Department of
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AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

SEXUAL HEALTH PROMOTION

Strategy & Action Plan 2008 - 2013

Investing for Health

November 2008

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Ministerial Foreword

Since becoming Health Minister I have been increasingly concerned about the health of our population, particularly young people and the ways in which lifestyle and behaviour impact on our health.

Sexual health is an important aspect of our physical and mental well-being. While sex is to be regarded as a natural part of life, certain aspects of sexual behaviour can also have a negative impact on our health. For example, the increasing rates of sexually transmitted infections and the rate of teenage pregnancy within our population.

It is widely acknowledged that sexual health can be a controversial subject. Many people in Northern Ireland have passionate opinions about what is the best approach in this area.

In developing the sexual health strategy, much discussion around moral and religious views, cultural and lifestyle choices, and respect and tolerance has taken place to address concerns and take account of the diverse beliefs and attitudes within our society. The production of this document has been a lengthy and extensive process, but the biggest issue has always been on trying to get the emphasis right.

I believe now we have a Sexual Health Promotion Strategy and Action Plan which sets out a strategic vision for promoting positive sexual health. It aims to improve, protect and promote the sexual health and well-being of the whole population of Northern Ireland with a focus on prevention, training, education and access to services.

I would acknowledge at this time also the excellent work carried out by all those delivering sexual health services and driving forward the promotion of sexual health over recent years. I now look forward to a co-ordinated approach being deployed. I am delighted that a multi-agency Sexual Health Promotion Network is being established to oversee implementation of the

Strategy and Action Plan and provide the leadership and expertise in improving the sexual health of our population.

Michael McGimpsey
Minister for Health, Social Services & Public Safety

CHAPTER 1 - INTRODUCTION

1.1 Sexual health is an important part of physical and mental health, as well as emotional and social wellbeing.

1.2 One definition of sexual health is:

> "*A state of physical, emotional, mental and social wellbeing related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled*"[1].

1.3 Many factors can adversely impact on people's sexual health including poverty, unemployment, poor education, substance misuse and social exclusion. Improving sexual wellbeing therefore requires a holistic approach that incorporates personal, social, emotional and spiritual, as well as physical aspects of sexuality.

1.4 The promotion of good sexual health and prevention of sexual ill-health is not just a matter for health professionals. Others, including education professionals, communities, the family, and churches and other faith groups have an important role to play.

PROMOTING GOOD SEXUAL HEALTH

1.5 The *Investing for Health* Strategy, published in March 2002, provides the framework for improving health and wellbeing and reducing health inequalities. It identifies sexual health as an important part of physical and mental health and emphasises that good personal relationships

can promote health and wellbeing. It also highlights that unsafe sex can lead to sexually transmitted infections (STIs) and unplanned pregnancies.

1.6 Under the Investing for Health Framework a number of strategies already in place, or being developed will help to promote good sexual health. These include the Teenage Pregnancy and Parenthood Strategy and Action Plan, the new Strategic Direction for Alcohol and Drugs, the Promoting Mental Health Strategy and local sexual health strategies. Other initiatives such as the Strategy to tackle Sexual Violence, the Neighbourhood Renewal Strategy, and Relationships and Sexuality Education (RSE) guidelines in schools also have a positive impact.

DEVELOPMENT OF ACTION PLAN

1.7 A draft Sexual Health Promotion Strategy and Action Plan, which included an Equality Impact Assessment, was developed by an inter-sectoral Working Group and was issued for consultation. Responses from a wide range of organisations and individuals to the consultation have helped to further develop this Action Plan.

VALUES AND PRINCIPLES

1.8 This Action Plan adopts the framework of values and principles set out in the *Investing for Health* Strategy. In addition, the principles set out below are appropriate for action on sexual health promotion. These principles form the foundation of the Action Plan 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 individuals and groups.
- **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.

PRIORITIES

1.9 The Action Plan aims to promote the sexual health of the entire population and the related strategies and initiatives referred to in paragraph 1.6 will also assist this. However, as outlined in Chapter 2 some groups are particularly vulnerable and require particular action. These include:

- young people under 25 years and especially those who are looked after or leaving care;
- gay and bisexual men; and
- commercial sex workers.

Some people with a disability or from an ethnic minority community may have particular requirements in accessing information, advice and services and these must be addressed. Additionally, the number of diagnoses of HIV in persons from outside the United Kingdom is increasing and appropriate action needs to be taken regarding health promotion among such groups.

EQUALITY IMPACT

1.10 The Department considers that the Action Plan should impact positively on the health and wellbeing of the population. 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 needs of all the population and help to reduce negative attitudes and discrimination.

1.11 The Equality Impact Assessment is available online on the Department of Health, Social Services & Public Safety's website:- www.dhsspsni.gov.uk

CHAPTER 2 – CURRENT CONTEXT AND POSITION

INTRODUCTION

2.1 In Northern Ireland many people attach great importance to stable and exclusive relationships as it is widely recognised that they are the safest place to engage in sexual activity. For many people marriage is also the preferred context for a sexual relationship and the best model for family stability and raising children. In addition many believe that abstinence or delayed sexual activity in young people are healthy and positive choices and are socially acceptable.

2.2 Nowadays, in contrast to even 15-20 years ago, there is much more media discussion about sexuality which is frank, detailed and explicit. On occasions this can lead to misleading or distorted images of relationships and sexuality.

2.3 Moral or religious attitudes in Northern Ireland may discourage some people from talking about sexual issues. Some people therefore may receive mixed messages about sex and sexuality from an early age, resulting in confusion between sexuality and morality. 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. The combination of secrecy with the scale of information and sometimes misinformation in the media places young people at risk and makes it harder for some people to develop a healthy attitude to their sexual health in adulthood.

EVIDENCE OF SEXUAL HEALTH

2.4 Sexual health in Northern Ireland is poor, with high levels of teenage pregnancy and increasing numbers of sexually transmitted infections (STIs). For example, in 2006 there were 147 births to teenagers aged under 17 years and over 9,590 STI diagnoses, of which around 7,100 were new diagnoses, made by genitourinary medicine (GUM) clinics in

Northern Ireland. In addition, between 2001 and 2004 recorded sexual offences here increased by over 50%. Latest figures available show that there were over 1,800 sexual offences reported in 2006/07[2].

Sexual Behaviour

2.5 A 2003 survey of children and young people in Northern Ireland[3] (11 to 16 years of age) showed that:

- 28% had no sexual experience;
- 65% either had no sexual experience or had not experienced anything beyond kissing; and
- 11% had indicated that they had experienced sexual intercourse. Of those 69% were under 15 years of age at the time when they first experienced it.

2.6 There is limited information available on the sexual behaviour and attitudes of the adult population in Northern Ireland. However, a survey in 2001 provides some limited information on how respondents learned about sexual matters when they were growing up. For example, 53% had learnt from friends, 47% learnt from lessons at school and 35% learnt from their mothers[4].

2.7 A recent survey of the sexual health of gay men indicates that of those questioned from Northern Ireland 35% of men had an STI check-up in the last year[5].

Harassment/Discrimination

2.8 Findings of a survey in 2003 indicate that a significantly higher percentage of gay males have experienced homophobic harassment and violence than in other parts of Britain and Ireland[6]. Other research shows that young gay people reported that homophobic bullying was often ignored, accepted or even encouraged[7].

2.9 Research[8] 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.

Commercial Sex Workers

2.10 The media has highlighted prostitution as a growing problem especially in larger urban areas. However, there is little information available on commercial sex workers in Northern Ireland and few people attending GUM clinics identify themselves as being involved in prostitution.

Unplanned Pregnancies

2.11 Unplanned pregnancy and parenthood can have an important impact on individuals, and in particular, young people. The number of births to teenage mothers has fallen in recent years. In 2006 there were 1,427 births to teenage mothers a decrease of more than 20% from the high of 1,791 such births in 1999.

2.12 In 2006, approximately 26% of visits to a voluntary sector sexual health and advice service for those under-20 years were for emergency contraception[9]. In 2006, the known number of abortions performed in England on residents from Northern Ireland was 1,295 approximately 16% of whom were under 20 years of age. The figures show that 213 teenagers from here travelled to England to have an abortion.

Sexually Transmitted Infections (STIs)

2.13 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. A 2003 review of STIs and sexual health services in Northern Ireland indicated that STIs are on the increase here[10]. A report on HIV and STI surveillance in Northern

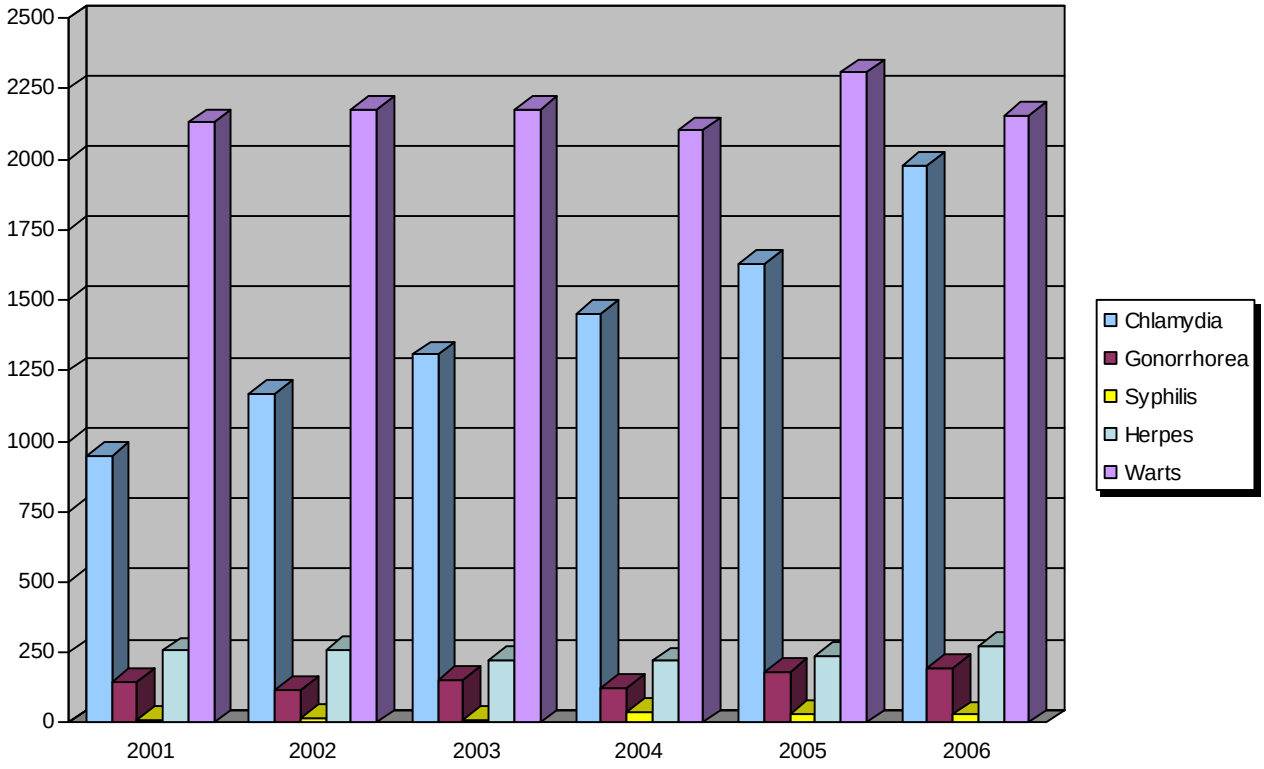
Ireland sets out the latest data available and also reflects epidemiological trends over time[11].

2.14 In 2006 there were:

- 195 new diagnoses of gonorrhoea (an increase of 7% over 2005 figures);
- 1,979 people diagnosed with chlamydia (an increase of 21% over 2005 figures); and
- 43 new diagnoses of syphilis (an increase of 13% over 2005 figures).

Figure 1:

Cases of Main Sexually Transmitted Infections diagnosed in Northern Ireland

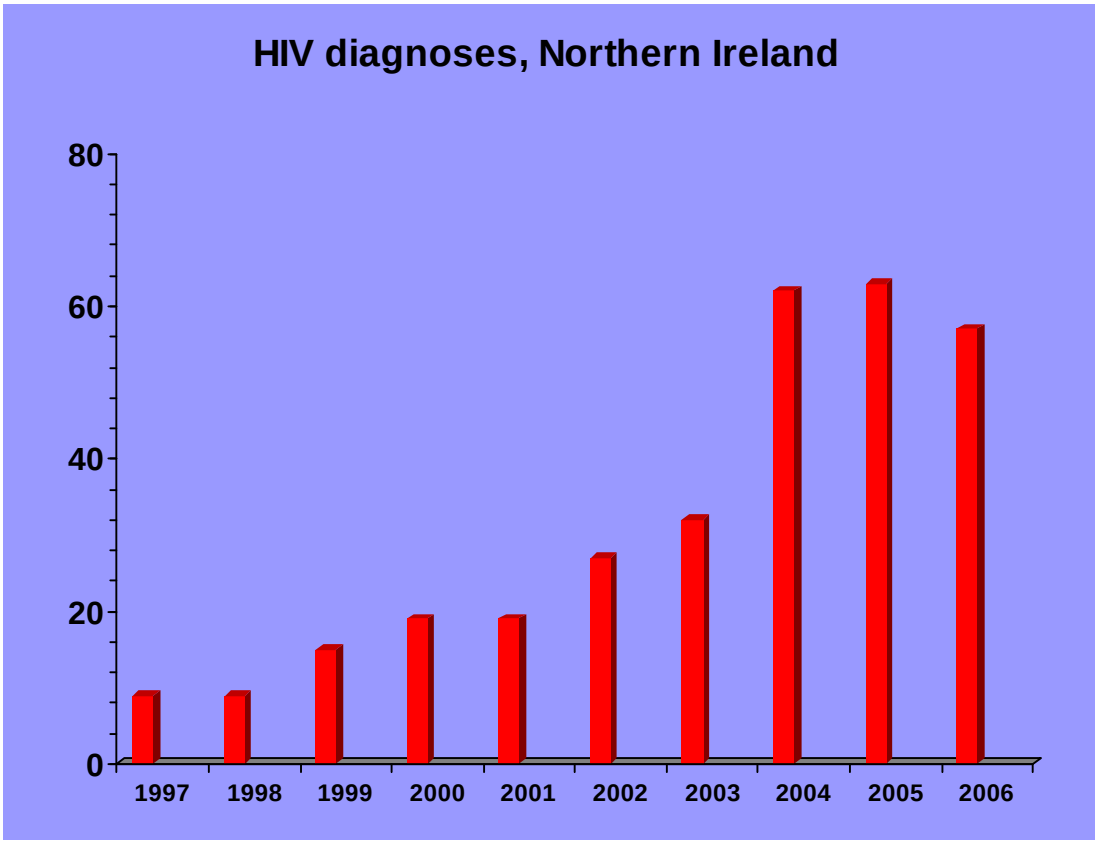


2.15 There has been an inexorable rise in the numbers of new cases of sexually transmitted infections diagnosed in the four home countries of the United Kingdom over the last decade. However, it is a complex picture and simple direct comparisons between countries are further complicated by differential rates between conditions, and within

particular age and sex groups.

2.16 Although the prevalence of HIV/AIDS remains lower in Northern Ireland than the other UK countries, the annual number of new cases of HIV infection (whose first UK diagnosis was made in Northern Ireland) has increased since 2001, almost doubling between 2003 and 2004 (Figure 2). In 2005, there were 63 new diagnoses recorded here the largest number since reporting began. However, in 2006 there has been a small decrease, over the previous year's figure, with 57 new diagnoses recorded.

Figure 2:



INEQUALITIES

2.17 Sexual ill-health can affect anyone in the population. It is not however, equally distributed throughout the population as shown, for example, by the increasing incidence of STIs among young people and gay men. The highest rates of infections in both men and women were diagnosed

in the 20-24 years age group. Research in England indicates strong links between social deprivation and STIs, abortions and teenage pregnancies[12]. Unplanned teenage pregnancy and early motherhood is associated with poor educational achievement, poor physical and mental health, social isolation and poverty.

2.18 Research in Northern Ireland shows that respondents from a partly skilled socio-economic background were twice as likely as those from a professional/managerial background to have had sexual intercourse before the age of sixteen[4].

ECONOMIC IMPACT

Teenage Births

2.19 On the basis that a teenage pregnancy effectively withdraws the mother from the labour market for at least one and a half years, an estimate[13] of the cost of teenage pregnancy to the Exchequer (unemployment benefits and administration, plus tax revenue foregone) stands at £20,000 per mother. Assuming only those mothers aged 17-19 years of age are likely to be unemployed, a conservative estimate of their Exchequer cost is approximately £25 million, based on 2005 Northern Ireland births data (there were 1,254 births to 17-19 year olds).

2.20 Hospital delivery costs associated with births to teenage mothers in Northern Ireland were estimated to be £2.5 million in 2005/06. Health service actions aimed at reducing the number of teenage pregnancies in 2005/06 were also estimated to cost £0.8 million. The economic cost associated with teenage pregnancy here is therefore about £28.3 million per annum.

2.21 Additionally, 146 young mothers in 2005 were aged between 13 and 16 years of age. This group would place increased demand upon social,

health, and education services and their own families through the requirement to have someone look after the newborn child whilst the mother continues compulsory education. Furthermore, statistics indicate that they are more likely to have achieved no formal qualifications until they are in their early 30's.

2.22 The prevention of unplanned pregnancies by contraception has estimated savings of approximately £85 million in Northern Ireland per annum (based on research by the Department of Health in England).

Sexual ill-health

2.23 Sexual ill-health incurs significant human and economic costs. There are sizeable healthcare costs associated with the treatment of STIs.

2.24 In 2005/06:

- there were 174 inpatient episodes for genitourinary type conditions, costing an estimated £224,000; and
- approximately 26,000 outpatient attendances costing an estimated £5.4 million.

2.25 There are potential savings from early treatment of chlamydia via chlamydia screening. The complications resulting from untreated chlamydia, such as pelvic inflammatory disease, ectopic pregnancy and tubal-factor infertility cost an estimated £1.5 million, per annum. (This is based on Department of Health (England) figures published in 2004 and reflects our lower than national average prevalence rate for chlamydia). Infertility arising from untreated chlamydia can result in the need for In Vitro Fertilisation (IVF) treatments. These treatments currently cost just under £3,000 per cycle, according to the National Institute for Health & Clinical Excellence (NICE-2004), with the cost per live birth increasing as the age of the mother increases.

2.26 Combination drug therapies for those with HIV/AIDS can cost from £4,000 - £11,000 per annum, per patient. In Northern Ireland 235 people (at the end of 2006), were undergoing combination drug therapies at a cost of approximately £1 million. The British Medical Association (in a submission to the Health Select Committee January 2005) advised that the monetary value of preventing a single onward transmission of HIV is estimated to be between £0.5 million and £1 million in terms of individual health benefits and treatment costs avoided.

PREVENTION

2.27 With proper 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. A key element in the promotion of good sexual health is therefore the provision of positive and accurate information about sexual health issues, including the message that everyone should treat their own and other people's bodies with respect and manage their sex lives with care. Another key element is everyone having the life skills and access to services to enable them to make informed choices and to deter the development of health compromising behaviours. This is particularly important for young people as the majority of parents, health and education professionals agree that sexual relations are best delayed until a young person is sufficiently mature to participate in a mutually respectful relationship.

Families

2.28 It is important that parents and carers have the skills and knowledge to talk to their children as good parent/child communication about sexual health issues can help delay first sexual experience and limit poor sexual health outcomes. Initiatives such as Surestart, Healthy Schools and Workplaces, Health Action Zones and Healthy Living Centres

provide ideal opportunities for partnership working with young people, parents and carers, to develop good parenting skills. Partnership between parents, schools and health services will promote and support a more consistent approach to sex and relationships education.

Education sector

2.29 It is clear that schools have an important contribution to make in influencing and developing young peoples' sexual health and wellbeing through the delivery of effective Personal Development in the revised curriculum, including Relationship and Sexuality Education (RSE). Effective RSE in schools, and the work of the youth service, support young people in developing the knowledge and skills to enable them to make informed and responsible decisions about sexual health issues. Further and Higher Education establishments also have a key role to play in ensuring that students have access to sexual health information, advice and services.

PLANNED DEVELOPMENTS

HPV Vaccine

2.30 There is a known link between cervical cancer and infection with human papilloma virus (HPV). Cervical cancer is the second most common cancer in women worldwide. Almost all of the cancers are caused by HPV, which is spread through sexual activity. New HPV vaccines offer tremendous potential for public health as they prevent up to 70% of cervical cancers.

2.31 In response to the Joint Committee on Vaccination and Immunisation recommendation the Department will introduce the HPV vaccination programme to protect young girls from cervical cancer, with the introduction of the routine programme targeting 12-13 year olds and then a catch-up programme, for older girls up to the age of 18.

Chlamydia

2.32 Rates of chlamydia are rising and it is the second most common STI diagnosis, with the highest new infection rates being in those aged between 20 and 24 years (men and women). A significant proportion of cases, particularly amongst women, is asymptomatic and so is liable to remain undetected, putting women at risk of developing Pelvic Inflammatory Disease.

2.33 Following assessment of the scope for introduction of chlamydia testing in Northern Ireland by a regional Working Group, it is intended to commence a regional testing programme.

NICE Guidelines

2.34 In 2006 the Department established formal links with NICE (National Institute for Health and Clinical Excellence) and agreed that it would review all NICE guidelines, including public health guidance, for its applicability to the Northern Ireland Health and Personal Social Services and to determine whether it can be implemented here.

2.35 In February 2007 NICE published health guidance on '*One to one interventions to reduce the transmission of sexually transmitted infections (STIs) including HIV, and to reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups.'* The Department will be issuing the guidance and a commentary highlighting the Northern Ireland differences in 2008.

TRAINING

2.36 Many people experience difficulty in dealing with the sensitive issues in this area and education and training are needed to help people work more effectively. 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, and youth and community workers.

2.37 It is important that health professionals, particularly GPs and nurses, are supported in changing working practice around sexual health. Therefore, professionals from a range of disciplines should have access to appropriate, accredited training, tailored to their particular requirements and those of their client groups.

2.38 Training should cover core skills and issues including awareness, values, attitudes, information, communication skills, sexual orientation, relationships, cultural differences and the needs of those with a disability. People with disabilities have particular needs and it is essential that appropriate training is given to ensure they receive a service that fully meets their needs.

SERVICES

2.39 There is a range of sexual health services, including primary care, family planning, cervical screening, GUM clinics, information and advice, currently being provided by professionals in the statutory, voluntary and community sectors. Services are also provided for people with psychosexual problems and sexual dysfunction. These services play a major role in promoting and maintaining good sexual health.

2.40 It is important that these services are accessible to all users including young people who are looked after by a Health and Social Care Trust, disabled people and those from an ethnic minority community. For example, some users may have particular access difficulties; others may have communication difficulties resulting in lack of privacy and confidentiality. If we are to promote good sexual health it is essential that all users can access services in an atmosphere which encourages openness and ensures confidentiality.

Primary Care

2.41 General Practitioners provide a range of sexual health related services and advice as well as directing patients to appropriate specialist services such as GUM and family planning clinics. GPs play a key role in raising awareness of important issues such as STIs amongst their patients and reinforce messages relating to safe sex. The Departmental circular (HSS (MD) 34/2008) outlines best practice for healthcare professionals when offering and recommending HIV testing. It highlights the importance of early detection of the condition and emphasises that the test can be conducted outside the specialist setting.

Family Planning Clinics

2.42 Comprehensive contraceptive services, advice and information is provided free of charge at a range of health service facilities including some primary care settings, all family planning clinics, and hospitals. Services are also provided by voluntary agencies working in the sexual health field.

GUM Services

2.43 GUM services, which are currently delivered primarily from hospital clinics, are a key element in the prevention of sexual ill-health. To ensure rapid access to screening and treatment and early tracing of sexual contacts, they have traditionally operated an open access system. As a result of increasing pressure on services, a number of clinics have had to introduce an appointment system with many people having to wait up to six weeks.

2.44 A review of sexual health and GUM services was undertaken in 2006 by the four Health & Social Services Boards. The Review Report outlined recommendations and proposed a number of measures to address the issues including:

- the development of specialist secondary care GUM services which would allow 48 hour access across Northern Ireland;
- agree models of care for provision of services within primary/community care;
- development of appropriate training to ensure the quality of service delivery;
- adequate support services; and
- the need for the introduction of Chlamydia testing to be fully considered.

2.45 Implementation of the recommendations will take time and will depend on availability of resources. However, in response the Department made £250,000 available in the 2007/08 financial year to support the development of GUM services and in particular to improve access to services. An Implementation Plan has been developed to take forward the recommendations.

RESEARCH AND EVIDENCE BASE

2.46 A sound evidence base will be critical for informing the implementation of this Action Plan. There is currently a lack of local information on sexual attitudes and behaviours of the population.

2.47 As a result the development of targets in this Action Plan has been constrained due to a lack of baseline information. It will therefore be important to closely monitor the position and as more information becomes available to give consideration to the setting of additional targets.

2.48 The implementation of the Action Plan should be underpinned by sound research findings. Existing research, which has been carried out nationally and internationally, will be assessed informing the need for a local research programme. The Sexual Health Promotion Network,

DHSSPS and the Research & Development Office will collaborate in order to commission research to meet any local needs.

CHAPTER 3 - AIM, OBJECTIVES AND TARGETS

3.1 **The overall aim of this Action Plan is:**

"to improve, protect and promote the sexual health and wellbeing of the population in Northern Ireland."

OBJECTIVES

3.2 The key objectives are:

- to enable the population to develop and maintain the knowledge, skills and values necessary for improving sexual health and wellbeing;
- to promote opportunities to enable young people to make informed choices before engaging in sexual activity, especially, empowering them to delay first intercourse until an appropriate time of their choosing;
- to reduce the number of unplanned births to teenage mothers;
- to ensure that all people have access to sexual health services; and
- to reduce the incidence of Sexually Transmitted Infections (STIs) including HIV;

APPROACH

3.3 To meet the overall aim and objectives of this Action Plan it will be important to adopt a co-ordinated partnership approach involving the statutory sectors, particularly health and education, voluntary organisations and communities. Specific approaches should include:

- education and information programmes to promote openness about sexual health issues including sexual orientation; empowering young people to make informed choices; and tackling discrimination associated with HIV, STIs and sexual orientation;
- ensuring that services are accessible and responsive to need, including the needs of disadvantaged groups and

those at highest risk; and

- action to tackle the determinants of sexual health based on an evidence based approach and linking with other healthy lifestyle strategies.

OUTCOMES

3.4 If successful, implementation of this Action Plan will lead to an improvement in health and wellbeing and a reduction in health inequalities.

TARGETS

3.5 The targets in this Action Plan have been set to help achieve the overall life expectancy and equality targets in the DHSSPS Public Service Agreement.

3.6 The following specific targets will be used to measure the success of this Action Plan in achieving its overall aim:

- **92% of 11 to 16 year olds should not have experienced sexual intercourse by 2013;**

  Baseline: 89% of 11 to 16 year olds reported they had not experienced sexual intercourse in 2003 (Young Persons Behaviour & Attitude Survey).

  Note: Teenage Pregnancy and Parenthood Strategy 2000-2007 set a target that 75% of teenagers should not have experienced sexual intercourse by age of 16.

- **a reduction of 25% in the rate of births to teenage mothers under 17 years of age by 2013;**

  Baseline: 3.1 births per 1000 females aged under 17 years 2003-2005.

  Note: Compatible with PSA 8 target of 40% reduction by 2010, on the 1998-2000 baseline rate of 4.1 births per 1,000 females. The percentage reductions for the 2010 and 2013 targets differ because different baselines have been used.

- **by March 2008, all patients assessed as clinically urgent to access specialist Genito-Urinary Medicine/Sexual Health services within two working days;**

  Note: This is one of the recommendations arising from the review of sexual health and

GUM services which was undertaken in 2006 by the four Health and Social Services Boards, and the target is ongoing.

- **a reduction of 25% in the number of new episodes of gonorrhoea by 2013.**

  Baseline: 182 cases in 2005

  Source: KC60 statistical return

  Note: This target was agreed following discussion with regional experts from GUM services and the Health Protection Agency. The numbers of new cases of Gonorrhoea is considered a good proxy measure of sexual ill health in the population and usage of GUM services.

CHAPTER 4 - ACTION PLAN

4.1 This chapter identifies specific actions, timescales and delivery partners under the headings of prevention, training, services, research and monitoring.

Timescales

4.2 All the actions contained within this chapter have been assigned a specific timescale in which they should be taken forward and they are:

- short term (up to one year)
- medium term (up to three years)
- long term (up to five years)

ACTION AREA: PREVENTION

Action 1	**Timescale**	**Delivery Partners**
To develop a phased sexual health public information campaign which is accessible to all groups and aims to: (i) promote sexual health and wellbeing; (ii) raise awareness of specific sexual health issues, including HIV/AIDS with particular focus on those most at risk; (iii) to tackle discrimination and stigma associated with HIV, STIs and sexual orientation.	Medium Term.	Department of Health Social Services & Public Safety (DHSSPS), Health Promotion Agency (HPA), Department of Education (DE), Health and Social Care (HSC), and voluntary and community organisations.

Action 2	**Timescale**	**Delivery Partners**
To further develop community based programmes to promote sexual health and wellbeing including the prevention of STIs and HIV/AIDS with particular focus on those most at risk and taking account of the needs of those with a disability or from an ethnic minority community.	Ongoing.	HSC, HPA, Investing for Health Partnerships and voluntary and community organisations.

Action 3	Timescale	Delivery Partners
To ensure that health promoting workplaces include action to support positive sexual health.	Medium Term.	HPA and HSC.

Action 4	Timescale	Delivery Partners
To continue to implement, in partnership with other Departments, the Strategic Direction for Alcohol & Drugs.	Ongoing.	DHSSPS, DE and Department for Employment and Learning (DEL).

Action 5	Timescale	Delivery Partners
To continue to implement guidelines on Relationships and Sexuality Education (RSE).	Ongoing.	DE and voluntary and community organisations.

Action 6	Timescale	Delivery Partners
To issue and implement NICE Guidelines on prevention of Sexually Transmitted Infections and under-18 conceptions.	Short/Medium Term.	DHSSPS, HSC, DE and voluntary and community organisations.

Action 7	Timescale	Delivery Partners
To provide opportunities for young people in school and youth settings to develop the skills they need for life to support them in appropriately managing their relationships, including sexual lifestyles.	Short/Medium Term.	DE, DHSSPS, and HPA.

Action 8	Timescale	Delivery Partners
To further develop community based programmes and courses in parent/child communication.	Short/Medium Term.	DHSSPS, HSC and HPA.

Action 9	Timescale	Delivery Partners
To further develop, particularly in areas of socio-economic deprivation and rural areas, community based teenage personal development programmes that will incorporate sexual health issues and risk taking behaviour.	Short/Medium Term.	HSC and voluntary and community organisations.

Action 10	Timescale	Delivery Partners
To introduce a HPV immunisation programme.	Short/Medium Term.	DHSSPS and HSC.

ACTION AREA: TRAINING

Action 11	Timescale	Delivery Partners
To ensure that general training is provided for staff involved in sexual health issues. To cover core skills and issues such as awareness, attitudes, information, communication skills, sexuality, and relationships & sexual health.	Short/Medium Term	DHSSPS, HSC and voluntary and community organisations.

Action 12	Timescale	Delivery Partners
To ensure that there is specialised training in sexual health skills for health & social care professionals providing sexual health services including training to enable them to deal effectively with issues facing lesbian, gay and bisexual men and women and all other Section 75 groups.	Short/Medium Term.	DHSSPS, HSC, HPA and voluntary and community organisations.

Action 13	Timescale	Delivery Partners
To ensure that appropriate sexual health training which takes account of the needs of Section 75 groups is made available to teachers implementing RSE guidelines and youth workers involved in sexual health promotion.	Short/Medium Term.	DE, Education and Library Boards and voluntary and community organisations.

Action 14	Timescale	Delivery Partners
Appropriate training will be made available which includes the needs of Section 75 groups to youth & community workers involved in sexual health promotion in non-statutory settings.	Short/Medium Term.	HSC and voluntary and community organisations.

ACTION AREA: SERVICES

Action 15	Timescale	Delivery Partners
To ensure that information on local services is made available and accessible to all those wishing to avail of sexual health services.	Short Term.	HSC and Investing for Health Partnerships.

Action 16	Timescale	Delivery Partners
To develop and deliver innovative services based on an assessment of the needs of commercial sex workers which will promote and facilitate their increased access to sexual health information and services.	Medium Term.	HSC and voluntary and community organisations.

Action 17	Timescale	Delivery Partners
To continue to take forward the Implementation Plan (June 2007) on improving access to Genito Urinary Medicine and Sexual Health Services in Northern Ireland.	Medium/Long Term.	DHSSPS and HSC.

Action 18	Timescale	Delivery Partners
To put in place arrangements for the Primary and Community Care sector to deliver accessible sexual health services.	Medium/Long Term.	DHSSPS and HSC.

Action 19	Timescale	Delivery Partners
To commence a Chlamydia testing programme.	Short/Medium Term.	DHSSPS and HSC.

Action 20	Timescale	Delivery Partners
To develop a pilot scheme to expand a sexual health services clinic for students.	Short/Medium Term.	DHSSPS, EHSSB and Queens University Belfast.

ACTION AREA: RESEARCH

Action 21	Timescale	Delivery Partners
To assess the existing research base and consider the need for a local research programme.	Medium/Long Term.	Sexual Health Promotion Network, DHSSPS and Research and Development (R&D) Office.

Action 22	Timescale	Delivery Partners
To commission relevant research to meet any identified local need.	Medium/Long Term.	Sexual Health Promotion Network, DHSSPS and R&D Office.

ACTION AREA: MONITORING

Action 23	**Timescale**	**Delivery Partners**
To establish a multi-agency Sexual Health Promotion Network to oversee the implementation of the Action Plan.	Short Term.	DHSSPS and HSC.

Action 24	**Timescale**	**Delivery Partners**
To report progress on the implementation of the Action Plan to the Ministerial Group on Public Health (MGPH).	Annually.	DHSSPS and Sexual Health Promotion Network.

Action 25	**Timescale**	**Delivery Partners**
To review and integrate the Teenage Pregnancy and Parenthood Strategy and Action Plan into the Sexual Health Promotion Action Plan.	Short Term.	DHSSPS and Sexual Health and Teenage Pregnancy and Parenthood Implementation/Network Group.

CHAPTER 5 - MAKING IT HAPPEN

Introduction

5.1 This Action Plan 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 Action Plan. If the objectives outlined in Chapter 3 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 Action Plan

5.2 The Ministerial Group on Public Health (MGPH) will be responsible for the overall monitoring of the Action Plan. A multi-agency Sexual Health Promotion Network will be established to oversee and drive forward the actions outlined in Chapter 4. The Network will report progress to MGPH annually. The Action Plan will be reviewed after five years.

5.3 While it is envisaged that the targets should be met within the designated timescales it is also recognised that some actions may require additional unforeseen work to allow for completion of specific tasks. In such circumstances, it will be for the Sexual Health Promotion Network and the Department to agree any revised timescales.

5.4 Depending on the prevailing conditions at the time, the Department may also need to reprioritise the delivery timescales of the identified actions, and/or add new actions to the plan.

Key Areas for the Sexual Health Promotion Network

5.5 The DHSSPS will be asking the Sexual Health Promotion Network to consider and advise on the approach to the promotion of better sexual health in Northern Ireland and the implementation of the actions in this

Plan. Research - The existing research base will be assessed informing the need for a local research programme. The Network will collaborate with the Research and Development Office and DHSSPS to ensure the commissioning of relevant research to meet local needs. The findings of any local research will be disseminated to help inform best practice. The Network will also help to monitor and evaluate the progress of the Action Plan and assist with the identification of any training and development needs. Targets – The aim is to improve the sexual health of the population resulting in a reduction in the number of all STI diagnoses. The Network will also therefore be asked to keep the targets under review as it is anticipated that with investment and improvement of services including accessibility to GUM clinics the number of diagnoses of STIs may initially rise.

Resources

5.6 The Department of Health, Social Services and Public Safety will make £900,000 available in 2008/2009 to implement the Action Plan with continued support over its five year lifespan.

REFERENCES

1. Definition of sexual health developed through a consultative process with international experts beginning with the Technical Consultation on Sexual Health in January 2002.

2. Source: Police Service of Northern Ireland Central Statistics Unit.

3. Young People's Behaviour and Attitudes Survey. Central Survey Unit of the Northern Ireland Statistics and Research Agency 2003.

4. Health and Wellbeing Survey 2001, Department of Health Social Services and Public Safety.

5. Sigma Research. Vital Statistics Ireland. Findings from the All-Ireland Gay Men's Sex Survey 2000. June 2002.

6. An Acceptable Prejudice? - Homophobic Violence and Harassment in Northern Ireland; Neil Jarman and Alex Tennant; Institute of Conflict Research 2003.

7. Schubotz, D., Simpson, A., Rolston, B. Towards Better Sexual Health: A survey of sexual attitudes and lifestyles of young people in Northern Ireland. fpaNI in partnership with University of Ulster. 2002.

8. Queiry, Marie. A Mighty Silence. A Report on the Needs of Lesbians and Bisexual Women in Northern Ireland. Lesbian Advocacy Services Initiative (LASI). March 2002.

9. Source: as advised by Brook Belfast.

10. Regional Advisory Committee on Communicable Disease Control.

Sexually Transmitted Infections and Genitourinary Medicine Services in Northern Ireland. Report from the Sexually Transmitted Infections Subcommittee to the Chief Medical Officer. Department of Health, Social Services and Public Safety. 2003.

11. Communicable Disease Surveillance Centre (Northern Ireland): Report on HIV and STI Surveillance in Northern Ireland 2007.

12. Department of Health. The National Strategy for Sexual Health and HIV. September 2001.

13. Bivand, P., Centre for Economic and Social Exclusion, 2000. (Estimated cost of £17,820 uplifted for inflation).