Equality and Human Rights
Screening Template

The Agency is required to address the 4 questions below in relation to all its policies. This template sets out a proforma to document consideration of each question.

What is the likely impact on equality of opportunity for those affected by this policy, for each of the Section 75 equality categories? (minor/major/none)

Are there opportunities to better promote equality of opportunity for people within the Section 75 equality categories?

To what extent is the policy likely to impact on good relations between people of a different religious belief, political opinion or racial group? (minor/major/none)

Are there opportunities to better promote good relations between people of a different religious belief, political opinion or racial group?

SCREENING TEMPLATE

See Guidance Notes for further information on the 'why' 'what' 'when', and 'who' in relation to screening, for background information on the relevant legislation and for help in answering the questions on this template .

(1) INFORMATION ABOUT THE POLICY OR DECISION

1.1 Title of policy or decision

Relationship and Sexuality Education (RSE) in the community service specification.

1.2 Description of policy or decision

- **what is it trying to achieve? (aims and objectives)**
- **how will this be achieved? (key elements)**
- **what are the key constraints? (for example financial, legislative or other)**

Sexual health is an important part of physical and mental health, as well as emotional and social well-being. It is a broad area including: healthy sexuality throughout life, reproduction, family planning, contraception, Sexually Transmitted Infection prevention, treatment and management and includes both the promotion of good sexual health and the provision of sexual health and social services.

The strategic direction for sexual health in Northern Ireland was set by the Department of Health and Social Services and Public Safety in the Sexual Health Promotion Strategy and Action Plan, 2008-2013 (the Strategy[1]). The aim of the strategy was to improve, protect and promote the sexual health and well-being of the population of Northern Ireland. The Strategy and Action Plan highlighted the following definition of sexual health:

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

The PHA **Corporate Plan 2017–2021 sets out the strategic direction for the Public Health Agency (PHA) for the next four years, taking account of Department of Health (DoH) priorities, especially the *Making Life Better* public health framework, the *Draft Programme for Government Framework 2016–21*, and local government-led community planning, within the context of financial constraints and HSC reform and restructuring.**

Relevant outcome identified in the plan is:

- All individuals and communities are equipped and enabled to live long healthy lives.

RSE Service Provision

The RSE in the community service was tendered in 2015 and contracts were awarded to 3 plus 1 consortium providers working across 5 Lots (5 HSCT areas) on 1st July 2015. Providers have successfully delivered on their contracts and in 2017 the PHA commissioned an external evaluation of the current

[1] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/sexual-health-promotion-strategy-and-action-plan-2008-13.pdf

service delivery to assess impact and outcomes.

Currently several organisations provide a range of community based RSE programmes for young people aged 11-25 years throughout Northern Ireland. The Public Health Agency (PHA) now wishes to re-tender these programmes. The information from the evaluation, PHA monitoring and evidenced based practice across NI and UK highlighted the necessity for the service to ensure young people have access to appropriate programmes to improve their sexual health and wellbeing and, the need to make slight changes.

- The experience to date points to the younger age group of 11years and older age group of 18-25 years as not being priority groups for this type of programme. Therefore this new tender will refocus the programme to prioritise the 12-14 year olds, 15-16 year olds and the 17-19 year olds. (PHA Monitoring)
- To move from a lot based on geography to one of age group this would ensure all participants in a defined age group would receive the same programme from the same provider. (Quality/Consistency).
- Moving from a capacity based funding allocation to age group populations in Trust. (Equitable.)

This tender process will be more inclusive as it will allow the organisations who are currently doing this work plus other interested organisations to apply.

The aim of the RSE in the community programme is to improve the sexual health and well-being of young people aged 12-19 years across Northern Ireland by enabling them to make healthier choices. Programmes commissioned will target young people in community settings throughout Northern Ireland. This will include:

- Young people in the 20% most deprived Super Output Areas in each PHA locality;
- Young people who are looked after and young adults who have recently left statutory care;
- Those attending alternative Education Projects such as EOTAS (Education Other Than at School);
- NEETS (young people Not in Education, Employment or Training),
- Those attending Government Training Schemes such as Rutledge, Prince's Trust;
- Vulnerable young people identified in Regional Colleges;
- Homeless young people;
- Those involved with the Youth Justice system;
- Young mothers and fathers;
- Young people affected by alcohol and drugs;
- Minority Ethnic young people (including Travellers);
- LGB&T (Lesbian, Gay, Bisexual and Transgender) young people.

Although programmes will be delivered in community settings, young people attending school youth clubs in disadvantaged areas will also be targeted. The programmes provided will be high quality and evidence based. They will represent good value for money and be responsive to the needs of specific population groups.

The key constraints

1. It is critical that the delivery organisations have a detailed knowledge and understanding of the types of messages that need to be delivered through the information and that suitable/ blended delivery techniques are used to effectively deliver these messages to particular age groups and priority client groups. It is considered that specialist trainers who are qualified to deliver this type of information will primarily be working outside the main HSC structures and would be better able to develop and present the necessary information materials. (This is a requirement of the tender).
2. The programmes can only be delivered when invited by youth organisations and therefore it is hard to manage rural need. (Requirement of tender to demonstrate how this will be managed).

1.3 Main stakeholders affected (internal and external)

For example staff, actual or potential service users, other public sector organisations, voluntary and community groups, trade unions or professional organisations or private sector organisations or others

Internal: Public Health Agency staff

External: Voluntary & Community Sector, Young people

1.4 Other policies or decisions with a bearing on this policy or decision

- **what are they?**
- **who owns them?**

- Sexual Health Promotion Strategy and Action Plan 2008-2013, DHSSPS.
- Sexual Health Thematic Plan 2012-2013, PHA
- Sexual Health Improvement Network- This is a regional network with members from statutory and voluntary sectors across Northern Ireland. Action 23 in the Sexual Health Strategy stated that a multi-agency Sexual Health Promotion Network be established to oversee the implementation of the action plan.
- In 2018 the Chief Medical Officer requested the Sexual Health Improvement Network to develop a revised Action Plan 2019-2015 with updated actions to deliver on the aims of the original Strategy. The CMO requested a further updated action plan 2019 -2025 this is currently with DoH for approval. As the strategic direction in the Strategy 2008-2013 and its Addendum remains the same, that is, to improve, protect and promote the sexual health and well-being of the population of Northern Ireland this.
- This specification will not include young people with a learning disability and those with a sensory disability as this work is commissioned separately as specialist skills are required.
- Young people with mental health issues, those who have a physical disability, those from ethnic minority groups and those who are lesbian, gay, bisexual or transgender are included as part of the target group.

(2) CONSIDERATION OF EQUALITY AND GOOD RELATIONS ISSUES AND EVIDENCE USED

2.1 Data Gathering

What information did you use to inform this equality screening? For example previous consultations, statistics, research, Equality Impact Assessments (EQIAs), complaints. Provide details of how you involved stakeholders, views of colleagues, service users, staff side or other stakeholders.

- Commissioned evaluation (2017-2019) of the existing tendered service along with monitoring of the existing contracts will be used to inform the development of the specification. The evaluation included Providers, Service Users (young people) and the organisations responsible for the young people who attended.
- PHA Meetings – Sexual Health Locality Leads meetings, Regional Sexual Health Improvement Network, meetings with Health Intelligence, Planning, PALS.
- Two PPI events are to take place which are both early evening to enable young people to attend.

These are in Belfast 23rd January 2020 and Omagh 28th January 2020. The invite to these sessions was:

- on the PHA web site,
- sent out on PHA social media sites,
- emailed to : Parenting NI, Girls Brigade, Boys Brigade, Youth Engagement services, Drugs & Alcohol coordination teams
- Current providers were requested to share the invite with organisations they worked with a request for young people who received the service to come along if possible.

- Commissioned evaluation of the service which involved the providers of the service, the users (young people) and the organisations who had requested the service.

- Quarterly monitoring and end of year evaluation gathered from the providers of the service by the PHA.

2.2 Quantitative Data

Who is affected by the policy or decision? Please provide a statistical profile. Note if policy affects both staff and service users, please provide profile for both.

Category	***What is the makeup of the affected group? (%) Are there any issues or problems? For example, a lower uptake that needs to be addressed or greater involvement of a particular group?***
Gender	**NI Population Statistics* (Census 2011)** Male 49%, Female 51% Population of Northern Ireland in 2011 was 1,810,900 **Mid-Year population estimates, 2018** Estimated Northern Ireland population 1,881,641

Population by gender and age, Mid-year population estimates, 2018

Age group	Females		Males		All persons
	N	%	N	%	N
12-14 years	33,725	48.5	35,778	51.5	69,503
15-16 years	21,868	48.9	22,824	51.1	44,692
17-19 years	33,381	48.2	35,818	51.8	69,199

Transgender
No specific data is available on the number of transgender people amongst the target age cohort in Northern Ireland. Young people who are transgender may choose not to be identified so trainers may not be aware they are in the target group.
The number of patients in active treatment with in active treatment with the Brackenburn Clinic in Northern Ireland is 145 with 333 on a waiting list for treatment (June 2019).[1]

Age

Young people aged 12-19 years are the target group for this work. Specific issues for this age group include: increased rates of sexually transmitted infections, teenage pregnancy and underage sex.

Population by age, Census 2011

Age group	N	%
12-14 years	73,581	4.1
15-16 years	50,352	2.8
17-19 years	92,087	5.1

Source: NISRA Age - Single Year: QS103NI (administrative geographies) https://www.ninis2.nisra.gov.uk/public/ViewDataSet.aspx?ds=2678&lh=37&yn=2011&sk=136&sn=Census 2011&yearfilter=

Population by age, Mid-year population estimates, 2018

Age group	N	%
12-14 years	69,503	3.7
15-16 years	44,692	2.4
17-19 years	69,199	3.7

Source: NISRA https://www.nisra.gov.uk/publications/2018-mid-year-population-estimates-northern-ireland

Religion

Population by religion, Census 2011

	N	%
Catholic	738,033	40.8
Presbyterian Church in Ireland	345,101	19.1
Church of Ireland	248,821	13.7
Methodist Church in Ireland	54,253	3.0
Other Christian (including Christian related)	104,380	5.8
Other religions	14,859	0.8
No religion	183,164	10.1
Religion not stated	122,252	6.8

Religion or religion brought up in by age by sex, Census 2011

		Total	Catholic	Protestant and Other Christian (including Christian related)	Other religions	None
Aged 10-14	N	119,034	58,904	49,833	799	9,498
	%		49.5	41.9	0.7	8.0
Aged 15-19	N	126,241	61,818	54,121	801	9,501
	%		49.0	42.9	0.6	7.5

Political Opinion

National Identity, Census 2011

	N	%
All usual residents	**1,810,863**	
British	722,379	39.9
Irish	457,482	25.3
Northern Irish	379,267	20.9
British and Northern Irish	111,748	6.2
Irish and Northern Irish	19,132	1.1
British, Irish and Northern Irish	18,406	1.0
British and Irish	11,877	0.7
Other	90,572	5.0

Marital Status

There has been a general increasing trend in the number of marriages registered in Northern Ireland since 2000 with; 8,300 marriages registered in 2017, similar to 2016 - 8,306 and 2015 - 8,355.[2]
Of the 8,300 marriages registered in 2017, 15.7% (1,303) were to individuals 0-24 years.[3]

In 2018 there were 659 births to mothers under the age of 20 years. The majority (95.6%) of mothers under the age of 20 years were not married.[4]

Marital status NI residents 16+ years, Census 2011	**N**	**%**
All usual residents	1,431,540	
Single (never married or never registered a same-sex civil partnership)	517,393	36.1
Married	680,831	47.6
In a registered same-sex civil partnership	1243	0.1
Separated (but still legally married or still legally in a same-sex civil partnership)	56,911	4.0
Divorced or formerly in a same-sex civil partnership which is now legally dissolved	78,074	5.5
Widowed or surviving partner from a same-sex civil partnership	97,088	6.8

There is no evidence to suggest that marital status has a higher or lower uptake in relation to public participation.

<table>
<tr><td>Dependent Status</td><td>While the number of births to teenage mothers in Northern Ireland has fallen in recent years, like the rest of the UK, the rate is higher than in other European countries.

In 2018 there were 659 births to mothers under the age of 20 years and 52 of these births were to mothers under the age of 17 years.[5]
• Of the 692 births to mothers under 20 years, 31.4% were registered to fathers under 20 years, 39.3% to fathers aged 20-24 years, 5.8% to fathers 25-29 years and 1.2% to fathers over 30 years of age; 21.4% had no father registered.[6]

The rate of births to teenage mothers (<20 years) living in the 20% most deprived areas is around 3 times higher than in the 20% least deprived areas (17.2 vs 4.2 births per 1,000 population).[7] There is also variation by Health and Social Care Trust.

A report on young people leaving care during the year ending 31 March 2018 found that:[8]

• 12% of care leavers aged 19 were parents (19 young women and 11 young men);
• Almost one in five (18%) of female care leavers aged 19 in 2017/18 became mothers on or before their 19th birthday. During 2017, 1% of 15-19 year old females in the general population in Northern Ireland became mothers.[9] Although these figures are not directly comparable, it does indicate a higher prevalence of teenage mothers in the cohorts of care leavers.

Caring responsibilities
Census 2011 data reveals that the majority of carers are aged 35–64 years, with one third (33%) aged 35–49, and a further 31 per cent aged 50–64. However, there are also a significant number of young carers (those aged under 18). For example, 6,700 young people (aged 0–17) in Northern Ireland provide between 1 and 19 hours of unpaid care per week, while a further 960 provide 20–49 hours, and 820 care for 50 hours or more.</td></tr>
<tr><td>Disability</td><td>Figures show that one in five people in Northern Ireland has a long term health problem (20.7%).[10] Data also shows that 6.7% of those aged 10-19 years had a long term health problem or disability.

<table>
<tr><th colspan="4">Long-term health problem by age group, Census 2011</th></tr>
<tr><td></td><td>All usual residents</td><td>Day-to-day activities limited a little/a lot (n)</td><td>Day-to-day activities limited a little/a lot (%)</td></tr>
<tr><td>Aged 10-14</td><td>119,034</td><td>8,161</td><td>6.9</td></tr>
<tr><td>Aged 15-19</td><td>126,241</td><td>8,190</td><td>6.5</td></tr>
<tr><td>Total 10-19 years</td><td>245,275</td><td>16,351</td><td>6.7</td></tr>
</table>
</td></tr>
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Type of long-term conditions reported for young people aged 10-19 years, Census 2011	N	%
All usual residents 10-19 years	**245,275**	
Deafness or partial hearing loss	1,582	0.6
Blindness or partial sight loss	1,011	0.4
Communication difficulty	3,776	1.5
A mobility or dexterity difficulty	3,697	1.5
A learning, intellectual, social or behavioural difficulty	11,984	4.9
An emotional, psychological or mental health condition	2,983	1.2
Long-term pain or discomfort	2,005	0.8
Shortness of breath or difficulty breathing	17,974	7.3
Frequent periods of confusion or memory loss	491	0.2
A chronic illness	2,970	1.2
Other condition	6,443	2.6
No condition	205,842	83.9

Source: Table DC3101NI: Type of long-term condition by age by sex

Educated other than at school (EOTAS)[11]

- In 2018/19, for the second time, data was collected on pupils educated in a setting other than a school (EOTAS centres). EOTAS makes educational provision for children with social, emotional, behavioural, medical or other issues who, without its provision cannot access suitable education.
- In total, 676 pupils were enrolled in EOTAS centres in October 2018. This includes pupils that are 'dual registered' with a mainstream school, and may be accessing the EOTAS centre for a temporary period. Just 71 pupils are 'single registered' at EOTAS centres; this means that they no longer have a link to a mainstream school.

Ethnicity

NI Population Statistics *(Census 2011)	N	%
White	1,778,449	98.21
Chinese	6,303	0.35
Indian	6,198	0.34
Mixed	6,014	0.33
Irish traveller	1,301	0.07
Pakistani	1,091	0.06
Other Asian	4,998	0.28
Black African	2,345	0.13
Black other	899	0.05
Bangladeshi	540	0.03
Black Caribbean	372	0.02
Other	2,353	0.13

The results of the 2011 census show that the number of people usually resident in Northern Ireland who were born outside the UK was 119,186, with those born in the Republic of Ireland accounting for 37833 of this group.[12]

Main language, Census 2011 – 10 most common	Northern Ireland	
	N	%
All usual residents: Aged 3+ years	1,735,711	
English	1,681,171	96.86
Polish	17,731	1.02
Lithuanian	6,250	0.36
Gaelic (Irish)	4,130	0.24
Portuguese	2,293	0.13
Slovak	2,257	0.13
Chinese (Not otherwise specified)	2,214	0.13
Tagalog/Filipino	1,895	0.11
Latvian	1,273	0.07

Annual school census[13]

The school census for 2018/19 highlights the ethnic diversity of pupils in schools in Northern Ireland with 4.6% of the school population recorded as non-white. It also reports a rise in the number of pupils whose first language is not English. In 2018/19, there are approximately 90 first languages spoken by pupils, with Polish and Lithuanian being the most common behind English.

Table 6a: Ethnicity of pupils by school type, 2018/19

Funded pre-school education, Primary, Post Primary and Special Schools [R]

	White (excluding Irish Traveller)[R]	Chinese	Irish Traveller	Indian/Sri Lankan	Pakistani	Black	Other ethnic group	Mixed ethnic group	Total[R]
Voluntary and Private Pre-School Centres (funded children only)	7,689	17	#	26	#	23	#	#	8,022
Nursery Schools	5,560	22	18	24	7	34	61	106	5,832
Nursery Classes & Reception	9,185	44	24	60	17	68	121	193	9,722
Primary Schools & Prep. Departments (Year 1 - Year 7)	165,989	675	667	950	203	961	2,197	2,881	174,523
Secondary (Non Grammar) Schools	76,228	167	262	129	59	587	1,054	891	79,377
Grammar Schools (Year 8 - Year 14)	59,981	462	12	537	86	205	780	799	62,862
Special Schools	5,655	22	62	27	6	30	74	83	5,959
EOTAS Centres[R]	59	-	*	-	*	6	*	*	71
ALL FUNDED PRE-SCHOOL, NURSERY, PRIMARY, POST-PRIMARY AND SPECIAL SCHOOLS	330,297	1,409	1,058	1,753	388	1,908	4,421	5,063	346,297
ALL FUNDED PRE-SCHOOL, NURSERY, PRIMARY, POST-PRIMARY, SPECIAL SCHOOLS and EOTAS Centres[R]	330,356	1,409	1,059	1,753	389	1,914	4,424	5,064	346,368

Fewer than 5 cases.

* Number suppressed.

[1] Enrolments for special schools and EOTAS centres relate those where pupils are single registered to the school, or are dual registered and the special school/EOTAS centre is recorded as the main school.

[R] The number of pupils with white ethnicity and total pupils at EOTAS centres was revised.

Travelling Community

The All Ireland Traveller Survey 2010 estimated that there were 3,905 Irish Travellers in Northern Ireland.[14] Main Areas of Traveller Population: Belfast, Newry and Armagh, Foyle, Mid Ulster, West Tyrone.

Travellers live in a range of accommodation types, including social housing, serviced sites, grouped homes, on public land, private rented land, and on the side of the road.

Mortality rates among Traveller children up to 10 years of age have been found to be 10 times that of children from the 'settled' population.

('Key Inequalities' document, Equality Commission for Northern Ireland).

The 2010 Survey suggests that the cohort of 15-24 year-olds is particularly marked amongst the Traveller population in Northern Ireland. It appears that 10-24 year olds make up about 36% of this population - around 1,400 individuals.

A Housing Executive needs assessment of the accommodation needs identified 480 Traveller households. [15] Subsequently 384 face-to-face interviews were carried out across Northern Ireland, highlighting that 1,262 individuals were living in these households. The younger age profile of the population is indicated by the fact that more than one-quarter (29%) of household members were aged between six and 15 and 17% were aged five or under. For the Northern Ireland population as a whole, 21% were aged under 16 according to the 2011 Census.

Sexual Orientation

There is variation in estimates of the size of the LGB&T population in Northern Ireland. Historically, estimates are as high as 5-7% (65-90,000) of the adult population Northern Ireland (based on the UK government estimate of between 5-7% LGB&T people in the population for the purposes of costing the Civil Partnerships Act). A similar proportion or more recently the Office of National Statistics estimate 1.5-2% which would be closer to 20-30,000 adults.[16,17] This latter document is disputed by various LGB&T organisations.

The latest figures from the NI Continuous Household Survey and the NI Northern Ireland Life and Times Survey are shown in the table below:[18]

	Northern Ireland Continuous Household Survey 2017/18	Northern Ireland Life and Times Survey 2017
Heterosexual/Straight	97.8%	97%
Gay/Lesbian	0.6%	1%
Bisexual	0.5%	1%
Other	0.3%	1%
Don't know/Refusal	0.7%	-

Most recently, data published by ONS for 2017 showed that 1.2% (CI 0.6-1.9) of Northern Ireland survey respondents identified as lesbian, gay or bisexual.[19] ONS also produced estimates of sexual identity by UK country by sex and age group, 2013-2015.[20]

Sexual identity estimates for Northern Ireland by sex 2013-2015, ONS				
	Gay or lesbian (%)		Bisexual (%)	
Northern Ireland: Males	1.6	(CI 0.9-2.3)	0.6	(CI 0.1-1.1)
Northern Ireland: Females	0.3	(CI 0.1-0.5)	1.4	(CI 1.0-1.8)

Note: Quality measures (including confidence intervals and coefficient of variance) for the estimates are displayed within the datasets; users should consider these when interpreting the results.

Data shows that those in younger age groups are more likely to identify as Lesbian, gay or bisexual.

Sexual identity estimates for Northern Ireland by age group 2013-2015, ONS

	Gay or lesbian (%)		Bisexual (%)	
Northern Ireland: 16 to 34	1.9	(CI 0.9-2.9)	1.4	(CI 0.6-2.2)
Northern Ireland: 35 to 49	0.9	(CI 0.2-1.6)	0.9	(CI 0.5-1.3)
Northern Ireland: 50 to 59	0.2	(CI 0.1-0.5)	0.9	(CI 0.4-1.4)
Northern Ireland: 60 and over	0.2	(CI 0.0-0.4)	0.8	(CI 0.4-1.2)

Note: Quality measures (including confidence intervals and coefficient of variance) for the estimates are displayed within the datasets; users should consider these when interpreting the results.

2.2 Qualitative Data

What are the different needs, experiences and priorities of each of the categories in relation to this policy or decision and what equality issues emerge from this? Note if policy affects both staff and service users, please discuss issues for both.

Category	***Needs and Experiences***
Gender	Groups can be mixed gender groups or single gender groups. This will be dependent upon the needs of the young people. The Trainers will discuss this with group leaders before a session. Single sex groups may be required in certain circumstances eg for young people who are travellers. The Health Survey Northern Ireland reported that: • over three-quarters of females (77%) compared to over half of males (56%) agreed that they would not have sex with a new partner if they did not have any condoms (2018/19).[21] • a higher proportion of males compared to females (14% vs 8%) reported having 3 or more sexual partners in the last year (2013/14).[22] • around three-quarters of respondents had heard of Chlamydia, Genital Herpes, Genital Warts, Gonorrhoea, and Syphilis and nine in ten respondents had heard of HIV, with females more likely to have heard of these STIs than males (2015/16).[23] The Young Persons' Behaviour and Attitudes survey found that since 2000, the proportion of young people reporting having had sexual intercourse has declined, from 12% in 2000 to 4% in 2016; boys (5%) were more likely to report having had sexual intercourse than girls (3%), as were those in the older year groups (less than 1% of year 8 compared with 15% of year 12).[24] A survey exploring the sexual health awareness, attitudes and behaviour among adults aged 16-45 in Northern Ireland found that males engage in sexual activity at an earlier age than females for example, the average age of vaginal intercourse for males was 16.6 years compared to 17.4 for females.[25] Men who have sex with men (MSM) are at disproportionate risk of contracting some STIs accounting for 79% of male infectious syphilis, 72% of male gonorrhoea, 18% of male herpes and 29% of male chlamydia infections.[26] It follows that MSM have accounted for the majority of the increase seen in

	syphilis and gonorrhoea diagnoses during 2018.
Age	The target group for these programmes will be 12-19 year olds. Findings from the Young Peoples' Behaviour and Attitudes Survey of young people aged 14-16 years in post-primary schools shows that they most commonly report learning about sexual matters and relationships from lessons at school (72%). While young people also identify mothers (47.2%) and fathers (23.7%) as sources of information, some report finding it 'difficult' to talk about or 'don't discuss' sexual matters with their mother or father (14.2% vs 18.7% and 33.6% vs 44.5% respectively).[27] The Young Persons' Behaviour and Attitudes survey found that since 2000, the proportion of young people reporting having had sexual intercourse has declined, from 12% in 2000 to 4% in 2016; boys (5%) were more likely to report having had sexual intercourse than girls (3%), as were those in the older year groups (less than 1% of year 8 compared with 15% of year 12).[28] In 2016, of those pupils in Years 11&12 who reported their age when they first had sex, around three quarters were between 13-15 years. Just over a third (34%) of young people in Years 11&12 said they would not find it easy to get contraceptives.[29] The Health Survey Northern Ireland reported that: • a higher proportion of those aged 16-24 years reported having 3 or more sexual partners in the last year compared to other age groups (26% 16-24 years, 9% 25-34 years, 6% 35-44 years and 5% 45-55 years) (2013/14).[30] • over half of respondents (51%) reported having their first sexual experience between the ages of 16 and 18 years. While over half of respondents (56%) believed their first sexual experience occurred at about the right time, a quarter of respondents felt they should have waited longer before having sex (27%), with females more likely to indicate they should have waited (34%) than males (18%) (2014/15).[31] • young people 16-24 years said that they would find it 'difficult' or 'very difficult' to talk with a new partner about: – the number of people he/she has slept with previously (30%); – whether he/she has ever had unprotected sex (29%); – whether he/she has ever had been tested for STIs (40%); or – wanting to use condoms/another method to protect against STIs (18%) (2015/16).[32] The most recent surveillance data from genitor-urinary clinics in Northern Ireland shows that trends in annual diagnostic rates of the more common and most significant STIs have varied by disease type, age, gender and male sexual orientation between 2006-2018.[33] The highest diagnostic rates of the common STIs occur in 16-24 year old females and 20-34 year old males. People aged 16-34 year old account approximately 80% of new STIs. • From 2012–2018, diagnostic rates of chlamydial infection in females were consistently highest in the 16–24 years age group, peaking between 20 and 24 years. In males, the highest rates were in the 20–34 years age group, again peaking between 20 and 24 years.

	• Diagnostic rates in first diagnoses of genital herpes in females were consistently highest in the 16–24 years age group. In males, the highest diagnostic rates were in the 20–34 years age group. The figures in the 20-24 age band in males have almost doubled since 2011. • Since 2010 there has been an increasing trend in the number of new episodes of gonorrhoea diagnosed. The increase in diagnoses since 2010 has largely affected MSM and females. In females, the increases since 2011 have mostly affected the 16-19, and 20-24 age groups. In 2018, the number of diagnoses in females has increased by 15% when compared to 2017. In males there has been an increased trend in diagnostic rates across all age groups since 2011. The largest increases and highest diagnostic rates have consistently been in the 20–24 years age groups, followed by the 25-34 years age group.
Religion	The trainers will respect the religious backgrounds of young people. Before a session commences the trainer will communicate with the youth leader or the person organising the session for the young people to discuss the needs of the young people. It may not always be possible for Trainers to use 'neutral' venues but a balance of religious and non-religious venues will be accessed in order to ensure inclusiveness where possible. Young people from minority religions maybe less likely to come forward to participate due to the sensitivity of the issues for some cultures. Programmes will be adapted by Trainers to ensure cultural sensitivity for minority religions.
Political Opinion	The trainers will respect the political background of young people (they will be unaware of their political opinion unless the young person chooses to disclose this). Before a session commences the trainer will communicate with the youth leader or the person organising the session for the young people to discuss the needs of the young people.
Marital Status	It is envisaged that the majority of the young people will not be married or in a civil partnership. The majority will be under 18 years. In 2017 there were 692 births to mothers under the age of 20 years. The majority (96.7%) of mothers under the age of 20 years were not married.[34] A survey exploring the sexual health awareness, attitudes and behaviour among adults aged 16-45 in Northern Ireland found that level of knowledge relating to STIs and protection against STIs was lowest among those who are single compared to married/cohabiting.[35]
Dependent Status	Some of the young people attending sessions may be young parents. Their needs will be identified by their youth leader/organiser.
Disability	The service specification will not include young people with a learning disability or those with a sensory disability. This work is commissioned separately as specialist skills are required. For young people with a physical disability issues around accessibility of venue and specific information needs will be discussed with the person who has requested the programme and the Trainer.
Ethnicity	Young people from ethnic backgrounds will be invited to take part in the

	programmes. The youth leader/organiser will identify needs when they meet with the trainer. These may include cultural and religious differences as well as language. Some individuals from certain ethnic groups may have a preference for a trainer the same gender as themselves. **All Island Traveller Health Study** The All Island Traveller Health Study reported that around 1 in 10 (10.4%) of NI Travellers reported no formal education (31.1% reported this as not applicable).[36] The highest level of education for those under 30 was primary school (40.4%), followed by secondary school (13.1%). The study also reported on women's health issues. Information on family planning was elicited only from the ever-married women who took part in the survey (n=679 in ROI; n=137 in NI). Overall 40.8% in ROI and 50.4% in NI had ever been on the contraceptive pill and this showed a strong age pattern, with the group most likely ever to be on the pill those in the 30-44 year age group (53.6% in ROI and 51.9% in NI). The pill was the most frequently employed method in the last 12 months (39.4% in ROI and 44.1% in NI), followed by natural family planning (18.8% ROI and 32.3% NI) with very low rates of barrier methods (4.6% ROI and 2.2% NI). Notably around a quarter cited 'other' methods. Other minority ethnic groups: There were gaps in knowledge of how to access services; it was best known how to access family planning/contraception (48%), information on pregnancy/childbirth (40%), and cervical screening/smears (39%). Access to parent support (24%, breast screening (26%), and health visitor (27%) were least well known.[37] Sexual health (sexually transmitted diseases, HIV / AIDs, Hepatitis C and B) has been identified as one of the main health issues for migrants. For the majority of migrants entering the country, there is no greater risk of infectious diseases than for the indigenous population. However, there are certain individuals who come from countries with high prevalence of diseases such as tuberculosis, hepatitis B and C and HIV.[38]
Sexual Orientation	All programmes will be inclusive of LGB&T young people and the language etc of the trainers will reflect this. The advertising of the programmes need to state they are inclusive e.g. leaflets advertising the programme explicitly state that all young people are welcome no matter what their sexual identity. Some young people may choose not to disclose if they are LGB or T and trainers need to respect this. The difficulties in estimating the proportion of LGB&T individuals in a population are recognised.[39,40] In addition to the sensitivity around such research, there are methodological challenges, including whether LGB&T respondents are classified according to identity or behaviour or whether individuals are asked about current status versus any experience. A Northern Ireland study of young people identifying as LGB&T found that 77% of young people realised that they were gay, lesbian or bisexual between the age of 10 and 17 years (average for males was 12 years and the average for

	females was 13 years).[41] Eight out of ten first "came out" to someone between the age of 14 and 21 years (for males the average was 17 years and the average for females was 18 years). This suggests that it may take some time for young people to come to terms with their sexual orientation or transgenderism. A survey of LGB&T young people commissioned by the Department of Education to explore their experience in post-primary school found that almost half of respondents (48.4%) had experienced bullying as a result of their sexual orientation or gender identity.[42] It also reported that • A majority of both LGB respondents (61.3%) and transgender respondents (73.8%) experienced a negative or very negative impact on their emotional wellbeing. A minority of LGB respondents stated that their experience as an LGB pupil in post-primary school had a negative or very negative impact on their attainment (19.4%), attendance (21.9%) and career planning (15.0%). A greater proportion1 of transgender respondents reported a negative or very negative impact on attainment (38.5%), attendance (41.5%) and career planning (35.9%). Focus groups with LGB&T young people also found that participants felt that the relationships and sexuality education which was provided to them either ignored the needs of LGB&T young people or actively advocated against their interests. The participants had largely taught themselves about sex and relationships using the internet as a resource. A UK study found that bisexual behaviour in teenage boys and girls was associated with greater sexual risk taking than exclusively heterosexual behaviour. It found that boys were more likely to report partner pressure and regret in relation to first same-sex genital contact than first heterosexual intercourse, but girls showed no differences according to partner type, suggesting that boys are vulnerable to unwanted sex. Teenagers with bisexual behaviour reported greater pregnancy or partner pregnancy risk than teenagers with exclusively opposite-sex partners.[43] A survey of adults aged 16-45 in Northern Ireland found that level of knowledge relating to STIs was lowest among heterosexuals compared to LGB&T individuals.[44]

2.3 Multiple Identities

Are there any potential impacts of the policy or decision on people with multiple identities? For example; disabled minority ethnic people; disabled women; young Protestant men; and young lesbians, gay and bisexual people.

These programmes will be inclusive of all young people. The target group identified include LGB&T young people, Minority Ethnic young people, young mothers and fathers etc. Some may have multiple identities.

2.4 Making Changes

Based on the equality issues you identified in 2.2 and 2.3, what changes did you make or do you intend to make in relation to the policy or decision in order to promote equality of opportunity?

In developing the policy or decision what did you do or change to address the equality issues you identified?	***What do you intend to do in future to address the equality issues you identified?***
The target group are young people aged 12-19 years. This includes young people who may have mental health issues, those who have a physical disability, are from a minority ethnic group etc. Specialist programmes have been designed and commissioned for those not included above (those with a learning or sensory disability) as these are commissioned separately by the PHA. In the specification the following will be highlighted for tenderer (s) • Tenderer(s) should demonstrate how they support Trainers to ensure that they have relevant skills and training. • Tenderer(s) will demonstrate their experience of targeting and recruiting target groups of young people as listed above in 1.2 and devising innovative programmes to attract these hard to reach groups. • Tenderer(s) will demonstrate how they have developed RSE programmes for young people with low literacy and other needs. • The service provided should promote social inclusion, addressing issues around disadvantage, sexual orientation, gender identity, ethnicity, disability and rural/urban communities. • Tenderer(s) will have policies for staff on child protection and guidelines for staff around disclosure and other sensitive issues. • Trainers will display non-judgmental attitudes when discussing topics such as unplanned pregnancy, condom use, emergency contraception, Lesbian, Gay, Bisexual and Transgender issues.	As this specification is taken forward equality issues will be reviewed and addressed as appropriate. This will also be included in the monitoring forms which the successful organisation will have to complete every quarter. Addressed in the response to the tender specification.

2.5 Good Relations

What changes to the policy or decision – if any – or what additional measures would you suggest to ensure that it promotes good relations? (refer to guidance notes for guidance on impact)

Group	*Impact*	*Suggestions*
Religion	The trainers will be recruiting young people through local contacts such as youth groups, children's homes etc so they will not have a direct influence over who attends programmes but the PHA will require them to be mindful of the need to be inclusive in their recruitment.	Links with local organisations to reach target groups.
Political Opinion	As above.	As above.
Ethnicity	As above.	As above.

(3) SHOULD THE POLICY OR DECISION BE SUBJECT TO A FULL EQUALITY IMPACT ASSESSMENT?

A full equality impact assessment (EQIA) is usually confined to those policies or decisions considered to have major implications for equality of opportunity.

How would you categorise the impacts of this decision or policy? (refer to guidance notes for guidance on impact)

Please tick:

Major impact	
Minor impact	x
No further impact	

Do you consider that this policy or decision needs to be subjected to a full equality impact assessment?

Please tick:

Yes	
No	No

Please give reasons for your decisions.

The PHA's role covers a wide range of issues across health improvement, health protection, service development and screening and has the aim of improving the health and wellbeing of all people in NI (covering all section 75 groups) as well as reducing health inequalities.

Based on need and evidence based practice the programmes will have specific target groups. The specification will be put out to tender and organisations will be assessed regarding specific outcomes. This process is a mechanism for allocating and monitoring PHA funds. As this specification is taken forward equality issues will be reviewed and addressed as appropriate. However in doing this we were mindful of the need to ensure that the process and related documentation is accessible to all and widely available in different formats e.g. accessibility statement, detailed guidance notes for applicants. The collection of monitoring data will allow assessing need for further targeted interventions in the future.

(4) CONSIDERATION OF DISABILITY DUTIES

4.1 In what ways does the policy or decision encourage disabled people to participate in public life and what else could you do to do so?

How does the policy or decision currently encourage disabled people to participate in public life?	***What else could you do to encourage disabled people to participate in public life?***
The PHA as an organisation actively promotes the inclusion of disabled people in service planning, monitoring and evaluation such as through Personal and Public Involvement initiatives and advisory groups.	Encourage disabled young people to get involved in user groups etc. Always ensure that venues are completely accessible. Seek to ensure that timings of programmes are such that young people can use public transport and provide appropriate car parking facilities.

4.2 In what ways does the policy or decision promote positive attitudes towards disabled people and what else could you do to do so?

How does the policy or decision currently promote positive attitudes towards disabled people?	***What else could you do to promote positive attitudes towards disabled people?***
The PHA promotes positive attitudes towards disabled people and values their views. This will be reflected in the contract of the successful tender.	Encourage positive attitudes to disabled people and challenge negative stereotyping through programmes and inclusive language of trainers and during the advertising of programmes. Challenging negative stereotypes/myths which young people may have in relation to disabled people.

(5) CONSIDERATION OF HUMAN RIGHTS

5.1 Does the policy or decision affect anyone's Human Rights? Complete for each of the articles

ARTICLE	Yes/No
Article 2 – Right to life	No
Article 3 – Right to freedom from torture, inhuman or degrading treatment or punishment	No
Article 4 – Right to freedom from slavery, servitude & forced or compulsory labour	No
Article 5 – Right to liberty & security of person	No
Article 6 – Right to a fair & public trial within a reasonable time	No
Article 7 – Right to freedom from retrospective criminal law & no punishment without law	No
Article 8 – Right to respect for private & family life, home and correspondence.	No
Article 9 – Right to freedom of thought, conscience & religion	No
Article 10 – Right to freedom of expression	No
Article 11 – Right to freedom of assembly & association	No
Article 12 – Right to marry & found a family	No
Article 14 – Prohibition of discrimination in the enjoyment of the convention rights	No
1st protocol Article 1 – Right to a peaceful enjoyment of possessions & protection of property	No
1st protocol Article 2 – Right of access to education	No

*If you have answered no to all of the above please move onto to move on to **Question 6** on monitoring*

5.2 If you have answered yes to any of the Articles in 5.1, does the policy or decision interfere with any of these rights? If so, what is the interference and who does it impact upon?

List the Article Number	Interfered with? Yes/No	What is the interference and who does it impact upon?	Does this raise legal issues?* Yes/No
NOT APPLICABLE	NOT APPLICABLE	NOT APPLICABLE	NOT APPLICABLE

** It is important to speak to your line manager on this and if necessary seek legal opinion to clarify this*

5.3 Outline any actions which could be taken to promote or raise awareness of human rights or to ensure compliance with the legislation in relation to the policy or decision.

Methods and approaches developed will recognise the value of a human rights based approach.

(6) MONITORING

6.1 What data will you collect in the future in order to monitor the effect of the policy or decision on any of the categories (for equality of opportunity and good relations, disability duties and human rights?

Equality & Good Relations	Disability Duties	Human Rights
A range of information and data will be collected to help us fulfil our legal requirements as well as assist in the planning of services for the future. This information will include gender breakdown, age breakdown.	A range of information and data, including inclusion and participation of disabled people where possible, will be collected to help us fulfil our legal requirements as well as assist in the planning of services for the future	Data on promoting a culture of respect for human rights within the PHA.

Approved Lead Officer: Denise McCann

Position: Health & Social wellbeing Manager

Date: 7th February 2020

Policy/Decision Screened by: Barbara Forbes

Please note that having completed the screening you are required by statute to publish the completed screening template, as per your organisation's equality scheme. If a consultee, including the Equality Commission, raises a concern about a screening decision based on supporting evidence, you will need to review the screening decision.

Please forward the completed template to:
Equality.Unit@hscni.net

Template produced February 2011

If you require this document in an alternative format (such as large print, Braille, disk, audio file, audio cassette, Easy Read or in minority languages to meet the needs of those not fluent in English) please contact the Business Services Organisation's Equality Unit:

2 Franklin Street; Belfast; BT2 8DQ; email: Equality.Unit@hscni.net; phone: 028 90535531 (for Text Relay prefix with 18001); fax: 028 9023 2304

[1] Email Personal communication 10th June 2019.
[2] NISRA. Marriage Statistics https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/marriages_method_1887_2017.xls
[3] NINIS. Marriages by age and sex (administrative geographies)
[4] Table 3.10 Live births, stillbirths and maternities1, by sex of child, marital status of parents and age of mother, 2018 https://www.nisra.gov.uk/publications/registrar-general-annual-report-2018-births
[5] Table 3.10 Live births, stillbirths and maternities1, by sex of child, marital status of parents and age of mother, 2018 https://www.nisra.gov.uk/publications/registrar-general-annual-report-2018-births
[6] Table 3.19 Live births by age of mother and age of father1, 2018 https://www.nisra.gov.uk/publications/registrar-general-annual-report-2018-births
[7] Department of Health. Health inequalities annual report 2019 Data Tables Available at: https://www.health-ni.gov.uk/sites/default/files/publications/health/hscims-report-2019-data-tables.xlsx
[8] Department of Health. Northern Ireland care leavers 2017/18. Belfast: Northern Ireland Statistics and Research Agency, 2018. https://www.health-ni.gov.uk/sites/default/files/publications/health/nicl-17-18.pdf
[9] Registrar General Annual Report 2017 Births, Northern Ireland Statistics and Research Agency 2018; 2017 Mid-Year Population Estimate (NISRA 2018).
[10] NINIS Census 2011 Table CT0364NI: Long-term health problem by age by sex
[11] Annual enrolments at schools and in funded pre-school education in Northern Ireland, 2018/19 https://www.education-ni.gov.uk/sites/default/files/publications/education/Revised%2029%20April%202019%20-%20Annual%20enrolments%20at%20schools%20and%20in%20pre-school%20education%20in%20Northern%20Ireland%2C%20201819_0.pdf
[12] NINIS. Country of Birth - Basic Detail: QS207NI (administrative geographies) / Long-term International Migration Statistics for Northern Ireland (2017) https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/Mig1617-Bulletin.pdf Page 29
[13] Annual enrolments at schools and in funded pre-school education in Northern Ireland, 2018/19. https://www.education-ni.gov.uk/sites/default/files/publications/education/Revised%2029%20April%202019%20-%20Annual%20enrolments%20at%20schools%20and%20in%20pre-school%20education%20in%20Northern%20Ireland%2C%20201819_0.pdf
[14] AITHS Team (2010b). All Island Traveller Health Study. Our Geels. Technical Report 1: Health survey findings. Dublin: UCD. Available at: www.dohc.ie/publications/aiths2010/TR1/AITHS2010_TechnicalReport1_LR_All.pdf?direct=1 Accessed 8th March 2013.
[15] Housing Executive. Traveller Accommodation Needs Assessment 2014. https://www.nihe.gov.uk/getmedia/8228725d-b5f2-468f-a37c-bd03ba6a9959/traveller-accommodation-needs-assessment-2014-published-march-2015.pdf.aspx?ext=.pdf
[16] Final Regulatory Impact Assessment: Civil Partnership Act 2004. London: Department of Trade and Industry; 2004. As cited in Meads C, Pennant M, McManus J and Bayliss S. A systematic review of lesbian, gay, bisexual and transgender health in the West Midlands region of the UK compared to published UK research. Birmingham, West Midlands Health Technology Assessment Group, University of Birmingham, 2009.
[17] Theodore Joloza T, Joanne Evans J, Rachel O"Brien R, Potter-Collins A. Measuring sexual identity: An evaluation report. London: Office for National Statistics, 2010.
[18] NISRA. 2021 Census. Sexual Orientation Topic Report. 2019 https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/Sexual%20Orientation%20Topic%20Report.pdf
[19] Sexual orientation, UK: 2017 https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2017
[20] Subnational sexual identity estimates, UK: 2013 to 2015 https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/articles/subnationalsexualidentityestimates/uk2013to2015#quality-and-methodology

[21] Health Survey Northern Ireland 2018/19. https://www.health-ni.gov.uk/sites/default/files/publications/health/hsni-first-results-18-19_1.pdf
[22] Health Survey (NI) First Results 2013/14. Personal communication email request - received 14/01/15
[23] Health Survey (NI) First Results 2015/16 http://www.safefood.eu/SafeFood/files/f7/f74bbe40-294e-400c-854b-4a1e7086ef13.pdf
[24] Information Analysis Directorate.Young Persons' Behaviour and Attitude Survey 2016 Health Modules. Belfast: Department of Health, 2017.https://www.health-ni.gov.uk/sites/default/files/publications/health/bulletin-16-ypbas.pdf
[25] Public Health Agency (PHA). Survey exploring the sexual health awareness, attitudes and behaviour among adults aged 16-45 in Northern Ireland. Belfast: PHA, 2009. Unpublished.
[26] Public Health Agency. Sexually Transmitted Infection surveillance in Northern Ireland 2019. An analysis of data for the calendar year 2018. https://www.publichealth.hscni.net/sites/default/files/2019-08/STI%20surveillance%20report%202019.pdf
[27] Central Survey Unit. Young Persons' Behaviour and Attitudes Survey 2013. Belfast: Northern Ireland Statistics and Research Agency (NISRA), 2014.
[28] Information Analysis Directorate.Young Persons' Behaviour and Attitude Survey 2016 Health Modules. Belfast: Department of Health, 2017.https://www.health-ni.gov.uk/sites/default/files/publications/health/bulletin-16-ypbas.pdf
[29] Young Persons' Behaviour & AttitudesSurvey 2016 https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/YPBAS2016ToplineResults.pdf
[30] Health Survey Northern Ireland 2013/14. Personal communication email request - received 14/01/15
[31] Information Analysis Directorate. Health Survey Northern Ireland First Results 2014/15. Belfast: Department of Health, 2015.https://www.drugsandalcohol.ie/24797/1/hsni-survey-first-results-14-15.pdf
[32] Information Analysis Directorate. Health Survey (NI) First Results 2015/16. Belfast: Department of Health, 2016. https://www.health-ni.gov.uk/sites/default/files/publications/health/hsni-first-results-15-16.pdf
[33] Public Health Agency. Sexually Transmitted Infection surveillance in Northern Ireland 2019. An analysis of data for the calendar year 2018. https://www.publichealth.hscni.net/sites/default/files/2019-08/STI%20surveillance%20report%202019.pdf
[34] Table 3.10 Live births, stillbirths and maternities1, by sex of child, marital status of parents and age of mother, 2017 https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/Births_2017.xls
[35] Public Health Agency (PHA). Survey exploring the sexual health awareness, attitudes and behaviour among adults aged 16-45 in Northern Ireland. Belfast: PHA, 2009. Unpublished.
[36] AITHS Team (2010b). All Island Traveller Health Study. Our Geels. Technical Report 1: Health survey findings. Dublin: UCD. Available at: www.dohc.ie/publications/aiths2010/TR1/AITHS2010_TechnicalReport1_LR_All.pdf?direct=1 Accessed 8th March 2013.
[37] Jarman, N. (2009). Health and social needs among migrants and minority ethnic communities in the Western Board area. Belfast: Institute for Conflict Research.
[38] BHDU (Belfast Health Development Unit) (2011). Barriers to health: migrant health and wellbeing in Belfast. Belfast: BHSCT. http://www.belfasttrust.hscni.net/pdf/Migrant-Health-Strategy.pdf
[39] Fenton K, Johnson A, Sally McManus S and Erens B. Measuring sexual behaviour: methodological challenges in survey research. Sexually Transmitted Infections 2001;77:84-92.
[40] Michaels S and Lhomond B. Conceptualization and measurement of homosexuality in sex surveys: a critical review. Cadernos de Saúde Pública 2006; 22(7): 1365-74.
[41] Shout. The needs of young people in Northern Ireland who identify as lesbian, gay, bisexual and or transgender. Belfast: YouthNet, 2003. Available at: www.youthnetni.org.uk/Site/29/Documents/shout%20pdf.pdf Accessed 15 February 2013.
[42] Department of Education. Post-primary school experiences of 16-21 year old people who are lesbian, gay, bisexual and/or transgender (LGB&T). Belfast: DoE, 2017. https://www.education-ni.gov.uk/sites/default/files/publications/education/Research%20briefing%20Sep%202017.pdf
[43] Parkes A, Strange V, Wight D, Bonell C, Copas A, Henderson M, Buston K, Stephenson J, Johnson A, Allen E and Hart G. Comparison of Teenagers' Early Same-Sex and Heterosexual Behavior: UK Data from the SHARE and RIPPLE Studies. Journal of Adolescent Health 48 (2011) 27–35.
[44] Public Health Agency (PHA). Survey exploring the sexual health awareness, attitudes and behaviour among adults aged 16-45 in Northern Ireland. Belfast: PHA, 2009. Unpublished.