



Cynulliad Cenedlaethol Cymru  
The National Assembly for Wales

# A strategic framework for promoting sexual health in Wales

**Better** Health  
**Better** Wales

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# INTRODUCTION

## 1.1 Background

*Better Health – Better Wales* (Cm 3922)<sup>1</sup> highlighted concerns about the high rates of teenage pregnancies and sexually transmitted infections in Wales, and suggested that more effective communication about sexual health was needed if these issues were to be addressed successfully.

In recognition of these concerns, the *Better Health - Better Wales Strategic Framework*<sup>2</sup> included a commitment to drawing up a Sexual Health Strategy for Wales for consultation in 1999. The task of coordinating this work was given to Health Promotion Wales (now the Health Promotion Division of the National Assembly of Wales), in partnership with FPA Cymru, the NHS, and education and social services. A Steering Group comprising representatives from these sectors was convened in June 1999 to take forward the work on the strategy (see Appendix 3).

## 1.2 Aims and remit

The aims agreed for the strategy were:

- **To improve the sexual health of the population of Wales.** This relates to the need to address illnesses and conditions which are a significant cause of physical and mental ill-health and premature death, e.g. sexually transmitted infections, including HIV infection; unintended pregnancies, particularly among teenage girls; and family and relationship problems relating to sexuality.
- **To narrow sexual health inequalities.** It was recognised that prevalence of some of the conditions listed above may be linked to social exclusion, ethnicity and sexual orientation (for example, teenage pregnancy rates are higher in areas of social deprivation; in some parts of the UK, rates of teenage pregnancy may be higher among black and ethnic minority groups; and gay men are the group in Wales most affected by HIV infection). Prevention initiatives and service provision arrangements need to take account of these inequalities.

- **To enhance the general health and emotional well-being of the population by enabling and supporting fulfilling sexual relationships.** This aim encompasses delivery of appropriate and effective sex education to young people within school and in other youth settings. It also recognises the need to ensure that the population as a whole has access to sources of information and advice on sexual health and relationships.

The remit of the Strategy Steering Group was as follows:

- To review existing data relevant to the sexual health status of the population of Wales.
- To obtain data on the sexual health services currently available in Wales.
- To review evidence of the effectiveness of interventions designed to improve sexual health, and to identify examples of good practice in relation to sexual health promotion.
- In the light of the above reviews, to recommend a policy framework for sexual health promotion spanning the activities of health, education, professional and voluntary organisations.
- To recommend appropriate targets and performance indicators for the implementation, impact and outcomes of the strategy.
- To identify areas in which research may be needed in order to inform the strategy.

Tasks 1, 2 and 3 are covered in Sections 2, 3 and 4 respectively. Tasks 4, 5 and 6 are addressed in Sections 5 and 6.

### 1.3 Links to other National Assembly for Wales and UK Government initiatives

Within the *Better Health – Better Wales* Strategic Framework, with its strong emphasis on social inclusion and inter-agency collaboration, there are a number of policy initiatives which are relevant to the Sexual Health Strategy. These include the Children’s Strategy; the Health Promotion Strategy; the Communicable Disease Control Strategy; the review of the National Curriculum, including the Personal and Social Education Framework, which has been undertaken by the Qualifications, Curriculum and Assessment Authority for Wales (ACCAC); and the review of health visiting and school health services in Wales. Other relevant National Assembly for Wales initiatives include the Primary Care Strategy, the Children First programme in Wales and the “People in Communities” initiative.

In taking forward the strategic work on sexual health, efforts have been made to maintain a dialogue with those working on these other initiatives and to ensure that proposals are generally congruent and complementary.

Another important point of reference is the Social Exclusion Unit's report on teenage pregnancy<sup>3</sup>, which looks both at prevention of teenage pregnancies and at ways of combating the risk of social exclusion for vulnerable teenage parents and their children. The recommendations on prevention, particularly those relating to sex education and provision of advice and services to young people, have been carefully considered in the light of Welsh circumstances and of work already being undertaken in Wales.



## 2. Sexual health in Wales: the current situation

The past century has witnessed a widespread liberalisation in sexual attitudes within British society, with greater social acceptance of contraception, abortion, divorce, pre-marital sex, cohabitation of non-married partners and homosexuality. In many cases, these changes in attitudes and behaviours have been supported by legislation. However, they have also been viewed with concern by some sections of society. The present situation is one in which attitudes to many aspects of sexual behaviour are diverse and often polarised, with consequent difficulties for both policy-making and individual behaviour change.

### 2.1 Age at first intercourse

The age of first intercourse is falling throughout the UK for both men and women. In 1991, the National Survey of Sexual Attitudes and Lifestyles found a strong relationship between current age and age at first intercourse: a greater percentage of younger respondents were likely to report sex under the age of 16 than older respondents. The figures for Wales showed that 25 per cent of men and 15 per cent of women aged between 16-24 years reported that they were sexually active before the age of 16. In comparison, 19 per cent of men and only 4 per cent of women aged between 35-44 years reported this behaviour.<sup>4</sup>

These data also highlighted marked differences in sexual behaviour between urban and rural parts of Wales, particularly for men. Men living in urban areas were more than five times as likely as those living in rural areas to report having had sexual intercourse before the age of 16.

More recently, the 1999 Welsh Youth Sexual Health Survey, reporting on the sexual knowledge, attitudes and behaviour of 15-16 year olds in Wales, found that 40 per cent of boys and 35 per cent of the girls reported ever having sexual intercourse. The most common age for first intercourse was 15 for both sexes, with reported first experience of intercourse ranging from 9 years to 16 years. Of those who were sexually active, half of the boys and two thirds of the girls reported having had only one partner in the last 12 months. Nearly a quarter of the boys and one tenth of girls reported having had three or more partners.<sup>5</sup>

### 2.2 Conception and birth rates

In recent years the overall conception rates have generally been lower in Wales than in England: in 1997 the conception rate for all ages in Wales was 71.8 per 1000 women, compared to 74.6 in England.<sup>6</sup>

#### 2.2.1 Teenage conceptions (15-19 year olds)

Within Western Europe, the UK as a whole stands out as having the highest teenage birth rate: twice that of Germany, three times as high as France and six times as high as the Netherlands.<sup>7</sup> Within the UK, since 1974, when the Office of National Statistics started to publish teenage conception rates on a regular basis, Wales has consistently had a higher rate than England. In 1997, the conception rate for 15-19 year olds in Wales was 68.5, compared to 62.2 per 1000 for women of this age group in England.<sup>6</sup>

Regional variations in teenage conception rates and the percentages leading to abortion can also be identified within Wales (see Appendix 1, Table 1). In general, areas with high conception rates also have the lowest abortion rates.<sup>8</sup>

## 2.2.2 Under-age conceptions (13-15 year olds)

The annual number of conceptions to girls aged under 16 in Wales is relatively small and variable, and the rate for a single year should therefore be treated with caution. Since 1992 the rate in Wales has been consistently higher and has risen more rapidly than in England. In Wales, the rate for underage conceptions in 1997 was 10.3, compared to 8.8 per 1000 women aged 13-15 in England.<sup>6</sup>

## 2.2.3 Why does teenage pregnancy matter?

It is important to recognise that not all teenage pregnancies are unwanted or unintended and that the outcome for both mother and child can be a positive experience. However, the following negative aspects are also associated with teenage pregnancy:<sup>3</sup>

- Teenage mothers tend to have poor ante-natal health, lower birth weight babies and higher infant mortality rates. Their own health and their children's is worse than average.
- Relationship breakdown is more common among teenage parents.
- Teenage parents usually have low incomes and teenage lone mothers are likely to be more dependent on benefits than other single mothers.
- The daughters of teenage mothers are more likely to become teenage parents themselves.

It has been argued that these poor outcomes are the result of poverty rather than teenage parenthood. It is true that the disadvantaged backgrounds of many of these teenagers contribute to the effects, but having a baby young makes their situation worse.<sup>3</sup>

## 2.2.4 Why are rates of teenage pregnancy so high in Wales?

No single reason can explain why the rates are so high. The Social Exclusion Unit's report identified three contributory factors common to countries with high rates which are likely to be applicable to the situation in Wales:<sup>3</sup>

**Low expectations:** Teenage pregnancy is a problem that affects the whole of Wales. Even some of the more affluent areas in Wales have teenage birth rates which are high by European standards. But it is clear from regional variations in conception and abortion figures that teenage conceptions and birth rates are highest in areas with greater levels of social exclusion, which score highly on indicators such as low income, high unemployment, poor health, low educational attainment, living in a poor physical environment, and high levels of crime. Throughout the UK, teenage pregnancy is more common among young people who have been disadvantaged in childhood and have poor expectations of education or the job market. These young women see no reason against having a child, and may regard motherhood as a positive option.

**Ignorance:** Many young people in the UK lack accurate knowledge about contraception and are less likely to use it the first time they have sex in comparison with their European peers. Findings from the 1999 Welsh Youth Health Survey suggest that a substantial number of young people in Wales are either not using, or are not consistently using, reliable forms of contraception: nearly a quarter of sexually active girls reported not having used any form of contraception the last time they had intercourse.<sup>5</sup>

**Mixed messages:** A lack of consistency exists in the messages young people receive about sex. Teenagers are bombarded with sexually explicit messages and an implicit message that sexual activity is the norm. But often parents and public institutions are embarrassed or silent, hoping that if sex is not talked about, it will not happen.

## 2.3 Abortion

The rate for legally induced abortions in Wales in 1996 was 12.6 terminations per 1,000 women aged 15-44, 1.5 higher than in 1995 and the highest rate since the Abortion Act was introduced.<sup>9</sup> The comparable rate in England was 15.7 abortions per 1,000 women aged 15-44, an increase of 1.1 from 1995.<sup>10</sup> This was the first increase in the annual number of abortions in England and Wales since 1990. There is evidence that these increases were due at least in part to unintended conceptions resulting from short-term discontinuation of oral contraceptives by women in reaction to the 'pill scare' of October 1995.<sup>11</sup>

### 2.3.1 Abortion rate by age

In Wales, as in England, abortion rates are highest among 20-24 year old women (24 per 1000 in 1996). The rate of terminations among young women under 15 increased from 3.1 per 1,000 in 1995 to 4.1 in 1996, and the rate for 15 year-olds increased from 7.9 to 9.0. There was an increase in the rate in 1996 for all age groups except for women aged 45 and over, reflecting the impact of 'pill scare' mentioned above. Rates in England were higher than those in Wales for all age groups except for those aged 15 and under.<sup>10</sup>

### 2.3.2 Abortion rate by marital status and parity

In 1996, seven out of ten terminations in Wales were carried out on single women; about two in ten were on married women. Half of the women having terminations had no previous children. 79 per cent of the women had not had a previous abortion and 18 per cent were having their second abortion.<sup>10</sup>

## 2.4 Sexually transmitted infections

Sexually transmitted infections affect people of all ages in Wales. Incidence is greatest among people under 25, but it is also an issue for older men and women, particularly those who are entering new partnerships following the break-up of a long-term relationship.

## 2.4.1 Chlamydia

Chlamydia is currently the commonest curable bacterial sexually transmitted infection in England and Wales. The 1997 K60 data for Wales show peak rates among 20 to 24 year olds, but rates are also high among 16-19 year old women<sup>12</sup> (see Appendix 2, Table 2). The consequences of chlamydial infection can be severe, particularly for women, in whom infection may lead to pelvic inflammatory disease, ectopic pregnancy, tubal factor infertility and chronic abdominal pain.

## 2.4.2 Genital wart virus (Human papillomavirus)

The viruses causing genital warts, the commonest sexually transmitted infection in England and Wales, are varieties of human papillomavirus (HPV). HPV has been identified in virtually all cervical cancers.<sup>13</sup> Although the types of HPV most frequently associated with genital warts are unlikely to lead to the development of cancer, other HPV types associated with a small proportion of genital warts are found in most cervical cancers. The highest rates of HPV in Wales are among 20 to 24 year olds, but rates are also high in women aged 16-19 years and among 25-34 year old men<sup>14</sup> (see Appendix 2, Table 3).

## 2.4.3 Genital herpes

Genital herpes simplex virus is the commonest ulcerative sexually transmitted infection in England and Wales. It can produce painful, disabling and recurrent genital ulcers, but up to 60 per cent of cases are thought to remain asymptomatic. Rates in Wales are highest among women aged 20-24, followed by women aged 16-19. Rates among men are highest for 20-24 year and 25-34 year olds<sup>14</sup> (see Appendix 2, Table 4).

## 2.4.4 Gonorrhoea

Gonorrhoea is a curable bacterial infection. The incidence of gonorrhoea in England and Wales has decreased for both men and women since 1981. However, between 1995 and 1997 the number of cases appeared to be rising, particularly among men. In Wales the rates are highest among men in the 20-25 year old age group<sup>15</sup> (see Appendix 2, Table 5).

## 2.4.5 Viral hepatitis

Hepatitis is an inflammation of the liver which is usually caused by one of a number of viruses. Hepatitis B, a common and highly infectious strain, can be transmitted through unprotected sex. In Wales, the number of cases of hepatitis B peaked in 1996 with 193 cases and then decreased to 147 cases in 1997 and 152 in 1998.<sup>16</sup> Rates are higher in men than in women, and gay men are particularly at risk. Effective immunisation is available against hepatitis B.

## 2.5 HIV infection

HIV infection, the virus that can cause AIDS, is a particularly important sexually transmitted infection because it is potentially fatal. Recent developments in combination drug therapies mean that the life expectancy of many HIV positive people has been extended. A reduction in mortality will result in an increase in the number of people living with HIV long-term, which in turn will increase the potential for greater spread of the virus.

Recent statistics show that, for the first time since 1993, there has been an increase in HIV incidence in Wales (37 new infections in 1998 compared with 33 in 1997).<sup>17</sup> This reflects recent increases in the rest of the UK. It should be noted that it is likely that the number of people with HIV in Wales is greater than suggested in the figures: some people with HIV in Wales will have been tested outside Wales but receive care within Wales.

The cumulative number of HIV infections in the UK to the end of 1998 was 33,764, of which 519 were in Wales. The main transmission route for HIV infection continues to be sex between men; 56 per cent of reported cases in Wales were acquired in this way. The remaining cumulative cases are accounted for by sex between men and women (24 per cent); injecting drug use (5 per cent); blood transfusion/blood products (11 per cent) and 'other', including mother to child transmission (4 per cent).<sup>17</sup>

New guidance has recently been issued in England on screening of pregnant women for HIV infection.<sup>18</sup> Guidance for Wales is being developed in the context of the Communicable Disease Control Strategy.

## 2.6 Factors influencing rates of sexually transmitted infections, including HIV

Factors likely to influence the rates of sexually transmitted infection rates in Wales include:

**Awareness:** Surveys show that awareness of HIV transmission risks are high among adults and young people in Wales.<sup>4-5</sup> However, knowledge of some more common sexually transmitted infections is less good. Although young people tend to be better informed about sexually transmitted infections than older adults, their knowledge is variable.<sup>19</sup> The 1999 Welsh Youth Sexual Health survey found a low level of awareness about chlamydia in particular, with only one in three girls and one in five boys aged 15-16 having heard of it. Awareness of all sexually transmitted infections was generally higher among girls than boys. Over half of all respondents thought that they received too little education on sexually transmitted infections.<sup>5</sup>

**Condom use:** Research has shown that most people in Wales are aware of the importance of condoms in preventing infection.<sup>4-5,20</sup> The 1999 Welsh Youth Health Survey found that young people generally demonstrated a positive attitude towards using condoms. However, boys who reported having had sex appeared to hold a less positive attitude towards condoms than all the other respondents. In summary, nearly half felt that condoms made sex less enjoyable, and two fifths reported that they would not stop having sex with a new boyfriend or girlfriend just because they did not have a condom.<sup>5</sup>

**Homophobic attitudes:** An analysis of the Welsh data from the 1991 National Survey of Sexual Attitudes and Lifestyles found that attitudes towards homosexuality were more censorious in Wales than in other parts of the UK, and noted that this placed difficulties in the way of HIV prevention work with gay men.<sup>4</sup> While it is possible that these attitudes may have modified over the past decade, commissioning and targeting of this work remains a difficult area.

## 2.7 Psycho-sexual problems

There are no statistics available on the extent of psycho-sexual problems among the population in Wales. However, health professionals working in the field of sexual health report that such problems are by no means rare and that those suffering from them are increasingly seeking clinical help. The range of problems includes both problems of sexual functioning (impotence and ejaculatory difficulties in men, painful intercourse and lack of orgasm in women) and problems of lack of desire; in addition, problems may relate to other situations such as the consequences of unrequested sex (childhood sexual abuse and rape). Sexually transmitted infections, particularly HIV, may generate psychological consequences which require counselling. A further category of situations for which help is sought include gender dysphoria, transvestism, and acceptance of sexual orientation. These conditions require sensitive handling and intensive clinical input. The specialist help available in Wales for psychosexual counselling is currently very limited.

## 2.8 Sexual abuse

There are difficulties in determining the numbers of children who are abused. Each Social Services Department holds a central child protection register of all children in the area who are considered to be suffering from or are likely to suffer significant harm and for whom there is an inter-agency protection plan. However, the registers do not reflect the full extent of child abuse because not every case is reported, and many referrals are resolved without the need to enter the child on the register, for example, where the abuse is unsubstantiated, if the child is removed from the home or if the abuser leaves the household. It should also be noted that not all children listed on the register have been abused; some will have been registered because there was a likelihood of future abuse.

Despite the above caveats, the child protection register does offer an indicator of child abuse in Wales. The register contains four separate categories of abuse and combinations of these: neglect; physical abuse; sexual abuse and emotional abuse. In 1998 2,473 children were included in the child protection register, and in approximately 15 per cent of these cases the children were seen to be at risk from sexual abuse.<sup>21</sup>

## 2.9 Vulnerable groups

In research carried out within the UK, some groups of people have been identified as being at heightened risk for teenage pregnancy and/or sexual ill health in general:

**Children in care or leaving care** have repeatedly been shown to be at higher risk of teenage pregnancy. Survey findings have shown that a quarter of care leavers had a child by the age of 16<sup>22</sup>, and nearly half were mothers within 18 to 24 months after leaving care.<sup>23</sup>

Several studies have shown an association between **abuse in childhood and teenage pregnancy**. UK Childline reported that about 5 per cent of more than 7,000 calls received about teenage pregnancy in 1995-96 also talked about sexual abuse.<sup>3</sup>

There is an association between **teenage parenthood and involvement with the police**. It has been estimated that 25 per cent of the 11,000 prisoners in the Young Offenders institutions in England and Wales are fathers.<sup>24</sup>

There is evidence to suggest that the sexual and reproductive health needs of **people with learning disabilities** are not being met.<sup>25</sup> The reasons for this are twofold: on the one hand there is an underlying assumption that people with learning disabilities are unable to be responsible for their own sexuality and fertility, and on the other, there is a denial that these

people have a sexual identity, leading to the assumption that there is no need for these aspects of health to be addressed.<sup>26</sup> It has been suggested that not meeting the sexual health needs of people with learning disabilities ultimately increases their risk of practising unsafe sex and their vulnerability to sexual abuse.<sup>27</sup>

Almost 8 per cent of people under twenty years of age in Wales belong to a **black or ethnic minority group**.<sup>28</sup> There are no comprehensive statistics on either live births or abortions by ethnic group because the mother's ethnic group is not collected at birth registration or abortion. In England, findings from other surveys suggest an over-representation of some ethnic minorities among teenage parents. The reasons for this are complex. For some groups the main influence may be traditions of early marriage and early childbirth, while for many ethnic minority communities the link between social exclusion and early parenthood will be relevant.<sup>3</sup> No specific data are currently available for ethnic minority groups living in Wales.

As mentioned above, levels of homophobia in Wales are high in comparison to the rest of the UK.<sup>4</sup> These attitudes can increase difficulties for **young gay men and women** in coming to terms with their sexuality and accessing relevant sexual health information and services.<sup>29</sup>



## 3. Sex education and sexual health services in Wales

This section presents an overview of current sex education and sexual health service provision in Wales. As data are sparse, the picture is not complete.

### 3.1 Sex education in schools

#### The law

The legal framework for sex education is quite complex. Sex education is seen as falling under the legal requirements set out in the Education Reform Act 1996 for schools to provide a curriculum which:

- Promotes the spiritual, moral, cultural, mental and physical development of pupils at the school and of society; and
- Prepares such pupils for the opportunities, responsibilities and experiences of adult life.

In maintained primary schools, governing bodies have the responsibility of considering whether or at what stage to offer sex education. They must keep an up-to-date written statement of the policy they choose to adopt, which must be available to parents. Responses to a 1998 survey indicated that more than 90 per cent of schools in Wales have a policy, but among these, approximately one in ten choose not to teach sex education.<sup>30</sup>

In maintained secondary schools, sex education (including education about HIV/AIDS and sexually transmitted infections) must be provided for all registered pupils. As in primary schools, the governing body must make a written statement of their policy on sex education available to all parents. Parents have a legal right to withdraw their children from sex education, except those parts that are within the National Curriculum.

The National Curriculum Programme of Study for Science provides for the teaching of the basic biological aspects of human reproduction. Some of the key stage statements, particularly those for Key Stage 2, are open to a wide range of interpretation. Medical uses of hormones, including the control and promotion of fertility, are covered at Key Stage 4.

#### Guidance

In 1994 the Welsh Office issued a circular on the content and purpose of sex education.<sup>31</sup> It offers guidance on the development and implementation of sex education policies and programmes, describing the roles of governors, head teachers and other staff, local education authorities and parents and indicating the action expected from those concerned.

#### Practice

In most schools, sex and relationships education forms part of wider provision often grouped under the title Personal and Social Education (PSE). This is not part of the National Curriculum. It is a developing discipline for which no specialist qualification exists.

In primary schools, practice seems to vary widely. Some schools do nothing, with the result that some girls start their periods with no idea what is happening to them, and a small minority become sexually active before they have received any sex education at all. On the other hand, some primary schools provide detailed and extensive programmes from quite early ages.

Most teachers who teach sex and relationships education or the wider personal and social education are primarily teachers of another curriculum subject. In 1998, nearly two thirds of primary schools in Wales reported no in-service training in the last three years relating to sex education.<sup>30</sup> Research has shown that both primary and secondary teachers often feel ill equipped in relation to teaching sex education.<sup>32</sup>

The school nurse or other health professionals can play a valuable role in promoting and teaching sex and relationships education, as their clinical training and pastoral activity may give them added credibility with pupils when discussing sex and contraception. With the consent of school governors, nurses in some secondary schools also provide confidential advice to pupils on a range of issues, including sexual health, and can act as a bridge to GP and other medical services for young people.

As part of the inspection process, Estyn (formerly OHMCI Wales) evaluates and reports on the effectiveness of a school's personal and educational guidance. This includes schools' policy statements and programmes for personal and social development, including sex education and health education.

During 1999, as part of the National Curriculum Review in Wales, a consultation has taken place on a new Framework for Personal and Social Education. This framework covers ten aspects of a person in society, including a sexual aspect, which can be developed in a school context. The framework outlines different learning outcomes for each aspect at each key stage. The new framework, together with supporting guidance, is due to be issued in 2000.

## 3.2 Contraceptive and sexual health services

Contraception is supplied by both community contraceptive and sexual health clinics and by GPs, and people are free to choose between these outlets. For women with children, GPs are often the most convenient source of contraceptive advice, as this can be provided in the context of post-natal services and general continuity of care for the woman and her family. However, the range of contraceptive methods offered by GPs is generally not as comprehensive as that found in community contraceptive clinics. GPs are also less likely to offer specialised services such as young people's clinics and psychosexual counselling. Women who attend community contraceptive clinics are more likely to be young, single women who are concerned about confidentiality and anonymity and who prefer to see a woman doctor. This dual system of provision therefore meets consumer needs.<sup>33</sup>

As in the rest of the UK, more people in Wales seek contraceptive advice from their GPs than from community contraceptive clinics: in 1997/98 around 54,700 people (49,900 women and 4,800 men) attended a community clinic for contraceptive advice, compared with almost 176,900 who visited a GP for the same advice in 1996/97.<sup>34</sup>

Community contraceptive and sexual health clinics are accessed primarily by women (49,900 in 1997/98). However, the number of men using the services has more than quadrupled, rising from 775 in 1990/91 to 4,800 in 1997/98.<sup>34</sup>

More young people in Wales are accessing community contraceptive and sexual health clinics than previously. In 1997/98, 28 per cent of women attending were under 20, compared with only 16 per cent in 1990/91; of these, 6 per cent were under 16 compared with only 1.4 per cent in 1990/91. In contrast, the percentage of 20-34 year olds attending community contraceptive and sexual health services decreased from 63 per cent in 1990/91 to 52 per cent in 1997/98.<sup>34</sup>

Clinic opening times are an important aspect of access to services, particularly for young people. Approximately half of contraceptive clinic sessions in Wales take place during the day, between the hours of 9am to 4pm, and the other half take place in late afternoon or the evening, between the hours of 4pm to 9pm. All sessions take place on weekdays. This implies that, in terms of opening hours, at least half of all regular contraceptive clinic sessions should be accessible to young people of school age and to people who work during the day. It should also be noted that some day time clinics take place during lunch hours.

A small number of young people's clinics operate in Wales. These clinics operate after school hours or occasionally on Saturday mornings. At present, the number of locations at which these are available is limited.

The majority of community contraceptive and sexual health services in Wales provide some 'well woman'/cytology clinics, and a limited number also run HRT/menopause clinics, termination of pregnancy clinics, vasectomy counselling, psycho-sexual counselling and community gynaecology clinics.

### The law on contraceptive provision to under 16s

The 1985 House of Lords ruling in the Gillick case established the current legal position in England and Wales that people under 16 who are fully able to understand what is proposed and its implications are competent to consent to medical treatment regardless of age. A doctor has discretion to give contraceptive advice or treatment to a girl under 16 without her parents' knowledge or consent provided that, in the doctor's opinion, the girl is capable of understanding the nature and possible consequences of the procedure.

Further guidance was issued by the Department of Health and the Welsh Office after the Gillick judgement, advising doctors to consider the following issues when consulted by people under 16 for contraceptive services:

- Whether the patient understands the potential risks and benefits of the treatment and advice given;
- The value of parental support must be discussed;
- The doctor should take into account whether the patient is likely to have sexual intercourse without contraception;
- The doctor should assess whether the patient's physical or mental health is likely to suffer if she does not receive contraceptive advice and supplies;
- The doctor must consider whether the patient's best interests would require the provision of contraceptive advice or methods without parental consent.

The duty of confidentiality owed by a doctor to a person under 16 is as great as the duty owed to any other person. An explicit request that information should not be disclosed to particular people must be respected other than in the most exceptional circumstances, for example when the doctor believes that the young person is being abused.

## 3.3 Abortion services

In 1996, more than 38 per cent of abortions carried out on women living in Wales took place in hospitals or clinics in England. Of these terminations, 39 per cent were in the private sector, but the majority (57 per cent) were carried out through agency agreements. Of the 4,337 terminations carried out in Wales, only 24 were outside the NHS. In 1996, there was a four-fold increase (mainly by North Wales and Gwent health authorities) in the use of agencies, which accounted for 22 per cent of terminations in 1996.<sup>10</sup>

### 3.4 Genitourinary medicine service

The Genitourinary Medicine Service in Wales provides a confidential open access service for advice, diagnosis and the management of sexually transmitted infections, HIV and other related problems. In 1998 there were 20,294 new attendances and a total attendance of 48,223.<sup>35</sup> The 19 clinics in Wales are situated both in District General Hospitals and some Community Hospitals, and run a combination of 'appointment only' and 'walk-in' clinics. Most clinics offer contraceptive advice, but the majority only prescribe emergency contraception and condoms. A survey by the British Cooperative Clinical Group in 1997 commented that few GUM services in the UK ran clinics specifically for young people,<sup>36</sup> in Wales there are only two clinics which provide this service. There are currently nine consultant genitourinary physicians practising in Wales.

### 3.5 Integration of sexual health services

In Wales, as in the rest of the UK, it is recognised that there is a need to develop multi-agency initiatives around sexual health. To date there has been close liaison between a variety of sexual health services (for example, community contraceptive services, genitourinary medicine clinics and youth clinics) and localised integration of services in a few localities. None of the Health Authorities in Wales has yet established a fully integrated service, but planning for this is currently underway in at least one Authority. Integration of sexual health services could lead to one clinical service providing all facilities, or to contraception and genitourinary medicine services being provided from the same location but not by the same provider. Individual Health Authorities need to tailor their service according to local needs and in the light of local arrangements.

### 3.6 Public education services

FPA Cymru provides a helpline, funded by the National Assembly for Wales, which offers information and advice on contraception and other aspects of sexual health, including details of local services. The volume of calls handled by the helpline, which has increased steadily in recent years, now stands at nearly 9,000 per year. The helpline opening hours have recently been extended to increase accessibility for young people.

Health Information Wales is a national telephone helpline providing free, confidential advice on a range of health issues. In the year to March 1999, Health Information Wales dealt with 17,316 telephone enquiries, of which approximately 4 per cent related to sexual health issues. It is proposed that in 2000 Health Information Wales will be integrated into NHS Direct Wales, a 24 hour helpline service.

### 3.7 Child protection services

The major responsibilities for child protection are outlined in the consultation document *Working Together to Safeguard Children*,<sup>37</sup> which provides guidance on child protection for local authority, health authority, voluntary and private sector services. Issues relating to child protection lie within the remit of the Children's Strategy currently being developed by the National Assembly for Wales. In the context of this strategic framework, it can be noted that there are a range of multi-agency training issues which need to be considered in relation to sexual health, and child protection is a particularly important one.

## 3.8 Other sexual health initiatives

Innovative projects aimed at promoting sexual health have been funded by some Health Authorities in Wales and through other sources such as the National Lottery. Many of these projects are delivered by the voluntary sector. Examples of these types of initiatives include: community-based sex education programmes aimed at disadvantaged young men; sexual health services based in easily accessible youth settings; outreach HIV prevention work for men who have sex with men; and psycho-sexual counselling for people living with disability.

## 3.9 Issues raised by service providers

In discussions with sexual health service providers in Wales, concerns have been expressed about the following issues:

- Provision of in-service training for both teachers and youth workers in sex and relationships education.
- Difficulties of access to services in rural and valley areas;
- Issues of real or perceived lack of confidentiality in rural and valley areas, particularly for young people;
- Difficulties of access to emergency contraception out of hours in some localities.
- Limitations on the supply of free condoms. Health professionals encourage young people to practise the 'double dutch' method of contraception, in order to combine the prophylactic effect of condoms with the greater contraceptive effectiveness of the pill. However, funding constraints may limit in the number of condoms which are supplied free. Often young women may be given a three month supply of the pill but only a few condoms. It is unlikely that this will encourage consistent condom use.
- Inadequate provision of abortion counselling services in Wales.
- Inadequate provision of psycho-sexual counselling services in Wales.
- Limitations on availability of some newer, more effective but more expensive contraceptive methods, e.g. Gynefix, Mirena.
- Lack of routine availability of some of the more sophisticated methods for testing for sexually transmitted infections (for example, the chlamydia urine test).



## 4. What works: best practice in promoting sexual health

This section summarises the available evidence-based literature and good practice guidance on promoting sexual health.

### 4.1 Sex education for young people

The Sex Education Forum, an independent body representing organisations involved in providing support and information on best practice to sex educators, advises that sex and relationships education should:

- be an integral part of the learning process;
- be for all children and young people, including those with physical, learning or emotional difficulties;
- encourage exploration of values and moral issues, consideration of sexuality and personal relationships and the development of communication and decision-making skills;
- foster self-esteem, self awareness, a sense of moral responsibility and the skills to avoid and resist unwanted sexual experience.<sup>38</sup>

A popular misconception about sex education is that it will lead to greater sexual activity among young people. In fact, research evidence suggests that it does not increase sexual activity or pregnancy rates. Well-designed sex education programmes can encourage the postponement of sexual intercourse among young people who are not yet sexually active, and are associated with the effective use of contraceptives by those who are.<sup>39</sup>

The following factors have been identified as contributing to effective sex education programmes aimed at reducing teenage pregnancy:

- The timing of the start of sex education is important. As young people who are already sexually active are less likely to change their sexual and contraceptive behaviour, sex education should start before young people become sexually active.<sup>39-40</sup>
- Sex education programmes should be linked to skills development such as discussing condom use and learning that it is “OK to say no”. Participatory teaching methods such as role play which allow the practice of communication and negotiation skills are particularly effective.<sup>39,41</sup>

- Sex education programmes should include activities that address relevant social, peer and media influences.<sup>40-41</sup>
- Sex education needs to reflect the positive aspects of sexual relationships and of being young, rather than coming across as negative in tone and content.<sup>40</sup>
- Education programmes aimed at preventing pregnancy, increasing contraceptive use and preventing HIV/AIDS should combine discussion of these topics, rather than addressing them as separate issues that happen to relate to the same behaviour.<sup>40</sup>
- The most effective school based programmes in increasing contraceptive use and reducing unwanted teenage pregnancy are those which combine sex education with access to contraceptive services.<sup>39-40</sup> Examples of successful initiatives in this area include involving health service staff in the delivery of sex education programmes and activities to familiarise young people with clinic staff and processes; making arrangements so that school nurses or other members of staff can book appointments with a local service provider for young people who need emergency contraception; providing a clinic on school premises to promote access to information, advice and methods; and organising school group visits to local clinics to improve accessibility and boost confidence.<sup>42</sup>
- Effective sex education requires effective delivery. It should be provided by trained and confident staff and delivered within environments that are supportive and safe for staff, visitors, and pupils.<sup>43</sup>

Not all young people can be reached through school-based educational programmes. Some of the young people most vulnerable to teenage pregnancy and sexual ill health are absentees from school. These young people are often in public care, come from the most deprived communities or are runaways. Development of educational programmes for these young people will necessitate collaboration between a number of different statutory and non-statutory agencies involved in the health and welfare of young people. Specific interventions might include education programmes in children's homes, youth settings, or counselling in a health care setting.<sup>39</sup>

## 4.2 Public education

**Media campaigns** can be a valuable way of raising public awareness about health-related issues. However, they also have their limitations. Media campaigns have not been effective in conveying complex information or teaching social skills; for example, evaluation of early HIV/AIDS media campaigns found that while many young people were aware of the main HIV transmission routes, they expressed considerable uncertainty about their ability to put safer sex advice into practice. Again, media campaigns do not provide the support necessary for motivation of individuals who wish to change their behaviour in adverse physical and social circumstances.<sup>44</sup> It is therefore unlikely that media campaigns alone would be sufficient to have an impact on a problem such as teenage pregnancy, which is inextricably linked with social exclusion.

On the other hand, mass media campaigns have been successful in raising awareness about public health issues, conveying simple information (i.e. single messages), and influencing single time choices (for example, attending a clinic). The use of mass media has been shown to be influential in increasing health service use, including increasing the number of people seeking HIV testing,<sup>45</sup> and pilot work suggests some success in promoting the use of emergency contraception among young women.<sup>46</sup> Using mass media in conjunction with community-based initiatives has also been shown to be effective in health promotion campaigns.<sup>47</sup>

**Telephone helplines** offer a confidential and accessible source of information and advice on sexual health matters. Other benefits to the user include immediacy of response, a personalised response, nil or minimal cost, and referral to other services.<sup>48</sup> In Wales, helplines have been used to offer information on contraception, HIV/AIDS and other sexual health issues, and to provide support for gay and lesbian people.

Evaluation of helpline services is difficult because of the importance of maintaining caller anonymity. However, some evidence does exist to suggest that helplines are cost effective, and that their anonymity appeals particularly to young men who traditionally do not use existing services.<sup>3</sup>

From a health promotion perspective, **the internet** offers increasingly easy access, privacy, easily updated information, and the potential for interactive learning. The extent of sexual health material on the web is considerable, but the quality of websites is extremely variable. There are also concerns about the potential for internet use to create unintended outcomes (e.g. inappropriate access by children to sexually explicit websites). The UK National HIV Prevention Information Service<sup>49</sup> has produced a good practice guide to sexual health promotion on the internet, which highlights the following issues: clearly targeting the intended audience; ensuring that the educational intent of a site is clearly signposted;

demonstrating concern for parents and children through clear content labelling of the site; linking the site to other carefully reviewed sites; and ensuring that any sexually explicit images of young people always indisputably represent people aged 16 or over.

## 4.3 Targeted risk reduction

Research carried out with individuals at elevated risk for sexually transmitted infections suggests that they can be helped to achieve short-term change in their risk behaviours through multiple-session interventions which:

- involve face-to-face small group work with peer support;
- are based on theories of behaviour change;
- are sensitive to local culture and context;
- address cognitive and attitudinal factors;
- build motivation;
- address gender issues;
- focus on development of risk reduction skills such as sexual assertiveness and discussing and negotiating condom use.<sup>50-53</sup>

## 4.4 Delivery of sexual health services

### 4.4.1 Cost effectiveness of contraceptive services

Contraceptives when used properly are highly effective at preventing pregnancy. Recent economic evaluations have shown that contraceptive services are also highly cost-effective and provide a high rate of return to the NHS;<sup>54-55</sup> one study calculated that for every £1 spent on contraception, £10 is saved for the public purse.<sup>54</sup> The authors concluded that there can be no economic justification for imposing any restrictions on the availability and accessibility of a full range of contraceptive methods and service providers. In particular, when the resource consequences of a pregnancy are taken into account, the costs of providing contraceptive and counselling services to young people are far less than the health and social costs of unplanned pregnancy.

## 4.4.2 Service delivery for young people

Research findings show that, for a variety of reasons, young people often do not feel comfortable accessing sexual health services.<sup>56</sup> The following issues have been identified as crucial to addressing these barriers:

- **Access:** Key factors in ensuring accessibility of services include: involving young people in planning of services; basing services in or near places where young people congregate (e.g. schools, colleges, youth centres, shopping centres); being close to public transport; having suitable access for people with disabilities; being open in late afternoon, evenings and weekends; offering consultation by both appointment and drop-in; and advertising services widely in ways that will reach diverse groups of young people, including young gay and lesbian people and those from black and ethnic minorities.<sup>57</sup>
- **Image:** Contraceptive clinics are often perceived by young people as places for older or married couples, or for women to attend rather than men. Young people are less likely to respond to services which are provided in a 'clinical' atmosphere, and more likely to respond to services which: decorate waiting areas with posters and health promotion materials designed for young people; provide waiting areas with young people's magazines; make refreshments available; install music, television and videos; arrange seating in waiting areas informally; and encourage staff to wear everyday clothes. Additionally, services should be renamed to reflect their concern with young people's broader sexual and reproductive health needs.<sup>57</sup>
- **Confidentiality:** Many young people fear that visits regarding contraception advice, particularly in relation to GP and GUM services, will not remain confidential.<sup>5</sup> Existing services must offer reassurance to users that their visit will be confidential or young people may simply fail to use the services available.<sup>57</sup>
- **Staff training:** Both perceived and real judgementalism is a major barrier to service uptake by young people.<sup>58</sup> To be most effective, both reception staff and health professionals may need training on issues linked to: approachability; avoiding a judgemental manner; communication skills, particularly with regard to discussing sexual matters; and awareness of equal opportunities, to ensure that services deal sensitively with the needs of 'non-traditional' service users such as young heterosexual men, young people from black and ethnic minorities, young lesbians and gay men, young disabled people, and young people with learning difficulties.<sup>57</sup>

- **Variety of settings:** As the needs of individual young people differ widely, sexual health services should be made available in a variety of settings such as specialist clinics, GP surgeries, youth advisory centres and through community-based outreach work.<sup>57</sup>
- **Range of services:** A wide range of family planning and sexual health services needs to be offered, including: a full range of condoms, including extra-strong and female condoms; emergency contraception; dual methods of contraception, in order to offer protection against sexually transmitted infections as well as pregnancy; smear tests; on-the-spot pregnancy tests; screening for sexually transmitted infections, including HIV-related counselling; referral to genitourinary medicine services; advice and referral for termination of pregnancy; advice and counselling on the full range of sexual issues likely to affect young people, with referral as necessary.<sup>57</sup>
- **Emergency contraception:** Emergency hormonal contraception has an important role to play in preventing teenage pregnancy because of the often unplanned or sporadic nature of sexual activity in this age group. Barriers to emergency contraception use include confusion about when it should be taken; the popular name – “the morning after pill” – has led many women to underestimate the period within which it can be effective (up to 72 hours after intercourse, although it is most effective within the first 24 hours). Perceptions of health risks relating to emergency hormonal contraception on the part of women and GPs have also been identified as a reason for not using this method, although the safety and effectiveness of these formulations are well documented in the scientific literature. In addition to greater publicity about and access to emergency contraception, there is also a need for programmes to educate teenagers and others in order to allay their fears about the absolute risks.<sup>39</sup>
- **Integration of sexual health services:** In order to offer a coherent approach to the promotion of young people’s sexual and reproductive health, efforts should be made to integrate the various aspects of service provision.<sup>39-40,57,59,60</sup> This means bringing together services linked to contraceptive provision and advice, services for the prevention and treatment of sexually transmitted infections, and services concerned with the promotion of more general aspects of young people’s health.<sup>57</sup>
- **Links between services and sex education:** Integration of these two elements has been shown to be effective in reducing the risk of unintended teenage conception.<sup>39</sup>
- **Vulnerable young people:** Prevention and education services need to be targeted at vulnerable groups and those that are harder to reach. These groups include: non school attendees; girls attending existing services for pregnancy testing or emergency contraception; children of ‘teenage’ parents; homeless or runaway adolescents; teenagers living in deprived areas; and young people in care.<sup>39,42</sup> Innovative approaches such as outreach services may be needed to reach some of these groups.

- **Boys and young men:** The literature also suggests an under-emphasis on work with boys and young men. This group should be targeted through more accessible, dedicated youth services (including men-only clinics), community outreach work, and sex education projects.<sup>42,61</sup>
- **Monitoring and evaluation of services:** In order to be accessible and appropriate to young people, and in order to maintain their effectiveness, services require careful monitoring and evaluation. This can be carried out in a variety of ways, including initial and ongoing assessments of young people's needs; monitoring of service user characteristics; monitoring of service appropriateness and acceptability; and evaluating the effects of service provision locally.<sup>57</sup>

Many of these good practice guidelines are also relevant to services for adult men and women.

### 4.4.3 Screening for sexually transmitted infections

The Expert Advisory Group on Chlamydia convened by the Chief Medical Officer in England concluded that chlamydial infection represents a largely preventable source of reproductive illhealth.<sup>62</sup> Pilot programmes are currently underway in England to determine the most effective approaches to targeted screening. In Wales, this issue is being considered in the context of the Communicable Disease Control Strategy.

Research carried out in Swansea has shown that routine screening for genital tract infections including chlamydia in women attending for termination of pregnancy is an effective intervention.<sup>63</sup>

### 4.4.3 Partner notification

There is evidence to suggest that partner notification (follow-up by genitourinary medicine clinic staff of partners of clinic patients diagnosed with an infection) leads to identification and treatment of cases of sexually transmitted infection. Further research is required to establish the direct effects that this has on the incidence and prevalence of sexually transmitted infections within the community, and the comparative efficacy and cost effectiveness of different strategies.<sup>64-66</sup>



## 5. Conclusions

On the basis of the data in the previous sections, the main issues which need to be addressed in the Sexual Health Strategy are as follows:

### 5.1 Sex education

Young people need education about sex and relationships as part of their preparation for adulthood. There is no evidence to suggest that sex education encourages early sexual experimentation. Well-designed sex education programmes can encourage the postponement of sexual intercourse among young people who are not yet sexually active, and effective use of contraceptives by those who are. The most effective school-based sex education programmes are those which link education with access to sexual health services. There is a potentially important role for school nurses and other health professionals in bridging the gap between education and services.

Schools are not the only setting for young people to receive sex education. Parents, the youth service, the voluntary sector, and further and higher education all have important roles to play in terms of educating young people about sex. Alternative settings may be of special importance in accessing some of the most vulnerable groups who are also the most likely not to attend school.

### 5.2 Teenage pregnancy

Wales has the highest teenage pregnancy rates in Europe. Rates are particularly high in areas which score highly on a number of social exclusion indicators. Social deprivation, restricted education and employment opportunities, and low expectations are important causes of teenage pregnancy. Groups who are particularly at risk of teenage pregnancy include young people who truant from school, looked-after children and homeless or runaway adolescents. More guidance is needed to service providers in health and local government on ways of providing these young people with sex education and sexual health services.

## 5.3 Services for young people

Ignorance about contraception and inconsistent use of contraception also contribute to the high rates of teenage pregnancy. It is important that young people are able to make informed choices about contraception and that they have access to services. Difficulties of access and issues of real or perceived lack of confidentiality, particularly in rural and valley areas, are causes of concern to young people. Service providers (both community contraception clinics and GPs) need to address these issues.

The number of sexual health clinics in Wales which cater specifically for young people is limited. Such services need to be more widely available and to reflect the service guidelines set out in Chapter 4 of this report.

Helplines offer a confidential and accessible source of information and advice on sexual health matters. Use of the FPA Cymru helpline has increased in recent years. A helpline service needs to be maintained and to be promoted more strongly to young people.

## 5.4 Emergency contraception

Emergency hormonal contraception has an important role to play in preventing teenage pregnancy because of the often unplanned or sporadic nature of sexual activity in this age group. There is a need to raise public awareness about emergency contraception. The potential role of nurses and pharmacists in making emergency contraception more widely available needs to be explored.

## 5.5 Sexually transmitted infections

Public awareness about sexually transmitted infections, particularly chlamydia and its association with infertility, is low in Wales. The incidence of chlamydia and genital wart virus is rising, particularly in young women. Targeted screening for chlamydia has been shown to have health benefits, and pilot programmes are underway in England to determine the most effective approaches. Factual, non-judgemental public education messages will be essential to the success of any screening programme.

## 5.6 HIV infection

Gay and bisexual men continue to be the group in Wales most affected by HIV infection. More extensive efforts are needed to promote safer sex among this section of the Welsh population, particularly among those men who do not identify themselves as gay and may be difficult to reach.

## 5.7 Promoting men's sexual health

Research shows that men in general are less well informed than women about sexual health issues, are less concerned about risk reduction, and are less likely to access sexual health services. Sex education programmes need to address the needs of young men, and services need to be more user-friendly and accessible to this group.

## 5.8 Abortion services

There is a perception that provision of abortion counselling in Wales is inadequate.

## 5.9 Psycho-sexual problems

There appears to be growing unmet need in Wales for counselling and treatment for psycho-sexual problems.

## 5.10 Integration of sexual health services

Integration of sexual health services offers a more coherent approach to the promotion of sexual and reproductive health not only for young people, but for the population as a whole. Some Health Authorities in Wales are already moving towards this approach.

## 5.11 Training

There is a need to increase training opportunities not only for health professionals with a sexual health specialism, but for other health professionals, teachers, youth workers and social workers whose work involves discussion of sexual behaviour and personal risk.

## 5.12 Inter-agency collaboration

Greater inter-agency cooperation and collaboration on sexual health issues, both within the health sector and between health, local government and the voluntary sector, would be of value in providing coherent prevention messages and ensuring a better service to the public.

## 6. An action plan for Wales

In the light of the findings outlined above, the following objectives are proposed for an action plan to fulfil the aims of the strategy:

- Ensure that all young people in Wales receive effective education about sex and relationships as part of their personal and social development.
- Ensure that all sexually active people in Wales have access to good quality sexual health advice and services.
- Reduce rates of teenage pregnancy in Wales.
- Reduce incidence and prevalence of sexually transmitted infections in Wales.
- Promote a more supportive environment which encourages openness, knowledge and understanding about sexual issues and fosters good sexual health.
- Strengthen monitoring, surveillance and research to support future planning of sexual health services and interventions.

A detailed action plan is set out on the following pages.

## 6.1 Ensure that all young people in Wales receive effective education about sex and relationships as part of their personal and social development

ACTION	DETAIL	WHO AND WHEN
<b>6.1.1. Link sex and relationships education to a broader framework of personal and social education, and encourage Local Authorities/schools to adopt framework</b>	Schools to utilise the new Wales Curriculum 2000 Personal and Social Education (PSE) framework. This sets out a non-statutory entitlement for all 5 to 16 year olds in which sex and relationships education is supported by the wider curriculum on personal and social education.	ACCAC (Qualifications, Curriculum and Assessment Authority for Wales) to circulate final version of PSE Framework in the spring term 2000, and to publish guidance linked to PSE Framework by the end of the summer term 2000.
<b>6.1.2. New guidance on sex education in schools</b>	National Assembly for Wales to issue new guidance on sex education in schools, to replace WO Circular 45/94. Issues to be covered: sex education policies in primary schools; good practice; consultation with parents; pastoral aspects.	National Assembly for Wales (Education Department) to issue draft for external consultation by end of 2000.
<b>6.1.3. Teacher training and accreditation in PSE, including sex and relationships education</b>	National Assembly for Wales to include training relating to the new PSE Framework (see 6.1.1) in the categories for GEST funding in 200-2001.  Work is being undertaken by Teacher Training Agency to (1) review content and quality of initial teacher training in relation to personal and social education, including sex education, and (2) produce proposals for accreditation of teachers as specialists in sex and relationships education. National Assembly for Wales to consider these proposals and any follow-up action required in the Welsh context.	National Assembly for Wales (Education Department) by early 2000.  National Assembly for Wales (Education Department) by end of 2000.
<b>6.1.4. Role of school nurses and health visitors</b>	Potential role of school nurses/ health visitors as resources in sex and relationships education, and implications for sexual health training requirements, to be considered in the forthcoming review of health visiting and school health services in Wales.	National Assembly for Wales (Nursing Division) by spring 2000.
<b>6.1.5. Strengthen capacity of youth service to undertake sex and relationships education</b>	Guidance to be issued on sex education issues in the youth service, including a policy framework and guidelines on confidentiality. Training requirements on sex education for youth workers to be reviewed.	National Assembly for Wales (Education Department)/ Wales Youth Agency by April 2000.
<b>6.1.6. Encourage the provision of sexual health information and education in colleges and institutions of Further and Higher Education</b>	NAW to provide guidance to FE & HE colleges and institutions on the inclusion of a sexual health component in their development of 'Healthy College' initiatives, including access to support services and information on site or in the community.	National Assembly for Wales (Health Promotion Division/ Education Department) by March 2001.
<b>6.1.7. Inspection</b>	As part of the six-year cycle of school inspection, Estyn to continue to inspect the quality of support and guidance on sex and relationships education produced by schools. The framework for inspection will be reviewed in accordance with Curriculum 2000 and will take account of statutory requirements.  Estyn to review arrangements for inspection of sex and relationships education in the youth work sector.	Estyn by autumn 2000.  Estyn : timescale under consideration.

## 6.2 Ensure that all sexually active people in Wales have access to good quality sexual health advice and services.

ACTION	DETAIL	WHO AND WHEN
<p><b>6.2.1. All Health Authorities and Local Health Groups to have written strategies and service specifications for sexual health services.</b></p>	<p>Directors of Public Health to take lead role in coordinating Health Authorities, Local Authorities and the voluntary sector to work in partnership to produce local sexual health strategies. Local inter-agency groups (including representatives from general practice, health visiting, midwifery, community pharmacy, social work and the voluntary sector) to be set up to identify local needs and inform local strategies.</p> <p>Health Authorities and Local Health Groups to draw up service specifications for sexual health, ensuring that appropriate arrangements are made for the following issues:</p> <ul style="list-style-type: none"> <li>● Accessibility of services</li> <li>● Confidentiality of services</li> <li>● Publicising services</li> <li>● User-friendly services for young people, including young men</li> <li>● Out of hours access to emergency contraception</li> <li>● Policy on availability of free condoms</li> <li>● Integration of sexual health services where appropriate</li> <li>● Referral protocols with key partners</li> <li>● Targeted interventions for vulnerable/ at-risk groups</li> <li>● Psycho-sexual services</li> <li>● Training and accreditation programmes for staff involved in delivering sexual health services, particularly key workers with young people.</li> </ul>	<p>Health Authorities/ Local Authorities/ voluntary sector by September 2000.</p> <p>Health Authorities and Local Health Groups to have service specifications in place by March 2001.</p>
<p><b>6.2.2. Maintain and promote helpline for the public on sexual health issues.</b></p>	<p>Continue to fund and promote telephone helpline and information service on sexual health issues.</p>	<p>National Assembly for Wales (Health Promotion Division); ongoing</p>

### 6.3 Reduce rates of unintended teenage pregnancy in Wales

ACTION	DETAIL	WHO AND WHEN
<b>6.3.1. Encourage the development of services geared specifically to the needs of young people.</b>	Health Authorities, GPs, local authorities and the voluntary sector to consider development of innovative approaches to provision of services for young people, e.g. through Healthy Living Centres initiatives.	National Assembly for Wales (Chief Medical Officer) to issue guidance by end of 2000.
<b>6.3.2. Increase awareness and availability of emergency contraception.</b>	<p>Public education campaign to highlight availability and benefits of emergency contraception.</p> <p>Health Authorities to ensure that out-of-hours availability of emergency contraception, either via A&amp;E departments or other local arrangement, is included in sexual health services specification.</p> <p>Support principal of extending access to emergency hormonal contraception via appropriately trained nurses, midwives and pharmacists. Recent submission of progestogen-only emergency hormonal contraceptive formulation to Medicines Control Agency for licensing may facilitate this development.</p>	<p>National Assembly for Wales (Health Promotion Division) by spring 2001.</p> <p>Health Authorities by March 2001.</p> <p>National Assembly for Wales (Chief Medical Officer/ Health Professionals Group/ NHS Directorate).</p>
<b>6.3.3. Develop interventions directed at young people at greatest risk of teenage conception (e.g. teenagers from deprived communities; looked-after children; homeless or runaway young people).</b>	Local Health Alliances to explore possibilities for innovative interventions, e.g. educational programmes in children's homes or youth settings; outreach interventions; counselling in a health care setting.	Local Health Alliances by March 2001.
<b>6.3.4. Strengthen guidance issued in relation to "People in Communities" programme to tackle social exclusion.</b>	NAW to strengthen guidance on the production of action plans in People in Communities areas to ensure that prevention of teenage pregnancies and support for teenage mothers are given appropriate priority by local partnerships.	National Assembly for Wales (Housing and Community Renewal) by March 2000.
<b>6.3.5. Issue guidance on sex education and sexual health issues for looked-after children.</b>	NAW to issue guidance on sex education and sexual health issues for looked-after children.	National Assembly for Wales (Family Health Division/Social Services Inspectorate for Wales).

## 6.4 Reduce incidence and prevalence of sexually transmitted infections in Wales

ACTION	DETAIL	WHO AND WHEN
<p><b>6.4.1. Develop national public education campaign on sexually transmitted infections.</b></p>	<p>This should cover a number of sub-themes:</p> <p>(1) campaign targetted at teenagers and young adults on STI risks in general;</p> <p>(2) campaign specifically on chlamydia and risks of infertility;</p> <p>(3) campaign on HIV and other STI awareness/ risk assessment/ prevention targeted at men who have sex with men, particularly among men who do not identify with a gay lifestyle.</p> <p>These campaigns should reflect and support any relevant recommendations arising from the Communicable Disease Control Strategy.</p> <p>The national campaign should provide support for in-depth motivational work at a local level.</p>	<p>National Assembly for Wales (Health Promotion Division) by autumn 2001.</p> <p>Health Authorities/ Local Health Alliances.</p>
<p><b>6.4.2. Ensure wider availability of condoms.</b></p>	<p>Health Authorities, in consultation with Local Authorities, further education and higher education institutions and the voluntary sector, to explore the possibility of making condoms more widely available through:</p> <ul style="list-style-type: none"> <li>● Condom machines</li> <li>● Free distribution to vulnerable groups</li> </ul>	<p>Health Authorities by end of 2000.</p>

## 6.5 Promote a more supportive environment which encourages openness, knowledge and understanding about sexual issues and fosters good sexual health.

ACTION	DETAIL	WHO AND WHEN
<p><b>6.5.1. Set up all-Wales Sexual Health Network to take proactive role in media advocacy and promulgation of good practice in promoting sexual health.</b></p>	<p>The Network would provide a discussion forum for a range of agencies involved in promoting better sexual health. It would be a means of promoting best practice and increasing public understanding of sexual health issues.</p>	<p>National Assembly for Wales (Health Promotion Division) to set up Network by end of 2000.</p>

## 6.6 Strengthen monitoring, surveillance and research to support future planning of sexual health services and interventions

ACTION	DETAIL	WHO AND WHEN
<b>6.6.1. Set up Strategy Monitoring Group.</b>	National Assembly for Wales to set up Strategy Monitoring Group to develop indicators to measure strategy outputs and to monitor progress in implementing strategy.	National Assembly for Wales by summer 2000.
<b>6.6.2. Evaluate public education initiatives.</b>	Ensure that all major public education initiatives and campaigns arising from the strategy include an evaluation component.	National Assembly for Wales (Health Promotion Division).
<b>6.6.3. Encourage research into innovative approaches to delivery of sexual health services, particularly those which target high risk groups.</b>	Brief Welsh Office of Research and Development on strategic priorities in this area.	National Assembly for Wales/ Welsh Office of Research and Development by summer 2000.

# References

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# Appendix 1

Table 1. Conceptions to women under 18 (numbers, rates and percentage leading to abortion): area of usual residence 1995-97.

Area of usual residence	Number of conceptions	Rate (per 1000 women aged 15-17)	Percentage leading to abortion
<b>Isle of Anglesey</b>	150	37	36
<b>Gwynedd</b>	271	43	39
<b>Conwy</b>	314	55	40
<b>Denbighshire</b>	222	46	36
<b>Flintshire</b>	327	40	48
<b>Wrexham</b>	392	54	38
<b>Powys</b>	210	32	45
<b>Ceredigion</b>	108	30	51
<b>Pembrokeshire</b>	271	40	31
<b>Carmarthenshire</b>	430	45	37
<b>Swansea</b>	723	57	39
<b>Neath Port Talbot</b>	397	51	29
<b>Bridgend</b>	431	62	30
<b>The Vale of Glamorgan</b>	319	45	36
<b>Cardiff</b>	852	52	28
<b>Rhondda Cynon Taff</b>	871	65	31
<b>Merthyr Tydfil</b>	231	69	24
<b>Caerphilly</b>	679	68	28
<b>Blaenau Gwent</b>	277	69	25
<b>Torfaen</b>	299	56	27
<b>Monmouthshire</b>	137	28	42
<b>Newport</b>	425	56	26

## Appendix 2: Rate of sexually transmitted infections in Wales.

Table 2. Number of chlamydia infections in Wales, 1995-97, by age and sex (rates per 100,000 population).

		Age					
Year	Sex	<16	16-19	20-24	25-34	35-44	45-64
<b>1995</b>	male	1.7	60.1	235.4	93.5	22.6	1.5
	female	25.3	294.0	236.4	69	7.9	0.2
<b>1996</b>	male	3.5	94.5	208.9	102.8	28.1	2.3
	female	43.5	261.6	279.4	62.7	15.0	0.6
<b>1997</b>	male	1.8	91.6	212.3	96.9	25.0	3.5
	female	31.0	306.3	322.9	66.3	14.3	1.1

Table 3. Number of genital warts virus (first attack) in Wales, 1995-97, by age and sex (rates per 100,000 population).

		Age					
Year	Sex	<16	16-19	20-24	25-34	35-44	45-64
<b>1995</b>	male	6.7	190.2	576.8	259.5	83.2	18.8
	female	56.0	613.9	534.6	155.9	49.9	7.2
<b>1996</b>	male	5.2	170.9	597.7	272.5	72.8	23.2
	female	59.8	582.3	619.2	165.1	55.5	10.1
<b>1997</b>	male	5.2	196.6	693.2	278.9	81.6	19.4
	female	51.2	645.2	703.6	173.4	53.7	10.0

**Table 4. Number of genital herpes virus (first attack) in Wales, 1995-97, by age and sex (rates per 100,000 population).**

		Age					
Year	Sex	<16	16-19	20-24	25-34	35-44	45-64
<b>1995</b>	male	0.0	14.3	44.8	43.0	18.0	2.4
	female	3.6	89.9	102.7	50.0	16.3	1.9
<b>1996</b>	male	0.0	16.7	61.1	41.6	20.3	6.2
	female	7.2	104.9	102.4	44.7	20.8	5.5
<b>1997</b>	male	3.5	14.8	45.2	37.0	23.5	5.8
	female	1.8	95.0	104.8	43.7	18.4	6.0

**Table 5. Number of gonorrhoea infections in Wales, 1995-97, by age and sex (rates per 100,000 population).**

		Age					
Year	Sex	<16	16-19	20-24	25-34	35-44	45-64
<b>1995</b>	male	1.7	18.6	36.7	24.3	9.5	0.5
	female	1.8	32.0	30.9	4.8	1.0	0.2
<b>1996</b>	male	1.7	34.7	34.3	28.0	6.8	2.0
	female	5.4	38.4	18.6	9.2	0.5	0.9
<b>1997</b>	male	0.0	23.0	66.6	22.5	9.2	0.6
	female	0.0	36.9	27.1	5.0	1.0	0.0

Source: Communicable Disease Surveillance Centre, Wales

## Appendix 3. Membership of sexual health strategy steering group

Mr Alun Burge, Director, FPA Cymru

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Ms Sonia Edwards, School Nurse, Pembrokeshire

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Mr Clive Rees, Public Health Directorate, Bro Taf Health Authority

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### **National Assembly for Wales**

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Dr Jane Ludlow (Health Professionals Group)

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Mrs Christine Peat (Family Health Division)