Welcome to the Department of Health’s Sexual Health Promotion Toolkit.

As part of the Department of Health’s commitment to implementing the National Strategy for Sexual Health and HIV, a Sexual Health Promotion Toolkit has been developed for use by all of those professionals working in primary care trusts, local authorities and other organisations who are involved in sexual health promotion and HIV prevention work.

On this website you will find a copy of the published toolkit, which describes sexual health promotion and its objectives, provides guidance on developing and implementing a local sexual health and HIV prevention strategy and guidance for good practice.

Here you will also find additional web-based resources designed to support the toolkit. These have been prepared for the Department by Jo Adams, Director of the Centre for Sexual Health and HIV, Sheffield and are informed by a wealth of practical experience from work in the field. They include a holistic model of sexual health and sexuality, practical tips for working with particular groups, case studies which show how the principals in the toolkit have been put into practice, plus a valuable list of further resources and contact details.

Your are free to print and circulate this material for use in training or health promotion activities, but please acknowledge the source when doing so.

We welcome further examples of best practice in sexual health promotion and feedback on the toolkit. Please send any comments or additional information to geoff.rayment@doh.gsi.gov.uk.

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PART ONE - 10 PRACTICAL TIPS FOR CONDOM PROMOTION

While most of the section below relates to male condoms, there is one female condom - Femidom - currently on the market in the UK, although it is not widely available free of charge, is relatively expensive to buy and is much less commonly used than male condoms. For more information on the female condom, see the leaflet mentioned in “Further Reading” at the end of this section. For the purposes of this section, ‘condom’ is taken to mean male condoms for the most part, as the most commonly used condoms and those used by both heterosexuals and gay and bisexual men.

1. ‘THAT CONDOM MOMENT’
Research has shown that there is a critical moment at which people feel comfortable raising the issue about wanting to use a condom. This is that moment when it is clear that both partners want sex but while it is still possible to say ‘no’. It is worth offering suggested lines which people could use in that brief ‘window of opportunity’ to raise the issue of using a condom.

Practising these in advance can mean people feel much better prepared when ‘that condom moment’ arrives. This may be especially important if they are affected by alcohol and/or drugs at the time. So, a woman might want to say for her it is about safer sex and not wanting to get pregnant – or she could just pass the man a condom or put it on him herself.

For men, they could simply put on a condom – and it might be useful to let them know that many women say that this helps them to feel cared for, so they really appreciate it. And for gay or bisexual men, putting condoms on each other can be part of the overall sexual experience.

It can feel especially difficult for people with HIV to raise the matter of condom use. Sometimes people in this situation express the dilemmas as “If I say I want to use condoms, they might assume I have something to hide, and therefore that I have HIV” or “If the other person doesn’t ask to use condoms, then they must be HIV positive too”. For these reasons, it is particularly important to offer support to people with HIV in how to ensure they protect their own future health and that of their partner by feeling comfortable and confident in negotiating condom use.

One line which can work for either gender and which takes any hint of suspicion or assumptions about the new partner out of the picture is “I’d never have sex without one” which is hard to argue with or counter. If the partner protests, the ‘broken record’ technique of repeating this line is an assertive way to insist on the right to use a condom - and can be rehearsed in advance through role play methods. Not apologising, justifying, arguing the case or making excuses can also be practised in these role-plays.

2. BE PREPARED - FOR THE PROBLEMS TOO
Men – and perhaps their male or female partners too - can be alarmed if they are not prepared for the fact that they are likely to lose a complete erection temporarily when putting a condom on. This is sometimes given as a reason for reluctance to use condoms. Given that many men say their greatest concerns about sex relate to performance anxiety, this topic should be addressed.
It is therefore best to be open about this in advance when discussing condom use, to allay anxieties and acknowledge that this happens to most men but will only last a few seconds. Obviously, the more that men can practice in advance, the more relaxed they will become about this momentary erection loss being a temporary stage in effective condom use.

3. CONDOM DEMONSTRATION
The fear of fumbling about and being inept is a huge obstacle to using condoms – so we should help people to overcome this. Being comfortable with using condoms is will come about with repeated practice and the confidence which comes with knowing how to use them effectively.

You may make condom demonstrators available to show people - both men and women - how to put on a condom properly and give them a chance to practice using the demonstrator. This could be repeated until it becomes easy, simple and loses its sense of strangeness. Suggest that they then practice on themselves at home. All of this will require us to become adept at demonstrating condom use ourselves. After all, if we as workers are clumsy and awkward in this skill, this will simply serve to reinforce negative perceptions in those people who we are trying to encourage to adopt regular condom.

Remember condom demonstrators come in many shapes, colours and sizes too and are increasingly lifelike - it is even possible now to get demonstrators which lose their erections, are flexible and ejaculate. So choose the ones which you think your client group would relate to most easily. And do try to use these more life-like aids rather than resorting to the carrot or courgette demonstration, which has become a bit of an object of fun and ridicule and seems light years away from the reality of sexual experience. In all of this, emphasise the fun element and the pleasure condoms can offer if they are made an exciting part of sex itself, as this will encourage condom use.

4. THE GREATER THE RANGE OF CONDOMS THE BETTER
Research shows that comfort and fit are major determinants of condom use so remember to have a wide range of condoms available or publicised. These might include flavoured condoms – for oral sex (N.B. these are often not suitable for penetrative sex and this point should be clearly made when giving them out); extra strong; polyurethane varieties or other condoms shown in trials to be suitable for people who are latex-allergic; a range of more snug fitting and large condoms; and coloured condoms including black ones. Any information and publicity about condom use should always also include the advice

- to keep them in cool, dark conditions so they do not deteriorate
- to check that latex condoms comply with the European standard, EN600
- to make sure they are not past their expiry date printed either on the foil packet or the box

There is some evidence that people assume condoms available free through NHS outlets such as clinics and GPs will be old-fashioned and ultra-thick. It is therefore worth making sure if you are working in these settings that you buy a range of more desirable condoms and publicise this variety and choice available.

5. STORING CONDOMS SAFELY
If your project or organisation buys condoms in bulk, remember to store them in cool, dry and dark conditions. Not to do so risks them losing quality and effectiveness before they reach their ‘sell-by’ date. If you discover any condoms have gone past their expiry date, you could still use these for demonstration purposes and safer sex workshops. But do take care in such cases to make sure no-one smuggles any out for their own use as can sometimes happen.
6. REMEMBER THE NEED FOR EXTRA-STRONG CONDOMS AND LUBRICANT

Always ensure you provide extra strong condoms and lubricant to allow choice. Not only does providing extra strong condoms and lubricant show you are aware of the needs of gay men but also evidence suggests that anal sex between heterosexual couples may be on the increase. Everyone therefore needs to be aware of how important using a condom is for anal sex.

There are reports that some heterosexual couples are opting for anal sex in order to avoid pregnancy. It is therefore vital that people making this choice are aware of the other potential risks of anal sex in terms of STI and HIV transmission and therefore the particular need to use condoms. In fact, though there may be no need for contraception in anal sex, the need for condom use and lubricant is heightened - because the potential for tearing and trauma is actually greater than vaginal sex making transmission of HIV and other STIs a higher risk.

There is another issue here too - though one not so directly related to condom use for anal sex. This is that if girls and young women are coming under pressure from male partners to have anal sex in order to avoid condom use or because he wants a ‘tighter’ fit, this issue needs to be addressed with them. They should be advised that looking after themselves and their own needs is more important than simply pleasing someone else and may need support to say ‘no’ to anal sex if it is not what they want.

Remember to discuss, too, the use of appropriate lubricants. Although both male and female condoms are already lubricated - some male ones with a spermicide - many people do choose also to use lubricant. And advice given by most gay and bisexual men’s sexual health and HIV projects is that you can’t use too much lubricant (provided it is put on and not in the condom). If someone needs to use additional lubricant (for example for vaginal dryness) then it’s vital they are aware that for most condoms they should only use a water-based lubricant such as KY Jelly, Liquid Silk or Maximus. Any oil based lubricant – such as baby oil, massage oil, margarine or butter (all things which workers in the field of sexual health regularly hear about being used) - will weaken latex condoms and make it much more likely they will split. It’s also important that people are careful if they have been using massage oil that this doesn’t come into contact with a condom.

Some research shows that regular condoms, provided that are used with plenty of water based lubricant, can be just as effective for anal sex. This is particular relevant to men who may find extra strong condoms difficult to use because they cause loss of erection of sensitivity, in which case they should use a regular condom with plenty of lubricant, rather than not use a condom at all.

Research evidence also suggests that condoms or lubricants containing nonoxynol 9 (a spermicide) can actually increase the risk of HIV transmission, and should not be used for frequent vaginal sex (for example by commercial sex workers) or for anal sex.

In general, when talking about choice in which condoms to use and whether or not to use additional lubricant or spermicide, the fpaf leaflet mentioned at the end of this section is a useful resource.

7. THE DOs AND DON’Ts OF SAFE CONDOM USE
The majority of condom failures are not in fact the result of the condom itself being faulty and failing, but rather of not using them properly. So be aware of the “do's and don'ts of safe condom use” and make sure that people you are giving condoms to - or discussing condoms with - become familiar with these too. Wherever possible have leaflets with visual aids of simple steps on how to use a condom.

Your tips on safety might include:

- To guarantee the quality, check that condoms meet the European standard (EN 600) and also that they aren’t past their sell-by date
- If you have ragged or sharp finger-nails or are wearing rings or jewellery, be careful not to catch or tear the condom when putting it on or taking it off
- Remember to squeeze the air out of the tip of the condom
- Using lubricant - but on the condom, never in it - can help stop condoms splitting or tearing
- Roll the condom right down to the bottom of the penis to ensure it is firmly on (and don’t try to unroll the condom before you put it on).
- Hold the condom on the penis when withdrawing after sex, to make sure it doesn't leak or slip
- Never use a condom more than once – and never use other things (like cling-film or plastic bags) as a condom, they just won't work

8. ACCENTUATE THE POSITIVE

There are many aspects of using condoms which can positively enhance sexual experiences and deepen emotional relationships. So if we are to counter the old myths and canards about “eating a sweet with the wrapper on”, it will be worth emphasising the beneficial emotional and psychological effects of condom use. For example, using condoms can mean both partners can relax and enjoy sex the more because:

- they aren’t worried about taking a risk,
- they know the possibility of contracting an STI is dramatically reduced (although we should be realistic about the fact that condoms will not offer a total guarantee of protection),
- there are fewer anxieties about the woman becoming pregnant.
- men can take longer to climax using a condom, it can make the sex last longer allowing for heightened and extended sexual pleasure for both partners.
- by integrating condoms into foreplay, they can actually add to rather than detract from eroticism.

Of course we should meet people half-way in terms of problems they are experiencing and the resistance they may feel about using condoms. However, drawing attention to some of the positive aspects is not specious trickery on our part or trying to dragoon people into an activity they are wary of - these are genuine advantages of condom use which are not usually spoken of. It is our role to let people know about them so they can make their decision by weighing up all the facts

9. PUBLICISE SOURCES OF FREE CONDOMS – AND PROVIDE THEM WHERE POSSIBLE

Expense is a real issue for many people in choosing whether or not to use condoms. This means that the easier we can make it to access free condoms, the less economic factors will militate against people using them. These considerations are particularly important when we think about reducing sexual health inequalities because for people living in poverty, spending money on condoms may not be a priority.

Produce and disseminate as much local publicity as possible for where free condoms are available – from Family Planning and Youth Clinics, for example or from GUM Clinics, Walk In Centres and increasing numbers of GPs
surgeries. There may be existing condom outreach schemes in gay pubs and clubs or youth centres which should also be publicised.

Could your agency or organisation actually provide some condoms free? Some sexual health or sexual health promotion organisations or clinical settings such as doctors’ surgeries, for example, leave out bowls or baskets of condoms, lubricant and sexual health leaflets in the toilets for people to help themselves.

10. HELP PEOPLE PRACTICE REFUSAL SKILLS

Often even supposedly confident people report failing to be able to negotiate condom use – so practice is needed before ‘that condom moment’ (see point one) if these skills are going to be ready when the need arises. This can be done in lots of ways – from a question in a clinical consultation such as “How do you like to suggest using a condom with a partner?” to role plays and exercises in group work settings.

A ‘carousel exercise for practising this, taken from the “Go Girls” Pack on building self-esteem in girls is added here as one example.

11. CONDOM CLICHÉ CAROUSEL.

A carousel method involves lots of short discussions in pairs, with people moving on to discuss an issue with a new partner so they get lots of perspectives. In this example, girls role play in pairs how to respond to the cliché condom lines boys may come out with listed below. In these pairs, one will play the boy and the other will be the girl. You could get the girls to contribute the boys’ condom clichés from their own experience or that of their friends. These could, for example include:

- But I thought you loved me?
- It’s like chewing a sweet with the wrapper on
- It gets in the way of the spontaneity
- What’s the matter, don’t you trust me?
- But you’re on the pill
- It’s all right, I promise I’ll pull out before I come
- I can’t get hard using one of those
- I want us to be really close
- It’s like having a bath with your wellies on
- They always split, you can’t rely on them
- Why – have you been with someone else?

In the final round get them to process the learning and in the large group feedback share and compare all the ripostes they have developed to counter these anti-condom arguments. Flipchart all of these and give every girl a copy afterwards so she can ‘fix’ the learning and draw on these if she ever needs to.

Further reading: Your Guide To Male and Female Condoms - free leaflet from the Fpa
1. **REMEMBER THE INEXTRICABLE LINK BETWEEN SELF-ESTEEM AND SEXUAL HEALTH**

Low self-esteem may result in a range of consequences for a person's sexual health. For example, it may mean:

- They lack the confidence to approach sexual health services or ask for sexual health advice and support for fear that they will be judged or disapproved of.
- They do not feel they have the right to say "no" to sex they do not really want, or they may simply agree to sex because someone else asks them rather than because they are making a positive choice for themselves.
- They are unable to ask for what they do want sexually or to ensure that they themselves actually enjoy the experience. Often low self-esteem can result in someone looking after their partner’s pleasure rather than believing that their own matters too.
- They may not take the best possible care of themselves sexually. They may have compulsive or chaotic sexual encounters with a number of partners; they may put up with abusive or exploitative relationships as their due; they may have sex when drunk or using drugs (or even for drugs) or they may get involved in prostitution.
- They are likely to lack the skills, confidence, and sense of self-worth to enable them to negotiate sexually in a way which will support their sexual health. For example, they may not be able to ask for condoms or contraception to be used, or to insist that the sex is conditional on this. Or they may feel unable to refuse to do things sexually which they don’t actually want to.

2. **THINK ABOUT “WHY DO PEOPLE HAVE SEX?”**

Many people have sex in order to get other things that are lacking in their lives - perhaps attention or affection, reassurance or popularity. Or maybe they are hoping that having sex will result in a sense of belonging or of being needed or status in their peer group. To expect sex to deliver all these things is unrealistic, and all too often people who are hoping it will do this are disappointed. It is in fact much more likely that having sex for the reasons above - in other words, simply to feel better about themselves - will result in compounding the problem of their low self-esteem rather than resolving it.

An effective response to this in terms of sexual health promotion is to work consciously to build the self-esteem of people or groups who can easily slip into these self-destructive behaviours. This will mean helping them to build strategies for finding the things they hope sex will provide - maybe affection, cuddles, attention, and status - in other ways in their lives. They could do this, for example, through strengthening their friendships and support networks as an antidote to low self-esteem. In our work we can support this:

- by organising listening skills and friendship skills courses
- by arranging joint activities so friendships can develop
- by helping such groups consciously focus on the effect friendship can have on their lives.

3. **THINK ABOUT THE ENVIRONMENT WE OFFER PEOPLE**

The environment we are offered - for example in schools, clinics, surgeries and residential care settings - has a powerful effect on our self-esteem. If we live in poor housing and our neighbourhoods are full of graffiti, litter and refuse, if we lack play space or open green areas for recreation or go to schools which are in disrepair – it is going to be hard to feel good about ourselves. If we then go to surgeries or clinics where the paint is fading and chipped, the
magazines are torn and old and the notice-boards are covered in yellowing and out-of-date posters, this is likely to compound this sense of not being valuable or important. However, there are many cheap and immediate ways of enhancing the environment. These might include:

- displaying attractive and colourful modern posters
- having inspirational sayings pinned up on the walls
- having pot plants and flowers (not sickly or dying ones!)
- putting nicely framed prints on the walls
- providing fresh magazines to read
- putting bowls of fruit out
- having scented candles burning. One youth clinic visited in Sweden has candle-lit counselling rooms, creating a safe and very special atmosphere
- playing background music
- offering a range of up-to-date leaflets in attractive display racks
- making a range of drinks available – tea and coffee, fruit and herb teas, juice and iced water
- having children’s books and toys available
- displaying a poster of pictures of all staff members with their names and roles and perhaps a bit about them

All of these things are possible on a low budget – and yet they can make a huge difference in helping people to feel valued, welcome and special.

4. ASK PEOPLE FOR FEEDBACK ON HOW THEY EXPERIENCE SERVICES AND SUPPORT

Asking people for feedback on how their experience of using services can be enhanced is an important process. Being consulted in this way can dramatically increase people’s sense of self-advocacy and control over their lives. But this will only be effective if we do listen and act on what they tell us. Not doing so is going to decrease their self-esteem still further and lead to feelings of hopelessness about ever having any influence or impact.

5. CONGRATULATE PEOPLE FOR SEEKING OUT SEXUAL HEALTH INFORMATION, ADVICE, SUPPORT AND RESOURCES

Anyone accessing sexual health services or support may have had to overcome some difficult feelings or concerns about doing this, especially people with low self-esteem. It is therefore crucial that we give them unsolicited positive feedback for being brave and responsible. This will be particularly important when people may be nervous about being judged – for example for young women wanting to access emergency contraception, for gay or bisexual men who are seeking HIV or other STI screening after unsafe sex or for any woman seeking an abortion.

6. HELP PEOPLE MAKE SMALL CHANGES

It is important to help people who may lack a sense of self-worth do things which will build a sense of achievement. It is equally important that we do not encourage them to ‘walk before they can run’ in this respect. So starting with small things is likely to be the most effective strategy. This may involve supporting them in saying “no” to an unwanted date; in insisting on some time and space to themselves if they normally are servicing everyone else’s needs; or in finding ways of giving themselves small treats such as a bunch of fresh flowers, a treat magazine or a punnet of out-of-season raspberries, or having a scented bath.

However, be aware that making these changes may set up a reaction in people – it may trigger a harsh internalised self-critic which accuses them of being selfish, unkind or extravagant. We should therefore remember to congratulate
them (and encourage them to praise themselves, too) for being brave enough to make these changes, which are so indicative of a growing sense of self-worth.

7. SMILE AT PEOPLE – IN SCHOOLS, IN SURGERIES, IN CLINICS
It may sound bizarre or like something from a glib self-help manual, but the impact of smiling at people and making it clear they are welcome can be profound – and can help change the culture of a workplace or a service. There is anecdotal feedback from people attending Family Planning Clinics, GUM services or GP surgeries that they feel awkward and uncertain and that nothing practical is done to reassure them that they are welcome. This can put them off returning, or put off others who might have otherwise thought of attending. With no extra resources this one change has the capacity to help transform the experience of service users, of people seeking information and advice – and of the staff themselves.

8. REINFORCE A SENSE OF RIGHTS – AND OF SEXUAL HEALTH RIGHTS IN PARTICULAR
People frequently embark on sexual relationships or access sexual health service provision without a deeply held sense of their own rights. These include the basic rights to be treated well, to respect, to kindness and sensitivity. But these rights also comprise ones more directly related to sexual health – for example their right to say “no”, to ask for and get clear and honest information, to confidentiality and to make choices about their own sexuality. One Bill of Sexual Health Rights for young women, developed by participants on a “GirlPower” self-esteem training is as follows:

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I have the right to ..... Clear information about sex
  Sexual pleasure
  Express and explore my sexuality as long as it does not hurt anybody
  Change my mind
  Be respected for who I am and what I am
  Access to services without judgement
  Say “no” to any sex that I don’t want at any time
  Knowledge that helps me acknowledge and control my sexual health
  Ask for what I want
  Not be judged because of my sexuality
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We should think creatively about how to help people develop and internalise a sense of their sexual health rights as well as how we can help them claim these in practice. This may include offering assertiveness training or group-work in negotiation skills. It may involve those of us who provide direct services drawing up and displaying a statement about the rights of service users - along with their responsibilities too, if this is appropriate. For example, one Gay Men’s Health and Community Centre has the following statement displayed:

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SHOUT! CENTRE RIGHTS AND RESPONSIBILITIES
  Welcome to the SHOUT! Centre - a place for all gay and bisexual men, and men attracted to men.
  You will be listened to and treated with respect.
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● Your right to confidentiality and privacy will be respected.
● If you would like to talk to one of the workers in private please ask them (they will be wearing name badges so you know who they are).
● If you have any needs we cannot meet, we will endeavour to refer you to an appropriate agency or organisation.

We expect all those who attend the Centre to respect others using the service or working there, e.g. no personal insults; no malicious gossip; no aggressive or abusive behaviour; no talking about people when they are not there. This will hopefully ensure that the SHOUT! Centre is a safe and enjoyable place for everyone.

9. DEVELOP PEER EDUCATION AND SUPPORT INITIATIVES

Whether these are young people’s projects based in schools, or gay men’s outreach projects on the commercial scene, parents’ peer support projects or initiatives training up community educators in BME communities, the outcome is likely to be the same. Being involved will result in an increase in a sense of self-worth and self-efficacy in those taking part. Taking some kind of leadership in and control over our own lives is integral to gaining in a sense of our value, and peer education is a great vehicle for this. So to build self-esteem in groups and communities, consider establishing peer education projects.

10. THINK ABOUT YOUR OWN SELF-ESTEEM TOO

In terms of self-esteem building as a key methodology for sexual health promotion (as well as for the promotion of mental health and emotional well-being) those of us involved in the work should address issues of our own self-esteem too. Only in this way can we become excellent role models for others.

So all of the above points may be relevant for us as well as for our clients, students or service-users. But it may be helpful, too, to think about how we can enhance the self-esteem of the teams in which we work, in the workplace. Nancy Kline’s book “Time To Think” gives us very positive and practical guidelines on how to create what she terms a “Thinking Environment” in which the best innovative ideas and most effective practice can be generated. See the Resources and Reading list for details.

One of the most effective ways to increase self-esteem in colleagues, teams and workplaces is through building in mechanisms by which people can both give and receive positive feedback. This might, for example, be about their work, their contribution, their personal and professional gifts and their qualities. Some teams do this, for example, by adding such a process - it should always be two-way - into supervision sessions or staff meetings. If we are not told what we have done well, all too often we will dwell on what we have done badly. The mechanisms described here are simply a way of redressing an unhelpful and artificial imbalance. If we develop and nurture our own self-esteem we will be great role models for others. But also of course, and even more importantly, we will positively promote and enhance our own sexual health!
SECTION THREE
PART THREE - PRACTICAL TIPS FOR GENERAL SEXUAL HEALTH PROMOTION

1. FAMILIARISE YOURSELF WITH THE FULL RANGE OF LOCAL SEXUAL HEALTH SERVICES.
Have details of times, waiting lists and mechanisms for referring to relevant local services e.g. by self-referral or only via GP. You might suggest to your local sexual health promotion team, or the Teenage Pregnancy Co-ordinator, that you could produce a directory of local sexual health services. These could be in the form of a booklet - containing details for professionals on how to refer clients to everything from vasectomy services to PMS, menopause and abortion services. Or it could take the form of a web-site - if enough people have access to the technology. This has the advantage that you can regularly add to and change it to keep pace with new developments.

If you do produce such a resource, make sure it is updated frequently, as otherwise it will quickly become out-of-date. Send copies to all the possible partners in this work who may need to be clear how to refer on people to sexual health services or support. These will include Community Psychiatric Nurses, Health Visitors and Practice Nurses, Learning Mentors and Connexions Personal Advisers. See Section 2.2 of ‘Effective Sexual Health Promotion’ for a fuller list of these.

2. GIVE OUT INFORMATION MATERIALS WHENEVER POSSIBLE.
Have a range of these to hand – for example leaflets, "credit cards" and information flyers with opening times of local sexual health services. Whenever you have discussed anything about sexual health with someone, try to back this up with some written materials to leave with them. If people are embarrassed talking about these issues, they may feel more relaxed reading about them in privacy later.

3. DISPLAY POSTERS OFFERING POSITIVE IMAGES.
Much of the early HIV prevention education and information in the UK broke new ground in offering positive and affirming images of gay men together. In doing so, it sought to reassure men who were feeling isolated or self-hating that their sexuality could be a source of pride and optimism and to provide them with good role models for this. It also offered confident images to the wider world to counter ingrained prejudice, stereotypes and assumptions. Look for similar positive images of groups who may not traditionally find these of themselves. These might include:

- men providing each other with emotional support and friendship
- young women being assertive and saying “no” confidently
- people whose sexuality is all too often taboo as sexual beings – such as older people and disabled people – in positive relationships.

4. IF POSSIBLE, CONSIDER MAKING FREE CONDOMS AVAILABLE.
This gives out a strong signal that you are supporting sexual health in a positive and practical way. Consider offering a variety of types of condoms as well as lubricant.

5. DON’T ASSUME EVERYONE IS HETEROSEXUAL - OR SEXUALLY ACTIVE.
Try to remember that using the term “partner” makes it clear you are not assuming anything about people’s sexual choices. If you have already used the term “boyfriend” or “wife”, for example, this makes it much harder for someone to let you know that their partner is of the same gender. By having literature and information and images around which
show gay as well as heterosexual relationships, you make it clear that it is safe to talk to you about such issues and that you will not be judgmental or disapproving.

While giving clear signals that you are open to talking about sex and relationships, do not assume everyone is – or wants to be – sexually active. Many people – partnered, married and single – lead lives in which they have chosen not to be sexual. In particular don’t assume that everyone who is currently married is sexually active with their partner. This may not be the case and can be a difficult thing for someone to share. It will also be important to offer the opportunity for people to talk about sex (or the lack of it) within their marriage or other relationships. Clearly, if this is causing them distress and is a situation they would welcome support in resolving, then it may be helpful to refer them to counselling or psychosexual services. But it may be a happy and chosen state for them.

6. **LEAVE SUPPLIES OF INFORMATION OUT IN ACCESSIBLE PLACES.**

Leave information such as leaflets in places where it can be picked up unseen. For example, this may best be done in toilets or corridors. If people are feeling awkward about asking for help, advice or support then materials which can be read in private can be an excellent way of getting information across. Be aware of places where you can offer such resources which are more discreet, perhaps, than the main leaflet rack. Make sure the information is regularly up-dated as well. These kinds of materials date fast, as telephone numbers and addresses change and new services emerge.

7. **REMEMBER THE NEED FOR STAFF TRAINING.**

Even though we may be professionals with sexual health roles to play, many of us probably received no positive Sex and Relationships Education ourselves either at school or at home. It takes time, thought and training o come to an awareness and understanding about sex, sexuality and sexual health. However, it’s essential we have this opportunity since this will enhance our work and allow us to develop approaches which will help everyone to feel safe and validated within our services. We should all probably reflect on the values and attitudes which we have accumulated around these matters or which we learnt early on from our families, playgrounds and peers, our cultures, the media, religions and communities.

However, training for staff is available from a number of sources. For example, it can be accessed locally from Sexual Health Promotion Units, Sexual Health and HIV Prevention teams or from Primary Care Development Workers. Or national organisations such as the fpa or the Centre for HIV & Sexual Health offer a range of courses to meet these needs or can design training to fit your requirements.

8. **SEXUAL HEALTH INVOLVES EMOTIONAL WELL-BEING TOO.**

Ask about feelings if a client, young person or service user raises sexual health concerns with you – or if you have introduced the issue. Are they experiencing any anxieties or emotional difficulties? Is there anything which you can give them reassurance about? Would they welcome the opportunity to discuss any difficult feelings they are having to manage – for example, jealousy, fear of rejection, feelings of unattractiveness or a lack of confidence in relationships?

Be careful not to offer yourself as a counsellor or therapist unless this is the specific nature of your work – but there are many ways of giving people the space to talk about their feelings without stepping over this boundary. Opening up this area for discussion reminds people of the vital link between their sexual health and their emotional well-being, helping them to address these as integrally involved rather than two entirely separate aspects of their lives.

9. **THERE MAY BE SEXUAL HEALTH ASPECTS TO OTHER PARTS OF OUR WORK.**

Too often, sexual health stays in a ‘bubble’ and doesn’t get connected up to other parts of people’s lives. So, if someone is having chronic back pain – do we raise the topic of how this may affect their sexual relationships or...
partnership, and how to continue to be sexual while managing the pain? Or if we are offering support to someone who has had radical surgery which has changed their body image – a mastectomy, perhaps or a colostomy - do we give them the opportunity to discuss the impact this has had on their self-image and self-esteem with any attendant issues for their relationship?

From mental health work to medical interventions around Coronary Heart Disease, from dealing with eczema to bereavement – clients and service-users are likely to be relieved and grateful if we create the opportunity for them to talk through issues and concerns they have related to sexual health and emotional well-being.

10. **HAVE REFERRAL NUMBERS FOR RAPE CRISIS, SURVIVORS AND ABUSE SERVICES.**

If someone tells you they have been raped, sexually assaulted or abused – whether this was some years ago or last night – you are likely to want to refer them on to specialist counselling and support services. However, remember that they have chosen you to tell in the first instance, no doubt because they feel they can trust you and that you have an empathy with them. Although it is understandable to want to refer them straight onto a specialist service, to do so may give them the message that you cannot cope with what they have shared, that they have over-burdened you. So, offer them this information by all means – but make sure that you let them know your door is still open to them and that you are concerned about what happens to them next.

Remember, too, that many people who have been raped, assaulted or abused feel guilty and believe they are in some way to blame. So reassuring them on this - that you believe them, that it was not their fault and that it was a terrible thing to happen to them - will be very important.

Make sure you also have a number for a support service such as Survivors for men who have been raped and remember that for men, divulging this still carries an extra taboo. This is perhaps particularly acute for gay and bisexual men who may feel that in some way that because of their sexuality, they were responsible for what happened or deserved it.

11. **AND FINALLY – LOOK AFTER YOUR OWN SEXUAL HEALTH.**

We do some of our most effective work almost unconsciously – by how we model to our clients, service users, and the communities and young people we are in touch with. So it is vital that we take good care of our own sexual and emotional health and well-being. That covers a great range:

- It may mean talking to people about our emotions if we are having a difficult time, and seeking support rather than bottling things up and feeling we have to be strong.
- Or it may mean gaining training, assertiveness skills and confidence in saying “no” - perhaps to a sexual partner or to a manager asking us to add yet one more piece of work to an already over-stretched work-load.
- It may mean getting regular check-ups and doing self-examination for breast or testicular lumps.
- It should also include giving ourselves treats and, pampering ourselves
- Most of all, it will involve reminding ourselves we are precious, special and worth taking good care of and that our task doesn’t simply end with attending to the needs of others. We count too – and if we look after ourselves in these ways and pay attention to our own needs, this will also help us to be excellent role models for other people as well.
SECTION THREE
PART FOUR - PRACTICAL TIPS FOR SEXUAL HEALTH PROMOTION WITH GAY AND BISEXUAL MEN

1. HOMOPHOBIC COMMENTS.
The self-esteem and sexual health of gay and bisexual men does not exist in a vacuum but is created and maintained by a whole range of cultural, institutional, social and political forces around them. So, homophobic jokes and remarks all make up a world in which gay and bisexual men feel less than equal, less safe, less deserving of respect and less able to claim their sexual health rights than other people. You can contribute to the creation of a positive culture in relation to sexuality by making sure you do not collude with homophobic jokes or comments and showing that you support gay and bisexual men's rights to be free from prejudice and discrimination.

2. TRY TO ENSURE THAT ANYWHERE CONDOMS ARE AVAILABLE THIS INCLUDES EXTRA STRONG ONES AND LUBRICANT
Wherever possible, make condoms visibly available and ensure that these include ones particularly suitable for gay and bisexual men. Now combination therapies are increasingly effective in managing the progression of HIV, there is a risk that safer sex will fall off gay men's agendas and that many people will return to having unprotected sex. For young gay and bisexual men this may be because they identify HIV as a phenomenon for an older generation of gay men – despite the fact that rates are rising fastest in this younger group. For older gay and bisexual men, a worrying but understandable "condom-fatigue" may be setting in. Whatever the reasons, the challenge of encouraging gay and bisexual men to continue to care for their sexual health while still being sex-positive is probably greater than ever.

It is important that every opportunity is taken to make condoms easily available to gay or bisexual men and that education on effective prevention continues to be done with energy and imagination. This will include making it clear that there is a small but evident risk associated with oral sex as a route of HIV transmission (see the Expert Advisory Group on AIDS briefing for more information on this).

3. THINK ABOUT RE-NAMING ‘FAMILY PLANNING CLINICS’
The historical term "Family Planning" is a limited one. It is to be hoped that, with its explicit narrow emphasis on reproductive health, this no longer describes accurately the full scope of most clinics’ activities. If service providers want to ensure that their services are as relevant and attractive as possible to a wide section of the population, it may be useful to contemplate a move to a title which reflects this. "Sexual Health Clinic" or "Sexual Health and Well-being Clinic" implies that services are responsive to everyone and inclusive of everyone’s needs.

This makes it clear that a person’s sexual identity need be no bar to them accessing the service, and will be more welcoming to all men and young people, for whom planning a family may not be their immediate concern. Once clinics make it clear in this (or any other) way that they are applicable to people who are concerned with sexual health issues other than reproduction, they can effectively offer a broad range of services including:

- condoms
- psychosexual services
- referrals on to other services such as Hepatitis vaccinations, GU medicine and Health Advisers
- relationships counselling
- HIV and STI prevention
- access to HIV and STI testing and screening opportunities
However, bear in mind that such a development is likely to necessitate re-training for staff on sexuality issues.

4. **USE THE TERM “PARTNER” RATHER THAN WIFE OR GIRLFRIEND.**

Small things convey great meanings – and carefully avoiding the term “wife” or girlfriend”, replacing it with the less gender-specific “partner” lets everyone know that you acknowledge the possibility that someone may be in a same-gender relationship, while not offending anyone who is not. If you have already made it clear that you assume someone is heterosexual, it will be so much harder for them to raise the issue themselves and counter this assumption should they need to. Not only does using more general language open the door to someone wanting to talk about being gay, it also sends a signal to married men who may also be having sex with or be attracted to men that they can talk to you about this. See also point 9.

5. **THINK ABOUT WEARING A RED RIBBON – AND ENCOURAGE OTHERS TO DO SO AS WELL.**

Wearing or displaying a red ribbon demonstrates support for HIV prevention initiatives as well as affirming your commitment to the rights of people living with HIV. It shows that you are unafraid to be counted among those people who are trying to address the problems which HIV and AIDS have caused in our society. It also makes it clear that you are a champion for the rights of those most vulnerable to HIV – whether that is for example people in sub-Saharan African countries or gay and bisexual men in the UK. It also identifies you as an “ally” to people who may be unsure of whether they risk rejection if they are open about their sexuality or if they will be welcome. To make this clear in such a non-verbal and yet unequivocal way can be immensely reassuring for people, such as gay and bisexual men, who may fear being judged or stigmatised by others.

You might also give out Red Ribbons, or develop a special “Red Ribbon Project” – perhaps around World AIDS Day – in which supplies of Red Ribbons are made available in a number of venues - schools or colleges, GP surgeries or shops, health clinics or youth centres, shops, pubs and night-clubs. This can make a simple but effective project for raising public awareness. The National AIDS Trust can provide further information on the resources available to promote AIDS awareness and the Red Ribbon.

6. **CONSIDER SELF-ESTEEM ISSUES.**

Like many other groups in society who have historically been on the receiving end of prejudice, discrimination and violence, many gay and bisexual men have internalised the negative images presented to them by society. This in turn often leads to chronically low self-esteem, putting men in a position where they may not feel able to claim their rights to sexual health. This may manifest itself as not insisting on respectful and welcoming services – and indeed in avoiding using these for fear of being on the receiving end of judgmental, punitive or insensitive attitudes. For this reason, it is important to remember that gay and bisexual men may need particular reassurance that they are welcome to use services.

Many gay and bisexual men are not “out” about their sexuality and will need acknowledgement and positive messages before risking the potential judgement of professionals if they are open about their sexual choices. So don’t make the mistake of assuming that the only gay men you are encountering are the ones who talk comfortably about their sexuality – they will in fact only be a very small proportion of the gay and bisexual men you are unknowingly working with.

Of course there are many gay and bisexual men for whom their sexuality is a source of pride, who are comfortable about it and well-able to articulate their needs. But it’s important to remember the cultural context in which gay and
bisexual men are socialised, the negative messages which are promoted by institutions and individuals and the adverse impact this can potentially have on someone’s self-esteem.

When you do work with a gay or bisexual man, it is likely they will be watching you closely for negative signs, braced for rejection, for dismissive or contemptuous attitudes. In other words they may be waiting for any signal that you regard them as not to be treated equally and with respect. Such anxieties are not unjustified since they have been the lived experience for many gay men for too long in their transactions with health services, education and other service providers. You should therefore make it clear that you are positive about working with them, to make a particular effort to welcome them and to dispel their fears about encountering negative attitudes.

7. **CONSIDER HAVING POSITIVE IMAGES OF GAY MEN ON DISPLAY IN APPROPRIATE SETTINGS.**

The environment we work in and present to service-users tacitly gives strong messages, without that necessarily ever being our explicit intention. If we only display heterosexual images and are silent about any other sexual relationships, choices or identities - then the message we will be unwittingly giving out is that we only appreciate and support such relationships and we disapprove of or are unaware or any others. These images should not be confined to sexual health posters or campaigns – what about images of positive role models for gay and bisexual men?

These could include those who have spoken out for equal rights and have struggled against discrimination and those who have made a positive contribution to society in other ways. Remember, too, not to present images which show all gay men as heterogeneous – white, professional, young, slim and attractive. Such images, although certainly better than nothing, risk alienating men who fall well outside that narrow view as much as no images at all.

8. **FIND OUT WHAT SUPPORT GROUPS AND SERVICES ARE AVAILABLE LOCALLY.**

Have a range of leaflets, posters and cards available which you can give out so that people have access to their own information about this. It is also a good idea to have made contact with the relevant advice and support groups yourself – for example a local Gayphone, Lesbian and Gay Youth Group, Gay Bereavement Support Service or HIV support group. You could invite representatives from these services along to one of your team meetings so you have had the opportunity to discuss making referrals – as well as identifying and considering any possibilities there might be for joint working or shared training, if appropriate.

This means that you can refer on with confidence – it’s even better if you have a contact name of someone you know in one of these services who you can recommend personally. For many men approaching such groups or services this will be an enormous step and they are likely to feel very anxious and apprehensive about doing this – so any support and encouragement you can give at this stage will be vital.

It may be helpful for the staff or volunteers in other local organisations to know about your agency’s services so they can promote the use of these by gay and bisexual men and can refer them to you confidently.

9. **REMEMBER MARRIED MEN.**

Remember that some married men and men in relationships with women will also be attracted to other men – they may perhaps already be sexually active, or at a stage of contemplating this. The extreme isolation experienced by such men and often their heightened fear of exposure can result in them being at great risk in terms of unsafe sex. For example, they may find it difficult to keep condoms at home or indeed to negotiate condom-use with their female partner. When they do have sex with another man they may need this to be anonymous and hurried, so that they do not risk discovery. In such a situation it can obviously prove very difficult to negotiate safer sex or condom use, so offering
highly sensitive and confidential sexual health support and advice to such men is going to be important to ensure you meet your sexual health goals.

If there is a local support group for these men make contact with it. And don’t always assume that married men never have sex with other men. The testimony of outreach workers in settings such as cruising areas, parks, saunas and public toilets or ‘cottages’ is that they work with a high level of married men and otherwise supposedly heterosexual men. So if you are offering a sexual health service to the general population, try not to make any assumptions about the kind of sex men who are married or living with female partners may be having.

10. **CONSIDER YOUR ORGANISATION’S STATEMENTS AND EXPLICIT POSITIONS.**
For example, are issues of gay and lesbian sexuality included in its statements on reducing health inequalities, on valuing diversity, on harassment and on equal opportunities? Sometimes these are left out and “Equal Opportunities” issues are seen simply to comprise race, gender and disability. If this is so – how can you raise the issue in your organisation and get your policies changed to acknowledge sexuality issues?

If your organisation has policies on bullying – does this include homophobic bullying alongside other kinds? If your organisation requires certain standards of behaviour from service users and client groups – for example no racist language or offensive behaviour - are comparable issues of homophobia also addressed? Organisations often (perhaps unintentionally) make powerful statements about whether or not they value the rights and needs of gay men, lesbians and bisexuals by what they omit from their organisational policies as well as by what they include.
1. AN APPROACH THAT WORKS
Research shows that an effective approach for bringing about and sustaining behaviour change in terms of sexual health choices for gay and bisexual men is that of developing relevant practical skills. However, just awareness-raising, self-reflection opportunities or practical skills development on their own are limited in their capacity to assist change. Bringing these elements together in one approach makes this methodology powerful and the outcomes sustainable.

Gay men often report having had extremely negative experiences of formal schooling, as a direct result of homophobic bullying and harassment frequently coupled with institutional indifference or negligence about this happening. It is therefore important to replace negative, fearful notions of education and learning with more positive, empowering ones.

2. THE CONTEXT FOR SKILLS DEVELOPMENT AND WIDER COMMUNITY DEVELOPMENT
Skills development work needs to be part of a multi-faceted approach which aims to bring about social, cultural, political and institutional change as well as change at community and individual levels. This work needs to place itself firmly in the context of the broader social and political factors which impact on, shape and often constrain and damage the lives of gay and bisexual men. Such factors include prejudice, stigma and discrimination as well as low self-esteem and an internalised self-image which is likely to reflect all the negative messages which men have received about gay sexuality.

To deliver skills development work without also understanding and acknowledging these social and political factors will render such work ineffectual. However, if skills development work makes these important links it has the ability to bring about truly transformational change.

An example of good practice which has intelligently side-stepped this potential pitfall of delivering skills development in a vacuum is the model of assertiveness which has been developed and broadly adopted in the UK in relation to gay men and sexual health. This takes as its starting point a concept of an internalised negative self-image or ‘internalised oppression’, enabling participants to recognise how this has been acted out in their own lives. It then goes on to support them in gaining the self-awareness and practical skills to move beyond this experience, so reducing its power to sabotage their attempts at positive change.

Overall, skills development needs to be seen as just one aspect of working with gay and bisexual men. All sexual health promotion work should ideally reflect the holistic model of sexual health. In terms of work with this particular group, skills development work could fit within many of the ‘petals’ - for example self-advocacy skills or dealing with the media could come under ‘political’, safer sex negotiation skills under ‘sex’, assertiveness and communication skills under ‘social’ or dealing with difficult feelings under ‘emotional’. Providing it is seen as just one approach within a whole repertoire of methods, skills development can be a vital component part of sexual health promotion.

3. WHAT KIND OF TRAINING HAS HAPPENED?

Assertiveness Training
Probably the over-riding model being used is that of Assertiveness training. Within the assertiveness and sexual health model which has been trained throughout England and the rest of the UK, these elements would include
Dealing with difficult feelings  
Saying ‘no’  
Anger  
Asking for what you want  
Assertive confrontation  
Negotiation  
Bill of Rights and Sexual Rights  
Rights and respect  
Compliments

Mostly these courses have lasted from 4 to 12 sessions, giving men the opportunity to practice and consolidate these skills over a number of weeks. These courses are extremely practical and use a role-play model as the core component, offering men the opportunity to practice being more assertive again and again during the training so that they are well-prepared to make and then sustain these practical changes in their lives and relationships.

Other courses which have run in different places - including many organised by PACE - include:

**Positive Gay Sexuality:** including developing relationships and friendships, coming out, meeting men, dealing with discrimination, looking after our sexual health  
**Friendships Skills:** The skills for making and maintaining strong, supportive friendships between gay and bisexual men  
**Protective Behaviours/Protecting Yourself:** Risk and safety issues, self-defence, getting out of difficult situations, risk avoidance  
**Dating and cruising:** Staying safe, meeting people, relationships, risk issues and sexual health  
**Sexual Health:** Safer sex and condom negotiation workshops and group-work  
**Internet Liaisons:** Using the Internet and related safety issues  
**Stress reduction:** Relaxation techniques, yoga, meditation and anxiety management  
**Alcohol and drug use:** Particularly in relation to sexual health and decision-making  
**Self Expression work:** Writing workshops, art therapy, photography skills, dance workshops

Some training and skills development work specifically targets particularly vulnerable groups or those who might benefit from meeting together for support, including:

**Young and Gay:** Dealing with friends and family, coming out, being gay at school, dealing with bullying, sexual health, accessing services  
**Living Well – for people with HIV:** Covering issues such as disclosure of HIV status, sexual health, rights, benefits, therapy regimes and complementary therapies  
**Assertiveness courses for Black Men/Men from other Minority Ethnic communities**  
**Getting On/Life Begins at 40:** Support and skills development for older gay and bisexual men

Other skills training not related directly to sexual health – for example on CV and interview skills, literacy, IT and computer skills – has also been offered within Gay men's work in recognition of the need for a holistic approach to sexual health and mental and emotional well-being. This has the added purpose of developing a competent and effective community in which men can feel proud and gain support in their wider lives. All of this will have a positive impact on self-image and self-efficacy and this in turn will play a part in promoting positive health. As another aspect of this, smoking cessation training has also been run for gay and bisexual men in acknowledgement of the fact that the stress many men experience because of cultural and social factors and discrimination leads to disproportionate numbers smoking – as with other marginalised and stigmatised groups.

4. **THE MAIN BENEFITS OF SKILLS DEVELOPMENT APPROACHES**

Skills development work can be one of the most dynamic methodologies available to us in sexual health promotion. It has the potential to empower historically marginalised, fragmented and socially disenfranchised communities.
Skills development can be a vital component part of a greater endeavour of community development. It can do this by contributing to the creation and celebration of a community spirit and sense of pride – and the links between a strong sense of community and individual self-efficacy have been well demonstrated.

Some of the other specific positive aspects of this way of working are:

- Skills development work brings about real, positive and tangible changes in gay and bisexual men’s lives, their relationships, their sexual practice and decision-making. In this way it has been demonstrated to be one of the most effective methods for bringing about change at an individual level. Also, the fact that these changes can be observed and measured makes this a method well-suited to systematic evaluation.

- Because people are learning together with other gay and bisexual men, this work begins to develop and build on a positive community spirit, creating supportive relationships between people who may have previously found trust difficult.

- As trainers and group facilitators, gay and bisexual men running skills development courses act as positive role models for others and can speak from their own direct experience about what has worked for them and the changes that acquiring and practising these skills have made in their lives.

- Working in small groups offers participants the opportunity to reflect at a deeper level and can be an intensive experience in trusting other group members. It is often also the first time such men will have met in a non-competitive, non-sexualised environment outside the ‘scene’ with no put-downs and cliquiness and without alcohol or drugs. As such it can be a powerful experience of individual and group authenticity and solidarity.

- Gay and bisexual men who have experienced this skills development work, gaining new assertiveness skills and a greater sense of their rights are likely to become very effective and responsible service-users. We should be realistic that this may cause some short-term problems for service-providers, if they become clearer at articulating their needs or perhaps their unhappiness with aspects of the service which do not meet these, for example. However it is to be welcomed overall since it allows gay and bisexual men to play an active part in offering constructive feedback – as well as affirmation when it is deserved – which will enable services to change, improve and become more responsive where this is necessary.

- This method lends itself well to targeting at particular groups – for example such as older men, young gay men, men from BME communities, married and bisexual men, those who are HIV positive and those who use Public Sex Environments. This means courses can be tailored to suit the specific needs of different groups and communities.

- It is motivating work for staff, too, who can sometimes doubt the long-term impact of their work. This approach can be seen to have a direct effect and to bring about relatively rapid but nonetheless powerful transformation. Many men who have experienced skills development work really do say “It changed my life” – and if this isn’t what our work is about – then what is?

- With all of this capacity, this approach has an even more powerful potential – to bring about much-needed and long-lasting social, political, cultural and institutional changes all of which will play essential roles in promoting gay and bisexual men’s positive health and in HIV prevention.

For all of these reasons, use of skills development approaches are strongly recommended in sexual health promotion with gay and bisexual men – indeed they cannot reasonably be omitted from our work if we are to have the maximum impact and the most positive effect.

5. SOME PROBLEMS IN SKILLS DEVELOPMENT
Although this work offers many practical and useful ways in to sexual health promotion and HIV prevention with gay and bisexual men, it is not a panacea and should be placed alongside other methods and approaches. Some of the problems are:

- It tends to be the more advantaged men - who are for the most part better-educated, more middle class, less socially isolated and white - who feel most comfortable with skills development training. Therefore only using these approaches may drastically limit those who can be reached. Specifically, it is particularly difficult to engage Black men and those from other minority ethnic communities through these methods.
- If training courses are explicitly targeted for gay and bisexual men, that will exclude many men who have sex with other men but – perhaps for reasons of culture, ethnicity or religion – would never identify themselves as gay or bisexual.
- In small communities, men may fear the loss of confidentiality and anonymity which being part of a group on a course may bring – and in any sized community they may simply fear the intimacy of sharing such group experiences together.
- The workers and those delivering the training are sometimes perceived by those targeted by the training as ‘sorted’ and therefore not realistic role models living in the real world. The fact that they have jobs and salaries, are paid to work around sexual health and seem to be in control of their lives can sometimes generate resentment and an “It’s all right for you…” attitude.
- Such an approach can by definition only reach small numbers of men at a time – probably most groups would not exceed 12, for example and are often more likely to be 8. It is therefore labour-intensive (and expensive) in terms of worker time.
- However, if attempts are made to overcome this last point by cascading training and training up other local trainers to deliver courses, there is concern that there may be a loss of quality. If this sort of training is done badly and delivered without good facilitation skills or a real understanding - of both the content and of group processes – at the worst it may have the capacity to do more harm than good.
- There are concerns about the sustainability of this work, so it does not simply become a series of one-off events but brings about long-term change in whole communities as well as at an individual level.
- It is challenging for workers constantly having to find new fresh ways of packaging and marketing this training, and individuals and communities can start to suffer from ‘course fatigue’ if imaginative new ways in to this work are not found.

6. GUIDELINES FOR BEST PRACTICE AND RECOMMENDATIONS

If we are to maximise and build on the strengths described earlier and to minimise and avoid the pitfalls outlined above, we should be thoughtful and ingenious. We should have a clear sense of what we want to achieve and how we are most likely to make this a reality. The points below offer a route-map into some ways of doing this and some starting points for designing and establishing new initiatives.

Choose, prepare and support the trainers well

The abilities of those delivering skills development work are paramount – and the effectiveness of this approach will rise or fall on this aspect of the work. Ensure that people taking on this role have had adequate training for this themselves – seek out some of the excellent courses which exist, for example on group work, facilitation skills, training for trainers, sexual health awareness and particular techniques such as assertiveness or self-esteem building.

Just experiencing a course themselves is not enough preparation for workers then to replicate it and pass it on. They should also have the opportunity to reflect on their own role as a facilitator and to have explored their own attitudes and values so these will not get in the way of the group’s learning. There are also particular skills which they need the
opportunity to gain and practise – such as dealing with difficult feelings which can arise in groups, handling participants’ distress and managing conflict and anger in the group.

Actually choosing and recruiting suitable people to take on this facilitation role will be vital. So for example it may be best to avoid people with their own strong agenda which they simply want to pass on, people with poor communication and inter-personal skills or those who are more focused on their own needs than that of the participants.

Once you have your group facilitators and trainers in place, they will need good quality supervision and support. It will be important that they either have regular supervision, or consultancy in this role from a specialist in these ways of working or are part of a support network where they can share and learn from each other’s experiences.

**Target marginalised groups**

This work can by default exclude some groups and individuals who are likely to feel it is not for them – but who might in fact benefit greatly from skills development. It will be important to ensure that as many ways as possible are found for reaching those men who might otherwise discount themselves from involvement, assuming “it’s not for me”. These might, for example, include targeted publicity, tailoring the languages and images used and the venues.

It will be important wherever possible to have men as trainers and facilitators who come from the particular sub-groups and communities being targeted. This will provide positive role models and tangibly demonstrate that these approaches are relevant for the target group. However, these trainers will need a high level of support to cope with the inevitable sense of rejection, disappointment, failure or frustration which they may experience in the process of trying to establish work with groups and individuals who have previously discounted themselves from skills development.

This is not to imply that the needs of more middle class and maybe less socially isolated gay and bisexual men are not important too, and that their sexual health is not a matter for our concern and efforts. We should ensure that programmes of skills development training should be accessible for them as well.

**Consultation and Needs Assessment**

Skills development approaches should always (as in any other kind of sexual health promotion work) be based on partnership with the relevant communities. Consultation should be carried out with formal and informal groupings to assess their needs and responses. Essential information to inform planning stages can be gathered in this way and translated into appropriate action.

This might, for example, relate to what kinds of needs should be catered for in the training. So perhaps in any area where there is a spate of homophobic street attacks, safety and self-defence skills could be offered. Or consultation could result in hearing about what venues are most accessible and attractive for training or what sort of publicity materials for recruiting participants will be most effective.

**Evaluate the training and monitor its effect**

While it is always worth investigating the possibility of gaining funds for formal research and evaluation – such as that carried out by Project Sigma on the Assert Yourself courses – getting your own evaluation systems in place is important even if external help is not available. Carrying out baseline questionnaires with participants on their knowledge levels, attitudes, beliefs or sense of their own skills and capacities can provide very helpful data against which you (and they) can measure their progress and changes further on in the training.
Retrospective evaluation – say 3 or 6 months after the training finishes – can show the long-term effects of a course and prove (or question) the sustainability of any changes made. In some cases, group participants meet again after a time has elapsed to share experiences or even continue as an informal network once the course has ended. This can provide an invaluable source of support in building on the learning and maintaining changes made. Evaluation by the trainers themselves both of the group process and the actual skills developed will also be illuminating as will anecdotal feedback from others – maybe service providers, friends and significant others or other service users.

**Be clear about the aims and objectives**

We should be clear about what we want to achieve through skills development, our overall aims and objectives and then to proceed in the way most likely to achieve these. Just thinking of this as a tool for preventing transmission of HIV or cutting down on STIs is far too restrictive and not visionary enough about what such approaches can achieve. So map out at the start of any new initiatives exactly what you want to achieve as a core purpose – as well as trying to anticipate what some other outcomes might be.

For example, in offering assertiveness training the overall aim could be

*For men to develop a greater sense of their rights and within this the ability to negotiate sexual encounters and safer sex more equally*

Other objectives for the participants could include developing a stronger sense of self-worth, (“feeling ok about myself”), looking after themselves better, improving their relationships, getting better at asking for what they want and saying “no” to pressure. It is worth making these aims and objectives clear, in an accessible and appropriate form, in publicity about the training so people know what to expect and can measure what they get out of the experience against this. In the publicity it may also be helpful to state clearly that the group will be safe, supportive and confidential – since it is often fears and anxieties about these aspects which can act as obstacles to people getting involved.

**Harness the influence of Peers**

In terms of raising enthusiasm and interest in skills development work, nothing is as effective as word of mouth and the testimony of peers. If course attendees are positive about the experience, involve them as advocates with their peers. They may be able to help design and disseminate publicity, or talk informally in social settings. Or they may be able to do a snowball exercise, each telling at least 6 friends.

We should use these networks of influence imaginatively and positively where they exist. It will be particularly important to take this approach when designing and delivering skills development training with more socially excluded and marginalised gay men since these may be those most reluctant to take advantage of such opportunities.

**Be prepared for the impact and ripples of change**

When this work is done well, it can bring about profound change in individuals and also those around them, and also in the wider community or services they use. Be prepared for this and have responses planned and in place. For example, some agencies who offer services to gay and bisexual men may find that numbers of referrals are increasing, or service users are becoming more assertive and clearer about claiming their rights. Or mainstream services – such as Primary Care or Family Planning or Youth Clinics – may experience an increase in uptake of their services by gay and bisexual men who have previously assumed these were not available for them or been fearful of negative reactions. In such cases, it will be helpful to have done some preparatory work with staff in key organisations and settings to ensure they are skilled up and able to respond with appropriate, high-quality services.
Finally, some men may need support in dealing with the impact of some of the personal changes they may face through their involvement in skills development work. So it will be important to have networks of help in place. These could, for example, include self-help group support systems in the community or access to counselling services.

This section is based on a Think-Tank held with a number of men working directly in the field of skills development with gay and bisexual men - and men who have sex with men. Thanks for their contribution to this, or for commenting on this Section to:

Anthony Bains, Centre for HIV & Sexual Health, Sheffield
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Gary Dyke, Independent Consultant
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Will Nutland, Terrence Higgins Trust
Paul Richards, Wigan , Leigh and Ashton Specialist Health Promotion Service
Phillip Smith, Big Up@ GMFA
Matthew Torreson, MESMAC Leeds
SECTION THREE
PART SIX - PRACTICAL TIPS FOR SEXUAL HEALTH PROMOTION WITH YOUNG PEOPLE

1. REASSURE THEM ABOUT CONFIDENTIALITY AND THAT SERVICES ARE FREE.

Research with young people has reported that the two aspects of support and services which they are most anxious about – and therefore need most active reassurance on – are that these should be both confidential and free. Sometimes young people can pick up misinformation which might deter them from accessing services, so we should be constantly listening to what they want or what they believe, in order that we can correct any misinformation.

For example, in the wake of the publicity about being able to buy emergency contraception in pharmacists, youth clinics were reporting that some young women were assuming they would have to pay £20 for this when they came to clinics too. It is therefore important that there is effective proactive publicity about where this service is available FREE. Fear that their confidentiality will not be kept and that parents or Head Teachers will be told is still the factor most actively deterring young people from using services. So messages of reassurance about this should be bold and explicit, while being clear that questions about abuse, exploitation and Child Protection will also be addressed where this is necessary.

Service-providers and youth workers will need support and training to be knowledgeable and confident about the levels of confidentiality they can provide. For example, most professionals and agencies tend to assume they are more often required to break confidentiality than is actually the case legally. The RCGP Toolkit on confidentiality is an invaluable resource for this purpose.

2. PRAISE THEM AND WELCOME THEM - DON'T JUDGE THEM.

Young people fear being judged and disapproved of when they go to sexual health services. This is often not a groundless fear since the testimony of many young people is that this is what actually happens to them. No-one, of whatever age, is positively motivated by the experience of being treated as inferior or careless, and young people are no exception to this.

So the golden maxim “Here to listen, not to tell” should be our guide. And since young people’s fear of being judged may develop into an assumption that they will be judged, we will have to make imaginative and conscious efforts to reassure them this is not the case. Something as simple and resource-free as smiling at them when they come in to use a service can help to make a difference. It will involve us being clear that we believe young people have a right to our services and communicating this equally clearly to them. It will mean congratulating them for their responsibility in taking care of their own sexual health and that of their partner, if they have one. All of these things, which may seem obvious to us, will have a powerful effect in letting young people know they are welcome and that we care about them.

One story from some Family Planning nurses on a “GirlPower” training course was a good example of this. At lunchtime on the second day of the course, they had to go off to run a youth clinic and returned triumphant and excited to report that they had seen 3 young women who had wanted emergency contraception. Instead of their usual practice – which would be professional but not to do more than offer the clinical service - this time they were warm, positive and reassuring. The result was significant – much more positive and engaged conversations with the young women who relaxed and brightened in response. This meant that these service-users actually got more than a clinical intervention – they had a transaction which was sensitive to their needs. If anything is likely to encourage young people to take
responsibility for their sexual health and to diminish their sense of powerlessness, it will be being treated in this respectful way, as young adults taking positive control of their lives. And the corollary to this is of course that the professional staff themselves gets much greater satisfaction from the work, too.

HELP THEM PRACTICE SKILLS SUCH AS SAYING “NO”.

Often as professionals we say glibly to young people “Why don’t you just say “no” to someone who’s putting pressure on you or exploiting you?” when we are quite unable to say it in our own personal lives. It is important, therefore that we ground this aspect of our work in an imaginative understanding of the constraints which stop young people from doing what seems such a simple thing. Think back to what it was like to be 15 – when the approval and support of our friends and peers was all-important and when losing popularity or being rejected seemed the worst thing which could happen. It is this hunger for acceptance and approval which often fuels and motivates young people - and this need doesn’t stop when we are 18. So if we have the opportunity to do group work or one-to-one work with young people for longer than the span of a clinical consultation, raising these issues with them will be important.

When supporting young people to gain the skills to say “no” - whether this is to sex or to drugs, alcohol or pressure from their friends - start by exploring what their fears and fantasies are about the potential losses for them from such a course of action. A brainstorm about this will probably throw up factors such as “might be laughed at”, “seen as a spoilsport”, “people will think I’m scared”, “goody-goody”. They can then move on to focusing on what the possible gains in their lives would be from saying ‘no’. For example, these might include – “feeling more independent and grown-up”, “not doing things which make me feel bad about myself”, “stay safer”, “won’t worry about being pregnant” and “won’t get in trouble with police”.

Once they have seen the potential gains to be had from putting their needs, rights and wishes first and saying “no”, then it is time to help them get the skills to put this into practice. These might include for example the assertiveness skill of the ‘broken record’ technique – that is repeating the same phrase of refusal until someone finally ‘hears’ it. Role playing saying “no” to different requests, in different situations can be a powerful rehearsal for the real thing.

But in doing this, work up from minor things to the huge challenge of saying ‘no’ to sex, since this is the situation which people most fear, with its attendant anxiety about losing someone’s approval or love. So start with saying “no” to lending someone £2, or to going out when they have homework they need to finish or to babysitting for a neighbour. When their skills and confidence are growing - move on to saying "no" to pressure to have sex. It also helps to remind people that when they say “no” to someone, they are saying “yes” to themselves - and that they count too. There is another aspect to saying ‘yes’ as well, which is that there is a distinction between saying ‘no’ to sex entirely and saying ‘yes’ to what feels right at a certain stage in a relationship. We are likely to connect better with young people if we acknowledge this is the reality rather than presenting an ‘everything or nothing’ scenario. For more on this, the Lothian Health pack “Pathways to Sexual Health” has an excellent cartoon-style exercise on skills for making and refusing requests.

CHECK THAT IF THEY ARE HAVING SEX THIS IS CONSENSUAL.

Our work may often bring us into contact with young people who are having sex under the age of consent. In such instances we may want to work with them on whether this is a positive choice, whether they are using contraception and practising safer sex and also to introduce the idea that they do not have to continue to have sex just because they have “done it” once. However, it would be a serious error to assume there are child protection issues in all these cases. Where a young person is reasonably mature, able to make informed choices and under no pressure to be sexual, there are very unlikely to be child protection issues and therefore there is no imperative to share this fact e.g. with Social
Services or their parents. In fact, keeping their confidentiality will be essential to building trust. This said, of course, there will be some cases which do involve child protection issues, and these should be properly dealt with.

Watch out for telltale signs of coercion, exploitation or abuse. For example, a young woman of 13 or 14 with a much older boyfriend of 20 or more, may be being “groomed” for child abuse through prostitution. Particular danger signs may be if the boyfriend is attempting to cut her off from her friends and family and making her totally dependent on him. See the “Whose Daughter Next” video package mentioned in the Resources Section below for more background on this. Or some youth clinics and teenage sexual health clinics report that when they see very young people – maybe of 11 or 12 – once they trust the doctor or nurse, disclosures of abuse by family members or friends are quite high. For this very reason, it is probably not a good idea to put a lower age limit on who can access the service. In fact to do so may be to cut off the very life-line of help that these young people need. In this case, it will be vital to involve the young person in the process of informing the necessary statutory authorities once abuse has been established. To invoke Child Protection procedures without informing and supporting the young person through these risks simply compounding their sense of powerlessness and vulnerability.

There may be a grey area between actual exploitation and the young person making a positive choice to be sexual. In this case, it would be helpful to explore with them the importance of waiting to be sexual until it is something they want for themselves, rather than something they are doing because someone else wants it, or simply because they have been asked and assume they have to agree. Providing them with clear evidence on the detrimental effects of early sexual intercourse and pregnancy - for example in terms of their future health, mental health and general social involvement - (much of this can be found in the Social Exclusion Unit’s 1999 Teenage Pregnancy Report) gives them more information on which to base their choices. –This is a key element of an empowering process while absolutely separate from abstinence approaches, which have been seen to be ineffective.

MAKE SURE YOUNG PEOPLE HAVE DETAILS OF LOCAL SEXUAL HEALTH SERVICES.

Developing the skills to negotiate safer sex – or whether to have sex at all – is only one part of the task to be accomplished with young people. They also need our energetic support in gaining up-to-date information about the sexual health services available – whether in clinical or community settings, in Primary Care surgeries or specialist clinics – and how to access these. Again, since young people often have myths and fantasies about what will happen if they use a service, just giving them information will not always be enough to help them actually cross the thresholds. They may well be highly anxious that they will be told off, or that their parents or Head Teacher will be told, or that there will be intrusive physical examinations.

One way of helping them overcome the barriers created by these misapprehensions is to take young people – individually or in groups - along to see the services for themselves. In some areas “Mock Sexual Health Clinic” projects are run, drawing on a model of working developed in Sweden. In this, youth workers or teachers or school nurses take groups of young people down to their local Youth Clinic (or GU Clinic, or GP practice) when it is not open. They are able to see inside the premises, meet some of the staff and have the opportunity to ask questions about what using the service will entail. In some instances, over the course of a school year, a whole year group (say of Year 9 or 10 students) makes these visits.

Evidence from this work shows that familiarising themselves with services in this way has an enormous and significant impact on the numbers of subsequent follow-up visits made by young people. As such, this can be an effective element in a robust Reducing Teenage Pregnancy Strategy as well as in reducing STIs.
USE METHODS WHICH ENGAGE THEM AND GIVE LOTS OF SPACE FOR DISCUSSION.

The evidence base for what works best with young people demonstrates that we should be using methodologies which are active, dynamic and positively engage their interest. Traditional, didactic teaching methods may (or may not) work for the more scientific or biological end of information giving – for example about the technicalities of reproduction. But the much more important aspect of this work is the part which involves young people in thinking about making choices about sex, about communicating and negotiating and asking for information, about managing relationships and handling difficult and strong emotions. This will avoid the accusation young people so often level at their sex education – that it is “too little, too biological and too late”.

This means we should bring our creativity and imagination to bear. For example we can:

♦ Use excellent resources such as “Pathways to Health” referred to earlier, “The Essence” game, SexTalk kits or videos such as “Beyond My Backyard” or “The Lyric” as discussion starters. The fpa or the Centre for HIV and Sexual Health can provide more details of how to access these.

♦ Try role-play or games such as adaptations of “Scruples” or the Car Park exercise, which encourage young people to think about some of the moral and ethical dilemmas posed by sex and relationships. Again, the Centre for HIV and Sexual Health or the fpa can help you find these.

♦ Learn from youth health projects which have done media work, encouraging young people to become better advocates for their own sexual health needs. Or from projects which have supported young people to become “mystery shoppers” trying out services incognito, reporting back on these and making recommendations for what improvements could be made.

♦ Recruit, train and support young people to become peer educators or peer counsellors or as publicists for local sexual health services and support. We can also involve them in designing and disseminating new information leaflets and other materials such as videos and posters.

The more we engage young people’s imagination and energy, and offer them opportunities for reflection and personal development, the more control and responsibility they will be encouraged to take over their own sexual health and relationships. We should create an atmosphere and culture in which it is safe for them to ask questions and to reveal their lack of knowledge without fear or mockery. This will mean creating a positive and supportive group-work environment with clear group guidelines of ways in which people can support each other’s learning. See the section on Group Work and Facilitation skills for more on this.

TALK WITH YOUNG MEN ABOUT EMOTIONS, FEELINGS AND ANXIETIES.

Often our culture reveres a ‘hard’ notion of masculinity and rewards macho behaviour and attitudes, and no-one offers young men models for other ways of being and relating. We may be the people who can help them move beyond the constraints of this gender conditioning. This will mean helping them question the cultural imperatives to be sexually experienced and to be tough, not to discuss their feelings or to present as ‘weak’. It will involve us in providing space and encouragement for young men to talk about their anxieties about sex; to ask questions which might reveal their ignorance or lack of experience; to talk about feelings and emotions and to practice being a young man without being tough and unconcerned with others.

In order to do this, we will need – both as male and female workers – to model these ways of approaching talking about sex and relationships, never colluding with sexism or misogyny for example, or with the homophobia that equates anything not ultra-masculine with being feminine, weak and gay. We should also tackle the difficult project of raising
boy’s self-esteem, helping them where necessary to replace aggression and combative ways of being in the world with assertiveness and due respect for themselves and others.

We should ensure that all sexual health support and services are welcoming and open to young men and demonstrably put their concerns on the agenda. Clinics should advertise their services to young men, making it clear they are welcome. Staff will benefit from having some training around specific needs of boys and how they can ensure services are responsive and appropriate to meeting these needs. It will not benefit anyone if efforts are put into attracting boys and young men to use services but then, when they actually turn up, the services have not put any thought into how to make them feel comfortable and welcome. What about displaying positive images of boys and young men too, so this welcome is made tangible in the environment? See Section on working with men, young men and boys for much more on this.

SEEK FEEDBACK FROM SERVICE–USERS.

We should use thoughtful and innovative methods for finding out from young people what they think of the sexual health services and support on offer and of their Sex and Relationships Education. Once we know this, we should then feed it back to those providing the services or education. So:

♦ try focus groups using semi-structured conversations
♦ leave out questionnaires in services to gather feedback
♦ do informal needs assessments in classrooms and informal youth settings to find out what young people themselves say they want from our services, input and support
♦ “snowball” these surveys. This means asking every young person to hand a questionnaire on to a friend, to reach out as broadly as possible to the hardest to reach young people
♦ offering incentives will always help increase the motivation of young people to become involved. These could include vouchers for shops, meals or the cinema or small cash payments.
♦ always make sure that confidentiality is maintained about young people’s feedback. So for example if you are giving out questionnaires, you can increase the response rate by putting out an attractive, secure and colourful box for these to be returned in, decreasing any anxieties that responses might be accessed and read by others.

When seeking this feedback, we should also ask those who don’t currently use services. Just surveying those who already feel confident enough to cross the threshold doesn’t help us to discover what deters and discourages others. Making alliances with colleagues in a range of agencies and settings – for example detached youth workers, residential care workers, youth justice workers, drugs workers, Connexions Personal Advisers and learning mentors - will help us reach a large number of current or potential service-users. We should ensure that all groups are represented, for example, including young men, teenage parents, young people from Black and Minority Ethnic communities, young lesbians and gay men and young carers. In other words, the group we carry out this research with should be as heterogeneous as the whole community we serve. Finally, remember to put the findings into practice. We should not imagine that this process in itself is enough, but should also ensure that the suggested changes are made wherever this is practicable. In this way services can take on young people’s proposals for making them more relevant, appropriate and user-friendly.

TALK ABOUT DIFFICULT THINGS.

While we should be careful to mention pleasure, love, intimacy and fun when we discuss sex and relationships with young people – we should also address some of the vexing and contentious issues which surround sexual health for them. These may include, for example, regret about sex, hating their bodies or peer pressure. For example how to
manage the expectation from others that they will use drink or drugs, how to resolve the pressure to be competitive and impress others and how to deal with the potential conflict between demands of parents and peers and culture. If we create the time and space to allow them to explore these matters, they are less likely to be buffeted by the forces of pressure and expectation. In turn, they will be more able to find their own way safely through the maze of decisions they are faced with.

**PRACTICE DECISION-MAKING SKILLS.**

If young people are to become intelligent and expert decision-makers in their own lives, they need to have the skills necessary for making the choices which will be most positive in their impact and outcomes. Being able to make positive, proactive decisions is a basic skill for young people if they are to grow to be rounded and effective members of society – and to take responsibility for their lives and futures. But making good decisions is as much a skill as driving, swimming or playing the guitar – and we can draw on our life-time of experience of decision making to help young people gain, practice and polish this vital skill.

Think of ways in which young people can reflect on the different component parts of making decisions – for example through role plays, scenarios and case studies, mock magazine problem pages or by examining how characters in soap operas take difficult decisions. These component parts might, for example, include:

- reviewing all the options
- thinking through the likely consequences of each course of action
- seeking opinions from other people
- getting all the necessary information and getting the facts clear
- dealing with people’s disapproval or rejection if you make a decision they don’t like
- being open to the possibility of changing your mind if the first decision doesn’t work out well.

Then apply these elements to more and less weighty decisions – practising initially with minor ones such as whether to go to the cinema, bowling or to a club. Having gained some awareness, then go on to the next stage and work through whether or not to spend money on a new piece of clothing, a CD or a night out. Eventually, move them on to more momentous decisions, such as what subjects to opt for at school, whether to take drugs, whether to have sex with someone and whether to refuse to have sex without using condoms.

And finally, remember that it is OK to set boundaries for young people - in fact these may be welcomed for providing parameters at a time in their lives when things can often feel in turmoil. Some clinics and services have a ‘Clinic Charter’ displayed on the walls which makes it clear what people can expect when using the service, and what is expected from them. Obviously it may be helpful to consult with young people who themselves have an investment in services feeling safe and welcoming for ALL. While we want to encourage young people to take up the services which are offered, this doesn’t mean that they have the right to infringe the rights and freedoms of staff or service users. Spelling this out clearly and specifically can be reassuring for everyone, resulting in a safe and respectful environment.

**Contract for Work in Schools**

This document was produced to negotiate agreements with schools where Sex and Relationships Education is being set up. It aims to establish a reciprocal arrangement, with the expectations of each party (i.e. the school and the Sexual Health Promotion Unit or Sex and Relationships Education Adviser) clearly laid-out . It is offered here as one model if services, schools or sexual health projects want to develop such an agreement.

**CENTRE FOR HIV AND SEXUAL HEALTH CRITERIA FOR WORKING IN SCHOOLS**
Background

We work with a large number of schools and individual teaching, education and health staff across the city. In over a decade of this work our practice has become, we hope, more and more responsive to need. In order to clarify what the Centre can offer and to enable schools to use our services in the way that will be most helpful, the following guidelines have therefore been prepared. Like any intelligent process these provide a useful framework and starting point and details can, of course, be negotiated as appropriate. Drawing from our extensive practice the guidelines, we believe, offer a helpful set of parameters to facilitate the highest possible quality of work.

Liaison with school

♦ The Centre expects at least half a term’s notice from the school when requesting session(s) in order to maintain a manageable workload and to ensure the best possible response to requests for our input.
♦ We need a named contact in the school who will act as key co-ordinator and be responsible for liaison and communication.
♦ Centre staff will want to see and work within the school’s Sex Education Policy. All schools are required to have a sex education policy which describes the organisation of sex education in the school. If the school does not have an up to date policy, we can offer assistance and support in developing one.
♦ Before the session(s), Centre staff will meet the key co-ordinator and other staff who will be present in the session to discuss shared expectations and desirable outcomes.
♦ If a teacher wants to co-facilitate the session, there must be an opportunity for meeting and preparation time before the session. This allows time for checking out styles, approaches, and content and to discuss how to handle any difficult situations, which might arise.

Preparation for sessions

♦ Experience has demonstrated that students benefit most when the Centre’s input is an integral part of an ongoing Sexual Health, Relationships and PSHE programme in which there has been relevant teaching and learning beforehand, so that students have some background to the issues. This preparatory work could include involving pupils in planning the visit and welcoming the visitor.
♦ It is helpful, in order for us to assess the level of awareness and understanding of the students, if each pupil is given an opportunity to write their own anonymous questions on the issues to be covered. If the school ensures we receive these before the session, we can use them to inform our planning process.

The session

♦ Centre staff will arrive at least ten minutes before the start of the session. We need to be met by a named teacher or pupil and to have received clear directions of where to meet beforehand.
♦ It is desirable for each class or group to have a maximum of 20 pupils. This enables the students to get the greatest amount out of a session. Ideal group sizes are 10 - 15. However, we are realistic about the fact that such a situation, however ideal, may not always be possible.
♦ It is helpful if the sessions can take place in a room where furniture is moveable, and if desks can be moved and chairs placed in a circle before the start of the session to allow for a ‘discussion group’ set up.
♦ Teachers are generally invited to take an observing role (unless this issue has been previously discussed with the Centre staff). We would prefer it if teachers intervene in relation to discipline only if the Centre staff member asks for this.

Following the sessions
It is essential that after the lesson some time is allocated for pupils to fill in an evaluation sheet. This lets us know about the effectiveness of the session and helps ensure that young people’s needs have been met. These evaluations are also useful for teachers in providing feedback on the group’s ongoing needs.

Teachers are also requested to fill in an evaluation of the session and to ensure that copies of all of these forms are sent back to the Centre staff.

After the programme has been completed it would be useful for Centre staff and the teachers involved to arrange a feedback session. This gives an opportunity to compare experiences, to talk about any matters raised and to discuss how to carry issues forward, to arrange further sessions, provide necessary resources etc.

Confidentiality

The Centre staff will work within the school’s Confidentiality Policy. If there is no policy, the Centre staff will not encourage pupils to disclose private information in the classroom session.

If a pupil, either individually or in the class, discloses that they are in danger and there is a child protection issue the Centre staff will work within the school’s Child Protection procedures. In such a situation, the pupil will be informed of the need to break confidentiality and supported throughout the process.

Resources

The Centre provides a range of free booklets, leaflets and posters, videos, condoms and condom demonstrators to Sheffield schools and colleges, by prior arrangement.

Any teacher or school nurse can order and collect stocks of our materials on a regular basis to ensure distribution to appropriate students throughout the school year.

Further resources, e.g. books, training packs, videos, and contraception display kits are available on loan from the Centre library. Baby Think It Over random crying dolls are also available for loan once staff have done a day training session on effective use of these in practice.
SECTION THREE
PART SEVEN - 10 PRACTICAL TIPS FOR SEXUAL HEALTH PROMOTION WITH WOMEN AND GIRLS

REMEMBER THE NEEDS OF WOMEN IN THEIR 30s, 40s - AND BEYOND
Remember the needs of women over 30, particularly those who are newly single and divorced. Often, when we are considering the sexual health needs of women, we think of young women. Increasingly with the current emphasis on teenage pregnancy this means most attention is being paid to the needs of young women under 20 and older women may risk being forgotten.

However, rates of unintended pregnancies and terminations are high in women over 30 and GUM clinics report increasing rates of STIs in women who are recently divorced or separated. These women, coming out of long-term relationships, are particularly vulnerable. Such women are of a generation who were not targeted with safer sex messages and who probably did not receive very adequate or comprehensive sex education when they were younger. They may have been married or in a settled relationship before condom promotion was so prevalent – and they are unlikely to identify themselves as vulnerable to STIs. They may be unused to negotiating sex and how to look after themselves in new sexual relationships. If they have come out of marriages and are facing separation or divorce, this may have had a very negative effect on their self-esteem, leaving them even less able to take good care of themselves and think about what they want and need. Older women from BME communities sometimes also need additional support to discuss these issues - see Section on BME communities for more on this.

All this shows that this is potentially a group with very particular concerns when it comes to sexual and emotional health and well-being - yet still there is very little information targeted specifically at them. It may therefore be worth developing information resources or services particularly with the needs of this group in mind, using appropriate images and languages as well as relevant community languages.

PUT ISSUES SUCH AS PRE MENSTRUAL SYNDROME AND MENOPAUSE ON THE AGENDA
Often, when work is done on promoting women's sexual health it focuses exclusively on issues related to fertility, contraception and pregnancy. And yet there are other vital concerns for women which have the potential to affect the quality of their lives, but which are much more rarely addressed – including Pre-Menstrual Syndrome and the Menopause. Apart from the physiological ill-effects which can be caused by these, they can also have an impact on women's emotional well-being and their relationships.

Have relevant information and leaflets available – perhaps about the possible side-effects of the menopause on women's sexual relationships or on managing PMS - and consider having these in community languages, too. Find out what specialist services you can help women access locally and publicise these. Because these issues historically have been side-lined and trivialised, it is important that positive effort is put into redressing this imbalance. This will involve acknowledging the difficulties, disruption and distress which can be caused in women's lives – and those of their partners and families – if these matters are not given good attention.

PROVIDE THE FULL RANGE OF CONTRACEPTION CHOICES
Whether you are involved in offering education and information to women or in providing actual clinical services, discuss and acknowledge the whole range of choices available. Only in this way can women decide which is most appropriate and manageable for them. Often, women are effectively offered oral contraception and nothing else.
Be prepared to discuss the benefits and drawbacks of other methods. Talk about using condoms alongside oral contraception, as a method of STI prevention. And have Femidoms available as well as male condoms among the range of contraception choices. Although the reaction to female condoms has been mixed and some women have reported considerable problems in using them, having them available sends a strong signal that women have the right to be in charge of their own fertility and sexual health.

**ADDRESS MENSTRUATION ISSUES**

Probably one of the last - and strongest - taboos in the field of women’s sexual health is that surrounding menstruation. There are still reportedly primary schools, for example, where there is an embargo on teachers discussing these issues with children, despite the fact that research shows that many girls now start their periods before going to Secondary school. So breaking the taboo needs to start by openly and easily talking about menstruation, rather than seeing it as a source of embarrassment. Consider making sure that toilets have tampons and sanitary towels available.

Try to ensure that there are hygienic disposal facilities for tampons and towels. Again many Primary schools still lack these, forcing girls to have to make their own arrangements at an age where this can cause acute embarrassment. Discussing pain management can help too, not just taking painkillers but the beneficial effects of taking exercise and doing relaxation exercises.

One group of Primary Care practices in South London organises group-work sessions for 10 and 11-year-old girls where they can learn about everything from the physiology of periods to managing mood-swings and basic hygiene. In another practice, in Northern Ireland a GP offers consultations with girls about effective use of tampons and any questions they may have about these.

**TALK ABOUT BODY IMAGE AND SIZE**

Girls and women still exist in a world which often judges them for their looks, their size, their shape, their clothes and their appearance. All of these things can deeply damage their positive sense of self-worth, resulting in them entering into sexual relationships with little belief in themselves or their rights. We should be addressing this issue directly by helping girls and women gain a greater understanding and awareness of the pressure on them – from the media and advertising, from TV and the fashion industry – in relation to how they supposedly should look.

This can be done, for example, by doing an exercise in which girls look through magazines, newspapers and advertisements and make a collage of all those images which represent how women are supposed to look. Then, by drawing from the same newspapers and magazines, they can create a companion collage of how women really look – older women and larger women, Black women and disabled women. Or they can do a project going into local shops to find out what proportion of clothes on sale are for women of size 16 or more - and how fashionable, or attractive these clothes are.

They can be encouraged to give each other positive feed-back on qualities which are nothing to do with how they look. And they can consider the qualities they admire in their heroes or heroines which don’t relate to appearance – Nelson Mandela’s courage and leadership, Anita Roddick’s business flair, Ellen MacArthur’s determination in relation to her vision of sailing round the world, Venus and Serena Williams’s formidable tennis-playing.

All of these activities can help girls and women to develop a critical awareness and analysis of the pressure on women to look and behave in certain ways – and having this awareness is the first stage in actually resisting that pressure.
REMEMBER, ABORTION IS LEGAL
Discussing abortion still seems taboo and many people are still fearful about raising this option – in schools and youth settings, for instance.

It is therefore important that those of us involved in the project of sexual health promotion remember and remind ourselves – and encourage each other – to talk about abortion as a legal choice for women facing unintended and unwanted pregnancies, a medical intervention offered and delivered by the NHS every day. This position which is reflected in UK law needs to be spoken clearly.

We should ensure that all women of whatever age have access to termination services, to information about these and to support for their right to choose to have an abortion if that is the best option for them. We should also ensure that people know about the availability of medical abortions and the need to present early to be within the time limit for these, rather than putting off taking the first step. This can be done by producing and circulating leaflets and information about these services and by placing this choice along-side that of keeping a baby or having it adopted or fostered. We can also work with other colleagues - for example in health, education and social services - to break the culture of silence around abortion.

ACKNOWLEDGE THE NEEDS OF LESBIANS AND BISEXUAL WOMEN
Lesbians often report that when they access sexual health, or other health services they are assumed to be heterosexual unless and until they specifically state otherwise. This kind of heterosexism is a barrier to people who are already likely to be anxious about being at the receiving end of judgement and prejudice. So rather than asking a woman: “What kind of contraception are you using?” it is better first of all to enquire whether she is having sex which calls for contraception. Remember, this will not only be a relevant question for lesbians since some married heterosexual women in fact never have penetrative sex or are in “celibate” marriages.

Other ways of demonstrating a welcome include:
- Stating that services are for all women – including lesbian and bisexual women.
- Having positive poster images of lesbians on the walls.
- Having leaflets available on lesbian sexual health.
- Having referral numbers for self-help groups and counselling organisations for lesbians.

Remember, too, that some health issues may be of particular relevance for lesbians – for example, breast cancer rates are likely to be higher in this group so screening opportunities might be particularly targeted via lesbian self-help groups. Also, depression and mental health problems are often more prevalent in groups which have been traditionally stigmatised and marginalised within an historically homophobic society. Links could therefore usefully be made with mental health support services.

OFFER OPPORTUNITIES FOR ASSERTIVENESS TRAINING
Many girls and women have effectively been socialised to look after everyone’s needs but their own. This can result in them being stuck in what has been called ‘the compassion trap’, which requires women constantly to look after others rather than themselves. In terms of sexual health, this means many women may not be able to say ‘no’ to sex which someone else wants but they don’t. They may not be able to ask for what they do want sexually and may not believe they have the right for their needs to be acknowledged. This can make girls and women very vulnerable and at risk in sexual terms.
An effective way to counter this is by offering girls and women assertiveness training. This can help them to build a sense of their own rights and gain the practical skills to assert these and to take good care of themselves. These skills include how to negotiate - for example, to ask for condoms to be used or to agree the kind of sexual activities they want and don’t want. It involves addressing the barriers to saying ‘no’ - fear of disapproval or rejection perhaps - and how to get beyond these. Only then can women believe they can choose for themselves and put these choices into action. Assertiveness can also help girls and women to gain confidence in approaching sexual health services and ask for what they want - for example, for assurances about confidentiality and can being clear that they will not accept disrespectful or insensitive treatment.

Assertiveness trainers can usually be contacted via your Community Education provision or through your sexual health promotion team. Be sure to use someone well-qualified and skilled in this work since assertiveness training by untrained or poorly-skilled staff can be counter-productive and set people up to fail. A useful adjunct to assertiveness training can be self-defence courses.

HELP GIRLS FIND WAYS OF HAVING STATUS WITHOUT HAVING A BOYFRIEND
There is a salutary and thought-provoking exercise - which can be done with young women or professional staff - which starts with a brainstorm about “Why do girls have sex?” The answers tend to be wide-ranging and usually include ‘status’, ‘popularity’, ‘to keep a boyfriend’, ‘for attention’, ‘for affection’ or ‘to belong’. Having identified some of the reasons they may be having sex, it can be useful to go on to discuss whether these methods work. So does having sex with someone necessarily make you popular or stop a boyfriend from leaving? In fact, the learning here may be that some of the reasons why girls have sex are not born out by the reality of the experience. The initial motivation of trying to resolve feelings of bleakness, loneliness or low self-esteem may be exacerbated by an alienating sexual experience.

We should work with girls to help them get the things they hope sex will deliver – perhaps status or approval, a sense of being important and popular, of being wanted and loved – in other ways. This might be through friendships and by offering girls opportunities to develop, strengthen and nurture their friendships with other girls or boys. This can be done, for example:

- by developing girls’ activities
- through crafts and outdoor activities
- through away-days, outings and residential
- through courses and groups on listening skills, conflict management or assertiveness

All of these activities can increase girls’ self-esteem. This in turn will mean that, when they do come to sexual activity, it will be more likely to be a happy and satisfying experience for them, rather than something which damages their self-esteem.

TALK ABOUT PLEASURE.
We are probably all familiar with the gender double standard over the centuries which has led to the assumption that sex is for men’s pleasure, with women all too often left – literally – holding the baby. We should counter this traditional imbalance. So when we discuss masturbation in Sex and Relationships Education, it needs to be clear that this is relevant to both girls and boys, for women and men - and not simply male territory. When we introduce information about the sexual anatomy and physiology – are we mentioning the clitoris? And if not, why not? An interesting piece of research by Michael Reiss was reported in the journal of Research in Science and Technological Education, Vol. 16,
1998. This showed that out of the 15 most commonly used Sex and Relationships Education textbooks in Britain today, 10 make no mention of the clitoris or of women's orgasm.

In our information resources, teaching materials, consultations with women and our acknowledgement of their needs for support and discussion, we should keep issues of pleasure on the agenda. This may also mean:

- talking about painful sex including vulval pain, which is a much greater problem than is often recognised.
- helping women to discuss and resolve this problem which can cause huge disruption in previously happy sexual relationships.
- helping women - of whatever ages - to say 'no' to sex which is not a positive and pleasurable experience for them.
- making it OK for women to talk about learning about their bodies and what turns them on.

This may take some courage but it will help equality in sexual relationships and in supporting women's sexual health and emotional well-being.
SECTION THREE
PART EIGHT - 10 PRACTICAL TIPS FOR WORK WITH MEN, YOUNG MEN AND BOYS

POSITIVELY AND PROACTIVELY TARGET MEN, YOUNG MEN AND BOYS

In many cases, sexual health services, information and education have been considered to be both the responsibility and preserve of women. To redress this imbalance and ensure that men, young men and boys receive their absolute right to the same level of support and services - as well as taking on their share of the responsibilities - specific sexual health promotion activity needs to be developed with them. Also, services should acknowledge and act on the information which has been gathered from men about their attitudes to services. For example:

- men consistently say they want services which are open outside working hours,
- they want some men-only provision, and
- they like to see someone immediately rather than be kept waiting.

Rather than just making every effort to attract men in to use what is currently on offer, service providers should consider what needs to change to become men-friendly.

This might, for example, entail devising publicity initiatives and campaigns which speak directly to men - using affirming images and positive messages which are likely to appeal to them. It also will probably require being imaginative and creative about where to reach men. This might mean advertising and sexual health promotion in places where men gather - from pubs, gyms, sports and recreation centres to workplaces and service settings such as Army or TA Barracks. Or it might mean using media of particular relevance for men - who tend to be more enthusiastic listeners than readers, for example - so local radio may be more effective than written materials in gaining their attention.

Attracting men to use services isn’t necessarily going to be a ‘quick fix’ though and publicity alone is unlikely to result in floods of men suddenly accessing services. We should take a long-term approach and have only modest expectations in the early stages. We have to build up credibility with men, ensure the experiences they have of using services are as positive as possible, and ensure they feel these are appropriate and responsive to their needs.

The Internet and linked technologies are sure-fire ways of reaching men, young men and boys too, as the principal users of these. It will be especially important to use positive, attractive messages - ones that are not lecturing or blaming, while at the same time not falling into the ‘laddy’ trap of using images or language which might reinforce sexism and misogyny. One image from decades ago which continues to have high levels of recall is that of the pregnant man. Think in terms of coming up with something with as much impact and relevance now.

In targeting boys, young men and men it may be helpful for us to name some of the myths and fears which abound among them about sexual health screening. In fact it will only be after we have named and dispelled these that we will persuade some men to access services and support at all. These myths and fears often include:

- “They still use an umbrella device to scrape out bacteria from your willy” (it is extraordinary how many men still believe this)
- “What if someone else sees me going in? They’ll think I have a nasty disease”
- “If I got hard during an examination, I’d die of embarrassment”
- “You have to have an examination even if you’re just going for condoms”
- “I would be too embarrassed to let a women check out my tackle - and I’m not having a man fumbling with my bits”
By encouraging young men and men to discuss these kind of concerns we will be able to offer them more information so that they feel less anxious about using a service. If we don’t give permission for these fears to be voiced or put them on the agenda ourselves they will continue to hinder men from gaining the support they deserve for their sexual health.

HELP MEN, YOUNG MEN AND BOYS TO GAIN CONDOM CONFIDENCE AND COMFORT

The old myths about condoms still persist among many men, young men and boys - that these impede pleasure and are like ‘having a bath with your wellies on’. For many men these are doubtless learned response, offering a convenient way-out of sharing responsibility for contraception or STI/HIV prevention. But equally these may be based in genuinely negative experience or real anxieties and fears.

If we are to encourage men to take responsibility for condom use we should approach this problem in a host of well-considered ways. The Section on promoting condom use has much more on this issue. Strategies could include:

- Helping men gain skills in how to raise the issue of condom use with a partner - is it best simply to get one out and put it on at ‘that condom moment’, or to discuss it before-hand and agree together?
- Enabling them to develop an understanding of what constitutes safe and effective condom use - and having condom demonstrators available for every possible educational/awareness raising opportunity with men.
- Research shows that the majority of condom failures are the result of them not being used properly and are entirely preventable with enough preparation and support. So offer lots of opportunities for condom practice until this becomes matter-of-fact, without fuss and simply routine. At this stage, a real level of ‘condom comfort’ can be achieved.
- Talking about the myths and difficulties and the benefits and positive effects of using condoms so that the blocks and barriers - which are often imagined rather than real - can be surmounted.
- Making sure you know and publicise where condoms can be accessed free. Given that the belief persists among some men that condoms which are available in NHS settings will be old-fashioned and unattractive, it may also be worth stating the range and choice of condoms on offer, to counter this particular myth.
- Lack of money is also a real issue preventing many men, young men and boys from using condoms so it is particularly important that we emphasise that FREE condoms are available from specific settings - such as GUM Clinics, Family Planning or Youth Clinics, as well as some GP surgeries and Walk-In Centres

TALK ABOUT SELF-EXAM - TESTICULAR AND PROSTATE CANCER TOO

Rates of both testicular and prostate cancer are rising as well as deaths from both of these. Often men leave it very late before approaching health services about a lump or any other significant body change - and yet the prognosis, if caught early, for both these conditions is very hopeful. If we work with men generally and young men in particular on becoming more comfortable with self-examination and gaining greater comfort with and awareness of, their own bodies, then we should have a dramatic effect on these rates.

Discuss self-examination with men, young men and boys - and where possible have anatomical demonstrators to show what they are looking for and how to spot anything suspicious. Through one-to-one and group-work as well as by means of leaflets, posters and other media, let them know what early signs to spot and how to detect key body changes. Mention these issues, too, alongside contraception and STI prevention in sexual health consultations or in condom demonstrations. Encourage men to feel they have the right to go along for a health check if they have any doubts or concerns. Take every opportunity to help them surmount their feeling that doctors are only for people who are ill and therefore not relevant for themselves most of the time. All of this awareness-raising has the capacity to save lives.
DO PARENTING AND FATHERHOOD WORK WITH BOYS AND YOUNG MEN

Until recently, the topic of fatherhood and opportunities to gain and practice parenting skills have been lacking from the lives of men, young men and boys. The result has been that this area of men’s experience has suffered from a lack of support. For example, we know that currently more than 50% of fathers lose contact with their children within 2 years of divorce. Of course, this in turn is likely to have devastating and long-term effects not just on them but on their partners and children too.

There are increasing instances now of programmes of work being undertaken with boys and young men to ensure that they will be able to play an active part in their children’s lives as well as providing a positive male role model for them. All sorts of approaches to this work can be explored - from practice tending to a ‘Flour-Baby’, painted egg or ‘Baby think it over’ random crying dolls to group work discussions about their experiences of their fathers - what they appreciated and what they would have liked to be different.

Another aspect of this work is to explore and dispel the myth that prevails amongst some groups of young men that the only way to prove your manhood is by fathering a child. In such cases, we should be offering other imaginative and effective ways to become adult which do not involve a lifetime’s responsibility for someone else. And remember to continue to work with men on these issues, because being a father is a lifelong commitment. If they are distanced from their children - maybe as a result of divorce or of being in prison - help them find ways to keep in touch with their children. For example, one programme in prisons works with fathers to make up stories for their children, and they then tape or write these to share with their children as a way of maintaining positive contact.

DO SKILLS DEVELOPMENT WITH MEN, YOUNG MEN AND BOYS - BUT REMEMBER TO TALK ABOUT EMOTIONS, ANXIETIES & CONCERNS TOO

Experience of those working with men and boys shows that these groups initially feel much more comfortable with acting rather than talking. So taking a skills development approach - perhaps about how to use condoms effectively, or hold a baby or ask someone out - is likely to be the best route in to this work. We should balance this with the fact that too often the images of sex and men which men, young men and boys have been exposed to will be related to action, conquest, and ‘scoring’. Increasingly these may be accessed via internet or satellite pornography or ‘lads’ magazines. What is likely to be missing from such sources of information is any mention of tenderness, intimacy and relationships.

Sexual health promotion work should therefore offer boys and young men safe ways to reflect on emotions and relationships with sheltered opportunities for admitting ignorance, sorting out confusion and discussing feelings. Above all, becoming familiar with and comfortable around the world of emotions will serve them well in terms of building satisfying relationships as well as making positive sexual choices for themselves, rather than simply being pressured into being sexual by the expectations of others. Alongside this, we should be enabling boys and young men to gain communication skills for expressing their feelings and wishes, as well as listening sensitively and with interest to those of others. Only in this way can they become really comfortable dealing with issues of sexual relationships and go on to take responsibility for their own sexual health.

One area we should help men, young men and boys discuss is that of ‘performance anxiety’. There can put enormous pressure on men to live up to the supposed sexual ‘ideal’ offered. It is important that we challenge this, allowing men to ditch their anxiety about not being a ‘super-stud’ and to accept and appreciate themselves as they actually are. If we can make space for this, and give men the opportunity to explore and examine the pressures they are under, it may also help them to drop the sexual bravado and macho posturing which can so often alienate them from intimacy and
warmth in their relationships. Rather than going straight into a ‘problem’ approach though - we may find it much more acceptable and interesting for men if we come at this a different way. For example by starting with their idea of what being a good lover is and then addressing matters like taking responsibility for contraception, erectile dysfunction, condom use and homophobia in this context.

ACKNOWLEDGE THAT SOME MEN AND YOUNG MEN WILL HAVE SAME-SEX FEELINGS

When considering feelings and sexual relationships, we should be aware that some men and young men will have sexual feelings for other men, while not in any way consciously identifying as bisexual or gay. Don’t assume that the only men you deal with who will be having sex with other men will be ‘out’ and open about this. Sexual Health projects throughout the country now work with married men or men living in heterosexual relationships, who also have sex with other men - frequently without the knowledge of their female partner. Obviously this puts tremendous psychological pressure on these men who may either feel they are ‘living a lie’ or be in a complete or intermittent state of denial about this aspect of their lives. It also potentially puts the health of themselves and their partners at risk if they feel unable to negotiate condom use in either or both relationships - or fear that to keep condoms at home would risk discovery of the fact that they have sex with other men.

Those providing sexual health services and information can help by making it clear that any man who does not come out as gay may in fact be having sex with other men, as well as with women. Referring to ‘your partners’ for example shows that you are not making assumptions about gender and that you are open to discussing any relationships men are concerned about. Having leaflets or addresses on display too, for any local support groups for bisexuals or married men who have sex with other men also demonstrates our awareness of this possibility. And if such groups do not exist in your area and you perceive the need for one - what about trying to find some other colleagues who would be interested in starting such an initiative with you? For more on this area generally, - see Section on work with Gay and Bisexual men.

PUT DIFFICULT ISSUES SUCH AS RAPE ON THE AGENDA

Culturally, men can come under huge pressure to disclaim any problems about sex since this might clash with the necessity of being seen as cool and ‘sorted’. However, in addition to some of the fears already covered here, there are other difficult issues which men, young men and boys may be left to deal with alone if we fail to send out conscious signals that they are welcome to discuss them with us. These might include matters of rape, abuse and sexual assault. The numbers of men who have experienced and survived such experiences is probably far greater than we know - and the numbers of men who have perpetrated or colluded in these might also surprise us. So we should air these matters - and if there is a local Survivors group or similar support and self-help group for male survivors of rape and abuse, it will be essential to have details of this so men can be referred on to it. Equally, it may be helpful to make contact with a local Rape Crisis organisation or Victims Support group, to establish whether they can offer counselling, support or referral on to appropriate networks. Only by putting male rape or sexual assault on the agenda can we be part of removing the taboo on talking about or acknowledging it.

Other issues we may want to address with men are erectile dysfunction and loss of libido and desire. These may of course have physiological causes or be the side effects of medication but are often also linked to emotional matters. They may even be a response to the relentless pressure for men to be sexual - where the only sexual success is seen as erection and penetration. In such cases, it will be important for us to discuss with men the whole range of sexual activities and mutual pleasures. It will also be helpful if can enable them to discuss and explore notions of intimacy, closeness and emotional sharing between partners, to counteract the strong cultural messages about what a real man is and what constitutes real sex.
NEVER PUSH ANYONE INTO DOING ANYTHING
The pressure on men to be sexual and prove their manhood and virility can lead them to assume they have the right to press for sex or to manipulate someone into being sexual with them against their wishes. When coupled with the fact that many girls and women do not feel they have the same degree of power in a relationship as their male partner, this can result in boys and men taking advantage of a woman’s vulnerability or need or lack of confidence in saying ‘no’.

In all the work we do with men, young men and boys we should therefore reiterate the message that no-one has the right to push anyone into doing anything sexual which is not of their choice. Equally, they themselves should never feel they have to give anything which is not freely, willingly and happily given. In this way - and through some of those points made in the equivalent section on work with girls and women - we will play our part in ensuring that sexual coercion and pressure cease to be seen as acceptable ways of behaving.

ACKNOWLEDGE THE PRESSURES ON MEN, YOUNG MEN AND BOYS TO LOOK GOOD
Current research shows that 1 in 10 of people with Eating Disorders are male and of this number, approximately 20% are thought to be gay, telling us that this is a particular issue for gay young men. Although acute body-unhappiness is still primarily a female experience, the numbers of boys manifesting these conditions is increasing at a worrying rate.

Perhaps this is a result of media and advertising images of men with the perfect ‘six-pack’ and pecs. Or maybe it signifies a deeper malaise developing in men’s consciousness. Whatever the underlying causes, the effect and the increasing numbers of men, young men and boys affected in this way mean that in our work we should be talking about this. We should be undertaking self-esteem building programmes and helping boys and young men in particular to develop an awareness of media pressures on them to look and present in certain prescribed ways and a critique which will allow them to resist this.

WORK CLOSELY WITH THOSE WORKING WITH MEN, YOUNG MEN AND BOYS
We may want to reflect on how we could increase the direct involvement of men in doing the work of delivering sexual health promotion services, to send a direct message that this realistically involves men as well as women. We could also consult proactively with boys and men on what they want to support their sexual health, rather than assuming we already know or that it will be the same as for women and girls.

These will signal to us what our starting points should be and we can then build an approach which reflects men’s real concerns. In addition, to maximise the ‘reach’ of the ideas and practice in this Section, we should be building partnerships and making links with any agencies, organisations, departments and community groups whose clients and service users are primarily or predominantly men, young men and boys. In this way we can help our colleagues in these fields to become equipped, skilled, informed and confident in raising sexual health promotion. For example, these organisations we want to develop closer work with might include Probation, Youth Offending and Arrest referrals teams, sports clubs and male youth or community groups. They could be alcohol and drug abuse agencies, workplaces with mainly male work-forces or religious and faith groups in which men take leadership roles.

We can also offer such organisations training for their staff in sexual health work with men. In this way, as well as raising awareness and recruiting others to support these endeavours, we can develop skills in a range of agencies - and hopefully establish networks of support between those involved in this work in a wide range of settings. In addition, if we can ensure some of these colleagues we skill up and train in partner agencies are also men themselves, then we will be adding to the positive role models available. We will be providing men, young men and boys with images of men...
who take their own sexual health seriously - and that of the men they work with. So by using our imagination and ingenuity and building strong networks with ‘brother’ organisations, we can influence the lives and enhance the sexual health of men, young men and boys in many settings.
HAVE PUBLICITY AND INFORMATION MATERIALS AVAILABLE IN ANY RELEVANT COMMUNITY LANGUAGES

One of the most effective ways we can achieve the commitments in the NHS national plan related to reducing health inequalities and increasing access to services, is by ensuring that we reach those people currently not taking up services or whose access is limited. Many of these will be people from BME communities who are discounted either because they feel that sexual health services will not be appropriate and sensitive to their needs, or because they are not aware these services exist. Ensuring that services are well-publicised in the main community languages used in your area demonstrates your active commitment to services being available to all groups. Don’t rely solely on written materials to publicise services and support, as many people who speak a language cannot necessarily read it. Your local PCT can help you with information about local population groups and how to obtain such resources.

ENSURE THAT EFFECTIVE INTERPRETATION SERVICES ARE AVAILABLE

Before attracting people from BME communities we should ensure that effective interpretation services are available for those whose first language is not English.

Because of the particularly delicate nature of sexual health matters, translators and interpreters should be required to have training on sexual health and, in particular, on issues of confidentiality.

It may be undesirable for a family member acting as interpreter in a consultation where there may be highly sensitive and confidential things to be discussed - from general sexual health problems to abuse or marital rape, same-sex relationships or abortion.

There may also be gender issues to be considered. For many women from South Asian communities for example, to have a female interpreter and clinical staff may be essential for their relaxation and comfort. Again, speak to your PCT about access to interpreting services or to telephone interpreting services such as Language Line.

PROACTIVELY SEEK OUT POSITIVE IMAGES OF PEOPLE FROM BME COMMUNITIES

Consider whether all the images displayed in sexual health posters and leaflets portray a uniformly white, English (and often middle-class, able-bodied, heterosexual and youthful) society. If so, people may understandably make assumptions about the service’s awareness and sensitivity to their needs based on the evidence which is presented.

Any service or provision wishing to celebrate diversity and to reflect the multi-cultural society in which we live needs to proclaim this in positive and conscious ways. Many organisations produce resources of this kind – such as Terrence Higgins Trust, the NAZ Project, Brook Advisory Services and the Centre for HIV and Sexual Health. The Black Health Agency is a key source of resources advice, support and information on all these issues (See Section 5 on Organisations for contact details for these agencies). Make a point of seeking these out and displaying these resources – they will send a signal that you are committed to people from BME communities receiving the best possible services and support.

DO NOT COVER UP RATES OF SEXUAL HEALTH PROBLEMS IN PARTICULAR BME COMMUNITIES
Epidemiology tells us clearly that some sexual health problems proliferate in certain communities. For example each year there are many new HIV infections in gay and bisexual men and African Communities, and chlamydia rates are currently rising steeply among young heterosexual women. We also know from the evidence that in some areas STI rates such as gonorrhoea may be particularly prevalent among black Caribbean young men or HIV rates may be disproportionately high in some sub-Saharan African communities – from Kenya, Zimbabwe and Zambia, for example.

The context for this work is fraught with history and complexity, with racism abounding in interpretations and accounts of the HIV epidemic world-wide. It is no surprise then if many organisations and individuals are fearful that to address issues of race and ethnicity in relation to sexual health, STIs and HIV will risk stigmatising already oppressed groups still further. As a result, sometimes, we can all contribute to the silence in relation to this in the fear that to discuss these issues might be interpreted as racist. Even if well-meant, this position does not serve anyone’s needs well. Not addressing such issues, because of these anxieties is likely to result in people not receiving the information, resources, support and services which they have a right to and which they deserve. The most sensitive and effective way of working therefore involves close partnerships with BME community groups who are also concerned to develop sexual health work, together forging action which responds to community needs without colluding with blame, stigma or taboo.

DEVELOP AN INFORMED UNDERSTANDING OF THE CULTURAL DIFFERENCES BETWEEN DIFFERENT BME GROUPS

All those involved in providing sexual health services and support need an informed understanding of the cultural differences between different BME groups, rather than dealing with them as a homogenous, non-white mass.

This may require intelligent and committed fact-finding, making links with different community groups in the local area and consulting with them on what they perceive to be their needs in terms of sexual health. This consultation should not just be via one broker or set of community leaders. For example, the imams may have a very different perspective on such needs from young school-aged women, and very often designated community or faith leaders will be older and male. In fact they may not speak for other sub-groups within their community such as women, lesbians, bisexuals and gay men, or represent their interests positively.

HAVE A DIVERSE RANGE OF CONDOMS AVAILABLE

Obviously, it is important that sexual health services always have a range of condoms available – extra-strong, flavoured and polyurethane - according to the different needs of community members we are in contact with. In addition to these, Black condoms - together with Black condom demonstrators and latex models - may be more acceptable and preferable for some Black clients and service-users, although others may question the inappropriate colour of Black condoms since they in no way reflect the range of skin shades to be found among Black and Minority Ethnic groups. But for those who do prefer them, make sure these are readily available and that this is made clear and well-publicised. Again, this sends a strong signal that there is a consciousness of the needs of people from BME communities and a commitment to ensuring these are responded to.

PLACE SEXUAL HEALTH SERVICES WITHIN A BROADER HEALTH CONTEXT

There may be strong barriers and taboos about certain groups visibly accessing sexual health services. For example this may be especially true for women from some Asian and sub-Saharan African communities or gay and bisexual men within BME communities. In order to overcome these difficulties, it may be helpful to offer such services and support wherever possible under the umbrella of broader health and well-being services. In this way, by attending the service people do not label themselves as necessarily accessing the sexual health aspect of the clinic, surgery,
outreach project or community centre. It is this fear of labelling, of visibility that can so effectively disbar many women and gay men in particular from getting the support and information they need.

**RAISE ISSUES OF FEMALE GENITAL MUTILATION**

Female Genital Mutilation (FGM) – sometimes known as female circumcision – is illegal, unacceptable, and a violation of the human rights of the young girls (usually aged between four and ten) who suffer it. All procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs, whether for cultural or other non-therapeutic reasons, have been illegal in the UK since 1985.

Even so, in some BME communities, there are still high levels of community support for the practice of FGM. In these areas, colleagues in GUM Clinics, Family Planning Services or Primary Care settings often see examples of infection, psychosexual problems and continuing pain and trauma as a result of FGM having been carried out on girls and young women. If this is a factor in your local area, make contact with any local or national organisations (such as “Forward” – see national organisations list) which are struggling against this practice and which are leading in educating and informing communities to bring about positive cultural change in relation to FGM.

There are additional issues resulting from FGM which may need addressing with colleagues in other agencies. One example of these has been ensuring that teachers in schools where there may be young women who have been the subjects of FGM (for example because they come from particular ethnic communities in which this is still practised) realise the potential consequences. So, do they allow for the fact that girls going to the toilet will need to be given adequate time for this, because urinating takes longer when there are blocks to the urethra? We should all be aware, informed of this issue and prepared to address it. We should also ensure that staff members who encounter the results of FGM and are exposed to the trauma and continuing pain of women get support in processing the strong and upsetting feelings this can cause them.

**DO YOUR LOCAL HIV SERVICES AND HIV PREVENTION INITIATIVES SUPPORT THE NEEDS OF PEOPLE FROM SUB-SAHARAN AFRICAN COMMUNITIES?**

Every year, there are new cases of HIV in refugee and other communities, particularly those from Sub-Saharan Africa. At a local level, this requires active responses in terms of adequate HIV and AIDS treatment and care. But it also means that HIV prevention initiatives and education with these communities should be a priority. So the relevant organisations should ask “Are local HIV support services geared predominantly to the needs of gay and bisexual men, or of drug users?” And if so, what could be done to address and change this?

It is often noted that people from Sub-Saharan African communities present late with HIV – and often not until they are ill and symptomatic. This means that getting early access to new therapy regimes is impossible, which in turn is likely to have a very negative impact on their health. It may be appropriate, therefore, to work with community groups to target awareness and information campaigns within these communities. These could, for example, focus on the benefits of early testing, giving information about guaranteed levels of confidentiality and about how to access testing services. Or work could also be done addressing the taboos in the community against discussing HIV, and the resulting ostracism that some people have experienced if known to be HIV positive. In this way we can help to combat some of the prejudice about this, and the misery and isolation that this can cause.

**MAKE STRONG LINKS WITH OTHER LOCAL BME GROUPS**
In order to be effective in this work we should have many friends, allies and ‘brokers for sexual health’ within different BME communities. These immensely helpful networks of shared support and joint work can be developed by consulting with Community projects – such as Black Caribbean Youth Centres, Yemeni Community Centres and Asian Women’s refuges. These links will allow sexual health workers and sexual health promotion specialists to offer training, support, resources and services to workers in these projects. This means that sexual health matters can be addressed by people within their own communities who feel skilled, confident, informed and well-prepared to do this.

One way of building capacity in terms of sexual health promotion and HIV prevention activities at a community level is to train up a group of peer educators (sometimes called community educators or lay educators) within the community itself. These people can then play a key role and be the best advocates of positive sexual health. If you are doing this, perhaps by running a ‘Training for Trainers’ course within the community, remember to offer ongoing support, advice and information to the trainers’ group. Their role in offering this service may generate anger or backlash from some community members. So in order for them not to feel isolated or vulnerable because of their advocacy of sexual health issues, they should feel part of an active and continuing support network.

Another way of developing links with key communities is to establish a local BME sexual health forum that includes representatives from community organisations (see the Enfield and Haringey case study for an example of this). Such a forum can discuss issues of common concern, develop a local strategy for sexual health work with BME communities and share good practice. It can also set up training opportunities to meet any staff needs for greater understanding, information and awareness which have been identified.
In recognition of the specific needs of African communities, over and above the points made in the section on work with BME communities in general, there are the following additional suggestions:

**NEEDS ASSESSMENT AS THE FIRST ESSENTIAL STEP**
To offer the best and most appropriate services, there should be an understanding of communities’ particular needs. Carrying out a local needs assessment allows important data to be gathered - such as the countries people come from, the languages they speak and their religious and cultural backgrounds, as well as more formal demographic and epidemiological information. Your Local Authority or PCT will be able to help with this information. Remember, though that in some cases community numbers can be underestimates as some people - particularly refugees and asylum seekers - may be reluctant to register for statutory services. Build on this information by setting up consultation processes asking community members directly what they want from HIV prevention and sexual health services, how they would like this delivered and who by. Such partnership working in some areas has been further formalised into establishing African community forums, also involving professional staff from agencies working with people from these communities (see Section on BME communities).

**BE ESPECIALLY REASSURING ABOUT CONFIDENTIALITY**
In many African communities - as in other communities, too - sex and sexuality are considered deeply private matters. So it is especially important to be sensitive about discussing these issues, offering a choice in terms of the gender of staff member seen, for example. Reassuring people about confidentiality will also be crucial as they may have anxieties about this in terms of their family and social networks, and also in relation to employers and other statutory services. If people are HIV positive they may have major concerns about disclosure of their status. To encourage people to use services, being clear and specific in any publicity materials about the levels of confidentiality they can expect is often a critical factor.

**ADDRESS ANY DIFFICULTIES RAISED BY LANGUAGE ISSUES**
For people to receive information and sexual health promotion messages in ways they can hear and put into practice, they should feel comfortable with the language used and understand it. This means that those offering services should be sensitive about negotiating what language will be acceptable and accessible to their service users. This situation can pose particular challenges - for example in Ugandan communities there is no acceptable word for ‘vagina’ - and these in turn call for imaginative and thoughtful responses. Often interpreters are used by services - but it is vital that when they are working in sexual health services they have received specific sexual health training before taking on this role. This is to let them have the opportunity to address any concerns or embarrassment they may have themselves about discussing these issues, and also to ensure they understand the particularly crucial role of confidentiality in this area of work. Given that in some small African communities, interpreters may already be known to service users, clarity that their responsibility for confidentiality is to the client is very important.

**NEW WAYS OF DOING THE WORK**
To reach new communities of people, sometimes we will have to use entirely new methods for our work, ones which are more in line with the culture of the community we want to work with. For members of African communities, using songs and story-telling, dance and poetry can be acceptable ways of communicating messages about potentially taboo
subjects such as sex and sexuality, HIV and condom-use. This might even set precedents for more innovative and creative approaches with non-African communities too, for whom these methods might in fact be more effective than the usual lecturing or literature based ones.

It is also important that the staff of services reflect the local population. If you have large numbers of a particular group in your area, make sure your staff recruitment programme targets these communities.

**REACHING OUT**

In the same way as finding more effective methods for communicating sexual health promotion and HIV messages, we should also take these messages to places which are used by members of African communities, rather than assuming they will necessarily access through the customary routes. For example we can reach out to social and cultural networks via African shops, barbers and hairdressers, churches and mosques and through African cultural, social and welfare organisations if they exist locally. Or we can use African media channels such as press, newsletters, community TV stations or radio stations, arranging coverage through the mechanisms of interviews, news items or advertisements.

Some organisations also use the ‘gossip networks’ which exist within close communities as an effective way of getting word out. Get to know who the key people in the community are who can tap into these informal networks for spreading news and ideas. If you can gain their co-operation and work in partnership with them, this can be invaluable in achieving coverage and credibility within communities.

**DEVELOP MATERIALS WITH POSITIVE IMAGES**

Written materials may not always be the most appropriate tools for sexual health promotion purposes. Explore the possibility of producing different kinds of materials. For example tapes (in which case make sure they are in the range of appropriate languages for the communities you are wanting to reach, such as French, Portuguese and Arabic which are often understood by Africans from specific countries, or in community languages). Or produce posters displaying positive images of African people, again ensuring that by their appearance and their clothes these are people who the communities you want to communicate with will recognise and identify with. Do this by testing these images with community members before finalising your drafts. Videos are a third way of communicating - and of course leaflets and credit cards may be also be appropriate providing they reflect positive images and use appropriate languages and terminology.

Once you have these resources, make sure they are distributed and displayed in places which may be used by your target groups. Certainly in waiting rooms and leaflet racks of services, but also in the community where they may easily be seen by people who would never otherwise cross the threshold of a service or clinic.

**PSYCHOSEXUAL ISSUES WILL BE IMPORTANT TOO**

Many members of certain African refugee and asylum-seeking communities - as well as other refugees, for example from Bosnia or Serbia - may have come from the experience of traumas such as rape, torture or war. In these cases, psychosexual services should be engaged in supporting individuals and families where necessary and should make themselves known to communities in terms of what they can offer. Some of these experiences may not only result in severe trauma for the survivors, but also may be accompanied by stigma or result in them being ostracised by a community response which ‘blames the victim’. In these cases, the role of sexual health promotion workers and other sexual health staff could also be sensitively to offer support to those in the community who are trying to change some of these punitive and judgmental cultural norms.
BE AWARE OF THE PLACE OF RELIGION AND TABOO
As in many societies, religion can play a powerful role in matters of sex and sexual health in African communities. While on the one hand it may be a source of comfort and strength, it may also give rise to religious beliefs such as a prevalent one which equates illness with punishment - which in turn adds an extra stigma to an HIV or STI diagnosis. Or there may be religious injunctions on taking medication, believing instead in the power of prayer alone to heal. In some communities, use of traditional medicine may be found and in others religious rituals such as fasting may adversely affect therapy regimes. So, as part of the needs assessment described at the beginning of this section. Make sure you establish what religious beliefs and taboos may be found in the communities in which you are working which may impact on sexual health work. While treating these issues with respect and care, it is important to consider ways to work alongside them which ensures that the health needs of individuals and groups within the community are not sacrificed or overlooked.

GIVE POSITIVE MESSAGES ABOUT CONDOM USE
In some communities the issue of condoms - and indeed of contraception - may be contentious because of negative religious and cultural attitudes towards them. Condoms may be rejected by men who are reluctant to use them because they assume their sense of masculinity would be threatened by doing so. For men in communities who already feel vulnerable or under threat, the fear of further loss of power if they use condoms may seem to them unacceptable. However understandable this attitude may be, it increases sexual health risks. So part of the role of health promoters in terms of reducing sexual health inequalities will be to support women and women’s groups within communities to gain the information, skills and sense of rights which will empower them to take more control over their own sexual health choices and freedoms. Any culturally-acceptable means of positively promoting condom use will therefore be vital in promoting the sexual health of the whole community.

SEXUAL HEALTH IN AFRICAN COMMUNITIES IS ABOUT MORE THAN JUST HIV
While HIV in African communities is clearly a cause for major concern, this should not be seen as the only aspect of sexual health relevant for African people. For example, access to a range of contraception choices within their own control is the right of African women as much as to any other woman in the UK. In some communities FGM continues to be culturally acceptable and even required, even though it is illegal. Part of the role of staff involved in health promotion can then be supporting the struggles and educational endeavours of those within these communities advocating positive cultural change which will result in this practice losing its social acceptability and currency. Issues of sexuality also need recognition within African communities - and sources of support for those in same gender relationships (although they may not self-identify as lesbian, gay or bisexual) should be available. The right of all young people to Sex and Relationships Education is also an issue which needs addressing. This can probably best be achieved by working with parents groups to answer their questions about this, to allay any anxieties they have and to enable them to see such education as protective rather than pressurising.
SECTION THREE
PART ELEVEN - 10 PRACTICAL TIPS FOR WORKING WITH PEOPLE IN PRISONS OR IN THE CRIMINAL JUSTICE SYSTEM

ADDRESS ISSUES OF SELF-ESTEEM
Large numbers of those who are in prison or in the broader criminal justice system suffer from terribly low levels of self-esteem and the high rates of self-harm. Whether low self-esteem stems from poor parenting and education, from the experience of abuse and violence, from social and financial deprivation or from the experience of custody itself, it is likely to result in self-destructive behaviours as well as ones which are harmful to others.

The links between sexual health, emotional well being and self-esteem are familiar and positive interventions which are developed to raise people’s self-esteem will impact favourably on their sexual health.

The argument can be made that such initiatives may also affect future offending rates. For example a Gardening and Tree Planting Scheme was established for women prisoners in San Francisco County Jail to help them re-connect with the good, able aspects of themselves, those parts that were positive and nurturing. The statistics speak for the effect on the prisoners’ self-esteem, the result of putting women in touch with their own abilities and giving them back a sense of self-respect from being involved in such a productive venture. For those working on these gardening and tree projects, there was a marked reduction in recidivism. Research showed that four months after release, the general re-arrest rate for prisoners was 29% - but it was a startling 6% for garden project participants. Within two years, the rates were 55% and 24% respectively.

So self-esteem building projects, of whatever kind, can have a whole range of positive effects. However, even without specialist projects such as these, simple things can be done in everyday practice to bolster self-esteem - such as treating those in custody as human beings with hopes and dreams and believing in them as people. All of these things will generate a sense of value and self-worth, which will in turn strengthen people’s sexual health.

LINK WITH LOCAL SEXUAL HEALTH AND HIV SERVICES
If you work with people in the criminal justice system have a well-developed information base of sources of sexual health support available locally. You can get invaluable information and contacts by linking with these - for example services such as GU clinics, Family Planning Clinics, Primary Care Practices and Walk In Centres which offer free condoms or emergency contraception – and establishing what help they can offer. When working with people who are in the criminal justice system but living within the community, this will be crucial information to give them - offered for example in the form of a small, easy to read directory of services and posters displayed in appropriate places. Some prison settings have successfully made links with sexual health services who provide outreach services. For those people in custody, information can also be disseminated through media such as prison newsletters.

Think about the potentially vulnerable and volatile times for people in relation to sex and sexual activity. For example, anecdotal evidence from young men in Young Offender Institutions shows that they frequently report binge drinking and sexual activity - mostly unsafe, unprotected sex - when they are anticipating being sentenced. Obviously the time immediately after release is another equally vulnerable stage where opportunities for sex may be seen as more important than healthy choices and decisions. Again, working with local services helps you gain the support and understanding to ensure that people are prepared in advance whenever possible with the information, skills and resources to face such times in ways which are least likely to be damaging to their sexual health.
In all of this a useful starting point is making contact with your local sexual health promotion or HIV prevention initiatives - which can usually be contacted through your Primary Care Trust. They should have detailed information about what is available in the locality and any related specialist services that are also available - for example psychosexual provision, counselling for people who have been raped or abused and self-help networks for people who have hepatitis or are HIV positive. Some sexual health projects have even successfully organised sexual health awareness days in prison, with a range of stalls offering information on different issues and services.

**PUT SEXUAL HEALTH IN HEALTH NEEDS ASSESSMENTS**

There are high rates of STIs among women prisoners and of fatherhood amongst young men in Young Offenders Institutions, along with reported levels of sexual abuse and exploitation. This shows that we cannot ignore the sexual health support, advice, information and treatment needs of those in custodial settings and others who are under the auspices of the broader criminal justice system.

If sexual health and HIV prevention are to be prioritised in prison health issues, these should be acknowledged in the local Prison Health Improvement Plan. Including questions about the sexual health of prisoners in the Health Needs Assessment which shapes the eventual Plan - along with practical strategies for supporting this - will ensure that this aspect of health does not get overlooked when drawing up action strategies to improve prisoner health.

**MAKE CONDOMS AVAILABLE WHERE POSSIBLE**

It is Prison Service policy that prison doctors should prescribe condoms and water-based lubricants on application, if in their clinical judgement there is a known risk of HIV infection. This in turn has the potential to have a very positive impact on the sexual health of prisoners’ partners and the broader public health. Clearly, in such instances it will be important to ensure that extra strong condoms - and, if possible lubricant too - are available. In some women’s prisons, dental dams can be accessed on request. The Prison Service has issued written advice to prison doctors about how its policy on condoms should be implemented in practice.

Think about the possibility of making condoms available on release from prison or for home leave as well as ensuring that people still living in the community - under supervision orders, on bail or on probation perhaps - have supplies of condoms available. It may be that your local HIV prevention monies, Teenage Pregnancy budget or Primary Care Trust can support such provision. Or, if no such funding is available, you could investigate the possibility of staff from your GU clinic, Family Planning or Youth Clinic offering you an outreach session where they bring clinics to a bail hostel or Probation Office, for example. At the very least, you should establish the sources of free condoms which exist locally, make sure your clients know about these and are encouraged to take advantage of them.

Just providing condoms is not enough, however. It will also be important for people to gain the information and skills to use them effectively. Having condom demonstrators available, getting skilled at using these and comfortable about supporting your clients in gaining effective condom-use skills will also be vital. You may be able to get stocks of free leaflets about using condoms successfully from your local sexual health promotion or HIV prevention team, which can also offer you further advice on this. See Section on promoting the effective use of condoms for more information and ideas.

**SUPPORT HARM REDUCTION IN INJECTING DRUG USE**

Issues of sexual health and injecting drug use are clearly inextricably entwined. This is specifically in relation to the transmission of HIV and Hepatitis, but there are also issues for people selling sex to finance a drugs habit or
exchanging sex for drugs. (See the sections on working with commercial sex workers and with IV drug users for more on this). All of these issues will be crucial when addressing sexual health promotion with clients in the criminal justice system, whether in custodial or non-custodial settings.

In custodial settings, consider what harm reduction arrangements are appropriate and possible. At the very least, information and education should be provided on the risks of sharing ‘works’ and how to avoid these. In community based settings, make links with local needle and syringe exchange schemes and ensure clients have information about how to access these – as well as offering the kind of information on safety and risk-avoidance referred to in the first paragraph of this section. In addition, because of the high levels of drug use among people entering prison, Hepatitis immunisation programmes should be encouraged and support groups established for people with Hepatitis wherever possible. From an infection control perspective, along with information about not sharing needles for injecting, advice should be given on prisoners using their own toothbrush, razor and clippers and on the dangers of ‘home-made’ tattooing kits.

**INCLUDE SEX AND RELATIONSHIP SKILLS IN LIFE AND SOCIAL SKILLS PROGRAMMES**
The Prison Service already has a well-developed Life and Social Skills Programme and the Open College network accredits the Life and Social Skills modules of this. One sure way of promoting the positive sexual health of prisoners and others in the criminal justice system is by addressing sex and relationships skills via this route. This is already well under way in Young Offenders’ Institutes, since Action Point 21 of the Teenage Pregnancy Strategy specified that the Prison Service should ensure Sex and Relationships Education and parenting skills should be offered in all YOIs.

The curriculum laid out in the document “A package of three Sex and Relationships Education resources for working with young people in Young Offender Institutions based around an Open College Network Accreditation”: Blake, S (ed) (2001) and “If it teaches me something that protects me - Positive Guidance on SRE Activities Handbook Student Portfolio”, the workbook accompanying these (available from the DfES or by e-mailing the Sex Education Forum, see Resources section below) lay out a comprehensive framework for such courses. It is based in a model of both rights and responsibilities in relation to relationships and sexual health and aimed at developing awareness, knowledge and practical skills such as decision making, negotiation and assertiveness. These are approaches familiar to those engaged in sexual health promotion, and the input of specialist practitioners in setting up and running such courses will prove invaluable.

All of this material is relevant to the needs of those in the adult system too - most of whom will have failed to get satisfactory Sex and Relationships Education while at school themselves. It is never too late to have education, information and support about sex and relationships. Addressing this sensitive issue with adults in the criminal justice system is offering them a vital opportunity to change old patterns, to review their risk behaviours and to take more positive control over their sexual health.

**ADDRESS PARENTING SKILLS AND ISSUES**
Many of those in the criminal justice system will not have had the best of parenting (many of them will have grown up in care or had intermittent experience of this) and they may in turn struggle with parenting their own children. To break this frequent cycle of deprivation and negative experiences, robust and sustained work approaches should be taken. There are excellent models of these from work which has already been developed. For example the Trust for the Study of Adolescence has carried out an evaluation of Parenting Education programmes in YOIs which gives us insights into some of the good practice which is around.
At Deerbolt YOI, parenting classes are well-developed having been running since 1984. Within this programme, issues such as responsibility, attitudes, relationships and masculinity are addressed as well as childcare and all its related areas. Research has shown how effective the Deerbolt approach is in changing both levels of knowledge and attitudes to parenting and fatherhood as well as increasing information about contraception and STIs, which are also issues covered during this course.

Expertise should be available locally to support the development and delivery of such courses. From SureStart and SureStart Plus programmes, or voluntary organisations such as Home Start or Parentline to Health Visitors or Community Midwives based within the NHS, there should be help available. It is important too that parenting skills training is not only seen to be about young offenders - there are many adults in prison or on probation, for example, who may welcome the opportunity to do such training. Large numbers of men lose contact with their children when in prison and many women prisoners will have the traumatic experience of having their children taken into the public care system. So think about parenting classes and skills training for all.

FIND OUT ABOUT MODELS OF BEST PRACTICE

There are already instances of excellent and innovative practice to be found in custodial settings. For example HMP Holloway have involved relevant voluntary agencies such as Blackliners and Positive Women in their sexual health work and have also pioneered the provision of HIV post-exposure prophylaxis to prison staff. In East Surrey an advice and referral system for men who have sex with men in custodial settings was established - accessible to men who do not identify themselves as gay or bisexual as well as to those who do.

Many group-work and training programmes - for prisoners and staff - have been set up. In the past these have included a 5-day course for Lifers at HMP Wormwood Scrubs using drama to look at HIV issues and challenging racism and bullying - including sexual bullying. Some of those who completed this course then went on to train as peer educators. Training courses for prison staff often cover factual matters such as HIV, other STIs and Hepatitis and their transmission. They also cover attitudinal training, for example on sexuality, homophobia and skill-based work such as building relationships and negotiation skills. All of these instances offer starting points for thinking about what would be possible and suitable in a range of different custodial situations. For more details of such programmes, see the NHPIS Resource Guide on HIV Sexual Health Promotion in prisons.

MAKE CONTRACEPTION SERVICES AVAILABLE PRE-RELEASE

If you are working with or in a women’s prison, explore the possibility of making contraception provision on offer to prisoners before their release. Making the move from a custodial setting back into the community can be a sensitive time - full of expectations and often disappointments. Anything which can be done, therefore, to ensure that women (and their partners) stay as protected as possible during this stage will positively support their sexual health. Referring back to the first point in this Section covering outreach sexual health services, there are great benefits in liaising with a sympathetic local Primary Care Practice or Family Planning clinic who could to provide such a service for women before the transition period of release. As well as offering contraception and information about local community-based services, condoms could also be provided so that STI and HIV issues are also addressed. Prisoners leaving packs could also include information on sexual health services and condoms.

ACCESS TRAINING FOR STAFF

Staff training is equally important for those working in the criminal justice systems. Feeling comfortable with issues of sex and sexuality is key to playing a successful part in supporting the sexual health of this vulnerable group, whose needs in relation to sexual health may not have been met in the past. Finding good support for staff and prioritising
some initial training on these matters will be important if the work is to move forward. Probably the first point of helpful contact in relation to this will be local sexual health promotion staff based in your PCT. They should be able to offer training to staff working for example in the prison, probation or youth justice service to enable them to gain the skills, understanding and confidence to run Sex and Relationships Education programmes with their client groups. Even staff and institutions who are not planning to take on a formal role in relation to this, can through training be enabled to feel more open and relaxed about the part they can play in preparing their client group to make more positive, healthy and safer sexual choices in the future.

Further Reading: A Resource Guide to HIV Sexual Health Promotion in Prisons - Produced by the National HIV Prevention Information Service, Health Development Agency.
SECTION THREE
PART TWELVE - 10 PRACTICAL TIPS FOR WORK WITH INJECTING DRUG USERS

TAKE A MULTI-FACETED APPROACH
To be effective in sexual health promotion and HIV prevention with people who inject drugs, our work should be multi-faceted and encompass:

- education and information about drug use, about the risks of sharing works, about harm reduction approaches and safer sex and sexual health risks
- distributing clean needles, syringes, condoms and lubricant via community outreach programmes and/or making these available via needle and syringe exchange schemes or sexual health services
- outreach work with both women and men involved in formal or informal commercial sex work. As well as outreach by community-based workers (such as youth workers and Connexions Personal Advisers), this should also include work by sexual health services (such as Health Advisers and Family Planning workers). They should offer both direct services where possible (e.g. pregnancy testing, and referrals to termination services) and referrals and links back to clinics.

AND A MULTI-AGENCY APPROACH WILL BE ESSENTIAL TOO.
The best sexual health promotion practice always links up with as many other agencies and colleagues as possible. The more we are in touch with other organisations, particularly those which work with different target groups and communities, the more we can ensure we reach groups we may have previously considered 'hard to reach'. Equally, we can ensure that they all act as advocates and publicists for our work and services. Sexual health service providers and those with sexual health promotion roles should, therefore, work closely with:

- Drugs agencies, drugs education projects, drug rehabilitation units and their local Drug Action Team to ensure sexual health issues are addressed at all these levels
- Primary Care teams who offer specific services to IV drug users
- Housing and homelessness agencies and projects, night-shelters and hostels
- Prisons and Young Offenders’ Institutions, Bail and Probation Hostels and Youth Offending Teams
- Mental Health services, CPNs, Child and Adolescent Mental Health services, SORT teams and assertive outreach projects
- Police, magistrates courts and Arrest Referral Teams
- Social Services, Early Years services, SureStart, Connexions and Child Protection Action Teams/Liaison Groups

In some areas joint Drugs and Sexual Health action groups have been established. These meet a few times a year, developing a shared agenda and planning activities such the production of local Sexual Health/Drugs Directories of Services or running ‘Information Fairs’ where drugs organisations can discover about local sexual health initiatives and vice versa. In this way gaps in services and needs for further work can be flagged up and funding sought to develop responses.

TRAINING EXCHANGES FOR DRUGS WORKERS AND FOR SEXUAL HEALTH STAFF
Workers in the drugs field should be aware, informed, skilled and confident to address sexual health issues with clients and service-users. This means having the opportunity to reflect on their sexual values, beliefs and attitudes as well as gaining accurate information about issues relating to sexual health, Hepatitis and HIV prevention.
Equally, sexual health service staff should be trained in how to work effectively with drug users, recognising the interplay between drug-use and sexual risk-taking. Often the most urgent priorities in the lives of people injecting drugs may be to do with homelessness or poverty, the need for food, a bath and a safe bed rather than sexual health. Until these basic needs have been met, staff should realise that raising sexual health issues may be ineffective. This demonstrates the need for joint approaches with drugs agencies who will be familiar with responding to these concerns in their client group. The sort of multi-agency approach referred to earlier, can also provide an excellent starting point for jointly identifying training needs and ways of responding to these. Training could be offered on a reciprocal basis - by specialist drugs trainers for sexual health and HIV prevention workers, and by sexual health and HIV prevention trainers for drugs workers. In this way, everybody gains.

In working together we will probably also start to identify joint training needs – for example on the links between alcohol use and sexual health, or on rape and sexual assault – which could provide the topic for a multi-agency training event. These shared experiences invariably develop and enhance working relationships as well as increasing knowledge and understanding of each others’ working practices and perspectives.

**REMEMBER SEXUAL HEALTH SERVICE USERS MAY ALSO BE INJECTING DRUG USERS**

Sometimes we assume we will automatically know when someone is an injecting drug user, and that we will only access these people via drugs projects and services. This will not always be the case and we should be aware that sexual health service-users may also inject drugs. We should ensure the necessary support is available in our sexual health services - for example in the form of information about safer injecting or about local drugs services. The staff training programmes on drugs awareness for sexual health service staff referred to in the previous point will ensure that we are all well-prepared for this role.

**PROVIDE FREE CONDOMS WHERE POSSIBLE**

In some areas Drug Action Teams have provided funding for sexual health promotion services to buy condoms in bulk for distribution to injecting drug users. Supplies of these are then offered to drugs workers and agencies, but with two vital provisos. The first is that staff from these agencies agree to attend sexual health training so they have the confidence, understanding and skills to discuss sexual health matters with their clients and service users. The second is that they are asked to complete recordings and informal evaluation sheets about the distribution of these resources. Only when they have demonstrated that they have fulfilled these two conditions can they then receive further condom supplies so that we are ensuring quality in practice.

Small credit cards advertising local sexual health services, GUM, Family Planning and Youth Clinics have also been produced as part of these schemes. Drugs workers can give these out to their clients to ensure people who inject are aware of the services they are entitled to access and the benefits of doing so. This has proved a very effective approach in ‘outreaching’ sexual health and could be built on further – for example by adding pregnancy testing kits to the resources available for distribution.

**SAFE NEEDLE DISPOSAL**

The safe and responsible disposal of needles will reduce the risk of accidental transmission of Hepatitis and HIV. People who inject drugs should therefore be offered guidance and support on safe ways of getting rid of their needles so that these do not present a public health risk. If they are not able to use a sharps bin or box specifically designed for this purpose, techniques for safe disposal can include putting the needle in an empty coke can and crumpling it up to
preventing the needle protruding. Safer sex information materials produced for injecting drug users could maximise their effectiveness in terms of sexual health and HIV and Hepatitis prevention by making reference to this issue.

REMEMBER GYMS AND STEROID USERS – IT’S THE NEEDLE NOT THE DRUG THAT COUNTS
There are many people who share needles and syringes for injecting steroids - for example in body-building gyms - but would never identify themselves as ‘drug-users’. Even though the risk of infection is just as great for them, they might discount themselves from safer injecting or HIV and Hepatitis information and education campaigns. It is important therefore that in their outreach and information-dissemination programmes sexual health promotion, HIV prevention and drugs workers make contact with users of gyms where needle-sharing may be happening.

SAFER INJECTING INFORMATION NEEDS:
Many people who inject drugs are not only at risk of HIV infection and Hepatitis from unprotected sex, they can also contract both of these from unsafe injecting and sharing ‘works’. Information therefore needs to be readily available about harm minimisation in their injecting practice. For example the importance of not sharing needles, or if there is no alternative to this then thoroughly cleaning works between injectors by using cleaning tablets. However it is important to let people know that no method of cleaning needles, syringes or drug injecting equipment can completely guarantee non-infection with HIV or Hepatitis. People also need information about accessing needles and syringes e.g. via local exchange schemes – which should now all be offering condoms, lubricant and sexual health information and support alongside free needles and syringes.

There are other safety issues in working with this group, too. Many drug users, whether or not they inject, may additionally be at risk of rape or sexual assault if they are involved in commercial sex as a way of providing an income to feed a drugs habit. So sexual health promotion and HIV Prevention work with these groups and individuals should also therefore consider addressing issues such as personal safety and self-defence as part of supporting broader health and well-being.

TALK ABOUT HEPATITIS
Contracting Hepatitis is a clear risk for people who are injecting and therefore part of the role of sexual health promotion is encouraging people to get vaccinated. GU clinics and most GPs offer a combined vaccination for Hep A and B although currently there is no vaccine for Hep C. While actively encouraging uptake of this service, it is important to remember that it is not always effective and some people will never build up resistance, so other protection methods should also be taken. All staff who might be working in a community or clinical setting with people - such as those injecting drugs - who may have Hepatitis should also have the vaccination. We should be offering information, advice and support on being tested for Hepatitis, since the sooner people know their status the earlier they can start treatment, giving a better long-term prognosis. Also this has the further benefit of alerting people to the dangers of transmitting the virus to others and how to prevent this.

REMEMBER WIDER SEXUAL HEALTH NEEDS TOO
Because we are understandably very focused on HIV and Hepatitis prevention as high priorities when working with people who inject, we should also bear in mind that they may have other sexual health needs. Encourage discussion about sexual choices and contraception, about the right to sexual pleasure and to say ‘no’, about risk taking behaviours – for example when under the influence of drugs – and psychosexual issues. Discuss the effects of drug taking and of going through rehabilitation and detox processes on sexual libido and performance. All of these may be factors in the wider sexual health of drug injectors, so we will best serve their needs if we take this broader and more holistic approach, rather than equating drug injecting simply with the risk of HIV and Hepatitis.
SECTION THREE
PART THIRTEEN - 10 PRACTICAL TIPS FOR WORKING WITH PEOPLE WITH HIV

KEEP UP TO DATE WITH NEW DEVELOPMENTS
The world of HIV treatment, care and the associated therapy regimes is ever-changing. Enabling the people we work with who have HIV to keep up with these developments will be important in terms of them feeling they have greater control over their lives, choices and futures. This can be done by helping them to access new research via the Internet, for example or by subscribing to newsletters and research briefings which provide coverage of new knowledge and emerging understandings. All of this, together with inviting in specialists and speakers who can talk about issues and answer questions in accessible, intelligible ways can alleviate anxieties and reduce a sense of powerlessness.

SET UP SUPPORT NETWORKS
The benefits of sharing emotional or medical problems are enormous - from swapping practical ways of managing a condition to exploring together the impact of living with a life-changing diagnosis. This strong emotional and psychological need to come together is often best served by establishing local support groups and networks. In doing so it may be appropriate to think of the kind of sub-groups who share a particular experience and perspective and setting up groups for women or for gay men, for people from African or refugee communities, for parents or for people who inject drugs, for instance. Having said this, sometimes powerful, supportive relationships and alliances can also be made across these perceived boundaries too, transcending supposed differences and uniting in sharing a particular experience.

Some groups have taken information-gathering as their focus, some promoting their own well-being, others have explored arts approaches and self-expression such as writing or painting and many will have tried all of these and more. These can all play a role in reducing social and psychological fears and feelings of isolation. Often such support groups are city or town-based but it is important, too, to respond to the needs of people who may experience the compounded isolation of having HIV and living in a rural area. This could be done perhaps by arranging meetings in the most central town or village, or by setting up Internet groups which can be shared by people from remote areas.

Remember, too, that working with such a group calls for skills in group dynamics and facilitation. See Section on working with groups for more on this

ADDRESS STIGMA ISSUES
Reports of rejection and the reality of discrimination related to HIV continue even though we are 20 years into the epidemic. Anecdotal evidence confirms that people still face the effects of HIV-related stigma both within their communities and also from some services. For example, stories persist about people with HIV experiencing problems in accessing non-judgmental sexual health services. To address this within services it will be necessary to provide good programmes of staff training aimed at raising awareness and offering guidance for best practice. This may be done within the NHS, for example with Primary Care practices and GUM or Family Planning services or for other services such as housing, benefits agencies, colleges and schools.

Sometimes it seems as though HIV has fallen off the agenda of anyone but those directly involved in working in this field and if we are not to lose some of the ground gained in the 1990’s, the necessity of providing ongoing professional training and support is clear. Parallel awareness-raising is important within those communities most affected by HIV and with the wider public. This should aim to counter prevailing myths and replace misconceptions with real understanding and accurate information, and written resources can be used to supplement this by providing clear facts.
We know that stigma and prejudice is fuelled by ignorance and fear - so the best way to diminish this will be by reducing these within our communities and among our service providers.

**BUILD STRONG LINKS BETWEEN TREATMENT AND PREVENTION SERVICES**

The stronger the links between those services providing HIV testing and treatment, health and social care for people with HIV and those whose role is HIV prevention and sexual health promotion, the better it will be for everybody. This will involve joint working wherever this is possible, so explore all possible avenues for this. Inter-agency and multi-disciplinary approaches will always be beneficial and can be achieved by developing joint outreach programmes, setting up shared training and establishing multi-agency projects and initiatives. Such approaches enable agencies to agree who should take the lead role and responsibility for which areas of work, so avoiding duplication and ensuring we can respond to any gaps in education and service provision which are identified.

**REMEMBER PEOPLE WITH HIV ARE NOT A HOMOGENEOUS GROUP**

People with HIV do not become a homogenous group just because of a medical diagnosis. Being sensitive to the particular cultural and social norms of the group which someone with HIV comes from and seeing them first and foremost as a person from that group is essential, rather than perceiving them as the bearer of a medical label. So, as with the support group approaches outlined above, make sure you sub-target sexual health promotion accordingly taking into account the particular needs and concerns of certain groups, along with any constraints and anxieties which may be part of living in their specific culture and community.

**ENCOURAGE GOOD EMOTIONAL HEALTH AND WELL-BEING**

People with HIV often experience extremely negative reactions to their diagnosis in terms of self-image and particularly their body image. Low self-worth and self-hatred, depression and even suicidal feelings are not uncommon. To counteract these strong negative emotions, it helps to offer a range of activities which can feed a more positive sense of self and can provide pleasurable, self-nurturing experiences. Think about making sessions available on relaxation or meditation, on complementary therapies such as aromatherapy for example. You could offer some local training for practitioners on ways of working sensitively and effectively with people with HIV. Group-work and individual work on self-esteem building can also help with self-acceptance - alongside the space to explore difficulties with body image, and other health matters relating to good nutrition and self-care.

**DISCUSS DISCLOSURE ISSUES**

The issue of if, when and how to disclose their HIV status is an understandable preoccupation for many people with HIV. This will apply in a whole range of life settings and is a decision they will have to make time and time again as there is no one definitive point of ‘coming out’ about having HIV, it is a perpetually unfolding process. People may have particular concerns about disclosure to different groups - about having to ‘look after’ friends and families who may suffer strong reactions on hearing the news; about facing discrimination or enduring gossip in work settings; about being at the receiving end of rejection or even violence in communities or within relationships. There are also the vexed questions of what to disclose to potential sexual partners and when to do this - often accompanied by fears about a consequent loss of opportunities and interest from others. Some people may decide not to disclose in this situation, and in that case it will be valuable to offer them time to reflect on the implications of this and the importance of making choices which are healthy for them and their prospective partners.

Offering time and space for people to think through these choices, perhaps using role-play techniques to practice how to tell, what to say and ways of fielding possible responses can all be helpful preparatory stages. Some of the techniques described in the Skills Development section such as managing difficult feelings and assertiveness skills -
are not particular only to work with gay men but could be appropriate to working with these issues with a range of different groups and individuals. “Managed” disclosure is a term used these days to signify people making conscious decisions over who they tell and how they choose to do this in a way which will be as supportive and positive in outcome as possible both for the person disclosing and those disclosed to. Both one-to-one and group-work approaches can be appropriate for helping people prepare for doing this.

**DEVELOP ADHERENCE WORK**

Anti-retroviral drug therapy regimes are highly dependent on regular and reliable adherence. This relies on basic factors such as people remembering to carry their drugs with them, to take them at the right times and to keep to any dietary requirements of these complex treatments. There are many effective models now for supporting people on such complicated therapy regimes - such as adherence “buddying” arrangements or putting someone newly on treatment in touch with a peer who already has this experience in order to pass on helpful hints on living with complex arrangements. The “wheel - your personal pill planner” produced by the National AIDS Manual can also be a helpful accessory in this work (access this on www.aidsmap.com) as can the testimony and experience of those who have faced and resolved some of these challenges. Some HIV treatment providers offer Adherence or Compliance Clinics, too, where people can review their own particular obstacles and barriers and be supported in finding ways to overcome these so the quality of their response to treatment is not adversely affected.

**CONTINUE TO TAKE A SEX POSITIVE APPROACH WITH PEOPLE WITH HIV**

Take account of the fact that people with HIV do have sex, and need support for this. This is especially important given that many people in this situation may restrict their social and sexual lives radically and often unnecessarily out of anxiety about onward transmission. But the needs of people with HIV for sex, love, intimacy and affection are no different from any other group in the population. So it is vital that those working with them do not let judgmental or critical attitudes intrude on tangible and practical support for people enjoying a healthy sex life. Providing them with the encouragement, resources and skills to do this in a way which safeguards their health and that of others is crucial to sexual health promotion and HIV prevention, rather than denying or over-looking this aspect of people’s lives.

**REMEMBER YOU WON’T ALWAYS KNOW IF SOMEONE HAS HIV - AND NEITHER WILL THEY**

All of the points in this Section presuppose that you will know who has HIV - both because they themselves know and because they feel able to tell you. But clearly this is far from true. We know for example that there are many people in the population with undiagnosed HIV, although estimates of the extent of this vary considerably. We also know that many people - maybe because of the stigma or the self-hatred mentioned above do not feel safe to disclose their status to others, such as health care workers. So do not assume anyone who has not told you they are HIV positive is not, because this may not be the case. There have been reports, for instance, of white heterosexual women being told by sexual health workers that HIV testing is not an issue for them to consider, even when the woman herself knew this not necessarily to be true. By now we should all be aware that HIV status observes no boundaries, although experienced by larger numbers in certain groups than others within the population overall.

So be sure you extend supportive sexual health promotion and HIV prevention initiatives to anyone you are working with and remember any of them may have HIV, and all of our work should be appropriate if that should turn out to be so.

*Further Reading: HIV Prevention and Sexual Health Promotion with people with HIV*

*Produced by the National HIV Prevention Information Service*
SECTION THREE
PART FOURTEEN - 10 PRACTICAL TIPS FOR WORK WITH COMMERCIAL SEX WORKERS

DON'T JUST WORK ON A SEXUAL HEALTH AGENDA
Their own sexual health may not be at the top of the agenda of commercial sex workers, in fact for some it is sometimes hardly on their agenda at all. There may be other pressing concerns which they experience with much more immediacy - for example poverty and benefits, housing problems, issues of childcare, anxiety about social services - even how to get out of prostitution. All of this may mean that we may have to address these matters with sex workers too, if they are to take seriously our role in supporting and helping them.

USE CONDOMS AS A “PASSPORT” IN TO OTHER WORK
When trying to establish positive links with those working in prostitution, providing free condoms can be a quick and effective route into raising sexual health matters - offering us the equivalent of a “passport” with which to gain acceptance. This can be true if working in street settings but is also the case in literally gaining entry to premises-based commercial sex settings such as saunas and massage parlours. Remember to make sure you have a range of condoms available - including flavoured ones for oral sex and extra-strong ones, with lubricant as well.

BE RESPECTFUL ABOUT THE RELATIONSHIPS WOMEN CHOOSE TO MAKE
Often working with women involved in selling sex, we will come into contact with their boyfriends or pimps and this can severely test our bounds of tolerance. Letting this show, however, will not do our work or the woman concerned any favours and is likely to put her in the unenviable position of having to choose between our approval and his.

Being non-judgmental and supportive is a key element of good practice which should inform all our work and our service-provision. It is vital we extend this attitude to this area of work and do not make it apparent if we feel frustration or irritation about women tolerating poor treatment at the hands of their boyfriend or pimp. Accepting her relationships is part of accepting her - although we may want to make it clear that we support her right not to be treated violently and address this issue directly with her. See the following point for more on this.

ADDRESS MATTERS OF SAFETY AND VIOLENCE
The Section on Outreach and Detached work deals in detail with the safety of staff, it is the purpose of this Section to explore safety and risk issues of commercial sex workers.

Many sex workers report experiencing violence - from rape, sexual assault and attack by ‘punters’ to domestic violence at the hands of their boyfriends or threats from pimps. Part of a holistic approach to working with this group is to put their immediate needs on our agendas, and a fear of violence and anxiety about finding ways of staying safe will probably be high among their concerns. Our response can be multi-faceted. For example, we could work with local Domestic Violence projects and workers or with staff from refuges who could offer outreach work, advice and support alongside our sexual health service. Or we can provide small tips and practical hints on self-defence and safety.

However it will be most appropriate to offer this on the streets while doing the rest of our work. Setting up workshops or providing separate self-defence training is unlikely to be attractive or feasible for people who need to be out earning, can ill-afford to take time out for such an activity and probably will not share our “training workshop” frame of reference. It will also be useful to familiarise ourselves with other schemes concerned with promoting safety - such as ‘Ugly Mugs’
in which details of dangerous punters are circulated with warnings, an initiative which is described more fully in the section on Outreach and Detached work.

**DRUG USE IS A MAJOR ISSUE**

For many of those involved in selling sex - whether male or female - drug use is a major issue, in fact for some it is likely to be the major issue. Whether selling sex is done to finance their own drugs habit or that of their partner, or they end up using drugs to numb the feelings caused by being involved in prostitution, the need for drugs is likely to be uppermost in the minds of many of the people we work with. So we should devise thoughtful and positive partnership approaches with our colleagues working in drugs services. For example, it may be possible to ‘piggy-back’ on outreach being done by them - such as needle and syringe outreach schemes - and offer our sexual health outreach alongside. Or if we have established sexual health outreach projects, they will be undoubted benefits from inviting drugs agencies colleagues to accompany us and offer their services along with ours. At the very least, we should offer input on harm reduction in drug use and information about where people can access further services and support.

We should be aware that commercial sex workers are frequently offered larger sums of money in return for unprotected sex. Where the imperative of servicing a drug habit exists (or that or a partner, boyfriend or pimp), it may be hard to withstand the pressure to accept this long-term risk for a short-term gain. We should therefore explicitly address this matter wherever possible, offering those selling sex for money the opportunity to discuss it and to come up with their own choices, informed by any input we can helpfully offer.

**WRITTEN MATERIALS ARE OFTEN LESS IMPORTANT THAN FACE-TO-FACE WORK**

If we rely on written materials - for instance leaflets and credit cards - in our work with this client group, we are overlooking the fact that for some their literacy skills may not be well-developed. So we should ensure we use other methods too - word of mouth and face to face work, perhaps even developing peer education schemes where some sex workers can hand on information about sexual health, condoms and services to others. Adopting such approaches also means the work can continue by powerful word of mouth - even when we cannot be doing our outreach on the streets or in other commercial sex settings.

**LINK WITH OTHER AGENCIES**

Sexual health promotion work will benefit from close liaison with other agencies. This may be particularly so when making contact with commercial sex workers who may harbour suspicion and resentment about statutory services - assuming we are going to intervene in unhelpful or disrespectful ways. So where work has already been successfully initiated by other agencies, we will be well-advised to build partnership working. Where we ourselves have established projects with this group, then inviting other agencies to accompany us and develop outreach alongside us expands the services on offer to sex workers and may provide us with co-workers and peer support. In this way everybody’s needs are met. Agencies who may also be interested in working with this client group can include drugs services, benefits and advice workers, child protection teams, police and social services. However, in choosing our partners we should ensure we have a common value base and that our ways of working are congruent. It may also be helpful for us, if we have the greater expertise and established experience in this field of work, to offer training for staff in other services in order to raise awareness of the range of needs of people selling sex.

**TRY NOT TO MAKE ASSUMPTIONS**

Most of us have grown up in a society which has not historically accorded much respect or sensitivity to those involved in commercial sex work, so it will be understandable if we have negative perceptions. Perhaps, for example, we make assumptions that everyone involved in such work is “riddled with infection” or that every man in their life is exploitative
and violent. Or if our work has been in radical health or community outreach projects, we may have taken on negative assumptions about the police and the judiciary that are not going to facilitate our working well with these groups. It will be helpful if we acknowledge and then overcome any preconceptions we may be bringing, and strive to challenge our own prejudices and limiting assumptions. This should stop us falling into the trap of being patronising, dismissive or over-controlling, ensuring we listen with respect and belief to the experiences of people involved in selling sex.

ADDRESS A RANGE OF SEXUAL HEALTH ISSUES
Offering sexual health support to this group is not just a matter of condom promotion and the prevention of HIV and other STIs. Many of the people we contact will have other sexual health concerns and we should ensure our services also include offering access to a range of contraception choices including emergency contraception, pregnancy testing and referrals to termination services, Hepatitis vaccinations and psychosexual counselling.

REMEMBER THERE ARE MEN AND BOYS INVOLVED IN THIS WORK TOO
Certainly the majority of sex workers are women - but many young and adult men are involved in this work too. So our work should address these groups and ensure we equip them with the knowledge, skills and resources to safeguard their own sexual health. We should not make any assumptions about the sexuality of this group either, because heterosexual young men may become involved in selling sex or men doing this may identify as bisexual or gay. Whatever the case is, our work needs to take account of the particular needs of this smaller but nonetheless needy group.
SECTION THREE
PART FIFTEEN - 10 PRACTICAL TIPS FOR SEXUAL HEALTH PROMOTION WITH OLDER ADULTS

CONFRONT THE TABOOS.
Despite the silence and cultural taboos surrounding the sexual health of older adults, older people are just as capable of loving passionately, tenderly and sexually as anyone else. Sex can still be an important part of their relationships, bringing pleasure, intimacy, personal fulfilment and fun. Indeed, some people say that when you’re no longer afraid of pregnancy and when there is less pressure to ‘perform’, sexual intimacy can bring new and unexpected pleasures. Sadly, many older people encounter the belief that sex is only for the young and that it's not OK to show interest in the sensuous side of loving. This leads to an assumption that for older people to enjoy sex is somehow ‘dirty’ or that lovemaking no longer has any meaning because they can't still have children.

Sexuality is more than just sexual intercourse - it's also companionship, friendship, and being able to relax intimately with someone. So, it meets our needs for affection, pleasure, feeling accepted and feeling alive. For many older adults, the loss of a partner can mean losing all this, yet sexual feelings may well still be there even if their partner has died.

REASSURE OLDER ADULTS THAT IT’S FINE TO TALK ABOUT SEX, SEXUALITY AND RELATIONSHIPS.
When most older people were growing up, attitudes towards sexuality were more rigid than now and often sex wasn’t discussed. For this reason, it may not be easy to talk about sex or to find a language that is open and expresses their feelings. But, communication is important between partners. So it may be helpful to suggest someone tries discussing sexual issues during non-sexual times together. Often a health or community work professional may be able to offer the necessary support – for example GPs may be familiar with sexual health issues for older adults and may feel comfortable discussing these. However, some older people may find this embarrassing, perhaps because they know their doctor well or their doctor does not seem very open to these issues. In such instances, it might be useful to offer the opportunity to talk matters through with someone who specialises in relationships issues, such as a Relate counsellor.

LONG TERM PARTNERSHIPS – AND STARTING NEW ONES.
For some older adults who are in long-term relationships, these may well become more comfortable over time as people learn how to give each other pleasure more and more effectively. However, in such relationships interest in sexual activity can diminish because of boredom, routine or lack of communication. One or both partners’ physical disability, illness or loss of interest may affect sex and holding back in love-making may be misinterpreted as rejection. So it’s important that we support older adults in understanding any changes taking place - and to realise that it’s normal to have difficulties and perhaps to need professional help from time to time. Similarly, people whose mental powers are failing still have sexual needs and desires. And the partner of a person who is confused or has dementia may have sexual needs which can no longer be met in the relationship. Again, it may be helpful to offer professional advice in these cases.

Throughout society, there are powerful pressures to be ‘a couple’. For people who are single again after a long partnership it's not easy to begin again. It may be helpful for us to suggest someone tries to reach out beyond their usual circle, that when they meet someone new they should think of this as a friendship - and remember that it may take some time for a new relationship to develop. It will be important that they are prepared to communicate and
negotiate what they want. With sex it's never too late. If people are 'dating' for the first time in many years, they may appreciate reassurance that it is normal to feel awkward and unsure both of what to expect and what will be expected of them. Sometimes partners are happy to have a non-sexual relationship but feel pressured by the sexual expectations they imagine their partner has. So, as with other groups we work with it may also be helpful to stress they don't have to be sexual unless both partners want to.

**PSYCHOSEXUAL PROBLEMS ARE NOT ALL ABOUT AGE.**

All too often older adults do not seek help with sexual problems such as erectile dysfunction or vulval pain – or are dismissed if they do so with assurances that these are simply inevitable manifestations of ageing. In fact these can occur at any age. It is always worth checking with health professionals or relationships counsellors, since they can often be treated so that they cease to impede otherwise happy and fulfilling sex lives.

**RECOGNISE CHANGING NEEDS – INCLUDING ONES ABOUT PHYSICAL HEALTH AND WELL-BEING.**

Sexual relations at any age are affected by many factors, both physical and psychological. For example, operations or amputations; chronic illnesses or conditions such as arthritis, incontinence or heart problems; use of aids such as catheters or stoma bags, may all affect sexual relationships. Medication can also have an impact on someone’s ability or desire to be sexual. People whose mental powers are failing may also have sexual needs and desires - sexual feelings don't go away just because memory and other mental functions are in decline.

Older adults in this kind of situation have found that there are many ways of experiencing sexual pleasure and that intercourse is not the only form of love-making. Gratifying sex without penetration is possible and there are a variety of other ways of providing pleasure. For example, these can include tender touching, stroking and hugging. Others have found new ways of enabling them to continue having intercourse and to overcome the effects of their conditions. For example, using new positions; learning how to cope with stoma bags and catheters; using sexual aids to help obtain an erection or stimulation; using lubricating gel for dryness can all help in continuing sexual activity with a partner.

**SOME DO'S AND DON'TS FOR MAINTAINING A HAPPY SEX LIFE INTO OLD AGE.**

It may be helpful to remember these “practical tips” about sex – and offer advice and support to older adults who discuss any difficulties with you. Remember to:

- Change positions if you have pain
- Take your time and don’t attempt to hurry sex
- Try using a water-based lubricant such as KY jelly
- Try sex in the morning, when you’re more relaxed
- Use touch and massage with each other
- Take painkillers before starting to have sex, if prescribed them
- Don’t only stick to set times and days for sex - be spontaneous!
- Make sure you have enough time without interruptions
- Find out the possible side-affects of any medication you are taking and discuss these with your doctor – particularly if they are likely to affect your libido/desire levels

It may also be worth encouraging older adults to remember some “Don’ts” – for example:

- Don’t assume you are ‘past it’ because of physical problems during sex
- Don’t always judge good sex on having an orgasm
Avoid too much alcohol before having sex

Try not to have sex after a heavy meal

Don't assume that a lower sex drive or sexual problems are to do with age - it may be linked to medication

Don't assume penetration is the only real way to sexual fulfilment

And finally - Don't be anxious about seeking help

**PRIVACY – PARTICULARLY IN RESIDENTIAL CARE OR LIVING WITH CHILDREN.**

At whatever age, it can be daunting to think that others know we are being sexual – and to risk their rejection or disapproval because of this. For older adults, who have to confront the extra cultural taboos explored earlier in this section, this anxiety may be particularly strong. It is therefore important that they are supported in negotiating privacy in their living situation. This may involve, for example, their right to lock the door if they live in residential care. If they live with their adult children, it may include agreeing with them that people will knock on their bedroom door before entering. It may mean, if the older adult is still living in their own home, that people don’t let themselves into the house without warning. Although these may seem trivial issues, they flag up the rights of older adults to respect and self-determination in an extremely significant way.

**STILL ADVOCATE CONDOM USE AND SAFER SEX.**

Even though for older adults there may not be fertility issues and therefore the need for contraception, it is important that safer sex issues are discussed with them and that they have information on this. This will ensure they do not put themselves or their partners at risk of getting HIV or other sexually transmitted infections (STIs). These are emphatically not only issues for younger people, and in fact increasing numbers of older adults are presenting annually at GUM Clinics anxious about STIs.

It is therefore important that we give older adults information about condom availability, the range of condoms suitable for different sexual activity (including flavoured ones for oral sex and extra-strong ones for anal sex) and about non-penetrative sex which will not risk infection. Using condom demonstrators to show effective use and discussing lubricant use to minimise the risk of condoms tearing and breaking will be just as important with older adults as with other groups we work with, too. They also need information about where they can get information and support if they are worried they might have an STI or want more information about HIV and other STIs. And remember, it will be helpful to stress the confidentiality and accessibility of services such as GUM Clinics.

**ACKNOWLEDGE DIVERSITY OF SEXUALITY.**

As with any other group in the population, there will of course be a diversity of sexuality among older adults. There are strong taboos on older adults being sexual at all, but the silence about older people’s right to be sexual is even greater when it comes to older adults who are gay, lesbian or bisexual. If an older adult feels strongly attracted to people of the same sex or has sexual relationships with them, they may be particularly fearful of rejection - for example by their children or friends – and this may result in a huge sense of isolation. These feelings can be especially painful if a lover of the same sex is ill or dies and it may be hard to ask for support for fear of people’s reaction. For this reason, we should make no assumptions about the heterosexuality of all older adults – and there should be information and support for those who are gay, lesbian or bisexual or for those who “come out” in their later years.

**STAFF TRAINING ON THEIR OWN PREJUDICES, ASSUMPTIONS AND UNDERSTANDING**

Many staff will come to sexual health work with older adults with unthinking assumptions, or embarrassment and awkwardness. To ensure this does not hinder this group getting the services and support they deserve, we should
make sexual health and sexuality training opportunities accessible for staff working in these settings. This will give them the space to review and move on from any limiting assumptions they are making. It will also enable them to become more open to supporting the sexual health and relationship choices of older adults.

Such training should be available both to those offering sexual health services and to those working with older adults – whether within health or social services, the voluntary or community sectors or in private residential care. Ideally, it should be multi-disciplinary, including those from sexual health services and from older adults’ agencies. In this way, each group can learn from the other and networks of support and referrals can be established, ensuring the most seamless and holistic possible sexual health promotion for older adults.

Further Resources: Ageing, Loving and Sexuality - Centre for HIV and Sexual Health
SECTION THREE
PART SIXTEEN - 10 PRACTICAL TIPS FOR SEXUAL HEALTH PROMOTION WITH PEOPLE WITH DISABILITIES INCLUDING BOTH PHYSICAL AND SENSORY IMPAIRMENT

HAVE YOU GOT APPROPRIATE PUBLICITY MATERIALS?
If you are addressing issues of how to make services and support accessible for people with sensory impairment, are you sure you have a range of materials which will take on the different potential needs – for example, do you have information and publicity leaflets in large print? Yellow paper printed with black 14 point is good as a minimum standard and glossy paper should be avoided. Is the information also accessible in Braille or tape? To provide these not only ensures that people with sensory impairment can use these resources, it also sends a strong signal that you are aware of their sexual health needs and of their rights to support and are trying to respond to them.

WHAT ABOUT PHYSICAL ACCESS TO SERVICES?
Are all the sexual health services in the area wheelchair accessible? This should not only be in statutory health services like GUM clinics, youth clinics and Family Planning clinics – but also within HIV support groups, Rape Crisis and Abuse counselling services, Pregnancy Advisory Services and Gay and Lesbian organisations. And if this provision is to be holistic – are condom and tampon machines in toilets available at a height suitable for wheelchair users and in accessible toilets for disabled people? Are there also induction-loops and minicomms for hearing impaired people? All of this, of course, takes time and investment, but these are issues which need addressing alongside any others if we truly are committed to reducing all inequalities in sexual health.

SEXUAL HEALTH SERVICES STAFF TRAINED IN AWARENESS OF DISABILITY.
If services are publicised widely through disability-focused groups, will there be appropriate provision when people actually access them? For example, have all the staff been trained in disability awareness and disability equality issues? To encourage people to take up provision and then not to tailor that provision accordingly is not fair to those accessing the services or to the service-providers.

TRAINING FOR PERSONAL ASSISTANTS AND PARTNERS AND FOR STAFF AND SIGNERS.
Sometimes the people who should be the best allies to this work – personal assistants and partners or signers, for example - may act unwittingly as “gatekeepers” to sexual health. Their own agendas, anxieties and fears or the fact that they, too, are likely to be affected by the taboos and silence surrounding the sexuality of people with disabilities may all result in them controlling access to sexual health services for the disabled person they are supporting. Other people possibly having the power to limit the autonomy of disabled people in making their own decisions can result in an infantilising attitude which builds dependency.

If there is any one arena of life in which our humanity to some extent depends on us being able to choose for ourselves, it is probably that of our relationships, our sexuality, our sexual activity and our choice of partner. In order to increase the likelihood of disabled people having a right to these choices, work needs to be done with carers, partners, signers, Independent Living Assistants and staff in disability services on their awareness and knowledge of sexual health. Just as disability awareness is necessary for sexual health support staff (see point 3 above), those working or living with disabled people should have access to training, support, resources and information about sexual health. Courses which increase their understanding of this area and their recognition and support for the sexual health rights of disabled people are therefore essential in building this sexual health support capacity within these services.
BEING BASED IN A RIGHTS AGENDA.

Over the past years, great progress has been made in the field of advocacy for the rights of disabled people. Similar but separate ground has been gained in the field of sexual health rights for marginalised groups, or for groups whose sexuality has been a contentious issue. Bringing these movements together – in advocacy of and increased support for the sexual health rights of disabled people - can only serve to further the end of social justice. This will include acknowledging and advocating their rights to sensitive, accessible and respectful treatment and services, to adequate Sex and Relationships Education and to many of the other issues raised in the points in this section. It will also include supporting them in developing the self-advocacy skills to press for these rights themselves. Having a human rights basis for the work also enables people who may have uncertainty or a long-standing resistance to this work to see that it serves an unarguable aim.

PROVIDE SEXUAL HEALTH INFORMATION MATERIALS AND SERVICE DETAILS IN RESIDENTIAL AND OTHER CARE SETTINGS.

It has become something of a cliché that there is an enormous social taboo and silence about the sexuality of disabled people. It is also known that this silence has meant that, until recently, high levels of abuse of disabled people have gone unchecked, for example in residential care settings. For this reason, both to break through the taboo and to protect the needs of vulnerable people in care – it important that work is done in such settings to offer information, support and training to staff.

It is also important that this information and support is offered to those living in this care system and that they are enabled, for example, to have privacy and form sexual relationships. Much progress has been made and many institutions are now closing, meaning that people are moving to their own homes in the community with support, some for the first time in their lives. Our ongoing work to ensure privacy, dignity and the right to relationships is a vital part of any such move.

APPROPRIATE SEX AND RELATIONSHIPS EDUCATION.

Often, those involved in delivering mainstream Sex and Relationships Education or producing materials for this assume that no-one involved in sexual activity has an impairment. SPOD’s excellent video “The Lyric” is a moving, emotionally intelligent, person-centred and engaging resource for use in this work which places the sexual health needs and rights of disabled people at its centre. This is useful for Sex and Relationships Education with this particular group and other groups too, to make the sexuality of disabled people tangible, visible and worthy of attention and respect. See Section on Resources for further details.

FIND POSITIVE IMAGES OF PEOPLE WITH DISABILITIES EXPRESSING THEIR SEXUALITY

How we understand and construct the world is greatly influenced by the images we are presented with, through the media for example. To increase awareness of the sexuality of disabled people, it is important to offer positive images. These might include people being intimate and sexual and people talking in a lively way about their own sexual feelings. Films such as “Coming Home”, or the Department of Employment’s poster campaign about disability awareness are helpful in presenting us with these images. Finding and using such images will help change the perceptions about sexuality and disability held both by disabled people themselves and by others.

It is also important we address issues of body image, attractiveness and notions of normality. For most of us, how we look is inextricably bound up with our self-esteem and our sense of our own sexuality. For disabled people, their experience of disability itself is likely to have a negative impact on their sense of themselves sexually. This should be
acknowledged, worked with and positive attempts should be made to enable them to tackle any negative self-image resulting from living with impairment and disability.

**REMEMBER, NOT EVERYONE WITH A DISABILITY WILL BE HETEROSEXUAL.**

When we are working with disabled people to increase their sense of sexual health rights and autonomy, it may be assumed that everyone in this group is heterosexual. It is hard enough for people to challenge and overturn one huge social taboo – that of sexuality and disability – without then also having to deal with heterosexism and homophobia. So we should keep in mind that people with disabilities are as varied in their sexual health needs as any other group.

**WORK WITH THE SPECIALIST AGENCIES.**

To be serving the needs of people with physical and sensory impairments, we should be working with all the key specialist agencies at local level. This might include:

- PHAB Clubs
- Deaf Societies,
- RNIB
- local authority day-care settings,
- specific support groups focussing on particular diseases and conditions – such as arthritis, Parkinson’s disease, MS or muscular dystrophy
- Independent Living organisations.

Making such alliances will mean those of us involved in sexual health promotion can help these agencies put sexual health and sexual rights on their agenda. In doing this remember that there is quite a different culture between organisations for disabled people (for example the MS Society and RNIB etc.) and organisations of disabled people, and work with these accordingly.

Working in these alliances also means we can learn from these organisations about how to make all our education, our materials, our campaigning, our support and our services in the field of sexual health relevant to the needs of disabled people.
In preparing for this section I took advice from two nationally-respected sources about the language I should use – and confusingly was offered two different viewpoints. I am aware that some people use and prefer the term “people with Learning Difficulties” and others “people with Learning Disabilities”, each for well-argued and understandable reasons. I have taken the decision to use the term “Learning Difficulties”, and if anyone finds this problematic, I apologise. I do believe, however, that the content of the Section will be relevant and useful for everyone.

PEOPLE WITH LEARNING DIFFICULTIES ARE SEXUAL BEINGS TOO!
Do not de-sexualise people with Learning Difficulties. There are still strong social taboos related to the sexuality of disabled people and this also encompasses people with learning difficulties. People with learning difficulties are often infantilised – by the media and press, by social stereotypes and also by parents and carers and service providers. Therefore, if they live in a world which treats them as permanent children and offers them this image of themselves, it may well be difficult for them to claim an independent, adult sexuality. In turn, this is likely to impede their ability to make the choices and decisions about sex and sexuality which are appropriate for them.

By responding to the sexual health rights and needs of people with learning difficulties we can ensure that we do not collude with the taboo and silence which has for too long surrounded this subject for this group.

HAVE DISCUSSIONS ABOUT BODY CHANGES AND PUBERTY.
With young people with learning difficulties, careful thought needs to be given to supporting them through the changes of puberty and adolescence. For example this could involve discussion on body changes such as developing body hair, talking about menstruation and everyday personal hygiene, as well as how to use a tampon and how to dispose of tampons or sanitary towels. Make sure these discussions are with boys as well as girls – while making it clear that menstruation only happens to girls. There have actually been cases where this distinction was not made clear and boys became distressed because they had not started their periods. It will also be important to talk about erections and wet dreams (with girls as well as boys – although again while saying this is about boys’ experience). In all of these cases, having simple visual aids – such as anatomical dolls or posters - designed especially for this purpose will be very helpful and should prevent misunderstandings.

OFFER SEX AND RELATIONSHIPS EDUCATION – IN A SAFE SETTING.
Just as when tackling Sex and Relationships Education with other groups of young people (or adults) it will be important to set up a safe and mutually-respectful environment within which discussion of these topics can take place. Some of the tips in the Section on Group Work may be helpful here and clearly the agreement which is made with the group about how people will work together should tackle how to manage difficult feelings or the rights of others to feel safe in the group. So it may be helpful, for example to make an explicit agreement that “Even if we disagree, we won’t shout at each other or hit each other” or “If we get upset, we’ll stay in the room and try to talk about it”. One way of finding a language for talking about bodies and sexual activity which everyone can understand and agree to, is to take some large paper (like lining paper) and get the group to draw round the outline of their bodies. They can then fill in the bits of the bodies they need to talk about when discussing sex and agree what they all feel comfortable calling these “bits”. Further books to use in Sex and Relationships Education with young people with learning difficulties are included in the Resources and Reading Section.
SEXUAL HEALTH TRAINING FOR STAFF WORKING WITH PEOPLE WITH LEARNING DIFFICULTIES.

To move forward and break out of the constraints related to sexuality, staff in any key roles – for example in special needs education, residential care, health services, day care, sheltered housing, independent living, or the voluntary sector - need training in sexual health awareness. This should cover areas which often create extreme anxiety for staff – for example:

- Confidentiality and the law
- Attitudes to sex and sexuality
- The sexual health rights of people with learning difficulties
- Staff’s personal attitudes and difficulties about people with learning difficulties being sexual
- Other sexual health matters such as contraception, condom use and safer sex

It is hard to move on from traditionally-held values which hamper our work, unless we have support and the time and space to reflect on these values and jettison those which that do not serve the purpose of positively promoting sexual health. Good training and staff development for those working with people with learning difficulties can provide these opportunities. This in turn can result in people being freer and more effective both in their attitudes and their work practice.

WORK ON FRIENDSHIPS AND RELATIONSHIP SKILLS.

Young people – and indeed adults - with learning difficulties are often under as much pressure to have a boyfriend or girlfriend as anyone else. To help them build a strong basis of peer support and self-esteem, it is useful to develop activities which consciously enable them to develop and sustain friendships and to have a sense of how they can be good friends to others. It is also possible to offer opportunities for them to develop other relationships skills – such as handling difficult feelings, dealing with jealousy or feeling left out and how to share well with other people. (see section on Self-Esteem Building for more ideas).

WORK ON APPROPRIATE AND INAPPROPRIATE TOUCH, SAYING NO AND SETTING BOUNDARIES.

The lives of many people with learning difficulties may have abounded in people making decisions for them, and engaging in physical behaviours such as dressing, washing or ‘grooming’ with no sense that their privacy is to be respected. In such a context, it is difficult for anyone to develop a sense of what is and is not appropriate, what does and does not invade the personal and private. At its most benevolent end, this can result in people with learning difficulties being infantilised and not learning to manage themselves and their lives to their full capacity. At its most malign, it can of course result in physical, sexual or emotional abuse.

It is important therefore to model to children and young people with learning difficulties that they have a right to say “no” to touch or something being done to them. This can be done, for example by asking their permission to touch them and getting their agreement to this or by knocking before entering their bedroom. It will also be useful to convey and repeat – and to check that they understand – certain messages such as “remember nobody has the right to touch you in a way that hurts or feels nasty” or “sex isn’t meant to be painful or unpleasant”. There is a useful programme of training called “Protective Behaviours” which can help professional staff support people with learning difficulties to develop strategies for staying safe and to identify key adults who will help them if they are at risk of harm or abuse. For more details see the List of Organisations Section.
Such work should be placed in a wider context of education and support about choices and decision-making. If a young person – or, indeed, an adult – has never been given choices or had the opportunity to learn to make decisions, they will struggle with the right to say “no”.

**WORK WITH PARENTS AND CARERS.**

One of the barriers to responding adequately to the sexual health needs and rights of people with learning difficulties is the protective attitude taken by many parents and carers. This is understandable, usually stemming from anxieties that their children will be exploited or abused. However, it may also result in part from the difficulty many parents have with the idea of their children becoming sexually active as they reach puberty and adulthood. But in the case of the parents of people with learning difficulties, they continue to have more control over their children as they grow up.

For these reasons, training, support and information given to parents is one way of ensuring that those around people with learning difficulties are able to support them in their right to claim their sexuality. This training may well need to cover some of the issues already mentioned in point 4 above. It will also be helpful to enter into constructive communication and dialogue with parents and carers about these matters, discussing their fears and anxieties and exploring their needs. They may not have been offered this from any other source before, and will usually welcome the opportunity to find the best way to support their child's sexuality while at the same time keeping them safe from harm. See Section 3.18 for more on this.

**DEALING WITH MASTURBATION**

This is probably the most perplexing issue for staff in just about all settings working with people with learning difficulties. Of course people with learning difficulties should learn about what is appropriate in terms of masturbation – for example choosing private places such as their bedroom or the bathroom for this and making it clear that it is not appropriate in public. But this should be far from a punitive approach which punishes masturbation or ignores it as a “necessary evil”. Much better to discuss it both with young people and with adults with learning difficulties, to acknowledge it did help them to understand appropriateness.

Rather than only addressing this issue when it presents problems, it is helpful if staff in any setting working with people with learning difficulties can discuss and agree on a policy about masturbation which takes a level and relaxed approach to this, while not reinforcing attention-seeking behaviour. So, it may be helpful to encourage staff to reflect on why a person is masturbating. For example, may there be other factors such as boredom or general frustration in their lives, which can be responded to directly? It is also positive in terms of broader sexual health promotion or staff to be open to discussing sensuality with their service users and clients. It might be that they make aromatherapy bath oils available to those they are working with in residential settings, or demonstrate how to give a massage to someone's hands or feet as non-sexual ways of enjoying their sensuality.

**WATCH FOR INAPPROPRIATE SEXUAL BEHAVIOUR OR CHANGES IN BEHAVIOUR.**

These changes can often be an early sign of possible abuse or forced sexual activity and should therefore be a cause for concern. They may include touching other people intimately perhaps or masturbating publicly, or very provocative sexualised language or behaviour. Obviously, it is important to explore the causes of such behaviour changes in a way which is not alarmist or accusatory.

We should be aware that ignoring these changes will risk any abuse continuing. On the other hand, simply addressing this issue with the person displaying the behaviour change risks dealing with them as if they are the problem, putting them in the wrong and not addressing what may be being done to them. Helpful comments about the right to set your
own boundaries to being touched and to make your own choices will be a positive approach. This should be accompanied by gentle questioning which makes it clear you are supporting them, they are not in the wrong but that they should not protect someone else or keep secrets if these are about what someone else has been doing to them. There are now some good models of staff teams who have trained as a core group together to deal with these issues. As a result they have felt more able to respond effectively to them when such situations arise as well as proactively taking measures which prevent such things from happening. This requires an acknowledgement that a high level of training and support for staff in these situations is vital.

WORK ON DEVELOPING TECHNIQUES FOR EMOTIONAL MANAGEMENT

People with learning difficulties will also benefit greatly from having the opportunity to develop techniques for emotional management. This might for example cover how to handle strong and difficult feelings, how you react when you want something you can’t have, and how you can come to terms with this. It may be helpful to encourage them to discuss how to cope with rejection or with being pushed away – or with not feeling attractive. It will also be important to focus on how it is not fair or right ever to push someone into doing something they don’t want to, particularly in terms of sex. Of course, the corollary to this is already covered in point 6 dealing with having the right to set their own boundaries and not to be pushed into doing something just because someone else wants to – or simply to please them. To support the sexual health and emotional well-being needs of people with learning difficulties it would also be appropriate to engage in some broader-based general self-esteem building approaches with groups and individuals. See Section 3.2 for more ideas on this.
SECTION THREE
PART EIGHTEEN - 10 PRACTICAL TIPS FOR SEXUAL HEALTH PROMOTION WITH PARENTS

ENCOURAGE PARENTS TO TAKE EVERY OPPORTUNITY WHICH ARISES TO TALK WITH THEIR CHILDREN ABOUT SEX AND RELATIONSHIPS.

Parents often report that they feel awkward raising issues of sex and relationships with their children. They are unsure how to choose their moment and the spectre of the obligatory and embarrassing “birds and bees” talk still looms. It may be better both for parents and their children if these things are done in relaxed ways, which are more integrated into the rest of their family lives. This means, for example, answering any questions which are asked - about bodies and relationships, other families and what particular words mean, rather than ignoring or dismissing these.

It may be necessary to find age-appropriate answers. For example the question, “What is war rape?” arising out of watching a news item on conflict is likely to need a different response for a 6 year-old than for an 11 year-old, but it does need a response that can be understood. Changing the subject or fobbing the question off with a dismissive remark or a joke is simply going to give the child the message that these subjects are not for discussion – and to deter them from asking more. This will consign them to having to pick up information from friends, magazines and the media – none of them known for their reliability, accuracy or sympathy of approach.

So in our sexual health promotion work it is worth pointing out to parents the opportunities provided by the news, by soap operas or by situations which arise with their friends such as separation, divorce and marriage.

This simple approach can pay huge dividends in terms of developing an understanding of the world, of relationships and of emotions – all of which is the context in which any Sex and Relationships Education needs to take place. It also means parents can take some proactive control of their input – whether around information, values or ethics - rather than only reacting when their children are brave or desperate enough to raise the issues.

DEVELOP GROUPS OF PARENT PEER EDUCATORS.

One effective approach to this work is to develop groups of parent peer educators who can run sessions for other parents on “Talking with your children about sex”. This model has already worked very successfully in some areas which now have active groups of parents who have been trained up as peer educators. Parents for these projects are usually selected through interview, because it is important that those who get involved have the capacity to work sensitively with others. They then receive a comprehensive training course – for example 6 mid-week evening sessions and one all-day session at a weekend - which prepares them to run a basic 2-hour session with other parents on “Talking with your children about sex”. In some places this has proved such a successful approach – with parents’ groups in schools and community settings – that the peer educators themselves have gone on to develop longer courses to explore some more of the complexities of this issue. But the evaluation of even the shorter sessions prove the worth of peer education in terms of developing confidence and skills in parents. The sessions delivered also support parents in understanding that they don’t have to know everything to talk with their children, and that they are not alone in feeling daunted by this aspect of parenting.

SUPPORT PARENTS IN PLANNING HOW THEY WILL RESPOND TO THEIR CHILDREN’S QUESTIONS.
Obviously some of these will be basic ones about sex, bodies and reproduction – from the early “where did I come from?” and “do you have to be married to be a mummy?” to ones for example about menstruation, contraception or wet dreams. Practising answers to these in advance can help, so that parents don’t feel totally unprepared when the situation arises, but have some thought-out responses ready. There will be other, perhaps more challenging, questions too. These might for example include “What is gay?”, “When did you first have sex?” or questions about abortion or masturbation.

It is important to have anticipated some of these and to decide, for example, how much they are willing to answer questions about their own lives, choices and sexual experience. There is no right answer to this, it will depend on the parent’s preference and the levels of sharing or privacy which are established in the family. In terms of answering questions, it is helpful for parents to understand they can return to the issue later and do not have to be “word-perfect” at the time of asking. For example they can say “Do you mind if I think about that and talk to you about it later? I promise I will.”

Obviously, the more parents have factual information about sex, sexuality, biology and relationships – the more confident and skilled they will be to deal well with questions as they occur. For this reason, we should be providing them with resources such as leaflets and videos to help them feel properly equipped to take on what can sometimes seem like an unnerving role. So explore the possibility of distributing these resources via schools, or by Primary Care practices, by Health Visitors or SureStart programmes or within community groups, for instance.

Parents often report the fear that their own levels of ignorance or gaps in knowledge will be revealed in talking openly to their children. They may even be anxious that their children will be more worldly or informed than they themselves feel. It is therefore important to reassure parents that it’s OK not to know everything, and it’s fine to reply – “I’m not sure – shall we try to find out?” and then get hold of the information they need. Or they can say “I’ll need to check that and then I’ll let you know”. In either of these instances, it’s vital that if they give an undertaking to come back to the discussion at a later point, they actually do this and do not use it as an avoidance device. Not to return to it as promised will effectively close down this subject for any future communication.

**REMEMBER TO OFFER SUPPORT TO ADULTS IN QUASI-PARENTAL ROLES.**

Recently a community health needs survey was carried out by one sexual health promotion unit with more than 100 young people, and when asked “Who would you feel comfortable talking to about things which were troubling you?” several responded “my grandparents”, or “my Nan” or “my Grandma”. Clearly there is a resource for supporting young people here which often goes unrecognised. So, in developing any kind of consistent work with parents, we should be imaginative about also reaching out to those in formal or informal carer or support roles in young people’s lives, such as grandparents.

Others who may benefit from this input will include step-parents and foster carers. Step-parents often feel that discussing sex and relationships with their step-children is a contentious issue. Not only should they agree an approach with their current partner but also with the ex-partner, i.e. the step-child’s other natural parent. Where there is a clash of ideologies – for example where the ex-partner may not want certain sex and relationships issues raised (or indeed any mention of these topics) - it may be difficult for the step-parent to have any rights in decisions in relation to this. In fact, when this happens they may feel constrained in taking on any sex and relationships education role at all with their step-children, however much they want to do this.
The third group to fall under this “quasi-parental” heading are foster carers. The needs of young people who are looked-after in the public care system have been relatively well-chronicled. Research shows that teenage pregnancy rates among such young people demonstrate their extreme vulnerability in the area of sex and relationships. We should therefore develop a consistent response to the needs of these looked-after children and young people for information, education and support which will enable them to protect themselves and make positive informed choices. This will necessitate not just robust efforts by staff and management in residential care settings but also a confident and positive response from foster-carers, who have responsibility for the majority of young people in care within the UK. Any work with parents suggested in this section also needs to be initiated with foster carers and those working in any aspect of the care system. It is vital that training, education, support and resources are provided which will enable their confidence and skills to be developed in this area.

PREPARE PARENTS FOR SOME POTENTIALLY CHALLENGING SCENARIOS.

Parents often report that it is not only dealing with directly-asked questions which they fear, but how to react in other highly-challenging situations. It may be helpful, for example, to give parents the space to discuss how they would feel in a number of hypothetical situations. For example, how might they react if they found condoms in their 15-year-old son’s bedroom, or if their daughter told them she needed emergency contraception, or if their 16-year-old daughter confided that she thought she was gay, or if they found pornography under their son’s bed? Practising how to respond in such situations can help build their overall confidence around these issues. It also allows them to work through their likely “knee-jerk” responses, to review their attitudes and – if they want – to revise and move beyond these.

So a first reaction to the daughter’s emergency contraception request might be horror, disappointment and disapproval that she was already having sex. However starting from this viewpoint with the daughter may alienate her completely and make it impossible to build on the foundation of trust which she is offering in discussing this issue with her parents. With the opportunity to think about this, parents might come to recognise that the daughter is being very responsible in seeking immediate help. They could then go on to consider taking their daughter to the GP or Youth Clinic to discuss future contraception, or to talk over with her how to make positive, informed choices about her body and sex for herself.

When doing an exercise such as this with parents, you might want to help them devise some imaginary situations – or ones they have already been confronted with – so they can explore some of their own areas of anxiety.

In any of these cases, the format which may be useful to take people through is as follows:

- What are your immediate feelings?
- On reflection, what are your thoughts about the issue?
- What would you like the outcomes of this situation to be?

It is important to be aware that all three levels are likely to be in play in reacting to any such situation. The preparation offered by an exercise such as this gives the opportunity for parents to ensure they do not get stuck at the first stage of raw emotion. It is more constructive to have these emotions and then to move beyond them to a considered position and a problem-solving approach which has a positive resolution as its goal.

SUPPORT FATHERS IN THEIR SEX EDUCATION ROLE, AND REMEMBER BOYS’ NEEDS.

Often it is assumed that mothers will do all the sex education and discussion of relationships within the family. However, with support fathers can learn to feel more confident in this role and can become equal and important partners in their children’s emotional development and their education in the realm of sex and relationships. All too
often, what is lacking are positive role models for men in terms of talking with their children about relationships and about the responsibilities as well as the rights which come with sex.

Can you find some men who feel comfortable in doing this – or who would be willing to train as peer educators for other men? Just the very act of men discussing emotions, anxieties and their fears in this whole area can be radical and liberating. For boys and girls, young men and young women to see men taking on these issues carries huge significance. It may be appropriate to set up some men-only sessions to encourage the development of these skills and to confront some of the anxieties and concerns which, in our gender-conditioned and role-bound society, are bound to assert themselves for men when addressing sex, relationships and the emotions.

The other aspect of this part of the work is ensuring that we encourage parents – mothers and fathers and other carers to talk to their sons as well as their daughters. Only attending to girls’ needs to know about sex, relationships and contraception has two very negative results. The first is that it reinforces the double standard, that girls have to take sole responsibility for sexual health and contraception, as well as attending to the emotional aspects of relationships. The second is that boys are left with unanswered questions and unmet needs for support, information and the opportunity to share their feelings, anxieties and concerns.

For both these reasons, whenever we are working with parents or carers on these issues, it will be important to help them find ways of proactively raising these issues with their sons. It will also be helpful to enable parents to think about the gender roles and stereotyping they may be colluding with in the family dynamics. For example, are they relaxed about boys expressing their feelings, crying and playing with non-traditional toys? Can they be helped to support boys’ positive emotional development – and not to impose a heavy burden of expectations about their sons acting out their masculinity in “macho” behaviour? Again, role models of men who are comfortable in resisting these gender stereotypes will be useful for both boys and girls – whether these role models come from their teachers, youth workers, family members, friends or health workers.

It can also be useful to draw attention to boys and men behaving in non-traditional ways – on television and in the media – so that the notion that there is only one way of being a man is constantly questioned. The other aspect of this will be ensuring that girls in families are equally encouraged to step outside traditional gender roles – of childcare, domestic responsibility, caring for others and attending to their appearance. Can they too be encouraged to express themselves in more diverse ways, developing their lives and futures without narrow roles and expectations?

**REMEMBER THE NEEDS OF PARENTS OF LESBIAN, GAY AND BISEXUAL YOUNG PEOPLE.**

When young people are questioning their sexuality – or are aware that they are attracted to people of the same gender - they may want to talk to their parents about this, while at the same time being terrified of the resulting reaction. Dealing with a child who is confused or in the process of ‘coming out’ can be extremely upsetting and confusing for parents. As a result, often those who suffer most from this confusion are the young people themselves, who may feel it is they who are the problem.

There is a very helpful national organisation which can offer crucial support, information and befriending to parents who are going through this process – which can sometimes feel like a parallel “coming out”. This is FFLAG - the Friends and Families of Gay and Lesbian Children. See organisations list for more details. It may be helpful to contact them in advance so that you have the information and contact ready if and when the need arises. In this way, you can discover what support and resources are available locally and nationally to parents of children who come out as gay or lesbian and offer these when the situation arises. Or, having made this contact you could set up an event publicising FFLAG – perhaps a workshop or seminar or talk.
HAVE A RANGE OF LEAFLETS, VIDEOS AND APPROPRIATE MATERIALS AVAILABLE.

It is often helpful to follow up a talk about sex by offering information in a written form. So it can be very helpful to have a range of back-up materials available for parents, to give to their children to support and reinforce any discussions they have. It also means parents can offer vital extra information such as addresses and contact points for local services including youth clinics and how to access emergency contraception. Providing parents with written materials means they can use them either as support in this way, or as a catalyst to a conversation if they feel uncertain about how to broach these issues. It frequently happens that parents do not feel certain about their own knowledge about sex. In this situation, these materials can lend them extra confidence to respond to their children’s enquiries with accurate and comprehensive answers.

HELP PARENTS AND CARERS REFLECT ON WHAT HELPS YOUNG PEOPLE TALK TO THEM ABOUT SEX AND RELATIONSHIPS.

A skill which most parents and carers should gain or further develop is that of feeling comfortable talking with their children about sex, sexuality and broader sexual health issues. This means talking in an open-minded and relaxed manner, which takes practice and encouragement. It is therefore invaluable to provide the opportunity to share with other parents the embarrassment and awkwardness that discussing these issues may provoke in us all. There’s nothing wrong in having such feelings – and most parents probably did not have easy discussions about these matters with their own parents and carers. But it is a loss if any difficult feelings inhibit them from offering information, support and a listening ear. One useful exercise which can be done with groups of parents and carers is to consider four key questions:

- What gets in the way of young people talking with their parents or carers about sex and relationships? And what helps them to talk?
- What gets in the way of parents or carers talking with their children about sex and relationships? And what helps them to talk?

Usually, each group has similar inhibitions about the other. For example, for both the barriers to talking identified usually include “Uncertain what language to use”, “Feeling embarrassed”, “Anxious about looking stupid”, “They are so different from me, it’s hopeless” and “We won’t understand each other”. Comparing the lists which result from this part of the exercise can be extremely illuminating, because often what they tell us is that both groups are labouring under the same anxieties, fears, and self-imposed constraints.

But who has the responsibility - and possibly the power - in this situation to help this potential duo to talk to each other more comfortably? Clearly the lesson we can draw from this is that parents, as the adults, have the responsibility to get the confidence, skills and resources to move beyond their limitations so they can help their children move beyond theirs too. Only in this way can we be sure that we will be creating environments in which young people feel free to ask their parents for the information and advice they need.

WORK WITH PEOPLE WHO WORK WITH PARENTS.

To support parents and carers in becoming excellent allies in sexual health promotion with young people, we should work with professional groups who regularly come into contact with them. For example links should be made with Head Teachers, with Health Visitors, SureStart staff and Practice Nurses, with GPs and School Governing bodies, with community and faith groups. Offering training, resources and information for these professionals can skill them up to
raise issues with parents about supporting their children’s sex education, their understanding of relationships and their emotional development. It will also be helpful to point out that one of the extra incentive for doing this work is that it has the capacity to promote the broader health of young people, not just their sexual health.

We should enable our colleagues and allies in this work to be clear that parents who have the courage to discuss these vexed and anxiety-creating issues with their children are likely to feel confident and courageous about tackling other sensitive areas with them. These may include matters of drug and alcohol use, depression and the promotion of broader mental and emotional health and well-being, dealing with loss or bereavement, and the problems generated by other issues such as bullying, conflict or illness within the family or divorce and separation. Supporting parents in gaining the skills to raise these issues of sex and relationships with their children is therefore inevitably going to increase their communication skills, their awareness of their children’s needs and their broader parenting skills.
SECTION THREE
PART NINETEEN - 10 PRACTICAL TIPS FOR SEXUAL HEALTH PROMOTION IN
PRIMARY CARE AND CLINICAL SETTINGs

PRODUCE SEX TALK BOARDS AND SEX TALK KITS
This idea was originally pioneered by Cal Chikwendu in schools in Southern Derbyshire and has since been developed by other sexual health promotion specialists elsewhere. These “SexTalk” boards are attractive and colourful large cork boards, covered in information about local sexual health and drugs education services. Provided free of charge, these can be offered to Primary Care Practice, as well as in schools, colleges and youth centres - as a way of offering patients and service-users extra sexual health information. This is an excellent way to ensure all Primary Care service-users get information on how to access sexual health services and support.

These have proved so popular that they are now being supplemented by “SexTalk Kits” also made up by the Centre. These are easily-portable bags containing demonstration samples of a range of contraception methods as well as Femidoms, condoms and condom demonstrators and other “sexual health discussion-starter” items such as Red Ribbons to promote HIV and AIDS awareness, leaflets about STIs and sachets of lubricant. Accompanied by a set of guidelines on how to use them, these kits provide a starting point for raising a whole range of subjects related to sexual health with young people and other service-users.

CONSIDER PROVIDING FREE CONDOMS AND LUBRICANT.
Some of the best sexual health promotion initiatives promote condom-use alongside other forms of contraception in order to reduce rates of STIs, including HIV. This approach should be modelled within Primary Care settings, so funding should be sought (perhaps via Teenage Pregnancy monies) to provide free condoms and lubricant in Primary Care. As well as being offered as a result of consultations on contraception or other sexual health matters, these can be distributed by leaving free condoms and lubricants in the toilets or in the Waiting Room. One member of a Practice staff expressed her reservation about this on a training day saying “But what if we get complaints from old ladies?”. The apt reply was “I have to tell you old ladies have unsafe sex too and also need our attention in terms of sexual health”! See section on sexual health work with older adults.

Remember, if you are offering this service you should ensure that there is a range of condoms available – including extra-strong and hyper-allergenic ones. Having this range available explicitlyflags up that you are aware service-users will reflect a range of sexuality, ethnicity and health needs. Remember too that the majority of condom failures are related to their ineffective use, so have condom demonstrators available. Make sure you show people how to use condoms properly, giving them the chance to practice this using a demonstrator. Lubricant should always be offered with condoms, leaflets on effective condom-use should be displayed and given out and the notices described in point 3 below should offer condom demonstration sessions.

PUBLICISE THE PRACTICE’S SEXUAL HEALTH SERVICES.
Think about how you can inform Practice patients of the range of sexual health services offered by the Practice, because it may not occur to the majority of them that they can access more than just contraception. You might display a poster in the surgery waiting room stating what sexual health services are available in the Practice to stimulate uptake of services. Your poster could read:

The Sexual Health Services and Support we offer include:
<table>
<thead>
<tr>
<th>Referral to termination services</th>
<th>Support if you are questioning your sexuality</th>
<th>Free condoms</th>
<th>HIV testing/counselling</th>
<th>Pre Menstrual Syndrome support</th>
<th>Pregnancy testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening for chlamydia and other STIs</td>
<td>Psychosexual counselling</td>
<td>Menopause services</td>
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<tr>
<td>Emergency contraception (&quot;morning after pill&quot;)</td>
<td>Information about self-help groups</td>
<td>Vasectomy services</td>
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<tr>
<td><strong>Someone to talk to about sexual problems, difficulties and relationship stress</strong></td>
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<tr>
<td><strong>Ask to speak to the Practice Nurse, a Doctor or the Counsellor about any of these</strong></td>
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</table>

It can also be effective to produce a Practice leaflet specifying information about what services are available and disseminating this throughout Practice patients. Remember to pilot it with some service-users to check it is clear, intelligible and does not omit any important points. In one GP practice in Bromley, a group of young people produced their own leaflet to encourage other young people to be proactive service-users. This answered questions about what the Practice offered, how to access services and what would be involved in doing this, as well as giving reassurances about confidentiality.

**USE THE “BIRTHDAY CARD” OR TEEN TALK APPOINTMENT SYSTEM.**

Some Practices have a system in place under which young people receive a birthday card on their 16th birthday and an invitation to a “health check” session with a Practice Nurse offering all kinds of sexual health promotion advice and information. Sexual health services and support can be an important part of such an activity. In some Practices, this approach is made via parents to ensure they support the initiative. Evaluation of such schemes shows them to be very popular among both young men and young women.

Another project of this kind was the teenage appointment scheme developed by Kerry Smith in Brighton/East Sussex Youth Service. In this scheme, by using a “fast-track” credit card a young person can be guaranteed a rapid and confidential appointment with a member of Practice staff, without having to answer questions from reception staff. Particularly useful for publicising rapid access to emergency contraception, such schemes may well offer a positive way to increase young people’s uptake of generic mainstream Practice services.

**CONSIDER THE IMPACT OF OTHER TREATMENT AND MEDICAL CONDITIONS ON SEXUAL HEALTH.**

It is important we do not only address sexual health issues when these are either the “presenting problem” or the intended focus of a consultation. An awareness of how a range of health conditions can have a negative impact on sexual health and relationships will be essential in promoting sexual health within broader medical treatment. For example, diabetes and high blood pressure may result in erectile dysfunction for men. So when people are consulting about these health matters, it will be important also to address this delicate sexual health issue with them – for this is part of holistic, person-centred care. Similarly, if someone has had radical surgery which is likely to have a profound effect on their body image and self-esteem, these matters should be discussed with them and support offered for dealing with the potential impact of such a life-change on their relationships.

It is also important to be clear about side-effects of drug treatments – on libido or sexual performance for example - so that people can be prepared for these. This also offers the opportunity to discuss with patients how they might manage such occurrences. Giving people the opportunity to talk about all of these things, to ask questions and get helpful information on tackling any difficulties is important in treating the “whole person”.

A multiplicity of conditions – from asthma to psoriasis, from back pain to incontinence – can raise sexual health and well-being needs and we do not serve patients’ best interests if we ignore or dismiss these – or are too embarrassed to
broach them. Even ending every consultation with the simple question “What else is going on in your life?” can pay huge dividends in opening up the possibility of people talking about other factors which are impacting on their health – in which sex and relationships may play a key part.

**OFFER A RANGE OF CONTRACEPTION METHODS.**

It will be helpful to consider the range of contraception methods which are available within the Practice. Too often people assume that only oral contraceptives are available - or that if they want any other form of contraception they have to go to a specialist Family Planning Clinic. For example, are women aware of the choice they can make - including contraception implants, Depo Provera, having an IUD fitted, or using condoms or a diaphragm - and the benefits of each of these? Helping them to see “the pill” alongside all these other methods, and to weigh up the benefits and drawbacks of each method is much more likely to result in them choosing the most appropriate methods for their particular circumstances and needs. In turn, this is most likely to mean they will persist in their contraception use and therefore be less likely to become unintentionally pregnant. It may be a good idea to include this range of available contraception methods on the Practice sexual health poster displayed in the Waiting Room (see point 3 above) so that people are aware of the choices open to them.

**PUBLICISE OUT-OF-HOURS AND HOLIDAY SERVICES.**

There is frequently an increase in unintended pregnancies and women accessing termination services shortly after Christmas and New Year. This is no doubt testimony both to the fact that people have more unplanned sex at this time, but also that they may not know how to access services such as emergency contraception over the holiday period. Displaying a poster or handbill publicising clinic and surgery opening times and also having a recorded announcement on the surgery answer-phone giving these times can radically reduce the numbers of people who subsequently present as unintentionally pregnant. Other services – such as GP Co-ops offering out-of-hours treatment and Walk-In Centres, many of which provide emergency contraception – will also help to meet these needs. Additionally, information should also be available about the fact that an IUD can be fitted to prevent a pregnancy up to 5 days after unprotected sex – and where to get this done. In many cases, if there are not Practice staff trained to do this, this service will best be accessed via the nearest Family Planning Clinic. Details of their holiday opening times should therefore be included, along with ones for the nearest GUM clinic.

**ENSURE STAFF HAVE RELEVANT TRAINING IN SEXUAL HEALTH.**

One of the main barriers to high quality sexual health services and support being available in Primary Care practices is a lack of staff who are confident, trained and skilled in this field. In introducing any new sexual health services or raising the Practice profile on these matters, it is important that there is a sense of shared ownership and interest by all the Practice staff. Otherwise, the staff with direct responsibility for this development may feel isolated and unsupported and the quality of service given may depend upon which particular member of staff is encountered. For clinical and medical staff this training might, for example be, on taking a sexual history; for receptionists it might be on providing a non-judgmental and welcoming service.

Too often receptionists can be portrayed as ‘dragons’ – fierce guardians of morals within the Practice. While this may still be true in some instances, in many cases good training can bring receptionists on board as vital allies in the work of extending the Practice’s sexual health promotion activities. For example, a group of Primary Care Practice receptionists on a training course drew up this list of how to work with young people. This provides a useful aide-memoir of key points to address in developing sensitive practice with young people. It also demonstrates effectively the contribution all members of the Practice Team can make to service improvement if they are consulted and their views and ideas are taken on board.
DEVELOP A “WHOLE PRACTICE” APPROACH TO PROMOTING SEXUAL HEALTH.

One GP, Dr Tony Robinson from the Black Country Family Practice in the West Midlands, has drawn up the useful list below relating to what makes a Practice one that promotes the sexual health and well-being of all its patients and service-users.

**Characteristics of a Sexual Health-Promoting Practice:**

- Staff have all been trained in issues of sexual health, communication skills and confidentiality
- Confidentiality is guaranteed and assured
- Sexual health services are offered to all young people, including those under 16
- A wide range of services is offered e.g. free condoms, access to vasectomy, menopause, termination and Pre Menstrual Syndrome services alongside contraception, STI screening and sexual health support
- The Practice works collaboratively with other sexual health services e.g. GU Medicine, Family Planning and School Nurses
- The Practice leaflet has an explicit and positive statement about sexual health for all
- It is clear that sexual health services are for everyone including men, older adults, gay men and lesbians and young people of any age
- Leaflets and information are available on a wide range of sexual health issues and in a range of community languages

*It is worth noting here that any Primary Care practice which works in a way which promotes sexual health is likely also to promote other aspects of health with its clients and service users. In addition, it will probably address broader health needs and health inequalities, both in the services it provides and in the way in which it provides them.*

**BE ABLE TO REFER ON TO OTHER SERVICES.**

No service, however high quality, is likely to be able to meet all the sexual health needs of its service-users – including the needs for information, education, treatment, clinical services and support. It is fine not to have all these available on demand – but vital that you have information about where and how these can be accessed. This will mean knowing for example about self-help groups, perhaps in the voluntary sector. These may include support for lesbians, gay men and bisexuals, for people (both men and women) who have been raped or sexually assaulted, for survivors of sexual abuse and for people who are transsexual, transgender or who cross-dress. It will also mean having up-to-date information about other sexual health services, their opening hours, waiting times and referrals procedures. These services will include Psychosexual Clinics, HIV counselling and testing, STI screening, fertility services, vasectomy and sterilisation, termination services and post-abortion counselling follow-up. It will also involve knowing when it is best to refer on to one of these specialist services – or to the generic Family Planning Clinic or youth clinic.
To offer comprehensive and high quality sexual health promotion, it is not necessary to offer all the services ourselves – but it is vital that, in the words of the saying “we know a man (or, just as likely, a woman) who does”! It may be helpful to put together a folder, directory or dossier of all the possible services and their details – or to suggest that one is produced for your District, perhaps by the local Sexual Health Strategy Group. See Section 2.1 for more details. It is also useful to do this process in reverse and to let all sorts of agencies and colleagues who may be working with potential users of your sexual health services know about what you can offer in order to support their clients’ sexual health needs. These may range from New Deal Schemes to Drugs Treatment services, from Learning Difficulties organisations to Youth Offending Teams, from Asylum Seekers organisations to those for homeless and roofless people, from Older Adults Support to Mental Health Care Half-Way Homes.

By publicising our services to others in touch with potentially vulnerable people, and by referring on effectively to relevant services, we can all become greater than the sum of our individual parts. This will ensure we provide a seamless service, with no gaps which people’s sexual health needs can fall through.

Further Resources: Handbook of Sexual Health in Primary Care: Y Carter, C Moss, A Weyman; Royal College of General Practitioners, 1998

Getting Better With Practice – Practical Strategies for Primary Care Teams offering Sexual Health Services and Support to young people. Jo Adams; Centre for HIV and Sexual Health
SECTION FOUR – AN EXAMPLE OF A HOLISTIC MODEL OF SEXUAL HEALTH AND SEXUALITY

These all add up to how we define ourselves as sexual beings
Sexuality = sexual selfhood
Sexuality involves our relationships with ourselves, those around us and the society in which we live - whether we identify as gay, heterosexual, lesbian, bisexual or celibate

©Carol Painter & Jo Adams
Design: Jon Fox
A commonly-used model for sexual health and sexuality is that developed by the Centre for HIV & Sexual Health. This is holistic, seeing many aspects of personal experience as integral to this complex and central part of our lives. Click here to see the model.

This model shows the multi-faceted nature of sexuality and the factors through which sexual health and sexuality are developed and expressed. For sexual health promotion to be rooted in this holistic model, we should not limit our efforts to one ‘petal’ - but work across all. For instance, this may mean ensuring that we are engaging with individuals, groups, communities and the broader public through some - or all - of the following methods:

- Outreach, casework, information-giving and skills development work within clinical consultations are all likely to be with individuals.
- Sex and Relationships Education or sexual health training for staff and professionals will be with groups.
- Community development and building capacity in marginalised and stigmatised groups will be with communities.
- Media campaigns or the development of policy will address the whole spectrum of public health and sexual health will be aimed at the general public.

To work effectively at all these levels, it is important to develop appropriate responses in each of the areas. These could include:

1. **POLITICAL**
   Work might comprise:
   - supporting campaigns, self-help groups, service developments or training opportunities for marginalised, stigmatised and vulnerable groups.
   - working with commissioners, policy-makers and service providers to ensure that inequalities in sexual health are addressed.
   - advocating for sexual health to be acknowledged as a key element in the wider social inclusion agenda.

2. **SEX/ SEXUAL PRACTICE**
   This might include working with service providers to make services well-publicised, fully accessible and to ensure they address different aspects of sexual health. This may mean promoting the use of condoms and the prevention of STIs alongside the provision of contraception, or running training on condom negotiation skills, assertiveness and saying ‘no’ to unwanted sex.

3. **EMOTIONAL**
   This can include:
   - development of emotional literacy as part of Sex and Relationships Education work in formal or informal educational settings. This might include managing difficult feelings, identifying and understanding emotions and developing the communication skills to discuss these with other people.
   - Training health professionals to become comfortable addressing the emotional aspects of sexual health.

4. **SOCIAL RELATIONSHIPS**
   This could include:
   - couple counselling and psychosexual work for relationship difficulties,
   - work with parents and grandparents and peer education with gay men.
• work to strengthen relationships and friendships. For example among young women friendships can be a powerful factor in promoting their self-esteem, increasing their ability to resist pressure to be sexually active or to have a baby.

• work with young men on sexual health and on their attitudes to fathering.

5. SENSUALITY
Work could be done with groups or individuals on how sensuality and activities such as massage or caressing can provide ways of exploring intimacy. An appreciation of the senses is part of a broader education about pleasure and fulfilment in sexual terms. It can also offer a helpful approach through “sensate focus” work in psychosexual couple-counselling or with those who are unable to, or do not wish to have penetrative sex because of impairments or for physiological reasons— for example related to their age, medical condition or disability.

6. SELF-IMAGE
In order to counter the “body fascism” and tyranny of conforming to certain images, useful educational work on feeling comfortable with our bodies can be done with groups of young people — or with others where there is a strong “looks” imperative, such as women or gay men. This can include critical analysis of the images portrayed in the media and educational and self-esteem building work with people with eating disorders.

7. SPIRITUALITY
Attention also needs to be paid to this aspect of our sexuality and sexual health, encompassing the more mysterious and mystical elements of our experience. This includes recognising the part of our sexuality which is a sense of being deeply connected to others and to the planet, and the feelings of awe and wonder which can be drawn forth by deep love, profoundly moving sexual experience or intimacy. If we leave these out of the picture in our work, we risk presenting an image of sexuality and sex which is all physical and social. In doing so, we omit any reference to the special “spark” which is what makes this area of human experience perhaps the most profound part of our consciousness.

*While this model does not claim or attempt to be entirely comprehensive, it can offer us a route-map to ensuring that sexual health promotion is as multi-faceted and rounded, as holistic and positive as the sexual health, sexuality and sexual selfhood that we are striving to honour and support.*
SECTION FOUR
CASE STUDIES IN PRACTICAL SEXUAL HEALTH PROMOTION AT A LOCAL LEVEL

The following four case studies present a brief outline of how sexual health promotion initiatives can be developed at a local level all with the overall aim of promoting positive health and reducing sexual health inequalities. As you can see, this is done by supporting particular communities, using a host of methods and based in a range of settings. Each is followed by some practical advice on developing such initiatives.

Interestingly the same themes which keep occurring in this are the importance of:

- building positive multi-agency partnerships,
- involving targeted communities and service users
- supporting and nurturing staff and strong teams

SECTION FOUR
PART ONE - ENFIELD AND HARINGEY HEALTH DEVELOPMENT SERVICE

With three major target groups for their work - African communities, Gay men and young people - this service combines primary aims of HIV prevention and reducing teenage pregnancy. All three programmes work in close partnership with both statutory and voluntary organisations including local authorities, education, Connexions, community organisations, GU and other sexual health services and health providers.

Some specific activities include:

African communities:
The funding of HIV sexual health promotion workers in African community organisations to provide information on HIV through outreach work, workshops and condom distribution as well as commissioning research projects, resource production and dissemination, strategic development and training. A Forum for African community groups has also been developed.

Particularly innovative projects have been outreach with West African communities using Hometown clubs and old school associations; work with religious leaders to provide information on HIV and AIDS and a young African Girls project working holistically with young girls as a way of introducing sexual health/HIV prevention.

Gay Men
Based in a holistic Gay men’s Health approach, this work contributes to the London Gay Men’s HIV Prevention Partnership as well as commissioning discrete projects locally to reach gay men in the district. Such projects include the Sex Rights media campaign, outreach work in Public Sex Environments, Zone 15 dedicated sexual health service for gay men, Haringey LGB Community Safety Forum; commissioning the GMFA self-development campaign ‘Like it, lump it, change it’ and condom distribution/health promotion at London Mardi Gras.

Particularly innovative projects have been establishing 4-day “Assert Yourself” courses for Gay men in London which ran twelve times before being contracted out to GMFA, the creation of the Outzone project for young gay men - now one of the largest projects for Lesbian, Gay and Bisexual young people in London and contracted out to PACE.
Teenage Pregnancy
Direct delivery of Sex and Relationships Education in schools; using media including the Internet, radio, press and TV

Particularly innovative projects have been the 4YP bus providing young people’s sexual health outreach services, a community sexual health education project training professionals working with young people; the SHEP team of specialist sexual health educators, SexFM Theatre In Education project and production of an interactive video

Our advice to others developing this work would be
- Involve the targeted communities and key agencies from the beginning - and don’t assume you necessarily know best
- Ensure the support of senior management is secured - both from health services, the local authority and the community/voluntary sector
- Take the long-term, strategic view when planning
- Be realistic about time frames in setting up new work and allow for this in the planning stages
- Develop strong links with your communications leads - these issues always attract media attention!
- Invest in your workers and their professional development - as well as in resources
- Make sure front-line workers have all the necessary training before starting new programmes of work
- Aim for continuity - of workers, of resources and of work programmed
- Develop strong partnerships
- Be innovative, creative and take risks!
SECTION FOUR
NEWCASTLE AND NORTH TYNESIDE SEXUAL HEALTH PROMOTION SERVICE
This team aims to promote sexual health and reduce the spread of HIV with people living and working in Newcastle and North Tyneside. Fundamental to the work is the fact that HIV and teenage pregnancy disproportionately affect marginalised and disadvantaged groups and work is therefore prioritised with gay and bisexual men, young women and men, drug users, BME communities, women, people in contact with the Criminal Justice System and people with learning disabilities. Most of the work offers advice, training and support to sexual health and other workers to enable them to take on a sexual health promotion role confidently, with work occasionally also being done to offer direct support to groups in the community.

Activities include
A co-ordinated training programme is offered regionally as well as locally. Courses include self-esteem, assertiveness and negotiating skills, group-work skills, accredited training courses both for community language interpreters and a 5-day course for youth workers and those working with young people in community settings. ‘Sexually Healthy Schools’ training is offered in schools settings and externally evaluated - and other work includes support for LGB community work and HIV prevention initiatives in voluntary organisations.

Particularly innovative projects have been Hothouse - a laboratory to create and test out practical ideas for Sex and Relationship Education for boys and young men, a poster project with young dads and a research programme looking at young men’s involvement in decisions about termination; the C-card condom distribution scheme to young people under 25 (especially popular with boys); a local HAZ-funded media campaign on teenage pregnancy which won media awards; a 3 year project to support sexual health work with people with learning disabilities and the development of policy and practice guidelines for those working with people in the criminal justice system supported by a training programme.

Our advice to others developing this work would be
- Make priorities by identifying and clarifying local needs within the context of goals and strategies set at a national level
- Build up a ‘critical momentum’ by developing advocates and champions for sexual health in a wide range of services, agencies and settings
- The power of working in partnership should never be underestimated
- Create allies wherever possible and model positive ways of working for them
- Offer interest, support and expertise back to the community - for example by sitting on management groups
- Don’t get trapped into having to justify your work by meeting unachievable goals
- Take small steps and aim to do less, better
- ‘You get what you settle for’ - so aim for excellence balanced with capitalising on less-than-perfect opportunities to get your foot in the door
- Make sure of viability and sustainability of projects before raising too many expectations in communities
- Build up a well-deserved reputation for excellence so that you have more equality and credibility from which to negotiate the way you work with other agencies
- Invest in your workers, build your team, develop their skills and support them
- Celebrate your successes - loudly!
SECTION FOUR
HULL AND EAST RIDING SEXUAL & REPRODUCTIVE HEALTH CARE
PARTNERSHIP

This works on a ‘hub and spoke’ model, with a city centre ‘hub’ supported by services and sexual health promotion activities offered in 30 different community settings such as community centres, youth centres and Connexions services - in other words, the ‘spokes’. This provision includes GU medicine, Family Planning, young people’s services, Community Gynaecology and psychosexual counselling.

Activities include:
This Partnership ensures that both sexual health services and sexual health promotion and educational initiatives are offered in a range of settings, with the key agencies working closely together in a well co-ordinated and supportive way. Projects which have been developed include a GP condom distribution scheme; Theatre in Education work devising a locally-based play for schools and providing a range of community-based points at which to access sexual health services. This includes a Young People’s Drop-In Centre which offers an accompanying service to clinics as well as on-the-spot advice, information, condoms and support.

Particularly innovative projects have been working with young people to develop an interactive computer game, service Open Days, work with local night-clubs to provide ‘Teen Discos’ and with the local football team and the ‘Safe and Sound’ campaign using local DJs in schools. A training pack for those working in schools with Key Stages 2,3 and 4 is currently being developed with colleagues from the LEA.

Our advice to others developing this work would be

- Begin by focusing on local needs and paying attention to the evidence base
- Involve all the target groups from the beginning
- Have clear aims and remain focused on them
- Aim to work in partnership with other services and agencies and build up a cohesive sexual health team across service boundaries
- Evaluate campaigns work and use the conclusions, along with the evidence base to inform further work planning and targeting
- Involve the media in joint working approaches wherever possible
- Remember the sometimes ‘hidden’ needs of particular groups, for example those living in rural areas and those with less developed literacy skills
- Co-ordinate local campaigns alongside national ones, to maximise the effectiveness of both
SECTION FOUR
CENTRE FOR HIV AND SEXUAL HEALTH, SHEFFIELD

With the overall aim of reducing teenage pregnancies, HIV and STI prevention and support for positive sexual health of the whole population, this team uses a number of methods. These include community development with marginalised groups, training and policy development for organisations and service providers, needs assessment, production and dissemination of materials, as well as leading on the co-ordination of Sheffield’s sexual health strategy.

Activities include:
Primary care support including a regular sexual health newsletter, seminars and training to join the GP condom distribution scheme; outreach work with Gay and Bisexual men in pubs and clubs; Training Sexual Health Trainers; information and peer education with students at the universities and FE colleges; ‘Baby Think It Over’ loan and training scheme; production of leaflets, videos and training packs and free dissemination of these throughout the city; a local Directory of the full range of Sexual Health Services updated annually

Particularly Innovative Projects have been the establishment of DASH - a Drugs and Sexual Health Forum; the production of an HIV information tape resource for African communities in partnership with the northern AIDS Forum; the Red Ribbon HIV Education project in schools; the Shout Centre - a sexual health and community centre for Gay and Bisexual men; Undercover young people’s services assessment scheme and Go Girls and Boys Own training programmes on self-esteem

Our advice to others developing this work would be

- Work in a way which acknowledges people’s sexual health rights while at the same time empowering them to take responsibility for their own sexual health
- Tackle stigma, discrimination and prejudice - but do it in ways which can be heard and responded to and which help people to find solutions
- Work in respectful and sensitive ways - whether with community groups, other organisations, commissioners or service providers
- Help marginalised and stigmatised communities find a voice to express their sexual health and HIV prevention needs
- Make active links with other colleagues doing this work regionally, nationally and internationally to share ideas and models of good practice
- Get the support of your commissioners and funders as you go - and keep on raising their awareness and understanding so they are able to advocate your work
- Support staff, train them, resource them, let them make decisions - and, inevitably, mistakes - and positively celebrate their achievements
- Be creative and bold - and remember Margaret Meads’ maxim:

“Never doubt the ability of a small group of intelligent, committed citizens to change the world. Indeed it is the only thing which ever has”
# SECTION FIVE

## SOURCES OF SUPPORT FOR SEXUAL HEALTH PROMOTION

### SECTION FIVE

#### PART ONE - RESOURCES AND READING

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<th>GENERAL SEXUAL HEALTH – AND RELATED ISSUES</th>
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<tr>
<td>Sexual Health, Assertiveness &amp; HIV</td>
<td>Sexual Health - Foundations for Practice</td>
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<tr>
<td>Carol Painter; Daniels Publishing, 1996</td>
<td>H Wilson, S McAndrew; Bailliere Tindall, 2000</td>
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<tr>
<td>The FPA's Guide to Commissioning Sexual Health Services</td>
<td>Time To Think</td>
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<td>Family Planning Association, 1998</td>
<td>Nancy Kline; Ward Lock, 1999</td>
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<th>GAY AND BISEXUAL MEN</th>
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<td>The Sexual Health Needs of HIV+ Gay &amp; Bisexual Men</td>
<td>Primary Health Care – Working with Gay &amp; Bisexual Men</td>
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<td>Anthony Bains, Edmund Cross; Centre for HIV &amp; Sexual Health, Sheffield, 1997</td>
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<th>YOUNG PEOPLE</th>
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<td>Taking Sex Seriously - Practical Sex Education Activities for Young People</td>
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<td>Moving the Goalposts</td>
<td>Pathways to Sexual Health – a resource pack for use with young people</td>
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<td>Max Biddulph, Simon Blake; FPA, 2001</td>
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<th>VIDEOS</th>
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<tr>
<td>Whose Daughter Next? A Video package on children abused through prostitution</td>
<td>The Whole Monty – Myths and Realities of using Sexual Health Services</td>
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<td>Barnado's, 1999</td>
<td>Centre for HIV &amp; Sexual Health, Sheffield, 1999</td>
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<td>Abortion – Whose Choice? Education for Choice</td>
<td>Four Carrier Bags and A Buggy – the reality of being a young parent Red Rose Chain/Alpha Films, 1999</td>
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<td>Safe – A Video Resource for Sexual Health work with Young Men</td>
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<td>The Young Men’s Video Project; The B Team</td>
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<p>| WOMEN AND GIRLS |  |</p>
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<tr>
<th>Title</th>
<th>Author/Creator</th>
<th>Publisher/Publication Date</th>
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<tr>
<td>The Mirror Within - a new look at Sexuality</td>
<td>Anne Dickson</td>
<td>Quartet Books, 1997</td>
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<td>Women's Sexual Health</td>
<td>Gilly Andrews</td>
<td>Bailliere Tindall, 1997</td>
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<tr>
<td>Pressured Pleasure – Young Women and the Negotiation of Sexual Boundaries</td>
<td>J Holland, C Ramazanoglu</td>
<td>Tufnell Press, 1992</td>
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<td>Lesbian Health Matters</td>
<td>London Lesbians in Healthcare</td>
<td>1995</td>
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<td>BLACK AND MINORITY ETHNIC COMMUNITIES</td>
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<td>Religion, Ethnicity Sex Education: Exploring the Issues</td>
<td>Rachel Thompson</td>
<td>Sex Education Forum</td>
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<tr>
<td>HIV &amp; Black Communities 2: Primary &amp; Secondary HIV Prevention Issues for African Communities</td>
<td>C Bhatt</td>
<td>The HIV Project, 1995</td>
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<td>VIDEOS :</td>
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<td>Thinking Positive With Batanai</td>
<td>Sheffield Zimbabwe HIV Action</td>
<td>1999</td>
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<td>OLDER ADULTS</td>
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<tr>
<td>The Existence of older Lesbian, Gay and Bisexual Patients in General Practice Raising awareness of their lifestyles and health care need</td>
<td>C E Hall</td>
<td>Dept of Healthcare for Elderly people - University of Sheffield 1995</td>
</tr>
<tr>
<td>Ageing, Loving and Sex – a leaflet of advice on sex, sexuality and relationships for older adults,</td>
<td>Jo Adams, Rob Brown, Dorothy Angell, Jane Bailey; Centre for HIV and Sexual Health, Sheffield, 1996</td>
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<tr>
<td>PEOPLE WITH DISABILITIES</td>
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<td>No Worries Ahead – sex education &amp; contraception</td>
<td>Sex Education for Young People with a Physical Disability</td>
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<td>AIDS Ahead (British Deaf Association)</td>
<td>M Davies</td>
<td>SPOD</td>
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<td>What About Us? Sex Education for Children with Disabilities</td>
<td>Exploring Sexuality and Disability - a resource for trainers</td>
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<tr>
<td>A Craft, D Stewart; Home &amp; School Council, 1993</td>
<td>M Shelvin, G McCormick</td>
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<tr>
<td>Personal &amp; Social Education for Children and Young People Who Are Visually Impaired</td>
<td>North West Support Services for Visually Impaired, 1995</td>
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**VIDEO**

| The Lyric - Sex and Relationships Education | SPOD; 1999 |

**PEOPLE WITH LEARNING DIFFICULTIES**

<table>
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<tr>
<th>Sex and the 3Rs - a sex education package for working with people with learning difficulties</th>
<th>Sex In Context: Setting up a personal and social development programme for children and adults with profound, multiple impairments</th>
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<tr>
<td>Sexual Health Education - children &amp; young people with learning disabilities, a practical way of working</td>
<td>Sex &amp; Staff Training - a training manual for staff working with people with learning difficulties</td>
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<tr>
<td>Talking Together about growing up - a workbook for parents of children with learning disabilities</td>
<td>Picture Yourself - a flexible teaching resource for use with people with learning disabilities</td>
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<tr>
<td>Lorna Scott, Lesley Kerr-Edwards; Family Planning Association, 1999</td>
<td>Hilary Dixon, Anne Craft; Joseph Rowntree Foundation</td>
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<tr>
<td>Breaking In... Breaking Out (social &amp; sex education for men with learning difficulties)</td>
<td></td>
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<td>Martin Hazelhurst; The B Team, 1993</td>
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**PARENTS**

<table>
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<tr>
<th>Family Outing - A Guide for Parents of gays, lesbians and bisexuals</th>
<th>Sex Education for Parents - a resource pack for professionals to support parents in sex education</th>
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<tr>
<td>Peter Owen; Dickens, 1995</td>
<td>Health Promotion Wales and Family Planning Association, 1996</td>
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<td>Family Planning Association ; 2000</td>
<td>Jo Adams, Jane Fenellon, Boo Spurgeon, Liz Wilson; Centre for HIV and Sexual Health. 2000</td>
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<tr>
<td>Partnerships with Parents in Sex Education</td>
<td>Talking about Sex and relationships – A Factsheet for Foster Carers</td>
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<tr>
<td>Lorna Scott; Sex Education Forum, 1996</td>
<td>Hansa Patel-Kanwal; Sex Education Forum and National Foster Carers Association, 2001</td>
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**PRIMARY CARE**

| Getting Better With Practice – Practical Strategies for Sexual Health History Taking in General |

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<th>Author(s)</th>
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<tr>
<td>Primary Care Teams offering Sexual health Services and Support to young people</td>
<td>Jo Adams; Centre for HIV and Sexual Health, Sheffield, 2001</td>
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<tr>
<td>Confidentiality and Young People - improving teenagers uptake of sexual and other health advice</td>
<td>Health Promotion and HIV Prevention in General Practice</td>
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<td>Royal College of General Practitioners and Brook Advisory Services, 2000</td>
<td>Hilary Curtis; Radcliffe Medical Press, 1996</td>
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<tr>
<td>Care for people with HIV in General Practice</td>
<td>D Mottram; George House Trust, 1999</td>
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<tr>
<td>Handbook of Sexual Health in Primary Care</td>
<td>Y Carter, C Moss, A Weyman; Royal College of General Practitioners, 1998</td>
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<tr>
<td>VIDEO</td>
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<tr>
<td>Clueless - a Video Resource Pack for teaching communication skills to Medical Students</td>
<td>Royal College of General Practitioners, 1998</td>
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<tr>
<td>SELF-ESTEEM</td>
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<tr>
<td>Jo Adams; Centre for HIV and Sexual Health, Sheffield, 2002</td>
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<td>Alex Yellowlees; Daniels, 1997</td>
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<td>Feel the Fear and Do It Anyway</td>
<td>Jump Starters - quick classroom activities that develop self esteem, creativity and co-operation L Nelson McElherne 1999 Free Spirit Publishing</td>
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<td>Susan Jeffers; Rider, 2000</td>
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<tr>
<td>The Lesbian and Gay Self-Esteem Handbook</td>
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<td>Kimeron P Hardin;</td>
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</table>
SECTION FIVE
PART TWO - NATIONAL ORGANISATIONS

CENTRE FOR HIV & SEXUAL HEALTH
22 Collegiate Crescent
Sheffield S10 2BA
Tel: 0114 226 1900
Fax: 0114 226 1901
e-mail: admin.chiv.chs.nhs.uk
website: www.sexualhealthsheffield.co.uk

BROOK ADVISORY SERVICE
421 Highgate Studios
53-79 Highgate Road
London NW5 1TL
Tel: 020 7284 6047
Fax: 020 7284 6050
email: information@brookcentres.org.uk
website: www.brook.org.uk

PROTECTIVE BEHAVIOURS
The Children’s Society
The Coffee Hall Family Centre
135 Jonathan's Coffee Hall
Milton Keynes
Tel: 01908 604113

NATIONAL AIDS TRUST
New City Cloisters
188/196 Old Street

Fpa
(Formerly Family Planning Association)
2-12 Pentonville Road
LONDON N1 9FD
Tel: 0207 923 5222/5232
Fax: 0207 928 373042
e-mail: margaretm@fpa.org.uk
website: www.fpa.org.uk

HEALTH PROMOTION ENGLAND
50 Eastbourne Terrace
London W2 3QR
Tel: 020 7413 2627
Fax: 020 7725 9031
e-mail: kim.grant@hpe.org.uk
website: www.hpe.org.uk

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6th Floor
50 Eastbourne Terrace
London W2 3LX
Tel: 020 7725 2606
Fax: 020 7725 2796
email: forward@dircon.co.uk
website: www.forward.dircon.co.uk

SEX EDUCATION FORUM
c/o National Children’s Bureau
8 Wakley Street
London EC1V 7QE
Tel: 020 7843 6052
e-mail: sexedforum@ncb.org.uk
website: www.ncb.org.uk/sexed.htm

NATIONAL HIV PREVENTION INFORMATION SERVICE
Trevelyan House
30 Great Peter Street
London SW1P 2HW
Tel: 020 7413 2001
Fax: 020 7413 8929
e-mail: nhpis@hda-online.org.uk
website: www.hda-online.org.uk/nhpis

FFLAG
(Families and Friends of Lesbians and Gays)
P.O. Box No. 84
Exeter EX4 4AN
Tel: 01392 279546
e-mail: info@fflag.org.uk
website: www.fflag.org.uk

GAY MEN FIGHTING AIDS (GMFA)
Unit 43
Eurolink Centre

NATIONAL HIV PREVENTION INFORMATION SERVICE
Trevelyan House
30 Great Peter Street
London SW1P 2HW
Tel: 020 7413 2001
Fax: 020 7413 8929
e-mail: nhpis@hda-online.org.uk
website: www.hda-online.org.uk/nhpis

BRITISH INSTITUTE OF LEARNING DISABILITIES
Wolverhampton Road
Sexual Health Promotion Toolkit

London EC1V 9FR
Tel: 070 814 6767
Fax: 070 216 0111
e-mail: info@nat.org.uk
website: www.nat.org.uk

49 Effra Road
London SW2 1BZ
Tel: 020 7738 6872
Fax: 020 7738 7140
e-mail: gmfa@gmfa.demon.co.uk
website: www.demon.co.uk/gmfa

Kidderminster
Worcestershire DY10 3PP
Tel: 01562 850251
Fax: 01562 851970
e-mail: bild@bild.demon.co.uk
website: www.bild.org.uk

NATIONAL YOUTH AGENCY
17-23 Albion Street
Leicester LE1 6GD
Tel: 0116 285 3700
Fax: 0116 285 3777
e-mail: nya@nya.org.uk
website: www.nya.org.uk

SPOD
(The Association to Aid the Sexual and Personal Relationships of People with a Disability)
286 Camden Road
London N7 0BJ
Tel: 020 7607 8851
Fax: 020 7700 0236
e-mail: spoduk@aol.com
website: www.spod-uk.org

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Tel: 01494 481632
Fax: 01494 481632
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52-54 Grays Inn Road
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Tel: 020 7831 0330
Fax: 020 7242 0121
e-mail: info@tht.org.uk
website: www.tht.org.uk

MENCAP
123 Golden Lane
London EC1Y 0RT
Tel: 020 7454 0454
Fax: 020 7696 5540
e-mail: information@mencap.org.uk
website: www.mencap.org.uk

CHILDLINE
Studd Street
London N1 0QW
Tel: 020-7239 1000
Fax: 020-7239 1001
website: www.childline.org.uk

BLACK HEALTH AGENCY
339 Stretford Road
Hulme+
Manchester M15 4ZY
Tel: 0161 226 9145

WORKING WITH MEN
320 Commercial Way
London SE15 1QN
Tel: 020 7732 9409
Fax: 020 7732 9409

THE NAZ PROJECT
Palingswick House
241 King Street
London W6 9LP
Tel: 020 8741 1879