

# Towards a Highland Sexual Health and Relationships Strategy

2005 – 2010

Discussion Document



# CONTENTS

|  |           |
|--|-----------|
| <b>1. Introduction</b>   | <b>1</b>  |
| <b>2. Values</b>   | <b>2</b>  |
| 2.5. Respect   | 2         |
| 2.6. Human Rights  | 2         |
| 2.7. Reducing inequalities   | 2         |
| 2.8. A positive view of relationships, sex and sexuality                       | 3         |
| <b>3. Setting the scene</b>  | <b>3</b>  |
| <b>4. Sexual Health Promotion</b>  | <b>6</b>  |
| <b>5. Sexual Health Services</b>   | <b>11</b> |
| 5.5. Sexual dysfunction and psychosexual services                              | 14        |
| 5.9. Services for people who may have been raped, sexually abused or exploited | 15        |
| 5.10. Contraceptive services   | 16        |
| 5.15. Termination and stillbirth   | 17        |
| 5.17. Sexually transmitted infections – diagnoses and treatment                | 17        |
| <b>6. Young people</b>   | <b>19</b> |
| Early sexual activity  | 19        |
| 6.2. The wider context   | 21        |
| 6.3. The role of parents and carers  | 21        |
| 6.4. Young people with special needs   | 22        |
| 6.5. The role of schools   | 22        |
| 6.9. Young people who are lesbian, gay, bisexual or transgender                | 25        |
| 6.11. Young people with Special Needs  | 26        |
| 6.12. Young people who do not attend school                                    | 26        |
| 6.13. Young people who are withdrawn from sex and relationships education      | 27        |
| 6.14. The role of the community  | 27        |
| 6.15. Helping to support the young person's moral development                  | 28        |
| 6.16. Supporting and building community capacity                               | 28        |
| 6.17. The peer group   | 29        |
| 6.18. Access to services   | 29        |
| 6.20. Confidentiality  | 30        |
| 6.21. Looked after and accommodated young people                               | 30        |
| <b>7. Specific groups other than young people</b>                              | <b>31</b> |
| 7.1. People with disabilities  | 31        |
| 7.2. Older People  | 32        |
| 7.3. People who are Lesbian, Gay, Bisexual, or Transgender (LGBT)              | 32        |
| 7.4. Commercial sex workers  | 33        |
| 7.5. People who are involved in substance abuse                                | 34        |
| 7.6. Prisoners   | 35        |
| 7.7. Ethnic minorities   | 35        |
| 7.8. Homeless people   | 36        |
| 7.10. Structures to support sexual health                                      | 37        |
| 7.17. Resource implications  | 38        |

Sexual Health is: *“the integration of physical, emotional, intellectual and social aspects of sexual being in ways which are enriching and that enhance personality, communication and love”*  
World Health Organisation

## 1. Introduction

- 1.1. This is the second Highland Sexual Health Strategy and follows on from our first strategy, “Sex Matters” which covered the period from 1997.
- 1.2. The issues and services covered by the term “sexual being” as it is used in the WHO definition are many and wide-ranging. This strategy’s direct scope is limited to those issues and services customarily regarded as sexual in their nature but seeks to build links into related areas such as wider aspects of reproductive health, domestic abuse, mental health, child protection, maternity services and so on. That such services and issues are not specifically identified for action in this strategy does not indicate any lack of importance attached to them or imply lack of interest in their relationship to “sexual being”. It simply signifies that these issues are predominantly addressed in other settings and by other strategies to and from which sexual health will form one of a number of links (see Strategic objectives 2, 3 and 4).
- 1.3. Throughout this document the term “sexual relationship” is taken to mean any relationship involving sexual attraction, whether or not sexual intercourse takes place.
- 1.4. NHS Highland has developed an Ethical Framework for Decision-Making that seeks to ensure that ethical values underpin its key decisions. To date, this process has been used in relation to some single decisions, for example, whether a particular patient should be provided with a particular treatment. However, it is often the strategic development process which generates or determines key decisions. It is important, therefore, that ethical values are also used to assess the ethics of strategic development. Highland Sexual Health Strategy Group has used the Ethical Decision Making Framework to underpin and guide the development of this Sexual Health Strategy.

The components of the ethical decision making process are:

- Accountability – requiring transparency in strategic development;
  - Justice – requiring strategic decisions to be founded on merit and not on discrimination;
  - Supportive of quality – requiring that strategic developments are based on good quality;
  - Realism – requiring honesty in what is and what is not possible to achieve in any strategy;
  - Engagement – requiring engagement with key groups and individuals at every stage of the strategic development process;
  - Flexibility – requiring a recognition of the particular needs of particular people;
  - Meaningful Relationships – requiring support for critical and constructive dialogue with our community about our strategies, plans and developments.
- 1.5 There are seven background papers, one covering each aspect of the ethical decision-making process, which informed the development of this document. These are available on [www.show.scot.nhs.uk/nhshighland/](http://www.show.scot.nhs.uk/nhshighland/) by following the links to “Your Health” and then to “Health Promotion”, or on request from NHS Highland Health Promotion Department, Assynt House, Beechwood Business Park, Inverness IV2 3HG.

## 2. Values

2.1. Development of a value-free sexual health strategy is neither possible nor desirable. In the course of preparing this document every discussion held focused as much on values around sex and sexuality as it did on practical aspects such as sex education or clinical services. Throughout our discussions no one suggested that sexual health could or should be value-free. Individuals, however, held a wide range of views on the precise set of values that the sexual health strategy should adopt.

2.2. The key values around which the Highland Sexual Health Strategy is based are:

- Respect
- Human rights
- Reducing inequalities
- A positive view of relationships, sex and sexuality
- Responsibility

### 2.3. Respect

Respect is key in promoting positive sexual health. Without respect, people are unlikely to behave responsibly.

Respect starts with self-respect. If we don't have respect for ourselves it is far more difficult to have respect for others. But the process is two-way. If others do not respect us, our self-respect is undermined and that is particularly the case if lack of respect is endemic within our society. If we don't have respect for ourselves or for others we are likely to undervalue or devalue relationships, particularly sexual relationships.

Respect also determines how those involved in sexual health at a professional level will acknowledge and accommodate the views and values of those they are working with, whether or not they accord with society's accepted norms, or the professional's own views. It is important that professionals working with individuals, families and communities recognise and embrace the views and values people bring with them.

### 2.4. Human Rights

It would seem self-evident that nothing we do should infringe a person's human rights. Indeed, one might assume that a value base of human rights would hardly need stating.

There is some evidence, however, that people's human rights are not always respected within our society. This has particularly been the case where minority groups are involved. People from certain groups suffer heavily from discrimination, some of it intentional but some of it simply springing from ignorance or thoughtlessness. Children's rights, particularly the right of older children to privacy, full access to health services and the right to have their voices heard in matters concerning them are also important and are not widely understood by the general public.

### 2.5. Reducing inequalities

Good sexual health is not distributed evenly around society and is not governed by chance. It is closely related to socio-economic status and there are serious pockets of very poor sexual health in Highland. Teenagers in the lowest income quintile have teenage pregnancy rates more than double those of teenagers in the highest income quintile. If we are to improve the sexual health of society as a whole, we must carefully focus our effort on tackling the sexual health of those who are currently most significantly disadvantaged.

## 2.6. A positive view of relationships, sex and sexuality

As a society and as individuals we tend to cherish those things we perceive as worthwhile and treat as disposable those items we do not value. Sex is, for most people most of the time, a worthwhile, fulfilling and enriching aspect of life. Yet all too often sex, relationships and sexuality are portrayed in entirely negative terms.

It is difficult to see how we can persuade people, and young people in particular, to value and cherish sex and to be selective and discriminating in decisions around sexual relationships while and if we focus predominantly on negative aspects.

## 2.7 Responsibility

It is important that people are empowered to take responsibility for their own and their partners' sexual health. This is not as easy as it sounds. There are those who are not in a position to take responsibility - it is, for example, impossible for someone who is in an abusive relationship to assume responsibility for his or her own sexual health. Gender stereotyping, substance abuse, low self-esteem, poor levels of access to information or services, pressure from partners peers family or community, prejudice, deprivation, age and disability may all reduce an individual's ability to have any real control over their own sexual health.

Neither can there be a formula to determine responsibility. People are all different, circumstances vary and no two relationships are the same. What is "responsible" for one individual in a given set of circumstances and a particular relationship may not be responsible for someone else whose circumstances and relationships are different.

Promoting responsibility is not simply a matter of telling people what they should be doing, or of laying the options before them and expecting them to choose the "responsible" course of action. It is, rather, a complex and time-consuming process of working with a wide variety of sectors progressively to tackle the multiplicity of factors which currently reduce the ability of some to take responsibility for their own and their partners' sexual health.

## 3. Setting the scene

### Overall Strategic Aim

*To recognise and positively influence the wider cultural, social and economic pre-cursors to good sexual health*

3.1. There is a strange dichotomy in the way we deal with issues around sex. On one hand we are surrounded by sexual imagery. Sex pervades our TV screens and features as one of the main themes in the popular press. Sex is the chief subject matter of a wide variety of top-shelf publications aimed at men and both soft and hard pornography are readily obtainable. Sex, in a different form, is also an important element of mainstream publications aimed at women and young people, particularly girls. Sex is used to sell just about everything from shampoo to cars.

On the other hand there is a great reluctance in our society to talk openly and freely about sex and many people find such discussions awkward and embarrassing. This can present real and significant problems. People can be inhibited from seeking advice and help in relation to sexual matters though embarrassment. Many parents find talking to their children about sex too difficult and leave such discussions to their children's schools. It is important that we strive to open up discussion around sex and view it in a more straightforward and positive manner.

## Objective 1

### **To encourage a wide variety of agencies throughout Highland to work towards a culture that is increasingly at ease with of sexual matters**

*Accords with the ethical principles of Engagement, Quality and Realism.*

- 3.2. There are wider social, economic and cultural determinants of sexual health which a sexual health strategy, on its own, cannot address. These will include such issues as gender stereotyping, family norms and relationships, ethnicity, the media, disability, homophobia and transphobia (hatred or fear of gender identities which differ from biological gender and those who experience these differences), social pressures, drug and alcohol use and socio-economic circumstances. It is nevertheless important that we do not lose sight of these and that we work, where possible, to minimise or eliminate those factors which have a negative impact on sexual health while promoting those which have a positive effect.
- 3.3. Highland agencies produce a number of plans and strategies seeking to address a wide variety of issues. Some of these plans and strategies will have implications for sexual health. The National Sexual Health Strategy requires that Local Authorities and NHS Boards ensure that Community Plans, Local Health Plans and Children's Service Plans complement their local inter-agency sexual health strategies and address the issues that impact on sexual health especially in relation to equalities.
- 3.4. As time goes on agencies will produce a wide variety of strategies and planning papers. Where these can affect sexual health and its pre-cursors, it is important that the sexual health implications are recognised and that steps are taken to ensure appropriate linkages are made.

## Objective 2

### **To encourage a wide variety of agencies and organisations to influence the wider social, economic, societal and cultural pre-cursors to good sexual health**

*Accords with the ethical principles of Engagement, Justice, Quality, Meaningful Relationships and Realism.*

- 3.5. One of the key determinants in our view of sex and relationships comes from media sources. The Draft National Sexual Health Strategy proposes that a National Sexual Health Advisory Committee develop a media strategy at national level.  
However, local media also have an important part to play. Local newspapers are widely read and local radio in the Highlands has a high listener base. With the advent of community radio and TV, it is important that we work to engage fully with local media at a local and community level to improve sexual health in the Highlands.  
Because sex can be seen as a contentious issue, the media can sometimes be viewed as an enemy rather than a friend. This is a mistake. Local and community media outlets have a high level of commitment to the communities they serve and place great value on the availability of high-quality information and advice on health-related matters. There are enormous opportunities to engage fully with local and community media to improve the quality of information and advice on health-related matters for the whole community.
- 3.6. There are two main strands which should come into play in working with the media. Firstly, the media can play a major role in opening up discussion about sex and relationships and in helping to establish a more frank and free culture around these issues. Secondly, there is a real need, in protecting public health, to raise public awareness of the importance of the use of barrier contraception. Barrier contraception is important in addressing the continued spread of STIs and, along with other methods of contraception, is vital in preventing unwanted pregnancies.

## Objective 3

**To establish and maintain productive relationships with all local media and to encourage them to raise the profile of sexual health and provide reliable sexual health information**

*Accords with the ethical principles of Engagement Quality, Meaningful Relationships and Realism.*

- 3.7. There is regular and ongoing press advertising around sexual health. Most of this, however, currently concentrates on Inverness and involves little targeting in relation to addressing health inequalities or focusing on the needs of particular target groups. The differences in sexual health outcomes for different groups indicates that greater targeting, particularly towards disadvantaged communities and individuals, is essential.

## Objective 4

To review advertising policy in consultation with Community Health Partnerships and formulate an effective annual advertising plan.

*Accords with the ethical principles of Accountability, Flexibility Justice and Quality.*

## 4. Sexual Health Promotion

### Strategic Aim

*To develop and implement a comprehensive programme of sexual health promotion across Highland to empower and enable all communities and individuals to maximise their sexual wellbeing and minimise adverse sexual health outcomes*

4.1. Sexual Health can be seen in some quarters as a youth issue. Certainly issues around sex and relationships do affect young people but they affect the rest of the community as well. While a minority of young people under the age of sixteen are sexually active, almost everyone will eventually become sexually active.

Good sexual relationships are enhancing at the deepest of levels. At an individual level they raise our sense of self and our self-esteem. These are important in promoting mental health and will also have some impact, though it is less easy to define, on physical well being. Within a relationship good sexual experiences can develop and reinforce love, tenderness and bonding and have the potential to increase the strength and stability of both opposite-sex and same-sex relationships. This is a valuable outcome in itself both for the parties involved and for a society that depends to a great extent on successful bonding between individuals. For many people in opposite sex-relationships, this bonding will be in the form of marriage.

Successfully bonded relationships can also provide financial security and a relatively successful and secure environment in which children may be raised. While good sexual experiences are not the only factor contributing to family stability, they are an important piece in a complex jigsaw.

While there has been much focus in recent years on tackling and preventing sexual ill-health largely as a consequence of the impact of HIV/AIDS there has been far less focus on promoting and improving positive sexual health and wellbeing.

### Objective 5:

**To promote a positive view of sex and sexuality for all people regardless of age, disability, ethnic origin, gender and sexual orientation**

*Accords with the ethical principles of Flexibility, Justice and Quality.*

*Accords with the views of most of those who participated during the pre-consultation Engagement process, but **conflicts** with the views of some Faith groups who would not wish to encourage a positive view of sexual relationships outwith marriage.*

4.2. Sex and relationships education is often viewed exclusively as a school-based intervention aimed solely at young people. In reality learning about sex and relationships takes place throughout life and in a variety of settings. There are many reasons why learning needs to be lifelong. These include:

- Varying levels of experience of and engagement with sex and relationships education during the teenage years;
- Changing life circumstances such as bereavement, divorce, or coping with the aftermath of rape, abuse or violence which may herald major changes in the nature of men's or women's sexual relationships;

- Physical or mental ill-health, injury or disability which may affect sexual relationships;
  - A changing social and cultural landscape which affects openness around aspects of sex and sexuality
  - Changes in living arrangements particularly for older women and men in residential settings
  - Developments in services and interventions
  - Changing responsibilities over a woman's or a man's lifetime, such as the need to adopt parental responsibilities in relation to the sexual health of children
- 4.3. Sex and relationships education for young people in schools is relatively straightforward. Almost the entire population attends school and a high level of coverage can be achieved in this setting. This relative simplicity does not apply in the wider adult context. There is no single place where adults congregate and lifelong learning requires to be promulgated in a wide variety of settings including the community, the workplace, colleges and universities, leisure/entertainment outlets, etc. Training will be required to enable people who are not routinely involved in sexual health to provide accurate and appropriate interventions. Peer education may be particularly important for some groups.
- 4.4. The Internet is an increasingly important source of information on a diverse range of subjects. However, while its usefulness should be recognised and exploited, Internet provision of information carries its own problems and risks.
- Chief amongst these is the issue of social exclusion. Those in the most disadvantaged economic groups and with the poorest sexual health are also least likely to have ready access to the Internet.
- For young people Internet access to information about sexual health can also be problematic as many facilities for young people use filtering systems to prevent all access to "adult" sites. This is done using a key word system. Sites containing "sex" or "penis" could be expected to be barred from most such systems.
- There is already a substantial body of web-based information around aspects of sexual health, so much so that development of a major new resource for Highland would seem somewhat superfluous. It is important that people living in the Highlands have easy access to the range of sites which are now available in relation to sexual health and it would be useful to collect and collate links to these on one site, probably on a sexual health page of the new Highland NHS site which is currently under construction.
- There is also a potential difficulty with this approach, however, as Highland NHS could be held morally responsible for the full range of content on these sites. Some may consider some of the content on sites which are particularly useful for certain groups too explicit for inclusion for more general consumption.
- 4.5. Our society is not homogeneous. It is important to recognise that men and women may not be equally represented in all settings. There are more men than women in the workforce, for example, while more women than men are likely to be seen in doctors' surgeries. There are also differences between men and women in the information, advice and support which may be required at various stages in life. People with different sexual orientations will also have different sexual health promotion needs, as will people from different faith and cultural perspectives and with differing levels of ability and disability.

## Objective 6:

**To improve access to education, advice, information and support through multi-agency working in a diverse range of appropriate settings**

*Accords with the ethical principles of Engagement, Flexibility, Justice, Quality, Meaningful Relationships and Realism.*

- 4.6. In the Highlands there is no single template which, if followed, will ensure that optimum sexual health is achieved throughout the area. The area consists of a multiplicity of diverse geographical communities from the rapidly-expanding and increasingly cosmopolitan city of Inverness to remote villages and hamlets which may be bereft of public transport and many miles from the most basic of facilities. In the Highlands a community development approach to sexual health promotion is not an optional extra, it is essential. Elements of a community development approach will vary from area to area and between different aspects of sexual health need. Community Health Partnerships, along with Local Authority local area structures, will be best placed to take the lead in community development work in their areas.

### Objective 7:

**To continue to develop and expand a community development approach to sexual health promotion, informed by the Community Planning process and guided by local sexual health forums.**

*Accords with the ethical principles of Engagement, Flexibility, Quality, Meaningful Relationships and Realism.*

- 4.7. Specific vulnerable and disadvantaged groups are at particular risk in terms of sexual health. A variety of life circumstances can lead to vulnerability and disadvantage. Poverty, for example, is key indicator in poor sexual health. Aspects of lifestyle (which may be created or exacerbated by poor life circumstances) such as promiscuity, substance abuse and commercial sex carry clear risks in relation to sexual health and wellbeing. While it is important to work to improve life circumstances and to promote healthier lifestyles, it is essential that this is not done in a way which leads to a culture of blame.

### Objective 8:

**To ensure that sexual health promotion continues to identify and meet the needs of the most vulnerable and disadvantaged groups in a non-judgemental way**

*Accords with the ethical principles of Accountability, Flexibility, Justice, Quality, Meaningful Relationships and Realism.*

*Accords with the views of most of those who participated during the pre-consultation Engagement process, but **conflicts** with the views of some of the Faith groups who expressed a view that, while tolerance should be shown to individuals regardless of lifestyle, sexual practices and preferences of some consenting adults were wrong and such practices/preferences could not be dealt with non-judgementally*



- 4.8. For many heterosexual couples, protecting against sexually transmitted infections (STIs) takes second place to preventing pregnancy. Many STIs are silent in their early stages, presenting no early symptoms in most people. There is a real need to raise awareness of STIs and the need for people to come forward for testing, even where there may be no symptoms. It is important to recognise that success in this strategic objective is likely to have the result of creating an apparent increase in STIs in Highland; the more asymptomatic people who are tested the more cases of illness will be uncovered.

## Objective 9:

**To raise awareness of the silent nature of many sexually transmitted infections and to persuade people likely to be at risk to be tested**

*Accords with the ethical principles of Accountability, Engagement, Quality and Realism*

- 4.9. The importance of barrier methods in preventing the spread of STIs requires continued emphasis. Improving access to and correct and consistent use of barrier contraception, including a wide variety of condoms, lubricant, female condoms and dental dams will continue to provide the cornerstone in combating the spread of sexually transmitted infections. Highland Sexual Health has administered the Free Condom Scheme in Highland for several years. However, awareness of the availability of free barrier contraception appears anecdotally to be quite low, both amongst the general public and amongst GPs.

The amount of resource Highland NHS Board is currently able to allocate to the scheme is insufficient to allow for any major expansion. The National Sexual Health Strategy, however, recommends that the Scottish Executive make additional funding available to enable wider free provision of condoms.

- 4.10. The majority of cases of condom failure are due to incorrect use, for example, putting the condom on before penetration but after genital contact has taken place, snagging on fingernails or jewellery, slippage during withdrawal and so on. If the effectiveness of condoms in addressing the spread of STIs and the incidence of unintended pregnancies is to be improved it is vital that people have the skills and knowledge to use condoms correctly.

It is sometimes assumed that only young people need to be taught how to use condoms. This is not the case. Widespread condom use is a fairly recent phenomenon. Many middle-aged and older people who have spent some time in stable relationships and are now single again through divorce or death of a partner, may never have used condoms when they were younger. There is a constant need to reinforce not only the use of barrier contraception, but also correct and consistent use of barrier contraception.

Reinforcing correct and consistent condom use is one challenge but there are several other issues around barrier contraception which are even more problematic. The female condom is a more recent innovation. While most people understand what it is for, knowledge of the correct use of female condoms is likely to be even lower than it is for condoms.

Sexual practices are varied and two in particular, other than vaginal intercourse, carry some risk of spreading STIs. Oral sex is practised by more than three-quarters of sexually active people between the ages of 16 and 40 in Scotland and anal intercourse, sometimes thought of as an exclusively male homosexual practice is, in fact, practised by 11% of women 15% of men in this age group with an opposite sex partner. As the proportion of men who report ever having had sex with another man is 5% (and not all of them practise anal intercourse) it is clear that the vast majority of people who have anal intercourse are doing so in a heterosexual rather than a homosexual context.

There are implications for sexual health promotion in the prevalence of both oral and anal sex. Despite the innovation of flavoured condoms for oral sex, many people remain unaware that some STIs can be spread by oral sex and are therefore unaware of the importance of the use of condoms and dental dams for oral sex. Many are also unaware that some types of condoms sold for use during oral sex may not be safe for vaginal or anal sex.

Extra strong condoms and lubricant, produced particularly with anal intercourse in mind, tend to be promoted within the context of homosexuality. While it is important that homosexual men who practice anal intercourse are aware of the significance of extra strong condoms and lubricant, greater promotion amongst the heterosexual community in relation to safer anal intercourse is also required.

## Objective 10:

**To continue to seek ongoing improvement in the availability and correct and consistent use of barrier protection particularly in relation to high risk groups.**

*Accords with the ethical principles of Engagement, Flexibility, Justice and Quality, Meaningful Relationships and Realism. Accords with the views of most of those who participated during the pre-consultation Engagement process but conflicts with the views of some faith groups who believe that promotion of condoms encourages promiscuity and leads to increased levels of unwanted pregnancy and STIs.*

4.11. While there are a wide range of issues which have to be covered within sexual health promotion, HIV/AIDS remains a key issue. The continuing spread of STIs in Highland suggest that messages around safer sex may no longer have the resonance they carried a decade ago. While diagnosed HIV prevalence in Highland is still relatively low, it is clear that unless safer sex messages are effectively promoted and heeded HIV could eventually spread exponentially within the sexually active population.

## Objective 11:

**To produce a HIV Health Promotion strategy.**

*Accords with the ethical principles of Accountability and Quality.*

## 5. Sexual Health Services

### Overall Strategic Aim

*To develop and implement a comprehensive, flexible and interlinked model of appropriate, accessible and culturally sensitive sexual health service provision which will meet the needs of the whole Highland community, particularly its most vulnerable and marginalised members.*

- 5.1. The National Sexual Health Strategy sets out a model of service provision and specifies that any person should be able to access each level of service through a minimum of two separate routes.

#### **Self-management**

Self-management of sexual health has always been, and will continue to be, the main mechanism by which most people maintain their sexual wellbeing. In order that individuals can self-manage effectively, high-quality appropriately targeted information and health promotion activities must be provided through both formal and informal routes. Routes for health promotion are covered in the Health Promotion section of this strategy.

#### **Individualised information with some intervention**

There are a number of mechanisms by which individuals can access individualised advice and information. In Highland at present this falls mostly to GPs. However other health professionals are well placed to enable wider and easier access to such information. Nursing professionals such as Health Visitors and Practice Nurses, School Nurses and Community Pharmacists are all well placed in widening choice in access to these services.

#### **Community-based services**

In Highland GPs constitute the major providers of these services. Highland Brook and REACHOUT Highland, both based in Inverness, also provide these services. Highland Sexual Health, with clinics throughout the Highlands, can also provide these services though its main area of expertise lies in specialised sexual health services.

There is major concern, however, that Community-based services are not readily accessible to large numbers of people in Highland. A combination of factors such as lack of childcare, poor public transport provision and attendance at school effectively lock groups of people out of confidential access to community-based health services, including sexual health services. There will be a need to ensure that these services are fully available to all. Provision in more community-based generic health-related settings would free up organisations with the greatest expertise, such as Highland Sexual Health, to concentrate on higher-level services.

#### **Enhanced sexual health and reproductive services**

These services represent a level of service which is in excess of the services covered by the GMS contract. Many GPs currently provide services. Highland Sexual Health provides all enhanced services while REACHOUT Highland provides elements of such services, particularly around HIV testing and pre and post test counselling.

### **Specialist sexual health and reproductive services**

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 service levels as well as services such as specialist HIV treatment and care, contraception and reproductive health services, co-ordination of partner notification, psychosexual medicine and termination of pregnancy.

In Highland, services at this level are largely provided by Highland Sexual Health and this is likely to remain the case. Exceptions are around termination of pregnancy, carried out in Raigmore Hospital, Inverness and Caithness General, Wick and psychosexual medicine, carried out at Highland Sexual Health and at New Craigs Hospital Inverness. Patient choice in accessing such services is through out-of-area referrals.

The National Sexual Health Strategy recommends that the further development of enhanced services should enable specialist 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 will also provide greater choice for patients at a local level.

Specialist services 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 community and enhanced services 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 be able to adopt a more integrated approach to care incorporating the service provision offered within enhanced services.

Development of the service structure will necessitate:

- Development and maintenance, in partnership with Highland Information and Resources Service, of existing sexual health resources;
- Identification, at CHP level, of appropriate human resources to broaden access to basic intervention services including exploration of the potential for delivery of these services in the Community Pharmacy and Nursing settings;
- Confirmation of community-based services in relation to Primary Care Practices and Voluntary Sector services.
- Identification of the most appropriate configuration of enhanced-level services at CHP level (through Primary Care, Highland Sexual Health and voluntary service providers) to enhance patient choice at local level;
- Development of Highland Sexual Health to provide a comprehensive specialist service across Highland in partnership with CHPs and Practices;
- Formulation of a clinical network in sexual health with a clearly identified clinical lead who will be responsible for clinical health services across Highland.

- 5.2. People from the most disadvantaged groups suffer disproportionately from the poorest sexual health. In the past a variety of health and non-health services have been developed to meet the needs of the average person. Sometimes such services do not adequately address the needs of the most disadvantaged, exacerbating the cycle of poor sexual health. There is a real need to embark on service development which starts from the perspective of the most disadvantaged communities, groups and individuals.
- 5.3. Minority groups may have specific sexual health needs. Some gay men and lesbians find their access to sexual health services impeded by assumptions of heterosexuality on the part of professionals dealing with members of the public. People from Black and Minority Ethnic groups and some older people can have specific needs such as a cultural requirement to see a professional of the same gender. Travelling families can often experience difficulty accessing health services which are primarily designed for a static population. Young people may find the style or configuration of sexual health services off-putting. The term “family planning”, in wide use as a traditional service descriptor amongst health professionals, is anachronistic to anyone not intending to plan a family. Shortcomings in service delivery can make what is already a tense and stressful situation for patients infinitely worse and can determine whether people will actually use a service which is theoretically accessible to them.

## Objective 12:

**To introduce, in discussion with all relevant parties, an integrated, structured framework for the delivery of sexual health services**

*Accords with the ethical principles of Accountability, Engagement, Flexibility, Justice, Quality and Realism.*

- 5.4. The National Sexual Health Strategy recommends that, where a health care practitioner is unable or unwilling to provide sexual health services him or herself there should be a requirement on them to provide information and refer patients to alternative, readily-accessible services.

This should not be difficult within cities or large towns or even in more rural settings with multi-practitioner practices. However in some parts of Highland this may constitute a particular challenge, particularly in “single-handed” practices in remote areas where there are significant transport difficulties.

A service cannot be described as “readily accessible” if it is many miles away, there is no (or infrequent, or expensive) public transport by which a patient could reach the service and the patient doesn’t have access to private transport, or the financial resource to pay for the fuel costs of the journey.

## Objective 13:

**To ensure, in consultation between CHPs and health practitioners, that all health practitioners who are unwilling or unable to provide sexual health services have mechanisms in place to provide information and refer patients to readily accessible services**

*Accords with the ethical principles of Accountability, Flexibility, Justice, Quality, Meaningful Relationships and Realism.*

### 5.5. Sexual dysfunction and psychosexual services

While the need to treat both sexual ill-health and reproductive failure has long been recognised, scant regard has historically been placed on helping people, where possible, to have enjoyable sexual relationships. Very often people themselves do not fully recognise difficulties in enjoying sex as being something they can take to their GP, either because of embarrassment at discussing such issues, or because of the belief that nothing can be done. Anecdotally it seems this attitude may be changing where men are concerned. Though there has been a long-standing capacity to deal with erectile problems in men, the much-publicised advent of drugs like Viagra have made men much more aware that help is available.

- 5.6. While psychosexual medicine can be closely related to sexual health issues, psychosexual issues are more likely to manifest themselves as a component of wider mental health issues. This is an issue which, therefore, straddles both mental health services and structures and sexual health services and structures.

There is current provision within Highland for various manifestations of sexual dysfunction and issues requiring psychosexual services at a variety of levels from basic counselling to consultant-led interventions. Provision, however, tends to be patchy. Diverse groups of people may require services in these fields. These may include:

- Female and male victims of rape, abuse, domestic and sexual violence;
- Men and women affected by relationship break-down;
- Those with medical or mental health conditions which impede sexual function;
- Women and men with recent or pre-existing disabilities which impede sexual function;
- People who have problems arising from body image, for example due to obesity or following mastectomy;
- Male or female transsexuals who may or may not wish gender reassignment.

It is important that services to improve the sexual wellbeing of such groups are available, accessible and managed in a joined-up and coherent manner.

- 5.7. Sexual dysfunction and psychosexual difficulties can come upon men and women in the wake of particular events, injuries, illnesses and hospital procedures. At the moment patients who have conditions with a known potential to induce such problems may or may not have their sexual health needs addressed during the course of treatment and rehabilitation.

- 5.8. There appears to be a particularly large population of people who identify as transgender in Highland. International figures on transgender issues would suggest that there should be something in the region of one biological female and ten biological males in the Highlands whose sense of self does not match with their physical gender attributes. Many of these would not be "out". However, the professionals working in this field are clear that greater numbers of people who identify as transgender are already known to various services in the area.

## Objective 14:

**To review, in consultation with the appropriate mental health and sexual health clinical leads, the provision of services around sexual dysfunction, gender identity disorders and other psychosexual issues with a view to providing a Managed Clinical Network, clear lines of referral, appropriate overall clinical leadership and increased awareness of the problems of sexual dysfunction**

*Accords with the ethical principles of Flexibility, Justice, and Quality*

## 5.9. Services for people who may have been raped, sexually abused or exploited

Women, men or children who have been raped or sexually abused have a wide range of linked and complex sexual health needs and are likely to be deeply traumatised and extremely vulnerable. Needs may include:

- Specialised counselling
- Psychosexual therapy
- Forensic examination
- Pregnancy and STI testing
- Emergency contraception, IUCD fitting or termination of pregnancy
- Treatment for STIs
- Surgical intervention/repair of damaged tissue

If there is one area where the service should be absolutely seamless and client led, this is it. The service in Highland, however, is fragmented.

Forensic examination for rape and sexual assault requires to be carried out under circumstances in which the potential for contamination of samples is reduced to an absolute minimum. Northern Constabulary has a specially designed forensic examination suite at Dalneigh in Inverness. As there are no other facilities equipped to this standard in Highland all men, women and children who have reported rape or sexual assault are taken to Dalneigh for forensic examination.

Northern Constabulary contracts with a private company to provide the full range of medical forensic services. Work involving sexual offences is a part of the wider generic forensic medical service with individuals working in a generic capacity rather than specialising specifically in rape and abuse.

The focus in this role is on gathering reliable evidence which will stand up in a court of law. Doctors performing forensic examinations may advise clients to attend their own GP for further health checks, but there are no protocols in place to ensure this happens or to take samples or swabs for sexual health purposes. There is no specialised counselling routinely available for adults who report rape or sexual abuse, though help-line phone numbers would be supplied, and there is no health follow-up. People who do subsequently visit their GPs or attend a sexual health clinic find themselves in another round of swabs and samples.

The situation for children is markedly better as protocols are in place for the involvement of social workers and paediatric specialists in the child protection process.

### Objective 15:

**To explore, in consultation with the Lead Clinician in Sexual Health and Northern Constabulary, the potential for further integration of forensic medicine and sexual health services for people who report rape or sexual abuse.**

*Accords with the ethical principles of Flexibility and Quality.*

## 5.10. Contraceptive services

There is a real and pressing need to reduce the number of unwanted pregnancies in Highland each year and to prevent the continuing spread of STIs. People are more likely to use contraception consistently and correctly if that contraception meets their individual needs. These needs can be thwarted due to issues such as cost, geographical availability and so on. If we are to encourage effective and consistent use of contraception we must lift barriers to its availability and accessibility.

- 5.11. It is important that patients using non-barrier methods of contraception should be aware that this will not protect them from Sexually Transmitted Infections.
- 5.12. Women can become pregnant after unprotected sex or following contraceptive failure. Emergency contraception, taken orally within 72 hours of unprotected sex can prevent pregnancy. Even after this threshold, the insertion of an IUCD can prevent pregnancy. The use of the terms “Morning After” in relation to post-coital contraception may lead some women to believe it can only be used within a much shorter time of unprotected sex and may lead both to unnecessary distress and to unwanted pregnancies.
- 5.13. Clearly where post-coital contraception is used, regular contraceptive methods have failed or have not been used. It is important that emergency contraception is not used to replace regular contraception.
- 5.14. Emergency contraception is available through Highland Sexual Health, from GPs’ surgeries, from accident and emergency departments and from Highland Brook. Pharmacists can sell emergency contraception to women over the age of sixteen. Comprehensive as this coverage sounds, there is a real need to make emergency contraception more widely available in a range of settings, particularly in rural parts of the Highlands where travelling to the point of issue on a timescale which gives a reasonable prospect of effectiveness may be challenging.

### Objective 16:

**To engage with CHPs to ensure provision of the widest possible range of contraception in the widest variety of settings, raise awareness of the efficacy of different contraceptive methods including Emergency Contraception and, where a non-barrier method is being used, promote the additional use of barrier protection.**

*Accords with the ethical principles of Engagement, Flexibility, Justice, Quality, Meaningful Relationships and Realism.*



### 5.15. Unwanted pregnancy and termination

Unwanted pregnancy is a deeply traumatic event for those involved whether the pregnancy results in delivery or termination.

5.16. Unintended pregnancy can arise as a result of:

- underestimation of risk;
- impairment of judgement; perhaps through alcohol or drugs;
- mismanagement of or accidents with contraception;
- rape

Unintended pregnancy can be a real disaster for many women, particularly younger women who may be deeply traumatised and whose mental health may be at risk. Women who require termination of pregnancy form a very vulnerable client group and must be treated with the utmost professionalism and sensitivity. Highland's termination service has adopted the RCOG guidelines "Care of Women Requesting Induced Abortion".

Timing is critical in termination of pregnancy. It is important that once a woman and her two medical advisors have determined that ending the pregnancy is the most appropriate course of action under the terms of the Abortion Act 1967, this happens as soon as is possible. Depending on the woman's stage of pregnancy, delay can mean the difference between medical and surgical termination, between early and late termination and, in some cases, may rule out termination altogether.

#### Objective 17:

**To ensure that appropriate counselling and support are available to women experiencing unintended pregnancy and that all interventions leading up to termination of pregnancy are progressed as quickly as possible in full accord with relevant national guidelines.**

*Accords with the ethical principles of Accountability, Quality and Realism,*

*Accords with the views of most of those who participated during the pre-consultation Engagement process but **conflicts** with the views of some faith groups who believe, variously, that termination should not be carried out or should be restricted to particular groups, e.g. rape victims.*

### 5.17. Sexually transmitted infections – diagnoses and treatment

There is a nationally reported increase in diagnoses of sexually transmitted infections in Scotland. Most STIs can be cured if treated early. Where there is no current cure, such as in relation to HIV, early diagnosis and treatment are vital in improving the lives of people living with a long-term illness. The effects of STIs which remain untreated can range from death in the case of illnesses such as HIV/AIDS, through to infertility and ectopic pregnancy in the case of Chlamydia.

However many STIs are also silent in their early stages, presenting no early symptoms in most people. HIV and Chlamydia are two examples of STIs which may be silent in their early stages. There is a real need to raise awareness of STIs and the need for people to come forward for testing, even where there may be no symptoms. There is also a need to make testing as simple, straightforward and accessible as possible. The geographic and demographic difficulties alluded to elsewhere in this strategy make provision of access to STI testing particularly challenging in Highland.

The National Demonstration Project on Sexual Health, Healthy Respect, has developed Chlamydia testing kits which can be picked up free in a variety of outlets (such as pharmacies, colleges, record shops, sports venues, etc.). Similar kits may soon be available to cover a slightly wider range of STIs. The use of such kits has obvious potential to increase the accessibility and availability of testing and would therefore be likely to improve uptake of testing for STIs.

## Objective 18:

**To identify how uptake of STI testing can be improved with particular reference to:**

- **Increasing availability of testing wherever possible**
- **Exploring the options for more pro-active advocacy**
- **Recommending, on an opt-out basis, HIV testing to all GUM attendees who are not already known to be HIV positive and who present with a new STI**
- **Identifying further within the population where testing for specific STIs should be offered routinely on an opt-out or opt-in basis and determining in which settings this should take place along with provision of appropriate support and counselling**
- **Identifying laboratory resource and cost implications likely to arise from increased provision of STI testing**
- **Identifying the costs of these approaches and weighing these against the cost of subsequent health care to treat STIs which are not diagnosed at an early stage**

*Accords with the ethical principles of Accountability, Flexibility, Justice, Quality, Meaningful Relationships and Realism.*

5.18. The foregoing should form the “gold standard” in sexual health services for all people in Highland regardless of age, gender, disability, ethnicity, religious belief or sexual orientation. However there are some groups within the community who have specific additional needs.



### Overall Strategic Aim

***to empower young people in developing a considered, responsible, confident and positive approach to sexuality, sexual health and relationships enabling them to maximise their own and their partners' sexual wellbeing and minimise adverse sexual health outcomes by***

- ***Seeking to delay first sexual intercourse and reduce number of sexual partners;***
- ***Seeking to ensure that, where sexual intercourse does take place, young people take appropriate precautions against the possibility of pregnancy and/or STIs;***
- ***Where unprotected sexual intercourse has taken place, seeking to ensure the availability of services such as emergency contraception, STI advice/diagnosis/treatment/counselling, advice/counselling on options in the case of pregnancy.***

6.1. This strategy adopts a clear view on what it seeks to achieve in relation to the sexual health of young people.

In this context “young people” are primarily regarded as under twenty. There is no lower age limit. The precursors to good sexual health – self-esteem, respect, parent/child communication, religious, cultural and media influences, aspirations for the future – start to make an impact from a child’s earliest days. We must also be aware that very young children are sometimes victims of sexual abuse. It is important, therefore, that work around relationships with other people, respect and self-esteem, names for body parts, discussion of parts of one’s body which other people shouldn’t touch and so on is carried out with very young children.

#### **Early sexual activity**

Just over a third of young people are sexually active before they reach the age of sixteen. For some young people sex, even at a relatively early age, is fulfilling and brings a sense of enjoyment and wellbeing. For others, however, early consensual sexual activity is an unhappy and regretted experience and some will experience negative sexual health outcomes such as unintended pregnancy and acquisition of STIs.

The only foolproof way of preventing pregnancy and Sexually Transmitted Infections is abstinence from sexual intercourse and, in the case of some STIs, abstinence from various associated sexual practices such as oral sex. The Highland Sexual Health Strategy will employ methods which, as primary tools in promoting sexual wellbeing, seek to encourage young people to delay their first experience of sexual intercourse. The evidence from other northern European countries shows that this is an achievable and realistic aim.

However, we also recognise that some young people will continue to experience sexual intercourse at a relatively early age. No country in the world has been able to eliminate early sexual intercourse and it would be unrealistic to expect that we are likely to do so. Sexual intercourse in the adolescent years can be viewed as falling within the normal spectrum of adolescent development and behaviour.

Young people who have sexual intercourse at a relatively early age may or may not have chosen to become sexually active. For most this will be their own choice – something they may see as part of the experience of growing up. But some young people may be raped, abused or coerced into inappropriate sexual relationships.

In either case it is important that sexually active young people are aware of the ways in which they can reduce levels of risk. Where young people have been raped or sexually abused access to such services as counselling, provision of emergency contraception (in the case of young women) and STI testing will be of particular importance. For those in consensual relationships there is clear evidence that the use of condoms and other barrier methods are vital in reducing the risk of STI transmission and it is imperative that young people have reliable access to a full range of barrier methods. In order to reduce the number of unintended pregnancies young women who are sexually active need to have reliable access to contraceptive advice and services.

There is no point in young people knowing how to reduce their levels of risk if services to enable them to put this knowledge into practice are not available and accessible. We must seek to ensure that services which are appropriate to the needs of this group are developed and improved.

Finally, we must ensure that where young people are suffering the physical, mental or emotional consequences of forced, unplanned or regretted sexual activity they are aware of the options available to them. In addition to the services outlined above, young women should be aware of the range of services available to them in the case of unplanned pregnancy including the option of termination of the pregnancy where the terms of the Abortion Act 1967 are met. We must ensure that appropriate, accessible services are provided.

Clearly, we would have a major problem if the aim to encourage delay in first sexual intercourse and the aim to provide appropriate education, information and services for those who are sexually active were mutually incompatible. There is no way to identify which young people are likely to become sexually active early and we cannot, therefore, pluck this group out to teach them alone about issues around risk reduction. If we are going to teach about risk reduction we must teach it to all in order to hit the group of young people who need to know. In any case, almost all people do eventually become sexually active and it is important that people are aware of what they can do to make sex as enjoyable and trouble-free as possible when the time comes.

To some it seems obvious and logical that discussion of sex will encourage young people to try it for themselves. Similar arguments are often made in relation to discussion around homosexuality. Many feel that the provision of any sexual health service aimed at young people has the effect of sending the wrong message – a message which says, effectively, that sexual hedonism is OK. This, some seek to argue, puts increased pressure on young people who might otherwise wish to abstain from sex.

The evidence shows beyond any reasonable doubt that such fears, though genuine, are entirely misplaced. Neither teaching about sex and relationships, nor overt promotion of sexual health services appears to lead to early sexual intercourse. We can, therefore, be confident that measures designed to reduce risk will not conflict with measures intended to encourage delay in first sexual intercourse.

## 6.2. The wider context

It is sometimes assumed that young people can be persuaded to abstain from early sexual activity through school-based relationships and sex education. While education clearly has a part to play, it is important that we don't expect relationships and sex education to do the job on its own.

There is unlikely to be a single magic bullet which can encourage a more considered approach to sexual activity. We need to use a variety of techniques if we are to encourage young people to delay their sexual debut.

Young people are born into certain circumstances which neither they nor this sexual health strategy can alter. If they are born into poverty and spend their lives in poor housing and social conditions they are twice as likely to suffer from poorer sexual health than those born into a more prosperous setting. If they are born into a harmonious family with a strong value base who discuss issues around sex and relationships in an open and non-judgmental way they are likely to fare better than young people from abusive, neglectful or morally judgmental family backgrounds. If they have high levels of cognitive and emotional maturity and good levels of educational goals and attainment, their sexual health is likely to be enhanced. It has been said that the best contraceptive for teenagers is aspiration.

Measures which, on the face of things, have nothing whatsoever to do with sex and relationships nevertheless have great potential to improve young people's sexual health.

Government, Scottish Executive, Highland Council and other organisations' policies to tackle poverty, improve housing and raise young people's levels of educational aspiration and attainment should all serve, if successful, to improve sexual health and encourage delay in first sexual intercourse.

## 6.3. The role of parents and carers

The role of parents or carers is central to a young person's life. This applies every bit as much to promoting good sexual health as it does to any other area. Recent years have seen an upsurge in interest in the relationship between parent-child communication and sexual health outcomes. It is clear that the nature of communication between parent or carer and young person is a key factor in influencing the age at which young people will first have sexual intercourse and the level of benefit or harm they experience from their choices around sex and relationships.

A parent's influence over a young person's sexual health probably begins before birth. They involve the attitudes and values in the household, willingness to talk, openness of approach to issues around relationships and sex and much, much more. When parents hold their babies for the first time they are already sending messages which will begin to shape a whole range of aspects of that baby's development, including relationships and sex.

As the years go by parents and carers can influence positive sexual health outcomes by being open, non-judgmental, willing to discuss a wide range of issues and available to answer questions honestly as they arise. They can work to help their children feel valued and develop self-respect and respect for others and to recognise the differences between mutually beneficial relationships and those which may be exploitative or coercive.

On the face of it, none of this has anything to do with sexual health and yet these predominantly non-sexual interactions may do more to influence sexual health than any amount of specific information, advice and discussion on relationships and sex later on. That is not to suggest that such specific information does not matter. It matters greatly. But if the building blocks are already in place in terms of good general parenting and caring, the benefits are all the greater.

Parents and carers in the Highlands overwhelmingly recognise the importance of discussing sex and relationships with young people but few cover the range of subjects they believe should be covered and many find it difficult to discuss these issues, particularly as young people move into their teenage years. Parents and carers wish more help, advice and guidance to be available in discussing sex and relationships.

#### 6.4. Young people with special needs

Sex and relationships can be a particularly difficult area for parents and carers of young people with special needs. In particular the parents and carers of young people with learning disabilities can have very specific concerns over their children's sexual health. Parents and carers of both boys and girls can be concerned that their children may be vulnerable to sexual exploitation and harm or that they may display inappropriate sexual behaviours. There are also concerns over practical issues such as personal hygiene, coping with menstruation and so on.

If young people with special needs are to be encouraged to develop positive and fulfilling emotional and sexual relationships as they move into adult life it is particularly important that parents and carers are given strong support to help their children with issues around growing up and emerging sexuality.

### Objective 19:

**To seek to establish opportunities for supporting good parenting and caring in relation to the young person's sexual health needs**

*Accords with the ethical principles of Engagement, Quality and Realism*

#### 6.5. The role of schools

A role has been assumed for schools in relation to sex education over many years but until relatively recently this has covered little more than issues around puberty, menstruation and conception. In order to address HIV and AIDS, however, other aspects of sexual health, including sexually transmitted infections and condom use have also been covered. Over recent years the evidence-based SHARE programme has been introduced to third and fourth years of secondary schools in the Highlands. As well as seeking to increase knowledge and competence around relationships and sex, this provides an important element of education on the skills around relationships and sex: for example how to say "no" to sexual intercourse while maintaining a relationship, or how to negotiate condom use within a relationship. SHARE moves sex education away from the traditional biological and towards a view of sex which is firmly grounded within the context of dealing with relationships and emotional involvement.

There are three main strands of opinion around relationships and sex education in schools.

- Relationships and sex education should not be covered within the school curriculum at all as this is the proper domain of parents;
- Relationships and sex education should be covered within schools, but should focus solely on abstaining from sexual intercourse and should not discuss contraception or condom use;
- Relationships and sex education should be covered within schools in partnership with parents using a wide and comprehensive programme including relationships, emotional issues, sexual orientation, abstinence, contraception, condom use and teaching the skills (such as negotiating within a relationship) young people may need if they are to improve their sexual health.

Most parents particularly welcome school input, regarding relationships and sex education as a shared responsibility.

Parents do recognise the importance of their own role in discussing sex and relationships with their children. Around a fifth of parents, however, never discuss relationships and sex with their children and, of those who do talk to their children about these issues, the extent of issues covered was “worryingly low”. Relying on parents alone to deliver relationships and sex education would mean a significant minority of young people receiving sex and relationships information solely from friends and the media while the majority would be left with large gaps in their knowledge, understanding and skills base.

Parents who take the view that they, along with the inevitable input of the media and their children’s peer group, should be the only sources of information about relationships and sex have the right to withdraw their children from school-based relationships and sex education.

The second strand of opinion – that school-based relationships and sex education should focus entirely on abstaining from sexual intercourse and should not discuss contraception or condom use is also a minority viewpoint. While most of those who attended the Faith Groups meeting during the pre-consultation phase of this strategy felt that school-based sex and relationships education should only cover abstinence until marriage, this view was not supported in any of the other scoping or focus group work undertaken during the pre-consultation phase. It is flatly contradicted by the independent research work which has been undertaken with parents in Highland and elsewhere.

The available evidence demonstrates no benefit from abstinence-only education and some studies indicate that abstinence-only sex and relationships education may be counter-productive, increasing rates of teenage pregnancy amongst the female partners of boys who have been exposed to it. National policy is that relationships and sex education should be wide-ranging and should cover a broad range of sexual health issues.

- 6.6. However, questions remain as to whether the work currently being carried out and built upon in schools is sufficient to meet the needs of young people. In the course of scoping and focus group meetings during the pre-consultation phase of developing the sexual health strategy, there were frequent references to the need to begin programmed sex and relationships education earlier.

Some specific relationships and sex education is already carried out in most primary schools. Highland Council’s Sexual Health Education Guidelines sets out the issues to be covered at each stage and associated assessment levels. It is clear, however, that not all primary schools adhere to all aspects of the guidance, and anecdotal evidence is that their implementation at primary school level is patchy.

6.7. The provision of sex and relationships education has broadened out over the years. Older members of the community will remember when sex education, such as it was, was firmly in the biology teacher's domain. For many years now, sex education has been part of Personal and Social Education, delivered by Guidance Teachers in secondary schools and Health Education in Primary schools.

Several factors including the changing role, status and function of school nurses, and the enthusiastic adoption in Highland of both Integrated Community Schools and the Health Promoting Schools initiative will lead to further broadening of the setting for discussion around sex and relationships. As a result more individuals from a variety of different disciplines are likely to become involved in delivering or reinforcing aspects of sex and relationships education to young people. It is vital that all those who may be involved in work of this nature are motivated and supported to promote sexual health and are effective in reducing inequalities in sexual health within minority groups.

## Objective 20:

### **To promote and assist compliance with Highland Council's Sexual Health Education Guidelines as part of lifelong learning**

*Accords with the ethical principles of Accountability, Flexibility, Quality and Realism,*

*Accords with the views of most of those who participated during the pre-consultation Engagement process but **conflicts** with the views of some representatives of faith groups who would prefer that young people were taught only to abstain from sex until after marriage.*

6.8. As the nature of the school community changes, more external agencies and organisations are likely to become involved in aspects of sexual health and sex and relationships education in a school or Integrated Community School setting. Some of these external agencies will be partner agencies to Highland Council, for example, Highland NHS. Others may be voluntary sector agencies such as Highland Brook or REACHOUT Highland.

It is important that there is clarity in recognising the standards to which professionals in partner agencies operate and ensuring they are not impeded in their professional capacities. It is also important that those working with children are carefully checked in relation to appropriate levels of disclosure of offences which may make working with children inappropriate. Where external groups are concerned it is important to ensure that the messages they are delivering around sex and relationships are consistent with best practice. In Highland, the relevant Quality Assurance Officer in the Education, Culture and Sport Department of Highland Council has carried out substantial work in drawing up protocols for both partner agencies and external agencies working within schools or in the context of New Community Schools.

## Objective 21:

### **To establish and monitor mechanisms for ensuring compliance with protocols for agencies working within the Integrated Community Schools context**

*Accords with the ethical principles of Accountability, Engagement, Flexibility, Quality, Meaningful Relationships and Realism.*

## 6.9. Young people who are lesbian, gay, bisexual or transgender (LGBT)

A significant minority of young people self-identify as lesbian, gay, bisexual or transgender and their journey through adolescence can be a particularly challenging one. At present, sex and relationships education does not provide LGBT young people with the information that is relevant to issues they may be addressing and is therefore not inclusive or responsive to their needs. In order to minimise the risk of alienating young LGBT people and maximise the effectiveness of sexual health promotion within an education setting, it is important that professionals don't make assumptions about an individual's gender identity or sexuality.

LGBT young people frequently experience bullying, discrimination and isolation. For many, other aspects of health, particularly mental health, can be adversely affected. The invisibility of LGBT relationships issues in the context of sex and relationships education allows bullying and discrimination to flourish and further isolates young LGBT people.

### Objective 22:

**To identify the effects that homophobic discrimination has on the school population and introduce effective ways of combating homophobia and heterosexism (the assumption that everyone is heterosexual) within schools' anti-bullying strategies**

*Accords with the ethical principles of Accountability, Engagement, Flexibility, Justice, Quality, Meaningful Relationships and Realism.*

6.10. There are two distinct schools of thought around education about LGBT relationships in schools:

- LGBT young people have as much right as young heterosexuals to education which recognises, respects and meets their needs;
- Discussion of LGBT issues in schools will encourage young people who would otherwise be heterosexual to experiment with same-sex relationships and will cause those who are experiencing nothing more than a same-sex adolescent crush to assume LGBT personas, practices and behaviours.

Despite exhaustive research there is no evidence to support the opinion that content or tone of relationships and sex education in schools can influence the sexual orientation of an individual. Sexuality and sexual orientation cannot be viewed as lifestyle choices.

Our aims for young people's sexual health are set out in paragraph 6.1. These are our aims for all young people in Highland. It is difficult to see how any of these aims can be achieved through school-based sex and relationships education in relation to LGBT young people if it fails to specifically acknowledge and address the needs of this group.

### Objective 23:

**To ensure that all staff are equipped to tackle homophobia and heterosexism and that school based relationships and sex education is equally appropriate, respectful and responsive to the needs of lesbian, gay, bisexual, transgender and heterosexual young people**

*Accords with the ethical principles of Accountability, Flexibility, Justice Quality and Realism*

*Accords with the views of most of those who participated during the pre-consultation Engagement process, but **conflicts** with the views of some of the Faith groups participants who felt that discussion of homosexuality is inappropriate in a school setting and may lead young people who are going through a period of confusion in relation to sexuality to become homosexual.*

#### 6.11. Young people with Special Needs

Young people with special needs may be educated in mainstream or specifically designated education settings, or a mixture of the two. The increased pressure of specialised teaching around life skills in relation to some of these young people can sometimes lead to sex and relationships issues being largely overlooked. The very explicit nature of some work around sex and relationships, particularly where young people have learning disabilities, may inhibit teachers in covering this issue in a way young people can understand.

### Objective 24:

**To ensure that young people with special needs receive the information, education and advice they need to prepare them for an adult life encompassing positive and happy relationships, including sexual relationships**

*Accords with the ethical principles of Engagement, Flexibility, Justice and Quality,*

#### 6.12. Young people who do not attend school

A minority of young people do not attend school regularly. There can be a variety of reasons for this:

- long-term or recurrent illness
- truancy
- exclusion
- parents' preference that the child does not attend school, for example in the case of parents who prefer home education.

Young people in several of these categories are, statistically, at particular risk of poor sexual health and it is, therefore, particularly important that young people who are not regular school attendees are specifically targeted to ensure that they receive appropriate sex and relationships education.

### Objective 25:

**To devise appropriate mechanisms for targeting sex and relationships education at young people who are not regular school attendees.**

*Accords with the ethical principles of Engagement, Flexibility, Justice, Quality, Meaningful Relationships and Realism.*

### 6.13. Young people who are withdrawn from sex and relationships education

A small minority of parents may wish to withdraw their children from sex and relationships education, as is their right. Dialogue between parents and schools, enshrined within the guidelines developed by Highland Council, should be such that parents are well informed about the nature and scope of sex and relationships education. This will minimise withdrawals by parents who may have simply misunderstood or misinterpreted the information their children are likely to receive. It is important that, wherever possible, young people withdrawn from school-based sex and relationships education by their parents nevertheless have access to appropriate information to allow them to protect their sexual health. Initiatives could include: packages aimed at parental delivery, training of individuals who can offer sex and relationships education from specific cultural or religious perspectives, provision of relevant resources, mechanisms similar to those used in relation to children who are not regular school attendees.

#### Objective 26:

**To ensure parents who do not wish their children to receive sex and relationships education in school are encouraged to think about how they will ensure their children's sex and relationships education needs are met and to be able to offer a range of appropriate support**

*Accords with the ethical principles of Engagement Flexibility, Justice, Quality, Meaningful Relationships and Realism.*

### 6.14. The role of the community

The wider community also has a role in promoting a young person's sexual health and wellbeing. Community input can range from helping to establish the wider social and cultural context within which a young person's sexuality develops, to health promotion around sexual health. The wider community, and a variety of communities of interest are also important in supporting young people and their parents.

The way in which communities view young people is critical in many of the pre-cursors to good sexual health and delay in first sexual intercourse. Where the community involves and values its young people, the self-esteem of young people is likely to be improved and sexual health is, therefore, likely to be better also.

#### Objective 27:

**To engage with a wide variety of agencies and organisations to promote a positive view of young people and to encourage young people's involvement in their communities.**

*Accords with the ethical principles of Engagement, Quality, Meaningful Relationships and Realism.*

### 6.15. Helping to support the young person's development

There is clear evidence that young people who have the opportunity to develop a strong values base from which to view sex and relationships are more likely to delay first sexual intercourse. For most young people values will come from the family and, as they get older, from their community and their peer group.

For young people who are active members of faith groupings religious faith may be of great importance in helping the young person's moral development. The various faiths and denominations, therefore, have an important part to play in the moral development of the young people who make up their own congregations.

However attempts to superimpose specific faith-based moralities onto young people who have no natural affinity to those views appear to be counter-productive.

For the majority of young people who are not active members of faiths or denominations there are also many non-faith groups and organisations working with young people. These groups, which as part of their core work concentrate on respect for others, developing self-esteem, providing young people with opportunities to develop and fulfil aspirations are no less important in enabling and equipping young people in the development their own moral perspectives.

This may be particularly the case for young people who have little recourse to help, support and advice from other quarters – those who are disaffected, who do not get on well with their parents or who are, for whatever reason, not regular school attendees.

There is also a great need for sensitivity to the particular circumstances of individual young people. Young people who are LGBT are seven times more likely to report a serious suicide attempt than are heterosexual young people. Everyone needs to reflect on how the messages they deliver around sex, sexuality and relationships may affect the pressures to which an individual young person may be subjected.

### 6.16. Supporting and building community capacity

The importance of community development work around young people's sexual health cannot be overstated. Agencies with specific expertise in sexual health and groups and organisations (whether faith-based or not) need to pull together to fulfil the common aim of maximising and improving young people's sexual health.

Specific community development initiatives can be closely targeted towards young people from the most deprived communities; those who would be likely to have the poorest sexual health. Community development initiatives can often be more youth-friendly than school-based interventions could be and can have greater impact on groups such as young men, young people who are in trouble with the law and young people with substance-abuse problems.

## Objective 28:

**To work with young people's organisations to encourage, promote and support evidence-based community development around sexual health targeted at the most disadvantaged communities**

*Accords with the ethical principles of Accountability, Flexibility, Justice, Quality, Meaningful Relationships and Realism.*

### 6.17. The peer group

People are strongly influenced in their approach to various aspects of life by their peer group. Young people's attitudes to sex and relationships can be influenced by peer pressures at a time when fitting with their peer group is a significant objective for most and a real challenge for some. Peer influences can have a variety of effects on young people. Sometimes young people can exaggerate their level of sexual experience because they feel this is the acceptable position within the group. This effect can be self-perpetuating. If a few young people exaggerate their level of experience then it will appear to others that they are being left behind. For some young people misunderstandings of this nature may lead to early and regretted sexual intercourse or to other ill-considered and potentially damaging sexual encounters.

There is no evidence that peer pressure can lead young people to change their sexuality, but there is some evidence that peer pressure may play a part in determining how LGBT young people perceive their sexuality.

### 6.18. Access to services

The geography and demographic circumstances in Highland which, in turn, lead to immense transport difficulties, make provision of services in the area particularly problematic. This is particularly the case in relation to sexual health services where confidentiality and often anonymity are key issues.

Access to services is particularly problematic for young people. Many school-aged young people in Highland are bussed to and from their rural homes to school. If they require to leave school during the school day to visit a doctor, they will have to bring a letter from a parent. If they need to visit a doctor outwith school hours, they will often require a parent to drive them to any such appointment. Many young people in the Highlands are effectively locked out of confidential access to all health services, not just sexual health services.

6.19. The manner in which improved access to sexual health services for school-aged young people can be improved will vary widely from area to area. In cities and larger towns where young people have choice in service provision, services within a school setting are not usually popular, particularly where they are specifically identified as sexual health services. However, there are some areas where it is difficult to see how access to appropriate services could possibly be provided other than in a school setting, because the school may be the only public building for miles around or because school rules may prevent any young person in the first four years of secondary education from leaving the premises during the school day, including lunchtimes and breaks.

As with so much around service provision in Highland, the sheer geographic and demographic diversity of the area means that a one-size-fits-all approach is not only inappropriate in theory, but impossible to implement in practice. Development of mechanisms to ensure that school-aged young people do have realistic access to confidential services must be locally led. In particular, where service provision needs to be within a school building, perhaps under the auspices of Integrated Community Schools, it is important that all appropriate stakeholders are fully involved in decision-making. Decisions made locally can then be incorporated into Community Plans and Local Health Plans.

## Objective 29:

**To identify and develop mechanisms to ensure that all young people have full access to the confidential services to which they are entitled under the terms of the Fraser Guidelines**

*Accords with the ethical principles of Accountability, Flexibility, Justice, Quality and Realism*

*Accords with the views of most of those who participated during the pre-consultation Engagement process, but **conflicts** with the views of some of the Faith group participants who felt that parents should always be informed where young people attempt to access sexual health services.*

## 6.20. Confidentiality

Services which place a high premium on confidentiality and where the young person knows their confidentiality is assured are the cornerstone in the drive to improve young people's sexual health. The research evidence in relation to young people's confidentiality is clear and unequivocal. Young people's rights to confidential access to sexual health services are laid out in the terms of the Fraser Guidelines and a more general right to privacy is set out within the Human Rights Act.

Clearly, confidentiality can never be absolute either for adults or for young people and there will be occasions where maintaining confidentiality may not be in a young person's best interests. A minority of sexually-active teenagers may be involved in coercive or exploitative sexual relationships and may require protection from harm.

### Objective 30:

**To build on evidence from Healthy Respect and in conjunction with all relevant stakeholders develop guidance on confidentiality/disclosure of information for use by all service users and for all relevant health, social care and education staff.**

*Accords with the ethical principles of Quality, Flexibility and Accountability*

*Accords with the views of most of those who participated during the pre-consultation Engagement process, but **conflicts** with the views of some of the Faith group participants who felt that young people under the age of 16 should not be able to access sexual health services without their parents' consent.*

## 6.21. Looked after and accommodated young people

The sexual health of young people who do not live with their parents but are looked after under the supervision of Local Authorities is known to be particularly poor and requires special mention.

These young people, who may be in foster care or residential care, have often suffered very disrupted lives. The range of circumstances that have resulted in them being unable to continue living with their original families can leave young people traumatised or with low self-esteem, disrupt their education and deprive them of aspiration for the future. Factors of this type are known to have a profound impact on subsequent sexual health.

Foster carers and staff working in residential settings can sometimes feel uncertain in delivering corporate parenting around a young person's sexual health. This can be a sensitive enough issue for parents to handle with their own children. How much more difficult it is for foster carers and for both professional and domestic staff in residential care settings in light of the knowledge that they are dealing with someone else's children? In addition, carers may not always be fully aware of children's backgrounds. If sexual abuse has formed part of the young person's background, discussion of sexual health may be particularly traumatic for the young person.

Looked after and accommodated young people may also be in particular need of the services offered by external agencies in order to secure their sexual health.

### Objective 31:

**To ensure that foster carers and staff dealing with young people in residential settings receive appropriate and comprehensive training to fulfil their roles in relation to young people's sexual health.**

*Accords with the ethical principles of Flexibility, Engagement, Justice, Quality, and Realism*

## 7. Specific groups other than young people

### Overall Strategic Aim

*Assess and address the specific sexual health needs of particular communities of interest, including people with disabilities, older people, the LGBT communities, commercial sex workers, people who are involved in substance abuse, prisoners, ethnic and cultural minorities and homeless men and women.*

#### 7.1. People with disabilities

The term “disability” covers a wide spectrum of conditions but a very small part of any individual’s identity. People with disabilities are people first and foremost and have the same range of basic needs and aspirations as anyone else. The only point at which the disability should become significant is in the measures that may be required to allow people who have disabilities to take advantage of those rights and opportunities.

Amongst these needs and aspirations are those around relationships. Like anyone else, most men and women who have disabilities aspire to have close personal relationships including sexual relationships. The benefits of good sexual relationships are the same as they would be for anyone else.

Some forms of physical disability can also affect sexual function and measures to address this are outlined under Objective 14.

It is important that sexual health advice, guidance, support and services are available to all. This means providing information and support materials in a variety of formats including tape and low literacy materials. It also means ensuring that all services are both physically accessible and feel accessible, by developing and maintaining a warm and welcoming ethos.

### Objective 32:

**To work across agencies to encourage broad societal understanding of the rights of disabled people to have the same opportunities as everyone else including those around sexual health**

*Accords with the ethical principles of Accountability, Engagement, Flexibility, Justice, Quality, Meaningful Relationships and Realism.*



## Objective 33:

**To develop specific health promotion interventions for people with learning disabilities, their parents, carers and the professionals working with them, to improve knowledge of sexual health and sexual health services and to enhance decision-making and negotiating skills**

*Accords with the ethical principles of Engagement, Flexibility, Justice, Quality and Realism.*

Sexual health can be a challenging area for both the person with disabilities and carers and professionals who support him or her. This may particularly be the case for women and men with learning disabilities.

People with learning disabilities are clear about their right to develop relationships of their own choosing. The Human Rights Act gives people the right to private and family life. During discussions facilitated by the Health and Happiness project in the Highlands learning disabled people accepted that their choices would not always serve them well but pointed out that the same applies to people without learning disabilities. Many people with learning disabilities report being prevented or hindered in this area by the well-meaning people who support them.

Many parents, carers and professionals, on the other hand, worry that the person they are supporting may be vulnerable to exploitation and abuse and they can often be correct in that assessment.

It is important that the rights of people with learning disabilities to develop relationships including sexual relationships are upheld and reinforced. It is also important, however, that people with learning disabilities are properly protected from abusive or exploitative relationships.

### 7.2. Older people

The general societal assumption that sexual health is predominantly an issue for young people creates particular difficulties for older people. Promotional materials tend to portray young people and this makes an already difficult situation, where many older people have been brought up not to discuss sexual matters, much worse.

The reticence of older people in discussing sex and relationships is often matched by a reticence amongst those professionals working with older people to raise sexual matters with them. This makes the standard length of a consultation with the GP particularly problematic as neither party is likely to be able to raise or properly discuss sexual difficulties during the time-frame.

Older people can find access to services difficult and daunting. Confidentiality in the provision of sexual health services is often viewed as an issue affecting young people. Older people, however, may be as affected by concerns over confidentiality. Providing a choice of at least two service providers at each service tier as described in paragraph 5.1 may be of particular importance to older people who may, over the years, have become familiar with their GP to an extent that makes them particularly uncomfortable about discussing sexual health. It is also important for those who may be concerned about explaining their presence in the waiting room to neighbours or relatives.

## Objective 34:

**To raise the profile of sexual health for older people by provision of appropriate materials and encourage professionals dealing with older people to raise issues around sexual health sensitively but pro-actively**

*Accords with the ethical principles of Engagement, Quality and Realism.*

### 7.3. People who are Lesbian, Gay, Bisexual, or Transgender (LGBT)

Accessing sexual health services can be difficult and embarrassing for people who are heterosexual but the picture is even worse for those who do not identify as heterosexual. LGBT people are likely to present later in an illness when treatment is potentially more difficult.

There has been a focus over recent years on HIV risk for gay men.

While this risk is real and profound, concentration on HIV has had the effect of detracting from other sexual health issues affecting the LGBT community. In particular the risk for lesbians from STIs is poorly understood, as are sexual health issues for transgender people. There is limited targeting of sexual health information (apart from issues around HIV/AIDS) towards the LGBT community. There appears to be a recent increase in risk-taking sexual behaviour in gay men. Strategies to redress these issues are encompassed within the main text of this Draft Strategy.

There is continuing concern over the incidence of HIV in gay men. Though more cases of HIV have been reported arising from sexual intercourse between men and women in Highland than from sexual intercourse between men, the fact that there are many more heterosexual people in Highland than there are gay and bisexual men means that, proportionately, there is still a far higher relative rate of infection in men who have sex with other men. Gay and bisexual men are clearly at greatest risk from HIV and yet men living in Scotland who are gay and bisexual are less likely to test for HIV than gay and bisexual men living in other parts of the UK. Highland Sexual Health and REACHOUT Highland both pay particular attention to the emotional needs of gay and bisexual men who have HIV or AIDS and it is important that this holistic approach to gay and bisexual men's sexual health is maintained.

There appears to be a relatively large number of transgender people living in Highland. Many health professionals still confuse transgender issues with issues around sexual orientation rather than understanding gender identity as an entirely separate issue. Just as people whose own perception of their gender matches their physical characteristics may be attracted to people of their own gender, the opposite gender or to people of either gender, so it is with people whose perceptions of their gender do not match with their physical characteristics. Issues of discrimination and prejudice are a particularly common experience for transgender individuals and their sexual health needs can often be ignored.

The Stonewall organisation has been working on such issues with Scotland's LGBT community through their INCLUSION project. This covers three main strands:

- Challenging homophobia and transphobia
- Improving accessibility and appropriateness of mainstream services
- Development of specialist support services

#### Objective 35:

**To acknowledge the findings of the INCLUSION project in relation to improving services for the LGBT communities and to identify ways of improving targeted interventions, accessibility and appropriateness of services for LGBT people in Highland.**

*Accords with the ethical principles of Engagement, Justice, Flexibility, Quality and Realism.*

### 7.4. Commercial sex workers

As with any other part of the country, some men and women in Highland sell sex commercially. Some of those who trade sex do so for cash. Many travel outwith the area to work but a few do work regularly in the area. The bartering of sex for alcohol, drugs, goods or accommodation appears to be more common than cash transactions for those who trade in sex in the area. The commercial sex industry operates throughout Highland and men and women who are prepared to trade in sex can be found in most communities.

Clearly it is vital that barrier contraception is made freely available to women and men working in the commercial sex industry. Encouraging this group to have regular testing for STIs is also very important.

In addition, as hard cash often doesn't change hands, many of those trading sex commercially in exchange for goods and services may not self-identify as prostitutes. Health promotion messages and sexual health services specifically marketed at prostitutes may, therefore, miss their mark to a great extent.

The family of a commercial sex worker is rarely aware of how (s)he makes his or her living and this makes confidentiality particularly important. There is often a reluctance to visit GPs for sexual health services due to the embarrassment of (for example) asking for regular supplies of very large quantities of condoms.

If services are judgmental, unwelcoming and there are doubts about confidentiality, people will simply not use them. Word of mouth is the usual mechanism by which men and women establish whether the tone and style of a service is appropriate to their needs.

### Objective 36:

**To explore mechanisms for increasing the availability of barrier contraception, STI testing and other sexual health services aimed specifically at men and women working in the commercial sex industry in welcoming, confidential and non-judgemental settings.**

*Accords with the ethical principles of Engagement, Flexibility, Quality, Meaningful Relationships and Realism*

#### 7.5. People who are involved in substance abuse

There are clear and strong links between substance use and abuse particularly, given its prevalence in a social setting, alcohol use, and sexual health. People drink alcohol to reduce their social inhibitions. Social inhibitions tend to be a key factor for many in preventing casual sex so reductions in inhibitions tend to go hand in hand with an increased likelihood of casual sex. Even moderate use of alcohol can be held accountable for casual sexual encounters. Over a quarter of 16 - 24-year-olds in Highland have had casual sex in the previous year as a result of drinking alcohol. The same issues apply to many manifestations of drug misuse.

Use of alcohol and drugs also has the potential to impair judgement, so where sex does take place, it often takes place less safely than would otherwise be the case.

### Objective 37:

**To raise awareness particularly amongst young people of the extent to which substance use/ misuse can lead to casual sex and to encourage them to carry appropriate barrier protection**

*Accords with the ethical principles of Flexibility, Quality and Realism*

## 7.6. Prisoners

There is ample evidence that sexual activity is fairly widespread within the prison system. Though the evidence around sexual activity in Porterfield Prison is scant, there is no reason to assume that these issues at Porterfield are significantly different from the more general Scottish Prison system.

Though prisons in England now make barrier protection available to prisoners during their incarceration this is not permitted in a Scottish context. The National Sexual Health Strategy recommends that male prisoners should have access to condoms and that female prisoners should have access to dental dams. If the ban on provision of barrier protection during a prisoner's incarceration is lifted, it will be important to make arrangements to ensure the best possible access to these goods for prisoners in Porterfield prison.

A liberation pack which includes condoms and lubricant is available to prisoners on their release from prison. However, awareness of entitlement to this is low and condoms are not always routinely given to prisoners on their release.

A significant proportion of prisoners in Porterfield Prison have some literacy problems. The provision of low-literacy materials will be important in this context.

### Objective 38:

**To work with the Scottish Prison Service to ensure that all prisoners in Highland receive appropriate sexual health protection and promotion both during their time in prison and on their release**

*Accords with the ethical principles of Accountability, Engagement, Flexibility.*

*Accords with ethical principle of Realism, in so far as it is clear that some prisoners are sexually active during their incarceration but also **conflicts** with an aspect of realism in that the law does not currently allow provision of barrier protection to inmates.*

## 7.7. Ethnic Minorities

The Highlands has long benefited from the ethnic and cultural diversity of its population. In addition to an indigenous ethnic minority community there are several distinct ethnic minority groups, members of which have moved to the Highlands more recently.

The traditional travelling community forms a distinct indigenous ethnic and cultural group with its own strong moral perspectives around sex and relationships. There is a need to more fully understand the travelling community's perspective on sex and relationships in order to ensure appropriate health promotion, education and service provision. Some of those who belong to this cultural group no longer travel. However, many retain a peripatetic way of life. Models of provision which rely on fixed places of residence will inevitably make access for this group more difficult than it is for those with geographically settled life circumstances.

At the time of the 2001 census about 1,600 Highland residents (0.8% of the population) identified themselves as coming from specific non-white ethnic minorities. The low numbers in these groups can sometimes make them seem invisible. Cultural attitudes to sex, sexuality, sexual health and relationships can vary widely between and within different cultural and ethnic groups. Clearly, in Highland, it is difficult to provide separate sexual health provision for those from different cultural and ethnic groups. This means that cultural and ethnic awareness and sensitivity in all forms of existing sexual health provision are of particular importance.

From time to time distinct groups, for example, migrant workers from particular regions of the world come to the Highlands. Where there is advance notice of such activities, it will be useful to plan in advance for the sexual health needs of such groups.

### Objective 39:

**To develop, improve and disseminate understanding of the particular cultural and ethnic needs around sexuality, relationships and sexual health in the Highlands of all of our minority groups and to ensure that all services are aware, sensitive and culturally appropriate**

*Accords with the ethical principles of Accountability, Flexibility, Justice and Quality*

### 7.8. Homeless people

Sexual health problems can be exacerbated for those who are homeless. Individuals may be persuaded to engage in sex in return for accommodation. Access to services is also more difficult for those who are homeless. In clinical services appointments systems may depend on individuals having a postal address. Many homeless people have a history of health problems and these may compound each other.

### Objective 40:

**To ensure that homeless people have access to a full range of sexual health information, advice and services and to ensure that health promotion initiatives specifically encompass the needs of this group.**

*Accords with the ethical principles of Accountability, Flexibility, Justice and Quality.*



### Overall Strategic Aim

*to ensure that appropriate tools and resources are in place to underpin and support sexual health and that progress towards achieving strategic aims and objectives can be properly assessed and measured.*

7.9. Measurement of sexual health outcomes is crude and tends to measure that which can be easily measured rather than indicators which could give clearer insights. There is a clear need, at a local level, to gather additional information in order to assess whether the work we are doing is achieving its objectives.

Information we are likely to need includes information on:

- The extent of consistent condom use
- Teenage pregnancy
- The spread of STIs (bearing in mind that increases in diagnoses of some STIs may simply reflect increased numbers of people coming forward for testing)
- The proportion of young people under the age of sixteen who have had sexual intercourse
- The circumstances surrounding first sexual intercourse for people aged under sixteen in relation to coercion and regret
- Information on some of the precursors to good sexual health such as substance misuse, mental health, etc.

### Objective 41:

**To develop a practical set of indicators of sexual health and to devise mechanisms by which these can be measured**

*Accords with the ethical principles of Accountability, Engagement and Quality.*

### 7.10. Structures to support sexual health

The National Sexual Health strategy proposes leadership structures to support sexual health both nationally and locally. Some of the mechanisms proposed, for example, a multi-agency sexual health strategy which reflects local need are already in place in Highland and are described below.

The Joint Health Improvement Plan is an important new mechanism which widens the context of Health Improvement from a purely medical model to encourage and enable a much wider multi-agency perspective which fully recognises the diversity of life circumstance factors which contribute to Health Improvement. The Health Improvement Committee is the umbrella group under which Health Improvement now sits. It is vital that sexual health sits foursquare within the HIC's remit.

7.11 The Highland Sexual Health Strategy Group, a multi-agency grouping currently comprising representation from health, social work, education, voluntary organisations, a Church of Scotland minister, Child Protection and Porterfield Prison, has overseen strategic development around sexual health since the mid-1990s. It has proved a valuable forum for developing and co-ordinating wide-ranging sexual health initiatives and has facilitated a joint approach to strategic planning, including the planning and production of this draft strategy.

- 7.12. There are several established special interest groups in relation to sexual health in Highland. There is an autonomous Highland Learning Disabilities and Relationships group. Other special interest groups operate under the auspices of REACHOUT Highland. The pre-consultation work carried out during the development of this strategy has opened up possibilities for more regular contact with other interest groups
- 7.13. There have been many significant developments since the Highland Sexual Health Strategy Group first formed. A recent review of membership illustrated gaps which have arisen due to these developments and appropriate changes were made to the configuration of the group. If the Highland Sexual Health Strategy Group is to remain relevant and effective, it is important that its membership continues to be reviewed against an evolving background.
- 7.14. The first Highland Sexual Health Strategy was produced in 1997 and was successfully implemented between then and 2002. The current draft strategy has been in development for some time. It was felt appropriate to wait until after the Draft National Sexual Health Strategy became available to complete this work in order to ensure a high degree of congruence between local and national strategies.
- The sexual health needs of the population do change over time. It is important that the Highland Sexual Health Strategy Group continues to build on its experience and expertise in strategic development, refocusing and redefining the strategy as appropriate.
- 7.15. The National Sexual Health Strategy sets out clear structures at both national and local level to facilitate the implementation of measures to improve sexual health. This Draft Highland Sexual Health Strategy follows the template laid down in the National Strategy.
- Appointment, by the Director of Public Health, of a Lead Clinician for sexual health in Highland.
  - Maintenance of appropriate Specialist Health Promotion capacity in sexual health.
  - Appointment by the Director of Education of a strategic lead for sexual health
  - Identification by each CHP of a lead officer with responsibility for sexual health.
- 7.16. This strategy has been drawn up incorporating views sought at local level. Many (possibly most) of the strategic objectives outlined require to be delivered at local level. CHPs will be fundamental to this local delivery and to ensuring that delivery is appropriate to local needs. This will require the input of a team at CHP level under the guidance of a local lead officer.

## Objective 42:

**To ensure appropriate management of sexual health at Highland-wide level through the maintenance and further development of the Highland Sexual Health Strategy Group and its linkage to the Health Improvement Committee, development of CHP-level sexual health forums, and Highland-wide special interest standing groups, appointment at Highland level of appropriate officers to move the strategy forward and identification within CHPs of appropriate lead officers in sexual health.**

*Accords with the ethical principles of Accountability and Quality. Both **accords** and **conflicts** with the ethical principle of Realism – on one hand a structure of this nature is required if sexual health is to be competently addressed in Highland, on the other there may be revenue costs associated with some new appointments.*

## 7.17. Resource implications

There are resource implications from every development. There are also resource implications of doing nothing. Both the National Sexual Health Strategy and this draft Highland Sexual Health Strategy propose changes and developments. Some of these can be met by reassigning existing resources but some will require additional financial input.

The National Strategy proposes that the Scottish Executive make additional resource available for development of sexual health services.

It recommends that NHS boards should make additional resource available for:

- Enabling a wider range of general health care professionals to respond to their local populations' sexual dysfunction needs
- Training and back-filling posts to support the implementation of the clinical service approach

Clearly, if the measures laid out in the Highland Sexual Health Strategy are to be implemented there remains a substantial funding gap.

The key additional expenses not allowed for above will involve:

- Additional costs under the GMS contract in relation to providing services at CHP level

Some services such as Chlamydia testing, proactive vaccination against Hepatitis B, pro-active HIV testing and provision of ready access to barrier contraception will lead to substantial savings at a later date and/or relieve service pressures in the primary or acute sectors.

As teenage pregnancy is a key factor in an inter-generational cycle of deprivation measures to reduce this will have an impact on the cross-sectoral costs associated with the consequences and effects of deprivation.

There are some fixed costs associated with this strategy. Some are likely to be funded by the Scottish Executive and some are not. Though aggressive implementation of the strategy should lead to substantial cost savings and/or reduce service pressures further down the line, the investment resource needs to be made available in the short to medium term. Some of the "pump-priming" funding proposed from the Scottish Executive may help in the short term, but there will be an underlying need to make a longer term resource available for sexual health promotion and to build improvements in clinical services into the clinical planning process.

## Objective 43:

**To develop an implementation plan identifying the resource implications of measures required to implement the Highland Sexual Health Strategy and subject it to NHS Highland's Planning and Prioritisation Process.**

*Accords with the ethical principles of Accountability and Realism.*







Comments and responses to this  
consultation document should be sent to:

Sexual Health  
Health Promotion Department  
NHS Highland  
Assynt House  
Beechwood Business Park  
Inverness  
IV2 3HG

Or emailed to:  
[Sexual.Health@hnb.scot.nhs.uk](mailto:Sexual.Health@hnb.scot.nhs.uk)