

Enhancing Sexual Wellbeing in Scotland - A Sexual Health and Relationships Strategy

Analysis of Written and Non-Written Responses to the Public Consultation

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This paper outlines key findings from the two-part public consultation on the draft Sexual Health and Relationship Strategy (SHRS) conducted between November 2003 and April 2004. The first part of the consultation invited key stakeholders and the general public to submit written responses to the draft Strategy. The second part of the consultation involved conducting focus groups and consultation exercises, including with some specific groups who were identified as having the greatest barriers to good sexual health and with representatives from organisations working with these groups.

Main Findings

- A considerable number of respondents welcomed action to tackle the growing problems of unplanned or unwanted pregnancies and sexual ill health. Some respondents felt the draft Strategy provided a valuable and welcome opportunity to discuss the issues.
- The responses were characterised by two broad strands of opinion on what action should be taken. One had a focus on personal and parental responsibility. The other was based on a recognition of the realities of people's lives.
- Where some respondents felt the Scottish Executive should take a 'moral' view and questioned the absence of 'love' and marriage from the draft Strategy, others felt that 'the government cannot dictate for love'.
- Some felt that the draft Strategy outlined a very positive role for parents and carers while others felt that some elements of the draft Strategy undermined the role of parents and carers. There was support for a comprehensive media strategy and many respondents felt that any campaign should promote positive messages of sex, and avoid fear and sensationalism.
- Many health professionals and equality groups expressed support for the role of schools in promoting Sex and Relationships Education (SRE) while some individual and faith group respondents felt that schools should have no role in providing SRE. Many young people expressed a preference for having youth workers, rather than teachers deliver SRE.
- Health professionals were generally very supportive of developing closer links between schools and clinical services. However, many parents feared such links would undermine their role. Some young people had concerns about the implications for confidentiality and anonymity.
- There was broad support for proposals relating to access to services, although it was recognised that there are substantial challenges in overcoming the barriers to access.
- There was a strong view expressed by health professionals that the draft Strategy does not recognise the existing funding and resource problems within Genito-Urinary Medicine and sexual health services, and does not identify where additional resources will come from.

Background

The consultation process on the draft Sexual Health and Relationships Strategy (SHRS) which had been prepared under the direction of an independent expert Reference Group was launched on 12 November 2003. The draft Strategy was published in the form submitted by the expert Reference Group and submitted to the Scottish Executive (Scottish Executive 2003). It contained over 100 recommendations. The Minister for Health invited comment on any aspect of the draft Strategy in total or in part. In particular, the Minister asked for comment on whether the draft Strategy provides an acceptable framework for improving sexual health in Scotland or whether there are any points or issues that should be given greater or less emphasis.

Methods

The draft Strategy was distributed to a wide range of consultees and was also made available in electronic format on the Scottish Executive website. A wide range of organisations were invited to respond including those that have an interest in issues for children, disability, education, equalities, minority ethnic communities, justice, NHS Scotland and other medical interests, older people, religious and faith organisations and women's issues.

There were almost 1,400 written responses including submissions by e-mail and contributions to the electronic discussion forum. In addition, a number of non-written responses were invited through a series of consultation and research exercises including focus groups and interviews conducted across Scotland. These aimed to open up the consultation to a wider audience and to include the views of those who are identified as having the greatest barriers to good sexual health¹.

Setting the Context

A considerable number of respondents welcomed action to tackle the growing problems of unplanned or unwanted pregnancies and sexual ill health. However, there were key differences in attitude amongst the respondent groups on what action should be taken and on whether the Strategy should, or could, be neutral. Where some respondents felt

1 These were people of African descent living with HIV; working men who were not otherwise categorised as 'young'; men who have sex with men but don't necessarily identify themselves as gay or bisexual; commercial sex workers or prostitutes; and older people.

the Scottish Executive should take a 'moral' view and some questioned the absence of 'love' and marriage from the draft Strategy, others felt that *'the government cannot dictate for love.'* Some felt that the draft Strategy had in fact adopted an overly liberal approach to sex and relationships, and many considered that encouraging young people to delay the onset of sexual activity was the only solution.

Two broad strands of opinion were evident in the written responses and in the discussions. One had a focus on personal and parental responsibility. The other was based on a recognition of the realities of people's lives.

The Current Picture

A considerable number of respondents welcomed action to tackle the growing problems of unplanned or unwanted pregnancies and sexual ill health, although views diverged on how this should be achieved. While some respondents supported actions to reduce unintended teenage pregnancies complemented by other targets and initiatives, others questioned the focus on "teenage pregnancy". Care needs to be taken in presenting the actual target, which refers to reducing pregnancies amongst those aged 13-15 years old rather than applying to all teenage pregnancies. Additionally, it was felt by some that the draft Strategy was too focused on the sexual health of young people.

The Wider Influences on Sexual Health

In line with the two broad strands of opinion, some did not like the links made with wider social issues such as poverty, wanting to see a greater emphasis on personal responsibility, whereas others felt that the draft Strategy did not go far enough in addressing some of the wider influences on unintended teenage pregnancies.

There was a need identified for the Strategy to address stigma and discrimination, not only in relation to HIV and sexuality, but to challenge what are seen as unhelpful attitudes towards sex and relationships.

The Media and Mass Communications

There was support for a comprehensive media strategy and recognition of the substantial challenges this will present. Any campaign should promote positive messages, avoid fear

and sensationalism and not just focus on the use of barrier contraception. A media campaign could play an important role in breaking the 'cycle of embarrassment' through assisting parents in talking to their children.

Some felt that, in order to be effective, a media campaign would need to be linked to other elements of the Strategy, including tackling the reluctance and stigma around condom use.

Meeting the needs of those facing the greatest barriers to sexual health

Respondents proposed that, in addition to those mentioned in the draft Strategy, target groups should also include looked-after children, people with physical and learning disabilities, those that have been subject to domestic violence and abuse and survivors of child sex abuse. Sex workers, men, older people, LGBT people, and people living with HIV were seen as facing the greatest barriers to sexual health.

Acquiring Knowledge and Skills about Sexual Health and Wellbeing: the role of schools

Many respondents, including health professionals and equality groups, recognised the importance of schools in promoting better sexual health and expressed support for consistency in SRE in all schools (but also felt that it should be sensitive to differences in culture and beliefs). Some felt that it was unrealistic to expect consistency. Others, particularly individuals and faith groups, felt that schools should have no role in providing sex education or that they should have a different role to that outlined in the draft Strategy.

There was some scepticism amongst young people themselves about the value of SRE and teachers were not a popular option to deliver it. Relationships with teachers, their age and gender and the extent to which confidentiality is assured all affect the extent to which young people feel comfortable about teachers delivering SRE. Many prefer youth workers or youth group settings as the best way to deliver SRE.

The involvement of parents was seen as very important to ensure sensitivity although not all parents see a need to be

involved or have the confidence in their own knowledge to discuss sex and sexual relationships.

In respect of the content of SRE, there was support for a wider focus than avoiding pregnancy, with calls for more information on STIs and challenges to unhelpful attitudes towards gay, lesbian and bisexual young people. Amongst the written responses there was a strong feeling from individual respondents and some respondents representing education and young people that there should be more emphasis on abstinence. Most of the other respondents felt this would be inappropriate and ineffective and would like to see a greater emphasis on the positive aspects of SRE rather than a primary focus on the potentially negative outcomes of sexual activity.

Developing closer links between schools and clinical services

Views regarding developing closer links between schools and clinical services were mixed. Health Professionals were generally very much in support of developing closer links between schools and clinical services, but had some concerns about the practicalities involved.

Whilst some others supported closer links between schools and clinical services, there were also fears, particularly from parents and faith groups, that this would be an inappropriate development and that parental rights and responsibilities would be undermined. Young people had mixed views about accessing sexual health services through schools, largely due to concerns about confidentiality and anonymity.

The role of parents and carers

Some felt that the draft Strategy outlined a very positive role for parents and carers while others felt that some elements of the draft Strategy (such as links between schools and clinics and teaching SRE for young people) undermined the role of parents and carers.

Lifelong Learning for Adults

Media campaigns and information targeted at parents were considered to address some of the sexual health promotion needs of adults, but were not considered to be sufficient in themselves to effect change in sexual attitudes and behaviour amongst the wider population. Many simply do not see themselves as at risk. Attempts to change behaviour in the adult population need to challenge people's

perceptions of who is at risk in addition to a number of stigmas and taboos, and to tackle issues of abuse and violence. Attitudinal barriers such as unwillingness to accept the sexuality of older people also present challenges.

The Role of Sexual and Reproductive Health Services

The introduction of a tiered system was broadly welcomed by health professionals as a positive model of service delivery. There were concerns expressed about how this might function in rural areas, how cross border services would be funded and the role of the voluntary sector within this tiered system.

With regard to sexual health promotion, a need was highlighted to make better use of, and give greater recognition to existing services, particularly in the voluntary sector and to other individuals in communities, as well as specialists. There was a strong view from health professionals that the draft Strategy does not recognise the existing funding and resource problems within Genito-Urinary Medicine (GUM) and sexual health services and does not identify where additional resources will come from. Health professionals require further detail about how the Strategy is to be implemented and how it will fit in with existing structures.

Specific Actions to Reduce STIs

There was agreement from a number of respondents that greater access to free condoms, in conjunction with health promotion activities and more information, is important for both men and women. However, some individual and faith group respondents were not supportive of making condoms and other contraceptives freely available to young people.

While there was support in principle for offering HIV testing to all GUM clinic attendees, respondents highlighted a need for sensitivity in making these services routine, and for developing cultural competence amongst staff delivering all sexual health services. Some suggested that HIV testing should also be offered in family planning and reproductive health clinics. Lastly, it was suggested that, where people travel to neighbouring health boards to access services, funding mechanisms should reflect this.

Supporting Access to Services

There was broad support for proposals relating to access to services, although it was recognised that there are substantial challenges in overcoming the barriers to access.

The barriers highlighted included concerns about confidentiality and anonymity, embarrassment, stigma and prejudice. Again, developing the cultural competence of staff was thought to be a major challenge.

The proposals relating to access to termination were met with mixed responses. Health professionals in particular welcomed proposals to make services more quickly accessible and to ensure equitable services across Scotland. Other respondents raised concerns that the target to ensure access to terminations within one week of initial consultation would not enable women the time to fully consider the options available to them or enough time for counselling. Many of the written respondents were opposed to termination altogether. Other responses suggested that the Strategy should give more prominence to the alternatives to termination and to the availability of counselling.

Clinical Service targets for STIs

Health professionals indicated overall support for clinical service targets. While some professionals believed that the targets set should be flexible to reflect issues in different areas and that timescales were currently too tight, others felt that some of the targets were too weak and that end dates could be brought forward.

Many individual and faith group responses felt that the only way to reduce STIs is to promote the delay of sexual activity until in a stable relationship, preferably marriage.

Supporting Change

There was some scepticism about the ability of the proposed framework to champion sexual wellbeing at all levels, although there was some support and recognition of the challenges of the task.

There were concerns, mainly from health professionals, as to whether the necessary level of resources would be available to implement the Strategy, particularly over the long term.

There was a clear preference for resources to be directed to those working at community level, although there was little consensus on the relative merits of Health Boards and local authorities as lead agencies.

Conclusion

This research does not provide a single definitive view of the draft Strategy, but includes a wide range and depth of views on many of the issues amongst diverse groups in the

Scottish population. Whilst there is some common ground, the sometimes challenging, frank and divergent views expressed illustrate the real challenges that any strategy faces. It must reconcile different opinions and interpretations of what should be the appropriate content and address the practical difficulties of changing attitudes, behaviours and the implementation of services to deliver sexual wellbeing in Scotland.

The Consultation Analysis

The analysis of written responses to the consultation was carried out by TNS Social Research and is published in the report “Enhancing Sexual Wellbeing in Scotland - A Sexual Health and Relationships Strategy: Analysis of Written Responses to the Public Consultation.” The analysis of non-written responses to the consultation was conducted by Research for Real and is published in a separate report: “Enhancing Sexual Wellbeing in Scotland - A Sexual Health and Relationships Strategy: Analysis of Non-Written Responses to the Public Consultation.” Findings from the focus groups conducted by Children in Scotland, Poverty Alliance and the Scottish Civic Forum are integrated into the latter report and into these Research Findings.

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