

**Sexual Health Forum
EU Commission
Brussels, 13th January, 2010**

DG SANCO is the acronym for the Directorate General for Health and Consumer Affairs at the European Commission. Their public health initiatives include the support of a Sexual health forum with the remit to implement the policy to improve young people's sexual health. Regular meetings are held between the EU Commission, representatives of EU countries, youth representatives, researchers and public relation experts in the sexual health forum. Stakeholders are invited to participate in the ongoing debate on:

- involving young people in developing, spreading and implementing strategies
- methods of informing and communicating with young people
- best practices in EU countries
- access for young people to appropriate sexual-health services
- improving data collection on sexual transmitted diseases.

The latest meeting was held in snowy conditions. There were about 30 delegates present.

Robert Madelin, Director General, DG SANCO welcomed the delegates and opened the meeting. He described the continuing reconfiguration of the Commission, with the Health Commissioner designate, John Dalli from Malta, attending confirmation hearings on the day. The outgoing Commissioner, Mrs Vassiliou, had been confirmed into a Commissioner appointment with responsibility for Education, Culture and Youth, so it may be hoped the issues of young people's sexual health may be carried forward in joint approaches. Since the new Commission was not fully confirmed, no decisions could be made but an up to date brief for the new commissioner based on the day's proceedings could be prepared. A permanent secretariat to the sexual health forum had been appointed to allow work between meetings. By the end of February a call for tender could be expected around communication and social marketing in sexual health. A further meeting in September was planned.

Andrez Rýs chaired the rest of the day

Copies of the presentations will be on the website
http://ec.europa.eu/health/sexual_health/events/forum_en.htm

Monica Idestrom from the Swedish Department of Social Health and Welfare gave a summary of the Swedish experience of provision of sexual health services for young people. She described an ongoing chlamydia epidemic despite 400,000 tests per year. Surveys taken in 2006 and 2008 revealed a lack of structure to local services. The National Board for Health and Welfare set out a plan of action to focus on chlamydia management and on primary prevention. They are taking a logical framework approach. This involves deciding on measurable goals and specified indicators with knowledge based activities to reach the goals in four arenas- schools, health,

leisure and communications. Evaluators have been appointed to assess progress. The aim is by 2014 to achieve progress in four main areas; increased condom use with new or occasional partners; increased self-knowledge of the consequences of unprotected sex; higher proportion of the population of young people seeking STI testing and enhanced awareness of risk behaviours. Each main area will have 3-5 indicators. All counties will take part in partnership with NGOs, and the NBHW are issuing knowledge based summaries on good practice. She described an example of good practice within a county with low incidence of STIs. Among the features of the services in this area centralised contact tracing using specialised midwives and social workers.

Jan Clarke from the English National Chlamydia Screening Advisory Group presented a description of the development of the chlamydia screening programme in England in the context of developing community based sexual health services and diversity of providers in devolved local health economies. National performance targets had accelerated the development of the programme and changes in policy, practice and legislation had allowed an expansion of screening and treatment in community settings. She felt the goal of achieving 50% annual coverage to drive down prevalence is feasible, since projections indicated this could be done with recruitment of around 60% of key venues (contraceptive clinics, general practices) screening one person per working day. Social marketing to healthcare professionals to promote offer of testing was essential in addition to promoting the acceptance of testing by marketing campaigns aimed at young people. She presented data to show current coverage was around 24% with over 1 million tests being screened outside specialist services in 2008/9. The programme was under scrutiny by the English Parliament and a report was awaited from the Public Accounts Committee.

Penny Cook from the North West Public Health Observatory, England presented data on alcohol and sexual health in England. She presented evidence from a rapid review of studies of alcohol use in young people, mainly based in England. She described the UK youth culture as being one of drunken dating. The media linked youth, sexuality and alcohol in strong images of attractive people advertising and supporting heavy drinking habits. The culture of supermarket bargains meant drinking was a much cheaper pastime than access to sporting events and activities. Binge drinking was related to violence, regretted sexual activity and forgetfulness. High volume drinks such as cider with a low cost per unit of alcohol were more closely linked to violent behaviours compared with drinking spirits. There were self esteem issues linked to alcohol use, with body image concerns linked to binge drinking. In a survey of school life and alcohol use, better performing schools were associated with lower alcohol use in their pupils. Sexual experience at 13-14 years was closely associated with alcohol consumption rates; in those describing no or little alcohol use only 10% had been sexually active, compared with 60% of those drinking regularly. Protective elements seemed to be sports and hobbies and parental supervision of drinking. Teenage pregnancy, admission for alcohol related problems and social deprivation were linked in English studies, but in Denmark, where there is the highest rate of drinking in 15-16 year olds there is a low teenage pregnancy rate. During the discussion, the representative from the Public Health forum described the

development of a response by the Royal College of Physicians, BASHH and public health researchers. A sexual health and alcohol group had been convened to gather evidence related to STIs and alcohol, develop new management and training protocols and to encourage good practice dissemination.

Christine Klapp from Berlin presented her experience of sex education in schools delivered by the Doctor's Association for the promotion of women's sexual health. This was a network of 85 female doctors delivering preventative medical education to young people in schools, and specific programmes targeted at immigrant women. She described a survey indicating increased knowledge of STIs in young people following the sessions. A discussion followed, with German health ministry delegates emphasising that SRE is compulsory in German schools, and that Germany has the lowest teenage pregnancy rate in Europe and low HIV prevalence. NGO groups stressed the benefits of involving young people in development of education, with the focus on empowering them to make safe choices.

After lunch

Professor Alain Giami from INSERM, France, presented a consideration of healthy sexuality. He stressed that sex was part of well being. In recent times there had been dissociation between the erotic and reproductive aspects of sexuality. Procreation was now seen as an individual choice instead of a probable consequence of sexual activity in heterosexual couples. Attitudes to homosexual behaviour were also evolving towards acceptance of diversity. He described the attempts by the World Health Organisation and World Association for Sexuality to develop definitions of sexual health which focus on rights to emotional sexual expression in the context of responsible sexual behaviour.

The aspects of adolescent sexual rights were more complex. There was wide variation in legal codes affecting sexual health issues cross Europe, such as age of consent, access to contraception and SRE.

Teenage sex tended to be labelled as regretted and risky – but young people enjoyed having sex and there was not enough emphasis on when sex could give satisfaction and fun. Authorities tended to press the message to say “no” – but not when should a young person say “yes”.

Hanneke de Graaf from Holland presented her work reviewing the literature on influences on sexual health of young people. Which key skills and competencies do young people have to develop in order to maintain and improve their sexual health? Interactional competence seems to be a key element in order to arrange sexual encounters in a rewarding way. This social competence requires skills such as ability to manage ambivalence, to perceive subtle and non verbal cues, to have a sense of connectedness between parents, adolescents and their partners and the ability to build a good romantic relationship. She discussed various gender specific models for key skills in sexual health.

Discussion included how Internet access may be influencing young people in influencing their perception of sex and sexuality through pornography and as a meeting point for partners through networking sites.

Round table discussion – What sort of sex and relationships education do we need?

Malta – restrictions due to strong Catholic community pressures- emergency contraception is illegal, no comprehensive SRE. The abstinence only model has recently been challenged and skills, knowledge and values based teaching is being developed.

Finland – formal and informal SRE begins at 5-11 years old. A new mandatory SRE curriculum from 2006 aims at increasing self esteem and teaching emotional and social skills. This includes emotional, sexual and physical elements of sexual health. In older children, EHC and condoms are available from school nurses. This year, following project RESPECT, mandatory age specific sexual health counselling is to be introduced. Issues of the optimum way to improving quality of SRE delivery, training teachers and monitoring outcomes were still challenges.

Poland – young people's surveys were very difficult to develop. The social setting was similar to Malta with considerable restrictions to access to young people for SRE.

European Youth forum – an umbrella group for 99 youth organisations and youth councils across Europe. Advocates for youth friendly sexual health services and policies. Stressed the possible role for youth organisations in informal SRE outside the school setting.

Utrecht study – in a study of risk behaviours in school age students a subgroup of about 20% emerged with high levels of mental health issues, high alcohol intake and sexual risk taking behaviours. This group was overrepresented in lower achievement schools. The question of possible targeted approaches was discussed.

Andrez Rýs

Summing up the day, motivational interviewing to alter sexual behaviour was a strong theme in SRE, but could this be applied in all EU countries? The Sexual health forum was looking to develop a library of resources and to provide help with translation.

Products from the forum were planned to include

- work towards a European school curriculum(in association with UNESCO);
- training the trainers work;
- circulation on short attachments of experts to share what works and what does not;

A preventative role for ECDC could be developed.

Picking up points from the presentations, he reflected on the costs of screening and legal environment allowing chlamydia screening in England; the close links between the sexualisation of young people close link between alcohol and sex in the British media; the importance to stress the healthy aspects of sexual behaviour and how we influence the 20% of young people at particular risk through their behaviour.

Gunta Lazdane, Regional Director for WHO was the final participant. She presented her views on the next steps.

She stressed the WHO still had only a working diagnosis of sexual health. Data on sexual health parameters in the EU was still difficult to reconcile. In 27 centres, different age ranges and definitions were used. REPROSTAT 3 data would be available at a Sexual Health in Europe meeting to be hosted by the Spanish government at a date in October (tbc) and global standards for sexuality education were being developed.

If Europe was developing a sexual health strategy then WHO would be happy to collaborate. Special consideration should be given to the sexual health needs of adolescents, the elderly, those HIV infected, the disabled and immigrants.

Andrez Rýs then thanked all the speakers and participants and closed the meeting.

Jan Clarke
January 2010
Jan.clarke@leedsth.nhs.uk