.

Availability and accessibility of condoms

Recommendation 1 from the NASC 2000 Report focused on the availability and accessibility of condoms in the country. It specifically stated: '*Health boards throughout the country should address the issue of condom availability to NGOs for distribution free of charge.*'

While the availability of condoms in rural areas has improved, with condoms being sold in pharmacies, pubs and clubs throughout the country, the NGOs contacted for the review stated that they had not received a dedicated budget specifically allocated for free condom distribution. Respondents in the 2006 *Irish Study of Sexual Health and Relationships* (ISSHR) raised the issue of the cost of condoms in Ireland, where they are among the most expensive in Europe (Layte *et al,* 2006). One of the recommendations from the ISSHR was for the removal of the 21% VAT on condoms in order to make them more accessible to young people and low-income groups. In 2008, VAT on condoms was reduced to 13.5%.

Participation

Recommendation 2 centred on the valuable work of the NGOs and how to enhance their role in HIV and AIDS education and prevention. It stated that NGO involvement on the National AIDS Strategy Committee and its sub-committees is seen as a model of good practice '*for participation in strategy development and implementation at health board level*'. Since 2000, a number of strategies have been developed at regional and local level; however, the participation of NGOs has been uneven across the country, with some regions achieving this to a greater extent than others.

Recommendation 16 urged that the Education and Prevention Sub-Committee consult with people living with HIV. A number of consultation processes with people living with HIV have been organised and the culmination of this work has been the development of an *All-Ireland Charter of Rights for People living with HIV*, which is used by NGOs and service providers to inform the ongoing development of services. A positive person living with HIV has been co-opted onto the sub-committee and the NASC, and is actively involved in the policy development and monitoring process.

Partnership and capacity-building

Recommendation 13 stated that partnership and capacity-building should be continued as an approach in all health boards working with marginalised groups, such as the Traveller community, injecting drug users, ethnic minorities and non-Irish nationals. Under the National Drugs Strategy, Regional and Local Drugs Task Forces (LDTF) have been established and these seek to develop the capacity of marginalised groups to enable participation in the LDTF process.

It appears that statutory bodies often confuse consultation with partnership, and yet there have been good examples of effective partnership between lesbian, gay, bisexual and transgender (LGBT) community organisations and statutory services over the past 5 years. For example, the response to the Syphilis outbreak in 2000 was met by the Syphilis Outbreak Control Team consisting of LGBT NGOs, statutory health providers, public health specialists and consultant medical staff. The team pioneered new initiatives to target men who have sex with men (MSM) on sexual health issues, including on-site testing, which was subsequently replicated in other EU Member States.

An annual All-Ireland Gay Health Forum is organised and hosted by the Gay Men's Health Service to share research and best practice in service delivery on HIV, MSM and LGBT-related matters.

HIV and AIDS education for MSM

The role of LGBT organisations in providing vital health information, pertinent to the needs of MSM people, is highlighted under Recommendation 12 (*see below*). It is noted that a number of organisations have been established throughout the country; the health services have been particularly supportive of this and are funding LGBT organisations, such as the Cork Gay Community Development Project, Outhouse in Dublin and Dundalk Outcomers. The monthly publication of *Gay Community News* is noted as a step forward in information dissemination to this 'at risk' group, many of whom are dispersed throughout the country and may have little or no other involvement with LGBT organisations.

In 2007, a mapping exercise was undertaking by HSE on the health and social service provision for LGBT people. The forthcoming report will greatly inform the further development of a range of health-related and sexual health services for this population group.

Under Recommendations 11 and 12, the mainstreaming of programmes targeting gay disadvantage was recommended. In fulfilment of these recommendations, a number of projects have moved towards full mainstreaming. For example, the Gay and Lesbian Equality Network (GLEN) has worked strategically and in partnership with Government, political parties and other social partners to achieve change in policy and practice impacting on the lives of LGB people in the areas of policy and legislative change, education, health and community development. Gay HIV Strategies (GHS), a GLEN initiative, has worked with the Gardaí to make their services more accessible to LGB people, following recommendations in the 2003 report by the National Economic and Social Forum (NESF, 2003). In addition, funding has been secured for various LGB community groups across the country in the main urban areas.

Training initiatives

Recommendation 15 related to funding for training initiatives to enhance education and prevention capacity. Two events per year have taken place, including training provided by the HIV Services Network to front-line staff and volunteers.

Recommendation 17 endorsed the funding of NGOs so that they can develop and provide innovative training initiatives. The list of such programmes from various NGOs is testament to this happening. Several NGOs have been able to employ full- and part-time staff due to HSE funding. These training initiatives include supporting the delivery of RSE in schools, peer education, training of community leaders and of health professionals who target both vulnerable and 'at risk' individuals and groups, as well as working with people living with HIV and the general population. The Sexual Health Centre, Cork, was funded to organise a national conference on 'Understanding Sexual Health'. In addition, AIDS West and NUI Galway have delivered a National Certificate in sexual health promotion, accredited by NUIG.

Counsellors and staff in HIV and AIDS and drug treatment clinics

Recommendation 19 recognised the vital role of counsellors and staff in HIV and AIDS services and drug treatment clinics in relation to targeting education and prevention messages *'at those at most risk'*. It recommended that *'consideration be given to developing their prevention role'*. HIV Services Network has provided some support in this regard, but a more detailed overview of practice was difficult to gather.

Young people 'at risk' population group

Several recommendations highlighted provisions for particular 'at risk' population groups. Young people were the focus of Recommendations 5 and 7. Recommendation 5 supported the inclusion of HIV prevention into the Relationships and Sexuality Education (RSE) Programme in schools, which is taught in the context of Social, Personal and Health Education (SPHE). SPHE became a mandatory element of the Junior Cycle syllabus in 2003, but the RSE programme has not necessarily been integrated within this. One survey found that RSE was available to 73% of First Year students, 69% of Second Year and 63% of Third Year (Geary and McNamara, 2003). Teachers are attending in-service training to deliver RSE (1,500 in the last 3 academic years). A study of the barriers and facilitators to the full implementation of RSE has already been mentioned (*see page 25, 'Research from the Crisis Pregnancy Agency on RSE'*). Within schools, the lack of support and negative experiences of lesbian, gay and bisexual (LGB) young people are also highlighted by Recommendation 5 since they may result in underachievement and have been linked to risky sexual behaviours. A study conducted at Dublin City University investigated this issue and made recommendations to the education sector (O'Higgins-Norman, 2008).

Recommendation 7 examined the importance of outreach work to promote sexual health with young people in out-of-school settings. It is recommended that funding be continued for this work, which often involves peer education. The NGOs, as well as the health services, are working in this field with numerous projects and programmes. The Local Drugs Task Forces in Dublin and Cork are also running sexual health and drug prevention programmes with young people.

The recognition of young LGBT people has progressed significantly since 2000 with the establishment of the 'BeLonG Youth Community Development Project'. The project provides youth services to LGBT young people in Dublin and actively supports the development of LGBT youth work around Ireland. It provides a national policy and advocacy voice on LGBT young people's issues in the health and education sectors. Together with the Gay Health Network (GHN), it produced the HIV information comic for younger MSM ('Donnie got laid') and is producing drugs information for LGBT youth, funded by the North Inner City Drugs Task Force.

Refugees and asylum-seekers 'at risk' population group

Recommendation 9 acknowledged *'the special problems which refugees and asylum-seekers face and it is recommended that training should be provided to staff in key sites working with refugees and asylum-seekers to provide appropriate culturally specific support services, including medical treatment, risk assessment and risk reduction counselling'*.

Again, both NGOs and the statutory services are working in this area. In the Dublin region, the training needs of staff in relation to this 'at risk' population group have been examined and funding has been allocated to improve access to the health services via culturally appropriate programmes and training of cultural mediators. It is also recognised that training must be accompanied by appropriate 'person-centred' service planning in order to ensure that resources, skills and service plans are delivering the best service.

At the strategic and policy levels, a number of important developments have occurred. The need for more consistent collection of ethnic equality data has been identified in the Government's National Action Plan against Racism, *Planning for Diversity,* which commits to 'inclusion through the development of a comprehensive approach to social and equality statistics' and confirms that the development of 'a statistical and data framework focusing on social and equality objectives will assist in the process of setting targets and measuring progress in related areas'. From a health services perspective, it is acknowledged that unequal health outcomes can occur on the basis of ethnicity. The importance of collection of data to identify, address and monitor such changes and disparities in outcomes among ethnic groups over time is underlined by various policy documents, including the National Anti-Poverty Strategy. Following a consultation process and a piloting exercise, an agreed ethnic identifier question has been achieved by the health sector and gathering data with this indicator is now underway.

In addition, HSE has published a National Intercultural Health Strategy 2007-2012. This strategy is informed by research, reviewing the experience and practice of other countries and identifying good practice already in place. It will facilitate delivery of healthcare in an inclusive, respectful and fair way to minority communities and provides a framework for establishing the current context, as well as setting out a range of recommendations to address issues identified as priorities in the area of intercultural health in Ireland. Recommendations contained in the strategy are wide-ranging, across all pillars of HSE, and implementation of these will be effected on a prioritised, phased basis over a 5-year period.

Injecting drug users 'at risk' population group

Injecting drug users (IDUs) are another 'at risk' group, noted by Recommendation 10 to have ongoing needs in relation to safer sex and injecting information. It stated that there was '*continued need for targeted approaches, within the context of a more holistic response. HIV prevention initiatives need to be maintained and strengthened, particularly in relation to young drug users*'. The National Drugs Strategy established 10 Regional and 14 Local Drugs Task Forces (LDTFs). These LDTFs in Dublin, Bray and Cork have evaluated a wide range of projects with a view to mainstreaming them. The statistics indicate that at least some of these projects have been successful in HIV education and prevention since new cases of HIV among IDUs have remained steady at around 60 per annum since 1999.

A slight increase in community-based needles exchanges, along with the introduction of 'mobile' exchanges for rural areas, has been supported by HSE.

Prisoners 'at risk' population group

Prisoners are seen as another 'at risk' population group, many of whom are, or were, injecting drug users (IDUs). In relation to HIV education and prevention, Irish prisons have made some progress since 2000, including the introduction of methadone maintenance programmes, which have done much to reduce risk behaviour related to drug use. Since 2006, the Irish Prison Service has provided opiate substitution treatment for 1,363 patients, 167 of whom were treated for the first time. Service-level agreements signed with HSE and St. James's Hospital have seen the introduction of addiction psychiatry services and STI services directly to prisoners. The addition of addiction counselling services will add greatly to the support and education of prisoners and plans are at an advanced stage to extend this service. Further expansion of the Hep C services available to prisoners are in development; 12 of the 14 prisons now have qualified nurses on staff to facilitate the delivery of on-site health services.

Open *heart* House, since 2001, has developed a peer-led outreach initiative with the Dublin prison system, ensuring that prisoners when released are immediately linked directly to support services.

Recommendation 14 stated that following the Department of Justice, Equality and Law Reform 2000 Report on Hepatitis B, Hepatitis C and HIV in Irish prisons (Allwright *et al*, 2000), its '*recommendations should be explored with a view to improving prevention of these diseases in that environment*'. The WHO (2005), European Commission and the Irish Prison Service's (2001) *Review of the Structure and Organisation of Prison Health Care Services* have all made recommendations in relation to the HIV health services that should be available in prisons. Ireland is one of the few European jurisdictions where condoms are not freely available to prisoners. The same is true of needle exchanges or bleach to clean needles. Sterile syringes cannot be accessed by injecting prisoners despite the successful implementation of needle/syringe exchange programmes in other countries. The number of drug-free units within the prison system has increased since 2000, but these 'cannot be seen as an alternative to harm-reduction measures'. The Department of Justice, Equality and Law Reform (2006) has introduced a Drugs Policy and Strategy that focuses on the supply-and-demand reduction elements of care. This policy also includes the introduction of specialist addiction nurses to facilitate increased screening for blood-borne viruses, early diagnosis and treatment, and Hep A and B vaccination coverage. While mandatory drug testing (MDT) has been discussed in this policy, it has not, as yet, been introduced. MacDonald (1997), in an evaluation of MDT in the UK, found that it actually increased heroin use, exacerbated tensions between staff and prisoners, and had an adverse effect on prisoners accessing voluntary drug treatment programmes.

National survey of sexual knowledge, attitudes and behaviours

Recommendation 6 called for a national survey of knowledge, attitudes and behaviours of Irish people in relation to sexual health. This study, undertaken with joint funding from the Crisis Pregnancy Agency and the Department of Health and Children, was conducted in 2006 and its findings published as the *Irish Study of Sexual Health and Relationships* (ISSHR) in October of that year (Layte *et al*, 2006). As was envisaged, this survey of 7,441 adults, aged 18-64, has created a national baseline that will act as a benchmark by which programmes and policies on HIV/STI and sexual health promotion can be evaluated in the future (*see page 23, 'Irish Study of Sexual Health and Relationships*'). From the information provided in the ISSHR, Recommendation 18 will be met, in that the Education and Prevention Sub-Committee can now make an informed decision on whether to include sexual health promotion and STIs in its brief.

HSE, through a partnership with the Gay Men's Health Service (GMHS), the Rainbow Project and Sigma Research, has also funded the annual Internet-based survey, *Real Lives,* among MSM.

Educational and preventative information

Recommendations 3, 4 and 8 focused on the dissemination of educational and preventative information in relation to HIV and AIDS.

Media campaigns

Recommendation 4 stated that national media campaigns '*should be continued, with a special emphasis on target groups with high or increasing rates of infection from HIV, STIs and Hepatitis. The campaigns should have the twin aims of (a) challenging discrimination and stigma, and (b) presenting a balanced view between raising awareness of new treatments while promoting the importance of primary prevention*'.

A range of national media campaigns have been run since this recommendation was made in 2000. Areas such as HIV prevention, drug misuse prevention and crisis pregnancy prevention have all been covered. In addition, specific campaigns have been implemented in response to issues such as Syphilis

and Chlamydia. Many local media campaigns have been created by NGOs on specific local issues and/or in relation to national or international HIV and AIDS Days. Individually, these campaigns have been evaluated as effective in their own right, but no integration or coordination of either the campaigns or related strategy areas has been facilitated. Also, a range of additional issues require further research to inform targeting of non-mainstream groups, such as migrants and sex workers.

Convenience advertising
Recommendation 3 stated that '*convenience advertising to continue and the venues extended*'. In 2005, an evaluation was carried out on the current approach to public awareness campaigns since 2000, financed by the Health Promotion Policy Unit of the Department of Health and Children. This report found that the 'Chlamydia Campaign' had been highly successful in targeting all age groups: while the 18-25 age group perceived the poster as being targeted at younger people, only 5% of the older age groups felt this. Those asked saw the message as being targeted *at them* and so were unlikely to resist or dismiss it.

Leaflets
Recommendation 8 stated that the Health Promotion Policy Unit of the Department of Health and Children '*in consultation with appropriate agencies, should be responsible for developing an information leaflet on HIV, Hepatitis and STIs, and that it be made available at appropriate outlets*'. HSE has published a detailed booklet on HIV and AIDS, and this is disseminated through the free phone Helpline and a range of health service sites. Nationally, after consultation with relevant groups, various booklets have been funded for publication by NGOs. Examples include *Love Bugs* (an STI booklet) and *In the kNow* (HIV-testing booklet), both produced by the Gay Health Network; the *Directory of Services* booklet, published by the HIV Services Network; and a booklet on *Sexual Health,* published as a local initiative by the Northern Area Health Board and the Irish Family Planning Association. The Gay Health Network was also funded to translate its publications into 7 languages and to make them available on its website (www.gayhealthnetwork.ie).

In 2005, to mark World AIDS Day, Dublin AIDS Alliance and Limerick Red Ribbon Project were funded to run a public relations campaign targeting young adults with a safe sex message. In Cork, the Sexual Health Centre was also funded to produce *Sexual Times*, also targeting young people and parents with sexual health information. This was followed up in 2007 by the Dublin AIDS Alliance publication of *Don't Panic – Guide to Sexual Health*, produced in 6 languages (English, Polish, Mandarin, Arabic, Russian and French). These booklets were produced in consultation with focus groups representing ethnic minority groups and formed part of Phase 1 of a current project identifying barriers in accessing HIV support services and information. This element of the project was funded by a diverse mix of private sector inputs.

Once-off additional funding

Since 2000, a number of once-off funding programmes have been made available to NGOs and others involved in the area of HIV prevention. These funding streams have allowed for the implementation of additional projects targeting particular sub-groups over and above the planned services. HSE and the Department of Health and Children have been responsible for the allocation of the majority of these funds and, to this end, have sought to ensure that the best evidence available has been applied in the development of the projects and also that there has been a nationwide spread of the funding to ensure that the needs of as many groups as possible have been met.

Significant funding has also been made available to address the issue of stigma and discrimination in Ireland. The national awareness campaign called *Stamp Out Stigma* was launched in November 2007 to make a compassionate appeal to people across Ireland to challenge their personal prejudices

against those living with HIV and AIDS and to encourage them to reflect on their attitudes and understanding of HIV. The campaign was the result of a unique partnership of domestic and international development agencies working in the field of HIV and AIDS, statutory agencies and HIV-positive people. This partnership, called the Multi-Stakeholder Forum, delivered a year-long awareness campaign on the irrationality of HIV-related stigma and discrimination. It also commissioned a benchmarking study on stigma and discrimination experienced by people living with HIV in Ireland (*for further information*, *see* www.stampoutstigma.ie).

Policy update on sexual health

The National Health Promotion Strategy 2000-2005 stated that '*sexuality is an integral part of being human and healthy sexual relationships can contribute to an overall sense of well-being*' (Department of Health and Children, 2000c). The strategic aim set out in this policy was to promote sexual health and safer sexual practices among the population. A number of important policy developments have taken place since 2000 to support the achievement of this aim:

- In response to the specific issues regarding unplanned pregnancy, the Crisis Pregnancy Agency (CPA) was established by Statutory Instrument in 2001, funded in its entirety by the Department of Health and Children. The CPA is a planning and coordinating body established to formulate and implement a strategy to address the issue of crisis pregnancy in Ireland. Its work has substantially influenced the field of sexual health with regard to research, service delivery and visibility of awareness campaigns.

  The CPA is in the process of implementing its second strategy covering the period 2007-2011, which focuses on 3 central objectives: to reduce the number of crisis pregnancies, to reduce the number of women choosing abortion as an outcome of crisis pregnancy and to safeguard women's physical and mental health following termination of pregnancy. Seven strategic priorities have been set to deliver these objectives: knowledge about relationships and sexuality for adolescents; contraception; communications; crisis pregnancy services; continuation of pregnancy; research; and policy influence.

- A number of areas within HSE have developed regional sexual health strategies, with dedicated human and financial resources allocated to them.

- The WHO *Global Strategy for the Prevention and Control of Sexually Transmitted Infections, 2006-2015* was passed at the World Health Assembly in September 2006 (WHO, 2006b).

Summary

Since 2000, there have been significant developments to support the overall aims and objectives of HIV and AIDS education and prevention in Ireland. The epidemiology on HIV and AIDS, together with the widespread incidence of STIs, shows that there remains a need for ongoing allocation of resources in this area and for the continued development of education and prevention services. Over the past number of years, the policy and service areas have developed considerably and many successful programmes to support HIV and AIDS education and prevention have been implemented. The strong research foundation now available from the 2006 ISSHR provides baseline information from which to plan policy and practice. The partnerships necessary for effective HIV and AIDS education and prevention have been further strengthened through the work of the National AIDS Strategy Committee (NASC). The close involvement of a wide range of stakeholders in steering and implementing the recommendations set out in the 2000 NASC report provides a solid foundation for the delivery of this HIV and AIDS Education and Prevention Plan 2008 – 2012 in the future.

Chapter 3
Action Plan for implementation of HIV and AIDS Education and Prevention Plan 2008 – 2012

So far, this report has set out a review of the evidence of best practice in HIV and AIDS education and prevention, an update on current research findings, an overview of Ireland's international commitments, epidemiological trends, an update on current activity and feedback from consultations with stakeholders. The key issues identified have informed the development of the following Action Plan over a 4 year period. A number of key principles and themes have emerged for consideration in the context of drawing up the plan and these are discussed first.

Key principles and themes informing the Action Plan

- **Scaling-up activity:** In order to achieve improved results, proven effective approaches for HIV and AIDS education and prevention must be scaled up. These include community-based, school-based and peer-led approaches; cognitive behavioural intervention methods; raising awareness; harm-minimisation strategies; and secondary prevention. Such interventions must address the particular dynamics of HIV transmission as they currently exist in Ireland. Benchmarking existing practice against best practice will inform the scaling-up of evidence-based approaches so that they will be capable of making a significant impact at a national level.

- **Working in partnership:** Partnership with target population groups and across relevant sectors is essential for the success of HIV and AIDS education and prevention. In this respect, the potential for synergies with other key policy areas – such as HIV and AIDS treatment, sexual health, drug and alcohol strategies, mental health promotion, prison health and policies for groups experiencing some of the most acute health inequalities – needs to be highlighted.

- **GIPA Principle:** Greater involvement of People living with HIV and AIDS (GIPA) is recognised as central to the successful implementation of all HIV education and prevention activity. This principle will inform the implementation of this action plan.

- **Capacity-building:** The translation of evidence into practice must be supported by capacity-building to ensure that those most relevant are enabled to engage in best practice prevention. Workforce development – including continuing professional development and the acquisition of new skills and expertise to meet changing needs – is critical to the continued implementation of high-quality programmes and actions. Building up evaluation and monitoring skills among practitioners is also required so that examples of best practice of HIV prevention in the Irish context can be documented, evaluated and disseminated.

- **Coordination:** At national, regional and local levels, improved coordination is necessary to strengthen the strategic development of HIV prevention activities. This will also require that a comprehensive mapping of existing services is undertaken to identify both gaps in the current level of provision of HIV prevention and examples of best practice that are currently being implemented. This action plan will provide a framework for HIV and AIDS education and prevention across the statutory and voluntary sectors. This framework will be best supported by a clearly defined coordination mechanism within HSE and other key agencies to ensure HIV prevention is delivered comprehensively and nationwide in an integrated, coherent and efficient manner.

- **Research, monitoring and evaluation:** A need still exists for detailed research on the most effective prevention interventions and the risk behaviours of a number of population groups in order to inform a greater understanding of the dynamics of HIV transmission and also the development of effective prevention approaches. Qualitative research is required to complement the existing surveillance data and programme evaluation findings. This type of information would be particularly helpful in informing programme development with ethnic minority groups, socially marginalised groups and people living with HIV in Ireland. A greater emphasis on evaluation of HIV and AIDS education and prevention measures is also required to ensure that current resources are being directed towards evidence-based best practice and that these examples are documented and disseminated. Progress at the national, regional and local levels in meeting recommendations set out in this action plan should be monitored and subject to review on a regular basis. In particular, there is a need to track progress in meeting the needs of vulnerable and high-risk groups, and ensuring that programmes are targeted where they are most needed in an effective and accessible manner.

- **Leadership, advocacy and implementation:** Political will and leadership are necessary to support sustainable, comprehensive and effective HIV prevention. The wider health and social gain from high-quality HIV prevention approaches needs to be emphasized and promoted among decision-makers. Advocacy for HIV prevention needs to engage the support of policy-makers, opinion leaders, people living with HIV and a range of community groups. In particular, there is a need to have public discussion on sexual health in a positive manner and to build a public demand for positive sexual health promotion and effective HIV prevention. Tackling HIV-related stigma and discrimination and increasing awareness of the importance of sexual health for overall health and well-being will play a critical role in shifting social norms and practices, and in mobilising a demand for effective HIV prevention and treatment services.

- **HIV testing and screening:** Early knowledge of HIV status results in better prognosis for the individual and can have an impact on onward transmission. To achieve this, accessible HIV screening and testing must be made available. Testing for HIV is voluntary in Ireland and this should continue. Voluntary counselling and HIV testing (VCT) has been shown to be effective in the prevention of secondary infection for many different population groups (King and Bartlett, 1999; UNAIDS, 1998). The introduction of new HIV testing methods can have a great impact (e.g. rapid testing), while home-testing kits mean availability and access to HIV testing is removed from medical and clinical settings. New approaches to HIV testing have been implemented in other countries (e.g. on-site in pubs and clubs, in NGO settings and in rapid-testing centres) and these would need to be examined for the development of good practice guidelines for an Irish setting.

The Action Plan set out on the following pages integrates these key issues, principles and themes, and provides the framework for the HIV and AIDS Education and Prevention Plan covering the period 2008-2012.

Action Plan

The overall aim of this action plan is to contribute to a reduction in new infections of HIV and AIDS through education and prevention measures. A secondary aim is to guide and inform the development of policy and services in the statutory and non-statutory sectors with responsibility in this regard. The plan is set out under 6 Action Areas, as follows:

1. Building leadership and strengthening necessary infrastructure
2. Addressing the broader determinants
3. Preventing new infections
4. Addressing stigma and discrimination
5. Monitoring and evaluation
6. International commitments

Within **Action Area 3** – *Preventing new infections* – the Action Plan is set out by population group:

1. young people;
2. men who have sex with men;
3. injecting drug users;
4. sex workers;
5. prisoners;
6. people from countries where HIV is endemic;
7. people living with HIV.

For each population group, actions are arranged under the following headings:

- education and raising awareness;
- [population group] – specific interventions;
- increasing screening and testing;
- research and capacity-building;
- linkages to relevant policy frameworks.

Action Area 1

Building leadership and strengthening necessary infrastructure		
Actions	**Lead responsibility**	**Key partners**
1. Political leadership at the highest level should be maintained through national structures and ongoing political engagement in HIV- and AIDS-related policy.	Department of An Taoiseach	Department of Foreign Affairs – Irish Aid Department of Health and Children
2. A national-level committee with relevant statutory and non-statutory representation should be maintained, with clearly defined roles and responsibilities for all members in HIV and AIDS policy development and monitoring.	Department of Health and Children	Health Service Executive Other relevant Government departments Relevant NGOs and PLHIV
3. Civil society groups and people living with HIV should be supported to develop leadership and advocacy capacity to ensure participation in decision-making, policy formulation, implementation, policy monitoring and evaluation.	Health Service Executive	National AIDS Strategy Committee Relevant NGOs
4. A mapping of all HIV and AIDS prevention activity in the 4 HSE areas should be undertaken to assess current service provision and to plan for implementation of the National Action Plan and further service development.	Health Service Executive	National AIDS Strategy Committee Relevant NGOs
5. An assessment of current NGO activity in HIV and AIDS prevention should be undertaken with a view to identifying current service levels, models of best practice and services suitable for mainstreaming.	Health Service Executive	Relevant NGOs
6. Clear structures will be established within HSE with responsibility for HIV and AIDS strategy implementation.	Health Service Executive	National AIDS Strategy Committee
7. A formal consultation process with relevant partners should be established to ensure strategies and research are working to complement each other, e.g. the Crisis Pregnancy Agency, National Drugs Strategy Teams.	National AIDS Strategy Committee	Health Service Executive

Action Area 2

Addressing the broader determinants		
Actions	**Lead responsibility**	**Key partners**
1. A National Sexual Health Policy should be developed to provide the appropriate broader context for the HIV and AIDS Education and Prevention Plan.	Department of Health and Children	Health Service Executive Sexual health service providers Crisis Pregnancy Agency Other relevant Government departments Relevant NGOs
2. HIV prevention targets should be integrated into policies designed to address the social determinants of health and health inequalities, e.g. into the National Action Plan for Inclusion.	Department of Health and Children	Health Service Executive Office for Social Inclusion

Action Area 3

Preventing new infections

Population Group 1: Young people

Actions	Lead responsibility	Key partners
1. Education and raising awareness		
1. Implement comprehensive school-based sex education throughout the school system: • Relationships and Sexuality Education (RSE) should be universally implemented in the context of SPHE from primary through to senior cycle. • Health and education sectors should continue to work together to develop resources and provide teacher training to support RSE implementation. • Guidelines should be developed for schools to ensure best practice in using outside agencies to support RSE implementation in the classroom. • The quality and effectiveness of RSE in schools should be evaluated in the context of Whole School Evaluation and other inspection processes. • The RSE programme should be monitored and evaluated on an ongoing basis to ensure its relevance to young people.	Department of Education and Science	SPHE Support Service Department of Health and Children Health Service Executive Relevant NGOs
2. Enhance support for Relationships and Sexuality Education (RSE) in the out-of-school education setting: • All Youthreach and Early School-Leaver Education Centres should have access to training and resource materials to support implementation of RSE. • All Youthreach and Early School-Leaver Education Centres should develop a policy on RSE and allow for its provision in the curriculum. • A monitoring and evaluation system should be put in place to ensure full implementation within these Centres.	Department of Education and Science	Youthreach National Youth Council of Ireland National Youth Health Programme Health Service Executive Relevant NGOs

Action Area 3: Preventing new infections **Population Group 1: Young people (*continued*)**

Actions	Lead responsibility	Key partners
Youth sector: • All youth organisations should be supported to develop and implement a policy to promote sexual health. • Funding programmes targeting young people should allow for age, gender and culturally appropriate peer-led initiatives to promote sexual health.		
3. Parenting and sex education in the home: • Training and education programmes to enable parents to 'talk about sex' with their children should be offered as part of parenting support initiatives. • Web-based and other resources should be developed and made available to support parents in talking about sex with their children.	Family Support Agency	Department of Education and Science Health Service Executive Crisis Pregnancy Agency National Parents Council Relevant NGOs
4. Media awareness campaigns targeting young people will be maintained: • Ongoing and sustained social marketing media campaigns to promote condom usage as the primary prevention method for people at risk of HIV/STIs should be maintained, with specific targeting of identified groups, including: ◦ early school-leavers; ◦ young unemployed; ◦ young people with low literacy levels; ◦ young people from migrant populations; ◦ gay and bisexual young people. • These media campaigns should seek to change attitudes to condom usage and address issues related to stigma of condoms, particularly for girls.	Health Service Executive	Relevant NGOs

Action Area 3: Preventing new infections **Population Group 1: Young people (*continued*)**

Actions	Lead responsibility	Key partners
2. Young people – Specific interventions		
1. Accessible and appropriate sexual health services for young people should be delivered in primary care, hospital and youth settings.	Health Service Executive	Sexual health service providers Sexual health clinics Youth sector
2. Improved access to condoms for young people will be achieved through the following measures: • A mechanism should be put in place to ensure availability and wider distribution of condoms for people at risk of HIV and STIs. This should allow for distribution of free condoms as necessary through outreach programmes and other relevant interventions. • All third-level institutions and FÁS Centres should have in place a condom distribution mechanism. • Primary care centres and sexual health services should encourage condom use and make condoms available.	Health Service Executive	Sexual health service providers Sexual health clinics Relevant NGOs Third-level institutions Student health services FÁS
3. Increasing screening and testing		
1. Sexual health services should ensure access for young people to HIV and STI screening and testing. 2. Primary care and other community settings should increase availability of HIV and STI screening and testing.	Health Service Executive	Sexual health service providers Sexual health clinics Primary Care service providers
4. Research and capacity-building		
1. A national survey of sexual knowledge, attitudes and behaviours of young people should be commissioned (similar to the ISSHR completed for the adult population in 2006). 2. A programme should be devised to support the development of monitoring and evaluation skills among those working with young people.	National AIDS Strategy Committee	Department of Health and Children Department of Education and Science Crisis Pregnancy Agency Relevant statutory agencies Other relevant Government departments

Actions	Lead responsibility	Key partners
3. Capacity-building should be developed in the youth, education and health sectors to enable youth participation and professional development in order to address young peoples' sexual health.		
5. Linkages to relevant policy frameworks 1. Clarification on the age of consent should be given and this information should be passed on to young people and organisations working with young people.	Department of Justice, Equality and Law Reform	Department of Health and Children Health Service Executive Other relevant Government departments

Action Area 3

Preventing new infections

Population Group 2: Men who have sex with men (MSM)

Actions	Lead responsibility	Key partners
1. Education and raising awareness 1. National information campaigns should be developed based on accurate knowledge of the behaviour of men who have sex with men (MSM) and sub-populations, as appropriate. These campaigns must address the issue of message fatigue among gay and bisexual men, and take account of new technologies and innovative methodologies. They must also target MSM in relationships, migrants and the population of MSM who are not exposed to information targeting gay and bisexual men. 2. Harm-minimisation information targeting MSM should be produced to address degrees of risk-taking and the effects of alcohol and other drugs. 3. Improved availability and access to sexual health promotion materials should be achieved outside of cities.	Health Service Executive	Relevant NGOs
2. MSM – Specific interventions 1. Resources targeting primary care and mental health providers should be developed to increase their knowledge of the health and social needs of MSM and to promote access to health services for MSM.	Health Service Executive	Relevant service providers
3. Increasing screening and testing 1. Regular STI and HIV screening should be encouraged among MSM, with a particular focus on those sub-groups most at risk. 2. Opportunities for HIV screening and testing (including rapid testing) should be expanded in the community setting. Pilot initiatives will be implemented and evaluations used to inform future practice.	Health Service Executive	Sexual health service providers Sexual health clinics Relevant NGOs

Action Area 3: Preventing new infections **Population Group 2: Men who have sex with men (MSM) (*continued*)**

Actions	Lead responsibility	Key partners
3. Sexual health services should prioritise MSM as a client population through direct targeting or through the provision of specific clinics for MSM. 4. All STI, GUM and A&E services should have information available to provide referral to MSM and HIV support services.		
4. Research and capacity-building		
1. Research should be commissioned to increase the evidence base informing strategic policy recommendations. This research will aim to: • increase the understanding of the sexual lives of MSM; • identify the links between social exclusion factors affecting MSM and poor sexual health, including risk for HIV.	All relevant statutory agencies	National AIDS Strategy Committee Health Service Executive Relevant NGOs
2. Community and voluntary agencies working with MSM should be resourced to build the capacity of MSM (including MSM living with HIV) to participate in the implementation of this action plan.	All relevant statutory agencies	National AIDS Strategy Committee Health Service Executive Relevant NGOs
3. Training on MSM sexual health needs should be included in the pre- and post-qualification training of health professionals.	Medical and Nursing schools	Relevant agencies and NGOs
4. Key statutory agencies with responsibility for the delivery of actions in this plan should develop protocols for the engagement of MSM representation in the planning process.	All relevant statutory agencies	
5. Linkages to relevant policy frameworks		
1. MSM should be identified as a named population in relevant health policy to ensure that mainstream provision provides a quality service to meet their health needs and to facilitate the development of specialist provision where necessary.	Department of Health and Children	Health Service Executive

Action Area 3

Preventing new infections

Population Group 3: Injecting drug users (IDUs)

Actions	Lead responsibility	Key partners
1. Education and raising awareness 1. Harm-reduction messages and programmes should be developed to prevent HIV in the context of education and awareness-raising initiatives for injecting drug users (IDUs). 2. Safer sex messages aimed at IDUs and HIV+ IDUs should be developed and integrated into the broader supports effected by the drug treatment services.	Health Service Executive	Drug treatment services Relevant NGOs National Drugs Strategy Team *in conjunction with* Local and Regional Drugs Task Forces
2. IDUs – Specific interventions 1. The Joint Report by the National Drugs Strategy Team and the National Advisory Committee on Drugs to the Interdepartmental Committee on Drugs (IDG) – entitled *An assessment of needle exchange provision in Ireland – The context, current levels of service provision and recommendations* – should be implemented in full. 2. Early intervention and service access should be prioritised for non-IDUs to prevent injecting drug use and syringe use developing.	Designated Government departments/agencies/ sectors assigned to each recommendation in the Joint Report, overseen by the IDG	Health Service Executive Department of the Environment, Heritage and Local Government Irish Prison Service Department of Justice, Equality and Law Reform Health Research Board National Advisory Committee on Drugs National Drugs Strategy Team *in conjunction with* Local and Regional Drugs Task Forces
3. Increasing screening and testing 1. Access and uptake of HIV/STI screening and testing in drug treatment services should be improved. 2. In line with the NDST/NACD report, referral to appropriate services for screening and innovative approaches to HIV/STI screening and testing should be piloted to increase access and uptake. This should include mobile services and new technology.	Health Service Executive	National Drugs Strategy Team *in conjunction with* Local and Regional Drugs Task Forces Drug treatment services Relevant NGOs

Action Area 3: Preventing new infections **Population Group 3: Injecting drug users (IDUs) (*continued*)**

Actions	Lead responsibility	Key partners
4. Research and capacity-building 1. Research into sex practices of IDUs should be commissioned in order to develop a knowledge of this area.	National Advisory Committee on Drugs	National AIDS Strategy Committee Health Service Executive Relevant NGOs
5. Linkages to relevant policy frameworks 1. The National Drugs Strategy should have an integrated approach to HIV prevention as a core element.	Department of Community, Rural and Gaeltacht Affairs	National AIDS Strategy Committee

Action Area 3

Preventing new infections

Population Group 4: Sex workers

Actions	Lead responsibility	Key partners
1. Education and raising awareness 1. Education and awareness-raising measures targeting sex workers should be integrated into sexual health campaigns. This must be informed by a review of best practice to include approaches to target new populations, illegal immigrants, indoor workers and those buying sex.	Health Service Executive	Relevant NGOs
2. Sex workers – Specific interventions 1. Negotiation skills training for sex workers, using a peer-learning approach, should be piloted and evaluated with a view to developing and implementing a programme of training. 2. Enhanced interagency approaches should be encouraged to maintain current outreach programmes working with sex workers. 3. A mechanism for condom distribution should be provided by all services working with sex workers.	Health Service Executive	Relevant NGOs
3. Increasing screening and testing 1. Specific initiatives should be implemented in partnership between services working with sex workers and STI services to make screening and testing for HIV and STIs available.	Health Service Executive	Sexual health service providers Sexual health clinics Relevant NGOs
4. Research and capacity-building 1. Mechanisms should be put in place to build the capacity of sex workers to participate in relevant fora to represent the needs of this group and to inform relevant policy and practice. 2. Research should be commissioned into the appropriate methodologies for HIV and AIDS education and prevention for indoor sex working and working with new populations in order to inform the development of innovative prevention approaches.	Health Service Executive	National AIDS Strategy Committee Relevant NGOs

Action Area 3: Preventing new infections **Population Group 4: Sex workers (*continued*)**

Actions	Lead responsibility	Key partners
5. Linkages to relevant policy frameworks		
1. A review of the current legislation governing prostitution should be undertaken to ensure that access to health and social services is not impeded.	Department of Justice, Equality and Law Reform	Department of Health and Children Health Service Executive

Action Area 3

Preventing new infections

Population Group 5: Prisoners

Actions	Lead responsibility	Key partners
1. Education and raising awareness 1. Specific HIV/STI education programmes should be implemented for prisoners and prison staff within a broader health promotion context.	Prison health services	
2. Prisoners – Specific interventions 1. A mechanism to provide condoms in prisons should be established. 2. Improved linkages should be developed between Prison health services and services within the community for people who are HIV-positive in order to ensure appropriate care pathways in the transition from prison to community.	Prison health services	Health Service Executive
3. Increasing screening and testing 1. Comprehensive and confidential HIV/STI screening and testing programmes should be introduced in all prisons.	Prison health services	
4. Research and capacity-building 1. A review of current care programmes for HIV and drug treatment should be undertaken. This will aim to evaluate both the content of these programmes and make proposals on the linkages between the Prison health services and community HSE services.	Prison health services	Health Service Executive National Drugs Strategy Team
5. Linkages to relevant policy frameworks 1. The recommendations of the National Drugs Strategy should be implemented in full.	Prison health services	Department of Community, Rural and Gaeltacht Affairs National Drugs Strategy Team

Action Area 3

Preventing new infections

Population Group 6: People living with HIV (PLHIV)

Actions	Lead responsibility	Key partners
1. Education and raising awareness		
1. Information on living with HIV should be developed and resources published. These should address sensitive issues, including support towards disclosure and details of available services, and also address the specific needs of sub-populations, such as people living with HIV (PLHIV) in relationships, migrants, injecting drug users, and gay and bisexual PLHIV. Informational resources should also be provided for partners and family members, and specific information should be developed for children and adolescents living with HIV.	Health Service Executive	Relevant statutory agencies Relevant NGOs
2. PLHIV – Specific interventions		
1. Health promotion and psychosocial support staff should be available to PLHIV in clinical and community settings.	Relevant service providers	Health Service Executive Relevant NGOs
2. Interventions that contribute to increased self-esteem and personal development for PLHIV, including behaviour change and disclosure supports, should be developed and implemented.	Health Service Executive	Relevant NGOs
3. Specific interventions should be implemented targeting migrant PLHIV in the community setting, taking account of language and cultural needs.	Health Service Executive	Relevant NGOs
4. Ongoing educational interventions will be delivered by health and social care professionals and through peer interventions to address immediate and emerging issues for PLHIV.	Health Service Executive	Relevant service providers Relevant NGOs
5. Resources targeting primary care and mental health providers should be developed to increase their knowledge of the health and social needs of PLHIV and to promote access to health services for PLHIV.	Health Service Executive	Relevant service providers Relevant NGOs

Action Area 3: Preventing new infections **Population Group 6: People living with HIV (PLHIV) (*continued*)**

Actions	Lead responsibility	Key partners
3. Increasing screening and testing 1. Clinical staff should have information relevant to the needs of different populations of HIV-positive people and appropriate HIV prevention methodologies, with referral capacity to other supports as appropriate.	Health Service Executive	Sexual health service providers Sexual health clinics
4. Research and capacity-building 1. Research should be commissioned to explore the needs of HIV-positive people in an Irish context. 2. Supports should be made available to people who are HIV-positive to enable them to act as advocates in relation to their own needs. 3. Key statutory agencies within health, education, social services and justice should actively engage PLHIV in the planning, delivery and evaluation of actions in this action plan.	Health Service Executive Relevant statutory agencies	Relevant statutory agencies Relevant NGOs
5. Linkages to relevant policy frameworks 1. PLHIV should be identified as a named population group to ensure that mainstream provision provides a quality service to meet their health needs and to facilitate the development of specialist provision where necessary.	Health Service Executive	Department of Health and Children

Action Area 3

Preventing new infections

Population Group 7: People from countries where HIV is endemic

Actions	Lead responsibility	Key partners
1. Education and raising awareness 1. Appropriate HIV and AIDS education and prevention programmes specific to the needs of new communities should be developed and implemented, allowing for gender, ethnic and religious sensitivities. 2. Communication and resource development in appropriate languages should be an integral element of sexual health and HIV prevention campaigns, and include use of ethnic media in all such campaigns.	Health Service Executive	Relevant statutory agencies Relevant NGOs
2. People from countries where HIV is endemic – Specific interventions 1. Condoms should be available in Reception Centres and Hostels free of charge. 2. Support the development of peer-led and targeted outreach interventions, specifically aimed at reaching undocumented migrants.	Health Service Executive	Relevant statutory agencies Relevant NGOs
3. Increasing screening and testing 1. Availability of HIV/STI screening and testing for refugees and asylum-seekers should be increased. 2. Healthcare workers and NGOs working with migrant communities should encourage HIV/STI testing by the provision of information on the services available.	Health Service Executive	Relevant statutory agencies Relevant NGOs
4. Research and capacity-building 1. Support should be made available to groups representing people from countries where HIV is endemic to enable them to act as advocates in relation to their own needs.	Health Service Executive	Relevant NGOs Community and Church leaders
5. Linkages to relevant policy frameworks 1. HSE's Intercultural Health Strategy should be implemented as recommended to ensure adequate health and social care services are delivered.	Health Service Executive	

Action Area 4

Addressing stigma and discrimination		
Actions	**Lead responsibility**	**Key partners**
1. Support should be given to the Multi-Stakeholder Forum's approach to addressing stigma and discrimination.	Relevant statutory agencies	Department of Foreign Affairs – Irish Aid Relevant NGOs and networks of PLHIV Department of Health and Children Health Service Executive
2. Legislation, policies and other measures should be enforced to protect the rights of people with HIV.	Department of Justice, Equality and Law Reform	Relevant statutory agencies
3. Awareness-raising and training opportunities on stigma and discrimination of people with HIV/AIDS for GPs, other healthcare professionals, prison staff and primary care practitioners should be integrated into pre- and in-service medical and nursing education.	Medical and Nursing schools	Health Service Executive Prison health services

Action Area 5

Monitoring and evaluation		
Actions	**Lead responsibility**	**Key partners**
1. Quality standards for HIV and AIDS prevention should be developed to support implementation of this action plan.	National AIDS Strategy Committee	Department of Health and Children Department of Education and Science Health Service Executive Other relevant statutory agencies Relevant NGOs Department of Foreign Affairs – Irish Aid
2. A mid-term and final report on the implementation of this action plan should be published.	National AIDS Strategy Committee	Department of Health and Children Health Service Executive
3. A national minimum dataset should be agreed to assist in the collection of epidemiological and risk factor data, in liaison with the Surveillance Sub-Committee.	Health Service Executive – Health Protection Surveillance Centre	National AIDS Strategy Committee Department of Health and Children

Action Area 6

International commitments		
Actions	**Lead responsibility**	**Key partners**
1. To continue to support the work of the Irish Aid Programme in relation to HIV and AIDS.	Department of Health and Children	Department of Foreign Affairs – Irish Aid
2. Ireland should continue to participate in relevant EU, WHO and UN networks and policy development fora to inform best practice.	Department of Health and Children	Relevant NGOs Relevant statutory agencies
3. An all-island dialogue in relation to HIV and AIDS prevention should be supported.	Department of Health and Children	National AIDS Strategy Committee CAWT (Cooperation and Working Together)

Bibliography

Abraham, C. and Sheeran, P. (1994) 'Modelling and modifying young heterosexuals HIV-preventive behavior – A review of theories, findings and educational implications', *Patient Education and Counselling*, Vol. 23, No. 3, pp. 173-86.

Adams, B.D., Sears, A. and Schellenberg, E.G. (2000) 'Accounting for unsafe sex: Interviews with men who have sex with men', *Journal of Sex Research*, Vol. 37, No. 1, pp. 24-36.

Aggleton, P. (1996) 'Global priorities for HIV/AIDS intervention research', *International Journal of STI & AIDS*, Vol. 7, pp. 13-16.

AIDS Care Education and Training (ACET) (2002) *Irishlinks*: ACET. Available at: http://www.activelink.ie/irish/organisation.php?id=123 (accessed April 2008)

Aitken, C.K. (2002) 'Promising strategies for media health campaigns'. In: W.D. Crano, M. Burgoon and S. Oskamp (eds.), *Mass Media and Drug Prevention: Classic and contemporary theories and research*. Hillsdale, NJ: Lawrence Erlbaum.

Alexander, P. (1992) 'Sex work and health: A question of safety in the workplace', *Journal of the American Medical Women's Association (JAMWA)*, Vol. 53, No. 2, pp. 77-82.

Alford, S. (2006) *The sexual health of Latino adolescents*. Washington, DC: Advocates for Youth.

Allwright, S., Bradley, F., Long, J., Barry, J., Thornton, L. and Parry, J.V. (2000) 'Prevalence of antibodies to Hepatitis B, Hepatitis C and HIV, and risk factors in Irish prisoners: Results of a national cross-sectional survey', *British Medical Journal*, No. 321, pp. 78-82.

Amaro, H., Raj, A. and Reed, E. (2001) 'Women's Sexual Health: The need for feminist analyses in public health in the decade of behavior', *Psychology of Women Quarterly*, Vol. 25, No. 4, pp. 324-34.

Atkinson, M. and Hornby, G. (2002) *Mental Health Handbook for Schools*. London: Routledge Falmer.

Auerbach, J.D. and Coates, T.J. (2000) 'HIV Prevention Research: Accomplishments and challenges for the third decade of AIDS', *American Journal of Public Health*, Vol. 90, No. 7, pp. 1029-32.

AVERT. *Australia – Statistics Summary*. Available at: http://www.avert.org/ausstatg.htm (accessed April 2008)

AVERT. *Recreational drug use and HIV.* Available at: http://www.avert.org/druguse.htm (accessed April 2008)

AVERT. *Overview of HIV Prevention*. Available at: http://www.avert.org/prevent-hiv.htm (accessed April 2008)

Barry, M. and O'Higgins, S. (2006) *Tender proposal for Review of Education and Prevention Sub-Committee*. Galway: Health Promotion Research Centre, National University of Ireland, Galway.

Bailey, J.V., Farquher, C., Owen, C. and Mangtani, P. (2004) 'Sexually transmitted infections in women who have sex with women', *Sexually Transmitted Infections*, No. 80, pp. 244-46.

Basen-Engquist, K., Coyle, K.K., Parcel, G.S., Kirby, D., Banspach, S.W., Carvajal, S.C. and Baumler, E. (2001) 'School-wide effects of a multi-component HIV, STD and Pregnancy Prevention Program for High School Students', *Health Education and Behavior*, Vol. 28, No. 2, pp. 166-85.

Bennett, P. and Bozionelos, G. (2000) 'The theory of planned behaviour as predictor of condom use: A narrative review', *Psychology, Health & Medicine*, Vol. 5, No. 3, pp. 307-26.

Bloor, M., Thomas, M., Hood, K., Abeni, D., Goujon, C., Hausser, D., Hubert, M., Kleiber, D. and Nieto, J.A. (1998) 'Differences in sexual risk behaviour between young men and women travelling abroad from the UK', *The Lancet*, Vol. 352, No. 9141, pp. 1664-68.

Bluthenthal, R.N., Kral, A.H., Gee, L., Erringer, E.A. and Edlin, B.R. (2000) 'The effect of syringe exchange use on high-risk injection drug users: A cohort study', *AIDS*, Vol. 14, No. 5, pp. 605-11.

Bluthenthal, R.N., Malik, M.R., Grau, L.E., Singer, M., Marshall, P. and Heimer, R. (2004) 'Sterile syringe access conditions and variations in HIV risk among drug injectors in three cities', *Addiction*, Vol. 99, No. 9, pp. 1136-46.

Bockting, W.O., Robinson, B.E., Forberg, J. and Scheltema, K. (2005) 'Evaluation of a sexual health approach to reducing HIV/STD risk in the transgender community', *AIDS Care*, Vol. 17, No. 3, pp. 289-303.

Boily, M.C., Lowndes, C. and Alary, M. (2002) 'The impact of HIV epidemic phases on the effectiveness of core group interventions: Insights from mathematical models', *Sexually Transmitted Infections*, No. 78 (Supplement 1), pp. i78-90.

Bonell, C., Strange, V., Allen, E. and Barnett-Page, E. (2006) 'HIV prevention outreach in commercial gay venues in large cities: Evaluation findings from London', *Health Education Research*, Vol. 21, No. 4, pp. 452-64.

Bowen, A., Gambrell, A. and DeCarlo, P. (2006) *What are rural HIV prevention needs?* (Fact Sheet No. 26ER). San Francisco: Center for AIDS Prevention Studies and AIDS Research Institute, University of California.

Brown, L., Macintyre, K. and Trujillo, L. (2003) 'Interventions to reduce HIV/AIDS stigma: What have we learned?', *AIDS Education and Prevention*, Vol. 15, No. 1, pp. 49-69.

Bryant, J. and Zillmann, D. (eds.) (1994) *Media Effects: Advances in theory and research*. Hillsdale, NJ: Lawrence Erlbaum.

Buchanan, D., Shaw, S., Teng, W., Hiser, P. and Singer, M. (2003) 'Neighborhood differences in patterns of syringe access, use and discard among injection drug users: Implications for HIV outreach and prevention education', *Journal of Urban Health*, Vol. 80, No. 3, pp. 438-54.

Campbell, C. and Mzaidume, Z. (2001) 'Grassroots participation, peer education and HIV prevention by sex workers in South Africa', *American Journal of Public Health*, Vol. 91, No. 12, pp. 1978-86.

Canadian Public Health Association (2003) *2003-2004 HIV/AIDS Work Plan: Canadian Strategy on HIV/AIDS*. Toronto: Canadian Public Health Association.

Canadian Public Health Association (2005) *Leading together: Canada takes action on HIV/AIDS (2005-2010)*. Toronto: Canadian Public Health Association.

Caplinskiene, I., Caplinskas, S. and Griskevicius, A. (2003) 'Narcotic abuse and HIV infection in prisons', *Medicina (Kaunas)*, Vol. 39, No. 8, pp. 797-803.

Celentano, D.D. (2003) 'HIV prevention among drug users: An international perspective from Thailand', *Journal of Urban Health,* Vol. 80, No. 4 (Supplement 3), pp. iii97-105.

Centers for Disease Control and Prevention (1999) *Compendium of HIV Prevention Interventions with evidence of effectiveness – from CDC's HIV/AIDS Prevention Research Synthesis Project*. Atlanta, GA: National Center for HIV, STD and TB Prevention, Division of HIV/AIDS Prevention-Intervention Research and Support.

Chalmers, H., Tyrer, P. and Aggleton, P. (2006) 'Sex and relationships education in schools: Evaluation of a pilot programme for the certification of community nurses', *Health Education Journal*, Vol. 65, No. 1, pp. 28-40.

Chapman , S. and Lupton, D. (1995) T*he Fight for Public Health: Principles and practice of media advocacy*. London: BMJ Publishing.

Charleston, S., Oakley, A., Johnson, A., Stephenson, J., Brodala, A., Fenton, K. and Petruckevitch, A. (1996) *Report on a pilot study for a randomised controlled trial of peer-led sex education in schools*. London: Institute of Education.

Choopanya, K., Des Jarlais, D.C., Vanichseni, S., Kitayaporn, D., Mock, P.A., Raktham, S., Hireanras, K., Heyward, W.L., Sujarita, S. and Mastro, T.D. (2002) 'Incarceration and risk for HIV infection among injection drug users in Bangkok', *Journal of Acquired Immune Deficiency Syndromes (JAIDS)*, Vol. 29, No. 1, pp. 86-94.

Clover, D. (2006) 'Overcoming barriers for older gay men in the use of health services: A qualitative study of growing older, sexuality and health', *Health Education Journal*, Vol. 65, No. 1, pp. 41-52.

Cohen, D.A., Wu, S.Y. and Farley, T.A. (2004) 'Comparing the cost-effectiveness of HIV prevention interventions', *Journal of Acquired Immune Deficiency Syndromes (JAIDS)*, Vol. 37, No. 3, pp. 1404-14.

Coleman, L.M. and Ford, N.J. (1996) 'An extensive literature review of the evaluation of HIV prevention programmes', *Health Education Research*, Vol. 11, No. 3, pp. 327-38.

Cowan, F.M. (2002) 'Adolescent reproductive health interventions', *Sexually Transmitted Infections*, Vol. 78, No. 5, pp. 315-18.

Coyle, K., Kirby, D., Robin, L., Banspach, S., Baumler, E. and Glassman, J. (2006) 'ALL4YOU! A randomized trial of an HIV, other STDs and pregnancy prevention intervention for the alternative schools students', *AIDS Education and Prevention*, Vol. 18, No. 3, pp. 187-203.

Coyle, S.L., Needle, R.H. and Normand, J. (1998) 'Outreach-based HIV prevention for injecting drug users: A review of published outcome data', *Public Health Reports*, No. 113 (Supplement 1), pp. i19-30.

Crepaz, N. and Marks, G. (2002) 'Towards an understanding of sexual risk behaviour in people living with HIV: A review of social, psychological and medical findings', *AIDS*, Vol. 16, No. 2, pp. 135-49.

Crisis Pregnancy Agency (2004) *Research on teenagers' sexuality – for parents*, Summary of research, Vol. 1, No. 1. Dublin: Crisis Pregnancy Agency.

Crosby, R., Sanders, S., Yarber, W.L. and Graham, C.A. (2003) 'Condom use: Errors and problems. A neglected aspect of studies assessing condom effectiveness', *American Journal of Preventive Medicine*, Vol. 24, No. 4, pp. 367-70.

Crosby, R.A. and St. Lawrence, J.S. (2000) 'Adolescents' use of school-based health clinics for reproductive health services: Data from the National Longitudinal Study of Adolescent Health', *Journal of School Health*, Vol. 70, No. 1, pp. 22-27.

Curran, J. (2003) 'Reflections on AIDS, 1881-2031', *American Journal of Preventive Medicine*, Vol. 24, No. 3, pp. 281-84.

Dal Cin, S., MacDonald, T.K., Fong, G.T., Zanna, M.P. and Elton-Marshall, T.E. (2006) 'Remembering the Message: The use of a reminder cue to increase condom use following a safer sex intervention', *Health Psychology*, Vol. 25, No. 3, pp. 438-43.

Darbes, L., Kennedy, G., Peersman, G., Rutherford, G. and Zohrabyan, L. (2002) *Behavioral interventions for decreasing HIV infection in racial and ethnic minorities in high-income economies* (Protocol). Cochrane Database of Systematic Reviews 2002, Issue 1.

De Cock, K.M., Fowler, M.G., Mercier, E., de Vincenzi, I., Saba, J., Hoff, E., Alnwick, D.J., Rogers, M. and Shaffer, N. (2000) 'Prevention of mother-to-child HIV transmission in resource-poor countries: Translating research into policy and practice', *Journal of the American Medical Association (JAMA)*, Vol. 283, No. 9, pp. 1175-82.

De La Cancela, V. (1989) 'Minority AIDS prevention: Moving beyond cultural perspectives towards socio-political empowerment', *AIDS Education & Prevention*, Vol. 1, No. 2, pp. 141-53.

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

Department of Health and Ageing, Australia (2005) *National HIV/AIDS Strategy: Revitalising Australia's Response 2005-2008*. Canberra: Department of Health and Ageing.

Department of Health and Children (2000a) *AIDS Strategy 2000.* Dublin: The Stationery Office.

Department of Health and Children (2000b) *Review of services for sexually transmitted infections in Eastern Regional Health Authority.* Dublin: Eastern Regional Health Authority, Health Service Executive.

Department of Health and Children (2000c) *National Health Promotion Strategy 2000-2005*. Dublin: The Stationery Office.

Department of Health and Children (2001) *Quality and Fairness*: *A Health System for You. Health Strategy.* Dublin: The Stationery Office.

Department of Health and Children (2002) *Sexual Health Strategy*. Cork: Health Service Executive, South.

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

Department of Justice, Equality and Law Reform (2006) *Keeping drugs out of prison: Drugs Policy and Strategy*. Dublin: The Stationery Office.

Deptula, D., Henry, D., Shoeny, M. and Slavick, J. (2006) 'Adolescent sexual behavior and attitudes: A costs and benefits approach', *Journal of Adolescent Health*, Vol. 38, No. 1, pp. 35-43.

Des Jarlais, D.C., Perlis, T., Arasteh, K., Hagan, H., Milliken, J., Braine, N., Yancovitz, S., Mildvan, D., Perlman, D., Maslow, C. and Friedman, S.R. (2004) ' "Informed Altruism" and "Partner Restriction" in the reduction of HIV infection in injecting drug users entering detoxification treatment in New York City, 1990-2001', *Journal of Acquired Immune Deficiency Syndromes (JAIDS)*, Vol. 35, No. 2, pp. 158-66.

Devine, P., Hickson, F., McNamee, H. and Quinlan, M. (2006) *Real Lives – Findings from the All-Ireland Gay Men's Sex Surveys*, *2003 and 2004.* Dublin: ARK, GMHP/HSE, Rainbow Project and Sigma Research.

DiClemente, R.J. and Wingood, G.M. (1995) 'A randomized controlled trial of an HIV sexual risk-reduction intervention for young African-American women', *Journal of the American Medical Association (JAMA)*, Vol. 274, No. 16, pp. 1271-76.

DiClemente, R.J., Wingood, G.M., Harrington, K.F., Lang, D.L., Davies, S.L., Hook, E.W. III., Oh, M.K., Crosby, R.A., Hertzberg, V.S., Gordon, A.B., Hardin, J.W., Parker, S. and Robillard, A. (2004) 'Efficacy of an HIV prevention intervention for African-American adolescent girls: A randomized controlled trial', *Journal of the American Medical Association (JAMA)*, Vol. 292, No. 2, pp. 171-79.

DiIorio, C., Dudley, W.N., Lehr, S. and Soet, J.E. (2000) 'Correlates of safer sex communication among college students', *Journal of Advanced Nursing*, Vol. 32, No. 3, pp. 658-65.

DiIorio, C., Resnicow, K., McCarty, F., De, A.K., Dudley, W.N., Wang, D.T. and Denzmore, P. (2006) 'Keepin' it R.E.A.L.!: Results of a mother-adolescent HIV prevention program', *Nursing Research*, Vol. 55, No. 1, pp. 43-51.

Dillon, L. (2001) *Drug use among prisoners: An exploratory study*. Dublin: Health Research Board.

Docherty, B.Q. (2002) 'A survey of sexual activity in HIV-positive gay men', *Journal of Research in Nursing,* Vol. 7, No. 2, pp. 139-50.

Dolan, K., Rutter, S. and Wodak, D. (2002) 'Prison-based syringe exchange programmes: A review of international research and development', *Addiction*, No. 93, pp. 153-58.

Dore, G.J. and Cooper, D.A. (2006) 'HAART's first decade: Success brings further challenges', *The Lancet*, Vol. 368, No. 9534, pp. 427-29.

Dorfman, L.E., Derish, P.A. and Cohen, J.B. (1992) 'Hey girlfriend: An evaluation of AIDS prevention among women in the sex industry', *Health Education Quarterly*, Vol. 19, No. 1, pp. 25-40.

Douaihy, A.B., Stowell, K.R., Bui, T., Daley, D. and Salloum, I. (2005) 'HIV/AIDS and homelessness. Part 1: Background and barriers to care', *AIDS Read*, Vol. 15, No. 10, pp. 516-20.

Doull, M., O'Conner, A., Robinson, V., Wells, G. and Tugwell, P. (2004) *Peer-based interventions for reducing morbidity and mortality in HIV-infected women* (Protocol). Cochrane Database of Systematic Reviews 2004, Issue 2.

Downs, J., Bruin, W., Murray, P. and Fischhoff, B. (2006) 'Specific STI knowledge may be acquired too late', *Journal of Adolescent Health*, Vol. 38, No. 1, pp. 65-67.

Drumright, L.N., Patterson, T.L. and Strathdee, S.A. (2006) 'Club drugs as causal risk factors for HIV acquisition among men who have sex with men: A review', *Substance Use & Misuse*, Vol. 41, No. 10-12, pp. 1551-1601.

Dubois-Arber, F., Jeannin, A., Konings, E. and Paccaud, F. (1997) 'Increased condom use without other major changes in sexual behavior among the general population in Switzerland', *American Journal of Public Health*, Vol. 87, No. 4, pp. 558-66.

Dutt, D., Pandey, G.K., Nair, N.S., Subramanyam, M., Nagaraj, K. and Banerjee, B. (2005) *Interventions to modify sexual risk behaviors for preventing HIV infection in street children and young people in developed countries* (Protocol). Cochrane Database of Systematic Reviews 2005, Issue 4.

Dworkin, S.L., Exner, T., Melendez, R., Hoffman, S. and Ehrhardt, A.A. (2006) 'Revisiting "Success": Post-trial analysis of a gender-specific HIV/STD prevention intervention', *AIDS & Behavior*, Vol. 10, No. 1, pp. 41-51.

Ehrhardt, A., Exner, T., Hoffman, S., Silberman, I., Leu, C., Miller, S. and Levin, B. (2001) 'A gender-specific HIV/STD risk reduction intervention for women in a health care setting: Short- and long-term results of a randomized clinical trial', *AIDS Care*, Vol. 14, No. 2, pp. 147-61.

Ekstrand, M. (2006) *How does stigma affect HIV prevention and treatment?* (Fact Sheet No. 60E). San Francisco: Center for AIDS Prevention Studies and AIDS Research Institute, University of California.

Ellen, J.M. (2003) 'The next generation of HIV prevention for adolescent females in the United States: Linking behavioral and epidemiologic sciences to reduce incidence of HIV', *Journal of Urban Health*, Vol. 80, No. 4 (Supplement 3), pp. iii40-49.

Ellis, S., Barnett-Page, E., Morgan, A., Taylor, L., Walters, R. and Goodrich, J. (2003) *HIV prevention: A review of reviews assessing the effectiveness of interventions to reduce the risk of sexual transmission*. London: Health Development Agency, National Health Service.

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

Elwy, A.R., Graham, J., Hawkes, S. and Petticrew, M. (2002) 'Effectiveness of interventions to prevent sexually transmitted infections and HIV in heterosexual men: A systematic review', *Archives of Internal Medicine*, Vol. 162, No. 16, pp. 1818-30.

European Commission (2005) Communication on *Combating HIV/AIDS within the European Union and in the neighbouring countries, 2006-2009*. Brussels: European Commission.

European Monitoring Centre for Drugs and Drug Addiction (2002) *Annual report on the state of the drugs problem in the European Union and Norway*. Luxembourg: Office for Official Publications of the European Communities.

European Public Health Alliance (2004) *A coordinated and integrated approach to fighting HIV/AIDS in EU and in its neighbourhood,* A paper adopted by the European Commission, September 2004. Brussels: European Public Health Alliance.

EuroHIV (2007) 'Mid-year report 2006', *HIV/AIDS Surveillance in Europe*, No. 74, EuroHIV (European Centre for the Epidemiological Monitoring of AIDS). Saint-Maurice: French Institute for Public Health Surveillance. Available at: http://www.eurohiv.org/reports/index_reports_eng.htm

Exner, T.M., Dworkin, S.L., Hoffman, S. and Ehrhardt, A.A. (2003) 'Beyond the male condom: The evolution of gender-specific HIV interventions for women', *Annual Review of Sex Research*, No. 14, pp. 114-36.

Exner, T.M., Gardos, P.S., Seal, D.W. and Ehrhardt, A.A. (1999) 'HIV sexual risk reduction interventions with heterosexual men: The forgotten group', *AIDS and Behavior*, Vol. 3, No. 4, pp. 347-58.

Family Planning Association, UK (2005) *Teenagers: Sexual health and behaviour*. Available at: http://www.fpa.org.uk/information/factsheets/documents_and_pdfs/detail.cfm?contentID=512 (accessed April 2008)

Fenton, K.A., Mercer, C.H., McManus, S., Erens, B., Wellings, K., Macdowall, W., Byron, C.L., Copas, A.J., Nanchahal, K., Field, J. and Johnson, A.M. (2005) 'Ethnic variations in sexual behaviour in Great Britain and risk of sexually transmitted infections: A probability survey', *The Lancet*, Vol. 365, No. 9466, pp. 1246-55.

Ferñandez, M.I., Bowen, G.S., Caryl, L.G., Tiffany, R.M., Evelyne, B. and Jeffrey, A.K. (2003) 'HIV, Sex, and Social Change: Applying ESID principles to HIV prevention research', *American Journal of Community Psychology*, Vol. 32, No. 3, pp. 333-44.

Fisher, J.D. and Fisher, W.A. (2000) 'Individual level theories of HIV risk behaviour change'. In: J. Peterson and R.J. DiClemente (eds.), *Handbook of HIV prevention*. New York: Plenum.

Folch, C., Marks, G., Esteve, A., Zaragoza, K., Munoz, R. and Casabona, J. (2006) 'Factors associated with unprotected sexual intercourse with steady male, casual male and female partners among men who have sex with men in Barcelona, Spain', *AIDS Education and Prevention*, Vol. 18, No. 3, pp. 227-42.

French, J. (2004) *Components of successful media campaigns*. London: Health Development Agency, National Health Service.

Fried, S. (1997) *If I grow up: Talking with teens about AIDS, love, and staying alive*. Available at: http://www.thebody.com/fried/safer_sex.html (accessed April 2008)

Galbraith, J., Ricardo, I., Stanton, B., Black, M., Feigelman, S. and Kaljee, L. (1996) 'Challenges and rewards of involving community in research: An overview of the "Focus on Kids" HIV Risk Reduction Program', *Health Education Quarterly*, Vol. 23, No. 3, pp. 383-94.

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

Godin, G., Michaud, F., Alary, M., Otis, J., Masse, B., Fortin, C., Masse, B., Fortin, C., Gagnon, M. and Gagnon, H. (2003) 'Evaluation of an HIV and STD prevention program for adolescents in juvenile rehabilitation centers', *Health Education Behavior*, Vol. 30, No. 5, pp. 601-14.

Gonzales, N.A., Cauce, A.M., Friedman, R.J. and Mason, C.A. (1996) 'Family, peer and neighborhood influences on academic achievement among African-American adolescents: One-year prospective effects', *American Journal of Community Psychology*, Vol. 24, No. 3, pp. 365-87.

Goodwin, R., Kozlova, A., Nizharadze, G. and Polyakova, G. (2004) 'HIV/AIDS among adolescents in Eastern Europe: Knowledge of HIV/AIDS, social representations of risk and sexual activity among school children and homeless adolescents in Russia, Georgia and the Ukraine', *Journal of Health Psychology*, Vol. 9. No. 3, pp. 381-96.

Gott, M., Galena, E., Hinchliff, S. and Elford, H. (2004) ' "Opening a can of worms": GP and practice nurses' barriers to talking about sexual health in primary care', *Family Practice,* Vol. 21, No. 5, pp. 528-36.

Gowing, L., Farrell, M., Bornemann, R., Sullivan, L. and Ali, R. (2004) *Substitution treatment of injecting opioid users for prevention of HIV infection* (Review). Cochrane Database of Systematic Reviews 2004, Issue 4.

Grilli, R., Ramsay, C. and Minozzi, S. (2002) *Mass media interventions: Effects on health services utilisation* (Review). Cochrane Database of Systematic Reviews 2002, Issue 1.

Gunn, R.A., Lee, M.A., Callahan, D.B., Gonzales, P., Murray, P.J. and Margolis, H.S. (2005) 'Integrating Hepatitis, STD, and HIV services into a drug rehabilitation program', *American Journal of Preventive Medicine*, Vol. 29, No. 1, pp. 27-33.

Guzmán, B., Schlehofer-Sutton, M., Villanueva, C., Dello Stritto, M.E., Casad, B. and Feria, A. (2003) 'Let's talk about sex: How comfortable discussions about sex impact teen sexual behavior', *Journal of Health Communication*, Vol. 8, pp. 583-98.

Hagan, H. and Thiede, H. (2003) 'Does bleach disinfection of syringes help prevent hepatitis C virus transmission?', *Epidemiology*, Vol. 14, No. 5, pp. 628-29.

Hamers, F.F. and Downs, A.M. (2004) 'The changing face of the HIV epidemic in western Europe: What are the implications for public health policies?', *The Lancet*, Vol. 364, No. 9428, pp. 83-94.

Harden, A., Weston, R. and Oakley, A. (1999) *A review of the effectiveness and appropriateness of peer-delivered health promotion interventions for young people*. London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London.

Harold, J. and Robert, S.J. (2003) 'Incorporating HIV prevention into the medical care of persons living with HIV. Recommendations of CDC, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America', *Morbidity and Mortality Weekly Report, Recommendations and Reports*, Vol. 52, No. RR-12, pp. 1-24.

Harper, G.W., Bangi, A.K., Contreras, R., Pedraza, A., Tolliver, M. and Vess, L. (2004) 'Diverse phases of collaboration: Working together to improve community-based HIV interventions for adolescents', *American Journal of Community Psychology*, Vol. 33, No. 3-4, pp. 193-204.

Hart, G.J., Williamson, L.M. and Flowers, P. (2004) 'Good in Parts: The Gay Men's Task Force in Glasgow – A response to Kelly', *AIDS Care*, Vol. 16, No. 2, pp. 159-65.

Hays, R., Rebchook, G. and Kegeles, S. (2003) The Mpowerment Project: Community-building with young gay and bisexual men to prevent HIV', *American Journal of Community Psychology*, Vol. 31, No. 3/4, pp. 301-12.

Health Development Agency, UK (2004a) *The effectiveness of public health campaigns* (No. HDA Briefing No. 7). London: Health Development Agency, National Health Service.

Health Development Agency, UK (2004b) *The effectiveness of public health interventions – and implications* (No. HDA Briefing No. 1). London: Health Development Agency, National Health Service.

Heise, L., Moore, K. and Toubia, N. (1995) *Sexual coercion and reproductive health: A focus on research*. New York: Population Council.

Hillsdon, M., Cavill, N., Nanchahal, K., Diamond, A. and White, I. (2001) 'National-level promotion of physical activity: Results from England's ACTIVE for LIFE campaign', *Journal of Epidemiology and Community Health*, No. 55, pp. 755-61.

HIV/AIDS Treatment Adherence, Health Outcomes and Cost Study Group (2004) 'The HIV/AIDS Treatment Adherence, Health Outcomes and Cost Study: Conceptual foundations and overview', *AIDS Care*, No. 16 (Supplement 1), pp. i6-21.

Holtgrave, D.R. (2002) 'Extending the methodology of the Committee on Clinical Preventive Service Priorities to HIV-prevention community planning', *American Journal of Preventive Medicine*, Vol. 22, No. 3, pp. 209-10.

HPSC (2005a) *AIDS Surveillance data: Cases reported to the HPSC up to the end of September 2005*. Dublin: Health Protection Surveillance Centre, Health Service Executive.
HPSC (2005b) *Sexually Transmitted Infections 2004: Annual Summary Report.* Dublin: Health Protection Surveillance Centre, Health Service Executive.
HPSC (2006) *Annual Report 2006*. Dublin: Health Protection Surveillance Centre, Health Service Executive.
HPSC (2007a) *Voluntary antenatal HIV testing in Ireland: Results of the screening programme, 2002 to 2006.* Dublin: Health Protection Surveillance Centre, Health Service Executive.
HPSC (2007b) *Newly diagnosed HIV infections in Ireland. Quarter 3 and 4, 2006, and 2006 Annual Summary.* Dublin: Health Protection Surveillance Centre, Health Service Executive.
Hughes, C. and Evans, A. (2003) 'Health needs of women who have sex with women', *British Medical Journal*, No. 227, pp. 939-40.
Huntington, S., Hope, V., Hutchinson, S., Goldberg, D. and Ncube, F. (2006) 'Diversity of needle exchange provision in the UK: Findings from a national survey', *Eurosurveillance*, Vol. 11, No. 8, E060810.4. Available at: http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=3022
Huo, D., Bailey, S.L., Hershow, R.C. and Ouellet, L. (2005) 'Drug Use and HIV risk practices of secondary and primary needle exchange users', *AIDS Education and Prevention*, Vol. 17, No. 2, pp. 170-84.
Hyde, J., Appleby, P.R., Weiss, G., Bailey, J. and Morgan, X. (2005) 'Group-level interventions for persons living with HIV: A catalyst for individual change', *AIDS Education and Prevention*, Vol. 17, No. 1 (Supplement A), pp. A53-65.
Hyde, A. and Howlett, E. (2004) *Understanding teenage sexuality in Ireland*. Dublin: Crisis Pregnancy Agency.
International Centre for Criminal Law Reform and Criminal Justice (2001) *International Compendium of current practices to address infectious diseases in prisons, October 2001*. Vancouver: International Centre for Criminal Law Reform and Criminal Justice, and International Corrections and Prisons Association.
International Collaboration on HIV Optimism (2003) 'HIV treatments: Optimism among gay men. An international perspective', *Journal of Acquired Immune Deficiency Syndromes (JAIDS)*, Vol. 32, No. 5, pp. 545-50.
Irish Prison Service (2001) *Irish Review of the Structure and Organisation of Prison Health Care Services*. Dublin: Irish Prison Service.
James, M., Hoff, T., Davis, J. and Graham, R. (2005) *Grant Watch Report – Leveraging the power of the media to combat HIV/AIDS*. Millwood, VA: Project HOPE – The People-to-People Health Foundation.
Jeannin, A., Konings, E., Dubois-Arber, F., Landert, C. and Melle, M.G. (1998) 'Validity and reliability in reporting sexual partners and condom use in a Swiss population survey', *European Journal of Epidemiology*, Vol. 14, No. 2, pp. 139-46.
Jemmott, J.B. III, Jemmott, L.S., Braverman, P.K. and Fong, G.T. (2005) 'HIV/STD risk reduction interventions for African-American and Latino adolescent girls at an adolescent medicine clinic: A randomized controlled trial', *Archives of Pediatrics & Adolescent Medicine*, Vol. 159, No. 5, pp. 440-49.
Jemmott, J.B. and Jemmott, L.S. (2000) 'HIV risk reduction behavioral interventions with heterosexual adolescents', *AIDS*, No. 14 (Supplement 2), pp. ii40-52.
Johnson-Masotti, A.P., Pinkerton, S.D, Kelly, J. and Stevenson, L. (2000) 'Cost-effectiveness of an HIV risk reduction intervention for adults with severe mental illness', *AIDS Care,* Vol. 12, No. 3, pp. 321-32.
Johnson-Masotti, A.P., Pinkerton, S.D., Holtgrave, D.R., Valdiserri, R.O. and Willingham, M. (2000) 'Decision-making in HIV prevention community planning: An integrative review', *Journal of Community Health*, Vol. 25, No. 2, pp. 95-112.
Johnson-Masotti, A.P., Pinkerton, S.D., Sikkema, K.J., Kelly, J.A. and Wagstaff, D.A. (2005) 'Cost-effectiveness of a community-level HIV risk reduction intervention for women living in low-income housing developments', *Journal of Primary Prevention*, Vol. 26, No. 4, pp. 345-62.

Johnson, A.M., Mercer, C.H., Erens, B., Copas, A.J., McManus, S., Wellings, K., Fenton, K.A., Korovessis, C., Macdowall, W., Nanchahal, K., Purdon, S. and Field, J. (2001) 'Sexual behaviour in Britain: Partnerships, practices and HIV risk behaviours', *The Lancet*, Vol. 358, No. 9296, pp. 1835-42.

Johnson, B.T., Carey, M.P., Chaudoir, S.R. and Reid, A.E. (2006) 'Sexual risk reduction for persons living with HIV: Research synthesis of randomized controlled trials, 1993 to 2004', *Journal of Acquired Immune Deficiency Syndromes (JAIDS)*, Vol. 41, No. 5, pp. 642-50.

Johnson, B.T., Carey, M.P., Marsh, K.L., Levin, K.D. and Scott-Sheldon, L.A.J. (2003) 'Interventions to reduce sexual risk for the human immunodeficiency virus in adolescents, 1985-2000: A research synthesis', *Archives of Pediatrics & Adolescent Medicine*, Vol. 157, No. 4, pp. 381-88.

Johnson, W.D., Hedges, L.V. and Diaz, R.M. (2002) *Interventions to modify sexual risk behaviors for preventing HIV infection in men who have sex with men* (Review). Cochrane Database of Systematic Reviews 2002, Issue 4.

Joint United Nations Programme on HIV/AIDS and UNAIDS Intercountry Team for Eastern and Southern Africa (1998) 'New materials for AIDS education at school', *SAfAIDS* News, Vol. 6, No. 1, pp. 13-19.

Justice Kirby of the High Court of Australia (2006) *HIV/AIDS – Implications for Law and the Judiciary*. 50th Anniversary Convention, Fiji Law Society, Sigatoka, Fiji Islands.

Kaiser Family Foundation (2002) *AIDS at 21: Media coverage of the HIV Epidemic 1981-2002.* Available at: http://www.kff.org/kaiserpolls/7025.cfm

Kalichman, S.C., Kelly, J.A. and Rompa, D. (1997) 'Continued high-risk sex among HIV seropositive men', *Health Psychology*, No. 16, pp. 369-73.

Kalichman, S.C., Rompa, D., Cage, M., Simpson, D., Austin, J., Luke, W., Buckles, J., Kyomugisha, F., Benotsch, E., Pinkerton, S.D. and Graham, J. (2001) 'Effectiveness of an intervention to reduce HIV transmission risks in HIV-positive people', *American Journal of Preventive Medicine,* Vol. 21, No. 2, pp. 84-92.

Kamb, M.L., Fishbein, M., Douglas, J.M. Jr., Rhodes, F., Rogers, J., Bolan, G., Zenilman, J., Hoxworth, T., Malotte, C.K., Iatesta, M., Kent, C., Lentz, A., Graziano, S., Byers, R.H. and Peterman, T.A. (1998) 'Efficacy of risk-reduction counselling to prevent human immunodeficiency virus and sexually transmitted diseases: A randomized controlled trial', *Journal of American Medical Association,* Vol. 280, No. 13, pp. 1161-67.

Keller, S.N. and Brown, J. (2002) 'Media interventions to promote responsible sexual behavior', *Journal of Sex Research*, Vol. 39, No. 1, pp. 67-72.

Keller, S.N., LaBelle, H., Karimi, N. and Gupta, S. (2002) 'STD prevention for teenagers: A look at the Internet universe', *Journal of Health Communication*, No. 7, pp. 341-53.

Keller, S.N., LaBelle, H., Karimi, N. and Gupta, S. (2004) 'Talking about STD/HIV prevention: A look at communication online', *AIDS Care*, Vol. 16, No. 8, pp. 977-92.

Kelly, J.A. (2000) 'HIV prevention interventions with gay or bisexual men and youth', *AIDS*, No. 14 (Supplement 2), pp. S34-39.

Kelly, J.A. (2004) 'Popular opinion leaders and HIV prevention peer education: Resolving discrepant findings and implications for the development of effective community programmes', *AIDS Care – Psychological and Socio-Medical Aspects of AIDS/HIV*, Vol. 16, No. 2, pp. 139-50.

Kelly, J.A. (2006) 'Popular opinion leaders and HIV prevention peer education: Resolving discrepant findings and implications of the development of effective community programmes', *AIDS Education and Prevention*, Vol. 18, No. 3, pp. 227-42.

Kelly, J.A. and Kalichman, S.C. (1995) 'Increased attention to human-sexuality can improve HIV-AIDS prevention efforts: Key research issues and directions', *Journal of Consulting and Clinical Psychology*, Vol. 63, No. 6, pp. 907-18.

Kelly, J.A., Murphy, D.A., Sikkema, K.J., McAuliffe, T.L., Roffman, R.A., Solomon, L.J., Winett, R.A. and Kalichman, S.C. (1997) 'Randomised, controlled, community-level HIV-prevention intervention for sexual-risk behaviour among homosexual men in US cities', *The Lancet*, Vol. 350, No. 9090, pp. 1500-05.

King, M. and Bartlett, A. (1999) 'British psychiatry and homosexuality', *British Journal of Psychiatry*, No. 175, pp. 106-13.

Kippax, S. and Race, K. (2003) 'Sustaining safe practice: Twenty years on', *Social Science & Medicine*, Vol. 57, No. 1, pp. 1-12.

Kirby, D.B. (2001) *An updated meta-analysis of teenage pregnancy-prevention programs, focusing on newly proven successful programs.* Washington, DC: National Campaign to prevent Teen Pregnancy.

Kirby, D.B., Baumler, E., Coyle, K.K., Basen-Engquist, K., Parcel, G.S., Harrist, R. and Banspach, S.W. (2004) 'The "Safer Choices" Intervention: Its impact on the sexual behaviors of different subgroups of high school students', *Journal of Adolescent Health*, Vol. 35, No. 6, pp. 442-52.

Kocken, P.L., Van Dorst, A.G. and Schaalma, H. (2006) 'The relevance of cultural factors in predicting condom-use intentions among immigrants from the Netherlands Antilles', *Health Education Research,* Vol. 21, No. 2, pp. 230-38.

Kondagunta, N., Nair, N.S., Bhat, H.V., Dutt, D. and Sathiakumar, N. (2006) *Behavioral interventions to reduce the transmission of HIV infection among commercial sex workers and their clients in developed countries* (Protocol). Cochrane Database of Systematic Reviews 2006, Issue 2.

Kral, A.H., Anderson, R., Flynn, N.M. and Bluthenthal, R.N. (2004) 'Injection risk behaviors among clients of syringe exchange programs with different syringe dispensation policies', *Journal of Acquired Immune Deficiency Syndromes (JAIDS)*, Vol. 37, No. 2, pp. 1307-12.

Ksobiech, K. (2003) 'A meta-analysis of needle sharing, lending and borrowing behaviors of needle exchange program attenders', *AIDS Education and Prevention*, Vol. 15, No. 3, pp. 257-68.

Ksobiech, K., Somlai, A.M., Kelly, J.A., Gore-Felton, C., Benotsch, E., McAuliffe, T., Hackl, K., Ostrovski, D. and Kozlov, A.P. (2005) 'Demographic characteristics, treatment history, drug risk behaviors and condom use attitudes for US and Russian injection drug users: The need for targeted sexual risk behavior interventions', *AIDS and Behavior*, Vol. 9, No. 1, pp. 111-20.

Lammers, C., Ireland, M., Resnick, M. and Blum, R. (2000) 'Influences on adolescents' decision to postpone onset of sexual intercourse: A survival analysis of virginity among youths aged 13 to 18 years', *Journal of Adolescent Health*, Vol. 26, No. 1, pp. 42-48.

Lawless, S., Kippax, S. and Crawford, J. (1996) 'Dirty, diseased and undeserving: The positioning of HIV-positive women', *Social Science & Medicine*, Vol. 43, No. 9, pp. 1371-77.

Layte, R., McGee, H., Quail, A., Rundle, K., Cousins, G., Donnelly, C., Mulcahy, F. and Conroy, R. (2006) *Irish Study of Sexual Health and Relationships (ISSHR)*: *Main Report.* Dublin: Department of Health and Children, and Crisis Pregnancy Agency.

Leukefeld, C.G., Pechansky, F., Martin, S.S., Surratt, H.L., Inciardi, J.A., Kessler, F.H., Orsi, M.M., Von Diemen, L. and Meyer Da Silva, E. (2005) 'Tailoring an HIV-prevention intervention for cocaine injectors and crack users in Porto Alegre, Brazil', *AIDS Care*, No. 17 (Supplement 1), pp. S77-87.

Lindemann, D.F., Brigham, T.A., Harbke, C.R. and Alexander, T. (2005) 'Towards errorless condom use: A comparison of two courses to improve condom use skills', *AIDS and Behavior*, Vol. 9, No. 4, pp. 451-57.

Loff, B., Overs, C. and Longo, P. (2003) 'Can health programmes lead to mistreatment of sex workers?', *The Lancet*, Vol. 361, No. 9373, pp. 1982-83.

Lottes, I.L. (2002) 'Sexual health policies in other industrialized countries: Are there lessons for the United States?', *Journal of Sex Research*, Vol. 39, No. 1, pp. 79-83.

Lyles, C.M. and Des Jarlais, D. (1998) *Interventions to modify drug-related risk behaviors for preventing HIV infection in drug users* (Protocol). Cochrane Database of Systematic Reviews 1998, Issue 3.

MacDonald, M. (1997) *Mandatory Drug Testing in Prisons*. Birmingham, UK: Centre for Research into Quality, Birmingham City University.

Marrazzo, J.M., Coffey, P. and Bingham, A. (2005) 'Sexual practices, risk perception and knowledge of sexually transmitted disease risk among lesbian and bisexual women', *Perspectives on Sexual and Reproductive Health*, Vol. 31, No. 1, pp. 6-12.

Marston, C. and King, E. (2006) 'Factors that shape young people's sexual behaviour: A systematic review', *The Lancet*, Vol. 368, No. 9547, pp. 1581-86.

Martin, S.S., O'Connell, D.J., Inciardi, J.A., Surratt, H.L. and Beard, R.A. (2003) 'HIV/AIDS among probationers: An assessment of risk and results from a brief intervention', *Journal of Psychoactive Drugs*, Vol. 35, No. 4, pp. 435-43.

Mathew, C., Coetzee, N., Zwarenstein, M., Lombard, C., Guttmacher, S., Oxman, S. and Schmid, G. (2001) *Strategies for partner notification for sexually transmitted diseases* (Review). Cochrane Database of Systematic Reviews 2001, Issue 4.

Matic, S., Lazarus, J.V. and Donoghoe, M.C. (2006) *HIV/AIDS in Europe: Moving from death sentence to chronic disease management.* Geneva: World Health Organization.

Matson, P., Chung, S. and Ellen, J. (2006) 'Condom use trends and relationship patterns among adolescent girls', *Journal of Adolescent Health*, Vol. 38, No. 2, pp. 98-99.

Mayock, P., Kitching, K. and Morgan, D. (2007) *Relationships and Sexuality Education (RSE) in the context of Social, Personal and Health Education (SPHE): An assessment of the challenges to full implementation of the programme in post-primary schools*. Dublin: Crisis Pregnancy Agency and Department of Education and Science.

McCoy, H.V., McCoy, C.B. and Lai, S. (1998) 'Effectiveness of HIV interventions among women drug users', *Women & Health*, Vol. 27, No. 1-2, pp. 49-66.

McKeon, B. (2006) *Effective Sex Education* (Fact Sheet). Washington, DC: Advocates for Youth.

Melby, T. (2007) 'A Flurry of good news', *Contemporary Sexuality*, Vol. 41, No. 2, pp. 3-5.

Mellanby, A.R., Newcombe, R.G., Rees, J.B. and Tripp, J.H. (2001) 'A comparative study of peer-led and adult-led school sex education', *Health Education Research*, Vol. 16, No. 4, pp. 481-92.

Mellanby, A.R., Rees, J.B. and Tripp, J.H. (2000) 'Peer-led and adult-led school health education: A critical review of available comparative research', *Health Education Research*, Vol. 15, No. 5, pp. 533-45.

Milburn, K. (1995) 'A critical review of peer education with young people with special reference to sexual health', *Health Education Research*, Vol. 10, No. 4, pp. 407-20.

Miller, R.L., Klotz, D. and Eckholdt, H.M. (1998) 'HIV prevention with male prostitutes and patrons of hustler bars: Replication of an HIV prevention intervention', *American Journal of Community Psychology*, No. 26, pp. 97-131.

Miner, M.H., Robinson, B.E., Hoffman, L., Albright, C.L. and Bockting, W.O. (2002) 'Improving safer sex measures through the inclusion of relationship and partner characteristics', *AIDS Care*, Vol. 14, No. 6, pp. 827-37.

Ministry of Health, New Zealand (2001) *Sexual and Reproductive Health Strategy – Phase One.* Wellington: Ministry of Health.

Ministry of Health, New Zealand (2006) *AIDS – New Zealand,* Issue 57, February 2006. Available at: http://www.moh.govt.nz/moh.nsf/238fd5fb4fd051844c256669006aed57/ed0c1c41deeb681dcc257145007a9021?OpenDocument

Mize, S.J., Robinson, B.E., Bockting, W.O. and Scheltema, K.E. (2002) 'Meta-analysis of the effectiveness of HIV prevention interventions for women', *AIDS Care*, Vol. 14, No. 2, pp. 163-80.

Monash, R. and Maly, M. (2006) *Young people: The centre of the HIV epidemic*, WHO Technical Report Series, No. 938, pp. 15-41 and discussion pp. 317-41. Geneva: World Health Organization.

Morrison-Beedy, D. and Nelson, L.E. (2004) 'HIV prevention interventions in adolescent girls: What is the state of the science?', *Worldviews on Evidence-based Nursing*, Vol. 1, No. 3, pp. 165-75.

Mukoma, W. and Flisher, A.J. (2004) 'Evaluations of health promoting schools: A review of nine studies', *Health Promotion International*, Vol. 19, No. 3, pp. 357-68.

Munro, D. (1996) 'Effective HIV/AIDS strategies, policies and programs for the correctional centre system', *Papua New Guinea Medical Journal*, Vol. 39, No. 3, pp. 230-33.

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

Myer, L., Morroni, C., Mathews, C. and Tholandi, M. (2001) *Structural and community-level interventions of increasing condom use to prevent HIV and other sexually transmitted infections* (Protocol). Cochrane Database of Systematic Reviews 2001, Issue 4.

NASC (1992) *The First Report of the National AIDS Strategy Committee.* Dublin: Department of Health.

NASC (2000) *AIDS 2000: Report of the National AIDS Strategy Committee.* Dublin: Department of Health and Children.

National Assembly for Wales (2000) *A strategic framework for promoting sexual health in Wales.* Cardiff: Welsh Assembly Government.

National Institutes of Health, USA (2002) *Fiscal year 2003 plan for HIV-related research. VI: Behavioural and Social Science.* Bethesda, MD: Office of AIDS Research, National Institutes of Health.

Nelles, J., Fuhrer, A., Hirsbrunner, H.P. and Harding, T.W. (1998) 'Provision of syringes: The cutting edge of harm reduction in prison?', *British Medical Journal*, Vol. 317, No. 7153, pp. 270-73.

Nelles, J. and Harding, T.W. (1995) 'Preventing HIV transmission in prison: A tale of medical disobedience and Swiss pragmatism', *The Lancet*, Vol. 346, No. 8989, pp. 1507-09.

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

Noble, R. (2006) *How can HIV transmission be prevented.* Available at: http://www.avert.org/prevent-hiv.htm (accessed April 2008)

Norman, P., Abraham, C. and Conner, M. (eds.) (2000) *Understanding and changing health behaviours.* Amsterdam: Harwood Academic Publishers.

O'Connell, J.M., Kerr, T., Li, K., Tyndall, M.W.M., Hogg, R.S., Montaner, J.S. and Wood, E. (2005) 'Requiring help injecting independently predicts incident HIV infection among injection drug users', *Journal of Acquired Immune Deficiency Syndromes (JAIDS)*, Vol. 40, No. 1, pp. 83-88.

O'Donnell, L., Stueve, A., O'Donnell, C., Duran, R., San Doval, A., Wilson, R.F., Haber, D., Perry, E. and Pleck, J.H. (2002) 'Long-term reductions in sexual initiation and sexual activity among urban middle schoolers in the reach for health service learning program', *Journal of Adolescent Health*, Vol. 31, No. 1, pp. 93-100.

Oh, M.K., Grimley, D.M., Merchant, J.S., Brown, P.R., Cecil, H. and Hook, E.W. III (2002) 'Mass media as a population-level intervention tool for *Chlamydia trachomatis* screening: Report of a pilot study', *Journal of Adolescent Health*, Vol. 31, No. 1, pp. 40-47.

O'Higgins-Norman, J. (2008) 'Equality in the provision of Social, Personal and Health Education in the Republic of Ireland: The case of homophobic bullying?', *Pastoral Care in Education*, Vol. 26, No. 2, pp. 69-81.

O'Sullivan, B.G., Levy, M.H., Dolan, K.A., Post, J.J., Barton, S.G., Dwyer, D.E., Kaldor, J.M. and Grulich, A.E. (2003) 'Hepatitis C transmission and HIV post-exposure prophylaxis after needle- and syringe-sharing in Australian prisons', *Medical Journal of Australia*, Vol. 178, No. 11, pp. 546-49.

Pai, N.P., Lawrence, J., Reingold, A.L. and Tulsky, J.P. (2006) *Structured treatment interruptions (STI) in chronic unsuppressed HIV infection in adults* (Review). Cochrane Database of Systematic Reviews 2006, Issue 3.

Paltiel, A.D., Walensky, R.P. and Schackman, B.R. (2006) 'Expanded HIV screening in the United States: Effect on clinical outcomes, HIV transmission and costs', *Annals of Internal Medicine*, Vol. 145, No. 11, pp. 797-806.

Parker, R.G., Easton, D. and Klein, C.H. (2000) 'Structural barriers and facilitators in HIV prevention: A review of international research', *AIDS*, No. 14 (Supplement 1), pp. i22-32.

Patterson, T.L. and Semple, S.J. (2003) 'Sexual risk reduction among HIV-positive drug-using men who have sex with men', *Journal of Urban Health*, Vol. 80, No. 4 (Supplement 3), pp. iii77-87.

Pearlman, D.N., Camberg, L., Wallace, L.J., Symons, P. and Finison, L. (2002) 'Tapping youth as agents for change: Evaluation of a peer leadership HIV/AIDS intervention', *Journal of Adolescent Health*, Vol. 31, No. 1, pp. 31-39.

Pedlow, C.T. and Carey, M.P. (2003) 'HIV sexual risk-reduction interventions for youth: A review and methodological critique of randomized controlled trials', *Behavior Modification*, Vol. 27, No. 2, pp. 135-90.

Peersman, G.V. and Levy, J.A. (1998) 'Focus and effectiveness of HIV-prevention efforts for young people', *AIDS*, No. 12 (Supplement A), pp. S191-96.

Peretti-Watel, P., Obadia, Y., Dray-Spira, R., Lert, F. and Moatti, J. (2005) 'Attitudes and behaviours of people living with HIV/AIDS and mass media prevention campaign: A French survey', *Psychology, Health & Medicine*, Vol. 10, No. 2, pp. 215-24.

Peterson, J.L. and DiClemente, R.J. (eds.) (2000) *Handbook of HIV prevention* (1st edition). London: Springer.

Pinkerton, S.D., Cecil, H. and Holtgrave, D.R. (1998) 'HIV/STD prevention interventions for adolescents: Cost-effectiveness considerations (brief record)', *Journal of HIV/AIDS Prevention and Education for Adolescents and Children*, No. 2, pp. 5-31.

Pinkerton, S.D. and Holtgrave, D.R. (1998) 'The cost-effectiveness of HIV prevention from a managed care perspective', *Journal of Public Health Management & Practice*, Vol. 4, No. 1, pp. 59-66.

Pinkerton, S.D., Holtgrave, D.R., DiFranceisco, W.J., Stevenson, L.Y. and Kelly, J.A. (1998) 'Cost-effectiveness of a community-level HIV risk reduction intervention', *American Journal of Public Health*, Vol. 88, No. 8, pp. 1239-42.

Pinkerton, S.D., Holtgrave, D.R., Leviton, L.C., Wagstaff, D.A. and Abramsom, P.R. (1998) 'Model-based evaluation of HIV prevention interventions', *Evaluation Review*, Vol. 22, No. 2, pp. 155-74.

Pinkerton, S.D., Holtgrave, D.R. and Valdiserri, R.O. (1997) 'Cost-effectiveness of HIV-prevention skills training for men who have sex with men', *AIDS*, Vol. 11, No. 3, pp. 347-57.

Pinkerton, S.D., Johnson-Masotti, A.P., Holtgrave, D.R. and Farnham, P.G. (2002) 'A review of the cost-effectiveness of interventions to prevent sexual transmission of HIV in the United States', *AIDS and Behavior*, Vol. 6, No. 1, pp. 15-31.

Pinkerton, S.D., Johnson-Masotti, A.P., Otto-Salaj, L.L., Stevenson, L.Y. and Hoffmann, R.G. (2001) 'Cost-effectiveness of an HIV prevention intervention for mentally ill adults', *Mental Health Services Research*, Vol. 3, No. 1, pp. 45-55.

Quinn, T.C. and Overbaugh, J. (2005) 'HIV/AIDS in women: An expanding epidemic', *Science*, Vol. 308, No. 5728, pp. 1582-83.

Raboud, J.M., Boily, M.C., Rajeswaran, J., O'Shaughnessy, M.V. and Schechter, M.T. (2003) 'The impact of needle-exchange programs on the spread of HIV among injection drug users: A simulation study', *Journal of Urban Health*, Vol. 80, No. 2, pp. 302-20.

Rappaport, J. (1981) 'In praise of paradox: A social policy of empowerment over prevention', *American Journal of Community Psychology*, No. 9, pp. 1-25.

Reece, M., Plate, P.L. and Daughtry, M. (2001) 'HIV prevention and sexual compulsivity: The need for an integrated strategy of public health and mental health', *Sexual Addiction and Compulsivity*, No. 8, pp. 157-67.

Rekart, M.L. (2005) 'Sex-work harm reduction', *The Lancet*, Vol. 366, No. 9503, pp. 2123-34.

Rice, R.E. and Aitken, C. (1994) 'Principles of successful public communication campaigns'. In: J. Bryant and D. Zillmann (eds.), *Media Effects: Advances in theory and research*. Hillsdale, NJ: Lawrence Erlbaum.

Robertson, A., Stein, J. and Baird-Thomas, C. (2006) 'Gender differences in the prediction of condom use among incarcerated juvenile offenders: Testing the information-motivation-behavior skills (IMB) model', *Journal of Adolescent Health*, Vol. 38, No. 1, pp. 18-25.

Robin, L., Dittus, P., Whitaker, D., Crosby, R., Ethier, K., Mezoff, J., Miller, K. and Pappas-Deluca, K. (2004) 'Behavioral interventions to reduce incidence of HIV, STD and pregnancy among adolescents: A decade in review', *Journal of Adolescent Health*, Vol. 34, No. 1, pp. 3-26.

Robinson, N.J., Mulder, D.W., Auvert, B. and Hayes, R.J. (1997) 'Proportion of HIV infections attributable to other sexually transmitted diseases in a rural Ugandan population: Simulation model estimates', *International Journal of Epidemiology*, No. 26, pp. 180-89.

Robinson, B.B.E., Bockting, W.O., Rosser, B.R.S., Miner, M. and Coleman, E. (2002) 'The Sexual Health Model: Application of a sexological approach to HIV prevention', *Health Education Research*, Vol. 17, No. 1, pp. 43-57.

Roseman, M.J. and Gruskin, S. (2003) 'The UNGASS Declaration of Commitment on HIV/AIDS: One year later', *Canadian HIV/AIDS Policy & Law Review*, Vol. 8, No. 1.

Rosser, S., Bockting, W.O., Rugg, D.L., Robinson, B.B.E., Ross, M.W., Bauer, G.R. and Coleman, E. (2002) 'A randomized controlled intervention trial of a sexual health approach to long-term HIV risk reduction for men who have sex with men: Effects of the intervention on unsafe sexual behavior', *AIDS Education & Prevention*, Vol. 14, No. 3 (Supplement A), pp. A59-71.

Rotheram-Borus, M.J. (2000) 'Expanding the range of interventions to reduce HIV among adolescents', *AIDS*, No. 14 (Supplement 1), pp. S33-40.

Rotheram-Borus, M.J., Cantwell, S. and Newman, P.A. (2000) 'HIV prevention programs with heterosexuals', *AIDS*, No. 14 (Supplement 2), pp. S59-67.

Rotheram-Borus, M.J., Flannery, D., Rice, E. and Lester, P. (2005) 'Families living with HIV', *AIDS Care*, Vol. 17, No. 8, pp. 978-87.

Rotheram-Borus, M.J., Gwadz, M., Ferñandez, M.I. and Srinivasan, S. (1998) 'Timing of HIV interventions on reductions in sexual risk among adolescents', *American Journal of Community Psychology*, Vol. 26, No. 1, pp. 73-96.

Rotheram-Borus, M.J., Lester, P., Song, J., Lin, Y., Leonard, N.R., Beckwith, L., Ward, M.J., Sigman, M. and Lord, L. (2006) 'Intergenerational benefits of family-based HIV interventions', *Journal of Consulting and Clinical Psychology,* Vol. 74, No. 3, pp. 622-27.

Rundle, R., Leigh, C., McGee, H.H. and Layte, R. (2004) *Irish Contraception and Crisis Pregnancy (ICCP) Study: A survey of the general population.* Dublin: Crisis Pregnancy Agency.

Salway, S. (1994) 'How attitudes toward family planning and discussion between wives and husbands affect contraceptive use in Ghana', *International Family Planning Perspectives*, Vol. 20, No. 2, pp. 44-74.

Sangani, P., Rutherford, G. and Wilkinson, D. (2004) *Population-based interventions for reducing sexually transmitted infections, including HIV infection* (Review). Cochrane Database of Systematic Reviews 2004, Issue 3.

Santelli, J., Ott, M., Lyon, M., Rogers, J., Summers, D. and Schleifer, R. (2006) 'Abstinence and abstinence-only education: A review of US policies and programs', *Journal of Adolescent Health*, Vol. 38, No. 1, pp. 72-81.

Santhya, K.G. and Dasvarma, G.L. (2002) 'Spousal communication on reproductive illness among rural women in southern India', *Culture, Health and Sexuality*, Vol. 4, No. 2, pp. 223-36.

Sarker, M., Milkowski, A., Slanger, T., Gondos, A., Sanou, A., Kouyate, B. and Snow, R. (2005) 'The role of HIV-related knowledge and ethnicity in determining HIV risk perception and willingness to undergo HIV testing among rural women in Burkina Faso', *AIDS & Behavior*, Vol. 9, No. 2, pp. 243-49.

Scottish Government (2005) *Respect and Responsibility: Strategy and Action Plan for Improving Sexual Health*. Edinburgh: Scottish Government Publications.

Scottish Prison Service (2005) *The direction of harm reduction in the SPS: From chaotic drug use to abstinence.* Edinburgh: Scottish Prison Service.

Seal, D.W. and Ehrhardt, A.A. (2004) 'HIV-prevention-related sexual health promotion for heterosexual men in the United States: Pitfalls and recommendations', *Archives of Sexual Behavior*, Vol. 33, No. 3, pp. 211-22.

Seal, D.W., Kelly, J.A., Bloom, F.R., Stevenson, L.Y., Coley, B.I. and Broyles, L.A. (2000) 'HIV prevention with young men who have sex with men: What young men themselves say is needed', *AIDS Care*, Vol. 12, No. 1, pp. 5-26.

Semaan, S., Des Jarlais, D.C., Sogolow, E., Johnson, W.D., Hedges, L.V., Ramirez, G., Flores, S.A., Norman, L., Sweat, M.D. and Needle, R. (2002) 'A meta-analysis of the effect of HIV prevention interventions on the sex behaviors of drug users in the United States', *Journal of Acquired Immune Deficiency Syndromes (JAIDS)*, No. 30 (Supplement 1), pp. S73-93.

Setswe, G., Herman, A. and Mokwena, K. (2005) *Behavioral interventions for reducing HIV infection in employees in occupational settings* (Protocol). Cochrane Database of Systematic Reviews, Protocols 2005, Issue 2.

Schackman, B.R., Gebo, K.A., Walensky, R.P., Losina, E., Muccio, T., Sax, P.E., Weinstein, M.C., Seage, G.R., Moore, R.D. and Freedberg, K.A. (2006) 'The lifetime cost of current human immunodeficiency virus care in the United States', *Medical Care,* Vol. 44, No. 11, pp. 990-97.

Shain, R.N., Perdue, S.T., Piper, J.M., Holden, A.E., Champion, J.D., Newton, E.R. and Korte, J.E. (2002) 'Behaviors changed by intervention are associated with reduced STD recurrence: The importance of context in measurement', *Sexually Transmitted Diseases*, Vol. 29, No. 9, pp. 520-29.

Shelley, J. (2006) *Submissions of the Intervenors of the Irish Penal Reform Trust and the Canadian HIV/AIDS Legal Network*, European Court of Human Rights. Application No. 23800/06.

Shepherd, J., Weston, R., Peersman, G. and Napuli, I.Z. (1999) *Interventions for encouraging sexual lifestyles and behaviours intended to prevent cervical cancer* (Review). Cochrane Database of Systematic Reviews 1999, Issue 4.

Shrier, L.A., Ancheta, R., Goodman, E., Chiou, V.M., Lyden, M.R. and Emans, S.J. (2001) 'Randomized controlled trial of a safer sex intervention for high-risk adolescent girls', *Archives of Pediatrics & Adolescent Medicine*, Vol. 155, No. 1, pp. 73-79.

Shrier, L.A., Goodman, E. and Emans, S.J. (1999) 'Partner condom use among adolescent girls with sexually transmitted diseases', *Journal of Adolescent Health*, Vol. 24, No. 5, pp. 357-61.

Sikkema, K.J., Kelly, J.A., Winett, R.A., Solomon, L.J., Cargill, V.A., Roffman, R.A., McAuliffe, T.L., Heckman, T.G., Anderson, E.A., Wagstaff, D.A., Norman, A.D., Perry, M.J., Crumble, D.A. and Mercer, M.B. (2000) 'Outcomes of a randomized community-level HIV prevention intervention for women living in 18 low-income housing developments', *American Journal of Public Health*, Vol. 90, No. 1, pp. 57-63.

Simon, V., Ho, D.D. and Abdool Karim, Q. (2006) 'HIV/AIDS epidemiology, pathogenesis, prevention and treatment', *The Lancet,* Vol. 368, No. 9534, pp. 489-504.

Sixsmith, J. (2006) *An evaluation of mass media interventions to promote health.* Galway: Department of Health Promotion, National University of Ireland.

Smith, M., Gertz, E., Alvarez, S. and Lurie, P. (2000) 'The content and accessibility of sex education information on the Internet', *Health Education & Behavior*, Vol. 27, No. 6, pp. 684-94.

Smoak, N.D., Scott-Sheldon, L.A., Johnson, B.T. and Carey, M.P. (2006) 'Sexual risk reduction interventions do not inadvertently increase the overall frequency of sexual behavior: A meta-analysis of 174 studies with 116,735 participants', *Journal of Acquired Immune Deficiency Syndromes (JAIDS),* Vol. 41, No. 3, pp. 374-84.

Sorensen, J.L. and Copeland, A.L. (2000) 'Drug abuse treatment as an HIV prevention strategy: A review', *Drug and Alcohol Dependence,* Vol. 59, No. 1, pp. 17-31.

Speier, T. (2005) 'Special projects of national significance and the Alaska Tribal Health System: An overview of the development of a best practice model for HIV/AIDS care and treatment in Alaska', *Journal of Psychoactive Drugs,* Vol. 37, No. 3, pp. 305-11.

Stark, K., Herrmann, U., Ehrhardt, S. and Bienzle, U. (2006) 'A syringe exchange programme in prison as prevention strategy against HIV infection and hepatitis B and C in Berlin, Germany', *Epidemiology and Infection,* Vol. 134, No. 4, pp. 814-19.

St. Lawrence, J.S., Eldridge, G.D., Shelby, M.C., Little, C.E., Brasfield, T.L. and O'Bannon, R.E. III. (1997) 'HIV risk reduction for incarcerated women: A comparison of brief interventions based on two theoretical models', *Journal of Consulting and Clinical Psychology,* Vol. 65, No. 3, pp. 504-9.

St. Lawrence, J.S., Jefferson, K.W., Alleyne, E. and Brasfield, T.L. (1995) 'Comparison of education versus behavioral skills training interventions in lowering sexual HIV-risk behavior of substance-dependent adolescents', *Journal of Consulting and Clinical Psychology,* Vol. 63, No. 1, pp. 154-57.

Steele, C.M. and Josephs, R.A. (1990) 'Alcohol Myopia: It's prized and dangerous', *American Psychologist*, Vol. 45, No. 8, pp. 921-33.

Steele, C.M. and Southwick, L. (1985) 'Alcohol and Social-Behavior. 1: The psychology of drunken excess', *Journal of Personality and Social Psychology*, Vol. 48, No. 1, pp. 18-34.

Stephenson, J.M., Oakley, A., Charleston, S., Brodala, A., Fenton, K., Petruckevitch, A. and Johnson, A.M. (1998) 'Behavioural intervention trials for HIV/STD prevention in schools: Are they feasible?', *Sexually Transmitted Infections*, Vol. 74, No. 6, pp. 405-8.

Stephenson, J.M., Imrie, J. and Sutton, S.R. (2000) 'Rigorous trials of sexual behaviour interventions in STD/HIV preventions: What can we learn from them', *AIDS*, No. 14 (Supplement 3), pp. 5115-24.

Stephenson, J.M., Strange, V., Forrest, S., Oakley, A., Copas, A., Allen, E., Babiker, A., Black, S., Ali, M., Monteiro, H., Johnson, A.M. and Ripple Study Team (2004) 'Pupil-led sex education in England (Ripple Study): Cluster-randomised intervention trial', *The Lancet*, Vol. 364, No. 9431, pp. 338-46.

Stover, H. and Nelles, J. (2003) 'Ten years of experience with needle and syringe exchange programmes in European prisons', *International Journal of Drug Policy*, Vol. 14, No. 5-6, pp. 437-44.

Stover, J., Walker, N., Garnett, G.P., Salomon, J.A., Stanecki, K. A., Ghys, P.D., Grassly, N.C., Anderson, R.M. and Schwartlander, B. (2002) 'Can we reverse the HIV/AIDS pandemic with an expanded response?', *The Lancet*, Vol. 360, No. 9326, pp. 73-77.

Stover, J., Bertozzi, S., Gutierrez, J.P., Walker, N., Stanecki, K.A., Greener, R., Gouws, E., Hankins, C., Garnett, G.P., Salomon, J., Boerma, J.T., De Lay, P. and Ghys, P.D. (2006) 'The global impact of scaling up HIV/AIDS prevention programs in low- and middle-income countries', *Science Express*, Vol. 311, No. 5766, February 2006.

Sumartojo, E. (2000) 'Structural factors in HIV prevention: Concepts, examples and implications for research', *AIDS*, No. 14 (Supplement 1), pp. S3-10.

Svenson, G. and Burke, B. (2005) *Formative Research on Youth Peer Education Program: Productivity and sustainability. Youth Research Working Paper No. 3*. Research Triangle Park, NC: Family Health International.

Swann, C., Bowe, K., McCormick, G. and Kosmin, M. (2003) *Teenage pregnancy and parenthood: A review of reviews. Evidence briefing.* London: Health Development Agency, Department of Health.

Sweat, M. (1998) *Counselling and testing for preventing HIV infection* (Protocol). Cochrane Database of Systematic Reviews 1998, Issue 3.

Taylor, L.D. (2005) 'Effects of visual and verbal sexual television content and perceived realism on attitudes and beliefs', *Journal of Sex Research*, Vol. 42, No. 2, pp. 130-37.

Teixeira, P.R., Vitoria, M.A. and Barcarolo, J. (2003) 'The Brazilian experience in providing universal access to antiretroviral therapy', *Economics of AIDS and Access to HIV/AIDS Care*, Vol. 11, No.19, pp. 69-88.

Tenner, A.D., Trevithick, L.A., Wagner, V. and Burch, R. (1998) 'Seattle Youth Care's prevention, intervention and education program: A model of care for HIV-positive, homeless and at-risk youth', *Journal of Adolescent Health*, No. 23 (Supplement 2), pp. ii96-106.

Tripp, J. and Viner, R. (2005) 'ABC of adolescence: Sexual health, contraception and teenage pregnancy', *British Medical Journal*, Vol. 330, No. 7491, pp. 590-93.

UN (1989) *Convention on the Rights of the Child.* Geneva: United Nations Office of the High Commissioner for Human Rights. Available at: http://www.ohchr.org

UN (2001) *Declaration of Commitment on HIV/AIDS.* New York: United Nations, General Assembly.

UN (2006) *Declaration of Commitment on HIV/AIDS: Five years later. Report of the Secretary-General (No. A/60/736).* New York: United Nations, General Assembly.

UNAIDS (1998) *Cost-effectiveness analysis and HIV/AIDS,* UNAIDS Technical update, UNAIDS Best Practice Collection. Geneva: UNAIDS.

UNAIDS (1999) *Sexual behavioural change for HIV: Where have theories taken us?* Geneva: UNAIDS.

UNAIDS (2004) *HIV Prevention* (Fact Sheet). Geneva: UNAIDS.

UNAIDS (2005) *Policy Position Paper: Intensifying HIV Prevention.* Geneva: UNAIDS.

UNAIDS (2006) *UNAIDS 2006 Report on the Global AIDS Epidemic: A UNAIDS 10th Anniversary Special Edition.* Geneva: UNAIDS.

UNAIDS and UNHCR (2005) *Strategies to support the HIV-related needs of refugees and host populations.* Geneva: UNAIDS/UNHCR.

UNFPA (2003) *Preventing HIV Infection, Promoting Reproductive Health: UNFPA Response 2003.* New York: United Nations Population Fund.

UNFPA (2005) *State of the World Population 2005: The Promise of Equality, Gender Equity, Reproductive Health and the Millennium Development Goals.* New York: United Nations Population Fund.

UNICEF (2006) *Child protection and children affected by AIDS: A companion paper to the framework for the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS.* New York: United Nations Children's Fund (UNICEF).

UNODC, WHO and UNAIDS (2006) *HIV/AIDS prevention, care, treatment and support in prison settings: A framework for an effective national response.* Vienna: United Nations Office on Drugs and Crime, WHO and UNAIDS.

Underhill, K., Operario, D. and Montgomery, P. (2007) *Abstinence-only programs for HIV infection prevention in high-income countries* (Review). Cochrane Database of Systematic Reviews 2007, Issue 4.

Van den Borne, H.W. (2005) *Effect-evaluation of a systematic developed cognitive behavioral skills training aimed at the prevention of STDs and HIV/AIDS: A randomized controlled trial in Creole, Antillean and Ghanaian women in the Netherlands.* Dutch Research Database (NOD).

Vanwesenbeeck, I. (2001) 'Another decade of social scientific work on sex work: A review of research, 1990-2000', *Annual Review of Sex Research*, No. 12, pp. 242-89.

Vidanapathirana, J., Abramson, M.J., Forbes, A. and Fairley, C. (2005) *Mass media interventions for promoting HIV testing* (Review). Cochrane Database of Systematic Reviews 2005, Issue 3.

Weinhardt, L.S., Carey, M.P., Johnson, B.T. and Bickham, N.L. (1999) 'Effects of HIV counselling and testing on sexual risk behavior: A meta-analytic review of published research, 1985-1997', *American Journal of Public Health*, Vol. 89, No. 9, pp. 1397-1405.

Weller, S. and Davis-Beaty, K. (2002) *Effectiveness of male condoms in prevention of sexually transmitted diseases* (Protocol). Cochrane Database of Systematic Reviews 2002, Issue 4.

Weller, S.C. and Davis-Beaty, K. (2002) *Condom effectiveness in reducing heterosexual HIV transmission* (Review). Cochrane Database of Systematic Reviews 2002, Issue 1.

Wellings, K., Nanchahal, K., Macdowall, W., McManus, S., Erens, B., Mercer, C.H., Johnson, A.M., Copas, A.J., Korovessis, C., Fenton, K.A. and Field, J. (2001) 'Sexual behaviour in Britain: Early heterosexual experience', *The Lancet*, Vol. 358, No. 9296, pp. 1843-50.

WHO (1986) *Ottawa Charter for Health Promotion*. Geneva: World Health Organization.

WHO (2005) *Status paper on prisons, drugs and harm reduction.* Copenhagen: World Health Organization Regional Office for Europe.

WHO (2006a) *HIV and AIDS in Europe: Moving from death sentence to chronic disease management.* Geneva: World Health Organization.

WHO (2006b) *Global Strategy for the Prevention and Control of Sexually Transmitted Infections, 2006-2015.* Geneva: World Health Organization.

WHO (2007) *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector. Progress Report, April 2007.* Geneva: World Health Organization, UNAIDS and UNICEF.

WHO and UNAIDS (2003) *HIV/AIDS Statistics.* Geneva: UNAIDS.

WHO, UNAIDS and UNDOC (2004) *Policy Brief: Provision of sterile injecting equipment to reduce HIV transmission: Evidence for action on HIV/AIDS and injecting drug use.* Geneva: World Health Organization.

Williams, M., Bowen, A., Timpson, S., Ross, M. and Aitkenson, J. (2006) 'HIV prevention and street-based male sex workers: An evaluation of brief interventions', *AIDS Education and Prevention*, Vol. 18, No. 3, pp. 204-15.

Wingood, G.M. and DiClemente, R.J. (2000) 'Application of the theory of gender and power to examine HIV-related exposures, risk factors and effective interventions for women', *Health Education & Behavior*, Vol. 27, No. 5, pp. 539-65.

Wingwood, G.M. and DiClemente, R.J. (1996) 'HIV sexual risk reduction interventions for women: A review', *American Journal of Preventive Medicine,* Vol. 12, No. 3, pp. 209-17.

Wodak, A. and Cooney, A. (2004) *Evidence for action technical papers: Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting users.* Geneva: World Health Organization.

Women's Health Council (2006) *Women and Sexually Transmitted Infections: A gendered analysis.* Dublin: Women's Health Council.

Wong, C-Y. and So-Kum Tang, C. (2004) 'Coming out experiences and psychological distress of Chinese homosexual men in Hong Kong', *Archives of Sexual Behavior*, Vol. 33, No. 2, pp. 149-57.

Wood, E., Kerr, T., Spittal, P.M., Small, W., Tyndall, M.W., O'Shaughnessy, M.V. and Schechter, M.T. (2003) 'An external evaluation of a peer-run "Unsanctioned" syringe exchange program', *Journal of Urban Health*, Vol. 80, No. 3, pp. 455-64.

Wood, E., Li, K., Miller, C.L., Hogg, R.S., Montaner, J.S.G., Schechter, M.T. and Kerr, T. (2005a) 'Baseline self-perceived risk of HIV infection independently predicts the rate of HIV seroconversion in a prospective cohort of injection drug users', *International Journal of Epidemiology*, Vol. 34, No. 1, pp. 152-58.

Wood, E., Li, K., Small, W., Montaner, J.S., Schechter, M.T. and Kerr, T. (2005b) 'Recent incarceration independently associated with syringe sharing by injection drug users', *Public Health Reports*, Vol. 120, No. 2, pp. 150-56.

Wright, A.A. and Katz, I.T. (2006) 'Home testing for HIV', *New England Journal of Medicine*, Vol. 354, No. 5, pp. 437-40.

Yzer, M.C., Siero, F.W. and Buunk, B.P. (2000) 'Can public campaigns effectively change psychological determinants of safer sex? An evaluation of three Dutch campaigns', *Health Education Research*, Vol. 15, No. 3, pp. 339-52.

Zaric, G.S., Barnett, P.G. and Brandeau, M.L. (2000) 'HIV transmission and the cost-effectiveness of methadone maintenance', *American Journal of Public Health*, Vol. 90, No. 7, pp. 1100-11.

Zea, M.C., Reisen, C.A. and Diaz, R.M. (2003) 'Methodological issues in research on sexual behavior with Latino gay and bisexual men', *American Journal of Community Psychology*, Vol. 31, No. 3-4, pp. 281-91.

Ziersch, A., Gaffney, J. and Tomlinson, D.R. (2000) 'STI prevention and the male sex industry in London: Evaluating a pilot peer education programme', *Sexually Transmitted Infections*, Vol. 76, No. 6, pp. 447-53.

Useful Websites

AVERT: International AIDS charity	www.avert.org
Centers for Disease Control and Prevention (CDC)	www.cdc.gov
Crisis Pregnancy Agency	www.crisispregnancy.ie
Department of Community, Rural and Gaeltacht Affairs	www.pobail.ie
Department of Education and Science	www.education.ie
Department of Health and Children	www.dohc.gov.ie
Department of Justice, Equality and Law Reform	www.justice.ie
Dublin AIDS Alliance	www.dublinaidsalliance.com
EuroHIV (European Centre for the Epidemiological Monitoring of AIDS)	www.eurohiv.org
European Centre for Disease Prevention and Control	www.ecdc.eu.int
European Correlation (Health and Social Inclusion) Network	www.correlation-net.org
Eurosurveillance: Europe's leading journal on infectious disease epidemiology, prevention and control	www.eurosurveillance.org
Gay and Lesbian Equality Network	www.glen.ie
Gay Health Network (GHN): Information on safer sex, HIV, STIs and HIV testing	www.gayhealthnetwork.ie
Gay HIV Strategies	www.iol.ie/nexus/ghs.htm
Gay Men's Health Project (GMHP): Services, reports and links	www.gaymenshealthproject.ie
Health Protection Surveillance Centre	www.ndsc.ie/hpsc/
Health Service Executive	www.hse.ie
HIV Services Network (HSN): Directory of HIV and STI agencies in Ireland	www.hivireland.ie
International HIV/AIDS Alliance: Supporting community action on AIDS	www.aidsalliance.org
Irish Prison Service	www.irishprisons.ie
Limerick Red Ribbon Project	www.redribbonproject.com
National Consultative Committee on Racism and Interculturalism	www.nccri.ie
National Youth Council of Ireland	www.youth.ie
National Youth Health Programme	www.youthhealth.ie
Sexual Health Centre, Cork	www.sexualhealthcentre.com
Stamp Out Stigma: National awareness campaign	www.stampoutstigma.ie
UNAIDS: Joint United Nations Programme on HIV/AIDS	www.unaids.org
World Health Organization	www.who.int
Youthreach: Education and training programme for early school-leavers	www.youthreach.ie

Appendices

Appendix 1: Review of effective interventions

Prevention of HIV infection depends on the promotion of safer sexual behaviour, including the use of condoms (an increase in condom use is a marker for reduction in risk behaviours), harm reduction through needle exchanges and the early and effective treatment of sexually transmitted infections (STIs) and Hepatitis C virus (HCV). Success in HIV prevention approaches has been demonstrated through programme evaluations, intervention research and country-level experiences over the last 25 years.

It is critical that the best available evidence is used to support the development of best practice and policy in HIV prevention at national level. With this in mind, a review of the international evidence base concerning the effectiveness of HIV education and prevention approaches was undertaken in order to identify examples of successful interventions implemented with different population groups across a range of settings.

In undertaking a review of the available scientific evidence on best practice, the following sources and electronic databases were consulted:

- The Cochrane Database of Systematic Reviews, Database of Abstracts of Reviews of Effectiveness (www.mrw.interscience.wiley.com/cochrane) and the National Health Service Centre for Reviews and Dissemination (CRD), University of York, UK (www.york.ac.uk).
- Evidence briefings on HIV and AIDS prevention produced by the former UK Health Development Agency (HDA). Each evidence briefing report is a review of reviews assessing the effectiveness of interventions to impact on the factors, both personal and structural, that influence sexual risk behaviours. These reports identify gaps in primary and review-level research, make recommendations for research methodology and suggest implications for policy and practice.
- The Sexual and Reproductive Health databases of UNAIDS and the World Health Organization.
- Medline 1966-2006, using the search terms 'HIV', 'AIDS', 'interventions', 'prevention', 'legislation', 'programmes' and 'education'.
- The websites of relevant international and national organisations, State agencies and NGOs, and their publications and guidelines on best practice, e.g. Centers for Disease Control and Prevention (CDC).
- Strategy documents from relevant countries.

Multi-component and multi-level interventions

The HDA's 2004 evidence briefing on STIs (Ellis and Grey, 2004) concluded that the most successful interventions are multi-component interventions, which include the personal determinants of risky sexual behaviours, such as knowledge and skills, as well as addressing structural issues, such as peer group and social norms. Multi-level interventions are those that target not only the individual but also groups, communities and the wider society. Building a range of components into group-level interventions has been found to contribute to their effectiveness in influencing sexual risk behaviours (Ellis *et al*, 2003).

An integrated approach to overall HIV risk reduction needs to include:

- risk reduction – condom use;
- risk substitution – substituting lower risk behaviour for higher risk behaviours;

- contextual modification – as, for example, unprotected sex only within long-term seroconcordant relationships, 'informed altruism' and 'partner restriction' (Johnson *et al,* 2006; Des Jarlais *et al,* 2004).

There is sufficient review-level evidence to conclude that small-group and community interventions can be effective in influencing the sexual risk behaviours of black and minority ethnic groups (Ellis *et al*, 2003) and MSM (Johnson *et al*, 2006). (It should be noted that the risk reduction observed across trials with MSM was generated from relatively short interventions.)

In considering a range of interventions, the HDA's evidence briefing (Ellis and Grey, 2004) concluded that interventions are more likely to be effective if they include the following features:

1. use of theoretical models of behavioural change in developing interventions;
2. targeted and tailored interventions (in terms of age, gender, culture), making use of needs assessment or formative research;
3. provision of basic accurate information through clear unambiguous messages;
4. use of behavioural skills training, including self-efficacy.

In addition, this evidence briefing also found promising review-level evidence to conclude that interventions are more likely to be effective if they:

- emphasize risk reduction rather than promote abstinence;
- use peers and community opinion leaders.

These features are echoed in the literature and are used below to structure the discussion on effective interventions.

1. Theoretical models of behavioural change

Cognitive and behaviour change theories

The threat of AIDS and HIV has provided a major impetus into the study of factors involved in determining behaviour, both in relation to safer sex and injecting practices. Theories about how individuals change their behaviour have provided the foundation for many HIV prevention interventions (*see Table A1*). Nearly all of the psychological theories (such as the Health Belief Model or the Theory of Planned Behaviour) originated in the Western, industrialised part of the world, but they have been used internationally. Only one of the psychosocial theories discussed below – the AIDS Risk Reduction Model (ARRM) – was developed specifically for AIDS.

Basing models of behaviour on rational theories of decision-making may ignore the dyadic nature of sexual behaviour. Such theories tend not to consider the important contextual factors that influence an individual's sexual behaviour. However, Fisher and Fisher (2000) in their review of the utility of theories (which have assumptions of individual-level, gender-neutral behavioural change) found empirical support for the majority of models. In particular, constructs such as self-efficacy and perceived barriers as they relate to specific behaviours (such as condom use) have been found to be powerful predictors of safer sex practices (Norman *et al*, 2000).

It is important to note that the theories and models set out in Table A1 do not constitute an exhaustive list. It should also be stressed that the empirical basis for one theory over another is still contested. Stephenson *et al* (2000) state that differences in choice of theory and the way theory is implemented do '*not appear to explain the differential effectiveness of the interventions*'.

Table A1: Overview of most frequently used theories of human behaviour

Level	Theory or Model	Behavioural Determinants	Examples of Programme Application
Individual level	**Health Belief Model**	• Perceived susceptibility • Perceived severity • Perceived benefits and barriers • Cues to action	• Increase level of risk perception • Influence beliefs of severity • Assess and influence beliefs about benefits/barriers of changing behaviour
	Theory of Reasoned Action*	• Attitudes • Subjective norms • Behavioural intentions	• Assess and influence attitudes • Assess and influence norms in the social group • Assess and influence behavioural intentions
	Social Cognitive Theory Social Learning Theory	• Outcome expectancies • Self-efficacy	• Sexual communication, need for social support to reinforce behaviour change • Modelling of safer behaviours
	Stages of Change	• Precontemplative • Contemplative • Preparation • Action • Maintenance	• Assess and influence outcome expectations and norms, perceived risk • Assess and influence self-efficacy, intention • Assess and influence self-efficacy, intentions and outcome expectations • Assess and influence outcome expectations and norms • Assess and influence norms, self-efficacy
	AIDS Risk Reduction Model (ARRM)	• Labelling • Commitment • Enactment and maintenance	• Assess and influence risk perception, aversive emotions and knowledge • Assess and influence perceptions of enjoyment, self-efficacy and risk reduction • Assess and influence communication, informal networking, formal help-seeking
Social and and community level	**Diffusion of Innovation**	• Change agent • Communication channels • Context	• Who are the influential people in the community • Most effective means to spread information, including community leaders • Assess type of social networks in community
	Social Influences	• Context of social interactions • Social norms • Social rewards and punishments	• Equip young people with social skills, including peer pressure resistance skills • Assess and influence social norms
	Social Network Theory	• Social networks • Social support	• Assess composition of social network • Assess, build up social support
	Theory of Gender and Power	• Social sexual norms and power dynamics	• Address social structure of gender relations
	Empowerment	• Community organisation • Community building	• Assess community priorities • Assess key activities of the community and facilitate alliance-building
	Social Ecological Model for Health Promotion	• Intrapersonal (knowledge, attitudes, perception of risk) • Social, organisational, cultural (social networks) • Political factors (regulation)	• Increase in knowledge, skills development, influence risk perception • Community organising, mass media • Advocacy
	Socio-economic and Environmental Factors	• Policy • Resources; Living conditions • Access to prevention	• Advocacy; Community organising • Social services • Increasing access to prevention (condoms)

* A more recent theory, the *Theory of Planned Behaviour,* is an update of the *Theory of Reasoned Action*. It was developed by one of the authors of the *Theory of Reasoned Action* to account for behaviours that are subject to forces beyond the individual's control.

Shepherd *et al* (2000) concur with Peersman and Levy (1998), in that '*there is little consensus about which theories are most powerful in affecting behavioural outcome*'.

Social models

The main difference between individual behaviour change models and social models is that the latter aim at making changes at community level.

To fully understand the crucial determinants of behaviour, it must be seen in its social, cultural, political and economic contexts. The sexual impulse is a basic human drive, underpinned by primal needs for procreation as well as pleasure. Aggleton (1996) points out that in many cases the motivations for sex are complicated, unclear and may not be thought through in advance; he asks, for example, how well can self-efficacy in condom use and sexual negotiation skills, as taught in educational settings, be generalisable to the '*sexually charged atmosphere of the bedroom?*' Abraham and Sheeran (1994) conclude that HIV preventive behaviour will '*depend on effective management of sexual excitement, which may, in turn, rely on self-acceptance of sexuality*'.

2. Targeted and tailored interventions

The most effective interventions are those that are designed to fit the needs and knowledge base of their target community. It is important to recognise the contextual issues and needs of the participants. So, for example, IDUs, in common with all population groups, are not homogeneous; some may have immediate needs in terms of housing and employment that will affect their ability to adopt safer sexual or injecting practices in order to improve their sexual health. Such insights are most cost-effectively gained by involving members of the community in the needs analysis, design and delivery of the intervention programme (De La Cancela, 1989; Seal *et al*, 2000). Economic arguments underpin the need to target and tailor interventions. Ellis and Grey (2004) found promising review-level evidence that STI prevention interventions can be cost-effective – and even cost-saving – when targeted at 'high risk' groups (such as commercial sex workers, injecting drug users or men who have sex with men). Similarly, the *Irish Study of Sexual Health and Relationships* (ISSHR) concluded that to be effective, health services and policies need to be tailored to the '*preferences and circumstances of specific groups and individuals*' (Layte *et al*, 2006, p. 280). These specific groups include women, ethnic groups, men who have sex with men (MSM), injecting drug users (IDUs), people living with HIV and AIDS, young people, prisoners and commercial sex workers.

Research emphasizes the importance of broadening the focus of interventions to recognise the contextual issues and needs of the participants. Seal *et al* (2000) found that '*young men voiced the opinion that HIV prevention topics should be embedded in the context of other issues they face, such as dating and emotional intimacy and the development of relationships; self-esteem, self-care and self-love; coming-out issues; pessimism concerning one's future; safer sex negotiation and communication; alcohol and illicit drug use; and gaining acceptance by one's peers, family members and society as a whole*'.

Prevention strategies need to determine, in a participatory manner, the particular needs and circumstances of different population groups and ensure that there is an ecological fit between the content and delivery of the intervention and the reality of the everyday lives of the participants. Special attention needs to be paid to issues of culture, ethnicity, gender and age, and how these factors may contribute to inequalities in sexual health and access to information and services.

3. Provision of basic accurate information

Effective communication of basic accurate information can inform and change attitudes, and give people properly informed choice through the use of clear unambiguous messages. The analysis by King and Bartlett (1999) of 38 different national AIDS-control programmes found that 90% focused on correcting misconceptions about AIDS; about 80% provided information about personal risk assessment. Many mass education efforts globally have raised HIV and AIDS awareness. In some cases, condom sales have increased and a reduction in new HIV cases has ensued (Kalichman *et al,* 1997). As Grilli *et al* (2002) point out, '*the mass media play several important functions in society, including providing information, entertainment, articulating and creating meaning, setting agendas for individual and societal discourse, and influencing behaviour*'.

Population surveys show that mass media are the leading source of information about important health issues, such as HIV and AIDS (Chapman and Lupton, 1995), and have been over a 25-year period. In the area of prevention, risk reduction and drug information, it has become common to seek a 'partnership' or 'shared agenda' with the mass media in communicating health information to the public. The Global Media AIDS Initiative was launched in January 2004 with the aim of activating media organisations to reach a global audience – especially young people – with information about how to prevent and treat HIV, and to help combat AIDS-related stigma and discrimination. UN Secretary-General Annan stated at the time, '*With two-thirds of the estimated cases preventable through information and education, the power of the media is one of the most formidable tools that we have in fighting HIV and AIDS … Broadcast media have tremendous reach and influence, particularly with young people, who represent the future and who are the key to any successful fight against HIV/AIDS. We must seek to engage these powerful organizations as full partners in the fight to halt HIV/AIDS through awareness, prevention and education*'.

Health advocates have developed several basic strategies for working with the media, including:

- mass media campaigns (using social marketing and entertainment education);
- embedded messages;
- media advocacy;
- media literacy;
- small media;
- Internet interventions.

Each strategy has its strengths and weaknesses. Results suggest that intentional use of the media in the interests of sexual health is valuable. To be effective, messages about HIV and AIDS must be both educational and entertaining (the two are not necessarily mutually exclusive), as noted in UNAIDS' 2004 report: '*This task requires vision, dedication and, above all, creative programming that truly engages audiences.*'

The use of theory to enhance the effectiveness of mass media interventions has been clearly demonstrated (Rice and Aitken, 1994; Aitken, 2002). Sixsmith (2006) outlines seven distinct areas of best practice for mass media campaigns, two examples of which are given below.

Good practice 1: 'Stop AIDS' campaign in Switzerland

Switzerland has had a national social marketing campaign for the past 20 years called 'Stop AIDS'. It has been associated with a 48% increase in condom use and with no increase in sexual activity among 17-30 year-olds over a 10-year period. About two-thirds of the population report protecting

themselves by using condoms during casual sex and at the start of a new relationship. The rates of HIV testing have increased and stigmatisation of homosexuality has decreased significantly (Dubois-Arber *et al*, 1997).

The Swiss campaign continually adapts the prevention messages as changes in the epidemic are observed. The Swiss AIDS Transmission Survey, a prospective study, investigates the detailed circumstances of new HIV infections with patients, thus gaining insights into the current dynamics of the epidemic and the circumstances of HIV transmission. This information is then used to further target and adapt the prevention messages and work.

The Swiss have successfully introduced messages cumulatively, with each new wave of advertising adding to the previous message, rather than replacing it. In 2005, the overall theme was changed to 'Love life – Stop AIDS', aimed at emphasizing the joy and fun of a healthy sex life and using protection as part of this. The 2006 campaign used the slogan 'No action without protection' and showed images of naked people engaged in playing sports with a high risk of injury, such as fencing and ice hockey; the clear message was to raise public awareness of the need for self-protection in sexual activity too. 'Love life – Stop AIDS' messages are disseminated through billboard posters, print advertising and TV commercials, as well as on a website (www.lovelife.ch) and at a variety of public events, such as music festivals. In addition, commercial marketing partnerships with condom manufacturers are ongoing and continue to be developed.

The Swiss HIV prevention campaign is multifaceted and being conducted at several different levels:

- the broad effect of information for the general public, through mass media campaigns via posters, advertisements, television, cinema and radio;
- the broad effect with in-depth effect, through specific information campaigns targeting certain groups with high-risk behaviour or a high prevalence, such as MSM, sex workers and IDUs;
- in-depth effect, through information to individuals by counselling and personalised advice provided by different sources, such as Swiss AIDS Association, doctors and outreach workers.

The Swiss HIV prevention campaign is evaluated every second year by an external research company *(for further information, see* www.swissinfo.org).

Good practice 2: The Internet

The literature highlights the Internet as one of the underexploited areas of mass media in terms of HIV prevention and education. The study by Keller *et al* (2004) found that of the 160 million Internet users in the USA, 52 million use it for information on health and many of these are teenagers – 46% of 12-17 year-olds had gone online in the previous month for an average of 303 minutes per month. The Kaiser Family Foundation survey (2002) also found that 28% of 15-17 year-olds listed the Internet as their primary source of sexual information.

The Internet allows for audience segmentation beyond a level ever possible before. Keller *et al* (2004) noted that '*the Internet's uniquely intermediate status between a mass medium and interpersonal communication makes it an ideal venue for communicating sensitive information because if offers anonymity and sophisticated message tailoring*'. It is interactive like a conversation and reaches large audiences with individualised messages. It has the capacity to relay information, provide online peer support and answer questions on demand as the need arises. Thus, as Keller *et al* (2002) state, '*this consumer-driven feature of the Internet makes it an especially important service for issuing reproductive health information to young people*'.

However, use of the Internet in the area of HIV prevention and education is not without its limitations, some of which include:

- certain groups of people, such as low-income groups, may have less access to computers;
- inaccurate and inappropriate information may be disseminated on websites due to a lack of quality control on information published;
- violations of privacy and confidentiality are issues of concern;
- certain software programs, such as Cyber Patrol, used by libraries and schools screen out sexual references;
- research into the impact of the Internet on people's lives and sexual behaviour is needed.

4. Behavioural skills training

Cognitive and behavioural interventions

HIV and AIDS is one of the threats to health for which the only effective solution is behavioural. Kirby (2001) documented that as knowledge is only weakly related to behaviour, interventions need to achieve more than an increase in knowledge. Behavioural interventions have contributed directly to decreases in HIV infections throughout the world (Darbes *et al*, 2002). Effective interventions that focus on behavioural preventions are very important, whether directed at the individual or at the community level. Cognitive behavioural group work, focusing on risk reduction, sexual negotiation and communication skills training and rehearsal (e.g. through role play), can be effective in influencing the sexual risk behaviours of MSM (Ellis *et al,* 2003). The literature also demonstrates a strong correlation between talking with one's partner and positive sexual health outcomes (Heise *et al*, 1995; Guzmán *et al*, 2003; Salway, 1994; Santhya and Dasvarma, 2002).

Peer-led interventions

According to Charleston *et al* (1996), peer-led interventions are '*interactions between individuals with shared characteristics, such as behaviour, experience, status or social and cultural backgrounds*'. Sociological theories posit that society is made up of various sub-cultures and it is the peer group within such a sub-culture that the individual most identifies with. Peers have been shown to be the most credible and influential sources of information (Stephenson *et al*, 2004). Using strategies that enlist community mobilisation to modify the norms of the peer network in order to support positive changes in behaviour will be effective, even if the vulnerable community (e.g. IDUs or sex workers) does not have the larger societal support (Kelly and Kalichman, 1995). When individuals are actively involved in finding and implementing solutions to their problems, their behavioural change is more long-lasting (Gonzales *et al*, 1996; Rappaport, 1981).

The strength of evidence from the literature for peer-led interventions is extremely strong. Changing norms and values within communities has become one of the aims of peer-led interventions. Community mobilisation approaches can be peer-facilitated in 'bottom up/informal' interventions, which have long-term effects for specific communities (Svensen and Burke, 2005). The 1999 EPPI Report notes that in the USA there has been success with the use of community mobilisation approaches with young gay men in peer-delivered health promotion (Harden *et al,* 1999). Ellis *et al* (2003) conclude that community-level interventions, involving peers and popular opinion leaders, can be effective in influencing the sexual risk behaviours of MSM. Seal *et al* (2000) in their qualitative interviews with young gay men found that the vast majority of them were born into and reared in heterosexual families and social systems. There are few models available for learning roles related to dating, developing relationships, sexuality or developing a positive sexual self-identity (Kelly and Kalichman, 1995; Hays *et al,* 2003). In these areas, older gay mentors could be important influences.

The 1999 EPPI Report stresses '*all health promotion interventions with young people should only be implemented on the basis of a thorough assessment of both young people's self-defined needs and their views on what kind of intervention they would find most appropriate*' (Harden *et al*, 1999). Studies have shown that it is the young peer leaders themselves who benefit over the longer timeframe from their role in terms of their own knowledge and positive sexual health behaviours (Pearlman *et al,* 2002; Harden *et al,* 1999). Women may find peer-led interventions more relevant and acceptable since they bring the unique experience and common outlook of a peer (Doull *et al*, 2004).

The objectives of such interventions are often:

- to enhance self-esteem, confidence and self-efficacy;
- to improve physical and emotional well-being;
- to increase access to treatment and support;
- to enhance personal skills.

Appendix 2: Overview of the National Consultation Day and key issues for the future

The purpose of the National Consultation Day, held with key stakeholders in Dublin during November 2006, was to present the main findings of the *Draft Report of the Evidence Briefing on Best Practice in HIV and AIDS Education and Prevention* to those in the field and to gain an insight into their views on the issues and way forward. Approximately 60 representatives of statutory and civil society organisations and groups involved in the area of HIV and AIDS education and prevention attended the meeting. The consultation process aimed to be inclusive and participative, and discussions were facilitated in workshop sessions to allow the experts present to contribute to the process of developing recommendations for the next five years.

The discussions reflected the following main points:

- Reaction to the evidence briefing on best practice and the main issues raised.
- What should be maintained of the current infrastructure and practice to support the implementation of best practice outlined?
- What are the key challenges/gaps that must be addressed to make this approach to education and prevention a reality?
- What is needed now to move forward?

Each discussion group presented their points to the larger group and these were all duly noted. As with any large group of experts, discussions ranged over and beyond the questions outlined above and broad agreement emerged on the main issues, as follows.

Reaction to evidence briefing

- The general consensus was that the evidence briefing contained a wealth of information, but that it was difficult to consider all the points in the short timeframe of the workshop session. It was generally agreed that much of the work going on in Ireland is in keeping with international findings on best practice.

Building on good practice

- The group was eager that a national platform for sharing good practise be created. This forum could then broaden the 'pockets of excellence' into 'a country of excellence'. The desire to harness the good work and good practice that is going on was emphasized. For example, the Gay Men's Health Project model was highlighted as evidence of good practice and one that has the potential to be replicated with other 'at risk' groups.
- The national forum could be responsible for collating and disseminating the evidence and information gathered by all the different projects and programmes.
- The information would need to be disseminated in as many languages as possible in order to reach all the ethnic groups now living in Ireland.
- The need to map what is working well within the country was noted in the discussions.
- The dearth of evaluations of current interventions was also highlighted. This is due to a lack of funding and resources.

National leadership network

- Political will is needed to spearhead a renewed effort in Ireland in order to 'halt and reverse the spread of HIV'.
- The idea of the '3 one's' – 1 agency, 1 national framework, 1 national monitoring and evaluation plan – was given as a framework for moving the HIV and AIDS Education and Prevention Plan forward.
- A clear mandate within Government was called for, to create a sexual health strategy that would be a blueprint for action, not just aspirational.
- The HIV and AIDS Education and Prevention Plan needs to be health-promoting, i.e. inclusive and based on partnership, empowerment, collaboration, coordinated and long term.

An integrated sexual health model

- A refocusing of the HIV and AIDS Education and Prevention Plan was recommended in order to move away from the idea of 'one disease' and progress instead towards more comprehensive sexual health. Broadening the strategy may help reduce the stigma of HIV, once it is framed with other STIs.
- One group suggested that policy-makers should review the marketing strategy of the Crisis Pregnancy Agency since it is working so effectively and apply similar approaches to the sexual health campaign.
- It was agreed that the Education and Prevention Plan should be multi-level and multi-layered, targeting 'at risk' groups as well as the wider population in order to change social norms around sexual health and behaviours.
- The Education and Prevention Plan should be integrated with reproductive and addiction services.
- All 'at risk' groups should be included in needs analysis, planning, implementation and evaluation of interventions.
- The Education and Prevention Plan should build on principles of community development and peer-led education.
- The Education and Prevention Plan should have multi-sectoral involvement in its planning, implementation and evaluation, embracing the health services at all levels (GPs, nurses, health workers, etc), education, social services (social workers, housing, etc) and non-governmental organisations.

Resources

- Funding of the HIV and AIDS Education and Prevention Plan needs to be long term and sustained in order for positive developments to emerge.
- Evaluation needs to be built into all funding arrangements.
- Dedicated staffing is needed, with built-in workforce development, in order that the skills and expertise necessary are developed to meet the changing sexual health needs of the nation.
- Employment ceilings are impacting on service delivery.
- One group noted that, with HSE reorganisation, the whole edifice appears to be returning to a medical focus and moving away from the community and health-promoting areas.

Sexual health services

- The mapping of existing services dealing with HIV education and prevention is needed; some areas of the country simply have no services available.
- An audit of what people want in relation to sexual health services and where they want them needs to be carried out.
- A synthesis of all available epidemiological data is needed and a more comprehensive surveillance system.

County-based services

The invaluable and underutilised role of primary care in relation to sexual health was highlighted:

- GPs and nurses have the opportunity to promote sexual health with patients; further training may be required.
- More youth-friendly services are needed.
- Integrate sexual health and contraceptive services.
- Make voluntary testing and counselling standard medical practice, as part of a general health check-up.
- There is a need for dedicated staff.

Vulnerable groups

- The clear message here was that people living with HIV and AIDS (PLWHA) need to be at the core of the solutions and involved in the process of planning, implementation and evaluation.
- In order for PLWHA to be involved, capacity-building is necessary to give them the skills for meaningful participation.
- The issues of stigma and discrimination were highlighted as not having 'gone away' and were seriously affecting those living in Ireland with HIV and AIDS.
- The creation of a non-discriminatory environment was necessary in order to enable disclosure and to work on secondary prevention interventions.
- Secondary prevention needs to be part of all intervention and treatment programmes.
- Children living with HIV and AIDS will become an issue in Ireland and was highlighted as another potential arena for discrimination; anecdotal evidence was shared in relation to crèches not taking these infants.
- It was acknowledged that stigma and discrimination would be dealt with by the national campaign to tackle HIV-related stigma and discrimination – *Stamp Out Stigma*, launched in November 2007.

Young people and their parents

- Social, Personal and Health Education (SPHE) was seen as a powerful tool, which is *not* being embraced fully by the school system.
- Parents were noted to be in need of support in their vital role as primary educators. One group explored the use of the mass media to inform and encourage that role; a version of 'Super Nanny' programmes was discussed, to be shown at prime viewing time and giving tips on all aspects of healthcare for children, including sexual health.

Ethnic minority groups

- The issue of not being able to buy condoms in direct provision accommodation was highlighted and also the fact that condoms are not freely available in homeless and migrant hostels.
- The role of culture as it influences behaviour and knowledge was noted and needs to be included in any interventions with ethnic minority groups.
- Issues involving gender roles and the vulnerability of women within certain communities were also raised.

Irish contextual issues

- Discussions took place on the need to change Irish social norms in relation to young women's fear of pregnancy, influencing their use of the pill as their contraceptive rather than condoms. This is because STIs are not seen as problematic by many young people.
- Irish reticence to discuss sexual issues needs to be challenged and a forum for open and honest discussion created within all levels of society.
- Issues for women about negotiating safer sex within relationships where they are disempowered were discussed.

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