

**Sexual Health In Scotland:
Attitudes, lifestyles and the changing epidemiology of pregnancy,
abortion and sexually transmitted infections**

1. INTRODUCTION

- 1.1 This paper presents a summary of the findings from the Scottish sample of the 1999/2000 NATSAL survey (Macdowell et al 2002), compares these to the results of the 1990/91 NATSAL survey and places this in the context of the changing pattern of pregnancy, abortion and sexually transmitted infections in Scotland. It provides the background against which many of the recommendations within the proposed Sexual Health and Relationships Strategy are placed, both in terms of sex and relationships education and in clinical service proposals.
- 1.2 The full report of the 1999/2000 NATSAL study can be found at www.healthscotland.com/hebs . Further details on sexually transmitted infections can be found www.show.scot.nhs.uk/scieh and www.show.scot.nhs.uk/isd. The latter website also contains information on conceptions and abortions.
- 1.3 In reading this paper, the following should be noted:
- 2001 is the most recent year for complete data reporting by the Information and Statistics Division (ISD) of the Common Services Agency, although some data is available for 2002 and is reported here – more recent epidemiological data has been provided by Scottish Centre for Infections and Environmental Health (SCIEH)
 - Unless specified, the data in this paper is derived from information provided on attendances at genito-urinary medicine (GUM) clinics in Scotland. This has its limitations. For example it does not include sexually transmitted infections (STIs) treated in other clinical settings – in particular general practice or family planning clinics – some data derived from the Continuous Morbidity Recording (CMR) system is included to provide an insight into the issue of GP consultation
 - Patients with HIV infection differ from most of those with other STIs in that infectious disease specialists treat the majority.
 - The NATSAL survey covered males and females aged 16-44 with many results being compared between those aged 16-29 and those aged 30-44

2. ATTITUDES AND LIFESTYLES AS REPORTED IN THE NATSAL SURVEY

Key facts

- The median age of first intercourse is 16 for females and males: this is lower than the earlier 1990/91 NATSAL results (18 for females and 17 for males)
- Sexual competence (based on variables relating to first intercourse: regret, willingness, autonomy of decision and contraception use) has increased among those aged 16-29, which included an increase in the use of condoms at first intercourse. Sexual competence declined as the age of first intercourse decreased
 - Men had more sexual partners than women, and were more likely to have more than one sexual partner at the same time
 - Pregnancy was cited as the most important reason to use contraception, the most popular of which were condoms and the oral contraceptive pill
 - Women were more likely to have accessed the medical profession for contraceptives than men
 - A substantial minority believed homosexuality is always or mostly wrong
 - Whilst sex before marriage was largely accepted, sex outside a regular relationship was not viewed positively across the Scottish population both young and old
 - Parents were not the main source of information about sexual matters for most young people
 - Those who reported learning about sex from parents or school were significantly less likely to report first intercourse before the age of 16 and more likely to report condom use when it did occur (whole UK sample)
 - Educational level, family structure, lack of discussion with parents and in some instances sources of information outside school/parent were associated with poorer sexual health outcomes

2.1 Learning about sex: Supporting Paper 2 outlining the wider determinants of sexual wellbeing and Supporting Paper 4 detailing sexual health and relationships education for young people highlight the range of ways individuals learn about sex. In summary, parents, schools, friends and the media were cited as the most common sources of information, although parents were less likely to be consulted compared to other sources. Those who did not cite parents or schools as their main source were less likely to use contraception at first intercourse.

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Implications for the proposed Sexual Health and Relationships Strategy

- *Opportunities to deliver health promotion messages regarding sexual health should be maximised by everyone delivering sexual health education and services*
- *Supporting parents and carers in being an information route on sex and sexual health should be key activity for health promotion and other service providers*
- *Involving parents and carers in school based sex and relationships education is a key partnership in providing young people with accurate information about sex and relationships*

- 2.2 More information on STIs, relationships, and contraception for all ages was a strong theme from respondents. More than half of male respondents wanted more on STIs (compared to 40% of females) whilst just under half of females wished increased information on feelings and relationships. Whilst there was little difference between males and females wanting help in saying “no”, more women than men reported regret after their first sexual intercourse.

Implications for the proposed Sexual Health and Relationships Strategy

- *Sex and relationships education should include aspects of STIs as well as emotions and relationships*
- *Further research is required to understand the feelings of regret experienced after intercourse to identify appropriate support to minimise this*

- 2.3 Early heterosexual experiences and sexual partners: Those aged 16-29 reported greater sexual competence compared to those aged 30-44. In other words, they reported less regret following their first intercourse and mutual respect for sexual encounters. Younger respondents were twice as likely to use condoms at first intercourse whilst those aged 30 and over were more likely to report oral or no contraception.

Implications for the proposed Sexual Health and Relationships Strategy

- *Work is required to ensure that condoms are used consistently over a prolonged period in addition to oral contraception*
- *The cost implications of condom use need to be addressed if increased use is to be encouraged*

- 2.4 In general, men reported having one and half times as many partners as women during their lifetime and those aged under 30 had had more partners in the year prior to the study compared to those aged over 30. Around one in ten males and one in sixteen women had had two or more partners at the same time. Older men were more likely to have had same sex contact than younger men with the opposite being true for women, although this has not changed since the 1990/91 NATSAL study.

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Implications for Sexual Health and Relationships Strategy

- *Services should be aware, and prepared to address, the inequity that exists between service provision for heterosexual and homosexual groups.*

- 2.5 Pregnancy and abortion: a quarter of women reported parenthood before 18: this is a similar result for the UK as a whole. Younger women were more likely to report early parenthood and more likely to report having had an abortion than older women. More than one in ten women said that they had had an abortion: 2.5% reported this occurring before age 18. This compares to 4% for England and Wales. A very small percentage of men under 29 (0.3%) and none of the older age group reported parenthood prior to age 18.
- 2.6 Around a third of men and women thought abortion was wrong whilst about one in five viewed it as being rarely or not wrong at all. This is a much higher response compared to England and Wales.
- 2.7 Ongoing contraception use: especially those under 30 reported the condom and oral contraceptive pill as most popular methods. About one in ten young men used withdrawal as a method of contraception. GPs and family planning clinics were the most preferred sources of professional advice for both men and women: around one in ten aged under 30 stated a preference for a dedicated sexual health service.
- 2.8 The main reason cited for using contraception was to prevent pregnancy. Only a minority reported the risk of infection as the reason for protection. Data on the number of people using both the condom and contraceptive pill was not collected, despite this being the most effective means of protecting against STI and unintended pregnancy when having intercourse.
- 2.9 The personal risk of HIV was seen as low: 4% of men and 2% of women. Injecting drug users and people with multiple heterosexual partners were perceived as being at greatest risk of HIV/AIDS. Around one in ten men and women had been tested for HIV with the most common reason for women to cite being pregnancy – routine antenatal HIV screening was introduced in 2003 but was available in some NHS board areas. Respondents perceived that the risk for male homosexuals was dependent on their use of condoms. Around one in four men and one in five women reported changing their sexual behaviour in response to HIV and STIs, particularly young men. The most common change reported was condom use.

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Implications for Sexual Health and Relationships Strategy

- *Information on effective contraceptive methods and the importance of maintaining effective protection once in a relationship should form part of sexual health and relationships education and health promotion activities*
- *Services should reflect the access and other needs of their target audience*
- *National and local mass media communications should work together to raise awareness of the risks of STIs, including HIV and the realistic likelihood of transmission particularly among those embarking on sex with new partners (for example, younger people and the older “newly singles”)*

2.10 Attitudes to sexual relationships and experiences: A small number of respondents (3%) believed sex outside marriage was wrong. The majority of respondents, and particularly women and young people, considered that sex outside stable relationships as always or mostly wrong. One night stands were more accepted by men than women and younger people are more tolerant of one night stands than those in the older age group (although the gender difference was still visible). This supports the results from the Health Education Population Scotland (HEPS) survey.

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3. CONCEPTIONS

- 3.1 The overall birth rate in Scotland is declining and will continue to decline in the next decade – a situation mirrored in the other UK countries. The provisional data for all and live births to end March 2002 confirms this: in terms of individual NHS Board areas, the Western Isles shows the highest rate with Greater Glasgow recording the lowest rate of births. The number of stillbirths recorded for Scotland as a whole has also steadily reduced: in 1976 about one in every hundred births was recorded as a stillbirth whilst this rate had been halved by 2001. Whilst there are variations across the NHS Board areas, particularly due to small numbers, the overall trend is in decline (see [Graph 1](#)).
- 3.2 In terms of pregnancies among females aged between 13-19 years, the rate per 1000 women has changed very little in recent years: the 2001 rate of 43.3 per 1000 females is the same as that recorded for 2000. However, this masks a significant decline in the rates for those aged 13-15 years which peaked in 1996 at 9.5 per 1000 falling to 7.6 per 1000 in 2001. The equivalent rate of those aged 16-19 years was recorded as 71 per 1000 females. [Graph 2](#) gives the pregnancy rate for those aged 13 to 19 years over the period 1991 and 2001.
- 3.3 The picture across NHS Boards is also mixed. The latest data for 2001 identifies Borders as having the lowest rate of teenage pregnancy in females aged 13-15 whilst Grampian has the lowest rate for those aged 16-19. By contrast the highest pregnancy rates for both age groups were seen in Ayrshire and Arran and Tayside NHS Boards. Dundee City Council had the highest pregnancy rate in those under 19, 63.1 per 1000 women aged 13-19. [Graph 3](#) shows the outcome of teenage pregnancy by age group at conception between 1991 and 2001.
- 3.4 The number of therapeutic abortions has changed very little in recent years. In 2002, the rate per 1,000 women aged 15-44 is 10.8, compared to 11.4 during 1998. Terminations by medical methods (49.8% in 2002) and performed at earlier gestational period (65.5% at less than 10 weeks in 2002) have been the most significant developments over the last ten years. There is also an increasing trend of terminations being performed on women aged 30 and over: 28% in 2002 compared to 22.4% in 1991. In 2002, Tayside and Lothian NHS Boards recorded the highest rate of terminations per 1,000 women aged 15-44 with Dumfries & Galloway and the Island Boards (Orkney, Shetland and Western Isles) having the lowest rates. [Graph 4](#) gives the rate of abortions by mother's age between 1968 and 2002.
- 3.5 Among 13-15 year olds, the delivery and abortion rates have remained fairly constant: 3.6 deliveries per 1000 and 4.0 abortions¹ per 1000 females. In the older age group the abortion rate is much lower than the

¹ Abortions includes therapeutic abortions and miscarriages

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delivery rate, averaging 27 per 1000 women. However, since 1991, the proportion of teenage pregnancies proceeding to full term has changed, particularly in this older age group: in 2001 almost 42% of pregnancies miscarried or aborted. The proportion of pregnancies in those aged 15 and under failing to reach full term has remained fairly constant at around 52%.

- 3.6 In terms of births in areas of deprivation, there are 4-5 times the proportion of births to mothers aged under 20 in the more deprived groups compared to the least deprived over the period 1976 to 2002. This is in spite of total number of births in this age group nearly halved over this period. In the 20-24 age group the ratio of babies born in the least deprived areas to the number born in quintile five is approximately one to two, but this starts to reverse in the age group 25-29, and for the age groups 30-34 and 35-39, the ratio is two to one with little change in this proportion over the time period. Much the same sort of pattern is seen when all births are examined rather than just first births. This leads to the conclusion that delaying reproduction and having smaller families is a factor for all society. Graph 5 shows the age distribution of first births by deprivation in 2002: this shows that women in the most deprived areas tend to have children about 12 years earlier than those in the least deprived areas.

Implications for the proposed Sexual Health and Relationships Strategy

- *Direct comparisons cannot be made with pregnancy rates in other UK countries as their data does not include miscarriages*
- *More appropriate service options are required to respond to the increasing number of abortions in older women*
- *Further research is required to ascertain the reasons behind the increasing termination rates in those aged 16-19*

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4. SEXUALLY TRANSMITTED INFECTIONS

Key Facts

- New diagnoses of sexually transmitted infections have risen continually in the last 10 years
- Diagnoses of chlamydia have more than doubled since 1995
- New cases of genital herpes increased by 11.4% between 1998/1999 and 1999/2000: recurrence rates rose by 12%
- Numbers of new cases of gonorrhoea dropped between 1984 and 1994 but have increased in last three years
- Although cases of syphilis are rare, a series of outbreaks throughout UK (including Glasgow) in 2002 are causing concern
- The most frequently reported STI in 1999/2000 was genital warts
- The number of young people, gay and bisexual men, and some minority ethnic populations diagnosed with sexually transmitted infections is disproportionately higher compared to the general population
- Improvements in HIV treatments have resulted in a greater number of people living with HIV requiring long term treatment
- Gay men are at highest risk of acquiring HIV
- Rising number of HIV infections being acquired through links with Africa and other high prevalence countries (for example Eastern Europe and Far East)
- The number of injecting drug users who acquire HIV is steadily declining
- Glasgow overtook Lothian in recording the highest number of new HIV diagnoses in 2001
- Access to specialist sexual health services is becoming increasingly limited – the median time to first appointment in 2002 was 12 days for men and 14 days for women
- 9% of Scottish men and 13% of Scottish women reported having had an STIs in the 1999/2000 NATSAL survey: one in sixteen young women reported having been tested for chlamydia (compared to 1 in 77 young men)

Sexually Transmitted Infections: recent changes

- 4.1 An increase in the transmission and diagnosis of sexually transmitted infections signposts changes in high-risk sexual behaviour. STIs can have a significant impact on the short and long term health of both men and women. The capacity to bear children may be impaired and poor health outcomes such as pelvic inflammatory disease, ectopic pregnancy, cervical cancer and death may be a subsequent result. Health promotion and prevention activities, linked to the early diagnosis and treatment of STIs, can help prevent such complications.

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Trends in Diagnoses

- 4.2 Diagnoses of acute bacterial STIs in GUM clinics have more than doubled in recent years and continue to rise each year. Between 1980 and 2000 all STIs for both men and women increased by almost 18%. Specifically:
- First occurrence of genital warts increased from 4700 to 5433, recurrence² rates increased from 1781 to 2382 between 1994 to 2000;
 - Chlamydia increased by 16% between 2001 and 2002 for all ages and 62% increase on that recorded for 2000
 - Genital herpes increased by almost 30% between 1992 and 2001
 - Gonorrhoea in males increased by 219% between 1992-94 and 2001-02

Graphs 6, 7 and 8 show trends in chlamydia, genital warts and genital warts between 1992 and 2000³.

- 4.3 A number of NHS Boards have introduced screening and testing for these STIs following the publication of SIGN Guideline 42 which may partly explain the increased detection rate. However, due to the acute symptomatic nature of gonorrhoea and syphilis in particular, it is more likely that these new cases are associated with an increase in higher risk sexual behaviour.
- 4.4 As it is not possible to determine whether infections in men are occurring among those who have sex with women or those who have sex with other men. Analysing STIs in women can give a picture of the extent of infection among the heterosexual population. Moreover chlamydia infection rates are likely to under-report the true extent of infection given its often asymptomatic nature: increases are more likely to be due to changes in screening practice. However, the opposite is more likely for herpes simplex and gonorrhoea.
- 4.5 Between the early and late 1990s almost all of the increase in herpes simplex incidence occurred among females: the annual number of cases among males has hardly altered between 1992 and 2002 (SCIEH weekly report 2003, 37; 166-171). In 2002, Highland and Lothian report the highest incidence.

² Recurrence describes episodes where patients have been free of warts for three months or more and also those patients in whom warts persist for more than three months despite treatment

³ Further information can be found in: Sexually Transmitted Infections in the UK: New episodes seen at Genitourinary Medicine Clinics, 1991-2001" available to download from: http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/publications/sti_report2002.pdf for full publication or tables http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/publications/sti_report2002_tables.pdf

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- 4.6 Not all STIs (such as chlamydia) have recognisable and/or long-term symptoms, which mean that they often go unrecognised. As part of its ongoing activities, the Healthy Respect demonstration project in Lothian tested a cohort of male army recruits and found that almost one in ten tested positive for chlamydia: similar results are being found from work targeted at young women. Many of those being diagnosed were unaware of their infection and therefore at risk of developing chlamydia related complications as well as potentially passing the infection on to current and future partners. In 2002, 71% of all chlamydia diagnoses were attributable to women: the highest incidences being seen in Lothian and Dumfries and Galloway whilst Lothian and Highland recorded the highest male incidences. Some of this increase will partly reflect local screening policies.
- 4.7 Among the heterosexual population, there has been relatively little change in the incidence of syphilis and gonorrhoea infections. Since 1990 there has been between 5 and 20 diagnoses of syphilis each year. Unlike genital herpes simplex and genital chlamydia infections, the majority of cases of gonorrhoea are male. Between 1992-94 and 2000-2002, there has been a 219% increase in diagnoses among males, due largely to transmission among men who have sex with men. Whilst the incidence of gonorrhoea among women across Scotland has remained static between 2000 and 2002, there are potentially significant regional variations are emerging. Lothian and Argyll & Clyde are on the increase whilst numbers in Lanarkshire and Highland are decreasing.

Implications for the proposed Sexual Health and Relationships Strategy

- *Increasing diagnoses of sexually transmitted infections reflect the increasing numbers attending GUM and family planning clinics, an increased prevalence of STIs in the wider community and increased testing following the SIGN guideline. These increasing demands place additional pressures on the preventive activities of specialist services (eg partner notification and counselling/support). This can mean that the holistic approach to sexual health may be lost.*

Those at Greatest Risk

- 4.8 There are a number of groups within the population who, due to the risks they take in relation to their sexual behaviour, are particularly susceptible to infection and re-infection with STIs.
- 4.9 **Young people, particularly teenage females.** More than 52% of chlamydia cases diagnosed in 2002 were among young people aged under 25 (65% if extended to age 30). Of particular concern is the 66% increase in the diagnosis of women aged under 16 between 2001 and 2002. At a local NHS Board level, increases in chlamydia diagnoses greater than 50% were recorded in Ayrshire and Arran and Argyll and Clyde. In 2002 54% of infections from genital herpes simplex were for

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people aged under 30 years. In the same year, 67% of episodes of gonorrhoea infection among females occurred in those under 25 years: the corresponding rate for males was 35%.

- 4.10 The high number of cases detected in young people may be partly due to the SIGN guideline recommendation of testing this age group. There may be equally worrying trends in males and other age groups which are as yet undiagnosed.
- 4.11 **Men who have sex with men.** In 2002 there was an alarming increase in both infectious syphilis and rectal gonorrhoea among men who have sex with men: 79% of syphilis diagnoses (31 of 39) were reported for this group. The number of diagnoses in the previous two years for men who have sex with men was eight and less than five respectively.
- 4.12 There is a, though not as dramatic as syphilis, increase in gonorrhoea among men who have sex with men (as indicated through diagnoses of rectal infection among men). The majority of those infected lived in Glasgow and Lothian NHS Board areas: syphilis was found more in Glasgow and gonorrhoea more in Lothian. Thirty out of the 31 men diagnosed declared a total of 253 sexual contacts in the 3 months prior to diagnosis: only 18% of these contacts were subsequently traced successfully for treatment which highlights the extent of unprotected sexual intercourse amongst population and the huge potential for onward transmission. Significantly almost one third of these men were diagnosed as HIV positive.
- 4.13 **Ethnic minority groups.** Evidence from other parts of the UK has shown that bacterial STIs, particularly gonorrhoea is particularly high among the black Caribbean population. It is not yet known whether this is similarly the case in Scotland.

Implications for the proposed Sexual Health and Relationships Strategy

- *There is a lack of information about STIs and unintended pregnancy among black and minority ethnic groups. This masks the need for increased services (for example translation/communications, more same sex staff). Further work is needed to ascertain the extent of sexual ill health among BME communities and ways of promoting sexual wellbeing relevant for BME communities*

- 4.14 Although risk taking in sexual behaviour is a key factor in STI transmission, other determinants may limit attempts to prevent the spread of disease. For example, high levels of asymptomatic transmission, ineffective partner notification measures, poor access to specialist sexual health services, psychosocial factors preventing individuals seeking treatment. It therefore follows that interventions targeted at preventing STIs should take account of an individual's behaviour as well as ability to access and use services appropriate to needs.

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Implications for the proposed Sexual Health and Relationships Strategy

- *Inequalities in service provision are exacerbated in both rural and urban areas but for different reasons: high disease prevalence and increasing demand are particular factors faced by services in urban areas whilst poor access and overstretched staff compound the problems faced by rural services. Those in greatest need often have the poorest access to sexual health services, from primary care through to specialist services or may perceive their access to be poor or not appropriate to their needs, for example young people or men who have sex with men. This means that there is no single solution to meeting the sexual health agenda in Scotland.*

Trends in HIV infections

- 4.15 A range of influences affect the incidence and transmission of HIV infection within the population: these include changes in sexual behaviour, the uptake of HIV testing and subsequent treatment, service use, patterns of injecting drug use, mother to child transmission and individuals importing infection from areas of high prevalence.
- 4.16 Despite advances in treatment, HIV is still an avoidable communicable disease, it involves high treatment and care costs, results in significant and long term morbidity and ultimately death. It may also take a long time before symptoms emerge and diagnosis is made.
- 4.17 It is estimated that around one third of HIV infected people have not yet had their diagnosis confirmed: up to March 2003 around 3634 HIV diagnoses had been made with between 750 and 1500 estimated to be undiagnosed.
- 4.18 The introduction of highly active anti-retroviral therapies has had a significant impact on HIV diagnosis and on AIDs-related deaths. This has also shows been a fall in number of AIDs cases up to 2000 mainly as a result of early diagnosis and improved treatment: the upward trend shown in 2001 and 2002 may represent problems of side effects, compliance, resistant strains and late presentation especially among those from abroad and will require careful monitoring to ascertain whether this can be reversed.

Implications for the proposed Sexual Health and Relationships Strategy

- *Responding to the increasing need for anti-retroviral medication for HIV might jeopardise the funding for other HIV/STI prevention measures*
- *The ringfenced allocation of HIV monies to NHS Boards should be reviewed to assess its effectiveness in meeting the increasing costs of HIV treatment and care*

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Those at greatest risk

- 4.19 Men who have sex with men are the group at highest risk of acquiring HIV in the UK and this picture is no different in Scotland. Figure x shows the data for the period 1990 to 2002: in this last year the number of new HIV diagnoses increased, around 18% having acquired their infection abroad. It is not known whether this increase is due to increased testing, an overall increase among men who have sex with men or due to an increase in imported HIV acquired infections. Until 2001 it looked as if there was a declining incidence among this group: this will only be confirmed through an analysis of data from further years although an increase in HIV would be in line with similar increases in gonorrhoea and syphilis among this population.
- 4.20 The prevalence of HIV infections in other population groups is varied. Since 1987 a declining trend in HIV diagnosis among injecting drug users has been offset by increases among heterosexual men and women, especially those who have acquired their HIV abroad (around 9% prevalence). In 2002, this increased by 76% and for the first time since testing began, the number of new diagnoses in the Glasgow NHS Board area superseded Lothian. Nevertheless HIV is still relatively uncommon among the general heterosexual population in Scotland (around 0.1% prevalence).

Implications for the proposed Sexual Health and Relationships Strategy

- *The increasing number of HIV infections acquired abroad means that services must be responsive to the different needs of the populations served, including needs related to culture, language and sexual orientation.*

- 4.21 Whilst there are low numbers of infections being reported among the indigenous Scottish population and injecting drug users, the risks are greater than ever. With the Scottish HIV-infected population increasing by at least 100-200 per year, and with increasing high-risk behaviour, the potential of exposure to HIV through unprotected sexual intercourse is increasing. Moreover, as the sharing of injecting equipment remains high among drug users, they are also at increased risk of acquiring HIV and hepatitis C virus through this route.

Implications for the proposed Sexual Health and Relationships Strategy

- *Timeous and accurate recording and reporting of disease patterns among populations at risk is essential at both national and local levels*
- *Needle exchange programmes should be sustained so that the potential for blood borne virus transmission among IDUs and their partners can be minimised*

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- 4.22 Mother to child HIV transmission can be dramatically reduced by treating the mother, caesarean section and the avoidance of breastfeeding (from one in four to less than one in fifty). Since April 2003 all NHS Boards have introduced the offer of HIV testing as part of routine antenatal screening programmes. Whilst the number of children becoming infected with HIV is small in Scotland, the capacity of services to respond to the needs of such children and their families should not be underestimated.
- 4.23 In 2002, the prevalence of HIV among pregnant women was 5.8 per 10,000 which is almost double the rate recorded in the mid to late 1990s. Considerable increases in the prevalence among pregnant women in Tayside and Greater Glasgow NHS Board areas were recorded. The reasons for this increase are not clear: it may reflect the overall increase in imported HIV infections as data over the last three years reflects an increase in this patient group. Monitoring of future infections will help confirm/reject these suspicions.
- GUM Activity**
- 4.24 In year 1999/2000, attendances at GUM clinics by all age groups increased by 5% over the previous year: attendances by women increased fourfold compared to males. Attendances by 15-19 year olds increased by just over 10% and accounted for almost 13% of all attendances: more than twice as many young females attended compared to young males: by contrast attendances in those aged under 15 dropped. The over 35 age group comprised almost a quarter of all attendances with twice as many males attending as females. Graph 9 shows the age distribution of patients seen at GUM clinics in 1999/2000.
- 4.25 The availability and accessibility of GUM clinics affects the number of patients attending from different NHS Board areas. Some NHS Board areas have very limited access to GUM services (for example island or remote rural areas); some patients prefer to use services in other areas to assure anonymity. Some patients may prefer to see their GP if there is a long way to go to attend a GUM clinic although some GPs may not provide these services. Differences in the rates for each NHS Board will also reflect actual underlying differences in local disease patterns - Graph 10 shows the STI and Non STI rate for local populations aged 15 to 64 years in 1999/2000.
- 4.26 In 1999/2000 Grampian, Lanarkshire and Tayside GUM services experienced the greatest increases in new attendances whilst those with no full time GUM service had the lower rates (Borders, Dumfries & Galloway and island areas).

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4.27 Patients attending GUM clinics attend from a variety of conditions, not all of which are STIs. The types of infection diagnosed and treated at GUM clinics have changed in recent years. As shown above these reflect changing sexual behaviour, treatment effectiveness and expansion of clinical expertise within GUM departments. In particular the latter includes the management of patients diagnosed with HIV and AIDs and partner notification. In relation to partner notification, the number of cases diagnosed following initial contact has increased for both chlamydia and gonorrhoea. Tables 1 – 3 show the contact, incidence and prevalence rates by gender and age group for year ending March 2000.

4.28 General practitioners may also treat STIs. Using the CMR system⁴ the following can be seen:

- Genital herpes: the pattern mirrors that of GUM clinics with comparable age structure and higher incidence in females. A significant proportion is likely to be referred or encouraged to attend GUM clinics
- Genital warts: the data suggest that a number of patients consult their GPs more than once with this condition, indicating that many are treated within general practice
- Chlamydia and Gonorrhoea: there is a low rate of chlamydia diagnoses compared to gonorrhoea. This may reflect the recording requirements of having a diagnosis on consultation and it takes several days to diagnosis chlamydia. Those with chlamydia might be classified with gonorrhoea until verified by the laboratory results.

⁴ CMR = Continuous Morbidity Recording system involves recording data from patient consultations by a number of GP practices across Scotland. The participating practices are chosen to reflect the population profile of Scotland. Whilst it is recognised that this data is limited and is likely to be incomplete, it does provide an insight into GP consultation.

5 CONCLUSION: MEASURES TO RESPOND TO THE IMPACT ON EXISTING SEXUAL HEALTH SERVICE PROVISION

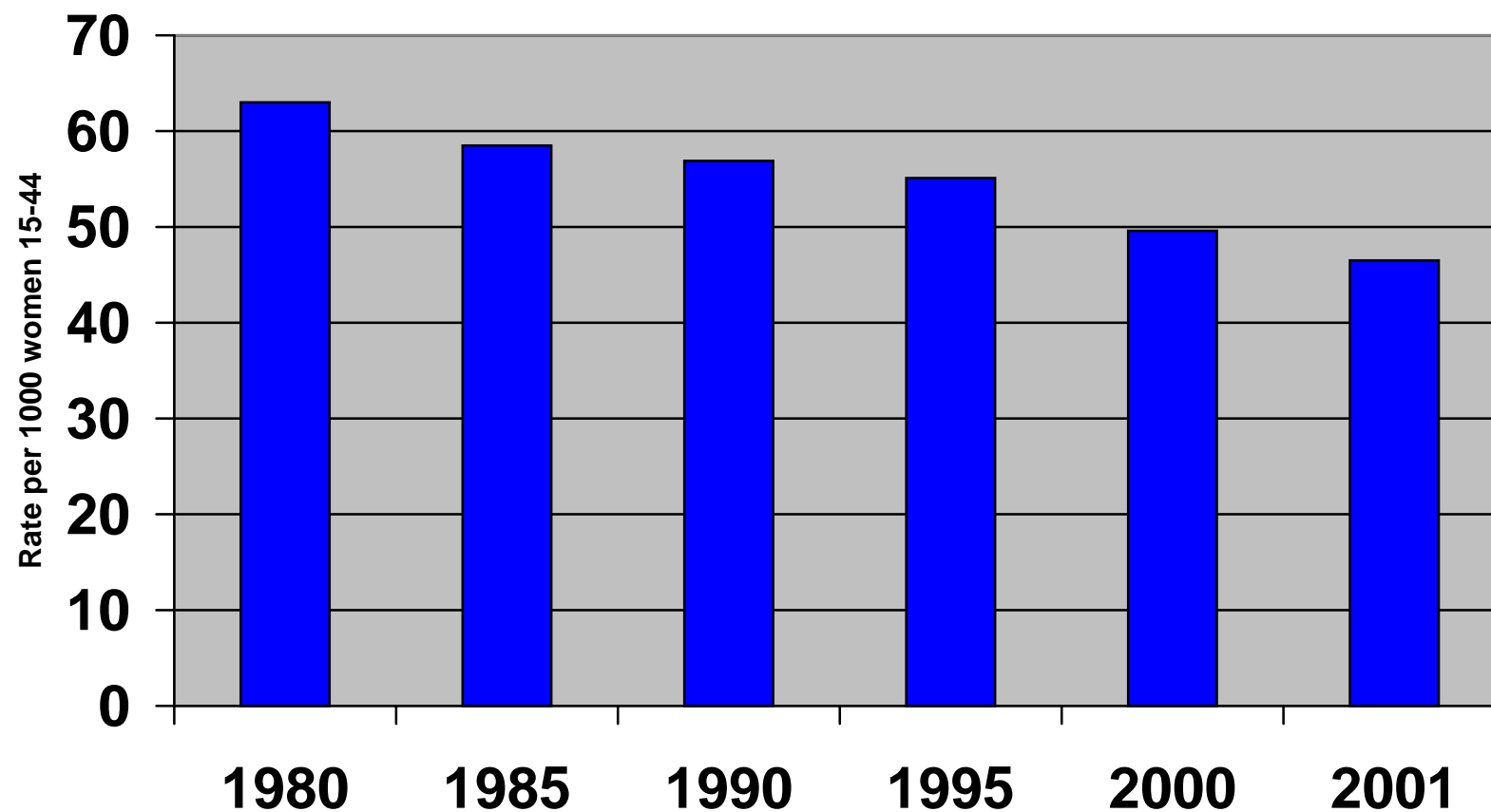
- 5.1 Recent increases in high risk sexual behaviour, rising STIs and HIV diagnoses, linked with sexual health promotion and the ability to self refer to some services has led to increased service uptake but often without the necessary additional resources. There is some evidence that access to services is inconsistent, service provision is variable and at times unco-ordinated with some staff providing a service for which they are inadequately prepared/resourced.
- 5.2 Poor access to services reduces the effectiveness of preventing and managing STIs. People at increased risk tend not to seek timely treatment and may continue to spread their infection. Early and effective treatment of disease should be the primary goal of STI control.
- 5.3 The proposed tiered service approach (as set out in Supporting Paper 5A) is intended to help improve access to services at the most appropriate point for the individual in need. This must, however, be supported through adequate resourcing, professional skills development and data surveillance. The proposed Sexual Health and Relationship Strategy recommends the following range of actions to support the detection and management of sexually transmitted infections:
- Knowledge about sexual behaviours and sexual health through school based sex and relationships education, lifelong learning and mass communications
 - Population based screening for all women under 25 and targeted screening for males
 - Increased HIV testing within GUM services
 - Targeted interventions for population groups facing the greatest barriers to sexual ill-health
 - Sustaining and improving HIV and STI surveillance
 - Development of professional standards
 - Development of competency based programmes to equip a range of staff to provide sexual health services

In addition, the proposed Sexual Health and Relationships Strategy recommends enhancing current population surveys to include specific sexual health aspects so that the views and attitudes of the general population can be tracked alongside data on service uptake and delivery.

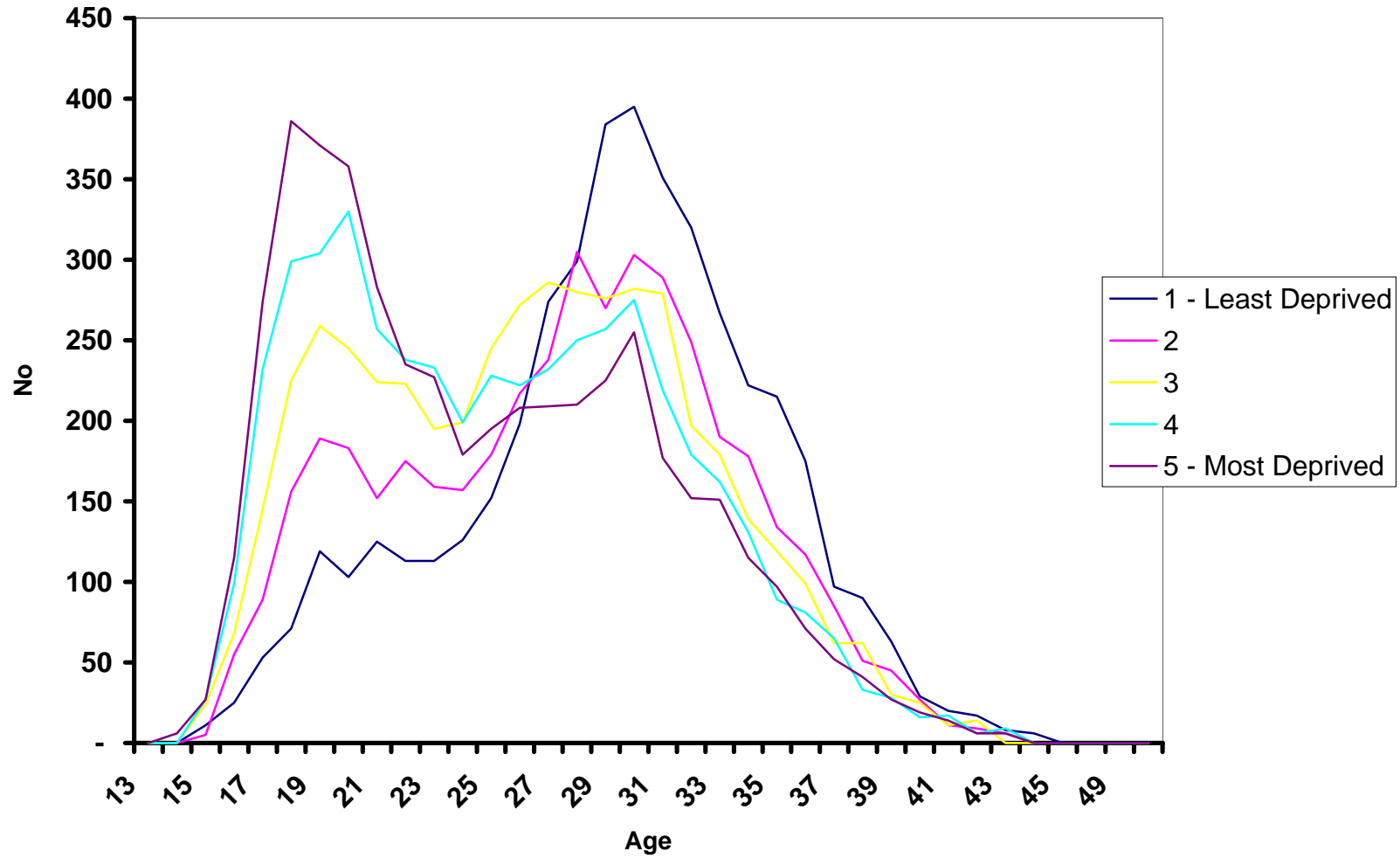
September 2003

Graph 1

Live Births in Scotland, 1976 - 2000



First Birth by Age of Mother and Deprivation Category
Year ending 31 March 2002 ^P

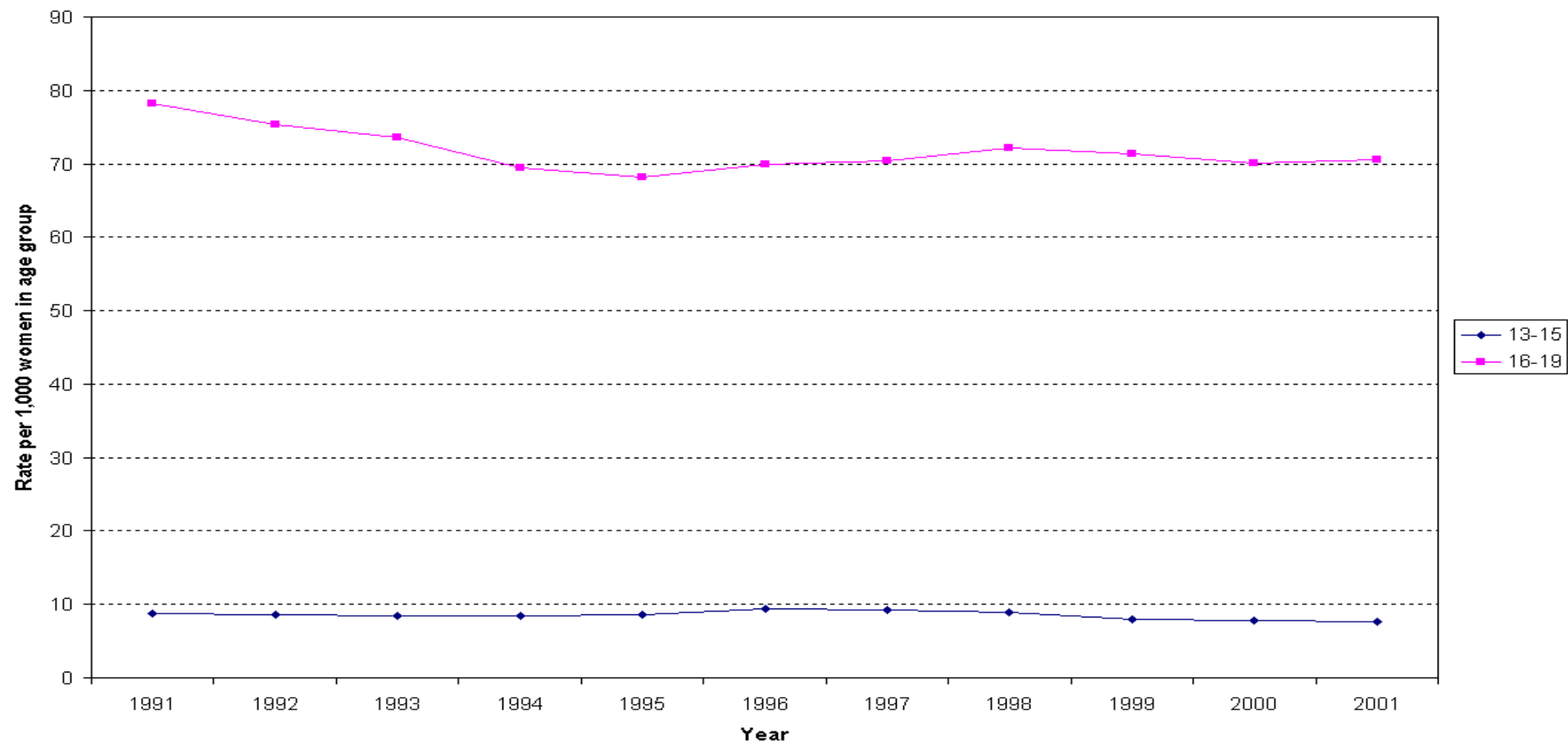


Graph 5

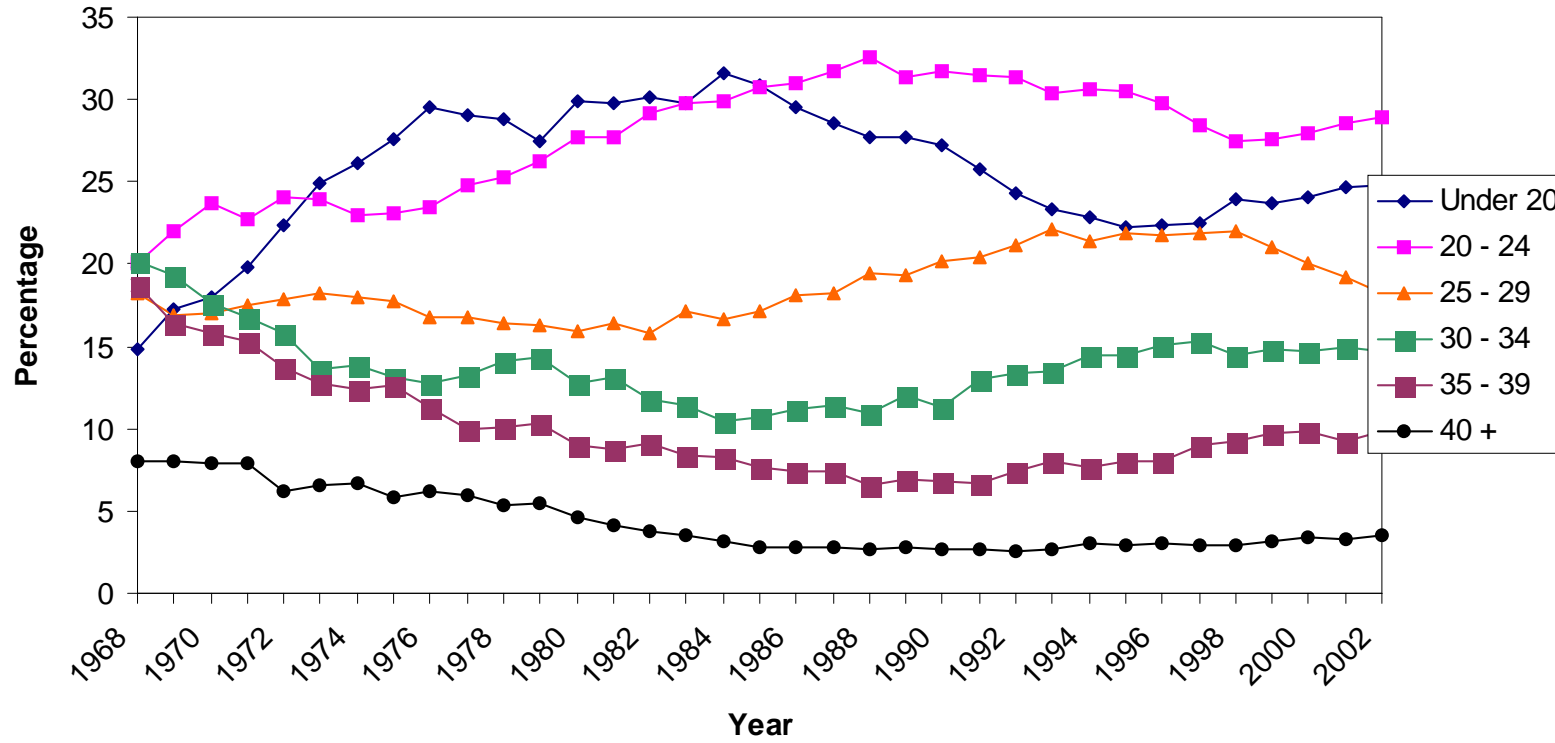
Graph 2

**Chart 1 - Teenage Pregnancy Rates, 1991-2001,
by Age Group at Conception**

This is an ISD Scotland
National Statistics release.



Abortions performed in Scotland by age of mother, 1968-2002

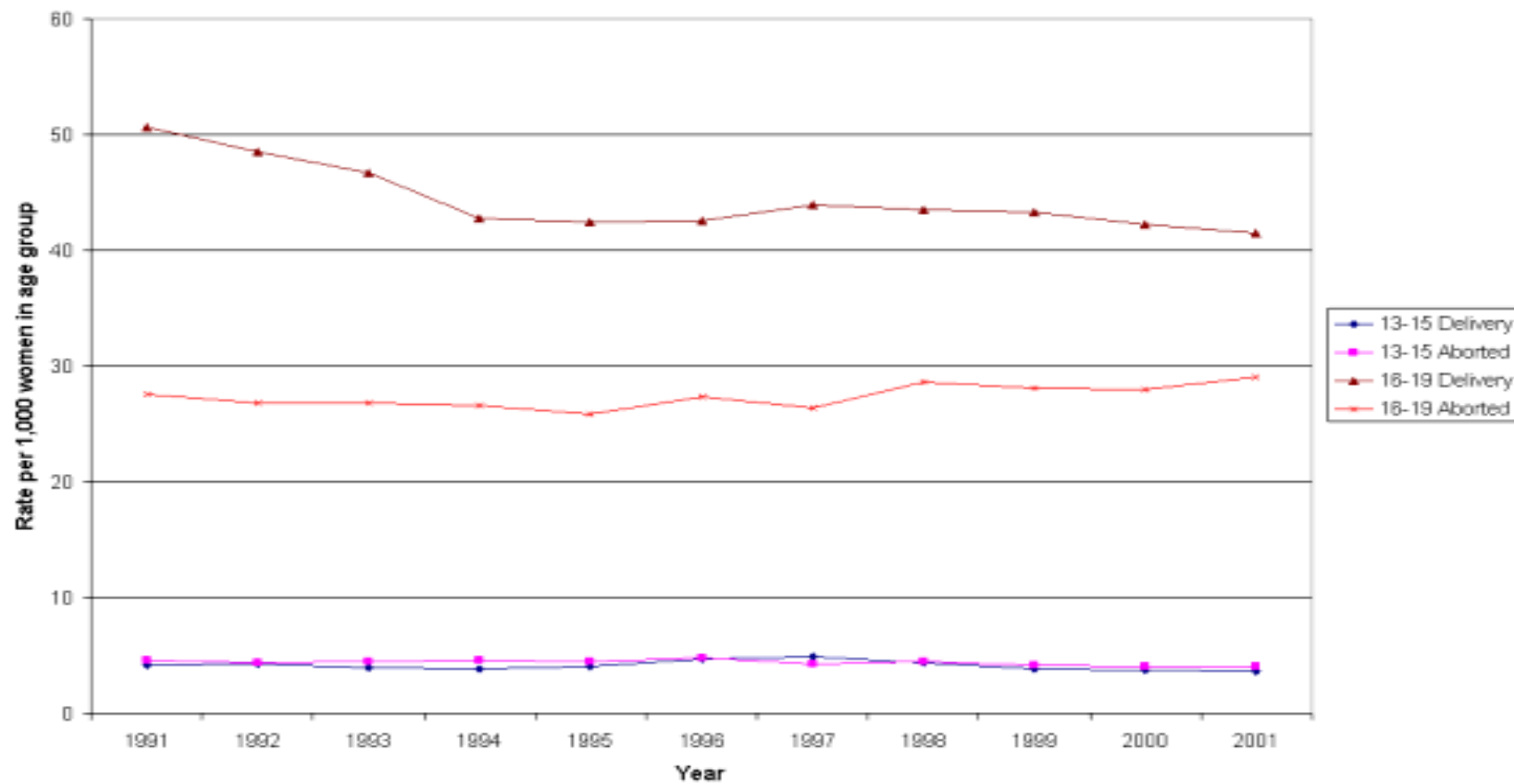


Graph 4

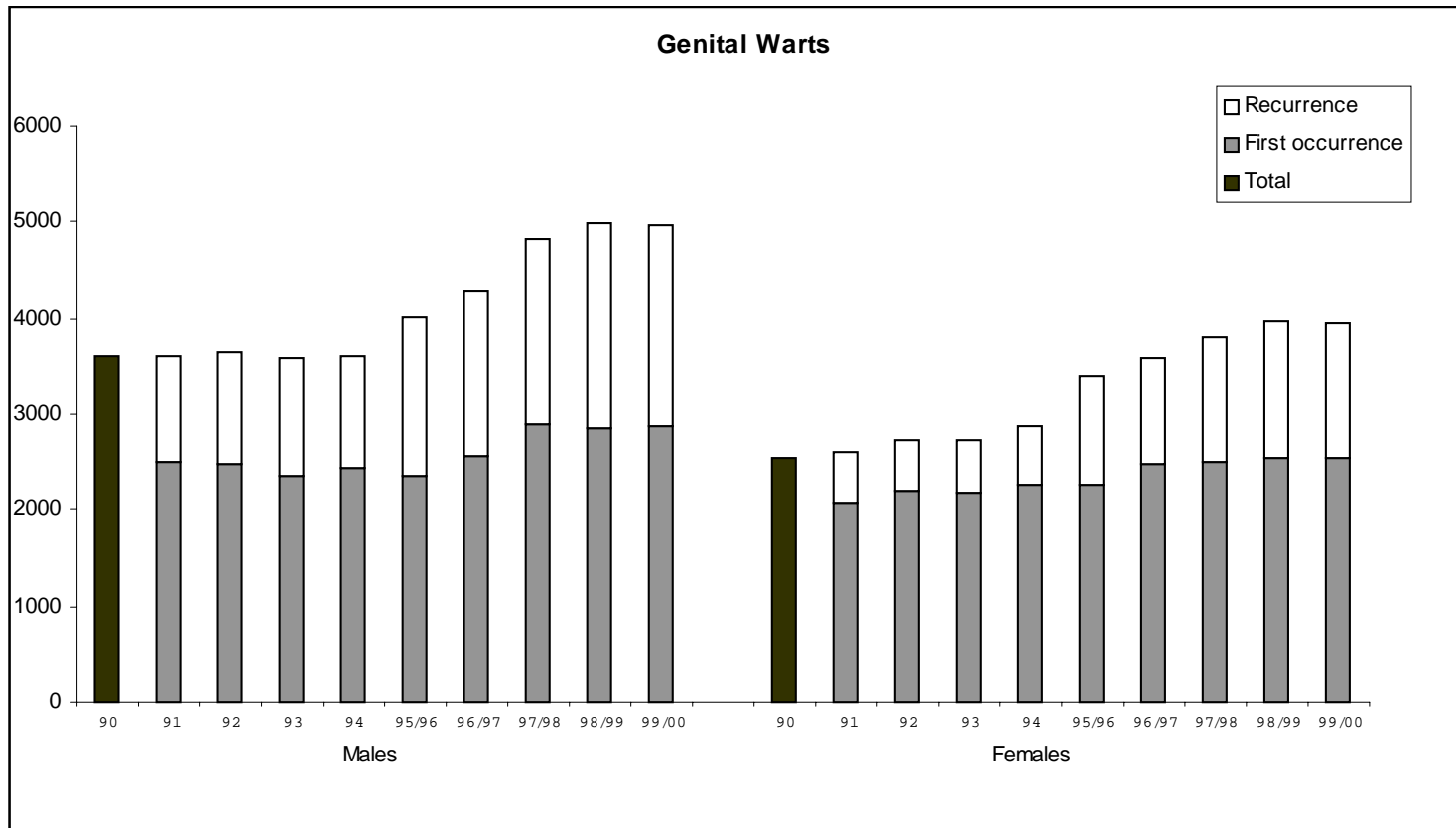
Graph 3

**Chart 2 - Outcome of Teenage Pregnancy, 1991 - 2001,
by Age Group at Conception**

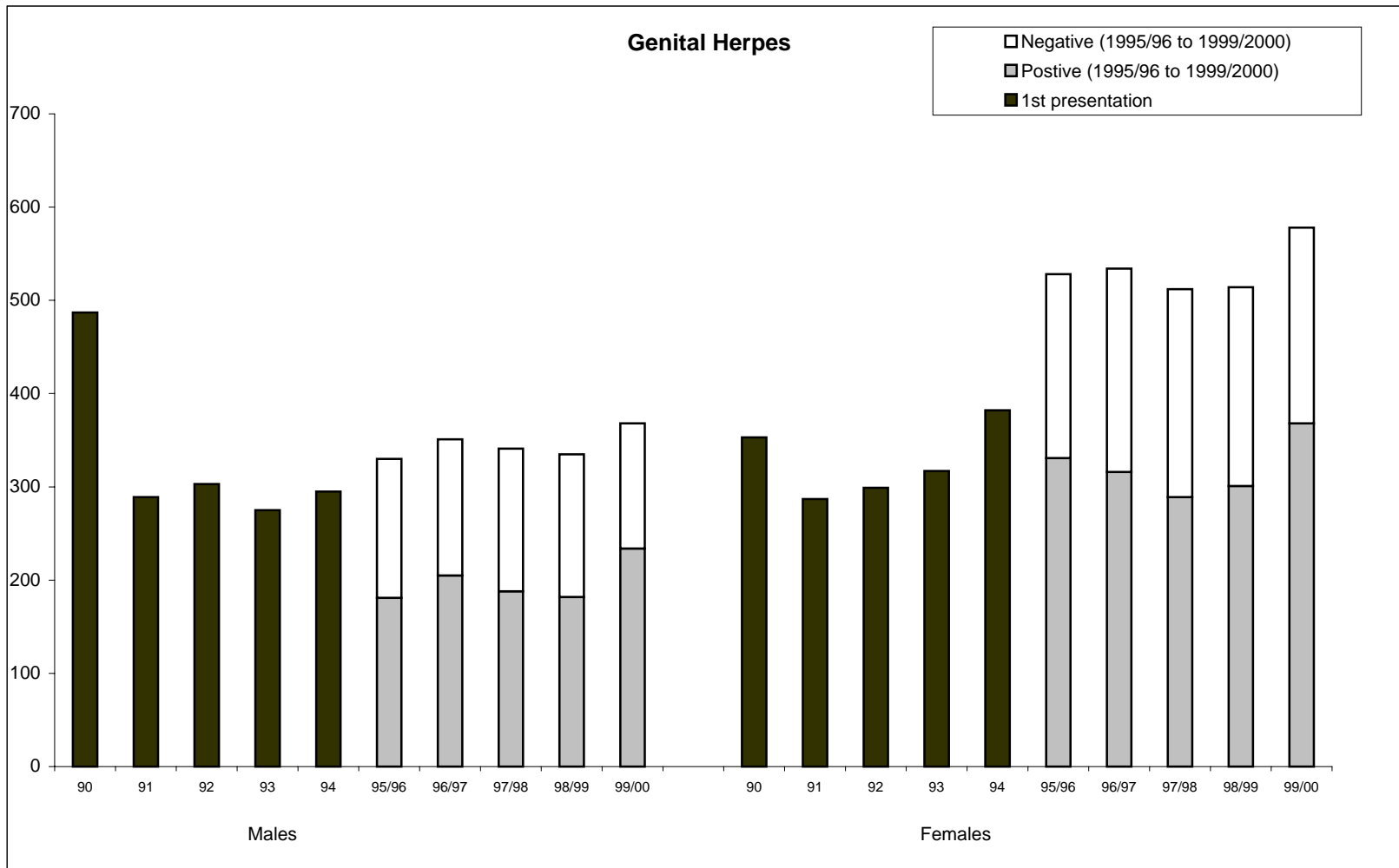
This is an ISD Scotland
National Statistics release.



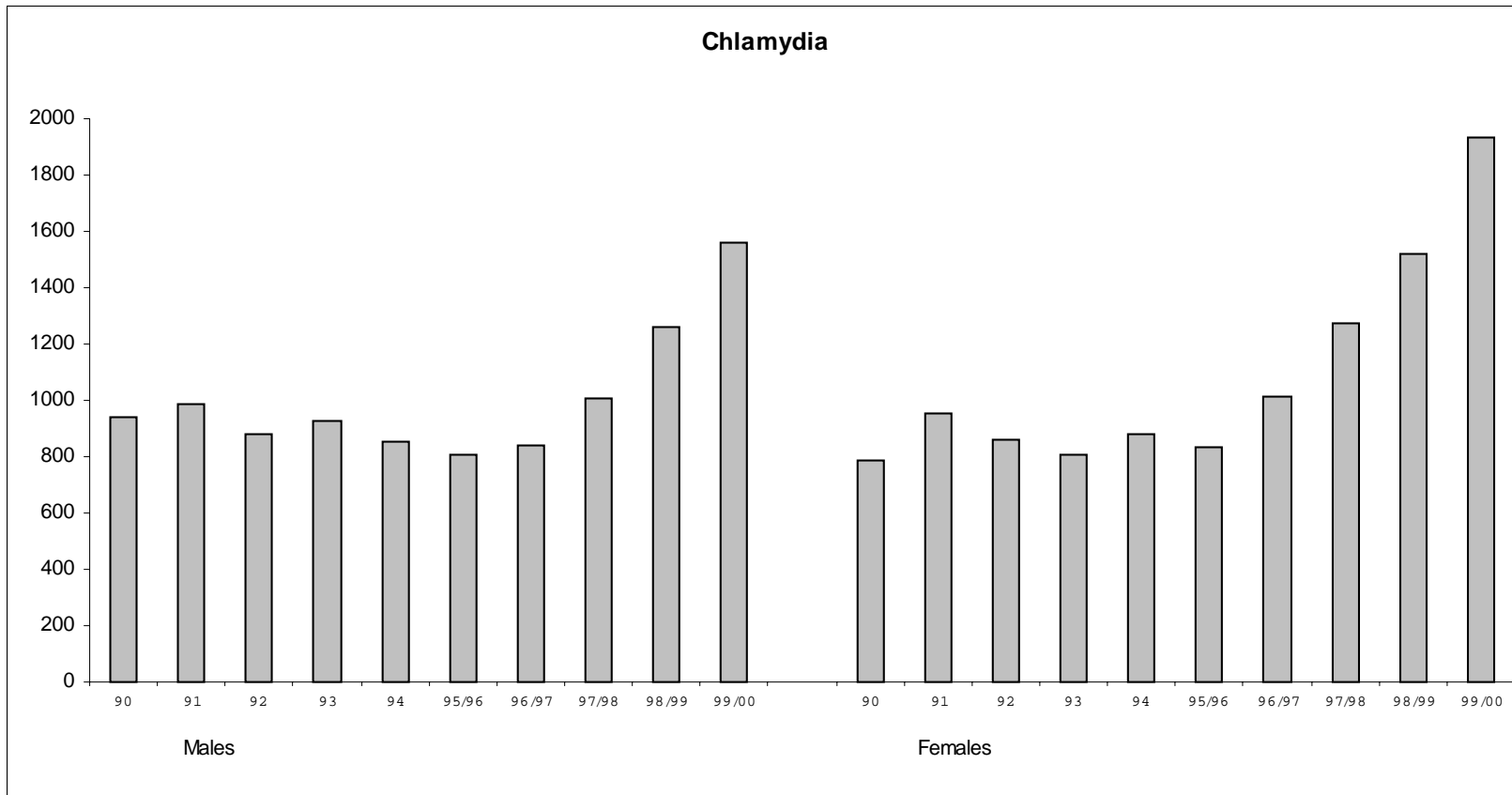
Graph 6: Trends in Genital Warts 1990 to 1999/2000



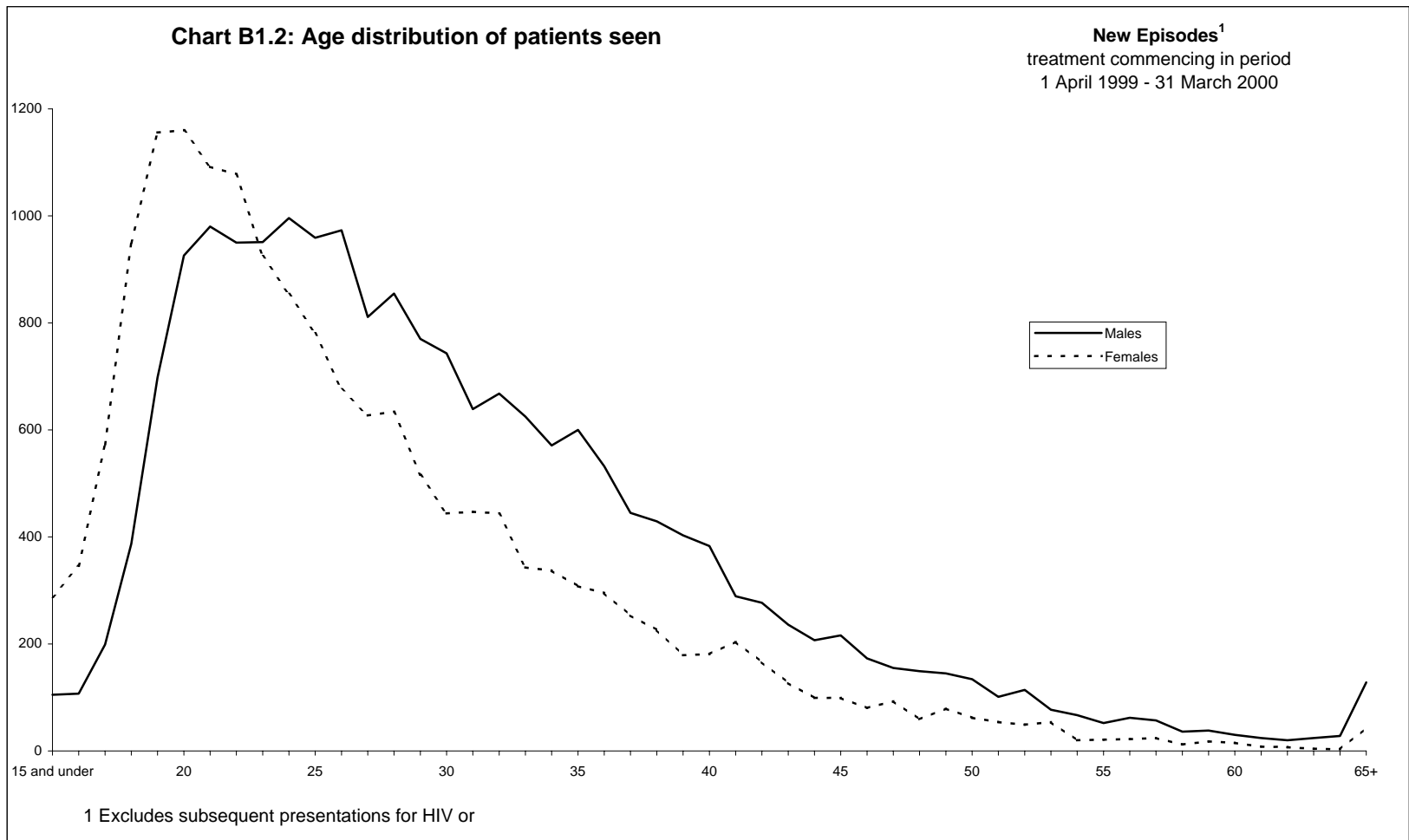
Graph 7: Trends in Genital Herpes: 1990 to 1999/2000



Graph 8: Trends in Chlamydia: 1990 to 1999/2000

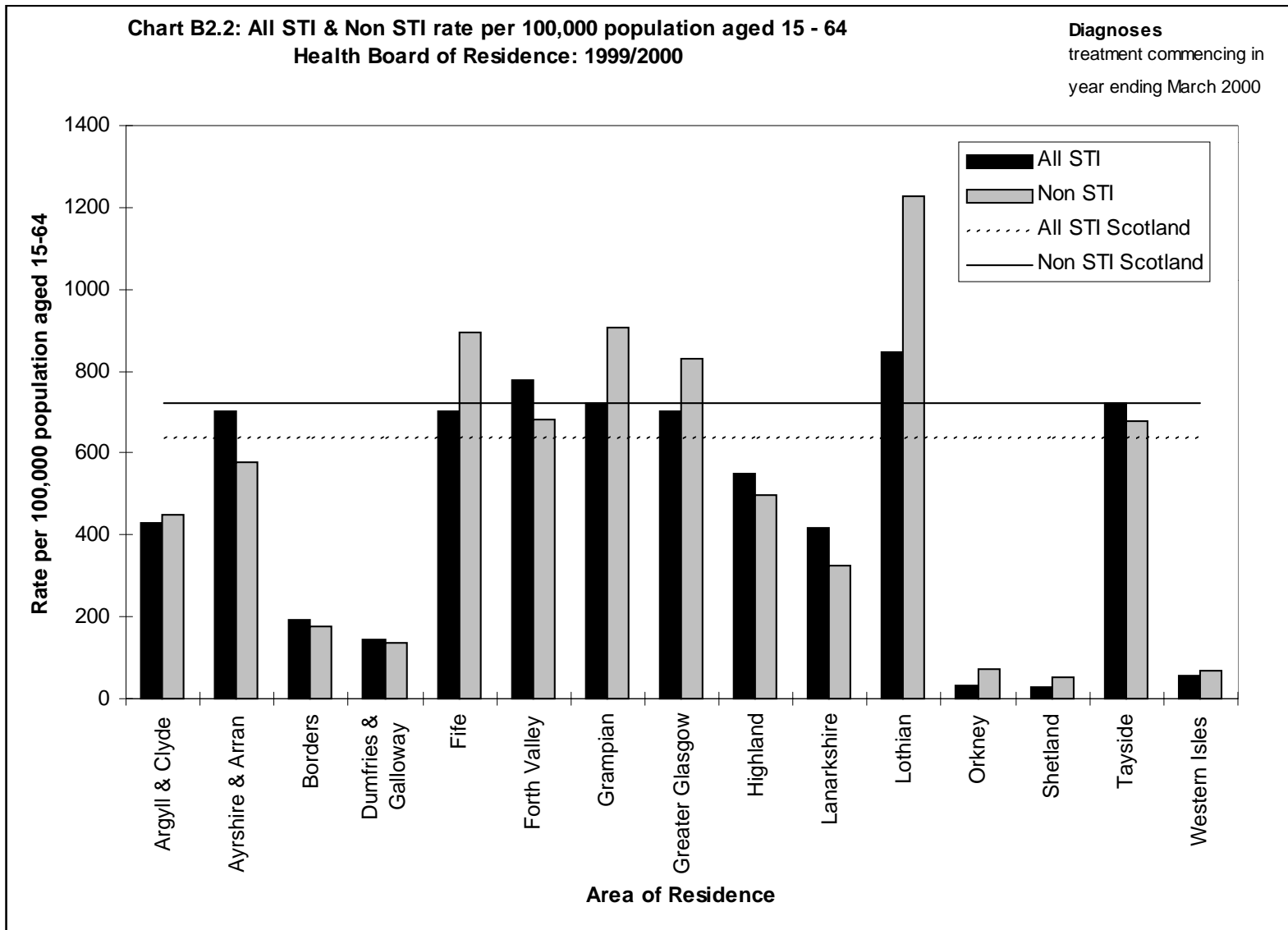


Enhancing Sexual Health in Scotland: A Sexual Health and Relationships Strategy
Graphs to accompany Supporting Paper 1



Enhancing Sexual Health in Scotland: A Sexual Health and Relationships Strategy
 Graphs to accompany Supporting Paper 1

Graph 10



Enhancing Sexual Health in Scotland: A Sexual Health and Relationships Strategy
 Graphs to accompany Supporting Paper 1

Table 1: Genital Warts - contact, incidence and prevalence rates per 1,000 population

by gender and age group for Scotland; year ending March 2000

	population	number of contacts	contact rate	number of first and recurrence diagnoses	incidence rate
Males					
All ages	152 033		226	1.5	162
0 - 4	8 578		2	0.2	2
5 - 14	20 351		3	0.1	3
15 - 24	19 053		62	3.3	51
25 - 44	47 523		136	2.9	92
45 - 64	37 990		21	0.6	14
65 - 74	11 446		1	0.1	-
75 - 84	5 802		1	0.2	-
85+	1 290		-	-	-
Females					
All ages	155 708		216	1.4	133
0 - 4	8 134		3	0.4	1
5 - 14	19 189		2	0.1	1
15 - 24	17 945		104	5.8	64
25 - 44	46 631		92	2.0	57
45 - 64	37 356		13	0.3	9
65 - 74	13 428		-	-	-
75 - 84	9 408		1	0.1	-
85+	3 617		1	0.3	1

Enhancing Sexual Health in Scotland: A Sexual Health and Relationships Strategy
 Graphs to accompany Supporting Paper 1

Table 2: Gonorrhoea - contact, incidence and prevalence rates per 1,000 population
 by gender and age group for Scotland; year ending March 2000

	population	number of contacts	contact rate	number of first/ recurrence diagnoses	incidence rate
Males					
All ages	152 033		16	0.1	10
0 – 4	8 578		-	-	-
5 – 14	20 351		1	0.0	1
15 – 24	19 053		2	0.1	1
25 – 44	47 523		7	0.1	4
45 – 64	37 990		4	0.1	2
65 – 74	11 446		1	0.1	1
75 – 84	5 802		1	0.2	1
85+	1 290		-	-	-
Females					
All ages	155 708		8	0.1	7
0 – 4	8 134		-	-	-
5 – 14	19 189		-	-	-
15 – 24	17 945		2	0.1	2
25 – 44	46 631		3	0.1	3
45 – 64	37 356		1	0.0	1
65 – 74	13 428		1	0.1	-
75 – 84	9 408		-	-	-
85+	3 617		1	0.3	1

Enhancing Sexual Health in Scotland: A Sexual Health and Relationships Strategy
 Graphs to accompany Supporting Paper 1

Table 3: Genital Herpes - contact, incidence and prevalence rates per 1,000 population

by gender and age group for Scotland; year ending March 2000

	population	number of	contact	number of first/	incidence	number of	prevalence
		contacts	rate	recurrence	rate	patients	rate
				diagnoses			
Males							
All ages	152 033	34	0.2		25	0.2	26
0 - 4	8 578	-	-		-	-	-
5 - 14	20 351	1	0.0		1	0.0	1
15 - 24	19 053	7	0.4		5	0.3	5
25 - 44	47 523	16	0.3		13	0.3	13
45 - 64	37 990	9	0.2		5	0.1	6
65 - 74	11 446	-	-		-	-	-
75 - 84	5 802	1	0.2		1	0.2	1
85+	1 290	-	-		-	-	-
Females							
All ages	155 708	99	0.6		72	0.5	70
0 - 4	8 134	2	0.2		1	0.1	1
5 - 14	19 189	-	-		-	-	-
15 - 24	17 945	32	1.8		26	1.4	27
25 - 44	46 631	50	1.1		32	0.7	32
45 - 64	37 356	11	0.3		9	0.2	7
65 - 74	13 428	3	0.2		3	0.2	2
75 - 84	9 408	1	0.1		1	0.1	1
85+	3 617	-	-		-	-	-

Enhancing Sexual Health in Scotland: A Sexual Health and Relationships Strategy
Graphs to accompany Supporting Paper 1

THE WIDER FACTORS INFLUENCING SEXUAL HEALTH AND WELLBEING

1. INTRODUCTION

1.1 Supporting Paper 1 has briefly outlined sexual attitudes, knowledge, behaviour and sexual ill health of people in Scotland. This paper presents further detail about the rationale underpinning the proposed strategy. It presents evidence which clearly indicates that wider social and cultural influences have a considerable impact on both attitudes to sexual health and actual behaviour. Further, that rather than view the wider social context as an 'add-on' to a strategy which is primarily concerned with reducing pregnancies and sexually transmitted infections (STIs), the opposite approach should be taken. This paper advocates a socially-orientated approach which acknowledges the significance of social and cultural factors from the outset and develops the strategy accordingly.

1.2 Scotland is an increasingly sexualised society. Sexual imagery pervades many aspects of the environments in which we live. Other countries, such as the Netherlands and the Scandinavian countries have experienced similar changes in their societies,¹ but do not have the same burden of sexual ill health.^{2;3} The reasons are multi-factorial and more research is required to reach a better understanding. However, it has been suggested that, unlike these countries, the UK (including Scotland) has failed to appreciate the importance of the social and cultural environment on sexual behaviour and sexual health and, as a result, has failed to adequately equip its population, and particularly its young people, to cope with this new world.¹

1.3 This strategy has adopted a holistic approach to sexual health, and the Reference Group endorses the World Health Organisation (WHO) definition as:

“A state of physical, emotional, mental and social wellbeing related to sexuality; it is not merely the absence of disease, dysfunction or

infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.”^a

1.4 Attitudes, expectations and behaviours relating to sexuality and sexual behaviour, as well as the range of sexual health outcomes, are significantly influenced by social and cultural factors. These include socio-economic circumstances and the inequalities these cause, family and parents, gender, sexual stereotypes, ethnicity, faith perspectives, and the media. These influences are explored in more detail in this paper and in Supporting Paper 3 which explores the influence of the media and mass communications.

1.5 Social policy often develops in response to what is happening in society, but it also has an important part to play in leading change on some issues, for example, encouraging widespread use of seatbelts when driving. If we accept the significance of the social context in affecting sexual health this implies the importance of the social policy and legislative framework. Given the link between sexual health, social context and the social policy and legislative framework, it is apparent that sexual health issues cut across many policy arenas which are often out with traditional health fields, for example education and social inclusion. For these reasons an integrated ‘joined-up’ approach which links the implementation of the sexual health strategy to other related policy areas is vital at both local and national levels.

1.6 A socially orientated approach must also inform the design and delivery of services. This means moving away from an individualistic approach where

^a http://www.who.int/reproductive-health/gender/sexual_health.html. This was discussed at an international WHO Technical Consultation on Sexual Health (28-31 Jan 2002), then refined and amended by a small working group thereafter.

the emphasis is primarily on the delivery of health services relating solely to the physical outcomes of sexual intercourse. In terms of learning, a socially orientated approach will focus on placing the physical aspects of sex in the broader context of emotions and relationships.

- 1.7 The determinants described in this paper are not separate and distinct. Many impact on or influence others, for example, societal views of gender can be reinforced within families and the roles that parents adopt. However, for ease of comprehension, the factors are set out in individual sections.

2. SOCIO-ECONOMIC STATUS

- 2.1 Health inequalities are clearly seen in sexual health; those with lower incomes and socio-economic status have poorer general health, including sexual health, than those who are more affluent.^{b 1;2;4;5;7;8} Lower social class is associated with an earlier start of sexual activity^{4;9;10} which in turn is linked to subsequent regret,^{11;10;12} less protection against conception and STIs, and more subsequent sexual partners.^{10;13;14} Higher levels of deprivation are associated with less consistent contraceptive use¹³ and a higher risk of teenage pregnancy.^{5;13;15;16} The subsequent outcome of teenage conception varies significantly with more young women from lower socioeconomic backgrounds opting to continue their pregnancy than those from more affluent families.¹⁷ There is little information about teenage fathers but what there is suggests that those who became fathers before the age of 22 are more likely to come from lower socio-economic groups.^{6;16;18;19}

- 2.2 The geographical distribution of teenage pregnancy confirms this link. Research has found that, in Scotland, those in the poorest areas have conception rates three times higher and birth rates up to ten times higher than those in the most affluent areas.^{5;17;20} This difference increased during the 1980s and 1990s.⁵

2.3 Low socio-economic status has also been associated with certain STIs and HIV.¹³ The first HIV epidemic in Scotland was amongst injecting drug users in deprived areas of Edinburgh and Dundee, with the potential for subsequent sexual transmission. Men who have sex with men with lower socio-economic status appear to be more susceptible to sexual ill health than those from more affluent backgrounds.^{21;22} However, although gonorrhoea rates have been shown to be associated with deprivation in London²³ and Leeds,²⁴ in both cases ethnicity was a far more important factor, and a recent survey found that chlamydia infection did not vary by social class.²⁵

2.4 Access to the means to maintain sexual health is important and sexual ill health may in part be explained through difficulty in accessing services especially for those in areas of higher deprivation. However, motivation to maintain sexual health is necessary and evidence suggests that educational and cultural factors are particularly influential and potentially more significant.^{2;5;14}

Economic factors and education

2.5 Teenagers from areas of higher deprivation tend to have lower expectations about educational achievement and the benefits of education. Lower expectations and attainment are associated with earlier onset of sexual activity and lower rates of contraceptive use.^{3;14} Good educational and employment prospects are associated with higher contraception use and less risky behaviours.¹⁸ In women, higher levels of education are linked to fewer unwanted pregnancies, fewer babies with low birth weight, and lower rates of infant mortality.^{2;26} In addition, girls whose educational achievement declines between the ages of 7 and 16 are at greater risk of teenage parenthood.²⁶ A substantial proportion of young women who are looked after have a child by the age of 16 and nearly 50% become mothers within 18 to 24 months of leaving care.^{2;77}

^b One negative sexual health outcome that seems to be unrelated to deprivation is sexual

2.6 Pregnancy and parenthood are positive choices for some young people. However, teenage parenthood is all too often associated with lifelong economic, social and health consequences for both the mother and child and is therefore of considerable social and political concern. If young people have low aspirations, or see no opportunities for their future, they will see few reasons to justify either postponing sexual activity or using contraception.^{5;14} The incentive to avoid early parenthood stems from having a stake in the future, a sense of hope and an expectation of inclusion in society.¹ This reinforces the importance of addressing problems in the wider economic and social environment that contribute to the poor life circumstances and dearth of opportunities that exist for the most deprived people in Scotland.

Economic factors and culture

2.7 The role of education as a mediating factor between economic disadvantage and poorer sexual health outcomes may be primarily through its influence on culture. The sexual values and skills of teenagers tend to reflect their community and their socio-economic status.²⁷ Deeply held cultural beliefs about gender roles in society which encourage sexual risk taking by men and female responsibility for sexual behaviour and sexual health are also an important aspect of this.²⁸

2.8 Since 1997 the Government has made significant progress in addressing social exclusion and deprivation^{29;30;31} and, as part of this, reducing teenage pregnancy is identified as important.³¹ Sexual health specific health promotion or health care programmes in areas of deprivation are more likely to be effective if they are delivered alongside these broader social inclusion initiatives. It is therefore important that holistic, socially oriented approaches are taken to addressing teenage pregnancy and rising STIs and that the different policies and strategies aiming to combat deprivation and associated problems support each other.

3. PARENTS AND FAMILY INFLUENCES

- 3.1 Parents and families are fundamental in the development of sexual values, attitudes and skills, as well as in influencing sexual behaviour.³² Parents influence developing attitudes to sex and to gender identity, which build foundations for different styles of sexuality, and the family provides a moral and value framework which influences sexual conduct.³²
- 3.2 Communication about sexuality in the family is likely to increase teenagers' knowledge about sexual health, enable them to communicate more effectively with a sexual partner, and to consider, plan and implement safer sex strategies and more responsible decision making about sex.^{32;33} Evidence has shown that most parents feel that they have a responsibility to discuss sex and sexual health with their children.³⁴ However, many find this difficult and only half of these parents will actually do so.³⁴ Even then, discussions with daughters are more likely than with sons.^{16;34;35}
- 3.3 Families in Scotland vary in terms of, for example, ethnic background, sexuality, values and beliefs. Family structure in Scotland is also changing, for example the 2001 census recorded more people as never married and living alone, a slight increase in single parent families, and found that dependent children are now more likely to be in lone parent or cohabiting couple families than in 1991.³⁶ These changes should be reflected in policies and services, such as Children's Services, in order that they are appropriate and inclusive.
- 3.4 Associations have been found between family composition and sexual risk-taking.^{37;38} Children from families where both biological parents are present are least likely to be pregnant by 18 years of age³⁷ or to have high numbers of partners at 15 years.³⁹ Teenage pregnancy is linked to family history, with the daughter of a teenage mother estimated to be one and a half times more likely to become one herself thus repeating the risk of lifelong socio-economic disadvantage.^{15;26;40;41}

3.4 Sweeting *et al.* concluded from their own longitudinal data that “school achievement, heterosexual behaviour, pregnancy and experience of drugs were each related to family structure” but that the effects of family structure must be understood in relation to the effects of family processes, and that the latter are probably more important.³⁷ Important processes include time spent together in family activities, parental support, parental monitoring (in terms of control or restrictiveness), and minimising family conflict.^{11;34;37;42} Young people who report more emotionally available parents were more likely to have intimacy orientated attitudes toward sexual relations, as opposed to physically oriented attitudes, which is linked to delays in first intercourse, higher levels of prior discussion of, and use of, contraception.³⁴

3.5 Whilst family and home influences can be positive and provide building blocks for establishing and managing relationships and sexual behaviour, the family can also be an unsafe place for women and children if they experience violence, sexual abuse or child abuse. Support is necessary for those who are abused in order to minimise future health and social problems. The National Strategy on Violence Against Women⁴³ and the linked NHS Guidance on Responding to Domestic Abuse for Health Care Workers in NHS Scotland⁴⁴ are attempting to tackle this. Implementation should be linked to implementation of this sexual health strategy.

4. GENDER

4.1 Although opportunities for women have increased in the last few decades, societal differences between women and men still continue and are often seen as natural. The way society is organised based on notions of men and women, and the resulting economic, social, cultural and domestic behaviours and roles, is critical to sexual attitudes and behaviours. As discussed in the section above, gender roles and stereotypes are learned from infancy through one’s family and the wider society, and have an important effect on developing sexuality and, in turn, on sexual behaviour.³³

- 4.2 Individual attitudes and sexual norms are learnt differently according to one's sex and gender.^{45;46} There is a dominant view that teenage pregnancy, for example, is primarily a problem of girls. The responsibility of boys is downplayed considerably.^{28;33} This is reinforced by the paucity of evidence about teenage parenthood and boys.¹⁸ In part, this has followed the policy lead as funding for research is largely driven by national and local policy.
- 4.4 Gender stereotypes are very persistent and throughout adolescence and adulthood people are under social pressure to conform to gender-specific sexual roles that are particularly promoted through the media.^{47;48} Cultural stereotypes tend to suggest that femininity is 'passive' and that women should learn to act in the way men expect, whilst also taking responsibility for protecting themselves and others from risk. Masculinity, on the other hand, is 'active' and involves taking risks and that 'maleness' means that the sexual act is more important than the relationship.³³ The tendency is for young women to experience sexual activity as part of how they relate to boys and gain approval and social acceptance, while young men experience it as a form of achievement.^{28;45;46} Boys who do not fit the dominant stereotypes are often subject to homophobic attitudes.^{49;50;51}
- 4.5 There are significant gender differences in relation to whether or not first sexual intercourse was reported as being 'wanted'. A significant proportion of first sex is unwanted, the proportion being greater the younger the age.⁵² However, more young men report that their partner was 'equally willing' at first sexual intercourse than young women.¹¹ More young women than young men report that sexual intercourse either happened too early or shouldn't have happened at all¹² and report feelings of regret.¹⁶
- 4.6 In terms of coercion and consent, being 'forced' at first sexual intercourse is more common for women, especially if first sex occurs before 14 years

of age,^{11;52;53} ranging from 2%⁵³ to 7%.¹¹ When asked if they had come under pressure to have sex this rises to between 20 and 25% of girls.

4.7 Gender also appears to be a significant factor in relation to contraceptive use. Young women are expected to, but often find it difficult to, negotiate the initial use of contraception and to maintain the use of contraception once relationships become more established.^{47;54;55} This is reflected in the way that information and services tend to be delivered; despite growing recognition of the inappropriateness of treating women as the guardians of sexual health and fertility, sexual health promotion, school-based sex and relationship education and sexual health services tend to focus on protecting women from the consequences of sexual activity.³³ The importance of boys and young men protecting their own, as well as their partner's sexual health, has not been a priority.²⁸ This reinforces stereotypes about women as being both passive in sex, sometimes having little choice, yet being active in assuming responsibility for herself and others, and excludes and disempowers men, perpetuating deeply held negative cultural beliefs about their roles and responsibilities within relationships.⁵⁶

5. SEXUAL STEREOTYPES: HOMOSEXUALITY AND HETEROSEXISM

5.1 Despite increasing acceptance of diversity in many forms in society, lesbian, gay, bisexual and transgender (LGBT) people continue to experience social exclusion and prejudice as a result of discrimination on the basis of their sexual orientation. This is still widely seen as acceptable in Scotland,¹⁶ as was demonstrated in the reaction to the repeal of Section 2A of the Local Government Act 1986.⁵⁷

5.2 Fear or dislike of homosexuality in others or oneself (homophobia) and the assumption of heterosexuality as the norm in sexual relationships (heterosexism) create stigma and discrimination. This can lead to feelings of isolation, stress and anxiety for LGBT people⁵⁸ and create unnecessary divides in society.⁵⁹ LGBT people are themselves a diverse group with other social determinants impacting on their lifestyle and health such as

disability, race, ethnicity and economic factors which can compound their isolation.

5.3 Being excluded from society has an impact on many aspects of the lives of LGBT people, including health, substance use, homelessness and suicide.^{60,61} Migration of LGBT people from rural and suburban areas to urban settings that have a 'gay scene' is a common occurrence but may well add to, rather than reduce, social isolation. Young LGBT people are more likely to engage in risk taking behaviours in response to their social isolation and vulnerability.⁶² These young people also fear they will not fit into the gay scene and this results in added pressure and impact on mental health.⁶³ The perception of many of these young people is that homophobia makes them into second class citizens.

5.4 Access to services is difficult for a number of reasons, including risk of identification as being LGBT, lack of appropriate services especially in rural areas, attitudes of health service staff, etc. In particular, services for gay and bisexual men may perpetuate inequality as they tend to focus on sexual health and ignore other aspects such as mental health.⁶² Lack of services is particularly pertinent for lesbians, as emerging data show higher or similar prevalence of STIs compared to women who have not had sex with women.⁶⁴ A recent review of the impact of homophobia, heterosexism and social exclusion on the health of LGBT people concluded that the health of LGBT people is largely ignored both by health care services and within the inequalities policy agenda in Scotland.⁶⁵ However, there are broader moves at the UK and Scottish policy levels to address inequalities experienced by lesbian and gay people, for example improved protection against discrimination on the grounds of sexual orientation.

5.5 Social, school and personal attitudes lead to constraints in dealing effectively with same sex relationships in school based sex and relationships education.⁶⁶ Supporting Paper 4 discusses education for young people in more detail. Whilst not all teachers or schools are

homophobic, a heterosexist assumption underlies Scottish sex education and this perpetuates the invisibility of LGBT sexuality.⁶⁶

6. ETHNICITY AND FAITH

6.1 Little is known about the sexual health needs and outcomes of those who belong to black or minority ethnic (BME) communities as ethnic group information is not collected for routine figures on sexual health. People from BME communities face discrimination in many aspects of their lives, and a lack of information about minority sexual health is also discriminatory because important problems may be ignored.⁶⁷ However, since there tends to be greater proportions of young people in BME communities than in Scotland as a whole, and young people tend to be more sexually active and thus more at risk of poor sexual health outcomes, there is a need to address sexual health issues with these communities.⁶⁸

6.2 In addition to the lack of data on BME communities, there are also different cultural expectations and attitudes which may make it difficult to access these groups. The dominance of 'mainstream' cultural values may result in the marginalisation, stigma, and reluctance to access appropriate health services for people from minority groups. Cultural and religious attitudes to sexuality and marriage from within certain ethnic and faith groupings may pose tensions, particularly for those young people who face dissonance between the dominant social norms and those of their family or faith group.⁷¹

6.3 Evidence from a number of small scale studies suggests that people in some BME communities lack knowledge and have limited access to appropriate and relevant information about sexual health.^{67;68} BME communities are often grouped together but there are vast differences in cultural expectations, attitudes and experience of the sexual aspects of life both between and within these groups. For example, age at first intercourse varies considerably between ethnic groups and shows pronounced gender differences,⁶⁷ and there are some indications that

teenage pregnancy and STIs are more likely in some minority ethnic groups.^{15;22;69;70}

6.4 Recent epidemiological reports indicate a high prevalence of HIV among people in Scotland who have links with Sub-Saharan Africa.^{72;73} Trends in high prevalence areas globally will be reflected in Scotland, including Scottish residents as well as other more transient communities such as workers from overseas, asylum seekers, and students. Issues related to HIV and other sexually transmitted infections can be particularly difficult for BME communities in Scotland, especially with regard to stigma and discrimination as well as the inaccessibility of many services. Clinic and community approaches need to adapt to meet the needs of these communities. This will require activity at national level to identify need and to encourage adoption of promising and good practice. Work will also be required at a local level to build and strengthen the capacity of HIV and sexual health agencies working with BME communities. Ideally HIV and sexual health issues will be integrated with those of minority ethnicity.

6.5 NHS Fair For All is a major initiative that is seeking to address inequalities experienced by BME communities within the NHS in Scotland⁷⁴ but has yet to tackle sexual health issues.

7. DISABILITY

7.1 The term 'disability' describes the social exclusion that prevents people with a range of physical, intellectual, sensory and psychological impairments from having full and equal citizenship.⁷⁵ Disabled people are sexual beings with sexual and emotional needs and desires. However, their sexuality is often ignored, stereotyped or distorted, which may lead to the development of low expectations about sexual relationships and impact up on their self-esteem.

7.2 The sexual health experiences and needs of disabled people are varied and complex, and issues will vary from individual to individual. In promoting the sexual health of disabled people, professionals should have

regard to the person and not the impairment. Resources should contain practical information that is specific and appropriate and is in an accessible format for those with sensory impairments and/or intellectual difficulties.

7.3 The overall objective should be to integrate people with physical and learning disabilities more effectively into sexual health services from which they are all too often excluded, and for society as a whole to recognise and respect their right to express their sexuality.⁷⁶

8. IMPROVING SEXUAL HEALTH FOR EVERYONE, INCLUDING THOSE NEEDING ADDITIONAL SUPPORT.

8.1 This paper has briefly discussed the broader social issues influencing sexual health and, in particular, how they relate to some groups in Scotland. From this discussion various barriers to sexual wellbeing can be identified. These can be categorised as:

- individual barriers, such as knowledge, attitudes, lack of competence or confidence;
- physical barriers, such as distance, cost or accessibility;
- social barriers, including staff attitudes and skills, and parents' and teachers' unwillingness to discuss sex with young people; and
- cultural barriers, which include unwillingness to accept young people's sexuality, the gender roles that influence sexual behaviours, and the influence of faith perspectives, culture or ethnicity.

8.2 Many groups face one or more of these barriers and some of these groups have been addressed earlier in this paper. These include, but are not limited to, young people, those with physical or learning disabilities, people living with HIV, LGBT people, those from BME communities, homeless people, victims of domestic abuse, and men and women in prostitution.^c

^c The term prostitution is used here in preference to 'sex work' or 'work in the sex industry' which some feel suggest prostitution is something that people choose to do and that it can be legitimised as an acceptable form of work.

Barriers are likely to have the greatest impact on those who are most disadvantaged in society.

8.3 If the barriers are recognised and addressed when planning local services for lifelong learning and health care the sexual health of many in these groups will be improved, for example, by improving the consistency, accessibility, quality, cultural competence and ethos of lifelong learning and appropriate and responsive sexual health services. However, there are a number of groups whose sexual health is of particular concern (for whom STIs are increasing and/or unintended pregnancies are high), or those who are particularly hard to reach, for whom additional support will be required. Respondents to the engagement exercise suggested a number of target groups.^d Whilst the Reference Group lacked the time for a detailed examination of all of these many groups, there is compelling evidence that, in terms of STIs and unintended pregnancies, the following groups are particularly vulnerable and more so if they live in deprived areas:

- Young people under 25, and especially those who are looked after or leaving care, those excluded or under performing at school, and those involved in crime^{18;26;77;78}
- Children of teenage mothers, particularly daughters^{15;79}
- Male and female prostitutes⁸⁰
- Men who have sex with men^{22;78}
- Those who have travelled from Sub-Saharan Africa and other areas of high HIV prevalence^{22;72;78}

This list is neither comprehensive nor exhaustive as the current evidence has many gaps. It should be reviewed as further evidence and information emerge.

^d During the engagement exercise, the range of target groups suggested included young women and men, young people looked after or leaving care, LGBT people, teenage mothers, teenage fathers, disabled people, people with learning disabilities, women experiencing domestic abuse, homeless people, gypsies and travellers, BME communities, drug users, men who have sex with men, young offenders, the prison population, prostitutes/commercial sex workers, refugees and asylum seekers, individuals with HIV or AIDs, older people, parents. Some submissions stated that focussing on specific groups was not appropriate.

8.4 Targeting may not require newly developed or sexual health focussed services; appropriate responses may be to increase the scope of existing services or organisations that are already successfully reaching target groups. These organisations can incorporate basic sexual health information and services either by training the existing staff or by providing specialist outreach. Innovation should be encouraged in reaching the hardest to reach. Specialist services, however, must link with other local services and provide opportunities for referral between services. In all cases care must be taken to avoid reinforcing the isolation and stigma already being experienced.

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PROMOTING POSITIVE SEXUAL HEALTH THROUGH THE MEDIA AND MASS COMMUNICATIONS

1. INTRODUCTION

1.1 Mass communications is the term used to describe the use of the media to interact with the general public. The media is made up of many different forms including television, radio, magazines, newspapers, advertising and the Internet. Some media are Scottish based but, increasingly, media influences are UK wide or global and this presents additional challenges both in analysing the effect of the media on individuals and in developing appropriate media strategies for use locally.

1.2 Like many western countries, Scotland is increasingly becoming a media saturated society. Some studies estimate that young people (6-17 year olds) spend around five hours per day with one form of media or another.¹ Most research has been done on the effect of the media on young people and young adults, however we know that the media is a dominating influence for all ages. Given this it is virtually impossible to ignore the media as a potential vehicle for delivering health related messages.

1.3 Sexual intercourse, or its implication, is often used as a marketing tool and sexual imagery pervades many aspects of modern society. These messages tend to reinforce stereotypes about the expected activities and behaviours of women and men, ignore the risks associated with sexual behaviour and have little resemblance to real life.² The media also presents a range of views about gender roles, body image and relationships. When messages in the media about sex (and particularly those targeted at young people) were compared across newspapers, television and teen magazines, the following themes were highlighted:^{3;4}

- young people were nearly always portrayed as heterosexual;
- references to homosexuality were typically made through humour and fear;

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- sexual stereotypes were reinforced, with young men viewed as 'up for sex' and young women as interested in emotions;
- the limited references to contraception were within the context of female responsibility;
- there was little discussion of how safe sex might be negotiated;
- male magazines aimed to titillate rather than educate, while the content of female magazines was graded according to age to provide information and advice; and
- newspapers tended to focus on sex crimes and the dangers of teenage sex.

1.4 In the absence of other reliable sources of information and advice unbalanced or inaccurate media messages can therefore lead to pressures and confusion over the realities of sex and sexuality particularly for young people. Feedback from the NATSAL survey shows that young females, in particular, view the media as one of their main sources of information.⁵ It is therefore important to provide some balance to these messages, including provision of accurate, positive information about sex and sexual health. One important way of doing this is through the media, but this must be supported by a range of other activities.

1.5 The evidence would suggest that the media is a useful means to provide information to the general public, and particularly for a target audience, to raise awareness of a particular issue and to reflect back current thinking to users. In addition, popular media can be powerful in shaping attitudes and supplementing knowledge while either facilitating or inhibiting discussion.^{6,7} There is little evidence of media interventions changing behaviour directly, however findings from those that have suggest that campaigns are most effective when they have a positive message and are combined with a range of activities of which the media is only one. Whilst the media alone is limited in its potential to affect change, it has an important role in a multifaceted approach to sexual health improvement, as is being advocated by this strategy.

1.6 This strategy is proposing an approach to working with the media to promote sexual wellbeing that has three broad components: media campaigns, media advocacy and media literacy. It is vital that this approach links activities at both national and local levels. At a national level the media is a useful scene setter and provides a context for work at a local level; national media activities are most successful as part of an integrated approach which is multi-faceted and co-ordinated with other work on the ground. At local level it is vital to provide tailored information to the population, to address area specific needs, to promote local services, to build up relationships with local press and to support and reinforce key national messages. While the way that national and local media communicate can and will vary, it is important that the core messages are consistent.

2. MEDIA CAMPAIGNS

2.1 There is considerable research and practitioner experience in the field of media campaigns, but in terms of sexual health this is largely in relation to young people under 30.

2.2 The most recent evidence suggests that key features of effective media campaigns aimed at young people include:⁸

- one clear and consistent message;
- positive, factual and non judgemental tone;
- respect for the target audience, treating them as responsible for their own choices;
- accurate reflection of the target group's world;
- communication through a range of formats for different facets of the message;
- reinforcement of the key message over time;
- delivery of messages from an organisation considered to be impartial, authoritative, trusted and identifiable; and

- consideration of the needs of specific groups e.g. young men while avoiding gender stereotypes.

2.3 The same authors looked at communicating with parents and society at large and concluded that campaigns for parents should draw attention to the importance of sex education to the future welfare of their children but must also provide them with the tools to communicate effectively with their children at various ages.⁸ They also cited evidence that adverse media coverage can damage campaigns and so, to avoid this, proactive approaches to communicating the key facts to the media need to be adopted.

2.4 Evidence suggests that communications about sexual health which have personal relevance and which recognise the realities of sexual encounters will communicate as well to young adults from ethnic minorities as to the mainstream audience as language is not normally a problem for this age group.⁸

2.5 More research and work with older age groups is needed to increase our understanding of the role of the media in promoting sexual health with them.

3. MEDIA ADVOCACY

3.1 This is defined as the strategic use of mass media to influence the public and policy makers and encourage social change. It can be used to educate the public, sway public opinion and influence policy makers. It assumes that media exposure will be positive, in this instance, to sexual health.⁹

3.2 The media have a tendency to sensationalise sex, sexuality and sexual health issues and this helps to reinforce negative stereotypes, stigma and discrimination. It follows that in order to successfully influence a broader community, an initial target for media advocacy work is the media itself.

3.3 Elements of media advocacy work include:

- **a proactive press and public relations strategy**, and particularly through interaction with media at a local, as well as national, level.
- **influencing the content** and the way in which sexual health issues are communicated. There are problems in this area, not least the globalised nature of our media, there are recognised successes too, such as 'fly on the wall' documentaries of sexual health services and soaps operas with storylines that include teenage pregnancy. In the USA, guidelines for media personnel have been developed and endorsed by the National Commission on Adolescent Sexual Health. If they are followed, a more balanced image of sexuality in the media may emerge.
- **giving users a voice**, by providing opportunities for people to produce their own media messages and make contact with the broader media. Some successful examples of this have taken place with young people in Scotland (for example, the Young Scot project).

4. MEDIA LITERACY^a

4.1 Media literacy is the ability to interpret and analyse media messages and has been described as an alternative to censoring, boycotting or blaming the media when it is perceived as not promoting 'accurate' points of view.

4.2 Supporting the development of media literacy may enable users of the media to be more critical, more aware of the power of the media and, importantly, help them develop skills to interpret the media in the context of their own lives. However, media literacy is relatively new in the UK and while there is some evidence from the USA, more research into the effectiveness and usefulness of this approach is required.

5. CONCLUSION

5.1 The Reference Group concludes that work with the media should support action to improve sexual health. Specifically, the National Sexual Health

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Advisory Committee, which will be established as part of this strategy, should link with those with media responsibility in NHS Health Scotland and the Scottish Executive to develop a multifaceted mass communications strategy for improving sexual health. This should include the three components highlighted above (media campaigns, media advocacy and media literacy) and link activities at national and local levels. Whilst the key messages require to be agreed, the approach should seek to:

- Encourage a cultural shift towards a more open and positive view of sexual relationships and sexual health that is accepting of diversity;
- Promote an ethos that promotes relationships based on equity and respect;
- Challenge gender stereotypes and reinforce the responsibility of both men and women for protecting sexual health;
- Provide support for parents in communicating with their children about sexual relationships and sexual health;
- Increase awareness of ways to reduce poor sexual health outcomes;
- Raise awareness of services at both a local and national level; and
- Encourage interaction with the public on sexual health matters.

The development and implementation of this mass communications strategy should be overseen by the National Sexual Health Programme Co-ordinator.

5.2 This will require:

- Identification of the target groups based on broader priorities and effectiveness of methods
- Identification of the most effective means of reaching the target groups
- Development of 'core' messages from the strategy to be used with national and local media; and
- Delivery from a trusted source.

^a see www.medialit.org/cml for more information about media literacy.

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5.3 The mass communications strategy should support local practitioners by:

- Ensuring that support and training is provided for practitioners at a local level to work with local media; and
- Developing mechanisms to link media coverage in Scotland and across the UK with local information, lifelong learning and health service provision in order that local services are prepared to respond to increased demand.

5.4 There will also be a need to provide information and support to, and develop relationships with, different media both in Scotland and across the UK. This should include:

- Establishment of a pool of experts from a variety of disciplines and from localities across Scotland which local or national media can approach for accurate information and comment;
- Means to facilitate proactive work and innovative ideas to promote key sexual health messages with different aspects of the media in Scotland at both local and national level; and
- Development of information packs and/or guidelines for media.

5.5 Finally, because there are significant gaps in evidence, further work and research should be commissioned to:

- explore the potential of media literacy training, including a pilot project;
- learn more about the way in which media, in particular sexual media, is used by consumers;
- further investigate and expand existing opportunities to give consumers a voice; and
- better understand the influence of the media on gender.

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SEXUAL HEALTH AND RELATIONSHIPS EDUCATION FOR YOUNG PEOPLE

1. INTRODUCTION

- 1.1 In supporting the proposed Sexual Health and Relationships Strategy, this paper provides an overview of the issues influencing learning about sex and sexual health among young people and summarises the research findings in terms of levels and sources of young people's knowledge about sexual health.
- 1.2 It details the background to effective sex education and then highlights the key influencers on young people's learning about sex and sexual health. A detailed commentary is provided on early childhood programmes, the role of parents and carers and school based sex and relationships education and sex education outside school settings.

2. BACKGROUND

- 2.1 For some time, issues relating to the sexual health of young people have featured in health and education policy in Scotland. The two major issues that have dominated public health policy and research are HIV/STIs and teenage pregnancy. More recently, work has begun to explore other aspects of poor sexual outcomes such as coercion and regret in relationships.
- 2.2 Why focus on young people? Research indicates that early sexual behaviour can put young people at increased risk of poor sexual outcomes such as sexually transmitted infections and unintended pregnancies in teenage years. These can have long-term health, social and economic consequences (as highlighted in Supporting Paper 2 on the wider social and cultural factors which influence sexual health and wellbeing).
- 2.3 Reviews of international and national evidence indicate that the number of unintended pregnancies and sexually transmitted infections can be reduced through:

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2.3.1 A good general education or vocational programme leading to:

- Increased aspirations and expectations
- Motivation to avoid risk behaviour

2.3.2 The provision of sex education which aims to:

- Provide skills and confidence to maintain respectful relationships
- Provide information and skills to delay the timing of first sexual activity
- Provide information and skills to encourage individuals to protect themselves against unwanted pregnancy and sexually transmitted infections
- Increase knowledge of contraceptive use and availability of contraceptive services
- Increase awareness and understanding of post coital contraception.

2.3.3 The provision of contraceptive services and counselling which seek to:

- increase contraceptive use and compliance
- increase the use of post coital contraception following unprotected sex or contraceptive failure

2.4 Many factors are associated with early sexual initiation, contraceptive use and teenage pregnancy and have been identified in other supporting papers. A summary of these factors is shown in the table below:

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Table 1: Factors associated with early initiation, contraceptive use and teenage pregnancy (NHSCRD, 1997)

Socio-economic	Individual	Family	Educational	Community	Contraception
Poverty/income	Age of first intercourse	Family structure	Academic achievement	Social norms	Contraceptive services
Employment prospects	Emotional maturity	Family size	Educational goals	Peer influences	Awareness
Housing and social conditions	Knowledge	Parenting style	Sex education	Cultural and religious influences	Availability
Poor general education	Self esteem	Parent to child communication	Truancy or exclusion	Media influences	Accessibility
Limited opportunities and aspirations	Skills base	Mother or sister as teenage mothers			
	Cognitive maturity	Child abuse or neglect			
	Physical maturity				
	“Experimental” behaviour				

3. INFLUENCES ON LEARNING ABOUT SEX

3.1 Learning opportunities are important to improving sexual health but learning about sex does not occur in a vacuum. It is a lifelong process that commences in childhood through adolescence and into adulthood. From an early age, children and young people are exposed to a range of influences such as parents, siblings, friends, community and schools. References to sexuality abound in Scottish culture, especially in the media. The social context in which people live has a great impact on how young people view sexual health. Providing young people with the confidence and skills to interpret the sometimes mixed messages from all these sources is key to sex education.

3.2 There is much evidence about learning about sex based on school based sex education and whilst important, it is important to recognise the other influences as identified in Table 1. Parents, peers, the media and the community at large have a vital role helping young people gain the

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confidence and self esteem to be able to make informed choices about their sexual behaviour and influence their sexual wellbeing.

Early Childhood Programmes

- 3.3 A number of studies have evaluated early childhood programmes (the Seattle Social Development Programm and the Abecedarian project). Follow-up of the children at age 18 and 21 found that participants in both programmes were less likely to report a pregnancy than those in the comparison group (Hawkins et al, 1999). They also achieved higher intellectual and academic levels (Campbell 1999).
- 3.4 These findings have been reinforced by the results from a systematic review of the long term effects of day-care which highlight the benefits of long term strategies beginning in early years in preventing teenage pregnancy (Zoritch et al 2000). Further research is needed to identify the essential elements of early years prevention programmes.

Parents and Carers

- 3.5 From an early age, parents and carers are key to the development of sexual values and skills of their children as well as influencing their sexual behaviour because:
- parents and carers provide role models for inter-personal relationships
 - parents and carers teach about the roles of males and females in both family and wider contexts
 - the family provides a moral and values framework which influences sexual behaviour
 - good parent to child communication about sexuality and sexual health can increase knowledge and may help more responsible decision making.
- 3.6 The role of the family is discussed further in Supporting Paper 2. In terms of learning, the key aspects of family dynamics include the amount of time spent in family activities, parenting style and monitoring and parental

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support (Wight et al 2002, Aggleton 1998, Ingham and van Zesson 1998). Seamark and Gray (1997) and MacDowell (2002) showed that family discussion about sexual matters can result in lower incidence of sexual risk taking behaviour and increased knowledge whilst Wellings (2001) and Currie et al (1999) reported that males who talked to their parents about sex tended to use contraception more often when compared to those who did not talk to their parents about such matters.

What do parents currently do?

3.7 There is some evidence which indicates that parents do have some discussion with their children about a range of sexual health issues. However, what is discussed between parents and young men and women varies greatly ranging from very little to detailed discussion of personal relationships. Currie et al (1999) showed that parents were more likely to discuss sex and sexual health with their daughters on at least one occasion compared to their communication with their sons. This is supported by the findings of the Scottish sample of the Natsal survey (MacDowell 2002) which also found that young people want to discuss such matters with their parents.

3.8 Ingham explored the extent of sexual health discussion from a parental perspective and found significant differences between what parents felt they should talk to their children about and what they actually did talk about in terms of contraception, abortion, saying “no”, the role of emotions and abuse and rape. (Ingham 2002)

Who does the talking?

3.9 There are differences between mother/father and son/daughter discussions about sex. Feldman and Rosenthal (2000) showed that this is influenced by the general parenting styles adopted.

3.10 Numerous studies have shown that mothers tend to be the main educators in the household (Walker et al 2001, Feldman and Rosenthal 2000 and

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Miller et al 2001) and this is no less the case in respect of sexual health matters. Moreover, young people see it being more important for mothers than fathers to communicate about sex (Feldman and Rosenthal, 2000). This is likely because they view mothers as being less judgemental than fathers. In addition, Walker et al (2001) found that mothers can relate to their own daughters by drawing on their own experience. This does point to the need to influence informal sex education for boys within the family environment. This is particularly pertinent as young men are expected to know about sex without ever having been taught and then adopt the “macho” predatory sexual male attitude (Wight 1994, Holland et al 1998)

How can parents be helped to talk to their children about sexual health?

3.11 Walker et al (2001) and Ingham (2002) identified a number of barriers which prevented parents talking about sexual health:

- Lack of awareness of the need for sex education
- Embarrassment
- Uncertainty about what they should do or knowledge of what is going on in schools
- Lack of accurate knowledge
- Absence of skills to communicate about sexual health

3.12 Enhancing factors to help parents in their role as sex “educators” identified by Walker et al (2001) and Feldman and Rosenthal (2000) include:

- Stimuli which trigger opportunities for discussion, for example TV
- Rejecting notion that sexual health matters in the family are taboo
- Open communication and better general communication
- Introducing and responding to ideas in line with child’s development
- Better communication between parents and the school
- Access to information and resources

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3.13 The proposed Sexual Health and Relationships strategy suggests a range of initiatives to enhance the role of parents and carers:

- Mass media initiatives focussing on general communication between parents and their children
- Provision of better resources and information for parents
- Involving parents more actively in school based sex education programmes and school based services
- Community based initiatives supporting improved parenting skills

3.14 This builds on the existing activities within Scotland that are supporting parents and carers, for example:

- Healthy Respect: booklets to support parents in role as sex educators and information on confidentiality issues
- Highland Health Board: research with parents of children under 10
- HEBS/Healthy Respect: booklet for parents with teenage children

School Based Sex & Relationships Education

3.15 Whilst it is acknowledged that parents have a key role in sex education, it is also recognised that many parents have opted out of this role with the result that schools have had to fill the void and be actively engaged in sex education. (MacDowell 2002, Ingham and van Zesson 1998) This is not a new phenomenon and was recognised as early as 1943 by the Board of Education. Improvements have continued to be made to school based sex education (particularly more recently by Curriculum Paper 14 (1974) and the Report of the Working Group on Sex Education, McCabe Report (Scottish Executive 2000)). Both of these recognised the complementary role of schools and parents in sex education.

3.16 The objective of school based sex and relationships education (SRE) is to help and support pupils through their physical, emotional, moral and spiritual development regardless of whether this is in denominational or non-

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denominational schools¹. SRE should link with other parts of the school curriculum such as moral and religious education and be firmly rooted in good Personal, Social and Health Education (PSHE) as laid out in the guidance from the Scottish Executive Education Department (see appendix, also found on website www.scotland.gov.uk/library3/education/nat.advice.pdf) Effective SRE helps young people make responsible and well informed decisions about their lives by enabling them to develop considered attitudes, values and skills which influence the way they behave. As early as 1985 the World Health Organisation recommended that sex education should be “an integral part of education in every school system, to be implemented before puberty and enforced by legislation”. (WHO 1984)

3.17 The Report from the Working Group on Sex Education in Scottish Schools (Scottish Executive 2000) goes some way to meeting this recommendation (although is not enforced by legislation). Key principles for sex education were identified by the McCabe Report as:

- Sex education should be viewed as one element of health education, set within the wider context of health promotion and the health promoting ethos of the school
- Sex education should contribute to the physical, emotional, moral and spiritual development of all young people within the context of today’s society
- Education about sexuality should reflect cultural, ethnic and religious influences within the home, school and community
- Sex education starts informally at an early stage with parents and carers and continues through adulthood both within the home and at all stages of school life.

3.18 Guidelines for school based sex education have been set out by the Scottish Executive Education Department and supported by Learning and

¹ Denominational and non denominational schools are subject to the same statutory and legislative requirements in terms of school curriculum and are thus governed by policies from the Scottish Office Education Department and inspection framework from HMIE.

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Teaching Scotland (appended is a summary of the range of guidance currently in force). Her Majesty's Inspectorate of Education (HMIE) is reviewing its implementation: the report on secondary schools is due in 2003 and will be followed by 5-14 curriculum review the following year. Healthy Respect and its partners are developing guidelines on confidentiality and an educational curriculum framework to support sex and relationships education across primary and secondary schools. These will be piloted in Lothian as part of the next phase of Healthy Respect.

Approaches to school based SRE

3.19 A range of providers may deliver SRE programmes: teachers, peers and external professionals. Collins et al (2002) categorised such programmes into two types: abstinence only and comprehensive sex education/abstinence plus programmes.

Box 1: Key Features of Abstinence Plus Education and Abstinence Only Education programmes

Abstinence Plus Education (also known as comprehensive sex education)	Abstinence Only Education
<p>Explore the context for and meaning involved in sex:</p> <ul style="list-style-type: none"> • Teach that sexuality is a normal healthy part of life • Promote abstinence from sex (or delay in initiation) • Offer students the opportunity to explore and develop values • Acknowledge that many teenagers will be sexually active • Teach about contraceptive and condom use • Discuss contraception, abortion, STIs, HIV 	<p>Includes discussion about values, character building and in some cases refusal skills:</p> <ul style="list-style-type: none"> • Teach that sex outside marriage will have negative emotional, physical and social consequences • Promote abstinence from sex • Teach one set of values as morally correct for all students • Do not acknowledge that many teenagers will be sexually active • Avoid discussions of abortion • Cite STIs and HIV as reasons for abstinence • Discuss condoms only in terms of failure rate

3.20 Abstinence only programmes:

When compared to comprehensive (abstinence plus) sex education programmes, abstinence only programmes have not been found to have any additional effect on either delaying sexual activity or reducing pregnancy (Christopher and Roosa, 1990; Jorgensen 1991. Kirby (1997) found no measurable impact on the initiation of sex, frequency of sex or the number of partners in a 12 month follow up study of the Postponing Sexual Involvement programme and in a subsequent study of abstinence programmes (Kirby 2002). Dicenso (2002) found that there was a rise in the number of pregnancies among those participating in abstinence only programmes.

3.21 Abstinence Plus programmes (also known as comprehensive sex education programmes):

Some abstinence plus sex education programmes are associated with delay in first intercourse and increased condom and other contraception at first and subsequent intercourse (NHSCRD 1997). There is no evidence to suggest that the provision of these programmes leads to increased sexual activity or higher rates of pregnancy (NHSCRD 1997, Wellings et al 1996, Wight et al 2002). Jemmott (1998) identified that abstinence plus programmes had longer-term effects on the use of birth control than abstinence only interventions. In other European countries, particularly Scandinavia and the Netherlands, indicates that good sex education is associated with fewer teenage pregnancies, particularly when linked with access to services (Hosie 2002).

3.22 In Scotland, the SHARE (Sexual Health and Relationships: Safe Happy and Responsible) programme has been piloted in two areas: Lothian and Tayside. This is a teacher delivered abstinence plus programme aimed at 13-15 year olds. Interim findings from the pilot are mixed (Wight et al, 2002, Buston et al 2002, Wight and Buston (in press)). The pilots confirmed that sex education does not encourage earlier sexual activity, pupils and teachers evaluated SHARE more highly than other sex education

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programmes, and it led to increased sexual health knowledge and reduced regret of first sex with most recent partner. There was however no reported difference in levels of sexual activity or in the use of condoms or contraceptives. Buston et al (2002) found that for the minority of some young women, who start sex at an early age, the programme had been delivered “too late” for themselves or their sexually active peers and that the programme tended to be seen as supplementary to other sources, such as friends, magazines and mothers. In addition, SHARE does not explicitly cover same sex relationships and issues relevant to people with learning disabilities. The timing and content of SRE programmes and training of deliverers are important factors in influencing the effectiveness of the programme (Buston et al 2002). Further information on the MRC research from SHARE can be found on www.msoc-mrc.gla.ac.uk/Reports/Pages/share_MAIN.html.

Variations on models

- 3.23 School based education with parental involvement: some programmes have had limited success in reducing risk behaviours. These used parent newsletters with information on the programme, HIV/AIDS, STIs and pregnancy together with tips on talking with teenagers and student/parent homework activities to facilitate communication (Safer Choices, Managing the Pressures before Marriage and Growing Together programmes (Blake 2001, Nicholson and Postrado 1991 and 1992). Healthy Respect is developing activities to encourage parental involvement which will build on the work being taken by schools to consult with parents (as recommended by the McCabe Report (Scottish Executive 2000)).
- 3.24 Links to contraceptive services through schools may face a number of barriers which restrict their establishment as reported by Santelli (2003). However, such programmes have shown success in reducing pregnancy rates and STIs:
- Zabin (1986) found that school based sex education combined with an on site sexual health advice and contraceptive service resulted in a

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delay in sexual activity among young women, increase in contraceptive use among men and women already sexually active and significant decrease in pregnancy rates. When the programme discontinued, pregnancy rates increased. Similar results were found by Hosie (2002) in examining a reduction in school based health support in Finland.

- Vincent and Dod (1989) found that at 2 year follow up teenage pregnancy rates dropped as a result of a multifaceted community programme involving sexuality education training for school staff, classroom training and decision making skills for students, school nurse dispensing condoms and transport to contraceptive services. Following prohibition of contraceptive provision, Koo et al (1994) discovered rising pregnancy rates.
- Kirby (2001) demonstrated that schools with health clinics and schools with condom availability have consistently shown that the provision of condoms or other contraceptives through schools does not increase sexual activity.

Supporting Paper 5B on Clinical Services sets out more detail on links between schools and services.

- 3.25 The findings from programmes involving one to one education through counselling in health care settings have had mixed success in reaching “harder to reach” groups including black and minority ethnic populations (St Lawrence, Jefferson et al 1994, Jemmott 1993)
- 3.26 Although the majority of sex education programmes are school-based, a number of innovative out of schools programmes have been developed (Olsen and Farkas 1991, Allen and Philliber 1997, Philliber et al 2002). For example, community based programmes that aim to address the education needs of young people within and outside the school setting. Such programmes link school programmes with young people’s home setting or community settings (i.e. youth clubs).

3.27 The links between educational attainment and aspiration and positive sexual health outcomes are highlighted in Supporting Paper 2 on the wider determinants of sexual health. Evidence suggests that educational and job related interventions could be successful in reducing teenage pregnancy rates. Kirby and Coyle (1997) suggest that their success is due to ongoing relationships between participants and mentors, supervision and alternative activities reduced opportunities for problem behaviour and volunteering improved self esteem. Philliber (2002) found similar results from the CAS-Carrera after school youth development programme which combined sexuality education with academic and vocational advice and access to health services.

3.28 Community education programmes, which are designed to foster ownership, empowerment and involvement for young people, have shown promising results in reducing behaviour associated with HIV transmission, which in turn will impact on STIs. (NAM, 2001) Studies have highlighted the need for an understanding of the social and sexual networks of the target population and identification and involvement of appropriate peers to lead such programmes.

4. Features associated with successful education programmes

4.1 Despite the variety of the different approaches used in the delivery of sex education programmes, some general lessons emerge. For example, there is consistent evidence that providing comprehensive sex and relationships education in school settings does not lead to an increase in sexual activity or incidence of pregnancy. Indeed, the provision of clear information about contraceptive methods and how and when to access contraceptive services appears to be important to the success of educational programmes.

4.2 Kirby (2001) identified 10 characteristics of effective sex and HIV education programmes which are reinforced in this review of the evidence:

- Deliver and consistently reinforce clear prevention messages about abstinence, condom use and other forms of contraception

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- Provide basic, accurate information about the risks of sexual activity and about ways to avoid intercourse or methods of protection against HIV/STI and pregnancy
- Include activities that address social pressures related to sexual behaviour
- Provide examples of and rehearse with communication, negotiation, and refusal skills (for example, role plays)
- Focus on reducing one or more sexual behaviour that lead to unintended pregnancy or HIV/STI infection
- Use teaching methods that involve students and have them personalise the information
- Incorporate behavioural goals, teaching methods and curricula that are appropriate to the age, sexual experience, and cultural of students
- Last a sufficient length of time
- Employ theoretical models
- Select teachers or peer leader who support the programme and provide them with adequate training.

Box 2 sets out the general features and key learning objectives of school based SRE programmes promoted by the proposed Sexual Health and Relationships Strategy.

Box 2: General features and key learning objectives of school based SRE programmes

General Features		
<ul style="list-style-type: none"> • Educational and employment opportunities that encourage future aspirations and build self-esteem. • A range of formal and informal learning opportunities delivered in an open and pragmatic way to help develop and maintain respectful relationships, whatever one's sexual orientation, and make informed choices about sex. • The provision of appropriate and accurate knowledge and skills to help young people become "sexually competent"², ideally delivered at an age and ability appropriate to the individual. • Be supported by easily accessible, confidential clinical services including contraception. 		
Key Learning Objectives	Up to and including S1, and returned to from S2 onwards	S2 and beyond
Develop knowledge of:	<ul style="list-style-type: none"> • Human reproduction • How bodies develop through puberty • How the body is protected from infection • People and services from whom they can seek help, and how to access them • 	<ul style="list-style-type: none"> • Anatomy of sexual organs • Main STIs, their symptoms and consequences • Different methods of preventing pregnancy and transmission of STIs • Options if pregnant • Local sexual health services and how to access them • Moral issues • How laws impact on sexual health, e.g. age of consent, UN Convention on the Rights of the Child
Develop understanding:	<ul style="list-style-type: none"> • That one's own body is unique • About issues of discrimination and the right to equal opportunity for all • Of interrelated rights and responsibilities, e.g. within the family, with peers and in the wider society • About the link between gender, body image, self worth and external influences • That peer and media influences can affect decisions • Of the health benefits of good personal relationships • That one should never have to do anything sexual one does not want to do 	<ul style="list-style-type: none"> • Of good things and difficult things about relationships • That sexuality is a natural and healthy part of who we are • About the significance and appropriateness of sexual language • That everyone feels differently about their sexuality, and may express it differently • Of gender differences in meanings and preferences around sex • About the pressures young people face regarding sexual orientation and behaviour • Of how power can be exercised in relationships • Why many young people regret their early sexual experiences • Of the risks and consequences of unplanned pregnancy and STIs • That one should protect oneself and sexual partners from unwanted pregnancy and STIs • Of the responsibilities of parenthood
Develop skills to:	<ul style="list-style-type: none"> • Cope with personal and interpersonal challenges, e.g. failure, negative emotions, and negotiating and resolving conflict. • Make positive health choices • Seek help and advice for personal difficulties 	<ul style="list-style-type: none"> • Start, maintain and end relationships appropriately • Communicate one's feelings in a relationship • Communicate how far one wants to go sexually • Recognise sexually risky situations and avoid them • Avoid being pressured, or pressurising someone, into unwanted sexual behaviour • Plan for safer sex • Get, negotiate about, and use condoms effectively • Access sexual health services

² NATSAL defines sexual competence by assessing variables relating to first intercourse: regret, willingness, autonomy of decision and contraception use.

Delivery of Programmes

4.3 Peer Led Sex Education - Peers

The delivery of educational messages ranges from the traditional didactic approach to more innovative participatory approaches such as peer education. Peers are an important influence on young people's health behaviours, and are considered credible role models and disseminators of social information and have been used to deliver a number of health promotion activities (Fennell 1993). The Social Exclusion Unit in England has recommended peer led approaches for delivering sex education in schools (Social Exclusion Unit, 1999). These approaches are popular with young peer educators and professionals (Mellanby et al 2001, Strange et al 2002a and 200b, Forrest 1997).

- 4.4 Robust evidence of effectiveness of peer led programmes has been limited to date (Harden et al. 2001) but may be addressed through the findings of a MRC funded school based peer delivered programme (RIPPLE). Initial results point to benefits for peer educators (Strange et al. 2002a; Strange et al. 2002b).

Peers V Adults

- 4.5 Few studies have compared the effectiveness of different forms of programme delivery of the same programme. Jemmott and Mellanby attempted to compare peer v adult led sex education (Jemmott et al. 1998; Mellanby et al. 2001). They concluded that both adult and peer led education have an important place in effective sex and relationships education: peer leaders are more effective at establishing conservative norms and attitudes to sexual behaviour than adults whilst less effective at imparting factual information and involving students in classroom activities. This confirms the view that the methods used should fit the aims of the SRE programme.

Timing of Programmes

- 4.6 The timing of educational programmes is important. It is likely that young people who are already sexually active at the commencement of an intervention, for example, are less likely to change their sexual and contraceptive behaviour. This is borne out by the recent SHARE study which found that the greatest effects were with those already sexually active at the start of the programme (Wight et al 2002). However, skills based programmes have to be currently relevant to their target group. One of the limitations of delivery timetabled across the whole year group and for whole classes is that individuals are unlikely to develop sexual negotiation skills at the time most salient to them.
- 4.7 Young people are not all same and have different needs at different times. It is important that programmes should be tailored to the needs and experiences of the group, at an age relevant to their needs and delivered by those with an interest and training in delivering sex and relationships education. This can include a mix of inputs from teachers, to peers, to outside experts. The proposed Sexual Health and Relationships Strategy promotes an integrated model, which combines teacher skills with those of available non school professionals and who are all trained in the delivery of sex and relationships education.
- 4.8 A targeted approach complementing existing sex and relationships education might be appropriate so that young men and women who are considered more likely to engage in early sex are provided with an opportunity to develop relevant skills. Work in Fife and West Lothian has incorporated SRE into wider health promotion activities.

Cost Effectiveness

- 4.9 Few studies have included a cost effectiveness evaluation of prevention programmes. In Wang's evaluation (Wang et al 2000), the US Safer Choices programme was estimated to cost \$105,243. At one year follow-up, it achieved a 15% increase in condom use and an 11% increase in

contraceptive use among 345 students. This was estimated to prevent 0.12 cases of HIV, 24 cases of chlamydia, 2.8 cases of gonorrhoea, 5.8 cases of pelvic inflammatory disease, and 18.5 pregnancies. Furthermore, it was estimated that for every dollar invested in the programme \$2.65 in medical and social costs was saved.

5. SUMMARY OF SEX EDUCATION PROGRAMMES

- 5.1 This review of sex education programmes aimed to reduce teenage pregnancy and/or improved sexual health among children and young people confirms findings from a number of studies that the provision of comprehensive school based sex and relationships education does not lead to early sexual behaviour.
- 5.2 Those studies that have demonstrated a reduction of teenage pregnancy and/or promotion of positive sexual health adopted a multi faceted approach linking sex education programmes with youth development projects and/or to sexual health services, including contraceptive services.
- 5.3 However, the lack of evidence of effectiveness of other approaches may reflect the poor evaluation design – lack of appropriate control group, small sample sizes or short follow-up. Such design flaws may account for the absence of significant effect rather than ineffectiveness of the programme.
- 5.4 Most of the evaluated programmes described in this paper address a number of individual factors associated with teenage pregnancy and sexually transmitted infections, and have shown some success. Some provide an analysis of the range of social, economic and educational factors associated with an increased risk of early sexual initiation and teenage pregnancy. However, only a small number attempt to tackle the underlying social, economic and educational factors associated with increased risk of pregnancy or risky sexual behaviour: those that do have shown some encouraging findings (Social Exclusion Unit 1999, see also update reports

from Teenage Pregnancy Unit www.doh.tpu.gov.uk). Further research is needed in this area.

- 5.5 Programmes that focus on both sexual and non-sexual antecedents, which are “comprehensive” and long term in duration, have shown reductions in the number of sexually transmitted infections and unwanted pregnancies among participating young people. (Swann et al 2003, Philliber et al 2002, Philliber and Allen 1992). It is evident that adopting a simplistic approach to a highly complex area of social behaviour will not succeed in changing adolescent sexual behaviour or reducing teenage pregnancy. With this in mind, the proposed Sexual Health and Relationships Strategy advocates a multi faceted approach, of which sex and relationships education is just one part of the agenda to address sexual health and wellbeing in Scotland.

ADDITIONAL ISSUES FOR SCHOOL BASED SEX AND RELATIONSHIPS EDUCATION

Gender inequity: Educational research suggests that boys and girls may be treated very differently within the classroom (Innes 2002, Holland et al 1992 and 1998, Nayak and Kehily 1996). Boys are often viewed as irresponsible and less open to discussion and learning than girls. As a result, teaching, including sex and relationships education is aimed more at girls. This is problematic for two reasons. First, responsibility is imposed upon females when they often lack control. Second, around a third of boys cite school as their main source of information about sex and relationships (MacDowell 2002). If they are being excluded, deliberately or not, this means that a large proportion of boys are ill-prepared when it comes to making informed decisions about their sexuality.

Heterosexism and homophobia: some people argue that schools force young people to strive for normality as a survival mechanism. Proving normality involves identification of “other”. Lesbian, gay and bisexual young people are an invisible minority and arguably one of the most “at risk” group of adolescents (Big Step review, Coia et al 2002, Sharpe 2002). Schools do

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not do well in protecting young people from homophobic bullying and can actively contribute to it through teachers' own homophobia. SHARE research indicates that teachers were sometimes complicit in homophobia (Buston and Hart 2001). Of course, teachers are not all homophobic but there is a heterosexist assumption underpinning sex education which perpetuates the invisibility of gay and lesbian sexuality.

Epstein (1997) highlights the difficulty in teaching for LGB teachers and coming "out" as a teacher and the dilemmas faced by gay and lesbian teachers having to hide their identity. Homophobia is also directed at children of gay men and lesbians (Redman 2000).

The proposed Sexual Health and Relationships Strategy promotes the inclusion of LGB aspects among sex and relationships education programme, sitting alongside aims for the heterosexual population.

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Sex Education in Scottish Schools: A Summary of National Guidance

(published by the Scottish Executive, 2001 -original document also available at

www.scotland.gov.uk/library3/education/nat.advice.pdf

– additional information and updated websites included)

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Preface

This document, *Sex Education in Scottish Schools: A Summary of National Advice*, follows the report of the Working Group on Sex Education in Scottish Schools (June 2000). It is intended that this document be used in conjunction with Scottish Executive Education Department Circular 2/2001 *Standards in Scotland's Schools, etc. Act 2000: Conduct of Sex Education in Scottish Schools*, the *Guidance for Schools and Local Authorities on Effective Consultation with Parents and Carers* and *A Guide for Parents and Carers*.

Sex education should be presented in a context that values stable relationships, healthy living and personal responsibility and firmly sets sex education within the wider context of health education, religious and moral education and personal and social development. The Executive seeks to ensure that national advice and curricular guidance is suitable for all authorities and schools in Scotland. It is recognised that religious authorities with a role in denominational education do provide guidance for their denominational schools, and that that right will continue as at present. The summary that follows gives a succinct and readily accessible outline of the relevant national advice and the appropriate guidelines throughout all stages of schooling. It includes an outline of guidance produced by the Catholic Education Commission.

Introduction

In Scotland the curriculum is not prescribed by statute and the responsibility for its delivery and management rests with education authorities and school managers. However, national guidelines on the curriculum, developed through wide consultation, are provided by the Scottish Executive Education Department and by Learning and Teaching Scotland. The advice they contain seeks to ensure that health education, including sex education, has a secure place within the curriculum in all schools.

All guidelines, for example *A Curriculum Framework for Children 3 to 5*, the revised 5–14 guidelines, the revised *Guidelines for Schools on Curriculum Design for the Secondary Stages* and *Higher Still Rationale* emphasise the importance of developing in young people the respect and caring for self and others that is at the heart of personal and social development.

There is, however, specific national advice that makes it clear that sex education is best planned and delivered as part of a wider health education programme and as an integral part of programmes of religious and moral education and education for personal and social

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development. National advice has much to say about the importance of pupils developing self-esteem, respect for others, good personal relationships, respect for diversity and non-discriminatory views, and respect for individual differences. This is the appropriate climate for school sex education.

Section 1: Sources of National Advice

This section lists a number of key sources of information, as well as support materials that address issues relevant to sex education as an integral part of personal and social development and of health education. Other helpful sources of advice can be found in Appendix 1 of *A Route to Health Promotion: Self-Evaluation Using Performance Indicators*, SEED, 1999 or by accessing the websites listed at the end of this section.

Key sources of national advice include the following:

<p><i>A Curriculum Framework for Children 3 to 5, Scottish CCC, 1999</i> This document provides advice and guidance on the learning and development needs of children as young as three. It describes the scope of children’s learning between the ages of three and five, placing particular emphasis on their emotional, personal and social development.</p> <p><i>Health Education: 5–14 National Guidelines, LT Scotland, revised 2000</i> <i>Environmental Studies – Society, Science and Technology: 5–14 National Guidelines, LT Scotland, revised 2000</i> <i>The Structure and Balance of the Curriculum: 5–14 National Guidelines, LT Scotland, revised 2000</i> <i>Personal and Social Development: 5–14 National Guidelines, Scottish CCC, 1993</i> <i>Religious and Moral Education: 5–14 National Guidelines, Scottish CCC, 1992</i> <i>Religious Education 5–14: Roman Catholic Schools, Scottish CCC, 1993</i> These guidelines provide a clear and coherent framework to support schools and teachers as they plan, teach and assess programmes of learning and teaching across the 5–14 age range.</p> <p><i>Guide for Teachers and Managers: Health Education 5–14, LT Scotland, 2000</i> <i>Guide for Teachers and Managers: Science 5–14, LT Scotland, 2000</i></p>	<p><i>Guide for Teachers and Managers: The Structure and Balance of the Curriculum 5–14, LT Scotland, 2000</i> <i>Guide for Teachers and Managers: Information and Communications Technology 5–14, LT Scotland, 2000</i> Guides for Teachers and Managers accompany the revised guidelines in health education, environmental studies, the structure and balance of the curriculum, and information and communications technology (ICT). They are working documents, provided by Learning and Teaching Scotland, offering advice on how to address various aspects of the different guidelines. While the guidelines provide the ‘what’ of the curriculum, the guides offer advice on the ‘how’.</p> <p><i>Personal and Social Development: 5–14 National Guidelines – Exemplification, Scottish CCC, 1995</i> <i>Religious and Moral Education: 5–14 National Guidelines – Exemplification, Scottish CCC, 1995</i> In both cases exemplification, provided by Scottish CCC, takes the form of staff development materials designed to help teachers plan programmes and organise learning.</p> <p><i>Relationships and Moral Education, Catholic Education Commission, 2000</i> This document, presently under consultation, is designed to accompany the guidelines on religious education 5–14 in Roman Catholic schools, and provides targets under the headings ‘Self’, ‘Relationships’, ‘Making the right choices’ and ‘Sexual awareness’</p>
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<p><i>Health Education in Scottish Schools: Meeting Special Educational Needs, SO, 1994</i> This document provides curriculum audit processes, guidelines, a curriculum framework and menus, illustrative case studies, advice on parental involvement in health education and the contribution of other professionals to health education, as well as a list of health education resources. It is designed to assist staff, parents and other professionals to promote health education for pupils with special educational needs.</p> <p><i>Helping Hands: Guidelines for Staff who Provide Intimate Care for Young People with Disabilities, SOEID, 1999</i> The purpose of these guidelines is to set out a framework within which staff who provide intimate care to children with special needs can offer a service and an approach that acknowledges the responsibilities and protect the rights of everyone involved. The children's special needs might arise for a variety of reasons including learning disabilities, physical, visual, hearing or speech and communication impairments. These children will be found in all settings: pre-5 centres, primary, secondary and special schools.</p> <p><i>Curriculum Design for the Secondary Stages: Guidelines for Schools, Scottish CCC, 1999</i> The Rationale points up one of the major purposes of education as providing young people with the knowledge and skills, and with opportunities, to think through major issues, to form opinions and to work out values on which they will base their lifestyles. Experiences should help young people to develop into healthy, responsible human beings leading personally rewarding lives.</p> <p><i>Standard Grade Religious Studies, Scottish Examination Board, 1991</i></p>	<p><i>Standard Grade Biology, Scottish Examination Board, 1997</i> Elements of sex education are located in the <i>Arrangements for Standard Grade Biology</i> and <i>Standard Grade Religious Studies</i>.</p> <p><i>Higher Still Personal and Social Education (CD-ROM), Scottish Qualifications Authority, 1999</i> In all Higher Still Personal and Social Education (PSE) courses there are two principal contexts <i>Personal Awareness and Development</i> and <i>Social Awareness and Development</i> that relate to the development of self awareness and interpersonal skills and encourage the development in young people of interpersonal and group skills, including relationships, and of self-awareness, self-reliance and self-confidence, including rights and responsibilities.</p> <p><i>Higher Still Religious, Moral and Philosophical Studies (CD-ROM), SQA, 1999</i> There are units at various levels that encourage young people to investigate the nature and scope of morality and to develop the skills involved in recognising moral stances and in making moral decisions within the context of both religious and other stances for living. These include:</p> <ul style="list-style-type: none"> • Access 3 Questioning Morality (mandatory) • Intermediate 1 Making Moral Decisions (mandatory unit) • Intermediate 2 Making Moral decisions (optional unit) • Higher Ethics; Religious Perspectives in a secular context • Advanced Higher Bio-Ethics (optional) <p><i>Circular No. 10, Protection of Children from Abuse – The Role of Education Authorities, Schools and Teachers, SOEID, May 1990</i></p> <p><i>Circular 4/96, Children and Young People with Special Educational Needs (Assessment and Recording), SOEID</i></p> <p><i>The Health Education for Living Project (HELP), SOEID/ Strathclyde Region, 1995</i> These materials were made available to all schools. They provide detailed advice on health education, including sex education, from pre-school to S6. They cover suggested content and give advice on learning and teaching activities</p>
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<p><i>Personal Relationships and Developing Sexuality</i> University of Strathclyde, 1994 This staff development resource for teachers was made available to all local authorities for distribution to schools in 1994. The pack contains advice for teachers on sex education, gives a suggested curriculum framework for sex education and provides materials to be used as part of teachers' in-service training. Publication was followed in many local authorities by in-service training.</p> <p><i>A Route to Health Promotion: Self-evaluation Using Performance Indicators, SEED, 1999</i> This document, published in 1999, is designed to help schools to evaluate the quality of health promotion, including aspects of health education such as sex education. Issued by the HMI Audit Unit, it provides a framework for undertaking a structured audit and builds directly on the national approach to self evaluation set out in <i>How Good is our School? Self-Evaluation using Performance Indicators</i>.</p> <p><i>Issues in Health Education: A Study of Good Practice in a Sample of Primary and Secondary Schools, SOEID, February 1996</i> This document offers examples of good practice in schools providing health education.</p> <p>Scottish Virtual Teachers' Centre: www.svtc.org.uk</p> <p>Scottish Schools Ethos Network: www.ethosnet.co.uk</p> <p>The Anti-Bullying Network: www.antibullying.net</p> <p>Research Unit into Health Behavioural Change: www.ruhbc.ed.ac.uk</p>	<p>and resources.</p> <p>Additional Resources (piloted at time of compiling guidance, now available for use)</p> <p><i>Respect Resource Pack, Zero Tolerance Charitable Trust, 2001</i> This pack was piloted in two schools (primary and secondary) and two youth work settings, encourages boys and girls to develop healthy relationships based on respect and equality and to be active citizens in creating communities that do not tolerate violence against women. The <i>Respect Initiative</i> comprises:</p> <ul style="list-style-type: none"> • educational CD-ROM • primary curriculum • secondary curriculum • informal educational intervention (youth clubs) • training programme for adults delivering the <i>Respect Initiative</i> <p><i>The evaluation of the project is available from:</i></p> <p><i>Sexual Health and Relationships Education: Safe, Happy and Responsible (SHARE), The Health Education Board for Scotland (HEBS)</i> SHARE is a resource for secondary schools S2–S4 comprising a series of lessons over 20 periods. HEBS developed a classroom resource to support its application: training for trainers is also available via HEBS (now Health Scotland). Both are being updated and should be available from 2004.</p> <p>Websites</p> <p>Scottish Executive website: www.scotland.gov.uk</p> <p>HM Inspectors of Schools: www.scotland.gov.uk/structure/hmi/default.htm</p> <p>Health Scotland (formerly HEBS/PHIS): www.healthscotland.com</p> <p>Learning and Teaching Scotland: www.LTScotland.com</p> <p>Higher Still: www.higher-still.org.uk</p> <p>Scottish Health Promoting Schools Unit www.healthpromotingschools.org (live as of Spring 2004)</p>
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Section 2: Summary of National Advice

This section gives a short guide to the documents listed in Section 1 and indicates the ways in which they contribute national advice on sex education.

<p><i>A Curriculum Framework for Children 3 to 5, Scottish CCC, 1999</i> This document describes the scope of children’s learning between the ages of three and five, under five main areas of learning. It places particular emphasis on their emotional, personal and social development, which includes:</p> <ul style="list-style-type: none"> • developing confidence and a sense of worth • making friends and getting on with other children • learning to look after yourself – making choices, for example knowing who to ask for help • caring for other people and your surroundings • telling others how you feel and what you like best. <p><i>Health Education 5–14: National Guidelines, LT Scotland, 2000</i> The revised guidelines for health education 5–14 point up the close connection with personal and social development and the concept of the health promoting school. The guidelines are based on the three interconnected strands of physical health, comprising sexual health, emotional health and social health. Physical health explores physical factors in relation to our health and looking after ourselves. Emotional health explores emotions, feelings and mental health and how these affect us and our relationships. Social health explores the interactions of the individual, the community and the environment in relation to health and safety.</p> <p>The guidelines aim to help teachers to:</p> <ul style="list-style-type: none"> • increase the knowledge and understanding of a range of health issues that may play a part in the decisions young people make about health <p>young people the disposition to respect and care for self and others. This involves reflection on the need to take increasing</p>	<ul style="list-style-type: none"> • enable young people to explore and clarify their beliefs, attitudes and values • develop young people’s personal and interpersonal skills • provide opportunities for young people to explore their feelings and emotions, to share experiences and to discuss issues that are relevant to them in a secure and comfortable environment • develop in young people the skills and knowledge to take responsibility for their own health at an individual level, and as participating citizens. <p>The guidelines provide a clear framework within which individual schools and teachers can develop programmes responding to the health education needs of young people. They enable teachers to plan, teach and assess coherent health education programmes. They provide a flexible means by which schools can choose to integrate into personal and social development programmes and other curriculum areas those aspects of health education they consider best covered in such settings.</p> <p><i>Health education within the curriculum should aim to provide opportunities for young people to value themselves, gain in confidence and develop skills and knowledge to take responsibility for their own health at an individual level and as participating citizens.</i></p> <p><i>Health Education: 5–14 National Guidelines, LT Scotland, 2000, p. 4</i> <i>Environmental Studies – Society, Science and Technology:</i> <i>5–14 National Guidelines, LT Scotland, 2000</i> The Rationale emphasises an important aim of environmental studies as developing in</p> <p><i>Personal and Social Development: 5–14 National Guidelines, SOED, 1993</i> Personal and social development is both</p>
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<p>responsibility for their own and others' wellbeing, safety and needs. It encourages pupils to think how they as individuals contribute to their environment and culture when they make choices, decisions and courses of action related to society and the environment. In this way they develop the awareness that people hold diverse views and opinions about social and environmental concerns and of the need for such diversity. Each of the components provides opportunities for pupils to examine a range of issues that might impact on the wellbeing of themselves and others.</p> <p>The science section of the environmental studies guidelines, in the outcome 'Living things and the processes of life', examines the human life. Pupils are encouraged to observe features of growth in themselves and others. At the later stages of 5–14 pupils move to a broad study of the human body systems and related life processes.</p> <p><i>The Structure and Balance of the Curriculum: 5–14 National Guidelines, LT Scotland, 2000</i></p> <p>This document sets out the rationale and principles of the 5–14 curriculum. The aims state that children should acquire and develop 'the capacity to take responsibility for their health and safe living'. The document consolidates the importance of developing respect and care for self and others and a sense of social responsibility. An allocation of a minimum 15 per cent of time is given to personal and social development and within it to health education. A detailed explanation of personal and social development as a cross-curricular aspect is provided.</p> <p>of their sexuality. It also aims to help them understand that increased independence means increased responsibility and to see that while they have freedom to change what they want to do, they have to accept responsibility for that choice and the</p>	<p>the process of development through which children grow and mature as individuals in society and the contribution to this process that schools can make. This can be done through specific programmes, through a cross-curricular approach and, importantly, through establishing a positive and supportive whole-school ethos. Successful health education locates within all three approaches.</p> <p>The school is only one factor in the personal and social development of young people. All aspects of a child's experience at home and outwith school also contribute. For this reason, it is essential to establish positive partnerships between school, home and the wider community.</p> <p>The aims of PSD are to help pupils to:</p> <ul style="list-style-type: none"> • have appropriate positive regard for self, and for others and their needs • develop life skills to enable them to participate effectively and safely in society • identify, review and evaluate the values they and society hold and recognise that these affect thoughts and actions • take increasing responsibility for their own lives. <p>Personal and social development is particularly concerned with helping young people to develop:</p> <ul style="list-style-type: none"> • self-awareness and self-esteem • interpersonal relationships • independence and interdependence. <p>PSD aims to help pupils to realise that just as they grow and change physically, so too they grow and change emotionally and that this is important at all stages, but is particularly so when pupils are attempting to cope with puberty and the development</p> <p><i>Religious Education 5–14: Roman Catholic Schools, Scottish CCC, 1993</i></p> <p>These guidelines provide a coherent and progressive approach to religious education in Roman Catholic schools. Pupils are encouraged to:</p>
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<p>ensuing consequences.</p> <p><i>In recognising areas of potential conflict and reviewing commonly held values in a pluralistic, democratic society, pupils should be helped to clarify their own personal values and determine their own position in relation to that held by other people, groups or society at large. Maintaining a close partnership with parents is a key aspect of this process.</i></p> <p><i>Personal and Social Development: 5–14 National Guidelines, SOED, 1993, p. 2</i></p> <p><i>Religious and Moral Education: 5–14 National Guidelines, SOED, 1992</i></p> <p>Education is about the development of the whole person. Religious and moral education deals with this development in relation to self-awareness, relationships with others, and the realms of beliefs, values and practices that go to make up a religious outlook on life. The ‘personal search’ strand, in particular, encourages pupils to begin to reflect upon their own stance as they search for answers to important human questions.</p> <p>In an atmosphere of open discussion of religious and moral issues, pupils are encouraged to express their own views and feelings, and to listen with respect to the views and feelings of others. Additionally they are encouraged to develop responsible attitudes towards others and skills of moral judgement about what is considered right and wrong.</p> <p>The section ‘Planning for Health Education’ suggests that health education programmes can include:</p> <ul style="list-style-type: none"> • a clear statement of whole-school expectations concerning health education and health promotion • involvement of staff, pupils and parents in developing provision for health education • planned coverage of issues such as the 	<ul style="list-style-type: none"> • have values relating to family and community • reflect on their ability to make choices and come to some understanding about the relationship between choices and consequence • reflect on what it means to have respect for self and others • reflect on their personal physical, emotional, spiritual and moral changes. <p><i>Guide for Teachers and Managers: Health Education 5–14, LT Scotland, 2000</i></p> <p>The <i>Guide for Teachers and Managers</i> accompanies the guidelines. It offers practical advice on a range of issues such as meeting pupils’ needs and the health promoting school.</p> <p><i>While [young people] do need information about issues such as puberty, pregnancy, family roles and sexually transmitted infections, information alone will not be enough. It is necessary to provide them with the skills to cope with pressure and conflicts and to manage their relationships. Young people can be helped to develop specific skills that will enable them to establish, maintain or end relationships and make decisions that are important to them as individuals.</i></p> <p><i>Guide for Teachers and Managers: Health Education 5–14, Learning and Teaching Scotland, 2000, pp. 21–22</i></p> <p><i>Guide for Teachers and Managers: Information and Communications Technology 5–14, LT Scotland, 2000</i></p> <p>An exemplar of a local authority leaflet for parents outlining aspects of safe use of the internet. It emphasises the duty of schools and local authorities to put suitable screening procedures in place in order to prevent young people from accessing</p>
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<p>misuse of drugs and alcohol, smoking, healthy eating, sex education and coping with stress</p> <ul style="list-style-type: none"> • attention to specific links between health education, religious and moral education and education for personal and social development. <p>The planning section also provides specific advice on sexuality and relationships and offers examples of long- and short-term planning for health education. The guide also suggests means by which schools can evaluate good practice in health education, meet pupils' health education needs and review effective features of a health education programme. It gives helpful advice on the stages at which various topics, including 'my body', 'feelings about self and others' and 'relationships' may be introduced.</p> <p><i>Guide for Teachers and Managers: Science 5–14, LT Scotland, 2000</i></p> <p>Exemplification of levels D and E in the strand the processes of life looks at the process of human reproduction.</p> <p><i>Guide for Teachers and Managers: The Structure and Balance of the Curriculum 5–14, LT Scotland, 2000</i></p> <p>This material provides exemplification of how schools can turn the principles of the guidelines into effective practice. It also provides advice on how learning can be managed effectively across the 5–14 stages as well as pointing up the benefits of the 5–14 principles of continuity, coherence and progression for teachers, pupils and parents.</p>	<p>inappropriate material. References are made to the Scottish Executive publication <i>Click Thinking</i>, which explores in depth the issue of safe internet access.</p> <p><i>Parents should be engaged as partners in the development of ICT and there is scope for this partnership not only in the development of learning and teaching but also in safeguards in using ICT.</i></p> <p><i>Guide for Teachers and Managers: Information and Communications Technology 5–14 LT Scotland, 2000</i></p> <p><i>Personal and Social Development: 5–14 National Guidelines – Exemplification, Scottish CCC, 1995</i></p> <p>Support material in the form of a staff development workshop for teachers. It focuses on a whole school approach to personal and social development and suggests approaches and addresses issues concerning attitudes, relationships and skills likely to aid the promotion and development of a positive and supportive school atmosphere which fosters the personal and social development of all.</p> <p><i>The importance of religious education is not confined to appreciating the historical and social role of religion. There is also a personal dimension linked to the individual's search for answers to questions about meaning, value and purpose in life.</i></p> <p><i>Religious and Moral Education: 5–14 National Guidelines, SOED, 1992</i></p>
<p><i>Religious and Moral Education: 5–14 National Guidelines – Exemplification, Scottish CCC, 1995</i></p> <p>Suggests ways in which teachers might explore issues such as caring for others and help pupils develop the skills for personal search including to:</p> <ul style="list-style-type: none"> • begin to think independently about ideas • reflect on the implications • begin to formulate opinions based on a degree of knowledge and understanding • share ideas and feelings 	<p><i>Health Education in Scottish Schools: Meeting Special Educational Needs, The Scottish Office, 1994</i></p> <p>Pupils with learning difficulties have the same right to a broad and balanced curriculum and educational opportunities as their peers. This document is the product of a project investigating issues arising from health education provision for young people with special educational needs.</p>

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<ul style="list-style-type: none"> • justify opinions • recognise the validity of other viewpoints. <p><i>Relationships and Moral Education, Catholic Education Commission, 2000</i></p> <p>This document, designed to accompany <i>Religious Education 5–14: Roman Catholic Schools</i>, outlines a framework for a positive, competent and relevant primary through secondary moral/sex education programme. Under the four broad headings of ‘Self’, ‘Relationships’, ‘Making right choices’ and ‘Sexual awareness’, the document offers targets for various attainment levels and accompanying exemplification. Targets include:</p> <ul style="list-style-type: none"> • knowing ways of looking after their bodies and feelings • being aware of the natural order – birth, growth, maturity, of plant, animal, human • understanding that sexual development is a natural part of human growth • expressing ways in which they value and care for themselves • understanding the role of the family in their lives. <p>In the later stages of secondary, targets also include life matters and the concept of love. Pupils should be able to, for example:</p> <ul style="list-style-type: none"> • understand the principles of how life begins • develop an awareness of the relationship between happiness and good relationships • know that parents have certain duties to their offspring. <p>The key aims are:</p> <ul style="list-style-type: none"> • to raise awareness and to make practical recommendations based on good practice • to provide guidance and reassurance to staff in a climate of litigation and give information about the legal context of intimate care • to provide ideas for appropriate staff development and training, induction programmes, consultation and involvement of parents • to safeguard the rights of children and young people to be protected from exploitation and all forms of abuse – 	<p>The document contains practical advice for teachers and school managers and is organised in eight units, as follows.</p> <ol style="list-style-type: none"> 1 Introduction and Rationale 2 Curriculum Auditing within the context of School Development Planning 3 The Curriculum Guidelines 4 The Curriculum Framework and Menus 5 The Case Studies 6 Parental Involvement in Health Education 7 The Contribution of other Professionals 8 Health Education Resources <p><i>Helping Hands: Guidelines for Staff who Provide Intimate Care for Young People with Disabilities, SOEID, 1999</i></p> <p>All education authorities in Scotland have guidelines and procedures for child protection to ensure the safety and wellbeing of children and young people and to protect those adults working with them. This document provides particular guidance to staff working with pupils with special educational needs, most notably where intimate care is involved. It draws on good practice already in evidence across a wide number of schools.</p> <p><i>Standard Grade: Arrangements in Religious Studies, Scottish Examination Board, 1991</i></p> <p>Unit 4, ‘Issues of Morality’ examines the nature of morality, general moral principles and values and specific moral issues and religious responses arising from the following areas.</p> <ul style="list-style-type: none"> • Sexual morality – freedom and responsibility in relationships between the sexes • The taking of life – is it ever justifiable?, war, abortion and euthanasia <p><i>Standard Grade: Arrangements in</i></p>
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<p>physical, emotional and sexual – and to safeguard adults required to operate in sensitive situations.</p> <p><i>Curriculum Design for the Secondary Stages: Guidelines for Schools, Scottish CCC, 1999</i></p> <p>Among the curricular goals identified by this document are:</p> <ul style="list-style-type: none"> • respect and care for self • respect and care for others. <p>Along with others, they are identified as fundamental to moral life and a sound guide on which to base personal choice.</p> <p>Skills identified include:</p> <ul style="list-style-type: none"> • personal and interpersonal skills • working with others. <p>The document also identifies as goals for pupils the ability to:</p> <ul style="list-style-type: none"> • deal responsibly with their emotions • take increasing responsibility for their own lives • look after their personal needs, health and safety • be sensitive and responsive to the needs of others • make decisions based on informed judgements. <p><i>Higher Still Religious, Moral and Philosophical Studies, SQA, 1999</i></p> <ul style="list-style-type: none"> • Access 3: Questioning Morality (mandatory unit) <p>Students are invited to choose examples of moral issues from one of the following areas of study:</p> <ul style="list-style-type: none"> – Moral issues and Human relationships: marriage/alternatives to marriage, divorce, sexual behaviour – Moral Issues and Human Rights: crime and punishment/racial sexual prejudice, rights of the child <ul style="list-style-type: none"> • Intermediate 1: Making Moral Decisions (mandatory unit) <p>The ‘human relationships’ element of this unit looks at marriage/alternatives to marriage, divorce and sexual behaviour.</p>	<p><i>Biology, Scot. Exam Board, 1997</i></p> <ul style="list-style-type: none"> • Topic 6, ‘Inheritance’, sub-topics (a) ‘Variation’, (b) ‘What is Inheritance?’ and (c) ‘Genetics and Society’ examine issues of inheritance, genetics and reproduction in human, animal and plant contexts. • Topic 7, ‘Biotechnology’, sub-topic (c) ‘Reprogramming Microbes’ examines issues of genetic engineering <p><i>Higher Still Personal and Social Education, SQA 1999</i></p> <p>At all levels principal contexts such as personal awareness and development, and social awareness and development focus on the key element of personal and social education relating to the development of self-awareness, self-reliance and self-confidence. Principal contexts offer the opportunity to develop group and interpersonal skills, including relationships. Various sub-contexts concerned with such issues as independent living, health-related issues, participating in community activity and using support services in the local community, provide opportunities to focus on improving personal wellbeing, to investigate some aspects of living independently and to examine the impact on their individual lives.</p> <p><i>Circular No. 10, Protection of Children from Abuse – The Role of Education Authorities, Schools and Teachers, SOEID, May 1990</i></p> <p>If a young person is at risk then the teacher and school must act to protect them. Such action may well involve disclosure to appropriate people or agencies and may bear upon the issue of consulting with parents or carers. Schools should have child protection guidelines to refer to as well as guidance from their education authority in line with the documents listed above.</p> <p><i>Circular 4/96, Children and Young People with Special Educational Needs (Assessment and Recording), SOEID</i></p>
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<p>Students are required to demonstrate an understanding of moral issues, analyse and evaluate them.</p> <ul style="list-style-type: none"> • Intermediate 2: Making Moral Decisions (optional unit) <p>As in Intermediate 1: Human Relationships. In addition the ‘gender’ element of this unit looks at dependence and interdependence and violence against women.</p> <ul style="list-style-type: none"> • Higher: Ethics – Religious Perspectives in a Secular Context (mandatory unit) <p>The aim of this unit is to develop in young people an understanding and analysis of an ethical area of study and to evaluate its relevance in today’s society.</p> <ul style="list-style-type: none"> • Advanced Higher: Bio-Ethics (optional unit) <p>This unit seeks to develop understanding and analysis of Christian and other perspectives on medical development in bio-ethics, evaluating related issues concerning the nature and quality of human life. Of particular relevance to sex education are the issues concerning artificial insemination, genetic engineering, the treatment of embryos and surrogacy in the area ‘The Beginning of Life’.</p> <ul style="list-style-type: none"> • To help teachers plan and deliver effective studies in health education: <ul style="list-style-type: none"> – as part of a planned programme of health education, taking account of national and local priorities – as part of studies in other curriculum areas or in personal and social education – as a result of cooperative activities among themselves, with parents and with health-promoting agencies in the community. • To help the school become a: <ul style="list-style-type: none"> – health-promoting establishment where care for young people is paramount – safe and attractive environment where young people can develop in an atmosphere of trust and mutual respect – focus for health promotion within the community. <p><i>Issues in Health Education: A Study of</i></p>	<p>The purpose of this circular is to advise education authorities and others about the statutory arrangements in Scotland for providing for children and young people with special educational needs.</p> <p>Consultation with parents and carers is essential in drawing up Individual Education Programmes, and there may be issues concerning aspects of sex education programmes that will require particular discussion with parents and carers.</p> <p><i>The Health Education for Living Project (HELP), SOEID/ Strathclyde Region, 1995</i></p> <p>The principal aim of HELP is to enable pupils, staff and the school as a whole to take positive steps towards the promotion of health and wellbeing.</p> <p>Specific aims are as follows:</p> <ul style="list-style-type: none"> • To help pupils to take appropriate responsibility for their own health and wellbeing through developing knowledge, understanding, attitudes and skills that enable them to: <ul style="list-style-type: none"> – develop effective personal relationships – look after themselves appropriately - live actively and safely <p>Curriculum framework</p> <p>A curriculum framework for primary and secondary schools linked to the 5–14 guidelines. The framework has been organised into a number of stages in the primary and secondary school. Three broad themes form the core of the framework:</p> <ul style="list-style-type: none"> – looking after oneself – relationships – health and safety in the environment. <p>As the framework progresses beyond 14, the two main themes developed are: personal development and relationships. Key resources are identified and linked to specific topics, but the issues and topics identified at each stage are suggestions only. (Although these will refer in some cases to previous guidelines, the material is nevertheless still relevant and useful.)</p> <p>Depending on the differing needs and</p>
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Good Practice in a Sample of Primary and Secondary Schools, SOEID, Feb 1996

Examples of good practice in schools providing health education on the key sensitive issues of drugs, alcohol, smoking, healthy eating, positive personal relationships and sex education.

Personal Relationships and Developing Sexuality, Univ of Strathclyde, 1994

Staff development resource for teachers that offers support to teachers in a number of ways. It provides the following:

- Guidelines

Background information on a number of aspects, including differentiation and confidentiality, related to teaching about sexuality and relationships. It includes some details on Scots law and a directory of helpful resources and agencies.

- Staff development activities

These give teachers the opportunity to think through a range of sensitive aspects in relation to teaching about relationships and sexuality.

Additional Resources:

Respect Resource Pack, Zero Tolerance Charitable Trust, 2001

Respect is an integrated prevention programme with an education focus, which specifically targets young people and adults working with young people.

It aims to:

- encourage young people to develop healthy relationships
- promote respect for self, respect for others and to respect difference
- challenge and decrease the tolerance of violence against women amongst young people
- encourage a sense of social responsibility.

The primary programme is designed for 10–12 year-olds to be delivered over eight sessions each lasting approximately 50 minutes. The secondary programme is designed for 14–16 year-olds to be

developmental stages of pupils, teachers may use ‘Look back’ or ‘Look forward’ to provide differentiated activities to address the needs of pupils at different stages of development within the same class.

A Route to Health Promotion: Self-Evaluation Using Performance Indicators, SEED, 1999

This document, published in 1999, is designed to help schools to evaluate the quality of health promotion, including aspects of health education such as sex education. Issued by the HMI Audit Unit, it provides a framework for a structured audit and builds directly on the national approach to self evaluation set out in *How Good is our School? Self-Evaluation Using Performance Indicators*. While the entire document is concerned with health promotion in the widest sense elements of performance indicators ‘3.3 Meeting Pupils’ Needs’, ‘4.1 Pastoral Care’ and ‘4.2 Personal and Social Development’ touch on issues related to sex education.

Sexual Health and Relationships Education (SHARE), The Health Education Board for Scotland, 2001

This resource targets secondary schools with a focus on S2 to S4, and is a development of the SHARE materials evaluated in Lothian and Tayside. The pack is designed to be used with pupils S2–S4 and offers a series of lessons over 20 periods.

SHARE aims to:

- help young people develop healthy and positive sexual relationships
- help young people to develop the skills and dispositions with which to make healthy and positive choices
- develop communication and negotiation skills through the use of video material
- engage young people in focused and teacher-led discussion about issues arising

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<p>delivered over seven sessions each lasting approximately 50 minutes.</p> <p>Each session (primary and secondary) contains:</p> <ul style="list-style-type: none"> • teachers’ notes that outline the aims of the lesson • exercises plus variations • materials needed • supporting notes for teachers • photocopiable resource sheets. 	<p>from the video scenarios.</p> <p>An initial intensive ‘train the trainers’ course over six days is available via Health Scotland. An associated classroom training resource is provided for trainers who in turn are available to develop more locally based training and staff development in sex education.</p>
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Section 3: Faith Perspectives

Education about sexuality should reflect the cultural, ethnic and religious influences within the home, the schools and the community and it should be nondiscriminatory and sensitive to the diverse backgrounds and needs of all young people. Personal values and morals play a large part in understanding about such matters as relationships and developing sexuality.

Young people's religious and cultural backgrounds influence these values.

This section offers guidelines on a number of faith perspectives in the form of statements provided by representatives of the faith groups concerned and should be taken into account in the development of sex education programmes. They are intended to assist teachers with a number of issues involved with some faiths and to indicate where further information may be obtained. It is important to remember that, in order to ensure trust and cooperation, all parents should be fully consulted about the context and content of the teaching and learning for sex education. There should be discussion between the school and the different faith groups on the most appropriate approach to education about relationships and sexuality.

Statements provided by representatives of faith groups follow.

The Catholic Church

The present day teaching of the Catholic Church on sexuality is based on the teaching of Jesus found in the Holy Scriptures and on the traditional values of the Christian community as it has progressed through the centuries. The two Christian commandments 'love God' and 'love your neighbour' form the basis of a whole way of living. People are encouraged to live according to Christian values such as respect, honesty, justice, care and integrity, and these qualities should be reflected in their attitudes to sexuality.

It is through the family home that the Catholic Church would hope to share and promote its teaching. A Catholic school would be expected to endorse and promote the values of a Christian home. It would not expect to take over the role or rights of parents. Its role would be supportive.

The Church promotes an integrated developmental programme, which helps young people to understand the moral concepts that are special to the Catholic faith. The home and the school combine to encourage this growth in understanding. There are many resources available that endorse the Church's teachings.

Further guidelines may be sought from the resource teams of the eight dioceses. These and details of specific publications are listed in the resources section. For further details contact:

Michael McGrath, Director, Scottish Catholic Education Service, 75 Craigpark, Glasgow

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Church of Scotland

Christians look to the Bible as an account of God's relationship with His people, to past experience and to present insights and understandings to form their views on human behaviour. Our sexuality is both a divine gift and a human responsibility. The Church of Scotland accepts that sexual intercourse is not solely or even primarily for the purpose of procreation but serves to enrich relationships and believes that our sexuality can be expressed in a variety of loving relationships that offer mutual joy and pleasure. Where a man and a woman love each other and wish to live together, marriage provides the best and securest foundation for a long and happy relationship. Marriage should be a lifelong commitment and in such a context of trust and security men and women engage in sexual relations, knowing that any child conceived will be welcome within a family setting.

Many within the church believe that sex education should include an appreciation of the value and importance of marriage that does not diminish the worth of other loving relationships. The intrinsic worth or moral superiority of any relationship does not depend on any ceremony religious or secular, but on the way people treat and regard each other in that relationship.

That part of a sex education programme which is taught in religious and moral education should encourage pupils to reflect on moral values and to learn from the beliefs on marriage, family and sexual relationships held by different world faith communities and even by different denominations or groups within these communities. It may also be important for children to think about the essential qualities of alternatives to marriage since most of them will already be familiar with these.

The curriculum, supported by sensitive teaching should:

- ensure that sex education is taught within the wider context of health education and personal and social education and, where appropriate, relates to aspects of religious and moral education
- encourage pupils to appreciate the value of stable family life, parental responsibility and family relationships in bringing up children
- emphasise the appreciation of each person's rights and needs and the importance of forming good and positive relationships based on mutual respect and love
- encourage pupils to appreciate the value of commitment in relationships and partnerships including the value placed on marriage by religious groups and others in Scottish society
- cover the whole range of orientation sensitively through sex education aimed at developing respect for others, self-respect and understanding – but always in consultation with parents
- support pupils in reaching considered views and making informed choices about values and beliefs relating to their own lifestyle and personal relationships.

For further details contact:

The Church of Scotland, Department of Education 121 George Street Edinburgh EH2 4YN

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Free Church of Scotland

The Free Church is clear that sex education should not take place in a clinical manner in which moral and social issues are sidelined. We would oppose any treatment of this significant subject that deals with sex in terms of human physiology without significant reference being made to the moral, spiritual, emotional and social context in which all human relationships take place.

In our approach to sex and human reproduction the Free Church recognises the authority and the continuing relevance of the Bible. We affirm the moral framework of the Judaeo-Christian tradition with the Ten Commandments at its core as the historical basis of our social values. We look to the detailed teaching of the Bible to discover principles for sex and relationships. These principles begin with a positive and affirming attitude to sexual desire. The Church has best reflected this Biblical teaching when it has affirmed sex as a gift from God that is of great value when used correctly but capable of causing great sorrow when used in defiance of the will of God. We recognise that the proper context for the expression of sexual desire is within the security and intimacy of a committed and faithful lifelong partnership.

As Christians we do not accept that our sexual urges are too powerful to be controlled. To concede this would be to demean humans to the level of instinct-driven animals. It is human to struggle with temptation. However, we offer the hope that God will provide the ability to gain self-control to all those who seek his help. The Christian ethic demands that we honour God with our body. We would expect marriage to be referred to in the curriculum not merely as an option but as the natural setting for the expression of human sexuality and as the most fitting basis for the cohesion of a stable family and a healthy society. Since sex is integral to the creation of the family unit and forms part of its core values no attempt should be made by schools or education authorities to instruct our children in sexual matters without first consulting the wishes of parents.

Further details may be sought from:

Youth and Education Committee, Free Church of Scotland Offices
15 North Bank Street, The Mound, Edinburgh EH1 2LS

The Jewish Faith

Jewish law lays down strict guidelines about sexual behaviour and morality. Jewish parents should be informed about the content of any lessons on relationships and sexuality, to ensure that there is no conflict with their beliefs.

For guidelines and advice contact:

Rabbi E. Levy, (Education Portfolio in the Chief Rabbi's Cabinet)

Education Department, Adler House, Tavistock Square London WC1H 9HN

or

Glasgow Jewish Representative Council, 222 Fenwick Road, Giffnock, Glasgow G46 6UE

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The Muslim Faith

Many Muslim parents feel that it is more appropriate that sex education should come from the home, but some are of the opinion that the school is better suited. It is essential that Muslim parents be consulted prior to any sex education being undertaken at school. In Islam, the only basis for family life is marriage and, thus, Muslim parents may wish their children to be exempted from any part of sex education that deals with extra-marital relationships.

Further details can be obtained from:

Sex Education – The Muslim Perspective (3rd edition),

Ghulam Sarwar, the Muslim Educational Trust, ISBN 0 907261 30 2

or by contacting:

The Education Officer The Muslim Educational Trust 130 Stroud Green Road London N4 3RZ

Further guidance

The guidance may not cover all the faiths represented within any one school. You may wish to obtain further guidance and information through consultation with parents and representatives of the faiths in your school.

Support and information can also be obtained by contacting:

The Scottish Inter-faith Council, St Mungo Museum of Religious Life and Art, 2 Castle Street Glasgow G4 0RH

Tel: 0141 553 2557 or E-mail: sifc@freeuk.com

An Integrated Tiered Service Approach

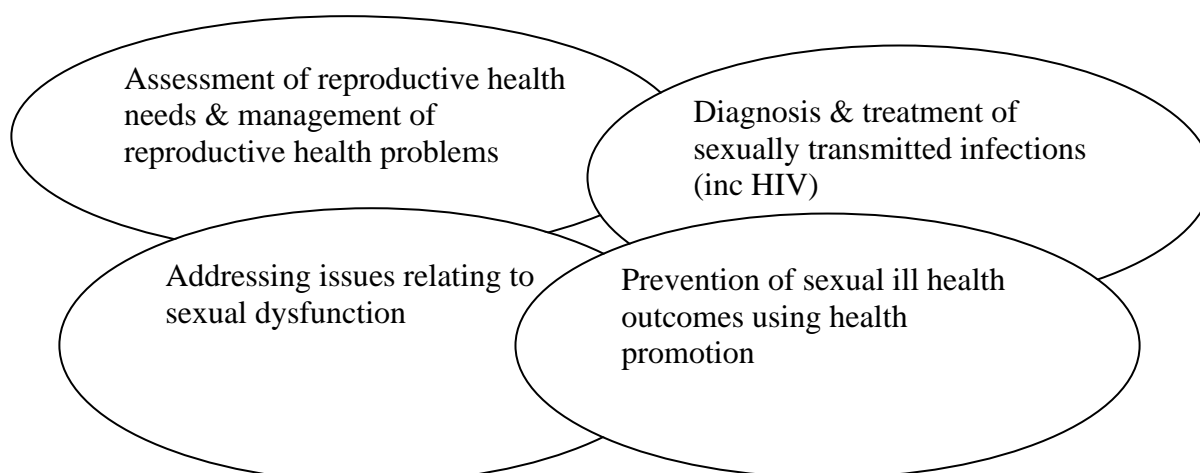
1. INTRODUCTION

- 1.1 This paper sets out the framework proposed by the Sexual Health and Relationships Strategy for the management and delivery of sexual and reproductive health services in Scotland. It also identifies some of the resource issues associated with implementing the tiered service approach. Supporting Papers 5B and 5C identify the issues which those services are seeking to address, and give pointers on the review level evidence and practice based evidence to support further practice and highlights the reasoning underpinning the proposed Strategy's recommendations in relation to clinical services.
- 1.2 Whilst this paper concentrates on clinical services, it is recognised that such service provision must complement the work undertaken to promote positive sexual health and lifelong learning about relationships and sexual health and to promote a more positive view of sexuality within Scotland.

2. BACKGROUND

- 2.1 Sexual and reproductive health services are provided by a range of providers including general practice, community family planning, genitourinary medicine (GUM), gynaecology and the voluntary sector. In addition, other services such as Accident & Emergency Departments, services for homeless people and drug and alcohol services may also provide support for the sexual health needs of their users. Responding to sexual ill health and promoting positive sexual health is a challenge both in terms of the geography of Scotland and in relation to the needs of local populations. Nevertheless the key components of sexual and reproductive health services should address:

Diagram 1: The inter-relationships between the components of sexual & reproductive Health Services



2.2 There are many examples of good and innovative sexual health services across Scotland as demonstrated in the responses made as part of the proposed Strategy's engagement process. However, there are wide variations in terms of availability, quality and choice in relation to these services which may discourage or delay individuals seeking help and can result in late diagnosis and treatment of preventable sexual ill health problems. The Scott Porter review of sexual health services (Butler and Solomon 2002), and the engagement exercise undertaken as part of the Strategy's development identified a range of issues which impact on the provision of sexual and reproductive health services in Scotland. Hosie's analysis of European sexual health policy (Hosie 2002), Ingham and Partridge's review of policies in Australasia (Ingham and Partridge 2002) also highlighted similar issues which need to be addressed if improvements were to be made in terms of service uptake and unwanted pregnancy and sexually transmitted infections reduced.

Box 1: Challenges currently facing sexual and reproductive health services in Scotland

- No clear strategic leadership or integrated clinical framework at national, regional and local levels
- Inconsistent service approaches between NHS Board areas
- Wide variation in availability of specialist sexual health services and lower staffing levels per head of population compared with other parts of the UK
- Inadequate data collection and information dissemination leading to an inaccurate picture of sexual illness, and an inability to make meaningful comparisons between services and NHS Board areas
- Lack of professional development structures for some specialist staff
- Consistent differences in service uptake by women and men based partly on gender assumptions about sex related differences
- Lack of knowledge about service provision (by both practitioners and users) leading to difficulties in accessing services
- Lack of clearly defined gender sensitive practice
- Different approaches to anonymity by different service providers
- Actual or perceived lack of confidentiality (particularly in remoter rural areas and for particular user groups such as young people and those with HIV)
- Inadequate service responses to the sexual health needs of those with HIV and others facing poorest sexual ill-health
- Inadequate services to support women and men post termination and following miscarriage and stillbirth
- Inconsistent links between service providers and police regarding the treatment and management of rape and sexual violence

- 2.3 In addition, several respondents in the engagement process commented on the failure of clinical services to address the broader social and cultural determinants of sexual health and thus presenting a medical model of health.

3 SERVICE PRINCIPLES

- 3.1 The Scott Porter review of services (Butler and Solomon 2002) and individual NHS Board sexual health strategies have identified a range of values and principles which should underpin sexual and reproductive health services. The proposed Sexual Health & Relationships Strategy identifies a core set of service values and principles which providers should use to assess their sexual and reproductive health service:

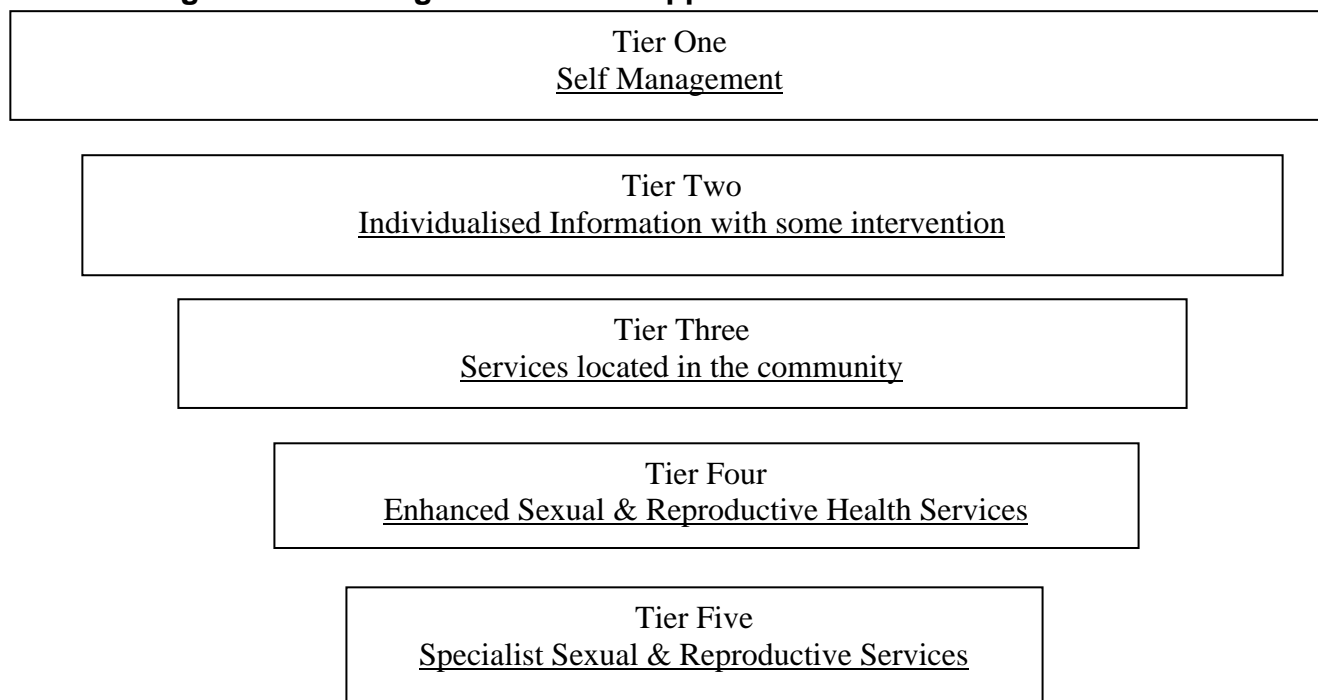
Box 2: Service Values and Principles

- Sexual and reproductive health should be viewed as a positive concept: for most people positive sexual health is an integral part of a fulfilling and healthy life
- Services should be sensitive, respectful, attractive, appropriate and user friendly as well as being culturally competent
- Services should promote empowerment, positive self esteem and self advocacy
- Services should offer support and information in making healthy choices and developing fulfilling and healthy relationships.
- An individual's right/entitlement to comprehensive sexual health services must be central to practice – for example, in relation to sex and relationships education, confidential services, information and service choices
- An individual should always have two or more alternatives in accessing service provision and be able to self refer to all services. When the required services are not provided by a practitioner of first choice, referral to appropriate provider must be made
- Staff providing sexual & reproductive health services must be supported through the provision of appropriate training/continuing professional development and resources

4 AN INTEGRATED SERVICE APPROACH

- 4.1 To provide a more cohesive seamless approach to clinical services, the Sexual Health and Relationships Strategy proposes the development of an integrated tiered services approach in each NHS Board area. This is based on the managed clinical network model and the increased emphasis on local decision making and local clinical leadership (NHS Circular HDL (2002) 69, NHS HDL (2003) 11). This approach proposed a model of integrated working based on five tiers:

Diagram 2: An Integrated Service Approach



- 4.2 The following paragraphs explain further each of the Tiers for the provision of sexual and reproductive health services in each NHS Board area, together with examples of the different scenarios which might apply depending on local resources and developments. It is recognised that, for the smaller or Island Boards, Tiers 4 and 5 may have to be provided by a neighbouring service provider as part of a service Tier agreement.
- 4.3 The range of sexual and reproductive health services which should be available at each Tier is set out at the end of this paper. This does not mean to say that all providers should provide every element: it will be dependent on appropriate knowledge, skills and attitudes. Whilst practitioners will continue to have the opportunity to opt-out of providing services, clear referral protocols should be developed and made well known so that individuals can be referred/self refer to other providers.

Tier One: Self Management

- 4.4 Individuals obtain information about sexual health matters and service provision from a range of formal and informal sources including sexual health trained staff, peers, magazines, the Internet, leaflets or television. Feedback during the engagement process suggests that such information may not be easily obtained or be out of date. It is important that individuals have access to the necessary information and services to enable each person to take responsibility for their own well being. This includes the prevention of unintended pregnancy and sexually transmitted infections. Information on sexual health issues and services should be standardised and evidence based, use modern accessible methods of communication and incorporate messages/information for those not accessing services. Websites and CD Roms have proven useful for younger age groups: the Healthy Respect demonstration project in Lothian has employed a range of different methods to help get information across, for example bus adverts convey messages to all age groups and can help discussions among different age groups. Using Websites can provide information on service locations and opening times and can be used to target specific populations, such as gay men or lesbians. In Glasgow, the Steve Retson Project has used the Internet to get responses from users about the quality of services. Feedback from user organisations and from NHS Boards indicates that information on how to access services and the range of services providers is not as freely available either to users or to other health professionals. This can lead to non-use of services or late presentation/referral to services that are more appropriate and potentially unavoidable ill health.

Tier Two: Individualised Information with some intervention

- 4.5 People may choose to obtain contraception and sexual health advice without the need to attend their doctor or a specialist service. Community pharmacists are seen as a source of valuable information, particularly in view of their drive to have private consultation areas (The Right Medicine, 2002). They have proven effective in providing community based responses for specific target groups (for example, needle exchange/methadone maintenance programmes and emergency hormonal contraception). This provides an additional opportunity to address sexual health issues through the provision of free condoms. Pharmacy involvement in condom distribution schemes (sometimes known as C-card) has provided a second access option for young people to access free condoms, as demonstrated in Fife and Lanarkshire. This is to be encouraged and further developed in non-participating areas. A similar experience has been seen in the uptake of chlamydia postal testing kits currently being piloted by Healthy Respect in Lothian.
- 4.6 Public health nurses working in schools are ideally placed to provide young people with accurate and up-to-date information on sexual health services including details of where these services are, when

they are open, how to book an appointment and what will happen during a visit (for example, through posters on notice boards, information in school welfare booklets, leaflets). Many already provide broader sexual health advice and information, for example on relationships, breast self examination, PMS. However, many are not confident about giving more detailed advice and support, although they perceive a need for it. (Craig 2002). The Framework for Nursing in Schools (Scottish Executive 2002) builds on the broader social role of school nurses in providing support and counselling to young people and provides a backdrop for further developing this role. (further examples on improving links between services and schools is given later)

- 4.7 The youth based service model identified in the Scott Porter review of services is an example of this Tier. Some are delivered in clinical settings, for example Fiz in Airdre and Teen Aid in Oban whilst others may be in a “youth project setting” as in Stonewall Youth. Sexual health services often form part of a more broader remit, that is youth training, wider health topics. All such services offer face to face delivery and may also provide a distance based services such as a website.

Tier Three: Baseline Services

- 4.8 There is a range of service providers who respond to an individual's basic sexual health and reproductive health needs. This includes GPs and other members of the primary health care team, specialist voluntary sector services (such as Caledonia Youth, Highland Sexual Health), community family planning clinics, outreach GP and/or family planning to generic drop in services with clinical outreach such as The Corner, Dundee and Sorted on Sex, Falkirk. Depending on the service required and the skills/competence of staff and resources, sexual health services may be provided on site or individuals referred onto more specialist services.

Tier Four: Enhanced Baseline Services

- 4.9 This Tier builds on the previous service provision. This could be via those general practices¹ who have an interest in providing more specialist sexual and reproductive health services alongside other general medical services or through existing family planning services or outreach GUM services (or any combination of these) or other provider service. Some general practices have already explored this avenue either through Personal Medical Service pilots (as in Stirling) or from their own interest. To extend this to other areas, general practice staff will require support and training so that they can acquire the additional skills and knowledge to provide these enhanced services as well as

¹ General practice refers to all members of the multi-disciplinary team which may/may not have a lead GP clinician; the model will be dependent on needs of population and the interest of individual practitioners

providing a source of local advice and expertise to practitioners in the lower tiers. Primary care staff operating in Tier Three should be able to refer individuals to these enhanced services thus providing a more localised service response as well as having the continued option of referring to family planning, GUM (genito-urinary medicine) and other specialist services as at present – again individuals should also be able to refer themselves. Thus Tier Four services will have an educational/liaison role for good practice dissemination, liaison with specialist providers and local laboratories and a leadership role to champion change within their locality.

- 4.10 To provide a more localised specialist service, the proposed Sexual Health and Relationships Strategy recommends that in each Community Health Partnership or locality, at least one service provider should be encouraged to provide Tier Four services. This might be a general practice or could be a family planning clinic: where developed, they could act as the local sexual health lead providing support and facilitating development to other practitioners in their locality. Rogstad et al (2002) have developed standards for comprehensive sexual health services for young people. These provide a useful template for setting up and monitoring such services. This supplements the Best Practice Guidance on the Provision of effective contraception and advice services for young people issued by the Teenage Pregnancy Unit in England (2000).

Tier Five: Specialist Led Services

- 4.11 This combines elements of sexual and reproductive health needs assessment, facilitating clinical governance and quality assurance, co-ordination of surveillance and data collection for all Tiers as well as services such as specialist HIV treatment and care, contraception and reproductive health services, co-ordination of partner notification, psychosexual medicine, termination of pregnancy.
- 4.12 Currently, Tier Five services are accessed directly by self referral or via primary care, other specialist services, other health services and voluntary agencies. Self referral is important since these services provide anonymity and confidentiality which is highly prized by people who feel awkward or unhappy about consulting a health professional that they may know in another context. Sexual health issues are often highly sensitive and difficult to address. The further development of Tier Four services should enable Tier Five services providers to develop the specialist aspects of their practice more fully and provide a greater degree of support to locally provided services. The development of enhanced general practice services at Tier Four will also provide greater choice for patients at a local level.
- 4.13 Tier Five will continue to be the main organisers and providers of specialist training. However there should be greater scope for the placement of staff who are doing a more generic sexual health training

in Tier Three/Four services. Tier Five will remain responsible for surveillance and data collection. They will also continue to be the experts in contact tracing and the management of complex conditions. They will hopefully be able to adopt a more integrated approach to care incorporating the service provision offered at Tier Four.

- 4.14 This tiered approach builds on the current wealth of knowledge and experience currently available within Scottish sexual and reproductive health practice. It is hoped that the proposed tiered service framework will promote a change of culture, which in time will allow service provision and contributions to be more evenly balanced across the tiers and ultimately will make it easier for patients to consult with practitioners in any tier about a range of sexual health topics.
- 4.15 Practitioners, particularly at Tiers Four and Five, should be able to develop the specialist aspects of their practice more fully and provide a greater degree of support to more locally provided services. In summary the tiered service approach should:

- Facilitate a more flexible and developmental approach to improve consistent and co-ordinated clinical services, from baseline Tier through to specialisation
- Represent a continuum in sexual and reproductive health care provision so that individual patients may move through the Tiers or stay at the same Tier for all of their treatment and care
- Enable practitioners in any setting to provide services from different Tiers
- Only a very small number of clinical services will provide all services – the key is to develop a seamless approach to sexual and reproductive health services that are responsive to the needs of both users and practitioners

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Some scenarios to help clarify roles of different tiers

Management of STIs			
Scenario	Current Position Tier Three	Possible outcomes from strategy	
		Short Term change	Long Term Change
24 year old man with urethral discharge	Inconsistent approach Limited patient information Usually refer direct to Tier Five for diagnosis, treatment, follow-up. If no Tier Five available may be managed by GP but: <ul style="list-style-type: none"> ➤ No access to immediate diagnosis ➤ Poor test for gonorrhoea ➤ Contact tracing not routinely done ➤ Prescription on best guess 	Bolster Tier Two <ul style="list-style-type: none"> ➤ Provide accurate patient information ➤ Provide clear referral guidelines ➤ Provide diagnostic kits or at least LCR for chlamydia ➤ Promote SIGN guidelines ➤ Provide support with contact tracing where appropriate ➤ Patient group directions (PGDs) for provision of azithromycin by nurses 	Provision of Tier Four service: <ul style="list-style-type: none"> ➤ Diagnostic service ➤ Contact tracing ➤ Nurse Led element* ➤ Counselling ➤ Health Promotion ➤ Specialist services ➤ HIV testing and counselling ➤ Full contraceptive service Tier Five – referral criteria better defined.**
Young woman going to GP for routine prescription for oral contraception (OCP)	Variable approach Probably no discussion about STI risk However nurse or GP who has had training in last five years is more likely to discuss condom use.	<ul style="list-style-type: none"> ➤ Routine provision of information re STI to patient requesting OCP – opportunity for patient to raise issue. ➤ Provision of basic proforma for use by GPs routinely providing contraception. ➤ Enhanced role of nurse ➤ PGD and stock in practice ➤ Kits for chlamydia testing 	Tier Four services as above
34 yr old woman with vaginal discharge	Commonly non STI Variable approach to history taking Diagnosis made on basis of vaginal examination and history - no microscope Treatment for thrush / BV prescribed by doctor. Can be advised to self medicate for thrush as over the counter medicine	<ul style="list-style-type: none"> ➤ PGD for supply of clotrimazole and fluconazole for candida and metronidazole for bacterial vaginosis ➤ Stock of medicine ➤ Enhanced role of nurse – PGD/ Protocol ➤ Guidelines about management of recurrence. ➤ Sexual examination routine to exclude STI ➤ Appropriate sexual health training courses available to staff to achieve required competencies 	Tier Four As above

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<i>Scenario</i>	<i>Current Position Tier Three</i>	<i>Possible outcomes from strategy Short term change</i>
21 yr old woman with vaginal discharge and recently new partner	Increasing awareness of chlamydia and possibility of other STI amongst young people. Inconsistent service response Poor diagnostic test availability Variable approach to history taking/examination Inconsistent approach to partner notification and contact tracing Usually refer straight to Tier Four	<ul style="list-style-type: none"> ➤ Routine sexual history taking ➤ Chlamydia test kits available ➤ Examination possible ➤ Support for PN / Contact tracing ➤ PGD and stock for nurses ➤ Explore contraceptive use and safe sex issues ➤ Promote SIGN guidelines
Sexual Health Scenarios from nursing perspective		
25 year old woman attends for routine hormonal contraception. Concerned about STI	Inconsistent approach Limited patient information on STI available Nurse / GP may take history to include STI In some areas majority of women will see both GP and nurse ² – contraception prescribed by GP. A small number seen by a nurse alone. STI - may be examined / managed by GP as appropriate or referred to Tier Five	<p>Bolster Tier Three</p> <ul style="list-style-type: none"> ➤ Routine provision of accurate patient information ➤ LCR for chlamydia ➤ Provide support with contact tracing where appropriate ➤ PGDs for supply of azithromycin / contraception by nurses
15 year old attends an outreach young people's service for contraception	Usually doctor and nurse available. Nurse will have Family Planning certificate and may have GUM experience. Routine provision of information re STI Nurse undertakes comprehensive history / assessment and uses PGD for supply of contraception if appropriate or requests prescription. Doctor available for advice or treatment if history complex or outwith PGD criteria Service not available in all areas in Scotland	<ul style="list-style-type: none"> ➤ Support with contact tracing ➤ Kits for chlamydia testing
<i>Scenario</i>	<i>Current Position Tier Three</i>	<i>Possible outcomes from strategy Short term change</i>
35 yr old woman presents with history of vaginal discharge	Commonly non STI Variable approach to history taking Diagnosis made on basis of vaginal examination and history – no microscopy Treatment for candida Information leaflets available but not consistently provided to patients Advice provided on self medication for thrush purchased as over the counter medication	<ul style="list-style-type: none"> ➤ PGD for supply of clotrimazole, fluconazole for treatment of candida and metronidazole for treatment of bacterial vaginosis ➤ Stocks of medicine kept at local level ➤ Enhanced role of nurse – use of PGD/protocol ➤ Guidelines about management of recurrence. ➤ Sexual history routine to exclude STI

➤ ² In Lothian 63% of women will see both GP and nurse – contraception will be prescribed by GP. 9% are seen by a nurse alone. (Craig 2002unpub)

5 HELPING TO DEVELOP THE TIERED SERVICE APPROACH

Developing Professional Roles to Respond Flexibly to the Tiered Service Approach

- 5.1 Education and continuing professional development covering generalist and specialist competencies underpins the proposed Sexual Health and Relationships Strategy. Staff at all levels will need increased knowledge and skills to deliver the Strategy. This includes those working in a specialist sexual health post as well as those whose major role is not sexual health but whose practice might involve an element of sexual health whether that is in providing information, advice or direct services or in health, social care, education and the wider community. The need for staff at all levels to develop core skills in communication, attitudes and relationships in relation to sexual health is supported by the proposed Strategy as one means of addressing this.
- 5.2 In addition, the need for a clearly defined career structure in sexual and reproductive health care, the acquisition of competencies for each Tier and knowledge acquired at undergraduate level and ongoing professional development was recognised in the development of the proposed Sexual Health and Relationships Strategy.

Local Sexual Health Lead

- 5.3 Within each Community Health Partnership (CHP) or locality, an identified sexual health lead will develop and support primary care and specialist sexual health provision. Depending on local arrangements the lead may be a general practice, community based sexual and reproductive health service or voluntary sector organisation. This CHP lead will help develop sexual health knowledge, skills and expertise amongst CHP providers and draw on additional input from the specialist sexual health services as required, for example on issues such as partner notification and the management of complex STIs.
- 5.4 It will be essential to those undertaking this locality lead role to have access to more specialist sexual and reproductive health practitioners (for example at Tier Four level). The range of supports suggested include:
- Access to mentoring/educational supervisor
 - Direct access to specialist support
 - Access to educational and relevant material, included protected time for CPD
 - Access to health advisor
 - Written confidentiality agreement for the service
 - Access to medical and surgical termination of pregnancy providers

Some of these will also be applicable to Tier Four enhanced services operating in primary care.

General Practice

- 5.5 General practitioners, practice nurses and other primary care providers such as local family planning clinics have an important role to play in the diagnosis and treatment of people with sexual ill-health as well as supporting positive sexual health promotion. Increasing the availability of sexual health services in primary care is a way of increasing access for those who are unable or prefer not to use GUM or family planning services. The Reference Group was mindful of the pressures currently faced by primary care providers. To achieve the balance of care provision across the proposed tiers, support through training and involvement in the managed sexual health networks will be key for primary care providers. The Reference Group recognises that by no means will every GP and practice nurse wish or be able to change their practice substantially. Many may adopt modest changes if they assist their everyday practice. They are more likely to use high quality Tier Four services if they are locally available, comprehensive and clearly understood.
- 5.6 Primary care already utilises the concept of skill mix over a variety of settings using nurse led clinics and the extension of this is envisaged for sexual health services. However, the need for adequate numbers and training of GPs and other members of the primary care team both to ensure consistent quality of Tier Three care and adequate numbers providing Tier Four services is recognised by the proposed Strategy. The Strategy's Reference Group recognised that the new GMS contract provides a specific fee to encourage practices to offer the improved and/or extended sexual health services necessary to meet this Strategy's aspirations. Where these additional or enhanced services are purchased from general practitioners, they should be provided to defined standards (the proposed guidance to accompany the Strategy's implementation will assist commissioners in identifying these standards). In addition, a local audit of training needs of all providers with gaps being met through an identified training programme is a task set for each NHS Board area. The key will be to develop an approach that develop a public health perspective to sexual health utilising all members of the primary care team and ensuring an enhanced access to services.
- 5.7 It is recognised that during the course of their vocational training, general practitioners might not have undertaken any GUM or family planning practice over and above their obstetrics and gynaecology module. Indeed, feedback from the engagement exercise indicated that where this option already exists, there are suggestions for its removal. Instead of removing such an option, the new SHO training scheme should include an attachment to GUM and Community Family Planning services. Those GPs who wish to provide an enhanced Tier Four sexual health service should also undertake a similar attachment so that they can demonstrate their competency in providing services at

this level: regular refresher periods should also be built into general practice standards for continuing professional development.

- 5.8 Research by Scade et al (Scade, Burns, and Graham 2002) identified that practice nurses are already carrying out aspects of sexual health care in a non specialist setting. Whilst giving out advice or information on a range of sexual health issues, many practice nurses report having had no formal qualification or training and whilst they may be interested in pursuing sexual health as a specialism, have many demands on their time and skills. (Craig, 2003). The proposed Sexual Health and Relationships Strategy will support the role of practice nurses through the development of local professional training programmes, ensuring general practice staff have access to up-to-date information on sexual health issues and knowledge of referral pathways to specialist sexual health services.

Specialist Sexual Health Medical Practitioners

- 5.9 The Reference Group noted that the Royal College of Obstetricians and Gynaecologists and the Faculty of Family Planning and Reproductive Health Care have proposed a well-defined career path for medical staff (RCOG, 2000). However, training positions have not received appropriate recognition or funding. The proposed Sexual Health and Relationships Strategy recommends that the appropriate Post Graduate Medical Deans and NHS Education Scotland should address this issue, for example through the provision of sufficient training rotations for specialist registrars and other medical practitioners. In addition, the status and career opportunities for non-consultant doctors, nurses and other health care staff working in sexual and reproductive health services need to be further explored and supported through employers providing identified training places, mentoring opportunities and appropriate management frameworks. The development of a sexual health network and professional training programme for practitioners working in all Tiers in each NHS Board as identified in the Strategy should help support this.

Nursing Staff

- 5.10 Nurses working in primary care and in specialised sexual health services have made progress in developing their role through their existing contact with women to promote sexual health, targeting men's health as well as addressing the needs of at risk populations. The engagement exercise highlighted a range of promising practice, some of which include:
- In a number of NHS Board areas, nurses supply or administer certain medications in accordance with patient group directions as well as providing specific training and support to other health care staff. There are also opportunities for nurses to undertake extended independent and supplementary nurse prescribing courses facilitating the supply and administration of hormonal

methods of contraception along with treatment for some genital infections.

- In Tayside a community learning disability nurse offers a weekly well woman clinic in conjunction with family planning services for women with learning disabilities. In Glasgow, community learning disability nurses shadow specialist sexual health staff so that they can provide a more effective response to the needs of their patients.
 - The Glasgow Learning Disability Partnership includes nurses working alongside residential and day care staff to support the sexual health needs of people with learning disabilities and their carers. Work is underway to produce sexual health promotion leaflets for people with learning disabilities
 - In Lothian, a number of nursing staff work in Healthy Respect projects linking between primary care and specialist sexual health services. A family planning community nurse in an inreach/outreach post teaches SRE sessions in schools and sign-post young people to a sexual health service provided by the same nurse. Another nurse works in Caledonia Youth focussing on increasing access to services for young people, particularly those who are vulnerable or have special needs. In GUM, nurses are facilitating the testing and availability of chlamydia testing with a particular emphasis on men.
 - In Argyll & Clyde, GUM services provide an outreach service to female prisoners and in Forth Valley health care staff in Cornton Vale women's prison provide a well women service including sexual health advice and treatment
- 5.11 Currently most 'nurse led' services require medical support as the nurse relies on patient group directions (PGDs) for the supply of medicines. The establishment of independent and supplementary prescribing will help make 'nurse led' services more fully independent. This, will, however depend upon the formulary and how useful the items included are for the treatment of sexually transmitted infections. A combination of prescribing and PGDs could be an interim solution to this problem.
- 5.12 Extending the role of nurse can be developed through experience, advanced training and practice and the use of protocols and guidelines. This will mean considerable training and support for nurses to take on this new role. Nurses due to the nature of their training and grounded with a public health promoting role, work differently to their medical colleagues. In order to avoid a task-oriented approach to sexual health, nurses will be facilitated to deliver a clinical service using a holistic supportive approach towards current and potential service

users. This may create a difficult tension since the balance of both quality and pace is critical to the provision of a safe and efficient service. However, some nurses already lead the provision of certain specialist services which are not primarily about the prescription of medicines. These may require expansion or development in Tier Four primary care services, for example, post abortion counselling, psychosexual counselling, menopause advice.

- 5.13 Building on the existing sexual health skills and effective practice of nurses at both specialist and primary care levels, the further development of nurse-led sexual health services and an enhanced career structure will address some of the capacity limitations likely to hinder the progress of the tiered service approach. Feedback from previous staffing surveys (Scade et al 2002, Lamont 2003) supports such developments in sexual health nursing and the need to develop competency based standards and guidelines. In response to this and as a first step, the proposed Sexual Health and Relationships Strategy recommends that NHS Education for Scotland help develop competencies to support the sexual health nurse role in specialist and primary care services. These competencies will create a baseline for the Higher Education institutions to develop relevant accredited courses.
- 5.14 The development of a career pathway for sexual health nurses will be necessary to enable nurses to respond to these competencies and the tiered service approach. It is recognised that some staff will wish to gain formal qualifications to support their practice whilst others may wish to gain recognition for their experience through a competency framework. The following suggests the range of examples associated with the proposed tiered approach:
- At Tier Two and below: the nurse should be registered on the First Part of the Register and have undertaken an accredited course of study which includes a general awareness of sexual health promotion and a knowledge of specialist services
 - At Tier Three: nurses should hold an accredited nursing qualification in Family Planning/Genitourinary Nursing
 - At Tier Four: In addition to Tier Three the nurse should hold or be working towards a specialist practitioner qualification in family planning or genitourinary nursing
 - At Tier Five: in addition to Tier Four, the nurse should hold or be working towards a Masters in Sexual Health Nursing
- 5.15 This was strongly supported in an open consultation with nurses working in sexual health as part of the Strategy's engagement exercise. The guidance for nursing staff developed by the Royal College of Nursing in response to the Sexual Health and HIV Strategy (RCN, 2001) would be a valuable resource in developing this further.
- Clinical Governance*

- 5.16 Whilst the Lead Clinician is charged with responsibility for overall clinical governance for all Tiers, individual practitioners have a responsibility for ensuring that their service meets appropriate standards and practice. An example of how clinical governance could be supported at local levels is appended.

Clinical standards

- 5.17 The integrated tiered service approach and the managed sexual health network require shared standards of care between all providers and all service levels. Clinical service standards should ensure consistency of approach by all staff involved in sexual health services. A number of evidence based speciality standards have been developed for specialist practitioners (BASHH, Royal College of Physicians, RCOG, FFPRHC). The Scottish Intercollegiate Guideline Network (SIGN) have developed a guideline on the management of genital chlamydia infection (SIGN 42) and the Society of Health Advisers have recently developed guidelines for partner notification. Additional standards in development include generic sexual health standards for Community Health Partnerships and practice standards for school nurses and other community based nursing staff
- 5.18 It is recognised that, without effective “policing”, implementation of these guidelines and standards may not be pursued with any uniformity and consistency which in turn affects service responses and user experiences. This may be due to lack of knowledge of their existence or the absence of implementation obligation or the fact that there are so many guidelines in so many areas. In addition there are no standards which cut across the whole of the patient’s sexual and reproductive health care journey and regardless of point of entry. The Scottish Infection Standards and Strategy Group (SISS) have developed standards for the detection and management of STIs which should help develop standardised practice in this area. Views on the value of formulating national sexual and reproductive health standards will be sought as part of the consultation on the proposed strategy.

6. Conclusion

This paper briefly sets out the clinical framework which underpins many of the recommendations laid out in the proposed Sexual Health and Relationships Strategy. This will be supported by the wider sexual health network detailed in Supporting Paper 6. Further implementation guidance will be developed following the wider consultation on the Strategy’s proposals

September 2003

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OUTLINE DETAIL OF TIERED SERVICE APPROACH		
Tier One: Self Help/Management		
Telephone helplines Generic drop ins Websites	<ul style="list-style-type: none"> • Information (oral & written) • Advice • Signposting • Condoms purchase • Fertility monitoring • Pregnancy testing 	Detached youth work Voluntary sector (generic & special interest) Peers NHS generic staff
Tier Two: Individualised Information with some intervention		
Face to face contact with generic staff	<ul style="list-style-type: none"> • Emergency contraception • C Card schemes • Chlamydia postal testing • Out of hours response • Pregnancy counselling • Pre conception counselling 	Community Pharmacy Public health nurses working in schools A& E departments GPs as signposters NHS 24
Tier Three: Baseline Services (equivalent to English Level 1)		
Direct face to face contact	<ul style="list-style-type: none"> • Sexual history & risk taking assessment • Hep B immunisation • STI testing for women and men using NAAT • STI management • Pregnancy testing/counselling/referral • Contraception information and provision (except IUDs and implants) • Simple partner notification • Hormone replacement therapy • Management of post sexual assault • Referral for suspect ectopic pregnancy • Cervical screening • Antenatal HIV screening • Counselling for female sterilisation & referral onwards • Referral onwards for gynaecological/obstetrics emergencies 	General practice Specialist voluntary sector eg Caledonia Youth MYPAS (Midlothian) SOS (Falkirk) Some Family Planning outreach/GP enhanced services

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<i>Routes (how)</i>	<i>Purpose (what)</i>	<i>Involvement (who)</i>
Tier Four: Enhanced Baseline Services		
Targeted approach for specific populations	<ul style="list-style-type: none"> • Assessment and provision of IUDs (planned and emergency) • Hormonal implants • Complex Partner testing • Support of partner notification in other tiers • Management of minor gynaecological problems • Management of complex contraception problems • Assessment and management of psycho-sexual issues • Menopause • Complex HRT • Management of Sexual assault • Advice on /diagnosis of fertility & pregnancy problems and signposting to other services 	Family Planning Enhanced General Practice Outreach GU <i>Signposting to & links with other service providers eg obstetrics & gynaecology & urology</i>
Tier Five: Specialist Led Services		
	<ul style="list-style-type: none"> • Co-ordination of training/CPD for all tiers across region • Provision of specialist training/updating of specialities within region • Support/co-ordination & provision of research 	Specialists such as Family Planning teams Community Gynaecologists GUM team Infectious Disease teams <i>Signposting to other services</i>
	<ul style="list-style-type: none"> • Provision of highly specialised contraception (gynaecology focus) • Management of medical gynaecological problems • Assessment & management of recurrent STIs or complications beyond the genital tract • HIV treatment and care • Colposcopy/menstrual dysfunction • Co-ordination of partner notification across region • Specialist andrology services (Erectile dysfunction, transgender) • Psychosexual support (consultant led) 	
	<ul style="list-style-type: none"> • Co-ordination of development & monitoring of quality/standard setting 	

Clinical Governance Framework for Sexual and Reproductive Health Services

The figure illustrates a possible clinical governance model for sexual services.

Clinical Services																	
<p>1</p> <p>History taking, examination, diagnosis & treatment Diagnostic tests including for pregnancy Referral to other agencies Screening tests Counselling Prescribing and dispensing Undertaking procedures/operations Follow up and ongoing support Partner notification Team approach Health promotion Provision of training Keeping patient records and data collection Participation in CPD/CG/PREP/PDP development Undertaking audit and research</p>	<p>2</p> <p>Maternity and gynaecology services Pathology and radiology services General medicine, paediatrics and dermatology GPs, public health nurses including health visitors and school nurses, pharmacists Dieticians Youth and community services Child protection services Social care Schools and colleges Drug Agencies and HIV services Brook, Caledonia Youth and other voluntary organisations Benefits agency Police Public health and health promotion</p>																
<p>Clerical and administrative support IT systems Site location and facilities appropriate to tasks Appropriate equipment and supplies and storage Appropriate caseload/workload Efficient patient record systems Pathology collection systems Sterilised supplies/sterilisation procedures Published service standards that are monitored Security at workplace Recruitment and retention policies for appropriately qualified staff Robust recruitment arrangements for those working with young people HR and employment policies supportive of part time and multi-site working Financial support and time to enable CG/CPD etc User consultation and robust complaints procedures Service promotion and advertising</p> <p>3</p>	<p>Community profiles/Health Needs Assessment Government strategies eg Sexual Health Fraser guidelines VD Regulations and other Public Health Law Abortion Act Child Protection procedures Organisation with a Memory, Data Protection Acts 1984 & 1998, Caldicott guidelines, Access to Medical Records Act Crown/Scottish Executive guidelines on nurse prescribing NMC and GMC guidance Scottish Executive policies: Strategy for nursing and midwifery in Scotland, Nursing for Health Advice from the professional Colleges and NES NHSQIS Health and Safety regulations Medicines Control Agency guidelines National voluntary organisations</p> <p>4</p>																
Support Services																	
<p>Internal Quality Assurance Dimensions:</p> <table border="0"> <tr> <td>Confidentiality</td> <td>Co-ordination</td> </tr> <tr> <td>Appropriateness</td> <td>Safety</td> </tr> <tr> <td>Availability</td> <td>Respect & caring</td> </tr> <tr> <td>Continuity</td> <td>Timeliness</td> </tr> </table>	Confidentiality	Co-ordination	Appropriateness	Safety	Availability	Respect & caring	Continuity	Timeliness	<p>External Quality Assurance Dimensions:</p> <table border="0"> <tr> <td>Confidentiality</td> <td>Co-ordination</td> </tr> <tr> <td>Appropriateness</td> <td>Safety</td> </tr> <tr> <td>Availability</td> <td>Respect & caring</td> </tr> <tr> <td>Continuity</td> <td>Timeliness-ordination</td> </tr> </table>	Confidentiality	Co-ordination	Appropriateness	Safety	Availability	Respect & caring	Continuity	Timeliness-ordination
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Clinical Service Framework

NOTES:

Quadrant 1: The rationale of the framework is that health professionals and their employers will need to ensure that they are able to provide a range of services/tasks outlined in this quadrant. The tasks described are for a “generic” professional providing a sexual health service, the balance of which will depend on the nature of the service and the health needs of the clients seen. The framework can be redrawn to consider individual aspects of professional activity in more detail. Clearly, appropriate training and qualifications are mandatory. Employers and their employees have a dual responsibility to ensure that they are appropriately qualified to undertake the tasks expected of them and to remain up-to-date. Quality assurance in professional activity should be based on needs led, evidence based and consistent approaches. This is largely the responsibility of individual health professionals and teams. If shortfalls are identified these should be made known to managers. The quality assurance boxes in the figure suggests a range of dimensions that need to be considered to ensure high quality services are (and are seen to be) provided.

Quadrant 2: This identifies in broad terms the important linkages that health professionals need in order to undertake their clinical work, such linkages need to be recognised, promoted, developed and fostered by the different management tiers.

Quadrant 3: lists the organisational support that health professionals require when undertaking their clinical work. Responsibility to ensure adequate provision of this essential non-clinical support lies with their managers.

Quadrant 4: lists some of the national and local policy context in which sexual health services are operating. It also recognises community health needs as a backdrop for the service. Awareness should be a professional and a managerial responsibility.

Conclusions:

Effective contributions and support from health professionals will help deliver high quality sexual health services. The clinical governance framework outlined here indicates that in order for health professionals to undertake clinical tasks safely and effectively, they are dependent on the active support of other professionals and agencies. Efficiency in sexual health services will require staff to have appropriate caseloads/workloads, the use of evidence based protocols, regular intra and inter professional links and meetings, sufficient opportunities for continuing professional development and audit, and having adequate administrative infrastructure.

NHS Boards providing these services should be able to demonstrate how such features will be recognised, safeguarded, developed and managed. When NHS Boards and the new Community Health Partnerships develop their inter agency sexual health strategies, they seek appropriate professional advice and support.

*Adapted from the Implementation Guidance for the Sexual Health and HIV Strategy
produced by Department of Health, London*

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Supporting Paper 5A: An Integrated Tiered Service Approach***

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Scottish Intercollegiate Guidelines Network *Guideline No 42. The Management of Genital Chlamydia Trachomatis Infection*. Edinburgh, SIGN, 2000

Teenage Pregnancy Unit. *Best Practice Guidance on the Provision of effective contraception and advice services for young people*. London, Department of Health, 2000 (www.teenagepregnancyunit.gov.uk)

Websites:

Royal College of Obstetricians and Gynaecologists: www.rcog.org.uk

MSSVD: www.mssvd.org.uk) now joined together to become BASHH:
Association of GUM clinicians) British Association for Sexual Health and HIV
www.bashh.org.uk

Royal College of Physicians (RCP): www.rcplondon.ac.uk/www.rcpsglasg.ac.uk

Faculty of Family Planning and Reproductive Health Care (FFPRHC):
www.ffprhc.org.uk

Supporting Access to Clinical Services and Reaching Those in Need of Services

1. INTRODUCTION

- 1.1 This paper complements Supporting Papers 5A and 5C by setting out the issues which sexual and reproductive health services are seeking to address and gives pointers on the review level and practice based evidence to support further practice and the proposed Sexual Health and Relationships Strategy.

ISSUES RELATING TO ACCESS

2. Service Configuration

- 2.1 How services are delivered and the attitudes and outlook of the staff who deliver the service is important for all age groups but particularly so for young people and other vulnerable populations as identified by the Scott Porter review (Butler and Solomon 2002) and by Hosie (2002). Evidence from the Healthy Respect demonstration project (Annual Report 2001) and other initiatives indicates that access to same sex GPs and nurses and nurse led services can influence the outcomes of interventions (Peersman, 1996, Burack 2000, Allen and Hippenley-Cox, 2000). Dehne (2000) found that the integration of STI education for prevention and counselling had a positive impact on user satisfaction and family planning acceptance.
- 2.2 Butler and Solomon (2002) and Hosie (2002) identified accessibility and acceptability as important issues for those sexual and reproductive health services. Glasier presenting evidence to the HEBS Young People and Sexual Health Seminar cited evidence demonstrating the links between increased contraceptive use and dedicated young peoples services (Glasier, 2002). Allaby (1995) and Clements et al (1999) also demonstrated the value of location to enhance service uptake. Furthermore services might not be viewed as being applicable to both sexes – men view sexual health services being targeted towards women only (HEBS 2002, Gelder 2002). Although there may be a wide range of services (and in different settings) available, they are not always accessible to those who need the service, for example

opening times, geographic locations, premises, (due in part to lack of funding resources). Service providers should also recognise and reflect the service needs of different life stages of their user population. Older people did not wish to attend family planning services as their needs were beyond the reproductive life stage.

2.3 Hughes and McGuire (1996) found that general practitioners were among the most accessible and available health providers for young people and the most cost effective way of delivering contraceptive services. Sengupta (1998) found that whilst the majority of general practitioners in Scotland were willing to provide contraceptive advice to under 16s, fewer were prepared to provide treatment and of those only half were willing to refer the young person onto further services. This study also found that GPs from minority ethnic communities trained abroad were less likely to provide advice and/or treatment but were willing to refer patients to other services. Burack (2000) also found that attendance was dependant on staff attitudes, staff knowledge of the rights of young people in accessing services, user perception of how confidentiality was dealt with and the availability of same sex practitioners. This supports the findings of the review of sexual health services in Scotland (Butler and Solomon 2002).

2.4 Butler and Solomon (2002) also identified five different models of service provision and examples of promising practice including one stop shops, generic drop in centres and integrated service provision, some involving co-location and others with clear integrated care pathways and referral protocols. Whatever service configuration is adopted, it should reflect the needs of the local population.

Responding to the Needs of People from Black and Minority Ethnic Communities

2.5 There is evidence to suggest that some BME populations are more at risk of STIs or teenage pregnancy compared to others and do not access services. If high risk BME groups have poor access to appropriate services, then

infections will persist within these groups with the burden of resistant sequelae. As with other at risk groups, sexual health service providers and sexual health promotion specialists should ensure that their services are sensitive, acceptable and accessible to their local minority communities. Culturally sensitive and innovative approaches to preventing disease will be critical and services will need to be targeted without stigmatising affected communities. This will mean that BME communities should be involved in planning and implementing services and where appropriate be represented on local inter-agency sexual health strategy groups.

Responding to the Needs of Men

- 2.6 Responding to the high rates of teenage pregnancy depends on increasing the involvement of boys and young men in decisions about relationships, contraception, sexual health and pregnancy. Although the number of men attending contraceptive services has increased in recent years, they still form a small proportion of overall attendances. Guidance from the English Teenage Pregnancy Unit and the review of Boys and Men's Health (Lloyd, 2002) provide useful pointers on ways of working with boys and young men – for example using one to one consultations, drama and theatre activities, offering incentives and sport activities and outreach work in conjunction with other services.
- 2.7 Gender is an important factor determining the source of health information used. In examining young men's use of sexual health services, Biddulph and Blake (2001) found that the average young man was unlikely to access any help or support at all if he had a problem. Staff attitudes and lack of choice of male practitioners might also be a factor in the decision whether to seek help (Banks 2001). A number of examples of promising practice were highlighted during the engagement exercise undertaken as part of the proposed Sexual Health and Relationships Strategy: these included the Health Opportunities Team in Lothian, the Men's Health Forum and specialist sexual health workers for men based working with Ayrshire and Arran NHS Board. Work being

undertaken by fpa Scotland will provide further practice-based evidence of what works with young men who live in areas of deprivation in Scotland.

Gender Issues

- 2.8 In developing services, providers need to be aware of health limiting behaviours often pursued by males and in particular their learned gendered behaviour. The latter suggests that men should be sexually experienced and competent, are the dominant species, and should conform to stereotypes, especially in relation to sexuality. In addition showing emotions is viewed as “feminine” and may cause problems with intimacy. In some ways, current services perpetuate these myths by focussing sexual health information, advice and services at women and these must be tackled if this imbalance is redressed. No single intervention or approach will work: a multi faceted approach starting at an early age through fathers talking with their sons (and daughters) about relationships and sexual health and continuing through adulthood would be a start. Ingham (2002) also suggests that gender variations are more pronounced among families in deprived areas thus suggesting an initial focus for such work. Duncan (2002) proffers that there may be gender differences in perceived responsibility for sexual health but more research is required to understand the relationship between perceptions of masculinity and attitudes to sexual health.

3. Improving links between services and schools

- 3.1 Supporting Paper 4 outlined the range of sexual health and relationship education (SRE) interventions for children and young people. Evidence indicates that SRE is more effective when linked to contraceptive and other sexual health services (Hosie 2002, Swann et al 2003). The variety of ways in which schools are working to improve pupils’ access to services can be seen as a continuum of involvement ranging from improving information on sexual health services supported by effective signposting and referral systems, to having daily access to multi agency support services on site. This continuum should demonstrate an appropriate response to local need. Whether services are provided in school or in the wider community with better links to schools is

dependent on a number of factors. The school is part of a local community and it is the local community as a whole that needs to ensure young people have access to confidential, respectful and professional support services. The key to getting it right for young people is to ask them what they need. The Community Schools Approach presents an opportunity for moving forward the sexual health agenda in a community context. It provides a framework which focuses in a holistic way on young people, families and the community and addresses aspects of social exclusion.

Increasing information in and around the school

- 3.2 Public health nurses working in schools are a source of information and advice about what services are available and how to access these. In addition to information provided as part of the sexual health and relationships education programme, examples from England have suggested that posters on student notice boards, information in student welfare booklets and general leaflets are useful ways of informing pupils of all health services, including sexual health services. Dedicated young people's telephone helplines in schools as provided in Sweden and Southampton has resulted in an increased number of students using services. (Nash 2000)

Visits by external agencies as part of a planned programme of SRE

- 3.3 Input by agencies outwith the education sector in classroom SRE sessions can add value by:
- providing accurate up to date information on contraception, sexually transmitted infections, service access
 - making local services visible to and making contact with groups of young people less likely to access services (for example young men)
 - dispelling myths, addressing misunderstandings, reducing fear of the unknown and reassuring young people about key issues such as confidentiality and physical examinations; and
 - providing a bridge to services by introducing a named contact and a familiar face

- 3.4 This has been shown in the work undertaken by Healthy Respect where there has been improved uptake of services where the same professional provides input to SRE and provides local services.
- 3.5 Health professionals also play a crucial role in awareness raising, training and supporting school staff, through informal discussions in the staff room, through team teaching and in more formal opportunities for staff, parents and school board members. Working together can help develop shared teaching goals and strategies to provide young people with the knowledge, understanding and skills to be able to access services.

Pupil visits to Sexual Health Services

- 3.6 Some SRE programmes include visits to community based clinics and evidence suggests that this improves both knowledge about services and future uptake. Hosie identified the value of this in Sweden and Nash reported that planned visits to sexual health services, particularly when linked to telephone access exercises was effective in improving knowledge about service location and facilities and improved likelihood of service use. Jackson and Plant (1997) report on the success of mock sexual health clinics provided as part of SRE. Based on the Swedish model of collaboration between teachers, school nurses and sexual health staff (Sex Education Matters pp 4-5, 2003), they report an increase of 30% of under 16 pupils accessing community family planning clinics after the first pilot year. Forrest et al (2002) assessed the benefits from developing a peer-led education approach in raising awareness of sexual health services: this has been well received by students, teachers and health professionals.
- 3.7 A number of mobile sexual health services have been established in England. Given the geography of Scotland, there may be merit in exploring this further. Barna (2002) identified the following benefits from mobile services:
- Staff can meet young people in a range of settings including schools, parks, housing estates and youth centres, increasing access to support those reluctant to attend mainstream services

- Mobile provision increase cost effectiveness and sustainability of local sexual health services when suitable venues are provided by partner agencies and organisations such as schools
- Schools and other locations with limited space do not have to provide secure storage facilities
- Young people may have more confidence in confidentiality as seen as separate from school
- Rural young people's needs are better addressed.

4. Confidentiality

4.1 Whilst most services would subscribe to providing confidential services, feedback from the engagement process suggests that users do not perceive services to be confidential and that there is much confusion among professionals about the scope of confidentiality. This especially applies to services in remoter areas and services for young people. The latter must be guided by professional standards and relevant legislation such as The Children Act, the European Convention on Human Rights and the Human Rights Act. For those vulnerable adults over sixteen the Adults with Incapacity Act also may be relevant.

4.2 Although the age of consent is 16 and some young people under this age will engage in consensual sexual activity, the issue of potential child sexual abuse has to be considered. This is sometimes contentious, particularly in terms of information disclosure to other professionals. For professionals working in the NHS, issues relating to disclosure are relatively clear. Young people under the age of 16 who are able to fully understand what is proposed and its implications are competent to consent to medical treatment. If a young person is not judged competent, consent from a parent or carer with parental responsibility is necessary. Whilst it may be preferable that a young person attending a sexual health service has the support of a parent or carer, this might not be a reality. In these circumstances, the young person's wishes, views and confidentiality should be respected. Reddy et al (2002) found that more than half of young women under 18 years would stop using all sexual

health services, delay testing for pregnancy or STIs or discontinue specific services if parental notification become mandatory.

4.3 Feedback from the engagement process indicated that individuals tended to use GUM and family planning services as opposed to other services given the experience of these services in dealing with confidentiality tended to inspire greater confidence in users compared to other services. This same confidence needs to be nurtured in primary care if fears about lack of confidentiality are not an obstacle to the role primary care can play in the tiered service approach. With this in mind, the proposed Sexual Health and Relationships Strategy recommends that clear messages about HIV testing and insurance issues should be made nationally and that procedures should be put in place to enable anonymous laboratory test requests from all referrers (the latter is discussed in section 5 on anonymity of testing).

4.4 A number of tools are available to help with confidentiality issues:

- Guidelines on the management of suspected STIs in children and young people have been developed by the UK Specialty Association for Genito-urinary Medicine and the Medical Society for the Study of Venereal Diseases (Thomas et al 2003): these would be of benefit to Scottish practitioners, although the legislative differences in Scotland would have to be borne in mind
- Healthy Respect has prepared a series of confidentiality guidelines for young people, parents, and service providers.
- A toolkit by the Royal College of General Practitioners has been produced for use in exploring confidentiality issues with staff (RCGP 2003).

4.5 Consideration should be given to the lessons learnt from this work and the usefulness of these guidelines as a template for the rest of Scotland.

5. Anonymity of Testing

5.1 In the main, adults over 16 are guaranteed confidential sexual and reproductive health services. However, in some circumstances, for example termination or primary care services, users would prefer anonymity in terms of testing and reporting records. A range of options were explored to address this:

- Maintenance of the status quo: GUM departments currently use an anonymous clinic number system for case notes and laboratory samples whilst all other practitioners use names and addresses. Feedback from agencies working with people living with HIV and AIDs suggest that this may prevent individuals from accessing GP services;
- Practitioners operating in Tiers Four and Five to use GUM type numbers. Whilst extending the anonymity boundaries, this could lead to potential confusion, for example GPs providing a Tier Four service would use the anonymous system for sexual health services but use names and addresses for non sexual health situations
- All samples for STIs taken by any doctor or nurse could be given an anonymous care numbers with the results being stored separately from other records. A bar coding system could be employed. With the advent of computerised records, this would allow the sexual health records to be subject to higher level access and thus only available to the appropriate health care practitioner.

5.2 The proposed Sexual Health and Relationships Strategy recommends the adoption of last option but recognises that currently there may be practical difficulties in implementing this, not least acceptability by service providers and laboratories. Two short term pilot projects on anonymous bar-coding and diagnostic test kits for STIs to assess user and patient acceptability, the impact on laboratory services and identify IT resource requirements should be funded by the Scottish Executive: one of these projects should be managed as

part of phase 2 of Healthy Respect and the other involving a remote rural GP practice.

- 5.3 In respect of requests for laboratory tests, the Sexual Health and Relationships Strategy proposes that these should be anonymised regardless of referral and that NHS Boards should ensure uniformity of recording of patient details across all providers (and thus address anomalies between GUM and primary care record keeping).

6. Sexual Dysfunction

- 6.1 It is recognised that many professionals working in the field of sexual and reproductive health can identify individuals who would benefit from support and intervention in relation to sexual problems. Feedback from the engagement exercise suggested that across Scotland, service provision was patchy, those services that were available were overstretched with long waiting lists and that individuals requiring support did not always have their needs recognised or be referred to the most appropriate service. In addition, the Reference Group was concerned that the location of these services may add to the stigma that prevents individuals seeking help: for example services located in psychiatric and gynaecology departments may promote the message that such problems are easily fixed, for example through the increased availability of drug therapies for erectile dysfunction. Nevertheless, there are examples of promising practice: for example in Forth Valley the voluntary sector supports the need of patients with sexual dysfunction problems (although funding limits the scope of support available).

- 6.2 In addition, there is also a need to educationally support health care practitioners in their knowledge and awareness of the issues surrounding sexual dysfunction. This would enable less complex problems to be dealt with at all tier levels, including within enhanced primary care services.

7. Sexual Assault and Rape

- 7.1 The latest crime statistics reveal that in England since 1985, reports of rape have increased by 400 per cent but convictions by only 40 per cent with only

7.5% of reported cases ending in a successful conviction. (Kershaw, 2000) In Scotland, there were 27 convictions out of a total of 591 reported rapes representing a conviction rate of less than 5% in 1999. (Rape Crisis Scotland, 2003).

- 7.2 The increase in recorded sexual offences may be due to an increase in reporting by the public and changes in police practice. However, international studies (Macdonald 2001) indicate that the majority of sexual assaults are not reported to the police. Some may specifically seek help and advice for their immediate medical needs from health care services; others may disclose the assault some time later when consulting with a health professional for other medical problems.
- 7.3 Burton and Kitzinger(1998) documented evidence of widespread acceptance of forced sex and physical violence against women. They found that one in five young men and one in ten young women said it was acceptable to be abusive or violent towards women. The proportions increased when commenting on specific circumstances such as if a female had slept with someone else or were married. Forcing a woman to have sex was widely accepted, particularly by young men and reinforced a widely held belief that women provoke violence through dress or “nagging”. Participants identified the need to discuss such issues without judgement so that such attitudes and assumptions could be changed. As part of the Healthy Respect partnership approach, an educational programme has been developed for professionals so that they can identify risk and support young people following sexual assault and/or rape. Positive feedback and over-subscription points to the need for such training on an ongoing basis and supports the findings of the recent NSPCC report on The Choice and Opportunity Project (Pearce 2003).
- 7.4 In some areas in England (Manchester and southeast London) there are dedicated sexual assault centres offering specialist response to the complainant. They accept referrals directly from the public and offer a forensic assessment including anonymous sampling for those who do not wish police

involvement at that stage. Feedback suggests that this is advantageous as delays in reporting to the police normally results in the loss of any medical and forensic evidence. (Rogers 2002). There are no such examples in Scotland despite the evidence that collaborative partnerships between police, procurator fiscal, health and voluntary services can lead to improved personal outcomes, increased reporting and successful prosecution of sexual assault cases. The proposed Sexual Health and Relationships Strategy supports the establishment of a pilot project for victims of sexual assault and rape providing forensic services, appropriate counselling and medical follow-up on a multi-disciplinary basis in order to test its appropriateness in the Scottish context.

8. Female genital mutilation (female circumcision)

8.1 Female genital mutilation is defined as all procedures involving partial or total removal of the external female genitalia or other injury to the female organs whether for ritual, cultural or other non therapeutic reasons (RCOG 2003). It is practiced mainly in Africa and is a cultural practice not related to religion (WHO, 1998). Cases usually occur between grandmother and granddaughter rather than mother and daughter thus indicating a strong familial link (RCM, 1998). We do not know how many young girls have undergone female genital mutilation or how many women have long term health problems, particularly in relation to childbirth and recurrent chronic pelvic and urinary infections.

8.2 Whilst the Prohibition of Circumcision Act 1985 makes it illegal to perform FGM in Britain, obstetricians, gynaecologists, midwives and other service providers may come into contact with women who have experienced FGM performed abroad.

8.3 Good practice suggests that:

- Interpretation services should be available if English is not spoken or well understood
- Female practitioners should be available if examination is required

- Questioning and physical examination should be kept to a minimum
- Properly informed consent must be obtained
- Feelings of humiliation and distress should be avoided
- Language used to describe FGM should be respectful and not insulting to individuals, their culture or traditions

8.4 Recognition of the different types of FGM is important as the complications differ in severity and will therefore have implications for practice responses. Information and knowledge to raise awareness about this practice needs to be disseminated to practitioners across all the Tiers of the integrated service approach, including those working in health, social care and voluntary sector in those areas with potential populations at risk of FGM.

9. CONCLUSION

This paper identifies some of the barriers that might prevent individuals from accessing services and outlines potential resolutions. It complements Supporting Papers 5A and 5C which cover other issues concerning clinical services: all of these will provide the platform for the development of guidance which will be necessary to support the implementation of the proposed Sexual Health and Relationships Strategy.

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Supporting Paper 5B: Supporting Access to Clinical Services and Reaching Those in Need**

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Minimising unintended pregnancy and managing sexually transmitted infections (including HIV)

1. INTRODUCTION

1.1 This paper highlights the review level evidence and practice based evidence underpinning the recommendations contained in the proposed Sexual Health and Relationships Strategy targeted at managing sexually transmitted infections and reducing unintended pregnancy. This complements the other supporting papers linked to the Strategy and in particular Supporting Papers 5A and 5B which highlight other aspects of clinical service provision.

2. BACKGROUND

Sexually Transmitted Infections (STIs)

2.1 STIs impact unequally on certain population groups who already face inequalities in relation to their sexuality, ethnicity and gender. However, the number of new diagnoses and repeat diagnoses with STIs is ever increasing and is at record levels (see Supporting Paper 1). This places increasing demands on service provision, resulting in longer waiting times. There is no clear or single explanation for the sharp rise of recent years: evidence does not exist to suggest that changes in sexual behaviour are the only cause - failure to practice safe sex and complacency may be more plausible answers. Whilst most females take the pill or emergency contraception to prevent pregnancy, evidence suggests that they and their partners are not using condoms either at first sexual encounter or long term in a stable relationship (Macdowell 2002). Reddy (2002) found that where young people said they would not seek contraception if parental notification was required, this would not lead to increased condom use among the same young people. This is in spite of condoms being an effective way of preventing STIs (beyond abstinence). Barriers to their use appear to be lack of knowledge, skills for appropriate use, culture issues, gender

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inequities and in some instances prohibitive cost. Initiatives developed in response to this include C-card schemes for young people, free availability in premises used by gay men and young people.

2.2 Promoting positive sexual health through sexual health promotion is under-recognised and under-valued to date. The proposed Sexual Health and Relationships Strategy attempts to raise the profile of sexual health promotion and for all practitioners involved in sexual and reproductive health care to take a proactive approach to sexual health promotion. The evidence relating to educational or behavioural interventions in relation to STI prevention tends to be very broad or focus on particular target groups (Grunseit 1997, Kirby 2000, McKay 2000, Peersman et al 1996, Shepherd 2001 and Stephenson 2000). However, the general conclusions drawn from this evidence point to:

- the importance of the provider or individual delivering the intervention (for example, teachers, health promotion specialists, clinical staff and peer educators),
- the setting in which the intervention takes place (formal education settings, community setting and clinical setting) and
- the method used (for example one to one learning/counselling, group learning/counselling and media campaigns).

2.3 For interventions to be effective, these should include the following features:

- the use of theoretical models of behaviour change (McKay 2000),
- the provision of basic accurate information (Kirby 2000). Wong (1995) found that although information is often insufficient by itself to effect behaviour change, it is necessary and important for STI prevention programmes to provide accurate comprehensive information and allay misconceptions before individuals can take actions to change behaviour

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- skills development, motivation building and attitude change (Shephard et al 2001)
- specific behavioural skills training including refusal skills and safer sex negotiation as this helps people build their sense of competency (McKay 2000, Kirby 2000)
- detailed understanding of background behaviours, beliefs and risk perceptions of target groups. Kirby identified age, sexual experience and culture being important issues (Kirby 2000) whilst Shephard et al (2001) and Peersman et al (1996) identified gender as a key issue.
- Use of peer educators, particularly for adolescent audiences (McKay 2000) – although Peersman et al (1996) contend that their effectiveness was yet to be demonstrated. Mellanby et al (2001) conclude that it may be more appropriate for adults to deliver factual information with peer-leaders concentrating on the social factors related to health
- Narrow focus on reducing specific risk taking behaviour such emphasis on condom use rather than abstinence (McKay 2000)
- Of appropriate duration, for example to have sufficient time to ensure all components implemented (McKay 2000, Kirby 2000).

2.4 In summary, if an intervention is to be successful, it needs to be tailored to the needs of its specific target group which in turns involves a “needs assessment” in each new setting so that an understanding of what the target group think, believe and need is developed.

2.5 Fleming and Wasserheit (1999) suggest that STIs, including HIV, are more easily transmitted from men to women than vice versa. Hart et al in their systematic review of the effectiveness of interventions to prevent STIs/HIV in heterosexual men could only find behavioural and/or social interventions rather than those aimed at reducing morbidity.

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2.6 There are no comprehensive statistics on STIs, HIV, teenage births or abortions among black and minority ethnic communities (BME). For births, information is collected on the nationality of the mother but this does not identify the BME community to which they are related. Whilst moves are underway to improve ethnic related information in terms of service uptake and epidemiology, its absence causes problems in understanding the extent of sexual ill health among BME communities and setting targets and indicators that are relevant for such communities. There is some evidence to suggest that some BME populations are more at risk of STIs or teenage pregnancy compared to others but not enough is known – this needs to be addressed in service provision.

HIV

2.7 Much of the report of the HIV Health Promotion Review Group (Scottish Executive 1999) is relevant to sexual health in general and in relation to those at risk of acquiring HIV, for example gay men, men who have sex with men, partners of people with HIV and so on. Some progress has been made, such as antenatal testing and counselling but more progress is required.

2.8 Evidence indicates that the needs of individuals with HIV and their partners are not being addressed as comprehensively as they should be. There is a recognition that HIV carries particular risks and is a global pandemic likely to affect Scotland increasingly: the number of newly diagnosed heterosexual patients (both males and females) has overtaken gay men and injecting drug users for the first time and estimates suggest that nearly half of all such infections are undiagnosed. For some people, treatment is started late mainly due to late presentation and subsequent diagnosis (BHIVA audit, 2002). Two thirds of HIV infected persons who attend a GUM clinic and who are undiagnosed prior to clinic attendance do not undergo named HIV testing at the clinic and thus remain undiagnosed (D Goldberg, 2003).

The long term aim should be to undertake increased HIV testing to detect undiagnosed infection at all tiers: as a pre-requisite there should be widespread awareness that negative HIV tests should not be reported to insurance companies.

- 2.9 Close surveillance of the population groups being newly diagnosed should be used to monitor the movements of newly identified at risk population groups (for example asylum seekers). Evidence indicates secondary prevention interventions involving, for example, individual counselling and testing, one to one peer support, free/subsidised condoms, multiple component motivation and skills education and involving users in service design can be effective when targeted at specific groups (drug users, men in workplace and clinic attendees) at reducing social/behavioural practice (Elwy et al (2002), Ellis and Grey (in press)).

Unintended Pregnancy

- 2.10 Supporting Paper 1 provides data on conceptions and terminations. The latter is usually used as a proxy for unintended pregnancy, particularly in young people. It is suffice to say that the UK is second only to the US in having the highest rate of pregnancies among young girls aged 19 and less in the world (UNICEF, 2001): this equates to a rate of 30 births per 1000 compared to the lowest rate of 7 per 1000. Whilst parenthood can be a positive and life enhancing experience for some, it may have negative impacts for other young people and their children, some of which are identified in Supporting Paper 2 outlining the wider cultural and social factors influencing sexual health. Adverse health outcomes can include anaemia, urinary tract infections (Konje 1992) and low birthweight babies (Miller et al 1996, Botting et al 1998).
- 2.11 Whilst much of the evidence on interventions on unintended pregnancy focus on young people, there will be some lessons to be learnt for those outwith their teens. School based sex and relationships

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education, particularly linked to contraception services, youth development services, community based education and the inclusion of parents in information and prevention programmes have been shown to help in reducing teenage pregnancy (NHSCRD 1997, DiCenso et al 2002, Cheesborough et al 1999, Franklin et al 1997, Grunseit A 1997, Kane and Wellings 1999, Kirby 2001, Peckham et al 1996).

2.12 In their evidence review of effective interventions on reducing teenage pregnancy and parenthood, Swann et al (2003) identified the following characteristics of services and interventions:

- Focus on improving contraceptive use and at least one other behaviour likely to prevent pregnancy and/or STI transmission
- Long term services and interventions
- Focus on high risk groups and working through opinion leaders and peer educators
- Services which are accessible, for example in terms of location, staff attitude, opening hours and confidentiality
- Encouraging an open and non judgemental discussion about sex, sexuality and contraception
- Inclusion of personal skills development such as negotiation and refusal skills
- Having a multi agency approach and working with communities

2.13 Evidence also suggests that good antenatal care, parental, psychological, social and educational support may help improve health and educational outcomes for young mums and their children (NHSCRD 1997). There are however, a number of areas where little or no evidence is available to demonstrate effective interventions: these include interventions aimed at those facing the greatest barriers to positive sexual health (for example looked after young people, those excluded from school), young men and the links between deprivation and teenage pregnancy. Supporting Paper 2 gives more detail on

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these and other areas identified by the proposed Sexual Health and Relationships Strategy.

- 2.14 Providing pregnant mums and teenage parents with increased opportunities to continue their education can give them the skills to gain future employment: this is a central pillar of the Teenage Pregnancy Strategy south of the border (SEUTP, 1999). Limited access to appropriate childcare does hinder plans for such opportunities although there are some promising practice examples in Scotland (Raymond in HEBS, 2002)
- 2.15 Fullerton (HEBS, 2002) states that there is currently little reliable UK evidence which identifies interventions to prevent unintended pregnancies among teenagers. Nevertheless, evidence is available to suggest that creative programmes, whether designed to prevent teenage pregnancy or support teenage parents are more holistic in approach and aim to address some of the identified factors associated with risk. This highlights the need for multi-component approaches aimed at preventing pregnancy and/or poor outcomes associated with unintended pregnancy.

3. MEASURES TO RESPOND TO SEXUALLY TRANSMITTED INFECTIONS AND UNINTENDED PREGNANCY

Contraception Provision

- 3.1 Accessibility to, and uptake of, the full range of contraceptive methods varies widely throughout Scotland, as does the quality of service provision. Community-based family planning clinics are a source of specialist knowledge whilst general practitioners have tended to remain generalists: there is no mandatory training requirement for general practitioners to update knowledge and skills in relation to contraception once they have qualified. This may result in more referrals than necessary to specialist clinics. In contrast, family planning practitioners must acquire professional specialist qualification and re-accreditation at regular intervals. This has led to a situation where GPs can prescribe contraception but may not have the expertise to fit them and where family planning clinics have the expertise but no funding for the devices. It will be for the Lead Clinician in each NHS Board area to assess services provided against the required competencies to meet agreed clinical standards and to ensure that practitioners address any skills deficit through training programmes (see Supporting Paper 5A).
- 3.2 Feedback during the Strategy's engagement process indicated that individuals might not know what contraceptive services were available until a consultation was made or knew of the strongly held views of practitioners in relation to contraception and/or the circumstances in which this would be made available. This may result in individuals not seeking contraception. Where service providers do not provide the full range of contraception that might be required by their patients, they must make this known in advance through information leaflets, practice booklets and to helplines such as NHS 24. In addition, individual patients should be referred to alternative accessible services if their requirements cannot be met at first consultation.

3.3 Research carried out in France (Bajos 2003) found that one in three pregnancies was unplanned with half of the women subsequently deciding to have an abortion. Whilst failure to use contraception properly was cited as the main reason for pregnancy, many women reported not knowing why their contraception had not worked. This research demonstrated the mismatch between a women's contraceptive needs, particularly over their life course and the methods they use. A similar response is likely to be found in Scotland. In addition, evidence on contraceptive uptake by young people indicate that young men in particular have low levels of knowledge about reproduction, time limits and safety of contraception (including emergency contraception) and contraceptive service availability (NHSCRD 1997, Graham et al 1996). It is therefore essential that to avoid unplanned pregnancies, men and women should be made aware of all the contraceptive choices available and that professionals acknowledge and take into account all the factors that impact on effective contraceptive use, such as lifestyle, age and type of relationship. The proposed Sexual Health and Relationship Strategy's intent of providing two choices for individuals to access services should help with this disparity in terms of contraception.

Condoms

- 3.4 The Strategy's Reference Group was pleased to note that many Health Promotion departments provide condoms to a range of access points free of charge – this includes general practices, local drop-in services, services for at risk populations such as LGBT, commercial sex workers, men who have sex with men and local community facilities. However, feedback from the engagement process suggests that this is not consistent across Scotland.
- 3.5 Feldblum et al (1995) demonstrated the efficacy of consistent and correct condom use in preventing the spread of HIV and STIs: Weller (2001) found that consistent condom use was associated with an 80%

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reduction in risk of heterosexual transmission of HIV. Despite this levels of condom use remain low among both the general population and those with high risk behaviours. The findings of the NATSAL study indicated that condoms were used to prevent pregnancy rather than to prevent sexually transmitted infections and in younger age groups (MacDowell 2002). Myer et al (Cochrane Review 2003) in developing their review protocol identified availability and accessibility and being able to use condoms effectively as key factors that act as barriers to prevent condom use during sexual intercourse. Abdool Karim et al (1992) found that the negative attitudes of health care providers might prevent uptake of condoms provided through health facilities, affecting especially young people. Condoms which are sold commercially may be price outwith the pocket of many potential users. The proposed Sexual Health and Relationships Strategy recommends that condoms should be freely available to both males and females. O'Reilly and Piot (1996) highlighted the value of structural interventions such as legislative changes in helping accessibility to condoms in other countries. For example Thailand's "100% condom" program aimed at sex workers has resulted in changes in sexual behaviour and declining incidence in rates of both HIV and STIs (Nelson et al 1996, Celentano et al 1998). Lamptey and Price (1998) demonstrate the value of linking social marketing ventures with condom promotion activities: successful projects have included exchanging coupons for condoms (Witte et al 1999, Dahl et al 1999), distribution to high risk groups such as sex workers (Albert et al 1998) or young people (Alstead et al 1999) or where high risk sexual contacts take place (Egger et al 2000), bars and other places.

- 3.6 Knowing how to use a condom and its effectiveness in different circumstances is crucial. Gardner et al (1999) suggest that awareness of male condoms as a simple prophylactic device is closely related to knowledge of HIV and AIDs. Albert et al (1995) showed that commercial sex workers who used condoms regularly reported low

rates of condom slippage or breakage suggesting that experience and practical knowledge may contribute to more effective condom use, which supports the findings of Peltzer (2000). This has implications for sex and relationships education in schools and sexual health promotion activities across the lifespan.

3.7 Even with access and practical knowledge of condoms, use is very dependent on the participation of both sexual partners. Reduced sensation, latex allergies and perceptions of lack of trust are reported as reasons for non use (Myer et al, 2002). Economic and gender imbalances between men and women, are documented as a major barrier to negotiating condom use, for example by commercial sex workers (Varga 1997).

3.8 Elwy et al (2002) examined interventions aimed at preventing STIs and HIV among heterosexual men but could not identify a single method as being effective in all situations aiming to change behaviours, increase knowledge or measure an intention to change. This supports the view that interventions must be targeted and be context-specific as found by Myer et al (2002), Wang et al (2000) Kim et al (1997) and Kirby et al (1994). Examples of promising practice were highlighted during the Strategy's engagement exercise: these include free access to condoms and advice and provision of nurse-led contraception service under patient group directions at young people's drop in clinics, free emergency contraception through community pharmacies, C-card schemes in Lanarkshire and Lothian and distribution of free condoms to health centres, NHS premises, community facilities and locations used by those most at risk of unplanned pregnancy and STIs. A project in Fife offers free pregnancy testing, free condom supply and counselling on STIs as well as free supply of emergency contraception located in community pharmacies. The suggested benefits identified in the interim findings include improved access to contraception, particularly in more rural areas, potential reduction in teenage

pregnancy rate and rates for other age groups (personal communication, Cath Brunton, May 2003). Five per cent of those using the service were under 16: those aged 16 to 20 were the biggest users followed by 21-30 age group. More than half of users expressed satisfaction with their experience of the project. The Right Medicine (Scottish Executive, 2002) foresees this type of activity being developed by other community pharmacies in the future.

Termination of Pregnancy (medically or surgically induced abortion)

3.9 Although one of the aims of the proposed Strategy is to reduce unintended pregnancies, it would be naïve to think that such pregnancies would never happen or that termination of pregnancy would be unnecessary. Feedback from the engagement exercise indicated that terminations currently account for more than 25% of gynaecological workload: around one in four women who have had an abortion will have a second one. Young people are particularly likely to make mistakes with contraception and pregnancy rates among young women are a cause for concern. In a study of unplanned pregnancies, Pearson (Pearson et al 1995) found that 80% of young people used contraception at the time of conception whilst a GP based study suggested that more young people who conceive do consult for contraception before that became pregnant (Churchill et al, 2000). Unwanted pregnancies among women aged between 20 and 30 years represent a quantitatively much larger problem as demonstrated in the rate of abortions for this age group. Supporting Paper 1 sets out the statistical data relating to abortions.

3.10 Tabberer et al (2000) explored the factors influencing a young woman's decision on whether or not to continue with a pregnancy. Few families had discussed abortion, no mention was made in school sex and relationship education (SRE), few sources of impartial advice and counselling particularly in the 7 to 14 week gestation period were

available and the context in which the pregnancy occurred was important, for example as a result of a one night stand, or already having a child. These need to be addressed by those involved in SRE and by service providers. Consideration should also be given to the development of a target aimed at minimising repeat abortions. Early indications from research in Lothian suggests a range of factors that predispose women to have more than one abortion, for example low income, singleton, influence of partners and peers. Followup at 16 weeks gestation found no significant difference between the two cohorts. (personal communication, Anna Glasier)

- 3.11 There needs to be a safe a, consistent and supportive environment to respond to the needs of women requiring such services. Services should assess their current provision against the guidance produced by the Royal College of Obstetricians and Gynaecologists on the Care of Women requesting induced abortion (RCOG, 2001). If this guidance was included in clinical service standards, the quality and consistency of abortion services would be improved.
- 3.12 Recent audits indicate that women do not appear to have problems accessing abortion services, although feedback from the engagement exercise suggests that there may been hidden access issues – for example, a reluctance by health practitioners to refer women for termination might mean that services are accessed at too late a stage for intervention. Lack of anonymity in more rural areas was also cited as a potential barrier. Whilst acknowledging the inconsistencies regarding gestation limits across Scotland and the restrictions placed on potential service expansion by legal requirements, the Reference Group considered that women should not have to wait longer 3 weeks to access termination services from initial consultation. This will help reduce the risk of potential complications.

3.13 The way abortion services are provided also poses problems. Hospital gynaecology services are combined with obstetric services with the result that the labour ward requirements tend to be given priority. This can often result in a conveyor-belt approach with little time or effort devoted to preventing repeat abortions. Follow up consultations and support post abortion also appears to be problematic: it is estimated that around one in two women will not attend their follow up consultation (personal communication, Anna Glasier). To address this, the proposed Sexual Health & Relationships Strategy recommends that before being discharged from hospital, women who have had an abortion should have their contraception needs addressed and initial supplies provided.

Partner Notification (also known as Contact Tracing)

3.14 Failure to treat partners may be a common cause of “treatment failure” of chlamydia infection (Gibson and Mindel 2001). International evidence indicates that partner notification is effective as a means of newly detecting infections and that provider referral generally ensures that more partners are notified and medically evaluated than self referral (Macke and Maher 1999, Mathews et al 2001). Oxman (1994) concluded that partner notification was more effective for HIV/AIDs than for STIs. However, all these studies suggest that offering patients a choice might be the most appropriate practice to follow.

3.15 Mathews’ systematic review (Cochrane Review 2001) also found that when used in conjunction with prompt laboratory testing and treatment and use of sexual health advisers, partner notification can help:

- Interrupt disease transmission and eliminate symptomatic infection, both of which can have long term health implications
- Identify individuals with asymptomatic infections
- Identify individuals with new HIV infection
- Promote risk reduction strategies for avoiding sexually transmitted infections

- 3.16 In addition, there was moderately strong evidence that the number of partners presenting for medical evaluation was best achieved through providers leading the referral process rather than patients taking responsibility. Limited success was achieved through nurse-led health education supported by lay counsellors (Mathews et al 2001).
- 3.17 The engagement exercise revealed that partner notification varied throughout Scotland, both in terms of consistency and standards of practice pursued. Although it is the primary remit of sexual health advisors working in GUM departments, in some areas family planning nurses may take the lead. The recent review of SIGN guideline on chlamydia indicated that a significant number of practice nurses were involved in simple partner notification with support from named sexual health advisors.
- 3.18 To achieve consistency in partner notification, the Society of Sexual Health Advisors have produced guidelines for use by secondary and primary care staff. There is however a current problem with the determination of the action taken by an individual following contact tracing due to the lack of data tracking across different service providers. The proposed Sexual Health and Relationships Strategy proposes that further work should be undertaken on a range of data collection issues, including the determination of partner notification outcome.

4. Clinical Service Targets for STIs

- 4.1 Chlamydia is the commonest treatable STI with the biggest potential in terms of health gain if diagnosis and treatment were optimised. It is largely asymptomatic but if left untreated can have severe long term consequences for women such as pelvic inflammatory disease (PID), ectopic pregnancy and infertility. Even with the limited available data

on prevalence, chlamydia is higher than gonorrhoea and syphilis in all NHS Board areas in Scotland.

- 4.2 Testing is also possible in a range of different settings, for example primary care, family planning, GUM services, specialist voluntary sector services as well as other hospital based services, such as obstetrics and gynaecology and urology. Evaluation of the Healthy Respect pilot of chlamydia postal testing kits will identify whether this is a useful alternative for access to testing, particularly for young people and for rural areas.
- 4.3 For more general practices to undertake such testing and subsequently make accurate diagnoses, they will need access to microscopy. However, some practices might not wish to pursue this. As an alternative, the Sexual Health and Relationships Strategy proposes the piloting of an STI diagnostic kit to diagnosis chlamydia, gonorrhoea and trichomonas: this would involve laboratories undertaking microscopy of urethral discharge from men or vaginal discharge from women with samples being sent on a glass slide in a plastic container. Piloting of this kit in one urban and one rural practice should enable evaluation of acceptability by patient, referrer and laboratory services as well as identifying any potential cost savings associated with a one-stop test.
- 4.4 Evidence clearly shows that screening asymptomatic women can reduce chlamydia infection and the incidence of PID. However, such targeting only fosters gender inequalities and reinforces the abrogation of men's responsibility for sexual and reproductive health care, (Duncan and Hart 1999). SIGN Guideline 42 recommends testing of asymptomatic "high risk" men (more restricted compared to its recommendations for women). Duncan et al (2001) identified the need for better information about chlamydia infection so that anxiety can be allayed following a positive diagnosis and treatment followed up

following partner notification. These issues need to be addressed as part of any national roll out of the suggested targets set out in Box 1.

- 4.5 A recent study suggested that a 3% prevalence could be taken as indicative of cost-effectiveness of screening, if age was used as a selection factor and DNA based tests were used in urine samples. If this was adopted, it would mean that a target of testing everyone up to the age of 30 should be set (Honey et al 2002). However, the proposed Sexual Health and Relationships Strategy suggests a more pragmatic stepped approach in accordance with what is achievable in terms of current resources as set out in Boxes 1 and 2. This builds on the intention of SIGN Guideline 42 but allows resources to develop capacity in an incremental manner and in response to local population needs. This approach should also allow individual Boards and Community Health Partnerships to identify target groups for testing once a clearer picture is shown of local prevalence rates and to identify locations where additional testing could be achieved.

Box 1: Interim national clinical service targets for chlamydia

- NHS Boards should analyse their current chlamydia test levels and agree incremental increases for achievement (within 18 months of strategy implementation)
- Each NHS Board should increase chlamydia testing by 25% per year (from baseline year to five years hence)
- Increase testing by 50% in those groups identified with a prevalence of more than 10% (baseline year)
- Nucleic acid amplification test (NAAT) used for chlamydia detection
- NAAT used for the diagnosis of gonorrhoea at Tiers One, Two and Three
- All male symptomatic patients should be offered testing at Tier Three services
- 90% of individuals diagnosed with chlamydia should be treated within four weeks of patient receipt of results
- 90% of patients with chlamydia should be interviewed by appropriately trained sexual health advisers or those supported and trained by sexual health advisers within 4 weeks of receipt of results
- 50% of all index patients with chlamydia must have at least one contact with a successful outcome¹

¹ If a patient visits health care services after contact with a sexual health advisor, this will constitute a successful outcome. This will have to be agreed locally as current data collection deficiencies do not allow for the tracking of patient attendances across different settings. Improvements in data collection should address this (see para x)

4.6 Given the increasing trends associated with HIV and gonorrhoea, particularly among at risk groups, it is important that there is little delay in the time between diagnosis and treatment. A similar incremental approach to that for chlamydia is proposed so that improvements can be made in responses for both diagnosis and treatment.

Box 2: Interim national clinical service targets for other diagnoses and treatment other than chlamydia

- 90% of individuals diagnosed with gonorrhoea should be treated within 4 weeks of patient receipt of results
- All treatment providers should undertake and document contact tracing
- Those undertaking partner notification should be appropriately skilled and supported by agreed professional protocols
- 90% of patients with gonorrhoea should be interviewed by appropriately trained sexual health advisers or those supported and trained by sexual health advisers within four weeks of receipt of results
- 50% of all index patients must have at least one contact with a successful outcome

- Each NHS Board should increase HIV testing by 25% per year (baseline year to five years hence) among individuals who present at Tiers Four and Five with a new STI
- Annual syphilis serology should be offered to individuals who are HIV positive
- Patients with HIV status should have their own sexual health needs recognised and responded to (for example, through regular testing of non HIV related sexual health aspects)
- 90% of mothers should be offered antenatal HIV testing

5. CONCLUSION

This paper sets out some of the issues relating to unintended pregnancy and sexually transmitted infections and highlights a potential way forward to help improve service responses. These support the developments proposed in the Sexual Health and Relationships Strategy and in its other background papers.

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SUPPORTING CHANGE

1. INTRODUCTION

- 1.1 This paper outlines the broader national and regional framework and leadership that will facilitate the development and ongoing implementation of the proposed Sexual Health and Relationships Strategy in Scotland. This framework is intended to support the delivery of clinical services, the enhancement of lifelong learning on sexual health and the promotion of a culture change towards positive sexual wellbeing in Scotland.
- 1.2 Throughout our discussions with NHS Boards, professional organisations and individuals with an interest in sexual and reproductive health matters, an explicit request was made for the proposed Strategy to be driven by clear strategic leadership from national level down to individual community level. In developing proposals, the Reference Group has supported the need for such a framework which **champions** sexual wellbeing at all levels, ensures its high profile among the other competing resource demands and enables all sexual health partners to develop multi-layered responses that will make a difference.

2. LEADERSHIP & ACCOUNTABILITY

At Scottish Executive level

- 2.1 The proposed Sexual Health and Relationships Strategy highlights the impact of wider cultural and social factors on sexual health and wellbeing. It is therefore essential that national policies, which address issues such as social inclusion, incorporate actions to address sexual health. In addition, tackling stigma and discrimination arising from an individual's sexual orientation or sexuality requires national action: opportunities to explore this as part of the social inclusion agenda should be taken.

At national level

National Sexual Health Programme Co-ordinator and National Sexual Health Advisory Committee

- 2.2 The proposed Sexual Health and Relationships Strategy should be viewed as an early step in the ongoing development of the sexual health agenda in

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Scotland. In order to maintain the momentum engendered by the Strategy's development, the Reference Group recognised the need to establish a clear multi-department sexual health lead within the Scottish Executive and supported by a central mechanism to drive the implementation, monitoring and evaluation of the Strategy. To this end, the Strategy proposes that the Scottish Executive appoint a National Sexual Health Programme Co-ordinator who will be supported by a National Sexual Health Advisory Committee. An appropriate Scottish Executive Minister should chair this in order to maintain the national emphasis on the sexual health and wellbeing agenda.

- 2.3 Membership of this advisory committee should not only reflect health interests but all the potential stakeholders who have an interest in sexual health and wellbeing. The range of members should reflect the wider determinants of sexual health and the range of statutory and voluntary sector providers, but could include representatives from or specialists in public health and epidemiology, GUM and family planning medicine and nursing, primary care, Local Authorities, school based education, social inclusion, health promotion, voluntary sector, the HIV community, user and self help groups and research/academia.
- 2.4 The main task of the advisory committee will be to oversee the initial implementation and ongoing development of the proposed strategy. As part of monitoring progress, annual reports are recommended together with a full review five years after the strategy's initial implementation. Given that it was recognised that the proposed Sexual Health and Relationships Strategy could not deal with the full breadth of sexual health agenda, this review should enable flexibility in national and local responses to emerging issues such as the sexual health needs of an ageing population, increasing ill health amongst those with links to those areas with high and increasing HIV prevalence and those facing the greatest barriers to good sexual health.
- 2.5 Key activities for the National Sexual Health Advisory Committee include:
- Development of a mass communications strategy involving campaigns, advocacy and literacy

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- Commission of research to identify actions to maximise sexual wellbeing among those at greatest risk of ill health
- Promotion of a consistent approach to school based sex and relationships education
- Addressing the needs of rural areas
- Facilitating a cross-departmental approach to sexual wellbeing

Healthy Respect National Demonstration Project

2.6 In undertaking its tasks, the Advisory Committee will be supported by the national demonstration project, Healthy Respect and the Sexual Health and Wellbeing Learning Network.

2.7 Healthy Respect is a partnership initiative bringing together 13 partners from health, four local authorities and the voluntary sector in Lothian. There are 19 projects working across a range of locations including schools, further education colleges, Caledonia Youth, Edinburgh Rape Crisis Centre and in hospital, primary care and informal youth settings. Activities focus on three main areas: teenage pregnancy, sexually transmitted infections, self-esteem and confidence among young people. As a national demonstration project, Healthy Respect acts as a “test bed” for new initiatives around sexual health: the lessons from phase one will inform national and local policy and practice on what works in respect of sexual health services for young people (anticipated being available in autumn 2004 - further details of Healthy Respect can be found at www.healthy-respect.com).

The Sexual Health and Wellbeing Learning Network

2.8 Based in NHS Health Scotland, the Sexual Health and Wellbeing Learning Network will support the ongoing implementation of the proposed Sexual Health and Relationships strategy through an evidence into practice programme comprising evidence dissemination, commissioning of research and resource development and disseminating learning from the partnership activities of Healthy Respect project (further details of the Learning Network found on www.phis.org.uk/projects/default.asp?p=fc)

2.9 Actions identified in the proposed Strategy for the Learning Network include:

- Reviewing and disseminating evidence on the needs of those facing the greatest barriers to sexual wellbeing: in the first instance, focusing on people with learning disabilities and black and minority ethnic communities
- Supporting the development of a consistent approach to sex and relationships education across the school curriculum
- Providing practitioner guidance on confidentiality/disclosure of information
- Developing guidance for commissioners to support the proposed Strategy's implementation.

At NHS Board level

2.10 During its deliberations on the proposed Strategy, the Reference Group considered it equally important that there is clarity of leadership and support for the Strategy at local NHS Board level. Responsibility for ensuring local implementation is given to each Director of Public Health (DPH), primarily because of the need to have clear lines of accountability both locally and nationally.

2.11 In responding to the proposed Sexual Health and Relationships strategy, each DPH should ensure that there is Board-wide **sexual health strategy** (whether in existence or in development) which reflects the key components of the national strategy and which:

- reflects local need
- evaluates current service provision
- promotes user involvement
- identifies resource investment (current and planned) and
- develops a phased approach to improving sexual health through enhanced service provision, health promotion, lifelong learning and identified actions to influence more general values and attitudes to sexual health.

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- 2.12 This work should be developed through a **multi-agency, multi-disciplinary strategy group** which reflects the composition of their local population. The emphasis is on developing and implementing a strategy which is owned by a range of agencies, not just the NHS and which includes actions for all the stakeholders with an involvement in the sexual health and wellbeing agenda.
- 2.13 In addition, the Director of Public Health should appoint a local **Sexual Health Co-ordinator** who will support and be supported by the local sexual health strategy group. This co-ordinator should manage the network of all relevant sexual health providers and interests that contribute to the implementation of these multi-agency strategies (this is what is meant by a managed sexual health network). For some areas, this might mean a new appointment but for others it might be a redesignation of existing roles. The local sexual health co-ordinator will be complemented by the appointment of a local **lead clinician** whose task will be to support the development of the tiered intervention approach (see Supporting Paper 5A).
- 2.14 In addition to the above, local sexual health co-ordinators will focus on:
- Ensuring that Community Plans and Local Health Plans address issues relating to sexual inequality, develop links between schools and services
 - Facilitating the development of lifelong learning opportunities, sexual health promotion and outreach services within a range of settings and for all ages as part of local strategy development and implementation
 - Supporting work with parents and carers
 - Implementing the recommendations of HIV Health Promotion Review Group
 - Developing a local training strategy based on needs assessment
- 2.15 The proposed Sexual Health and Relationships Strategy identifies a number of service and clinical targets for the improvement of sexual health and wellbeing: for example a maximum waiting time of 48 hours to access specialist sexual health services (Supporting Paper 5A gives fuller detail). Feedback on the appropriateness of these targets will be sought as part of the consultation on the strategy. Once these targets have been identified, each

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local strategy should identify how these will be achieved locally. Plans including proposed investment and progress should be set out in Local Health Plans for monitoring through NHS Board Accountability Reviews and annual reports to the National Sexual Health Advisory Committee. It is proposed that implementation guidance will be provided at the same time when the final strategy is released for implementation.

- 2.16 Given their responsibility for education and social care and the links between sexual health and the wider social and cultural environment, Local Authorities are recognised as key partners in implementing sexual health strategies at local level. Local Authorities will be required to designate a **lead Director** to progress the sexual health agenda through each Local Authority: This could be the director with the functional duty to promote health and wellbeing or the director responsible for children's services plans (in the latter case additional arrangements would be required to cover adults). Joint Health Improvement Plans, as part of Community Planning, should monitor progress and in particular identify partnership working initiatives in implementing the strategy.
- 2.17 Working in partnership with the voluntary sector and community-based groups (including faith organisations) will be essential to implementing the proposed Sexual Health and Relationships Strategy at national and local levels. Voluntary sector organisations have been, and are often, the "champion" for sexual health and promoting user involvement in shaping service provision. These experiences should be shared with statutory service providers and which will in part be achieved through the activities of the Sexual Health and Wellbeing Learning Network and if established, through the National Sexual Health Advisory Committee. In addition, there is potential for Voluntary Health Scotland to act as a link between the Advisory Committee and the wider voluntary sector.

At Community Health Partnership or locality level

- 2.18 The proposed Sexual Health and Relationships Strategy promotes the delivery of services at the most local level possible. To achieve this, leadership and supporting infrastructure similar to that for national and NHS Board area may be a useful parallel arrangement to develop. This may be at Community Health Partnership level or at smaller locality level depending on the geography and population coverage required. Local clinical leadership could be undertaken by local family planning clinics, general practice or other providers. Local areas might wish to duplicate the networking functions similar to those at NHS Board level: public health practitioners, Local Authority health improvement officers, public health nurses and staff working in the sexual health field will be a useful means of supporting this local and regional networking. For some areas, this might also mean joining up with neighbouring areas for both service provision and to exchange ideas and experiences. One of the principles between Tier 5 of the tiered service approach is that they should be able to support the other tiers in terms of training and expertise (see Supporting Paper 5A for further details).

3. RESOURCES TO SUPPORT IMPLEMENTATION

- 3.1 Staffing and other resource levels have not been set out in detail in the proposed Sexual Health and Relationships Strategy. This is deliberate as it is for individual NHS Boards, in conjunction with their Community Planning partners, to review their existing services, take account of staffing reviews and develop incremental implementation plans in response to the integrated lifelong learning and service framework and targets specified in the proposed Strategy. However, the Reference Group recognised the need to provide resources to “pump prime” the initial implementation stages so that a consistent approach could be made across Scotland. By providing such funding, the Scottish Executive could ensure that a “programme approach” to implementing the Strategy’s recommendations is adopted throughout Scotland.

- 3.2 In addition, clear guidance on what is required as part of the implementation, particularly in terms of the tiered service approach, links between schools and services and information/data collection will be required: the Sexual Health and Wellbeing Learning Network will take this work forward in conjunction with key stakeholders (see website for further details – www.healthscotland.com)

4. MONITORING AND EVALUATION OF THE STRATEGY

Benchmarking

- 4.1 Experience from elsewhere identifies the importance of being able to track both provider views and the wider public's views on the ongoing implementation of any strategy as well as tracking improvements in sexual health outcomes. This is important if we are to assess our progress in achieving “*a broad understanding of sexual health and sexual relationships.*” In addition, it will link into the proposed work on developing a mass communications strategy as identified in Supporting Paper 3.
- 4.2 The NATSAL survey and the Health Education Population Scotland (HEPS) provide a snapshot of the general population's knowledge, attitudes and lifestyles in relation to sexual behaviour. Neither currently explores detailed aspects of cultural and social attitudes or detail about specific interventions or services. The National Sexual Health Advisory Committee, in conjunction with key stakeholders, will consider the scope of including more detailed questions to assess the general population's views on timing, content and delivery of sex education programmes and to elicit views on sexual health service delivery. If undertaken, this would complement the user satisfaction work undertaken by individual service providers.
- 4.3 It will also be important to assess the impact the Strategy has had on service provision, from both staff and user perspective. This should be managed as part of an ongoing research and evaluation programme. The National Sexual Health Advisory Committee will consider the development of a tracking

programme which will include an analysis of the effectiveness and impact of the Strategy in supporting and developing an integrated service approach.

5. DEVELOPING AN EVIDENCE BASE FOR FUTURE WORK

5.1 The Reference Group identified several areas where there was little or no evidence of effectiveness and appropriateness of interventions aimed at influencing the cultural and social determinants of sexual health, sexual health behaviours and sexual morbidity. Lack of evidence does not equate to ineffectiveness but rather indicates a need for further research. There is a need to develop a sexual health research strategy for Scotland which takes account of the work of other agencies in this field (such as the Medical Research Council and the Health Development Agency) and is developed in conjunction with stakeholders at all levels. This will be an initial task for the National Sexual Health Advisory Group.

5.2 As part of the development of the strategy, the Reference Group identified a range of potential topics for consideration as set out below. Further discussions with other national organisations such as the Health Development Agency and the Teenage Pregnancy Unit, and local stakeholders, will help identify gaps that still exist and avoid duplication of work.

Evidence reviews

5.3 These reviews should combine needs assessment, an analysis of the effectiveness of differing methods of service delivery and organisation (thus linked to concept of evidence into practice) and recommendations for future policy. The topics for potential reviews identified include:

- sexual coercion/gender based violence (building on existing work)
- sexual dysfunction
- impact of health inequalities on sexual & reproductive health & wellbeing
- abortion services

Research/Surveys

- 5.4 The suggested range of issues which should be considered for further research include:
- Identification of potential barriers to partner notification (including harm arising from notification e.g. domestic violence)
 - Issues relating to “newly single” individuals
 - Media consumption
 - Further targeted interventions aimed at males (explore work based and non work based activities/approaches)
 - Development of non-invasive tests and their potential effectiveness and efficacy versus invasive test procedures
 - Extent and risk of female genital mutilation
 - Sexual health needs of lesbians

6. CONCLUSION

- 6.1 This supporting paper sets out the framework for taking forward the proposals contained in the draft Sexual Health and Relationships Strategy. This is intended to facilitate rather than hinder developments at national, regional and local levels. Notwithstanding this, strong leadership, clear accountability and appropriate resources will be paramount to help to progress the sexual health and wellbeing agenda in Scotland.

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