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National Action Plan *on STIs, HIV and Sexual Health*

2017-2022

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on STIs, HIV and Sexual Health

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Colofon

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Content

Synopsys

The National Action Plan on STIs, HIV and Sexual Health presents an integral approach for the coming five years that is centred around a positive approach to sexuality. A principle of sexual health is that the inhabitants of the Netherlands should be properly informed and able to make sensible choices in the matter. As well as good preventive measures, they must have easily accessible and affordable care in the event of problems.

The action plan has six cornerstones. Two of them are overarching topics: sexuality education, and surveillance and monitoring. Sexuality education is the basis for healthy sexual development and is important for preventing STIs, HIV, unwanted pregnancies and sexual violence. Surveillance means keeping track of how many people experience problems. This data is needed if effective measures, treatment and policy are to be set up. The effect is then recorded (monitoring).

The other four cornerstones state specific objectives for STIs, HIV, unwanted pregnancies and sexual violence, particularly among vulnerable groups. One of those objectives is to reduce long term complications resulting from the sexually transmitted disease chlamydia. Another target is to halve the number of new cases annually of syphilis, gonorrhoea and HIV. The following objectives for HIV have been included in the action plan:

By 2022, 95 per cent of people with HIV will be aware that they have the virus, 95 per cent of them will be being treated for it, and in 95 percent of these patients the HIV virus will no longer be detectable. Another target is that nobody will be dying of AIDS any more in the Netherlands. To prevent unwanted pregnancies, it is important that everyone in the Netherlands has easy access to contraception and proper information. Combating sexual violence is important, as is care for the victims. That is why schools will be paying attention structurally to behaviour that is unacceptable. Training and refresher courses for professionals in the healthcare and education sectors are central to this.

The National Action Plan on STIs, HIV and Sexual Health for 2017-2022 has been produced under the auspices of the RIVM (National Institute for Public Health) in cooperation with the key parties working in the field that are involved with sexual health.

Publiekssamenvatting

Het Nationale Actieplan soa, hiv en seksuele gezondheid presenteert voor de komende vijf jaar een integrale aanpak waarin een positieve benadering van seksualiteit centraal staat. Uitgangspunt van seksuele gezondheid is dat inwoners van Nederland goed geïnformeerd zijn om hierover verstandige keuzes te maken. Behalve goede preventieve maatregelen moeten zij bij problemen toegang hebben tot laagdrempelige en betaalbare zorg.

Het actieplan bestaat uit zes pijlers. Twee daarvan zijn overkoepelende onderwerpen: seksuele vorming en surveillance & monitoring. Seksuele vorming is de basis voor een gezonde seksuele ontwikkeling en is belangrijk om soa, hiv, ongewenste zwangerschap en seksueel geweld te voorkomen. Surveillance betekent bijhouden bij hoeveel mensen er problemen optreden. Deze gegevens zijn nodig om effectieve maatregelen, behandeling en beleid, op te kunnen zetten. Vervolgens wordt het effect daarvan in kaart gebracht (monitoring).

De andere vier pijlers benoemen specifieke doelen voor soa, hiv, ongewenste zwangerschap en seksueel geweld, vooral onder kwetsbare groepen. Een van de doelen is het verminderen van klachten door de geslachtsziekte chlamydia. Een andere ambitie: jaarlijks de helft minder mensen die syfilis, gonorroe en hiv oplopen. De volgende hiv-doelstellingen zijn in het actieplan opgenomen: 95 procent van de mensen met hiv in 2022 weet dat ze de ziekte heeft, 95 procent van hen is onder behandeling en bij 95 procent is het hiv-virus niet meer aantoonbaar.

Een ander streven is dat in Nederland geen mensen meer overlijden aan aids. Om ongewenste zwangerschappen te voorkomen is het belangrijk dat alle mensen in Nederland laagdrempelige toegang hebben tot anticonceptiemiddelen en goede informatie. Belangrijk is het tegengaan van seksueel geweld en zorg voor de slachtoffers. Op scholen is daarom structurele aandacht nodig voor grensoverschrijdend gedrag. Hiervoor staat (bij)scholing van professionals in zorg en onderwijs centraal.
Het Nationaal Actieplan soa, hiv en seksuele gezondheid 2017-2022 is onder de regie van het RIVM tot stand gekomen in samenwerking met de voornaamste veldpartijen die werken op het gebied van seksuele gezondheid.

Kernwoorden: Nationaal Actieplan, soa-bestrijding hiv-bestrijding, seksuele gezondheid, seksuele vorming, ongewenste zwangerschap, seksueel geweld

Foreword

This National Action Plan has been produced in cooperation with the key stakeholders for STIs, HIV and sexual health. Consultation rounds were held in 2016 and 2017 about it with these parties who are active in the field. Together, a picture of the challenges was produced in order to list potential improvements and to indicate how and by whom these improvements could be effected. The Ministry of Health, Welfare and Sport (VWS) commissioned this National Action Plan from the National Institute of Public Health (RIVM) .

The purpose of this National Action Plan is to promote sexually healthy lifestyles for everyone who lives in the Netherlands. The principle underpinning it is a positive attitude towards sexuality, with broad sexuality education as the foundation. This plan has been drawn up from a public health perspective. Attention has been paid to the prevention of and help for making the right choice about unintended pregnancies, prevention of unacceptable sexual behaviour or sexual violence, and further reductions in STIs and HIV by optimising how they are tackled. Six cornerstones have been defined.

The key national organisations cooperating with the RIVM-CIb (Centre for Infectious Disease Control) and stakeholders for STIs and sexual health are committed to this plan[1]. It describes detailed actions and responsibilities for specific objectives for the years 2017-2022. The realisation and funding of the goals requires agreements with new commissioning parties in many cases.

[1] Soa Aids Nederland, Rutgers, HIV Association (patient organisation), HIV Monitoring Foundation, the Sexual Health Centres (CSGs) of the Municipal Public Health Services(GGD), and the following professional organisations: NHG-SeksHAG (GPs' advisory group), NVHB (HIV treatment specialists), NVVS (sexology)

1 Nature and scope of the plan

Background

The Netherlands has an open and positive approach to the promotion of sexual health, focusing on and encouraging pleasant, voluntary and safe sex and not exclusively on the prevention of problems. Sex is not generally a taboo subject; problems are addressed without moral judgement and the focus is on the things that work. The integrated approach to sexual rights, sexual freedom and the resources and facilities available in the Netherlands are highly regarded internationally, the country is seen as one of the leaders in this matter. Although sexual health in the Netherlands is above average, this approach is not equally successful for all residents of the country. STIs, HIV, unwanted pregnancies and sexual violence still cause a lot of problems and burden of disease. People with limited health skills often have a low socioeconomic status, a lower level of education or a non-western background. There are also often problems in these groups with regard to sexuality, STIs and HIV. Because the focus is on preventing and combating sexual health problems, a positive approach to sexuality is often left by the wayside. We are asking for attention to be paid to this too.

Why is a plan being issued now?

Ongoing attention is required if sexual health is to be maintained at a high level in the Netherlands. The assumption is that an integrated approach will be used that covers both STI and HIV prevention and reduction of sexual violence and unwanted pregnancies. This plan brings the intentions in that regard together onto common ground. On top of that, the term for the "Strengthening and Enhancing" National Plan for STI/HIV expired in 2016. Existing policy documents relating to sexual health date from 2009, with an update in 2011[2], and they are therefore due for renewal.
On the international front, the WHO has set ambitious targets both for sexual health and rights and for STIs and HIV[3]. Additionally, the Netherlands is committed to

[2] *http://wetten.overheid.nl/BWBR0018743/2017-01-01*
https://www.loketgezondleven.nl/gezonde-gemeente; https://www.loketgezondleven.nl/preventie-het-zorgstelsel/alles-over-preventie-het-zorgstelsel
https://www.rijksoverheid.nl/documenten/kamerstukken/2009/11/27/seksuele-gezondheid
https://www.rijksoverheid.nl/documenten/kamerstukken/2015/12/04/kamerbrief-over-landelijke-nota-gezondheidsbeleid-2016-2019

[3] Commission Staff Working Document, Action Plan on HIV/AIDS in the EU and neighbouring countries: 2014-2016, SWD(2014)
Communication from the Commission to the Council and the European Parliament on combating HIV/AIDS within the European Union and in the neighbouring countries, 2006-2009, COM(2005)
Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on Combating HIV/AIDS in the European Union and neighbouring countries, 2009-2013, COM(2009)
Declaration of States and Governments from Europe and Central Asia under the aegis of WHO, Dublin 23/24 February 2004.
https://www.huiselijkgeweld.nl/beleid/landelijk/verdrag-van-de-raad-van-europa-inzake-het-voorkomen-en-bestrijden-van-geweld-tegen-vrouwen-en-huiselijk-geweld

the Sustainable Development Goals (there are 17 SDGs)[4]. We want to tighten up those goals for the coming years in the Netherlands on the points listed in this action plan and we want to define the corresponding activities.

Focus and cornerstones

This plan focuses on six cornerstones:

- monitoring and surveillance
- promotion of sexually healthy lifestyles (backed up by comprehensive sexuality education)
- prevention and control of sexually transmitted infections
- prevention and control of HIV
- prevention of unwanted pregnancies
- prevention of unacceptable sexual behaviour and sexual violence

The plan presents a cohesive approach from a public health perspective. Education and information for the public are preconditions for all these cornerstones, allowing individuals to take control of their own sexual health.

This plan prioritises four topics from the public health perspective: STIs, HIV, unwanted pregnancies and sexual violence.

The objectives in this plan have been formulated jointly with parties involved who are active in the field. These parties are committed to implementing the plan.

Sexual health covers more topics than just the cornerstones that have been prioritised and detailed in this plan. Achieving the objectives for the cornerstones also requires efforts by other parties involved, for instance the GGD, GPs and local authorities, the Ministry of Education, Culture and Science for achieving the core targets for education about sexuality, the Ministry of Justice and Security for improvement of the position of sex workers and people in detention, or the Ministry of Social Affairs and Employment for a targeted approach to sexual health in the naturalisation and integration of migrants. Where relevant, these parties will be stated explicitly and ways of cooperating and financing the activities will be investigated (see later).

Financial framework

The Public Health directorate of the Ministry of Health, Welfare and Sport (VWS-PG) has commissioned RIVM-CIb (Centre of Infectious Disease Control) to facilitate the production of this action plan. The breadth of the topics means they are at the crossover points of the mandates of RIVM-CIb and VWS-PG. When monitoring the implementation (and acquisition of funding) for the activities, links to the adjacent policy areas of other departments should be sought out. The implementation places a great deal of responsibility on the shoulders of GPs, who have a key role in all the cornerstones of this plan. In addition, there is a large degree of responsibility for the institutes themselves that are associated with each of the objectives, in particular Rutgers. This is especially important concerning the implementation of chapters 8 and 9 (prevention of unwanted pregnancies and prevention of sexual violence).

The plan focuses on optimum use of existing governmental resources and other sources for combating STIs and HIV and for promoting sexual health. The implementation of the requisite actions will also sometimes extend beyond the scope of the Ministry of Health, Welfare and Sport (for example to the ministries of Education, Culture and Science or Justice and Security).

In addition to regular healthcare under the Healthcare Insurance Act and funding from local authorities, the key sources of funding for current activities relating to sexual health are:

- subsidies from VWS-PG for institutes involved with the various themes – Soa Aids Nederland and Rutgers, HIV Monitoring Foundation and HIV Vereniging
- VWS commissioning RIVM for surveillance and control, and a coordinating role
- the ASG (Supplementary Sexual Healthcare subsidy) from VWS-PG
- other ministries such as OCW (Education, Culture and Science) and JenV (Justice and Security) are currently financing programmes or interventions – often on a per-project basis or through alliances – relating to emancipation and educational programmes and to violence respectively
- contributions from local authorities under the Public Health Act for their own policies and from the GGD

[4] *http://www.un.org/sustainabledevelopment/sustainable-development-goals/ http://www.sdgnederland.nl/*

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Vision and strategic goals

Vision

In the Netherlands, a positive approach to sexuality and broad sexuality education are seen as the foundation for sexually healthy living. Attention is paid to encouraging sexually healthy choices and sexually healthy relationships, as well as for preventing and reducing problems related to sexual health. The negative effects on health and welfare of the transmission of STIs and HIV, sexual violence and unwanted pregnancies are limited as far as possible.
Values related to sexual health (personal autonomy, resilience, respect and understanding of reciprocity) and sexuality education are central; proper and integrated assistance and care for sexual health are assured.

Strategic goals

Strategic Goal 1
Residents of the Netherlands are well informed and capable of making choices about their sexual health, aiming for sex that is pleasant, voluntary and safe, protected against STIs and HIV, sexual violence and unwanted pregnancies.

Strategic Goal 2
Residents of the Netherlands have access to appropriate, affordable health facilities, care, advice, support and protection if they need help or have problems related to their sexual health, including STIs and HIV.

3 Prevention and care

3.1 How is it set up in the Netherlands?

Both public health and regular healthcare

Prevention is put into effect by the people themselves, the public health system and the curative care system (primary and secondary care). There are tasks for the following in the prevention and reduction of unacceptable sexual behaviour, sexual violence, unwanted pregnancies, STIs and HIV:

- the public health system
- the regular healthcare system

If sexual health in the Netherlands is to be optimised, it is important that both the public health and regular healthcare sectors are properly aligned and work together where necessary.

Public health

Care for public health is enshrined in the Public Health Act. Municipal councils are responsible for implementing it. The purpose of the public health system is to promote and protect the health of the public. For the local authorities, this is essentially about:

- collective prevention that focuses on the entire population (universal prevention)
- prevention that focuses on specific groups that are at risk (selective prevention)

In order to support and work with both regional and local implementation of information for the public and prevention, the following have been set up nationwide:

- information channels for keeping the general public and risk groups informed, and
- preventive intervention, developed and tested and for which broad implementation is encouraged

Regular healthcare

Care for STIs, HIV and sexual health involves a large number of healthcare providers in the Netherlands, such as GPs, social care nursing staff, STI doctors, internal medicine specialists and infectiologists, medical and other sexologists, dermatologists, medical microbiologists, obstetricians and gynaecologists. GPs play an important role on the front line: it is estimated that they handle about 60% of all STI consultations and 80% of all STI diagnoses[5]; in addition, 85% of women go to their GP for contraception. GPs also have a key role in signalling cases of sexual violence. The GP has a major role when pregnancy is suspected (unwanted or otherwise) and in the follow-up care after a miscarriage or abortion. Referrals to and cooperation between primary and secondary care providers and the public health system must be carefully assured.

[5] RIVM Annual Report 2017; *http://www.rivm.nl/Documenten_en_publicaties/Wetenschappelijk/Rapporten/2017/Juni/Sexually_transmitted_infections_including_HIV_in_the_Netherlands_in_2016*

Prevention within regular healthcare is arranged inter alia in the Healthcare Insurance Act and the Long-Term Care Act. This regular prevention is targeted at the individual and comprises:

- measures to prevent illness or further damage to health, focusing on people with incipient health complaints or living in complex circumstances
- measures to avoid exacerbation or complications of a disease, or to improve people's ability to cope (care-related prevention)

If sexual health is to be optimised, it is important that both the public and curative healthcare sectors are properly aligned and work together where necessary.

Supplementary sexual healthcare

The Supplementary Sexual Healthcare subsidy (Dutch: ASG) are part of the subsidy arrangements for public health. This is how the Ministry of Health, Welfare and Sport (VWS) makes it possible for high-risk groups to be tested easily for STIs and HIV via a subsidy scheme (i.e. with no costs for the customer) without involving the healthcare insurers, and to provide help for young people with issues about sexuality at the Sexual Health Centres (CSGs) of the GGDs. The ASG subsidy were assessed in 2012, with the conclusion that they were being properly and effectively handled by the Municipal Public Health Services and that there was no distortion of competition with the GPs. A financial maximum was introduced as of 2015 in order to improve the efficiency. The current arrangements will be assessed in 2017 and the legal and financial setup will be analysed. VWS and RIVM-CIb plus the parties working in the field are making efforts to ensure that nationwide, uniform supplementary help for STIs, HIV and sexual health will remain easily accessible for high-risk groups.

Vulnerable groups

The plan often uses the terms 'vulnerable groups' and 'risk groups'. Whether people are deemed to be in a risk group depends on individual factors such as age, socioeconomic status, literacy, education and cultural/immigration background and the risky sexual behaviour. Risk levels are also estimated based on health skills, gender and sexual orientation. Vulnerability is also caused by environmental factors such as the elevated presence of infections, social norms about unacceptable sexual behaviour and the absence of facilities in the immediate vicinity of where they live.

Goal for 2022:
High-quality, appropriate, affordable and accessible facilities for care, advice, support and protection if people need help or have problems related to their sexual health (including STIs and HIV) are available for everyone in the Netherlands.

3.2 The challenges and the approach

Key bottlenecks in the current system are:

- reimbursements for STI tests in the regular healthcare system
- quality of care/implementation and improvement of existing interventions and guidelines
- low threshold access, wider reach and better cost effectiveness
- referrals and the care chain
- linking prevention and cure

Reimbursement for STI testing in regular healthcare

Reimbursement for regular healthcare are handled via the Healthcare Insurance Act. Costs for testing and treatment are reimbursed by the insurer, but due to the obligatory deductible excess it often means that they are paid for by the patient (costs of GP consultations are covered by the basic insurance package).

Approach:
Development of creative solutions by local/regional parties such as local authorities, GGD and health insurers in order to cover costs that present a barrier to easy access to STI testing

Parties involved:
National government: the Association of Dutch Municipalities (VNG); nationwide parties: GGD-GHOR Nederland (Municipal Public Health Services – Regional Medical Assistance Organisation), Municipal Public Health Services; care insurers, healthcare providers.

Quality of care/implementation and improvement of existing interventions and guidelines

To enable care professionals to do their work properly, ongoing attention is required for improvements in levels of their expertise via further education and refresher courses. Tools are currently being developed so that GPs and others will be able to respond appropriately to what

are for them relatively rare problems. This applies for example for sexual problems and sexual violence or online partner notification for STIs. More and more alerts are available in GP information systems for this purpose. Easily accessible education and refresher courses about sexual health for primary care providers (including GPs and doctors' assistants) are being provided successfully for instance via the digital learning weeks held by Soa Aids Nederland.

Approach:

- Strengthening the attention for quality of care (as per the guidelines) among inter alia GPs; for example via targeted refresher courses or regular case descriptions in specialised journals like. Huisarts & Wetenschap or the NTvG (Dutch Medical Journal)
- Keeping guidelines, incl. treatment guidelines, and other guidance documents up to date

Parties involved:
National government: RIVM-CIb; parties involved in education: NSPOH (public and occupational health training); scientific and professional organisations: NHG (SeksHAG), V&VN (nurses' association), NVDV (dermatology and venereology) and NVMM (medical microbiology – multidisciplinary working group on secondary care guidelines), NVVS (QA of training courses), NVIB (infectiology – WASS working group on STIs and sexual health).

Low threshold access, wide reach and cost effectiveness

Accessibility of care
People's health skills can be influenced negatively by a number of factors that mean they can then be deemed to be vulnerable groups (see above). These people are often not able to find the correct help in the current system. Also, they are at risk for unwanted pregnancies, sexual violence and catching STIs and HIV. These people can go to the CSGs for additional help, but extra attention is needed for these groups there as well to make care more easily accessible and to make allowances for their special requirements.
Various evidence-based guidelines and interventions have been developed for optimising prevention, testing and treatment. Nevertheless, there are barriers that make it difficult to implement them sufficiently.

E-health
In both regular and supplementary healthcare, there is increasing monitoring of cost-effectiveness of various forms of help; the underlying principle is to help make the general public better able to help themselves. There are technical options that offer opportunities for using e-health to reach people in good time and with tailored STI information, known as the 'stepped care' approach. When tackling STIs (either online or face to face), what is offered is matched up to the complexity of the need for help and online tools (e-health) are used for providing information. Various interventions have also been developed within the e-health programme Sense for young people aged 25 years or under. They have been linked together in a way that will help young people, appropriate for their needs in terms of information or assistance. Examples are the website sense.info and the Sense information line (phone and chat) for simple questions needing help, and Sense online help for more complex help needs and online partner notification. Good referral options to regular and supplementary care (within Sexual Health Centres) are important here.
The stepped care approach also takes account of specific groups with elevated risks who cannot easily be reached using the regular (face-to-face) care that is on offer. This is referring to groups of people who are less able or unable to cope for themselves. Within the additional items offered under the ASG subsidy, there are experiments currently with e-health interventions and online consultations in order to investigate how well these groups are being reached.

Approach:

- retaining subsidised, easily accessible access to additional facilities for sexual health, with extra attention for the most vulnerable groups (in particular people with low socioeconomic status, people with minor mental disabilities and Dutch people with immigrant backgrounds, including asylum seekers)
- prevention and care must be offered at a high level of quality, with specific attention for high-risk groups
- the existing assistance that is on offer should be expanded by using additional, innovative methods to improve accessibility
- enhanced efforts in e-health interventions relating to sexual health

Parties involved:
National government: VWS, RIVM-CIb, GGDs (incl. CSGs); nationwide institutes for specific themes: Rutgers, Soa Aids Nederland, Pharos; other organisations: Fiom (unwanted pregnancies); healthcare providers

Referrals and the care chain

The plan is to continue our efforts to link prevention and cure. General prevention such as providing information to the public about sexual health is intended to increase levels of knowledge and resilience. When a problem such as an STI occurs, rapid treatment is essential in order to prevent further spread. Therefore, the effect is preventive . The link between prevention and cure and agreement between all the partners is important for proper referrals and the care chain.
There are currently not many options in primary care for offering (preventive) sexual healthcare.

At the CSGs, clients who want an STI test but do not have a high risk profile are increasingly often being referred to the regular care chain or to other specialists such as those treating HIV, dermatologists, gynaecologists and sexologists. It is not clear what happens to these people and to what extent their care needs are met effectively and in good time. The care system often fails to make it possible to refer people quickly and directly (without intervention by the GP) to appropriate secondary care without special agreements between the GGD and the practitioner or insurer. There is therefore a risk of people not receiving proper care, being treated late and of STIs and HIV spreading further.

Approach:

- effective use of the care chain through preventive consultations in primary care
- direct referrals arranged from the CSGs to secondary or tertiary care this means that agreements will be made between care providers (and insurers) for referrals between the supplementary and regular care pathways
- the care partners will make agreements about streamlining the care chain so that patients are referred and treated appropriately this requires organisation and cooperation in the care chain and guidelines to ensure it is done

Parties involved:
National government: GGD; nationwide parties: GGD-GHOR Nederland; primary, secondary and tertiary care providers; care insurers.

Linking prevention and cure

Reimbursement for prevention
The Netherlands has a dichotomous care system with the regular healthcare for individuals on the one hand, and public health on the other. These two domains are not separate and there is overlap between them in practice.
The Dutch insurance system, however, takes no account of this overlap, gets in the way of effective interventions being implemented as well as they should be, and only reimburses preventive interventions and resources in exceptional cases. As regards sexual health, there is a demand for reimbursement e.g. for offering PrEP to HIV-negative risk groups, STI screening in asymptomatic men who have sex with men, individual preventive coaching to prevent sex-related problems or for offering preventive long-term contraception to vulnerable women and girls.

Increased effort to use existing preventive interventions
There are numerous accredited programmes and interventions for prevention that are that have been included in the RIVM-CGL (Healthy Living Centre) database. The use of interventions can be improved. That will be discussed in greater detail in this plan.

Approach:

- Changes to the existing care system to achieve optimum implementation of public health and curative care (prevention and cure) are high on the priority list of the national authorities
- Research into reimbursement for preventive interventions at the individual level within the insured care packages this requires cooperation by the GGD and local authorities for starting talks proactively with the insurers in order to discuss the benefits of reimbursing preventive measures
- Accelerated introduction of long-term evidence-based prevention initiatives/interventions relating to sexual health

Parties involved:
National government: VWS, local authorities (VNG), RIVM, GGD (incl. CSGs); nationwide parties: HIV Association; nationwide institutes for particular themes: Rutgers, Soa Aids Nederland; scientific and professional associations: NHG (SeksHAG), NVHB, NVVS, NVDV, NVIB; primary, secondary and tertiary care providers.

4 Surveillance of STIs and HIV and monitoring sexual health

4.1 The importance of surveillance and monitoring

Surveillance and monitoring provide insights into the number of infections and problems related to sexual health, including STIs and HIV. Monitoring the implementation of recognised interventions is important in preventing unwanted pregnancies and sexual violence. Surveillance and monitoring are about the picture of the situation at a given moment, trends over the course of time and within specific populations, as well as the impact and degree of implementation of recognised and other interventions. The latter is above all also important for preventing unwanted pregnancies and sexual violence. This provides evidence-based foundations for prevention, control and policy. We use a variety of data sources in surveillance and monitoring.
Appendix 1 gives an overview of the primary sources for STI/HIV surveillance and for the monitoring of sexual health in the Netherlands.

4.2 How is it set up in the Netherlands?

STI surveillance

A variety of data sources (SOAP; *NIVEL primary healthcare database*; HIV Monitoring Foundation) allow a good picture to be obtained of the people who get themselves tested on their own initiative. These are often people with an elevated risk of sexually transmitted infections.

Compared with other European countries, the Netherlands has a good view of the demographic factors and risk factors because they are part of the surveillance. The annual RIVM STI/HIV report [6]gives an overview of these sources. This data is also used as input for the ECDC's European database.

To allow monitoring the prevalence of STIs in the Netherlands, a random sample is taken from the general population via the lifestyle monitor for chlamydia (Pecan study) and in the current round of the nationwide sero-prevalence study for HIV (Pienter). The previous Pienter round (2006/7) already determined the sero-prevalence figures for HBV, HCV, HSV and chlamydia. A nationwide estimate had previously been made for chlamydia via the chlamydia pilot project and the chlamydia screening implementation (CSI)[7].

[6] RIVM jaarrapport 2017; –

[7] Van den Broek IV, et al. CSI Effectiveness of yearly, register-based screening for chlamydia in the Netherlands: controlled trial with randomised stepped-wedge implementation. BMJ. 2012 Jul 5;345:e4316. doi: 10.1136/bmj.
van Bergen JE, et al. Rationale, design, and results of the first screening round of a comprehensive, register-based, Chlamydia screening implementation programme in the Netherlands. BMC Infect Dis. 2010 Oct 7;10:293. doi: 10.1186/1471-2334-10-293

Monitoring sexual health

Sexual health monitoring has been carried out in the Netherlands by Rutgers in two periodic population studies: the participatory action study 'Seks onder je 25e' [Sex before the age of 25] among young people aged from 12 to 25, in cooperation with Soa Aids Nederland and the 'Seksuele gezondheid in Nederland' [Sexual health in the Netherlands] study among adults. In 2012, the Ministry of Health, Welfare and Sport (VWS) began harmonising the monitoring done by various institutes for specific themes as part of its lifestyle policy[8]. To do that, existing monitoring activities were included in the Lifestyle Monitor (LSM) A number of core questions about sexual health are included annually in the health survey held by Statistics Netherlands (the 'LSM core'). In addition, an additional module is held once every four years (LSM-A) in which sexual health is surveyed in greater depth among the Dutch population.

Data collection rounds were held in 2016 for the LSM-A (additional module) on sexual health and for 'Sex before the age of 25'. This means that there is a monitoring instrument for young people and adults aged from 12 to 80 in which wide-ranging questions are asked about sexual health via a large, non-selected, representative, random sample from the Municipal Population Register (the 'GBA'). Adolescents aged 12 to 16 are brought on board via their schools. This sample is used for creating a detailed description of sexual health in the Netherlands.

On top of that, Rutgers uses various existing sets of care records associated with sexological assistance, inter alia to get a picture of the scope of treatment of sexual dysfunction (e.g. through records of patient contacts in primary care and through sexologists and institutions) and abortion.

Objectives for 2022:

Availability of:

- Up-to-date, reliable figures about STIs, HIV and sexual health in order to reinforce policy for prevention and control.
- Up-to-date, reliable figures about the implementation of recognised interventions in sexuality education, prevention of sexual violence, unwanted pregnancies, STIs and HIV.
- Explanations and the significance of the current figures for STIs, HIV and sexual health.

[8] Landelijke nota gezondheidsbeleid: *https://www.rijksoverheid.nl/documenten/kamerstukken/2011/05/25/aanbieden-landelijke-nota-gezondheidsbeleid*

4.3 The challenges and the approach

The challenges in STI and HIV surveillance

We retain a good picture of the trends in STIs and HIV among high-risk groups, thanks to the data from the Sexual Health Centres (CSG). We do not however know very clearly how often STIs occur among the general population. There is no mandatory notification in the Netherlands for HIV or the majority of STIs to be reported; the exceptions -– notifiable conditions – are acute and chronic hepatitis B and acute hepatitis C. To obtain a picture of the prevalence of STIs, we have to rely on monitoring through GPs (NIVEL primary care records). This currently gives a fairly good idea of the trends in consultations about STIs among the Dutch population. There are, however, limitations in the coding method (there is no specific code for chlamydia; syphilis is not broken down by infectious stage), a lack of epidemiological data about high-risk groups and uncertainty in the estimates for rare STIs (syphilis, HIV and acute HCV in high-risk men who have sex with men [MSM]). Laboratory data is not well recorded with the GPs and the laboratories themselves do not provide standardised data, at any rate certainly not at a national level; moreover, a lot more epidemiological data about at-risk groups is missing here. Other data sources (hospitals, pharmacies) are also hard to use, limited and variable in terms of quality. There is virtually no insight whatsoever into the use and results of home testing kits. There is also no nationwide clinical registration system for hepatitis B and C. Monitoring high-risk groups (via the Sexual Health Centres) therefore has more of a sentinel function, with representativeness and continuity of the data being susceptible to changes in how triage is done. Gonococcal resistance is monitored at the Sexual Health Centres through the GRAS project. However, there is currently no resistance monitoring for gonorrhoea via GPs where a population with a lower than average risk is seen.

A summary of the challenges:

- Maintaining good nationwide surveillance and monitoring (STIs, HIV and development of resistance) for instance so that the effects of STI and HIV interventions can be quantified.
- Further developing sentinel monitoring in high-risk groups, based on the results of regularly repeated population surveys (combined with the sexual health monitoring surveys listed below).
- Implementing a clinical HBV/HCV registration system.
- Setting up a monitoring system for online testing.
- Optimising early signalling and partner notification.
- Real-time monitoring and early signalling.
- Optimising the monitoring of resistance in gonococci.

Approach:

- Additional cross-sectional studies are carried out periodically in order to maintain a clear picture of STI prevalence among the general population and high-risk groups. These fit in with existing surveys such as Pienter and the more in-depth module on sexual health from the lifestyle monitoring survey (LSM-A).
- Monitoring high-risk groups remains important. The monitoring system needs to be backed up with a flexible funding structure so that current insights into the occurrence of STI among high-risk groups can be maintained.
- In addition, introducing or reintroducing notifiable status for a number of STIs could be considered so that reporting infections and thus tracking the contacts is placed on a legal footing. A flow diagram has been developed to help weigh these issues up. Notifiable status could be extended to include chronic hepatitis C, HIV, syphilis and gonorrhoea and LGV; as is done in the majority of other western European countries.
- Clinical registration systems such as that for HIV should also be set up for hepatitis B and hepatitis C so that a cascade of care can also be determined for these infections. This gives a picture of where gains can be made in terms of prevention and detection, making it possible to work out whether the specific WHO objectives for HIV and hepatitis B and C can be achieved. The national hepatitis plan has defined the framework for this. The current pilots must be implemented in practice and financed in the longer term.
- Because of the increasing availability and use of tests that can be purchased online, we would like to investigate the options for a system that monitors the tests provided online. Data from laboratory information systems and insurers could also be used more.
- Monitoring systems could be modified in a way that allows real-time monitoring and could be linked to an early warning mechanism (investigating clusters and outbreaks) and to a partner notification and tracing system, for example by using real-time monitoring to identify and penetrate networks by intensifying partner notification (see also Chapter 6, 'STI prevention').
- To get a picture of the sensitivity pattern of gonococci diagnosed by GPs, a pilot will be carried out in the coming year looking at the feasibility of this in GP practices.

Parties involved:
National government: RIVM-CIb, GGD (incl. CSGs); nationwide parties: NIVEL, SHM, MMLs; national institutes for specific themes: Rutgers and Soa Aids Nederland.

Challenges in monitoring sexual health

This National Action Plan lists four topics for which periodic monitoring is important: sexual behaviour, sexuality education, sexual violence and unwanted pregnancy, contraception and abortion. Sexual behaviour and unwanted pregnancy, contraception and abortion are included sufficiently in the existing surveys (LSM-A and 'Sex before the age of 25') and the National Abortion Register. Nevertheless, as result of the sexual health survey among LHBT people, more in-depth monitoring among MSM looking at specific high-risk behaviour in this group was deemed desirable.
There is no long-term funding structure for carrying out 'Sex before the age of 25' (including young people with physical or intellectual disabilities), neither is there a link to this survey from a laboratory component for measuring the prevalence of STIs among the general population. Carrying out the LMS-A and 'Sex before the age of 25' surveys in parallel in 2016 added had a significant added value. It yielded an evidence-based foundation for policy and control (at the national and municipal levels) and creates a basis for institutes that focus on specific themes to develop and implement interventions jointly with GGD. In addition, it would be desirable to measure the effects periodically. Good results have been achieved in the past with this, using booster funds from ZonMW programmes (Netherlands Organisation for Health Research and Development).
Various nationwide institutes for specific themes are making efforts to implement interventions in education and to reduce sexual violence. There are no monitoring instruments for this that can be used to focus on improving the degree of implementation.

The care registries that Rutgers and others use for determining their strategy and activities (such as the new or continued development of implementations) are not set up for this objective. Any link between the data from these registries and the results of effect measurements will therefore be fragile.

A summary of the challenges:
Implementation of a structural four-yearly survey of sexual health among people aged 12 to 80 in order to get a broad update on sexual health, with sufficient capabilities for describing relevant subgroups such as LHBT and people from immigrant backgrounds.
Monitoring and implementation of recognised sexuality education interventions in the education sector and for preventing sexual violence.
Carrying out evaluations of the effects of recognised interventions in the education sector and for preventing sexual violence.

Approach:

- We rely on the four-yearly in-depth module of the LSM for information about sexual behaviour and sexual violence. More up-to-date figures are needed. We would like to explore the options for extracting the data from new or existing research, with a yearly figure for sexual violence and unacceptable sexual behaviour in the Netherlands.
- Based on the monitoring data, reports produced for various high-risk groups and target groups: young people, LHBT people and those with immigrant backgrounds. This latter group is difficult to reach in any national survey. A specific monitoring instrument is therefore advisable.
- We would like to look at what is needed and what is possible for a national monitoring system for looking at the degree of implementation of recognised interventions. This allows a picture to be obtained of the use of interventions in sexuality education in the education sector and interventions for the prevention of sexual violence and unacceptable sexual behaviour. It is then for instance possible to determine which school uses which interventions; it is important to have sufficient regional cover here (see also Chapter 5).
- We will examine the options for long-term funding of more regular effect evaluations.

Parties involved:
National government: RIVM-CIb, GGD (incl. CSGs); nationwide parties: CBS, ZonMW, NIVEL, LOPS; national institutes for specific themes: Rutgers, Soa Aids Nederland; care providers: abortion clinics.

5 The basis: sexuality education and development

Healthy and safe sexual development are the foundations for pleasant and healthy sexuality. To achieve and maintain that, information and parenting support are required, along with education, prevention, and sometimes signalling and care. Sexuality education allows children and young people to make responsible choices about relationships and sexuality. It lets them develop their own sexual identity and sexual lifestyle, learning to shape their own sexuality safely, comfortably and appropriately within respectful relationships between equals. Young people very much need to know whether their own physical and sexual development is part of the normal development patterns for young people. In addition, support for young people during their sexual development is important if sexual risks such as unacceptable sexual behaviour, STI/HIV, unwanted pregnancies and sexual problems are to be prevented.

A prevention policy appropriate for the phase of life is an important precondition for achieving a healthy sexual life without diseases, limitations or compulsion. This demands an efficient system of education, awareness, signalling and advice. In addition, high-risk groups and people with limited health skills should get targeted support to let them make the correct choices and find the help they need.

5.1 Sexual health among young people

The sexual health of young people in the Netherlands has recently been studied. A number of the figures from 'Sex before the age of 25' paint a somewhat more positive picture than in 2012[9]. Young people are starting to have sex later, protecting themselves against pregnancy better the first time, unacceptable sexual behaviour is down somewhat and the vast majority of young people enjoy sex. There are concerns, though:

- Unacceptable sexual behaviour and enforced sex are still commonplace among young people. 11% of girls and 2% of boys have at some time been forced to do or permit something sexual against their will.
- 6% of boys and 14% of girls have had at least one unpleasant experience with sexting.
- Use of condoms with the most recent partner is down. In casual contacts, 75% do not always use a condom.
- Those who start young protect themselves less well against STIs or pregnancy and have more experiences involving enforced sex.

[9] Graaf, H. de, Nikkelen, S., Van den Borne, M., Twisk, D. and Meijer, S. Seks onder je 25e: Seksuele gezondheid van jongeren in Nederland anno 2017 (Sex before the age of 25: Sexual health in young people in the Netherlands in 2017). Delft: Eburon

5.2 How is it set up in the Netherlands?

Broad sexuality education

In addition to the parents, the education system has a key role in sexuality education and the upbringing of children and young people. Sexuality education has been a mandatory element in education since the end of 2012, with attention being paid to sexuality and sexual diversity. This is defined inter alia in the core objectives for primary, secondary and special education[10]. To facilitate this, the Ministry of Health, Welfare and Sport is investing in information and education by subsidising institutes that work in specific areas. In addition, online channels have been set up for young people, such as sense.info and jouwggd.nl. One and a half million young people visit sense.info every year, giving the online information about sexuality an average score of 8 out of 10 in 2012.

Support for a healthy sexual development

There are biological, psychosocial and cultural aspects associated with sexual development. That development can be supported to a significant extent at home and at school through sexual education and upbringing. The youth health care services (JGZ) follow and support parents and children in a healthy sexual development (inter alia through the youth monitoring survey), basing their work on the JGZ guideline for sexual development up to the age of 19. The CJGs (youth and family centres) provide support for parents in questions about sexual upbringing. Since 2013, there have been additional contact moments in the JGZ[11] offering an opportunity to bring sexual health to the fore for teenagers. GPs and Sense at the GGD play a role in signalling sexual issues and supporting a healthy sexual development.
As part of their health promoting task, the GGD provide support for schools and teachers. This often uses a 'Healthy School Plan'.

Goals:

- Sexuality education is assured in the longer term in all types of education.
- More and more children and young people, including vulnerable groups, are able to find reliable information online and elsewhere about sexual health in the broadest sense, and receive evidence-based sexuality education that is appropriate for their phase of development.
- This is how we are working on cutting down on occurrences of STI and HIV, unacceptable sexual behaviour and unwanted pregnancies and encouraging respectful, safe and healthy behaviour.

5.3 The challenges and the approach

The Education Inspectorate noted in 2016 that structural assurance of sexuality education is lagging behind and needs improving in terms of quality[12]. Schools believe that sexuality education is important, but they are free to decide for themselves how to fulfil the core objectives. The educational offerings are fragmented, poorly targeted, dependent on the individual teacher and insufficiently assured in a continuous educational line, school policy or school curriculum. Existing recognised[13] classroom materials are not used structurally in all schools, by any means. It is estimated that 30% of schools in primary education use the classroom teaching package 'Kriebels in je buik' and 40% of schools in secondary education use 'Lang Leve de Liefde'. Sexuality education is only provided to a limited extent in vocational training and there is little or no assurance. There are still no properly substantiated classroom materials for the various stages of special education. Because of the low priority and limited capacity, the GGD do not provide optimum support for schools in all regions. The Healthy Schools long-term plan has not prioritised the theme. Teachers often feel competent enough, though find it an uncomfortable subject to tackle. However, they make little use of the support that is available. Young people believe that they do not get enough lessons about themes such as sexual wishes and limits, pleasant sex, sexual diversity and sex in the media. They give sexuality education an average score of 5.8 out of 10. Young people are not yet familiar enough with Sense.

[10] Core objectives for sexuality and sexual diversity in 2012: *https://www.rijksoverheid.nl/documenten/besluiten/2012/09/28/besluit-houdende-wijziging-van-de-kerndoelen-onderwijs-op-het-gebied-van-seksuele-diversiteit*

[11] Expanding the contact moments for young people with JGZ, decision taken by VWS in 2013: *https://www.ggdghorkennisnet.nl/?file=11940&m=1360756144&action=file.download*

[12] Education Inspectorate (2016). *Omgaan met seksualiteit en seksuele diversiteit. Een beschrijving van het onderwijsaanbod van scholen [Dealing with sexuality and sexual diversity. A description of the educational offerings at schools]*. The Hague: Ministry of Education, Culture and Science

[13] Recognition via RIVM/CGL

Although there is a structure for supporting a healthy sexual development and sexuality education, improvements can still be made in the scope, quality and assurance of sexuality education and prevention. The better this is arranged, the more costs can be saved in treating sexually related consequences and problems.

A summary of the challenges:
- Improving the support for a healthy and positive sexual development.
- Scaling up and improving the quality of sexuality education.
- More use of interventions in all educational settings that are theoretically well-substantiated or effective.
- Teachers, care professionals and parents have access to support for their competencies in sexuality education.
- For groups that run a greater risk and/or have lower levels of health skills, a continuous educational line for sexuality education is available, complemented by more intensive programmes.
- Monitoring the use and effect of interventions in sexuality education.

Improving the support for healthy sexual development

Children and young people are entitled to healthy sexual development, from a positive perspective. Young people often have nagging questions about what they are experiencing (or indeed not yet experiencing) about sexuality, their sexual preferences or the way in which their bodies develop are normal compared with what other young people are going through. This is a major determining factor for the information and support they need.
A large number of parties are involved in supporting healthy sexual development, sexuality education and sexual upbringing. It is important that those providing the facilities are aware of each other and that experiences are shared. GGD play a key role, often involving various departments and perspectives (youth health care, sexual health centres, health promotion).
The CJGs (youth and family centres) also have a role.
By no means all young people know of the supporting facility Sense. There are furthermore major regional differences in the degree to which the various parties cooperate

Approach:
- Specific attention is required for promotion and PR of sense.info and Sense assistance via educational and youth channels.
- Specific attention is required for the results of exchange and cooperation in prevention and sexual healthcare within and between GGD.
- Coherent information associated with parenting/ upbringing in various national channels.

Parties involved:
National government: VWS, RIVM-CIb, GGD; national parties: CJG; national institutes for specific themes: Soa Aids Nederland, Rutgers.

Scaling up and improving the quality of sexuality education

Not all pupils get complete sexual and relationship education at school that allows them (when older) to make sexually healthy and safe choices in respectful relationships between equals. Specific attention is required to support young people and adults with limited health skills to let them make the correct choices and find the help they need.

Approach:
- The strategy for scaling up sexuality education and encouraging the use of recognised interventions should be recalibrated in dialogue with the appropriate educational partners, in order to achieve a greater reach and guarantee improved quality in education.
- The core objectives must be made concrete (for vocational education as well) and specified in a sexuality education curriculum.
- Acquire more insights into successful strategies for adopting and implementing sexuality education in the education sector, inter alia through nationwide promotional campaigns such as 'Week van de Lentekriebels' and 'Week van de liefde'.
- Substantial improvement of the quality of sexuality education in schools. Both pupils and the Education Inspectorate must play a role in the evaluation.
- Advice and support must be embedded in the longer term in school policy, whether or not this is within the 'Healthy School' structure.
- The Inspectorate carries out structural quality checks on sexuality education.

Parties involved:
National government: VWS, OCW, RIVM-CGL, RIVM-CIb, GGD (incl. CSG, health promotion departments, youth healthcare), education councils, Education Inspectorate; other education parties: Stichting Leerplan Ontwikkeling, school governors; national institutes for specific themes: Rutgers, Soa Aids Nederland.

Support for teachers, care professionals and parents

The theme of sexuality education is insufficiently covered, if at all, in the refresher courses and further training for professionals in the education and care sectors. There are as yet no qualification requirements for specific skills for giving sexuality education. Teachers, care professionals and parents often have difficulty broaching the subject. This can be strengthened further if the scheme is made more of a component of a professionalisation process.

Approach:

- Formulate core competencies and quality frameworks for sexuality education for professionals in corporation with the training courses in question.
- Provide better assurance of sexuality education in the training of professionals, including support for parents in bringing up their children. Use refresher courses and extra training, e-learning modules, master classes and study days to create an optimum range of supporting material for teachers/lecturers in sexuality education.
- Sexuality education is explicitly included in lerarenregister.nl, which will encourage teachers to work on their skills.
- Where secondary vocational schools are not (or not yet) able to provide sexuality education themselves, a nationwide pool of guest lessons should be provided or arranged for the secondary vocational sector to give such education a 'boost' (given for instance by sexual health consultants or other high-quality providers).

Parties involved:
National government: GGD; nationwide parties: CJG, education councils, nationwide institutes for specific themes: Soa Aids Nederland, Rutgers; scientific and professional organisations: NVVS (sexology), harmonisation bodies: vocational teacher training, educational faculty directors, NIBI (biology); those carrying out work via a nationwide pool.

More intensive support for higher risk groups and/or those with a lower level of health skills

No recognised interventions are currently available for people with literacy problems and a low level of education (special, further special and level 1 secondary vocational education). The majority of interventions are badly outdated and there are some things for which there is a lack of good educational material. Support for sexuality education is also minimal in care institutions, but extra support is desirable.

Approach:

- Develop and provide more suitable and recognised interventions for special and further special education and levels 1 and 2 of secondary vocational education; these can be put into practice by e.g. the Healthy School approach.
- Train sufficient professionals so that youth healthcare can support young people in healthy sexual development.
- Encourage the use and appreciation of sense.info by young people with low levels of literacy or education.

Parties involved:
National government: GGD, the Health and Youth Care Inspectorate (IGJ, currently being set up), special and further special education, the MBO Raad (vocational education council); national parties: Jeugdzorg Nederland (youth care in the Netherlands), CJG, education councils, LecSo (national expertise centre for special education), nationwide institutes for specific themes: Soa Aids Nederland, Rutgers.

More knowledge about the use and effects of interventions

There are no figures about the use of recognised interventions in all educational settings. It is important to get a clear picture of this. The Inspectorate has noted that schools use a wide variety of educational material that by no means always has good theoretical underpinnings. In addition, it is often provided as an aside and the teachers make their own choices, meaning there is a risk that certain subjects will not be covered. There are indications that the quality of interventions for promoting sexual health and their degree of implementation are limited.

Approach:

- Setting up monitoring systems for tracking (long-term) use of recognised interventions in the education sector (all types of education) and youth care.
- Initiating new or additional good quality research (via 'Sex before the age of 25') into how pupils appreciate sexuality education. Monitoring that all relevant subjects for sexuality education are tackled in education.
- Obtaining a better picture of the impact and results of sexuality education for the education sector (teachers, schools and pupils).

Parties involved:
National government: RIVM-CGL (Healthy Living Centre of the National Institute for Public Health and the Environment); GGD, Education Inspectorate; nationwide institutes for specific themes: Rutgers, Soa Aids Nederland.

6
Prevention, detection and treatment of STIs

(Please refer to Chapter 7 for the prevention, detection and treatment of HIV)

6.1 Controlling STIs

Major steps have been taken in recent years in combating STIs in the Netherlands. More people are being reached with more information about symptoms, testing and prevention[14]. The number of STI consultations at the CSGs (Sexual Health Centres) rose from 121,000 in 2012 to 143,000 in 2016. The detection rate among members of high-risk groups who visit the CSGs has risen from 15% in 2012 to 18.4% in 2016[15]. Current knowledge about diagnosis and treatment is disseminated widely among professionals[16] and new tools for warning partners have been launched[17].
STIs in the Netherlands are largely found in younger people, men who have sex with men (MSM) and in particular MSM with HIV, and in people who come from areas where STIs are endemic. Longer-term trends in STIs are not only affected by sexual behaviour patterns but also by changes in the pathogens, network effects, technology, demographics, facilities and policy.
Policy with regard to preventing STIs is currently as follows[15]:

- Chlamydia is the most commonly occurring bacterial STI with an estimated 55,000 cases a year and no drop in recent years, despite test guidelines and effective preventive measures such as using condoms. Chlamydia is diagnosed most often in young heterosexuals.
- Syphilis and gonorrhoea occur most frequently in MSM and, after an earlier rise in 2017, have dropped slightly among MSM. Estimated numbers of infections were 1,200 and 14,000 respectively in 2016.
- The number of acute hepatitis B infections is low and stable at around 100 per year; the number of acute hepatitis C infections fell in 2016 to 44.

6.2 How is it set up in the Netherlands?

Detection and treatment of STIs are done both in the regular care lines and at the Sexual Health Centres (CSGs), which provide additional easily accessible care for high-risk groups. The incidence of STIs in the population at large is estimated at around 2%. Two thirds of those cases are found annually at GPs and one third at CSGs[15]. The CSGs can offer a complete package, including good follow-up care (treatment and tracing contacts). Prevention is primarily a task for municipalities via the GGDs (municipal public health services) and CSGs. They are supported by national institutes for specific themes offering interventions, refresher courses and further education for professionals, etc. At the same time, it can be seen that there is an increase in private – largely online – offerings for STI testing and STI care. Home-based testing can provide an easily accessible,

[14] Annual report SANL 2016: increases in visitors to sense.info, soa.nl and mantotman.nl

[15] RIVM Annual Report, STI including HIV in the Netherlands in 2016; *http://www.rivm.nl/Documenten_en_publicaties/Wetenschappelijk/Rapporten/2017/Juni/Sexually_transmitted_infections_including_HIV_in_the_Netherlands_in_2016*

[16] NHG congress about sexual health

[17] *https://partnerwaarschuwing.nl/*

relatively affordable option for people who are not eligible for the additional care provided in the CSGs.

The professional field wants to use this action plan to align itself with the high ambitions set as the longer-term objective by the WHO: ending STIs as a significant public health issue. For the coming period, we have translated that target into the following as the desired impact in the Netherlands:

Goals for 2022:

- Development of an effective strategy for reducing the burden of chlamydia.
- Halving the number of new syphilis infections to less than 500 per year (2016: 1,000:
- Halving the number of new gonorrhoea infections (2016: 10,000).
- Reducing the number of acute HBV and HCV infections to zero.
- Broad acceptance within society of sexual diversity and chronic STIs.

6.3 The challenges and the approach

As show in the most recent 'Sex before the age of 25' survey, knowledge about STIs has fallen. Over 40% of young people do not use a condom in a one-night stand[18]. Functionally illiterate people and those with lower levels of health skills are not being reached sufficiently with information about STIs and the facilities for them. Primary, selective prevention of STIs through proper information about safe sex (including the use of condoms), regular testing and HBV vaccination for high-risk groups are – and remain – essential. Getting and retaining a clear picture of hidden groups has become more difficult because of falling outreach capacity. Stricter selection at Sexual Health Centres leads to more referrals to GPs. Extrapolation suggests that the number of STI consultations at GPs fell, however, from 294,000 in 2013 to 266,000 in 201518. New private providers of STI tests do not always turn out to be reliable[19]. The test guidelines are not followed in practice as well as they could be. Partner notification is often not implemented fully. There is broad acceptance within society in the Netherlands of sexual diversity and chronic STIs and HIV. Stigmatisation and discrimination do however particularly affect people with HIV, but also play a part in other STIs and against people with a particular sexual preference or gender identity. This can result in people not asking for help in time when sexual issues are involved, getting themselves tested too late for STIs and HIV, and not looking for the appropriate care in time. There is growing awareness that people with low levels of health skills (low socioeconomic status, people with immigrant backgrounds, mild intellectual disabilities) need a specific approach. Innovative and careful use of data makes it possible to zoom in closer on high-risk networks and clusters so that the transmission chains can be broken there. There are positive examples of successful condom campaigns abroad. Using PrEP (pre-exposure prophylaxis) for preventing HIV means that high-risk groups are also being tested more often for other STIs. It seems possible to tempt private suppliers to meet the criteria for offering reliable testing. New treatment options for hepatitis C are making it possible to aim for elimination. Increasingly close cooperation between local and nationwide parties are improving the efficiency and effectiveness. Combating STIs is a topic that is discussed more and more often in local politics.
HPV vaccination is currently only given to girls in the Netherlands, in order to prevent cervical cancer. Depending on the vaccine, however, vaccination against HPV also has the potential to reduce the burden of the disease among men and MSM in particular (genital warts, cancer of the anus and penis). It is anticipated that the Health Council of the Netherlands will issue advice in 2018 about any expansion of the HPV vaccination scheme to all adolescents.

A summary of the challenges:

- Prevention, reducing high-risk behaviour
  - Strengthening sexuality education, including combating discrimination and stigmatisation (as was already mentioned in Chapter 6)
  - Increasing the accessibility and use of high-quality information about STIs that is suitable for all target groups
  - Increasing the use of condoms
  - Improving the HBV vaccination coverage in high-risk groups, a wide roll-out of HCV treatment within high-risk groups
- Improvement of the detection and testing policy
  - Improving how well hidden groups are reached by using innovative outreach methods
  - Increasing the number of actions taken at high-risk hotspots
  - Testing and treatment in line with the test policy
  - Increasing the number of private testing providers who meet the national criteria (Chapter 4)
  - Improving the results of partner notification and partner management (see also Chapter 4)

[18] *http://seksonderje25e.nl/files/uploads/Seks%20onder%2025%202017%20samenvatting%20(2).pdf*

[19] *http://www.rivm.nl/Documenten_en_publicaties/Wetenschappelijk/Rapporten/2016/september/Evaluatie_van_het_aanbod_van_online_aanbieders_van_soa_zelftesten_in_Nederland*

Preventing high-risk behaviour

Around 200,000 young people start becoming sexually active every year. It is important that they get the knowledge and skills to protect themselves against HIV and STIs. This should preferably be offered as an integral whole with information about contraception and preventing unacceptable sexual conduct, all in the context of aiming for positive sexual health (see also Chapter 5). Good information also increased social acceptance of diversity and counters stigmatisation. Information about STIs and the therapeutic possibilities can help lower the stigma and thereby reduce infections and morbidity (see Chapter 7 for the approach).
There are also other determinants of high-risk behaviour, such as the use of alcohol and drugs during sexual contacts. In order to let the public take their own responsibility for protection against STIs, they must be able to rely on up-to-date and reliable information about STIs, throughout the whole spectrum of behaviour options (prevention, testing, treatment, warning partners). A specific point of attention is that this information must make clear how serious the STI is, now that the threat of HIV (for instance) is seen as lower.

With the rise of effective biomedical prevention strategies for HIV (TasP, PrEP – see Chapter 7) and the emphasis on the importance of testing for STIs and treating them, there is a risk that the use of condoms is being insufficiently promoted and supported. In particular, choosing the correct size seems to be essential for effective use and enjoyment in practice. A current condom message and condom campaign offers the opportunity to locally strengthen awareness about safe sex and the motivation to stick to it.

Primary prevention (such as HBV vaccination) targeting high-risk groups is relatively successful, but demands additional efforts when extending the cover for instance to MSM and sex workers. Given the concentration of HCV in high-risk networks of MSM (with HIV), it is possible to use targeted and effective treatment to break the transmission chain (the test and treat approach). The principle here is avoiding re-infection. Vaccination against HPV may possibly also reduce the burden of the disease among young men and in particular MSM (genital warts, cancer of the anus and penis). An important point to pay attention to here is the backing given to wider HPV vaccination and an effective communication strategy. This requires insights into the determinants of behaviour patterns, such as knowledge, attitudes and intentions. What assumptions are made by the target group and their parents? Who takes the decision (the parent or the child) and how is it made? How will people find information about the subject and what questions play a role?

Approach:

- Update and increase the use of STI information on general nationwide websites (e.g. thuisarts.nl), on nationwide specific websites (sense.info, soa.nl, mantotman.nl) and local websites (municipal public health services).
- Develop an effective core message about the seriousness of STIs (other than HIV).
- Strengthen the self-sufficiency of clients by online assistance for risk assessment, advice, test requests, making appointments for counselling, supporting treatment (online STI outpatient clinic)
- Carry on developing innovative methods further for reaching groups, e.g. through wider use of Internet fieldwork.
- Develop a condom campaign and put it into effect.
- Target the use of existing interventions such as 'Lang Leve de Liefde' better in order to deflect negative developments.
- Provide long-term attention in professional training to support a broader implementation of effective interventions for sexuality education, with more attention to promoting the use of condoms.
- Continuation of HBV vaccination in high-risk groups and increased coverage.
- Expanding the test-and-treat approach to HCV among MSM (known as 'NoMoreC')
- Increase the use of information about HCV prevention among MSM.
- Investigation of the effectiveness and feasibility of HPV vaccination among target groups.

Parties involved:
National government: municipal public health services; national organisations: Rathenau Institute; national institutes for specific themes: Soa Aids Nederland, Rutgers; scientific and professional organisations: NHG (SeksHAG – GPs' advisory group), V&VN (nurses' association), NVIB (infectiology – WASS working group on STIs and sexual health); education sector parties: NSPOH (public and occupational health training); care providers: HIV treatment centres

Improvement of the detection and testing policy

Not all high-risk groups are reached by regular STI facilities or outreach programmes. These are groups that are difficult to reach out to, such as sex workers and MSM who do not identify themselves as homosexuals. Different and innovative strategies are needed for them.

STIs are not evenly distributed throughout the Netherlands but occur in clusters. Syphilis and gonorrhoea infections are for instance concentrated in high-risk networks of MSM. Nationwide real-time data from the Sexual Health Centres offers an opportunity for early warnings of outbreaks in specific groups or regions. Reported differences between ASG (Supplementary Arrangements for Sexual Health) regions in terms of numbers of tests and detection rates can also give information about the need for targeted local actions. Making use of social networks turns out for example to be effective in tracking down hidden chlamydia infections. In addition, an integral approach offers opportunities for improved detection.

Testing for STIs online and via private providers is becoming more popular. It is important that groups who use this should be reached and informed properly about the tests and the quality of what is on offer privately. That offering varies in quality and does not always guarantee and effective approach to STIs.

The detection rate among partners who have been warned is twice as high as that among all those who go to Sexual Health Centres (32% versus 18%)[20]. Partner warnings and partner management are therefore essential for the health of individuals (prevention of complications) and public health (breaking the chain of transmissions). It is known that the providers of online STI testing often do not have proper arrangements for the requisite treatment and tracing of contacts in the event of an infection being found.

Approach:

- Visualisation of STI hotspots, based on surveillance data and additional data to promote local, targeted actions. Development of a framework for ethical use of this data.
- Integral approach: combining case-finding for hepatitis and HIV, preventive consultations and working on hotspots on a local district basis.
- Continuing to develop and extending the reach of Advies.chat.
- Regular testing of the private (online) offerings for STI testing (repeat of the 2016 report).
- Passing on the criteria for self-test offerings to private providers, with reimbursement.
- Improving the insights into private (online) use of self-testing for STIs (see also Chapter 4).
- Increase the use of partnerwaarschuwing.nl (partner notification).
- Increasing the effectiveness of regional cooperation in the chain for partner notification and partner management by strengthening the proactive roles of GPs and HIV consultants in informing, alerting and early diagnosis and partner warnings for STIs (in particular for HIV, syphilis, gonorrhoea, LGV and HCV).

Parties involved:
National government: RIVM (National Institute for Public Health and the Environment), GGDs (municipal public health services); care providers; national institutes for specific themes: Soa Aids Nederland

[20] RIVM jaarrapport 2017; *http://www.rivm.nl/Documenten_en_publicaties/Wetenschappelijk/Rapporten/2017/Juni/Sexually_transmitted_infections_including_HIV_in_the_Netherlands_in_2016*

7 Prevention, detection and treatment of HIV

7.1 People with HIV in care

As of November 2016, there were 19,136 people with HIV in the Netherlands being cared for through one of the 26 HIV treatment centres. According to a model used by SHM (the HIV Monitoring Foundation), that is estimated to be 89% of the people in the Netherlands with HIV. Of those people who are in the care system, 92% had started antiretroviral combination treatments. In 95% of them, the virus had been suppressed to undetectable levels on their last check.
The number of undiagnosed cases of HIV in the Netherlands is currently estimated at 2,800 people. The number of new HIV diagnoses has fallen slowly over recent years. There were still almost 1200 new diagnoses in 2008, whereas 820 new HIV diagnoses were made in 2016, 67% of those among men who have sex with men (MSM). In 2016, 43% of the people with new HIV diagnoses came into the care system too late. The risk of this was higher for heterosexual men, people aged 45 and above and people from South and South-East Asia and sub-Saharan Africa[21]. The current offerings of testing for HIV do not apparently meet the needs of people from certain high-risk groups. It also seems likely that the stigma associated with HIV testing is an inhibitory factor.
It is important for the individual patient to start on medication as quickly as possible, preferably immediately after infection. Targeted and frequent testing are therefore essential in order for the life expectancy of someone who is infected with HIV to be improved by treatment. Viral suppression with HIV treatment has also been seen to reduce the risk of sexual transmission when condoms are not used to a zero or negligible level. Treatment thus also immediately offers protection. This is summarised in the internationally used slogan 'U=U' (Undetectable=Untransmissible).

UNAIDS and the WHO have stated ambitious international objectives for 2020, the '90-90-90' strategy: 90% of people with HIV will be aware of their infection and in the care system; 90% of the people with HIV in the care system will have started HIV treatment; and 90% of the people with HIV who have started HIV treatment will have an undetectable viral load (see earlier WHO goals). In the Netherlands, we have already almost met these objectives in 2017 (89-92-95). We can in fact even aim for at least 95-95-95 by 2022 (the WHO goal for 2030).

[21] ELM Op de Coul, AI van Sighem, K Brinkman, BH van Benthem, ME van der Ende, S Geerlings, P Reiss for the ATHENA national observational HIV cohort. Factors associated with presenting late or with advanced HIV disease in the Netherlands, 1996-2014: results from a national observational cohort. BMJ Open 2016;6:e009688 doi:10.1136/bmjopen-2015-009688.

Objectives for 2022:

- The number of AIDS deaths in the Netherlands will be zero.
- The number of new HIV diagnoses made annually will have been at least halved (2015: 900).
- In the Netherlands, 95% of people with HIV will know their HIV status, 95% of them will be receiving treatment and 95% of them will have an undetectable viral load.
- People with HIV who have a high level of risk will have the best possible protection against HBV and HCV.
- Of the people who have a suppressed viral load, 90% will have a good quality of life, including less stigmatisation and discrimination. Testing for HIV and treatment of HIV will have been normalised.

In addition to the timely tracking down of people with HIV and getting them into the care chain, there are challenges relating to the quality of life with HIV and prevention of HIV. Now that increasing numbers of people are able to live for a long time with an effectively suppressed viral load, more attention should be paid over the coming years to their quality of life. This is not only for combating comorbidity and multiple infections, but also for countering social exclusion and stigmatisation and for promoting their sexual health.
In addition, cases must be detected as quickly as possible, during the acute HIV infection, because the viral load is high during an acute HIV infection and transmission takes place more easily among people who also exhibit high-risk sexual behaviour. A study modelled on the Dutch MSM population has shown that almost three quarters of transmissions take place in the early phase of an infection[22]. Starting antiretroviral therapy shortly after infection can therefore have a significant impact on the HIV epidemic. The various aspects of good HIV care have been formulated by the NVHB (professional group for HIV treatment) in the HIV plan for 2017-2022: "Stappen vooruit in de hiv-preventie en hiv-zorg"[23] (Steps forward in HIV prevention and HIV care), which is aligned with this plan.

7.2 The challenges and the approach

HIV prevention and HIV treatment go hand in hand, but require further reinforcement. We have adopted a policy of primary, selective prevention (sexuality education and use of condoms, test & treat) for preventing infections (hepatitis B vaccination within the National Immunisation Programme and for high-risk groups, screening for pregnant women, screening of blood and organ donations, infection prevention in work and care etc.). In addition we are making efforts to achieve those objectives.

Summary of the challenges:

- Tracing and treating HIV infections in good time
- Tracing and treating acute HIV infections in good time
- Pre-exposure prophylaxis for HIV
- Attention to co-infections in people with HIV
- Quality of life and stigma

Tracing and treating HIV infections (including acute infections) in good time

The falling number of infections means that the need to reach subpopulations and locations with the highest risk of infection (hot spots) is increasing. The package of interventions and care for tracing people this way and setting up help for them must be aligned with their specific requirements.
In addition, even closer cooperation is needed between the various parties in the care sector and elsewhere to trace people who are infected with HIV and guide them into the care system.
With an eye on prevention, two aspects are important for recognising and rapidly treating acute HIV infections. Firstly, an acute infection can be missed because no antibodies have been produced yet in this phase. Secondly, MSM (men who have sex with men) with acute infections are important as the index individuals for mapping out transmission networks. Obtaining a clear picture of such networks can make targeted prevention possible. In British Columbia, real-time changes in transmission networks are being used to implement public health interventions (such as targeted testing e.g. for locations)[24].
Additional attention must be paid in all cases to further spreading of the virus and rapid transition to treatment and encouraging compliance with it. Reducing the viral load prevents further spread and improves the patient's prognosis.

[22] Ratmann O. et al. Science Tr Med 2016; *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4902123/*

[23] *http://nvhb.nl/2017/12/01/hiv-plan-voor-2017-2022-stappen-vooruit-in-hiv-zorg-en-hiv-preventie/*

[24] Poon, A.F. et al. Lancet 2016 *https://www.ncbi.nlm.nih.gov/pubmed/27126490*

Approach:

- Strengthening the early signalling of indicators for HIV infections (or the risk thereof) via GPs and the most relevant disciplines in secondary and tertiary care (together with better access to care and improved adherence to therapy).
- Making sure preventive options are easily available, such as information and advice about safe sex, optimum distribution of condoms, access to PrEP and the care related to that.
- Zooming in on hot spots (clusters of high-risk subgroups, networks and areas) and serving them better. This demands cooperation between various professionals (epidemiologists, data specialists, prevention workers) and the affected communities themselves, as well as demanding the use of new technology and visualisation options.
- Proactively offering tests and making them available, in both clinical and community settings as well as for self-administration and self-testing.
- Tracking down more infections through effective partner notification, with the those providing HIV treatment cooperating with the CSG (Sexual Health Centre) as necessary.
- Immediate treatment after a positive test result, as per the guidelines of the NVHB (professional group for HIV treatment).
- Further improvement of the effectiveness of HIV treatment by using new types of medication that are easier to use and/or have fewer negative side effects.
- Improvement of the accessibility of HIV care, including for patients from immigrant backgrounds and MSM with problematic drug use, by offering culturally aware, contextual forms of support. Every HIV patient who is resident in the Netherlands must be offered the best possible HIV care in order to prevent transmission, even if they are immigrants whose permission to stay is as yet in doubt. Cutbacks in the local assistance facilities (the 'bed-bath-bread' regulation) is threatening to create an untenable situation for these people, seriously hampering therapy compliance and resulting in an increased transmission risk and health risks for the individual.
- Quality monitoring and certification of HIV treatment centres

Parties involved:
National government: RIVM (National Institute for Public Health and the Environment), municipal public health services (CSGs); nationwide organisations: HIV Association, self-help organisations, local communities; care providers: those providing HIV treatment and offering consultations, GPs; scientific and professional associations: NVIB (infectiology – WASS working group on STIs and sexual health), NVHB, NHG (SeksHAG – GPs' advisory group), V&VN (nurses, specifically HIV consultants); national institutes for specific themes: Soa Aids Nederland; health insurers; informal care initiatives (for approaching the hotspots).

Timely tracing and treating of acute HIV infections

Approach:

- Implementation of a recognition algorithm for symptoms of acute HIV infection among MSM with high-risk behaviour patterns (operational since 2015 in the Public Health Service of Amsterdam / H-TEAM).
- Rollout of a nationwide campaign to improve recognition of acute HIV.
- Obtaining a clear picture of transmission networks with phylogenetic analysis.

Parties involved:
National government: RIVM (National Institute for Public Health and the Environment), municipal public health services (CSGs); nationwide organisations: HIV Association, self-help organisations, local communities; care providers: GPs, those providing HIV treatment and offering consultations; scientific and professional associations: NVHB, V&VN (specifically HIV consultants), NHG (SeksHAG).

Pre-exposure prophylaxis for HIV

The most recent major breakthrough in preventing HIV infections is prophylactic use of HIV medications by HIV-negative high-risk groups (such as MSM and transgenders). This is called 'pre-exposure prophylaxis' (PrEP). PrEP provides a high degree of protection against HIV infection if taken consistently. A precondition is that people must be free from HIV before starting to use PrEP and must get themselves regularly tested while using it for STIs, HIV and potential side effects of PrEP.
PrEP is not currently reimbursed by health insurers. As a result, people who want to use PrEP are using informal channels (abroad, the Internet) to obtain generic PrEP medication that is less expensive. One point of concern

is that these people are not getting the correct care associated with PrEP use (regular testing for HIV and other STIs as well as renal function tests).

Approach:
- Implementation of care (at the GP and/or municipal public health services) for PrEP use (particularly regular testing for STIs and renal function), whether regulated or not.
- Offering PrEP to seronegative steady partners of people recently diagnosed with HIV.

Parties involved:
National government: RIVM, municipal public health services; scientific and professional organisations: NVHB, V&VN (specifically HIV consultants), NHG (SeksHAG), NVIB (WASS); care providers: those providing HIV treatment and consultations, GPs.
Institutes for specific themes: Soa Aids Nederland.

Co-infections

Co-infections in people who are infected with HIV require specific attention, both because they can speed up the progression of the disease and because the transmission of HIV and other STIs can be promoted by co-infections. This is particularly the case for co-infections with HBV and HCV (7% of HIV patients in care in 2016 had chronic hepatitis B virus; 6% had chronic and 2% acute hepatitis C virus). People with chronic HCV infection are eligible in the Netherlands nowadays for treatment with direct-acting antiretrovirals (DAAs), which have fewer side effects and shorter duration. Using these is important for preventing transmission in high-risk groups such as MSM with HIV. Unfortunately, these medicines are not yet licensed for treatment of acute HCV. It is estimated that 28% of all HIV-positive individuals have never been exposed to HBV or have not been successfully vaccinated and continue to be at risk of co-infection with HBV. The way viral hepatitis B and C are being tackled is described in the national hepatitis plan of 2016, "Meer dan opsporen" [More than detection][25]. In addition, HIV infections are common among people from countries where tuberculosis is endemic. Simultaneous testing for tuberculosis and HIV is therefore important[26].

Approach:
- Aiming for immunisation against HBV for all MSM and other high-risk groups with HIV through an intensive vaccination programme for those who have not yet built up any effective protection.
- Improving the repeated testing for HCV among high-risk MSM and treating any infections found as quickly as possible.
- Aiming for an integrated approach to STIs (including HBV and HCV), TBC and HIV using mixed preventive methods (condom, PEP, PrEP – including good information about PrEP among the target group – and PrEP-related care), and treatment as prevention (TasP).
- Ensure proper registration of co-infections (see Chapter 4).

Parties involved:
National government: VWS (Ministry of Health, Welfare and Sport), RIVM, municipal public health services; scientific and professional organisations: NVHB, NHG (SeksHAG); care providers: those providing HIV treatment, GPs; national institutes for specific themes: Soa Aids Nederland, KNCV (for the tuberculosis fund).

Quality of life and stigma

Life expectancy among people for whom the diagnosis of HIV is made in good time and for whom combination therapy has been started is virtually the same in the Netherlands as for people who do not have HIV. The state of health among these people is mostly good, although people with HIV do get chronic comorbidity that is unrelated to HIV at a younger age.
A study among 650 people with HIV has shown that all of them have at times had negative reactions to the fact that they have HIV. The rejection reactions and the fear of it have a major impact on the psychological well-being of many people with HIV.
There has been a great deal of promising research in recent years into the prevention, diagnosis and treatment of HIV infections This is having major consequences for what we think about the transmission of HIV, living with HIV and setting up the care (including care for older people with HIV).

[25] *http://www.rivm.nl/Documenten_en_publicaties/Wetenschappelijk/Wetenschappelijke_artikelen/2017/Februari/Nationaal_plan_tuberculosebestrijding_2016_2020*

[26] *http://www.rivm.nl/Documenten_en_publicaties/Algemeen_Actueel/Nieuwsberichten/2016/Nationaal_hepatitisplan_een_strategie_voor_actie*

Approach:

- Activities focusing on society that counteract the exclusion, stigmatisation and isolation and that encourage participation in society and in the labour market by people with HIV (and other infectious diseases such as HBV and HCV). Being even more careful about a non-stigmatising tone in the information provided about HIV and taking greater account in the primary, selective prevention of the effect it has on secondary and tertiary prevention.
- Activities focusing on people with HIV for developing longer-term perspectives in terms of self-image, intimacy and sexuality (gender diversity) and social participation. Contact with others in the same situation and peer support are extremely important here, particularly among migrants. Facilitation and financial support are required.
- Making the quality of life and the quality of HIV care quantifiable by determining the effect of measures taken for reducing stigma and discrimination, using validated value-based healthcare questionnaires.

Parties involved:
National government: VWS, OCW (Ministry of Education, Culture and Science), RIVM, municipal public health services; scientific and professional organisations: NVHB, V&VN (specifically HIV consultants); care providers: those providing HIV treatment and consultations, GPs; nationwide institutes for specific themes: Soa Aids Nederland, HIV Association; interest groups.

Implementation

Implementation of the aims and intentions stated above can be encouraged by working with regional care standards. The key elements in this new concept are:

- a regional or local analysis of the problem that is broadly backed by the partners in the care chain, for instance in the form of a cascade of care for HIV that makes clear where the challenges are;
- a broadly-backed agreement about the local and regional goals that are to be jointly achieved;
- good agreement between the partners in the care chain about the optimum local and regional application of existing guidelines and the optimum organisation of the collaborative network.

8 Preventing unwanted pregnancies

8.1 Current status of contraception and abortion

Some form of contraception is used by 63% of all women in the Netherlands aged between 18 and 49. 30% use the pill (or a combination of the pill and condoms), 10% use condoms, 17% use an IUD and 5% use other forms of contraception. Of the women who do not use contraception, 42% have a good reason: they do not have sex, they are pregnant or they want to become pregnant. The other women are running an elevated risk of an unplanned pregnancy because they are not using contraception, they do have sex and they are fertile. Women who are running a risk of an unplanned pregnancy (8%[27]) are in particular those with a low level of education, those who start young, and women from Surinam, the Antilles and sub-Saharan Africa[28]. Other groups that are vulnerable to unplanned pregnancies are refugees and migrants. They have limited access to information and to contraceptives. Women whose socioeconomic status is low, women who have psychological problems and women who are addicts or have mild mental disabilities also turn out to be vulnerable groups in terms of unwanted pregnancy. Getting them the right information is also a greater challenge, along with choosing an appropriate form of contraception and using it properly.

Abortion figures in the Netherlands show that about one third of women who have pregnancies terminated were on the pill, one third used condoms and one third did not use contraception. The abortion figure has fluctuated for a number of years at around 8.6 per 1000 women aged 15-45. This figure represents approximately 27,000 per year[29]. Approximately one third of these terminations are not the first abortion.

8.2 How is it set up in the Netherlands?

Contraception

Contraception is covered in the basic health insurance up to age 21; from 18 onwards, young people generally end up paying for it themselves because of the mandatory own risk in the insurance. The infrastructure for contraceptive care is good. Women are able to go to the regular care circuit for contraception consultations (primary care, midwives, abortion clinics, gynaecologists) and to the addition facilities at the CSGs. There is an NHG (College of General Practitioners) standard for

[27] Seksuele Gezondheid in Nederland/LeefstijlmonitorSexual Health in the Netherlands/Lifestyle monitor]: Rutgers together with RIVM, 2017.

[28] Nationwide abortion records, Rutgers 2015

[29] Inspectie Jaarrapportage 2015 van de Wet afbreking zwangerschap [Annual Inspection Report for 2105 on the Termination of Pregnancy Act]. IGZ, 2017.

contraception[30]. A wide range of materials, brochures and websites are now available to help women choose a method of contraception and use it effectively. Support is also available to help make a choice after an unwanted pregnancy. Nationwide institutes for this specific theme work together and are receiving temporary extra backing in the form of subsidies (amendment funds).
Use of contraception for the first sexual contacts is high among young people[31]. One possibly contributory factor is that investments have been made over recent years in providing good information about contraception to young people, inter alia through sexuality education and sense.info. 92% of girls and 94% of boys use a method of contraception. This percentage has increased slightly over recent years.

Abortion care

Abortion care is provided by the Dutch abortion clinics. They perform 91% of abortions; 9% are done in hospitals. The Termination of Pregnancy Act states that both clinics and hospitals require a permit for this. The act defines the conditions for abortion care. In addition, there are the guidelines and protocols of the NGvA (Dutch Association of Abortion Specialists), which all the clinics and hospitals cooperate with.
Care and facilities for abortion and help with making choices in the event of unwanted pregnancy are also arranged through municipalities and often implemented through the CSGs.

Objective for 2022:
- Evidence-based information and counselling about contraception is available and accessible, for vulnerable groups as well.
- All forms of suitable, reliable contraception are easily available, again for the most vulnerable groups as well.
- The number of unwanted pregnancies has fallen thanks to effective use of suitable and reliable contraception.

8.3 The challenges and the approach

Not all women have access to contraception or make responsible choices about it. Contraception counselling in primary care is limited and still concentrates fairly much traditionally on the contraceptive pill. The counselling still does not cover the broad range of contraceptive options sufficiently and there is little attention to dealing with errors made by the users or monitoring the use. It is also unclear how women make their contraception choices – what sources of information they consult and which ones are valuable to them. In particular, people with low levels of literacy and education, migrant groups and other vulnerable groups need more intensive support. It is not yet clear whether financial considerations play a role in making the optimum choice for certain groups.

The study 'Seks onder je 25e' [Sex before the age of 25] shows that a large proportion of young people in the Netherlands use contraception for their first sexual contacts. That level must therefore be maintained. The choice of an abortion is associated with taboos for younger people and in certain groups, making the choice more difficult.

Targets for preventing unwanted pregnancies (among teenagers in particular) have been described in a specific memorandum calling for targeted improvement programmes[32]. The current cabinet plans have created space for national financing of nationwide individual support and help making choices in the event of an unplanned pregnancy. Part of this (individual guidance and assistance for young parents, for example) is beyond the scope of this action plan. There are however links with the public health aspect of sexual healthcare regarding
- Good information provided about contraception choices and assistance in making choices in the event of an unwanted pregnancy.
- Better-skilled professionals.
- Easy access to contraception.
- Monitoring knowledge and use of contraception.

[30] Contraception guideline: *https://www.nhg.org/standaarden/volledig/nhg-standaard-anticonceptie*

[31] Graaf, H. de, Nikkelen, S., Van den Borne, M., Twisk, D., & Meijer, S. Seks onder je 25e: Seksuele gezondheid van jongeren in Nederland anno 2017 (Sex before the age of 25: Sexual health in young people in the Netherlands in 2017). Delft: Eburon

[32] Prevention, support and care in the event of unintentional/unwanted pregnancies (among teenagers in particular). Recommendations from parties working in the field. June 2017. *https://www.bing.com/search?q=Preventie,+ondersteuning+en+zorg+bij+onbedoelde%2Fongewenste+(tiener)+zwangerschap.&src=IE-TopResult&FORM=IETR02&conversationid=*

Good information provided about contraception choices and assistance in making choices in the event of an unwanted pregnancy

It is unclear what sources of information women consult and how much value they place on the information about contraception and assistance in making choices in the event of an unwanted pregnancy. There are various websites such as sense.info for young people, seksualiteit.nl, anticonceptie-online.nl, thuisarts.nl, anticonceptie-voorjou.nl, zwangerwatnu.nl, siriz.nl and group counselling such as "Girls' Talk special", but we do not know enough about whether all groups have sufficient access to information and feel they are being supported in the prevention of unwanted pregnancies and making choices. There are still no suitable tools and/or self-help in making choices for adults and more vulnerable groups. Better insights are required into the inhibitory factors and the backgrounds to the appropriate choices when setting up tools for a broad group of women and vulnerable groups in particular. There should also be investigations into which tools are effective in preventing repeat abortions. A range of supporting items is being developed for professionals and offered to them regarding contraception counselling. The offering must be continually checked in terms of effectiveness and efficiency.

Approach:

- Exploration of the useful value and appreciation of the information provided.
- Further development of tools in order to achieve suitable choices of contraception and effective use.
- Improvements to the information provided through relevant information channels (including seksualiteit.nl and sense.info).
- Transition to reliable public information via targeted PR and social media campaigns.
- Investigation of the backgrounds to unwanted pregnancies and the motivating and inhibitory factors in use of contraception (including in the longer term), in particular among vulnerable groups and immigrant groups.
- Refreshers and extra training should be offered in contraception counselling, e-learning and study days for primary care professionals, abortion clinics, mental healthcare services, and professionals in the social domain.
- The theme should be embedded in training courses for midwives, GPs and social workers.
- A study into the quality of contraception counselling, paying attention to the broad spectrum, dealing with mistakes made by the users, and appropriate choices.
- Longitudinal study among high-risk groups into the effect of more intensive contraception counselling after abortions.

Parties involved:
National government: municipal public health services (incl. CSGs); nationwide institutes for specific themes: Rutgers; Other organisations: Fiom; scientific and professional organisations: NHG (SeksHAG), KNOV (midwives), doctors' medical assistants, POH, NGvA, V&VN; care providers: abortion clinics and Siriz (abortion support); educational institutions: training courses for care professionals.

Better-equipped professionals

Vulnerable women in particular benefit from more intensive contraception counselling and support in using contraception effectively. Pilots in Tilburg, Rotterdam and elsewhere have shown that more intensive contraception counselling can be effective. This methodology is being developed further and rolled out nationally (the 'Nu niet zwanger' project - Not Pregnant Now), focusing on further development, coordination and regional/local support. The theme of contraception and postponing having children could also be presented as more of an integral whole within the social domain where there are already contacts with vulnerable groups. It is as yet unclear what the key barriers are among high-risk groups against using contraception (especially in the long term). In addition, there should be additional attention paid to counselling and information to specific groups of migrant and refugee women (in particular those with backgrounds from Suriname, the Antilles and sub-Saharan Africa). A community-based approach based on a positive deviance methodology could be effective here (what can be learned from the women for whom it works).

Approach:

- Pilots (online or otherwise) with intensive contraception counselling or coaching for vulnerable groups in underprivileged neighbourhoods, with a nationwide rollout of successful methods (the 'Nu niet zwanger' project – Not Pregnant Now).
- Training and deployment of contraception counsellors, Sense, municipal public health services and educators from migrant and refugee target groups (preventive approach, positive role models/positive deviance methods).
- Provide an impulse to cohesive local policies for preventing unwanted pregnancies among vulnerable groups, linked where relevant to the availability of STI testing.
- Secondary prevention of abortion and investigation of the impact of intensive counselling and interventions, in cooperation with abortion clinics and immigrant groups.

Involved parties
National government: VWS, RIVM, municipal public health services (CSGs); nationwide organisations: GGD-GHOR (Regional Medical Assistance Organisation), VNG (municipalities); national institutes for specific themes: Rutgers, Fiom; scientific and professional organisations: NHG (SeksHAG), V&VN, KNOV.

Monitoring knowledge and use of contraception

Data is produced annually about abortions (the Dutch Healthcare Inspectorate and Rutgers), as are monitors of sexual reproductive health (Rutgers). These give a picture of the use of contraception, abortions and use of the morning-after pill. It is important to get a nationwide picture of the effects, the prevalence of unwanted pregnancies and the high-risk groups. It is also important to monitor the use of interventions associated with contraception counselling and access to information properly.

Approach:

- Implementation of the LSM-K and LSM-A (the core and additional modules respectively of the lifestyle monitor for sexual health, in which figures about the use of contraception and abortion are updated and presented to professionals and policy-makers).
- Monitoring of online information about contraception and the use of evidence-based interventions in this area.

Parties involved:
National government: IGZ; nationwide parties: Statistics Netherlands; national institutes for specific themes: Rutgers; Other organisations: Fiom; care providers: abortion clinics; scientific and professional organisations: NHG (SeksHAG).

9 Preventing unacceptable sexual conduct and sexual violence

9.1 Importance

Unacceptable sexual conduct and sexual violence are major problems from which the Netherlands is not spared.

- 53% of women and almost 22% of men in the Netherlands aged between 18 and 80 have experienced unacceptable sexual conduct, ranging from unwanted kisses to unwanted sexual intercourse; 11% of women and 1% of men have experienced sexual intercourse against their will; that approximates to 700,000 women and 65,000 men[33].
- Young people aged between 14 and 29 run a relatively high risk of unacceptable sexual conduct and sexual violence. In addition there are specific groups who run greater risks, such as people with an intellectual disability[34] and children in the youth care system.[35]
- The prevalence of unacceptable sexual behaviour and sexual violence is high among LHBT people: 15% of homosexual and bisexual men, 23% of lesbian women and 36% of bisexual women have experienced sexual violence.

The study entitled *Seks onder je 25*[e] (Sex before the age of 25) in 2017 has shown that the number of girls who have been forced to do or permit something sexual has dropped significantly with respect to 2012, from 17% to 11%. Among boys, the figure has fallen from 4% to 2%. The cause of this drop is unclear, but there may possibly be a favourable trend. Nevertheless, given the consequences, these figures are unacceptably high. This approximates to 130,000 girls and 25,000 boys in the age range 12 to 25 who have experienced sexual coercion at some point.

9.2 How is it set up in the Netherlands?

Information and counselling

Primary prevention is provided in the first instance within the education system via education about sexuality and relationships. Recognised teaching packages such as 'Lang Leve de Liefde' and 'Kriebels in je buik' pay attention to this in basic education and there are additional themed lessons. Selective prevention focuses on vulnerable groups who are exposed to additional risks of unacceptable sexual behaviour or who perpetrate it themselves, such as young people with mild intellectual disabilities and young people in the youth care system. Counselling programmes and training courses have been developed for a number of groups (e.g. 'Girls Talk (Plus)' and 'Make a Move' for the youth care sector and the 'Je lijf je lief!' package for

[33] Seksuele Gezondheid in Nederland/LeefstijlmonitorSexual Health in the Netherlands/Lifestyle monitor]: Rutgers together with RIVM, 2017

[34] Berlo, W. van, et al. (2011). Limited resilience. A study into sexual violence among people with a physical, sensory or intellectual disability. Utrecht: Rutgers WPF/Movisie

[35] Commissie Samson (2012). Surrounded by carers and still not safe. Sexual abuse of children removed from their homes by the authorities. 1945 to date. Amsterdam: Boom.

practical education). A number of campaigns have also been run over recent years, such as 'Maak Seks Lekker Duidelijk' [Be good and clear about sex] for improving communication between sexual partners and 'We Can Young', in which young people played an active role. Both campaigns have finished.

Secondary prevention involves timely signalling of sexual violence and making it something that can be discussed. The government introduced a Domestic Violence and Child Abuse (Obligatory Reporting Code) Act [Wet verplichte meldcode huiselijk geweld en kindermishandeling] in 2013, which obliges professionals in the education, care, social work and justice sectors to use a step-by-step plan when there is a suspicion of violence in dependency relationships, including sexual violence. Veilig Thuis, the central advisory and notification point, can help with advice and reporting. Various tools have been developed for professionals for signalling unacceptable sexual behaviour or sexual violence, for instance the Sensoa Vlaggensysteem ('flagging system'), which has been implemented throughout the Netherlands by Movisie. There are also protocols to assist institutions in developing policies for sexuality and the prevention of sexual violence.

Victims and perpetrators need appropriate care to prevent re-victimisation and recurrences respectively (tertiary prevention). Various facilities are available for assistance and treatment, including the Sexual Violence Centres (CSG) for acute care and institutions that provide help such as trauma centres, mental healthcare services, sexology practices and unaffiliated carers who offer various forms of treatment[36]. Victims of sexual violence can also go to the CSGs, which can arrange initial reception, tests for STIs and referrals, all in a short chain. The perpetrators are treated within the forensic care system. Training orders for juvenile sex offenders were abolished last year. Among the ministries, OCW (Education, Culture and Science) is responsible for the emancipation dossier and for education (see Chapter 5, Sexuality Education), VWS (Health, Welfare and Sport) for care and VenJ (Justice and Security) for tracking down and treating the perpetrators. The three ministries work together in the 'Geweld in Afhankelijkheidsrelaties' (GIA, Violence in Dependency Relationships) approach, which also covers sexual violence.

[36] *www.slachtofferwijzer.nl*

Objectives for 2022:

- Treating each other with respect is a point that receives structural attention in all types of education and it is embedded in general, positive information about sexuality.
- Current and future professionals in the care sector are receiving structural training about a healthy sexual development and the prevention of unacceptable sexual behaviour within their target groups.
- Good interventions are available that are being implemented appropriately for all groups that run extra risks.
- Awareness of the harmful effects of stereotypical gender norms has been increased.

9.3 The challenges and the approach

Unacceptable sexual behaviour, in particular in its serious forms, is a threat to a healthy sexual development and can affect the physical and psychological well-being, and thereby also affect social functioning. Prevention of unacceptable sexual behaviour and sexual violence and raising awareness about the harmful effects of underlying stereotypical gender norms demands an approach on several fronts.

A summary of the challenges:

- Structural attention at schools (complementary to the foundations that are laid through sexuality education), including for the 16-17 age group.
- Improved expertise (signalling, opening for discussion, setting limits)
- Development and implementation of interventions, including attention for the 18+ age group, which is significantly at risk.
- Attention for the development of a social norm that supports the prevention of sexual violence and counteracts stereotypical gender norms.

Structural attention to the matter at schools, with good interventions

Attention for unacceptable sexual conduct and sexual violence is not self-evidently part of the information provided. The study called '*Seks onder je 25e*' (Sex before the age of 25, 2017) has shown that young people are not taught sufficiently about (among other things) unacceptable sexual conduct. Tried-and-tested classroom packages that do pay attention to this are by no means used everywhere.

Monitoring of education in this respect is insufficient. In the context of their core objectives, schools have the legally required task of paying attention to unacceptable sexual conduct and its prevention. However, this is by no means always done (see also Chapter 6 and the report by the Education Inspectorate[37]). Only a small minority of schools that do provide education about this actually use a recognised intervention for the purpose[38]. In this context, 'recognised' means that it has a theoretical underpinning; the effectiveness in preventing unacceptable sexual behaviour has however not yet been demonstrated. There are no recognised interventions yet for primary special education, although that is exactly where the need is greater.
The 'Nationaal Rapporteur Mensenhandel en Seksueel Geweld tegen Kinderen' (National Reporter on Trafficking in Human Beings and Sexual Violence against Children) made a number of recommendations in its report about effective prevention of sexual violence, including research into the effectiveness of interventions for education and ensuring that information about quality and effectiveness is accessible. In addition, it makes the case for measures to make 16 and 17-year olds more resilient against sexual violence, because this age group is outside the core objectives of education (and is also at high risk)[39].

Approach:

- Moving on from the approach in education (Chapter 4), all schools in primary and secondary education and lower vocational colleges have 'wishes and limits' as a structural focal point. In addition, prevention of unacceptable sexual behaviour must be addressed more than just once during a school career.
- Monitoring the quality of the education in terms of sexual resilience and treating each other with respect, and research within the target group.
- Implementation of interventions with a proper theoretical underpinning in terms of wishes and limits and treating each other with respect.
- Studies of the effects of these interventions.

Parties involved:
National government: Education Inspectorate, education councils, OCW (Education, Culture and Science), municipal public health services; nationwide institutes for specific themes: Rutgers, Soa Aids Nederland.

Improving the expertise of professionals

Teachers and professionals in various parts of the care sector are often not properly equipped to recognise signals of sexual abuse in children or to make sexuality in general, and unacceptable sexual behaviour (both online and offline) in particular, a subject for discussion and to put limits on it where necessary.

Approach:

- Structural attention in vocational education (focusing on care professions) for a healthy sexual development and the prevention of unacceptable sexual behaviour.
- Professionalisation of staff in the education and care sectors through additional training and refresher courses.

Parties involved:
Nationwide institutes for specific themes: Rutgers; educational organisations: Care sector education, lower and higher vocational colleges.

Developing and implementing interventions

There are few if any interventions for young people aged over 18, whereas this group runs a higher risk. There is also as yet little or no evidence of the effectiveness of teaching packages about wishes and limits or of counselling programmes in this area. This requires investment in research. Implementation in the care sector is as yet not mandatory. Various institutions in the care sector and elsewhere see the importance of preventing unacceptable sexual behaviour, in particular for vulnerable groups, but the programmes are actually only used occasionally.

[37] Education Inspectorate (2016). *Omgaan met seksualiteit en seksuele diversiteit. Een beschrijving van het onderwijsaanbod van scholen [Dealing with sexuality and sexual diversity. A description of the educational offerings at schools]*. The Hague: Ministry of Education, Culture and Science

[38] *www.slachtofferwijzer.nl*

[39] Nationaal Rapporteur Mensenhandel en Seksueel Geweld tegen Kinderen, *Effectief preventief. Het voorkomen van seksueel geweld door seksuele en relationele vorming in het onderwijs (Preventively effective: Preventing sexual violence through education about sexuality and relationships)* (2017). The Hague: Nationaal Rapporteur

Approach:

- Implementation of existing, proven interventions for preventing young adults from experiencing or perpetrating unacceptable sexual behaviour, plus further development of such interventions where necessary.
- For a proper implementation, the chain of treatment with selective and indicated preventive measures must be clear. This demands inter alia agreement between the partners in the care chain, public health and the developers of the interventions.
- Internal cooperation from the municipal public health services (youth healthcare services) to support those bringing children up.
- Implementation and scaling up of interventions for groups that require special attention.
- Research into the effectiveness of interventions

Parties involved:
National government: the Ministry of Justice and Security, youth care, municipal public health services (youth healthcare services, CSGs and others they cooperate with); national organisations: MEE, Veilig Thuis; nationwide institutes for specific themes: Rutgers; healthcare providers: care for the disabled, mental healthcare institutions, Sexual Violence centres; partners in the education sector: including special education.

Attention for the development of a social norm that supports prevention

Setting the public's norms is a key step in counteracting stereotypical gender norms and thereby helping prevent sexual violence. There is sufficient evidence that there is a relationship between them.

Approach:

- Development of a campaign of norms for young people, focusing on eliminating gender stereotypes and preventing sexual violence (this will be realised as the Act4Respect Alliance, supported by the Ministry of Education, Culture and Science).

Involved parties
National government: OCW; nationwide institutes for specific themes: Rutgers; education sector parties; healthcare providers; other: media partners.

10
The process through to 2022

What is the next step?

The National Action Plan has been drawn up together with numerous parties active in the field, who have committed themselves to the plan. The RIVM-CIb (Centre for Infectious Disease Control) has facilitated this process, on instructions from the Ministry of Health, Welfare and Sport. Putting it into practice will depend largely on the parties in the field; where possible, they are mentioned in the approach that is needed to achieve the objectives.

Agreements between the various parties will be needed in order to achieve the objectives of this plan and determine the prioritisation of the main thrusts of the approach. A steering group will be set up for this that monitors the further detailing and implementation of the plan. Working groups will then be set up on instructions from the steering group to define the practical content of the activities for implementing the approach.

The RIVM-CIb will take the initiative at the beginning of 2018 to set up this steering group and will if necessary also take on chairing it (temporarily) as an independent party. The RIVM-CIb can also arrange for the staffing of the steering group's secretarial office.

11
Overview of the objectives for the Action Plan by 2022

Prevention and care

- High-quality, appropriate, affordable and accessible facilities for care, advice, support and protection if people need help or have problems related to their sexual health (including STIs and HIV) should be available for everyone in the Netherlands.

Surveillance and monitoring

Availability of:
- Up-to-date, reliable figures about STIs, HIV and sexual health (including STIs and HIV) in order to reinforce policy for prevention and tackling infections.
- Up-to-date, reliable figures about the implementation of recognised interventions in sexuality education, prevention of sexual violence, unwanted pregnancies, STIs and HIV
- Explanations and the significance of the current figures for STIs, HIV and sexual health.

The basis: Sexuality education

- Sexuality education is assured in the longer term in all types of education.
- Children and young people, including vulnerable groups, are able to find reliable information online and elsewhere about sexual health in the broadest sense, and receive evidence-based sexuality education that is appropriate for their phase of development.
- This is how we are working on cutting down the occurrences of STIs and HIV, unacceptable sexual behaviour and unwanted pregnancies and encouraging respectful, safe and healthy behaviour.

Prevention, detection and treatment of STIs

- Development of an effective strategy for reducing the burden of chlamydia.
- Halving the number of new syphilis infections to less than 500 per year (2016: 1,000:
- Halving the number of new gonorrhoea infections (2016: 10,000).
- Reducing the number of acute HBV and HCV infections to zero.
- Broad acceptance within society of sexual diversity and chronic STIs and HIV.

Prevention, detection and treatment of HIV

- The number of AIDS deaths in the Netherlands will be zero.
- The number of new HIV diagnoses made annually will have been at least halved (2015: 900).
- In the Netherlands, 95% of people with HIV will know their HIV status, 95% of them will be receiving treatment and 95% of them will have an undetectable viral load.
- People with HIV will have the best possible protection against HBV and HCV.

- Of the people who have a suppressed viral load, 90% will have a good quality of life, including less stigmatisation and discrimination. Testing for HIV and treatment of HIV will have been normalised.

Prevention of unwanted pregnancies

- Evidence-based information and counselling about contraception is available and accessible, for vulnerable groups as well.
- All forms of suitable, reliable contraception are easily available, again for the most vulnerable groups as well.
- The number of unwanted pregnancies has fallen thanks to effective use of suitable and reliable contraception.

Preventing unacceptable sexual conduct and sexual violence

- Treating each other with respect is a point that receives structural attention in all types of education and it is embedded in general, positive information about sexuality.
- Current and future professionals in the care sector are receiving structural training about a healthy sexual development and the prevention of unacceptable sexual behaviour within their target groups.
- Good interventions are available that are being implemented appropriately for all groups that run extra risks.
- Awareness of the harmful effects of stereotypical gender norms has been increased.

Annex 1
Overview of monitoring instruments

STI/HIV

Surveillance and monitoring tools are available in the Netherlands for various objectives; these are generally coordinated by the RIVM, which also handles communication from them.

- SOAP, a web-based application for reporting STI consultations and results, as well as Sense consultations from the Sexual Health Centres (CSGs).
- GP data (NIVEL, the Netherlands Institute for Health Services Research: primary healthcare database).
- Monitoring data from the Stichting Hiv Monitoring (SHM) about people in care who have HIV. The epidemiological data about newly reported HIV infections and the trends in new AIDS diagnoses after 2000 are reported in collaboration with the RIVM's CIb.
- Cohort studies in Amsterdam: HIV incidence data from the Amsterdam Cohort Studies about HIV/AIDS and the surveillance of recent HIV infections at STI outpatient clinics (RITA). The Amsterdam Cohort Studies began registering MSM with HIV and AIDS in 1984.
- Chlamydia (CT): total number of positive CT tests. Data from 20 laboratories is analysed for this; it is estimated to cover 40% of the most important laboratories in the Netherlands.
- Duty of notification (OSIRIS): The obligation to notify covers epidemiological data about newly diagnosed acute hepatitis B virus (HBV) infections and chronic HBV infections and acute hepatitis C virus (HCV) infections.
- Screening pregnant women for syphilis, HBV and HIV
- Screening blood donors for HIV, hepatitis B and C, and syphilis

Sexual Health

Rutgers carries out two population studies at regular intervals:

- the participatory action study 'Seks onder je 25e' [Sex before the age of 25] among young people aged from 12 to 25, in cooperation with Soa Aids Nederland
- The sexual health Lifestyle Monitor From 2013 onwards, data was gathered about a variety of lifestyle aspects from a cross-section of the Dutch population aged between 12 and 80 (the Lifestyle Monitor or LSM); annual collection of a standard set of indicators (the core LSM) plus a more in-depth module every four years (LSM-A) carried out by Statistics Netherlands in collaboration with Rutgers, Soa Aids Nederland and the RIVM.

Rutgers uses a variety of existing care records to obtain a picture of sexological assistance:

- records of patient contacts from sexologists in secondary and tertiary somatic healthcare (the LOPS)
- records of patient contacts in mental healthcare (the PTSG)
- records of patient contacts in institutions for people with intellectual disabilities (the SHVB)
- national abortion records (the LAR)
- records of Sense consultations at the CSGs
- records of patients with sexological complaints in general practice, based on NIVEL primary healthcare records

As an addition to the sexuality monitors and records listed above, there are various studies that include those aspects of sexual health:

- HBSC and PEIL studies among schoolchildren (Trimbos)
- youth monitors such as EMOVO (municipal public health services)
- social safety monitor (OCW)
- safety monitor (Statistics Netherlands)
- FRA (international study of sexual violence)
- the annual report of the Dutch Healthcare Inspectorate about the Termination of Pregnancy Act

List of abbreviations

ADEF	: general forum for directors of educational faculties
CASA clinics	: clinics providing assistance for unintended pregnancies and abortion
CBS	: Statistics Netherlands
CIb	: Centre for Infectious Disease Control
CJG	: Youth and family centres
CSG	: Centre for Sexual Health
Fiom	: knowledge centre for unintended pregnancies and heredity issues
GGD	: Municipal Health Services
GGD GHOR	: Association of Community Health Services in the Netherlands
IGZ	: Healthcare Inspectorate
JGZ	: Youth healthcare services (“Jeugdgezondheidszorg”)
J&V	: Ministry of Justice and Security
KNOV	: Royal Dutch Organisation of Midwives
LecSo	: national expertise centre for special education
LOBO	: national forum for basic teacher training for primary education
LOPS	: national forum for sexology outpatient clinics
LSM	: Lifestyle Monitor
LSM-A	: periodic additional module for the Lifestyle Monitor
LSM-K	: annual core questions for the Lifestyle Monitor
MEE	: national association that supports people with disabilities
MML	: medical microbiology laboratory
MBO	: secondary vocational education
MBO-Raad	: association of governing bodies of schools for vocational education
NCJ	: Netherlands Centre for Youth Healthcare
NGvA	: Netherlands Association of Abortion Doctors
NHG	: Dutch College of General Practitioners
NIBI	: Netherlands Institute for Biology
NIVEL	: Netherlands institute for health services research
NVVS	: Netherlands Association for Sexology
OCW	: Ministry of Education, Culture and Science
PO	: Primary education
POH	: national association within mental healthcare services
PO-Raad	: association of governing bodies of schools in primary education
Rutgers	: knowledge centre for sexuality
RIVM	: Dutch National Institute for Public Health and the Environment
SANL	: STI Aids the Netherlands
SeksHAG	: GPs’ advisory group on sexual health, part of the NHG (Dutch GPs’ association)
SOAP	: STI and sexual health determination
SHM	: HIV Monitoring Foundation
SLO	: Stichting Leerplan Ontwikkeling (foundation for developing learning plans)
Stimezo	: Abortion clinics in the Netherlands
VNG	: Association of Netherlands Municipalities
VO	: Secondary education
VO-Raad	: association of boards and schools in higher education
VSO	: Secondary special education
V&VN	: nurses’ and carers’ association
VWS	: Ministry of Health, Welfare and Sport
WASS	: Working group of physicians on STIs and sexuality

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