

Healthy Respect Executive Summary

Independent Evaluation, March 2005





A collaborative research team with SP CERH
University of Edinburgh

External Evaluation of Healthy Respect

A NATIONAL HEALTH DEMONSTRATION PROJECT

FINAL SUMMARY REPORT

March 2005

© Crown copyright 2005

ISBN: 0-7559-4575-1

Scottish Executive
St Andrew's House
Edinburgh
EH1 3DG

Produced for the Scottish Executive by Astron B40498 3/05

Published by the Scottish Executive, March, 2005

Further copies are available from
Blackwell's Bookshop
53 South Bridge
Edinburgh
EH1 1YS

The text pages of this document are printed on recycled paper and are 100% recyclable.
The full final report is available from Aberdeen University.

The External Evaluation Team

Dr Janet Tucker	Dugald Baird Centre for Research on Women's Health
Dr Gillian Penney	Scottish Programme for Clinical Effectiveness in Reproductive Health (SPCERH), University of Edinburgh
Mrs Janet Shucksmith	Centre for Educational Research
Dr Edwin van Teijlingen	Department of Public Health
Dr Kate Philip	Centre for Educational Research
Mrs Ann Fitzmaurice	Dugald Baird Centre for Research on Women's Health
Dr Mari Imamura	Dugald Baird Centre for Research on Women's Health
Ms Lynda Guthrie	Dugald Baird Centre for Research on Women's Health
Ms Jennifer Reid	Dugald Baird Centre for Research on Women's Health
Ms Suzanne Penfold	Dugald Baird Centre for Research on Women's Health
Mr Raymond Oliphant	Dugald Baird Centre for Research on Women's Health

Mailing address

Dugald Baird Centre for Research on Women's Health
Department of Obstetrics and Gynaecology
University of Aberdeen
Aberdeen Maternity Hospital
Cornhill Road
Aberdeen AB25 2ZL
Tel: 44 (0) 1224 553875
Fax: 44 (0) 1244 553708
E-mail: dugaldbairdcentre@abdn.ac.uk
<http://www.abdn.ac.uk/dugaldbairdcentre/>

Tucker J, Penney G, van Teijlingen E, Shucksmith J, Philip K on behalf of the Healthy Respect External Evaluation Team. Final Summary Report of the External Evaluation of *Healthy Respect*, a national health demonstration project.

Scottish Executive, St Andrews House, Edinburgh, EH1 3DG
Commissioned and Published by the Scottish Executive, March 2005.

Acknowledgements

This evaluation study was supported by a grant administered by the Chief Scientist Office of the Scottish Executive Health Department, number CZH/4/11.

We wish to thank all members of the *Healthy Respect* demonstration project, both in management and in the component projects for the large amounts of time they gave to compiling self-audit reports, passing on information and meeting for interviews and conversations.

We wish to acknowledge the generous cooperation offered by the schools and pupils, all the organisations and individuals contacted in services related to young people's sexual health in both Grampian and Lothian, and to the young people who took part in discussions and interviews, for giving us their time and continued support.

Danny Wight and Marion Henderson kindly gave permission to use the MRC SHARE questionnaires and we thank them for allowing us to draw on their experience and advice.

We are also grateful to staff for discussions on data linkage and data retrieval for this study: in particular thanks go to ISD Scotland and The General Register Office Scotland (GROS), Jim Chalmers, Etta Shanks, Steven Williamson, Jennifer Bishop and Gordon McLaren; and Hugh Young and Hamish McKenzie from the microbiology laboratories in Lothian and Grampian respectively for providing the chlamydia test data presented here; and to Alice McLeod for discussions on methodology in estimating effects of deprivation and rurality.

Contents

The External Evaluation Team	page iii
Acknowledgements	page iv
Contents	page v
Introduction	page I
Evaluation I. Sexual health outcomes for young people in Lothian	
A. Attitudes and behavioural change	page 2
B. Service access, acceptability and uptake	page 5
C. Comparative trends in age-specific conception, and abortion rates, STIs (Sexually Transmitted Infections)	page 8
Evaluation II. Mapping partnership working and networks for sexual health	
D. Formal Partnership	page 13
E. Informal networks	page 15
F. Partnerships and networks operating to the benefit of the client	page 17
Evaluation III. Implementation and process evaluation of component projects	
G. Implementation, innovation and evidence of best practice	page 24
Key Findings to inform policy and service	page 33
Glossary of terms and abbreviations	page 40

Introduction

Healthy Respect is one of four national health demonstration projects established in Scotland in 2000. The demonstration project is a partnership initiative bringing together a number of different agencies and organisations, and hence component projects under the umbrella authority of Lothian NHS Board.

Healthy Respect aimed to work towards improving the sexual health of young people in Lothian and the observation period of this report is November 2000 to February 2004. This external and independent evaluation considered the effect of the Lothian Demonstration Project, *Healthy Respect* from three perspectives shown below.

Outline of the external evaluation plan

I Sexual Health Outcomes

- A Sexual health attitudes and behaviour
- B Service access, acceptability and uptake
- C Comparative trends in age-specific conception and abortion rates and sexually transmitted infections

II Mapping partnership working and networks for sexual health

- D Existing services and formal partnerships of providers
- E Existing and evolving partnerships and networks
- F1 & 2 Implementation, coverage and effect on client

III Implementation and process of component projects

- G Implementation, innovation and evidence of best practice

This summary report presents findings in the order of outline evaluation plan.

I. Sexual health and behaviour outcomes

A: to evaluate the effect of Healthy Respect in improving sexual health attitudes and behaviour in young people in Lothian compared to Grampian.

Hypotheses

In relation to the timed implementation of the *Healthy Respect* Demonstration Project, in Lothian compared with Grampian:

1. There will be an increased proportion of young people who report better communication with parents on sexual health issues.
2. There will be an increased proportion of young people who report better communication with teachers/tutors on sexual health issues.
3. There will be a reduction in the proportions of young people who report having had sexual intercourse at ages <16 years.
4. There will be increased knowledge and improved attitudes and intentions about using condoms among young people.

A before-and-after survey of young people's sexual health knowledge, attitudes and behaviour was used to test *Healthy Respect's* Sexual Health and Relationship Education (SHARE) programme in 10 Lothian schools, compared with five non-SHARE Grampian schools. ¹

Main Findings

- Before *Healthy Respect's* SHARE intervention, Lothian pupils in 2001 consistently demonstrated significantly less knowledge, less positive attitudes and behaviour relating to sexual health, compared with pupils in Grampian.

Communication about sexual health issues

- Around half of pupils can talk to mothers whereas only one fifth can talk to fathers on these issues. Boys were less able to talk to mothers and girls less able to talk to fathers.

¹ Reported regional differences in behavioural outcomes remain after controlling for pupil-level socio-demographic variation, and with little evidence of consistent school-level effect between the regions.

After *Healthy Respect* and SHARE (2003) the proportion of pupils in Lothian (particularly the few boys feeling able to talk to their fathers) increased so that the difference with Grampian was no longer evident.

- Other results indicate no increase by 2003 in the low proportions of pupils in Lothian who report better communication with teachers on sexual health issues and advice, and Lothian pupils appeared only half as likely to approach school nurses compared with Grampian pupils (20% of pupils in Lothian vs. 38% in Grampian (2003)).

Sexual intercourse at ages <16

- Around 1 in 5 pupils reported having had sexual intercourse at age <16.
- Significantly more Lothian (~24%) than Grampian (~19%) pupils report having had sexual intercourse, both before and after the intervention, with no evidence of any reduction in Lothian by 2003.

Knowledge, attitudes and intentions in relation to condom use

- By 2003, the proportion of pupils in Lothian feeling confident (self-efficacy) about getting condoms, and using condoms properly, increased. Also more Lothian pupils (particularly boys) agreed by 2003 that sexually transmitted infections (STIs) are likely to be contracted unless condoms are used.
- However, no further evidence of narrowing of the regional gap was detected in improving other attitudes about condom use by 2003. Pupils in Lothian were more likely to feel embarrassed (especially girls) and more likely to think condom use would reduce sexual enjoyment (especially boys).
- Lothian pupils' intentions about condom use (as closer predictors of actual behaviour change) showed no sign of improvement despite the above noted improvements in self-efficacy and knowledge.
- Finally, clear differences in attitudes to condom use by gender were noted. These differences are shown below to better inform practice and gender-specific approaches to attitude change:

External Evaluation of Healthy Respect

Relative to girls, **boys were:**

- More likely to think condom use reduces sexual enjoyment
- More likely to think condoms are too expensive to buy
- Less likely to think STIs are likely to be contracted unless condoms are used
- Less likely to think an STI may show no symptoms at all
- Less likely to intend to discuss condom use with partners
- Less likely to value the importance of planning protection from an STI

Relative to boys, **girls were:**

- Less likely to think obtaining or using condoms is easy
- More likely to find it embarrassing to use condoms
- More likely to doubt the effectiveness of condoms against HIV/AIDS
- Less likely to get condoms by themselves.

B: To evaluate Healthy Respect's effect on access, acceptability and uptake of contraceptive and sexual health services in Lothian compared to Grampian

Hypotheses

In relation to the timed implementation of the *Healthy Respect* Demonstration Project, in Lothian compared with Grampian:

1. There will be increased provision of sexual health services and contraceptives for young people. (see II, mapping services and I-C, trends in sexual health outcomes)
2. There will be a reduction in young people's perceived barriers to sexual health services.
3. There will be increased access to sexual health services and contraceptives by young people.
4. There will be increased intentions to use sexual health services and contraceptives by young people. (see also section I-A)
5. There will be higher rates of uptake of sexual health services and contraceptives by young people. (see II, mapping services and I-C, trends in sexual health outcomes)

Findings from the questionnaire survey and focus group interviews in Lothian and Grampian evaluate the impact of the Lothian's *Healthy Respect* and SHARE programme on young people's preferences for and perceived barriers to sexual health services, advice and obtaining contraceptives.

Main Findings

Access and barriers to advice and sexual health services

- In both Lothian and Grampian the most popular services for pupils were drop-in centres, family planning clinics and family GPs.
- After *Healthy Respect*, the popularity of drop-in centres increased further in Lothian (49% to 60%), and decreased for family planning clinics and GPs compared with Grampian. There is little indication that barriers to other services (telephone helplines, internet, school-based staff) decreased in Lothian.
- School-based staff, and teachers in particular, were the least favoured source of advice. Focus group interviews revealed concerns about lack of confidentiality, embarrassment

External Evaluation of Healthy Respect

and the possibility of being treated differently by a teacher after disclosure of personal information.

- Pupils in the Lothian focus groups after the intervention said there were no specific sexual health services in their locality, especially in rural areas. Where services did exist, they were often judged unsatisfactory because of severely restricted opening hours.
- The kind of advice services preferred vary according to gender and whether or not young people reported already having sexual intercourse. Boys were more reluctant to seek advice from drop-in centres and family planning clinics, and girls were no more likely than boys to access GPs. Those who reported previous sexual intercourse were less likely to use GPs.

Access and barriers to obtaining condoms

- The most popular way to obtain condoms in both Lothian and Grampian was through vending machines in public toilets (~60%). Local chemists were regarded favourably (~40%), and family planning clinics appeared more popular in Grampian (~40%) than in Lothian (~25%). After *Healthy Respect* there is little evidence of any reduction in perceived barriers to these and other services which supplied condoms for Lothian pupils compared to Grampian pupils, except that the recognised availability of condoms at drop-in centres in Lothian did increase after the intervention (20% to 32%).
- Again, results show clear differences by gender and sexual activity. Boys were more likely to use vending machines than other methods to obtain condoms, probably due to the anonymity offered in this method.

Access to specific regional sexual health services

- Pupils still appear poorly informed about the availability of sexual health services in their region. After the intervention, increased proportions of pupils in Lothian had heard of *Healthy Respect*, and the c:card service (>65%), but only a minority of pupils had heard of other specific regional services presented to them (<30%) and few had used them (<10%).
- Although the *Healthy Respect* logo was well identified in focus groups in Lothian by 2003, few pupils were able to say what *Healthy Respect* signified, thus raising some doubts about the delivery of values associated with the brand.

- Grampian pupils were most likely to identify the *Health Promotions* shop in the main street of Aberdeen as an available sexual health service in their area (~60%), but, again, very few pupils recognised or used the other services listed.
- Boys were less likely than girls to access sexual health services, but those who were sexually active tended to show greater awareness of services available and to be more likely to use them.
- Whereas the younger pupils in focus groups commonly identified the Internet as a potential source of advice, older pupils noted that, in reality, restrictions on search terms and website contents on school premises (applying also to the *Healthy Respect* website) mean that potentially valuable sources of sexual health information remain unavailable.

Reported contraceptive use of sexually active pupils

- The survey findings showed that only around half of pupils who reported having had sexual intercourse said they had used a condom at first sexual intercourse.
- Before and after *Healthy Respect* and SHARE, there were no significant regional differences in the reported use of condoms, the contraceptive pill or the morning after pill at first sexual intercourse. By 2003 there was an indication of increasing reported use of all three methods in both regions.

C: To evaluate, in relation to the timing of Healthy Respect, longitudinal trends in teenage conception and abortion rates, and screening for STIs in Lothian compared with Grampian, and with Scotland as a whole.

Hypotheses

In relation to the timed implementation of the Healthy Respect Demonstration Project in Lothian:

1. Teenage conception rates will fall in Lothian. The rate of fall will exceed that in Grampian and in Scotland as a whole.
2. Teenage abortion rates will fall in Lothian. The rate of fall will exceed that in Grampian and in Scotland as a whole.
3. The number of tests for *Chlamydia trachomatis* undertaken in teenagers will rise in Lothian. The rate of testing among young people will exceed that in Grampian and in Scotland as a whole.
4. Compliance with national recommendations for the detection and management of genital *Chlamydia trachomatis* infection (SIGN Guideline 42) will be higher in Lothian than in other regions of Scotland.

This section compares sexual health outcomes (conception and abortion rates) for young people in Lothian and in Grampian and in Scotland as a whole in relation to the timed intervention of *Healthy Respect* in Lothian. Adjusted comparisons for Lothian and Grampian are presented. It also compares the performance of healthcare professionals in the detection and management of genital *Chlamydia trachomatis* infection. At time of reporting, complete teenage conception data for 2003 were unavailable.

Main Findings

Trends in teenage conception rates in Lothian and Grampian

- Over 1995 to 2002 the overall teenage conception rate was consistently higher in Lothian than the overall Scottish rate, whereas the rate in Grampian was consistently lower.
- Across all age groups (13-15, 16-17, and 18-19) and all years, conception rates are higher in Lothian than in Grampian.

- One *Healthy Respect* headline target relates to reducing health inequalities in conceptions in the youngest teenagers (13-15 year olds). Numbers and rates of conceptions in this age group are very low (~8 per 1000 women; compared to a rate of ~80 per 1000 for 18-19 year olds). Low rates and random effects make interpretation of trends and detection of significant differences problematic. In Grampian, the conception rate among 13-15 year olds has fallen consistently from 9.7 per 1000 in 1996 to 6.1 per 1000 in 2002. In Lothian, there is greater variation year on year, with no consistent downward trend.
- Using both 2001 Carstairs (7 Categories) and Scottish Index of Multiple Deprivation (SIMD 2004) (deciles), the data demonstrated the well-known association of increasing deprivation with increasing teenage conception rates in these data.
- There was no apparent consistent relation between rurality using Scottish Household Survey (SHS) (6 Categories) and teenage conception rates.
- For 2001 to 2002, the odds ratios for pregnancy for Lothian teenagers (and for different age groupings) were compared to their counterparts in Grampian. Unadjusted comparison showed Lothian teenagers were significantly more likely to have a pregnancy than Grampian teenagers (OR 1.21, 1.14-1.29). Adjustment for deprivation using Carstairs Categories reversed these odds (OR 0.93, 0.87-1.00), while adjustment using SIMD deciles had less effect but reduced the regional difference such that it became non-significant (OR 1.03, 0.96-1.09). This effect is evidence of continuing health inequalities. By taking account of deprivation in different regions, apparent differences in teenage pregnancy rates can be explained in fairer comparisons.
- Unadjusted and adjusted (SIMD) odds ratios for pregnancy for Lothian teenagers (in different age groupings) compared to their counterparts in Grampian were examined for each year from 1995 to 2002. Adjustment reduced or reversed the regional difference in risk of pregnancy.
- Adjusted odds ratios varied year on year and a longer period of monitoring is required to confirm any sustained trends in the difference between Lothian and Grampian in relation to the timing of *Healthy Respect*.

Trends in teenage abortion rates and abortion proportions in Lothian and Grampian

- Over 1995 to 2002 the teenage abortion rate in Lothian was consistently higher than the rate in Grampian. 2002 data suggest a narrowing of this difference.
- Using abortion proportions, overall ~40% of teenage conceptions end in abortion, with this proportion being only slightly higher in Lothian than in Grampian.

External Evaluation of Healthy Respect

- Using Carstairs (7 Categories), there was evidence of the well-established relationship of increasing deprivation associated with a decreasing proportion of teenage conceptions ending in abortion.
- For 2001-2002, the odds ratios for abortion for pregnant Lothian teenagers (in different age groupings) were compared to those for Grampian. Using unadjusted data, pregnant Lothian teenagers appeared no more likely to have an abortion than pregnant Grampian teenagers (OR 1.03; 95% CI 0.91-1.16). Adjustment for deprivation however, (using both Carstairs Categories and SIMD deciles) indicated that Lothian teenagers were significantly more likely to have an abortion than those in Grampian (Carstairs, OR 1.21, 1.06-1.38; SIMD, OR 1.19, 1.04-1.35). Again longer data monitoring is required, but these findings suggest that the variation between regions is not wholly explained by deprivation. Further associated factors may include decision-making and access.

Comparison of testing for C.trachomatis in teenagers in Lothian compared with Grampian

- Data from microbiology laboratories permitted some comparisons of chlamydia testing in Lothian and Grampian. Between January 2000 and March 2004, quarterly chlamydia tests on teenagers rose by 84% in Grampian (from 539 to 993) and by 121% in Lothian (from 751 to 1661). The rise in Lothian was particularly marked among male teenagers (186%, from 99 to 283).
- In both Lothian and Grampian, the proportion of all chlamydia tests from specialist GU services declined significantly over time (reflecting involvement of a wider range of clinicians in testing). The extent of this fall was similar in the two regions.
- In both Lothian and Grampian, the number of chlamydia positive teenagers detected annually increased over time. The increase from 2000 to 2004 was slightly greater in Lothian (65% increase) than in Grampian (59% increase).
- In both regions, and throughout the period 2000-2004, the rate of detected positive chlamydia tests among selected tested teenagers was consistently around 13%.

Comparative compliance with national recommendations for the detection and management of genital C.trachomatis infection (SIGN Guideline 42) in Lothian compared with Grampian.

- During the period of activity of the *Healthy Respect* demonstration project, few differences were detected between clinicians in Lothian and Grampian with regard to self-reported chlamydia-related practice.

I. Sexual health and behaviour outcomes

- In both regions, primary care clinicians (90%) appeared very aware of the need to test for chlamydia in patients with relevant symptoms; but were less likely to offer opportunistic testing to young patients without specific symptoms.
- However, a review of case records was less reassuring with only 26% of relevant general practitioner consultations including initiation of chlamydia testing, and data showed a mixed picture in comparisons between Lothian and Grampian clinical practice.
- Overall, *Healthy Respect* in Lothian appeared to have little impact on clinicians' practice although the few significant differences that were detected tended to suggest better practice in Lothian.

II. Mapping partnership working and professional networks for sexual health

Hypotheses

In relation to the timed implementation of the *Healthy Respect* Demonstration Project, in Lothian compared with Grampian:

- D. There will be significant change in the extent to which the service provider organisations in the initiative interact at a formal or institutionalised level
- E. There will be significant change in the extent to which the service provider organisations in the initiative (or individuals working within them) network at an informal level
- F1. There will be measurable or perceived benefit in the extent to which formal or informal connections and networks operate to the benefit of the client
- F2. There will be a measurable increase or change in the way in which provider agencies (of medical and education services) interact with the client group and their carers

Government policy has supported the broadening of responsibility for health beyond the NHS to other agencies, has encouraged the development of inter-agency and partnership working, and promoted the idea of incorporating users' views in developing services. This level of the evaluation explored whether Healthy Respect had made a significant contribution to the broadening of responsibility for sexual health advice and services for young people through the development of professional networking and partnership working. In this level of the evaluation the objective was to evaluate the success of Lothian Healthy Respect in forging partnerships and networks

Comparisons of networking and partnership activity in Lothian and Grampian throughout the intervention period are made using regional inventories of services associated with sexual health service provision. These were compiled from interviews with professional staff and young people and from scrutiny of committee documentation and project reports.

II. Mapping partnership working and professional networks for sexual health

D: To evaluate if there was a significant change in the extent to which the service provider organisations interact at a formal or institutionalised level.

In Lothian, after a hesitant start, *Healthy Respect* rapidly drew in partners to ensure extensive partnership working.

- At the outset of *Healthy Respect* with no Lothian-wide sexual health strategy in place, the evidence of strategic partnerships to improve the sexual health of young people was uneven, though earlier work around HIV had established some useful working partnerships.
- Three areas of Lothian had already developed strategic groups and action plans (West Lothian Sexual Health Promotion Group, Midlothian Young People's Sexual Health Promotion Group and the East Lothian Health Promotion Group) to enhance and increase service provision. In Edinburgh City no similar group existed at the outset of *Healthy Respect*.
- In terms of strategic partnerships, *Healthy Respect* was integral to the planning and shaping of both the local Lothian and the National Sexual Health Strategy documents.
- In terms of facilitative partnerships, *Healthy Respect* drew on both clinical and public health professionals and local authority partners to develop new forms of service delivery.
- Partners from the voluntary sector were also drawn in, and although small in scale and not as well resourced, these component projects were in a strong position to capitalise on the benefits of involvement with the demonstration project and used it to provide a new platform for the issues on which they worked.
- Voluntary sector involvement enabled *Healthy Respect* to benefit from work that was grounded in local communities or specific population groups, and to link with key agencies and individuals at an earlier stage than might otherwise have been possible.
- Partnership development was not a uniform process. Some potentially key agencies (e.g. community education and social work) were ignored or under-represented.
- Formal partnerships between the primary statutory service providers of health and education were slow and difficult to establish and more difficult to consolidate.
- Overall, however, this partnership working was a major achievement of *Healthy Respect* as it helped to raise the profile and the level of priority of sexual health work with young people in Lothian.

External Evaluation of Healthy Respect

By contrast, in Grampian, one strategy group met but no action plan had been produced at the beginning of the mapping process.

- This group had few connections and no partnerships with agencies outwith the NHS sexual health services.
- The later development of the Grampian Sexual Health Strategy was given urgency by the National Sexual Health Strategy development.
- Grampian Sexual Health Strategy development did not appear to link in a systematic way with work at a local level outside the health services. Although a considerable amount of strategic work with young people was going on in Grampian, with the Aberdeenshire and Aberdeen City Youth Strategies and with new community schools work, there was little evidence that this connected with the development of the Grampian Strategy.

II. Mapping partnership working and professional networks for sexual health

E: To evaluate if there was a significant change in the extent to which the service provider organisations in the initiative (or individuals working with them) network at an informal level.

In addition to strategic partnerships the evaluation looked at whether informal networking existed in a way which might lead to better service integration. There will be significant change in the extent to which the service provider organisations in the initiative (or individuals working within them) network at an informal level.

The funding for the demonstration project in Lothian gave a significant boost to opportunities to develop informal networks.

- *Healthy Respect* gave many small voluntary organisations links to a more established and powerful platform from which they could work, and acted as a catalyst to promote dialogue between partners.
- Many of the networks that developed used *Healthy Respect* as the hub, but horizontal linkages between component projects soon started to develop, particularly among the voluntary groups.
- There were many networking opportunities in *Healthy Respect*, but there were also hidden costs to this volume of activity, particularly for local authority partners and smaller voluntary organisations. The latter often subsidised their involvement in the demonstration project.
- Practitioner level dissemination activities helped to develop some new networking opportunities with non-*Healthy Respect* agencies.
- Inter-professional training, which was developed as part of SHARE, offered informal networking opportunities for those involved. These were appreciated at the time but were subsequently difficult to build on or sustain because of the way in which the delivery of the initiative was managed in schools.

In Grampian some interesting developments took place in terms of efforts to develop sexual health advice and services for young people, but, without the catalyst of demonstration project funding, these innovations were largely uncoordinated, often arose from short-term funding and were poorly disseminated.

- Grampian initiatives were reliant on very short term funding and the commitment of key individuals who were themselves locally well networked.

External Evaluation of Healthy Respect

- Where an informal group did come together the lack of any additional resource hampered its efforts to push forward any sort of sustained agenda.
- Uncertainty about the legitimacy of engaging in this area of work undermined attempts to develop sustainable networks particularly among youth work practitioners.
- Managerial support for such informal networking was uneven with little evidence of any continuing work throughout the period of the demonstration project in Lothian.
- In comparison to Lothian's extensive informal networking and opportunities, networking in Grampian appeared sparse and relatively unsupported.

II. Mapping partnership working and professional networks for sexual health

FI: To evaluate if there was measurable or perceived benefit in the extent to which service provider connections and networks operate to the benefit of the client.

Evidence regarding this objective is to be found in data reported in Section IA and IB as well as in the data collected specifically for this level of the evaluation. Better networking might have been expected to lead to lower threshold services for young people, to easier referral through services, and to services where education and service provision were better integrated. The development of networks with a greater range of providers, including NGOs, might also have been expected to have increased the reach of services to vulnerable groups of young people.

With regard to Lothian, young people did start to receive a noticeably different style and level of service.

- The linked education package and service provision component of the SHARE projects was the most obvious Lothian attempt to provide low threshold service for some young people.
- Although the SHARE education work was of high quality (in terms of its theory base, training package etc), a relatively small proportion of young people in the Lothian catchment (about 20%) were exposed to it. The schools for the SHARE intervention were selected pragmatically, rather than systematically sampled for example from those areas of greatest need.
- The SHARE drop-ins provided low threshold access to services, and survey work reported in Section I shows that offer of such services made an impact.
- There was, however, huge variability in the operation of these services, and it is difficult to assess from the data kept by the drop-ins themselves what proportion of young people needing service were well served by these new facilities.
- Drop-ins which offered direct access to contraception were more heavily used than those which only offered advice and counselling.
- The localised nature of such service provision suited some fractions of the youth population, but was not perceived as anonymous or confidential enough by others.
- The mixture of formal and informal services at the drop-ins had different appeal to young men and young women, with the former preferring the casual drop-in element, and the young women making greater use of clinical one-to-one services provided.

External Evaluation of Healthy Respect

- Younger adolescents liked the informal nature of the drop-ins as a venue for satiating their curiosity and allowing discussion of issues which were normally 'out of order', but their boisterous behaviour was seen as jeopardising service provision for older teenagers. This problem was not well addressed.

In Grampian, on the other hand, there was little evidence of a sustained attempt to link education and service provision, to develop low threshold services or to improve service integration

- Attempts to link sexual health services with schools were, with a few notable exceptions, stifled fairly quickly.
- Without any strong strategic leadership in the area for the development of sexual health advice and services, and without the pressure for strategic partnerships to deliver, education and health services stayed almost entirely separate.
- School nurses seem to have played a larger role in Grampian than in Lothian, according to the survey work reported here. They operated a number of drop-in services in Aberdeenshire, but these were not routinely advertised.
- Localised attempts to develop a multi-professional drop-in service in another area were forbidden to advertise the sexual health side of the work within the local secondary school.
- Young people in rural areas felt particularly exposed by having to use adult services like GP clinics or outreach family planning services, but high costs of travel from the rural areas made access to more anonymous services difficult.
- Family planning services directly geared to young people were revamped to make a more attractive service to young people but remained highly centralised.
- A mobile bus offering contraceptive advice and services to young people operated via Health Promotions as an outreach into rural areas, but its coverage was limited and sporadic.
- One Moray initiative seemed to offer an innovative approach which drew in partners, including young people themselves to both the planning and development of a service in an outlying area.
- Community and youth workers were hampered in their attempts to provide support and service to young people on sexual health issues by a lack of appropriate guidelines, leaving them feeling professionally exposed.

II. Mapping partnership working and professional networks for sexual health

F2: To evaluate if there was measurable increase or change in the way provider agencies interact with the client group and their carers.

This section considers whether partnership working or better networking allowed provider agencies within *Healthy Respect* to adapt their own policy and practice towards the provision of services for young people. Four aspects are focused on:

- changes in the way in which young people (and their parents) were consulted as service users;
- shifts in understanding in terms of the multi-professional contribution that could be made to improving young people's sexual health;
- changes in understanding about taking service to the client rather than expecting the client to come to the service;
- changing understandings about the different fragments of the youth population and the way in which service might have to be targeted towards them.

In both Lothian and Grampian there were many concurrent initiatives all aimed at changing service and thereby improving the life chances of young people e.g. new community schools, social inclusion partnerships, New Deal, Health Improvement funding, Sure Start, Excellence in Schools, and community regeneration support. Thus, throughout this section it is important to locate *Healthy Respect's* activities in the context of this wider array of initiatives trying to change the culture of service delivery to young people.

Participation and consultation with young people and parents as service users

In Lothian some attempts were made to develop consultation, but these often took the form of 'needs' assessments, where some professionals would argue that there is a 'rights' issue about young people's position as service users.

- Findings indicate that, even in *Healthy Respect*, consultation mechanisms and the participation of young people was generally poorly developed, with parental participation equally low. Few exercises moved above the level of "consultation" or "placating" rather than "participation".
- Consultation exercises about the Lothian drop-ins showed young people wanted longer opening hours, services at weekends and over holiday periods, service provision that included contraceptives and a holistic approach, but few of these demands were met.

External Evaluation of Healthy Respect

- The virtues of consultation are sometimes hard for service providers to understand. Protracted consultation processes with parents and stakeholders over the development of the drop-ins in Lothian, for instance, delayed service initiation and delivery for young people.
- The participation of young people is viewed as even more difficult because of professional doubts over young people's competence to be part of the planning process.
- Consultation mechanisms with stakeholders were rarely innovative. Asking potential users to come to the service provider to give views is unlikely to result in high turn-outs or ensure wide representation or participation.

In Grampian, whilst consultation mechanisms with young people were well developed in other spheres (e.g. community development planning), they were largely ignored in respect of sexual health services

- Some innovative work in Moray (Support Made Simple) provided good exemplars of new ways of drawing young people in as planning partners.
- Health Improvement Funding supported a needs assessment on young people's health and well-being in three Aberdeen LHCCs in 2001. Findings of the report indicated that young people wanted to be involved in decisions about health service provision.

Multi-professional contributions to improving young people's sexual health

Multi professional working was a major aspect of the *Healthy Respect* work in Lothian.

- Multi-professional SHARE training was highly rated by Lothian staff undergoing training, but subsequent delivery of the initiative was much patchier. Such approaches need to be championed by management at senior staff level in school and at partnership level in local authorities.
- School nurses contributed to SHARE drop-in centres in Lothian, but their capacity was limited. Skilled professionals from many backgrounds contributed to the success of work in the drop-in centres. Young people appreciated recognising staff who had given SHARE sessions in school also delivering services.
- *Healthy Respect* tackled the thorny issues of developing confidentiality and child protection guidelines across professional groups. Conflicting protocols on these issues are notorious for spoiling attempts at joint working.

II. Mapping partnership working and professional networks for sexual health

In Grampian, without demonstration project funding, it was more difficult to draw different professional groups together.

- Partnership initiatives such as Walk the Talk, Social Inclusion and Health Improvement Funding attempted small projects to draw professional groups together in the service of young people's health.
- Education was often missing as a partner in many such schemes.
- In relation to sexual health education and services for young people work seems poorly supported, often unevaluated and not widely disseminated.

Partnership working to take services to young people

It is important for service providers to explore ways of taking service out to young people in places, at times and in styles which suit them.

In Lothian, *Healthy Respect* had a number of ways of tackling this challenge.

- *Healthy Respect* attempted to do this largely through the drop-ins.
- *Healthy Respect* also attempted, through several component projects to re-conceptualise the nature of service provision on sexual health, looking at issues which might have more salience for young people, e.g. by looking at issues of sexual coercion or gender uncertainty.
- Those who actually worked with young people undertook training on these broader issues, but were not themselves well-placed to drive the issues to the top of their organisation's agenda or ripple out learning to influence practice generally.
- GPs are the major provider of sexual health services, as the survey work shows. However, despite being key providers and gatekeepers they were not involved in any systematic fashion in *Healthy Respect*. Only the Parents project involved GPs in the development of the GP Birthday Card scheme, and only a small number of drop-in clinics did develop through GP practices, but with one exception these were not initiated through *Healthy Respect*. No mechanism existed to link with GPs and LHCCs over the development of the SHARE drop-in services.

Without the SHARE intervention, there were fewer attempts in Grampian to take services out to young people through drop-ins and so on.

External Evaluation of Healthy Respect

- A number of drop-ins operated in Aberdeenshire, but in a very discreet way.
- A mobile bus service offering sexual health services for young people was sporadic in its coverage.
- Square 13, the city-centre family planning clinic in Aberdeen, did reorganise to offer more specific young people's clinics, but the service was very centralised and access to it for young people in rural areas was problematic, because of travel costs.
- Although GU services offered an outreach service in the Moray area in the final year of the study, local agencies including some health services, had poor knowledge of it.

Recognition of diverse needs of young people as a non-homogeneous group

Did new multi-professional ways of working cause service deliverers to appreciate the very different fragments of the youth population and the ways in which service might have to be targeted towards them?

Many lessons were learned in Lothian through the course of the first phase of *Healthy Respect*.

- Work within the drop-ins, as noted earlier; exposed the different needs of young men and young women.
- It also highlighted the different needs of young people of different ages, and also of those with and without sexual experience. All these groups made different demands on service which were not always compatible.
- The need to develop services that were sensitive to very different fragments of the youth population was appreciated within *Healthy Respect* around the needs of LGBT young people.
- There was little attempt to explore the need for services for ethnic minority young people.
- The absence of key agencies such as social work and community education from the *Healthy Respect* partnership was a serious gap in relation to work with some groups of socially excluded young people.

In Grampian, recognition of the different needs of fractions of the youth population was not always matched by action.

II. Mapping partnership working and professional networks for sexual health

- One multi-disciplinary group, the *Sexual Health and Looked After Young People* steering group was set up to meet the “Targeting Excellence” recommendations. These required development of appropriate health promotion and sexual health initiatives for young people looked after by the local authority (*Report on the sexual health and looked after young people seminars, 2003*). This group included medical practitioners, social work and public health. The report provides a wealth of information and advice but it is unclear at the time of writing, how this will be taken forward.
- Similarly, despite the development of an ambitious action plan for LGBT work by Aberdeen City Council in 2002, little evidence exists about implementation. It continues to be an area of work that is poorly supported. Outside Aberdeen there is little evidence of any work for LGBT young people at local level.
- No evidence was found of work with ethnic minority groups of young people on sexual health issues.

III. Implementation and process of component projects

G Implementation, innovation and evidence of best practice

Details of how the diverse component projects of *Healthy Respect* were delivered on the ground are given in this process evaluation. From close study of the way they operated (November 2000 to May 2004), some key lessons are highlighted for the demonstration project and others working in the field of health improvement and sexual health work with young people.

There was wide variety amongst the 19 component projects included in *Healthy Respect*. Some were existing or re-launched services or interventions; others were entirely new. Some had a clinical focus; others were community-based, or based in local authority or health board structures. Some were focused around small and discrete tasks; others took a remit across the whole demonstration project.

III. Implementation and process of component projects

19 component projects of *Healthy Respect* with the ten selected case studies* (in bold)

<i>Project letter</i>	<i>Component Projects titles</i>
A	Improving contraceptive services in abortion services
B	Young people with specific needs (a) Looked after and accommodated young people (b) Getting the message across at Caledonia Youth*
C	Chlamydia testing*
D	Emergency contraception and chlamydia testing
E	Sexual health promotion in Further Education colleges
F	Lesbian, gay, bisexual and transgender (LGBT) work*
G	Sexual health and relationships education (SHARE) in the school setting a) Edinburgh City* b) West Lothian* c) School nurses* d) Inreach/outreach work* e) East Lothian f) Mid Lothian
H	Confidentiality and child protection
I	Developing and supporting the role of parents*
J	Young men's sexual health*
K	Young women who have experienced sexual abuse or coercion*
L	Creating affirmative cultures
Cross-cutting	Developing young people's involvement

External Evaluation of Healthy Respect

The diversity of the component projects resulted in the adoption of a case study approach. A final purposive sample of 10 selected component projects for case study (bold above) was undertaken, ensuring that it represented balance across the intervention and took account of the differences in the orientation and capacity of the component projects.

- large-scale, resource-intensive projects vs smaller-scale low-cost interventions
- interventions nested within statutory settings (health services, local authority) vs voluntary settings
- interventions in rural settings vs urban settings
- interventions focusing on vulnerable or 'hard to reach' groups vs those focused on mainstream provision
- interventions which built on a base of existing work in an organisation vs those with a 'standing start'
- interventions which already possessed links with sophisticated networks and partnerships vs others with fewer connections.

Data collection included all project documents, observation at meetings, quarterly project audit returns, project reviews, interviews with project leaders, project workers, user and non-user groups, stakeholders and linked organisations. In the analysis of the work of *Healthy Respect's* component projects, success was judged around specified criteria from the literature used to define best practice, and also used the component projects' and demonstration project's own aims and objectives. Thus, projects showing best practice might demonstrate:

- training or capacity building activities
- outreach or inclusion activities to draw in marginalised or hard-to-reach fractions of the target group
- work with other agencies to add value to their own effort and to enable the provision of more seamless service for the client group
- encouraging a range of levels and styles of participation by the client group (here characterised as young people)
- sustainability beyond project funding

III. Implementation and process of component projects

- developing procedures for monitoring and reflection, allowing them to check for client satisfaction and quality of service provision
- dissemination of their activities

Evidence was gathered across the whole of *Healthy Respect*, though more intensively analysed for case studies. Case study outlines are included in the final technical report (Part One), and full reports for each of the ten case studies in Part Two. The case studies present the evidence that underpins the following summarised findings of the process evaluation.

Training/capacity building

- Training offers only an indirect way of making impact on the headline targets for sexual health improvement but considerable effort was put into this type of activity. Seven of the original 12 components (and 7 of our 10 case studies) opted to develop this work
- Most training was with professionals who in turn worked with young people. Only one project (Project I – Developing and supporting the role of parents) trained parents. None offered to train young people directly.
- Training was often primarily a form of awareness-raising (e.g. projects based at LGBT Youth, at HOT and at Edinburgh Rape Crisis). Much training was undertaken with small groups, involved contact with different agencies and aimed to convince them of the need for training. Although in some cases, agencies were actually 'preaching to the converted' (self-selecting groups with a pre-existing interest in LGBT issues, young men's issues or combating violence against women.)
- Some training was offered for those working with very challenging young people with behavioural problems or additional support needs (Projects B(a) on *Looked after and accommodated young people*, B(b) on *Getting the message across at Caledonia Youth*, and J on *Young men's sexual health*).
- Though training from many components was well received, there is little or no evidence for it cascading or rippling out. Fewer one-off sessions and more sustained work would have allowed trainees to develop deeper confidence and stronger skills. Evaluations of training were often superficial records of how well people had enjoyed the sessions. There is only one instance in the case studies where longer-term impact was monitored.
- SHARE training was undertaken on a multi-disciplinary basis, but did not lead to a partnership approach in the classroom. Other staff did contribute to school SHARE delivery, but always on an unequal footing. SHARE training was well received but many felt

External Evaluation of Healthy Respect

the need for continued support after training. We know little about the impact of SHARE-training on teachers' practice.

- The capacity of staff to deal with young people's sexual health issues may have been increased via these interventions, but the wide geographical coverage of the demonstration project will dilute observable impact. Capacity building has to be an ongoing process. The rate of staff turnover means that training has to be mainstreamed and constant in order to affect working cultures and practices.

Outreach or inclusion activities

- Projects working routinely with vulnerable or difficult-to-reach groups were Project B(a) (*Looked after and accommodated young people*), Project B(b) (*Getting the message across at Caledonia Youth*) and Project F (*Lesbian, Gay, Bisexual and Transgender (LGBT) work*). There were also projects which aimed to work directly with youth populations which did not make good use of traditional services (e.g. Project J on *Young men's sexual health*, Project C on *Chlamydia testing*).
- Mainstream services were taken out to new areas or redesigned specifically for young people in project G(d) (*SHARE Inreach/Outreach work*).
- The development of the drop-in services throughout Lothian will be one of the most useful legacies of the demonstration project. They clearly need time to develop a local reputation amongst young people for confidentiality and reliability, and will need to prove their effectiveness and worth to other stakeholders. Their success will depend on continuing articulation between the educational delivery and dedicated service delivery. In addition, emphasis at managerial level on continuing the development of partnership work is vital.
- Reluctant or vulnerable groups require sustained long-term intervention rather than hit-and-run services. Good work was done in this respect by Projects B(a), B(b) and J.
- The demonstration project had a universal approach, not one particularly targeted at vulnerable groups. Its impact on the latter will therefore be more limited. Ethnic minority issues were largely ignored across the demonstration project. There is no evidence of work with a community development focus that challenges the conditions within which people make poor health choices. Most projects embraced traditional health promotion messages of individual choice and self improvement.

III. Implementation and process of component projects

Interagency/partnership working

- On the ground, interagency working was well developed within the boundaries of the demonstration project, and especially amongst the projects based in voluntary organisations.
- Where agencies did work together there was evidence of real benefit for young people e.g. Projects B(a) (*Looked after and accommodated young people*), Project B(b) (*Getting the message across at Caledonia Youth*), Project J (*Young men's sexual health*).
- Not all partners felt or were treated as equals. Larger agencies appeared more powerful whilst the status of others rarely shifted from seeming peripheral contributors.
- The alliances between health and education were weak, undermining progress on unresolved contentious issues such as child protection or protocols for dispensing contraception. This probably resulted from the lack of partners' agreements, which should have been made at the start
- There is only scanty evidence of partnership with local people. The SHARE service delivery work in Midlothian would seem to be an exception, offering valuable lessons for use elsewhere. The strong branding of *Healthy Respect* and its location across all the Lothians was occasionally seen as undermining, rather than building on existing partnerships and ground-level developments.

Levels and styles of participation by young people

- Developing youth participation was one of the strongest themes in early project documents but was poorly developed and managed throughout. A decision was made at an early stage to package youth involvement as a cross-cutting component, but management responsibility for the work shifted continuously. There was little evidence of project staff challenging themselves or each other on this issue.
- Most of the work undertaken at demonstration project level and in component projects was consultative or needs assessment work. There is relatively little sign of young people being encouraged to become more involved in project design or management. SHARE service delivery work in Midlothian is an exception. Few of the components really got much further than the first rung up the ladder of participation.
- Some of the staff in component projects (especially in the voluntary organisations) had experience of youth work and community development skills that could have been put to good use in demonstrating different ways of working with young people. None were

External Evaluation of Healthy Respect

really resourced to do this and there was no encouragement from the centre to develop these sorts of approaches.

- Much of the designated work in young people's participation was out-sourced to an independent agency and was consequently not integral to *Healthy Respect* work. It always looked like a 'bolt on' or an afterthought.

Sustainability

- Some components could rightly claim that the sustainable outcome of their component project is a changed awareness of certain issues. They did make a real change in terms of problem or issue definition. Voluntary organisations in particular worked hard both on the ground and by positioning themselves at the heart of policy debates.
- Some components saw sustainability in terms of products. Some exciting and good quality videos, training packages and written materials were produced, but all these have limited shelf life and will soon date.
- Much of the work done in the component projects was experimental (albeit mostly in a rather random and unsystematic way). It is thus quite hard to discern what was being demonstrated; certainly not the feasibility of delivering service in an economic but effective way. As such, the work would not expect to be sustained in its current form, though it opens possibilities for further work where more structured and better audited service delivery experiments could take place
- Where good work did demonstrate realistic possibilities for changing mainstream practice, there is a question mark over whether component projects were given strong enough support from the demonstration project management. Individual projects did not have the leverage or the resources to forge new partnerships and alliances on their own.

Monitoring/evaluation

- The demonstration project started with little idea about how it would monitor or evaluate progress and achievements. Proper internal evaluation procedures were put in place from September 2001.
- The internal evaluator and management team were unfailingly helpful in supplying information to the external evaluation team.
- Though efforts were made to co-ordinate and minimise the demands placed on component projects, it was evident that the time needed to undertake such tasks had not

III. Implementation and process of component projects

been budgeted into component project resources from the start. Small projects were particularly disadvantaged. This could be seen as a failure, not just of early planning, but also of commissioning in a demonstration project.

- Because it had not been part of the early discipline of the demonstration project, components had rarely thought through how to audit both their activity or the impact of their work, and in many this had still not been addressed at the end. Most evaluations were short-term and did not attempt to assess impact.
- Some rather poor early attempts at needs assessments and surveys are evident across a number of projects. Staff need better central support in developing research instruments and interpreting data in the context of a demonstration project. They would not normally be expected to possess these skills themselves.
- Building profile was one of the goals of *Healthy Respect*, and management also had to work hard at maintaining alliances between partner organisations and external interests. The need to monitor and give accurate early assessments of what is working and what is not was often in conflict with the need to keep morale high in such a contentious demonstration project.

Dissemination

- Team meetings and partners meetings (as well as publicity leaflets and project newsletters) allowed a good flow of information about the work of the different components to flow around within *Healthy Respect* and undoubtedly encouraged many of the interagency links that did develop.
- Smaller projects with very little staff time were disadvantaged in this respect by having to eke meeting time out of their hours however; again, this does not seem to have been anticipated at the planning and commissioning stage. A number of projects were not resourced to disseminate and/or remitted this task to the centre.
- Given delayed starts, few component projects had results as such to disseminate much before the end of the demonstration phase, and some felt that they had not really completed their work even as they reached the finishing tape.
- Much of what was reported as dissemination by the components was awareness-raising about issues, or was a way of publicising projects to get access to settings where component staff wanted work to take place.

External Evaluation of Healthy Respect

- Overall, those working on *Healthy Respect* have made presentations at a number of conferences, taken part in planning and seminars with national agencies like NHS Health Scotland and so on. There are already some published, peer-reviewed papers emerging from the projects. TV and radio coverage has been extensive within the local area in particular.
- All this has undoubtedly contributed to raising the volume of discussion on young people's sexual health issues. Inevitably, it has also meant that the project drew fire from those antagonistic to certain ways of working.
- Any new phase of the work will have to tackle this issue head on by more proactive development of partnership working to build the strategic alliances and take the majority of the population along with changes in service delivery. To do this, *Healthy Respect* needs to learn to listen as well as talk.
- Sharing learning across the Lothian area will be important in any subsequent phase. There are more lessons to be learned about relative effectiveness and impact across a whole range of issues from the mundane (e.g. issues of siting and presentation, timing of clinics) to the more fundamental issues about service philosophy (e.g. should sexual health advice/services be embedded in much more holistic health services for young people?)
- The rapid turnover of short contract staff may mean that much of the learning is lost if it cannot be captured quickly by the associated Learning Network.

Key findings to inform policy and service

In this section the implications of the findings of the evaluation for the development of policy and practice on sexual health issues are explored.

Overall

- As yet there is little evidence indicating improved sexual health outcomes for young people in Lothian following the *Healthy Respect* intervention. This may be because *Healthy Respect* activity to date has centred on professional training and networking and the project has not yet delivered a focused intervention aimed at young people.
- *Healthy Respect* has, however, used its critical mass to push forward partnership working on sexual health and to widen the professional responsibility for young people's sexual health, though much remains to be done.
- There are caveats in any generalisation about the implementation and evidence of best practice derived from the diverse range of component projects. However, there were some challenging findings in the process evaluation. For example, the low levels of active participation by young people, the lack of information on the impact of the professional training, and that, in the absence of proper results to share as findings from full analysis of completed work, much dissemination activity was simply awareness-raising about the need to re-conceptualise the issue or explore new ways of working.

Sexual health outcomes

- Data on trends in sexual health outcomes (conceptions, births, abortions) during the period of the *Healthy Respect* are incomplete and require longer monitoring and methodological development in testing for temporal association.
- Unlike some other public health interventions, where there is a long lag time between intervention and noted health outcome, the lag time between the *Healthy Respect* intervention and changes in conception rates should be relatively short, and is therefore worth monitoring.
- Aggregated regional comparisons highlight the well-recognised relation between deprivation and teenage conception rates. Moreover, small area data also show substantial geographic variation within both regions (Grampian and Lothian). Focusing interventions in more deprived localities could clearly yield bigger health gains and is more likely to

External Evaluation of Healthy Respect

achieve the policy goal of reducing health inequalities, though the dangers of targeting and stigmatisation of sub-populations are acknowledged.

- Chlamydia laboratory data in this report includes the selective testing of high-risk groups (including testing undertaken in relation to other research studies in both regions in this time period). This bias was expected to inflate numbers of positive cases detected; clearly rates in high-risk groups will be higher than general population rates.
- Data presented suggest that primary health carers play a major role in sexual health services provision, but audit findings overall suggest a fragmented sexual health service, with poor continuity, and some delay in referrals in both regions. There is a lack of available data to monitor routinely the quality of referrals, treatment, and the effectiveness of care in partner tracing and re-infection rates.

Knowledge and behaviour outcomes in sexual health

- SHARE is a high quality and theory-based school sexual health education programme. However, our results show few improved knowledge and behavioural outcomes amongst young people exposed to the *Healthy Respect* SHARE programme compared with Grampian non-SHARE programmes. Our results are similar to previous reports that school-based educational interventions may demonstrate some increased knowledge, but have little or no success in changing attitudes and behaviour.
- Some pupils reported having first sexual intercourse at a young age. Information from our study is sparse to explore the sexual health education received in earlier years of schooling. For some of the most vulnerable pupils any sexual health education starting in S2 may have been too late.
- Despite the emphasis given in SHARE to multidisciplinary training of staff, young people continue to demonstrate marked reluctance about discussing personal issues with teachers. Despite the fact that schools may provide access to a large number of young people, attempts to provide better support for young people must weave in the provision for communication and advice from non-school staff to the educational input. The promise of SHARE with the introduction of multi-professional training was not uniformly carried through in the field. Existing partnership links between education and the other services need to be strengthened at strategic and managerial levels to allow this to happen routinely.
- Similarly, given the new public health role for school nurses, further exploration is required for a better understanding of the apparent lower popularity of school nurses for giving advice and support on sexual health issues in Lothian compared to Grampian. Tentative

explanations may include the length of time nurses were on site in Lothian schools, possible lack of provision or limited continuity due to school nurse staff turnover in Lothian, or that the relocation of some Lothian school nurse sessions to drop-in centres resulted in pupils no longer identifying those drop-in service providers as “school nurses”.

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

Schools as appropriate hubs for service delivery on sexual health?

- Poor knowledge and behaviour outcomes from the SHARE schools must lead to questions of whether schools are the most appropriate venues for the delivery of interventions aimed at improving sexual health. A clear attraction for those wishing to influence young people’s behaviour is the fact that education is a mass service delivery system – children move through in age cohorts regardless of emotional and physical maturity. But in sexual health education a proportion of any class must either hear the message too late or too early for them. It might be irresponsible to give no sex education at all, but from evidence it appears unrealistic to expect even the best curriculum to deliver significant changes in behaviour.
- Schools, given their own educational priorities and constituencies, are often reluctant to participate in sexual health interventions. Schools may also believe that an ‘up-stream approach’, that raises pupils’ expectations, achievements and aspirations is a better investment against the links between deprivation and poor sexual health outcomes and may solve the ‘problem’ by raising young people out of a lifestyle characterised by low expectations.
- The issue of confidentiality versus child protection remains an unresolved but central dilemma for school-based interventions. This is evidenced, not only in non-medical vs medical agencies’ conflicting guidelines following disclosure, but also, for example, in imposed filters on internet sources of information that bar access to sexual health education sites in schools. Young people are aware of mixed messages about openness and sexual health issues.

External Evaluation of Healthy Respect

Access to and acceptability of sexual health services

The complexity of attitudes to sexual health services by gender, age and presence or absence of reported sexual activity suggest that approaches that treat young people as one homogeneous group are unlikely to succeed.

- For the youngest people with low or non-existent levels of independent income, and reduced autonomy of movement because of school hours and so on, localised services like the SHARE drop-ins may be the best solution in terms of offering accessible, low threshold services. They may also be the solution for those who are merely curious. They may not be appealing for older teenagers who are more likely to be sexually active, require a guaranteed confidential service, and who may have more disposable income and freedom of movement.
- Older teenagers may be more likely to use family planning or GP services, but continued barriers to using such services include location, restricted opening times, embarrassment, and fears of judgmental staff attitudes.
- Not all young people want counselling or advice – they simply want the availability of contraceptives.
- Young people may also want to access information anonymously, or handle the paraphernalia of contraception and STI testing privately. This would account for the rapid disappearance of the postal testing kits experimentally left in record shops by the Chlamydia project, most of which will have been taken by the merely curious, rather than the explicitly needy. But the point has already been made that information on sexual health topics may be difficult to access anonymously even in this information-rich age, because of the filters on many school, library and home computers.

Building strategic and facilitative partnerships and networks

- It is in the area of building strategic partnerships and professional networks that *Healthy Respect* demonstrated most success. Fortunate in building on a legacy of multi-agency work in many areas of the Lothians, *Healthy Respect* consolidated this position and drew a whole range of partners into the intervention.
- Partnership at a strategic level was not particularly difficult to implement, and *Healthy Respect* forged ahead, playing a major part in the development of sexual health strategies at both national and regional levels.

- Facilitative partnerships where agencies work together to deliver service was a more difficult challenge however. Informal networking developed quickly within the *Healthy Respect* components and beyond, through training and personal contacts, dissemination activities and so on. More problematic was the fact that such informal networking was more likely to involve those directly delivering service, but not their line managers. Middle management was largely ignored in training and dissemination activities, and some initiatives were stifled by lack of professional support.
- Not building proper contractual partnerships between the 'giants' of local authority education services and health boards left a problem that remained to the end. Partnerships are starting to develop, but will take time to build.
- *Healthy Respect* was particularly successful in drawing voluntary groups into partnership and using their rootedness in the communities to good effect. This was a symbiotic relationship, however, with the voluntary agencies using the *Healthy Respect* platform to build their activity base and profile. The extent to which these agencies subsidised their own involvement does raise questions about the long term sustainability of these relationships.
- Partnership working may also cause tensions where it appears to involve subjugation of separate identities under a partnership banner or brand. Professional reputations or hard-won identity for a named organisation and its work are hard to give up, and ownership issues may arise.
- *Healthy Respect* had to work hard at supporting alliances between partner organisations and maintaining impetus. The need to monitor, and very early requests for assessments of what is working and what is not, was often in conflict with the need to keep morale high in such a contentious demonstration project.
- The end product of partnership has to be improved service for young people (in this instance) and this needs to be the focus and yardstick against which partnership work is constantly measured. In the case of *Healthy Respect*, partnership working allowed innovative low threshold services to be developed, encouraged services to network and think of more imaginative ways of training, and of framing youth issues. It also enabled access to more vulnerable and hard to reach groups, and drew more professional groups into accepting responsibility for young people's sexual health and overall wellbeing.

The process of implementation of Healthy Respect

There are issues about the process of establishment of *Healthy Respect* which impeded progress at the start and left weaknesses which could not be remedied.

External Evaluation of Healthy Respect

Commissioning and establishment

- Many of the components were clearly in a pre-demonstration rather than demonstration phase –randomly experimental, with poor evidence base etc.
- The demonstration project advanced on all fronts, rather than concentrating effort in some areas or on some styles of working which could have established an effective test bed for work on young people's sexual health.
- More attention needs to be paid at commissioning to the capacity, required funding (and willingness) of partner agencies that will host the projects.
- None of these errors are attributable to the current management team or to the component project workers within *Healthy Respect*, and both groups have worked very hard to reverse some of the earlier mistakes.

Being a demonstration project

- Demonstration project funding and status gave *Healthy Respect* the sort of critical mass and synergy where the whole could be more than the sum of its parts. Many individual projects and their host organisations felt they had gained from working together.
- Being part of something much bigger gave component organisations some protection against the hostile groups ranged against this type of work.
- The size of the intervention exposed but did not resolve a number of important issues where there is ambivalence and lack of consistent guidance at both national and local levels on young people and sexual health.
- The organisations selected for involvement had strongly-developed practice skills but not necessarily demonstration project skills. More support was required if these functions were not going to be carried out centrally within the management of the project.
- Training on consultation with young people needs to become a central concern.

Working on young people's sexual health

The process study revealed many individual examples of competent people extending themselves to develop new work. What does the demonstration project teach about ways of working with young people on contentious sexual health issues?

- *Healthy Respect* demonstrated that it is possible to redefine work on young people's sexual health through creating a brand that focuses on respect for self and others in tandem with extension of clinical services. But clarity and understanding of brand values needs to be strengthened.
- *Healthy Respect* helped define new issues and identify new target groups for concern. Some other neglected and vulnerable groups (e.g. ethnic minorities, excluded schoolchildren) still need to become the focus of attention.
- *Healthy Respect* demonstrated that there are some positive *service* outcomes that can accrue when service providers work together; but, crucially, there is a need now to deliver, achieve sustained levels of delivery, and further test impact on young people.
- *Healthy Respect* largely failed to explore and therefore to demonstrate the value of young people's active participation beyond anything other than first level consultation.
- Close consideration needs to be given to design/targeting of the intervention to ensure that it allows systematic exploration and evaluation.
- We know that staff appreciated the training that they received within *Healthy Respect*. We know too little about impact on practice and sustainability however, and suspect that more field support is needed to make staff feel confident to tackle difficult issues.

External Evaluation of Healthy Respect

Glossary of Terms and Abbreviations

Brook	Brook Advisory Service. Contraception and pregnancy counselling service for young people (now known in Scotland as Caledonia Youth)
c:card	Condom card – a system giving young people free access to condoms on presentation of a card
EWRSAC	Edinburgh Women's Rape and Sexual Abuse Centre (formerly Edinburgh Rape Crisis Centre)
EYSIP	Edinburgh Youth Social Inclusion Partnership
GP	General practitioner – a local family doctor
GU	Genitourinary
GUM	Genitourinary Medicine. Clinics dealing with STIs are commonly known by the shorthand of GUM Clinics
HEBS	Health Education Board for Scotland. Government-funded health improvement agency, now known as NHS Health Scotland
HOT	Health Opportunities Team (host organisation for component project J, Young Men's Sexual Health)
LGBT	Lesbian, Gay, Bisexual, Transgender. LGBT Scotland – an organisation working for young people in these categories (formerly known as Stonewall Youth)
LH	Lothian Health (managing agency for Healthy Respect)
LHCC	Local Health Care Co-operative. These are area groupings within which GPs, practice nurses, health visitors and other practitioners are based with the aim of organising joined up services.
LPCNT	Lothian Primary Care NHS Trust
LUHNT	Lothian University Hospitals NHS Trust
MYPAS	Midlothian Young People's Advisory Service
NGOs	Non-Governmental Organisations
Partners	The participating organisations (statutory and voluntary) which hosted the Healthy Respect component projects were designated as 'partners'
PHACE	Promoting Health and Challenging Exclusion
PSE	Personal and Social Education, a segment of the curriculum in which sexual health education is often lodged
PTKs	Postal testing kits (for chlamydia)
SCRO	Scottish Criminal Record Office. Agency which checks the credentials and criminal record of anyone wanting to work in proximity with children and young people
SHARE	Sexual Health and Relationship Education

SIP	Social Inclusion Partnership, an organisation funded on a temporary basis by government
STIs	Sexually transmitted infections (formerly often known as STDs)
Stonewall	Now known as LGBT Youth
WHEC	Wester Hailes Education Centre
WLDAS	West Lothian Drug and Alcohol Service



SCOTTISH EXECUTIVE

© Crown copyright 2005

This document is also available on the Scottish Executive website:
www.scotland.gov.uk

Astron B40498 3/05

Further copies are available from
Blackwell's Bookshop
53 South Bridge
Edinburgh
EH1 1YS

Telephone orders and enquiries
0131 622 8283 or 0131 622 8258

Fax orders
0131 557 8149

Email orders
business.edinburgh@blackwell.co.uk

ISBN 0-7559-4575-1



9 780755 945757

w w w . s c o t l a n d . g o v . u k