



HOW IS IT FOR YOU?

A SURVEY INTO THE SEXUAL HEALTH SERVICES NEEDS OF
YOUNG PEOPLE IN NORTH & WEST BELFAST

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March 2007.

Foreword

“ what young people want from sexual health services ”

Promoting the health and wellbeing of young people has been a fundamental theme of North and West Belfast Health Action Zone over many years. Sexual Health is central to this theme and has led to the development of 'A Strategy to Promote the Sexual Health and Wellbeing of Young People in North and West Belfast'. The Strategy was founded on a review of the evidence of effective intervention and best practice. It was written in response to the need for a coordinated approach to the issue, reflected in comparatively high rates of teenage pregnancy, acknowledged higher levels of poverty and disadvantage in North and West Belfast, and variation in access to services.

In January 2005 the Health Action Zone established a multi agency project board to oversee the implementation of the strategy. A number of areas were prioritised and it was agreed that a Services Sub Group would be set up to give particular attention both to the co-ordination of current service

provision and also to the identification of gaps. This survey is one aspect of the work of the group. Separately, the Education sub group have commissioned an audit of Relationships and Sexuality Education in schools as part of the strategy. This will be an important contribution to establishing the needs of teachers and other staff working with school aged children and young people. Together the two surveys will provide useful baseline information on which to plan a holistic approach over the coming years.

I am grateful to the Department of Health and Social Services and Public Safety for funding the survey and publication of this important report. The methodology adopted is consistent with the Health Action Zone principle of inclusion. Young peoples' views are centrally important to developing meaningful engagement and ultimately the development of better and more effective service provision.

I would like to thank everyone who was involved in this survey, most particularly Elaine Kelly and Opportunity Youth, who facilitated and led the development of the project. I would also like to thank the dedicated work of the Services Sub Group, chaired by Mary Crawford, for their commitment and good humour to the task. Multisectoral working is critically important – but it is people who make it work!

The importance of this contribution will be set alongside other aspects of the strategy and its implementation across many different sectors and agencies over the coming period and I look forward to our continuing development in a spirit of true partnership.



Mary Black

Health Action Zone Leader

Executive Summary



“ what young people want from sexual health services ”

The aim of this survey was to identify the gaps in the sexual health services provision to young people in North and West Belfast. The survey also set out to contribute to an understanding of what young people want from sexual health services and how their needs could be met. Views were also sought from a small group of health professionals who work in North and West Belfast.

Due to the lack of recent literature available on the sexual health needs and experiences of young people living in North and West Belfast, a number of research projects in Northern Ireland and the rest of the UK were important for setting this survey into context. These include;

- The Northern Ireland Health and Well-being Survey (NISRA, 2002)
- The Young Life and Times Survey (ARK, 2004)
- Towards Better Sexual Health: a Survey of Sexual Attitudes and Lifestyles of Young People in Northern Ireland (Schubotz, Simpson & Rolston, 2002)
- Young Persons Behaviour and Attitude Surveys (NISRA, 2004a and 2004b)



Methodology

Two means of data collection were used in this piece of work.

1. Young people were approached to complete a survey questionnaire. Respondents were recruited through organisations that had regular access to young people through their provision of sexual health education and services in North and West Belfast. It was anticipated that both service users and non-service users would take part in the survey. However, due to the nature of the sampling, the respondents were predominantly service users. Overall, 279 young people completed the questionnaire, 92% of these lived in North and West Belfast. Most respondents (86%) were aged 15-17 years. More males (57%) than females (43%) responded. Nine percent of respondents identified as gay, lesbian or bisexual.
2. Two focus groups were conducted, one with health professionals and one with young people. The aim of the focus groups was to collect more in-depth information that would complement the responses from the survey questionnaires. The questions asked in both focus groups were of a similar nature in order to establish comparisons between the two groups.

Six representatives of statutory and voluntary organisations took part in the group discussion with health professionals. Issues such as the main sources of information on sexual health services available to young people and perceived barriers to sexual health services were predominantly discussed.

Summary of findings

Sexual Health Information

The vast majority of respondents (87%) said they had received information on relationships and sexual health. Females (92%) were more likely than males (83%) to say that they had received such information. Respondents who identified as gay, lesbian or bisexual were significantly less likely to say that they received sexual health information (70%). The three topics covered most appropriately were found to be related to physical aspects of sexuality, whereas the three worst covered areas related to emotional aspects of sexuality.

Males were almost four times as likely as females to disagree that it is easy to 'say no to having sex'. One in five gay, lesbian and bisexual respondents found it difficult to ask for what they wanted in relationships.

Sexual experiences

Nearly three quarters (73%) of respondents said they had had sex. The mean age at first sex for these respondents was 14.5 years. Over half of all respondents had experienced not only heavy petting, but also sexual intercourse by age 15. At age 18, over nine in ten (96%) respondents said they had experienced sexual intercourse.

About two thirds of respondents (66%) said they had used contraception when they first had sex. Contraceptive use was significantly lower among respondents who said they were not heterosexual. Younger respondents were more likely than older respondents to say that they had used contraception at first sex; however, they were least likely to use contraception with their current partner. The most commonly used method of contraception was condoms (95%), 27.1% used the contraceptive pill.

Forty percent of respondents said they had used Emergency Contraception (EC); 60% of these had used it once, 30% had used it more than once but less than five times and 11% had used it more than five times. Over three quarters of respondents (79%) got their EC from Brook, 8% got it from a chemist, 6% from GPs and 5% from a family planning clinic.

Sexual Health Services

Over half of respondents (58%) said there was adequate sexual health information in their area. Respondents who said they had a disability were slightly less likely to think that sexual health services were adequate. Brook was identified by respondents as the main source of contraception as well as the main source of information on sexual infections. Friends, a chemist or respondents' partners were the next most often mentioned sources of contraception. The survey concluded that young women take more responsibility for accessing contraception and are more likely to look after their sexual health than males.

Young people who identified as gay, lesbian or bisexual were ten times more likely than heterosexual respondents to have used sexual health services and seven times more likely to use a sexual health helpline.



Recommendations

It is hoped that the following recommendations, which are drawn from the key findings, will inform current and future policy development. Some of the issues raised are not new; rather they reinforce similar recommendations made in the DHSSPS's Regional Teenage Pregnancy and Parenthood Strategy and the soon to be published Regional Sexual Health Promotion Strategy.

As emphasised in the strategies mentioned above and the local 'HAZ Strategy to Promote the Sexual Health and Wellbeing of Young People in North and West Belfast', this survey concurs that a coordinated approach to the delivery of sexual health information, education and services is key to ensuring that young people receive education and services which meet their needs. The following recommendations are based on this premise.

1. Do children and young people have access to high quality Relationships and Sexuality Education (RSE)?

The future delivery of RSE in schools will have to reflect the changing environment of Personal Development as part of the revised school curriculum for Northern Ireland. It will take time for the impact of these changes to become evident; however, this survey is timely as it can support and assist schools in the implementation of these changes.

Evidence from the survey supports the following recommendations:

- Multi-disciplinary training and protocol development is required for professionals on young people's rights, including the right (or not) to confidentiality.
- RSE needs to be inclusive of Lesbian, Gay, Bisexual and Transgender (LGBT) groups and young people with disabilities.
- RSE should be timely, age appropriate and not based solely on a medical model. A core element should be emotional feelings and the ability to develop and maintain safe and satisfying relationships.
- RSE should include confidence building activities as a priority, particularly for young men who often require assistance to ask for help and support on sexual health issues.

2. How do young people view the sexual health services in North and West Belfast?

The survey indicates that young people in North and West Belfast value the sexual health services currently available to them from the statutory and voluntary sectors in their area. They particularly highlighted the high standard of information provided and the effective communication between them and staff members. However, they also suggested how current services could be improved.

- Improvements should be made with regard to waiting times, location and opening times of services to reflect the needs of young people.
- Emergency Contraception (EC) should be available in all pharmacies in North and West Belfast.
- Sexual health service providers should be more proactive in addressing the needs of young men.

3. Is there a social climate that is supportive of young people's sexual health?

It is also important to consider the wider context in which the survey was carried out. In doing so, evidence from the survey supports the following recommendations:

- Information and training should be provided for young people on their rights including the right (or not) to confidentiality. This will enable them to make informed choices about which services they want to use.
- An open, inclusive public debate on the areas of RSE and sexual health services should be initiated with partners, stakeholders and, in particular, community groups, faith groups, parents and schools.
- Professional education and training should include an exploration of attitudes and values, together with factual knowledge related to the sexual health of young people.

4. The way forward?

As well as the above, evidence from the survey also confirms the need for the following recommendations:

- Further research should be conducted to include a more representative sample of young people in North and West Belfast.
- Appropriate resources should be allocated in North and West Belfast to allow the best possible services to be provided to all young people with particular attention to LGBT groups, young males and young people with disabilities.

1.0. Background to Survey



“reducing inequalities in health”

“Sexual health is a right for any individual or group, irrespective of their age, gender, race, religion, sexual orientation, economic or social status, political affiliation or existing medical condition”

(Wilson & McAndrew, 2000)

The sexual health of young people has been a key area for health promotion in recent years and the consequences of sexual ill-health continue to be a concern for policy-making in Northern Ireland. Regional and local strategies, for example, The Regional Teenage Pregnancy and Parenthood Strategy (DHSSPS, 2002), reference the importance of

young people accessing sexual health services and highlight the gaps in current research data on sexual health.

The UK government introduced the first Health Action Zones (HAZ) in England in 1998. HAZ's were established to target areas of social disadvantage in which poor health indicators were recorded. One of these indicators was sexual health. The Investing for Health Strategy for Northern Ireland was published by the DHSSPS in 2002.

The first two HAZ's in Northern Ireland were established in 1999, one in Armagh and Dungannon and the other one in North and West Belfast. In 2002, the North and West Belfast Health Action Zone (HAZ) developed the *Strategy to Promote the Sexual Health and Well-being of Young People in North and West Belfast* (2002).

This HAZ Strategy was based on a review of the existing evidence of effective interventions and best practice with the aim to meet the sexual health needs of young people in North and West Belfast. The strategy sets out clear objectives, which aim to improve the health and well-being of young people and to reduce inequalities in health. These are:

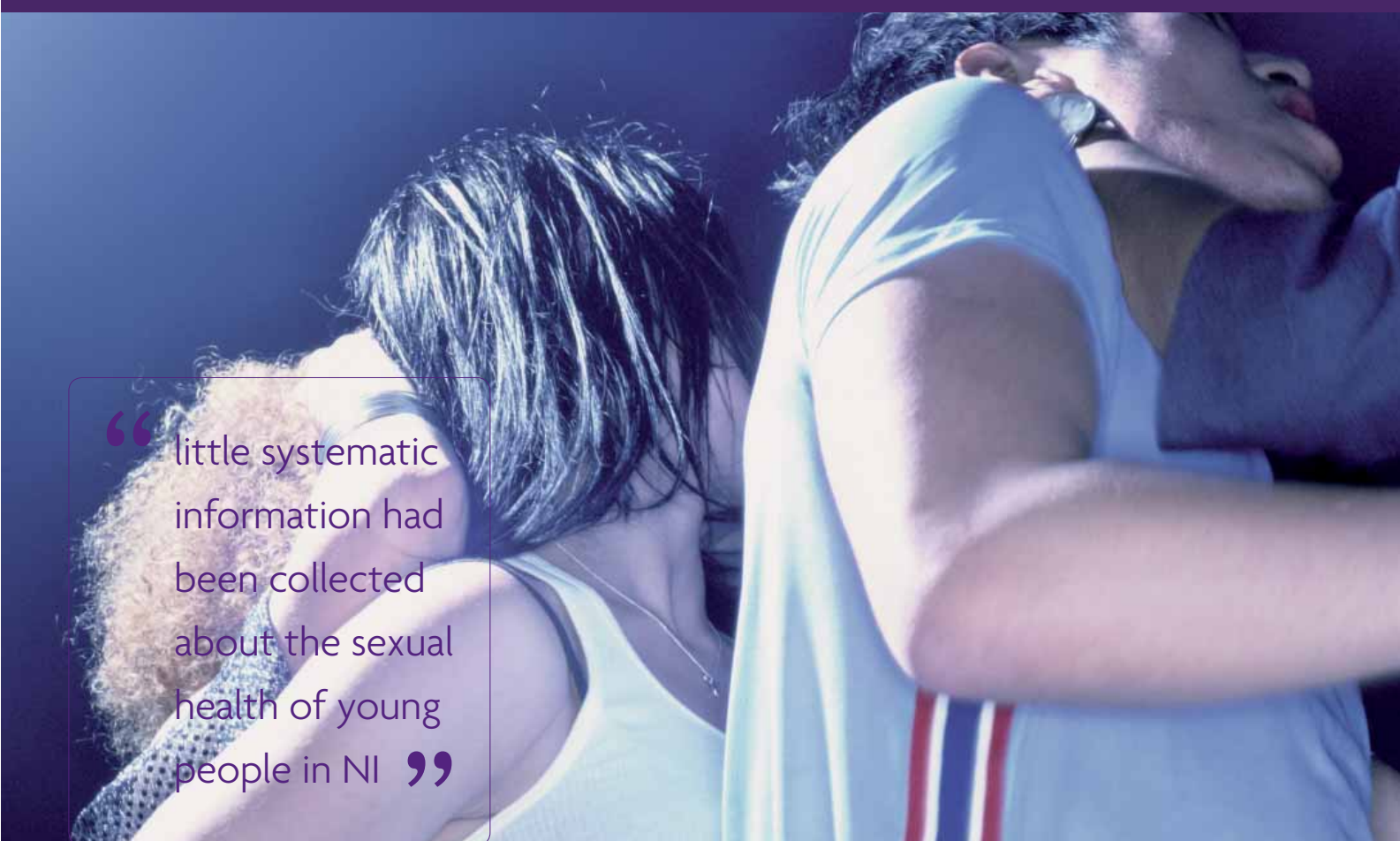
- To ensure that children and young people have access to high quality Relationships and Sexuality Education (RSE) appropriate to age and needs;
- To increase accessibility and availability of sexual health services which meet the needs of young people, for example contraception and advice services;
- Ensure that young people have access to accurate information through existing and innovative methods of information dissemination;
- To promote a social climate which is supportive of young people and their sexual health;
- To encourage research on sexual health services and education initiatives aimed at young people; and
- Encourage evaluation and promote good practice in the field.

(North and West Belfast HAZ, 2002.)

In January 2005, the North and West Belfast HAZ set up a multi-agency Sexual Health Project Board to oversee the implementation of this Strategy. As one measure it was agreed that the Services Sub-group of the Sexual Health Project Board would undertake a survey. The aim of this piece of work was to identify the gaps in the sexual health services provision to young people in North and West Belfast. The survey also set out to contribute to an understanding of what young people want from sexual health services and how their needs could be met.

The survey was committed to involving young people who are commonly seen as 'hard to reach', such as young people with disabilities and young people from minority ethnic communities. In addition, this piece of work aimed to explore the viewpoints of sexual health professionals working in North and West Belfast. It was the purpose of this survey to provide an evidence base that would support joined-up planning and practice of sexual health service provision for young people in North and West Belfast.

2.0. Literature Review



“ little systematic information had been collected about the sexual health of young people in NI ”

Compared to the rest of the UK, sexual health in Northern Ireland has been relatively under-researched. Northern Ireland was excluded from the National Survey of Sexual Attitudes and Lifestyles (NATSAL) (Johnson et al., 1994; Wellings et al., 2001), which were the two major sexual health surveys undertaken in the UK. Until fairly recently, beyond official statistics of sexually transmitted infections (STIs), little systematic information has been collected about the sexual health of young people in Northern Ireland.

However, at the start of the new millennium a number of social research projects provided some benchmark information on sexual health in Northern Ireland (Schubotz, Simpson & Rolston, 2002; NISRA, 2002; 2004a and 2004b). Since then, many more research

projects have focused on selected questions of sexual health, such as:

- The timing and age of first sexual intercourse;
- The extent of sex education received;
- The use of contraceptives;
- Sexual orientation.

Before this report was written, no recent information had been available on the sexual health needs and experiences of young



people living in North and West Belfast. Earlier literature included a report into Young People's Health in 1999. However, the literature review on previous research conducted sets into context the findings of the present survey (see Section 5).

2.1 Sexual behaviour and age at first sex

The only representative household survey undertaken in Northern Ireland, which asked (young) people about the age they first had sex, was the Northern Ireland Health and Social Wellbeing Survey 2001 (NIHSWB) undertaken by NISRA (NISRA, 2002). The survey found that 15 % of 16-24 year olds in the survey had had sex before they were 16 years of age. Young men were almost twice as likely as young women in this age group to report first intercourse by the age of 16 (20% and 11% respectively).

The only other survey that included questions on sexual intercourse and used a Northern Ireland-wide representative sample was the *Young Life and Times (YLT) Survey 2004*. Using the Child Benefit Register as a sample frame, YLT found that 21 per cent of 16-year olds reported that they had had sex. Again, males were more likely than females to say that they had had sex (23% and 20% respectively), but the difference was not as dramatic as reported by NISRA in 2002 (Hannahford, 2005).

The first large-scale survey of sexual attitudes and lifestyles of young people in Northern Ireland was undertaken by the fpaNI and the University of Ulster (Schubotz, Simpson & Rolston, 2002). Using an opportunistic sampling frame, the survey found that among the approximately 1,000 14-25 year-old respondents across Northern Ireland, 27 % had had sexual intercourse before the age of 16 years. Again, young men were more likely to report sex before 16 than young women. The average age of first sex for males was 14.9 years compared to 15.9 years for females.

In 1997/98 Northern Ireland was included in *The Health Behaviour of School Children* survey (HPA, 2000). The sample was representative of the Northern Ireland school population. However, only year 9-12 students who said that they ever had a boyfriend or girlfriend were asked about sexual intercourse. Among the 3,450 respondents who confirmed this, 15 % had had sex. Of this 15 % the average age for first sex for this group was 13 years for boys and 14 years for girls.

The 2000 and 2003 *Young Person's Behaviour and Attitude Surveys (YPBAS)* were undertaken by NISRA (2004a and 2004b) among 11-16 year old pupils from a representative sample of post-primary schools. The results of the 2000 survey showed that over three quarters (77%) of pupils had had a girlfriend or boyfriend, 12% of respondents had experienced sexual intercourse, with the majority being 14 years of age when they first had sex. The findings in the 2003 survey were similar, with 11 % of respondents saying that they had had sex. The age at first sex was again 14 years for the majority of respondents.

Some research evidence was also collected by organisations working in the area of sexual health in Northern Ireland. ACCORD (Loughrey, 2002) surveyed 15-17 year old pupils in the Catholic maintained school sector and found that 29 % of respondents had had sexual intercourse. In a survey carried out by *Love for Life* (2004) among approximately 11,000 pupils, who had seen the organisation's presentation on relationships in their school, 14 % of 14-year olds and 22 % of 15-year olds had had sexual intercourse. Males were slightly more likely to have had sex than females.

Considering the diversity of sampling frames, it is not surprising that results in the above surveys vary somewhat and are difficult to summarise. However, it appears to emerge that at age 16, a significant minority of young people (approximately one fifth to one quarter) have experienced sexual intercourse. Young men are more likely to have done so, or at least are more likely to report sexual intercourse.

Despite their diversity, the findings compare well with the findings of the NATSAL studies (Johnson et al., 1994; Wellings et al., 2001), which reported that approximately 30% of 16-19 year old males and 26 % of 16-19 year old females had had sex.

2.2 Use of contraception

Due to different sampling frames and different wording of questions, the results on contraceptive use among young people in Northern Ireland are also diverse and therefore quite difficult to compare.

The 2001 *NIHSWB survey* (NISRA, 2002) found that 87 % of sexually active respondents in the 16-24 age group used some form of contraception, with the condom being the most popular method followed by the pill.

The sexually active 12-16-year old respondents in the 1997/98 *Health Behaviour of School Children* survey (HPA, 2000) were somewhat less likely to report contraceptive use. However, still 79 % of respondents (84% of females and 76% of males) said they used contraception. Condoms were again most popular followed by the pill. Over one quarter of males and four in ten females said they would find it difficult to access contraceptives.

2.0. Literature Review

The YPBAS surveys (NISRA, 2004a and 2004b) found that over three quarters of respondents (76% in 2000 and 79% in 2003) had used some form of contraception at first sex, the most popular method being a condom. Only 63 % of respondents in the 2000 survey and 56 % of respondents in the 2003 survey said they would find it easy to access contraceptives.

The *Towards Better Sexual Health* survey (Schubotz, Simpson & Rolston, 2002) found that nearly three quarters (72%) of 14-25 year old respondents had used contraception at first sex. Here too, condoms were the most common method followed by the contraceptive pill. The survey found that failure to use contraception was significantly lower among those who first had sex when they were 16 years or older (17%) compared to those who first had sex when they were younger than 16 years (37%). Also, young people who said they could talk to their parents about sex were on average nearly twice as likely to use contraception at first sex than those who said they could not. Over one fifth of females (21%) and one quarter of males (25%) said they found it difficult to access contraceptives. This figure was significantly higher among younger respondents, with nearly one third (31%) of 14-16-year olds saying access would be difficult.

Due to ethical and moral principles and beliefs of all or some participating schools, neither ACCORD (2002) nor Love for Life (2005) asked questions on contraceptive use.

The most recent British data from NATSAL (Wellings et al., 2001) suggest that only seven per cent of 16-19 year old males and 10% of 16-19 year old females in the survey had failed to use any type of contraception when they first had sex. Thus, whilst the age of first sexual intercourse in Northern Ireland seems a little higher than in Britain, reported use of contraception appears to be somewhat lower.

2.3 Relationships and Sexuality Education (RSE)

According to the regional Teenage Pregnancy and Parenthood Strategy (DHSSPS, NI 2002) the teenage pregnancy rate in Northern Ireland is one of the highest in Europe. An effective Personal Development programme which includes Relationships and Sexuality Education (RSE) is seen as essential by the strategy for the promotion of responsible decision making and good sexual health. However, even though RSE guidelines for schools were published by CCEA in 2001, there is still no uniform or consistent RSE provision in Northern Ireland. Some schools see the subject of sex education as highly sensitive, and a lack of properly trained and dedicated teachers often means that RSE does not get the attention it deserves. fpaNI and HPANI (2003) stated this in their Sex Education in Schools Factsheet like this:

'Some schools provide well-planned sex education within the personal, social and health education and science programmes, coordinated across the curriculum. Other schools provide sex education as an occasional one-off topic, while others have no formal sex education and only answer questions when they arise.' (fpaNI & HPANI, p1)

The NIHSWB survey (NISRA, 2002) found that information from friends (53%), lessons at school (47%), and the mother or female carer (37%) were the three most common ways respondents learned about sexual health matters. Respondents were also asked from which source they learned most and the ranking was the same as above: 1) friends, 2) school, 3) mother, although young women (16-24 years) were most likely to have learned from female family members.

The 2004 YLT survey (Hannahford, 2005) found that 89 % of 16-year olds had received information on sexual intercourse in school. Similar to the NISRA findings, the three most important influences on respondents' views on sexual matters were friends (28%), the family (21%) and school (18%).

From Schubotz, Simpson & Rolston's survey (2002), friends (83%), school (78%) and books and magazines (74%) emerged as the main sources of females' sex education. The findings were similar for males, with friends (77%), school (69%) and TV/Radio (63%) being the three main sources. The vast majority of respondents wanted to have more sex education in school and from their families. Just 39% of respondents found it easy to talk to their mother about sexual matters, and just 11% of respondents found it easy to talk to their father about sexual matters. There was a significant gender difference, but still less than half (49%) of females found it easy to talk to their mother, and just one quarter (25%) of males found it easy to talk to their father about sexual issues. The survey found that sex education in school was most likely to cover issues related to anatomy and reproduction (such as puberty, menstruation, boys' and girls' bodies), but failed to relate to issues such as sexual feelings and emotions or homosexuality.

In a journal article based on the survey findings, the authors concluded that sexuality plays a key role in producing the moral system that underlies much of formal sex education in schools in Northern Ireland. Sex education is marked by conservatism and silence and by the avoidance of opportunities for informed choice in relation to sexuality on the part of young people (Rolston, Schubotz, & Simpson 2005).



More recently, however, the influence of this moral system may not be as evident. A survey on sex education provision undertaken by ACCORD (2002) among year 12 pupils in 17 Catholic post-primary schools in Northern Ireland found that only a minority of pupils agreed definitively with a number of statements derived from Catholic moral teaching; for example only 18 % supported the view that there should be 'no sex before marriage'.

The 1994 *Health Behaviour of School Children* survey found that half the boys who participated in this survey had not been given classes explaining menstruation or STIs apart from AIDS and almost one in four had never had a class on puberty (HPA, 1994; cited by fpaNI and HPANI, 2003). In their Factsheet on sex education in schools, fpaNI and HPANI state:

"The media bombards society with overt and often misleading information, which influences a young person's knowledge and attitudes to their own sexuality, as well as that of others. Families, parents and teachers often exclude young people from discussions about relationships and sexuality" (fpaNI and HPANI, 2003.)

2.4 Sexual health services

Apart from appropriate sex education, easy access to sexual health services is seen as a key to improving sexual health (Fullerton, 2002). According to the author, factors which influence the use of contraceptive services were accessibility, confidentiality, as well as advertisement of services and making sure they are available outside of school hours. Fullerton found that the availability of family planning clinics in a locality was associated with lower conception rates.

Findings from the UK (Stone and Ingham, 2003) also suggest that currently less than one third (29%) of young people use a sexual health service before having sex. There is evidence that young men in particular don't use sexual health services as readily as girls and seem to fear using these services more than their female peers (Royal, 2005).

In Northern Ireland, *The Regional Teenage Pregnancy and Parenthood Strategy and Action Plan 2002-2007* (DHSSPS, 2002) aims to improve sexual health services and to provide specific holistic teenage programmes in areas of social deprivation where teenage pregnancy rates are particularly high. Recent research results show that there is still a long way to go to achieve this aim.

The 2001 *NIHSWB* survey found that only seven per cent of men and five per cent of women who had had sexual intercourse had ever attended a Genito-Urinary Medicine (GUM) Clinic (NISRA, 2002).

The 1997/98 *Health Behaviour of School Children Survey* (HPA, 2000) revealed that boys were most likely to get condoms in public places, whereas girls were most likely used a pharmacy or shop. Considering the very young age of respondents in the survey (12-16 years), it is not surprising that only a very small minority (11% of girls and 2% of boys) had used a Family Planning Clinic to access contraceptives.

The Towards Better Sexual Health survey, (Schubotz, Simpson & Rolston, 2002) asked respondents for the sources of contraception used at first sex. Similar to the *Health Behaviour of School Children* survey, respondents were most likely to access contraception through Chemists (17%) through a GP (11%) or a public toilet (11%). Again, females differed from males in that males were significantly more likely to use

public places than females (18% and 6%) but significantly less likely than females to use a GP (5% and 16%) or another service, such as Brook (1% and 10%) or a family planning clinic (5% and 9%).

The survey showed that those who said that their parents were the main source of sex education were least likely to fail to use contraception when they first had sex. Over half of both females (57%) and males (50%) who said that their main sources of sex information were their friends did not use contraception when they first had sex.

With regard to Emergency Contraception (EC), Schubotz et al (2002) found that 46 % of sexually active respondents had accessed EC at least once. Three quarters of these respondents said they had no difficulty in accessing it; however, one in five found clinic opening times or the attitudes of staff off-putting. Respondents were most likely to access EC through their GPs (34%). When the survey was undertaken, EC was not yet available over the counter.

A recent piece of local research undertaken by the Omagh Women's Area Network (2005) found that 44 % of respondents did not know where to source help on contraception or pregnancy. The authors concluded that the needs of young people with regard to sexual health services were not being met, and their knowledge base was not sufficient to prevent risk-taking behaviour.

2.0. Literature Review

2.5 Sexual orientation

Sexual orientation has received more focused attention recently. This is related to increasing evidence that gay, lesbian and bisexual people suffer from poorer mental health and are more likely to be bullied. The *Crime Statistics of the Police Service of Northern Ireland* (PSNI) show a 12 % increase in homophobic incidents from 2004/05-2005/06. From April 2005 to March 2006, 220 homophobic incidences were reported (PSNI, 2006) in Northern Ireland. Referring to its own statistics, the PSNI states that they *'do not believe that these figures accurately reflect the actual number of incidents of this nature and many go unreported'*.

Most recently, McNamee (2006) conducted some research among same-sex attracted men in Northern Ireland and found that just a bully's perception of whether someone is gay or not seems to be enough to make some men targets. The mixed-method study produced strong evidence for the link between bullying, poor mental health and same-sex attraction.

Other small-scale research projects carried out in Northern Ireland prior to this yielded similar results. Of the 31 gay or bisexual boys who took part in a study undertaken by Foyle Friend (1999), one described having attempted suicide, two spent time in a psychiatric hospital and eleven said their schoolwork had been adversely affected. Experiences of bullying reported in this study were generally not one-off incidents but ongoing harassment, which continued outside of the school environment.

In another research project undertaken by YouthNet (Carolan & Redmond, 2003), 70 % of respondents had experienced homophobic attitudes from family members and 45 % felt compelled to leave the family home as a result. 29 % of respondents had attempted suicide and 24 % had been medicated for depression. Based on an opportunistic sample of 362 young people who identified as Lesbian Gay Bisexual Transgender (LGBT), Carolan and Redmond also found that 44 % of respondents had been bullied at school because of their sexual orientation. Participants who were bullied accounted for 53 % of those who had been on medication for depression, 54 % of those who had self-harmed and 57 % of those who had attempted suicide.

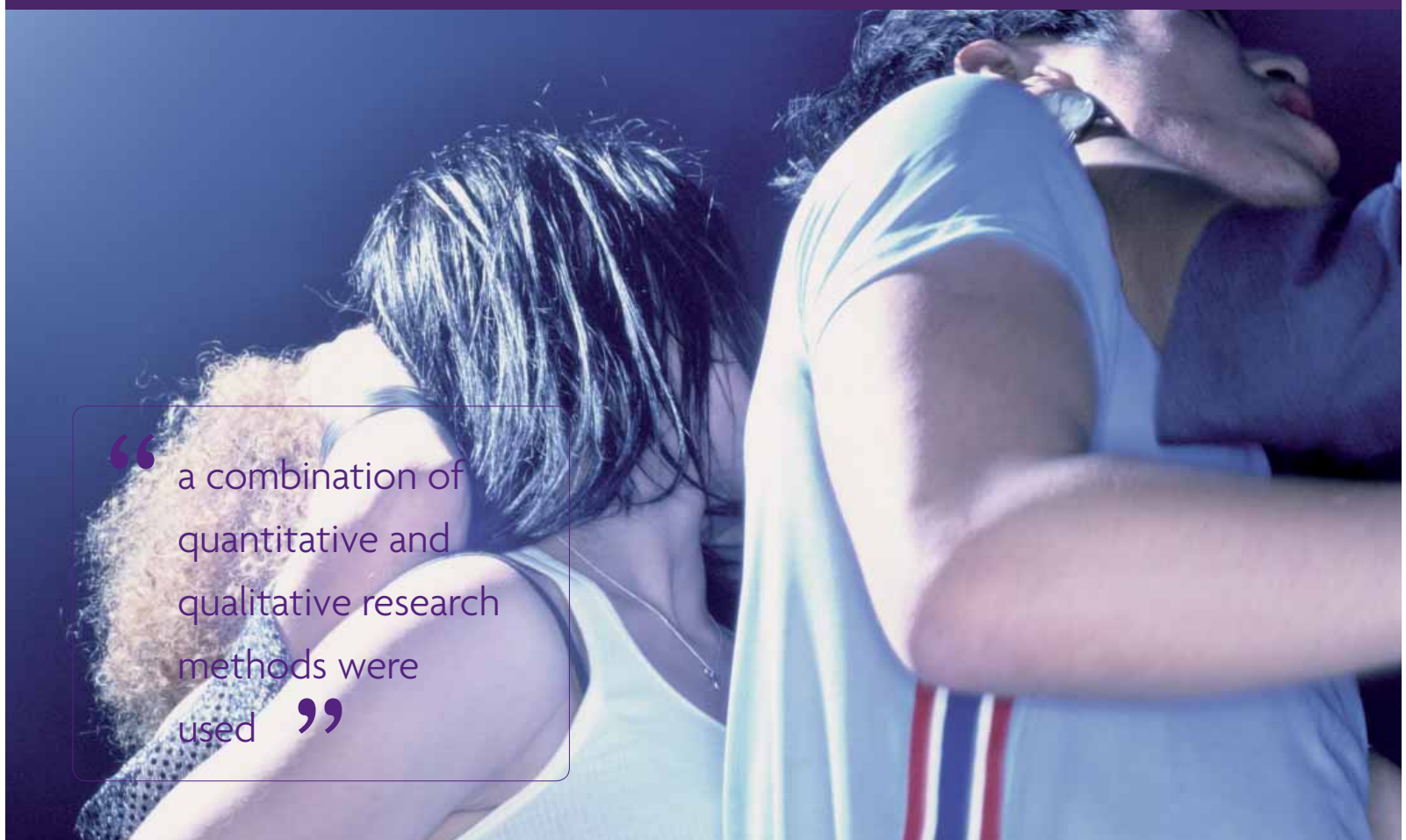
Research carried out by the Northern Ireland Human Rights Commission recognised the link between emotional problems and homophobia. The findings show that discrimination has significant adverse impact on the emotional, physical, social and economic rights, entitlements, needs and interests of lesbian, gay and bisexual people (Loudes, 2003).

Shubotz et al (2002) found that same-sex attracted respondents were less likely to report a close personal relationship with their parents, less likely to be able to discuss personal or sexual matters with them and less likely to have received relevant sex information at home.

A study on homophobic violence and harassment in Northern Ireland (Jarman & Tennant, 2003) revealed that 82 % of respondents had experienced some form of homophobic harassment, and 55 % had experienced homophobic violence.

Considering all of this, it is obvious that same-sex attracted young people are a particularly vulnerable group with regard to sexual health.

3.0. Methodology



“ a combination of quantitative and qualitative research methods were used ”

It was thought that a combination of quantitative and qualitative research methods would be best suited to this project. A questionnaire (Appendix IV) was designed consisting of a range of both open ended and closed questions. Respondents were asked a number of questions in relation to three aspects of sexual health, namely:

- The sexual health education they had received;
- Their own sexual behaviour; and
- The sexual health services that they had used or would use.

The questionnaire also recorded some background information, such as respondents' postcodes, their gender, whether they had a disability or not and their ethnic identity as well as their socio-religious background.

The questionnaire was piloted with 12 people aged 14-17 years from North and West Belfast and subsequently the wording in some of the questions was altered to be better understood by respondents.



In total, 1,000 survey questionnaires were distributed, using an opportunistic sampling method. Respondents were approached through organisations that had regular access to young people through their provision of sexual health education and services in North and West Belfast. These included: family planning clinics, schools, colleges of further education, training organisations, the BELB, community groups, as well as gay and lesbian lobby groups. Even though questionnaires were distributed through these organisations, it was hoped that both service-users and non service-users would reply. However, in the event predominantly those who used sexual health services or took part in sexual health education programmes replied to the survey. Appropriate levels of consent were requested from these organisations depending on their own confidentiality and child protection regulations. Questionnaires were generally self-administered; however, in some instances staff were available if needed when the young people were completing the questionnaires.

In April 2006, the questionnaires were distributed with a covering letter stating the purpose of the survey. Approximately one week later this was followed up by a phone call to the participating organisations to arrange collection dates and gauge the numbers of young people who completed the questionnaires.

In total 279 questionnaires were returned by May 2006. This equated to a return rate of 28 %. A typical response rate for a postal questionnaire for example is 30 % and taking into consideration the sensitive nature of the questionnaire, this was an adequate response rate. Responses from the questionnaire were coded, processed and analysed using SPSS. Open-ended responses and comments were coded and grouped into particular subject areas.

The second part of the project involved conducting two focus groups. One focus group was conducted with health professionals and one with young people. The aim of the focus groups was to collect more in-depth information that would complement the responses from the survey questionnaires.

Six representatives of statutory and voluntary organisations took part in the group discussion with health professionals. Issues such as the main sources of information on sexual health services available to young people and perceived barriers to sexual health services were predominantly discussed.

Participants for the focus group with young people were recruited through the survey questionnaire. A slip of paper was attached to the confidential questionnaire with a space provided for young people to state if they wanted to attend the focus group. Whilst quite a large number of young people had returned these slips, indicating that they were interested in participating in a focus group, only four young people attended when invited. The reasons for the low attendance of young people could be manifold, e.g. the timing of the discussion, fear or embarrassment. The questions asked in both focus groups were of a similar nature in order to establish comparisons between the two groups.

4.0. Findings



“ fifty-seven per cent of respondents were male and 43 % were female ”

4.1. Findings from the survey

4.1.1. Sample characteristics

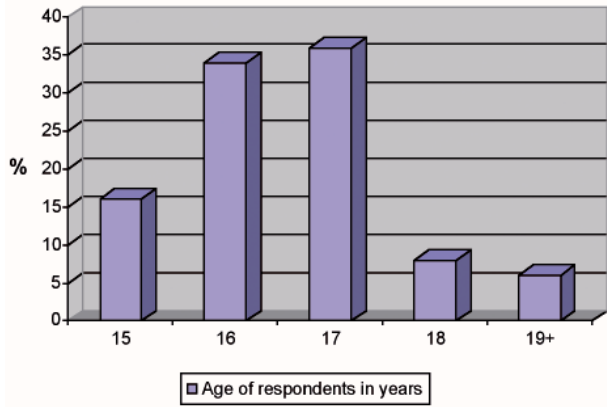
Of the 1,000 questionnaires that were distributed, 279 were returned. As stated in the methodology section, questionnaires were distributed through organisations that provided sexual health education and sexual health services locally. Nearly half (47%) of the respondents were recruited by the HYPE team, all from schools engaged with HYPE. Twenty-seven per cent of respondents completed their questionnaires in Brook, and 15 % of respondents were recruited

through Opportunity Youth. The remaining 12 % of respondents were recruited through the BELB, the Rainbow Project and the GUM clinic at the Belfast Royal Victoria Hospital.

Fifty-seven per cent of respondents were male and 43 % were female. As Figure 4.1 shows, the vast majority of respondents (86%) were 15-17 years of age. Just over five per cent of respondents were over 19 years old, the oldest respondent being 22.



Figure 4.1: Age breakdown of respondents



Respondents were asked for their socio-religious community background. Two thirds of respondents (66%) said they were Catholic, one in five respondents said they were Protestant (20%) and five per cent said they were neither. Nine per cent of respondents did not state their socio-religious affiliation.

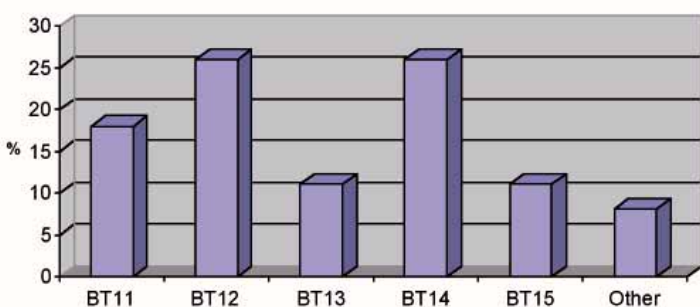
Table 4.1 compares the respondents' socio-religious background with the background of the population of North and West Belfast and Northern Ireland as a whole based on the 2001 Census data. For the purpose of

this comparison, respondents of the current survey who did not state their background were excluded from the analysis. The Table shows that there is a relatively good match of the respondents with the population in North and West Belfast. However, a crosstabulation of respondents' gender and socio-religious background shows that, 68% of Catholics in the sample were young men, compared to just 44 % of Protestants, and just 14 % of those respondents who were neither. This imbalance is most certainly a direct result of the way in which questionnaires were distributed.

Table 4.1: Socio-religious background of respondents compared with North and West Belfast population and Northern Ireland population.

		%	
	Current Research	North and West Belfast	Northern Ireland
Catholic	66	76	40.3
Protestant	20	23.5	39.5
Neither	5	0.5	20.2

Figure 4.2: Postcodes of respondents' home address



Unfortunately this means that the use of the socio-religious background variable will be very limited.

Respondents were asked to state their ethnic identity. Over nine out of ten respondents (94%) said they were white, three per cent identified as Irish Travellers and three per cent said they belonged to another ethnic group, such as Chinese, Pakistani or Black African/Caribbean. Nine per cent of respondents said they had a disability. Due to the low numbers of people with minority ethnic background and disability, the scope for the inclusion of these variables in data analysis is very limited.

In terms of sexual identity, of all respondents:

- 80% identified as Heterosexual;
- 5% said they were Gay or Lesbian; and
- 4% said they were Bisexual.
- 11% of respondents did not give details on their sexual identity.

Summary of findings

1. 57% of respondents were male and 43% were female
2. 86% of respondents were aged 15-17 years
3. 66% were Catholic, 20% were Protestants and 5% were neither
4. 92% of respondents came from the target area of North and West Belfast
5. 94% said they were White, 3% were Irish Travellers and 3% stated other
6. 9% said they had a disability
7. 80% stated they were Heterosexual, 5% were Gay or Lesbian and 4% said they were Bisexual

4.0. Findings

4.1.2. Sex education

Respondents were asked whether they had received information about relationships and sexual health. Nearly nine out of ten respondents (87%) answered in the affirmative.

Females were more likely than males to say they had received information on relationships and sexual health. This relationship was statistically significant ($p=0.013$). The relationship between the age of respondents and the question whether

or not they had received information on sexual health and relationships appeared to be statistically highly significant ($p=0.001$); however, this finding is more than likely spurious. It could have been expected that younger respondents were less likely than older respondents to have received information on sexual health, but as Table 4.2 shows, by age 15, 84 % of respondents had received some information on sexual health and relationships. The Table also shows that it is respondents who were 19 years or older who were least likely to say that they had received sex education. Whilst this

could theoretically be explained by a recent introduction of sexual health education in schools and organisations through which the questionnaires were distributed, the fact that all 18-year olds said they had received such information makes this hypothesis similarly doubtful. Thus, the only creditable conclusion is that within the limited age range of the survey, age is not a significant factor for exposure to sexual health education. Apparent differences are most likely due to sampling.

Table 4.2: Respondents by gender and age who said they had received information about relationships and sexual health

Gender		%					ALL
		Age					
Females	Males	15	16	17	18	19+	
92	83	84	93	84	100	56	87

There was no statistically significant difference between Catholics and Protestants with regard to the receiving of sexual health information. Ninety per cent of Protestants and 86% of Catholics said

they had received sexual health information. However, all respondents in the relatively small group ($n=14$) of those who identified as neither Catholic nor Protestant said they had received sexual health information (Table 4.3).

The difference in sexual health information received between those who identified as White and those respondents who said they belonged to another ethnic group was also statistically insignificant (Table 4.3).

Table 4.3: Respondents who said they had received information about relationships and sexual health by socio-religious community background and ethnic belonging

Community Background			%		All Participants
			Ethnic identity		
Catholic	Protestant	Neither	White	Other ethnic group	
86	90	100	88	81	87

Interestingly, sexual orientation of respondents was a significant factor ($p=0.025$) for whether or not respondents said they had received information on relationships

and sexual health. Whilst 90 per cent of those who said they were heterosexual had received such information, only seven out of ten (71%) of those who identified as Gay,

Lesbian or Bisexual agreed that they had received such information.

¹ Results are statistically significant if the variation in the figures between sub-groups (e.g. males and females or different age groups) cannot be explained by measurement error. Significance values are commonly displayed, using the variable 'p'. There are three levels of statistical significance: $p \leq 0.05$, $p \leq 0.01$ and $p \leq 0.001$. Smaller values indicate highest significance.

Respondents were asked where they had received information on sexual health and relationships. A list of 19 possible sources was given, and respondents could also add further sources if they wished. The responses to this question are summarised in Table 4.4.

The Table shows that respondents' school and friends were the most likely sources of sexual health information, with over half of respondents saying that they received information through school and four in ten respondents (40%) saying they received information from their friends. The opportunistic sampling method used by the survey – i.e. the fact that respondents were recruited through organisations that provide sexual health education or sexual

health services – explains the higher than expected ranking of Brook (ranked third) and Opportunity Youth (ranked fifth). Taking this into consideration, the ranking confirms the findings from previous surveys reported in the literature review of this report that school, friends and parents are the three most important sources of sex information. (Schubotz, Simpson and Rolston, 2002; NISRA, 2002; Hannaford, 2005)

As Table 4.4 also shows, in the current survey there was a gender difference in the availability and use of sexual health information. Males were significantly less likely than females to have received sexual health information from most sources, which again confirms the findings reported above. However, it is particularly noteworthy that

males in this survey were more likely than females to say that they received information from school (57% and 44% respectively). On the other hand, the finding that males were more likely than females to utilise electronic sources of information (TV, the internet), whereas females are more likely to use books or magazines for sexual health information verified previous survey results. Information received from home was clearly gendered, with males more likely to refer to male relatives for information and females to female relatives. Again this is in line with what the above-mentioned previous surveys found.

Table 4.4: Respondents' sources of sexual health information (ranked)

Source of Information	%				
	Male	Female	Heterosexual	Gay/lesbian, or bisexual	All
School/Personal Development lessons	57	44	53	41	51
Friends	33	47	37	65	40
Brook Clinic	23	44	33	29	33
Mother/female carer	14	46	24	59	29
Opportunity Youth	33	21	31	6	28
Books/magazines	15	32	22	47	23
Boyfriend/girlfriend/partner	15	18	16	41	17
TV/Radio	22	10	16	24	16
Older brother/sister	9	21	13	41	15
Father/male carer	22	5	14	12	14
Internet	18	9	13	24	14
HYPE	9	18	14	12	13
School nurse	4	14	8	0	9
GP	6	10	8	6	8
Family Planning Clinic	3	6	4	6	5
GUM Clinic	5	5	3	24	5
Faith Group	4	6	3	24	5
Chemist	2	3	2	6	3
Other	5	2	4	0	3
Help-lines	2	2	2	6	2

4.0. Findings

The main source of information for gay, lesbian and bisexual respondents were their friends (65%), as Table 4.4. shows. Heterosexual respondents were significantly more likely than gay, lesbian and bisexual respondents to have received information from school (53% and 41% respectively). Gay, Lesbian and Bisexual respondents were nearly twice as likely as Heterosexual respondents to retrieve information from the Internet (24% and 13%) and over twice as likely to use information from books and magazines (47% and 22%). Whilst the results suggest that they were also significantly more likely to receive information from the GUM clinic and – interestingly – from Faith Groups, the small number of respondents who had received information from these (9 and 10 respondents respectively) demand that these figures need to be treated with considerable caution.

There was also some variance in the sources of sexual health information with regard to respondents' socio-religious backgrounds. For example, Catholics were

less likely than Protestants and those who were neither Catholic nor Protestant to receive information from school (50%, 58% and 57% respectively). Protestants and Catholics were significantly less likely to have received information from their friends than those who were neither (35%, 37% and 57% respectively). The data also suggest that Catholics were significantly less likely to have received information from their mothers and female carers. However, some of these results can be explained by the fact that Catholic males were over-represented in the sample of this survey, as stated previously. The finding that Catholics appear to have received less sex education in school may simply be due to the fact that 68 % of Catholic respondents to the survey were male. This also explains the finding that Catholics received less information than other respondents from their mothers but more from their fathers. Unfortunately, within the existing sample, it is almost impossible to say with any certainty whether there are significant differences between

Catholics and Protestants with regard to sexual health information. Taking findings from previous surveys into consideration, it seems most sensible to assume that there are not.

Respondents were asked whether or not they thought the information they received prepared them for dealing with sexual health and relationships. Overwhelmingly, the majority felt that this information prepared them 'very well' or 'okay' (96%). Only 4% of respondents felt that the information prepared them 'badly' or 'not at all' for dealing with sexual health. Whilst females felt somewhat better prepared by the information than their male counterparts, statistically, only sexual orientation was a significant factor – albeit a relatively weak one ($p=0.043$) - on how well prepared respondents felt, with those identifying as Gay, Lesbian or Bisexual being more likely to feel ill-prepared, as Table 4.5 shows.

Table 4.5: How well has information prepared respondents for dealing with sexual health and relationships? By gender and sexual orientation.

	%				
	Gender		Sexual Identity		All
	Males	Females	Heterosexual	Gay, lesbian or bisexual	
Very well	41	54	48	47	48
Okay	54	44	49	35	48
Badly	2	1	1	12	2
Not at all	3	1	2	6	2

Respondents were finally asked how well a number of topics were covered in the sexual health information they received. Table 4.6 summarises the findings of this question. The results are ranked according to what topics

respondents felt were covered best. It is noticeable that the three topics covered best are predominantly related to physical aspects of sexuality whereas the three covered worst relate to emotional aspects of

sexuality. These findings correspond with the findings of Schubotz, Simpson and Rolston, (2002.)

The level of confidence with which young people express their sexual health needs and negotiate their sexual relationships can be seen as an indicator for successful sex education. At the end of the questionnaire

respondents were asked how much they agreed or disagreed with a range of statements, which can be seen as such expressions of confidence. Respondents were also given the chance to express if

they felt a statement did not apply to them (for example, if they had not been in a relationship or had never been in the position in which they wanted to say 'no' to having sex).

Table 4.6: How well were the following topics covered in the sexual health information respondents received?

	%			
	Very well	Okay	Badly	Very badly
How babies are made	68	27	3	2
Avoiding pregnancy	64	30	4	2
Proper names for body parts	57	40	1	1
Boyfriends/girlfriends	52	41	5	2
Sexually Transmitted Infections (STIs)	52	40	5	3
Menstruation/having periods	50	41	5	4
HIV/AIDS	50	40	8	3
Emergency contraception	50	38	7	4
Starting a sexual relationship	48	42	6	3
Abortion	46	38	13	4
Responsibilities of being a parent	43	44	11	2
Maintaining a long-term relationship	41	49	7	3
Naming basic feelings/emotions	34	57	7	2
Lesbian and gay issues	30	45	14	11

Table 4.7 shows that respondents found it easiest to access information on sexual health and to *understand* information on STIs. Eight out of ten respondents agreed with the respective statements. Nearly three quarters of respondents (72%) also felt that it was easy to ask for what they wanted in

relationships. However, over one quarter of respondents disagreed that it was easy for them to say 'no to sex' (28%) and to ask for help in sexual health issues (27%). The data suggest that these are areas in which sex education can be improved.

Table 4.8 shows a breakdown of these results by gender and sexual orientation. The Table displays the proportion of respondents who disagreed with the respective statements.

Table 4.7: Respondents agreeing or disagreeing with the statements:

	%		
	Agree	Disagree	Does not apply
I find it easy to say 'no' to having sex	56	28	15
I find it easy to ask for help regarding sexual health issues.	63	27	10
I find it easy to access information on sexual health.	80	11	8
I find it easy to understand information on STIs.	80	10	9
I find it easy to ask for what I want in relationships.	72	13	15

4.0. Findings

Table 4.8: Respondents disagreeing that it easy to:

	%			
	Gender		Sexual Identity	
	Male	Female	Heterosexual	Gay, lesbian or bisexual
...say 'no' to having sex	41	11	29	12
...ask for help regarding sexual health issues	33	18	28	25
...access information on sexual health	13	10	12	12
...understand information on STIs	13	12	14	4
...to ask for what I want in relationships	16	9	13	21

The results show that males are almost four times as likely as females to disagree that it is easy to say 'no' to having sex. This finding is highly significant ($p < 0.000$). This result is contradictory to the findings of the 2005 Young Life and Times Survey where respondents were asked a similar question, i.e. whether they had ever felt pressurised to have sexual intercourse even though they did not really want to. The YLT survey results suggested that there was no significant difference between males and females with regard to this question. (www.ark.ac.uk/ylt/2005/Pressures/PRESSSEX.html). The results from the current survey also somewhat contradict the findings from Schubotz, Simpson and Rolston (2002). In this survey females were significantly more likely than males (22% and 12%) to say that they would have liked to learn better in school 'how to be able to say 'no' to sex'.

As Table 4.8. shows, males also found it significantly harder than females to ask for help on sexual health issues ($p = 0.001$).

However, males and females differed little in how easy they found it to access sexual health information and to understand information on STIs. Whilst males were also more likely to disagree than females that it was easy to ask for what they wanted in a relationship, this difference was statistically insignificant.

Similarly, it appears noteworthy that heterosexual respondents found it much harder than Gay, Lesbian and Bisexual respondents to say 'no' to having sex, and to understand information on STIs, even though the differences were statistically not significant. The most likely reason for this is that the total numbers of gay, lesbian and bisexual respondents in the sample was very low. Nevertheless it is also remarkable that one in five gay, lesbian or bisexual respondents found it difficult to ask for what they wanted in relationships.

Summary of findings

1. 87% of respondents said they received information on relationships and sexual health.
2. Females were more likely than males to say that they had received information on relationships and sexual health, this relationship was statistically significant.
3. Respondents who were 19 years of age or older were least likely to say they received sexual health information.
4. Sexual orientation of respondents was a significant factor for whether or not respondents said they had received information on relationships and sexual health.
5. Only seven out of ten of those respondents who identified as Gay, Lesbian or Bisexual agreed they had received sexual health information.
6. School and friends were the most likely sources of sexual health information.
7. There was a gender difference in the availability and use of sexual health information. Males were significantly less likely than females to have received sexual health information.
8. The main source of information for Gay, Lesbian and Bisexual respondents was friends (65%).
9. The three topics covered most appropriately were predominately related to physical aspects of sexuality whereas the three worst covered areas related to emotional aspects of sexuality.
10. Males are almost four times as likely as females to disagree that it is easy to say no to having sex. This finding was highly significant.
11. One in five Gay, Lesbian and Bisexual respondents found it difficult to ask for what they wanted in relationships.

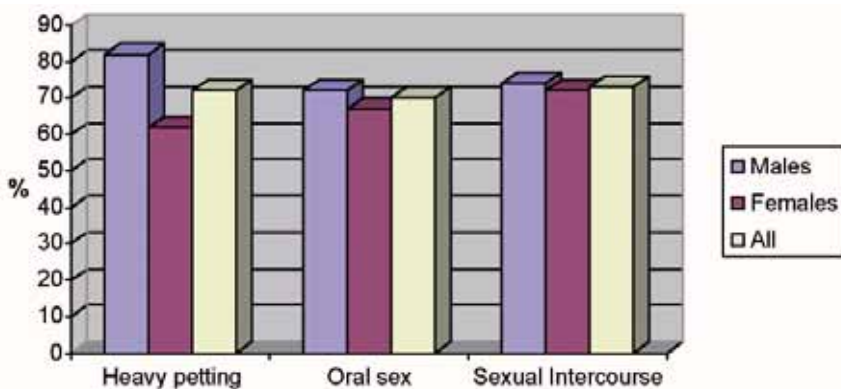
4.1.3. Sexual experiences

Respondents were asked whether they had taken part in sexual activities. Figure 4.3 shows that the difference between males and females in the sample with regard to 'oral

sex' and 'sexual intercourse' is very small and statistically insignificant. Seventy-four per cent of males compared to 72 % of females said they had had 'sexual intercourse'. With regard to 'oral sex', 72 % of males compared

to 67 % of females reported that they had experienced this. However, males were significantly more likely ($p=0.003$) to report experience of 'heavy petting' than females (81% and 62% respectively).

Figure 4.3: Sexual experience of respondents by gender



Nearly three quarters (73%) of respondents in the sample said that they had had sex. The average age for first sex was 14.5 years. There were two modes (2) with 26 % of respondents each saying they first had sex at 14 or 15 years. The mean age for first sex was slightly lower for males (14.2 years) than females (14.8 years). For males the mode² was 14 years and for females 15 years.

Figure 4.4 shows that over half of all respondents had experienced not only

'heavy petting', but also 'oral sex' and 'sexual intercourse' by age 15. At this age, 'heavy petting' (68%) and 'oral sex' (63%) were still more commonly experienced by respondents than 'sexual intercourse' (56%). This changes at age 16, when experience of 'sexual intercourse' (69%) becomes more common than 'heavy petting' (68%) and 'oral sex' (62%). At age 18, over nine in ten (96%) respondents said they had had 'sexual intercourse'. The fact that Figure 4.4 shows an apparent drop in sexual experience among those who are

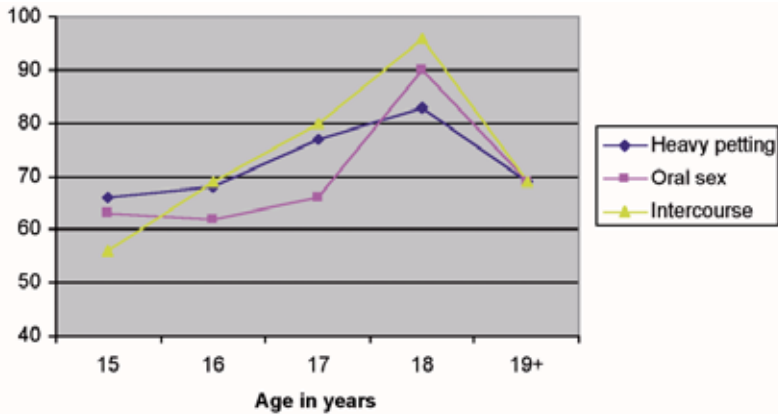
19 or older is likely to be simply due to the sampling employed by the survey.

There was no statistically significant difference in sexual experiences with regard to the socio-religious background of respondents.

² The mode is the value that most frequently occurs.

4.0. Findings

Figure 4.4 Experiences of sexual behaviour by age of respondents

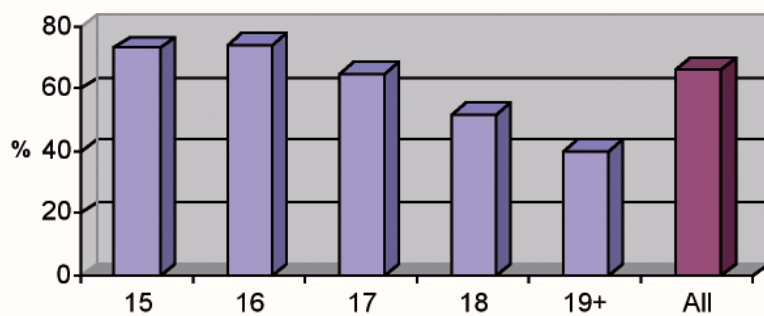


Just under two thirds (66%) of respondents said they had used contraception when they first had sex, with females being insignificantly more likely to have used

contraception than males (67% and 65% respectively). Contraceptive use was significantly lower among respondents who said they were not Heterosexual. Only 44 %

of Gay and Bisexual men and 31 % of Lesbian or Bisexual women had used contraception when they first had sex.

Figure 4.5: Use of contraception at first sex, by age



Interestingly, as Figure 4.5 shows, younger respondents were more likely than older respondents to say that they had used contraception when they first had sex. By far the most likely contraceptive method used was a condom, with 95 % of those who had used contraception saying that they had used this method. Over one quarter of respondents (27.1%) had used the contraceptive pill. This means that over one fifth (22%) of respondents who had used contraception at first sex had used more than just one method. Only one respondent in the whole sample had used another

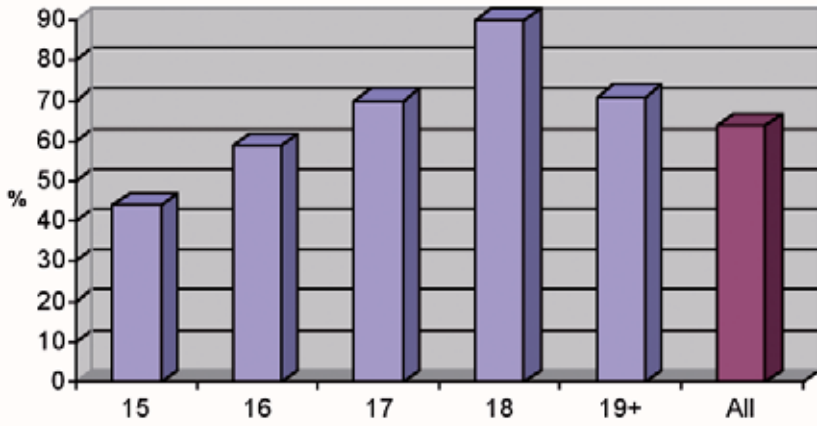
method of contraception than a condom or contraceptive pill at first sex. It is unknown whether those who identified as Gay, Lesbian or Bisexual first had sex with a partner of the same sex or the opposite sex. However, the findings suggest that the failure to use condoms certainly puts Gay, Lesbian and Bisexual respondents more at risk than their Heterosexual counterparts to contract STIs.

Just under two thirds (64%) of respondents said they were currently sexually active. Males were slightly more likely to say that they were sexually active than females (65%

and 62%). There was a highly significant difference ($p=0.003$) in sexual activity by age, as Figure 4.6 shows, with 15 and 16-year olds being least likely to be currently sexually active. Heterosexual respondents (61%) were less likely to be currently sexually active than respondents who identified as Gay, Lesbian or Bisexual (78%), but statistically this difference was not significant – this was most likely due to the small number of non-heterosexual respondents in the sample.



Figure 4.6: Respondents, by age, saying they are currently sexually active

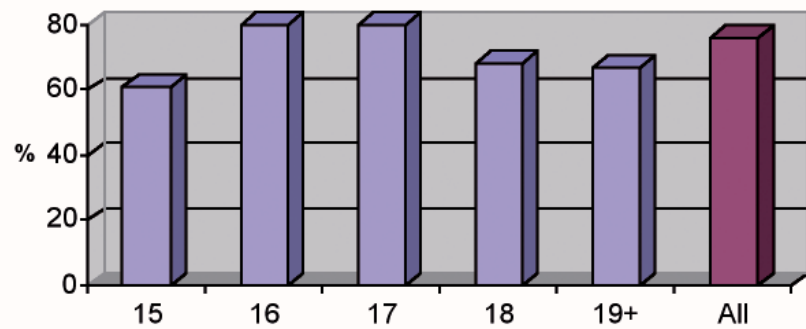


Around three quarters (76%) of sexually active respondents said that they used contraception with their current partner, as Figure 4.7 shows. These figures compare well with findings from previous surveys summarized in the literature review of this report. Males were actually more likely to say they used contraception than females

(81% and 70%), but statistically this difference was insignificant. Whilst it was reported earlier that 15-year olds were most likely to use contraception when they first had sex, they were least likely to say they used contraception with their current partner. In fact, almost four in ten (39%) 15-year olds said they did not use contraception with their

current partners. Even though the number of sexually active 15-year olds in the sample was relatively low (n=18), the figures suggest that some 15-year olds in North and West Belfast may be at risk of unplanned pregnancy or contracting STIs.

Figure 4.7: Use of contraception with current partner, by age



With regard to sexual identity, 78 % of respondents who identified as Gay, Lesbian or Bisexual said they were currently sexually active compared to 61 % of their Heterosexual counterparts. Again, the number of non-heterosexual but sexually active respondents in the sample was relatively low (n=19), which somewhat limits the reliability of these figures. Still it is noteworthy that less than half of

those respondents (47%) said they used contraception with their current partners, compared to over three quarters of Heterosexual respondents. This again would be an indication for the risk among these respondents to contract a STI.

In terms of the type of contraception used, all sexually active respondents who reported contraceptive use said they used condoms.

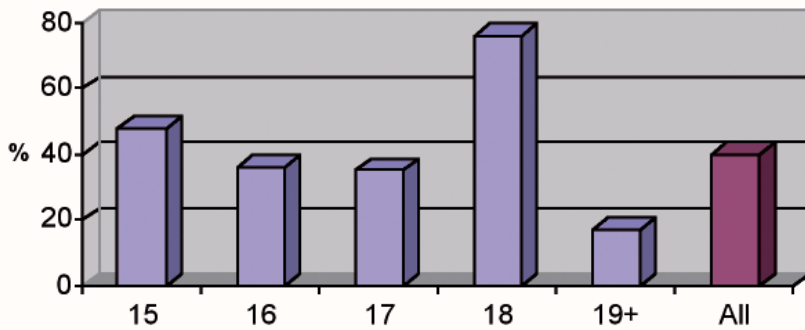
Forty-two per cent of these respondents also used the contraceptive pill and two per cent of respondents reported the use of an implant or contraceptive injection. Again the figures show that just under half (45%) of respondents used more than one contraceptive method with their current partners.

4.0. Findings

Four out of ten respondents who had had sex said they had used Emergency Contraception (EC). This is similar to the findings in the Schubotz, Simpson & Rolston, (2002), where this figure was 46%. 60% of those who had used EC had done so once, 30% had used it more than once, but less than five times, and 11% had used it more than five times. Since EC can per se only be taken by females, it was to be expected that young women were more likely to report EC use than young men who may not even be aware that their partners had previously

used EC. The survey shows that 58 per cent of sexually active females compared to 31% of sexually active males said they had ever used EC. Figure 4.8 provides a breakdown of EC use by age. Repeated use of EC was more common among older respondents in the sample. Of those who were 18 years or older, 50 per cent of EC users had used this type of contraception more than once, compared to one third of 15 and 16-year olds who had ever used EC.

Figure 4.8: Sexually active respondents, by age, who had ever used emergency contraception



Over three quarters of respondents (79%) said they got EC from the Brook clinic. The next most likely source of EC was a chemist (8%), followed by a GP (6%) and a family planning clinic (5%). The very high proportion

of respondents who used Brook may to some extent be a result of the fact that around one quarter of respondents to the survey were recruited through Brook.

Summary of findings

- 73% of respondents said they had had sex; the average age for first sex was 14.5 years.
- Over half of all respondents had experienced not only heavy petting, but also sexual intercourse by age 15.
- At age 18, over nine in ten (96%) respondents said they had experienced sexual intercourse.
- 66% of respondents said they had used contraception when they first had sex, with females being insignificantly more likely to have used contraception than males.
- Contraceptive use was significantly lower among respondents who said they were not heterosexual, only 44% of Gay and Bisexual men reported using contraception.
- Younger respondents were more likely than older respondents to say that they had used contraception at first sex.
- Most respondents used condoms (95%), 27.1% used the Contraceptive Pill.
- Even though 15 year olds were more likely to use contraception at first sex, they were least likely to use contraception with their current partner, and were therefore at a higher risk of unplanned pregnancy and contracting STIs. Gay, Lesbian and Bisexual respondents were also deemed to be at high risk of contracting STIs.
- Four out of ten respondents said they had used Emergency Contraception. 60% had used it once, 30% had used it more than once but less than 5 times and 11% had used it more than 5 times.
- 79% got their Emergency Contraception from Brook, 8% got it from a chemist, 6% from GP and 5% from a family planning clinic.



4.1.4. Sexual health services

Respondents were asked a number of questions in relation to sexual health services available to them. The first question asked was whether respondents felt there was adequate sexual health information available to them in their area. Fifty-eight per cent answered in the affirmative. There was almost no difference between male and female respondents and very little

difference between respondents of different ages. It also made no difference whether respondents identified as white or belonged to another ethnic group (58% and 53% were satisfied, respectively). Respondents who said they had a disability were slightly less likely to think that sexual health services were adequate than those without a disability, but again, this difference was statistically insignificant (57% and 65% respectively), and

most likely due to the fact that disabled respondents were so much in the minority in the sample. The difference was somewhat larger – albeit also statistically insignificant – between heterosexual respondents and respondents who identified as Gay Lesbian or Bisexual. A summary of this can be found in Table 4.9.

Table 4.9: Respondents saying that sexual health information services in their area are adequate

Gender		Sexual Identity		Disability		Ethnic Identity	
Male	Female	Heterosexual	Gay, lesbian or bi-sexual	Yes	No	White	Other
59	57	60	46	65	57	58	53

Figure 4.9: Respondents saying that sexual health information services in their area are adequate, by postcode

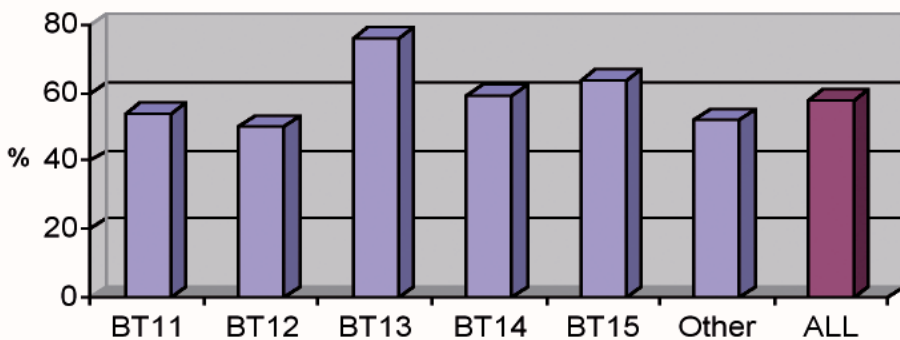
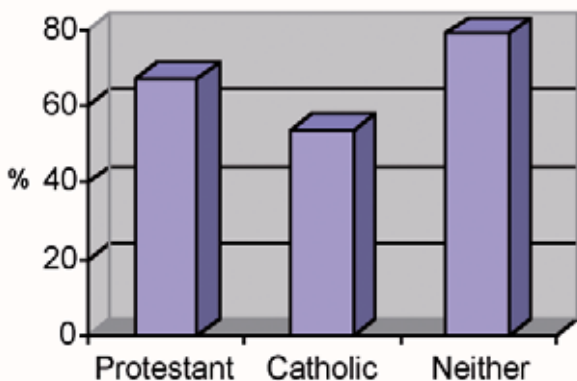


Figure 4.9 shows that the difference in respondents' perception of adequate sexual health services was also insignificant with regard to the areas where respondents lived. Respondents living in the BT13 area were somewhat more satisfied (76%) with the services provided, but this appears to be due to the sampling rather than any other factor.

Figure 4.10: Respondents saying that there are adequate sexual health services in their area, by socio-religious community



Catholics taking part in the survey were more likely to feel that services were inadequate than Protestants and those who belonged to neither socio-religious community, as Figure 4.10 shows. However, statistically, this difference was not significant, and may just be a result of the abovementioned disproportionate number of Catholic males in the sample.

4.0. Findings

Regardless of whether they had had sex or not, respondents were asked to identify the sources of contraception they would use. Table 4.10 summarises the results to this question. On average, each respondent identified two sources of contraception; however, some respondents said they would use a multitude of sources, whilst others only used one. The Table shows that most respondents acquired contraception through the Brook clinic. The next most popular sources were friends, a chemist, and respondents' boyfriends or girlfriends.

Table 4.10: Respondents' sources of contraception

Source	%		
	Male	Female	All
Brook Clinic	56	66	60
Friends	32	26	30
Chemist	26	22	24
Boyfriend/girlfriend/partner	20	29	24
Opportunity Youth	17	10	14
Family Planning Clinic	7	16	11
GP	7	15	10
Hype	4	6	5
Brother	6	3	5
Mother/female carer	3	6	5
Father/male carer	5	2	4
School	<1	5	2
Sister	<1	3	1
Other (please state)	6	4	5

Despite the fact that about one quarter of questionnaires were actually distributed through the Brook clinic, which will most certainly have skewed the data, without a doubt Brook must be seen as a very popular source for contraception for young people from North and West Belfast. Respondents who lived in the BT12 and BT13 postcode areas were much more likely than other respondents to say that they would use Brook (73% and 70% compared to under 60%). Respondents who lived in BT11 and BT13 postcode areas were more likely to say than others that they would use a Family Planning Clinic to access contraception.

Table 4.10 also outlines the differences in patterns of contraceptive access between females and males. Due to the fact that Catholic males were so much over-represented in the sample, it is not meaningful to provide a breakdown of this data by socio-religious background of respondents.

Respondents were further asked where they would seek advice on sexual infections, if they needed any. Table 4.11 provides a summary of the findings broken down by gender of respondents. The Table shows that Brook is the most popular choice

among respondents with regard to advice on sexual infections. Again, the fact that around one quarter of respondents were actually recruited through Brook is likely to have had an impact on the results presented in this table. Regardless of this, the results show that females were much more likely to say they would use Brook than males. Males were more likely to say they would consult their GPs or they would use the Opportunity Youth clinic. Again, this result could be simply due to the sampling used by the survey, i.e. that more male respondents were recruited through Opportunity Youth.

Table 4.11: Where would respondents seek advice on sexual infections? By gender

Source	%		
	Male	Female	All
Brook Clinic	46	71	57
GP	33	26	30
Opportunity Youth	25	14	20
GUM Clinic	17	16	17
Chemist	10	12	11
Helplines	12	8	10
Family Planning Clinic	8	12	10
HYPE Project	11	8	10

Finally, respondents were asked what sexual health services they had *actually* attended and how they would rate the services provided. A list of categories was presented for this. Table 4.12 shows the proportion of all respondents who had attended sexual health services, including the proportion of those who had never attended a sexual health service. This proportion was significantly higher among males (40%) than females

(28%). Bearing in mind that the survey results show that males were as sexually active as females, the findings suggest that it is young women who take responsibility for accessing contraception and are more likely to look after their sexual health. This is particularly obvious in the finding that the proportion of females attending a GUM clinic was twice that of males (8% and 4% respectively) in the survey. Young men were only *more* likely

than young women to use the sexual health clinic provided by Opportunity Youth and to go to the chemist (most likely in order to get condoms). All *other* services were more likely to be used by females than males. Due to the relatively small number of respondents, a statistically sound breakdown of this data by postcode cannot be provided.

Table 4.12: Sexual health services attended by respondents, by gender and by sexual identity

	%				
	Gender		Sexual Identity		All
	Males	Females	Heterosexual	Gay, lesbian or bisexual	
Brook Clinic	40	53	47	46	46
Opportunity Youth	16	8	14	8	13
Chemist	12	8	12	12	10
GP	8	12	9	17	10
Family Planning Clinic	3	11	6	12	6
HYPE Project	6	7	5	12	6
GUM Clinic	4	8	3	33	6
Helplines	4	4	3	21	6
No services attended	40	28	56	26	36

With regard to a breakdown of the data by sexual identity of respondents it is noteworthy that those young people who identified as Gay, Lesbian or Bisexual were ten times more likely than heterosexual respondents to have attended a GUM clinic (42% and 5%) and seven times more likely to use a sexual health helpline. In fact, Gay, Lesbian and Bisexual respondents were more likely to have used most sexual health

services. Again, because of the low numbers of respondents who identified as Gay, Lesbian and Bisexual these results should be treated with some caution.

Respondents were asked to rate the sexual health services they attended on a scale from 1-5 with the scores representing the following:

1: Excellent; 2: Good; 3: Adequate; 4: Not good; 5: Very disappointing.

Between 94% and 98% of respondents who had attended sexual health services rated the services in each of given categories. Overall, services were rated excellent or good by the vast majority of respondents, as Table 4.13 shows.

Table 4.13: Respondents' ratings of sexual health services they attended

	%				
	Excellent	Good	Adequate	Not good	Very disappointing
Friendliness of staff	60	35	4	<1	<1
How service meets clients' needs	47	45	7	<1	<1
Communication between client and staff	52	38	8	2	1
Standard of information given	45	44	9	1	<1
Suitability of opening times	28	41	19	10	2
Waiting times	26	40	22	8	3
Location	30	44	17	7	2

4.0. Findings

Another way of analysing scalar variables like the rating of sexual health services is to compute mean scores in each category. In

combination with the mode score, which shows how most respondents rated the services in each category, services can be

rated in order to establish strengths and weaknesses of services provided. Table 4.14 displays the results of this analysis.

Table 4.14. Rating and ranking of sexual health services

	Mean score	Mode*	Ranking
Friendliness of staff	1.47	1	1
How service meets clients' needs	1.63	1	3
Communication between client and staff	1.63	1	2
Standard of information given	1.68	1	4
Suitability of opening times	2.17	2	5
Waiting times	2.22	2	7
Location	2.19	2	6

* 1= excellent
2=good

In addition to the closed questions that were asked in the survey questionnaire, two additional open-ended questions were asked. The first question asked if respondents thought there was adequate information on the services provided in their area. Those who answered negatively were asked to state where they would like to see more such information. Forty-four young people (15.8% of all respondents) made a suggestion, the most common being that information should be displayed in community and youth centres. This accounted for 39 % of all open responses. The next most common response was for more information to be available in schools (20%). Other suggestions included hospitals, doctors, health centres, chemist and churches. Two per cent of respondents

would have liked more information distributed through parents.

The second open-ended question asked how respondents would like to see sexual health services improved in their area. There were 56 responses to this question (20% of all respondents). There were two suggestions made in the majority of responses: better opening hours for clinics and more information in youth clubs and youth groups. Although there were only a small number of respondents to these questions there was a definite need highlighted for more utilisation of community and youth settings for sexual health information. Other suggestions included mobile services to come to a particular area, more information at school and free condoms being distributed.

Summary of findings

1. 58% of respondents said there was adequate sexual health information.
2. Respondents who said they had a disability were slightly less likely to think that sexual health services were adequate.
3. Most forms of contraception were acquired from Brook, friends, chemist or respondents' partners.
4. Young women take more responsibility for accessing contraception and are more likely to look after their sexual health than males.
5. Young men were more likely than young women to use sexual health clinics provided by Opportunity Youth and to go to a chemist.
6. Young people who identified as Gay, Lesbian or Bisexual were ten times more likely than heterosexual respondents to have used sexual health services and seven times more likely to use a sexual health helpline.



4.2 Findings from focus groups

Two focus groups were conducted to complement the findings from the survey.

The first focus group was conducted with six health professionals from both the statutory and the voluntary/community sectors who worked in a range of sexual health services in North and West Belfast. The participants had a wealth of experience in policy development and had had input into consultations such as The Regional Teenage Pregnancy and Parenthood Strategy (DHSSPS 2002) and the Sexual Health Promotion Strategy. The purpose of the focus group with health professionals was to ascertain their beliefs and experiences of working directly with young people in sexual health services.

A number of questions were discussed as well as issues that had been identified through the survey, such as the main sources of information on sexual health available to young people in North and West Belfast. Focus group participants agreed that there is a lack of a co-ordinated and consistent approach in sexual health service provision. They were also aware that there is a problem with accessibility to such services in different areas.

The health professionals felt that other public places should be used better to display sexual health information, e.g. schools, universities and colleges, airports, leisure centres, disability organisations, and generally public areas that young people regularly frequent.

Barriers of access to sexual health services were discussed. Fears around confidentiality, the geographical location of the service, a shortage in funding for such services and a lack of integrated services were seen as the main barriers. There was recognition from the group that there should be a more strategic and integrated approach, with

properly funded services and education with appropriately funded staff.

From the point of view of the participants, accessibility to sexual health services could be improved if they were brought to young people, e.g. in colleges of further education and youth clubs. There should also be more involvement with services in schools.

The second focus group consisted of young people themselves. The young people were recruited through the survey (see methodology section) and it was the purpose of this focus group to give participants the chance to discuss in more detail the questions that were asked in the survey questionnaire. Even though, initially, quite a large number of young people had expressed an interest in participating in this focus group, only two males and two females aged 16-17 years actually showed up on the day of the discussion.

The participants discussed how they and their peers usually find out about issues such as relationships, sex and contraception. Participants confirmed the findings of the survey that friends are the main source of information. The young people admitted that (mis)information through hearsay, unfortunately, often lead to some myths around sexuality.

A discussion about whom the participants felt most comfortable talking to about sexual issues revealed that many felt uncomfortable talking to members of their family. However, there was evidence that young people sometimes felt comfortable giving advice to younger brothers and sisters.

With regard to the level of sexual health education in school, it became evident that schools in North and West Belfast provided different levels of sex education and that religious barriers to sex education in school still exist. Participants agreed that very little was taught about the different forms of contraception beyond condoms and the contraceptive pill. According to the participants, RSE in schools tended to be very biological in nature, a view that confirms the findings of previous research discussed in the literature review. The fact that some classes were given by older teachers in the schools meant that young people often found these teachers unapproachable.

Participants were finally asked what sexual health services they would like to see in North and West Belfast. More services in general were requested, as well as more advertising of the existence of such services. The participants believed that better RSE with a clear programme of teaching must be the major starting point for any improvements to be made.

The schedule of the two focus groups and the recorded responses can be found in the Appendix v of this report.

5.0. Discussion



“ eighty-seven per cent of respondents received sexual health information ”

The survey set out to identify gaps in the sexual health services provision to young people in North and West Belfast. This was done with the aim to inform policy development, namely to support the implementation of the *Health Action Zone’s Strategy to Promote the Sexual Health and Well-being of Young People in North and West Belfast*. The present survey aims to provide benchmark data from North and West Belfast for the following three action points of this Strategy:

- To ensure that children and young people have access to high quality RSE appropriate to their age and needs;
- To increase accessibility and availability of sexual health services which meet the needs of young people, for example contraception and advice services;
- To promote a social climate which is supportive of young people and their sexual health.

1. Do children and young people have access to high quality RSE?

Encouragingly, the survey showed that 87 % of respondents had received sexual health information. Equally encouraging is the fact that over 90 % of respondents felt that the RSE they received prepared them very well, well or ‘okay’ for dealing with their sexual health and with relationships.

As in other surveys previously conducted and discussed in the literature review of this report, females were significantly more likely to have received sexual health information than males. Also, the finding from the current survey that same-sex-attracted young people from North and West Belfast reported having received less RSE than their



heterosexual counterparts confirms previous survey results, namely those of Schubotz, Simpson and Rolston (2002) and McNamee (2006). Since it is unlikely that same-sex-attracted young people are *per se* excluded from RSE, the only conclusion can be that the information provided does not meet the needs of homosexual and bisexual young people.

Considering that information on sources of sex information may be somewhat skewed due to the fact that respondents were accessed through organisations and initiatives that provide such sexual health information, the results achieved of the present survey are very similar to other surveys that asked young people for sources of information. School, friends and parents are the main sources of young people's RSE. Interestingly, the present survey showed that males from North and West Belfast were more likely to report having received sex education from school than females. Again, this may be due to the fact that males on such education programmes were recruited through schools, whilst females were more likely to be recruited through sexual health clinics, such as Brook.

With regard to the quality of education provided, it is noteworthy that respondents to the survey and participants in the focus groups commented that RSE in school should be less anatomical and more focused on feelings and emotions. Unsurprisingly, Lesbian and Gay issues were rated worst by far; with one quarter of respondents saying these issues were covered 'badly' or 'very badly'.

According to the survey data, what sexual health information in North and West Belfast does best is to explain to young people how to access information on sexual health and how to understand the information on STIs. Shortcomings exist in particular in the area of confidence building to say 'no' to sex and asking for help on sexual issues when this is needed. It was young men from North and West Belfast who particularly expressed their concerns here.

2. How do young people view the sexual health services in North and West Belfast?

Just over half (58%) of respondents to the survey felt that the sexual health services in their area were adequate. Whilst there was no difference between males and females, same-sex-attracted young people were significantly less likely to say the services were adequate to them (46% agreeing).

By far the most commonly cited sexual health service was Brook with 60% of respondents saying that this is where they would get their contraceptives. The next most cited sexual health service was the family planning clinic (11% saying they would get contraceptives there). Clinics and services provided by Hype and Opportunity Youth were also reasonably common, but the survey results show that respondents were much more likely to access contraceptives through their friends (with 30% the second most popular source after Brook) than from any other dedicated sexual health service or even the chemist. Keeping in mind that previous sexual health surveys found that friends are certainly the most unreliable source of information on sexual matters, this shows that there is much room for improvement with regard to the accessibility of sexual health services and the publicity about the existence of their services. The results can also indicate that more needs to be done in North and West Belfast to develop these services in a young-people friendly way.

Over one third of respondents who had been sexually active had never attended any sexual health service, but this figure was significantly higher among males (40%) than females (28%). The survey concludes that despite all efforts to provide young men-specific services, so far, sexual health and contraception seems to remain a predominantly female domain.

Respondents who had in the past used any sexual health service were asked to rate this service along a number of quality indicators.

Overall the survey showed that over nine in ten respondents felt that staff were friendly, that the services met their needs and that the communication between clients and staff was excellent or good. Nearly nine in ten (89%) of respondents also felt that the quality of information provided was excellent or good. Over three quarters of respondents also agreed that the standards with regard to waiting times, location of the services and opening times were excellent or good, but these were the three areas where young people felt the performance of the services could be improved.

The focus groups confirmed this view and health professionals and young people agreed that one way of improving services would be for health professionals to place information where young people socialise or receive education, such as school or youth groups.

3. Is there a social climate that is supportive of young people's sexual health?

The information gathered by the project about the social climate in North and West Belfast with regard to sexual health is somewhat limited. However, what emerges as a very clear finding is that young same-sex attracted people remain stigmatised and disadvantaged with regard to the sexual health information and services they feel they can avail of. The focus groups and comments in the questionnaires also suggest that some school-based RSE continues to be influenced by conservative moralistic views; however, not much more than this can be concluded from the survey. Overall, the survey concludes that the vast majority of respondents and participants were satisfied with the information they received and the standard of sexual health services available to them.

6.0. Recommendations



“ young people value the sexual health services currently available to them ”

It is hoped that the following recommendations, which are drawn from the key findings, will inform current and future policy development. Some of the issues raised are not new; rather they reinforce similar recommendations made in DHSSPS's Regional Teenage Pregnancy and Parenthood Strategy and the soon to be published Regional Sexual Health Promotion Strategy.

As emphasised in the strategies mentioned above and the local HAZ Strategy to Promote the Sexual Health and Wellbeing of Young People in North and West Belfast, this survey concurs that a coordinated approach to the delivery of sexual health information, education and services is key to ensuring that young people receive education and services which meet their needs. The following recommendations are based on this premise.



1. Do children and young people have access to high quality RSE?

The future delivery of RSE in schools will have to reflect the changing environment of Personal Development as part of the revised school curriculum for Northern Ireland. It will take time for the impact of these changes to become evident. However, this survey is timely as it can support and assist schools in the implementation of these changes.

Evidence from the survey supports the following recommendations:

- Multi-disciplinary training and protocol development is required for professionals on young people's rights including the right (or not) to confidentiality.
- RSE needs to be inclusive of LGBT groups and young people with disabilities.
- RSE should be timely, age appropriate and not based solely on a medical model. A core element should be emotional feelings and the ability to develop and maintain safe and satisfying relationships.
- RSE should include confidence building activities as a priority, particularly for young men who often require assistance to ask for help and support on sexual health issues.

2. How do young people view the sexual health services in North and West Belfast?

The survey indicates that young people in North and West Belfast value the sexual health services currently available to them from the statutory and voluntary sectors in their area. They particularly highlighted the high standard of information provided and the effective communication between them and staff members. However, they also suggested how current services could be improved.

- Improvements should be made with regard to waiting times, location and opening times of services to reflect the needs of young people.
- Emergency Contraception (EC) should be available in all pharmacies in North and West Belfast.
- Sexual health service providers should be more proactive in addressing the needs of young men.

3. Is there a social climate that is supportive of young people's sexual health?

It is also important to consider the wider context in which the survey was carried out. In doing so evidence from the survey supports the following recommendations;

- Information and training should be provided for young people on their rights including the right (or not) to confidentiality. This will enable them to make informed choices about which services they want to use.
- An open, inclusive public debate on the areas of RSE and sexual health services should be initiated with partners, stakeholders and in particular, community groups, faith groups, parents and schools.
- Professional education and training should include an exploration of attitudes and values, together with factual knowledge related to the sexual health of young people.

4. The way forward?

As well as the above, evidence from the survey also confirms the need for the following recommendations:

- Further research should be conducted to include a more representative sample of young people in North and West Belfast.
- Appropriate resources should be allocated in North and West Belfast to allow the best possible services to be provided to all young people with particular attention to LGBT groups, young males and young people with disabilities.

Appendices



- I **References**
- II **Bibliography of fpaNI and HPANI Sexual Health Factsheets**
- III **Useful Websites**
- IV **Survey Questionnaire**
- V **Focus group schedules and responses**
- VI **HAZ Sexual Health Project Members' list**
- VII **Glossary**
- VIII **Abbreviations**

Appendix I References

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Appendices

Appendix II: Bibliography of fpaNI and HPANI Sexual Health Factsheets

- “Family Planning services in Northern Ireland”
- “Sexual Orientation”
- “Abortion”
- “Sexually Transmitted Infections (STIs)”
- “Teenage Pregnancy”
- “The Legal Position Regarding Contraceptive Advice and Provision to Young People”
- “Relationships and Sexuality Education in School (RSE)”
- “Sexual Behaviour and Young People”
- “Don’t Gamble with your Sexual Health”
- “Never Underestimate Peace of Mind”

Available at:

www.healthpromotionagency.org.uk/work/Sexualhealth/publications.htm

Appendix III: Useful websites

AVERT	www.avert.org
BBC (Bare All Survey)	www.bbc.co.uk/radio1/bareall/survey_results.html
Brook	www.brook.org.uk
Crisis Pregnancy Agency	www.crisispregnancyagency.ie
Family Planning Association	www.fpa.org
Health Action Zone	www.haz-nwbelfast.org.uk
Health Promotion Agency for Northern Ireland	www.healthpromotionagency.org.uk
Health Protection Agency	www.hpa.org.uk
Investing for Health	www.investingforhealthni.gov.uk
National Youth Agency	www.nya.org.uk
Northern Ireland Census	www.nicensus2001.gov.uk/nica/public/index.html
Northern Ireland Statistics Research Agency	www.nisra.gov.uk
Opportunity Youth	www.opportunity-youth.org
Scottish Government	www.scotland.gov.uk/publications
Young Life and Times	www.ark.ac.uk/ylt
Youthnet	www.youthnet.org



Appendix IV: Survey questionnaire

Please take a few minutes to complete this questionnaire. It is completely
PRIVATE AND CONFIDENTIAL

1. Are you (please tick)	Male	(1) ()	Female	(2) ()
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2. Please tick your age	15 () (1)	16 () (2)	17 () (3)
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3. Please tick your postcode area	BT11	(1) ()	BT12	(2) ()	BT13	(3) ()	BT14	(4) ()	BT15	(5) ()	Other (Please specify) (4) _____
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4(i). Have you received information about relationships and sexual health? (please tick)	YES	(1) ()	NO	(2) ()
--	------------	---------	-----------	---------

(ii) If so, where did you get it from? (please tick all that apply)	Mother/female carer	(1) ()	Brook Clinic	(11) ()
	Father/male carer	(2) ()	Chemist	(12) ()
	Older brother/sister	(3) ()	GP	(13) ()
	Boyfriend/girlfriend/partner	(4) ()	Family Planning Clinic	(14) ()
	Friends	(5) ()	GUM Clinic	(15) ()
	School/Personal Development lessons	(6) ()	Help-lines	(16) ()
	School nurse	(7) ()	HYPE	(17) ()
	Books/magazines	(8) ()	Opportunity Youth	(18) ()
	TV/Radio	(9) ()	Faith Group	(19) ()
	Internet	(10) ()	Other (please state) _____	(20) ()

5. How well do you think this information has prepared you for dealing with sexual health and relationships? (please tick)	Very well (1) ()	Okay (2) ()	Badly (3) ()	Not at all (4) ()
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6. How well do you think the following topics were covered in this information? (please tick)	Very well (1)	Okay (2)	Badly (3)	Very badly (4)
Naming basic feelings/emotions	()	()	()	()
Proper names for body parts	()	()	()	()
How babies are made	()	()	()	()
Menstruation/having periods	()	()	()	()
Boyfriends/girlfriends	()	()	()	()
Starting a sexual relationship	()	()	()	()
Maintaining a long-term relationship	()	()	()	()
Avoiding pregnancy	()	()	()	()
Emergency contraception	()	()	()	()
HIV/AIDS	()	()	()	()
Abortion	()	()	()	()
Sexually Transmitted Infections (STIs)	()	()	()	()
Responsibilities of being a parent	()	()	()	()
Lesbian and gay issues	()	()	()	()

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QUESTIONS 7 TO 12 RELATE DIRECTLY TO YOUR SEXUAL EXPERIENCES

7. Which sexual activities have you ever experienced? (please tick)

Heavy petting	YES (1) ()	NO (2) ()
Oral sex	YES (1) ()	NO (2) ()
Sexual Intercourse	YES (1) ()	NO (2) ()

8. What age were you when you first had sex? _____

9. Did you or your partner use contraception/protection? (please tick)

YES (1) () **NO (2) ()**

10. If yes, what contraception/protection did you use? (please tick)

Condoms	(1) ()	Injection	(4) ()
Contraceptive Pill	(2) ()	Implant	(5) ()
Other (please state) _____	(3) ()		

11. Are you currently sexually active (please tick)

YES (1) () **NO (2) ()**

12(i). Did you or your partner use contraception/protection? (please tick)

YES (1) () **NO (2) ()**

12(ii). If yes, what contraception/protection did you use? (please tick)

Condoms	(1) ()	Injection	(4) ()
Contraceptive Pill	(2) ()	Implant	(5) ()
Other (please state) _____	(3) ()		

QUESTIONS 13 TO 21 RELATE DIRECTLY TO SEXUAL HEALTH SERVICES

13(i) Do you think there is adequate information on sexual health services provided in your area?

YES (1) () **NO (2) ()**

13(ii) If no, where would you like to see more information?

14. If you needed to get contraception/protection where would you get it from? (please tick)

Boyfriend/girlfriend/partner	(1) ()	Mother/female carer	(6) ()	Family Planning Clinic	(11) ()
Brook Clinic	(2) ()	School	(7) ()	GP	(12) ()
Brother	(3) ()	Sister	(8) ()	Chemist	(13) ()
Father/male carer	(4) ()	Opportunity Youth	(9) ()	Other (please state)	(14) ()
Friends	(5) ()	Hype	(10) ()	_____	

15. If you needed advice or help with sexual infections, where would you get it from? (please tick)

Brook clinic	(1) ()	Help-lines	(5) ()
Chemist	(2) ()	HYPE	(6) ()
Family Planning Clinic	(3) ()	GP	(7) ()
GUM Clinic	(4) ()	Opportunity Youth	(8) ()

16. Have you ever attended any of these sexual health services? (please tick)

Brook clinic	(1) ()	Help-lines	(5) ()
Chemist	(2) ()	HYPE	(6) ()
Family Planning Clinic	(3) ()	GP	(7) ()
GUM Clinic	(4) ()	Opportunity Youth	(8) ()

17. Overall how would you rate the services provided? (please tick)

	Excellent (1)	Good (2)	Adequate (3)	Not good (4)	Very disappointing (5)
Friendliness of staff	()	()	()	()	()
How did the service meet your needs?	()	()	()	()	()
Communication between you and staff (were you able to ask questions?)	()	()	()	()	()
What was the standard of the information given to you?	()	()	()	()	()
Suitability of opening times	()	()	()	()	()
Waiting times	()	()	()	()	()
Location	()	()	()	()	()

18. Have you or your partner ever had to use emergency contraception/protection (the Morning-after Pill)? (please tick)

Yes once	(1) ()
More than once but less than 5	(2) ()
More than 5 times	(3) ()

19. Where did you/your partner get it? (please tick)

Brook clinic	(1) ()	Help-lines	(5) ()
Chemist	(2) ()	HYPE	(6) ()
Family Planning Clinic	(3) ()	GP	(7) ()
GUM Clinic	(4) ()	Opportunity Youth	(8) ()

20. Please state how you feel about the following statements? (please tick)

	Doesn't apply (1)	Fully agree (2)	Agree (3)	Disagree (4)	Fully disagree (5)
I find it easy to say no to having sex	()	()	()	()	()
I find it easy to ask for help regarding sexual health issues	()	()	()	()	()
I find it easy to access information on sexual health	()	()	()	()	()
I find it easy to understand information on STIs	()	()	()	()	()
I find it easy to ask for what I want in relationships	()	()	()	()	()

21. Please state how would you like to see the services improved in your area?

Appendices

QUESTIONS 22 TO 25 ARE EQUAL OPPORTUNITES QUESTIONS AND ARE ASKED TO MAKE SURE WE ARE INVOLVING ALL SECTIONS OF THE COMMUNITY IN OUR WORK.

22. Community Background (please tick)

- I am a member of the Protestant community** () (1)
I am a member of the Roman Catholic community () (2)
I am a member of neither community () (3)

23(i). Disability (please tick)

- Do you consider yourself to have/have had a disability?** Yes (1) () No (2) ()

23(ii). If yes: what is or what was the nature of the disability?

24. Ethnic Origin (please tick one)

- | | | | |
|-------------------------------------|---------|--------------------------------|---------|
| Chinese | (1) () | Irish Traveller | (4) () |
| Indian | (2) () | Black/African-Caribbean | (5) () |
| Pakistani | (3) () | White | (6) () |
| Asian Other (please specify) | _____ | | (7) () |
| Other (please specify) | _____ | | (8) () |

25. How would you describe your sexual orientation?

- | | | | |
|-----------------------------|---------|----------------------|---------|
| I am heterosexual | (1) () | I am lesbian | (3) () |
| I am gay | (2) () | I am bisexual | (4) () |
| Other (please state) | _____ | | (5) () |

WE ARE AIMING TO ORGANISE SOME FOCUS GROUPS FOR YOUNG PEOPLE LIKE YOU WHO MAY BE INTERESTED IN SHARING THEIR EXPERIENCES OF SEXUAL HEALTH SERVICES IN NORTH AND WEST BELFAST.

26. Would you like to be involved in discussing sexual health services for young people in North and West Belfast? (please tick)

- YES (1) () NO (2) ()

Please provide your name and contact number (mobile number if you prefer) and we will contact you within the next month.

Name _____

Telephone Number _____

THANK YOU VERY MUCH FOR COMPLETING THIS QUESTIONNAIRE IT IS GREATLY APPRECIATED.

Appendix V: Focus group schedules and responses

FOCUS GROUP 1 QUESTIONS – PROFESSIONALS

1. What sexual health services do you work for?
2. How much input have you had in recent consultations on sexual health?
3. What do you think are the main sources of information on sexual health available to young people in North and West Belfast?
4. Do you think there is adequate information on sexual health services provided in North and West Belfast?
5. Where would you like to see more information?
6. What are the barriers for sexual health services in North and West Belfast for young people in North and West Belfast?
7. How would you like to see the sexual health services improved in North and West Belfast?
8. Is there any other group other than young people that you think do not have enough access to sexual health services?

RESPONSES FROM FOCUS GROUP 1

Question 3.

Where would you like to see more information?

- Schools, universities and colleges
- Youth workers
- GP's/surgeries/nurses
- Bus depots/airports
- Outreach/youth clubs/community groups
- Leisure centres
- DHSS Offices
- Multi-cultural centres
- Pharmacies
- Residential care homes
- Libraries
- Simon community/homeless organisations
- North Belfast – there are very few pharmacies that supply contraception
- Concerts/festivals
- Disability groups
- Video shops/phone shops/gaming centres
- Hairdressers – call centres (places that have a lot of younger staff)
- Training Organisations
- Disability groups

Question 6.

What are the barriers for sexual health services In North and West Belfast for young people?

- Awareness of problem
- Different Minister in Government means that there is a different area for priority.
- Confidence levels
- Confidentiality
- Culture – countries with lower pregnancy rates are where sex and activity is talked about most
- Demography/geography
- Education/schools
- Gay community
- Influence of drugs and alcohol
- Waiting lists
- Legislation on abortion
- No 'One Stop Shop'
- Money/staff training
- Moral ethos/prejudice

Question 7.

How would you like the sexual health services improved in North and West Belfast

- More strategic, integrated approach
- Properly funded services, in education with appropriately trained staff
- Use consultation effectively, from the start, for young people and their specific needs
- Accessibility – bring services to where the young people are, e.g. Colleges, BIFHE
- Mobile services
- More involvement with schools
- Who delivers sex education? Knowledge around what young people actually want.
- Sensitive to external factors
- More parental involvement
- "Speakeasy" (fpaNI)/Surestart

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FOCUS GROUP 2 QUESTIONS – YOUNG PEOPLE

1. How do young people of your age usually find out about relationships, sex and contraception?
2. Do young people of your age talk openly to other people about sex and related issues?
3. Do the sources of information differ from girls and boys?
4. Did you all get sex education in school?
5. Was it useful?
6. What services would you like to see in your area?

RESPONSES FROM FOCUS GROUP 2

Question 1.

How do young people of your age usually find out about relationships, sex and contraception?

- Friends
- Hearsay
- Personal experience
- School nurse
- Some myths around the truth

Question 2.

Do young people of your age talk openly to other people about sex and related issues?

- Only with peers
- Not with parents/grandparents
- Maybe with younger brothers and sisters

Question 3.

Do the sources of information differ from girls and boys?

- Yes
- There is also a difference between religions and therefore schools
- People learn more through their own friends
- Education in schools is more biological

Question 4.

Did you all get sex education in school?

- Some was in primary school
- There are a lot of myths about sex and things that people think (if you have sex standing up you won't get pregnant)
- There is very little knowledge on the different forms of contraception, only condoms and the pill
- No designated time and person specifically, only older teachers (not necessarily a role model for young people)

Question 5.

What services would you like to see in your area?

- More services in smaller areas
- Stigma or fear of going to doctors in case a member of your family saw you
- Not enough advertising
- Services aren't sufficient
- Education should be the major starting point
- The culture of good sexual health education just doesn't exist

Question 6.

What are the barriers to sexual health education in your area?

- Embarrassment/stigma
- Don't understand or know what's there
- Going against religion
- A lot of people are not aware of the Morning-after Pill (Emergency Contraception) and where to get it

Appendix VI: HAZ Sexual Health Project Members' list**SEXUAL HEALTH PROJECT BOARD**

Name	Department/Organisation	Email address
Mary Black (Chair)	HAZ	mary.black@nwb.n-i.nhs.uk
Mary Crawford	Brook	mary.brook@btinternet.com
Dr Bernadette Cullen	EHSSB	b.cullen@ehssb.n-i.nhs.uk
Cathy Curry	HYPE	cathy.curry@nwb.n-i.nhs.uk
Peter Dornan	BELB	peterdo@belb.co.uk
Dr Olga Elder	NWBHSST	elaine.bailie@nwb.n-i.nhs.uk
Beth Gilhooly	HAZ	elizabeth.gilhooly@nwb.n-i.nhs.uk
Billy Graham	NWBHSST	billy.graham@nwb.n-i.nhs.uk
Joanna Gregg	Sexual Health Team, NWBHSST	joanna.gregg@nwb.n-i.nhs.uk
Joe Harris	Sexual Health Team, NWBHSST	joe.harris@nwb.n-i.nhs.uk
Stiofan Long	West Belfast Partnership	stiofan@wbpb.org
Jackie McBrinn	NWBHSST	jackie.mcbrinn@nwb.n-i.nhs.uk
Elaine McCarthy	HAZ	elaine.mccarthy@nwb.n-i.nhs.uk
Anne-Marie McClure	Opportunity Youth	anne-marie@opportunity-youth.org
Sam McDermott	BELB	sammcdermott@belb.co.uk
Audrey Simpson	fpaNI	audreys@fpa.org.uk
Amanda Stephens	shOUT	astephens@youthnet.co.uk
Jackie Walker	NWBHSST	jackie.walker@nwb.n-i.nhs.uk

SERVICES SUB-GROUP

Name	Department/Organisation	Email address
Mary Crawford (Chair)	Brook	mary.brook@btinternet.com
Cathy Curry	HYPE	cathy.curry@nwb.n-i.nhs.uk
Dr Olga Elder	NWBHSST	elaine.bailie@nwb.n-i.nhs.uk
Beth Gilhooly	HAZ	elizabeth.gilhooly@nwb.n-i.nhs.uk
Carmel Kelly	GUM Clinic	carmel.kelly@royalhospitals.n-i.nhs.uk
Elaine Kelly	Opportunity Youth	elaine@opportunity-youth.org
Nichola Madden	Challenge for Youth	nicholamadden@challengeforyouth.org
Anne-Marie McClure	Opportunity Youth	anne-marie@opportunity-youth.org

Appendices

Appendix VII: Glossary

Closed Questions – Questions in a questionnaire/survey/interview where there are a limited range of answers available (e.g. Yes or No).

Focus Group – A group of people brought together with the purpose of identifying the range of opinions and thoughts on a particular area, in this instance the area of young people and sexual health.

Mode – The value that most frequently occurs.

Open-ended Questions – Questions that are used to establish qualitative, more in-depth data from an individual or group.

Opportunistic sampling – The selection of a sample from a larger population that is available, simply because of its convenience.

Pilot Survey – This is when a questionnaire is distributed to a small sample before a larger survey is distributed in order to test the value and suitability of the questionnaire.

Qualitative Data – Data that is used to produce meanings and is also described as a descriptive approach to data gathering.

Quantitative Data – Data that is numerical in form, the type of data that is required when variables can be measured and directional towards the testing of hypotheses.

Relationships and Sexuality Education (RSE) – For the purpose of this survey the terms RSE and sexual health education will be used interchangeably.

Representative Sample – A selection from a larger population that is statistically found to be typical of that population.

Sample – A list of subjects of a total population, for example an electoral roll. Research subjects are subsequently selected from such a list.

Statistically Significant – Results are statistically significant if the variation in the figures between sub-groups (e.g. males and females or different age groups) cannot be explained by measurement error. Significance values are commonly displayed, using the variable 'p'. There are three levels of statistical significance: $p \leq 0.05$, $p \leq 0.01$ and $p \leq 0.001$. Smaller values indicate highest significance.

Variable – A characteristic that can be measured that differs dependent on particular subjects. (e.g. gender or religion).

Appendix VIII: Abbreviations

EC	Emergency Contraception
RSE	Relationships and Sexuality Education
LGBT	Lesbian Gay Bisexual Transgender
DHSSPS, NI	Department of Health, Social Services and Public Safety, Northern Ireland
HAZ	Health Action Zone
STIs	Sexually Transmitted Infections
CCEA	Council for the Curriculum, Examinations and Assessment
fpaNI	Family Planning Association Northern Ireland
HPANI	Health Promotion Agency, Northern Ireland
NISRA	Northern Ireland Statistics and Research Agency
GUM	Genito - Urinary Medicine
ELB	Education and Library Board

North and West Belfast
Health Action Zone
5th Floor, 16 College
Street, Belfast BT1 6BT,

T: (028) 9023 7026
F: (028) 9023 7452
E: hazadmin@nwb.n-i.nhs.uk
W: www.haz-nwbelfast.org.uk