Children and Young People's Sexual Health and Wellbeing

An Introduction to Needs in Plymouth

DRAFT v2 7th May 2009

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1. Demography

The total number of children and young people aged 18 years and younger in Plymouth is 56,150. This represents around 20% of the total population. Of these, 21,073 (37.5%) live in the most deprived neighbourhoods. A breakdown of the numbers of children and young people by age is shown in Table 1 below.

Map 1: Number of children aged 0-19 by locality

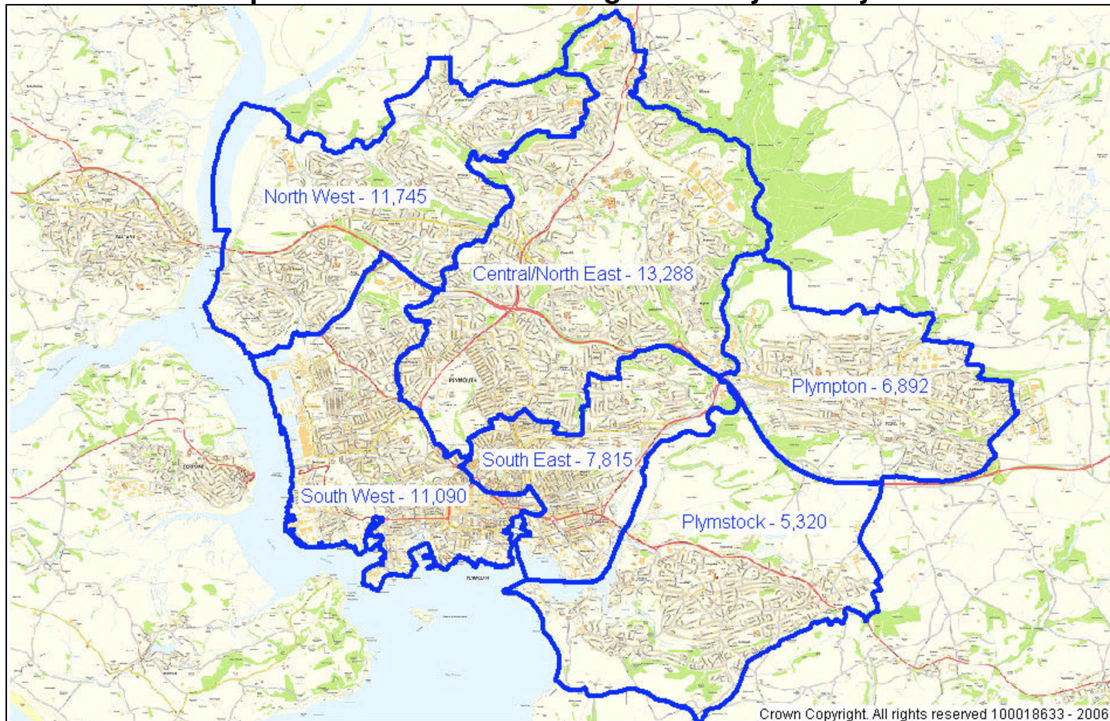


Table 1: Profile of age groups across Plymouth

Age profile	Total Population	As a % of 0-18 yr olds	As a % of total population	% living in most deprived areas	% living in least deprived areas
0-4 yrs	13,543	24.1	5.2	39.2	27.1
5-10 yrs	16,555	29.5	6.4	36.3	29.7
11-16 yrs	18,862	33.6	7.3	35.4	30.3
17-18 yrs	7,195	12.8	2.8	42.9	26.1
Total	**56,150**	100	20	37.5	28.9

Source: Population by age and neighbourhood PHDU 2006

1.1 Population by Ethnic Group

Black and minority ethnic groups (BME) make up about 9% of the total population of England. The South West region has the lowest percentage of all regions at 2.3%. All black and minority ethnic groups, other than Chinese, have a higher proportion of children aged 0–14 than the white population. (19%); Indians (23%); Black Africans (31%) and Pakistanis (34%).The percentage of the population aged 0–19 years is higher in black and minority ethnic groups compared to the white population in the South West region and every other region in England. Whilst the number of people from black and minority ethnic groups in the region may be considered small in absolute terms, they

are comparatively young and hence with higher proportions of Children[1]. BME groups make up 1.6% of the Plymouth population. Further breakdown of these groups are shown in Table 2, below.

Table 2: Population by ethnic group in Plymouth Local Authority

Ethnic group	Plymouth LA Number	(Percentage)
White	236,763	98.36%
Mixed	1,556	0.65%
Asian	741	0.31%
Black	455	0.22%
Chinese	690	0.50%
Other ethnic group	515	0.65%
Total ethnic minority	**3956**	**1.6%**
Base population	240,719	

1.2 Population Projections

The ONS data estimates that overall the population of England will increase by 5.2% over the next twenty years, whilst the population of the Southwest is expected to increase faster by ~9.5%. However, this is expected to be more prominent amongst older age groups. Thus the relative proportion of children and young people is expected to fall in the Southwest. Estimated population changes for Plymouth are shown in Table 3.

Table 3: ONS estimated population changes

Age bands	2001 census data	2021 projections
0-4 years	13,211	12,900
5-9 years	14,618	13,200
10-14 years	16,077	13,200
15-19 years	16,569	15,100
0-19 years	60,569	54,400

Source: SWPHO Children in the South West. Stickin' Out Demographics and Deprivation 2004 GOSW

Key factors influencing these population projections include migration, lower fertility rates and local policy to increase housing capacity.

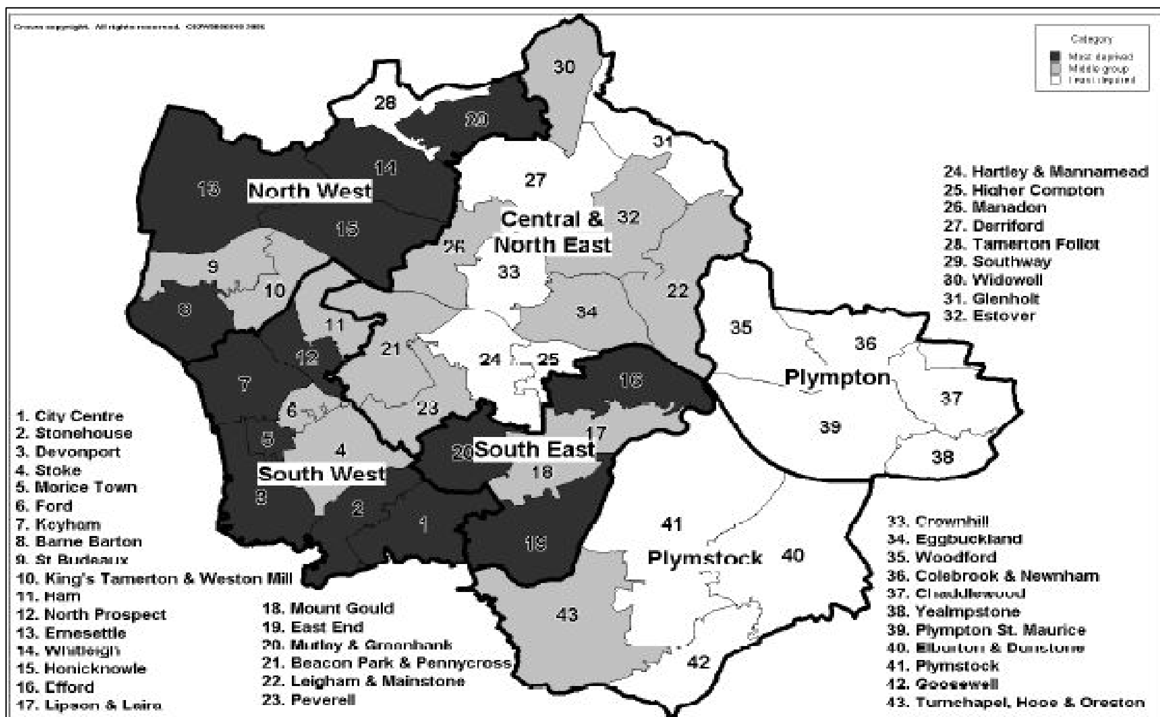
[1] SWPHO (South West Public Health Observatory) Stickin' Out... Demographics and Deprivation, 2004 GOSW

2. Deprivation

Compared with both regional and national statistics, Plymouth has a greater proportion of children living in deprivation[2]

However, deprivation varies widely across Plymouth. The Townsend score was developed in an attempt to identify materially deprived areas. This measure uses four census variables to assess the following; general lack of material resources and insecurity (unemployment); income (car ownership is used as a proxy indicator); wealth (owner occupation is used as a proxy indicator); and material living conditions (overcrowding)[3]. These scores have been calculated for 43 neighbourhoods in Plymouth (see Map 2).

Map 2: Plymouth by neighbourhood and deprivation groupings.



Plymouth neighbourhoods have been grouped together to form six localities as seen in Table 4. Each locality has been established on the basis of information from needs analysis, deprivation indicators and geographical identity. Localities with the highest levels of deprivation include i) South West, ii) North West, and iii) South East.

Data generated by the Health Visitor Survey (2006), shows that the concentration of families dependent on receipt of benefits is unevenly spread across the city, as seen in Table 4.

Table 4: Families dependent on benefits by locality

Locality	Number of Families	% of all families
South West	926	**37.6**
North West	975	**41.9**
Central & North East	295	11.6
South East	516	**36.4**
Plympton	93	11.7
Plymstock	179	19.9
Plymouth Total	**3006**	**27.6**

Source: Health Visitor Survey 2006

2 CYPP Plan Needs Analysis 2008-2011

3 Children's Atlas 2006

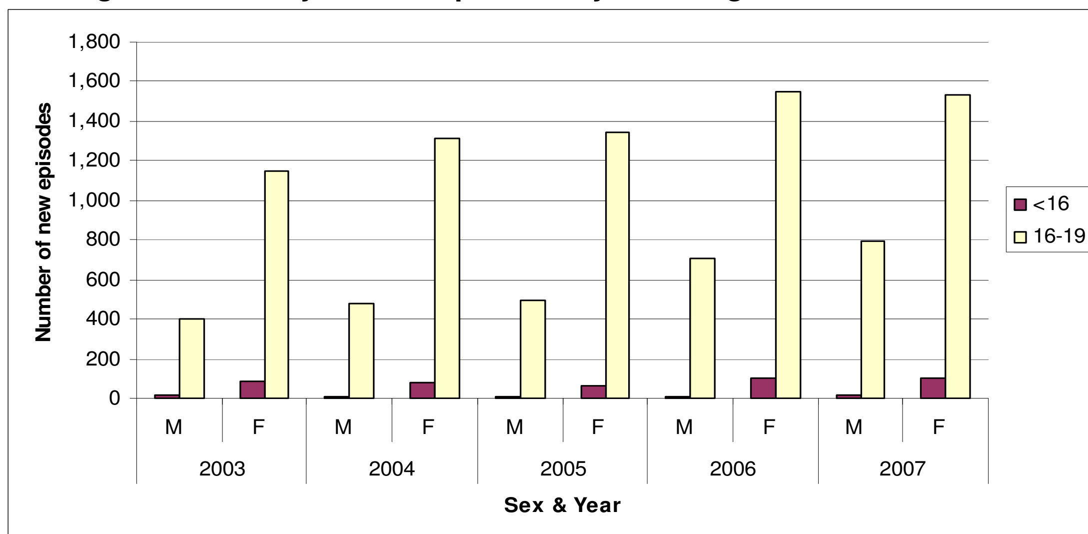
3. Prevalence of Sexually Transmitted Infections

Sexually transmitted infections (STIs) are, as the title suggests, infections that are spread during sexual activity. HIV is considered an STI, even though it can be transmitted in several ways, including sex.

Statistics produced by the Health Protection Agency show that Plymouth has among the highest prevalence of sexually transmitted infections (STIs) in the South West region.

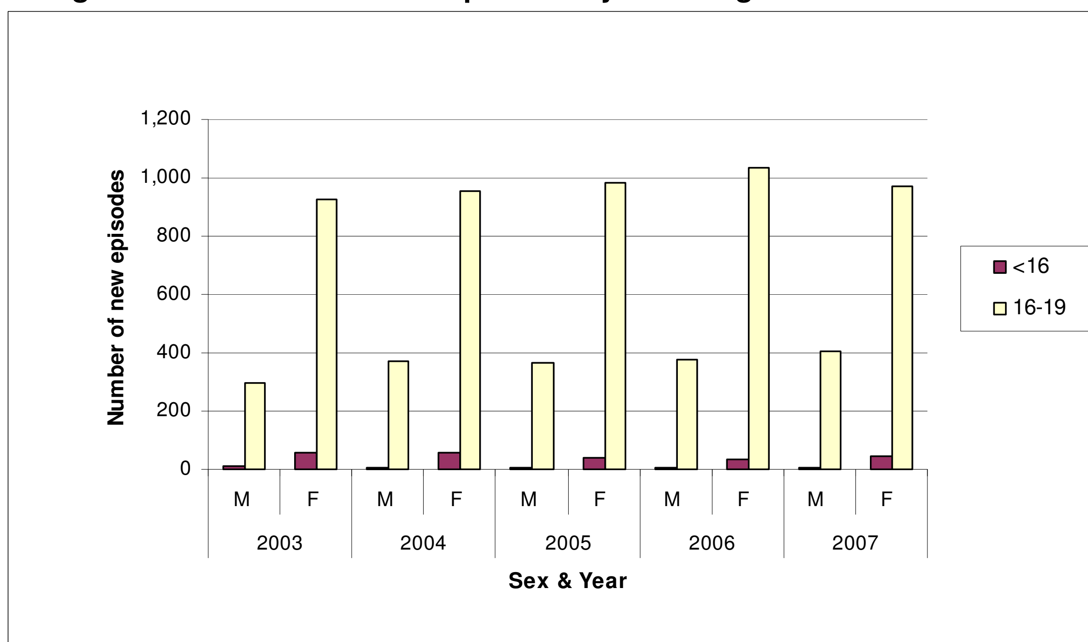
The most prevalent STI's among young people are Chlamydia[4] and Genital Warts. In recent years there has been a steep increase in Chlamydia detection rates, which has been enhanced with the roll out of the national Chlamydia Screening Programme. Figures 5, 6 and 7 show new episodes of Chlamydia, Genital Warts and Gonorrhoea by age and sex in the South West from 2003 to 2007.

Figure 5: Chlamydia New Episodes by Sex & Age in the South West



Source: Health Protection Agency, 2009

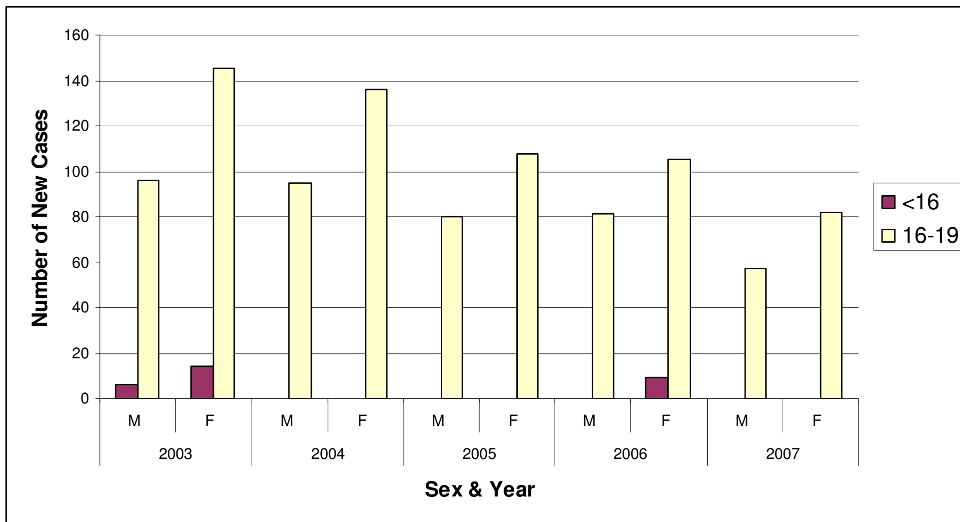
Figure 6: Genital Warts New Episodes by Sex & Age in the South West



Source: Health Protection Agency, 2009

[4] Chlamydia is an STI which infects the genital tract

Figure 7: Gonorrhoea New Episodes by Sex & Age in the South West



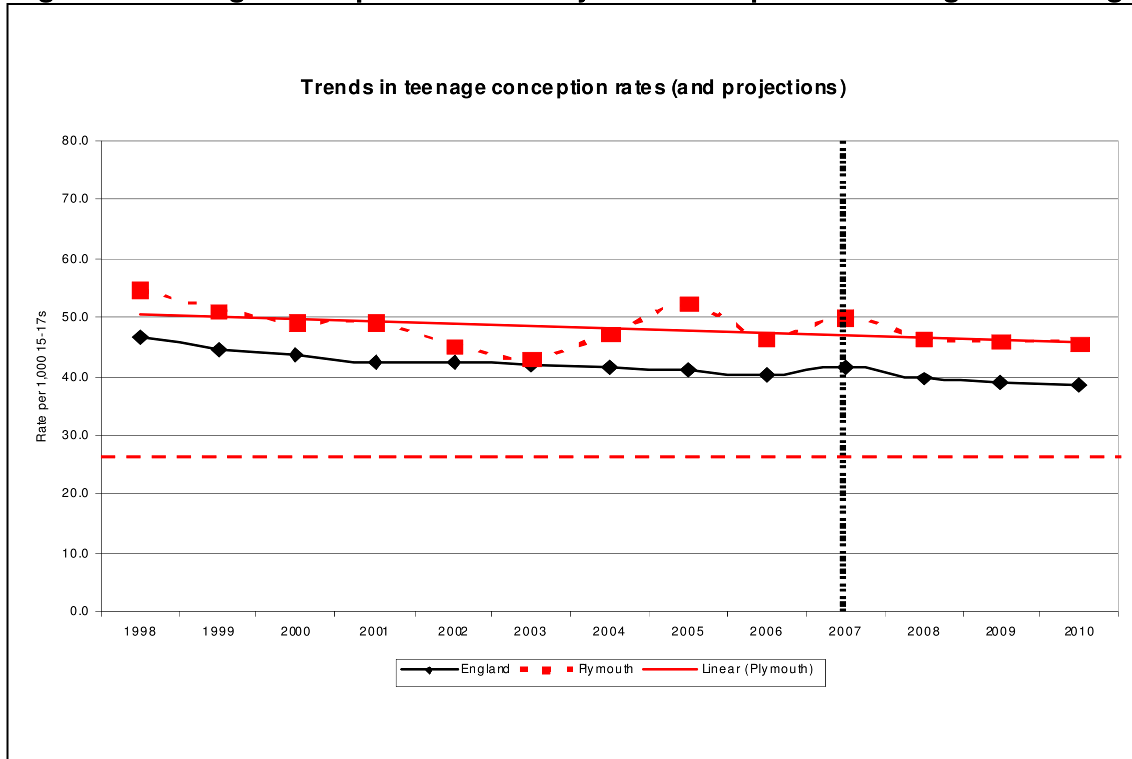
Source: Health Protection Agency, 2009

Plymouth has relatively high rates of new HIV cases among the general population compared with other areas in the South West. In 2008, the Health Protection Agency reported that while new HIV cases in the UK amongst young people remained low compared to other age groups, the number of new cases is rising, with the number of new HIV cases among young people in 2007 three times higher than it was in 1998.

4. Teenage Conceptions

The under-18 conception rate is significantly higher in Plymouth then the England average and the South West average, a trend which has continued[5]

Figure 1: Teenage conception rates in Plymouth compared with England average

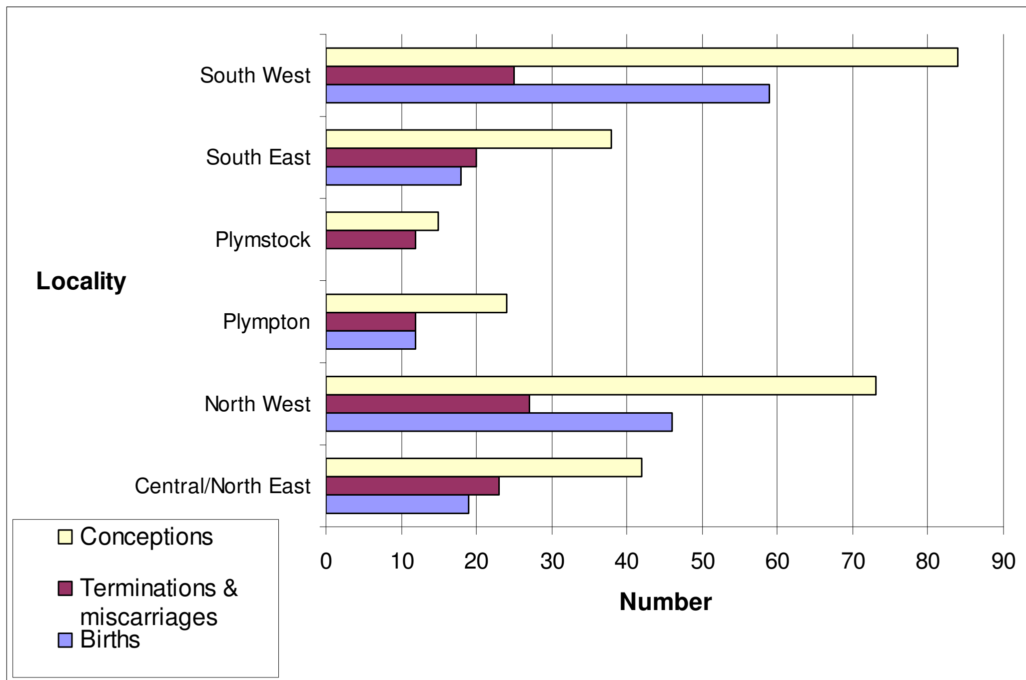


Source: PDHU 2008

5 Annual report of the Director of Public Health 2006/7

The rate of conceptions leading to birth varies across the City in terms of location, age and ethnic groups.

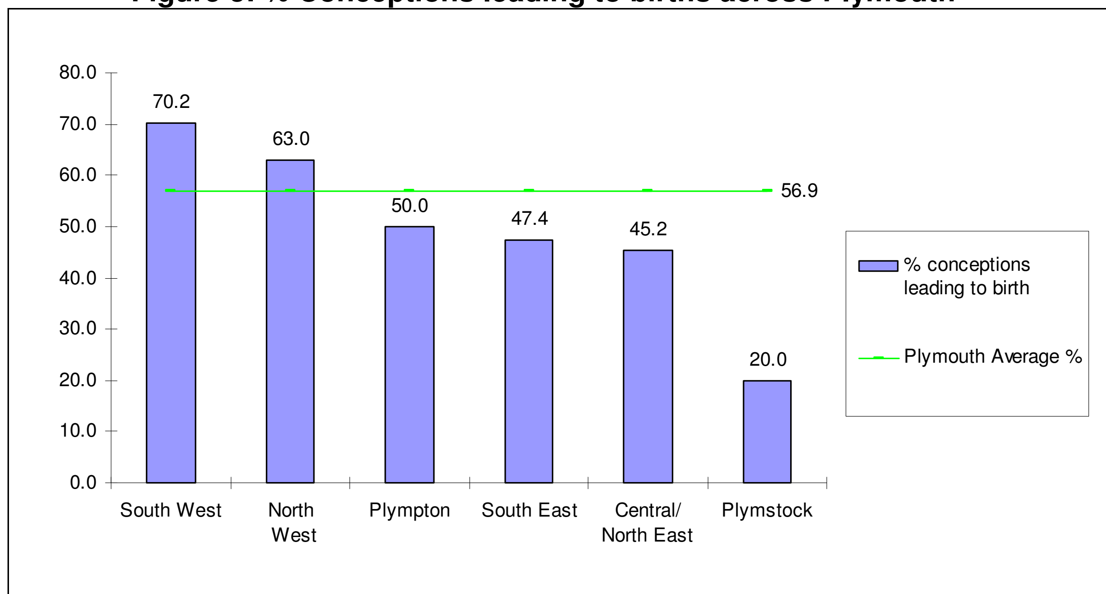
Figure 2: Number of Birth, Terminations & Miscarriages and Conception by Locality 2006



Source: PHDU 2006

Figure 3 shows that the South West and North West localities have an above average proportion of conceptions leading to births.

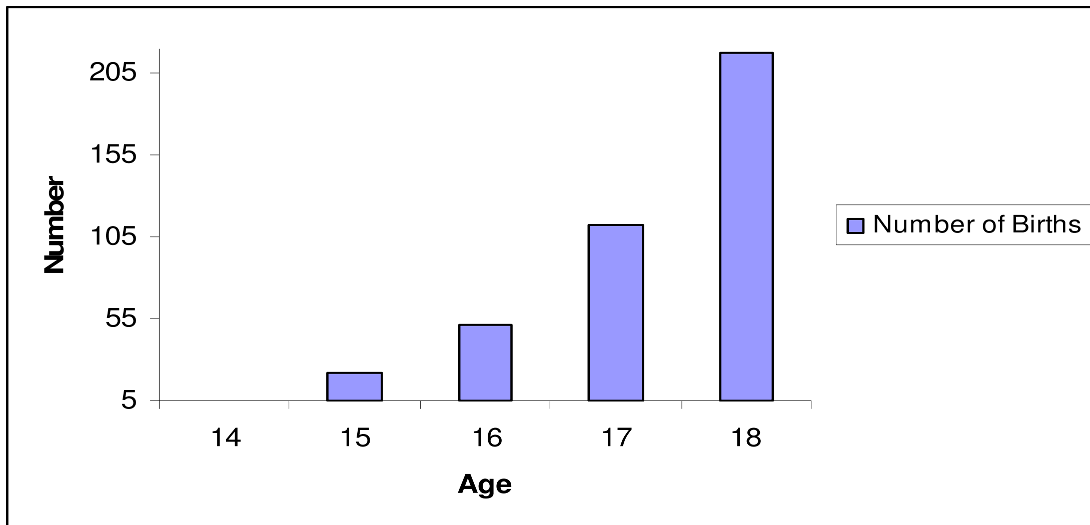
Figure 3: % Conceptions leading to births across Plymouth



Source: PHDU 2006

As seen in Figure 4, the highest number of births in 2007 and 2008 occurred amongst the 17-18yr age range year olds, and young mothers during this timeframe were predominantly White British.

Figure 4: Number of Births by age group 2007 and 2008 totals



Source: Plymouth Hospitals Trust Data, 2009

5. Teenage Parents

Evidence clearly shows that having children at a young age can damage young women's health and well-being and severely limit their education and career prospects. While young people can be competent parents, longitudinal studies show that children born to teenagers are more likely to experience a range of negative outcomes in later life, and are up to three times more likely to become a teenage parent themselves.

As outlined in the DCSF guidance 'Accelerating the Strategy to 2010', national data around teenage conceptions are stark:

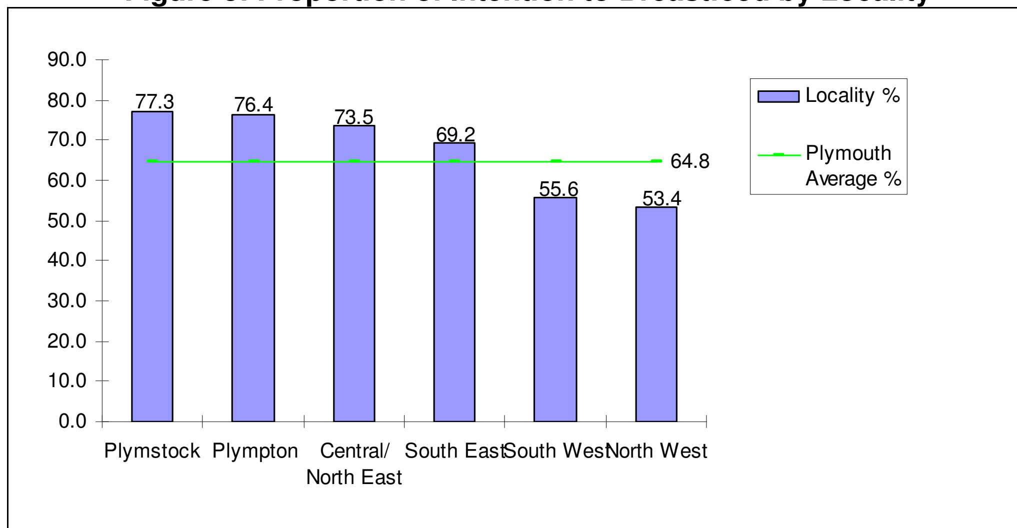
- At age 30, teenage mothers are 22% more likely to be living in poverty than mothers giving birth aged 24 or over, and are much less likely to be employed or living with a partner.
- Teenage mothers are 20% more likely to have no qualification at age 30 than mothers giving birth aged 24 or over.
- Teenage mothers are more likely to partner with men who are poorly qualified and more likely to experience unemployment.
- Teenage mothers have three times the rate of post-natal depression of older mothers and a higher risk of poor mental health for three years after the birth;
- The infant mortality rate for babies born to teenage mothers is 60% higher than for babies born to older mothers;
- Teenage mothers are three times more likely to smoke throughout their pregnancy, and 50% less likely to breastfeed, than older mothers – both of which have negative health consequences for the child;
- Children of teenage mothers have a 63% increased risk of being born into poverty compared to babies born to mothers in their twenties, have higher mortality rates under 8, and are more likely to have accidents and behavioural problems.
- Among the most vulnerable girls, the risk of becoming a teenage mother before the age of 20 is nearly one in three.

Teenage parents in Plymouth have numerous needs:

5.1 Repeat conceptions. Maternity data for 2007-2008 indicates that a significant number of Plymouth's teenage mothers have typically had at least one previous conception prior to giving birth to their first child. 7% of our teenage mothers already had one other child by the time they were 17yrs[6].

5.2 Breastfeeding prevalence among teenage mothers nationally is comparatively low compared to older mothers, around a third less[7]. In Plymouth, the proportion of mothers initiating breastfeeding is lower than the comparable and England averages. Overall, 64.8% of new mothers in Plymouth report that they intend to breastfeed, with this rate varying across the City.

Figure 8: Proportion of Intention to Breastfeed by Locality



Source: 2006 Public Health Development Unit

5.3 Smoking rates throughout pregnancy are three times higher among young mothers than with older mothers, including older mothers from lower socio-economic groups[8]. Plymouth Hospital Trust data for 2007/2008 shows that young mothers who smoke at initial booking often still smoke at delivery.

5.4 Not in Education Employment or Training (NEET): According to Connexions data, teenage mothers make up the largest proportion of NEETS in Plymouth, often due to low availability of or inflexible post 16 employment, education and training opportunities.[20] There are differing levels of NEETs in each locality, as illustrated in Table 5.

Table 5: NEETs by locality in 2009

Locality (23 March 2009)	% EET	%NEET
Central & North West	94%	5.0%
North West	**86%**	**13.0%**
Plympton	96%	3.3%
Plymstock	95%	4.1%
South East	**88%**	**10.6%**
South West	**87%**	**11.5%**

Source: Connexions 2009

[6] Plymouth Hospitals Trust Data April 2007- March 2008
[7] Teenage Parents Next Step: Guidance for Local Authorities and Primary Care Trusts. DCSF July 2007
[8] Teenage Parents Next Steps: Local Authority and Primary Care Trust Self Assessment Toolkit. TPU February 2008

6. The Views of Children and Young People

A city wide consultation with young people undertaken by the Children's Fund in 2008 included several questions about Sexual Health and Risk Taking Behaviours. Of the 3047 young people included within this consultation, 2091 were over the age of 13yrs. Children below this age were not asked questions regarding sexual activity or behaviours.

Table 6: Overview of sexual health related questions

	Yes	No	Total Answered	DNA	Total	% Yes
Ever had a sexual relationship?	694	1329	2023	1024	3047	34.31
Ever had sex under the influence of alcohol?	276	420	696	2351	3047	39.66
Feel confident about negotiating sex with partner?	530	129	659	2388	3047	80.42
Parents know about your sexual activity?	253	425	678	2369	3047	37.32
Have you ever been concerned about your sexual health?	231	442	673	2374	3047	34.32
Have you received sex education in school?	1855	152	2007	1040	3047	92.43
Do you know where to get condoms?	1154	735	1889	1158	3047	61.09

Of the 685 young people who were asked when they had their first sexual experience[9], 63% stated that they were between the ages of 13-14yrs, with an additional 23% experiencing this aged 15-16yrs. 14% of those consulted had their first sexual experience at 12yrs or under.

The top five responses provided when young people were asked who they would like to get information from regarding sexual health include, in order of preference:

1. Parents / carers
2. Friends
3. School nurse
4. Teacher
5. Doctor

In 2006, the Plymouth Youth Parliament produced a report about Sex and Relationships Education, which provided several recommendations for future action. Evidence to inform the report was generated through interviews with key professionals and a survey completed by over 150 young people.

The report found that:

- Young people want a structured SRE syllabus.
- Over half of young people interviewed wanted more information on the relationship side of SRE – more emotional education.
- When asked how SRE could be improved, popular responses included;
  - Better teachers, who explained things more fully and were comfortable with the content of SRE;
  - Want to learn more about contraception – such as correct use of condoms;
  - More information about the emotional side of having sex;
  - Should be taught about homosexual relationships.

[9] The term 'sexual experience' was not predefined and so young people responded to this question based on their own understanding of what constitutes sexual experience.

The report concluded that current SRE provision is far too inconsistent and lacking, and provided a number of proposals for change, as seen in Table 7.

Table 7: Proposals for change

Current System			Proposed System	
AREA OF SRE	**OPERATION**	**IMPACT ON YOUNG PEOPLE**	**OPERATION**	**IMPACT ON YOUNG PEOPLE**
Teaching	Teachers are not always specifically trained, and may lack knowledge, or ability to enthuse young people. They can often feel uncomfortable teaching the subject, creating inconsistency within regions/schools.	The inconsistency creates lack of knowledge within young people, which leads to increased STIs and teenage pregnancies. Poor teaching may produce lack of interest in SRE.	Specifically trained teaching staff employed and shared by several schools in one area (paid for through the LEA). Better and more innovative resources.	A better general awareness of sex and relationships, which will lead to a decrease in STIs and teenage pregnancies. To promote maturity within students.
Assessment	There is no formal compulsory system for assessing SRE.	Teaching of SRE is not consistent across different areas and schools, making it difficult for young people to properly understand every aspect of SRE.	SRE should be assessed and enforced by OFSTED, and also could offer accreditation for the students who study it.	Helps track the progress of schools, and ensures that all students receive the same level and standard of SRE. This will offer a reason to attend the classes.
Curriculum	A part of citizenship, but SRE itself is not compulsory or standardized. Some schools do not follow the curriculum (especially in some schools where it contradicts with their faith).	Students receive different SRE depending on the attitude of the school they attend. The level of learning varies, so there are students who have gaps in their education.	Compulsory, standardized curriculum, covering a number of issues, starting from primary school.	Ensure that all students obtain the same level of SRE, in order to decrease STIs, teenage pregnancies etc

Source: Plymouth Youth Parliament Sexual Health and Relationship Education Report 2006

At the end of 2008, 37 young people were consulted citywide to inform the development of a new citywide strategy to improve young people's sexual health and wellbeing. This consultation, which focused primarily on sex and relationships education, took place both in small groups and face to face with 26 girls and 11 boys between the ages of 11-13yrs.

Key findings from this consultation:

- Schools are the most popular place for where services should be delivered (because we are already there);
- Young people (years 7/8) felt that receiving SRE at 10-11yrs was the right age;
- Young people wanted to talk to their parents, but felt that their knowledge was out of date and they needed educating too;
- Young people want to see something 'real' about SRE, teenage pregnancy etc rather than just read or be 'taught';

- Young people value learning about SRE from someone who they can trust, is kind, has a sense of humour and is of the same sex. Discussing within same sex groups was also considered;
- Young people want to be anonymous about SRE – to ask the 'silly' questions that their friends may laugh at them about. Teachers are 'too familiar' and young people want someone they don't know – confidential and anonymous;

"It would be good to have someone who's impartial and not around everyday in school"

- SRE is inconsistent within primary and secondary schools
- Key barriers to effective SRE inside and outside of school included i) embarrassment (asking silly questions, other people knowing), and ii) Intimidation from older CYP
- The young people felt that teenage pregnancy rates were so high due to i) peer pressure, ii) alcohol & drugs, iii) self esteem issues – the need for love!, and iv) SRE is not hard hitting enough.

Key messages from the consultation with young people

1. How to get parents to engage with their children around sex and relationships.
2. The transition between primary and secondary school is important in relation to SRE. Young people want to have (age appropriate) SRE before going secondary school.
3. Language is not helpful in schools – SRE has different content according to age.

7. Other Stakeholder Messages

A one day data analysis workshop was conducted using data from a number of key services across the city. Review and analysis of this data was undertaken by stakeholders from across the city including, but not limited to; public health, community nursing, contraceptive services, voluntary and community sector, education, family nurse partnership and Connexions.

1. There are clear links between deprivation, poverty and high rates of conception. This is reinforced by neighbourhood / locality needs identified from data provided by key service areas (Maternity, Connexions, Public Health Unit). Key geographical areas of need that were consistently cited were North West, South West and South East Localities. Plympton locality was considered an area of growing need.

2. There is growing concern, and to a certain extent anecdotal evidence[10] that some young women in Plymouth are getting pregnant because of their perception that they are unlikely to ever achieve anything as important or be good at something else during the course of their lives. Having a baby provides a focus for their lives. Factors such as low self esteem, low achievement, mental health concerns and a poor family environment are critical elements of a young person's decision to have a baby. Additional factors such as the use of alcohol and opportunistic sex, parental aspirations, intergenerational expectations and peer pressure must also be considered.

3. Low aspirations, confidence and self esteem are considered a central factor in Plymouth's current conception rates, particularly for those young people with higher levels of vulnerability. As such, their sexual health needs will be different from other young people.

4. Significant levels of need remain for young parents during pregnancy, birth and up to the child's fifth birthday.

5. Anecdotal information from service providers suggests that there is no significant gap in ages between young mothers and young fathers.

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10 Based on informal feedback from within the Family Nurse Partnership, March 2009

6. There are significant educational needs of teenage parents, which do not fit within services currently available (post 18, CFE GCSEs, crèche facilities, timeframes for exams).
7. The needs of teenagers and teenage parents do not stop once they reach 18yrs. The data also acknowledges that many conceptions are occurring within the 18-19yrs age group
8. We know more about the mothers than the fathers. The sexual health needs of boys and the needs of fathers have been disproportionately explored compared to their role within conceptions and raising children. Concerns about serial impregnators within Plymouth were raised, but more investigation is required to validate this.
9. Informal feedback from service providers indicates that a significant proportion of young mothers have had contact with a mental health service at some point in their lives.

8. Groups of CYP with additional sexual health and wellbeing needs

In addition to more detailed information about risk factors associated with poor sexual health outcomes, this section presents further information about the needs of specific groups of children and young people with additional sexual health and wellbeing needs.

These include:

- Looked after children
- Young offenders
- CYP and ethnicity
- Young women with poor emotional wellbeing
- Lesbian, Gay, Bisexual and/or Transgender
- CYP with a disability
- CYP affected by sexual exploitation
- Boys and young men
- CYP who use alcohol and drugs

CYP Affected by Deprivation

While there are many factors that affect the prevalence of poor sexual health and teenage pregnancy, underlying many of these will be socio-economic issues. Children who grow up in low income families are less likely to stay on at school and gain qualifications; they are more likely to experience unemployment and poverty during adulthood and are at increased risk of experiencing health problems[11].

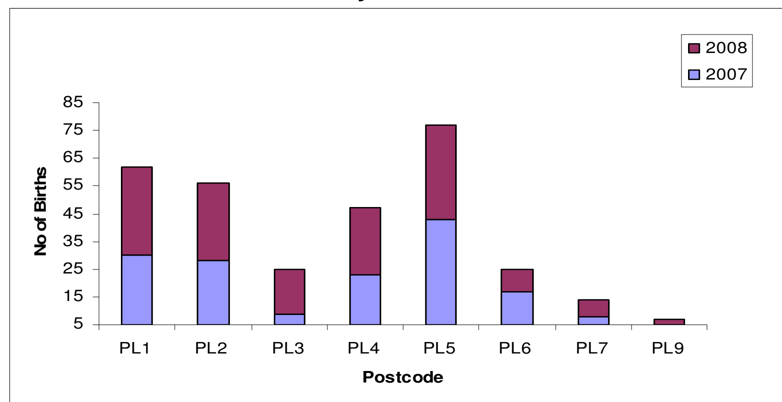
Variations in teenage pregnancy rates are highly correlated with deprivation levels across England.

- Half of all conceptions under-18 in England occur in the 20% most deprived wards.
- Teenage pregnancy rates among the most deprived 10% of wards are four times higher than in the 10% least deprived wards
- Teenage pregnancy 'hotspots', where more than 6% of girls aged 15-17 become pregnant, are found in virtually every local authority in England[12]

What is the situation in Plymouth?

Compared to both regional and national statistics, Plymouth has a greater proportion of children living in deprivation, with nearly 1 in 4 of 0-15 years defined as deprived by the Deprivation Affecting Children Index[13]. Key areas within the city have consistently high rates of births to teenage mothers. These include PL1, PL2 and PL5 which form part of the localities with the most significant levels of deprivation - North West, Central/North East and South West.

Number of Births by Postcode in 2007 and 2008



Source: Plymouth Hospitals Trusts Data 2007/8

Conception rates in most deprived areas

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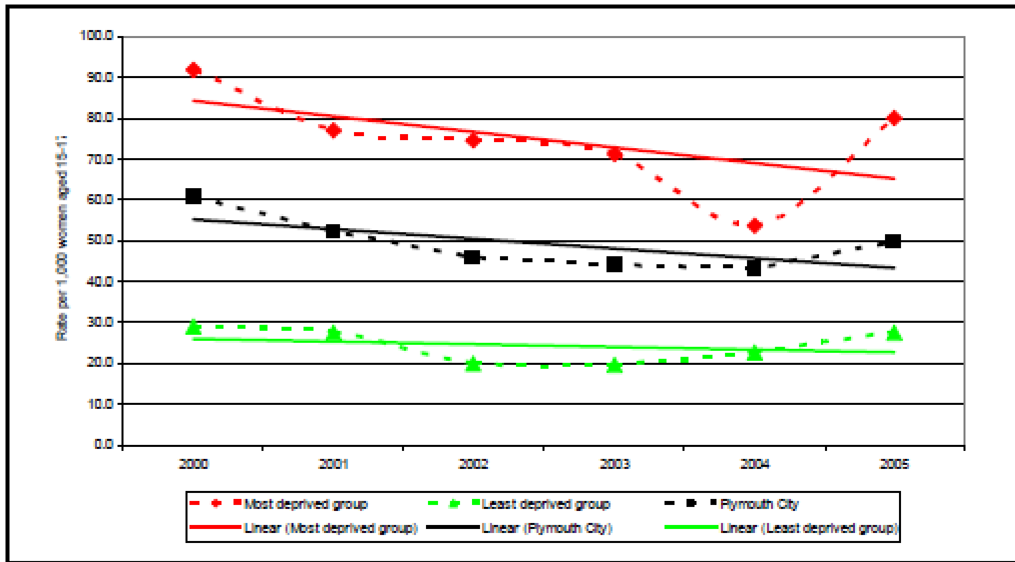
[11] Wellings K, et al (2001) *Sexual Health in Britain: early heterosexual experience.* The Lancet vol.358: p1834-1850

[12] Wellings K, et al (2001) *Sexual Health in Britain: early heterosexual experience.* The Lancet vol.358: p1834-1850

[13] CYPP Plan Needs Analysis 2008-2011


100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
Rate per 1,000 women aged 15-1
2000
2001
2002
2003
2004
2005
Most deprived group
Least deprived group
Plymouth City
Linear (Most deprived group)
Linear (Plymouth City)
Linear (Least deprived group)

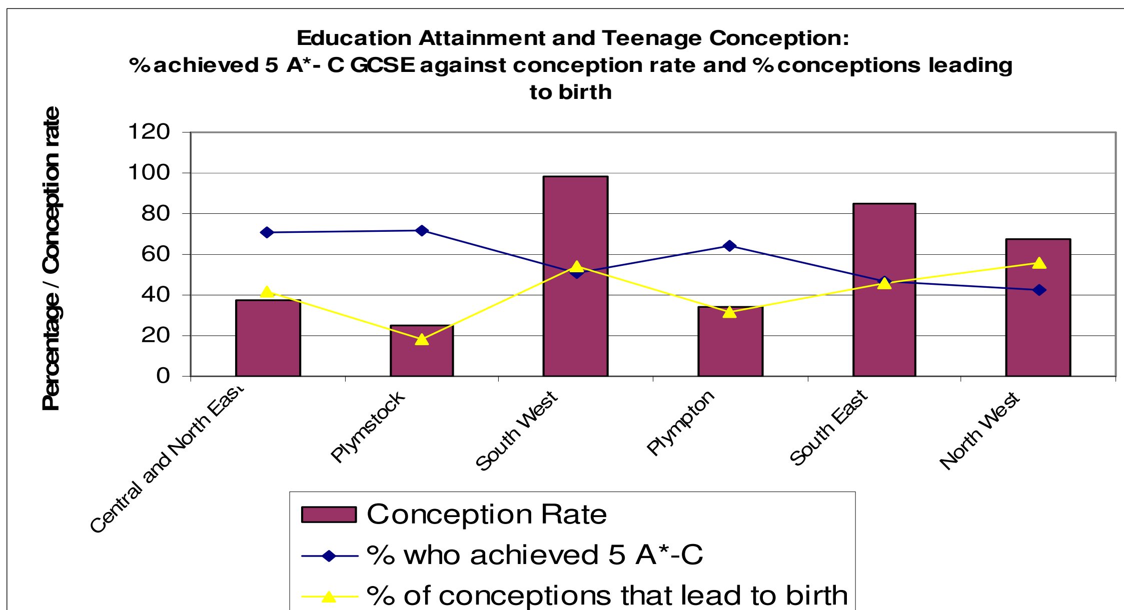
Low Academic Attainment

Research has shown that children and young people with low educational attainment are far more likely to become teenage parents[14]. Factors relating to education that are associated with poor outcomes in terms of teenage pregnancies and poor sexual have been described in the Department for Education and Skills Teenage Pregnancy accelerating the strategy guidance.

- **Low academic attainment** - On average, deprived wards with poor levels of educational attainment had an under-18 conception rate double that found in similarly deprived wards with better levels of educational attainment (80 per 1000 girls aged 15-17 compared with 40 per 1000)
- **Disengagement from schools** – This clearly occurs during pregnancy and after child birth however a survey of young mothers found that disengagement was often happening before conception
- **Leaving at 16 with no qualifications** - Among girls leaving school at 16 with no qualification, 29% will have a birth under 18, and 12% an abortion under 18, compared with 1% and 4% respectively for girls leaving at 17 or over. Leaving school at 16 is also associated with having sex under 16 and with poor contraceptive use.

What is the situation in Plymouth?

Educational attainment and conception rates.



Source: ??

The chart shown above illustrates is a clear correlation across the city between low attainment and high conception rates. Plymouth has a significant number of young people not engaged in formal education, employment or training (NEET). In Plymouth this was 6.8% in 2005 (8.5% in 2002)[15].

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14 DCSF Teenage Pregnancy – Accelerating the strategy to 2010

15 Children's Atlas 2006

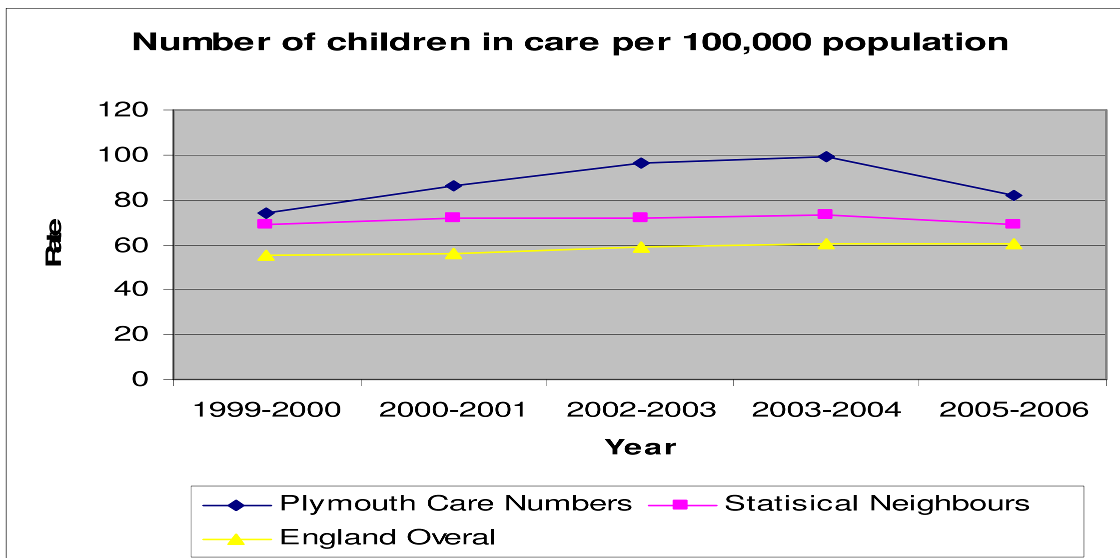
Looked After Children

Children find themselves in care for a variety of reasons. They may have experienced abuse or neglect, or a parent may be unable to care for them for a variety of reasons, or may have died. By definition many children in care will already be very vulnerable and have a higher risk of experiencing poor outcomes.

Research shows that by the age of 20yrs, a quarter of children who have been in care are young parents, and 40% were mothers[16]. The prevalence of teenage motherhood among looked after girls under-18 is around three times higher than the prevalence among all girls under-18 in England.

What is the situation in Plymouth?

Plymouth Local Authority currently has around 92 per 100,000 population under 18 accommodated under a care order or section 20[17]. This is significantly more than the national figure of around 66 per 100,000 population under 18.



Source:??

[16] Berrington A, Diamond I, Ingham R Stevenson J *et al* (2005) *Consequences of teenage parenthood: pathways which minimise the long term negative impacts of teenage childbearing'* University of Southampton

[17] Epidemiological Information on Children's and Young People's Mental Health Problems in Plymouth, Frier J, Public Health Development Unit, Plymouth PCT

Young Offenders

Research shows there are certain risk factors found among persistent offenders aged 10 -17yrs that increase the risk of them re-offending. These include[18]

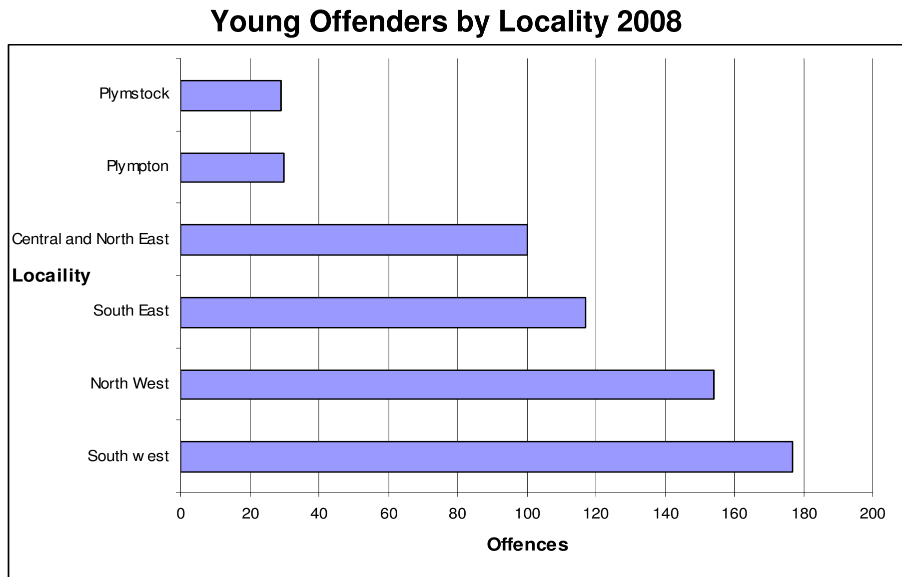
- Family issues, such as low income, conflict
- Education issues such as low achievement, lack of attendance
- Mental health issues, such as behavioural problems, conduct disorders.

Some of these risk factors also contribute towards an increased likelihood of poor sexual health, teenage pregnancy and other risk taking behaviours. Teenage boys and girls who have been in trouble with the police are twice as likely to become a teenage parent, compared to those who have had no contact with the police[19]. In addition, a high proportion of young people in custody aged 15-21 are parents - 25% of young offenders in custody are estimated to be fathers, while 39 per cent of female young offenders in custody are estimated to be mothers[20].

What is the situation in Plymouth?

Young offenders are unevenly spread across the city with the majority residing in the three most deprived localities.Using the figures outlined above (around 25%), the estimated figures of young offenders in Plymouth who are teenage parents is likely to be significant. There is currently no data on actual figures.

Young Offenders by Locality 2008



Source: Youth Offending Service

18 http://www.crimereduction.homeoffice.gov.uk/toolkits/py020201.htm

19 DCSF Teenage Pregnancy – Accelerating the strategy to 2010

20 Teenage Parents Next Step: Guidance for Local Authorities and Primary Care Trusts. DCSF July 2007

CYP and Ethnicity

Black and Minority Ethnic (BME) groups are amongst the most socially excluded group in society, being more likely than others to live in deprived neighbourhoods, be poor, be unemployed, experience ill health, and live in overcrowded and unpopular housing. Young people from black and minority ethnic communities experience the added jeopardy of widespread racial harassment and racist crime[21].

Asylum seekers and refugees form part of BME communities. These families have often experienced trauma, multiple losses and transitions, all of which could potentially have a powerful impact on their children's emotional and psychological well being and the family's functioning. Once in the UK, these families also have to cope with new languages, new social and cultural experiences, racism and significant levels of deprivation.

Ethnicity can shape sexual health knowledge, attitudes, behaviour and outcomes in different ways for different groups of young people. We cannot assume that all young people reflect the patterns that characterise their group as a whole[22].

Poor sexual outcomes for some BME young people include disproportionately high rates of HIV infection amongst young people from Black African backgrounds. Local studies from inner cities in the late 1990s and the 2000 NATSAL survey also indicate that other sexually transmitted infections vary with ethnicity. For example, the lowest prevalence of gonorrhoea and chlamydia was amongst South Asian men and women, and the highest was in black Caribbean and African men and Caribbean women[23]/[24].

Although the majority of teenage conceptions are among the white British population, the 'likelihood' of becoming a teenage mother is higher in certain ethnic groups[25]. However, the 'appropriateness' of a teenage pregnancy can vary between ethnic groups. In some BME groups, a teenage pregnancy will more likely to occur in the context of marriage, and therefore its consequences are not associated with the same patterns as they are in white majority ethnic groups[26 & 27].

For asylum seekers and refugees, the risk of sexual ill health is heightened when considering the barriers to sexual health information and services. Issues of knowledge, such as ignorance of UK laws with regards to rape, as well as service barriers such as the gender of the health worker, language or lack of interpreters could restrict accessibility to services. Many ASR men and women may also be survivors of sexual violence (including rape). In many cultures sexual violence and rape are taboo subjects; discussing experiences may be too uncomfortable.

What is the situation in Plymouth?

Annual audits by the local Ethnic Minority Achievement Service (EMAS) reveal some seventy languages being spoken in Plymouth schools and the growth of the city's University (which is the third largest in the UK with some 30,000 students) and other higher education institutes also indicates a growing diversity across educational sectors.

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21 Mental Health Specialist Library, NHS http://www.library.nhs.uk/mentalHealth/ViewResource.aspx?resID=111332

22 Fraser, S. & Sim, J. 2007. The Sexual Wellbeing of young Black and Minority Ethnic People. WISH, Health Scotland.

23 Low, N., Sterne, J.A. and Barlow, D. (2001). Inequalities in rates of gonorrhoea and chlamydia between black ethnic groups in South East London: cross-sectional study. Sexually Transmitted Infections, 77, 15–20.

24 http://www.everychildmatters.gov.uk/_files/153CD96ED093BB6CC43AB3409022600C.pdf

25 Teenage Parents Next Step: Guidance for Local Authorities and Primary Care Trusts. DCSF July 2007

26 Robson, K. and Berthoud, R. (2003). Early motherhood and disadvantage: A Comparison Between Ethnic Groups. Colchester, University of Essex, Institute for Social and Economic Research.

27 Higginbottom, G.M.A., Mathers, N., Marsh, P. et al. (2006). Young people of minority ethnic origin in England and early parenthood: views from young parents and service providers. Social Science and Medicine, 63, 858–870.

The city has also seen a substantial rise in migrant workers from those countries (Poland and the Czech Republic in particular) that acceded to the EU in 2004, and from becoming a Home Office dispersal site for asylum seekers since 2000. The most salient aspect of Plymouth's BME population is that it represents a rapid growth area for the city that is driven particularly across younger age groups.

As of January 2008, figures from the Borders Agency indicated a total of 363 asylum seekers receiving Section 95 Support. Of these, 167 are single, with 196 families and 223 under 18s[28] In addition, in August 2008, there were 16 unaccompanied asylum-seeking children currently being cared for by Children's Services.

CYP with poor emotional wellbeing

There is compelling evidence that strong social and emotional skills help to shape young people's level of self-awareness and self esteem, their ability to build warm relationships and empathise with others. This in turn has a positive impact not only on young people's learning and educational attainment but also on their emotional and mental health[29]

A review of the literature on the link between teenage pregnancy and self-esteem concluded that the risk of teenage motherhood is raised – possibly by up to 50% – among teenage girls with lower self-esteem than their peers. Precisely why low self-esteem has this effect is as yet unclear, but it is thought to be linked with an increased likelihood of unprotected intercourse[30] and therefore a risk of poor sexual health also.

In addition, research shows that young mothers have higher rates of poor mental health after birth for up to three years compared to older mothers. Poor emotional health not only affects the well being of a young mother but also affects her ability as a parent, which can lead to an increased risk of accidents and behavioural difficulties for her child.[31]

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28 The mental health of asylum seeking & refugee women, children and young people in Plymouth By Devon & Cornwall Refugee Support Council & Plymouth Teaching Primary Care Trust, February 2008

29 Teenage Parents Next Step: Guidance for Local Authorities and Primary Care Trusts. DCSF July 2007

30 Emler, N. (2001). Self-esteem: the costs and causes of low self-worth. York: Joseph Rowntree Foundation.

31 Teenage Parents Next Steps: Local Authority and Primary Care Trust Self Assessment Toolkit. TPU February 2008

Lesbian, Gay, Bisexual and/or Transgender

The Government estimates that 5-7% of the total UK population identifies as being LGBT, and no definitive figures exist because no national census has ever asked people to define their sexuality[32] It is useful to understand what it meant by these terms[33] in order to understand their sexual health and wellbeing needs.

Gay is a synonym for homosexual. Since the late 1960s, homosexual men and women have publicly adopted the word gay as a positive alternative to the clinical sounding homosexual. A lesbian is a homosexual woman. The word derives from the Greek island of Lesbos, where Sappho, a teacher known for her poetry celebrating love between women, established a school for young women in the sixth century B.C. A bisexual young person is sexually attracted by both sexes. Transgender people are those who, consistently and generally since a very early age, have felt that their gender is the opposite of their biological sex.

Young gay, bisexual and/or transgender young people can face specific challenges to their physical and emotional well-being. These include discrimination, victimization, homophobic bullying and an elevated suicide risk[34]. Such challenges can lead to certain risk taking behaviours which in turn can lead to poor sexual health outcomes.

Young LGBT may also face specific barriers in terms of advice and service provision. Sex and relationships education commonly focuses almost exclusively on heterosexual relationships and does not necessarily explore issues of sexuality and sexual orientation. Many young LGBT may feel as if their sexuality and experiences ‘don’t count’.

A new term has recently come into use, and is used primarily within health & HIV/AIDS fields is – ‘men who have sex with men’. This term recognises that some men who have sex with other men also have sex with women, and may not "identify" with being homosexual or bisexual.

While new cases of HIV are now increasingly common among heterosexual couples, men having sex with men (MSM) remains a group at highest risk of HIV, with a steady rise in the number of HIV diagnoses since 2000[35].

Proportion of the total male diagnoses attributed to MSM in 2007 in the South West.

STI	MSM
Chlamydia	3%
Gonorrhoea	17%
Syphillis	65%
Herpes	4%
Warts	3%

Source:HPA

Some lesbians/bi-sexual women who have or have previously had sex with men are also at risk of STI transmission/infection. A health survey conducted by Stonewall found that half of all lesbian and bisexual women who had been screened had an STI, and a quarter of these had only had sex with women in the last five years.

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32 http://www.stonewall.org.uk/information_bank/sexuality_key_questions/79.asp

33 http://www.fpv.org.au/2_9_1.html

34 Playing it safe: addressing the emotional and physical health of lesbian and gay pupils in the UK

35 http://www.tht.org.uk/informationresources/factsandstatistics/uk/menwithmen/

CYP with a Disability

Learning Disability

1.5 million people in the United Kingdom have a learning disability, of which around 350,000 are children and young people aged 0-19yrs[36]. Children and young people with a learning disability often don't get the same opportunities as other children and young people. They can face exclusion at all stages of their childhood, from early years support to accessing education services, play and youth opportunities and transition to adulthood.

Young people with a learning disability have the same range of sexual thoughts, attitudes, feelings, desires, and activities as people without disabilities[37]. According to the National Children's Bureau (2004) young people with a learning disability need information about how to protect themselves from unwanted pregnancies and sexual exploitation.

However, having a learning disability often makes it harder for people to learn, understand and communicate [38], so access to sexual health information and services can be difficult if services are not promoted in a way that is accessible to young people with learning disabilities.

In addition, children and young people with learning disabilities are often regarded by parents and carers as asexual 'eternal children' who need to be protected from the world of sex and sexuality[39]. These factors combine to limit the access of young people with learning disabilities to the advice, information and help that they need from formal services, and to the informal channels through which many other young people learn about sex and sexuality[40]

Research also indicates that youth with disabilities are four times more likely to be abused than their peers[41].

Physical Disability

There are physiological problems associated with some physical disabilities, such as reduced sexual function and loss of sensation. With regards to fertility, a physical disability tends to impact more on male fertility than female, since men with some disabilities can be troubled by impotence. Women with physical disabilities are generally as fertile as women without disabilities[42].

As with learning disabilities however, there can also be emotional and self esteem issues linked to body image concerns, and the prejudice of others[43]. Some forms of physical disability may evoke the same 'protective' response from parents and carers, thereby limiting the young person with the disability from accessing sexual health information and services.

What is the situation in Plymouth?

Needs mapping for the Integrated Disability Service identifies 1528 children and young people with disabilities that receive specialist services from Health or Children's Services. This is equivalent to 2.7% of known child population in the City. The North West and South West localities have the highest proportion of children with disabilities at 3.6% and 3.4% of total population under 19 respectively.

Compared with similar authorities, Plymouth has a slightly lower number of young people with learning difficulties, but a higher number of young people with speech, language and communication needs, as well as autistic spectrum disorder (ASD)[44]

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36 Mencap, 2008

37 http://www.disability.vic.gov.au/dsonline/dsarticles.nsf/pages/Disability_and_sexual_issues?OpenDocument

38 Journal of Health and Social Care Improvement, kuljit heer:June 2008,Teenagers, Pregnancy, Learning Disabilities: Wolverhampton City in context

39 Health Scotland. (2004). People with Learning Disabilities in Scotland: Health Needs Assessment Report:. Glasgow, Health Scotland.

40 Fraser, S & Sim, J. (2007) Sexual Health Needs of young people with learning Disabilities, NHS Health Scotland

41 Journal of Health and Social Care Improvement, kuljit heer:June 2008 Teenagers, Pregnancy, Learning Disabilities: Wolverhampton City in context

42 http://www.disability.vic.gov.au/dsonline/dsarticles.nsf/pages/Disability_and_sexual_issues?OpenDocument

43 http://www.disability.vic.gov.au/dsonline/dsarticles.nsf/pages/Disability_and_sexual_issues?OpenDocument

44 CYPP Plan Needs Analysis 2008-2011

Sexual Exploitation

In law, sexual exploitation is defined as the "sexual use of a child under the age of 18 by those responsible for his/her care, custody, and control for the purpose of pornography and/or prostitution[45].

In broader terms, sexual exploitation of children and young people under 18 involves exploitative situations, contexts & relationships where a person (or a third person or persons) receives 'something' (eg: food, accommodation, drugs, alcohol, affection, gifts, money) as a result of them performing, &/or another or others performing on them, sexual activities.

In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength &/or economic or other resources. Violence, coercion and intimidation are common. Involvement in exploitative sexual relationships is also often characterised by the child or young person's limited availability of choice resulting in their social/economic and /or emotional vulnerability[46].

Sexual exploitation in all forms will have negative impacts on sexual health, alongside a negative impact on the emotional well being and mental health of the child or young person involved.

Commercial Sex Work - The prostitution of children and young people is a form of sexual exploitation and abuse. Children can be drawn into commerical sex work by manipulative adults who wish to make money. Those who benefit from child prostitution use sophisticated methods to lure their victims in, and keep them there. It can begin with an 'exciting' new relationship with an older boyfriend who may in fact be, or become, a pimp. The child may receive expensive gifts and be introduced to alcohol and drugs. Before long the pimp creates a loyal and dependent relationship with the victim and can then persuade or force them to make money for him by providing sexual services to others. This is an illegal form of sexual abuse, which puts the child involved at risk from severe physical, emotional and psychological damage[47]

There are a variety of issues that can increase a child or young person's vulnerability to sexual exploitation:

1. **Substance misuse -** Alcohol can leave young people vulnerable to sexual assaults. Sex and drugs are strongly linked to commercial sex work, for example where young people sell sex in order to access drugs, or may use drugs to help them cope with being a sex worker. In addition, there are links with the use of alcohol and drugs within recreational environments, and situations where young people, primarily young women, who have run out of money may be prepared to have sex in exchange for drugs[48].

2. **Refugees and asylum seekers** – Some children and young people will have been subject to sexual violence and exploitation in their home countries– sexual violence has been used as a weapon through history to degrade and humiliate an enemy[49]. In addition, some children and young people may have been trafficked to the UK and forced into sex work.

3. **CYP with a disability** - there is well-documented vulnerability to sexual abuse and violence[50]/ [51]

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45 http://www.dss.mo.gov/cd/info/cwmanual/section7/glossary/glossary.pdf

46 http://www.croydon.gov.uk/contents/documents/meetings/621015/805236/2008-01-14/sexuaoject.pdf

47 http://www.peterborough.gov.uk/page-13492

48 Independent Advisory Group on Sexual Health and HIV, (2007) Sex, Drugs, Alcohol and Young People A review of the impact drugs and alcohol have on young people's sexual behaviour

49 Burnett, A. & Fassil, Y. (DATE) Meeting the health needs of refugee and asylum seekers in the UK. An information and resource pack for health workers. NHS, DoH

50 Beail, N. and Warden, S. (1995). Sexual abuse of adults with learning disabilities. Journal of Intellectual Disability Research, 39, 382–387

51 Sequeira, H. and Hollins, S. (2003). Clinical effects of sexual abuse on people with learning disability: critical literature review. British Journal of Psychiatry, 183, 451–456.

Boys and Young Men

Boys and men are often left out in our efforts to improve young people's sexual health, as many services, in particular contraceptive services are more geared towards meeting the sexual health needs of women. Yet we know that the behaviours and values of boys and young men affect the sexual health of young women[52], and a failure to address the sexual health needs of young men, contributes to the poor preparation of men for adulthood, contraceptive usage, and safe sex.

Here is some useful data[53] about the sexual health and wellbeing needs of boys and young men:

- The first National Survey of Sexual Attitudes and Lifestyles found that boys have their first sexual experience (as opposed to sexual intercourse) aged 13[54].
- The second National Survey found that the majority of 16-19 year old young men reported their first heterosexual intercourse aged 16[55].
- 30% of men in the same age group reported having sexual intercourse before the age of 16[56].
- 5% of men aged 16-24 report some homosexual experience[57].
- Boys were more likely to give their reasons for first sex as 'peer pressure, opportunity and curiosity' compared to girls who were more likely to cite being in love, but the difference between the sexes is becoming less pronounced[58].
- 1% of young men are fathers before the age of 18[59].
- Men are poor users of health services generally, leaving symptoms longer than necessary and can be reluctant to ask for or accept help[60]. Young men can view sexual health services as being for women and worry that they will be met with disapproval and judgmental attitudes.
- Young men's knowledge of contraception is low and confined mainly to condoms and to a lesser extent the combined pill[61].
- They are also much less likely than young women to know how or where to access services. The Schools Health Education Unit Survey in 2004 found that only 34% of 14-15 year old boys knew where their local young people's services were and 38% of boys in the same age band did not know where to get free condoms[62].
- Boys can feel particularly excluded by the focus during sex education on contraception and pregnancy which they often perceive as girls' responsibility and as irrelevant to them.
- There is conflicting evidence about young men's source of information about sex. The second National Survey of Sexual Attitudes and Lifestyles reported that school lessons had been the main source of information for 16-19 year olds. However, the Schools Health Education Unit Survey found that for 14-15 year old boys, school lessons ranked slightly below friends.

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52 http://www.rho.org/html/menrh_theme-adol-boys.html

53 Data sourced from www.brook.org.uk

54 K Wellings et al, Sexual Behaviour in Britain. The national survey of sexual attitudes and lifestyles, Penguin, 1994

55 K Wellings et al, Sexual behaviour in Britain: early heterosexual experience, The Lancet, Vol 358, December 1 2001

56 K Wellings et al, ibid, 2001

57 K Wellings et al, op cit, 1994

58 K Wellings et al, op cit, 1994

59 K Wellings et al, op cit, 2001

60 T Lloyd & S Forest, Boys and Young Men Literature and Practice Review, Health Development Agency, 2001

61 R Ingham et al, More than just a pill: young people's knowledge of, and views about, hormonal contraception, unpublished Brook research, 2001 and Lyndsey Edwards, unpublished research into the attitudes and behaviour of young men towards contraception, 2000

62 J Balding, Young People in 2004, Schools Health Education Unit, 2005

- Boys are less likely than girls to discuss sex and relationships with their parents. Fewer than 10% of 16-19 year old young men described parents as their main source of information compared to over 20% of women in the same age group[63].

CYP who Use Alcohol and Drugs

Alcohol Use

When young people use alcohol and/or get drunk it may be their choice, it may be coercion and peer pressure, or it may be against their will resulting from someone 'spiking' their drink. Statistics for young women aged 16-24yrs show that they now consume the same amount of alcohol as men of the same age group.

Possible outcomes of alcohol use is that young people may lose willpower or inhibitions. The greater the level of alcohol consumed, the greater the chance of unprotected sex. Studies from Scandinavia show that it is 2 or 3 times more likely that young people will have unprotected sex when drunk. In Norway, three quarters of 16-20 year olds use contraception while sober, compared to 59% who are moderately intoxicated and just 13% of those who are strongly intoxicated[64]. In addition, young women when drunk are more likely to have multiple sexual partners[65].

Drugs Use

Drugs are used for a range of different purposes in relation to sexual activity: as an aphrodisiac, to enhance the sex act, or just to 'feel good'. Drugs have a real effect on young people's inhibitions and judgment, and can lead to engagement in high risk sexual behaviours, alongside the serious physical and mental side effects to their use. Research shows a strong correlation between STIs, sexual behaviour and type of drug used.

In the UK, 40% of sexually active 13 and 14 year olds were "drunk or stoned" at first intercourse[66]. Of 15 to 19 year olds who have had sex with someone they knew for less than one day, 61% of young women and 48% of young men gave alcohol or drugs as a reason[67]

What is the situation in Plymouth?

The 2006 Children's Fund Consultation Report[68] found that;

- 77.5% of CYP have tried alcohol, 39.1% drink regularly
- 2.3% of those that drink regularly do so daily, 36.6% drink weekly
- The most popular method for obtaining alcohol is from the home, followed by friends
- and then relatives
- 24.1% of CYP have been offered drugs, with 10.5% having used drugs at least once
- 4.3% of CYP are regular drugs users

In addition, figures for alcohol attributable hospital admissions during 2006/07 showed that the 16-24 age group had the highest proportion of acute alcohol admissions.

63 K Wellings et al, ibid, 2001

64 Traeen B and Kvalem I (1996) Sex under the influence of alcohol among Norwegian adolescents, Addiction 91:pp995-1006.

65 Independent Advisory Group on Sexual Health and HIV, (2007) Sex, Drugs, Alcohol and Young People A review of the impact drugs and alcohol have on young people's sexual behaviour

66 Wight D et al (2000) Extent of regretted sexual intercourse among young teenagers in Scotland, British Medical Journal, no 7244, pp 1243-1244

67 Ingham R (2001) Survey commissioned by Channel Four for the series 'Generation Sex', presented 16th October 2001

68 http://www.voices.uk.net/reports

9. Glossary

To be completed

10. Bibliography

To be completed