10. Sexual Health Programme

The Sexual Health Programme aims to reduce the rate of teenage conceptions and reduce the transmission of Sexually Transmitted Infections (STIs) and Human Immunodeficiency Virus (HIV). This is being achieved through increasing accessibility, availability and acceptability of contraception, sexual health advice and health services to all those within the target group.

Initiatives of this programme include: Media and Communication Services, Work Force Development, Outreach Services for Boys and Young Men, implementation of ‘You’re Welcome’ Quality Criteria, Focused Parenting Skills, a Condom Distribution Scheme and Health Services in Schools (HSIS). Evaluation of the programme included review of existing service data and commissioned research into the impact of the HSIS initiative. This is being undertaken by the University of Salford and will be complete in September 2010. Preliminary findings are reported here.

Intended specific outcomes of the programme are:

- Reduce the rate of teenage conceptions
- Increase Chlamydia screening
- Decrease repeat termination rate in Under 25’s

10.1. Underpinning evidence

There has been some decrease in rates of teenage pregnancy over the last decade in the UK but rates are still considerably higher than those in other European countries (Paranjothy, et al. 2008). Pregnancy and childbirth during teenage years are coupled with increased risk of poorer health and well-being for both the mother and the baby, which can negatively impact on the socio-economic factors that tend to precede early pregnancy and childbirth. The effect on society is a perpetuation of the widening gap in health and social inequalities (Paranjothy et al., 2008).

Inadequate sexual health promotion and education has been identified as a priority area specifically amongst young people (Davies, et al. 2006; Perry and Thurston, 2008). Risky sexual behaviours within this population can result in an increased risk of sexually transmitted diseases, HIV/AIDS and pregnancy (Lindberg, et al. 2006). There is a breadth of evidence showing that good positive social, emotional and psychological health can equip young people against risky behaviours, emotional and behavioural problems such as violence, crime, teenage pregnancy and the misuse of drugs and alcohol (Adi, et al. 2007; Cebulla and Tomaszewski, 2009; Colman, et al. 2009; Graham and Power 2003).

Young peoples’ social and emotional wellbeing is influenced by a variety of factors, from their individual make-up and family background to the community and society within which they live. Therefore, it is recommended that activities in secondary education which aim to develop and protect young people’s social and emotional wellbeing only forms one element of a broader, multi-agency strategy (NICE, 2009; Dobbins et al., 2009; WHO Europe, 2006). Secondary schools can provide an environment that fosters social and emotional wellbeing as well as provide young people with the knowledge and
skills they need, to learn effectively and make healthier choices as well as prevent behavioural and health problems (NICE, 2009; Dobbins et al., 2009; WHO Europe, 2006; Thistle, 2003). There is also evidence that building stronger links between secondary schools and health services can improve young people’s access to professional advice and support (Dobbins, et al. 2009; WHO Europe, 2006; Thistle, 2003).

Combinations of multiple interventions such as educational and contraceptive interventions in school settings appear to be the most effective approach to reducing unintended pregnancies among adolescents (Oringanje, et al. 2009). NICE also highlights that emphasis should be placed on the role of school staff in delivering interventions, rather than depending on outside experts (NICE, 2010). However, evidence for programme impact on behavioural change is limited due to the lack of robust studies and evaluations. Many studies tend to collect just self-reported data and they neglect clustered randomised controlled trials and the use of different statistical analysis to report outcomes (Oringanje et al., 2009). There is limited evidence that information alone is effective (Thomas and Perera, 2006).

In response, Wirral has developed the Health Services in Schools (HSIS) initiative. It is a Wirral wide, school wide multi-agency partnership strategy utilising the school nursing service to deliver a convenient and holistic service with a clinical component around sexual health. In addition, the service includes a school based specialist youth service (Response) which works in conjunction with other school based agencies to raise awareness and promote health and well-being. The youth service acts as an interface into wider community services developed for young people.

There is evidence to suggest that interventions which improve family relationships and understanding and address young people’s needs and their peer’s needs in engaging with school can lead to great changes in young people’s risky behaviours (Cebulla and Tomaszewski, 2009). In addition, educational outreach interventions targeted to ‘Hard to Reach’ parents (i.e. with difficult lives, full schedules and from a low socio-economic background) have been shown to be effective when based on social development theory underscoring how parents can play a major role in shaping their young adolescent’s behaviour. This can be achieved using diffusion of innovation theory and the theory of planned behaviour through role model stories (O’Donnell, et al. 2005). Workplace based programmes have also been shown to have substantial effects on communication between parents and adolescents about sexual health (Schuster, et al. 2008). The impact and effectiveness of targeted parenting and family interventions still requires further study (Gates, et al. 2006).

In response, there is a component of the Sexual Health Programme delivering parenting skills training and specifically equipping parents to discuss sexual health with their children. The more targeted component of this scheme was deferred until 2010-11.

Perry and Thurston (2008) highlight the importance of ensuring that sexual health services for young people are relevant to their requirements. It also reports that sexual health services need to be relevant to both age and sex if they are to be effectively utilised. There is a need for more research regarding ways to improve existing sexual health and reproductive services for men (Lindberg, et al., 2006; Wilkins, 2010). It is clear from the evidence that men and boys don’t engage well with current health services (Wilkins, 2010). There is strong evidence in support of the impact of targeted health interventions specific to men and boys and the literature recommends that
commissioners and practitioners always take this into consideration when developing health promotion services for the population (Wilkins, 2010).

In response, NHS Wirral have commissioned a specific outreach programme for young men and developed age relevant web-based promotion of the national Chlamydia screening programme.

There is little evidence around the effectiveness of condom distribution schemes in increasing condom use and decreasing risky sexual behaviours. This is mainly due to the lack of robust studies and evaluations (Free, et al 2009). Condom distribution (as a distinct activity) was removed from the Strategic Plan in 2009-10 and has been subsumed, where relevant, into other aspects of programme delivery.

“You’re Welcome” are a set of criteria based on effective local practice working with people under 20 years old. These criteria aim to ensure that health, education and community services are ‘young people friendly’. They address barriers such as accessibility (e.g. location, ability to access without parental involvement and a non-intimidating environment), appropriate and clear publicity and clear explanations of confidentiality (DH, 2007). The criteria support the implementation of standard 4 of the National Service Framework for Children, Young People and Maternity services and Royal College of General Practitioners and Royal College of Nursing (DH, 2004; DH, 2002).

10.2. Performance and Effectiveness

10.2.1. Increased positive media and communication programme

Positive media campaigns have been developed by NHS Wirral to increase signposting and awareness of the different sexual health services available. Routine performance data show that the projected 2009-10 target number of positive media campaigns was 4. This was exceeded, with the actual figure being 6. The campaigns were:

- Be You Me media campaign – social marketing campaign providing young people with advice and guidance around sex and relationships
- Be You Me Fresher’s Week Campaign Wirral Met – launch of Be You Me campaign with new intake at Wirral Met
- Health Services in Schools article – Wirral Globe
- Health Services in Schools – Radio promotion (Juice FM)
- Health Services in Schools article – Daily Post
- Publication of Teenage Pregnancy Rates – publicised in local newspapers, websites etc.
- Teenage Pregnancy Cabinet Report publication

All campaigns aimed to promote young people’s sexual health services, sexual health information and contraception, whilst encouraging young people to delay first sex and engage in “healthy” relationships. The campaigns have helped to ensure the delivery of consistent messages, in turn contributing to improved sexual health of young people in Wirral and a reduction in the under-18 conception rate.
10.2.2. Increased level one contraceptive and sexual health services
The number of staff trained as facilitators to support parents to talk with their children about relationships and sexual health exceeded the target of 25, with 33 staff trained through the Speakeasy course. This figure was double that in 2008-09, where 15 staff were trained for this purpose. Courses include understanding the physical and emotional changes taking place at puberty, awareness of what sex and relationship education means in the context of family life and confidence and skills in identifying and responding to the needs of children.

The number of parents who received support to talk to their children about sexual health through Speakeasy was 80 in 2009-10. This was just short of the target of 100 parents, but again was an increase from the 50 parents supported in 2008-09. Feedback from parents indicates that the course has been well appreciated by participants but no formal evaluation has been undertaken. The service plans to tie courses in with Family Works and other similar organisations. There is currently a waiting list of schools hoping to run a course in September 2010.

10.2.3. Sexual health services in schools
The target for the number of young people attending Health Services in Schools was set at 400 for 2009-10. Figures show that this target was far exceeded, with 1580 young people attending the service between October 2009 and April 2010 (source: NHS Wirral Balanced Scorecard, 2009-10). By the end of March 2010, 15 schools were hosting this service. The programme continues to expand and develop and at time of writing, 22 schools were hosting an HSIS service.

The launch of HSIS has been overall successful, not least as a result of comprehensive stakeholder engagement including school governors, parents and media. HSIS has worked very well in some schools from the outset and significantly increased the profile but also the demands on the school nurses and youth workers involved. Staff feel it has enhanced the role of the school nursing services and raised their overall profile. One school has had to adopt a ticketed queuing system to manage the demand in each session. Momentum has been slower to build in other schools and this is thought to be due mainly to accessibility, location and timing of ‘clinic’ times.

Beyond the sexual health function, the youth service element of HSIS has identified some specific, and otherwise unrecognised, wellbeing issues and a demand for smoking cessation services. This engagement and interface function has resulted in direct referrals to appropriate health services.

As part of the commissioned evaluation, paper surveys for staff were sent to 16 schools and 15 were returned, completed either by school nurses or youth workers. The services were offered on both a scheduled and drop-in basis. However, there were more drop-in services than scheduled service hours. Responses indicated a variety of timings for scheduled or drop in provision. Clinic times ranged from 40 minutes to three hours over lunchtime one day per week to school based nurses who worked several whole days in a school. Some school-based nurses provided both scheduled and drop in sessions.

A wide diversity of services are offered through HSIS, beyond the sexual health services of interest for this programme. Advice about relationships, sexual health and Chlamydia
screening were widely provided through the service (Figure 10.1) with provision of emergency contraception and pregnancy testing slightly more restricted in terms of the schools offering these services.

Advice about contraception, advice about emotional health and advice about relationships were identified by 9 respondents as being successful. The administration of Emergency Contraception, pregnancy testing and Chlamydia screening were also identified as successful services (by 6 staff), with a further 4 staff considering these to be partially successful. Condom distribution and other STI Screening were identified by 5 staff as successful.

Key factors to the success of the services included the drop in nature of the provision (n=9 out of 14 respondents), the clear need for the service recognised by the pupils (n=9) and that the service has been actively supported by school senior management (n=8). Less than half of the respondents (42.9%) indicated that being a well advertised service was a key factor which is probably a reflection of the low key approach to the

![Figure 10.1](image-url)  
**Figure 10.1** Number of schools providing components of HSIS, showing scheduled and drop in services

launch of the service. The lack of local provision was only identified as significant by 3 respondents.
When asked about factors influencing low success for the service, 7 of the 16 staff did not respond, largely due to the very short space of time for which the service had been running. For the 9 respondents that answered, 7 indicated that the location was problematic. Comments included the need for dedicated rooms with enough space to accommodate the attendees, and for confidential discussions. In one case the respondent indicated a need to relocate to a room that was not the prayer room since the religious paraphernalia was off-putting for the students. Respondents also identified location, lack of time, and staff training as factors underlying their judgement that a service was partially successful and these issues all featured as aspects of the service that the staff would like to improve.

Factors that facilitated pupil engagement included “approachability of HSIS staff” (100%) followed closely by “it is a convenient service for the pupils” (94%) and “word of mouth recommendation by peers” (87%). In 73% of cases, it was felt by staff that “pupils are confident that their privacy will be maintained.” Factors that have formed a barrier to pupil engagement included the location (64%) and reluctance of pupils to change behaviour (50%), with some acknowledgement that pupils may not be confident enough to approach HSIS staff yet. In 6 schools, it was felt that the initiative is not actively promoted by teaching staff, and that pupils were not aware that they need the service.

Around 61% of staff responding felt that health behaviour in schools had improved as a result of HSIS. One respondent commented that during conversation pupils now show greater knowledge of basic health issues whilst another commented that pupils are now more likely to request information for general health concerns. One respondent felt that there was an improved awareness of STI, pregnancy and that more pupils were openly discussing this in clinic.

In a survey of pupils in one of the participating schools, sexual health advice ranked highest in terms of perceived support available from schools (Figure 10.2) with 69% (124/180) mentioning this. Advice about contraception also featured highly and this was the service most likely to have been accessed by pupils responding to the survey (43%, 77/180). The majority of respondents were 14 years old or younger.

In terms of profile of the service in this school, less than a third of respondents had seen any of the five posters in the service promotion campaign. The majority of those that saw the posters did not read them and could not remember anything about them. Only three of the 191 respondents visited the website address included on the poster and these pupils had divergent views on whether the website had given them all the information they needed about the service.

Fuller analysis of the impact and awareness of the service will be available in the final report from the evaluation provider in September 2010.
10.2.4. Increased volume of sexual health and contraceptive service provision

The percentage of clinics providing a full contraceptive service in 2009-10 was 50%, below the anticipated proportion of 75%. This lower performance was attributed to ongoing completion of staff training which, at time of writing, has now been achieved.

In 2009-10, a total of 9912 Chlamydia tests were undertaken for those under 25 years old across 126 individual sites in Wirral. This corresponds to an estimated 25% (9912/40362) of all 15-24 year olds resident in Wirral (Source: ON population estimates Mid2007). The Brook Advisory service (29%, 2881/9912) and GUM services (16.7%, 1660/9912) were the most common settings for these (Figure 10.3). Around 64% (1061/1660) of GUM services were accessed in the Community Sexual Health Clinic. GP practices were the next most common place to be tested, representing 13% (1259/9912) of the total capacity. Rates of positivity did not vary significantly between settings, although those being tested at the Chlamydia Programme Office appeared to be much more likely to be positive than average (26% compared with 10%) (Figure 10.3).
Around 73% (7145/9780) of those tested were women and the age distribution of those tested was very similar for men and women, with some evidence that women were being tested slightly younger (Figure 10.4).

Of tests undertaken, 975 (10%) were positive and this proportion varied by age and sex. Younger men and women (18 years and under) were slightly less likely than average to be positive, which might be expected given their (assumed) lower exposure compared...
with older age groups (Figure 10.5). The highest rates of positive test were observed amongst 22-24 year old men.

![Figure 10.5 Number of individuals tested for Chlamydia in 2009-10, by sex and showing proportions of tests that were positive](Figure 10.5)

Part of the promotion of Chlamydia screening activity in Wirral is through a website, [http://www.eazeescreen.co.uk/](http://www.eazeescreen.co.uk/). Focus groups of young people were asked in 2009-10 to evaluate 6 available Chlamydia screening promotion sites across Cheshire and Merseyside. They were asked to score the sites in terms of a) visual appeal and ease of navigation, b) quality of information provided, c) ease of ordering a postal kit and d) whether they would recommend to friends. The Eazeescreen site scored highest in this evaluation and will be rolled out across Cheshire and Merseyside in the near future. The success of this site is reflected in the high number (292) of postal tests submitted in 2009-10 (see Figure 10.3).

Available Wirral data (2008) show that the majority of sexually transmitted infections were diagnosed at Arrowe Park Hospital (89%); Royal Liverpool (6.3%); or the Countess of Chester (4.3%). Overall, prevalence in key infections was higher amongst males, though this varied by infection (Figure 10.6).

![Figure 10.6 Prevalence of Key Infections by Gender](Figure 10.6)
Data from the Centre for Public Health (LJMU) and the North West Public Health Observatory show that the prevalence of HIV and AIDS in Wirral increased across all age groups between 2002 and 2008. The greatest increases were amongst the over 60 age group (400% change since 2002) and the under 20 age group (300% change since 2002) although baseline prevalence in these groups was very low (Figure 10.7).

**Figure 10.7** Total HIV and AIDS Cases in Wirral (Source: Centre for Public Health and NWPHO, accessed via Cheshire and Merseyside Sexual Health Dashboard)

Under 18 conception rates in Wirral are decreasing, with an overall 21% reduction in under 18 conceptions between 1998 and 2008, with a particular drop between 2007 and 2008. This decrease is larger than that for the North-West (9.1%) and England (13.3%) (Office for National Statistics and Teenage Pregnancy Unit, 2008). (Figure 10.8).

**Figure 10.8** Wirral under 18 Conception Rates, showing 2010 target (Source: Office for National Statistics and Teenage Pregnancy Unit, accessed via Cheshire and Merseyside Sexual Health Dashboard)
10.2.5. Increased access to sexual health services by young men

Available Wirral data (2008) show that the prevalence of sexually transmitted infections in males was 2390.2 per 100,000 population amongst 20-24 year olds; 2104.5 per 100,000 population amongst 15-19 year olds; and 18.4 per 100,000 population amongst 10-14 year olds (Cheshire and Merseyside Sexual Health Network).

There has been an 18% increase in the proportion of young males who access sexual health services, meeting the 2009-10 performance monitoring target. In an effort to further support males to access sexual health services, an outreach programme was developed through the Brook Advisory Service to target young men. The outreach programme engaged young men in vocational training sessions with sexual health awareness, including offering Chlamydia testing. The service included the nationally accredited personal development programme ‘All Different All Beautiful’ with a focus on emotional and behavioural development, including aspects of sexual health. Another component of outreach was the ‘Man Matter’ programme addressing beliefs and attitudes to masculinity and sexuality.

In 2008-09, routine monitoring data shows that 300 young men were supported through this programme. This increased in 2009-10 to 530, which well exceeded the target of 400.

10.2.6. Workforce Development

The Workforce Development element of the sexual health programme involves offering a rolling programme of sex and relationship training to front line staff across the whole of the Children and Young People workforce, helping to ensure staff feel confident and able to deliver informed and consistent messages around sex and relationships to young people accessing their services. Employers from various agencies were invited to participate in sexual health training which was jointly commissioned as part of the Strategic Plan programme and led by NHS Wirral. In 2009-10, 167 members of staff from a wide variety of agencies and departments took part in the training (Figure 10.9).
Training sessions in the field of Sexual Health and Teenage Pregnancy were also held across Wirral (n=14 courses). Figure 10.10 shows the diverse titles of the training courses, along with the numbers of attendees at each course.

![Figure 10.10 Numbers of individuals attending a range of Sexual Health and Teenage Pregnancy Training courses in 2009-10](image)

Overall, 542 frontline staff were trained in 2009-10, which was double the anticipated target (250). The workforce development initiative has resulted in improved access to information for young people whilst building upon the multi-agency approach used to address Sex and Relationships Education in Wirral. The training of staff in a wide variety of departments, services and organisations increases the potential for opportunistic engagement with young people on issues of sexual health and represents a sustainable approach, in conjunction with other services described.

### 10.2.7. Expansion of “You’re Welcome” programme in primary care

The target proportion of eligible settings registering interest in working towards a You’re Welcome standard in 2009-10 was 50%. Overall, 21 sites registered interest in 2009-10 (Table 10.1).

<table>
<thead>
<tr>
<th>Organisations</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual and reproductive health services</td>
<td>15</td>
</tr>
<tr>
<td>Schools/Further Education</td>
<td>1</td>
</tr>
<tr>
<td>Child and Adolescent Mental Health Services</td>
<td>1</td>
</tr>
<tr>
<td>Paediatrics - hospital based including hospices</td>
<td>1</td>
</tr>
<tr>
<td>Walk-in Centres</td>
<td>1</td>
</tr>
<tr>
<td>Maternity Services</td>
<td>1</td>
</tr>
<tr>
<td>Accident and Emergency</td>
<td>1</td>
</tr>
</tbody>
</table>

**Table 10.1** Organisations registering interest in You’re Welcome
In 2009-10, the proportion of eligible settings identified as ‘Starting Out’ towards achieving ‘You’re Welcome’ standards was 40%. Eligible settings identified as ‘Getting There’ was 5%, and eligible settings identified as ‘meeting You’re Welcome’ was also 5%. Delays in progressing You’re Welcome nationally (including developing the toolkit) have meant that local developments have had to be put on hold and anticipated numbers of settings achieving the standard have not been met.

10.3. Summary of Programme Evidence

This evaluation of the sexual health programme describes several streams of work that aimed to increase the profile of sexual health amongst young people in Wirral, with a final goal of impacting health behaviour. This programme is in the context of high (national) prevalence of sexually transmitted infection and teenage pregnancy and increasing prevalence of HIV and AIDS. Most of the information available for 2009-10 describes the delivery of these work streams, but a longer period of follow up will be required to assess their impact on behaviour as well as on disease incidence and on unplanned teenage conception.

10.3.1. Information and education

The first approach to increasing the profile of sexual health was through information and education. Several media campaigns were delivered in 2009-10 to promote available services and ensure consistent messages were given in an appropriate style and format.

The Wirral website promoting the national Chlamydia screening initiative (http://www.eazeescreen.co.uk/) won the approval of young people in Cheshire and Merseyside in an evaluation of 6 such sites and will be used as a model for the region.

A successful outreach initiative raising awareness amongst young men was delivered by Wirral Brook advisory service and resulted in significant increases in men attending sexual health services.

10.3.2. Enhancing current services

The second approach to increasing the profile of sexual health was through enhancing awareness of and capacity within sexual health services for young people and maximising partnership opportunities for engagement with young people around sexual health.

Chlamydia screening has been extended to many settings in Wirral, with Wirral Brook contributing almost 30% of capacity but a wide range of other (mostly NHS) sites involved. An estimated quarter of the population of 15-24 year olds were screened in 2009-10 with an overall positivity rate of 10% and particularly high rates amongst 22-24 year old males.

Training was a key component of the programme. Incomplete training within the clinics expected to deliver a full contraceptive service was identified in 2009-10 and this is being addressed. A very wide range of frontline staff working with children and young people were equipped in 2009-10 to opportunistically deliver clear and consistent guidance around sexual health and relationships (through the workforce development programme). Numbers trained were more than double those planned.
To further enhance what health services can deliver, parents were also equipped to discuss issues of sexual health with their children through the Speakeasy course, and 33 facilitators were trained in 2009-10. Demand for courses is high with schools being a particularly positive partner.

The roll out of the You’re Welcome programme was also designed to enhance the capacity of health services to engage young people and progress has been made with this, though impacts on engagement are not yet clear.

10.3.3. New services

The third approach to increasing the profile of sexual health was the development of Health Services in Schools (HSIS). This service is not exclusively focussed on sexual health but affords an opportunity for engagement of secondary school children and signposting to other relevant services.

This initiative is very new and evidence suggests, very popular. Roll out is continuing across all schools in Wirral and has raised the profile and credibility of the school nursing service. A full evaluation of the service was planned for January to July 2010 and the University of Salford commissioned to provide this. There have been significant barriers and delays in delivering this evaluation and the full report will not be available until September 2010. Coordination of data collection from relevant health services in 2010-11 will also help demonstrate the additional impact of this service in meeting the sexual health needs of young people in Wirral.

10.4. References


