

CONSULTATION DOCUMENT

A FIVE YEAR

SEXUAL HEALTH PROMOTION

STRATEGY AND ACTION PLAN

[D.N. October 2003]

CONTENTS		PAGE
CHAPTER 1	WHY WE NEED A STRATEGY	1
CHAPTER 2	AIMS OF THE STRATEGY	13
CHAPTER 3	ACTION PLAN	17
CHAPTER 4	MAKING IT HAPPEN	25
ANNEX 1	EQUALITY IMPACT ASSESSMENT	27
ANNEX 2	DEFINITION OF ACUTE SEXUALLY TRANSMITTED INFECTIONS	50
REFERENCES		

CHAPTER 1

WHY WE NEED A STRATEGY

Introduction

- 1.1 Sexual health is an important part of physical and mental health, as well as emotional and social wellbeing. Sexual health is not just about the absence of disease or dysfunction of sexual or reproductive function, but also embraces the capacity to enjoy relationships and express sexuality without feelings of guilt or shame; to have pleasurable and safe sexual experiences; to control fertility and to avoid the risk of unintended pregnancy.
- 1.2 Sexual health does not just concern the young, everyone is a sexual being and sexual health is important throughout the life of the population. Many factors adversely impact on people's sexual health including poverty, unemployment, poor education, poor living and working environments and social exclusion.
- 1.3 The Executive in its Programme for Government under the theme "Working for a Healthier People" gave a commitment to promote sexual health, reduce unplanned births to mothers under 20 and to improve mental health and emotional wellbeing. The *Investing for Health* Strategy 2002 provides the framework for the Government's approach to improve health and wellbeing and reduce health inequalities. It identifies sexual health and teenage pregnancy as important areas for action and commits the Department of Health, Social Services and Public Safety (DHSSPS) to publish a Sexual Health Promotion Strategy.

Current Position

- 1.4 A number of initiatives are already in place which are relevant to this strategy. These include the Teenage Pregnancy and Parenthood Strategy and Action Plan, the Drug and Alcohol Strategies, the Promoting Mental Health Strategy, implementation of Relationships and Sexuality Education (RSE) guidelines in schools and local sexual health strategies and the Department of Social Development's Neighbourhood Renewal Strategy.
- 1.5 Sexual health in Northern Ireland is generally regarded as poor, with high levels of teenage pregnancy and sexually transmitted infections. In 2001, there were 21,962 live births to women in Northern Ireland, of which, 1524 (6.9%) were to teenagers aged 19 and under. In 2001/02, there were 19,765 new outpatient cases presenting to genitourinary medicine (GUM) clinics in Northern Ireland, including 17 new cases of HIV.
- 1.6 Regional surveys show considerable ignorance about issues relating to sex and sexuality, resulting in confusion, unhappiness and the breakdown of relationships¹. Research also indicates that sexual health services here are not well publicised; there are gaps in the provision of sexual health services; and there are difficulties in accessing emergency contraceptive services, in particular for young people².
- 1.7 The prevailing moral or religious attitudes in Northern Ireland may discourage some people from talking about sexual issues, while the media continues to present explicit and often misleading images of relationships and sexuality. For young people in particular, perceptions of sexuality can become distorted, especially if parents or teachers are too embarrassed to discuss

sexual issues openly and honestly. This combination of secrecy and misinformation places young people at risk and makes it harder for some people to develop a healthy attitude to their sexual health in adulthood.

Social Climate

- 1.8 The social climate in Northern Ireland is unique. Recent research by the Family Planning Association (fpa) indicates that due to social deprivation and religious segregation, there is a negative impact on establishing relationships across the socio-religious divides³. The survey also found that young people who were less able to talk to their parents about personal or sexual matters were less likely to use contraception when they first had sex.

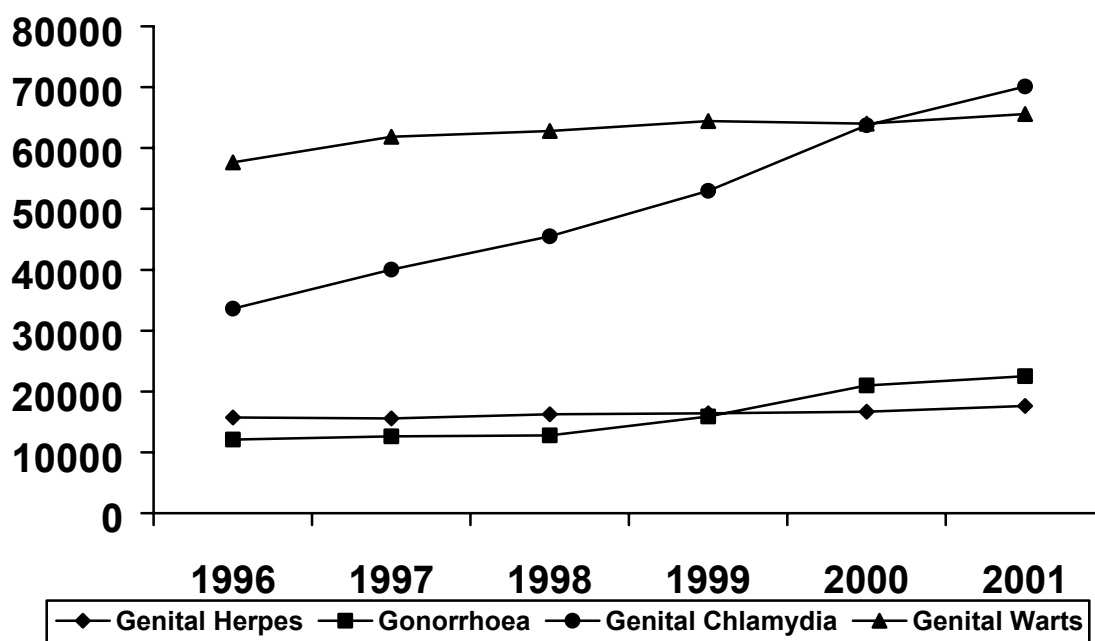
- 1.9 Over half of all respondents said that sex between men was always or mostly wrong³. Young gay people in the survey reported that homophobic bullying was often ignored, accepted or even encouraged. Other recent research⁴, on the needs of lesbians and bisexual women shows that 46% of those interviewed had experienced discrimination at work and 20% had experienced violent assaults.

- 1.10 Research (which was carried out in 1991 and remains the most recent information) indicates that homosexuality is more covert in Northern Ireland due to a generally negative and discriminatory attitude towards it, the major factor being the combined influence of religion and family⁵.

Sexually Transmitted Infections (STIs)

1.11 After the initial media attention and government interest during the 1980's, HIV and AIDS may now appear to be a low priority, but they have not disappeared. A rise in the number of STIs reported throughout the UK generally has prompted fears that unsafe sex is on the increase following the suspension of the HIV/AIDS campaigns of the 1990s.

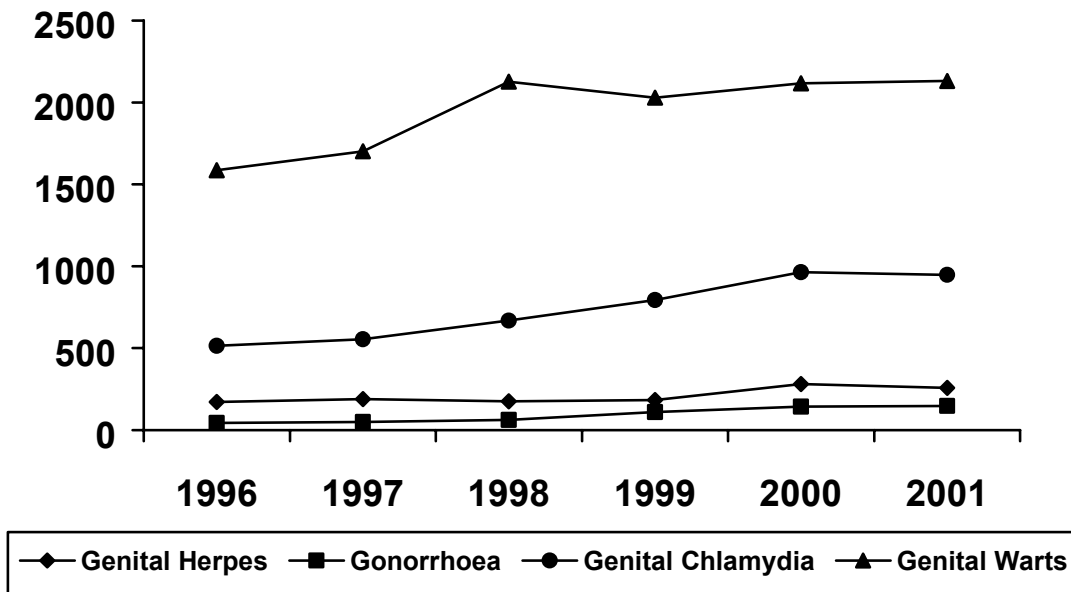
Figure 1. Cases of Main Sexually Transmitted infections treated in England and Wales.



Source: Public Health Laboratory Service

1.12 A recent review of STIs and services in Northern Ireland indicates that STIs are also on the increase in Northern Ireland⁶. In 2001 there were 148 new diagnoses of gonorrhoea and 947 people were treated for chlamydia. The most common conditions include non-specific urethritis, chlamydia, and genital warts.

Figure 2. Cases of Main Sexually Transmitted Infections treated in Northern Ireland.



Source: Public Health Laboratory Service

1.13 In 2001, there was an outbreak of infectious syphilis in Northern Ireland, which is continuing. Almost all of the cases were in men, and of these, the majority were in men who have sex with men. However, cases have occurred among heterosexuals, including in pregnancy. The risk of transmission of syphilis is associated with multiple partners and unprotected sex including oral sex.

1.14 STIs can have long-term effects on people's lives, with possible associated complications such as infertility; ectopic pregnancy; cervical cancer and other genital cancers.

Sexual Behaviour

1.15 A survey of children aged 11 to 16 years of age shows that:

- 27% of pupils had no sexual experience;
- 36% had a small amount e.g. kissing;
- 26% had some experiences, but no sexual intercourse; and

- 11% reported they had experiences, including sexual intercourse, with the majority being 14 years of age at first sexual intercourse⁷.

1.16 There is no information available on the sexual behaviour and attitudes of the adult population in Northern Ireland. However some limited information is available from a survey in 2001, which indicates the three most common ways that respondents learned about sexual matters when they were growing up:

- 53% of respondents learnt from friends;
- 47% of respondents learnt from lessons at school; and
- 35% of respondents learnt from their mothers⁸.

Since the majority responded positively to the questions on sexual health this indicates that it is now feasible to conduct a population survey on sexual behaviour and attitudes in Northern Ireland.

1.17 A recent survey of the sexual health of gay men indicates that of those questioned from Northern Ireland:

- the average number of sexual partners in the last year was five; and
- 35% of men had an STI check-up in the last year⁹.

Unplanned pregnancies

1.18 Unplanned pregnancy and parenthood can have an important impact on individuals, and in particular, for young people. There are currently no robust statistics available on the number of unplanned pregnancies. While some teenage pregnancies are planned the majority probably are not and the number of births to teenage mothers and the number of terminations are used as

proxy measures of unplanned pregnancy.

- 1.19 The Teenage Pregnancy and Parenthood Strategy and Action Plan published by DHSSPS in 2002 aims to facilitate a reduction in the number of unplanned births to teenage mothers; and minimise the adverse consequences of those births to teenage parents and their children.

Table 1 Births to Teenage mothers 1999-2001

Age	Live Births (number)			
	1999	2000	2001	Average 1999-2001
Under 16	63	58	41	54
16	150	164	129	148
17	349	310	279	313
18	565	482	491	513
19	664	600	584	616
Total (Under 20)	1791	1614	1524	1643

Source: Annual Reports of Northern Ireland Registrar General

- 1.20 Last year, approximately 25% of visits to a voluntary sector sexual health and advice service for those under-20 years were for emergency contraception¹⁰.
- 1.21 In 2001, the known number of abortions performed in England on residents from Northern Ireland was 1,577.

Table 2 Number of abortions performed in England to Northern Ireland residents

Age	Number of Abortions			
	1999	2000	2001	Average 1999-2001
Under 20	265	301	319	295
Over 20	1,165	1,227	1,258	1,217
Total	1,430	1,528	1,577	1,512

Source: Office of Population Census & Surveys

Inequalities

- 1.22 Sexual ill-health can affect anyone in the population. It is not however, equally distributed throughout the population as shown by the increasing incidence of STIs among young people and gay men.
- 1.23 Research in England indicates strong links between social deprivation and STIs, abortions and teenage pregnancies¹¹. Unplanned teenage pregnancy and early motherhood is associated with poor educational achievement, poor physical and mental health, social isolation and poverty. A recent survey shows that respondents from a partly skilled socio-economic group background were twice as likely as those from a professional/ managerial background to have had sexual intercourse before the age of sixteen⁸ (Table 3).

Table 3 How old were you when you first had sexual intercourse? (aged 16-44)

First sex age group	Prof/Man %	Skilled non-manual %	Skilled manual %	Partly skilled %	Unskilled %	Total %
11-15	7%	8%	21%	14%	17%	12%
16-20	58%	57%	62%	68%	70%	59%
21-25	23%	20%	9%	10%	8%	15%
26-30	6%	5%	3%	1%	2%	3%
31+	1%	1%	1%	0%	0%	0%
Not happened yet	4%	10%	5%	7%	5%	11%
Total (n)	298	769	304	402	66	2075

Source: Health and Social Wellbeing Survey

Estimated Costs of Sexual Ill-Health

1.24 Sexual ill-health has significant human and economic costs. It is estimated that in Northern Ireland, sexual ill-health results in an average of 3 deaths per annum. However, this figure disguises the sizeable costs associated with sexual ill-health.

- In 2001/02, there were 101 finished consultant episodes for genitourinary type diseases, costing an estimated conservative £34,000, and over 24,000 outpatient attendances costing an estimated £3 million per annum.
- The complications resulting from untreated chlamydia, such as pelvic inflammatory disease, ectopic pregnancy and tubal-factor infertility cost an estimated £1.5 million, reflecting our lower than UK average prevalence of chlamydia. There are potential savings from early treatment of chlamydia via chlamydia screening programmes. IVF treatments currently

cost in the range £1,500 to £6,000 per cycle with the cost per live birth starting at £12,000 at 24 years of age and £13,000 at 35 years of age, rising to over £20,000 at 39 years of age.

- The prevention of unplanned pregnancies by contraception has estimated savings of £64 million a year.
- Combination therapies for those with HIV/AIDS cost around £15,000 per year per individual. Assuming all those (currently 267 people) with HIV/ AIDS in Northern Ireland are undergoing combination therapy, the cost is just over £4 million annually.

Estimated Costs of Teenage Pregnancy

- 1.25 On the basis that teenage pregnancies effectively withdraw the mother from the labour market for at least one and a half years, an estimate of their cost to the Exchequer (unemployment benefits and administration plus tax revenue foregone) stands at £17,820 per mother (Bivand, P., Centre for Economic and Social Exclusion, 2000). Assuming only those mothers aged 17-19 years of age are likely to be unemployed, a conservative estimate of their Exchequer cost is over £24 million (based on 2001 births data).
- 1.26 Additionally, 170 young mothers in 2001 were aged between 13 and 16 years of age. This group would have increased demand upon social services, health, education and their own families through the requirement to have someone look after the newborn child whilst the mother continues compulsory education. Despite such opportunity costs, statistics indicate they are far more likely to have no formal qualifications until their early 30s.

Equality, Targeting Social Need and Human Rights

- 1.27 Section 75 of the Northern Ireland Act 1998 requires public authorities in carrying out their functions to promote equality of opportunity between persons of different religious belief, political opinion, racial group, age, marital status, sexual orientation, gender, disability and persons with dependants or without.
- 1.28 DHSSPS has identified sexual health promotion as a new policy requiring Equality Impact Assessment (EQIA). The Working Group, representative of the main interests involved, which was established to develop the Strategy, also carried out an EQIA and this is included at Annex 1.
- 1.29 The New Targeting Social Need (New TSN) policy aims to tackle poverty and exclusion by targeting the efforts and available resources of public agencies towards the people, groups and areas objectively defined as being in greatest social need. New TSN includes a special focus on tackling the problems of unemployment, but also targets inequalities in health, housing, education and other policy areas. Paragraph 1.23 highlights the link between poor sexual health and those in the lower socio-economic groups. The development of a Sexual Health Promotion Strategy is therefore included in the DHSSPS New TSN Action Plan 2003-2004.
- 1.30 The Human Rights Act 1998 came fully into force in October 2000. It provides additional focus and emphasis to the rights and freedoms of individuals guaranteed under the European Convention on Human Rights. There are some 18 Convention rights and protocols which range from the Right to Life to the

Right to Education. The Act requires legislation, wherever enacted, to be interpreted as far as possible in a way which is compatible with the Convention rights; makes it unlawful for a public authority to act incompatibly with the Convention rights; and, if it does, allows a case to be brought in a court or tribunal against the authority. DHSSPS intends to ensure that implementation of this Strategy is compatible with the Human Rights Act.

Strategy Framework

1.31 Chapter 2 describes the aim of the Strategy, Chapter 3 outlines an Action Plan to support Sexual Health Promotion and Chapter 4 sets out how the Strategy will be taken forward. Annex 1 outlines the EQIA and Annex 2 defines acute STIs.

CHAPTER 2

AIM OF THE STRATEGY

2.1 **The Strategy aims to improve, protect and promote the sexual health and wellbeing of the population in Northern Ireland.**

2.2 This aim will be realised through a co-ordinated partnership approach inclusive of the statutory, voluntary and community sectors.

Objectives

2.3 The key objectives are:

- to reduce the incidence of STIs including HIV;
- to reduce the number of unplanned births to teenage mothers;
- to provide appropriate, effective, accessible and equitable information and education to enable people to make informed choices about their sexual health and personal relationships; and
- to facilitate equitable access to quality sexual health services.

2.4 These objectives will be achieved by:

- promoting openness about sexual health issues, including sexual orientation;
- tackling the determinants of sexual health and linking with other health promotion strategies;
- taking action to reduce the discrimination and stigma associated with HIV, STIs and sexual orientation; and

- ensuring that services are focussed on people in need, including those disadvantaged and the Section 75 groups.

Values and Principles

2.5 This Strategy adopts the framework of values and principles set out in the *Investing for Health* Strategy. In addition, the following principles are appropriate for action on sexual health promotion. These principles form the foundation of the Strategy and provide criteria against which interventions, services and practices will be delivered and evaluated.

- **Involving People**

People's views should be sought in order to respond to the differing needs of different populations.

- **Respecting People**

Everyone is entitled to be treated in a non-judgemental manner.

- **Respecting Confidentiality**

Everyone is entitled to have his or her confidentiality respected, within the legal framework in Northern Ireland.

- **Building on success**

Future activities should, where possible, build on existing, evaluated, local, national or international good practice.

Priority Groups

2.6 The Strategy aims to promote the sexual health of the entire population, however the following groups have been identified as requiring particular action:

- those aged under 20 years, including looked after children, because of the high levels of teenage pregnancy and STIs within this age group;

- those aged between 20-34 years as this age range has the highest rates of STIs ;
- gay and bisexual men because of the disproportionately high levels of STIs and HIV, historical lack of information, lack of access to targeted services and high suicide rates among this group; and
- commercial sex workers because of the associated risks with this work.

Those with a disability or from a black and minority ethnic community have particular requirements in accessing information, advice and services and these must also be addressed.

Additionally, the number of diagnoses of HIV in persons from outside the British Isles is increasing and appropriate action needs to be taken regarding health promotion among such groups.

Target

2.7 The Strategy sets the following target:

- **a reduction of 25% in the number of newly acquired acute sexually transmitted infections, including HIV and AIDs by 2009**

Baseline: 6,161 in 2002

Source: Acute STIs [see Annex 2 for definition of acute STIs] from the KC60 and newly diagnosed cases of HIV and AIDS from the Unlinked Anonymous Seroprevalence Survey for HIV.

This Strategy also adopts the targets set in the Teenage Pregnancy and Parenthood Strategy and Action Plan 2002-2007, and in particular:

- a reduction of 40% in the rate of births to teenage mothers under 17 by 2007
(Baseline 4.1 per 1,000 girls aged under 17 years, 1998-2000).

Taking the Strategy Forward

2.8 The Strategy comprises a number of actions grouped under four areas:

- prevention;
- education and training;
- services; and
- data collection and research.

2.9 Chapter 3 sets out for each of these areas, the actions to be taken, initial target dates and the main partners.

CHAPTER 3

ACTION PLAN

- 3.1 The promotion of sexual health through the following actions requires a multi-agency approach and partnership working across sectors with expertise and resources.

Action 1

The **Department of Health, Social Services and Public Safety (DHSSPS)** will establish a multi-agency Sexual Health Promotion Strategy Implementation Group to oversee the implementation of the Strategy and Action Plan.

Target Date: September 2004.

Action 2

The **Sexual Health Promotion Strategy Implementation Group** will report progress on the implementation of the Strategy to the **Ministerial Group on Public Health (MGPH)**.

Target Date: Annually.

Prevention

- 3.2 Preventing sexual ill-health depends on everyone having the information, life skills and access to services to enable them to make informed choices. Increasing knowledge and raising awareness of sexual health matters can be achieved through sustained public information and education campaigns. An important factor for prevention is the development of life skills to increase confidence, self-esteem and assertiveness to enable relationships and sexual lifestyles to be effectively managed. A key issue is the provision of services to identify and treat those

with infections, especially where there are no symptoms, to prevent further transmission.

- 3.3 There is a paucity of information about the prevalence of Chlamydia infection outside of the Genitourinary Medicine (GUM) setting in Northern Ireland. A pilot study carried out in two areas in England found a prevalence of about 10% in 16-25 year old women. There may be benefit in undertaking a similar study on chlamydia prevalence in Northern Ireland.
- 3.4 Northern Ireland may have a relatively low incidence of HIV infection but there is no room for complacency. The growing number of STIs is an indication of the level of unsafe sex and the potential for HIV transmission. There is also the increased incidence of injecting drug misuse which has the potential for HIV transmission through the sharing of injecting equipment.
- 3.5 Promoting positive sexual health through information and education can increase people's knowledge and awareness. Access to information is particularly important for young people who are looked after by a Health and Social Services Trust, people with a disability and those from a black and minority ethnic community. With information and knowledge people are more likely to avoid risky behaviour, use contraception, know what local services are available and be more likely to use them. Peer-led interventions can be effective in increasing knowledge levels.
- 3.6 The Health Promotion Agency has been raising awareness through public information campaigns such as convenience advertising (a sexual health poster campaign targeted at young

people).

Action 3

HSS Boards and Trusts will offer routine testing for HIV to all GUM clinic attendees.

Target Date: September 2004

Action 4

DHSSPS in conjunction with the **Health Promotion Agency Northern Ireland** (HPANI) and the voluntary and community sectors, will further develop a phased accessible sexual health public information campaign with strands:

- (i) to raise awareness of sexual health issues, including HIV/AIDs;
- (ii) aimed at the priority groups; and
- (iii) to tackle discrimination and stigma associated with HIV, STIs and sexual orientation.

Target Date: First phase of public information campaign to commence in April 2005.

Action 5

HSS Boards with Investing for Health Partnerships will establish multi-disciplinary sexual health forums with responsibility for coordinating local initiatives, including the prevention of STI and HIV/ AIDs, and with particular emphasis on the priority groups.

Target date: April 2005.

Action 6

HSS Boards with Investing for Health Partnerships will build on the Teenage Pregnancy and Parenthood Strategy's directory of services and publish local directories of resources which are accessible to all those wishing to avail of sexual health services. Target date: September 2005.

Education and Training

- 3.7 Few areas of health promotion or service provision impinge so directly on personal knowledge, beliefs, experience and attitudes of staff as those of sexual health. It is important to recognise the difficulty many people experience in dealing with the sensitive issues in this area and that education and training are needed to help people work more effectively in this area. This applies not only to health, social services and education professionals but also to other personnel such as receptionists who come into contact with patients and clients.
- 3.8 Training should cover core skills and issues including awareness, attitudes, information, communication skills, sexual orientation, relationships, cultural differences and the needs of those with a disability. There are a number of gaps in sexual health training and education at undergraduate and postgraduate level. There is also an absence of accredited training. There is a need for health and social care professionals and youth and community workers to further develop skills in dealing with sexual health issues.
- 3.9 In schools, an effective Personal and Social Education Programme which includes Relationship and Sexuality Education (RSE) is essential in providing young people with the knowledge and skills to promote responsible decision making. A major step

towards achieving this has been the 2001 RSE Guidance for Primary and Post Primary Schools. This guidance places RSE in a values and morals context and aims to help young people make informed and responsible choices, which may include abstinence.

Action 7

HSS Boards and Trusts in partnership with the HPANI and voluntary and community organisations will ensure that staff whose work involves sexual health issues, in particular health and social care professionals, receive general training in sexual health skills.

Target Date: September 2006.

Action 8

HSS Boards and Trusts in partnership with the voluntary and community sectors will provide specialised training for health and social care professionals including primary care professionals to enable them to deal effectively with sexual health issues facing lesbian, gay and bisexual men and women, and all of the other Section 75 groups.

Target date: September 2006.

Action 9

Education and Library Boards will ensure that appropriate training which takes account of the needs of the Section 75 groups, is made available to teachers implementing RSE guidelines and youth workers involved in sexual health promotion.

Target Date: September 2005.

Action 10

HSS Boards and Trusts in partnership with the voluntary and community sectors will make available appropriate training which includes the needs of the Section 75 groups, is made available to youth and community workers involved in sexual health promotion in non-statutory settings.

Target Date: September 2005

Services

3.10 Sexual health services play a vital role in the promotion of good sexual health. A recent local review of STIs including services for their prevention, identification and treatment, makes a number of recommendations to improve current approaches to STIs⁶. A separate review included recommendations that family planning services should offer choice and be made as accessible as possible in terms of location, physical environment, scheduling of clinics and drop in access. It also recommended that commissioners of health care should ensure that arrangements are in place so that individuals can obtain emergency contraception should they require it, and that services are tailored to meet the particular requirements of young people of both sexes¹².

3.11 Traditionally sexual health services have been provided in a fragmented manner and across a range of specialities including genitourinary medicine, family planning, obstetrics and gynaecology, and primary care. There is a move towards a more holistic sexual health approach as it is recognised that people wish to access a range of sexual health services in the same setting and also, in some cases, wish to have their STI managed in a community setting such as a GP surgery.

- 3.12 The main elements of a comprehensive service are contraceptive care, diagnosis and treatment of sexually transmitted infections and services that address psychosexual and sexual problems such as sexual dysfunction. Additional elements of the service are partner notification and sexual health advice.
- 3.13 Negative attitudes of staff and client expectations cause problems in accessing services. Embarrassment, previous bad experiences and worries about confidentiality create barriers between people and the services they need.
- 3.14 Sexual health services need to make people feel that they can discuss problems about their sex lives. Services need to be able to assess patients and refer them on to specialist services, when that is appropriate. Improved services will result in an increase in detection of infections and this will impact on contact tracing, partner notifications and treatment.
- 3.15 The voluntary sector plays a major role in promoting sexual health and providing sexual health services. Some people find voluntary sector services more 'user friendly' than statutory based services.

Action 11

DHSSPS will consider the Report from the STI Subcommittee of the Regional Advisory Committee on Communicable Disease Control on Sexually Transmitted Infections and Genitourinary Medicine Services in Northern Ireland with a view to identifying opportunities to improve GUM services.

Target date: September 2004.

Data Collection and Research

- 3.16 A sound research base will be critical for informing the implementation of this strategy. There is currently a lack of information on sexual attitudes and behaviours of the population as a whole and in particular gay men and women and a need for improved STI statistics.
- 3.17 The targets in this Strategy have been constrained due to a lack of baseline information. The Implementation Group (Action 1) will consider the need for further research to inform the implementation of the Strategy (Chapter 4, paragraph 4.3).

Action 12

In order to obtain the information on sexual attitudes to inform implementation of the Strategy, **DHSSPS** will commission a pilot survey of sexual attitudes and lifestyles in Northern Ireland.

Target date: April 2004.

CHAPTER 4

MAKING IT HAPPEN

Introduction

- 4.1 This Strategy will be taken forward in the context of the *Investing for Health* Strategy. It will take time and partnership working between Government departments, statutory, voluntary and community organisations in a variety of settings to achieve the aims of this Strategy and Action Plan. If the objectives outlined in Chapter 2 are to be met, it is essential that structures are in place to oversee the programme of action. The Action Plan's success will also require sufficient resources and systematic arrangements for monitoring and accountability.

Managing the Strategy and Action Plan

- 4.2 The Ministerial Group on Public Health (MGPH) will be responsible for the overall monitoring of the Strategy and Action Plan. A multi-agency Implementation Group will be established to oversee and drive forward the actions outlined in Chapter 3. The Implementation Group will report progress to MGPH annually. The Strategy will be reviewed after five years.

Key Areas for the Implementation Group

- 4.3 The DHSSPS will be asking the Implementation Group to consider and advise on the approach to sexual health services through primary and secondary care. In addition, the Group will consider the need for additional research to help monitor and evaluate progress of the Strategy and Action Plan, training issues and the development and dissemination of information including

examples of best practice.

Resources

- 4.4 The Department of Health, Social Services and Public Safety will make £125,000 available in the first year to implement the Strategy and Action Plan with continued support over the five year lifespan.

EQUALITY IMPACT ASSESSMENT

1. Introduction

Northern Ireland Act 1998

- 1.1 Section 75 of the Northern Ireland Act 1998 requires the Department of Health, Social Services and Public Safety (DHSSPS) in carrying out its functions relating to Northern Ireland, to have due regard to the need to promote equality of opportunity:
- between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
 - between men and women generally;
 - between persons with a disability and persons without; and
 - between persons with dependants and persons without.
- 1.2 In addition, without prejudice to the above obligation, DHSSPS should also, in carrying out its functions relating to Northern Ireland, have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.
- 1.3 Consequently, each public authority is required to:
- review its policies and procedures to determine whether there is any adverse or differential impact as regards equality of opportunity in relation to any of the S75 groups;
 - make changes to address any identified adverse or differential inequalities;

- consider new ways of working to better promote equality of opportunity among the S75 groups.

1.4 An Equality Impact Assessment (EQIA) is a thorough and systematic analysis of a policy to determine the extent of differential impact upon the relevant groups and, in turn whether that impact is adverse. Adverse impact is where it has a negative impact on groups or individuals in relation to one or more of the S75 groups.

2. Aim of the Strategy and Action Plan

2.1 Sexual health is an important part of physical, emotional, mental and social wellbeing. Chapter 1 of this Strategy and Action Plan sets out why we need a Strategy, the social climate which can affect sexual health, and information on the number of sexually transmitted infections, number of unplanned teenage pregnancies and sexual behaviour in Northern Ireland.

2.2 The Strategy and Action Plan aims to improve, protect and promote the sexual health and wellbeing of the population in Northern Ireland. Actions to achieve the aims include raising awareness of sexual health issues through public information campaigns, sexual health education programmes, and providing appropriate and accessible sexual health information and services. The policy will also address inequalities by targeting vulnerable groups including:

- those aged under 20 years, including looked after children
- those aged between 20- 34 years

- gay and bisexual men
- commercial sex workers.

It will also ensure that the particular requirements of people with a disability and those from a black and minority ethnic background are taken into account and addressed.

3. **Groups affected by the Policy**

- 3.1 The Strategy and Action Plan is aimed at improving the sexual health of the whole population. Although it will affect all of the groups outlined in paragraph 1.1 the Strategy identifies age, gender, sexual orientation, disability and racial group as having particular requirements.

4. **Consideration of Available Data and Research**

- 4.1 There are a number of sources for sexual health data, with information on the nine equality groups. These are:
- Sexually transmitted infections (KC60);
 - Pupils' sexual experience - Young Person's Behaviour and Attitude Survey 2000;
 - Sexual attitudes and lifestyles of young people (aged 14-25) – Towards Better Sexual Health 2002;
 - Births to teenage mothers (General Register Office);
 - Legal Abortions in England and Wales on NI residents (Abortion Statistics 2001 published by the Office for National Statistics);
 - Health and Social Wellbeing Survey 2001– sexual health section;

- Beliefs, Attitudes and Experiences about relationships and sexual education in post-primary Catholic Schools 2002 – ACCORD;
- Data from the Sexual Attitudes and Lifestyles Survey 2000 in England;
- Love for Life Survey 2002;
- Vital Statistics Ireland 2000;
- Unlinked Anonymous Seroprevalence Survey for HIV (PHLS);
- Meeting the Challenge? Young People Leaving the Care of Social Services and Training Schools in Northern Ireland;
- A Mighty Silence; A Report on the Needs of Lesbians and Bisexual Women in Northern Ireland; and
- Disability and Sexuality: access to Family Planning Services.

A number of the data sources listed above are surveys and therefore are subject to sample error. Where differences between groups have been highlighted, the differences have been tested for statistical significance.

4.2 Data from each of these sources has been grouped under the nine equality group headings.

4.3 Summary

- More males than females attended GUM clinics suffering from syphilis, gonorrhoea or HIV. More females than males were suffering from herpes. There was no real difference by gender for chlamydia or warts.

- A significantly higher proportion of girls than boys aged 11-16 used something to prevent pregnancy the first time they had sex.
- A significantly higher proportion of males than females learnt about sexual matters from friends, while a significantly higher proportion of females than males learnt from lessons at school or their mother.
- There was no significant difference by gender in the proportion who said they had changed their lifestyle because of concern of catching AIDS or HIV virus (18% of males and 19% of females).
- A much higher proportion of males than females thought that sex between men was always wrong. A higher proportion of females than males thought that sex between women was always wrong.
- A much higher proportion of females (75%) than males (46%) reported never carrying condoms.
- A higher proportion of males than females felt that staff in sexual health clinics were disapproving. A higher proportion of females than males felt that staff were supportive.
- The highest rates for initial contacts with GUM clinics were in the 20-24 years age group.
- A higher proportion of people aged 16-24 reported that they had changed their lifestyle than respondents aged 35-44.
- A higher proportion of people who first had sex when they were under 16 than those aged 16-25 reported they would have liked to know more about sexual matters before they first had sex.
- A higher proportion of people aged under 16 than those aged 16-25 thought that sex between two men or women was always wrong.

- There was little difference in the proportion of people who never carried condoms between people aged under 16 (64.9%) and 16-25 (62.2%).
- 30% of females who had abortions in England or Wales were aged between 20 and 24 – 50% were aged between 20 and 29.
- The proportion of teenagers experiencing sexual intercourse increases with age.
- In Northern Ireland, 86% of gay men are under 40 years of age. This is based on the Vital Statistics Northern Ireland 2002, but given the sample was recruited at Gay Pride events and on the gay scene, it may be reasonable to assume the sample to be younger and therefore the real proportion under 40 in the Northern Ireland population would be less than 86%.
- A higher proportion of Protestants than Catholics thought that sex between two men or women was always wrong.
- During 2001/02, 19% of men suffering from gonorrhoea attending GUM clinics were homosexual.
- In England, Scotland and Wales 10.9% of people who reported having homosexual sex had been diagnosed with an STI in the past 5 years. This is significantly higher than 2.7% of people who reported not having homosexual sex.
- In Northern Ireland, exactly half the gay men had tested for HIV and 7% of those were positive.
- HIV prevalence is higher among homosexual or bisexual males than for heterosexual males or females.
- Six months after discharge 1:5 of the young people leaving care and 2:5 of those leaving training school were, or had been, pregnant.

- 46% of lesbian or bisexual women had experienced discrimination at work and 20% had experienced violent assaults.
- Only 26% of family planning clinics could provide sex education, family planning and/or sexual health information for those with sensory and developmental/intellectual disability.

GENDER

Sexually Transmitted Infections

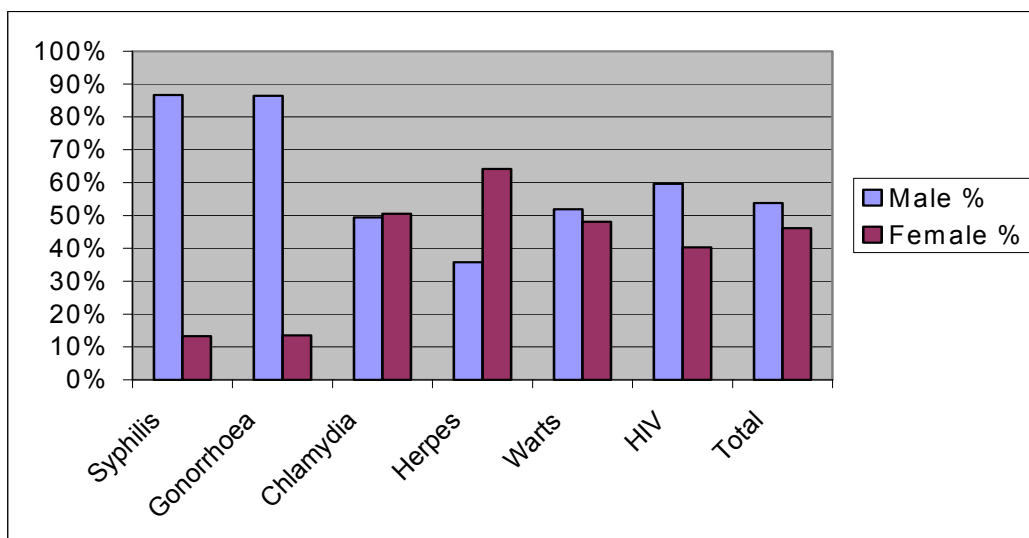
The graph below shows the number of initial contacts at Genitourinary Medicine (GUM) Clinics.

During 2001/02, 87% of people who attended GUM clinics suffering from syphilis were male and 86% of those suffering from gonorrhoea were male. 60% of people attending for HIV were male. 60% of people attending for HIV were male.

More females than males attended GUM clinics suffering from herpes (64%).

For chlamydia and warts, there is no real difference in terms of numbers for males and females.

Figure 1. Number of initial contacts at GUM clinics by gender 2001/02

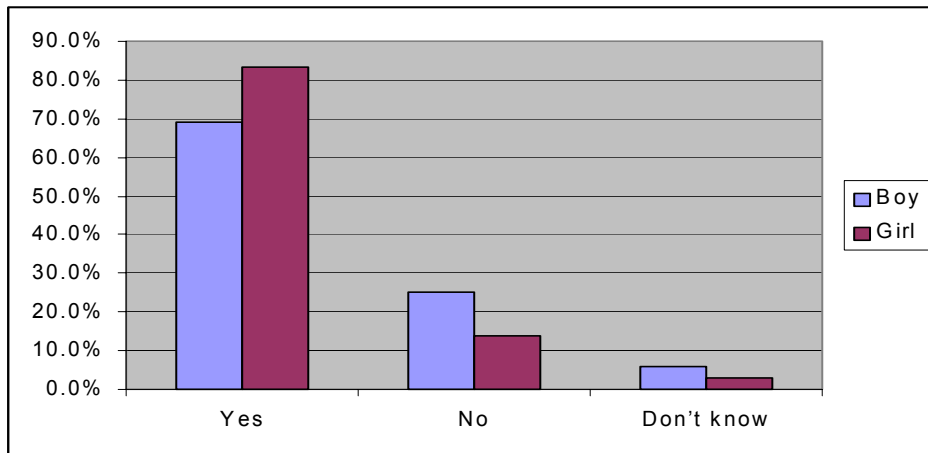


Source: KC60

Young Person's Behaviour and Attitude Survey 2000

A significantly higher proportion of girls than boys aged 11–16 used something to prevent pregnancy when they first had intercourse.

Figure 2. Did you or your partner use something to prevent getting pregnant?

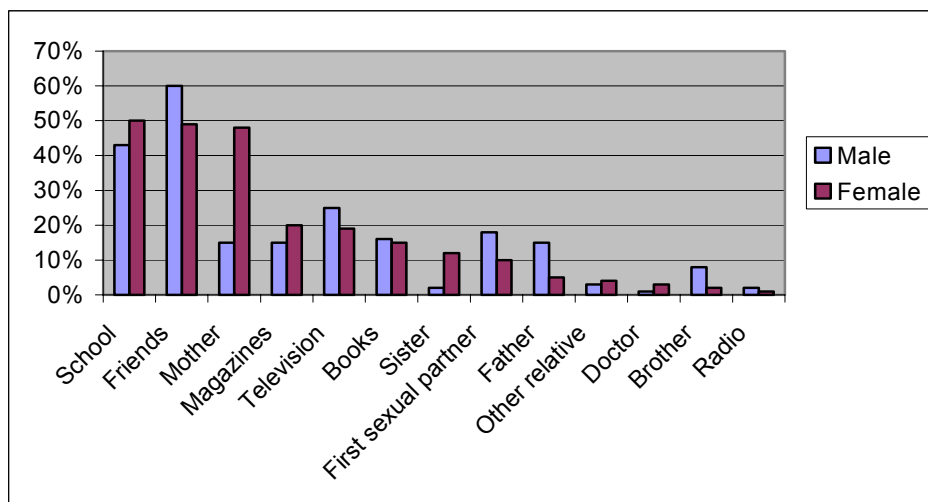


Source: Young Person's Behaviour and Attitude Survey 2000

Health and Social Wellbeing Survey 2001

Figure 3 shows the ways respondents learnt about sexual matters when they were growing up. The most common were through lessons at school or from friends and for females, from their mother.

Figure 3. How respondents learnt about sexual matters (all persons aged 16-44)



Source: Health and Social Wellbeing Survey 2001

A significantly higher proportion of males than females learnt from friends, while a significantly higher proportion of females than males learnt from lessons at school or their mother.

Respondents were asked if they had changed their sexual lifestyle because of concern of catching AIDS or HIV virus. There was no significant difference by gender in the proportion who said they had changed their lifestyle (18% of males and 19% of females).

Towards Better Sexual Health 2002

The table below shows the percentage of respondents who would have liked to know more information about particular items when they first had sex. There is little difference between males and females for each information need but a higher proportion of males than females wanted to know more about pregnancy and homosexuality and bisexuality.

Table 1. What respondents would have liked to know more about when they first had sex

	Male	Female
Safer sex techniques	42.9	39.8
STIs	37.5	35.9
Contraception	31.7	31
Pregnancy	26.8	23.5
Homosexuality & bisexuality	12.5	7.2

Source: Towards Better Sexual Health

Respondents were asked if they thought that sex between two men was wrong (Table 2). A much higher proportion of males (58.9%) than females (34%) reported that it was always wrong while a higher proportion of females (31.1%) than males (23.4%) thought it was not at all wrong.

Table 2. Attitudes towards homosexuality between two men

	Males	Females
Always	58.9	34
Mostly	3.5	8.6
Sometimes	5.5	6.4
Rarely	3.2	9.1
Not at all	23.4	31.1

Source: Towards Better Sexual Health 2002

When asked if they thought that sex between two women was wrong (Table 3), a higher proportion of females (33.6%) than males (23.6%) said that it was always wrong while a higher proportion of males (48.9%) than females (31.7%) thought it was not at all wrong.

Table 3. Attitudes towards homosexuality between two women.

	Males	Females
Always	23.6	33.6
Mostly	3.8	9.3
Sometimes	10.0	7.1
Rarely	8.3	8.3
Not at all	48.9	31.7

Source: Towards Better Sexual Health 2002

When asked if they carried condoms, 46.4% of men said that they never did and 21% said that they did when going out or on holidays. This compares to 75% of females who never carry condoms and only 6.6% who carry them when going out or on holidays.

In general, a higher proportion of females than males felt that staff in sexual health clinics were supportive. A higher proportion of males than females felt that staff were disapproving.

Table 4. Satisfaction with services at sexual health clinics.

	Males	Females
General Practitioner		
Supportive	44.8	60.2
Informative	34.5	28.7
Disapproving	20.6	11
Family Planning Clinic		
Supportive	53.2	70.6
Informative	25.0	21.8
Disapproving	21.9	7.5
Brook		
Supportive	53.3	80.0
Informative	20.0	16.3
Disapproving	26.7	3.8

Source: Towards Better Sexual Health 2002

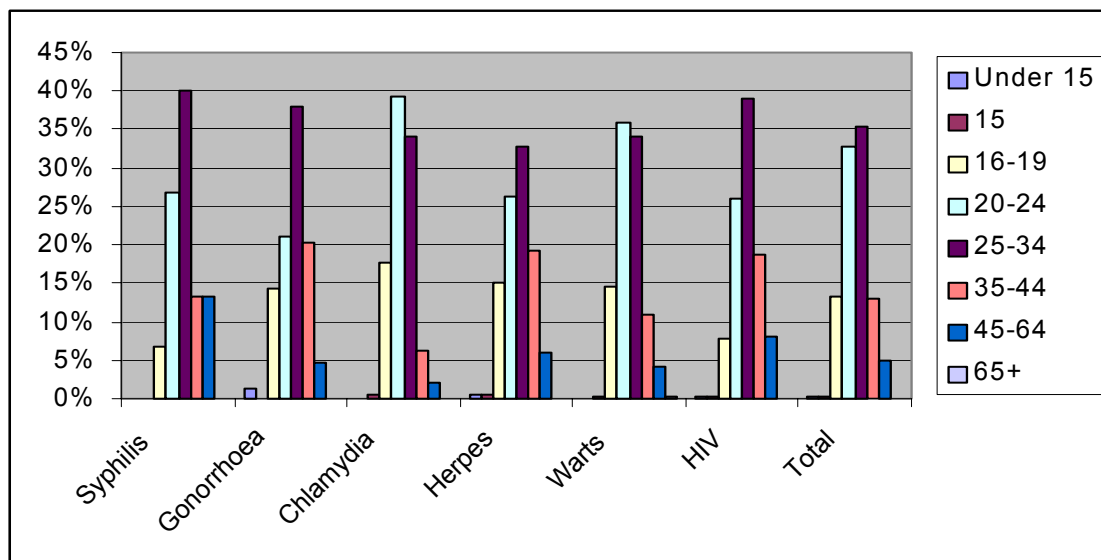
AGE

Sexually Transmitted Infections

The graph below shows the number of initial contacts at Genitourinary Medicine (GUM) Clinics.

The vast majority of people suffering from STIs are in the age groups 20-24 or 25-34 (68% overall). Very few people are aged 15 or under or over 65.

Figure 4. Number of initial contacts at GUM clinics by age group 2001/02



Source: KC60

The calculation of contact rates takes into account the age breakdown of the population in Northern Ireland. Contact rates per 100,000 for each age group are given in the table below. The rate is highest for people aged 20-24.

Table 5. Initial contact rates per 100,000 at GUM clinics by age group

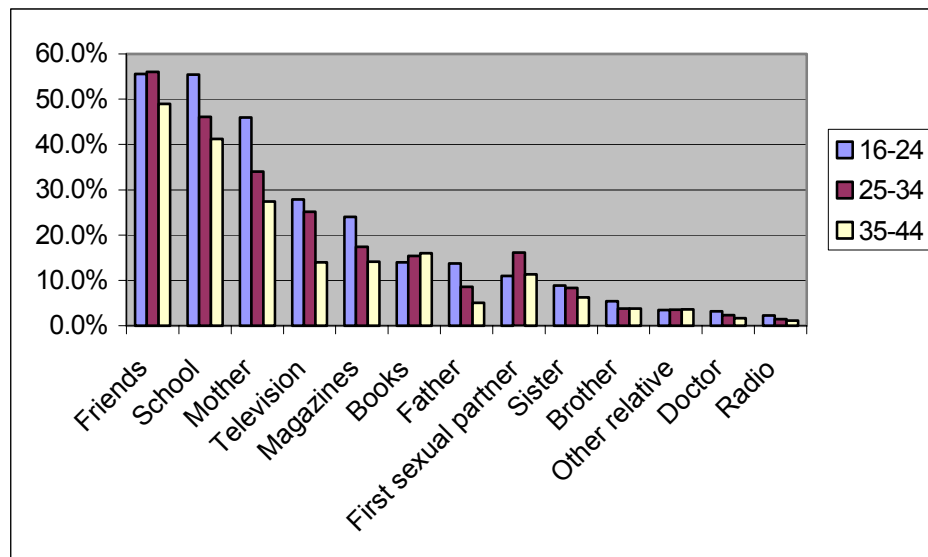
	Under 15	15	16-19	20-24	25-34	35-44	45-64	65+	All ages
Rates per 100,000	2	55	624	1445	709	252	65	3	287

Source: KC60 Mid Year population estimates 2001

Health and Social Wellbeing Survey 2001

The graph below shows the ways respondents learnt about sexual matters when they were growing up by age group. The most common for all three age groups were through lessons at school, friends and from their mother.

Figure 5. How respondents learnt about sexual matters (aged 16-44)



Source: Health and Social Wellbeing Survey 2001

Respondents were asked if they had changed their sexual lifestyle because of concern of catching AIDS or HIV virus. A significantly higher

proportion of people aged 16-24 reported that they had changed their lifestyle than respondents aged 35-44.

Towards Better Sexual Health 2002

First intercourse was most likely to occur at 15 or 16 years (20% and 18.7% of respondents respectively). About a third (36.7%) of all respondents had intercourse before 17, which is the legal age of sexual consent in Northern Ireland.

The table below shows the percentage of respondents who would have liked to know more information about particular items when they first had sex. A higher proportion of those who first had sex when they were under 16 wanted to know more about all the aspects listed in the table than those who first had sex when they were over 16.

Table 6. What respondents would have liked to know more about when they first had sex

	Under 16	Over 16
Safer sex techniques	50.2	34.2
STIs	40.2	34.6
Contraception	37.2	26.9
Pregnancy	30.9	19.2
Homosexuality & bisexuality	13	6.1

Source: Towards Better Sexual Health 2002

Respondents were asked if they thought that sex between two men was wrong. A much higher proportion of people aged under 16 (54.5%) than those aged over 16 (35.8%) reported that it was always wrong while a higher proportion of people aged over 16 (34.8%) than those aged under 16 (19.6%) thought it was not at all wrong.

Table 7. Attitudes towards homosexuality between two men

	Under 16	Over 16
Always	54.5	35.8
Mostly	7.2	6.0
Sometimes	4.7	7.1
Rarely	6.1	7.1
Not at all	19.6	34.8

Source: Towards Better Sexual Health 2002

When asked if they thought that sex between two women was wrong, a higher proportion of people aged under 16 (34.7%) than those aged over 16 (25.1%) said that it was always wrong while a higher proportion of those aged over 16 (42.3%) than those aged under 16 (34.2%) thought it was not at all wrong.

Table 8. Attitudes towards homosexuality between two women.

	Under 16	Over 16
Always	34.7	25.1
Mostly	7.9	6.4
Sometimes	6.8	9.6
Rarely	9.2	7.5
Not at all	34.2	42.3

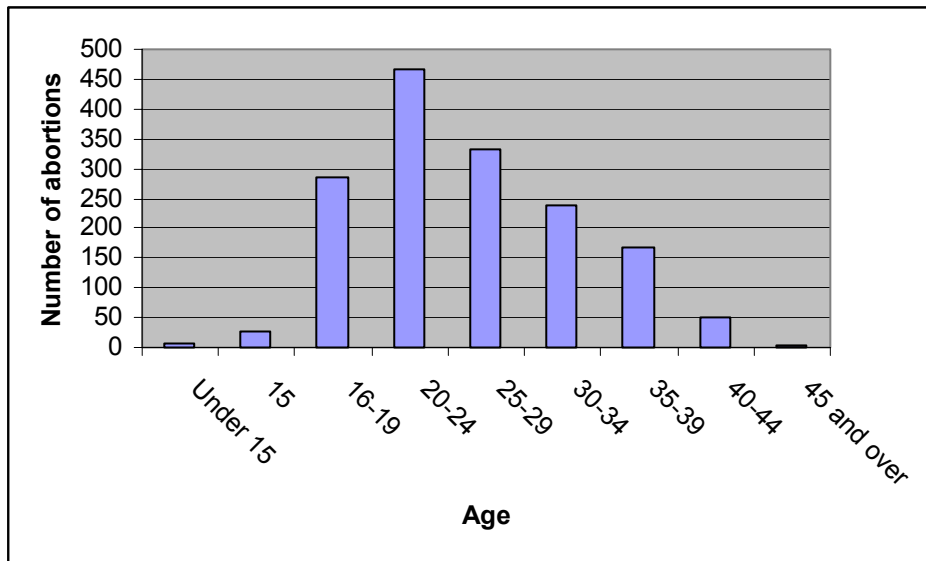
Source: Towards Better Sexual Health 2002

Respondents were asked whether or not they carried condoms. There was little difference in the proportion who never carried condoms between people aged under 16 (64.9%) and over 16 (62.2%).

Abortion Statistics 2001

The graph below shows the age breakdown of females from Northern Ireland who had abortions in England or Wales during 2001. 29.5% were aged between 20 and 24 and just over 50% were aged between 20 and 29.

Figure 6. Legal abortions in England or Wales 2001 – NI residents



Source: Abortion Statistics 2001

Love for Life Survey 2002

This survey was last conducted in 2002 and was completed by young people in schools in the Southern Education and Library Board to assess risk taking behaviour in post primary school children.

Table 9. Proportion of boys and girls in each age category answering YES to the question ‘ Have you ever had sexual intercourse?’

Ever had intercourse?	Age category		
	14 years	15 years	16 years plus
Males	16.4%	25.1%	37.5%
Females	11.8%	20.4%	29.1%

Source: Love for Life Survey 2002

As age increase, more boys than girls indicated that they had experienced sexual intercourse.

Table 10. Proportion of those who had ever had sexual intercourse answering YES to 'Have you had sexual intercourse in the last month?'

Intercourse in last month?	Age category		
	14 years	15 years	16 years plus
Males and females	4.8%	9.0%	13.8%

Source: Love for Life Survey 2002

As age increases, the proportion of young people who are sexually active increases.

Vital Statistics Ireland

This survey was conducted in 2000 across Ireland and the sample contains men who had sex with a man in the last year or who expected to have sex with a man in the future.

In Northern Ireland, 85.5% of gay men are under 40 years of age. At an all Ireland level, most gay men acquiring HIV are under 40.

Meeting the Challenge? Young People Leaving the Care of Social Services and Training Schools in Northern Ireland

This research was published in 1996 and describes the experience of young people leaving the care of both social services and Training Schools. Its findings show that:

- two fifths of the young people leaving Board care and three quarters leaving Training School had received formal preparation for leaving;
- young people leaving Board care from a residential placement were the most likely to receive preparation;

- six months after discharge 1:5 of the young people leaving care and 2:5 of those leaving training school were, or had been, pregnant.

The report recommended that:

- in preparing young people for leaving state care the full range of their psycho-social needs should be addressed with particular attention to family relationships, to sex and sexuality and to education, training and employment.

RELIGIOUS BELIEF

Towards Better Sexual Health 2002

Respondents were asked if they thought that sex between two men was wrong. A much higher proportion of Protestants (56.6%) than Catholics (32.4%) or any other group reported that it was always wrong.

Table 11. Attitudes towards homosexuality between two men

	Catholics	Protestants	Atheists	Other
Always	32.4	56.6	23.1	48.6
Mostly	6.3	7.5	1.5	4.1
Sometimes	8.4	4.1	4.6	8.1
Rarely	8.1	6.4	3.1	5.4
Not at all	35.0	16.3	61.5	31.1

Source: Towards Better Sexual Health 2002

When asked if they thought that sex between two women was wrong, a higher proportion of Protestants (39.6%) than Catholics (20.2%) said that it was always wrong.

Table 12. Attitudes towards homosexuality between two women

	Catholics	Protestants	Atheists	Other
Always	20.2	39.6	10.8	35.6
Mostly	5.8	8.7	3.1	4.1
Sometimes	9.4	7.3	6.2	12.3
Rarely	9.9	8.4	3.1	4.1
Not at all	45.0	27.6	72.3	41.1

Source: Towards Better Sexual Health 2002

SEXUAL ORIENTATION

Sexually Transmitted Infections (KC60)

During 2001/02, of all the men suffering from gonorrhoea attending GUM clinics for an initial contact, 19% were homosexual.

NATSAL

In 2000, 2.6% of men in England, Scotland and Wales reported having homosexual sex in the past 5 years. This is a significant increase from 1990 when 1.5% of respondents reported having homosexual sex.

Of respondents who reported having homosexual sex, 10.9% had been diagnosed with an STI in the past 5 years. This is significantly different to the figure for men who did not report having homosexual sex, 2.7% of whom were diagnosed with an STI.

Vital Statistics Ireland

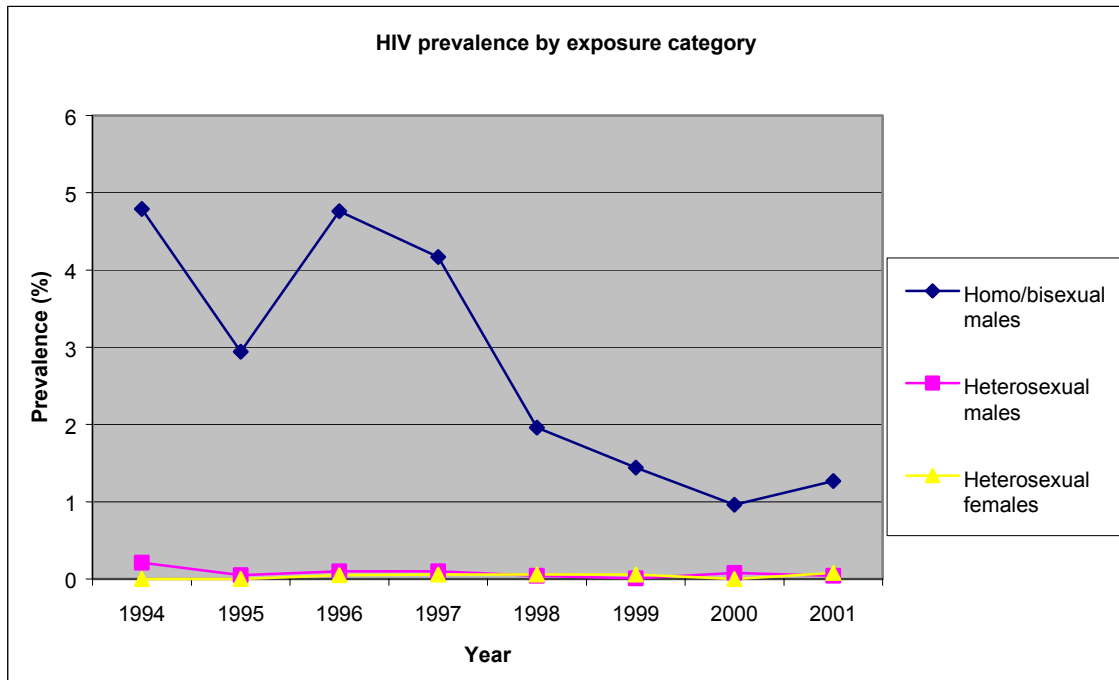
This survey was conducted 2000 and the sample contains men who had sex with a man in the last year and those who expected to have sex with a man in the future.

In Northern Ireland, exactly half the men had tested for HIV and 7% of those were positive.

Unlinked Anonymous Seroprevalence Survey for HIV (Belfast)

The graph shows that HIV prevalence rates among people attending GUM clinics in Belfast are higher for homosexual or bisexual males than for heterosexual males or females.

Figure 7. HIV Prevalence rates among people attending GUM clinics in Belfast.



Source: Unlinked Anonymous Seroprevalence Survey for HIV (Belfast)

A Mighty Silence: A Report on the needs of Lesbians and Bisexual Women in Northern Ireland

This report, which was published in March 2002, includes an assessment of the current needs and services available within the lesbian community in Northern Ireland. The findings highlight that:

- 20% of those interviewed had experienced violent assaults and none of these had reported the incident to the police;
- 46% of those interviewed state they had experienced discrimination at work;

- young lesbians and bisexual women continue to face rejection by their families, discrimination and harassment;
- experience of young women interviewed revealed that sexual orientation is largely ignored in our schools and the process of coming out can be an isolating and difficult experience;
- issues around sexual health of lesbian and bisexual women should be addressed.

Discussions with the voluntary sector have highlighted issues for gay and bisexual men women including:

- accessibility to GP and GUM services, particularly in rural communities;
- a perception that primary care attitudes, values and principles affect the quality of service provided;
- a perception of a lack of privacy/ confidentiality; and
- education system not addressing the needs of gay, lesbian and bisexual young people which in turn impacts on mental health and wellbeing and can lead to other risk taking.

DISABILITY

There is limited information available on the sexual health of those with a disability. However, discussions with the voluntary sector have highlighted issues for those with a disability, including:

- a lack of recognition that a person with a disability can participate in full sexual and family relationships;
- lack of consistent sex education across Northern Ireland within schools, including special schools and day centres;

- access to sexual health services for those with a physical, mental health, sensory, learning or hidden disability e.g. ramped/flat entrances, accessible treatment rooms, tables and toilets, large print signs etc.;
- access to sexual health information and advice particularly for those with a sensory impairment or learning disability e.g. provision of information in accessible formats such as audio tape, use of plain English and pictures and provision of sign language interpreters;
- lack of recognition of the needs of gay and bisexual people with disabilities;
- potential for abuse of vulnerable adults due to lack of information and knowledge; and
- issues for those who acquire a disability during their lifetime.

Disability and Sexuality: Access to Family Planning Services

This survey, which was carried out in 1998, assessed the levels of access for disabled people to family planning, sex education and sexual health in Northern Ireland. Questionnaires were completed by clinic staff. The findings highlighted that:

- 20-25% of family planning clinics are not accessible;
- less than half of the clinics had tactile floorways or large print signs;
- only 4 clinics had minicom systems. Of these only 2 were located in treatment rooms;
- only 26% of clinics could provide sex education, family planning and/or sexual health information for those with a sensory and development/intellectual disability;

- staff in 10 clinics had received disability awareness training, although in the majority (8) training had been to less than 25% of staff.

RACIAL GROUP

There is no information available on the sexual health of those from an ethnic minority background. However, responses to consultations on sexual health strategies in England and Scotland highlighted difficulties with accessing services and information including education services. Discussions with the voluntary sector here highlighted similar difficulties and also given the sensitivity of the subject the importance of confidentiality and privacy.

5. Assessment of Impact

- 5.1 Consideration of the data in paragraph 4 and discussions with voluntary organisations suggests that of the categories listed in 1.1 the groups most likely to be affected are age, gender, sexual orientation, disability and race.
- 5.2 In developing the Strategy the Working Group recognised that:
 - sexual ill-health is not evenly distributed throughout the population;
 - young people and gay and bisexual men mainly account for the increase in STIs;
 - the strong links between social deprivation and STIs, and teenage pregnancies;
 - the particular requirements of people with a disability and those from a black and minority ethnic community

e.g. access to sexual health information, education and services; and

- negative and discriminatory attitudes towards lesbian, gay, bisexual and trans-sexual people could have an adverse impact on access to provision of services.

- 5.3 The Strategy and Action Plan identifies four priority groups – under 20 year olds, under 35s, gay and bisexual men and commercial sex workers. It also highlights the particular requirements of people with a disability and those from a black and minority ethnic community.
- 5.4 The specific actions contained in the Plan have been developed with these groups in mind and it is the Department's view that they should not have an adverse impact on any of the groups. The actions should promote equality of opportunity by ensuring that sexual health information and services, education initiatives, public information campaigns are developed to take account of the specific requirements of the particular groups; and that professionals and others working in the field of sexual health receive relevant training and skills and are aware of the particular requirements of different groups. In addition the actions relating to education, training and public information campaigns will help to reduce negative attitudes and discrimination.
6. **Monitoring of Impact of Policy**
- 6.1 An Implementation Group is to be established to take forward the Action Plan. This group will advise on a research programme and report progress on an annual basis to the Ministerial Group on Public Health. Surveys will also be used to monitor progress [see Chapter 4, paragraph 4.3].

ANNEX 2

DEFINITION OF ACUTE SEXUALLY TRANSMITTED INFECTIONS

The Health Promotion Agency in England defines the following diagnoses as acute sexually transmitted infections:

Infectious syphilis

Uncomplicated gonorrhoea (post pubertal)

Complicated gonorrhoea

Chancroid/lymphogranuloma venereum (LGV)/donovanosis

Chlamydia infection (uncomplicated and complicated)

Uncomplicated non-gonococcal/non-specific urethritis in males

Complicated non-gonococcal/non-specific infection

Herpes simplex (first attack)

Genital warts (first attack)

Molluscum contagiosum

Trichomoniasis

Scabies/pediculosis pubis.

This classification is used in the Public Health Laboratory Service's report 'Sexually Transmitted Infections in the UK: New Episodes seen at Genitourinary Medicine Clinics, 1991 – 2001'.

The source for this data is the KC60 statistical return.

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