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Cheshire & Merseyside NHS sexualhealthnetwork

Top Tips for sexual health promotion

Full Report

Janet Ubido, Matthew Ashton,
Simon Henning, Alex Scott-Samuel,
Penelope A Phillips-Howard and Wendy Nicholson

Observatory Report Series No. 72

PROVIDING INTELLIGENCE FOR THE PUBLIC HEALTH

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About this report

Top tips for promoting sexual health is the fourth in a series of *Top tips* documents aimed at promoting public health. It was commissioned by the ChaMPs[1] Federation of Directors of Public Health from Liverpool Public Health Observatory.

Previous documents in the series were *Top tips for healthier hospitals*, published in November 2006; *Top tips for health in local authorities*, published in January 2008; and *Top tips for healthier workplaces*, published in September 2008.

The executive summary and full report of each of the publications can be found on the ChaMPs website at www.nwph.net/champs/Publications and also on the Liverpool Public Health Observatory website at www.liv.ac.uk/PublicHealth/obs
Printed copies can be obtained by contacting Francesca Bailey at the Observatory on 0151 794 5570

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[1] Cheshire and Merseyside Public Health Network

ChaMPs Public Health Network
Cheshire and Merseyside Partnerships for Health (ChaMPs for Health) is a public health network for primary care trusts, local authorities, NHS trusts and wider organisations.

The network's mission is to build partnerships to promote and protect public health and well-being, and develop capacity and capability in the public sector.
www.champs-for-health.net
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Liverpool Public Health Observatory
Liverpool Public Health Observatory is an NHS research and development unit based in, and closely integrated with, the Division of Public Health at the University of Liverpool. The Observatory was founded in 1990 and was the model for the regional public health observatories established across England in 1998. Its staff consists of a part-time director, three researchers, and an administrator.

The principal purpose of the Observatory is the analysis, synthesis, and interpretation of health relevant information for those who make or influence policies affecting public health, whether they be in the public, private, or voluntary sectors.
www.liv.ac.uk/PublicHealth/obs
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Cheshire and Merseyside Sexual Health Network
The Cheshire and Merseyside Sexual Health Network was launched in March 2006. It aims to promote good sexual health through:

- Empowering service users
- Easy and prompt access to services
- Effective prevention
- Equitable, high quality standards of care

The network is striving to promote commissioning of high quality interventions based upon local, national and international intelligence and evidence based practice wherever possible. For more information please visit www.cmshn.nhs.uk or contact the Network Administrator on 0151 201 4154.

Contents

Executive Summary

Introduction

The promotion of sexual health involves encouraging healthy patterns of behaviour which avoid the damaging effects of poor sexual health.

With that in mind, *Top tips for sexual health promotion* focuses on positive influences for sexual health in the community and how they can be promoted.

The tips reflect a lifelong approach from childhood through adolescence into adulthood and on to old age. The promotion of positive sexual health is also considered in various settings and among different population groups.

We do not cover information usually provided by sexual health services and in schools, where the promotion of sexual health is part of their normal area of work. There has already been much written on how services can improve, for example in the National Teenage Pregnancy Strategy (Accelerating the strategy to 2010, DfES, 2006b) and the Department of Health *You're welcome quality criteria* (Department of Health, 2006).

What is sexual health?

Sexual health is a state of physical, emotional, mental and social well-being 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

World Health Organisation (2002)

Our emphasis is on sex and relationships as a social issue. As the House of Commons Health Select Committee reported in 2003, sex and sexuality need to be "normalised", and regarded as a fundamental part of what it is to be human, rather than being "smutty or dirty" (House of Commons, 2003).

Background information, national policy and evidence and examples of good practice can be found in the full report, which details, for example, programmes which support parent involvement (*Speak Easy* and *Time to Talk*) where parents are encouraged to talk to their children about sexual health.

These top tips provide common sense, practical suggestions to approaching sexual health issues that will make a positive difference at home and in the workplace to you and those around you.

Simon Henning,
Network Lead,
Cheshire and Merseyside Sexual Health Network

1. Childhood and adolescence

Childhood and adolescence is a transient and turbulent period in which physical, cognitive and emotional growth is ever changing.

Not only are children and young people maturing at a younger age but they face societal pressures to grow up too quickly.

A contributory factor is thought to be lifestyle marketing where clothes, toys, music and the media reflect and promote celebrity-like "perfection" and the sexualisation of childhood.

Sexualisation is a particular pressure on girls. Adolescents in particular increasingly link their personal worth to their ability to be sexually attractive to men.

At the same time, we see increasing numbers of boys attending mental health services who often lack appropriate role models and parental support.

Sexual and homophobic bullying are issues in schools. Children and adolescents who find themselves in care, and those with learning and physical disabilities, face particular problems relating to their sexual health needs.

'Nine year old girls are being sold lacy, padded underwear'

(Mooney, 2007)

'People call me 'gay' every day, sometimes people kick me and push me, they shut me out of games during school gym and they steal my belongings'
(Hunt and Jensen, 2007)

16 – average age of first sexual intercourse

(Wellings et al, 2001)

Top tips for effective family, carer, school and community based interventions

Listen to children and young people

- Involve young people in developing creative approaches to positive sexual health awareness-raising
- Help young people to understand how to access appropriate, child/young people - friendly health services, for advice and guidance and clinical services as required
- Ensure young people understand they have a right to confidentiality
- Encourage young people to talk to their parents, family, carers or peers
- All services for young people should ensure they are working towards meeting the *You're welcome quality criteria* and meet local safeguarding children requirements

Develop negotiating skills and build self-esteem

- Develop social skills, including self-esteem, so young people can use the information they have to form more positive relationships
- Use techniques such as role-play, to increase confidence about relationships and decision-making, e.g. developing the skills to be able to say no to sex without condoms and no to unwanted sex
- Involve young people in peer support programmes to encourage open discussions and to gain insight
- In addition to work in schools, target youth services and community-based initiatives to all age groups, to reach vulnerable or at risk groups and communities

Involve parents and carers (including foster parents and corporate parents)

- Encourage parents and carers to talk with their children about relationships, sex and sexuality. This should include issues such as friendship, trust, safety and self-esteem (as in ”Time to talk”, “Speak Easy” and “Parent Line”)
- Promote parental involvement in controlling media influences, e.g. by watching TV with their children and discussing what they read or hear
- Involve parents in information and prevention programmes, so they are able to complement what is being taught in schools when their children come home
- Promote positive role modelling for young people – avoid the “do as I say not as I do” approach

Consider the needs of looked after children

- Ensure residential and foster carers and professionals working with looked after children and those leaving care are able to communicate effectively on sexual health issues and signpost to effective services
- Put clear care and referrals pathways in place for young care leavers to promote positive approaches to sexual health
- Develop peer support programmes to encourage discussions on sexual health

Consider the needs of children and young people with physical and/or learning disabilities

- Ensure that sex and relationship education (SRE) is part of the overall curriculum for people with disabilities. Provide tailored sexual health promotion education and individualised sex education plans for people with disabilities, to meet their specific needs
- Encourage healthcare professionals and carers to initiate discussions on sexuality, dealing with issues relating specifically to the disability itself
- Consider the fact that children with developmental disabilities are more likely to experience early pubertal changes, and so have to cope with puberty earlier than their able-bodied peers
- Provide opportunities for those with disabilities to socialise with their peers. Promote typical teenage social activities such as a shopping or cinema trip, nights out or sport. This will provide opportunities for those with disabilities to develop social skills, knowledge and self-esteem

- Promote independence. Provide deliberate training to promote independence in self-care activities. Ensure young people are afforded sensitive and confidential discussions with health professionals with dignity and privacy
- Support parents and carers in recognising the potential of children and adolescents with disabilities to enjoy intimacy and sexuality in their relationships
- Improve public awareness. Encourage positive attitudes to disability and sexuality, including challenging negative stereotypes such as misconceptions that disabled individuals are either child-like and asexual, or aggressively sexual with uncontrollable urges

Provide comprehensive SRE which is age appropriate, consistent, credible and delivered at school and supplemented at home

- Provide a dedicated SRE programme within the context of broader personal social and health education (PSHE) which is age appropriate and which is delivered seamlessly in primary, secondary and further educational settings
- Ensure that SRE teachers and partners within schools and colleges are supported in delivering holistic SRE appropriate to the needs of their pupils
- Use appropriately trained teachers to deliver the curriculum. Ensure each primary and secondary school has a dedicated, trained SRE teacher, with pooling of resources between schools and updated support structures where necessary
- Use a range of external partners and agencies to support teachers as required in giving advice on sexual health promotion in schools, e.g. school nurses, Brook and youth workers
- Ensure that boys and young men have access to SRE delivered by males, using outside agencies if necessary
- Include information about how alcohol and drugs can have negative effects on:
    - negotiation skills and keeping safe messages
    - ability to practice safer sex
    - ability to repel unwanted sexual attention
    - judgement - with heightened sexual attraction to people they would not normally be attracted to
- Ensure school IT systems have full access to approved websites providing quality information on sexual health, such as *www.ruthinking.co.uk* and any locally developed resources
- Schools and colleges should provide access to onsite services or be able to signpost young people to sexual health services
- Parents should receive information about what is taught at school and college so they can continue the discussions at home

Tackle sexual bullying

- Take action to prevent homophobic and other sexual bullying behaviour, as well as responding to incidents when they occur, using government guidance. There are many steps that can be taken, including challenging the use of inappropriate language, providing training/briefing for staff and providing information and support including peer support for pupils
- Through SRE, help young people to understand human sexuality and to respect the sexual orientation of others

Combat gender stereotypes

- Encourage debates on gender issues and sexual health in schools, provide resources to enable young people to discuss issues such as sexual commoditisation and challenging the impact of pornography, of masculinity and of peer pressure/expectations
- Encourage young people to think critically, helping to guide them around the issues. Use media literacy programmes in schools, which have been shown to be effective, for example in promoting positive body image among teenagers
- Emphasise gender equity issues in teacher training, especially in the training of child carers/childminders, preschool teachers and head teachers. There should be at least one teacher specially trained in gender issues in each large school
- Encourage more male nursery teachers, by e.g. encouraging boys to take up work experience placements in pre-school settings
- Encourage gender equity awareness in pre-schools: adopt an explicitly gender-conscious approach in pre-schools and include assessments of gender equity in school inspections

Increase school and community sexual health advice and clinic services

- Increase the provision of community-based sexual health advice and clinic services, including school sexual health services, ensuring they meet *You're welcome* standards (Department of Health, 2006). Such clinics provide a closer point of contact, ensuring young people can easily access services they may not be able (or want) to access in traditional clinical settings. In addition to sexual health promotion messages, young people's integrated clinics (including school provision) can offer condom provision, pregnancy testing, choice of contraception (including emergency contraception) and chlamydia screening
- During routine human papilloma virus (HPV) immunisations offer opportunistic sexual health promotion messages and interventions such as chlamydia screening
- Young people should have easy access to condom distribution services, such as c-card schemes

Provide sexual health awareness and communication training for youth workers and teachers, etc

- Provide training in SRE for youth workers, teachers and others working with children and young people
- Include sexual health communication as an essential component in job descriptions and training programmes of all people working with young people. This would include communication on risk taking behaviours that could affect sexual health, such as alcohol and drugs

Encourage positive extracurricular activities

- Encourage involvement in after school sports, other supervised extra-curricular activities and positive activities
- Encourage youth development programmes that focus on education, employment and/or life options, including skills and self-esteem building, sports and arts activities and voluntary work

Be aware of the possible signs of child sexual exploitation

- All those who work with children or related services need to be alert to possible signs of sexual exploitation. They will require mandatory training in safeguarding, which includes information about how to identify the warning signs of, and vulnerabilities to, sexual exploitation
- Check to ensure that staff working with young people have been CRB (Criminal Records Bureau) checked and trained in safeguarding and are aware of local policies and procedures

2. All ages

'Only a third of couples who meet in their thirties or forties use a condom with a new partner, compared to two-thirds of those in their late teens'
(Mercer et al, 2008)

'One-in-four of the over fifties would welcome additional information about STDs or HIV from sources such as magazines or the GP'
(Gott 2001)

'Alcohol is thought to be a factor in 30% of sexual offences and is associated with unprotected and unwanted sex'
(ODPM, 2005)

On workplace issues for people who are gay*:*

'I feel they have the right policies in place, so in terms of being gay, I feel safer here than I have in many organisations'
(Guasp and Balfour 2008)

Sexual health is relevant at all stages of life, with many issues such as self-esteem affecting older as well as young people. It needs normalising by encouraging active and open discussion rather than it being dealt with solely as a clinical or medical issue.

We all have a potential role in achieving better sexual health for the population, ensuring information is available to everyone at home and at work.

We need to ensure good sexual health information and services are available to all those who need them. They should also be tailored to individuals' needs, including those of students, older adults, adults with disabilities and medical conditions, ethnic minorities, transient populations including refugees and asylum seekers, people who are homeless, gay and lesbian people, and sex workers.

Top tips for effective community-based interventions

Promote sexual health

- Make local sexual health service information available through a range of locations including student unions, pharmacies, workplaces, sports clubs, night clubs and other community settings for people of all ages, sexualities and ethnic backgrounds, in culturally appropriate ways
- Offer sexual health awareness and communication training to workers in community and health and social care settings, so they can become more alert to the sexual health needs of their clients and reach vulnerable individuals or groups

- Consider the special needs of refugees and asylum seekers, and promote early HIV testing and access to health services for people who originate from areas of the world with high incidence
- Ensure those who are homeless and those involved in selling sex have easy access to sexual health promotion information, free condoms and sexual health services

Use the media

- Use the wide range of media available for providing information on sexual health. Repeat and adapt media messages to suit changing cultural attitudes, considering collaboration with other local health and social care organisations to raise the profile of media messages with greater effect. Messages need to be consistent, credible and visible to the target audience

Raise awareness of the effects of alcohol and drugs

- Encourage increased awareness that excessive alcohol (and drugs) can:
    - Increase sexual desire but diminish performance
    - Heighten sexual attraction to people not normally attracted to
    - Affect judgement, leaving individuals vulnerable to physical and sexual violence as well as becoming the victim or perpetrator of a crime
    - Be symptomatic of poor self esteem and poor communication skills

Stamp out homophobia and sexual harassment

- Deal with homophobia and all forms of sexual harassment in the workplace and elsewhere. Measure the outcomes of an organisation's equality and diversity initiatives against individual experience

Tackle sexual violence

- Sexual violence is strongly associated with domestic violence and needs to be considered in the assessment of domestic violence cases
- Promote awareness of the sexual assault referral centres and how people of all ages can access them

Full Report

1. Introduction

The promotion of sexual health involves encouraging healthy patterns of behaviour. There is also a need to address underlying social issues, since risky sexual health is often closely linked with broader social inequalities, poor educational attainment and low aspirations(WHO, 2004).

Aim

In producing this guide, the aim is to present tips on effective interventions for the promotion of sexual health in the community in Merseyside and Cheshire. The focus is on positive influences for sexual health in the community and how they can be promoted, rather than the prevention of disease and unintended pregnancy. The positive definition of sexual health quoted by the WHO is used as a starting point (Box 1).

Box 1
What is sexual health?

'Sexual health is a state of physical, emotional, mental and social well-being 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'

(WHO 2002: not an official WHO definition)

Sexual health should be seen as everyone's business, because it impacts on so many areas across the public and private sectors. With this in mind, the guide is intended to provide agencies, their partners and individuals not normally associated with sexual health with a better understanding of how these issues relate to them and their work. The top tips provide common sense, practical suggestions to approaching sexual health issues that will make a positive difference at home and in the workplace.

Objectives

- Background information on the sexual health of the population is presented using a lifelong approach, from childhood through adolescence into adulthood and old age.

- Relevant national policy and targets are outlined.

- Top tips for effective interventions are detailed. Tips are not sexual health service oriented, as there has already been much written on how services can improve, for example in the National Teenage Pregnancy Strategy document *Accelerating the Strategy to 2010* (DfES, 2006b) and the Department of Health's *You're Welcome* standards (DH, 2006). Rather, the tips focus on positive influences on sexual health in the community, and how these can be promoted. The emphasis is on sex and relationships as a social issue, rather than a clinical issue. As noted by the House of Commons Health Committee, sex and sexuality need to be 'normalised', and regarded as a fundamental part of what it is to be human, rather than being 'smutty or dirty' (House of Commons Health Committee, 2003).

The promotion of sexual health is considered in various settings and amongst different population groups. A wide range of determinants of sexual health are considered, such as access to services, and the effects of alcohol.

- Evidence and examples of good practice are presented, for example, details of programmes which support parental involvement (*Speakeasy* and *Time to Talk*) where parents are encouraged to talk to their children about sexual health.

2. Background

2.1. Childhood and adolescence

Early sexualisation

In physical terms, children are now maturing at a much younger age (Box 2). This has led to an increasing gap between the age of puberty and the age at which children reach psycho-social maturity (Gluckman and Hanson, 2006; Bellis et al, 2006a). At the same time, without being socially or psychologically prepared, children are being pressured by the commercial sector to grow up too quickly. There has been much debate recently over the state of childhood and the sexualisation of youngsters through teen magazines, advertising, films and music videos (Clark, 2008; Ringrose, forthcoming; Bray, 2008). Children pick up the message that being sexy is the way to be successful and feel good about themselves (Rush and La Nauze, 2006).

Box 2
Earlier onset of puberty

- *Girls:* 1 in 6 reach puberty by the age of eight, compared with 1 in 100 a generation ago.
- *Boys*: 1 in 14 reach puberty by the age of eight, compared with 1 in 150 a generation ago.

Early puberty is thought to be due to increased body fat levels.

Dempsey (2002)

A recent Compass report on the commercialisation of childhood noted the record levels of mental health problems amongst children, with girls suffering from eating and emotional disorders (Compass, 2006). A contributory factor is thought to be marketing activity in which clothes, toys, music, magazines and TV all reflect and promote the sexualisation of childhood, especially for girls (Box 3).

Box 3
The sexualisation of childhood

The boundaries between child and adult worlds are disappearing, for example;

- nine year old girls are being sold lacy, padded underwear (Mooney, 2007; Daily Mail, 2007);
- toys like the Bratz Secret Date Collection, with “date night accessories” have been marketed to 6 year olds (Compass, 2006);
- in 2006, a leading supermarket offered a Peekaboo Pole-Dancing kit in the toys and games section of its website (Mooney, 2007).

Similarly, research early in 2008 by the Girl Guides (Girlguiding UK, 2008) has suggested that the earlier sexualisation of children is contributing to mental health problems including eating disorders, panic attacks and self-harming. Girls who took part singled out pressure to wear clothes that make them look older and sexual advances from boys. Other pressures included magazines and websites which directly target young girls with messages they should lose weight, wear make-up and even consider plastic surgery.

Sexual bullying in schools

Sexual bullying includes name-calling, inappropriate touching, and young people being forced to do something sexual against their will. A recent BBC Panorama programme investigated sexual bullying in schools. They found that one in ten children aged 11-19 said they had been forced to do something sexual that they did not want to do (n=273) (BBC, 2009). The ‘TellUs3’ survey found that around 1 in 4 schoolchildren say they have been bullied once or more in the last year. More than 1 in

4 children worry about being bullied, and 44% feel that their school deals with bullying either not very well or badly (OFSTED, 2008).

Sexual misconduct covers a range of behaviour from explicit graffiti to serious sexual assault. During 2006-07, there were 3,500 exclusions from school for sexual misconduct – the equivalent of 19 in each school day. Of these, 260 were primary school children (DCSF, 2008a; BBC, 2009).

A recent study of lesbian and gay pupils found that homophobic bullying is widespread. Two-thirds experienced homophobic bullying, and seven out of ten said this has an impact on their work. Half said that they had missed school as a result of homophobic bullying (Hunt and Jensen, 2007) (Box 4).

Box 4
Homophobic bullying in schools

'people call me 'gay' every day, sometimes people kick me and push me, they shut me out of games during school gym and they steal my belongings'

(Hunt and Jensen, 2007)

Gender stereotypes

It can be difficult for schools and pre-schools to achieve gender equality. Research from Sweden suggests that rather than combating traditional gender stereotypes, preschools can often strengthen them (Vagero, 2006). One way in which this happens is in the labour market. Across the whole teaching profession, there are 74% female to 26% male teachers. Nursery school teaching is increasingly seen as a job for females. The number of men aged under 25 working in state nurseries in the whole of England fell from 8 in 2004 to 0 in 2007 (GTC, 2008). A recent study found that more than half of parents wanted more male childcare workers. The study concluded that early years settings can provide children with much needed access to a male role model – especially important for children in single parent households (CWDC, 2009).

It would appear that gender stereotyping in the production and marketing of toys is now greater than ever (Francis, 2008). The preliminary results of Francis's study show that '*toys for boys involved action, construction and machinery, suggesting boys should be making things, using their hands and solving problems, while the toys for girls were mainly dolls and toys with feminine interests such as hairdressing, suggesting girls should be caring, nurturing and creative*'. Many toys were separated into male and female sections in toy stores, giving the impression that many toys are either just for boys or just for girls.

Looked after children and care leavers

Research has found that for some looked after children, their earliest memory is of sexual abuse and that instead of love and security, home represents danger. In one study, 87% of young people leaving care had suffered sexual or physical abuse, which had started before they were ten. Early abuse leaves these young people often immature and emotionally ill-equipped for independence (Sergeant, 2006).

For some young people, becoming a parent is a positive choice. However, teenage pregnancy is often associated with poor health and social outcomes for both the mother and child. Young mothers are more likely to suffer postnatal depression and less likely to complete their education. Children born to teenage parents are less likely to be breastfed, and more likely to live in poverty and to become teenage parents themselves (Botting et al, 1998).

These outcomes are more adverse in the case of looked after children who become parents because this group are more likely than others to be unemployed, have more mental health

problems, be expected to be independent, and to have little social or economic support. Young people in care are recognised as being one of the principal groups to experience social exclusion, and social exclusion has been identified as a "key determinant of teenage pregnancy" (DH, 2001). Two years after leaving care, 35% will be either a mother or pregnant. Female looked after children are more likely to become prostitutes – it has been noted that a successful care system would halve the number of prostitutes. The "Handle with care" report calls for long-term stable, secure and loving care for those children in care and on leaving care (Sergeant, 2006).

Children and adolescents with physical disabilities

In their review of the literature on sexuality in children and adolescents with disabilities, Murphy and Young (2005) noted that the presence of a disability can affect the development of sexual identity, confidence, desire, function and in young adulthood, the ability to find a partner. With increasing numbers of people with disabilities such as cerebral palsy living into adulthood, there is a greater need for consideration of the problems associated with transition into adulthood (Wiegerink et al, 2008).

Evidence suggests that young people with disabilities (learning and physical) or chronic conditions are a sexually active group (Cambridge and Mellan, 2000). Murphy and Young's review concluded that adolescents with disabilities seem to be participating in sexual relationships without adequate knowledge and skills to keep them healthy, safe and satisfied (Murphy and Young, 2005). The results of a study of young people aged 16-25 with spina bifida replicated those of an earlier study, finding that, although sex education had been provided to almost all individuals, fewer than 1 in 4 received information specific to people with spina bifida (Verhoef et al, 2005). This was despite the fact that many of those surveyed had faced problems with sexuality that were directly related to their disability. Incontinence and lack of self confidence were the main obstacles to sexual activity. Continent individuals were twice as likely as those who were incontinent to have a partner. Almost all of those surveyed wished to have children in the future (Verhoef et al, 2005).

In a study of adolescents with cerebral palsy, it was noted that barriers to forming relationships included lack of self-confidence, physical obstacles such as wheelchair dependence, dependence on the help of others, attitudes of others, and difficulty with body contact. Just under half reported that it was more difficult to find a partner due to their disability. Of those who had had a sexual relationship, 1 in 4 reported problems in the performance of sexual activities because of physical limitations (Wiegerink et al, 2008).

Adolescents with physical disabilities generally participate in fewer social activities and have fewer intimate relationships than their able-bodied peers Wiegerink et al, 2008, Murphy and Young, 2005). As with children and adolescents with learning disabilities (see next heading), limited social experiences mean that there are fewer opportunities for acquiring sexual knowledge that teenagers often obtain from interactions with peers rather than with parents.

Part of growing up involves a gradual separation from parents, as the individual becomes more independent. Adolescents with physical disabilities are often denied this process, having limited opportunities to experiment and take on more responsibility for themselves, remaining dependent on their parents or carer (Murphy and Young, 2005).

It has been reported that children with disabilities are more than twice as likely to be sexually abused than children without disabilities (Murphy and Young, 2005). There are various explanations for this, including dependence on others for intimate care, exposure to large numbers of caregivers and settings, inappropriate social skills and poor judgement, inability to seek help or report abuse (Murphy and Young, 2005).

Children and adolescents with learning disabilities
Sex education for children with learning disabilities has often been overlooked, with such children almost being regarded as asexual, and not in need of such education (Nursing Times, 2007). In addition to having little or no formal sex education, often there are problems with communication skills. This means that children with learning disabilities often lack the opportunities that children with no learning disabilities have of picking up sex education from peers in the playground. Many have all their personal care carried out for them, and may have never have looked in a mirror, or may not even be aware if they are a boy or a girl (Nursing Times, 2007).

Griffiths (1999) noted that *'most learners with a developmental disability receive sexuality education only after having engaged in sexual behaviour that is considered inappropriate, offensive or potentially dangerous'* (also see Box 5). According to the youth offending team in Leeds, 40% of adolescents who commit a sexual offence have a learning disability. It would appear that improved sex education for this group is badly needed (Nursing Times, 2007).

Lack of knowledge
The House of Commons Health Committee reported that there is a worrying lack of knowledge on sexual health matters amongst children and young people from mainstream education, even amongst those who are sexually active and in contact with health services. The Committee referred to a Health Development Agency survey, in which over a quarter of 14 to 15 year olds thought that the pill protected against sexually transmitted infections (STIs) (House of Commons Health Committee, 2003). They quote from another survey, in which one in ten girls aged 13-16 had not had any information about periods prior to the onset of menstruation.

Teenage sexual behaviour, pregnancy and abortions
The average age of first intercourse is 16, as reported in the second National Survey of Sexual Attitudes and Lifestyles (NATSAL 2000 – reported in Wellings et al, 2001). The survey found that the previous increase in the proportion of women reporting first intercourse before age 16 years did not appear to have continued. Only a small minority of teenagers reported unprotected first intercourse. The survey reported a sustained increase in condom use and a decline in the proportion of men and women reporting no contraceptive use at first intercourse.

Between 1998 and 2007, there was an overall decline in teenage pregnancy in England and Wales. Cheshire and Merseyside mirrored the national trend, with the exception of Halton, where there was a 12.4% increase (Figure 1 and Table 1). However, in the UK, teenage pregnancy rates are still the highest in Europe, and more recently, rates have started to rise again in some parts of England, especially amongst those under 16, where rates rose by 11% between 2004 and 2007. There was a 6% rise in the under 18 pregnancy rate in the North West, and very high increases in some areas. In Cheshire and Merseyside, rates rose in all local authority areas between 2004 to 2007, with the exception of Warrington (Table 1 and Figure 1) (ONS, 2009).

Teenage pregnancy should not be regarded as a problem in its own right (Arai, 2009) – it is unwanted pregnancy that should be the focus of concern. It is important to ensure teenagers have the information and opportunities that allow each individual to make the best choice for them relating to sexual health.

The percentage of teenage pregnancies leading to abortion in England and Wales has increased from 43% in 1998/00 to 48% in 2005/07. The local authorities in Cheshire and Merseyside followed the national trend, with the exception of Halton, where percentages in 2004-07 were lower than 1998-2003 (Table 1). In St.Helens, although proportions of teenage pregnancies leading to abortion increased, there were still comparatively few (39%, compared to 57% in Sefton).

Sexually Transmitted Infections amongst teenagers

About 1 in 12 people under 25 who are tested are found to have chlamydia. Amongst the under 16s, the number of diagnoses of all sexually transmitted infections (STIs) in England rose by 58% between 2003 to 2007, from 2,474 to 3,913 cases (HPA, 2008a; Rose, 2009). The increase has been partly explained by the increase in those being screened, due to a national screening campaign.

Alcohol and drugs

Alcohol alters a person's ability to think clearly, causing impaired decision-making, mood elevation and the reduction of inhibitions (Bennett and Bauman, 2000). For instance, after drinking alcohol, one in seven 16-to-24-year-olds had unprotected sex, while one in 10 has been unable to remember if they had sex the night before (Gerard, 2007; Rondini). This finding is mirrored in the older age group studied by the sexual health charity fpa, who found that 15% of those aged 18-30 had not used a condom with a new partner and said they thought alcohol was a factor in the decision (fpa, 2009). Of those aged 14-17, one in 6 regretted having sex after drinking (TSNW, 2009) The ODPM reported that alcohol is a factor in 30% of sexual offences (ODPM, 2005). Similarly, the association between drug misuse and risky sexual behaviour has been well documented (Bennett and Bauman, 2000; Parkes et al, 2007). Focusing preventative strategies on the young is likely to yield the most benefit since there is the potential to establish healthy patterns of behaviour (Thurston & Alexander, 2006).

Figure 1 (see following table for data)

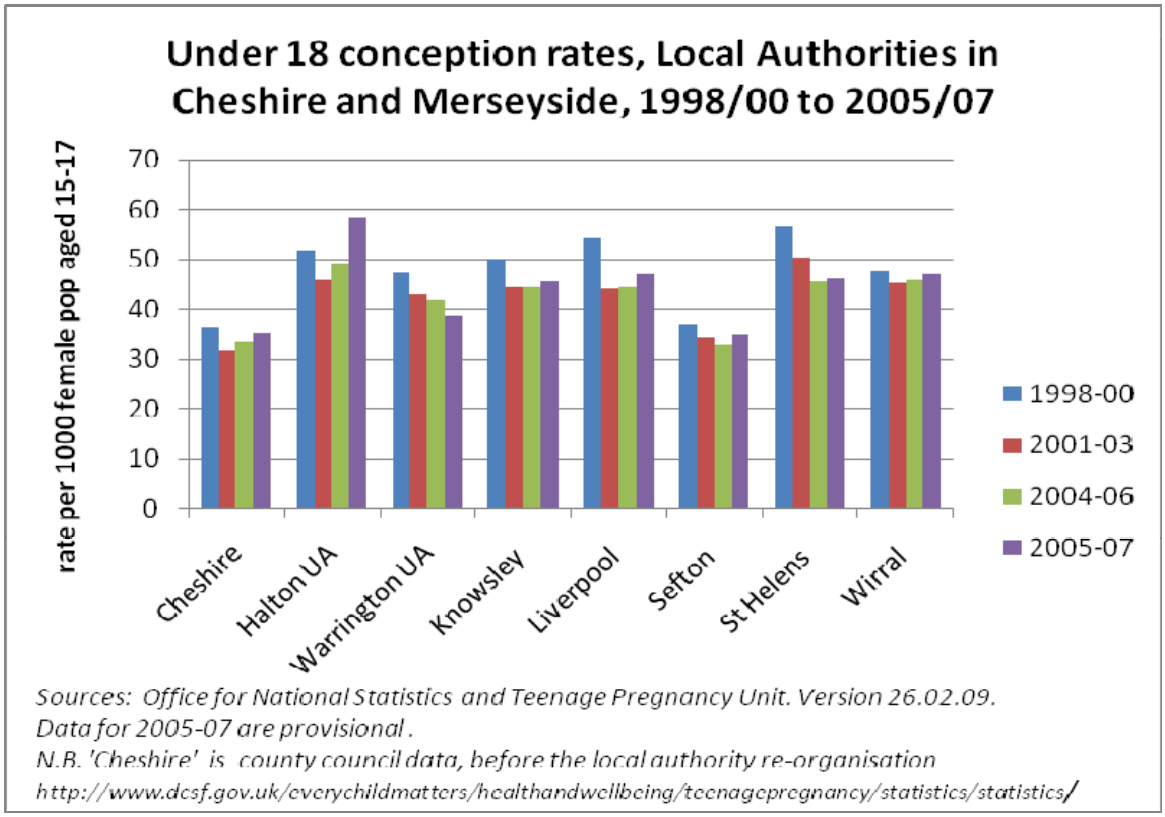


Table 1
Under 18 conception rates, with % leading to abortion.
Local Authorities in Cheshire and Merseyside, 1998/00 to 2005/07

	1998-00		2001-03		2004-06		2005-07		% change in rate
Area of usual residence	**Rate**	% leading to abortion	**Rate**	% leading to abortion	**Rate**	% leading to abortion	**Rate**	% leading to abortion	98/00 - 05/07
England and Wales	**45.4**	**43**	**42.7**	**46**	**41.4**	**47**	**41.4**	**48**	**-8.8%**
NORTH WEST	**48.9**	40	**45.2**	**42**	**45.5**	**44**	**45.9**	**46**	**-6.1%**
Cheshire	36.2	47	31.7	49	33.4	48	35.4	50	-2.3%
Halton UA	51.8	45	46.0	47	49.3	42	58.2	44	12.4%
Warrington UA	47.3	47	42.9	48	41.7	49	38.7	51	-18.1%
Knowsley	50.1	42	44.5	46	44.7	49	45.6	50	-9.0%
Liverpool	54.3	43	44.3	45	44.5	52	46.9	54	-13.7%
Sefton	36.8	47	34.4	51	32.8	55	35.0	57	-4.8%
St Helens	56.6	33	50.4	34	45.8	37	46.3	39	-18.2%
Wirral	47.5	47	45.5	47	45.9	49	46.9	50	-1.3%

Sources: Office for National Statistics and Teenage Pregnancy Unit. Version 26.02.09.
Data for 2005-07 are provisional
http://www.dcsf.gov.uk/everychildmatters/healthandwellbeing/teenagepregnancy/statistics/statistics
N.B. 'Cheshire' = county council data, before the local authority re-organisation

2.2. All ages

Since the early 1970s, rates of marriage have declined, with an increasing number of adults now either cohabiting or living alone (Table 2). Between 1976 and 2004, the proportion of women aged 18-49 cohabiting trebled. By 2005, there were almost twice as many men and women living alone compared with 1971. This increase was mainly due to increases in the numbers of people of working age living alone (Smallwood and Wilson, 2007).

Table 2:
Trends in marriage, cohabitation and living alone

(a) First marriage
rates per 1,000, ages 16+

	1971	2004
Male	82	26
Female	97	31

(b) Cohabitation
% females age 18-49

1976	2004
9	28

(c) Living alone
% of households that were one-person

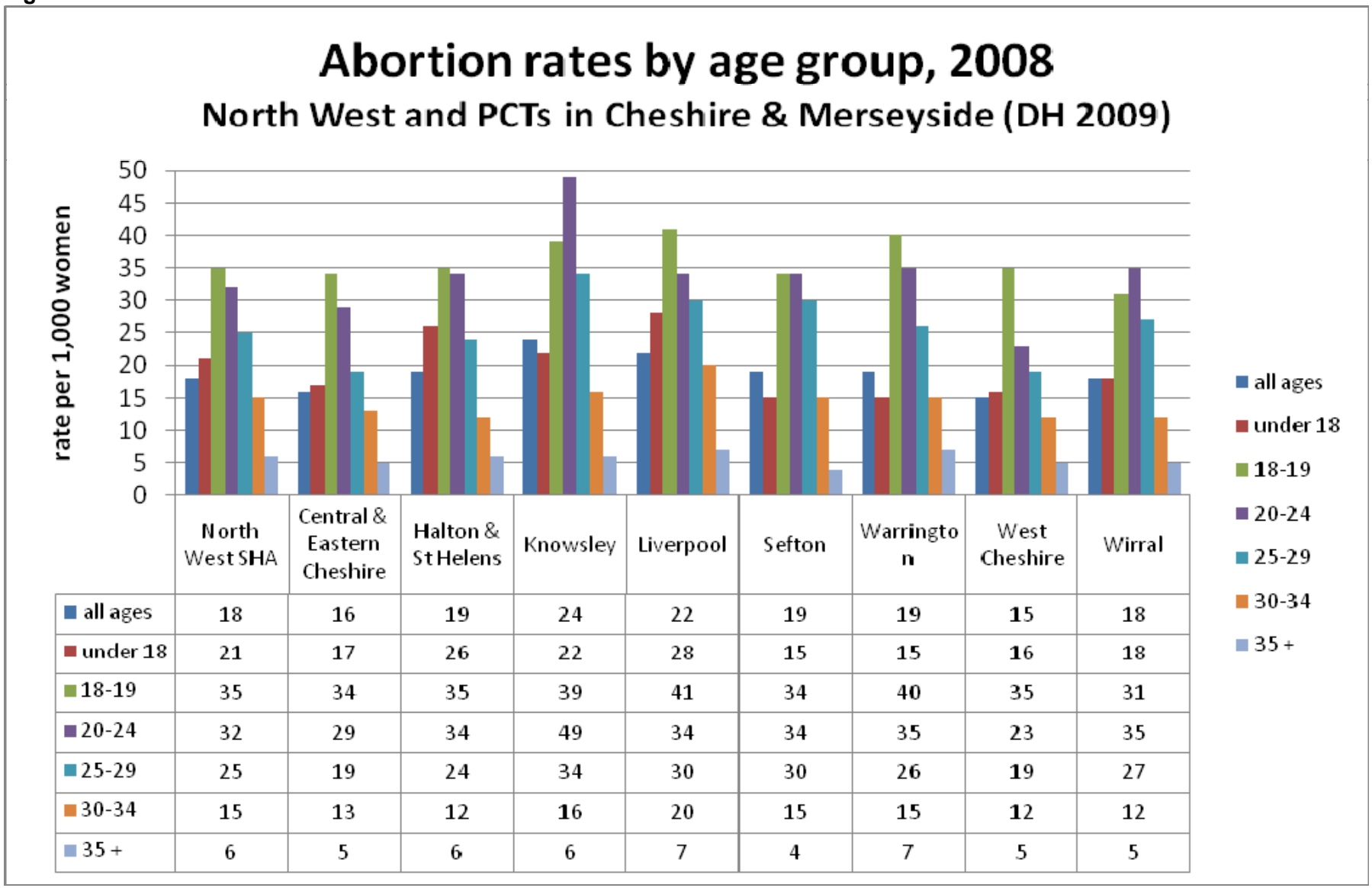
1971	2005
17	31

Source: National Statistics, (Smallwood and Wilson, 2007)

Abortions and unintended pregnancies.
The annual cost of unintended pregnancies in the North West is estimated to be £63 million (£19m in Cheshire and Merseyside) (Henning, 2009). Abortion rates are a proxy measure of unintended pregnancy. However, access to abortions may vary according to various factors, including age, geography or social status, so in some cases, abortion rates may underestimate the amount of unintended pregnancy.

Nearly a quarter of all pregnancies in England and Wales end in abortion (DH, 2004a). The abortion rate has continued to rise in recent years, although between 2007 and 2008, it fell slightly from 18.6 to 18.2 per 1,000. In 1997, it was 16.3. Around half of all abortions occur amongst those aged 25+ (49.7%) (DH, 2009a). In England & Wales and in the North West, the highest rate occurs in the 18-19 age group. The same is true in the Cheshire and Merseyside PCTs, where rates are often around twice as high as the rate for all ages, with the exception of Wirral and Knowsley, where those aged 20-24 have higher rates (Figure 2). Asian, Chinese, and people from 'other' ethnic groups are more likely to have abortions at the age of 35 or over than they are when they are aged under 20 (Ashton et al, 2005).

Figure 2



	North West SHA	Central & Eastern Cheshire	Halton & St Helens	Knowsley	Liverpool	Sefton	Warrington	West Cheshire	Wirral
all ages	18	16	19	24	22	19	19	15	18
under 18	21	17	26	22	28	15	15	16	18
18-19	35	34	35	39	41	34	40	35	31
20-24	32	29	34	49	34	34	35	23	35
25-29	25	19	24	34	30	30	26	19	27
30-34	15	13	12	16	20	15	15	12	12
35 +	6	5	6	6	7	4	7	5	5

STIs

The five most common sexually transmitted infections (STIs) are syphilis, gonorrhoea, chlamydia, herpes and warts. The annual direct costs of treating STIs in the UK, excluding long term effects, are considered to be in excess of £700 million (NICE, 2006). Direct medical costs to the North West were almost £60 million (Ashton and Lamont, 2005). Social costs can also be high, with affected individuals and their partners often experiencing emotional distress, stigma and discrimination (MedFASH, 2005).

Compared to other regions across the country, the North West as a whole shows higher rates of new diagnoses of chlamydia and syphilis. STIs and HIV infections are increasing in Cheshire and Merseyside, and in some areas the rise is dramatic, especially with syphilis (Thurston & Alexander, 2006). However, the dramatic rise is to some extent the reflection of an increase in detection as a result of the extremely successful chlamydia (and gonorrhoea) screening programmes that have been introduced (Ryrie, 2007). The National chlamydia Screening Programme aims to particularly support equitable access to screening for men.

HIV

STI and HIV statistics would suggest that sexual risk-taking behaviour is increasing across the population. More people in the North West than ever before are living with HIV or AIDS. The North West has the highest number of newly diagnosed cases outside London (UK Collaborative Group for HIV & STI Surveillance, 2006). In Cheshire and Merseyside, HIV infections via heterosexual sex are increasing (Thurston and Alexander, 2006). In the North West in 2007, heterosexual sex (49%) had overtaken sex between men (42%) as the most common route of new cases of infection of HIV (Hargreaves et al, 2008). Liverpool was the local authority with the greatest proportion of HIV infections acquired through heterosexual sex in the North West (66%). The number of men and women becoming HIV positive as a result of having heterosexual sex in the UK has nearly doubled in four years (HPA, 2008b).

Ethnicity

In London, the biggest rise in HIV in recent years has been through heterosexual intercourse. Nearly all these infections have been among Black Africans, three quarters of which were acquired in Africa (LPHO, 2008). Further analysis of Merseyside data is required to determine the patterns of infection according to ethnicity, so that resources can be targeted appropriately.

In all but one of the eight PCTs involved in the 2005 North West study, black people had significantly higher rates of STI diagnosis than white people. The differences were most marked in Central Liverpool, where the rate was 5 times higher (2,799 per 100,000 for black people, compared to 546 per 100,000 for white people).

Condom use

A recent study found that couples who meet in their 30s or 40s are less likely to use condoms than their younger counterparts. Amongst those in their late teens, two-thirds use a condom when first having sex with a new partner. For men and women aged 35-44, only one-third did so (Mercer et al, 2008).

Mental Illness

There is a strong correlation between a wide range of psychiatric disorders and risky sexual behaviour, for example with many studies demonstrating the association between mental health and the risk of HIV infection (Ramrakha et al, 2000; Bennett and Bauman, 2000). As with alcohol and drugs (see below), psychiatric impairment can interfere with the ability to

assess risk. Bennett and Bauman note that risky sex may represent an indirect expression of anger, and for seriously disturbed young people, sexual activity might be used to relieve tension or to seek affection.

Homophobia in the workplace
A recent Stonewall survey reported that many lesbian, gay and bisexual staff can find it difficult to fully be themselves in the workplace (Guasp and Balfour, 2008). They worry about what other staff will think, and about their job security. Bullying and harassment in the workplace can have many negative effects on the individual and on the organisation.

Individual impacts include:
- low self-confidence,
- de-motivation,
- stress,
- anxiety and depression,
- ill-health.

Impacts on the organisation include
- low staff morale,
- increased absenteeism,
- reduced productivity,
- recruitment and retention problems,
- costly legal action,
- damaged image and reputation,
- loss of client or customer confidence

(Stonewall, 2009)

Homelessness
Issues related to sexuality and sexual identity can play a key role in the onset of homelessness (CRISIS, 2005). CRISIS report that for gay, lesbian, bisexual or transgender (GLBT) youth, the loss of home as a runaway or as a result of being thrown out of their home is an all too common experience. It has been estimated that in urban centres, as many as 30% of the homeless population are gay or lesbian.

Sex workers
Street-based sex workers tend to experience very low standards of general and sexual health. They experience discrimination because of their work and the continuing criminalisation of prostitution. The stigma felt by many of those working as prostitutes means they do not come forward for a range of services, including general health care, dentistry and social services. Proposed new laws are likely to create further barriers (Ryan, 2005; RCN, 2007/08).

There has been pressure from various sources, including sex workers, researchers, service providers, and organisations including the British Medical Journal, to ensure that the recent Home Office strategy on prostitution, including tougher action on men who buy sex, does not become law (Home Office, 2006; Goodyear and Cusick, 2007). The strategy is based on the Swedish model that criminalises men who pay for sex, which includes using possession of condoms as evidence of sex work. This is likely to result in girls being pushed out into even more unsafe areas such as industrial estates. Outreach work, provision of condoms, needle exchange schemes, and primary care for a population rarely registered with a general practitioner could be compromised if the strategy becomes law, making it be harder for

health and social care support agencies to reach their clients. It will also result in prostitutes being less likely to use condoms, and less likely to seek help, due to fear about the safety and confidentiality of support services. At present, sex workers are unclear about whether the strategy has become law, but support agencies have already noted increased fear in sex workers about coming forward for help (Boynton and Cusick, 2006; Greenwell 2008).

Sexual dysfunction

There are many medical conditions, such as chronic kidney disease, that can strongly affect sexual function. There are several medicines associated with sexual dysfunction, including ant-depressants, anti-histamines, anti-hypertensives and anti-psychotics, as well as several over-the counter drugs (e.g. for heartburn) (Rheaume, 2008). The resulting sexual disability has been strongly linked to depression and anxiety, with serious impacts on quality of life (Lew-Starowicz and Gellert, 2008). Erectile dysfunction is only a small part of the sexual dysfunction agenda.

There are inequalities in access to the recently introduced drugs combating sexual dysfunction. It is estimated that only 10% of the estimated 2.3 million men suffering from erectile dysfunction in the UK receive treatment for it (House of Commons Health Committee, 2003). Men who have related physical conditions (e.g. prostate cancer) can obtain the anti-impotence drug sildenafil ('Viagra') free of charge. Otherwise, the cost is around £75 for six tablets for patients obtaining a private GP prescription. Only those who can afford it are likely to use it. There is a thriving black market for the drug. The existence of sexual dysfunction leads to costs in treating related depression, infertility and dealing with the consequences of marital breakdown. Sexual dysfunction therapy is time consuming and expensive (House of Commons Health Committee, 2003).To date, there has been no cost-benefit analysis carried out on the anti-impotence drug.

Older adults

There are myths and assumptions in society and amongst health care providers about the lack of sexual activity amongst older people, especially the over 45 age group (Bodley-Tickell et al, 2008). These myths need to be addressed. Sexual health research usually focuses on young people. There are relatively few studies on the sexual behaviour of older people – in fact recent national surveys do not include those aged 45 and older (Bodley-Tickell et al, 2008). This is despite the fact that the majority of older people are likely to be currently involved in one or more sexual relationship (82% of people over 50 in Gott, 2001). Bodley Tickell et al (2008) similarly report evidence that significant numbers of older people are continuing to be sexually active. They point out that as cohorts of people with more liberal sexual attitudes grow older, and with the ageing population, there will continue to be an increase in demand for sexual health services amongst older people

There have been various changes in social and behavioural patterns over the years that suggest the need for an emphasis on the sexual health needs of older people, especially those aged 45+. Societal and behavioural changes putting older people at risk include:

- the increasing likelihood of older people being single, or in relationship change;
- more international travel, with more likelihood of unprotected sex;
- increased use of the internet to identify casual sexual relationships;
- the introduction of drugs to counter erectile dysfunction

(Bodley-Tickell et al, 2008; Mercer et al, 2008).

Older people can be at increased risk of sexual ill-health because:

- they are less likely to use condoms;

- older patients and their GPs are both likely to be reluctant to initiate discussions about sexual health issues and risk factors for STIs;
- they are less likely to attend sexual health clinics, possibly out of embarrassment/ fear of stigma;
- when they do attend GUM clinics, there is a longer delay period between symptom recognition and clinic attendance than with younger people

(Gott et al, 1999; Gott, 2001; Bodley-Tickell et al, 2008; Mercer et al, 2008).

In the the UK, Health Protection Agency (HPA) data shows that over the last ten years, new episodes of STIs have increased, and that an increasing proportion of these are aged 35+ (HPA, 2007). In Gott's Sheffield study (2001) of people aged 50 plus, of the 1 in 4 individuals with sexual health concerns, 40% did not contact health care professionals.

Sexuality in care settings

The right to expression exists throughout the lifespan. Intimacy, if not sexuality, is a continuing human need for most people (Rheaume, 2008). However, as Rheaume points out, in most long-term care settings, attempts at sexual expression by residents are usually viewed by staff as 'problem' behaviour. Barriers to sexuality and intimacy include lack of privacy in communal living environments. Residents may feel inhibited by staff members or other residents who might overhear personal conversations, or observe intimate behaviour (Rheaume, 2008).

3. National targets and commitments

Every Child Matters
Every Child Matters (ECM) was published in 2003 as a green paper, and followed by the Children Act in 2004. It is a new approach to improving the wellbeing of children from birth to age 19. There are five ECM outcomes, which children and young people have cited as key to wellbeing in childhood and later life – these are; being healthy, staying safe, enjoying and achieving, making a positive contribution to society, and achieving economic wellbeing. The five outcomes provide a framework in which to assess children's overall potential for development.
Previously, many teachers, doctors, social workers and other professionals worked in isolation and sometimes secrecy, unwilling or unable because of red tape to share information and resources that might help children at risk. All the children's agencies were very compartmentalised, with for example schools feeling that they had to focus almost exclusively on the education side of children's development. Now, under ECM, all agencies are required to cooperate and react to individual situations according to the needs of children and their families. (DCSF; Jewell, 2006; Lepkowska, 2006).

National Healthy School Standard
The National Healthy School Standard is part of the Healthy Schools programme, led by the Department for Education and Science and the Department of Health (DfEE, 1999). Launched in 1999, it provides a model of partnership working between the health service and schools, with the aim of promoting a coherent and holistic message about the importance of a healthy lifestyle. The standard covers four key themes: Personal Social and Health Education (PSHE); healthy eating; physical activity; emotional health and well being (including bullying). The government wants every school to be working towards achieving national Healthy School status by 2009.

By November 2008, after almost 10 years of the scheme, progress in Merseyside and Cheshire was as follows: In Sefton and Liverpool, 73% of schools had achieved National Healthy Schools Status; in Wirral, 100 schools were reported to have achieved National Healthy Schools Status (for Cheshire East, Cheshire West and Chester, Halton, Knowsley and St.Helens, and Warrington, data was not available) (Healthy Schools, 2008).

Sex and Relationship Education Guidance
Sex and Relationship Education Guidance offers support for schools on how to deliver effective sex and relationship education (SRE). The guide states that SRE should be firmly rooted within PSHE and citizenship. All schools should have an up-to-date SRE policy developed in consultation with parents and the wider community. The guide explains how to approach issues such as sexuality and sexual orientation with honesty and sensitivity and how to deal with pupils' questions and offer support. Schools are required to tackle sexual bullying, including homophobic bullying (DfEE, 2000; DCSF, 2008b).

The DCSF has recently issued specific guidance on homophobic bullying in schools, and how this should be tackled through SRE (DCSF, 2007). It has asked the Anti-Bullying Alliance to develop guidelines on how teachers can deal with sexual bullying (Shepherd, 2009), and plans to release anti-bullying guidance related to gender and transgender during 2009 (DCSF, 2008c).

A recent review of SRE in 2008 recommended that PSHE, including SRE, should be made a compulsory part of the curriculum for all primary and secondary school age children (ages 5-

16) (DCSF, 2008b) – also a recommendation in the recent review of the National Sexual Health Strategy (MedFASH, 2008). It was suggested that specialist teachers be brought in to deliver PSHE lessons. The government has agreed to these recommendations, which will come into force in 2010 (Frean, 2008). This decision was welcomed by the sexual health charity fpa, who point out that SRE helps young people delay the time they first have sex and promotes responsible and healthy choices when they do become sexually active (fpa, 2008). They also point out that statutory SRE will form the missing foundation stone for the Teenage Pregnancy and Sexual Health Strategies.

National Teenage Pregnancy Strategy

The Social Exclusion Unit's report on teenage pregnancy (Social Exclusion Unit, 1999) forms the National Teenage Pregnancy Strategy, stating that teenage pregnancy is often both a major cause and consequence of social exclusion. The strategy has the following targets:

- to reduce the under-18 conception rate by 50% by 2010 (a joint Department of Health and Department for Education and Skills Public Service Agreement).
- to increase the participation of teenage parents in education, training or work.

In 2006, the DfES published *'Teenage Pregnancy: Next Steps'* (DfES, 2006a) and '*Teenage Pregnancy: Accelerating the Strategy to 2010* (DfES, 2006b), which set out plans to accelerate progress towards a target to halve the under-18 conception rate by 2010.

Teenage parents next steps: Guidance for Local Authorities and Primary Care Trusts

To complement guidance sent in 2006 to local areas on accelerating reductions in under-18 conceptions, the Department for Children, Schools and Families has launched a refreshed strategy designed to improve outcomes for teenage parents and their children (DH and DfSF, 2007). The strategy provides guidance for local authorities and primary care trusts on the integrated services that the government wants each local area to provide. It also gives details about the support that will be provided nationally to assist local delivery.

National Chlamydia Screening Programme

The National Chlamydia Screening Programme (NCSP) was established in 2003. It is a control and prevention programme targeted at the highest risk group for chlamydia infection in England, young people under 25 who are sexually active. The NCSP aims to ensure that all sexually active men and women under 25 years of age are aware of chlamydia, its effects, and have access to services providing screening, prevention and treatment to reduce their risk of infection or onward transmission. Using opportunistic screening in both health and non-health venues, the NCSP extends opportunities for young people to be tested in locations they frequently visit. As described on the NCSP website, the programme was rolled out in three phases. Phase one was launched in 2003 with 10 programme areas. In 2004, 26 new programme areas came on board and in 2007/08 the national rollout of the NCSP was completed. Today 86 programme areas are in operation covering all 152 Primary Care Trusts, with a total of 11,377 screening venue sites registered (NCSP, 2009).

The National Strategy for sexual health and HIV

The National Strategy (DH, 2001) argues that health education and health promotion are the foundation for improving sexual health. The aims of the strategy include:

- a reduction in the transmission of HIV and sexually transmitted infections (STIs): a 25% reduction in the number of newly acquired HIV and gonorrhoea infections by 2007,
- a reduction in the prevalence of undiagnosed HIV and STIs: GUM clinics to offer HIV testing to all attendees on first screening for STIs and to offer hepatitis B

vaccine to those from high-risk groups, including sex workers, injecting drug misusers and gay men,
- a reduction in the rates of unintended pregnancy,
- a reduction in the stigma associated with HIV and STIs.

In July 2008, a review of the National Strategy was published by the Medical Foundation for AIDS and Sexual Health (MedFASH). It recognised the progress made in the development of more modern, integrated sexual health services, as well as the widening of primary care and community sexual health provision. However, the review noted that the scale of sexual ill-health is still a cause for concern, with increasing diagnoses of HIV and STIs and increasing demand for abortion. Recommendations were made for priority action in five key areas, including investing more in prevention (MedFASH, 2008).

Sexual exploitation
Preventing sexual exploitation and helping young people to learn about safe, healthy relationships is central to the National Teenage Pregnancy Strategy and the National Strategy for Sexual Health and HIV. It is also a core part of the National Healthy Schools Programme, which aims to equip young people with the skills and attitudes to make informed decisions about their health (DCSF, 2009).

Commitments in the *Public Service Agreement* (PSA) (HM Treasury, 2004) and in *National Standards, Local Action* (DH, 2004b) reinforce some of the above targets, including:

- a reduction in the under-18 conception rate by 50% by 2010 as part of a broader strategy to improve sexual health,
- expanded service access,
- a decrease in the rates of new diagnoses of gonorrhoea,
- an increase in the percentage of people aged 15-24 accepting chlamydia screening by 2007.

Commitments in *Choosing Health* (DH, 2004c) include:
- investment to support service modernisation,
- accelerated implementation of the National Chlamydia Screening Programme (NCSP). Women who attend contraception services will be the main focus. The introduction and evaluation of chlamydia screening in retail pharmacies will start in London.

Housing
'Supporting People' is an initiative administered through the Office of the Deputy Prime Minister (ODPM), to provide housing-related support services to vulnerable people (including those with HIV) to enable them to live independently in accommodation that is decent, appropriate and affordable (ODPM, 2004).

Homophobia
Employers are legally obliged to protect their employees from bullying and harassment. All staff have been further protected since 2003 from discrimination on the grounds of sexual orientation (Stonewall, 2009).

Prostitution strategy
A co-ordinated prostitution strategy (Home Office, 2006) takes a zero tolerance approach to street prostitution focusing on five key areas: prevention, tackling demand, developing routes out of prostitution, ensuring justice and tackling off-street prostitution. Proposals in the strategy include the introduction of new Intervention Orders to be attached to anti-social behaviour orders (ASBOs) and revision of the law on street offences to 'provide a penalty specifically tailored to the needs of men and women in prostitution' The strategy does not support the creation of managed areas.

There are concerns that the adoption of this strategy will create further barriers to street sex workers accessing health care (Ryan, 2005; RCN, 2007/08).

Consultation on violence against women and girls:
In March 2009, the Home Secretary launched the largest ever cross-government public consultation on violence against women and girls. The '*Together We Can End Violence against Women and Girls'* strategy will set out government action to stop violence against women and girls, and what more can be done to challenge attitudes that may condone it (Home Office, 2009).

4. Top tips for sexual health promotion

4.1. Childhood and adolescence

Childhood and adolescence is a transient and turbulent period, with physical, cognitive and emotional growth ever changing. Children and young people are maturing at a younger age but they also face societal pressures to grow up quickly too. There is also growing concern regarding the youth of today, particularly with regard to their behaviour and health risks. Much of what we see reported in the media is linked to risk taking and sexual activity.

There are numerous individuals and agencies outside of sexual health services that can become involved in promoting the sexual health of children and adolescents. These include parents and carers, staff in education and children's social care, youth and community work, Connexions, health service, leisure services (including sport and leisure centres), community police, youth offending teams, social housing, voluntary organisations and the private sector (such as cinemas, shopping centres, pubs, cafes, restaurants and internet providers) (DCSF, 2009).

Top tips for effective family, carer, school and community based interventions

Listen to children and young people

- Involve young people in developing creative approaches to positive sexual health awareness-raising
- Help young people to understand how to access appropriate, child/young people friendly health services, for advice and guidance and clinical services as required
- Ensure young people understand they have a right to confidentiality
- Encourage young people to talk to their parents, family, carer, or peers
- All services for young people should ensure they are working towards meeting the "You're Welcome" quality criteria (Department of Health, 2006) and meet local Safeguarding children requirements

Involving young people in decision-making can develop credible, creative approaches to awareness raising and service provision, for example in teenage pregnancy work as set out in the guidelines by the Teenage Pregnancy Unit and the National Children's Bureau (Lewis, 2006; Teenage Pregnancy Unit, 2001).

There is a need for research into the experiences and concerns of children and young people on issues such as their sexualisation in the media (NSW CCYP, 2008).

The media should seek the opinions of children and young people on the development and production of material. They should enforce existing standards and regularly review them in light of consultations with children and young people, among others (NSW CCYP, 2008). The recent 'Good Childhood Inquiry', which consulted with around 20,000 children,

recommended that advertisers should stop encouraging premature sexualisation, in addition to heavy drinking and overeating (The Children's Society, 2008)

Develop negotiating skills and build self-esteem

- Develop social skills, including self-esteem, so that young people can use the information they have to form more positive relationships
- Use techniques such as role-play, to increase confidence about relationships and decision-making e.g. developing the skills to be able to say 'no' to sex without condoms and to unwanted sex
- Involve young people in peer support programmes to encourage open discussions and to gain insight
- In addition to work in schools, target youth services and community based initiatives to all age groups, to reach vulnerable or at risk groups and communities

Information campaigns are important, but they will not on their own bring about sustained behaviour change. In addition to receiving information, there is a need to build skills around sexual health, giving greater emphasis to handling relationships and developing social skills so that the individual can act on the information he/she has, using techniques such as role-play, to increase confidence in young people about relationships and decision-making e.g. with adolescents, developing the skills to be able to say 'no' to sex without condoms (HDA, 2004). This was also one of the recommendations of the House of Commons Health Committee report on Sexual Health, which noted that a significant proportion of young people regret their first sexual experience, and that many who have not had sex believe they are in the minority (House of Commons Health Committee, 2003). A Merseyside film company is planning to involve young people in looking at sexuality and gender issues through drama and role play (see examples of good practice).

In addition to work in schools, targeted community based initiatives are required for all age groups, to reach marginalised groups and communities. It was noted that this aspect of developing skills around sexual health was conspicuously absent from the government's sexual health strategy (House of Commons Health Committee, 2003). There has been some youth development work carried out more recently (see 'positive extra-curricular activities' below).

Peer support: Children and adolescents can be encouraged to become activists who critically examine the sexualising images in the media (APA, 2007). This can be achieved through the use of homemade internet magazines ('zines'), web blogs, and reading magazines or books that promote positive images of females, such as 'Adios Barbie (APA, 2007). Some youths have formed protest groups, e.g. in the USA, where a group of 13-16 year old girls successfully campaigned against a line of t-shirts printed with slogans such as 'who needs a brain when you have these'. They attracted national news attention, and the t-shirts were withdrawn from stores (APA, 2007).

Internet safety: Children need to be informed about the dangers of the internet, and how to protect themselves. This is the aim of a campaign called 'Think U Know', started by the Child Protection and Exploitation Agency in 2007, 'to help fight internet predators and child abusers' (Mooney, 2007).

Involve parents and carers (including foster parents and corporate parents)

- Encourage parents and carers to talk with their children about relationships, sex and sexuality. This should include issues such as friendship, trust, safety and self esteem
- Promote parental involvement in controlling media influences by e.g. watching TV with their children and discussing what they read or hear
- Involve parents in information and prevention programmes, so that they are able to complement what is being taught in schools when their children come home
- Promote positive role modelling for young people – avoid the 'do as I Say not as I do' approach

Talking with children about sex and sexuality: Young people whose parents discuss sexual matters with them are more likely to delay intercourse, use contraception and have fewer partners (HDA, 2004; Walker, 2004; Schuster et al, 2008). In 1991, a Welsh pilot project aimed to enhance parent's sex education skills, and led to the development of a resource pack (Blakey and Frankland, 1996). One of the problems with such programmes was that few parents were willing or able to attend. In an attempt to improve access for parents, an approach in the USA involved a series of sessions in thirteen workplaces. The programme included a follow-up period, and resulted in a relatively long-term increase in parent-child communication (Schuster et al, 2008). Commenting on this study, Kirby (2008) recommended that workplaces should be encouraged to offer programmes to improve the ability of parents to talk to their children about sex, and that school sex education should include homework assignments that increase parent-child communication.

Recently, initiatives such as the Speakeasy project have been successful in giving parents the confidence to talk about sexuality with their children (see Box 5 and Section 5.1). Similar initiatives include the web-based support groups '*Time to Talk'* and '*Parentline plus'*. As noted by the government health committee on sexual health, there will be some children who will prefer not to discuss such matters with their parents, and their right to privacy should be respected (House of Commons Health Committee, 2003).

Parental activism and campaigning Parents can be effective in confronting those responsible for sexualised images of girls, putting pressure on corporate sources. For example, the APA (2007) describe a parental letter-writing campaign that led to the cancellation of a planned production line of dolls based on the Pussycat Dolls, a music group known for its 'sexualised lyrics and dance routines' (APA, 2007).

Promoting parental involvement in controlling media influences: Parental involvement can help in other ways to counteract media influences. Parents and families are gatekeepers of children's access to much of the media (NSW CCYP, 2008).The APA highlight the beneficial effects of children watching TV with their parents, and discussing what they read or hear in the media: '*parental mediation and co-viewing' can play an important part in combating the potential negative effects of the media'* (APA, 2007). For example in one case control study, children watching TV clips portraying stereotypical gender roles were more likely to question gender stereotypes if they had been accompanied by questioning comments from an adult present at the viewing (Nathanson et al, 2002).

Box 5
Examples of evidence for the effectiveness of interventions that promote sexual health in children and adolescents

School-based sexual health advice has been found to provide a closer point of contact; ensuring that young people can easily access services they may not be able (or want) to access in traditional clinical settings (DfES, 2007).

Sex and relationship education (SRE): There is good evidence that school-based SRE, particularly when linked to contraceptive services, can have an impact on young people's knowledge and attitudes, delay sexual activity and/or reduce pregnancy rates (DfEE, 2000).

Targeted SRE work with looked after children – using interactive resources including drama episodes, website information and a practitioner pack in 9 residential children's homes in London to stimulate discussion of SRE issues was found to work well - in particular, in getting young men to think and talk about teenage pregnancy (DfES, 2006).

Tackling homophobic bullying: Action by schools can be effective in reducing homophobic bullying. The Stonewall study of schools found that, in schools that have said that homophobic bullying is wrong, gay young people are 60% less likely to have been bullied (Hunt and Jensen, 2007).

Sex education for children with learning disabilities: In Leeds, a 14 year old boy with learning disabilities had two anti-social behaviour orders for exposing himself to young children. *He had never received any sex education*. The children's learning disability nursing team then delivered their sex education workshop series to the boy's class. He learned the appropriateness of private and public places, along with the consequences of his actions, and the number of incidents reduced (Nursing Times, 2007).

Challenge media images: A US case control study found a college media literacy programme, encouraging young women to think more critically about media messages, was effective in helping women to question the thin ideal of beauty (Irving and Berel, 2001). Examples of similar studies are described in a paper by the American Psychological Association (APA, 2007).

Encourage participation in sport: Sports participation was found to be inversely related to engaging in risky sexual behaviour amongst high school adolescents, in a US multi-method study. The link was partly explained by the increased self-empowerment and improved body orientation associated with sport. Girls' sports involvement was significantly and positively related to sexual/reproductive health-seeking behaviour, even after controlling for socio-economic status and ethnicity (Lehman and Koerner, 2004).

Encourage parents to talk with their children about sex: The Speakeasy project aims to support and encourage parents to communicate with their children about sex, sexual health and relationships. An independent longitudinal evaluation of the course found that parents who completed the training showed a 47% increase in confidence in talking with children, and a 46% increase in overall knowledge of topics such as puberty, contraception, sexually transmitted infections and keeping safe. The positive impacts of the course were maintained over time (Coleman et al, 2007) (see Section 5 for more details).

Youth work programmes reduced by 39% the number of young women reporting a teenage pregnancy, as suggested by a systematic review of high-quality intervention studies aimed at tackling the social exclusion associated with unintended teenage pregnancy (Harden et al, 2006).

Parents, as well as youth workers, can encourage their children to engage in sport and other extracurricular activities which will have a positive influence on their sexual health (see 'positive extracurricular activities' below, and Box 5).

Involving parents in information and prevention programmes: There is good evidence that including the parents of teenagers in information and prevention programmes is effective (HDA, 2004). Parents may be encouraged to attend programmes with their children, or be involved in background work such as helping with homework, so that they are able to complement what is being taught in schools when their children come home. Programmes may address adolescents and parents at the same time, helping parent-adolescent communication, or parents may be invited to participate independently.

Consider the needs of looked after children and care leavers

- Ensure residential and foster carers and professionals working with looked after children and those leaving care are able to communicate effectively on sexual health issues and signpost to effective services
- Put clear care and referrals pathways in place for young care leavers to promote positive approaches to sexual health
- Develop peer support programmes to encourage discussions on sexual health

Long-term stable, secure and loving care is required for those children in care and on leaving care (Sergeant, 2006). Such children are more likely to have suffered sexual abuse, and are more likely to become teenage mothers or street sex workers, and yet are required to leave care at the age of 16 (Sergeant, 2006). Sergeant calls for the financial incentives which prevent local authorities providing long-term care to be acknowledged and removed, so that care is provided for as long as it takes for looked after children to move successfully into society.

Two recent government documents reviewing the Teenage Pregnancy Strategy (DfES, 2006a and b) called for more targeted work on SRE with children and young people in care. They regard such work as a key success factor in areas with declining under-18 conception rates. To assist in this targeted work, the government intends to take the following steps:

- include specialist SRE modules in the new training and qualifications framework for foster and residential carers
- provide SRE training modules for local authority leaving care teams
- provide resources to help schools, carers and social workers develop a shared approach to SRE for looked after children and care leavers
- provide an SRE toolkit for carers and teachers to help them discuss SRE issues with children and young people in care (see Box 5).

(DfES, 2006a and b)

Consider the needs of children and young people with physical and/or learning disabilities

- Ensure that SRE is part of the overall curriculum for people with disabilities. Provide tailored sexual health promotion education and individualised sex education plans for people with disabilities, to meet their specific needs
- Encourage health care professionals and carers to initiate discussions on sexuality, dealing with issues relating specifically to the disability itself
- Consider the fact that children with developmental disabilities are more likely to experience early pubertal changes, and so have to cope with puberty earlier than their able-bodied peers
- Provide opportunities for those with disabilities to socialise with their peers. Promote typical teenage social activities such as a shopping or cinema trip, nights out or sport. This will provide opportunities for those with disabilities to develop social skills, increase knowledge and self-esteem
- Promote independence. Provide deliberate training to promote independence in self-care activities. Ensure young people are afforded sensitive and confidential discussions with health professionals, with dignity and privacy
- Support parents and carers in recognizing the potential of children and adolescents with disabilities to enjoy intimacy and sexuality in their relationships
- Improve public awareness. Encourage positive attitudes to disability and sexuality, including challenging negative stereotypes such as misconceptions that disabled individuals are either child-like and asexual, or aggressively sexual with uncontrollable urges

Tailored sex education: Sex education needs to be tailored to meet the specific needs of people with physical disabilities. Individualised education plans should include the provision of sexuality education for children with disabilities (Murphy and Young, 2005).

Similarly, there is a need for tailored sex education to meet the needs of children with learning disabilities. Leeds PCT, who found that such education was patchy and almost non-existent, have produced a teaching pack on puberty and sexuality specifically for this group of children (Nursing Times, 2007, and see ‘examples of good practice’ in Section 5.1).

Children with learning disabilities first of all need to be helped to develop a sexual identity. Topics to be considered include:

- body changes
- public and private parts and places
- consent and assertiveness
- personal hygiene
- menstruation
- wet dreams
- male and female masturbation

(Nursing Times, 2007)

The involvement of parents from an early stage is important – some may initially be very reluctant for their child to receive such education (Box 6). Also some parents, for example, may not have considered that changing an older child in the living room is not appropriate (Nursing Times, 2007).

Box 6

'*there's a fear that after teaching sex education (to children with learning disabilities), they'll all go out and do it. Almost the opposite is the case'.*

(Nursing Times, 2007)

Sessions can initially be delivered by PCT nurses or voluntary agencies - in Leeds, this took the form of a series of 12 weekly workshops run by the PCT. Sex education can then be gradually handed over to school nurses and teachers, who can provide refresher sessions. The teaching pack has proved very popular and successful (see Box 5 on effective interventions), and is now recommended by the Department of Health.

Defend against possible abuse: Children and adolescents with disabilities are at more risk of sexual abuse, and so need to be helped to develop strategies to defend themselves against such possibilities (Murphy and Young, 2005). They need to be assisted in how to identify and report abuse. Care givers need to be aware of the possible signs of sexual abuse, such as changes in sleep, appetite, behaviour or bowel patterns (see 'sexual exploitation' heading, below).

Social skills training and counselling in relationships and sexuality: Such training should be part of the regular care for people with physical disabilities (Verhoef et al, 2005). Health care professionals and carers should be encouraged to initiate discussions on issues of sexuality. Studies have found that although only a small percentage of young adults with spina bifida had ever discussed issues of sexuality with their doctor, almost all would have welcomed such a discussion if their doctor had initiated the topic (Verhoef et al, 2005; Sawyer and Roberts, 1999). Of the small numbers in Verhoef's study who had discussed sexuality issues, topics covered included reproduction, birth control and sexually transmitted diseases. Problems with sexuality relating to spina bifida, such as the handicap itself, fertility, and heredity, had rarely been discussed. And yet these were the issues of most concern to the survey respondents. Of all those surveyed, 60% suggested improvements for health care professionals, including the need for a more proactive approach to sex education.

Early development: Consideration needs to be given to the fact that children with developmental disabilities are overall 20 times more likely to experience early pubertal changes, and so have to cope with puberty earlier than their able-bodied counterparts (Murphy and Young, 2005).

Provide opportunities for socialising with peers: Adolescents with physical disabilities have fewer opportunities for mixing socially with their peers, resulting in fewer opportunities for acquiring the sexual knowledge that teenagers often obtain from interactions with peers rather than with parents (Murphy and Young, 2005). Although it may often require careful planning, promoting typical teenage activities such as a shopping or cinema trip will provide invaluable opportunities for those with physical disabilities to develop social skills and knowledge and self-esteem (Murphy and Young, 2005).

Promote independence: To enable them to achieve as much independence as possible from their parent or carer, children and adolescents with physical disabilities will need deliberate training to promote independence in self-care activities (Murphy and Young, 2005). Health care providers can help to promote independence by discussing issues of sexuality in private with the adolescent, such as sexual development, sexually transmitted diseases, contraception and the health implications of pregnancy (Murphy and Young, 2005).

Parents and carers need to be encouraged not to infantilise children with developmental disabilities, especially if there are long-term needs for assistance with self-care activities such as toileting, bathing and dressing (Murphy and Young, 2005). Together with health providers, they need to recognize the potential of children and adolescents with disabilities to enjoy intimacy and sexuality in their relationships (Murphy and Young, 2005).

Improve public awareness: Societal attitudes on disability and sexuality need to be challenged. Murphy and Young (2005) comment that there are two extremes of misconceptions – either that disabled individuals are child-like and asexual – or that they are aggressively sexual with uncontrollable urges.

Provide comprehensive sex and relationship education (SRE) which is age appropriate, consistent, credible and delivered at school and supplemented at home

- Provide a dedicated SRE programme within the context of broader personal social and health education (PHSE) which is age appropriate and which is delivered seamlessly in primary, secondary and further educational settings
- Ensure that SRE teachers and partners within schools and colleges are supported in delivering holistic SRE appropriate to the needs of their pupils
- Use appropriately trained teachers to deliver the curriculum. Ensure each primary and secondary school has a dedicated trained SRE teacher, with pooling of resources between schools and updated support structures where necessary
- Use a range of external partners and agencies to support teachers as required in giving advice on sexual health promotion in schools, e.g. school nurses, Brook and youth workers
- Ensure that boys and young men have access to SRE delivered by males, using outside agencies if necessary
- Include information about how alcohol and drugs can have negative effects on:
    - judgement - with heightened sexual attraction to people they would not normally be attracted to
    - negotiation skills and keeping safe messages
    - ability to practice safer sex
    - ability to repel unwanted sexual attention
- Ensure school IT systems have full access to approved websites providing quality information on sexual health, such www.ruthinking.co.uk and any locally developed resources
- Schools and colleges should provide access to onsite services or be able to signpost young people to sexual health services
- Parents should receive information about what is taught at school and college so they can continue the discussions at home

Sex and relationship education (SRE) is now a core part of the National Curriculum (House of Commons Health Committee, 2003). A dedicated SRE programme within the context of

broader personal social and health education (PSHE) should be age appropriate and delivered seamlessly in primary, secondary and further educational settings.

The evidence for the effectiveness of school-based sex and relationship education (SRE) has been well documented elsewhere (HDA, 2004), so will only briefly be mentioned here. There is no evidence that sex education promotes sexual activity (HDA, 2003a). There is evidence that, particularly when linked to contraceptive services, SRE can have an impact on young people's knowledge and attitudes, delay sexual activity and/or reduce pregnancy rates. The recent Children's Society inquiry, featuring widespread consultation with children, recommended that SRE should be presented not as biology, but as part of social and emotional learning (The Children's Society, 2008).

Too often, unqualified and possibly unwilling teachers are expected to take sex education classes, without any training or adequate support. Properly trained SRE teachers, with the ability to tackle complex and sensitive issues, are needed to deliver SRE classes in schools, House of Commons Health Committee, 2003; DCSF, 2008b) (See Box 7). The 2001 Government Health Committee and the 2008 SRE review called for each primary and secondary school to have a dedicated SRE teacher, with pooling of resources where necessary (House of Commons Health Committee, 2003).

Box 7

'We have English teachers to teach English, but we do not have sex education teachers to teach sex education, yet surely this has a bigger impact on our lives ....'

(Erica Buist, quoted on p.83, House of Commons Health Committee, 2003)

The Health Committee recommended that schools make good use of support and advice from a range of outside individuals and agencies. Organisations such as Brook undertake outreach work, and can be invited by schools, colleges and youth clubs to provide sessions on sexual health promotion. For example 'Bite Size Brook' is a large, interactive and highly visible event that covers the key themes of contraception, STIs, condom use and sexuality (Brook, 2008) (see also 'examples of good practice', Section 5).

Lack of specific male input was recognised as a key problem in the delivery of SRE for young men. The Health Committee asks schools to ensure that young men have access to SRE delivered by males, using outside agencies if necessary.

It is recommended that government departments work together to compile a resource for schools, detailing websites with high-quality information on sexual health that are exempted from any filters that schools may apply to their IT systems (House of Commons Health Committee, 2003). Other recommended initiatives include making 'electronic babies' more widely available in schools, and investigating the possibility of introducing a text-messaging advice service.

Schools are required to liaise closely with parents to reassure them of the content of programmes (House of Commons Health Committee, 2003). Parents should receive information about what is taught at school and college so they can continue the discussions at home.

Tackle sexual bullying

- Take action to prevent homophobic and other sexual bullying behaviour, as well as responding to incidents when they occur, using government guidance. There are

many steps that can be taken, including challenging the use of inappropriate language, providing training/briefing for staff and providing information and support including peer support for pupils

- Through SRE, help young people to understand human sexuality and to respect the sexual orientation of others

There are plans to release anti-bullying guidance related to gender and transgender during 2009 (DCSF, 2008c). A recent publication presents strategies to reduce the incidences of gendered harassment in schools, including strong leadership and clear school policies developed through consultation with teachers, pupils and the wider community. The strategies emphasise transforming school cultures (Meyer, 2009). The DCSF has recently issued specific guidance on homophobic bullying (DCSF, 2007 - see 'National Policy' above). Schools are required to take action to prevent homophobic bullying behaviour, as well as responding to incidents when they occur. The guidance lists ten steps that can be taken, including challenging use of inappropriate language, providing training/briefing for staff, and providing information and support, including peer support, for pupils (DCSF, 2007). Following the guidance has been shown to be effective (Box 5)

'Stand up for us' is a 'Wired for Health' initiative offering practical approaches to help schools tackle homophobic bullying (DfES, 2004). Educational Action Challenging Homophobia (EACH) is a national, charitable organisation set up to challenge homophobia through education. It provides a professionally staffed national helpline which offers advice and support.

Sex and relationship education (SRE) teaches young people to understand human sexuality and to respect the sexual orientation of others (House of Commons Health Committee, 2003).

Combat gender stereotypes

- Encourage debates on gender issues and sexual health in schools, provide resources to enable young people to discuss issues such as sexual commoditisation and challenging the impact of pornography, of masculinity and of peer pressure/expectations

- Encourage young people to think critically, helping to guide them around the issues. Use media literacy programmes in schools, which have been shown to be effective, for example in promoting positive body image among teenagers

- Emphasise gender equity issues in teacher training, especially in the training of child carers/childminders, preschool teachers and head teachers. There should be at least one teacher specially trained in gender issues in each large school

- Encourage more male nursery teachers, by e.g. encouraging boys to take up work experience placements in pre-school settings

- Encourage gender equity awareness in pre-schools: adopt an explicitly gender-conscious approach in pre-schools and include assessments of gender equity in school inspections

Encourage debates on gender issues and sexual health in schools
According to Ringrose, the sexual commodification of girls' bodies is a continuing gender equity issue for schools (Ringrose, forthcoming). Most schools see gender equality in terms of exam results, but in reality, there are still gender inequalities in the ways popular culture portrays young women (Clark, 2008). To combat this, Ringrose has called for feminist debate to be re-introduced in schools, after finding that teenage girls regularly describe themselves using abusive male terms such as 'slut' and 'whore'. In her study of the social habits of schoolgirls, Ringrose found they increasingly linked their personal worth to their ability to be sexually attractive to men (Ringrose, 2008). Her study involved looking at the contents of social networking internet sites used by boys and girls aged 14-16.

Ringrose concluded that the answer is not heavier repression or control/surveillance of young people's activities. Feminism should not be associated with an anti-male 'moral panic', as it often has been in the past. Rather, educators need to provide resources to enable young people to discuss sexual commodification, and think critically about it, helping to guide youngsters around the issues (Ringrose, forthcoming).

Ringrose suggests that teachers should discuss gender issues and suggest positive role models such as Virginia Woolfe and even Lisa Simpson, to overcome the negative influences of celebrities such as Paris Hilton (Clark, 2008).

'*What are girls saying with their clothes?*' could be a starting point for debate. For example, Duits and Van Zoonan (2006) ask, does a belly-revealing crop-top mean fashion, sexual availability, pride in one's body, that it is incredibly hot outside, or is it worn out of sheer habit?

Sex education programmes in schools should include information about sexualisation and objectification of children (APA, 2007). Media literacy programmes in schools, where pupils are encouraged to view the media critically, have been shown to be effective in promoting positive body image amongst girls (see Box 5). Such programmes could be used to combat the effects of the media in the sexualisation of girls, although there has been no research on this yet (APA, 2007).

These issues could be included in addition to the traditional sex education topics which have been well-documented (HDA, 2004).

As a result of growing public concerns about the commercialisation of childhood in the UK, presented in the recent Compass report (2006), a ministerial inquiry was set up in April 2008 (Asthana, 2008). A related government review into the sexualisation of young teenagers and girls will form part of a national debate over tackling violence against women and girls (Travis, 2009).

The Children's Society has recently produced the results of its 'Good Childhood Inquiry', which involved large-scale consultation with around 20,000 children in various settings (2008). PCTs and public health bodies could add their voice to the concerns expressed, contributing to the national debate started by Compass. Groups who usually hold opposite views have come together on this issue, including the radical feminist movement, and the conservative 'moral panic brigade' (Duits and Van Zoonen, 2006). There needs to be pressure put on industry to reduce the use of sexualised images of children and adolescents in all forms of media and products (APA, 2007).

Emphasize gender equity issues in teacher training
There is a need to emphasize gender equity issues in teacher training, and especially in the training of child carers/childminders, preschool teachers and head teachers (Vagero, 2006).

Vagero suggests that there should be at least one teacher specially trained in gender issues in each large nursery.

Encourage more male nursery teachers.
In an attempt to encourage more males into the child-care professions, boys could be encouraged to take up work experience placements in pre-school settings (Vagero, 2006).

Encourage gender equity awareness in pre-schools:
An explicitly gender-conscious approach should be adopted in pre-schools, and assessments of gender equity should be included in school inspections (Vagero, 2006).

Increase school and community sexual health advice and clinic services

- Increase the provision of community-based sexual health advice and clinic services, including school sexual health services, ensuring they meet *You're welcome* standards (Department of Health, 2006)
- During routine human papilloma virus (HPV) immunisations offer opportunistic sexual health promotion messages and interventions such as chlamydia screening
- Young people should have easy access to condom distribution services

There is a need for more community-based sexual health advice and clinic services, including school sexual health services. School-based health advice services, with sexual health as a main component, have been found to be effective (see Box 5). Such clinics provide a closer point of contact, ensuring young people can easily access services they may not be able (or want) to access in traditional clinical settings (DfES, 2007). In addition to sexual health promotion messages, young people's integrated clinics (including school provision) can offer condom provision, pregnancy testing, choice of contraception (including emergency contraception) and chlamydia screening (HDA, 2003a). There are an increasing number of school clinics, with four schools in West Cheshire PCT now offering condom provision, pregnancy testing, first issue contraception, chlamydia screening and emergency contraception, in addition to sexual health promotion messages. (see 'examples of good practice', at the end of this document, for more details)

Young people should have easy access to condom distribution services, such as c-card schemes. Community based initiatives can reach marginalised groups and communities, for example, building on the scheme to provide a sex education session to those aged 13, leading to the issue of 'condom credit cards' for use at e.g. football grounds and scout (or girl guide) huts.
http://www.ccard.org.uk/using/index.html also
http://www.timesonline.co.uk/tol/news/politics/article6446355.ece

Provide sexual health awareness and communication training for youth workers and teachers etc

- Provide training in SRE for youth workers, teachers and others working with children and young people

- Include sexual health communication as an essential component in job descriptions and training programmes of all those working with young people. This would include communication on risk taking behaviours that could affect sexual health, such as alcohol and drugs

Youth workers, teachers and others working with children and young people need training in sex and relationship education (SRE) (DfES, 2006a and b). This will help them to be aware of sexual health issues, so they can assist children in developing the skills necessary to deal with, for example, adverse messages from the media promoting the sexualisation of children.

The Family Planning Association have produced a workers compendium, *'Beyond Barbie: Community based sex and relationships education with girls and young women'*. This shares skills, knowledge and best practice, aimed at professionals who work with girls and young women (Brown-Simpson). There is also a supplement aimed at promoting the sexual health of African-Caribbean girls and young women (Grey).

Those who work with children should be supported in developing programmes that help to counteract damaging images of childhood, such as promoting the creation of homemade internet magazines (zines), web blogs, extracurricular activities (such as athletics – also see next heading) and programmes that help children and adolescents feel powerful in ways other than through a sexy appearance (APA, 2007).

Encourage positive extracurricular activities

- Encourage involvement in after school sports, other supervised extra-curricular activities and positive activities

- Encourage youth development programmes that focus on education, employment and/or life options, including skills and self-esteem building, sports and arts activities and voluntary work

Physical activity: Participation in physical activity may be one of girls' best means of resisting objectification and sexualisation, and can favourably influence sexual behaviour and sexual health, according to the American Psychological Association (APA, 2007). They point out that sport encourages girls to develop a self-concept based on what they can do, rather than on how they look. The American Psychological Association (APA) described studies in which participation in sport led to increased self-esteem and healthier sexual development. One study showed that adolescents who were more involved in organised sports were more likely to show sexual/reproductive health-seeking behaviour (e.g. discussing precautions), and were more likely to engage in safe sex (i.e. using contraception, and not intoxicated), (Lehman and Koerner, 2004. See Box 5 for more details). Parents can play an important part in supporting their children in pursuing organised team sports from an early age (Lehman and Koerner, 2004).

Other extracurricular activities: Extracurricular participation and the development of a talent can be protective factors in adolescent risk behaviour such as early sexual activity (APA, 2007). Such activities would include drama clubs, and some dance forms. Membership of same-sex groups such as the Girl Guides can help to create space for young people, among supportive friends, for issues to be explored, away from the pressures of school (Girlguiding

UK, 2008). The Girlguiding report also suggested the importance of children being able to talk to someone they can trust, making sure they feel included at school and having stable and supportive family and friendship groups, in helping them to become resistant to outside pressures and avoid mental health problems.

Some activities are to be discouraged. Ringrose commented that pole dancing as a form of 'fun' fitness for women and girls has spread in recent years, but in Cardiff, its normalisation in ever younger contexts has been questioned. Here, the local authority has decided not to allow children under the age of 16 to sign up for pole dancing classes (Ringrose, forthcoming).

Youth development programmes: There is strong evidence that youth development programmes that focus on education, employment and/or life options can have a marked effect on preventing unwanted teenage pregnancies and increasing contraceptive use (HDA, 2003a; HDA, 2004; Harden et al, 2006; Fletcher et al, 2008) (Box 5). These approaches are more holistic than traditional approaches, and often do not focus on pregnancy, but on life skills (HDA, 2003a). The success of such programmes in the USA is thought to be the most likely explanation for the recent dramatic decreases in teenage birth rates there. The programmes combine some or all of the following:

- *Skills and self-esteem building*: these approaches tend to use a variety of techniques, including role-play, to increase confidence in young people about relationships and decision-making, e.g. 'saying no' (also see above heading, 'develop negotiating skills and build self-esteem').
- *Voluntary work/citizenship*
- *Educational support*
- *Vocational preparation*
- *Healthcare*
- *Sports and arts activities*
- *SRE*

(HDA, 2004)

Although the programmes encourage young people to delay first intercourse, they do recognise that young people become sexually active in their mid-teens. They recognise the importance of providing adequate education and information about sexual behaviour and its consequences, as well as confidential, affordable and accessible sources of contraceptive services and supplies (HDA, 2004).

However, a recent UK study of 54 youth development service sites found no evidence for the effectiveness in delaying heterosexual experience or reducing pregnancies, with some results even suggesting an adverse effect (Wiggins et al, 2009). They recommended that further implementation of such interventions should take place within randomised trials.

Be aware of the possible signs of child sexual exploitation

- All those who work with children or related services need to be alert to possible signs of sexual exploitation. They will require mandatory training in safeguarding, which includes information about how to identify the warning signs of, and vulnerabilities to, sexual exploitation

- Check to ensure that staff working with young people have been CRB (Criminal Records Bureau) checked and trained in safeguarding and are aware of local policies and procedures

All those who work with children or related services need to be alert to possible signs of sexual exploitation. This will include those directly involved with children and best placed to do so, such as parents, carers, teachers, social workers, doctors, school nurses, Looked After Children nurses, sexual health practitioners and youth workers (DCSF, 2009).

In their guide on *'Safeguarding Children and Young People from Sexual Exploitation*', the Department for Children, Schools and Families (DCSF) noted that there are people who are working in related services who also need to be aware of signs of possible abuse. They all require safeguarding training that includes information about how to identify the warning signs of and vulnerabilities to sexual exploitation. There should be a clear expectation that sexual exploitation is not something which should be kept confidential. It is the role of the Local Safeguarding Children Boards to ensure that such training is provided (DCSF, 2009).

Training needs to be provided to people working in the following child-related areas; education, children's social care, parents and carers, youth and community work, Connexions, health service, leisure services (including sport and leisure centres), community police, youth offending teams, social housing, voluntary organizations and the private sector (such as cinemas, shopping centres, pubs, cafes, restaurants, internet providers) (DCSF, 2009).

The DCSF noted that educational institutions need to be alert to sexual exploitation and education staff should be able to identify signs that a child or young person is at risk of or suffering sexual exploitation, and know what action to take in line with local procedures. Raising awareness of child sexual exploitation, including signposting to sources of advice and support, can be done as part of SRE.

The DCSF point out that health service staff are in a key position to recognise children and young people who are suffering sexual exploitation, especially school nurses, doctors, Looked After Children's nurses and sexual health practitioners. In addition, health services may also be in a position to identify concerns about adults who may be perpetrators of sexual exploitation. Health centres, Accident and Emergency services and sexual health clinics are well placed to display awareness raising literature about sexual exploitation services which children and young people will see. Social housing staff can also have a role in identifying the perpetrators of sexual exploitation.

The police can link work in identifying sexual exploitation to the response to missing young people and other public protection issues and can help to identify and manage risk at an early stage (DCSF, 2009).

Additionally, awareness raising activities could target people whose work places them in a position where they will notice and could then report worrying behaviours. The DCSF suggest this could include people such as shopkeepers, park attendants, CCTV operators, pub licensees, hotel and hostel managers and a broad range of others in the community who are not traditionally part of the safeguarding community.

Vulnerable groups of children and young people include looked after children, children who are regularly absent from education, or who are not receiving a suitable education, children in pupil referral units, children who go missing from home or who are homeless, children who have mental health issues or who abuse drugs or alcohol, children who have disabilities or special needs (DCSF, 2009).

4.2. All ages

Sexual health is relevant at all stages of life with many issues such as self-esteem affecting young as well as older people. It needs normalising by encouraging active discussion rather than it being dealt with solely as a clinical or medical issue. The sexual health strategy has been criticised for being too 'medical'. For all ages, the emphasis needs to shift from the clinical model, so that sex is seen as a social issue, focusing on prevention and more positive promotion of good sexual health (House of Commons Health Committee, 2003). We all have a potential role in achieving better sexual health for the population, ensuring information is available to all, including parents and carers, at home and work.

There is a need to ensure good sexual health information and services are available to all those who need them. This should also be tailored to need, including those of students, older adults, adults with disabilities and medical conditions, ethnic minorities, transient populations including refugees and asylum seekers, people who are homeless, gay and lesbian people, and sex workers.

Top tips for effective community- based interventions

Promote sexual health

- Make local sexual health service information available, through a range of locations including students unions, pharmacies, workplaces, sports clubs, night clubs and other community settings for people of all ages, sexualities and ethnic backgrounds in culturally appropriate ways
- Offer sexual health awareness and communication training to workers in community and health and social care settings, so they can become more alert to the sexual health needs of their clients and reach vulnerable individuals or groups, such as adults with disabilities, students and older people.
- Consider the special needs of refugees and asylum seekers, promote early HIV testing and access to health services for people who originate worldwide from areas of high incidence
- Ensure those who are homeless and those involved in selling sex have easy access to sexual health promotion information, free condoms and sexual health services

Provide wider access to sexual health information: In its evidence to the House of Commons Health Committee, the then Health Development Agency (HDA) made various recommendations. They recommended that, as part of the drive to reduce inequalities in sexual health, the government needs to work with other departments to ensure consistent cross-government policy, in, for example, allowing access to condoms in prisons (House of Commons Health Committee, 2003). Similarly, student unions could be encouraged to distribute free condoms.

Making STI information and possibly testing available, through a range of locations including pharmacies, workplaces, sports clubs, night clubs and other youth and community settings, using community outreach teams, would help to reach vulnerable individuals or groups. Such groups may have higher levels of sexual health need or may be less likely, or unable, to access mainstream services. They would include young people, men, black and ethnic

minorities, sex workers, homeless people, refugees and asylum seekers, lesbian, gay , bisexual and transgendered people, those with physical or learning disabilities, students and those whose first language is not English, who might otherwise find it difficult to access these services (House of Commons Health Committee, 2003; MedFASH, 2005). The National Union of Students (NUS) has called on the government to make it compulsory for PCTs to supply contraception to student unions. The NUS also want to reduce waiting times for sexual health clinic appointments, guaranteeing that students are able to get an appointment within 48 hours of making an inquiry (NUS, 2009).

Offer sexual health awareness raising and communication training in community settings: In various community and health settings outside the specialist sexual health service, opportunities may arise, or be created, to identify, a range of sexual health needs (MedFASH, 2005). Awareness amongst workers in these settings of the prevalence of sex and relationships difficulties can help practitioners become more alert to such needs. Sexual health awareness training needs to be offered to workers in community and health settings (e.g. see '*sexual health awareness training for youth workers'* p.29 above).

Primary care: Steps are needed to ensure that GPs have sufficient training and support to provide contraception and other sexual health services. It may be necessary to give GPs incentives to undergo further training in this area (House of Commons Health Committee, 2003).

GPs and other health care staff require awareness training on best practice in providing sexual health care for groups of people with special requirements, such as people with physical disabilities, learning disabilities, mental illness, medical conditions, and also people from ethnic minority groups, especially those whose first language is not English.

There have been calls for chlamydia screening to be offered to all young men and women who attend their GP, and for action to encourage the uptake of cervical screening amongst those aged 25-64 (NCSP, 2009).

Adults with disabilities: There should be adult sex education especially geared to the needs of those with physical disabilities and learning disabilities, through GPs or other health care providers. In a study of adults with cerebral palsy, 52% reported the need for more education about sexuality (Murphy and Young, 2005). For example for young women with cerebral palsy, there should be sex education covering specific topics such as physical problems related to pregnancy or childbirth, and any specific challenges to be faced in caring for the child after birth (Murphy and Young, 2005). The Hespian Foundation have produced a very clear and comprehensive health handbook for women with disabilities, including chapters on sexuality, family planning, and STIs (Maxwell et al, 2007).

Parents: Parents require assistance and advice on how to approach issues of sexuality with their children. This would include, for example, support for parents of gay people to help them to come to terms with their child's sexuality, or support for parents of disabled people, such as that provided by the Armistead Centre in Liverpool. There are various projects that will help parents feel more comfortable in discussing sexual health issues with their children (such as the fpa's Speakeasy – see Section 4.1 '*Involve parents'*, and Section 5 '*examples of good practice*').

Students: Students, many of whom are living away from home for the first time, are a vulnerable group. As with other community workers, staff dealing with students need to have sexual health awareness training. Action to curb excessive drinking amongst students would also help to improve their sexual health (see p. 7 above – Background). There are various interventions that would be effective in encouraging students to drink sensibly. These would include action to change the drinking culture, through e.g. stopping promotions of cheap

alcohol; promoting non-alcoholic drinks; promoting the provision of comfortable seating, food and free water; and minimum pricing of alcoholic drinks (Bellis et al, 2006b; CEC, 2006; Hughes et al, 2004; Ubido et al, 2008).

People with medical conditions: The sexual health needs, of people with serious medical conditions are often ignored. The promotion of sexual health should be addressed as part of their specialist care (MedFASH, 2005).

Sexual dysfunction: A government consultation found almost unanimous (98%) agreement that access to anti-impotence drugs should be widened. Such action would have the potential of reducing the costs of treating related depression, infertility and dealing with the consequences of marital breakdown (House of Commons Health Committee, 2003). A cost benefit analysis would be helpful here. The House of Commons Committee also called for the inclusion of sexual dysfunction within the wider sexual health strategy – at first, it only received 'scant mention', but it was included in the 2008 strategy review (MedFASH, 2008).

It should be recognised that erectile dysfunction is only a small part of the sexual dysfunction agenda – other aspects need to be identified and dealt with (House of Commons Health Committee, 2003).

Older people: There is a need to address the myths and assumptions in society and amongst health care providers about the lack of sexual activity amongst older people, especially those over 45 years of age:

- Encourage GPs and other health professionals to consider the sexual health of their older patients, especially those with medical problems or on long-term medication that may affect their sexual life. Older people feel that GPs could be a useful source of information on sexual health (Gott 2001, and see Box 8). Doctors often avoid mentioning sexuality with older patients, feeling it is not important in later life, or are maybe too embarrassed to bring it up. Education may be needed for doctors and other professionals to ensure they acknowledge the sexual health needs of their older patients and clients, and to perhaps overcome their own prejudices and stereotypes about later-life sexuality (Gott, 2001). The promotion of sexual health should be addressed as part of their overall care (MedFASH, 2005).

- In sexual health programmes, include interventions aimed specifically at older age groups, including strategies to encourage early diagnosis and treatment and provide age-appropriate educational materials

- Provide education for GPs and other health and social care professionals to ensure they acknowledge the sexual health needs of their older patients and clients, and to overcome any prejudices and stereotypes they may have about later-life sexuality.

- Address the promotion of sexual health as part of overall patient care.

- Provide opportunities for older people, including those in care homes, to express their sexuality - Care workers in homes for the elderly have an important role the promotion of sexual well-being of residents, ensuring that residents have opportunities for sexual relationships without fear, shame, violence or coercion (Rheaume, 2008). Staff can help residents fulfil their individual sexual needs, which may range from providing opportunities for residents to show affection through touch and companionship, to providing 'do not disturb' signs on rooms for conjugal visits (Rheaume, 2008).

- Protect vulnerable individuals. Special consideration needs to be given to residents who, because of their condition (e.g. dementia), are unable to interpret cues in relationships and act appropriately or give informed consent. Assessment by the staff of decision-making capacity of the residents is essential, so that residents can be protected from sexual exploitation and abuse, including unwanted touching (Rheaume, 2008)

Asylum seekers and refugees: The sexual health charity fpa have produced a sexual health handbook for people working with refugees and asylum seekers (Wilson, et al, 2007b). There are several examples of good practice, including sexual health radio broadcasts by the Ethiopian Community Centre (see 'examples of good practice' in Section 5.3). Asylum seekers and refugees have special needs, due to the fact that they are possibly fleeing sexual violence. They are also likely to have communication problems, and to suffer deprivation and sometimes lack of education that may put them at greater risk of sexual ill-health (Wilson et al, 2007b).

Homeless people: There is a need to introduce sexual health information and education in services for homeless people (CRISIS, 2005). In addition, hostels and shelters should aim to provide more positive environments for gay people, creating an atmosphere that is non-judgemental and respectful of diversities in sexual identity (CRISIS, 2005).

Few homelessness services will record sexual identity details of clients, except in relation to sexual and substance risk behaviours. CRISIS point out that for a homeless gay person, this reinforces the view that their sexuality is seen in a negative light. When dealing with homeless people, homelessness services should consider openly and routinely including questions on sexual identity This will help the homeless gay person feel that their sexual identity is worthy of attention, and acknowledges the fact that it may be associated with their becoming homeless. Clients should be reassured that any information gathered will be treated confidentially, ensuring a climate of safety and security for service users (CRISIS, 2005).

Street sex workers: Those involved in selling sex need to have easy access to sexual health promotion information, free condoms and sexual health services. Decriminalising prostitution and providing managed areas would help to improve the health of prostitutes and reduce levels of exploitation and violence (Ryan, 2005; RCN, 2007/08). It would help to encourage prostitutes to come forward for a range of services, including sexual health care. Managed zones, as those in Germany, Holland and Australia, would help to improve the health of prostitutes by making it easier for outreach services to access prostitutes, providing condoms and sexual health care (Ryan, 2005). Research by the Joseph Rowntree Foundation supported this view, concluding that an integrated, multi-stakeholder response to street sex work, including listening to the views of sex workers and residents, is essential (Pitcher et al, 2006; also see Box 8), e.g. consultation in Liverpool (see 'examples of good practice', Section 5).
http://www.cph.org.uk/showPublication.aspx?pubid=123

Use the media

- Use the wide range of media available for providing information on sexual health. Repeat and adapt media messages to suit changing cultural attitudes, considering collaboration with other local health and social care organisations to raise the profile of media messages with greater effect. Messages need to be consistent, credible and visible

As with other age groups, use of the wide range of media available for providing information on sexual health is to be encouraged. Media messages need to be repeated, and adapted to the changing cultural attitudes of the time. Lessons have to be learned from less successful campaigns, such as the mobile phone interactive drama aspect of the recent government 'Want respect, use a condom' campaign (DH, 2009b; utalkmarketing.com). It has been pointed out that mass media campaigns have a useful role in legitimising action – for example, in encouraging garage owners to feel more comfortable about displaying condoms on the shop counter (House of Commons Health Committee, 2003).

Raise awareness of the effects of alcohol and drugs

- Encourage increased awareness that excessive alcohol (and drugs) can:
    - Increase sexual desire but diminish performance
    - Heighten sexual attraction to people not normally attracted to
    - Affect judgement, leaving individuals vulnerable to physical and sexual violence as well as becoming the victim or perpetrator of a crime
    - Be symptomatic of poor self esteem and poor communication skills

The sexual health charity fpa recently published research showing that alcohol has a negative influence on decision-making relating to sexual matters. Alcohol is commonly seen as a factor in not using a condom with a new partner and regretting sexual activity (fpa, 2009a). Campaign's to increase awareness are needed, such as the fpa's 'One too Many' campaign in September 2009, where posters and materials were sent to universities, further education colleges, contraception and sexual health clinics and all general practices in the UK (fpa, 2009b).

Stamp out homophobia and sexual harassment

- Deal with homophobia and all forms of sexual harassment, in the workplace and elsewhere
- Measure the outcomes of an organisation's equality and diversity initiatives against individual experience

Research by Stonewall put forward a strong business case for good practice around sexual orientation in the workplace (Guasp and Balfour, 2008 and Box 8). Their study found a strong link between productivity and performance, and workplace climate. Staff who can be open about their sexuality at work are more likely to enjoy going to work, form honest relationships with colleagues, and be more confident and more productive.

A series of guides have been produced by Stonewall, advising employers of best practice in engaging with gay and lesbian staff (Stonewall, 2009). They recommend that workplaces set up network groups for gay, lesbian and bisexual employees, enabling people to come together to share information and support. Monitoring of lesbian and gay staff is encouraged, so that organisations can examine people's experiences and measure the outcomes of the

organisations equality and diversity initiatives. Advice on how to minimise anti-gay bullying and harassment is given.

Tackle sexual violence

- Sexual violence is strongly associated with domestic violence, and needs to be considered in assessment of domestic violence cases
- Promote awareness of the sexual assault referral centres and how people of all ages can access them

Following the government consultation on violence against women and girls that began in March 2009, the resulting strategy will set out government action to stop such violence and what more can be done to challenge attitudes that may condone it (Home Office, 2009). Initial reaction was that changes are necessary across all government services, from getting health practitioners much more aware of how to spot domestic violence, to discussing consent to sex in schools.

There is a need to continue to develop and promote awareness of the Sexual Assault Referral Centres. At present, there is one centre in Merseyside, called 'Safe Place Merseyside'. 'Safe Place Cheshire' is due to open in the autumn of 2010. http://www.cmshn.nhs.uk/services/Sexual%20Assault%20Referral%20Centre%20(SARC).html

Box 8
Examples of evidence for the effectiveness of interventions that promote sexual health in adulthood

Older people: A Sheffield survey of people aged 50+ found that 26.3% would like additional information about STDs or HIV. Preferred sources of information included magazines/TV (43.4%) and the GP (33%) (Gott, 2001).

Homophobia: Stonewall have collected personal experiences of lesbian, gay and bisexual employees, showing how workplace policies can be effective in improving workplace climate, and ultimately improving productivity and performance, e.g. '*I feel they have the right policies in place, so in terms of being gay, I feel safer here than I have in many organisations'* (Guasp and Balfour, 2008).

Street sex workers: A study looking at five residential areas used by female street workers considered whether residential streets could serve as shared spaces where residents and sex workers could coexist. Many residents and sex workers in the study supported the concept of designated spaces for working. The study concluded that an integrated, multi-stakeholder response to street sex work, including listening to the views of sex workers and residents, is essential (Pitcher et al, 2006). Results of a study in 2004 in Liverpool reached similar conclusions (Clark et al, 2004).

5. Examples of good practice

5.1. Childhood and adolescence

In Western Cheshire, there are now four schools and two colleges of further education offering on-site sexual health services. Within the schools a sexual health nurse works alongside a school health advisor in a lunch time drop-in session. The service is called **'Health Zone'** and provides advice on all aspects of health, so it is not immediately obvious that a young person may be attending for sexual health needs. The holistic approach means that both nurses can address risk taking behaviours of all kinds, promote safer sex, alcohol, smoking and drug use messages, and also provide pregnancy tests, emergency contraception and a full range of ongoing contraception - condoms, pills, injections, implants, chlamydia and gonorrhoea screening and chlamydia treatment on site.
Contact: nicola.mullin@wcheshirepct.nhs.uk

In Halton, the Youth Service and peer educators ran a sexual health summer camp in 2009 involving targeted groups including children in care, LGBT young people, young people with learning difficulties and disabilities, young women and young men. The aim was to create a safe environment where the groups felt comfortable sharing knowledge, chatting about sexual health and relationships and where to get information, advice and support. Participants also worked with a drama company to help them explore various issues. In the second phase of the summer camp, the young people created a DVD call 'SexEd TV'. Plans are now underway for planning sexual health summer camp for 2010.
Halton Youth Service also organised training a group of young people in peer-led research, leading to a peer-led report with recommendations for sexual health services in Halton.
Contact: Sally Carr, Operations Manager, Special projects for Halton Youth Service, Sally.Carr@connexionslive.com

Sexual Health Drama: Birkenhead's Active Drama Company put on a musical production 'Emma', which toured secondary schools and community venues throughout the north-west in 2004/05. The play focuses on young Emma and her relationships with her peers, using comedy, music and song to look at issues around young people and sexual health, including teenage pregnancy and personal safety. There were facilitated after-show discussions. The play was supported by the Health Protection Agency and a number of PCTs.
http://www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1231836548064?p=1158945065175

Youth film-making project: Merseyside film company Clapperboard UK is planning to explore issues of sexuality and gender in a youngster's film-making project during 2009. They are hoping to build on the success of last year's project, where six schools on Merseyside tackled the issues of gun, knife and gang culture, through writing and filmmaking with guidance from industry professionals. The themes for projects are devised by young people involved in the Active Citizenship Panel.
Contact: Maureen Sinclair at info@clapperboarduk.com or telephone: 07973 783 140.
http://www.clapperboarduk.com/

'BiteSize Brook' was developed in Wirral, and has been extended to Liverpool, taking information on sexual health issues into schools, colleges and youth clubs. The sessions are

interactive and fun, and help to create an openness about contraception and information giving (Brook, 2008). Other successful projects run by Brook include

- working with school non-attenders in Manchester – a group that may have received little or no sex education previously,
- Brook Burnley's 'Been and Seen', where visits have been arranged for young people to find out exactly what a Brook centre is all about, and
- Brook Blackburn's bus, taking the clinic out to young people in the town from 6pm until midnight each Friday evening, providing condoms, information, pregnancy testing chlamydia screening and emergency contraception. Typically, there are 70 young people gathered around the bus, with 40 coming on board (Brook, 2008).

So To Speak is Liverpool's Young Person's Sexual Health Education Outreach Team, funded through the Liverpool Teenage Pregnancy strategy. The project's aim is to equip at risk groups of young people with the information required to make informed choices about their sexual health; to promote a greater understanding of the broader issues that impact upon sexual health; and to support agencies that work with young people to appreciate their role in tackling those issues and thereby enabling good sexual health. The team also delivers staff training and support to agencies that work with vulnerable young people including youth workers, social workers, teachers, members of the Youth Offending Team and foster carers.
Contact: Tim Blackstone Service Manager tim.blackstone@sotospeak.nwest.nhs.uk

Parents' packs are handed out to parents of primary school age children, 10-11yrs, in parts of St.Helens and Knowsley. The packs include information about talking to your child about sex and puberty changes.
Contacts:
Knowsley: Colette Greaves, Cheshire & Merseyside Sexual Health Network
Colette.Greaves@nhs.net
St.Helens: Sheila Roberts, Teenage Pregnancy Strategy Manager:
SheilaRoberts@sthelens.gov.uk

Puberty and Sexuality for Young People with Learning Disabilities.
Nursing Times Awards 2006: The winning entry, from The Children's Learning Disability Nursing Team based at NHS Leeds, was a 'highly imaginative project' The team developed a teaching pack on puberty and sexuality for children with a learning disability.

Covering issues such as body changes, menstruation and masturbation, wet dreams, consent and sexual relations, the pack is aimed at any group working with children with a learning disability and designed to help them offer appropriate sex and relationships education to their client group.

This 'fabulous project' showed understanding, sensitivity and empathy, the judges said. 'It is a brilliant resource that could easily be transferred to mainstream primary education'.

From February 2009 the Department of Health funded the pack as a national resource. Ten hard copies of the pack have now been distributed nationally to every healthy schools co-ordinator per PCT in England. A PDF version of the pack is now available:
http://www.sexualhealthsheffield.nhs.uk/resources/pubertyandsexualitypack.pdf

Contact: owen.brigstock-barron@nhsleeds.nhs.uk

The Jiwsi Project is an fpa community education project delivering sexual health and relationships education to groups of vulnerable young people in community settings throughout North Wales. Since 2002, the project has worked with looked-after children, children with disabilities, excluded young people and young offenders. The project also provides sex and relationships training for professionals and runs a popular sex and relationships practitioners support network.

Jiwsi staff have produced a bilingual book of activities used and developed within the project work – a 'pick 'n' mix' of sex and relationships education activities. Each exercise has tips for making them as accessible as possible to young people with a variety of needs and abilities.
http://www.fpa.org.uk/Inthecommunity/Youngpeople/projectswithyoungpeople

Life Skills is an fpa project that works with vulnerable young people who are 11–14 years old and live or study in Hackney, London. Young people come along to weekly themed sessions organised by a key worker and the project officer at their local school, youth centre or community centre.

Life Skills offers young people tailored sessions on puberty, relationships, body image, gender roles, substance abuse, contraception, challenging behaviours and managing emotions.

Young people work together in groups, pairs or on their own to develop and gain new skills, friendships, knowledge and confidence. Sessions run for a maximum of an hour for 4–6 weeks. Youth workers and other youth professionals will sometimes refer an individual or groups of young people to other services.
http://www.fpa.org.uk/Inthecommunity/Youngpeople/projectswithyoungpeople

Interactive drama: The campaign *'Want Respect? Use a condom'* launched its first interactive drama by mobile phone earlier this year. The free 22 episode drama was aimed at teenagers. Viewers had the chance to interact with characters in a drama to give their own outlook via text, email or phone call, leading to a cliff-hanger at the end of each episode. Teenagers could sign up by visiting a web link, or sending a text message. The project was not entirely successful, and lessons have been learned, - see:
http://www.utalkmarketing.com/pages/Article.aspx?ArticleID=14148&Title=Government%27s_%27gimmicky%27_safe_sex_mobile_phone_campaign_slammed

Accredited training for youth professionals. Working with the National Youth Agency, the fpa has developed a set of core competencies which covers all the essential skills, information and values youth workers and people who work with young people need in order to run safe, informed, and practical sex and relationships work sessions with young people.
http://www.fpa.org.uk/Training

5.2. All ages

The Armistead Centre in Liverpool runs a parents carers group, providing support to parents of Lesbian, Gay and Bisexual (LGB) people. The help and support is around coming to terms with their child's sexuality, support on issues arising from the impact of a member of the family coming out, information regarding sexual health and safer sex, homophobia, awareness-raising of LGB lifestyle, culture and rights. One to one support or counselling is

available by appointment. Additionally Armistead run a helpline for all clients, including parents of LGB people.
Contact: Martin.Fenerty@armistead.nwest.nhs.uk

'Speakeasy' is an fpa initiative. It offers a non-threatening group-based opportunity for parents and carers to acquire the confidence and skills they need to talk to their children about sex and sexuality. It is designed to be fun and relaxed, providing an atmosphere where parents can learn together from their own experiences. It is locally organised and can link with educational, community and/or health provisions in a particular area (see Box 8).

http://www.fpa.org.uk/Inthecommunity/Speakeasy
http://www.fpa.org.uk/Shop/Sexandrelationshipseducationpublicationsandresources/Speakeasytalkingwithyourchildren

Similar initiatives include the web-based support groups '*Time to Talk'* and '*Parentline plus'*:
http://www.timetotalk.org/
http://www.parentlineplus.org.uk/

Homophobic bullying: As part of its informal conflict resolution procedure, Manchester City Council has a team of up to 16 Conciliation Officers who can mediate for and support employees who are experiencing bullying or harassment at work. The council has recognised that some lesbian, gay and bisexual (LGB) people may feel more comfortable receiving support from someone who has personal experience of sexual orientation issues, so it publicises the fact that LGB Conciliation Officers are available.
http://www.stonewall.org.uk/workplace/1473.asp

As part of the LAMP project, Knowsley run a Health & Wellbeing group for people with Severe Mental Illness (LAMP: Look After Myself Programme). This programme delivers all the key health promotion messages around the public health targets in a format that is appropriate for this patient group. They have developed a handbook to accompany the programme.
Contact: Maria Caves, Clinical Lead Nurse for Mental Health, Knowsley Health & Wellbeing maria.caves@knowsley.nhs.uk

Promoting healthy sexual lifestyles for individuals with learning disabilities in Knowsley: Person centred one to one sessions are provided by the Community Learning Disability Nursing Team. The individuals are referred when there are difficulties with their behaviour. Topics covered include safe sexual behaviour, relationships, vulnerability, and appropriate choice and decision-making including contraception.

Training, education and awareness sessions are available and delivered by the Cancer Screening Coordinator and Clinical Lead Nurse to all health care staff and staff who work in learning disability services on 'best practice' guidelines on sexual health matters.

For further information *contact*: Johanna Lee, Clinical Lead Nurse Learning Disabilities. Knowsley Health and Well-Being, NHS Knowsley. johanna.lee@knowsley.nhs.uk
or Lara Boddy, Public Health Cancer Screening Co-ordinator, NHS Knowsley.

Ethnic minorities and refugees/asylum seekers: The Ethiopian Community Centre in London regularly broadcasts information about sexual health in its two two hour slots each

week, broadcasting nationwide, with many more than 20,000 estimated listeners. Sexual health was thought to be taboo amongst Ethiopians, and the radio programme provides an effective way of breaking down barriers (Wilson et al, 2007a).
http://www.fpa.org.uk/Inthecommunity/Refugeesandasylumseekers

Ethnic minorities: The fpa in Lambeth works with women from ethnic minorities, promoting sexual health by:

- Running free sexual health information groups for minority ethnic women.
- Training workers from within communities to continue delivering the work.

The project works in a relaxed and open atmosphere with different minority ethnic groups over the age of 16, including refugees and asylum seekers. The project involves Lambeth Council, the local NHS and local voluntary organisations, based on the belief that the best way forward is for agencies to work in partnership with each other, and with the communities they serve.
Contact :Terri Ryland, email: terrir@fpa.org.uk
http://www.fpa.org.uk/Inthecommunity/Minorityethniccommunities

A similar scheme is operated in South and West Yorkshire (Wilson et al, 2007a&b, p.141):
Contact: Centre for HIV and Sexual Health, email admin@chiv.nhs.uk

'Sleepin' Safe, Sexin' Safe' is an fpa project promoting health choices for homeless young people in the North East and London. Working in partnership with Centrepoint, other youth homelessness organisations and health service providers, the aim is to increase and improve homeless young people's knowledge of sexual health and to encourage the use of sexual health services.

Topics covered in interactive workshop sessions include:

- puberty, fertility and reproduction
- sexually transmitted infections
- contraception, emergency contraception and family planning
- relationships and behaviour
- sexuality, sexual orientation and gender roles
- negotiation, consent and the law
- substance misuse and sex
- unplanned pregnancy and abortion
- sexual health choices and services.

http://www.fpa.org.uk/Inthecommunity/Youngpeople/projectswithyoungpeople

A consultation on a managed zone for sex trade workers was undertaken in Liverpool in 2004, involving interviews with residents, businesses and street based prostitutes. The vast majority of respondents were in favour of having a managed zone established.
http://www.cph.org.uk/showPublication.aspx?pubid=123

Sex workers into sexual health (SWISH) is a mobile outreach service in Coventry, using an outreach bus to encourage sex workers into sexual health. It receives funding from the Drug Action Team and Community Safety Partnership. The service currently concentrates on street workers, but is being expanded to incorporate parlours, saunas etc.

The service provides health services such as, a sexual health clinic, awareness training of sexual health issues, condom distribution and safer sex materials, SWISH also provides support and advice for those who wish to exit from sex work. The project has increased the

numbers of women accessing services and leaving the sex industry. It reduced offending, homelessness and the number of nuisance complaints to the police.
http://www.rcn.org.uk/development/practice/social_inclusion/sex_workers/good_practice_examples

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