Healthy Respect Phase Two

A Proposal to the Scottish Executive Health Improvement Strategy Division for Phase Two of the National Health Demonstration Project on Young People’s Sexual Health

Final version submitted 3 May 2005
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Healthy Respect Phase Two Summary Statement

Between March 2005 to March 2008, with funding from the Scottish Executive Health Improvement Strategy Division and NHS Lothian, Healthy Respect Phase Two will focus on the development of positive sexual health and respectful relationships amongst young people aged between 10 and 18 years in Lothian. Parents and professionals working with young people will also be targeted.

Healthy Respect Phase Two activity will mainly concentrate on the delivery of a multi-faceted approach of education, communication and services in two areas: Northwest Edinburgh and Midlothian, with a focus on schools, informal education and other settings to connect with hard to reach groups.

- North West Edinburgh: two secondary schools, informal settings and a cluster of three primary schools.
- Midlothian: Seven secondary schools (one Catholic Secondary School and one special educational needs), informal settings and a cluster of ten primary schools.

Work with the ten schools and drop-ins from Phase One will continue throughout Phase Two. Joint work with the Scottish Catholic Education Service will commence to develop an appropriate SRE resource and associated CPD materials for use in Catholic Schools. This will be piloted in three Catholic Secondary schools in Edinburgh.

Two other elements of the project: development of the Healthy Respect Brand and the Communications Programme will be implemented across Lothian.
1. Background

1.1 INTRODUCTION

Funded by the Scottish Executive Health Department, Healthy Respect began in February 2001 as a three year National Health Demonstration Project on young people’s sexual health. Its vision was to help young people in Lothian develop a positive attitude to their own sexuality and that of others, and a Healthy Respect for their partners, with the aim of reducing teenage pregnancies and sexually transmitted infections.

The Scottish Executive announced in March 2003 that the project would be continued for a longer period of demonstration and therefore the first three years of the project became known as Phase One of Healthy Respect.

Phase One had three main targets:

1. Teenage pregnancies
   • To reduce the pregnancy rate among 13-15 year olds by 20 per cent by 2010 (1995 baseline).
   • To reduce teenage terminations of pregnancy by 50 per cent (1995 baseline) by 2010 without an increase in the teenage birth rate.

2. Sexually transmitted infections (STIs)
   • To influence chlamydia testing and see an increase in the reported prevalence of chlamydia amongst young people by 2003, followed by a 50 per cent decrease by 2010.

3. Self esteem and confidence
   • Increased self esteem amongst the target group.
   • Increased contact with service providers.

Healthy Respect is a partnership initiative hosted by Lothian NHS Board. Phase One of the project comprised of 19 projects involved in the delivery of specific sexual health initiatives aimed at achieving the project’s overall objectives.

The project was one of four national health demonstration projects set out in the Government’s White Paper ‘Towards a Healthier Scotland’. The four projects were identified as test-beds for innovation to identify how to meet some of our health challenges in the 21st century.
The changes involved in working together for a healthier Scotland and reducing inequalities in health can be daunting. We need test beds for action. Therefore, in addition to working on a broad front to improve life circumstances and foster healthy lifestyles, the Government will establish 4 health demonstration projects to give focus to initiatives directed at securing sustained improvement in the health and well-being of our children, safeguarding the sexual health of our young people.....

(1999:48)

‘Healthy Respect’ will foster responsible sexual behaviour on the part of Scotland’s young people with emphasis on the avoidance of unwanted teenage pregnancies and sexually transmitted disease.

(1999:48)

Lothian Health Board was initially awarded the Healthy Respect project in February 2000. However the project did not begin until February 2001, due to the need to make revisions to the bid, organisational changes within the NHS and changes in the management of the project.

In order to measure the effectiveness of the project, the Scottish Executive commissioned an independent evaluation by Aberdeen University. The evaluation was based upon a before and after study, which was completed in October 2004, six months after the original end date for the project itself.

Although the project was located in the Lothian area, as a National Health Demonstration Project, Healthy Respect was expected to learn lessons of what works and doesn’t work in relation to improving young people’s sexual health so that learning about effective interventions can be shared throughout Scotland. In addition to the independent evaluation, the project designed an internal monitoring and evaluation system, based predominantly upon process and performance management.

This paper provides details of the Phase Two objectives and outcomes, a review of the existing evidence within the area of young people’s sexual health and an overview of the findings of Phase One of Healthy Respect. Included within the appendices are detailed plans for each objective, a more comprehensive review of the evidence, an outline of the local management structures and specification of the resources required to deliver the Phase Two objectives.
1.2 HEALTHY RESPECT PHASE TWO (HR2) PLANNING

Throughout the planning for Phase Two, the project has been guided through the evidence and related policy by the Healthy Respect Task Group. This was established by the National Co-ordinating Group for the demonstration projects in 2003. An outline of the task group remit and membership is attached in Appendix 2.

In addition to the Task Group, the project has involved its key partners from Phase One, potential future partners, and the management team at NHS Lothian to consider how to best develop the work. Consideration has also been given to the views of parents and young people obtained from our Phase One work.

1.3 PHASE TWO SUCCESS CRITERIA

Phase Two has been developed based upon the following success criteria which were outlined in the commissioning letter from NHS Scotland for Phase Two of Healthy Respect.¹

- Financial sustainability – Executive funding will cease by the end of Phase Two, and approaches which have been seen to be effective and value for money are expected to be mainstreamed.
- Senior level leadership – a visible commitment to Healthy Respect which is widely recognised and shared by local partners.
- Applicability for the rest of Scotland – evidence of what does and does not work and what may be transferable.
- Tackling health inequalities – showing effectiveness of targeted interventions on disadvantaged people or groups.

1.4 PHASE TWO EVALUATION

An Evaluation Commissioning Team (managed by NHS Health Scotland) has been formed in order to ensure the most effective evaluation design for HR2. The team has identified the following evaluation objectives, which will be included in a research brief for the external commissioning of the evaluation of HR2:

It was agreed that evaluation objectives should be ordered in terms of their priority as follows:

Essential objectives:

1. To assess overall programme effectiveness by comparing outcomes in young people exposed to Healthy Respect with outcomes in appropriate comparison groups
2. To assess the effectiveness of the locality approach in Phase 2 on reducing inequalities in sexual health outcomes

¹ Healthy Respect – Future Strategy; Commissioning of Phase 2: Pam Whittle 13 April 2004
3. To ascertain the impacts of variations in the delivery process and local contexts on programme effectiveness in Phase 2
4. To ascertain young people’s assessment of the relevance and effectiveness of Healthy Respect’s services

Desirable objectives of the external evaluation of Healthy Respect in Phase 2 are:

1. To assess the impact of Healthy Respect’s advocacy and leadership, partnership-working and knowledge transfer roles on professional thinking, culture and practice
2. To contribute to the development of new programme components (e.g. SHARE Homework element).
3. To conduct an economic evaluation of the cost-effectiveness of Healthy Respect

It is anticipated that the external evaluation team will be appointed by mid summer 2005 and that the evaluation plan will be finalised by October 2005.

To complement the external evaluation, the project will audit the delivery process and assess the achievement of programme reach/coverage and programme results. It is also concerned with evaluating Healthy Respect’s Programme Co-ordination functions, in particular the capacity-building and communications role. In summary, it is proposed that the internal monitoring and evaluation functions undertake the following:

- Monitoring the use of HR2 resources, activities, outputs and involvement in strategic/policy planning and advice
- Monitoring referrals to, and uptake of, services by young people and parents’ participation
- Auditing service provision and management against agreed quality standards
- Monitoring media coverage of sexual health and assessing the reach and impact of HR2 communications activities among the target group
- Monitoring the uptake and impacts of support and training provided to those delivering Healthy Respect services (teachers, youth workers, social work, support agencies).
2. Phase Two Objectives & Outcomes

Objectives and related outcomes for Healthy Respect Phase Two

2.1 VISION

To demonstrate how working with young people from specific areas of Lothian through a multi-faceted approach can enable them to develop a Healthy Respect and a positive attitude to their own sexuality and that of others.

2.2 STRATEGIC AIMS

1. To create an environment that will lead to long term improvements in the sexual health and well being of young people in Midlothian and North West Edinburgh through a multi-faceted approach which links education, information and services for young people aged 10-18.

2. To communicate the lessons from Healthy Respect in order to transfer learning and skills throughout Scotland.

Healthy Respect is a sexual health and wellbeing partnership network which draws together statutory and voluntary sector partners to deliver education, information and services for young people in designated areas of Lothian. The network enables young people to access support through a range of professionals and encourages youth and parental involvement where appropriate. Following recommendations from the Phase One Independent Evaluation, Phase Two will concentrate on two localities: Midlothian, to demonstrate implementation across a whole local authority and North West Edinburgh to demonstrate implementation within an area of high deprivation.

2.3 CONTEXT

The strategic aims for Healthy Respect Phase Two (HR2) have been refined to take account of the Independent and Internal Evaluation Results from Phase One and the National Strategy on Sexual Health and Wellbeing, Respect and Responsibility. HR2 will also operate within the context of the Lothian Sexual Health Strategy recently approved by Lothian NHS Board (March 2005) and Being Well – Doing Well, a Framework for Health Promoting Schools in Scotland. All schools are required to become health-promoting schools by 2007. In Lothian, those schools participating in Healthy Respect can use their SRE and service development work to contribute towards their accreditation as health promoting schools through the Lothian accreditation scheme.

With regards to Objective Four relating to communication, Healthy Respect will compliment and work within the communications plans for Lothian NHS and NHS Health Scotland to ensure most effective use of the Healthy Respect brand and communications strategy.
The objectives for HR2 are planned to build on learning from the evaluation of Phase One. They also take into account best possible evidence in this area, the need to reflect national policy with a clearer focus on reducing health inequalities. Finally, they are based upon a range of intermediate process outcomes achievable within the lifetime of Phase Two of demonstration and a set of longer term impacts which will require evaluation beyond 2008.

It should also be recognised that whilst the generic outcomes identified below are agreed, it is acknowledged that work is still required to identify what proportions of change can be identified through evaluation. This will be developed further in the initial stages of HR2.

2.4 OBJECTIVES

2.4.1 OBJECTIVE ONE: SCHOOL BASED SEX AND RELATIONSHIPS EDUCATION
To improve young people’s knowledge, attitudes and ability to communicate about sexual health and respectful relationships through the provision of focussed Sex and Relationships Education (SRE) programmes in schools in Midlothian and North West Edinburgh.

Process Outcomes
- Better integration of SRE and sexual health services, with a continuing emphasis on multi-sectoral and multi-disciplinary partnership working.
- Implementation of the Healthy Respect schools framework (in non-denominational schools) and development of appropriate SRE protocols and materials in the denominational school setting.
- Capturing the spectrum of young people’s perspectives on SRE, service availability and the connections between them.
- Increased teacher confidence in SRE delivery and lessons for wider applicability, including resource implications.
- Learning around confidentiality in policy and practice in schools.
- Implementation of a package delivered to pupils in primaries 6 and 7 as a pre-cursor to a secondary school SRE intervention.
- Fuller and more consistent engagement with parents in all aspects of SRE delivery.

2.4.2 OBJECTIVE TWO: SEX AND RELATIONSHIPS SUPPORT FOR YOUNG PEOPLE AT RISK
To improve the knowledge, attitudes and the ability to communicate about sexual health and respectful relationships of young people at high risk of poor sexual health outcomes through youth work, schools and support agencies.

Process Outcomes
- Greater consistency in delivery of SRE to all pupils, including looked after children, disaffected pupils and other vulnerable young people.
- School excludees targeted through existing youth strategy and social work teams and through secondary schools in both areas.
• Integrated education and service opportunities provided for hard to reach young people.
• Increased confidence of youth work and support agency staff to address SRE issues with young people.
• Interventions extended to support parents/carers of those excluded from school in Midlothian and North West Edinburgh.
• An increase in community capacity to support parents through the delivery of parents programmes within North West Edinburgh and Midlothian.

2.4.3 OBJECTIVE THREE: ACCESS TO SERVICES
To improve young people’s access to health care through the provision of a range of generic drop-ins which link to specialist sexual health services.

Process Outcomes
• All drop-in services include provision of general health and relationship advice and information, and where appropriate offer access to pregnancy and chlamydia testing, condom provision and links to counselling and support services.
• All services located within areas of high deprivation wherever possible, taking account of young people’s desires for a range of service options based upon being local and/or anonymous.
• All services meeting standards outlined in Healthy Respect’s drop-in guidelines “All I Want LIVE” (developed in Phase One).
• Management of all Healthy Respect clinical drop-in services located within existing specialist sexual health services or primary care for future mainstreaming purposes.
• Audit of service delivery undertaken to assess what factors increase access and acceptability.

2.4.4 OBJECTIVE FOUR: IMPROVED ATTITUDES TO SEXUAL HEALTH AND RELATIONSHIPS
To promote the values of the Healthy Respect ‘brand’ and implement, with NHS Health Scotland, an integrated communications programme designed to improve and challenge attitudes to sexual health and relationships, especially among young people.

Process Outcomes
• Implementation of the HR2 communications strategy (brand, web, print, advertising and PR functions).
• An awareness campaign aimed at parents focussing on the need for building family relationships and communication.

NB: Information illustrating the location of the schools participating in HR2 is provided in Appendix 7. Geographical and school population’s data are included in Appendix 8.
### 2.5 IMPACT OUTCOMES

Implementation of intermediate outcomes measures which embody the values of Healthy Respect and *Respect and Responsibility* – the Scottish Strategy and Action Plan for Improving Sexual Health.

<table>
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<tr>
<th>Young people in Lothian (aged 10-18) with analysis focused on the following sub-groups:</th>
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<tbody>
<tr>
<td>• Midlothian</td>
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<tr>
<td>• NW Edinburgh</td>
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<td>• HR1 school catchments</td>
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<td>• ‘High risk’ teenagers</td>
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<td><strong>Positive culture - values and attitudes underlying HR communications and brand</strong></td>
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<td><strong>Knowledge, attitudes and communication on sexual health and respectful relationships</strong></td>
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<td><strong>Access to confidential advice and help (knowledge, attitudes, use)</strong></td>
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<td><strong>Access to condoms, contraceptives and pregnancy testing (knowledge, attitudes, use)</strong></td>
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<td><strong>Access to testing for Chlamydia and other STIs (knowledge, attitudes, use)</strong></td>
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<td><strong>Behavioural outcomes, including contraceptive use, unsafe sex, regretted sexual activity, coercive sex</strong></td>
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<th>Parents of young people in Lothian</th>
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<td><strong>Values and attitudes related to HR brand</strong></td>
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<td><strong>Parental awareness, understanding and involvement in school SRE</strong></td>
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<td><strong>Parent-child relationships and communications</strong></td>
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<td><strong>Family connectedness</strong></td>
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To support local delivery, Healthy Respect also provides a number of Programme Coordination functions:

1. **Advocacy and Leadership**: as a Demonstration Project, Healthy Respect has a leadership and advocacy role nationally and locally for sexual health improvement and seeks to secure commitment to Healthy Respect which is recognised and shared by local partners and contributes to the development of policy and practice.

2. **Partnership Network**: this brings together statutory and voluntary sector organisations that deliver education, information and services for young people in designated areas of Lothian.

3. **Lothian-wide integrated communications** to promote the values of the Healthy Respect “brand” and improve and challenge attitudes to sexual health and relationships, especially among young people.

4. **Training**: to train those involved in the delivery of SRE and local sexual health services for young people in Lothian.
5. Monitoring and evaluation: to audit the quality of the services provided and monitor the reach and results of the programme.

6. Knowledge transfer: a National Learning Network on sexual health and well-being brings together and shares the knowledge gained from the implementation and evaluation of Healthy Respect that is relevant to practice in the rest of Scotland and disseminates the wider international evidence on effective sexual health interventions.
3. Evidence Base for Phase Two

Promoting A Healthy Respect: What Does the Evidence Support?
(Summary Section: Full Paper in Appendix One)

3.1 BACKGROUND

The sexual health of young people in Scotland is poor compared to that of young people in other European countries:

- The UK rate of teenage conceptions is the highest in Western Europe. In 2002/2003, there were four births for every 1000 women aged 13 to 19 years whilst in 2003, 25% of young Scottish women aged under 20 years reported having had a pregnancy terminated.

- Rates of teenage pregnancy are higher in areas of deprivation than elsewhere.

- The median age of first intercourse has fallen to 16 for both females and males with one in three young people being sexually active before age 16.2

- A large proportion of looked after young people (between 14% and 25%) have a child by age 16, and nearly 50% became mothers within 18-24 months after leaving care.

- Although more young people report using contraception at first intercourse, 16% of young men and 11% of young women still do not.

- A significant proportion of first sex is unwanted, particularly for women, and the younger the person is, the more likely it is that the sex is unwanted.

- The use of alcohol and other drugs has a considerable influence on sexual behaviour, especially amongst teenagers. Those who are intoxicated are more likely to have sex with someone they have just met, are more likely to engage in risky sexual behaviour and are more likely to regret it later.

- Around one in seven attendances to GUM clinics are by young people aged under 20.

- Between 1993 and 2003 there has been a 40% increase in chlamydia diagnoses in females less than 15 years old.

- Young people perceive the personal risk of HIV as being low yet HIV prevalence in Scotland is at an all time high.

- Between 2002 and 2003 there was a 69% increase in rectal gonorrhoea and a 32% increase in syphilis amongst men who have sex with men.

- Most parent’s feel that they have a responsibility to talk to their children about sex and sexual health, however only around half of parents actually do. Even then, discussions with sons are considerably less likely than with daughters.

- There is still considerable stigma and discrimination of those who are lesbian, gay, bisexual or transgender. LGBT young people are likely to feel isolated, to suffer mental health problems and are several times more likely to report a serious suicide attempt than heterosexual young people.

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2 This proportion is as self reported by the Scottish respondents to the 2001/2002 Health Behaviour of Schoolchildren Survey: the analysis of the NATSAL Scottish responses indicated that one in four young people were sexually active under age 16.
3.2 PROMOTING RESPECT AND RESPONSIBILITY

3.2.1 EFFECTIVENESS OF A MULTI-FACETED APPROACH

An analysis of the main contributing factors associated with the recent decreases in US teenage birth rates stated that ‘these findings suggest that the best strategy for continuing the declines in teenage pregnancy levels (and STIs) is a multi-faceted approach.’ In addition they said that although policies and programmes should encourage young people to delay first intercourse, it should be recognised that for some young people, their sexual debut is in their early teens (around one in four Scottish teenagers are sexually active before age 16\(^3\)).

As a consequence, services should be in place that help them adequately to prevent unintended pregnancy and sexually transmitted infections – ‘that means providing adequate education and information about sexual behaviour and its consequences, as well as confidential, affordable and accessible sources of contraceptive services and supplies.’ This approach is supported by evidence from other countries that have lower teenage conceptions and sexually transmitted infections (for example, Sweden and Holland).

Evidence commissioned to support the Scottish National Sexual Health and Relationships Strategy also identified the value of a combined approach comprising sexual health and relationships education across a range of settings supported by parents and professionals, improved access to specialist and generic sexual health services and a systematic marketing of positive sexual health messages.

3.2.2 TAKING ACCOUNT OF THE WIDER INFLUENCES

Economic, social and cultural influences impact on sexual health. In particular there are strong links between social disadvantage and poor sexual health, including early sexual activity linked to subsequent regret and inconsistent use of contraception with a higher risk of early unintended pregnancy or STI. Access to the means to maintain sexual health is important and sexual ill health may be partly explained through difficulty in accessing services especially in areas of high deprivation. However motivation and having a sense of a stake in the future can be more influential in maintaining positive sexual health and wellbeing. Thus the most successful interventions are multi-component and simultaneously address a range of personal and structural determinants of risk. Youth development programmes which combine some or all of the following: self-esteem building, voluntary work, educational support, vocational preparation, healthcare, sports and arts activities, and SRE, appear to be effective in reducing sexual ill health outcomes among young people. In addition, there is some evidence to suggest that individual risk counselling can be effective.

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\(^3\) This is the self reported proportion from the analysis of the 2000 NATSAL Scottish data – see also footnote 1 comment on the more recent 2001/2002 HBSC data
3.2.3 PROMOTING POSITIVE SEXUAL HEALTH

Young people (and others) do not engage with the media in a vacuum but rather the messages presented are influenced by personal experience and in interaction with significant others. A multi-faceted approach which combines media campaigns, promotes positive sexual health messages and helps young people make sense of media coverage of sexual health issues appears to be the most successful interventions in influencing sexual attitudes and behaviour. Whilst recognising that young people and those supporting them are a diverse audience, key components include:

- A single clear and consistent message which is constantly reinforced over time;
- Factual and non judgmental statements;
- Respectful of the target audience (and involving them in design and delivery, for example as peer role models);
- Use of different formats; and
- Targeting specific groups where appropriate.

Exploration of media content as part of sexual health and relationships education can promote a better understanding of stereotypical images of gender and diversity issues.

A positive social marketing approach to sexual health can usefully raise issues in order to promote discussion and debate among the general population as well as targeting specific messages for groups at risk of sexual ill health.

3.2.4 INVOLVING PARENTS

There is good evidence that providing parents with the skills and knowledge to participate in sexual health and relationships education and other activities aimed at preventing unintended pregnancy and sexually transmitted infections is effective. Further, young people whose parents discuss sexual matters with them in an open and non judgmental manner are more likely to delay early sexual activity and when they do become active, use contraception at first [and subsequent] intercourse.
3.3 PREVENTING UNINTENDED PREGNANCIES AND SEXUALLY TRANSMITTED INFECTIONS

3.3.1 SEXUAL HEALTH AND RELATIONSHIPS EDUCATION
There is good evidence that school-based sex and relationships education (SRE), particularly when linked to contraceptive services, can have an impact on young people’s knowledge and attitudes, delay sexual activity and/or reduce pregnancy rates. There is no evidence that increased provision of SRE increases the onset or frequency of sex, or the number of sexual partners. At present there is only weak evidence that peer-led approaches are effective.

Results from the first UK-based systematic evaluation of school-based SRE (SHARE) found that a high-quality, experientially based SRE programme was rated highly by young people, had a positive impact on knowledge, and reduced the level of reported regret over first sexual intercourse. It was also received positively by those who had received training in a multi-disciplinary format. It had no effect on contraceptive use on sexual behaviour. Results suggest that specific programmes on their own are unlikely to reduce conception rates, but are an essential part of a multi-faceted approach.

There is no strong evidence for the effectiveness of abstinence-only education approaches. School-based sexual health and relationships education can be effective in reducing sexual risk behaviour and there is some evidence to conclude that SRE does not increase sexual activity; and is more effective if begun before the onset of sexual activity.

Effective sex and HIV education programmes tend to:

- Focus on reducing sexual behaviours that lead to unintended pregnancy, or HIV or other sexually transmitted infections;
- Be based on theory and identify specific sexual antecedents to be targeted;
- Contain clear messages about abstaining from sex and if sexually active, about using contraception;
- Offer information about risks of sex, and ways to avoid intercourse or protect against pregnancy and sexually transmitted infections;
- Include activities to help with resisting social pressures;
- Give examples of, and practice with, communication, negotiation and refusal skills;
- Use participatory teaching methods;
- Have goals, teaching methods and materials appropriate to the age and comprehension of the target audience;
- Be of adequate and substantial duration; and
- Be led by those who believe in the programme and who are appropriately trained.

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SHARE = Sexual Health and Relationships Education, Safe Happy and Responsible
Evidence from outside the UK suggests that home based school assignments could improve parent-teen communication and knowledge and reach large numbers of parents. In addition interventions which involve direct communication between parents and children at home or in specially tailored sessions are likely to increase subsequent communication.

3.3.2 PROVIDING BETTER SERVICES - FEATURES OF EFFECTIVE INTERVENTIONS
Interventions are more likely to be effective if they:
- Use theoretical models in developing interventions
- Are targeted and tailored (in terms of age, gender, culture, etc), making use of needs assessment or formative research
- Provide basic, accurate information through clear, unambiguous messages
- Use behavioural skills training, including self-efficacy.

There is some evidence that interventions are more likely to be effective if they emphasise risk reduction rather than promoting abstinence only; and use peers and community opinion leaders to promote and support sexual health and relationships education, sexual health messages and service professionals.

Service attendance is also dependant on staff attitudes, staff knowledge of the rights of young people in accessing services, user perception of how confidentiality was dealt with and the availability of same sex practitioners. Having service staff delivering school based SRE provides a bridge between services and education and leads to improved service uptake.

3.3.3 SEXUAL HEALTH SERVICES
There is good evidence to support the effectiveness of sexual health services which adopt the following characteristics:
- Long-term services and interventions with a focus on improving contraceptive use and at least one other behaviour likely to prevent pregnancy and/or STIs;
- Clear, unambiguous information and messages;
- Encouraging an open and non judgmental discussion about sex, sexuality and contraception;
- Inclusion of personal skills development such as negotiation and refusal skills;
- Services and interventions tailored to meet local needs;
- Focus on local high-risk groups and working through opinion leaders;
- Key opportunities taken to deliver information and advice, e.g. when informing young people about negative results of pregnancy tests and STIs;
- Checks that interventions and services are accessible to young people, for example in terms of location, staff attitude and opening hours;
- Selected and trained staff who are committed to programme and service goals;
- Respect for the confidentiality of young people;
- Having a multi-agency approach and working with communities with joined-up services and interventions with other services for young people.
There is no evidence to support views that the use of family planning clinics, school-based health clinics and school-linked drop-in services encourages earlier sexual activity or increases sexual activity. SRE has been found to be more effective when linked to contraceptive and other sexual health services particularly when part of a continuum of support and advice to young people.

3.4 AT RISK GROUPS

Many groups face one or more barriers to maximising their sexual wellbeing. Improving the consistency, accessibility, quality, cultural competence and ethos of lifelong learning whilst also providing appropriate and responsive sexual health services can reduce these barriers. However, there are groups whose sexual health is particularly poor (mainly due to increasing STIs and/or unintended pregnancies) or those who are hard to reach for whom additional support is required. These include young people living in deprived areas, those with low aspirations, looked after young people, young people who are lesbian, gay or bisexual, youth offenders, those from black and minority communities and those with learning disabilities.

3.5 CONCLUSION

Thus, the evidence points to having:
- a combined multi-faceted approach comprising sexual health and relationships education across a range of settings supported by parents and professionals
- improved access to specialist and generic sexual health services
- a systematic marketing of positive sexual health messages.

Targeting those most at risk from sexual ill health may yield the greatest short-term improvements.

3.6 RATIONALE FOR PHASE TWO OBJECTIVES

The Phase Two objectives and related outcomes have been devised to reflect the current evidence base and the Independent and Internal Evaluation results from Phase One. The evidence as outlined above, tells us that multi-faceted approaches are required to enable the maximum possible impact on young people’s sexual health outcomes. Healthy Respect Phase One was based upon an approach which combined education, information and services for young people and parents which was supported by an overarching communications strategy including the use of the Healthy Respect brand and social marketing activities.

Therefore we plan to build upon the work of Phase One by strengthening this multi-faceted approach in Phase Two, but with greater concentration in two given geographical areas and with a focus on tackling health inequalities: both of which are recommended in the Independent Evaluation report of Phase One.
3.6.1 OBJECTIVE ONE: SCHOOL BASED SEX AND RELATIONSHIPS EDUCATION (SRE)

Phase One saw the beginning of multi-disciplinary training with over 140 people trained in the Health Scotland Sexual Health And Relationships Education (SHARE) package which was then delivered in 10 secondary schools across Lothian. The Independent and Internal evaluation of the project has identified the subsequent delivery of the SHARE programme in schools as inconsistent, with very few schools delivering all 20 SHARE sessions. This was due in the main to the timing of the programme beginning in schools, timetabling problems to enable multi-disciplinary input and the planning time required to make it a regular part of the curriculum.

Continuation of the 10 schools from Phase One will allow us to demonstrate the effectiveness of an enhanced SHARE package which is delivered consistently across Phase One schools and those additional schools which will become part of Phase Two in Midlothian and North West Edinburgh. Work in the Phase One schools will allow us to demonstrate what can be achieved over a longer period of time whilst the Phase Two schools work will demonstrate what can be achieved through a whole locality approach.

Evidence suggests that for some young people, Sex and Relationships Education (SRE) is delivered too late. Therefore, in Phase Two, we plan to test the effectiveness of linking a primary and secondary schools education package through the introduction of the Zero Tolerance RESPECT package within two cluster sets of primary schools. This package tackles issues surrounding gender and the need for respect within relationships in primary 6 and 7. One cluster will be chosen in each of the two locality areas, giving a total of 13 primary schools. This work will include development of a homework element to improve links between school and home, a key factor identified within a systematic review of interventions with parents. (Reference to this is made within appendix 1).

In addition, a recent Her Majesty’s Inspectorate of Education (HMIE) report concluded that implementation of SRE across Scotland is inconsistent. From Phase One, we know that teachers and local authorities lack confidence of what to teach at what stage of a young person’s development. In order to reduce this barrier in Phase Two, Healthy Respect has worked during the Transition Phase with the four local authorities in Lothian to develop a framework for schools which outlines what should be covered at what stage from pre-school to upper secondary: this will be tested as part of Phase Two. The draft framework does not cater for denominational schools; it is planned that Healthy Respect and the Scottish Catholic Education Service will adapt the framework and develop SRE resources and associated CPD materials for use in Catholic Schools as part of Phase Two demonstration. This work will be developed and piloted in partnership with the three Edinburgh Catholic Schools and the Archdiocese of St.Andrews and Edinburgh.

Phase One of Healthy Respect experienced many difficulties in engaging parents but was able to lay the ground for some innovative work with small groups of targeted parents which was well received. Phase Two will involve a wider reach of work with parents focussing on all schools within both of the locality areas in an attempt to demonstrate how to reach larger numbers of parents and how to improve their
relationships with their children. Parents will also be involved in learning about education and services which are available leading to a greater feeling of involvement, improved information and skills and more direct involvement in their own child’s education through the SRE homework package.

In June 2004, Healthy Respect and the MRC commissioned a systematic review of effective interventions with parents: the evidence is inconclusive but suggests a focus on improving ‘family connectedness’, could be effective and this will contribute to the approaches taken with parents. Homework interventions linking school and the home have shown some evidence of improving educational outcomes and will hopefully lead to greater acceptability of Healthy Respect amongst parents.

3.6.2 OBJECTIVE TWO: SEX AND RELATIONSHIPS SUPPORT FOR YOUNG PEOPLE AT RISK

Within each of the locality areas an approach involving youth strategy and informal settings will be used to target hard to reach young people including school excludees, looked after and accommodated, lesbian, gay, bisexual and transgender, ethnic minority and young people with learning disabilities. There is currently little evidence to suggest that targeting health inequalities actually improves sexual health outcomes, however, Phase One of Healthy Respect has shown some successes in reaching these groups and hope to contribute to the evidence base in this area through its work in Phase Two.

3.6.3 OBJECTIVE THREE: ACCESS TO SERVICES

Evaluation of Phase One showed that the Healthy Respect drop-ins showed the most potential in improving young people’s sexual health; however, staged starting points and therefore a lack of consistency in delivery made it difficult to fully measure their true contribution. Healthy Respect has developed a set of standards for its drop-ins which will be delivered consistently through Phase Two to demonstrate effectiveness of drop-in services for young people.

Continuation of Phase One drop-ins will show what can be achieved over a longer period of time, including demonstration of effectiveness and development of a service that is acceptable to the local community.

3.6.4 OBJECTIVE FOUR: IMPROVED ATTITUDES TO SEXUAL HEALTH AND RELATIONSHIPS

Phase One identified the Healthy Respect brand and social marketing approaches as key parts of the multi-faceted approach to improving young people’s sexual health; the evidence on social marketing supports this. One of the weaknesses identified in Phase One was that young people may identify the brand but not necessarily the values associated with it. Phase Two will aim to demonstrate whether the use of the brand can influence young people’s values and attitudes.
4. Evaluation of Phase One

4.1 SUMMARY OF THE HEALTHY RESPECT INDEPENDENT EVALUATION FINDINGS

The independent evaluation of Healthy Respect Phase One was carried out by a team at the Dugald Baird Centre for Research on Women’s Health at the University of Aberdeen, in collaboration with the Scottish Programme for Clinical Effectiveness in Reproductive Health (SPCERH) at the University of Edinburgh. The observation period for the evaluation was November 2000 to February 2004.

The report is well presented with many important findings that will be of interest to a wide range of stakeholders. It explores the complexities of the Healthy Respect intervention, the findings of the evaluation and the context within which the intervention has been implemented and evaluated, including the local and national political sensitivities that affect work in the field of sexual health for young people.

4.1.1 METHODS AND CONTEXT

The independent evaluation considered the effect of Healthy Respect (HR) from three perspectives:

1. Sexual Health Outcomes (A: Attitudes and behavioural change; B: Service access and acceptability; C: Comparative trends in age-specific conception, abortion rates and STIs)
2. Mapping partnership working and networks for sexual health (to assess context and added value of HR)
3. Implementation and process of component projects (to inform transferability) (10 out of the 19 component projects were selected for case studies).

- A before-and-after survey of young people’s sexual health knowledge, attitudes and behaviour was used to test Healthy Respect’s Sexual Health and Relationships Education (SHARE) programme in 10 Lothian schools, compared with 5 non-SHARE Grampian schools.
- Findings from the survey and focus group interviews in both areas evaluated the impact of HR and Lothian’s SHARE programme on young people’s preferences for, and perceived barriers to, sexual health services, advice and obtaining contraceptives.
- Sexual health outcomes were compared for young people in Lothian and Grampian in relation to HR in Lothian.
- The performance of healthcare professionals in the detection and management of genital Chlamydia trachomatis infection was compared in both areas.
- Comparisons of networking and partnership activity in Lothian and Grampian were made.
4.1.2 SUMMARY OF KEY FINDINGS

Overall

- There is strong evidence of benefit from HR in Lothian on the impact of partnership work, e.g. HR pulled together non-government organisations; de-medicalised services; enabled a broader spectrum of agencies to take responsibility for young people's health; provided a variety of services to young people.

- It is clear that in many ways HR was able to use its strong partnerships to address difficult issues and move forward the agenda on sexual health in a way that was not possible in Grampian.

- As yet there is little evidence indicating improved sexual health outcomes for young people in Lothian following the HR intervention. This may be because HR activity has centred on professional training and networking. There is a clear need for a longer lead-in time.

- Data on trends in sexual health outcomes during the period of HR are incomplete and require longer monitoring. The evaluation assessed the outcomes at the end of 2 years of the intervention (due to the non-availability of statistics for 2003). The achievement of the stated targets should be viewed in that context.

- Healthy Respect has however used its critical mass to push forward partnership working on sexual health and to widen professional responsibility for young people’s sexual health and overall well-being, though much remains to be done. Healthy Respect’s partnership working allowed innovative low threshold services to be developed, encouraged services to network and enabled access to more vulnerable and hard to reach groups.

- Healthy Respect tackled the difficult issues of developing confidentiality and child protection guidelines across professional groups. Conflicting protocols on these issues are notorious for undermining attempts at joint working.

- Focusing interventions in more deprived localities could clearly yield bigger health gains and is more likely to achieve the policy goal of reducing health inequalities, although the dangers of targeting and stigmatisation are acknowledged.

- Healthy Respect SHARE schools operated associated drop-ins on or near school premises, which proved popular with pupils when they were available. Systematic evaluation of the drop-ins was impossible given their very different timelines, operating procedures, staffing arrangements and varied forms of record keeping. More evidence is required about throughput, effectiveness and cost effectiveness, and more work is needed to identify which ages and type of young people utilise which aspects of the drop-in services.

- Poor knowledge and behaviour outcomes from the SHARE schools require thought about whether schools are the most appropriate venues to deliver interventions aimed at improving sexual health. A clear attraction for those wishing to influence young people’s behaviour is the fact that education is a mass service delivery system, but in sexual health education a proportion of any class must hear the
message too late or too early for them. It might be irresponsible to give no sex education at all, but from evidence it appears unrealistic to expect even the best curriculum to deliver significant changes in behaviour.

Sexual Health and Behaviour Outcomes

Before HR began in 2001, pupils in Lothian demonstrated poorer knowledge and less positive attitudes and behaviour relating to sexual health, compared to pupils in Grampian. In both areas around 1 in 5 pupils reported having had sexual intercourse aged under 16 years old.

In 2003:

- Lothian pupils were less able to talk to parents but the significant regional gap of 2001 narrowed by 2003 - especially for boys able to speak to their fathers
- The proportion of pupils in both regions who report better communication with parents by 2003 was most evident in Lothian
- Only a minority would seek advice of teachers and school-based staff – sustained in both regions. Concerns included lack of confidentiality, embarrassment and the possibility of being treated differently by a teacher after disclosure
- Despite the fact that schools may provide access to a large number of young people, attempts to provide better support for young people must weave in the provision for communication and advice from non-school staff to the educational input.
- Lothian pupils were half as likely to talk with school nurses – sustained. Possible explanations may include the length of time nurses were on site in Lothian schools, possible lack of provision due to school nurse turnover in Lothian or that the relocation of Lothian school nurse sessions to ‘drop-in’ centres meant that pupils did not identify them as ‘school nurses’
- Lothian pupils were significantly more likely to report previous sexual intercourse both before and after the intervention
- Significantly more Lothian pupils (especially boys) were confident about obtaining and using condoms properly and closed the significant regional gap by 2003. More Lothian pupils (especially boys) agreed by 2003 that STIs are likely to be contracted unless condoms are used.
- However, Lothian pupils’ attitudes, beliefs and intentions about condom use showed no improvement. There were clear differences in attitudes to condom use by gender.
- Lothian pupils were still more likely to report embarrassment (especially girls), and more likely to think condom use would reduce sexual enjoyment (especially boys).
- Amongst those sexually active, there was an overall reported increase in use of condoms at first intercourse by 2003 – not only for Lothian
- Boys were more likely to use vending machines than other methods to obtain condoms
SHARE is a high quality and theory-based sexual health education programme and the training was multi-disciplinary and well received – there was however a need for continued support after the training for those delivering the programme.

There is scant evidence that SHARE is any more effective than other (non-SHARE) programmes in changing behaviour. However, the lack of impact may stem from the timing of the implementation as some pupils may have become sexually active before this sexual health education began. For some of the most vulnerable pupil’s sexual health education in S2 may have been too late.

In both Lothian and Grampian the most popular services for pupils in need of help and advice on sexual health and relationships were drop-in centres, family planning clinics (FPCs) and family GPs.

In Lothian the popularity of drop-in centres increased even further after HR, although Lothian pupils became less likely than in Grampian to use FPCs and GPs by 2003. The recognised availability of condoms at Lothian drop-in centres increased.

In 2003, increased proportions of pupils in Lothian had heard of HR and c:card services, although pupils in both regions still appear poorly informed about the availability of sexual health services in their area.

The kind of advice services preferred vary according to gender and whether or not young people reported already having sexual intercourse.

Before and after HR and SHARE, there were no significant regional differences in the reported use of condoms, the contraceptive pill or the morning after pill at first sexual intercourse. By 2003, there was an indication of increasing reported use of all three methods in both regions.

Comparative Trends in Age-Specific Conception, Abortion Rates and STIs

There is substantial geographic variation between both regions and the data demonstrated that deprivation remains a major predictor of teenage conception and of teenage abortion in Lothian. This effect is evidence of continuing health inequalities.

Over 1995 to 2002 the overall crude teenage conception rate was consistently slightly higher in Lothian than the overall Scottish rate, whereas the rate in Grampian was consistently slightly lower. Across all age groups (13-15, 16-17 and 18-19) conception rates are higher in Lothian than in Grampian. As numbers and rates of conceptions in the 13-15 age range are very low, low numbers of pregnancies makes interpretation of trends difficult and do not give enough numbers for establishing statistically significant results.

Over 1995 to 2002 the teenage abortion rate was consistently higher in Lothian than in Grampian. 2002 data suggest a narrowing of this difference.

There was evidence of the well-established relationship of increasing deprivation associated with a decreasing proportion of teenage conceptions ending in abortion.
• Comparisons were made of Chlamydia testing in Lothian and Grampian. Between January 2000 and March 2004, quarterly tests on teenagers rose by 84% in Grampian and 121% in Lothian. The rise in Lothian was particularly marked among male teenagers.

• In both Lothian and Grampian the number of Chlamydia positive teenagers detected annually increased over time. The increase was slightly greater in Lothian from 2000 to 2004. In both regions the rate of detected positive Chlamydia tests among selected tested teenagers was consistently around 13%.

• In both regions 90% of primary care clinicians appeared aware of the need to test for Chlamydia in patients with relevant symptoms; but were less likely to offer opportunistic testing to asymptomatic young patients.

• There was some evidence of better Chlamydia-related practice in primary care in Lothian.

Mapping Partnership Working and Professional Networks for Sexual Health

• Whilst Healthy Respect might be unable to prove ‘effectiveness’, with the methods of evaluation available, the positive impact of the demonstration project on ways of working in the field of sexual health services in Lothian is incontrovertible.

• HR rapidly drew in partners to ensure extensive partnership working; in terms of strategic partnerships, HR was integral to the planning and shaping of both the local Lothian and National Sexual Health and Relationships Strategy documents.

• In terms of facilitative partnerships, HR drew on both clinical and public health professionals and local authority partners to develop new forms of service delivery; partners from the voluntary sector were also drawn in and enabled HR to benefit from work that was grounded in local communities or specific population groups; some potentially key agencies (e.g. social work and education) were under-represented.

• Formal partnerships between the primary statutory service providers of health and education were slow and difficult to establish and more difficult to consolidate.

• Partnership working was a major achievement of HR as it helped to raise the profile and the level of sexual health work with young people in Lothian.

Informal Networking

• HR gave many small voluntary organisations links to a more established and powerful platform from which they could work, and acted as a catalyst to promote dialogue between partners.

• Inter-professional training, developed as part of SHARE, offered informal networking opportunities which were appreciated at the time but were subsequently difficult to sustain because of the way the delivery of the initiative was managed in schools.
Many of the networks that developed used HR as the hub but horizontal linkages between component projects soon started to develop; practitioner level dissemination activities helped to develop new networking opportunities with non-HR agencies.

There were hidden costs to the volume of networking activities, especially for local authority and smaller voluntary organisations.

Benefits to Clients as a Result of Service Provider Networking

In Lothian, young people did receive a noticeably different style and level of service.

The linked education package and service provision component of the SHARE projects was the most obvious provision of low threshold services for young people; the drop-ins linked to SHARE provided low threshold access to services and survey work shows that offer of such services made an impact.

Although the SHARE education work was high quality, the scope of HR meant that about 20% of young people in Lothian were exposed to it.

The mixture of formal and informal services at the drop-ins had different appeal to young men and women, with the former preferring the casual drop-in element and young women making greater use of clinical one-to-one services provided; drop-ins which offered direct access to contraception were more heavily used than those which only offered advice and counselling.

Consultation exercises about the Lothian drop-ins showed young people wanted longer opening hours, services at weekends and over holiday periods, service provision that included contraceptives and a holistic approach, but few of these demands were met; in Lothian some attempts were made to develop consultation, but these often took the form of ‘needs’ assessments. Few exercises moved above the level of ‘consultation’ rather than ‘participation’.

HR, through several component projects, attempted to reconceptualise the nature of service provision on sexual health, looking at issues of sexual coercion or gender uncertainty; the need to develop services that were sensitive to very different fragments of the youth population was appreciated within HR around the needs of LGBT young people.

The localised nature of such service provision suited some factions of the youth population but was not perceived as anonymous or confidential enough by others.

Younger adolescents liked the informal nature of the drop-ins as a venue for sating their curiosity and allowing discussion of issues which were normally ‘out of order’, but their boisterous behaviour was seen as jeopardising service provision for older teenagers.
4.2 SUMMARY OF INTERNAL EVALUATION FINDINGS

Healthy Respect has produced eleven internal evaluation reports: on some of the component projects from Phase One. Reports are not available for all projects as the results of some projects were published in relevant academic journals. In addition, an overall summary of the experience of setting up and delivering a demonstration project has been produced from the viewpoint of the lead partner, NHS Lothian. Each of the reports outlines the processes involved in delivering each component and includes a summary of key lessons learned.

The main lessons emerging from the internal evaluation can be summarised as:

1. Hard-to-reach and marginalised young people can be accessed in necessary small numbers by specific services, joined up agencies and via talented, skilled staff.
2. Small group and individual work is resource intensive and has significant cost implications.
3. Skilled and trained staff are required to do sexual health teaching with young people. Young people, parents and carers initially want sexual health to be presented in the context of messages about general health and both in and out of schools settings.
4. Joining of educational and clinical services is desired and appreciated by young people.
5. Health promotion hardware (posters/kits/branding) is expensive and needs sufficient resources (i.e. good initial costing estimates).
6. Partnerships take time and are difficult especially between different statutory agencies and agencies and voluntary groups.
7. Field level and strategic level partnerships require different skills and timeframes.
8. Questions of ownership of work and issues of what branding means require extensive explicit and difficult negotiation.

The lessons and experience gained from Phase One have shaped the overall objectives for Phase Two. One of the key lessons not highlighted above is the issue of managing expectations. Phase One aimed to achieve a number of targets relating to improvements in sexual health outcomes for young people, some of which were long-term with a 2010 target date. The targets in some cases were practically unrealistic. For example, expecting Healthy Respect to reduce teenage pregnancies across Lothian when it was only active in ten small areas is now recognised as being a tactical misjudgement.

4.3 DISSEMINATION OF LEARNING

There is concern amongst many about the poor sexual health outcomes of young people in Scotland and a growing understanding about the complex influences which contribute to these outcomes. There is also recognition that we need a wider set of outcomes which not only reflect improvements in sexual health, but also in the quality of young people’s
relationships (as proposed in the National Strategy on Sexual Health and Wellbeing, *Respect and Responsibility*).

Strategic Aim Two of the Demonstration project is about the sharing of information about what works and what doesn’t work in the area of improving young people’s sexual health. Healthy Respect will work closely with the Sexual Health and Wellbeing Learning Network to share lessons from its work to those working with young people across Scotland. Dissemination will concentrate on the provision of Shared Learning Events across health board areas in Scotland and will involve NHS, Local Authority and Voluntary Sector partners. In addition, Healthy Respect will provide an Open Session once per month to offer a structured opportunity for interested individuals and agencies to learn more about the work of the demonstration project. Finally, learning will also be shared through publications in appropriate journals and through the Healthy Respect and Learning Network websites and newsletters.
5. Local Management Structures

Phase Two will continue to build on its partnership working from Phase One. The Phase Two plans clearly specify roles and responsibilities of each partner (within the detailed plans in Appendix 6) which will be monitored through quarterly reporting on objectives and finance which have been used effectively in Phase One.

NHS Lothian will continue to act as lead partner with accountability from the Chief Executive to the Scottish Executive. This is delegated to the Director of Public Health who has strategic lead for sexual health in Lothian. The project will contribute to the Lothian Sexual Health Strategy and report to the Director of Public Health via the Lothian Sexual Health Strategy Project Board. A Healthy Respect and Sexual Health Business Sub-Group has been formed to deal with operational management within the project itself, the Project Manager is responsible for the day to day management of all staff, objectives and finances. Diagrams outlining the planning and accountability structures are attached in appendices 3 and 4.

Outline costs for Phase Two is attached in appendix 5.
6. Exit Strategies

Phase One of Healthy Respect successfully utilised a tailored methodology for assessing the effectiveness of its projects. This will be reviewed and adapted for use in Phase Two.

Phase Two has been designed to ensure that the success criteria required by the Scottish Executive are achieved.

6.1 FINANCIAL SUSTAINABILITY

Activities have been designed to develop local capacity and skills to enable continuation of activities beyond the demonstration project. Phase One has taught us that resources can be a catalyst to achieving change, however, a change in working practices can often be more effective than provision of additional monies. Phase Two planning will focus on identifying clearly the contribution from the demonstration project (i.e. SEHD) and others, including local authority and health board resources.

6.2 SENIOR LEVEL LEADERSHIP

The evaluation of Phase One of Healthy Respect identified a lack of senior level leadership particularly with regards to the provision of education. Phase Two will be clearly identified within the local health plan and other relevant community plans including Children’s Services plans and Community Learning Plans of the four local authorities. The Lothian Sexual Health Strategy Project Board has identified Healthy Respect as its method of addressing young people’s sexual health in Lothian: the continuation of Healthy Respect beyond its demonstration period will form part of the Sexual Health Action Plan in each local authority area within Lothian.

6.3 APPLICABILITY TO THE REST OF SCOTLAND

Healthy Respect works closely with Health Scotland’s Sexual Health and Wellbeing Learning Network to ensure lessons from the demonstration project are shared widely. As outlined in 4.3 dissemination of learning will be delivered jointly with the Learning Network and Phase Two will include plans for the transfer of appropriate Healthy Respect materials and reports to Health Scotland upon completion of the demonstration project.

6.4 TACKLING HEALTH INEQUALITIES

Phase Two of Healthy Respect has been designed to enable targeting of those most at risk of poor sexual health outcomes. Different models of intervention and activity are being designed to meet differing needs including those living in areas of deprivation, lesbian, gay, bisexual, transgender, looked after young people and young people with learning disabilities. In addition a review of existing services and current users is being undertaken to ensure future service delivery is accessible to those who need it.
Appendices 1-8
Appendix 1

Evidence Base

Promoting a Healthy Respect: What Does the Evidence Support?

1. Introduction

Towards a Healthier Scotland set the target of reducing by 20% the pregnancy rate in 13-15 year olds by 2010. As a national health demonstration project examining issues pertaining to the sexual health of young people, it follows that working towards this target is implicit in the work undertaken by Healthy Respect. In addition, it is recognised that the project will have a major role in supporting the implementation of the national sexual health strategy, particularly in “testing” out different approaches to promoting positive sexual health among young people. However it is also acknowledged that this project is complex and multifaceted which reflects both an academic evidence base and experience from practitioners working on the ground and as recently highlighted by the Kings Fund the lack of an evidence base does not necessarily lead to less effective interventions (Coote et al 2004). Coote also stated that “acting only on what has been shown to work could greatly reduce the scope for activity, and inhibit creativity and risk-taking”.

Therefore in drawing together the proposals for Phase 2, consideration has been given to the key headline findings from both academic research and from the internal evaluation experiences relating to teenage pregnancy and sexually transmitted infections. This appendix covers research on the wider determinants influencing positive sexual health, sexual behaviour and knowledge, attitudes and beliefs; use of services; and groups at risk of sexual ill health. It draws on a range of sources including systematic reviews of the effectiveness of prevention and support interventions, national surveys and primary research studies. The main emphasis is on UK research, in particular drawing on the work commissioned to develop the draft national sexual health and relationships strategy and that undertaken by the English based Teenage Pregnancy Unit (where there is no Scottish equivalent research). Due regard is also given to relevant international evidence whilst acknowledging issues of transferability and generalisability.

A summary of the key findings is included in the main report.
2. Promoting Respect and Responsibility

2.1 TAKING ACCOUNT OF THE WIDER INFLUENCES

In those countries which have low levels of teenage pregnancy and sexually transmitted infections (STIs), adults tend to be more accepting of sexual activity among teenagers than British adults. (Hosie 2002) However, these countries also give clear and unambiguous messages that sex should occur within committed relationships and that sexually active teenagers are expected to protect themselves and their partners from pregnancy and STIs. Moreover, childbearing is seen as acceptable once young people have completed their education, are employed and are living in stable relationships.

Thus wider cultural and social influences have a significant impact on both attitudes to sexual health and on actual behaviour. Addressing these influences in partnership with improving access to services and promoting effective sexual health and relationships education is key to making progress. The failure to appreciate these links has been attributed to the lack of progress made in reducing sexual ill health in Scotland as demonstrated in other countries (UNICEF 2001).

These factors include socio-economic circumstances and the inequalities these cause, family and parents, gender, sexual stereotypes, ethnicity, faith perspectives and the media.

Social and Economic Environment

Recent research drawing on a cohort of children born in 1970 took account of associations arising partly from the fact that already disadvantaged teenagers are more likely to become young mothers. It found that the main consequence of having a teen birth is that these women are more likely to partner with men who are poorly qualified and more likely to suffer unemployment, thus reducing their standard of living. (Ermish and Pevalin 2003)

Low Self-Esteem and Educational Achievement

The risk of teenage motherhood is raised – possibly by up to 50% – among teenage girls with lower self-esteem than their peers. This is probably linked with an increased likelihood of unprotected intercourse. (Elmer 2001)

Young people scoring below average on measures of educational achievement at ages 7 and 16 have been found to be at significantly higher risk of becoming teenage parents, especially those whose performance declined between these ages. (Kiernan 1995). Around one in three sexually active young women leaving school at 16 without any qualifications had a child before the age of 18, compared with one in six who left at 16 with qualifications, and 1% of those who left at age 17 or over. (Macdowell et al 2002).
Family Structure

Parents and families are crucial in the development of sexual values, attitudes and skills as well as in influencing sexual behaviour. Parents influence developing attitudes to sex and to gender identity, which build the foundations for different styles of sexuality and the family, provides the moral and value framework which influences sexual conduct. (Feldman and Rosenthal 2001)

Young people who report more emotionally available parents are more likely to have intimacy-oriented attitudes towards sexual relationships as opposed to power based attitudes. This is linked to delayed sexual debut and higher levels of prior discussion of and use of contraception (Ingham 2002).

Media Influences

Sexual imagery is often used to reinforce stereotypes about the expected activities and behaviours of women and men, ignore the risks associated with sexual behaviour and bear little resemblance to real life (Lowry 1993). In the absence of other reliable sources of information and advice, unbalanced and inaccurate media messages can lead to pressures and confusion over the realities of sex and sexuality. Young women, in particular, reported the media as one of their main sources of information (Macdowell et al 2002).

The media is a useful means of providing information to the general public and as part of targeted campaigns of raising awareness and shaping attitudes (Strasburger 1995, Kitzinger 1999). Healthy Respect found that its targeted work on chlamydia, especially through the postal testing kits, raised awareness of that particular STI. But the media by itself has little impact on changing behaviour: it must have a positive message and be combined with other activities. Thus a multi-faceted approach appears to be the most successful intervention although further evidence is required on how sexual media is used and assimilated by young people (and parents) and how media literacy can be facilitated.

2.2 SEXUAL BEHAVIOUR

The National Attitudes and Sexual Lifestyles Survey (NATSAL) (MacDowell et al 2002) is a major source of information on sexual attitudes and behaviour among young people – a specific analysis was undertaken on the Scottish respondents. The median age at first intercourse for both males and females aged 16–19 was 16 – this is lower than the 1990/91 results when it was 18 for females and 17 for males. Men reported having more sexual partners than women and were more likely to have had more than one partner at the same time. Whilst there was little difference between males and females wanting help in saying “no”, more women than men reported regret after their first sexual intercourse. This confirms the view that earlier sexual debut is less likely to be an autonomous and a consensual event, and more likely to be regretted and unprotected against pregnancy and infection. (Wight et al 2000, Cheeseborough et al 1999).
Delaying sexual activity until ready is an underpinning aim of a pragmatic approach responsive to the needs of young people.

Whilst sex before marriage was largely accepted by NATSAL respondents, sex outside a regular stable relationship was not viewed positively, particularly by women and young people. Despite this young people, particularly males were more tolerant of one-night stands compared to those aged 25 and over. This reinforces the need to have approaches which take account of the different gender views to relationships (Wight et al 1998, Holland et al 1998 and Wight 1994).

Those who reported learning about sex from school or parents were significantly less likely to report early sexual intercourse and more likely to report condom use, particularly for initial contact. Additional influences on later sexual activity and more positive sexual health included socio-economic status, educational attainment, family structure and improved discussion with parents or significant others.

The 2001/02 Health Behaviour of School Children (HBSC) survey showed that of those 15 year olds questioned in the 27 participating countries, around one in four reported being sexually active. In Scotland the rates were higher (32.9% boys and 34.6% girls) slightly less than the proportion of sexually active young people in England and Wales. (Alexander et al 2004)

The tracking survey evaluating the impact of the English Teenage Pregnancy Strategy showed that whilst four out of ten people aged 13-21 years had fairly accurate perceptions of the proportion of young people who had sexual intercourse before the age of 16, almost all of the remainder mistakenly believed that more than half of young people had sex before they were 16. (BMRB International 2003). This supports the findings of a further study in an area with high teenage conceptions where almost 90% of respondents thought that the likely age of first sex was under the age of consent (Baraister et al 2004)

**Contraceptive Use (including condoms and emergency contraception)**

Reported use of condoms at first intercourse has increased significantly in recent years. Natsal 2000 (MacDowell et al 2002) found that younger respondents were twice as likely to use condoms the first time they had sex compared to those aged 30 years and over. The proportion of couples relying on the contraceptive pill has remained fairly stable, so the proportion of young people not using any method at first intercourse has decreased substantially. Less than 10% of those aged 16–19 reported using no form of contraception at first intercourse. The main reason for using contraception was to prevent pregnancy – only a minority reported the risk of infection as the reason for condom use.

The Health Education Population Survey (BMRB 2004) showed significant positive changes between 1996-1999 and 2001-2003 in attitudes to condom use among the Scottish population. Whilst there was no consistent change over time related to
HIV/AIDS for any age group, those aged between 25 and 34 were more likely to have changed their sexual behaviour, including increased condom use. Eight out of ten young people aged 16-24 agreed strongly with using a condom with a new partner suggesting that they are more likely to use condoms – long-term condom use is less consistent indicating the need for consistent media awareness over barrier contraception. They also expressed the greatest need for information regarding STIs, HIV testing and emergency contraception and the most concern about sexual health generally. This supports the NATSAL findings where more than half of males wanted more information on STIs. This suggests that those who see themselves as being at greatest risk appear to be more likely to adopt preventive strategies.

The latest HBSC survey indicates that over three out of four sexually active young people used a condom the last time they had sexual intercourse – five countries reported condom use in excess of 85% among boys although this only applied to girls in Spain. In Scotland 76.2% of boys and 63.4% of girls reported condom use at last sexual encounter. (Alexander et al 2004)

A 1999 survey of nearly 1000 students aged 16–18 across England and Wales found that use of contraception at first sex was related to having discussed contraception with their partner beforehand, for both males and females (Stone and Ingham 2002). For young men, rates of contraceptive use were higher among those who gave an intimate reason for having sex, and who had parents who portrayed sex positively. For young women, the rate was higher among those who were older at first sex, who had anticipated having sex beforehand, and who felt more comfortable interacting with teenage boys.

In a follow up study of women aged 14-29 between 1993 and 1997 (Rowlands and Lawrenson 2000) an average of 5% per year accessed emergency contraception: only 4% of these received it more than twice in any one year. More than 70% of those with no previous record of regular contraception use had used regular contraception within a year of using emergency contraception. Among young women participating in the 2002/03 Office of National Statistics Omnibus Survey, hormonal emergency contraception had not been used by 90% and 92% of those aged 16-17 years and 18-19 years respectively during the year before the interview. (ONS 2003).

**Teenage Conceptions**

Rates of teenage births (the number of births per 1,000 women aged 15–19) in the UK are five times those in the Netherlands, three times those in France, and twice those in Germany. These comparisons are for 1998, the most recent year for which comparable data are available (Unicef 2001). Nevertheless there has been a small but significant decline in rates of those aged under 16 (falling from a peak in 1996 of 9.5 per 1000 to 7.6 in 2001). It has been estimated that the cost to the NHS alone of pregnancy among those aged under 18 years is over £63 million per annum. (TPU Annual Report 2002)

Although the overall birth rate in Scotland appears to be declining over time, one in four women reported parenthood before 18 (similar rates were reported for respondents in
other parts of the UK). Those under aged 25 were more likely to have been parents at a young age. Socio-economic status has had a significant influence on parenthood – young women aged under 20 are up to five times more likely to be teenage mothers if they live in a deprived area (McLeod 2001, ISD Scotland 2003). Delaying motherhood is less likely for all women living in deprived areas compared with the most affluent areas – the latter tend to have children around 12 years later.

Termination rates in those under 16 are at a lower rate than those in England and Wales and much lower than those in age group 25 and over (ISD Scotland 2003).

**Sexually Transmitted Infections**

Nine per cent of men and 13% of women reported having had an STI in the Natsal survey (Wellings et al 2001): 1 in 16 women said they had had a chlamydia test compared to 1 in 77 men. Work within Healthy Respect indicates that around one in seven young women and one in ten men under 24 are chlamydia positive. The rise in diagnoses in females less than 15 years has been particularly marked (almost 40% between 1993 and 2003). Although much of this overall increase is due to improved screening practice, other indicators suggest that the incidence of chlamydia infection, particularly among young people in the 15-24 age group, has increased. This supports a continued proactive approach to chlamydia testing and improved awareness among those under 25 years.

Teenagers from black Caribbean backgrounds tend to be at higher risk of gonorrhoea and chlamydia than the white population and other ethnic groups. Genital warts, the most common sexually transmitted infections (STIs) in the country, are less common among all minority ethnic groups than among the white population. Although numbers are small, black African young people are disproportionately more likely to be receiving care for HIV infection. (Low 2001, Sinyemu, 2004) It should be noted that little is known about the sexual health needs of those from ethnic minority communities and in particular those who are seeking asylum.

**Use of Sexual Health Services**

The Omnibus Survey (ONS 2003) found that of those aged 16–17, 58% had not visited a service for family planning advice or supplies whilst the corresponding figure for 18–19 years olds was 34%. Among both 16–17 and 18–19 year olds, the most popular source was their own GP or practice nurse (21 and 55%), followed by family planning clinics (17 and 25%). The tracking survey for the English Teenage Pregnancy Strategy indicated that the main sources of advice were schools (teachers or school nurses), general practice (doctor or practice nurse); and family planning clinics (BMRB International 2003).

In 1999 a survey of nearly 1000 young people attending sexual health services revealed that 61% had first used a service after first intercourse (Stone and Ingham 2003). For men this was to obtain free condoms (63%), while for women it was an episode of
unprotected sex (32%). The interval between first sex and first visit varied from one day to six years. Among those who visited before first intercourse (29%), the main reason given was ‘to be prepared’.

How services are delivered and the attitudes and outlook of the staff who deliver the service is important for all age groups but particularly so for young people and other vulnerable populations as identified by Butler and Solomon (2002) and by Hosie (2002). Evidence from the Healthy Respect (Annual Report 2001 and 2002) and other initiatives indicates that access to same sex GPs and nurses and nurse led services can influence the outcomes of interventions (Peersman 1996, Burack 2000, Allen and Hippsley-Cox, 2000). Dehne (2000) found that the integration of STI education for prevention and counselling had a positive impact on user satisfaction and family planning acceptance.

Butler and Solomon (2002) and Hosie (2002) identified accessibility and acceptability as important issues for those sexual and reproductive health services. Glasier demonstrated the links between increased contraceptive use and dedicated young peoples services (Glasier, 2002) whilst Allaby (1995) and Clements et al (1999) identified the value of location to enhance service uptake. Burack (2000) also found that attendance was dependant on staff attitudes, staff knowledge of the rights of young people in accessing services, user perception of how confidentiality was dealt with and the availability of same sex practitioners. Healthy Respect has shown the value of having service staff delivering school based SRE in providing a bridge between services and education and improving service uptake.

Feedback received during the engagement process undertaken as part of developing the draft national sexual health and relationships strategy indicated that many young people preferred to use specialist sexual health services and drop in services rather than general practice. This was mainly due to the perception that general practitioners and other primary care staff are less confidential than other settings – this is particularly important when GPs might be the only source of advice and services in remote and rural areas. Evidence suggests that some GPs are themselves confused about the legal status of providing contraception to under-16s (Peckham et al 1996).

One study which examined over 800 GP practices in Trent region found that lower teenage pregnancy rates were associated with being seen by a female doctor, by one who was younger (under 36 years) and with more practice nurse time, even after adjusting for other factors such as deprivation and rural location (Hippisley-Cox et al 2000). A subsequent study showed that most teenagers who became pregnant had attended general practice during the previous 12 months (93%), with many having sought contraceptive advice (71%) and having been prescribed oral contraception (50%) (Churchill 2000).
3. Improving Sexual Knowledge, Attitudes and Beliefs

3.1 SOURCES OF SEX AND RELATIONSHIPS INFORMATION

Evidence consistently indicates that young people report their main sources of information about sex and relationships as being lessons at school, friends, mothers, magazines and TV. (Currie et al 1999, MacDowell 2002, Ingham 2002).

Whilst NATSAL showed that parents were a common source of information they were less likely to be consulted compared to schools and friends. There are differences between mother/father and son/daughter discussions about sex and this is influenced by the general parenting styles adopted. Mothers tend to be the main educators in the household (Feldman and Rosenthal 2000, Walker 2001 and 2004 and Miller et al 2001) and this is no less the case in respect of sexual health matters. Moreover, young people see it being more important for mothers than fathers to communicate about sex. This is likely because they view mothers as being less judgemental than fathers and potentially can relate to their own daughters by drawing on their own experience. This does point to the need to influence informal sex education for boys within the family environment. This is particularly pertinent as young men are expected to know about sex without ever having been taught and then adopt the “macho” predatory sexual male attitude (Wight 1994, Holland et al 1998).

3.2 SEXUAL HEALTH AND RELATIONSHIPS EDUCATION (SRE)

There is strong support for sexual health and relationships education (SRE), both as part of school based activity but also as part of lifelong learning. Whilst it is acknowledged that parents have a key role in sex education, it is also recognised that many parents have opted out of this role with the result that schools have had to fill the void and be actively engaged in sex education. (MacDowell 2002, Ingham and van Zessen 1998). In addition, 88% of young people and 86% of parents saw SRE as helping young people be more responsible about sex. In addition, 3 out of 4 young people and 2 out of 3 parents did not think that SRE encourages young people to have sex too early but many young people indicate that their sex education is “too little and too late” and “focuses too much on biological issues rather than the emotional and social aspects of building relationships”.

Evidence from elsewhere (Hosie, 2002, Kirby 2003) suggests that home based school assignments could improve parent-teen communication and knowledge and reach large numbers of parents. In addition interventions, which involve direct communication between parents and children at home or in special sessions, are likely to increase subsequent communication.
3.3 PARENTAL COMMUNICATION

Family characteristics such as parental support, connectedness and parental monitoring (in terms of control or restrictiveness) and low family conflict, combined with parent-child communication can help reduce adolescent risk taking (Dickson et al 1998, Ingham 2002, Sweeting et al 1998, Jaccard 1996).

Nearly half of young people (46%) said that they received ‘nothing’ or ‘not a lot’ of information on sex and relationships from their parents. More than half (52%) said they found it quite or very easy to talk to their mother about sex and relationships, but only a quarter (26%) said the same for their father. Over a third (38%) said they found it very difficult to talk to their father (BMRB 2003).

Young people aged 12–15 who participated in the HBSC survey were asked about their preferred sources of sex and relationships information (Currie et al 1999)). The majority of both boys and girls said their preferred source was their parents.

Parents feel strongly that there would be fewer teenage pregnancies if more parents talked to their children about sex, relationships and contraception. However, many feel ill equipped to undertake this role (Walker 2001, Ingham 2002, Walker 2004).

3.4 SEXUAL HEALTH SERVICES

When young people were asked about which attributes were important in seeking advice on sexual health and relationships, they identified confidentiality/privacy (60%); friendly staff (50%); being able to discuss things with someone of your own sex (36%); not being seen by anyone they knew (29%); convenient location (24%); and long opening hours (16%). Confidentiality/privacy was given as the single most important factor (BMRB International 2003).

Young people describe their ideal contraceptive service as confidential; easily accessible with minimal fear and embarrassment; frequent opening times; and operating as a walk-in centre with no appointment necessary. Other desirable features include having reception and waiting areas designed to minimise embarrassment, and staff who are warm, friendly, respectful and non-judgemental, who use non-medical language, who are well informed on gay and lesbian issues and make no assumptions about sexual orientation. (Butler and Solomon 2002, Barna et al, 2002, All I Want 2003)

The BMRB tracking survey (2003) found that 73% of young people aged 13–21 said they were aware of a clinic or other place they could visit in their local area if they wanted advice on sex. Girls were more likely than boys to be aware of a service, as were older rather than younger respondents. In a representative survey of nearly 3,000 members of the general population aged 18 and over in 2000, 64% of adults agreed that contraception should be more easily available to all teenagers, including those under 16. (Clarke and Thomson 2001). A recent survey in an area with high teenage pregnancies
revealed that whilst the majority of adults would tell a young person where they could obtain sexual health advice or contraceptive supplies, one in five respondents did not know where these services were located despite significant resources being locally available (Baraister et al 2004).

This survey also found that 44% of 13–21 year olds report having received some information on where they could go in their area for advice on sex and relationships. The most common forms in which this was conveyed were leaflets/flyers/postcards (60%), posters (29%) and radio advertisements/articles (23%).

The Healthy Respect communications activities found that around one in five young people attending the targeted further education colleges recalled the main convenience advertising message highlighting the need to “talk about contraception”. Overall feedback from young people suggested that they took appropriate action as a result of seeing a range of media about thinking about safer sex, seeking out sexual health services and talking about sexual health and relationships. The acceptability of accessing sexual health services among the target group appears to have increased following specific media campaigns (Healthy Respect 2004).

### 3.5 TEENAGE CONCEPTIONS

In the sample of 700 young people and 600 parents for the first wave of the BMRB tracking survey (2001), 67% of parents and 68% of young people felt that having a baby under 18 is ‘just about one of the worst things that could happen to a young person’.

Further research suggested that many adults thought that young people placed little importance on safety in terms of the prevention of pregnancy or STIs (Baraister et al 2004). Lack of information and irresponsibility were cited as the main reasons for this. This negative view of young people is of concern especially as many respondents were also parents who are potentially important sources of sexual health advice to young people.

### 3.6 SEXUALLY TRANSMITTED INFECTIONS

The 2003 BMRB tracking survey showed awareness of HIV/AIDS to be almost universal among young people (96%). However, knowledge of other STIs is lower: 69% were aware of genital warts, 69% hepatitis B, 69% syphilis, 69% gonorrhoea and 68% chlamydia.

Scottish respondents to the NATSAL survey (Macdowell 2002) indicated that they perceived their personal risk of HIV as being low. In 2004, the prevalence of HIV in Scotland is at its highest level to date and is likely to continue to increase year on year. Accordingly, people of all ages who have unprotected sex are at a greater risk of acquiring HIV than ever before.
4. Groups at Risk of Poor Sexual Health

Many groups face one or more barriers to maximising their sexual wellbeing. Improving the consistency, accessibility, quality, cultural competence and ethos of lifelong learning and appropriate and responsive sexual health services can reduce these barriers. However, there are groups whose sexual health is particularly poor (mainly due to increasing STIs and/or unintended pregnancies) or those who are hard to reach for whom additional support is required. These include the following:

4.1 THOSE EXPERIENCING DEPRIVATION

Young women from unskilled manual backgrounds are more than ten times as likely to become teenage mothers as those from professional backgrounds (social class I). Those living in areas with higher levels of social deprivation are also much more likely to conceive earlier, as well as being much less likely to opt for abortion. (Botting et al 1998). Drawing on the British Cohort Study 1970 (BCS70) women whose mother had no qualifications are about twice as likely to have a teen birth than those whose mother had some qualifications (Ermisch and Pevalin 2003). In addition, women whose mother was a teenage mother are about twice as likely to have a teen birth as those born to older mothers.

Recent UK research of mothers of twins showed that by the time their children were 5, those who had been teenage mothers had experienced more socio-economic deprivation, more mental health difficulties and drug problems, had lower levels of educational attainment, and were more likely to be living in deprived neighbourhoods. Their partners were more antisocial and abusive. Their children showed reduced educational attainment, had more emotional and behavioural problems, were at increased risk of maltreatment or harm, and showed higher rates of illness, accidents and injuries. (Moffit et al 2002)

4.2 LOOKED AFTER YOUNG PEOPLE

Between 14% and 25% of young women who have been looked after have a child by age 16 and nearly half become mothers within 18 to 24 months of leaving care. (Biehal 1992 and 1995, Garnett 1992, Corylon 1997)

4.3 YOUNG OFFENDERS

Estimates suggest that around 39% of young women under the age of 21 in prison are mothers, and one in four young men are fathers. (HM Chief Inspector of Prisons 1997). This is a similar picture for Scotland.
4.4 BLACK AND MINORITY ETHNIC COMMUNITIES

Caribbean, Pakistani and Bangladeshi women have higher teenage birth rates than white young women. In contrast, Indian young women have lower rates than white young women. Fertility rates in all South Asian groups have fallen substantially over the past 25 years, but have remained stable in white and black Caribbean young women. (Berthoud 2001, Low 2002). Those from ethnic minority groups tend to present late with sexual health problems – this is particularly true in relation to HIV (Sinyemu 2004). Cultural and religious attitudes to sexuality and marriage can pose difficulties, particularly for those young people who face dissonance between the dominant social norms of wider society and those of their family or faith group. This can lead to problems of acquiring knowledge about sexual health including SRE and accessing services (Low 2002).

4.5 THOSE WITH LEARNING DISABILITIES

The sexual health experiences and needs of young people with learning disabilities are varied and complex and issues will vary from individual to individual. However their sexuality is often ignored, stereotyped or distorted which may lead to the development of low expectations about sexual relationships and impact on their self esteem (Douglas Scott, 2003).

Young people who are lesbian, gay or bisexual

The assumption of heterosexuality as the norm in sexual relationships, particularly demonstrated in the media and in some SRE programmes, continues to create stigma and discrimination (Buston and Hart 2001, Lumsdaine 2002). This can lead to feelings of isolation, stress and anxiety for young people who are lesbian, gay or bisexual (LGB) (Donald and Bux 1996, Coia et al 2002, Beyond Barriers 2003). Seventy per cent of LGB people in Scotland have been verbally abused or threatened because of their sexual orientation. Young LGB people are more likely to engage in risk taking behaviours and are at high risk from suicide in response to their social isolation and vulnerability. Access to services can be problematic – reasons include fear of being identified as LGB, attitudes of staff, over-focus on sexual health issues rather than the inclusion of mental health issues (Lumsdaine 2002).
5. Effective Interventions Aimed at Preventing Unintended Pregnancy and STIS among Young People

5.1 IMPROVING SELF ESTEEM (AND ASSETS)

There is emerging evidence to indicate that if young people are supported to develop their strengths (assets) they are less likely to engage in risk taking behaviour, including delaying sexual activity until at least age 17 and increased contraceptive use (Oman et al 2004). These protective factors appear not to be affected by demographic variables such as age, gender, socio economic status and family structure. These include constructive use of time, positive adult and peer role models. This has important lessons for those involved in youth work settings and working with young people who are already sexually active or at risk for initial sexual debut.

5.2 PROMOTING POSITIVE SEXUAL HEALTH MEDIA

A multi-faceted approach which combines media campaigns, media advocacy and media literacy appears to be the most successful intervention in influencing sexual attitudes and behaviour among young people. Key components include:

- A single clear and consistent message which is constantly reinforced over time
- Factual and non judgmental statements
- Respectful to the target audience (and involving them in design and delivery, for example as peer role models)
- Use of different formats
- Targeting specific groups where appropriate

5.3 SEX AND RELATIONSHIPS EDUCATION (SRE)

There is good evidence that school-based SRE, particularly when linked to contraceptive services, can impact on young people’s knowledge and attitudes, delay sexual activity and/or reduce pregnancy rates (Swann et al 2003). There is no evidence to support the view that increased provision of SRE increases the onset or frequency of sex, or the number of sexual partners. (Kirby 2001) and at present there is only weak evidence that peer-led approaches are effective. (Swann et al 2003).

Effective SRE programmes
Kirby identified ten characteristics of effective sex and HIV education programmes. These include:

- Having a focus on reducing sexual behaviours that leads to unintended pregnancy or HIV/STIs;
- Being based on theory, identify specific sexual antecedents to be targeted;
- Having clear messages about abstaining from sex and/or using contraception;
- Information about risks of sex and ways to avoid intercourse or protect against pregnancy and STIs;
- Including activities to resist social and peer pressures;
- Including examples of, and practice with, communication, negotiation and refusal skills;
- Involving participatory teaching methods;
- Having goals, teaching methods and materials that match the group’s needs;
- Being of adequate and substantial duration; and
- Being led by those who believe in the programme and receive training.

The secondary school based SHARE programme (Sexual Health and Relationships Education: Safe, Happy and Responsible) has been rated highly by those young people who received it, has had some impact on knowledge, and reduced the level of reported regret over first sexual intercourse. The greatest effects were found on those who were sexually active at the start of programmes. However, it had no effects on contraceptive use and sexual behaviour. The results suggest that specific programmes on their own are unlikely to reduce conception rates, but are an essential part of a multi-faceted approach. (Wight et al 2002) In addition the experience of Phase One of Healthy Respect reinforced the value of multidisciplinary approach to SRE training and provision.

An intervention in which teachers gave a single lesson on emergency contraception to year 10 (14–15 year old) pupils resulted in increased proportions knowing the correct time limits for both types of emergency contraception at a six-month follow-up. There was no evidence of a change in either pupils’ sexual activity or their use of emergency contraception. (Graham et al 2002)

**Abstinence**

It is acknowledged that abstinence has an important role to play in preventing sexually transmitted infections and unintended pregnancies. However, there are many definitions of abstinence and it means different things to different people. For some, it means abstaining from vaginal penetration and engaging in oral or anal sex as alternatives. For others it means abstaining from sexual activity until marriage. It is therefore important to understand both the positive impact it can have as a preventive measure but also to recognise that its use might also have significant negative effects (for example in making people ignorant of risks when they become sexually active).

There is no strong evidence of the effectiveness of abstinence only education approaches (as defined in the US funded programmes as “sexual activity outside of marriage being wrong and harmful for people of any age” and thus prohibiting the promotion of contraception). (Swann et al 2003, SHWLN Briefing Paper (in press), The Alan Guttmacher Institute 2003) Applying strict methodological criteria to assess whether teenage pregnancy prevention interventions are effective, DiCenso concluded that there is some evidence that abstinence approaches may actually increase pregnancy rates due to the failure to use contraception. Specifically, this effect was seen in the female partners of male participants in the interventions. (DiCenso et al 2002).
However, programmes which include a focus on delaying sexual activity and which provide contraception and advice can reduce the incidence of regret among young people and once they are sexually active, improve consistent contraceptive use and fewer sexual partners.

5.4 LINKING WITH OTHER SCHOOL BASED AND OUTREACH PROGRAMMES

Many young people comment on the timing and content of their school based SRE – in particular they suggest that it is too “little and too late”. Emerging evidence from the Zero Tolerance Respect pilots suggests that promoting the values of relationships based on equality and respect at an early stage can help reduce homophobic attitudes and behaviour and may influence the timing of initial sexual activity. (Reid Howie Associates 2001). Providing this to older primary school pupils who subsequently receive the SHARE programme in secondary school is an area worth further exploration.

5.5 WORKING WITH PARENTS (AND SIGNIFICANT OTHERS)

There is good evidence that including teenagers' parents in information and prevention programmes is effective. Further, young people whose parents discuss sexual matters with them are more likely to use contraception at first intercourse. (Swann et al 2003, Stone and Ingham 2002)

Starting sex education in the early years, when children are of primary school age, has multiple benefits for both parents and children. This is because parents find it easier to talk about the subject at this age (McGuire 1996); it reduces the risk of teenage pregnancy later (NHSCRD 1997; Aggleton et al 1998) and improves parent-child communication overall where the child is an active participant in discussions rather than the passive recipient. In addition, a parent’s self efficacy, in being able to talk about sexual health issues with their child is a significant factor – health education can help dispel myths, remove barriers and support their partnership with schools in providing consistent SRE messages between home and schools (Few et al 1996, Walker 2001). In order to do this, parents need to be aware of the timing and content on their child’s SRE (which should occur if the recommendations from the report of the Working Party on Sex Education in Scottish Schools are followed (McCabe, 2000)). Aggleton et al (1998) and Hosie (2002) found that combining formal and informal SRE in Scandinavian countries, together with other factors, was responsible for low teenage pregnancy rates.

Parents need support and practice guidance in what to say, when to say it and how to approach it. Accessing resources is a major facilitating factor (Walker 2004). Fathers in particular need support to engage with their sons given that the evidence indicates that they are least likely to be involved in informal SRE.
5.6 SEXUAL HEALTH SERVICES

There has been little evaluation of the impact of contraceptive provision although there is good evidence to support services adopting the following characteristics (Swann et al 2003):

- Long-term provision;
- Clear, unambiguous information and messages;
- Services and interventions tailored to meet local needs;
- Focus on local high-risk groups;
- Key opportunities taken to deliver information and advice, eg negative pregnancy tests;
- Checks that interventions and services are accessible to young people;
- Selected and trained staff who are committed to programme and service goals;
- Respect for the confidentiality of young people;
- Joined-up services and interventions with other services for young people, aimed at preventing pregnancy and sexually transmitted infections.

There is no evidence to support notions that use of family planning clinics, school-based health clinics and school-linked clinics increases sexual activity rates. (Kirby 2001). The HDA review of reviews concluded that evidence surrounding any positive impact of school condom availability programmes is not clear. (Swann et al 2003)

Analysis from the SHARE questionnaires found that perceived need, knowledge and ability to access were important influences on the use of sexual health services (Parkes et al 2004). Many young people delayed using services until they had had intercourse more than once or with more than one partner: improving knowledge of, and being comfortable talking about sexual health and a perception of the effectiveness of school-based SRE, is associated with greater ease of future access to services. Proximity of services was also an influence – exploratory modelling found that increased school proximity to youth clinics was a critical factor.

5.7 YOUTH DEVELOPMENT PROGRAMMES

American youth development programmes have been shown to be the most promising approaches to teenage pregnancy prevention intervention. Reviews agree that there is evidence to support the effectiveness of a number of different models which combine some or all of the following: self-esteem building, voluntary work, educational support, vocational preparation, healthcare, sports and arts activities, and SRE. (Swann et al 2003, Kirby 2001).

5.8 EFFECTIVENESS OF A MULTIFACETED APPROACH

Explanations for recent dramatic decreases in teenage birth rates in the USA have been subject to much speculation. Analysis by the Alan Guttmacher Institute explored the main
contributing factors. They suggested that increased abstinence among young women had made some difference but, more significantly, it was due to increased use of newly available, more effective, long-acting hormonal methods of contraception in sexually active young women, in place of other less effective methods. Both these behavioural changes are influenced by broad societal changes in policy, programmes, attitudes and values, and the report does not quantify the relative impact of these. The decline in birth rates began several years before abstinence education came to prominence.

This report concludes: ‘these findings suggest that the best strategy for continuing the declines in teenage pregnancy levels is a multi-faceted approach.’ It states that although policies and programmes should encourage young people to delay first intercourse, they should recognise that most young people become sexually active in their teens. As a consequence, services should be in place that help them adequately to prevent pregnancy and STIs – ‘that means providing adequate education and information about sexual behaviour and its consequences, as well as confidential, affordable and accessible sources of contraceptive services and supplies.’ (Darroch and Singh 1999)

More recent research by the Alan Guttmacher Institute compared rates of teenage pregnancy in five developed nations. Comprehensive and balanced information about sexuality was associated with lower levels of adolescent pregnancy, easy access to contraceptives and other reproductive health services. This is confirmed by the Innocenti Report Card (UNICEF 2001) which concluded that improving access to contraception, provision of quality sex education and building incentives to avoid early parenthood are the main characteristics of countries with lower rates.

Kirby’s review of the evidence surrounding specific types of pregnancy prevention initiatives concluded by stating that ‘professionals working with youth should not adopt simplistic solutions with little chance of making a dent on the complex problem of teenage pregnancy.’ (Kirby 2001)

The Teenage Pregnancy Unit in England commissioned research to identify factors that might have contributed to changes in under-16 conception rates at local level between 1991 and 1997. This found that the 20 areas with the greatest decreases were more likely to recall having made concerted efforts in five key areas, compared with the 20 sites with the largest increases. These key areas were:

- Establishing inter-agency groups concerned specifically with sex and relationships education/teenage pregnancy
- Appointment of new staff to offer specialist advice on sex education
- Introduction of additional training for teachers involved in personal, social and health education
- Consultation with, and/or targeting, young people regarding sexual health
- Establishing new young people’s sexual health services. (Ingham et al 2000)

- All of this reflects the main focus of Healthy Respect in its Phase Two activities.
Appendix 2

TASK GROUP REMIT

- Provide guidance on evidence around young people’s sexual health
- Provide guidance on political/policy context around young people’s sexual health
- Keep Healthy Respect aligned with the strategic objectives of Phase 2 of the demonstration programme

MEMBERSHIP OF THE GROUP

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organisation</th>
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<tbody>
<tr>
<td>Danny Wight (Chair)</td>
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<td>Rod Burns</td>
<td>Pupil Support and Inclusion</td>
<td>Education Department, Scottish Executive</td>
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APPENDIX 3

HR2 Organisational Structure

Scottish Executive Health Improvement Strategy Division

Lothian Sexual Health Strategy Project Board

Healthy Respect Evaluation Advisory Group

Director of Public Health

Healthy Respect & Sexual Health Business Sub Group

DONA MILNE
Healthy Respect Manager

PAN LOTHIAN
Work Continued from Phase One

LOCALITY APPROACH
School, youth settings, parents

COMMUNICATIONS / EVALUATION
Young people, parents, stakeholders

Schools
(N.B. all Part-Time)
Dorothy Fleming (WL)
Fiona Gavin (WL)
Jackie Baggot (WL)
Lorraine McLean (WL)
Marilyn Woodhead (WL)
Ruth Paton-Smith (ML)
Sue Rust (Edin)
Chris MacGillvray (Edin)
Janet McGhee (Edin)
Janice McLeod (EL)

Midlothian, North Edinburgh and Catholic Schools
Christine Wallis (E & S)
Katy Carrick-Anderson (S)
Moray Paterson (E & T)
Kirsten Kernaghan (S)
Rachael Yates (E & T)
Vacancy:
Primary Schools and Catholic Schools (E)

Ben Rowlands (Evaluation)
Wendy Ball (Brand/Print)
Yvonne Powell (Communications)
Dan Plant (Design)
Vacancy: Evaluation Officer

SUPPORT SERVICES: Terry Forker, Leanne Hughes and Sandra Dickson

E = Education  T = Training  S = Services
Sexual Health and Healthy Respect Planning Structures

Current working groups:
- Learning Disability and Sexual Health Working Group

Glossary
- SHPG: Sexual Health Promotion Group
- CHPs: Community Health Partnerships
- HR SG: Healthy Respect Steering Group
Healthy Respect Phase 2 Costs 2005 - 2008

The total cost of delivering Healthy Respect Phase Two will be £2.5 million. The Scottish Executive have made a total contribution of £2.08 million towards the project with the balance of resources being provided by Lothian NHS and it’s partners.

<table>
<thead>
<tr>
<th>Budget Heading</th>
<th>2005-06</th>
<th>2006-07</th>
<th>2007-08</th>
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<tbody>
<tr>
<td><strong>Education and Services Phase One Continuation</strong></td>
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<tr>
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<td><strong>Education and Services Phase Two</strong></td>
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<td><strong>Total</strong></td>
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<td>195947</td>
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<td><strong>Evaluation, Project Management and Support Services</strong></td>
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<td>Non Pay</td>
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<tr>
<td><strong>Total</strong></td>
<td>914331</td>
<td>887885</td>
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Objective: One
School based sex and relationships education
To improve young people’s knowledge, attitudes and ability to communicate about sexual health and respectful relationships through the provision of focussed Sex and Relationships Education (SRE) programmes in schools in Midlothian and North West Edinburgh.

To deliver a comprehensive package of sex and relationships education to young people with support for parents:
- Within 10 schools from HR1
- Across all 7 secondary schools and a range of informal education settings within Midlothian (Schools include 1 school from HR1, 4 new schools, 1 denominational school, and 1 special education school).
- Across two secondary schools and a range of informal education settings within North West Edinburgh (Schools include 1 school from HR 1, and 1 new secondary school).
- Across primary school clusters surrounding two of the HR1 schools (10 primary schools in Midlothian and 3 primary schools in North West Edinburgh).
- Within the 3 Edinburgh Catholic secondary schools.

Outcome(s):
Deliver a comprehensive package of sex and relationships education within secondary schools.

Schools include:
10 from HR1 (in City of Edinburgh, Midlothian, East Lothian & West Lothian)
7 in Midlothian (including special needs and denominational)
2 in NW Edinburgh.
3 Catholic secondary schools in Edinburgh

<table>
<thead>
<tr>
<th>Output/ Methods:</th>
<th>Timescales</th>
<th>Partners</th>
<th>Role of Worker</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop SRE assessment tool</td>
<td>By May 05</td>
<td>HR, Ed. Dept, Learning Network, SEED, LTS</td>
<td>Develop tool</td>
<td>Research evidence</td>
</tr>
<tr>
<td>Write up Healthy Respect’s expectations around SHARE (How school will deliver, training programme)</td>
<td>By May 05</td>
<td>HR, Ed. Dept</td>
<td>Clarify and establish SHARE classroom and training programme</td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>Start Date</td>
<td>Responsible Party</td>
<td>Details</td>
<td>Source</td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Develop SHARE training programme and materials (inc session on parents)</td>
<td>By May 05</td>
<td>HR, Ed. Dept</td>
<td>Design training programme</td>
<td>Training budget</td>
</tr>
<tr>
<td>Develop Healthy Respect SHARE homework exercise.</td>
<td>May 05 – Dec 05:</td>
<td>Health Scotland Local Authorities to take lead on gathering evaluation from Young people and parents.</td>
<td>SHPS – lead development and co-ordination using external consultants as appropriate.</td>
<td>Enhanced SHARE programme from NHS Health Scot.</td>
</tr>
<tr>
<td></td>
<td>Jan 06 – June 06:</td>
<td>pilot in one school</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>August 06:</td>
<td>Roll out element to all Healthy Respect Schools.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meet with individual school.</td>
<td>By June 05</td>
<td>HR, school, Ed Dept</td>
<td>Lead discussions</td>
<td></td>
</tr>
<tr>
<td>Conduct needs assessment with individual school. (including consultation)</td>
<td>By End June 05</td>
<td>HR, School</td>
<td>Assess schools needs, consult parents &amp; YP. Review curriculum jointly with school staff.</td>
<td>Staff time</td>
</tr>
<tr>
<td>Create and agree on development plan for individual school.</td>
<td>By End June 05</td>
<td>HR, School</td>
<td>SHPS to lead in writing development plan</td>
<td></td>
</tr>
<tr>
<td>Using a range of options for each school, in line with development plan, create a tailored ‘menu’ of opportunities to meet with parents and offer support.</td>
<td>By End June 05</td>
<td>HR, School</td>
<td>SHPS to lead development of ‘menu’.</td>
<td>Staff time</td>
</tr>
<tr>
<td>Activity</td>
<td>Timeline</td>
<td>Responsible Party</td>
<td>Budget Responsibility</td>
<td></td>
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<tr>
<td>-------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Develop a training session and resources for teachers and external agencies delivering SRE, to enable them to offer support to parents in a variety of formats and settings.</td>
<td>By End June 05 – pilot session.</td>
<td>SHPS to co-ordinate dissemination of this session to SHARE trainers.</td>
<td>Staff time</td>
<td></td>
</tr>
<tr>
<td>Disseminate HR Schools SRE Framework across Lothian schools</td>
<td>By August 05</td>
<td>HR, Ed. Dept</td>
<td>Print Budget</td>
<td></td>
</tr>
<tr>
<td>Deliver teacher training programme</td>
<td>4 SHARE training sessions by Oct 05 3 SHARE training sessions Oct – Mar 06</td>
<td>HR, Ed. Dept, Schools, Sexual Health Team</td>
<td>Training budget</td>
<td></td>
</tr>
<tr>
<td>Establish structural systems for on-going support and CPD</td>
<td>4 CPD sessions pan Lothian by March 06</td>
<td>HR, Ed. Dept, Schools, Sexual Health Team</td>
<td>Training budget</td>
<td></td>
</tr>
<tr>
<td>Deliver training sessions on Supporting Parents</td>
<td>Roll out session August 05 onwards.</td>
<td>SHPS lead in the delivery of training</td>
<td>Training budget</td>
<td></td>
</tr>
<tr>
<td>Develop HR Schools SRE Framework for denominational schools</td>
<td>By June 06</td>
<td>HR, Ed. Dept, Catholic Education Service</td>
<td>Staff time</td>
<td></td>
</tr>
<tr>
<td>Disseminate HR Schools SRE Framework across denominational schools</td>
<td>By August 06</td>
<td>HR, Ed. Dept, Catholic Education Service</td>
<td>Print Budget</td>
<td></td>
</tr>
</tbody>
</table>

HEALTHY RESPECT PHASE TWO
<table>
<thead>
<tr>
<th>Deliver training for trainers. (1 trainer in each school)</th>
<th>Year 3</th>
<th>Health Scotland</th>
<th>Training budget</th>
</tr>
</thead>
</table>

**EVALUATION CRITERIA/OUTCOME INDICATORS**
(How you know what has been achieved/how successful it is)

- All existing and new schools will have included in their development plan a commitment to a variety of options for supporting parents and carers to develop knowledge and skills to enable them to talk to their child about relationships, sexual health and wellbeing.
- All SRE deliverers will have completed a session on working with parents and carers.
- Resource and training materials will be available for other workers to use to train other SRE deliverers in the future.

**PROCESS OUTCOMES**

- Better integration of SRE and sexual health services, with a continuing emphasis on multi-sectoral and multi-disciplinary partnership working.
- Implementation of the Healthy Respect schools framework (in non-denominational schools) and development of appropriate SRE protocols and materials in the denominational school setting.
- Capturing the spectrum of young people's perspectives on SRE, service availability and the connections between them.
- Increased teacher confidence in SRE delivery and lessons for wider applicability, including resource implications.
- Learning around confidentiality in policy and practice in schools.
- Implementation of a package delivered to pupils in primaries 6 and 7 as a pre-cursor to a secondary school SRE intervention.
- Fuller and more consistent engagement with parents in all aspects of SRE delivery.
Outcome(s):

Zero Tolerance Respect package delivered in primary school clusters surrounding two of the HR1 secondary schools in Midlothian and NW Edinburgh.

<table>
<thead>
<tr>
<th>Output/Methods:</th>
<th>Timescales</th>
<th>Partners</th>
<th>Role of Worker</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meet with cluster groups. (Mid &amp; NW)</td>
<td>By June 05</td>
<td>Ed. Dept, schools team</td>
<td>Lead discussions on Healthy Respect and future objectives.</td>
<td></td>
</tr>
<tr>
<td>Organise vision day (ZT Respect programme, links to secondary school SRE)</td>
<td>By August 05</td>
<td>Ed. Dept, Schools</td>
<td>Lead discussions around development of Respect package</td>
<td>Training budget</td>
</tr>
<tr>
<td>Plan and agree cluster-wide approach</td>
<td>By August 05</td>
<td>Ed. Dept, ZT</td>
<td>Write plan</td>
<td>Staff time</td>
</tr>
<tr>
<td>Conduct needs assessment with individual school. (including consultation)</td>
<td>September 05</td>
<td>HR, school</td>
<td>Lead in needs assessment work</td>
<td>Staff time</td>
</tr>
<tr>
<td>Create development plan for individual primary schools.</td>
<td>By End September 05</td>
<td>HR, school</td>
<td>Write plan for individual school</td>
<td>Staff time</td>
</tr>
<tr>
<td>Implement development plan with individual primary school.</td>
<td>October 05</td>
<td>HR, school, ZT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commission and deliver ZT Respect training for individual school.</td>
<td>December 05</td>
<td>ZT, Ed. Dept,</td>
<td>Oversee training programme</td>
<td>Training budget</td>
</tr>
</tbody>
</table>
Plan and implement on-going support strategy for individual school.

<table>
<thead>
<tr>
<th>Year 3</th>
<th>HR, Ed. Dept, School</th>
<th>Lead in planning work</th>
</tr>
</thead>
</table>

**EVALUATION CRITERIA/OUTCOME INDICATORS**
(How you know what has been achieved/how successful it is)

- All primary schools across 2 clusters delivering ZT Respect programme.
- Teachers in Healthy Respect primary schools have completed ZT Respect training programme.

**Priority/links to Strategic plans/other policies:**

Sexual Health & Wellbeing Strategy, Being Well – Doing Well, a Framework for Health Promoting Schools in Scotland, 3 – 18 Curriculum Review
Objective: Two
Sex and relationships support for young people at risk
To improve the knowledge, attitudes and the ability to communicate about sexual health and respectful relationships of young people at high risk of poor sexual health outcomes through youth work, schools and support agencies.

Work with those who support young people

Outcome(s):
Deliver a comprehensive package of sex and relationships education in a range of informal education settings within Midlothian and NW Edinburgh.

<table>
<thead>
<tr>
<th>Output/Methods:</th>
<th>Timescales</th>
<th>Partners</th>
<th>Role of Worker</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engage with local youth strategy / planning groups. (Mid &amp; NW Edin)</td>
<td>By May 05</td>
<td>Comm Ed, Social Work, Vol Sector</td>
<td>Identify relevant networks</td>
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<tr>
<td>Present Healthy Respect model and future objectives.</td>
<td>May 05</td>
<td></td>
<td>Deliver presentations on HR2</td>
<td></td>
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<tr>
<td>Identify appropriate settings. (LAAYP / School excludees / BME / LGBT / SEN-LD)</td>
<td>End May 05</td>
<td>Comm Ed, Social Work, Vol Sector, Sexual Health Promotion Group</td>
<td>Identify key agencies</td>
<td></td>
</tr>
<tr>
<td>Invite settings to participate in multi-disciplinary SHARE training (Education objective)</td>
<td>4 SHARE courses by Oct 05 further 3 courses during October-March 06</td>
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<td>Organise and deliver SHARE training</td>
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</table>

Training budget
<table>
<thead>
<tr>
<th>Task</th>
<th>Settings</th>
<th>Stakeholders</th>
<th>Details</th>
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<tbody>
<tr>
<td>Meet with individual settings / agencies.</td>
<td>4 settings in NW, 4 in Mid by Oct 05</td>
<td>Negotiate working relationship</td>
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<tr>
<td></td>
<td>4 settings in NW, 4 in Mid Oct – Mar 06</td>
<td></td>
<td></td>
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<tr>
<td>Conduct needs assessment with individual setting.</td>
<td>4 settings in NW, 4 in Mid by Oct 05</td>
<td>Comm Ed, Social Work, Vol Sector</td>
<td>Lead in needs assessment</td>
</tr>
<tr>
<td>(including consultation)</td>
<td>4 settings in NW, 4 in Mid Oct – Mar 06</td>
<td></td>
<td>Staff time</td>
</tr>
<tr>
<td>Create and agree on development plan for individual setting.</td>
<td>4 settings in NW, 4 in Mid by Oct 05</td>
<td>Comm Ed, Social Work, Vol Sector</td>
<td>Write development plan</td>
</tr>
<tr>
<td></td>
<td>4 settings in NW, 4 in Mid Oct – Mar 06</td>
<td></td>
<td>Staff Time</td>
</tr>
<tr>
<td>Work with settings to develop programmes &amp; curriculum for work with young people</td>
<td>4 settings in NW, 4 in Mid Oct 05 onwards</td>
<td>Comm Ed, Social Work, Vol Sector</td>
<td>Lead in development of materials and programmes</td>
</tr>
<tr>
<td></td>
<td>4 settings in NW, 4 in Mid Mar 06 onwards</td>
<td></td>
<td>Staff time, resources budget, training budget</td>
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**EVALUATION CRITERIA/OUTCOME INDICATORS**

(How you know what has been achieved/how successful it is)

- Implementation of acceptable (to young people, parents and professional) SRE packages with hard to reach young people through existing youth strategy and youth work agencies.
- All SRE deliverers have undertaken appropriate training.
## Work with those who support parents & families

<table>
<thead>
<tr>
<th>Activity Description</th>
<th>Date</th>
<th>Responsible Parties</th>
<th>Support Provided</th>
<th>Resource Requirements</th>
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<tbody>
<tr>
<td>Assess, for those agencies working with excluded young people, what the agency is already doing to support parents and carers.</td>
<td>March 05</td>
<td>Local agencies</td>
<td>SHPS to carry out assessment</td>
<td>Staff time</td>
</tr>
<tr>
<td>Support to parents and carers clearly identified within the development plan of Working Together in Edinburgh and Social work department in Midlothian.</td>
<td>Year 2</td>
<td>Education department, Working Together, Community Education</td>
<td>SHPS, Working Together/Social Work to negotiate inclusion of support to parents into plans</td>
<td>Staff time</td>
</tr>
<tr>
<td>Devise a session on sexual health to form part of a community based programme on general parenting with sexual health included (used with families in the social work system that need support with parenting).</td>
<td>October 05</td>
<td>Social work agencies that develop generic programmes.</td>
<td>SHPS and local staff to co-write session</td>
<td>Staff time; resource development budget</td>
</tr>
<tr>
<td>Pilot the new sexual health session to workers in the NE children and family centre.</td>
<td>Year 2</td>
<td>Local agency</td>
<td>SHPS to co-facilitate session or set up co-facilitation with local workers. SHPS to lead on devising a training/briefing session to MP trainers in NW and Mid.</td>
<td>Staff time</td>
</tr>
</tbody>
</table>
Evaluation Criteria/Outcome Indicators
(How you know what has been achieved/how successful it is)

- Agencies working with hard to reach young people will have: written commitment to ongoing work with parents in their development plans and trained workers with skills to give support to these parents.
- Parents report increased communication; intentions, self efficacy and increased parental monitoring.
- Strong links will be established between local agencies to offer ongoing support to each other in the area of supporting parents in SRE.

Process Outcomes
- Greater consistency in delivery of SRE to all pupils, including looked after children, disaffected pupils and other vulnerable young people.
- School excludees targeted through existing youth strategy and social work teams and through secondary schools in both areas.
- Integrated education and service opportunities provided for hard to reach young people.
- Increased confidence of youth work and support agency staff to address SRE issues with young people.
- Interventions extended to support parents/carers of those excluded from school in Midlothian and North West Edinburgh.
- An increase in community capacity to support parents within North West Edinburgh and Midlothian.
Objective: Three
To improve young people’s access to health care through the provision of a range of generic drop-ins which link to specialist sexual health services.

Outcome(s):

- All drop-in services include provision of general health and relationship advice and information, and where appropriate access to pregnancy and chlamydia testing, condom provision.
- All services located within areas of high deprivation wherever possible, taking into account of young people’s desires for a range of service options based upon being local and/or anonymous.
- All services meeting standards outlined in HR drop-in guidelines “All I Want Live”.
- Management of all HR clinical drop-in services located within existing specialist sexual health services or primary care for future mainstreaming purposes.
- Audit of service delivery undertaken to assess what factors increase access and acceptability.

Output/Methods:

<table>
<thead>
<tr>
<th>Output/Methods:</th>
<th>Timescales</th>
<th>Partners</th>
<th>Role of Worker</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Services</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Map areas and identify opportunities for service development. (Use Depcat markers, and current service provision alongside schools SRE).</td>
<td>By April 05</td>
<td>Local sexual health promotion groups</td>
<td>Produce map. Identify opportunities for service development.</td>
<td>Staff time. HIU statistics.</td>
</tr>
<tr>
<td>Identify location and service model for new drop-in service. Models: A- generic drop-in within school B- drop-in within a Health Centre C- drop-in within a Voluntary/Community setting</td>
<td>By April 05</td>
<td>NHS Lothian Primary Care Education dept FPWW MYPAS</td>
<td>Identify appropriate service model, exploring feasibility and future mainstreaming</td>
<td>Staff time</td>
</tr>
<tr>
<td>Healthy Respect Phase Two</td>
<td>Begin by May 05</td>
<td>NHS Lothian Primary Care Education dept. WLDAS FPWW MYPAS</td>
<td>Conduct Consultation and Develop Needs Assessment Tool</td>
<td>Staff time</td>
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</tr>
<tr>
<td><strong>All Healthy Respect Drop-in services</strong></td>
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</tr>
<tr>
<td>Identify lead person and other staff within each drop-in</td>
<td>By April 05</td>
<td>NHS Lothian Primary Care Education Dept WLDAS FPWW School Nurses</td>
<td>Develop a communication network with each drop-in</td>
<td>Staff time</td>
</tr>
<tr>
<td>Consultation with individual drop-ins, to agree audit and implementation of ‘All I Want - Live’ standards.</td>
<td>By May 05</td>
<td>NHS Lothian Primary Care Education Dept WLDAS FPWW School Nurses</td>
<td>Develop partnerships and sharing of Phase 2 objectives</td>
<td>Staff time and Travel</td>
</tr>
<tr>
<td>Consult on, and implement monitoring forms to all drop-ins</td>
<td>By April 05</td>
<td>All HR drop-in services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audit Current practice against ‘All I want LIVE’ Guidelines.</td>
<td>Begin by June 05</td>
<td>As above FP-Nurse Consultant</td>
<td>Develop audit tool, and conduct audit</td>
<td>Staff time, travel/admin costs</td>
</tr>
<tr>
<td>Agree SLA’s with partners.</td>
<td>By June 05</td>
<td>NHS Lothian and All partners</td>
<td>Consult and develop with each individual drop-in service.</td>
<td>Written contract Staff time + travel costs.</td>
</tr>
<tr>
<td>Identify appropriate health information leaflets and resources for drop-ins and systems to support this</td>
<td>Begin by April 05</td>
<td>HR Branding Team and HR Admin Support</td>
<td>Lead person in each drop-in</td>
<td>Promotional Materials</td>
</tr>
<tr>
<td>Develop Implementation plan of ‘All I want LIVE’</td>
<td>Begin by Aug 05</td>
<td>As above</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop and identify links to specialist sexual health services, and youth support networks, including counselling</td>
<td></td>
<td>Multi-agency CY, GUM, FP, local agencies</td>
<td>Lead person from each drop-in</td>
<td>Staff time</td>
</tr>
<tr>
<td>Consultation with HR Evaluation Team to agree Evaluation methods</td>
<td>By end year 1</td>
<td>Lead agency</td>
<td>Develop tool. Link to other aspects of HR evaluation.</td>
<td>Staff time</td>
</tr>
<tr>
<td>Plan and Implement ongoing support and CPD</td>
<td>By June 05</td>
<td>NHS Lothian Primary Care Education dept. FFWW MYPAS School nurses WLDAS</td>
<td>Develop support and CPD programme</td>
<td>Staff time</td>
</tr>
<tr>
<td>Consult and offer receptionist training in all drop-in areas for staff around HR aims and ‘All I want’.</td>
<td>By end of year 1</td>
<td></td>
<td>Arrange and develop training</td>
<td>Staff time</td>
</tr>
<tr>
<td>To revisit mainstreaming of service and exit strategy of Healthy Respect</td>
<td>By end of year 2</td>
<td>NHS Lothian And local sexual health groups FP, MYPAS</td>
<td>Consultation and agreed plan</td>
<td>Staff time</td>
</tr>
<tr>
<td>To maintain links with evaluation team</td>
<td>Ongoing from April 05</td>
<td>NHS Lothian Evaluation team Drop-in staff</td>
<td>Regular communication between drop-in staff and evaluation team</td>
<td>Staff time</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>----------------------</td>
<td>----------------------------------------</td>
<td>-------------------------------------------------</td>
<td>------------</td>
</tr>
</tbody>
</table>

**Evaluation Criteria/Outcome Indicators**

(How you know what has been achieved/how successful it is)

- Appropriate drop-in services established (within or nearby) HR2 schools.
- Services located within areas of high deprivation
- Acceptable and accessible services established and used by young people.
- Services delivered by a range of existing agencies
- New and existing services conform to standards of ‘All I want Live’.
- CPD and ongoing support in place for staff
- Effectiveness and cost-effectiveness of services established
- Mainstreaming of effective services

**Priority/links to Strategic plans/other policies:**

**Objective: Four**
To promote the values of the Healthy Respect brand and demonstrate the effectiveness of an integrated communications programme to improve young people’s attitudes towards their sexual health and relationships, and that of others.

**Outcome(s):**

**Process:**
Implementation of the HR2 Communications Strategy - brand, web, print, media campaigns (in line with national campaigns) and PR.

**Impact:**
Healthy Respect branding and identification of key values recalled by the target audience (young people and partners) in Lothian.

Young people report a change in their values and attitudes to align with the values of Healthy Respect

<table>
<thead>
<tr>
<th>Output/Methods:</th>
<th>Timescales</th>
<th>Partners</th>
<th>Role of Worker</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Communications Strategy</strong></td>
<td>Conduct snapshot communications perception review</td>
<td>By Feb 05</td>
<td>Representative sample from HR Network</td>
<td>Co-ordinate</td>
</tr>
<tr>
<td></td>
<td>Develop Phase 2 Communication Strategy</td>
<td>By May 05</td>
<td>HR Team, HR Management, Stakeholders</td>
<td>Develop and implement</td>
</tr>
<tr>
<td></td>
<td>Review Phase 2 Communications Strategy and update annually (and identify any toolkits/leaflets required)</td>
<td>By May 06 to May 07</td>
<td>Representative sample from HR Network, HR Team</td>
<td>Co-ordinate</td>
</tr>
</tbody>
</table>

<p>| <strong>Brand Development &amp; Awareness</strong> | Produce &amp; distribute Brand Strategy (outlines the what &amp; how of HR) | By May 05 | All HR Partners | Co-ordinate | Staff time |
| | Update Brand Strategy annually (nb include changes in brand awareness) | On-going | All HR Partners | Co-ordinate | Staff time |</p>
<table>
<thead>
<tr>
<th>Support partners agencies in understanding the partnership dynamic with HR – visits/possible presentations</th>
<th>Ongoing</th>
<th>HR Network &amp; potential partners</th>
<th>Co-ordinate Present</th>
<th>Staff time</th>
</tr>
</thead>
</table>

**Public Relations**

**External audiences**

<table>
<thead>
<tr>
<th>Develop &amp; implement a Media Relations Plan</th>
<th>Yr 1 - 3</th>
<th>Local Authorities, Press Offices, Churches Media Offices, Sexual Health &amp; Wellbeing Learning Network</th>
<th>Dissemination (conferences, print materials) Co-ordinate Devise briefs</th>
<th>Copy write, Staff time,</th>
</tr>
</thead>
</table>

**Internal audiences**

<table>
<thead>
<tr>
<th>Develop &amp; implement two-way Internal Communications Plan to keep all partners updated on key issues and developments in communication</th>
<th>On-going</th>
<th>HR Team &amp; Partners</th>
<th>Staff time, Photography budget, Print production budget, Dissemination budget</th>
</tr>
</thead>
</table>

**Website**

<table>
<thead>
<tr>
<th>Re-build website (improved navigation and enhanced functionality in line with RNIB accessibility guidelines)</th>
<th>June 05</th>
<th>NHS Lothian IT department, External web design agency</th>
<th>Develop</th>
<th>Staff time (transition phase)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Continued development of web site (private HR area, increased interactivity)</th>
<th>October 05</th>
<th>NHS Lothian IT department, External web design agency</th>
<th>Develop</th>
<th>Staff time</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Maintain &amp; update website</th>
<th>Yr 1 - 3</th>
<th>HR Team &amp; Network</th>
<th>Monitor &amp; update content</th>
<th>Staff time (YP, NH, DP)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Quarterly report of web use</th>
<th>Yr 1 - 3</th>
<th>NHS Lothian IT Department</th>
<th>Collate report (hits: number/section/day</th>
<th>Staff time (NH, YP)</th>
</tr>
</thead>
</table>

<p>| 3 monthly review of web site | On-going | HR Team &amp; Network | Co-ordinate Implement | Staff time Illustration &amp; photography budget |</p>
<table>
<thead>
<tr>
<th>Promotion of website built into advertising campaigns and featured on all HR produced print materials</th>
<th>Yr 1-3</th>
<th>HR Team</th>
<th>Co-ordinate</th>
<th>Staff time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promotion of website on network sites/print materials</td>
<td>Yr 1 - 3</td>
<td>HR Network</td>
<td>Make new contacts, Build on existing alliances</td>
<td>Staff time</td>
</tr>
</tbody>
</table>

**Media Campaigns**

<table>
<thead>
<tr>
<th>Plan, develop, implement and evaluate annual advertising campaigns using social marketing techniques.</th>
<th>Yr 1 - 3</th>
<th>External research agency, External advertising agency, HR Network, HR Team, NHS Health Scotland</th>
<th>Co-ordinate Commission Consult</th>
<th>Budget for research, creative development, print production and media buying</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish an expert advisory group from the HR network for media campaign.</td>
<td>Yr 1 - 3</td>
<td>Sample from HR Network</td>
<td>Recruit &amp; co-ordinate</td>
<td>Staff time</td>
</tr>
</tbody>
</table>

**Print**

<table>
<thead>
<tr>
<th>Develop flexible visual identity guidelines for production of HR &amp; associated partner materials</th>
<th>By May 05</th>
<th>Sample from HR Network</th>
<th>Develop &amp; consult</th>
<th>Staff time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Produce bi-annual newsletter</td>
<td>On-going</td>
<td>HR Network</td>
<td>Write copy Design Edit Produce Distribute</td>
<td>Staff time Print budget</td>
</tr>
<tr>
<td>Review, update, produce and distribute &quot;Safe n’ sorted&quot; (young people’s guide to services in Lothian) for all S3 pupils in Lothian.</td>
<td>On-going</td>
<td>HR Network (especially Local Authorities)</td>
<td>Review Design Edit Produce Distribute</td>
<td>Staff time Budget</td>
</tr>
<tr>
<td>Produce Phase 2 Information Pack for professionals &amp; parents</td>
<td>By August 05</td>
<td>HR Team</td>
<td>Write Design Produce Distribute</td>
<td>Staff time Budget</td>
</tr>
<tr>
<td>Develop guidelines for producing effective communication material for young people</td>
<td>By September 05</td>
<td>NHS Health Scotland, TASC agency</td>
<td>Develop</td>
<td>Staff time</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Drop-in resources - further develop drop-in promotional items</td>
<td>On-going</td>
<td>HR Team</td>
<td>Co-ordinate, design, produce &amp; implement</td>
<td>Staff time Budget</td>
</tr>
<tr>
<td>Develop and produce print materials to support other objectives</td>
<td>On-going</td>
<td>HR Team</td>
<td>Edit Design Produce Distribute</td>
<td>Staff time Budget</td>
</tr>
</tbody>
</table>

**Events**

<table>
<thead>
<tr>
<th>Organise Phase 2 launch seminar for HR Network</th>
<th>June 05</th>
<th>HR Communications team HR Partners</th>
<th>Co-ordinate</th>
<th>Staff time Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Profile HR during health weeks</td>
<td>On-going</td>
<td>HR Communications team HR Partners</td>
<td>Co-ordinate</td>
<td>Staff time Budget</td>
</tr>
</tbody>
</table>

**Distribution**

- Review current distribution channels
- Establish database for phase 2
- Update & monitor as part of implementing the Communications Strategy

| Yr 1 - 3 | HR Team | Staff time |
### Evaluation Criteria/Outcome Indicators

#### Process:
- Implementation of the HR2 Communications Strategy - brand, web, print, media campaigns (in line with national campaigns) and PR.

#### Impact:
- Healthy Respect branding and identification of key values recalled by the target audience (young people and partners) in Lothian.
- Young people report a change in their values and attitudes to align with the values of Healthy Respect.

### Priority/links to Strategic plans/other policies:

Sexual Health & Wellbeing Strategy, NHS Lothian Communication Strategy
# Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BME</td>
<td>Black Minority Ethnic</td>
</tr>
<tr>
<td>Comm. Ed</td>
<td>Community Education</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
</tr>
<tr>
<td>CY</td>
<td>Caledonia Youth</td>
</tr>
<tr>
<td>Ed. Dept</td>
<td>Education Department</td>
</tr>
<tr>
<td>GUM</td>
<td>Genito-Urinary Medicine</td>
</tr>
<tr>
<td>HR</td>
<td>Healthy Respect</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>FPWW</td>
<td>Family Planning and Well Woman</td>
</tr>
<tr>
<td>LAAYP</td>
<td>Looked After and Accommodated Young People</td>
</tr>
<tr>
<td>LGBT</td>
<td>Lesbian, Gay, BiSexual and Transgender Service</td>
</tr>
<tr>
<td>LTS</td>
<td>Learning Teaching Scotland</td>
</tr>
<tr>
<td>Mid</td>
<td>Midlothian</td>
</tr>
<tr>
<td>Mid &amp; NW</td>
<td>Midlothian and North West Edinburgh</td>
</tr>
<tr>
<td>MP</td>
<td>Mellow Parenting</td>
</tr>
<tr>
<td>MYPAS</td>
<td>Midlothian Young Peoples Advisory Service</td>
</tr>
<tr>
<td>NW</td>
<td>North West Edinburgh</td>
</tr>
<tr>
<td>SEED</td>
<td>Scottish Executive Education Department</td>
</tr>
<tr>
<td>SEN-LD</td>
<td>Special Educational Needs – Learning Disability</td>
</tr>
<tr>
<td>SHARE</td>
<td>Sexual Health and Relationships Education Package</td>
</tr>
<tr>
<td>SHPS</td>
<td>Senior Health Promotion Specialist</td>
</tr>
<tr>
<td>SLA</td>
<td>Service Level Agreement</td>
</tr>
<tr>
<td>SRE</td>
<td>Sex and Relationships Education</td>
</tr>
<tr>
<td>WLDAS</td>
<td>West Lothian Drug and Alcohol Service</td>
</tr>
<tr>
<td>YP</td>
<td>Young People</td>
</tr>
<tr>
<td>ZT</td>
<td>Zero Tolerance</td>
</tr>
</tbody>
</table>
## Appendix 8

<table>
<thead>
<tr>
<th>HR Phase2 - School Populations and associated drop-ins</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase1 2y School Populations</strong></td>
</tr>
<tr>
<td>Population</td>
</tr>
<tr>
<td>Newbattle Community HS</td>
</tr>
<tr>
<td>Craigroyston Community HS</td>
</tr>
<tr>
<td>Wester Hailes Education Centre</td>
</tr>
<tr>
<td>Queensferry High School</td>
</tr>
<tr>
<td>Musselburgh Grammar School</td>
</tr>
<tr>
<td>Broxburn Academy</td>
</tr>
<tr>
<td>James Young Community HS</td>
</tr>
<tr>
<td>Bathgate Academy</td>
</tr>
<tr>
<td>Deans Community HS</td>
</tr>
<tr>
<td>Whitburn Academy</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

| **Phase2 2y School Populations**                      |
| Beeslack Community HS         | 983             |
| Dalkeith HS                   | 770             |
| Lasswade HS Centre            | 1292            |
| Penicuick HS                  | 816             |
| St Davids RC HS               | 891             |
| Holy Rood RC HS               | 1043            |
| St Augustines RC HS           | 850             |
| St Thomas of Aquin's RC HS    | 694             |
| Broughton HS                  | 1092            |
| Saltergate (Special School)   | 120             |
| **Total**                     | **8551**        |

| **Primary School Populations**                         |
| Craighroyston Primary                                 | 343             |
| Primiehall Primary                                   | 237             |
| Forthview Primary                                    | 258             |
| Mayfield Primary                                     | 303             |
| Bryans Primary                                       | 195             |
| Langlaw Primary                                      | 155             |
| Newtonongrange Primary                                | 387             |
| Gorebridge Primary                                   | 353             |
| Borthwick Primary                                    | 38              |
| Temple Primary                                       | 41              |
| Stobhill Primary                                     | 118             |
| St Andrew's RC Primary                                | 143             |
| St Lukes RC Primary                                  | 146             |
| **Total**                                             | **2717**        |

| **Phase 1 2y Schools**                                | **8829**        |
| **Phase 2 2y Schools**                                | **8551**        |
| Grand Tot. Schools Target                             | 20097           |
| **Primary Schools**                                   | **2717**        |
Estimated population by sex, and administrative area; 30 June 2003

<table>
<thead>
<tr>
<th>Administrative Area</th>
<th>All Ages</th>
<th>10-18 Year Olds</th>
<th>10-19 Year Olds</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Both Males Females</td>
<td>Both Males Females</td>
</tr>
<tr>
<td>East Lothian</td>
<td>91,090</td>
<td>10,729 5,555 5,174</td>
<td>11,494 5,968 5,526</td>
</tr>
<tr>
<td>Edinburgh, City of</td>
<td>448,370</td>
<td>43,327 22,161 21,166</td>
<td>50,152 25,277 24,875</td>
</tr>
<tr>
<td>Midlothian</td>
<td>79,710</td>
<td>9,763   4,983 4,780</td>
<td>10,654 5,433 5,221</td>
</tr>
<tr>
<td>West Lothian</td>
<td>161,020</td>
<td>19,847 10,163 9,684</td>
<td>21,539 11,082 10,457</td>
</tr>
<tr>
<td>Lothian</td>
<td>780,010</td>
<td>83,642 42,846 40,796</td>
<td>93,816 47,744 46,072</td>
</tr>
</tbody>
</table>

*Note: Health Board Area boundaries are not contiguous with council area boundaries*

Source: GRO(S)

2001 Populations

<table>
<thead>
<tr>
<th>Ward</th>
<th>All Ages</th>
<th>Ageband</th>
<th>Male</th>
<th>Female</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muirhouse/Drylaw</td>
<td>9122</td>
<td>10-19</td>
<td>501</td>
<td>479</td>
<td>980</td>
</tr>
<tr>
<td>Pilton</td>
<td>8055</td>
<td>10-19</td>
<td>669</td>
<td>689</td>
<td>1358</td>
</tr>
<tr>
<td>Granton</td>
<td>7752</td>
<td>10-19</td>
<td>619</td>
<td>625</td>
<td>1244</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>24929</strong></td>
<td><strong>10-19</strong></td>
<td><strong>1789</strong></td>
<td><strong>1793</strong></td>
<td><strong>3582</strong></td>
</tr>
</tbody>
</table>

Source: Scottish Neighbourhood Statistics

*Note: The SNS populations are by 5 year age band - an exact 10-18 count for these wards is not available. The following is an estimate of the 10-18 population*

2001 Populations

<table>
<thead>
<tr>
<th>Ward</th>
<th>Ageband</th>
<th>Male</th>
<th>Female</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muirhouse/Drylaw</td>
<td>10-18</td>
<td>451</td>
<td>431</td>
<td>882</td>
</tr>
<tr>
<td>Pilton</td>
<td>10-18</td>
<td>602</td>
<td>620</td>
<td>1222</td>
</tr>
<tr>
<td>Granton</td>
<td>10-18</td>
<td>557</td>
<td>563</td>
<td>1120</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>10-18</strong></td>
<td><strong>1610</strong></td>
<td><strong>1614</strong></td>
<td><strong>3224</strong></td>
</tr>
</tbody>
</table>
References


Aggleton, P., Oliver, C., and Rivers, K. *The implications of research into young people, sex, sexuality and relationships.* London: Health Education Authority, 1999.


Baraister, P., Collander Brown, K., Horne, N. Community attitudes to the sexual behaviour of young people in an urban area with high rates of sexual ill health. *Journal of Family Planning and Reproductive Health Care* 2004: 30(4); 225-228.


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NHS Centre for Reviews and Dissemination. Preventing and reducing the adverse effects of unintended pregnancies. Effective Health Care 3(1); 1-12


