

SUMMARY OF RESPONSES TO CONSULTATION ON THE DRAFT SEXUAL HEALTH PROMOTION STRATEGY AND ACTION PLAN.

BACKGROUND

- 1.1 Sexual health is an important part of physical and mental health as well as emotional and social wellbeing. The overarching, Investing for Health Strategy, which was published in 2002, committed the Department to developing a Sexual Health Promotion Strategy and Action Plan. A draft Sexual Health Promotion Strategy and Action Plan which included an equality impact assessment was subsequently developed by an inter-sectoral working group.

CONSULTATION

- 2.1 The draft Strategy and Action Plan was issued for a 12 week public consultation exercise which ended on 19 March 2004. The consultation documents included the draft Strategy and a Questionnaire. The Questionnaire highlighted a number of key issues within the Strategy on which the Department particularly welcomed views.

- 2.2 The consultation Questionnaire elicited 164 responses. These came from a variety of sources including HSS Boards and Trusts, education sector, voluntary and community sector, political representatives, district councils, churches/other faith groups and the general public. The responses to the consultation greatly helped in the further development of the Strategy. [D.N. *It should be noted that the draft Strategy was not finalised for some time as a result of the high priority being given to smoke-free legislation and also suicide prevention*].

- 2.3 The main comments received to the 15 consultation questions are summarised below:

Q1 Do you agree with the overall aim of the Strategy set out in paragraph 2.1? If not, what do you think the overall aim should be?

- 2.4 There were 68 responses to this question. The overall aim of the Strategy was agreed by the majority (85%) with only 15% disagreeing. A number of respondents suggested that the aim should also refer to the importance of prevention/abstinence or delaying first sexual activity. Some respondents also referred to the need to mention relationships and appropriate behaviour.

Q2 Do you agree with the objectives set out in paragraph 2.3? If not, why not?

- 2.5 There were 137 responses to this question. The objectives were agreed by the majority (86%) and only (14%) disagreed. Some respondents suggested

additional objectives including one based on around preventing sexual ill health and unhealthy sexual choices, one around sexual dysfunction, one around education and school curriculum, one around expansion of GUM services and some on same sex relationships and stigma associated with STIs. A number of respondents indicated that they felt the objectives needed to be strengthened and should be SMART. Some respondents were concerned that the objectives concentrated too much on reducing the negative rather than encouraging positive aspects of sexual behaviour. A number of respondents felt that the objectives were unbalanced towards service provision and intimated more emphasis required on behaviour modification. Some also expressed concern about the allocation of adequate resources for implementation and the issue of equitable access to GUM services.

Q3 Do you agree with the priority groups set out in paragraph 2.6? If not, why?

2.6 There were 59 responses to this question. The overwhelming majority of respondents (92%) agreed with the priority groups as set out in the draft Strategy with only (8%) in disagreement. A number of respondents disagreed with the age bandings used ie under 20s and 20 to 34 age groups and suggested that children also be identified as a separate or special category. Some respondents indicated that the under 17s should be identified as a specific group with the older group being 18 to 34 to take account of the legal definition of childhood in Northern Ireland. A small number of respondents disagreed with using “up to 34 years of age” as they felt specific sexual health needs exist above this age group limit. Other priority groups suggested by respondents included victims/survivors of sexual abuse, young men, young women, young offenders/prison population, all young people travelling abroad, drug users, migrant population/travellers, those at risk of sexual exploitation or under age of consent and those unable to give consent because of mental/physical disability.

Q4 Do you agree with the target specified in paragraph 2.7? If not, why?

2.7 There were 126 responses to this question. The majority (89%) agreed with the target specified with approximately (11%) disagreeing. While a high number of respondents were in agreement with the target some also felt that it was too ambitious or optimistic for the timescale set and dependent on the allocation of adequate resources. Some respondents intimated that it might be useful to separate various STIs and set a target for each, including HIV. A number of respondents referred to the omission of abstinence and the contrast with the safe sex/condom approach.

2.8 In addition, a high number of respondents wanted inclusion of an additional target from the Teenage Pregnancy & Parenthood Strategy ie “75% of teenagers should not have experienced sexual intercourse by age of 16”. Other targets also

suggested by respondents included one around attitudes to same sex relationships, one for reduction of specific STIs and for re-infections, one centered on pro-actively delaying sexual activity and one based on access time for services.

Q5 Do you agree with the proposed actions for prevention set out after paragraph 3.6 of Chapter 3? Are there other actions you consider should be included?

2.9 There were 66 responses to this question. Approximately 82% of the respondents agreed with the actions on prevention with around 18% disagreeing. A small number of respondents replied to the question but were non-committal about agreeing or disagreeing. A high number of respondents commented on the importance of abstinence programmes and the need to include parents in preventative actions. Many believed it is necessary to have good cross sectoral working/partnership between the health and education sectors in all proposed actions.

2.10 Many respondents stated that there needs to be statutory action to include screening and monitoring of infection rates. The issue of an action around screening for chlamydia was also highlighted. In addition respondents suggested a number of additional actions including discouraging/delaying sexual activity, one on ascertaining the prevalence of STIs outside GUM, one on LGBT groups, action around behavioural changes/lifestyles and one on public information campaigns to explicitly encourage abstinence among young people.

Q6 Do you agree with the proposed actions for education and training set out after paragraph 3.7 of Chapter 3? Are there other actions you think should be included?

2.11 There were 62 responses to this question. The vast majority (89%) of respondents stated they were in agreement with the proposed actions and only 11% stated they disagreed. Some respondents expressed concern about the need to develop an agreed/appropriate regional strategic training framework to ensure consistency and standards. A high number of respondents were also concerned about the cost implications of training and how training would be filtered to the voluntary/community sectors. The issue of training for teachers in RSE was also mentioned and the impact on Section 75 Groups and parents rights.

2.12 A number of respondents intimated that an “abstinence based approach” should be given greater involvement in education and training especially with young people. Some other respondents suggested that the Department should introduce mandatory accredited training and the issue of confidentiality should be clarified first before any new education/training programmes are undertaken.

2.13 In addition a number of respondents were concerned about the CCEA guidelines and the appropriateness of training provided within the school curriculum (Hall 4). The training of staff dealing with disabled service users was also seen as being problematic and needed to be addressed. Other issues mentioned included the LARATOT initiative and cascade training for RSE.

Q7 Do you agree with the proposed action for services set out after paragraph 3.15 of Chapter 3? Are there other actions you consider should be included?

2.14 There were 50 responses to this question. The overwhelming majority 92% of respondents agreed with the proposed action for services with only 8% disagreeing. Some respondents suggested that the particular wording of the action should change to “will implement the report” and that GUM services might be improved through greater partnership working with voluntary sector organisations.

2.15 A number of respondents also suggested additional actions including an action relating to primary healthcare settings to prevent STIs, one that services should include testing for STIs, one relating to family planning services, an action to enhance unmet needs in a range of services such as contraception, advice and GUM and a specific action for service providers.

2.16 Some respondents expressed concern about the need to expand GUM services, that these services should also be made more flexible in relation to opening hours and at weekends/evenings. A number of respondents also stated that GUM/STI services should be managed in the community or non-hospital setting for ease of access and outreach services provided in rural areas such as a “one stop clinic”. Other issues raised by respondents included the attitude of staff and their level of training and the difficulties for those with disabilities using screening services.

Q8 Do you agree with the proposed action for data collection and research set out after paragraph 3.17 of Chapter 3? Are there other actions you consider should be included?

2.17 There were 47 responses to this question. None of the respondents disagreed with the proposed action for data collection and research. Some respondents were concerned about the adequacy of proposed resources/budget to deliver the programmes/research and that commissioners of research should be aware of issues around Section 75. Other respondents suggested that any proposed surveys should be undertaken by independent groups and not lobby groups. A number of respondents intimated that as well as attitudes information was needed on knowledge and behaviours in relation to sexual health.

2.18 Some respondents stated that data collected should be centrally held and all interested agencies should have access. A number of respondents also felt that data collection/research should not be a one-off but replicated at intervals throughout the lifespan of the strategy.

Q9 The process of equality impact assessment is a new field of work for most statutory organisations. Do you agree with the assessment as set out in Annex 1?

2.19 There were 47 responses to this question. The majority of respondents 87% agreed with the Equality Impact Assessment (EQIA) but some also intimated that the limited data available restricted its validity. Those disagreeing with the EQIA were concerned about issues relating to RSE/education and how the needs of Lesbian, Gay, Bisexual and Transgendered Groups were not adequately addressed. Some respondents suggested that there should be ongoing monitoring during the implementation stage to ensure equality of opportunity for all. The point was made that if possible the strategy should be revised if such monitoring shows greater adverse impact than predicted.

Q10 Do you think the Strategy and Action Plan will have an adverse impact on any of the groups identified in paragraph 1.1 of Annex 1. If yes, please state the group or groups and any adverse impacts that you feel the proposals are likely to have on them.

2.20 There were 41 responses to this question. 56% of the respondents stated that they felt there would be no adverse impacts while 44% intimated that they believed the draft strategy would have some adverse impacts. The main groups which respondents felt would be adversely impacted included; men, the gay community, religious/faith groups, disabled and racial groups, through access to information and communication.

2.21 A number of respondents referred to the inclusion of “sexual orientation” in the RSE guidelines and indicated that this issue would have to be dealt with sensitively by teachers to avoid adverse impact on gay/lesbian pupils.

Q11 Please state how these adverse impacts could be reduced or alleviated in the proposals?

2.22 There were 25 responses to this question. A number of respondents suggested that by giving greater prominence to the abstinence/delayed sex behavioural approach would help alleviate any adverse impacts. Some respondents referred to Section 75 Groups and felt these groups should be consulted at implementation stage to ensure their needs are met and to identify adverse impacts. It was also

stated that racial and disability groups have problems with awareness and communication issues and should be given much greater help in order to alleviate adverse impacts. Other respondents referred to RSE programmes in schools and the possibility of adverse impacts on students if experienced /trained teachers are not used in their delivery. A new inclusive strategy group was also advocated to replace current process.

Q12 If you feel the adverse impacts cannot be alleviated within the current proposed actions, please suggest alternative actions that could be considered to reduce the differential impact on the group or groups.

2.23 There were only 17 responses to this question. A number of the respondents indicated that there may be health benefits by adopting behavioural approaches such as abstinence/delaying first sex. Some others suggested that specialised training for teachers in personal development programmes etc so that a core of trained teachers is available may also be helpful. One respondent referred to on-going monitoring during the implementation stage as a way of ensuring equality of opportunity.

Q13 The Strategy and Action Plan are intended to contribute to the promotion of human rights. Do you think that the Strategy and Action Plan promotes human rights?

2.24 There were 47 responses to this question. The majority of respondents (64%) stated that they felt the Strategy and Action Plan promoted human rights. 19% of the respondents viewed the Strategy as failing to promote human rights in one way or another. Some respondents intimated that there was no provision for the rights of parents/carers who want their children to have access to abstinence centered programmes or to be educated in their particular beliefs system. This was viewed as in conflict with Article 2 of European Convention on Human Rights (ECHR).

2.25 Other respondents referred to issues such as the rights of people with sexual dysfunction, women's rights to free access to contraceptive advice/treatment and the impact on children before and after birth as being impinged or compromised. A number also intimated that they felt the strategy presented a potential conflict with ECHR.

Q14 Are there any aspects where potential violations may occur? Please indicate whom this impacts upon.

2.26 There were 21 responses to this question. The majority of respondents (62%) suggested that there may be potential violations of human rights with (38%)

stating they felt there would be no such violations. Respondents felt potential violations could occur in relation to certain groups including older people, unborn children, people with sexual dysfunction, women, section 75 groups especially ethnic minorities, homosexual/bisexual persons, those with disabilities and unmarried/married people. The lack of complete and accurate information was seen as a major problem in identifying human rights violations.

- 2.27 A few respondents also raised issues relating to childrens human rights and service provision particularly with reference to the “Fraser Guidelines” and the “Gillick competence”.

Q15 Do you have any other comments on the Strategy and Action Plan or any suggestions that you would like to make to improve the promotion of equality of opportunity and/or good relations, or human rights?

- 2.28 There were 121 responses to this question. A high number of respondents were concerned about insufficient funding being made available to take the strategy forward. Some respondents were of the view that public funding should not be provided to promote sexual practices outside marriage or to cover advertising campaigns aimed at reducing the social stigma suffered by homosexuals. A number of respondents referred to the lack of reference to abstinence programmes and considered these programmes would be a good method to achieve the Strategy’s aims and targets.
- 2.29 The issue of RSE programmes in schools within a morals/values context was also raised. One respondent sought a review of such programmes while another stated that the Strategy undermines the current RSE programme in schools. A number of respondents expressed concern about the definition of sexual health which it was alleged makes assumptions about moral and spiritual values in Northern Ireland.
- 2.30 A number of other issues were raised by respondents including the sexual needs of disabled/older people, need for discussions with religious/faith leaders, allegation that the strategy is driven by services and lacks holistic approach, role of pharmacy in sexual health promotion, absence of Love for Life programme, that actions should reflect the existing legal framework about sexual matters in Northern Ireland and that a new inclusive Strategy Group was needed.