Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Sexual Health Promotion Strategy and Action Plan 2008-2013

18 April 2012

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Paula Bradley
Mr Mickey Brady
Ms Pam Brown
Mr Mark Durkan
Mr Samuel Gardiner
Ms Michelle Gildernew
Mr John McCallister
Mr Kieran McCarthy

Witnesses:

Dr Bernadette Cullen	Public Health Agency
Dr Carolyn Harper	Public Health Agency
Dr Eddie Rooney	Public Health Agency

The Chairperson: Thank you for your briefing paper, which I read in hard copy. We are just getting used to the new technology. When the Public Health Agency (PHA) appears before the Committee or the media, it is usually to defend something that has happened. Carolyn, I think that you have experience of that. Eddie, I will allow you to introduce your team and invite you to make your presentation, after which we will open the Floor for questions and comments. As always, it is good to see you.

Dr Eddie Rooney (Public Health Agency): Thank you very much for the invitation to attend. To my left is Dr Carolyn Harper, who is the director of public health. Carolyn's responsibilities cover health protection, health improvement and research and development, all of which are pertinent to the issue of sexual health. To my right is Dr Bernadette Cullen, who is a consultant in public health and is the lead in sexual health. That is my subtle way of telling you to put the hard questions in her direction. Time-wise, we will keep the presentation very sharp.

Just before Carolyn kicks off, I will make the point that, overall, the role of the Public Health Agency is to protect and improve health and well-being, which means that everything that we do focuses on prevention. That is no less the case for sexual health than for many of the other issues with which we deal. In practice, it means that we are always dealing with two ends of the continuum. One is looking

at the social context and what is driving the issues that impact on our community. The second is dealing with the here and now and making sure that the agency's information, advice and assistance deal with the real needs of today. The presentation will reflect those two aspects.

Dr Carolyn Harper (Public Health Agency): Thank you, Eddie. I hope that you all have copies of the briefing paper. I will take you through it quickly and set the scene with some statistics and trends and an overview of our approach. Bernadette will then take you through some details on specific examples of interventions and projects on the ground.

Our briefing paper compares teenage pregnancy rates in Northern Ireland with those of a number of countries. Although our rate is lower than that of the US and is similar to that of other parts of the UK, it is higher than rates in the Republic of Ireland and most other European countries, being around four times higher than the lowest rates in Europe.

Over time, the trend for teenage pregnancies in Northern Ireland is going in the right direction. The teenage pregnancy rate, particularly in the under-15 and 15-year-old age groups, has decreased, which shows that pregnancy among young teenagers is certainly decreasing. When we consider teenage pregnancy rates in Northern Ireland by trust area, the rate is significantly higher in the Belfast Health and Social Care Trust area than in others. That pattern has been the case for some time.

Our briefing paper shows the rates of sexually transmitted infections (STIs) for four infections on a 10-year trend. The rates are mixed. The rate for chlamydia, for example, has increased. The rates for gonorrhoea and herpes are similar over that time period. However, the incidence of wart infections has decreased. Therefore, there is a mixed picture for STIs.

There has been a significant increase in the number of new HIV diagnoses each year for men who have sex with men (MSM) and those who have heterosexual sex.

The Department of Health, Social Services and Public Safety (DHSSPS) has issued its sexual health promotion strategy and action plan for 2008-2013, in which it sets a number of targets. There are five key action areas: prevention; training; services; research; and monitoring. The PHA was asked to lead on the strategy. In 2010, we established the sexual health improvement network (SHIN), very much taking a partnership approach. Anyone with an interest and key role in that area, from whatever perspective, is a member of the partnership, the aim and view of which is to learn and share throughout the region and to try to bring consistency and strategic drive to improve sexual health.

So far, the network has held two evidence-based workshops to look at what works and is most effective. We want to make a difference, have an impact on the rates and improve the trends. Therefore, it is important that we look at and learn from research and what has been shown to work elsewhere. Equally, if research or evidence is weak, we want to use best knowledge to form new interventions and test them. Five subgroups sit beneath the network and look at specific aspects of sexual health.

I want to give you a sense of the key elements of how the Public Health Agency is taking work forward strategically. From our review of the evidence, five key building blocks have to be in place. Evidence suggests that they are the most effective ways by which to reduce either teenage pregnancy rates or sexually transmitted infections. Good relationship and sexuality education (RSE) must be in place. There must be good provision of contraceptive and genito-urinary medicine (GUM) services. However, they alone are not sufficient. The issues that lead people into risky sexual behaviour must also be tackled. Evidence suggests that early childhood and youth development programmes must be provided so that support is given not only to young people in their teenage years and their families, but, long before that, in the antenatal period and the first five years of life in order to give families and children the best opportunity.

The United States has conducted the adverse childhood experiences (ACE) study. It found that of the 17% of children who experienced adverse circumstances in the early years because of alcohol, drugs, mental health problems or violence in the home, the rate of risky sexual behaviour is about three times higher than that of other children. It is, therefore, important to address all that and to put support in place.

Public information campaigns also have a role. However, they are very much about using an appropriate medium and tailoring the message. In addition to that universal approach, messages and services are tailored and targeted towards the highest-risk groups, which include commercial sex workers, and there is also a geographical focus on the areas in which teenage pregnancy rates are highest.

I will hand over to Bernadette, who will take you through some of the specific projects and interventions.

Dr Bernadette Cullen (Public Health Agency): Thank you, Carolyn. I will pick up on the five priority areas that Carolyn mentioned and give you a flavour of what is going on and of what we are doing.

The first priority area is relationship and sexuality education in a school setting. The evidence base that we looked at and reviewed over the past year or two showed us that, for RSE in particular settings, it is important that there is training, support, understanding and policy to support its appropriate delivery. Therefore, for RSE in schools, the PHA approach has been to devise a training programme in partnership with the Department of Education, which has been in place for some time in the Belfast and South Eastern Education and Library Board areas, to deliver training and support to teachers and schools to enable them to have good RSE policies and delivery. The teachers know the children and young people with whom they are working, and they can focus strongly on what needs to happen in schools. They may also want to invite in additional support, but it is important that schools have that basis from which to work. We are looking at those training programmes and considering a wider roll-out.

Now that the Public Health Agency is a regional organisation and the sexual health improvement network has been established, it is advantageous that those good practices can be shared more widely. We have been working in partnership with the Department of Education to try out the training programme this year in another education and library board area. A training programme was run in the North Eastern Board area in February. It was very well received, and a report is now with the Department of Education. Depending on what the Department thinks of the programme — I think that it is very happy with it — we hope to move forward in partnership to deliver the training and to offer it in all education and library board areas in the next academic year. That will allow us to build that capability, capacity and understanding in schools to support RSE.

RSE is also needed in other settings, and, for a number of years, there has been RSE activity in the youth and community sector. We are working closely with many community and voluntary organisations that deliver such work to look at the programmes and find out whether they are meeting the needs. We are looking at the development of a specification for standards in all those programmes. Most of the programmes are excellent, but we can standardise what we expect to be delivered in that range of settings. We hope that we will have a range of organisations that will deliver the programmes, which we can match with the needs of communities and organisations.

RSE also provides training for staff and organisations, including foster-parents, who work with or support young people so that they can have those conversations about sexuality and sexual education. We know that, even in our own family situations, that is not always an easy conversation. We can provide support for people who are working with young people day to day so that they can have those conversations and answer what may be difficult questions. It is hoped that that will support them and the young people.

The second priority area is early childhood and youth development programmes. That is very much about the Public Health Agency liaising internally and working with organisations to offer to support the work that is needed in early years and youth development programmes. From the beginning, that can support young people in being resilient and having good coping and decision-making skills, which will feed through to sexual health and many other areas and link into other programmes.

There is an interconnection between drugs and alcohol and sexual health. Therefore, to be holistic, we want to be as close as we can to those pieces of work and strategies. Young people do not think about these matters in separate boxes, and we need to make the connections. One-stop shops are

being commissioned and rolled out as part of the work of the Public Health Agency, and sexual health will be one element that young people might get support about in those settings.

The third priority area is contraceptive and GUM services. As Eddie mentioned, as well as doing a lot of work on prevention and positive work with helping young people to make good decisions, we need services for young people for the decisions that they are making now and to support them now. That is about making sure that we have services that are accessible and acceptable to young people. We already have a range of very good services. For example, we have a youth sexual health service in the Western Trust area that is run partly by the trust and is supported by some voluntary organisations. We have Brook services in Belfast. We have a range of different services around the Province that deliver very good services that are accessible to young people. In the scoping exercise, we are looking at whether we have enough services, whether there are gaps and where they are, and what we need to meet those gaps if we identify them.

We are also looking at working with pharmacies, because they are spread throughout the entire country. Can we work with pharmacies to improve how they work and interact with everybody, and young people in particular, on sexual health? Although I keep mentioning young people, the agenda is wider; it is aimed at the entire population, not just young people.

We are also involved in another exciting piece of work. We are working with a primary care partnership in the South Eastern Trust area, which aims to look at the provision of GUM services in the area. In May, we will begin a process whereby the GUM specialist service in the acute sector will work closely in partnership with primary care and GPs in the South Eastern Trust area in order to deliver the service through primary care and remove some of the pressure that is created by everybody's having to go to acute services. For example, people who are concerned that they may be at risk and need GUM sexual health screening will be able to get it from GPs, who will have support from the GUM specialist to allow them to do that. We hope that looking at other models and ways to deliver services better will help us to deliver that service in the future.

The fourth priority area is public information campaigns, about which the evidence is equivocal on what is needed and the best way to undertake them. At a simple level, we provide information about services and where they are located, and it is important for people to know that. We have also undertaken campaigns in the past. The most recent was probably the Sex — Just Don't Do It — Think It Through campaign, which was radio-based. We also want to explore in more depth and get better at using social media and other ways of getting direct access to people in general, and young people and high-risk groups in particular, in more innovative ways.

In the past, we have done that in our work with some voluntary organisations, which we have commissioned to make contact on our behalf. For example, we have worked with the Rainbow Project to reach high-risk groups. Through it, we provided information on internet sites, and so on. It is really about looking at whether we can get better at using that sort of medium to reach our target audience. So part of our work will be to assess the different ways of doing that and the needs of our audience.

That leads me to the fifth priority area of HIV and STI prevention. The evidence suggests strongly that we need to focus on that in particular with some of the high-risk subgroups. We mentioned some of them, such as men who have sex with men, people who live with HIV, and other vulnerable groups. We established a subgroup of the network to look at HIV and STI prevention. It is doing a stocktake of the interventions that are available to those groups at present, such as behavioural interventions that may, according to evidence, have more impact if people work closely on a one-to-one basis in a GUM or voluntary sector setting. We are looking at improving the expansion of HIV testing. It is important that we get people to come forward for HIV and other sexual infection testing if they are at risk. We are also working to develop further our outreach clinics, which we have had in place for some time, and to try to put clinics in the community and into settings in which we can access high-risk groups that may not access statutory services as easily as we would wish them to. It is about going out to them and having that engagement. Over the past couple of years, that has worked very well. We want to build on that work.

Our briefing paper provides a summary of funding allocations in localities for sexual health promotion.

The Chairperson: Thanks very much for your presentation. It was quite useful.

Do budget allocations go to a trust, or can they go to anybody?

Dr Cullen: Budget allocations do not just go to a trust. In a sense, that money currently sits in the Public Health Agency budget. A lot of it funds voluntary sector organisations rather than trusts. Some of it goes to trusts. However, the majority of it probably goes to community and voluntary sector organisations. We work closely in partnership with a range of organisations, and they have been very important.

The Chairperson: I appreciate that. I have been involved at the coalface of some of the work that you are doing.

Dr Cullen: Much of that will be done in partnership with a trust as part of the process, but much of the funding will go to the voluntary sector.

The Chairperson: Public Health Agency money should be seen as additional money going into constituencies, but I have a concern that the agency is funding what the trusts should be doing. Therefore, it might be useful if we get a copy of how that is broken down.

Dr Rooney: We will get you that breakdown.

The Chairperson: You also mentioned the GUM clinics. Will all GPs sign up to that?

Dr Cullen: We are doing that in the South Eastern locality as a pathfinder pilot process through the primary care partnerships. That will begin in May and run for six months. We will monitor it very closely, with the hope that, if it works well, it can be broadened out. Our initial indications in the South Eastern area are that the GUM consultants and the specialist nurses have worked closely with the primary care sector and have conducted training with GPs. The interest from GPs has been very good, so at this stage, it is very encouraging.

The Chairperson: That is useful to know. The reason why I am asking you that question is that I happened to meet a young married woman the other day who gave birth a number of months ago. She told me that she went to see her GP, who was not her normal GP, and he refused to give her contraceptives because he does not believe in them. That is an issue. I advised her what to do, and I do not want to go into any more detail. However, there should have been no issue about giving contraceptives to that young married woman. You need to keep an eye on that.

Other members wish to speak, so I will just make two quick points. First, there is an increase in HIV. When HIV was an issue a number of years ago, there was a hard-hitting campaign, and incidences started to go down. Is there an issue about public attention not being as focused on HIV now?

Secondly, you talked about teenage parenthood, and it is not just about teenage mothers. In my constituency, the use of virtual babies has had a positive impact. If you are targeting areas in which there are high levels of teenage pregnancy, can you outline to us what you are hoping to do, and who is hoping to do it?

Dr Harper: I will pick up on the HIV issue. The pattern of HIV has changed. It has almost become a long-term condition that can be managed medically. Survival rates have improved dramatically, which is very good news. At the same time, people's understanding and concerns about HIV have had an effect on behaviour. We have asked ourselves whether we need a further campaign to raise awareness again. We are working closely with the sector to identify the best ways to get those messages across, whether that is through radio, TV or more tailored approaches. Therefore, we have had, and will continue to have, discussions with the sector.

Dr Rooney: In all public information, we face the challenge of ensuring that it has the greatest long-term impact. We are aware that we can skip or lose generations as issues and social factors move on. However, when we are planning now, we look at the sustained need. Our planning is much longer

term, and we need to tailor each campaign. We will investigate further the role of campaigning about sexual health and take the longer view. However, we appreciate that, as time moves on, the nature of issues shifts. Therefore, we need to look at not only tailoring the message but ensuring that, over time, as pressure and awareness is taken off particular issues over time, we plug those gaps.

The Chairperson: What about the use of virtual babies?

Dr Cullen: Some of the organisations that we work with have used virtual babies. The evidence for whether they work is equivocal. I think that it is important to put a lot of focus on the communities at highest risk, and that is what we do. We ask the voluntary organisations that deliver a lot of our programmes, be they RSE-type programmes or youth development programmes, to target them at the areas of highest need and to look at the range of issues. It is not just about teenage mothers but young men; it is very much about them as well. The programmes aim to target both sexes — sometimes separately, sometimes together, and sometimes it is a combination of the two. They may do some sessions with them separately and then bring them together for a discussion. The programmes that have worked very well are those that bring them together so that they can understand each other's point of view. We got some information back about a recent programme: they said that when everything is done for a girl, young men can feel, in a sense, disempowered and as though it is nothing to do with them. So it is important to make them feel that they are an equal part in the whole process. We found that such programmes work well in those communities and are very well accepted. Many of the youth organisations bring in more expert sexual health voluntary organisations to support them in that sort of work.

Ms P Bradley: Thank you for your presentation. I was the member who asked that the issue of sexual health be raised in Committee. Michelle and I sit on the all-party group on sexual health. Its last meeting was on the issue of STIs. At the previous meeting, a lot of young people were present, and we had a wonderful adult debate; it was absolutely fantastic. They enlightened every one of us and told us some horrific tales of their experiences of sex education in school. One of the young guys said that his teacher stood up in front of the room during a sex education class and said that if one of his sons turned out to be homosexual, he would disown him. That is the sort of education that our children are getting from teachers who are not qualified to teach some of these subjects and who, quite frankly, are not comfortable teaching them. Their opinion should not be brought into it, no matter what it is, across the board.

After the meeting, I spoke to another young person who is in care, who said that other children were lucky because they could go home to their family and maybe speak to their mum, dad or whoever, whereas, the only sex education for children in care was what they had been told in school, which was not enough for them. So there are loopholes. The example of what happened at that school is very worrying. However, we then have those in foster care and residential care and looked-after children who are not receiving any sex education, because nothing is legally in place to say who should provide that. Who should do it? Is it social workers? Is it foster carers? Who is it that actually has the talk about sex education? There is nothing in place, so a big group of young people is not hearing the message. They are not being told that it is OK to say no, it is OK not to have it, and it is OK not to do it. They are not being told that. That is not getting through to them.

I notice from the statistics you have given for live births in Northern Ireland between 2005 and 2010 that the number has not really changed dramatically. What is more worrying for me is that we cannot get statistics for the number of pregnancies in Northern Ireland. Those statistics would be higher again if we looked at those who have lost children or had abortions, which is happening. The statistics would be an awful lot higher if those people were included. So how far have we really moved on?

I want to pick up on Sue's point. As a teenager growing up in the 1980s, the messages about HIV, AIDS, STIs and contraception were hammered into us. That is something that I was so aware of, and yet when I asked those kids what they would be most worried about the day after they had had sex, they said getting pregnant; they did not say anything about STIs. So our message is not getting out that contraception is not just there to prevent teenage pregnancy but to protect them from a lifetime of other issues. That message is still not getting out. I think that we really are doing them a disservice, in some way, by not getting that across. Those kids were from different classes and areas. Some were at grammar school. Some went to high school, like I did. It was not uniform. None of them

heard the same message. None of them came out of school being confident that he or she had the knowledge to say, "No, that is not for me. I want to wait", or, "I should always have condoms in my handbag or wallet." None of them came out with that knowledge. That is a great worry because it means that we will see those figures get worse in years to come. Something is not being done correctly.

On the positive side, my son attended a sex education class in the local youth centre in Glengormley. It was fabulous. I cannot fault it. It was absolutely wonderful. Of course, my son came home and told his sister and me far too much information. *[Laughter.]* I had to keep reminding him, "I am your mother, Joshua. Please, no more." However, it was fantastic — absolutely brilliant. Therefore, things are being done.

I worry about children who are in care: what are we doing for them? I am glad that you are looking at training for teachers because it is uncomfortable for some people to have those conversations. We all know and understand that. Someone who teaches sex education needs to be comfortable to be able to do that. Is that part of it, or is a teacher just told, "That is your class, so you are doing it"? That is what I have heard.

I know that it is probably not possible, but it would be interesting to get the pregnancy rates, rather than the birth rates, for Northern Ireland. I would say that we would see a very different picture of what is happening. When I spoke to staff at the Brook Centre, they said that we cannot tell how many abortions or miscarriages there are because we do not have those figures. All that we have are birth rates.

I want to make one more comment about GUM clinics. Some months ago, I spoke to someone from the Royal at an event. The number of people who are coming to GUM clinics is very worrying. Clinics are almost unable to meet demand. I do not know whether that is anything to do with the Public Health Agency, or whether we need to ask for figures to see how that is being managed and how much money is being spent in that area. It is very worrying, especially with regard to children.

Another interesting fact that we have been told is that it is not young people who are being infected with sexually transmitted diseases: at present, the people who are putting those figures up are those in their 40s and 50s, who are going into second relationships, or whatever it might be. Therefore, we cannot blame young people for everything.

I want us to start to make some difference in young people's lives out of this. If we can do that, that sets them on the road for their futures. We owe that to them. Good work is being done. Let us get that out across the board.

Dr Rooney: I will make a couple of general points, after which we can pick up on the details.

The Chairperson: Paula was on a roll there. I did not want to stop her. *[Laughter.]*

Dr Rooney: With regard to statistics, we are not complacent in looking at small changes in rates. When we break that down by social background, there is continuing disparity. Geographically, that is also reflected in differences. Small numbers can change dramatically from year to year. There is no complacency from us. We need a full, accurate picture on data. We will certainly not read small changes into that so that we can say that we have got it sorted.

The other side of the issue is that you cannot not be a citizen. I have two daughters who have just come through their teens. I must say that as we look at alcohol, drug misuse and other key issues, we find that there are interrelationships between all of them. We cannot but look at them as a whole-community issue. We need teachers and parents to be equipped to deal with those issues. It is every bit as much about educating us as a community as it is about targeting specific groups. I will admit that I had a lot of work to do to catch up on and understand the issues and pressures. However, there is no better place to get the real picture than from young people. They understand the issues incredibly well. They also articulate the pressures that they are handling and dealing with very well. We can all learn from their perspective. We need to keep in close touch. As Bernadette said, so much

of our work is done through the voluntary and community sector because that is the only way that we can have an impact. On some of the specific issues that Paula raised —

Dr Cullen: You mentioned relationship and sexuality education, and I agree with you completely. That is one reason why we are working closely with the Department of Education. It is great that the Department is keen to work with us because there needs to be a partnership between health and education to move the issue forward. The Department is keen to support a roll-out of the training programme. Usually, a couple of teachers will want to do the training programme, but some teachers will not want to do it, which is fine. We cannot expect everybody to do it. Some teachers will be good at it or will be interested in it, and others will not. Therefore, it is not about telling teachers that it is their turn and that they have to go and do it. It is about saying who will be good at doing it and who can we work with.

The training is not about giving teachers a package of information and telling them to deliver it. It is more about asking the teachers on the training programme to think about sexual health issues, asking them about their values and concerns, and doing some exercises to make them think about the worries and concerns they had when they were 13 years of age. Therefore, it is about letting them think through the issues and how they might start to discuss them. It is not about giving them a package and telling them to deliver it. The packages and the support are there, but it is about taking the teachers through how they approach the issues, how they deal with them, and how they can be inclusive about the young people sitting in front of them to try to understand where they are coming from.

It is important that RSE is done with schools because teachers know the young people much better than someone from outside that setting, so that is positive. The Department of Education seems to be keen to work in partnership with us to drive that forward. Therefore, we are not being complacent and saying that we have it sorted. We do not have it sorted. There is a lot to do to get that training out there. We hear bad stories about schools, but there are schools that do a very good job. However, we have to see that they are coming along with us and improving. We are moving in the right direction, but we still have some way to go.

That links into the issue of looked-after children. We recognise that they are a very vulnerable group, and a number of things are happening. They have access to anything that is being offered in school, and there is ongoing support and training for foster carers so that they can have those conversations, as we cannot assume that they are comfortable doing that. There are specialist nurses for looked-after children in a number of trusts, and many of those nurses are taking the brief about giving young people the opportunity to discuss sexual health issues with them. They are not there for sexual health alone, but they will address the issue. Therefore, several things are being done to try to give looked-after children the same opportunities as other young people who are going home to their parents. However, a lot of work remains to be done.

Dr Harper: Your final question was about GUM services. Everybody is supposed to meet the 48-hour waiting time access standard, and we worked with the Health and Social Care Board (HSCB) on the capacity and commissioning of those services. The Patient and Client Council did a nice piece of work on the patient experience, and improvement must be made on what it feels like to go through that service, working closely with the trusts as the providers.

In respect of cross-border work, we have been working with Co-operation and Working Together (CAWT) to provide additional clinics along the border counties. There are a number of different initiatives to make sure that access is as good as it can be.

Mr Wells: Eddie, do you accept that the ultimate aim is to try to encourage as many children and teenagers as possible to abstain from all sexual activity until marriage? Is that the ultimate goal?

Dr Rooney: The issue is not specifically about waiting until marriage. In a prevention model, we desperately want people not to engage in risky behaviour that will harm them.

Mr Wells: People could still be promiscuous and adhere to that.

Dr Rooney: As you know, across our areas, I would love people not to drink alcohol. *[Inaudible.]* We deal with the social context. We also deal with the other part of it, which is our real remit. *[Inaudible.]* We deal with young people on their terms *[Inaudible.]*

Mr Wells: Are they encouraged, as a primary part of your programmes, to abstain from all sexual activity until marriage?

Dr Rooney: We have a major emphasis on that, certainly in elements of the strategy and, indeed, with the groups with which we work. That is an extremely important issue for them, particularly the faith groups.

Mr Wells: That was not the question. Is encouraging teenagers to abstain from sexual activity a crucial part of the programme?

Dr Rooney: We encourage all teenagers to abstain from sexual activity until they are of sufficient maturity to engage in that responsibly and take responsibility.

Mr Wells: It is interesting that, yet again, the Southern Trust — I keep saying this — comes out as the area with the lowest rate of teenagers aged 13 to 16 giving birth. Are you aware of a certain organisation that operates mainly in the Southern Trust and may be helping to deliver those targets?

Dr Rooney: Are you referring to Love for Life?

Mr Wells: Yes.

Dr Rooney: I am aware of it, absolutely.

Mr Wells: Yet that is the first time that Love for Life has been mentioned today.

Dr Rooney: I met members of Love for Life in December, and, subsequently, we have had meetings with all the faith groups involved in promoting sexual health. It has been a live issue for them and within the network

Mr Wells: For folk who have not heard of Love for Life, it is a Christian-based organisation that promotes abstinence until marriage as a realistic aspiration or aim for young people. My understanding is that the only place in which it is adequately funded, between the Department and its partners in the Southern Education and Library Board (SELB), is the Southern Trust area. That seems to be a highly appropriate model to roll out throughout the country. However, my understanding is that, as far as funding is concerned, the only area in which it gets a chance really to show the benefits of that approach is the Southern Trust. Is there any potential, given the huge amount of money being given out for sexual education to tackle sexually transmitted diseases, to expand that type of work, which says to young people that refraining from sexual activity until it is right to do so is a realistic option? It seems to be having some considerable success in that area.

Dr Rooney: Sometimes, we focus on the minority of young people who engage in risk behaviour. We have to realise that the majority of children do not engage in dangerous sexual activity, and we want to keep it that way.

I must say that I was very impressed with the meeting that I had with Love for Life, and its programme is one of many. For us, it is certainly one of the programmes that we envisage being very beneficial when delivered to a high standard. However, as we heard earlier, and this is true of all sexual health programmes, much of that is dependent on the key people who deliver them, and schools must be well equipped for that purpose. You asked whether abstinence featured on our agenda, and the answer is yes, and we have been engaged in highly productive discussions with Love for Life on that.

Mr Wells: I declare an interest, as my daughter has volunteered for Love for Life, and my wife teaches in a school that has delivered its programmes. The universal view of participating schools is that it is a very positive development, but can it be rolled out throughout Northern Ireland? It operates in schools throughout the Province, but, until recently, the bulk of concentrated effort and funding has been in the SELB area. Is it an option to empower children to believe that abstinence is not a silly option and that they can stand firm and say that they will abstain from all sexual activity until they believe that they are with Mr or Mrs Right and go forward in life from that point on? Is there a way to do that so that people will see it as the right approach in life, as opposed to sniggering or regarding it as one taken by silly weaklings? Is there any way that the Department, as part of its strategy, could try to encourage that kind of approach throughout the Province?

Dr Rooney: As I said, it is certainly one of the approaches encouraged. We are having an active discussion on that, Jim. However, on the other side of the equation, we have to deal with reality. Much of the evidence that emerged on sexual health, particularly from about 15 years ago, was on behaviour at the very opposite end of the scale, so, at any point in time, we must deal with the real needs right across the board. It is an important issue as part of our public health agenda. My aspiration for public health is to have a community that does not lose 4,000 people a year unnecessarily to preventable diseases and ill health. We have a long way to go, and we have to take incremental steps to get there. There are issues with resourcing, the effectiveness of programmes and ensuring that programmes are developed. It is a broad agenda, and we are following that agenda.

Mr Wells: It is interesting to note that the area that seems to have this most under control is the one in which that type of group operates. You say that you regard encouraging abstinence as an option, but should it not be the primary option? The first hurdle to overcome should be encouraging young people not to take part in any risky activity. The fallback position should then be that, if they do, treatment is available. Is every child in Northern Ireland told that he or she should aim to avoid any sexual contact as a teenager?

Dr Cullen: I think that the vast majority, if not all, of the programmes that deliver RSE, be it in a school, youth or community setting, come at it from the perspective of saying, "You should delay until you are old enough, mature enough and sensible enough to have a good relationship." It is done in the context of relationships; it is not just about sex. I have always thought that the title RSE, relationship and sexuality education, was well worded. In England, it is called sex and relationship education. The relationship part is important. The vast majority, if not all, of RSE programmes delivered to young people say, "Delay any sexual activity until you are mature enough to make sensible, good decisions and are in a sensible, committed relationship." That is their starting point. If they are working with young people who may already be at risk, they will say, "If you are in this situation, this is what to do." Most will come at it from a perspective of delaying sexual activity. We are not there to encourage young people to engage in such activity sooner than they are ready to.

Mr Wells: I am not convinced that every child is getting that message.

Dr Cullen: I am not sure that everybody is getting the RSE message. That is part of what we are trying to do through our work with schools.

Mr Wells: I believe that every child in Northern Ireland should get the Love for Life model, or similar, as the first option. We know that that will dramatically reduce the number of sexually transmitted diseases, because it removes the element of risk.

I want to turn to the stats in your presentation on HIV. A graph shows three lines representing three categories, the bottom one of which is "other". Presumably, that encompasses intravenous drug users, those who receive blood transfusions, and so on. It seems that the issue of intravenous drug users contracting HIV has been almost taken off the scene. Have preventative measures wiped that out?

Dr Cullen: To a large extent, yes, through risk assessments of blood donations, and so on.

Mr Wells: We have always been told that the three main causes of HIV were promiscuous heterosexual activity, homosexual activity and drug abuse. Now, it seems that the problem of drug abuse has been solved. Is that right? In 2010, nobody who contracted HIV was not involved in risky sexual activity, or have I missed something?

Dr Harper: The figure of zero is also because of the safer handling of blood.

Mr Wells: What about the use of needles by heroin addicts?

Dr Harper: It is not that drug abuse has stopped. However, there are now needle exchange schemes, for example, and such risk minimisation has controlled the risk of infection.

Mr Wells: Is that not a major success?

Dr Harper: Absolutely.

Mr Wells: Given the figure of zero against the category "other", I am a bit surprised that I have not seen any press releases from the PHA acknowledging the great strides made in tackling the problem. Maybe you have not let this become known because you are shrinking violets.

Dr Harper: I suppose, Jim, that there are still huge challenges with drug use in Northern Ireland. Maybe we have not trumpeted that success enough. However, people are naturally cautious about claiming a success when they do not how sustained it will be.

I want to go back to the approach to RSE for a moment. We do not come with any particular view on that. Rather, we take an objective, scientific approach. If there is evidence for a programme, irrespective of its perspective, we certainly consider that and fund it as appropriate. The evidence is stronger for some programmes than others, but our mind is not closed. If robust evidence were to emerge about a programme — there are degrees of quality of evidence — regardless of the spectrum from which it comes, our minds would be open to that. Equally, that is our approach across all our work.

Dr Rooney: I want to add to the point about our not trumpeting what may be perceived as successes, particularly in this area. The reason for that is that we would be worried about taking off the pressure that leads to good practice. So we handle that very carefully and responsibly.

The Chairperson: A number of members still want to ask questions. I do not want to close down the discussion, so I am trying to give as much leeway as possible.

Mr Gardiner: I join my colleagues in expressing my gratitude to those who formed Love for Life. It is based in Waringstown in my constituency, which is where it was really formed, and it does sterling work. It would like to do more to protect young girls, in particular.

Do we need to focus more on funding in deprived areas, given that the teenage pregnancy rate there is double that of other areas? Does our rate of teenage pregnancy closely resemble that of the United States, rather than that of other European countries? The English language is used in television programmes and films directly lifted from the United States. I note that Australia and Canada, also English-speaking counties, broadcast the same material, and they also have higher rates than European countries.

Dr Rooney: I will deal with the first issue that you raised, Sam. We would love to target funding at where it would have the greatest impact. In so many of the issues that we deal with, the greatest need is in areas of high deprivation. The other side of that is ensuring that messages are pretty universal so that we do not take a single track. There are certain key messages that we want to ensure that all young people and, indeed, all adults get. The science is unlikely to reach a point at which we can target very tightly, but, with all of our programmes, we want to ensure that we are putting our resources into where the greatest need is, and we will be working on that.

Dr Harper: The countries that you mentioned, Mr Gardiner, share not only a common language but a culture and a —

Mr Gardiner: It is mainly the English language.

Dr Harper: Yes, and they share traditional cultural and societal values. There is a common origin and shared history among those countries, which may be a factor in their having higher rates compared with other European countries. We try to look at the countries with the lowest rates and the approaches that they have used. As I said, the evidence base is not only about services and education but about how to support families and young people from the antenatal period right through. That is also a key and developing part of the work that we do. Those sorts of programmes operate more strongly in other countries, particularly Scandinavia, than here in the UK.

Mr Gardiner: Do you have enough funding to do all that work?

Dr Harper: It is a constant debate. We have realigned some of our funding to some of those programmes, such as the Family Nurse Partnership and Roots of Empathy programmes, to get them going. We use those as demonstration models of the benefits so that we can go to policymakers and others with evidence of how they are working in the Northern Ireland context. We can then seek support for new and substantive additional money.

Mr Gardiner: Are you satisfied that you are getting adequate funding from the Department?

Dr Harper: Undoubtedly, if we were to get more, we could always use it. We would welcome more funding, and if we had more, we could do more. Equally, we are conscious of the financial constraints within which all of Northern Ireland plc works. So there is an onus on us to make best use of whatever funding we get. That is why we try to take that very evidence-based approach as far as we can.

Ms Gildernew: Thanks, a Chathaoirligh. Further to Sam's point, I think that the common denominator may not be that we all speak the same language but that we watch the same programmes, as broadcasting throughout the countries that he mentioned is similar.

Following on from Jim, I think it important that we do not take our eye of the ball or get complacent about HIV. I suspect that the line denoting levels of infection will be wiggly for a long time and that, however much the risk is minimised, we will not ever be able to say that we have done away with it.

It is important not to send out the message that the Health Committee is judgmental of any young people who participate in sexual activity. We live in the real world. Whatever we may hope for our children, constituents and people who live in our communities, we have to understand that there are many reasons why people engage in sexual activity, and they should get the support and advice that they need.

I am glad that you mentioned CAWT, because I am aware of the work that it does, particularly in border constituencies. It has probably helped to minimise the pressure on, say, the GUM clinic in Belfast, because people have been able to access services closer to home.

One area that concerns me is access to counselling services. Although not specifically about sexual health, it has an impact. The level of counselling services in urban areas, particularly Belfast, is considerably higher than outside Belfast. Many young people have access to counselling only when at school. When they leave because they have reached the appropriate age or, perhaps, have dropped out, access to counselling services for young adults — or any adults — is not the same. Will you look at that? I know that the Health Department and the Department of Education have worked well together on that issue. However, counselling is not available in rural areas for those who are not in school and need access to it. Any unplanned pregnancy, teenage or otherwise, or sexually transmitted infection, is extremely traumatic for anyone. The support might not always be there as part of someone's normal support network. Therefore, I ask that that be considered, and I might come back to you.

I want to ask a specific question about warts. Not only is it a horrible condition for someone who has it, it is easy to pass on to an unborn baby. The ramifications for that child and the operations that he or she will have to undergo are hideous. Will you give us some information about what is being done to counteract that STI problem? Although the figures peaked around 2005, they remain fairly static. Really and truly, can anything be done to decrease the number of people affected by transmitted warts?

Dr Harper: That is very much part of the overall strategy, as opposed to being targeted as a particular condition. Often, if someone has one infection, other infections are also present. We will take away and consider the points that you have made. To date, the approach has been more universal, whereby we get the message across about all STIs, rather than particular ones.

Ms Gildernew: Screening can be done for warts. I know, for example, about the impact of screening for cervical cancer in other parts of Europe. I might not be correct about that.

Dr Harper: The human papilloma virus (HPV) vaccine.

Ms Gildernew: My understanding is that the multi-dose HPV vaccine might also cover genital warts. Is that correct?

Dr Harper: I am not entirely sure.

Ms P Bradley: It is the one that has been introduced in England.

Dr Cullen: There were two possible vaccines. The one introduced initially was for two main categories. I think that they are now moving to the one that has wider coverage, which will cover some of the other cases.

Ms Gildernew: Will it also cover teenage girls? Will they have access to it?

Dr Cullen: I hope that it will. It is not my area of expertise but, as far as I am aware, the broader vaccine is also being brought in. We can check for you to make sure that that is the case.

Mr Durkan: I welcome the panel, and thank you for your presentation. Unusually, I want to congratulate you because it seems that you have met the targets set in 2008. That is not often the case when people come here. *[Laughter.]* However, it leads me to question whether those targets were ambitious enough and how you will move on from that point.

The Chairperson: That is like giving a child a lollipop and saying, "Do not lick it." *[Laughter.]*

Ms Gildernew: Never mind; credit where credit is due.

Mr Durkan: I agree entirely with and welcome your actions, particularly those on public information and texting. It is very important to embrace technology. If we as a Committee can do it, it is most important that you do it, particularly when it comes to communicating messages to teenagers. I suggest that you consider exploring that further through Facebook, BlackBerry Messenger or Twitter. All of that is very good, but I am also interested to hear about hard targets for the future.

I welcome the move on the expansion of HIV testing. To what can the rising number of diagnoses of HIV resulting from sex between men be attributed? In your opinion, is there a higher incidence or more diagnoses? I want to get to the bottom of that. Furthermore, how many HIV sufferers are there currently in the North? I find the amount of new diagnoses every year over the past 10 years startling, particularly in that group. Unfortunately, and regrettably, not all of those people will still be with us. I am interested to know how many sufferers there are across all the groups.

I will be parochial on the question of the budget. I am concerned that, for a change, the west is not the best. Indeed, the Western Trust is the worst and gets the smallest budget allocation. Is there a

formula attached to that? I would like to know how that is arrived at, because the area could do with more resources.

Ms Gildernew: There is a difference of £87,000 between the best-funded area and one of the worst-funded areas — that is a big difference.

Dr Rooney: I will pick up on the funding question in a second. In the context of targets, we will never be happy while arrows are going in the wrong direction or along flat lines. Some trends are moving in the right direction. However, for too many issues, that is either not the case or the downward trend is not fast enough. There is always a question of whether the targets set are too easy. That is not our concern; we want the rates to come down.

Mr Durkan: I congratulate you on that.

Dr Rooney: We will keep a focus on that. We are always concerned when some arrows go in the wrong direction, and that leads to the question of why that should be happening. Many issues that we deal with are not just local. There are so many other factors, including many international factors, that we need to take into account. We always need to take a very broad view. That is why, from our point of view, information and research are so important. Carolyn or Bernadette might be able to answer the question on what is driving the increased rate of HIV among men who have sex with men.

Dr Harper: This goes back to the earlier conversation. People's views of HIV may have changed, and some of the protective behaviour from the 1980s, when it first emerged, has changed. We need constantly to send out messages to new generations to keep awareness high and to ensure that behaviour is as safe as possible.

The final question was about the budget. Funding allocations are based on population, with deprivation and other factors also taken into account. That is done on a capitation basis, so it reflects the number of people living in an area as much as anything else. The Western Trust, for example, has the lowest population. There is also some reflection of historical funding and certain regional programmes that might be attributed to a particular locality.

Mr Durkan: Is that based on the full population or, for example, the teenage population?

Dr Harper: The capitation formula is based on the full population, but it takes account of the age profile in an area.

Mr Durkan: I would be keen to see more information on how that is worked out. You mentioned deprivation as one factor. On that basis, the west would score highly, or lowly, depending on how you look at it.

Dr Cullen: Carolyn mentioned some of the historical factors that may influence funding. A specific example that may explain that is that money for the Belfast and South Eastern Trusts includes funding for Brook services, whereas, in the Western Trust, the young people's sexual health service is delivered through the trust rather than through a voluntary organisation, so that funding is part of the trust's baseline and is not reflected in the Western Trust's allocation. When contraceptive-type services for young people were set up, some of them, such as those in the Western Trust, were delivered through the trusts, so that money is included in the trust's baseline; it is not in our budget. However, in Belfast, a decision was made to fund Brook to provide that range of services. As it is a voluntary organisation, the funding sits in the PHA. The levels of allocation can look different because of where the funding sits, but services are being delivered in both places. I hope that that helps to explain some of the anomalies between trusts.

Mr Durkan: It is complex, but I would definitely like to see a breakdown. I am not complaining that anywhere else has too much; it is just that the west does not have enough.

Mr McCallister: Chair, you mentioned virtual babies — if anybody wants a real baby for a night or two, they are welcome. *[Laughter.]* It has been a useful discussion, and I am sorry that I missed the start of the presentation.

It will always be a matter of finding the balance between living in the "real world" — Michelle, I think that you used that phrase — and reflecting the views of people from a church or faith background and ensuring that parents are comfortable with whatever relationship advice and guidance comes through schools, the home or youth groups. That is important, as is targeting. A few months back, many Committee members were involved in a Long Gallery session with Voice of Young People in Care (VOYPIC). That is a key target group. VOYPIC certainly told us that there was a lack of help and advice, so I am encouraged to see that one of your key target audiences is looked-after children.

There are wider issues. How do some of our stats compare with England and the rest of the UK? Are we doing better? Your presentation shows that some groups have unexplained spikes, lasting a couple of years, in the rate of HIV infection. I think that it was Carolyn who said that HIV's being viewed as more of a long-term condition could almost work against us. I may not be just as old as Paula, but I was a teenager in —

Ms P Bradley: How dare you.

Mr McCallister: — the second half of the 1980s.

The Chairperson: That is probably one of the reasons why you did not win that leadership election. *[Laughter.]* You have no tact.

Mr McCallister: You were not to mention that. Anyway, Paula did not have a vote.

I remember the adverts about HIV and AIDS at that time, featuring the iceberg and the tombstone. Have you had any discussions on that at a national level? Do we need to consider running another such campaign nationally? Is that likely to be on the radar as an option to tackle the issue? The statistics show significant increases at different times in the homosexual and heterosexual populations.

Dr Harper: As the numbers overall are small, there will be a fairly wide fluctuation from time to time. As health is a devolved function now, each country tends to look at its own patterns, priorities, and so on. The agency has talked internally about having a specific sexual health awareness campaign in 2012-13. The nature of that might be more along the lines of using social media, which we talked about, rather than radio and TV. It is all about tailoring the messages, format and medium to our target audience. That is certainly on the agenda for this year.

Mr McCallister: Is there a perception that the low number of people affected means that the risk is lower? Is that the problem? Paula made an excellent point earlier, which was that, for many young people, the biggest concern was pregnancy, not sexually transmitted infections. A young girl who is on the Pill might be protected against pregnancy, but, of course, not against STIs. Is the perception of low risk one that you come across in feedback from the groups with which you work?

Dr Harper: Bernadette, do you want to mention some of the engagement with the sector?

Dr Cullen: We always want to keep that issue in mind, because it can be a concern. When a condition is treatable, there can, sometimes, be a perverse effect, because some individuals think that its being treatable means that it is not a big deal. I do not think that it is a major problem. It may be that the generational issue means that we have to keep repeating the messages. We carry out what is called convenience advertising, for example, which involves putting posters on the back of toilet doors. That is aimed at social venues attended by young people aged between 18 and 30. We try constantly to refresh those messages, in which we provide information on a range of STIs, because a new group of young people is always reaching maturity or becoming sexually active and might not have got the message before.

All of the programmes that we deliver talk about STIs and the need for protection. They inform young people that the Pill might protect from pregnancy, but that it is not a protection from STIs. Our programmes talk about safer sex practices, condom use and the range of protective measures that we would like young people to put in place. It is good that treatments are available, but their availability may cause a little complacency. However, we do not think that it is a major issue.

One major factor in the fluctuation of numbers is that we are trying to encourage people to come forward for testing. A number of years ago, that approach was not taken to the same extent. Now, because the treatment is so much more effective, we want people to come forward earlier so that they can be treated when they are still well. There is much more encouragement to be tested, and that, in itself, may cause some of the fluctuation. A range of issues exists within that, and we are trying to keep all of them on the agenda as we move forward.

The Chairperson: I want to go back to a couple of points. I probably need to declare an interest, as I have two sisters who had babies when in their teenage years. I am not ashamed to say that, because they were, and still are, fantastic parents. One important factor for them was that they had strong family support. One issue nowadays is the breakdown in communities, whereas, a number of years ago, family members lived beside each other.

Your presentation, under early childhood and youth development programmes, refers to support for early years. Anyone reading that automatically thinks that it means support for a baby. First off, we are trying to stop people having babies in their teenage years. However, it happens, so what support is available for the young parents and, indeed, the babies? I am not suggesting that those born to teenage parents automatically become teenage parents, but we should target the support. It is not always a health issue, and other agencies need to play their part. We hear the old arguments for, and talk about, integrated services. What is happening there? I am asking you, because you have the overarching responsibility for that. If we are trying to break that cycle, what support are we giving to the parents?

Finally, you also mentioned four one-stop shops. What do you mean by that, and where are they?

Dr Rooney: You have hit on an issue that is at the core of our work, which is making earlier and earlier interventions. We want to move the balance away from constantly responding. We have been forging ahead with some initiatives in that area, particularly the Family Nurse Partnership, which currently operates in the Western Trust and will be extended to another two trusts. The whole purpose of that initiative is to try to get a fully integrated and intensive approach. It deals with young, first-time mothers in the most vulnerable areas, who, in many cases, have no support mechanism. It is not simply about giving them support but bringing them along and helping them to develop, while also helping their children to develop in a way that can be sustained in the long term. We were attracted to the programme because similar schemes have been running in some countries for over 35 years, and some of the long-term results have been spectacular in just about every measure from education through to broad health issues.

For us, getting in earlier and intensively, as well as working with all the other agencies that need to provide that support, is a different way of working. It is also a different way of working for the services, but that is required. The more that we can take that sort of approach, the better chance we will have of dealing comprehensively with the issues of parents who will always be vulnerable. Part of our job is to try to make sure that those parents are not vulnerable, and we do what we can under our responsibility to put the social fabric around them and give them a proper chance. That philosophy is at the core of what we have been trying to do. To be honest, Sue, we are in the early days of that and still have an awful lot to do. However, that is a crucial part of the direction of travel.

That sort of approach gives everything a focus, and the rest of the services start to make sense. For us, it is not simply about providing a service to recipients. We want all the health services to shift to that different way of dealing with communities. We want them all to move.

The Chairperson: So is it similar to the concept of Sure Start?

Dr Rooney: Very much so; the principles are very similar. It is about starting earlier and being much more intense. Sure Start, at its best, really picks up the mantle, if usually a little bit later. That sort of approach is also crucial to making that shift in how the services work and deal with communities. We are every bit as interested in the early impact that the Family Nurse Partnership programme, for example, is having on health visitors and health professionals. A light bulb has gone on in the way that those services deal with communities, and it is not a sort of dip-in and dip-out approach. That change of approach is vital for us. We want that to be developed, and we will be put a lot of effort into making that happen.

The Chairperson: What about the one-stop shops? That has been a buzzword for the past 30 years.

Dr Harper: I want to get the locations correct: the one-stop shops are in Carrickfergus, Bangor, Enniskillen and Newry. They are centres providing information and advice to young people on everything from health and well-being issues, such as alcohol, drugs, smoking, sexual health, mental health, and so on, to wider welfare issues, such as advice on education and training opportunities. They deal with a whole spectrum of issues — hence the name.

The Chairperson: It might be an idea for us to visit one of those centres. We hear about one-stop shops everywhere. I am so delighted that you did not mention Belfast, as my colleagues on either side of the table might have panicked. Other buzzwords that we come across are "holistic" and "integrated" in reference to approaches. Perhaps we should witness the work of one-stop shops at first hand. Also, I suggest that you use us as conduits to get that information out to young people through our constituency offices.

Mickey winked at me, so I will let him come in.

Mr Brady: I am glad that you mentioned Newry. I do not want to ask a question; I just want to thank you for your presentation and congratulate you on the work that you are doing. I am from a generation that went to single-sex primary and grammar schools and was taught by nuns and Christian Brothers, and sex education just did not feature. I know that we do not have a complete picture, but what you are doing and what is available for young people is brilliant.

The Chairperson: They did use tablets then, but they were tablets of stone. *[Laughter.]*

Ms Gildernew: Mickey, I thought that you were going to say that you were from a generation that did not have sex before marriage. *[Laughter.]*

Mr Brady: No. I have come across the organisation that Jim talked about, but I am afraid that it was too late in my case.

The Chairperson: OK. It was useful for the Committee to get an overview of all that is going on, and it is important that we can interact with you, as you have an overarching responsibility for sexual health across the region.

We mentioned some additional information that we would like, Eddie.

Dr Rooney: We will get that to you. We will also follow up on the one-stop shops. I think that it would be useful for the Committee to see their work.

The Chairperson: Yes, it would. On behalf of the Committee, thank you very much.