PSHE/Children's Health Select Committee

Report

March 2007

Kent County Council

Contents

Foreword

On behalf of this Select Committee I am pleased to present this report on PSHE/Children's Health. This report concentrates on significant concerns about vulnerable and at risk young people who are affected by the consequences of unintentional pregnancy and lack of understanding of sexual health issues.

This Select Committee is a result of issues raised by Members of the Kent Youth County Council. They were concerned with the lack of PSHE lessons in some institutions and, where they existed, with the teaching, content, quality of advice and support given in educational provision. We examined oral and written evidence from a wide range of experts and significant stakeholders.

There is no doubt that all Members found the evidence and concerns raised to be challenging and in some cases disturbing. While on a national level there has been a falling trend in the number of teenage pregnancies - and Kent has a better than average record - it is a serious matter that the UK has the highest rates of teenage pregnancy and sexually transmitted diseases in Western Europe.

National targets for improvement have been set to reduce conception rates and address the issue of social exclusion among teenage mothers. KCC's policies outlined in 'The Vision for Kent' and 'Towards 2010' are designed to promote greater awareness and provide a high quality PSHE programme.

Throughout this report Members were given evidence of a link between lack of educational achievement and poor sexual health - creating a significantly at risk group within the community - that needs to be addressed through finding a way to bring young mothers back into learning and skills training.

I believe that the recommendations in this report provide solutions and will help to create greater understanding, awareness and the support needed by these most vulnerable groups.

I would like to thank all my colleagues and officers on this Committee for their contributions and support as well as the many professionals who provided evidence. I am confident that this report reflects a consensus of our views and deliberations.

Thank you all.

Jane Cribbon
Chair of the Select Committee

1. Executive Summary

1.1. Committee Membership

The Committee consists of eight Members of Kent County Council (KCC): Five Members of the Conservative Party, Two Members of the Labour Party and one Member of the Liberal Democrat Party.

Mrs Ann Allen

Conservative Member for Wilmington

Ms Jane Cribbon

Labour Member for Gravesham East

Chair

Mr Jeffrey Curwood

Conservative Member for Maidstone Central

Mrs Margaret Featherstone

Liberal Democrat Member for Maidstone North East

Ms Angela Harrison

Labour Member for Sheerness

Mr David Hirst

Conservative Member for Herne Bay

Mr Peter Lake

Conservative Member for Sevenoaks South

Mr Roland Tolputt

Conservative Member for Folkestone South

1.2 Terms of Reference

In October 2006 a Select Committee was set up to consider the issue of children's health, focusing in particular on aspects of Personal, Social and Health Education (PSHE). The review explored the extent to which education and sexual health services met the needs and expectations of young people in Kent. A series of recommendations resulted from this task. The Terms of Reference of the Review were as follows:

1. Explore the educational effectiveness of Personal, Social and Health Education (PSHE), and particularly of Sex and Relationships Education (SRE), primarily in secondary schools.

2. Recommend a robust strategy directed at teaching young people sexual health, and aimed at reducing the rate of both sexually transmitted infections (STIs) and teenage pregnancies.

3. Ensure that the recommendations of the Committee contribute to strategic corporate objectives as stipulated in key documents, such as "Towards 2010" and the "Public Service Agreement 2" (PSA2).

1.3. Exclusions

The Select Committee did not explore issues related to obesity, drug use and misuse, and sport in schools. These topics were already investigated in recent Select Committees.

1.4. Scene Setting

1.4.1. The Select Committee was established in order to deal with a series of complex and critical issues. It was formed as a response to the requests of Members of the Kent Youth County Council (KYCC) to improve the quality of PSHE and SRE in Kent. The Committee received both oral and written evidence from several witnesses. The selection of witnesses included professionals dealing with PSHE and teenage pregnancy, clinicians, social workers, representatives of central government and young people including teenage parents. A full list of witnesses who provided both oral and written contributions is supplied in Appendix 1.

1.4.2. Although the national rate of teenage pregnancy in England and Wales is generally decreasing and it is at its lowest level for 20 years (41 per 1,000 females aged 15-17 in 2004), it is still the highest in Western Europe. In Kent, the under 18 conception rate is lower than the national average (38.1 per 1,000 females aged 15-17 in 2004). However, an increase by 2.5 per 1,000 females since 2003 makes the national target of halving the rate by 2010 particularly challenging.

1.4.3. The rate of Sexually Transmitted Infections (STIs) in the UK is also the highest in Western Europe. A staggering 10% of young people aged under-25 years has currently contracted Chlamydia in Britain.

1.4.4. The Committee focused the Review on the benefits that education can bring about in dealing with these serious issues. Effective sex and relationships education is crucial in teaching young people to make responsible and informed decisions about their lives. Education can help young people learn to respect themselves and others, and can ease the transition from childhood through adolescence into adulthood. It can facilitate breaking a cycle of low aspirations that can lead to unwanted teenage pregnancies. It can help teenagers delay pregnancy until they are better equipped to deal with the demands of parenthood.

1.4.5. The consequences of poor sexual health amongst young people can have a significant and harmful impact on their lives, and can incur economic costs to Kent residents at large. The strategic and leadership roles that Kent County Council performs can help improve the quality of life of all the people living in Kent.

1.5. Recommendations

Recommendation 1

That all those dedicated individuals working to provide young people in Kent with high standard sexual health services be commended. (Section 3.6, p29)

Recommendation 2

The Committee urges that all key agencies be wholly committed and signed up to the Kent Teenage Pregnancy Strategy in an effort to decrease the rate of teenage pregnancy. (Paragraph 3.6.7, p31 to Paragraph 3.6.15, p32)

Recommendation 3

The Committee endorses and supports all the efforts of the Kent Teenage Pregnancy Partnership. It recommends expanding the Partnership's reach to all the young people in Kent by further promoting its sexual health services in places young people frequent. (Section 3.6, p29)

Recommendation 4

The Committee strongly recommends the broad production, promotion and distribution of discreet information on local sexual health services and support. (Paragraph 3.6.19, p34 to Paragraph 3.6.26, p36)

Recommendation 5

The Committee recommends that all partner agencies involved must facilitate the expansion of the National Chlamydia Screening Programme, to ensure full screening coverage of all sexually active young people in Kent under the age of 25. (Section 4.3, p44)

Recommendation 6

That GUM clinics must replace appointments with a "walk in" service. The Committee insists that the proportion of Genito-Urinary Medicine (GUM) clinic attenders offered an appointment within 48 hours of contacting the service must reach 100% by 2008. (Section 4.3, p44)

Recommendation 7

That the number of school nurses working in secondary schools in Kent be increased, and that the number of accessible, confidential and young people friendly sexual health clinics in all secondary schools in Kent be raised by at least one per cluster by 2008. (Paragraph 4.3.15, p46; Section 4.3, p44)

Recommendation 8

The Committee commends and supports all those working with disengaged, vulnerable young people, and urges the effective re-integration of more young mothers and fathers into school to complete their statutory education. (Section 5.3, p52)

Recommendation 9

The Committee recommends that all schools in Kent work towards Healthy Schools validation by March 2009, through a process which is all inclusive to parents and governors. (Section 5.4, p56 and Section 5.5, p58)

Recommendation 10

The Committee strongly recommends a strategy for a more consistent and systematic Personal, Social and Health Education (PSHE) delivery, that is coupled with more robust assessment and monitoring methods, and that is adopted in all primary and secondary schools in Kent. (Section 5.6, p59)

Recommendation 11

The Committee urges that the new RE and Citizenship Advisor remains permanently in place to ensure that one advisor is permanently and wholly responsible and accountable for PSHE in Kent. (Paragraphs 5.3.14 and 5.3.15, p54)

Recommendation 12

That PSHE certificates for both teachers and nurses be widely promoted and supported. That each school cluster in Kent has a PSHE lead and each secondary school in Kent has at least one PSHE certified teacher. That PSHE awareness be raised through a countywide multi-agency conference, which includes all the decision makers, by March 2008. (Section 5.6, p59)

Recommendation 13

The Committee strongly urges the County Council to press Government to make PSHE statutory and therefore part of the core curriculum, thereby ensuring that a selection of PSHE lessons are duly observed during inspections by Ofsted. (Section 5.2, p51)

Recommendation 14

The Committee insists that all secondary schools in Kent ensure access to websites such as "foryoungpeople", "RUthinking" and "Frank", and that they provide permanent information on local sexual health services on a visible notice board. (Paragraphs 5.6.24 and 5.6.25, p63)

Recommendation 15

The Committee recommends that school governors ensure that strong and consistent sex and relationships education within a PSHE framework is delivered. That SRE be taught appropriately from primary school and by specialist teachers. (Section 6.4, p70)

Recommendation 16

The Committee strongly recommends that the "relationships" aspect of SRE be emphasised more than the biological aspect, and that, in order to reflect this emphasis, the name "sex and relationships education" be changed to "relationships and sex education". (Paragraphs 6.4.16 and 6.4.17, p73)

Recommendation 17

That the nature of SRE lessons reflects equality of responsibility between boys and girls, and therefore that it has a stronger focus on young men and on their attitudes and responsibilities when negotiating sexual relationships. That it be considered to teach particular aspects of SRE in single-sex groups. (Paragraphs 6.4.18, 6.4.19 and 6.4.20, p74)

Recommendation 18

The Committee commends that schools encourage greater involvement of both pupils and parents/carers in the planning and evaluation of SRE programmes. (Paragraphs 6.4.10 and 6.4.11, p71; Paragraph 6.4.21, p74; Paragraphs 6.4.22 and 6.4.23, p75)

2. Background Context

2.1. National Policies and Targets

2.1.1. The World Health Organisation (WHO) defines "sexual health" as "a state of physical, emotional, mental and social well-being related to sexuality; not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be protected, respected and fulfilled".[1]

2.1.2. Equitable relationships and sexual fulfilment are central elements to sexual health, as well as access to information and services to avoid the risk of unintended pregnancy and diseases. Young people are a category in society particularly affected by poor sexual health. The consequences of unwanted teenage pregnancies and sexually transmitted infections (STIs) can have long-term impact on young people, adversely affecting their education, employment prospects and their lives in general.[2]

2.1.3. Although the national rate of teenage pregnancy in England and Wales is generally decreasing and it is at its lowest level for 20 years (41 per 1,000 females aged 15-17 in 2004), it is still the highest in Western Europe.[3] [4] [5] In Kent, the under 18 conception rate is lower than the national average (38.1 per 1,000 females aged 15-17 in 2004). However, an increase by 2.5 per 1,000 females since 2003 makes the national target of halving the 1998 rate of about 42 per 1,000 by 2010 particularly challenging.[6]

2.1.4. The rate of Sexually Transmitted Infections (STIs) in the UK is also the highest in Western Europe. A staggering 10% of young people aged under-25 years has currently contracted Chlamydia in Britain.[7]

2.1.5. The significance and seriousness of high teenage pregnancy and STI rates in the UK have led to the creation of several documents, policies and strategies aimed at addressing these high-profile issues. National policy drivers include: The Teenage Pregnancy Strategy; The Green Paper Every Child Matters; The National Strategy for Sexual Health and HIV; the National Service Framework (NSF) for Children and the Healthy Schools Programme.

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[1] Department of Reproductive Health and Research (RHR), World Health Organisation (2002), World Health Organisation.
[2] South East Public Health Observatory, Department of Health (2006) *Choosing Health in the South East: Sexual Health*, Oxford.
[3] Department for Education and Skill (2006) "Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies", Nottingham.
[4] Department for Education and Skill (2006) "Teenage Pregnancy: Accelerating the Strategy to 2010", Nottingham.
[5] Janine Cooke, Children's Health Select Committee, 23 November 2006, Kent County Council.
[6] Kent County Council (2006) "The Kent Teenage Pregnancy Strategy Annual Report 2006", Kent County Council.
[7] Janine Cooke, Children's Health Select Committee, 23 November 2006, Kent County Council.

2.1.6. **The Teenage Pregnancy Strategy**

2.1.6.1. The Teenage Pregnancy Strategy was set out in the Social Exclusion Unit's report on teenage pregnancy, "Teenage Pregnancy" (1999), and was launched later the same year, in June.[8]

2.1.6.2. The two national targets presented in the Strategy are to:

- Halve the under 18 conception rate in England by 2010.
- Increase the participation of teenage mothers in education, training or work to 60% by 2010 to reduce the risk of long term social exclusion.[9]

2.1.7. **Every Child Matters**

2.1.7.1. The Green Paper Every Child Matters was produced in 2003, and resulted in the Children Act (2004) and in crucial transformations in the delivery of services for children, young people and families.[10]

2.1.7.2. Five central outcomes for children are detailed in the Paper. These are: being healthy; staying safe; enjoying and achieving; making a positive contribution and economic well-being.[11]

2.1.8. **The National Strategy for Sexual Health and HIV**

2.1.8.1. The National Strategy for Sexual Health and HIV is the first national strategy addressing the increase of sexually transmitted infections and HIV. The main objective of the Strategy is to modernise sexual health and HIV services.[12]

2.1.8.2. The Strategy identifies a strong link between deprivation, social exclusion and sexual health. It also maintains that variations in the quality of sexual health services across the country are unacceptable.[13]

2.1.9. **Choosing Health**

2.1.9.1. The Choosing Health White Paper was published in 2004 and, through consultation, it enabled the public to express views on health issues and on

[8] South East Public Health Observatory, Department of Health (2006) "Choosing Health in the South East: Sexual Health", Oxford.
[9] South East Regional Public Health Group, Department of Health (2006) "Teenage Pregnancy", GOSE.
[10] Department for Education and Skill (2003) "Every Child Matters: Changes for Children", London.
[11] South East Public Health Observatory, Department of Health (2006) "Choosing Health in the South East: Sexual Health", Oxford.
[12] Department of Health (2001) "Better Prevention, better services, better sexual health – the national strategy for sexual health and HIV", London.
[13] *Ibid*.

the relationship the Government should have with society and personal responsibility.[14]

2.1.9.2. Feedback from the consultation resulted in proposals including a "whole School" approach to promote children's health, and in a need for stronger partnership between the NHS, the voluntary sector, communities, the media, industry and others.[15]

2.1.9.3. Targets included in Choosing Health include:

- Accelerating the introduction of a comprehensive, national screening programme for Chlamydia that will encompass the whole of England and that will ensure the screening for Chlamydia of at least 50% of the sexually active under-25 population in each PCT by 2007. [16]

- Securing an appointment within 48 hours to all those referred to a Genito-Urinary Medicine (GUM) clinic by 2008.[17]

2.1.10. The National Service Framework (NSF) for Children

2.1.10.1. The National Service Framework (NSF) was published in September 2004. It recommends a 10 year strategy to enhance health services for children, young people and pregnant women. The main objective of the Framework is to create more inclusive services, centred particularly on the needs of children and families.[18]

2.1.11. The Healthy Schools Programme

2.1.11.1. The national Healthy Schools Programme was launched in 1999 as a joint initiative between the Department of Health (DH) and the Department for Education and Skills (DfES). It resulted from proposals made previously in the Excellence in Schools White Paper (1997) and in Saving Lives, Our Healthier Nation White Paper (1999).[19]

2.1.11.2. The Healthy Schools Programme helps schools meet the 5 outcomes specified in Every Child Matters, which are part of Ofsted inspection. Most other European countries have developed healthy schools strategies, and currently all local authorities in the UK have their own Healthy Schools Programme.[20]

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[14] Department of Health (2004) "Choosing health: making healthy choices easier", London.
[15] *Ibid*.
[16] *Ibid*.
[17] *Ibid*.
[18] South East Public Health Observatory, Department of Health (2006) "Choosing Health in the South East: Sexual Health", Oxford.
[19] Kent County Council (2006) website: www.clusterweb.org.uk/Children/hs.
[20] *Ibid*.

2.1.12. **The "Deep Dive" Reviews**

2.1.12.1. The Government's Teenage Pregnancy Unit (TPU) and members of the Independent Advisory Group on Teenage Pregnancy explored through "deep dives" the key characteristics of local strategies in areas where the rates decreased significantly, and compared them with statistically similar areas with static and increasing rates.[21]

2.1.12.2. The successful areas shared the following elements, confirming the evidence base for the Teenage Pregnancy Strategy (1999):

- The active engagement of all central partners having a role in reducing teenage pregnancy rates is crucial. The main partners are: Education, Health, Social Services and Youth Support Services.[22]

- A strong senior champion who is accountable for and who takes the lead in driving the local strategy.[23]

- The availability of a well-publicised contraceptive, sexual health service centred on the needs of young people.[24]

- A high priority given to PSHE teaching in schools, with support from the local authority to deliver comprehensive SRE programmes in all schools.[25]

- A strong focus on targeted interventions with young people particularly at risk of causing unwanted teenage pregnancies.[26]

- The availability and consistent engagement in SRE training for professionals in partner organisations.[27]

- A well resourced Youth Service.[28]

2.2. Local Policies and Targets

2.2.1. To reinforce the Government's commitments, Kent County Council (KCC) has developed its own local policies, strategies and targets. The following strategies are aimed at achieving corporate objectives.

[21] Department for Education and Skill (2006) "Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies", Nottingham.
[22] *Ibid*.
[23] *Ibid*.
[24] *Ibid*.
[25] *Ibid*.
[26] *Ibid*.
[27] *Ibid*.
[28] *Ibid*.

2.2.2. **The Vision for Kent**

2.2.2.1. The Vision for Kent, or Community Strategy for Kent, is a long-term plan spanning over 20 years with the objective of improving the economic, environmental and social well-being of the county of Kent.[29]

2.2.2.2. In order to promote healthy lifestyles, the Vision intends to educate young people to be healthy, and to ensure that all young people have access to support and counselling on relationships and sexual health. In addition, it encourages teenage parents to continue education and training, and take up employment.[30]

2.2.3. **Towards 2010**

2.2.3.1. Towards 2010 is a four-year strategy launched in 2006 which, through action plans, is aimed at achieving wide goals including improved health and quality of life.[31]

2.2.3.2. Objectives relevant to the Committee's Review are highlighted in specific targets within Towards 2010. Target 50 is perhaps the most relevant, and includes the introduction of a hard-hitting public health campaign targeted at young people in order to increase their awareness of – amongst other aspects – the risks of early or unprotected sex.[32]

2.2.3.3. More specifically, by 2010 KCC intends to focus on the provision of high-quality PSHE, to lead a multi-agency campaign informed by the views of young people and particularly aimed at reaching young men, and to build on strategies and initiatives already in place.[33]

2.2.3.4. Target 50 is supported by other targets, including: to continue to offer and develop further multi-agency support to parents by helping them with the problems they and their children face in everyday life (Target 13). Within this target it is suggested, for instance, to appoint more school nurses. Another Target's aim is to listen to young people's views and opinions and develop their ideas to improve education and life in Kent (Target 14).

2.2.4. **The Kent Agreement**

2.2.4.1. The Kent Agreement aims at increasing independence and personal fulfilment of Kent residents by facilitating collaboration between different organisations across the county.

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[29] Kent County Council (2007) website: www.kent.gov.uk/static/vision.
[30] *Ibid*.
[31] Kent County Council (2007) "Towards 2010: Kent, your county, your future, our promises to you", KCC.
[32] *Ibid*.
[33] *Ibid*.

2.2.4.2. The Agreement comprises the Local Area Agreement (LAA) and the Local Public Service Agreement phase 2 (LPSA2). These include targets that have been agreed between local partners in Kent and Central Government.[34]

2.2.4.3. The objective of Outcome 16 in the Kent Agreement is to "promote and improve the health of Kent's residents and reduce health inequalities by addressing variations in health across the country".[35]

2.2.4.4. The targets specified in the LAA reflect the targets in Choosing Health for people contacting GUM services to be seen within 48 hours. They also reflect the ambitious aim set out in The Teenage Pregnancy Strategy to reduce the current teenage pregnancy rate from 38.1 per 1,000 to 26.7 in 2008.[36]

[34] Kent County Council (2006) The Kent Agreement (Local Area Agreement).
[35] Kent County Council (2006) The Kent Agreement (Local Area Agreement), Outcome 16.
[36] *Ibid*.

3. Teenage Pregnancy

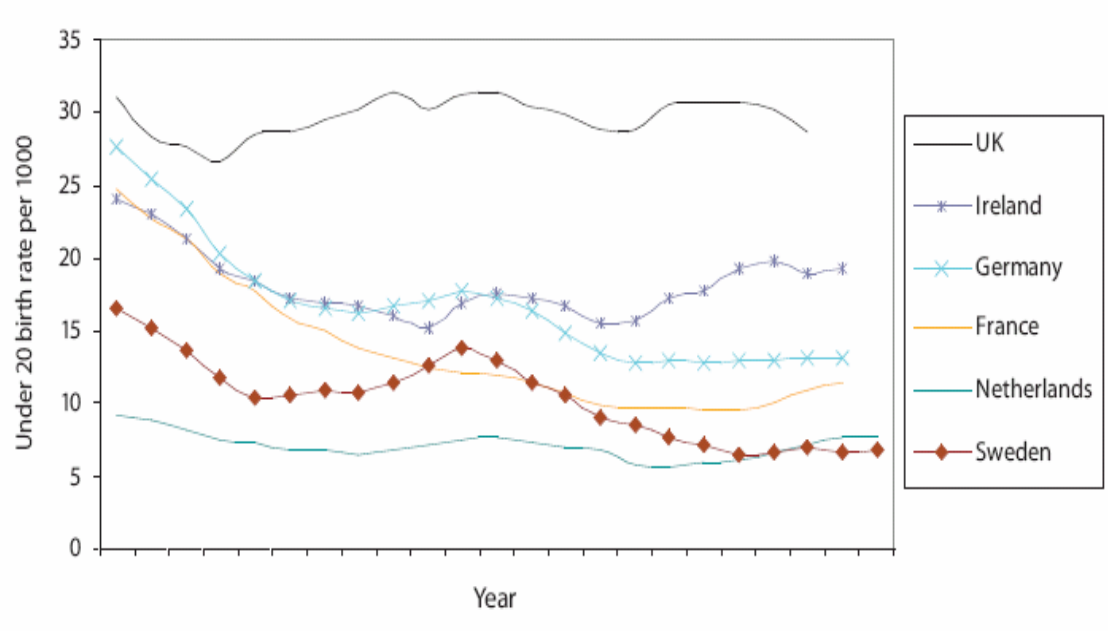
3.1. Why Teenage Pregnancy Matters

3.1.1. The UK has historically high rates of teenage pregnancy. In the last three decades the UK has had the highest teenage pregnancy rates in Western Europe. Until the mid1970s the under-20 rates in the UK were similar to those in many other Western European countries. However, since then the rates of these countries continued to drop while the rates in the UK have remained relatively static, with an under 18 conception rate generally exceeding 40 per 1,000 females.[37] [38] [39]

3.1.2. In 2002 the under-18 teenage pregnancy rate in Britain was about four times higher than the Netherlands, three times higher than France and twice as high as Germany.

3.1.3. Figure 1 below shows the under-20 birth rate in selected European countries from 1980 to 2002.

Figure 1: Under-20 birth rate in selected European countries 1980-2002

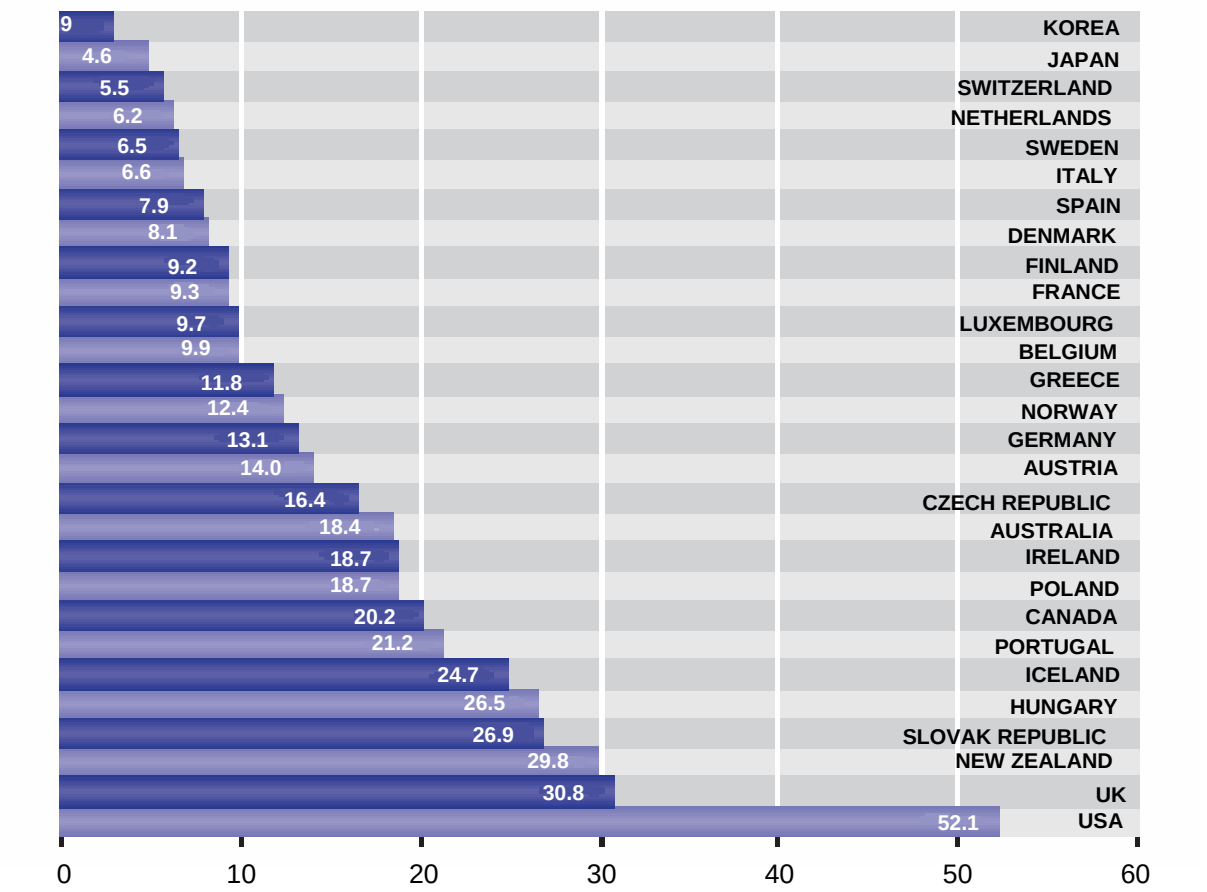


Source: Department for Education and Skill (2006) "Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies".

[37] South East Regional Public Health Group, Department of Health (2006) "Teenage Pregnancy", GOSE.
[38] Department for Education and Skill (2006) "Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies", Nottingham.
[39] Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council

3.1.4. Figure 2 below shows the annual number of births to women aged under-20 per 1,000 (women aged from 15 to 19 years). The data is for 1998, the most recent year for which comparable information is available from all countries.[40]

Figure 2: Annual number of births to women aged below 20 per 1,000 women aged 15-19, for 1998 or latest available year



Source: Eurostat, New Cronos Demographic Database 2000.

3.1.5. The age of first sex over the past 40 years has also generally declined in the whole Continent (please see Figure 1 in Appendix 3). In Kent, it is estimated that today approximately a third of young people under the age of 16 is sexually active.[41] [42]

3.1.6. Every year in England about 39,000 girls under 18 become pregnant. These pregnancies occur across the country although they tend to concentrate in deprived areas.[43]

[40] Innocenti Report Card, Issue number 3 (2001) "A league table of teenage births in rich nations", UNICEF.
[41] Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council.
[42] Roger Ingham, Children's Health Select Committee, 17 November 2006, Kent County Council.
[43] Department for Education and Skill (2006) "Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies", Nottingham.

3.1.7. “Hot spots” are present in nearly every local authority in England, where every year more than 6% of girls aged 15 to 17 becomes pregnant.[44] The great majority of under-18 conceptions are unintended and about half lead to an abortion.[45]

3.1.8. It is perhaps important to stress that the Committee and several witnesses agree that teenage pregnancy and early parenthood are not necessarily problematic; teenagers can be caring and successful parents.[46] [47] Indeed in some communities early parenthood is accepted as the norm and it is not regarded as a concern.[48]

3.1.9. However, evidence shows that early parenthood can bring about a series of negative outcomes.[49] [50] Early pregnancy is associated with high levels of regret; interestingly, both parents and young people agree that sex under the age of 16 is too young.[51] [52]

3.1.10. Teenage mothers are less likely to complete their education and are more likely to raise their children alone and in poverty.[53] They are 20% more likely to have no qualifications at age 30 than mothers giving birth when aged 24 or more.[54] They are more likely to bring up their children with men who are poorly qualified and more likely to experience unemployment.[55]

3.1.11. The infant mortality rate for babies born to teenage mothers is 60% higher than for babies of older mothers.[56]

3.1.12. Teenage mothers are three times more likely to smoke during pregnancy. They are also 50% less likely to breastfeed than older mothers. The health of their children is therefore more likely to be adversely affected.[57]

3.1.13. The rate of post-natal depression of teenage mothers is three times higher than that of older mothers, leading to a higher risk of poor mental health in the three years after giving birth.[58]

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[44] *Ibid*.
[45] *Ibid*.
[46] Ruth Herron, Children’s Health Select Committee, 3 November 2006, Kent County Council.
[47] Bill Anderson, Children’s Health Select Committee, 7 November 2006, Kent County Council.
[48] Department for Education and Skill (2006) “Teenage Pregnancy: Accelerating the Strategy to 2010”, Nottingham.
[49] Ruth Herron, Children’s Health Select Committee, 3 November 2006, Kent County Council.
[50] Claire Stubbs, Children’s Health Select Committee, 13 November 2006, Kent County Council.
[51] Department for Education and Skill (2006) “Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies”, Nottingham.
[52] Jenny Billings, Children’s Health Select Committee, 20 November 2006, Kent County Council.
[53] Department for Education and Skill (2006) “Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies”, Nottingham.
[54] Department for Education and Skill (2006) “Teenage Pregnancy: Accelerating the Strategy to 2010”, Nottingham.
[55] *Ibid*.
[56] Department for Education and Skill (2006) “Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies”, Nottingham.
[57] Department for Education and Skill (2006) “Teenage Pregnancy: Accelerating the Strategy to 2010”, Nottingham.
[58] Department for Education and Skill (2006) “Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies”, Nottingham.

3.1.14. Children of teenage mothers are 63% more likely to be born into poverty, when compared with children of mothers in their twenties. They are more likely to have behavioural problem and have higher mortality rates when under the age of 8 years.[59] They are also more likely to gain lower educational achievements and less likely to find better paid jobs.[60]

3.1.15. The risk for particularly vulnerable girls of becoming pregnant before reaching the age of 20 is almost one in three.[61]

3.1.16. Together with all these issues indicating a clear correlation between teenage pregnancy and social exclusion issues, persuasive economic arguments are also present. The NHS alone in England is estimated to spend every year approximately £63 million to deal with the issue of teenage pregnancy.[62]

3.1.17. Teenage mothers are more likely to need support from a range of services, including housing, education, employment and training. The cost of benefit payments to teenage mothers who have not been in paid employment during the three years after giving birth can range between £19,000 and £25,000 over that period.[63]

3.1.18. All this evidence suggests that it is crucial to tackle the underlying factors contributing to early pregnancy and its potential, adverse consequences.

3.2. Factors Contributing to Teenage Pregnancy

3.2.1. Teenage pregnancy is a highly complex issue. Several factors can result in teenage pregnancy, including location, young people's aspirations, level of knowledge about sex and relationships and about access to advice and support, educational attainment and parental guidance.

3.2.2. It appears that a strong correlation exists between high teenage pregnancy rates and deprivation and low aspirations. Variation in teenage pregnancy rates tends to reflect patterns of deprivation across the country. Half of all under-18 pregnant girls live in the 20% most deprived areas of England.[64] Teenage pregnancies in the most deprived 10% of wards are four times higher than in the 10% least deprived ones.[65] "Hotspots" reaching over 60 pregnancies per 1,000 girls aged 15 to 17 years exist across the country.[66]

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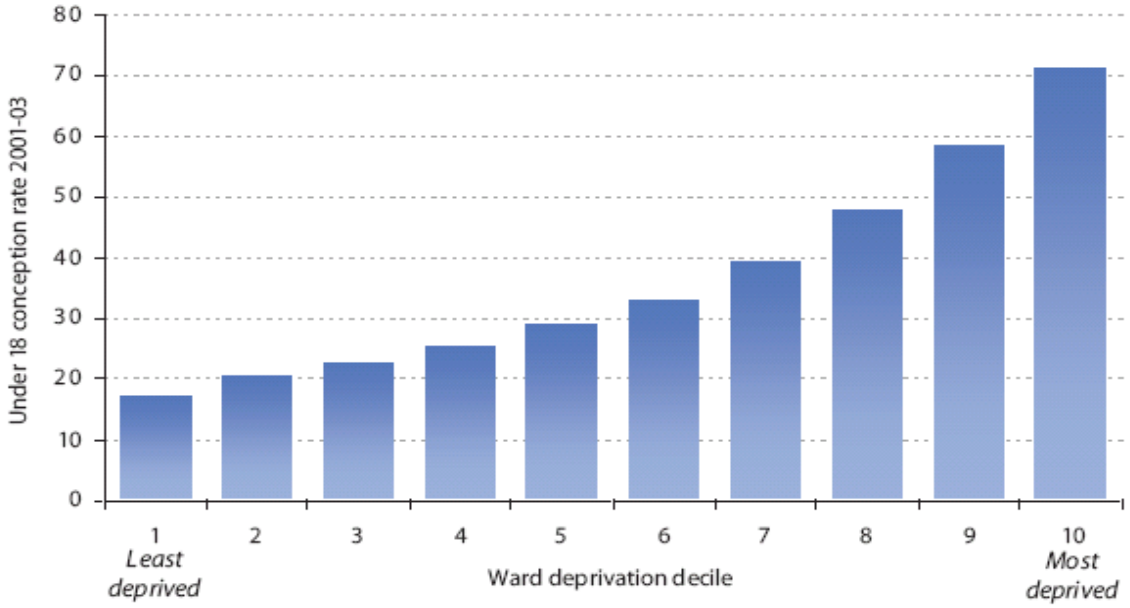
[59] Department for Education and Skill (2006) "Teenage Pregnancy: Accelerating the Strategy to 2010", Nottingham.
[60] Department for Education and Skill (2006) "Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies", Nottingham.
[61] Department for Education and Skill (2006) "Teenage Pregnancy: Accelerating the Strategy to 2010", Nottingham.
[62] *Ibid*.
[63] Department for Education and Skill (2006) "Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies", Nottingham.
[64] *Ibid*.
[65] Department for Education and Skill (2006) "Teenage Pregnancy: Accelerating the Strategy to 2010", Nottingham.
[66] Department for Education and Skill (2006) "Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies", Nottingham.

Figure 3: Under-18 conception rates in England by deprivation decile, 2001-2003



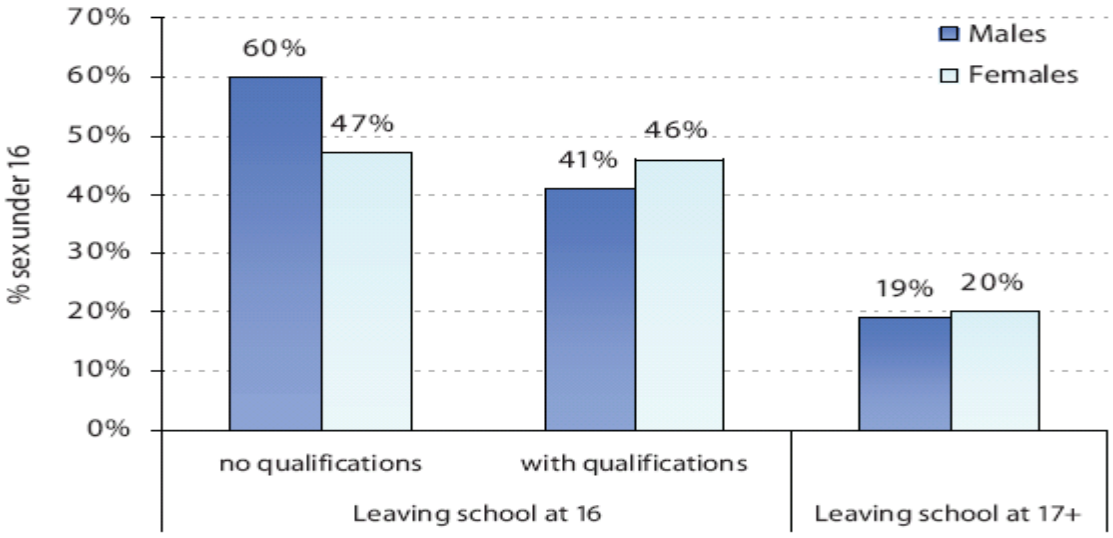
Source: Department for Education and Skill (2006) "Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies", Nottingham.

3.2.3. Educational outcomes also appear to be linked to teenage pregnancy.[67] Even when taking into account deprivation and socio-economic factors, low achievement is associated with pregnancy.[68] Deprived areas with better levels of educational attainment have rates half as high as deprived areas with lower educational levels.[69] The rate is about 80 per 1,000 girls aged 15 to 17 compared with 40 per 1,000.[70] (Please see Figure 2 in Appendix 3).

3.2.4. The age at which young people leave school also has an impact on the rate of pregnancy – even if school is left only one year later. Evidence shows that 60% of boys and 47% of girls leaving school at 16 with no qualifications had sex before the age of 16. If they leave school when 17 or over with qualifications, only 20% had sex before reaching 16.[71] Perhaps what makes this data particularly alarming is the fact that under-16 sex is strongly correlated with high levels of regret among both girls and boys.[72]

[67] Roger Ingham, Children's Health Select Committee, 17 November 2006, Kent County Council
[68] *Ibid*.
[69] *Ibid*.
[70] Department for Education and Skill (2006) "Teenage Pregnancy: Accelerating the Strategy to 2010", Nottingham.
[71] Department for Education and Skill (2006) "Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies", Nottingham.
[72] *Ibid*.

Figure 4: Proportion having first sex under-16, by qualification and school leaving age



Source: Department for Education and Skill (2006) "Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies", Nottingham.

3.2.5. Not only are teenagers leaving school at 16 with no qualifications more likely to have had sex earlier, but they are also more likely not to have used contraceptive measures. Approximately a quarter of boys and a third of girls leaving school at 16 do not use contraception when having sex for the first time; the proportion drops to 6% for boys and 8% for girls leaving school with qualifications when at least 17.[73]

3.2.6. A final link between education and high teenage pregnancy rates is evident when considering school attendance. Absenteeism and disengagement from education appear to be occurring frequently prior pregnancy.[74] Less than half of the girls interviewed in a study commissioned by the Teenage Pregnancy Unit (TPU) attended school regularly when they became pregnant.[75]

3.2.7. Even when analysing exclusively deprived areas, similar results are found. Amongst the most deprived 20% of local authorities, those with fewer than 8% of half days missed were found to have an average under-18 pregnancy rate of 33.6 per 1,000 girls; in deprived authorities with more than 8% half days missed the rate averaged 47.7.[76]

3.2.8. Together with location and education attainment, a range of other factors can contribute to high rates of teenage pregnancy. Ethnicity, mental health,

[73] Department for Education and Skill (2006) "Teenage Pregnancy: Accelerating the Strategy to 2010", Nottingham.
[74] Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council.
[75] Hosie, A. and Dawson, N (2005) *The Education of Pregnant Young Women and Young Mothers in England*, University of Newcastle and University of Bristol, Bristol.
[76] Department for Education and Skill (2006) "Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies", Nottingham.

teenage motherhood, parental aspirations, living in care, alcohol and drugs can all have a meaningful impact.[77] [78]

3.2.9. Research based on the 2001 Census illustrates that rates of teenage motherhood seem higher amongst some ethnic groups, even when taking deprivation into account. Rates appear to be higher amongst mothers of "Mixed White and Black Caribbean", "Other Black", "Black Caribbean" and "White British" ethnicity. By contrast, all Asian ethnic groups are under-represented.[79] This variation between ethnic groups, excluding deprivation, seems to suggest that cultural difference, and differences in behaviours and attitudes, could in part be an explanatory factor.[80]

3.2.10. Research also demonstrates that a link exists between mental health and teenage pregnancy. For example, a study conducted by the London School of Economics (LSE) showed that a third of young women with conduct disorder and behavioural problems become pregnant before the age of 17.[81] Another study concluded that teenagers who had contact with the police were twice as likely to become teenage parents.[82]

3.2.11. One of the most revealing factors is teenage motherhood; being the daughter of a teenage mother is the strongest predictor on teenage pregnancy.[83] [84] Also, about 20% of births conceived by under-18 mothers are subsequent births.[85] Finally, around 7.5% of under-18 abortions follow either a previous pregnancy or a previous abortion.[86]

3.2.12. Parental aspirations also influence the likelihood of teenage pregnancy.[87] For instance, a girl of 10 with a mother with low educational aspirations for her is more likely to become a teenage mother.

3.2.13. Living in care also seems to be linked to teenage pregnancy. Although the number of Looked After Children (LACs) is relatively low, about 25% of children who have been or are in care become parents by the age of 20. According to the DfES, in 2005 in England the proportion of teenage mothers in care was three times higher than the prevalence among all under-18 girls.[88]

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[77] Jill Wiles, Children's Health Select Committee, 7 November 2006, Kent County Council.
[78] Janine Cooke, Children's Health Select Committee, 23 November 2006, Kent County Council.
[79] Department for Education and Skill (2006) "Teenage Pregnancy: Accelerating the Strategy to 2010", Nottingham.
[80] Department for Education and Skill (2006) "Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies", Nottingham.
[81] Hobcraft, J. (1998*) Intergenerational and life-course transmission of social exclusion: influences of childhood poverty, family disruption and contact with the police*. CASE paper 15, LSE.
[82] Redgrave, k. and Limmer, M. (2005) *"It makes you more up for it". School aged young people's perspectives on alcohol and sexual health*. Rochdale Teenage Pregnancy Strategy, Rochdale.
[83] Department for Education and Skill (2006) "Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies", Nottingham.
[84] Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council.
[85] Department for Education and Skill (2006) "Teenage Pregnancy: Accelerating the Strategy to 2010", Nottingham.
[86] *Ibid*.
[87] Sam Higgins, Children's Health Select Committee, 27 November 2006, Kent County Council.
[88] Department for Education and Skill (2006) "Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies", Nottingham.

3.2.14. Finally, a significant aspect linked to teenage pregnancy is the abuse of alcohol and misuse of drugs.[89] [90] A recent study carried out in Rochdale showed that 20% of white, young women admitted to have found it difficult to negotiate consent and to have gone further sexually than intended because they were drunk.[91] The influence of alcohol also appears to be strongly correlated with high levels of regret and with a more limited use of contraception.[92]

3.2.15. So far the above explanatory factors and their consequences have been considered individually, however sometimes more than one factor can be experienced at the same time. When this happens, the risk of teenage pregnancy increases exponentially.

3.2.16. For example analysis of the 1970 British Cohort Study data showed that when young women experience five risk factors together – namely daughter of a teenage mother; father's social class iv and v; conduct disorder; social housing at 10 and poor reading ability at 10 - they have a 31% probability of becoming teenage mothers, compared with 1% if they did not experience any of them.[93] (Please see Figure 3 in Appendix 3)

3.2.17. Although very little data exists between the link of teenage pregnancy and the behaviour of young men, the above study revealed that young men experiencing the multiple risk factors listed above were 23% more likely to become fathers by the age of 23.[94]

3.2.18. This perhaps indicates that research on teenage pregnancy should have a stronger focus on the behaviour, attitudes and experiences of young men. It also suggests that boys should also receive adequate information, education, support and access to services to enable them to deal more effectively with their sexual health, with relationships with girls, and with the demands of fatherhood.

3.3. The Problems to Address

3.3.1. According to DfES guidance, all the factors considered indicate a series of general problems that need addressing in order to deal with the issue of teenage pregnancy. These overarching problems are:

- "Poor knowledge and skills among young people in relation to sex, relationships and sexual health risks;
- poor and inconsistent contraceptive use among young people;

[89] Jill Wiles, Children's Health Select Committee, 7 November 2006, Kent County Council.
[90] Janine Cooke, Children's Health Select Committee, 23 November 2006, Kent County Council.
[91] Redgrave, k. and Limmer, M. (2005) *"It makes you more up for it". School aged young people's perspectives on alcohol and sexual health*. Rochdale Teenage Pregnancy Strategy, Rochdale.
[92] Hosie, A. and Dawson, N (2005) *The Education of Pregnant Young Women and Young Mothers in England*, University of Newcastle and University of Bristol, Bristol.
[93] 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.
[94] *Ibid*.

- lack of support for parents and professionals on how to engage with young people on relationships, sex, and sexual health issues;

- disengagement from/dislike of school among those most at risk;

- low attendance/attainment at school;

- lack of aspirations among young people in the most disadvantaged communities".[95]

3.4. Addressing Teenage Pregnancy at National Level

3.4.1. A series of strategies, policies, initiatives and targets have been developed at national level to address the issue of teenage pregnancy and related problems.

3.4.2. As explained in Section 2.1, a number of strategies are already in place in order to deal with the causes and consequences of teenage pregnancy and sexual health related issues in general. The Government's Teenage Pregnancy Strategy, launched in 1999, is one of the most central initiatives. It requires, amongst other actions, that all local authorities halve their 1998 rate by 2010 and that participation of teenage mothers in education, training and work increases to 60% by 2010.[96] [97] [98]

3.4.3. Other strategies and policies include The National Strategy for Sexual Health and HIV, the 2003 Every Child Matters Green Paper and the Healthy Schools Programme.[99]

3.4.4. Non-statutory guidance includes the production of literature such as "Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies" (2006) and the subsequent "Teenage Pregnancy: Accelerating the Strategy to 2010" (2006).[100] [101]

3.4.5. More specifically, all this delivery guidance proposes particular actions that local authorities should pursue, and some actions that Central Government may adopt in areas with high and increasing rates. Below is a selection of the actions that the Government proposes to carry out.

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[95] Department for Education and Skill (2006) "Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies", Nottingham.
[96] South East Regional Public Health Group, Department of Health (2006) "Teenage Pregnancy", GOSE.
[97] Department for Education and Skill (2006) "Teenage Pregnancy: Accelerating the Strategy to 2010", Nottingham.
[98] Claire Stubbs, Children's Health Select Committee, 13 November 2006, Kent County Council.
[99] South East Public Health Observatory, Department of Health (2006) "Choosing Health in the South East: Sexual Health", Oxford.
[100] Department for Education and Skill (2006) "Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies", Nottingham.
[101] Department for Education and Skill (2006) "Teenage Pregnancy: Accelerating the Strategy to 2010", Nottingham.

3.4.6. The progress of all authorities in reducing their own teenage pregnancy rates will be monitored every year in February, when the annual under-18 conception rates are published.[102]

3.4.7. The improvement of Personal, Social and Health Education (PSHE) and of Sex and Relationships Education (SRE) is crucial, because "evidence from practice suggests that strong PSHE, active citizenship and pastoral care can improve engagement with learning through building self esteem, emotional development, reducing bullying and improving behaviour – as well as helping to tackle key health issues such as teenage pregnancy and substance misuse".[103]

3.4.8. The importance to the Government of PSHE is signalled for example by the inclusion of the subject in the mandatory requirements of the Healthy Schools Programme and the establishment of a new PSHE Subject Association.[104]

3.4.9. In brief, the Government wants to ensure that all young people have access to high quality information about sex and relationships and to support, in order to make positive choices about their sexual lives – including delaying early sex.[105]

3.4.10. Poor performing authorities will be encouraged to improve PSHE, and some schools will be expected to have a specialist trained PSHE teacher. In addition, Ofsted will be required to focus their next PSHE report on those schools, which will include feedback from students.[106]

3.4.11. In addition to improving the quality of PSHE, another national commitment entails further promotion of existing media campaigns to tackle risky behaviour. For example, the *RUthinking* campaign will be expanded by making RUthinking material available to schools. The *Want Respect? Use a condom* campaign will be improved by working more closely with independent retailers by displaying "Want Respect" messages.

3.4.12. Early interventions aimed at improving educational attainment are recommended in order to prevent children from falling behind other pupils, and from becoming disengaged. A more specific strategy includes *Aiming High: Raising the Achievement of Minority Ethnic Pupils* (2003).

3.4.13. Finally, the Neighbourhood Renewal Strategy, and the New Deal for Communities (NDC) in particular, have been used in several deprived areas to raise aspirations of local teenagers and to reduce their teenage pregnancy rates.[107]

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[102] *Ibid*.
[103] *Ibid*, p16.
[104] *Ibid*.
[105] *Ibid*.
[106] *Ibid*.
[107] *Ibid*.

3.5. Teenage Pregnancy Policies and Strategies in Kent

3.5.1. At more local level, several strategies, policies and initiatives are also been implemented. As explained in Section 2.2, the Vision for Kent, or Community Strategy, intends to educate young people to be healthy, and to ensure that all young people have access to support and counselling on relationships and sexual health. In addition, it encourages teenage parents to continue education and training, and to take up employment.[108]

3.5.2. Another strategic document - Towards 2010 - stipulates that, amongst other actions, by 2010 KCC intends to focus on the provision of high-quality PSHE, lead a multi-agency campaign informed by the views of young people and particularly aimed at reaching young men, and build on strategies and initiatives already in place.[109]

3.5.3. The targets specified in the Kent Agreement reflect the targets in Choosing Health; for people contacting GUM services to be seen within 48 hours. They also reflect the ambitious aim set out in The Teenage Pregnancy Strategy to reduce the current teenage pregnancy rate from 38.1 per 1,000 to 26.7 in 2008.[110]

3.5.4. The Kent Healthy Schools Programme follows the national Healthy Schools Programme. The Programme endeavours to help schools meet the 5 outcomes specified in Every Child Matters, which are part of Ofsted inspection (the Kent Healthy Schools Programme will be discussed in more detail in Section 5.5 below).[111]

3.5.5. Together with this selection of strategies, more specific initiatives are in place in order to reduce teenage pregnancy rates and improve young people's sexual health in general. These initiatives are embodied in the encompassing Kent Teenage Pregnancy Strategy.

3.6. The Kent Teenage Pregnancy Strategy

3.6.1. The vision of the Kent Teenage Pregnancy Strategy (2001-2011) is to provide young people across Kent with easy access to high quality sexual health services.[112]

3.6.2. The main goals of the Strategy are to reduce the conception rate of teenage girls aged 15 to 17 by 50% by 2010, and to reduce the isolation of teenage parents by increasing their involvement in education, training and employment.[113] [114]

[108] Kent County Council (2007) website: www.kent.gov.uk/static/vision.
[109] Kent County Council (2006)
[110] Kent County Council (2006) The Kent Agreement (Local Area Agreement), Outcome 16.
[111] Kent County Council (2006) website: www.clusterweb.org.uk/Children/hs.
[112] Kent County Council (2001) The Kent Teenage Pregnancy Strategy 2001/2011, Summary, KCC.
[113] *Ibid*.
[114] Kent County Council (2006) "KCC Annual Plan", Kent County Council.

3.6.3. Unfortunately the 2005/6 progress of the Kent Strategy moved from Green to Amber in the Government's "Under-18 Conception Rates for Top-Tier Local Authorities 1998 and 2004" traffic light evaluation system.[115]

3.6.4. The reason for this move is that teenage pregnancy in Kent increased from 35.6 per 1,000 girls in 2003 to 38.1 in 2004, making the task of halving the 1998 rate of about 42% to 21% by 2010 particularly challenging.[116] [117]

3.6.5. Nonetheless, since the Strategy began, the overall rates have decreased by 9.8%.[118] Although in 2003 the under-16 rates also increased, the latest rate in 2004 has decreased to become the lowest since the Strategy began, namely 6.7 per 1,000 females aged 13 to 15 years.[119] [120] (Please see Figure 4 in Appendix 3).

3.6.6. The range of principles and values that the Strategy supports reflects those outlined in the Social Exclusion Unit 1999 report on teenage pregnancy, and includes the recognition that:[121]

- Young people in Kent come from a variety of cultural backgrounds.
- Sexual health services have to meet the needs of young people.
- Effective service provision can only be achieved by working in partnership.
- The Strategy needs to be reviewed regularly.
- The views of young people, parents, professionals and others must be taken into account.[122]

[115] Kent County Council(2006) The Kent Teenage Pregnancy Strategy Annual Report 2006, KCC.
[116] Kent County Council(2006) The Kent Teenage Pregnancy Strategy Annual Report 2006, KCC.
[117] Kent County Council (2006) "KCC Annual Plan", Kent County Council.
[118] Kent County Council (2006) Kent Teenage Pregnancy Partnership Information Update for 2006, Kent County Council.
[119] *Ibid*.
[120] Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council.
[121] Kent County Council (2001) The Kent Teenage Pregnancy Strategy 2001/2011, Summary, KCC.
[122] *Ibid*.

Case Study

Lincolnshire

A multi agency approach is implemented in Lincolnshire in a bid to reduce the number of teenage pregnancies and delay sexual activity. The programme has been successful in contributing to a 21.8 % decrease in the under 18-conception rate since the 1998 baseline year. There has been significant and wide-ranging progress in the County to deliver quality sex and relationships education to young people and to help parents talk to their children about relationships and sex; develop generic based services that are accessible and young people friendly; strengthen young people involvement and participation; support teenage parents; and develop targeted campaigns and work with the media. Future priorities will include: a texting service for young people to text in sexual health queries; and improving sexual health outcomes for looked after children.

Department for Education and Skills (2006)

3.6.7. The progress of the Strategy is overseen by the Kent Teenage Pregnancy Partnership Board. This strategic board meets four times a year and is chaired by the Director of Children's Social Services. The Strategy plan is overseen by the Teenage Pregnancy Co-ordinator. It is represented by agencies including Health, Education, Social Services, Youth and Community Services, Drugs and alcohol and Youth Offending Teams, and voluntary partners.[123] [124]

3.6.8. Central Government currently devolves the funding for the delivery of the Strategy in Kent. As the Strategy's 2006 Annual Report explains, in high achieving authorities such as Kent funding is not ring fenced, but KCC has demonstrated its commitment by ring fencing the full grant funding until 2008.[125]

3.6.9. The aims and objectives of the Strategy are organised into four strands.[126] These are:

- Influence the provision of high quality SRE with emphasis on self esteem, negotiation skills and on delay of sexual debut.
- Enhance access to contraception and services.
- Improve outcomes for young parents.
- Ensure that young people, professionals and the public are engaged through the use of media.[127]

[123] *Ibid*.
[124] Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council.
[125] Kent County Council (2006) The Kent Teenage Pregnancy Strategy Annual Report 2006, KCC.
[126] Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council.

3.6.10. Each strand is driven by a steering group of relevant professionals. Implementation Groups within Primary Care Trusts (PCTs) ensure that strategic planning is put into practice according to local needs.[128]

3.6.11. It appears that PCTs' level of commitment to the Strategy has been variable. Although the recent restructuring of PCTs in Kent is proving challenging, "there is clear evidence that where the teenage pregnancy agenda has been prioritised the rates have decreased and where this has not been possible rates have increased or stayed static…".[129]

3.6.12. The Report explains that to some degree the success of different PCTs depends on the number of dedicated individuals working within them and on their existing arrangements.[130]

3.6.13. Nonetheless, it appears that a higher degree of sign up in East Kent than in West Kent has translated into the provision of a wider range of services.[131] [132] For example, East Kent provides Outreach Workers and services through youth clubs, Connexions points, colleges and homeless services.[133] Importantly, the Report maintains that the presence of a lead responsible for contraception and school health services is crucial.[134]

3.6.14. Equally important is the work carried out by school nurses, who in East Kent are involved for example in school clinics, self esteem and babysitting sessions within their core time.[135] By contrast, school nurses in West Kent were, for example, not allowed to attend the annual conference aimed at sharing best practice in contraception across Kent because of staffing concerns.[136]

3.6.15. It is important, then, that energy and commitment towards the Strategy are particularly necessary in West Kent, as the national reduction targets apply to the County as a whole.[137] (Please see Figures 5, 6 and 7 in Appendix 3).

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[127] Kent County Council (2006) Kent Teenage Pregnancy Partnership Information Update for 2006, Kent County Council.
[128] Kent County Council(2006) The Kent Teenage Pregnancy Strategy Annual Report 2006, KCC.
[129] *Ibid*, p8.
[130] *Ibid*.
[131] *Ibid*.
[132] Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council.
[133] Kent County Council (2006) The Kent Teenage Pregnancy Strategy Annual Report 2006, KCC.
[134] *Ibid*.
[135] *Ibid*.
[136] *Ibid*.
[137] *Ibid*.

Case Study

London, The Royal Borough of Kensington and Chelsea

The under 18-conception rate in the Royal Borough of Kensington and Chelsea has fallen by 42.2% between 1998 and 2004. The encouraging figures are the result of effective partnership working at a strategic and operational level. The Teenage Pregnancy Partnership includes the Local Authority's Family and Children's Services, Housing, Supporting People, Kensington and Chelsea Primary Care Trust, Children's Services and the voluntary sector. This multi-agency approach ensures that the issue of sex and relationship education and support for teenage parents is a mainstream issue for all services working with children, young people and their families. Another key to the success is the Borough's integrated Youth Support and Development Service, which incorporates Connexions, centre-based youth projects, detached/outreach support, youth sport, arts and health for 13-19 year olds. The Service has developed a clear curriculum to support young people's personal development which includes sex and relationship education and parenting issues.

Department for Education and Skills (2006)

3.6.16. Despite this difference in leadership and sign up levels, it seems that a wealth of initiatives and activities are carried out in Kent to address each of the four strands. Many of these activities are branded by the Partnership's "fouryoungpeople" logo, which is used to promote and identify free and confidential services for young people.[138]

3.6.17. In the Sex and Relationships Education (SRE) strand, the strategy promotes a strong delay message with the objective of providing young people with information that will help them make informed decisions. Abstinence programmes are less emphasised in this strand, although evidence received showed diverse opinions on its effectiveness.[139] [140] [141] [142] [143] [144] [145]

3.6.18. The SRE strand is supported by national programmes including the PSHE Certification Programmes for Teachers and for nurses (which will be discussed more in detail in Section 5.6) and the National Healthy Schools Programme.[146]

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[138] Kent County Council (2006) Kent Teenage Pregnancy Partnership Information Update for 2006, Kent County Council.
[139] Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council.
[140] Janine Cooke, Children's Health Select Committee, 23 November 2006, Kent County Council.
[141] Anna Pelham, Children's Health Select Committee, 27 November 2006, Kent County Council.
[142] Family Education Trust (2002) *Why the Government's Teenage Pregnancy Strategy is Destined to Fail*, Family Education Trust.
[143] Family Education Trust (2007) "Submission to the Kent County Council Children's Health Select Committee".
[144] Swann, C. et al.(2003) *Teenage Pregnancy and Parenthood: A Review of Reviews*, Health Development Agency, London.
[145] Roger Ingham, Children's Health Select Committee, 17 November 2006, Kent County Council.
[146] Kent County Council (2006) Kent Teenage Pregnancy Partnership Information Update for 2006, Kent County Council.

3.6.19. A non-exhaustive list of more specific initiatives carried out in Kent includes:

- The Hyp (healthy young people) Hop SRE Programme. The Hyp Hop programme was developed by young people and professionals and involves learning about relationships, peer pressure, confidentiality, contraception and STIs.[147]

- The "fouryoungpeople" (4YP) website, which is designed to provide young people with information, contact details and advice in an accessible and appealing language. For example, the site includes information on relationships, safe sex, emergency contraception and pregnancy testing. It also features a "virtual clinic" where young people can email questions and receive answers by a trained sexual health specialist.[148] [149]

- "Whatever" self esteem two-day training programmes, designed to emphasise to professionals working with vulnerable young people those skills and attitudes which can boost youngsters' self esteem.[150] [151]

- The "Great Expectations" training programme is aimed at teaching foster carers and professionals dealing with Looked After Children how to deal with these particularly vulnerable children, when faced with sex and relationships related matters.[152] [153] [154]

- The "7 Cs" one day training is offered to those working with young people. The training covers issues related to contraception, infections and communication with young people.[155] [156] [157] [158]

- The CD Rom "The Edge" is distributed to young people through schools, and contains information on sexual health services available, and on drugs and alcohol.[159]

3.6.20. In the strand dealing with contraceptive services a range of initiatives also exists, including:

- Fouryoungpeople (4YP) sexual health, young people friendly, clinics.[160]

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[147] *Ibid*.
[148] *Ibid*.
[149] Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council.
[150] Kent County Council (2006) Kent Teenage Pregnancy Partnership Information Update for 2006, Kent County Council.
[151] Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council.
[152] Sam Higgins, Children's Health Select Committee, 27 November 2006, Kent County Council.
[153] Kent County Council (2006) Kent Teenage Pregnancy Partnership Information Update for 2006, Kent County Council.
[154] Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council.
[155] *Ibid*.
[156] Kent County Council (2006) Kent Teenage Pregnancy Partnership Information Update for 2006, Kent County Council.
[157] Sam Higgins, Children's Health Select Committee, 27 November 2006, Kent County Council.
[158] Mick Price, Children's Health Select Committee, 20 November 2006, Kent County Council.
[159] Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council.
[160] Kent County Council (2006) Kent Teenage Pregnancy Partnership Information Update for 2006, Kent County Council.

- A Pharmacy scheme involving a short training for pharmacists before allowing them to supply free of charge Emergency Hormonal Contraception (EHC) to young people under the age of 20. The EHC, if taken within 24 hours of having intercourse, gives 87% chance of preventing pregnancy.[161]

- A GP pregnancy test and condom scheme in which free condoms and pregnancy tests are provided in young people friendly surgeries.[162]

3.6.21. Mystery shopper programmes allow young people to visit and assess service providers. [163]

3.6.22. A knowledge fold out leaflet provides young people with discreet information on services dealing with contraception and with STIs.[164]

3.6.23. In the "young parents" strand services available comprise:

- A local directory for young parents listing a range of services – in health, housing, childcare, education – available to them.[165]

- The "Speakeasy" training package. This package was designed by the Family Planning Association (FPA) and is delivered to parents by trained professionals. It helps parents talk to their children about matters related to sex and relationships and answer questions they may feel uncomfortable with. Kent has the largest uptake of parents in the UK.[166] [167] [168] [169] [170]

- "Supporting Young Fathers" helps young fathers build positive relationships with their children. Partner organisations involved in this initiative are Sure Start, Home Start and Health Promotion.[171] [172]

3.6.24. The final strand – Media – is also characterised by a wide range of initiatives. Some of them are briefly described below.

- The teenage pregnancy strategy is promoted to professionals working with young people through a variety of methods, including the "Network News" newsletter.[173]

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[161] Janine Cooke, Children's Health Select Committee, 23 November 2006, Kent County Council.
[162] Kent County Council (2006) Kent Teenage Pregnancy Partnership Information Update for 2006, Kent County Council.
[163] *Ibid*.
[164] *Ibid*.
[165] *Ibid*.
[166] Sam Higgins, Children's Health Select Committee, 27 November 2006, Kent County Council.
[167] Kent County Council (2006) Kent Teenage Pregnancy Partnership Information Update for 2006, Kent County Council.
[168] Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council.
[169] Roger Street, Children's Health Select Committee, 17 November 2006, Kent County Council.
[170] Cathy Donelon, Children's Health Select Committee, 20 November 2006, Kent County Council.
[171] Sam Higgins, Children's Health Select Committee, 27 November 2006, Kent County Council.
[172] Kent County Council (2006) Kent Teenage Pregnancy Partnership Information Update for 2006, Kent County Council.
[173] *Ibid*.

- Young people's views and ideas are regularly sought via consultation with groups such as the Kent Youth County Council (KYCC) and local youth forums.[174] [175]

- The "foryoungpeople" website and a dedicated 24 hour phone line promote the range of sexual health services available to young people in Kent. Following feedback from professionals working with young people, small credit card-sized information cards will also be available, with a blank space inside for information to be added. [176]

- A new texting service enables young people to access information about their local sexual health services by typing the postcode of their homes.[177]

- A4 posters are produced, containing information about the location and opening times of local clinics and pharmacies supplying Emergency Hormonal Contraception (EHC) services. Small cards providing details of EHC services and revamped 4YP stickers identifying young people friendly EHC services will also be available.[178]

3.6.25. So far the Report has explored the issue of teenage pregnancy, highlighting the reasons for its importance, its consequences and some of the initiatives aimed at dealing with it. Some of the topics examined, namely those closely related to Sexually Transmitted Infections (STIs), Personal, Social and Health Education (PSHE) and Sex and Relationships Education (SRE) will be investigated more in detail in the following chapters.

3.6.26. Having explored the issues outlined so far, the Children's Health Select Committee proposes the following recommendations:

Recommendation 1

That all those dedicated individuals working to provide young people in Kent with high standard sexual health services be commended.

Recommendation 2

The Committee urges that all key agencies be wholly committed and signed up to the Kent Teenage Pregnancy Strategy in an effort to decrease the rate of teenage pregnancy.

Recommendation 3

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[174] *Ibid*.
[175] Georgie Lindsay-Watson, Children's Health Select Committee, 23 November 2006, Kent County Council.
[176] Kent County Council (2006) Kent Teenage Pregnancy Partnership Information Update for 2006, Kent County Council.
[177] *Ibid*.
[178] *Ibid*.

The Committee endorses and supports all the efforts of the Kent Teenage Pregnancy Partnership. It recommends expanding the Partnership's reach to all the young people in Kent by further promoting its sexual health services in places young people frequent.

Recommendation 4

The Committee strongly recommends the broad production, promotion and distribution of discreet information on local sexual health services and support.

4. Sexually Transmitted Infections (STIs)

4.1. What are STIs?

4.1.1. Sexually Transmitted Infections (STIs) are diseases that can be transmitted by unprotected sex between two people. They usually present with acute conditions, their symptoms can be painful, and if untreated they can lead to serious complications and sequalae.[179][180]

4.1.2. People may be unaware that they have STIs, as they may not have symptoms for some time. However, during this time they are still able to spread the infection to any other sexual partner. For this reason STIs are called *asymptomatic infections*, and are usually detected by sexual health screening of individuals.[181]

4.1.3. Nonetheless, as the publication Choosing Health points out, "sexual health is not just about disease: ignorance and risky behaviour can also have profound consequences. Studies suggest that there has been an increase in risky behaviour since the mid 1990s, and that there is still considerable ignorance about the possible consequences".[182]

"You don't need a condom if the girl is on the pill…"

(Teenager, from Kent)[183]

4.1.4. The incidence of STIs has increased in the UK in recent years, particularly affecting young people; today the UK has the highest rate of STIs in Europe.[184] The spread of some infections, such as Chlamydia, has reached alarming levels.[185] [186] Below is a brief description of some of the most common infections.

4.1.5. *Chlamydia Trachomatis* is today the most common STI in both men and women in the UK.[187] This is perhaps partly due to a combination of increased and more accurate tests, such as the Nucleic Acid Amplifications Test (NAAT).[188]

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[179] Office for National Statistics (2004) "The health of children and young people", ONS.
[180] Health Protection Agency (1998) "Sexually Transmitted Infections", www.hpa.org.uk/infections/topics.
[181] *Ibid*.
[182] South East Public Health Observatory, Department of Health (2006) "Choosing Health in the South East: Sexual Health", Oxford.
[183] Jenny Billings (2005) *Service Development Programme: Maximising Life Opportunities for Teenagers*, CHSS, University of Kent.
[184] Janine Cooke, Children's Health Select Committee, 23 November 2006, Kent County Council.
[185] Health Protection Agency (2006) "Sexual health: Chlamydia rates continue to rise", HPA.
[186] Health Protection Agency (2006) "A Complex Picture: HIV and other Sexually Transmitted Infections in the United Kingdom", HPA.
[187] Janine Cooke, Children's Health Select Committee, 23 November 2006, Kent County Council.
[188] South East Public Health Observatory, Department of Health (2006) "Choosing Health in the South East: Sexual Health", Oxford.

4.1.6. The consequences of Chlamydia can have lifelong consequences, particularly for women. In men, complications are uncommon, although they can lead to painful inflammation of the testicles, which can lead to infertility.[189]

4.1.7. In women, if untreated, Chlamydia can lead to pelvic inflammatory disease (PID), which is an inflammation of the uterus, fallopian tubes and other female reproductive organs. PID can result in infertility, ectopic pregnancy and chronic pelvic pain.[190] [191] [192]

4.1.8. Gonorrhoea is an infectious disease caused by the bacterium *Neisseria gonorrhoeae*. The principal mode for transmission of Gonorrhoea is sexual contact.[193]

4.1.9. In men Gonhorroea can cause a painful inflammation of the testicles and prostrate gland. If left untreated, it can lead to a narrowing of the urethra and to abscesses.[194]

4.1.10. In women Gonorrhoea, like Chlamydia, can lead to PID and to infertility. If women have Gonorrhoea when pregnant, they can pass it to their babies. Babies can also be born with gonococcal eye infection, which must be treated with antibiotics as it can cause blindness.[195]

4.1.11. This year marks the 25th anniversary of the first reported case of acquired immunodeficiency syndrome (AIDS) and the beginning of human immunodeficiency virus (HIV) control.[196]

4.1.12. HIV is a disease associated with serious morbidity, high costs of treatment and care, and with considerable stigma. It can remain in a dormant state and undiagnosed for prolonged periods, and results in significant levels of mortality - although antiretroviral therapies have lead to substantial reductions of deaths in recent years. [197]

4.1.13. Syphilis is an infection not very common in the UK, although it is more prevalent in other countries. It is usually sexually transmitted, although it can be passed to unborn babies through their mothers.[198]

4.1.14. Syphilis is very contagious, and people infected with it may not have any symptoms or signs; the disease is diagnosed by a positive blood test. If left untreated Syphilis can cause heart problems, and can affect the nervous system.[199]

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[189] Avert (2006) "Gonorrhoea, Chlamydia and Syphilis symptoms, treatment and facts".
[190] *Ibid*.
[191] South East Public Health Observatory, Department of Health (2006) "Choosing Health in the South East: Sexual Health", Oxford.
[192] Janine Cooke, Children's Health Select Committee, 23 November 2006, Kent County Council.
[193] Columbia Encyclopaedia (2006) "Gonorrhoea", www.columbia.thefreedictionary.com.
[194] Avert (2006) "Gonorrhoea, Chlamydia and Syphilis symptoms, treatment and facts".
[195] Avert (2006) "Gonorrhoea, Chlamydia and Syphilis symptoms, treatment and facts".
[196] Health Protection Agency (2006) "A Complex Picture: HIV and other Sexually Transmitted Infections in the United Kingdom", HPA.
[197] South East Public Health Observatory, Department of Health (2006) "Choosing Health in the South East: Sexual Health", Oxford.
[198] Avert (2006) "Gonorrhoea, Chlamydia and Syphilis symptoms, treatment and facts".
[199] *Ibid*.

4.1.15. Other diseases that can be transmitted sexually include Hepatitis B and C, Genital Herpes and Genital Warts. The latter are also very common, especially amongst men.[200]

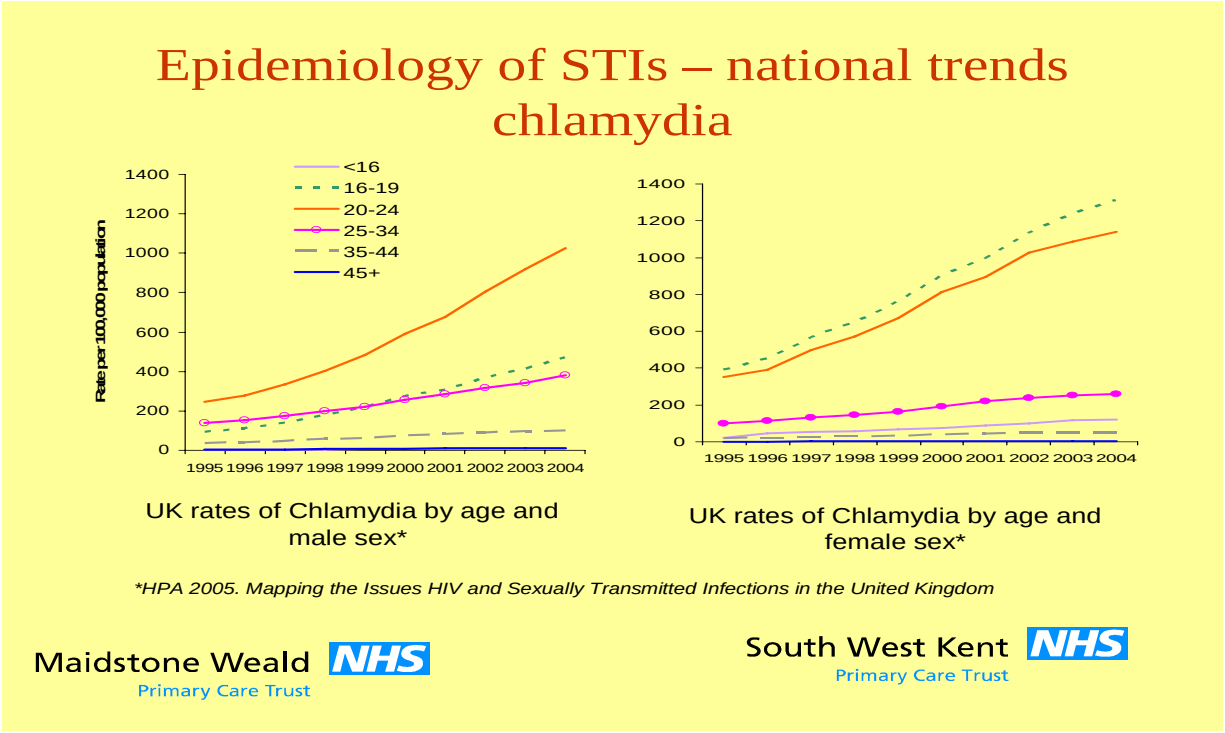
4.2. Facts and Figures about STIs

4.2.1. As explained above, Chlamydia is the most common STI in the UK. It is alarming that the English National Chlamydia Screening Programme found that 10% of young people under-25 years tested positive for Chlamydia.[201] [202]

4.2.2. Between 2004 and 2005 the rate of new diagnoses of Chlamydia among young people who attended Genitourinary Medicine (GUM) clinics in the UK dramatically increased by 5% (7% in men and 3% in women). The number of cases in the UK has risen steadily since the mid 1990s, from 30,794 in 1995 to 109,958 in 2005.[203]

4.2.3. The highest rates in young women are found in those aged between 16 and 19 (1,359 per 100,000) and between 20 to 24 years (1,156 per 100,000). In men, the highest rates are seen in those aged between 20 to 24 years (1,070 per 100,000).[204]

Figure 5: Epidemiology of STIs, national trends: Chlamydia.



Source: Janine Cooke, Children's Health Select Committee, 23 November 2006, Kent County Council.

[200] South East Public Health Observatory, Department of Health (2006) "Choosing Health in the South East: Sexual Health", Oxford.
[201] Health Protection Agency (2006) "A Complex Picture: HIV and other Sexually Transmitted Infections in the United Kingdom", HPA.
[202] Janine Cooke, Children's Health Select Committee, 23 November 2006, Kent County Council.
[203] Health Protection Agency (2006) "Sexual Health: Chlamydia rates continue to rise", HPA.
[204] *Ibid*.

4.2.4. In the area of Kent and Medway, the number of people diagnosed with Chlamydia at GUM clinics tripled, from 617 in 2001 to 1,856 in 2005.[205]

4.2.5. The highest number of women diagnosed with Chlamydia is found in those aged 16 to 19 (with 132 infected girls in 2001 and 401 in 2005), and 20 to 24 (with 121 infected girls in 2001 and 364 in 2005).[206]

4.2.6. The highest number of men is amongst those aged 20 to 24 (with 92 infected young men in 2001 and 387 in 2005), and 25 to 34 (with 85 men in 2001 and 233 in 2005).[207]

4.2.7. The second most common bacterial STI in the UK in 2005 is uncomplicated Gonorrhoea, with 19,392 infections diagnosed in GUM clinics – a 13% decrease from 2004.[208]

4.2.8. The highest rates of Gonorrhoea are present in young men aged between 20 and 24 years (196 per 100,000) and in young women aged 16 to 19 (133 per 100,000). The highest rates in the UK for both men and women are found in London.[209]

4.2.9. In Kent and Medway, although rates have been generally stable, the highest incidence of people infected with Gonorrhoea is found amongst men aged 20 to 24 (with 44 men infected in 2001 and 45 in 2005), and men aged 25 to 34 (with 44 men in 2001 and 39 in 2005).[210]

4.2.10. New diagnoses of HIV in the UK tripled between 1998 and 2003, reaching 3,800. The total number of diagnosed people infected with HIV and receiving care in the UK in 2003 was over 37,000, of which half lived in Greater London. An estimated 14,300 undiagnosed people were thought to be infected.[211]

4.2.11. In Kent and Medway, the number of people diagnosed with HIV also tripled between 1998 and 2003, from 31 to 90. In 2004 and 2005 the figures rose to 104 and 114 respectively, although provisional data for 2006 suggests that number of people affected is decreasing.[212]

4.2.12. Diagnoses of Syphilis in the UK have risen by 23% from 2,282 in 2004 to 2,814 in 2005.[213] New episodes of selected diagnoses of Genital Warts in the South East region in 2004 were actually found to be higher than Gonorrhoea, with just less than 120 cases per 100,000 women, and just over 120 cases per 100,000 men.[214] (Please see also Figures 8 and 9 in Appendix 3).

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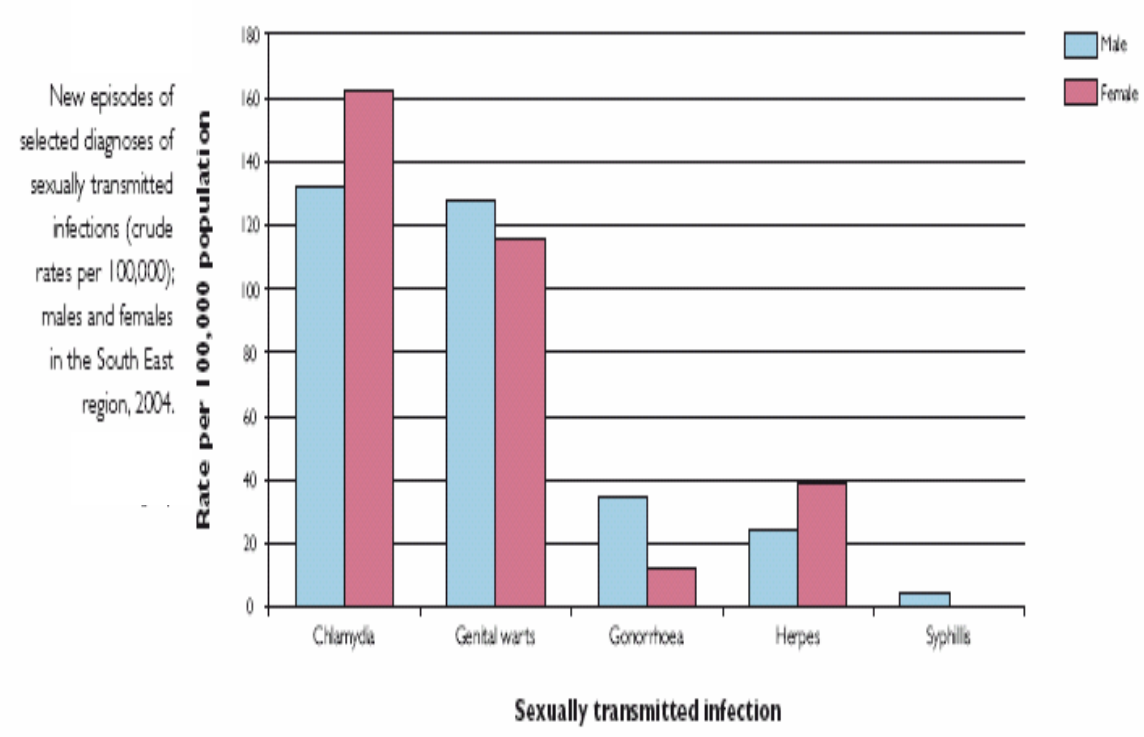
[205] Health Protection Agency (2006) "Diagnoses and rates of selected STIs seen at GUM clinics", HPA.
[206] *Ibid*.
[207] *Ibid*.
[208] Health Protection Agency (2006) "Sexual Health: Chlamydia rates continue to rise", HPA.
[209] *Ibid*.
[210] *Ibid*.
[211] Health Protection Agency (2006) "Sexual Health: HIV and Chlamydia diagnoses increasing", HPA.
[212] Strategic Health Authority (2006) "HIV diagnoses surveillance tables", Kent and Medway, SHA.
[213] Health Protection Agency (2006) "A Complex Picture: HIV and other Sexually Transmitted Infections in the United Kingdom", HPA.
[214] South East Public Health Observatory, Department of Health (2006) "Choosing Health in the South East: Sexual Health", Oxford.

Figure 6: Rate of new episodes of selected diagnoses of STIs in males and females in the South East region, 2004.



Source: South East Public Health Observatory, Department of Health (2006) "Choosing Health in the South East: Sexual Health", Oxford

4.2.13. Although only limited data on the impact of poor sexual health in the UK is available – partly because of its very diverse nature - it is possible to measure some of the costs of complications to individuals (although costing communicable diseases such as STIs is complex as their impact extends beyond the individual considered).[215]

4.2.14. Nevertheless, the current cost of STIs found in GUM clinics in England is estimated to reach £165million per year. The cost of looking after a patient with HIV is estimated at about £14,000 per year, with a total cost in the UK in 2002-3 of £345 million.[216]

4.2.15. Although the cost of Chlamydia is not easy to estimate, evidence suggests that screening for Chlamydia infections reduces the incidence of pelvic inflammatory diseases by 56%, and the proportion of ectopic pregnancies by 46%.[217]

4.2.16. Currently no evaluation of the costs resulting from pelvic inflammatory diseases exists, but in-vitro fertilisation in the UK is estimated at £2,771 per cycle of treatment.[218]

[215] *Ibid*.
[216] *Ibid*.
[217] *Ibid*.
[218] *Ibid*.

4.3. Initiatives and Strategies to Deal with STIs

4.3.1. In England, publications such as "The National Strategy for Sexual Health and HIV", produced in 2001, and the Public Health White Paper "Choosing Health" (2004), acted as a catalyst for the improvement of sexual health services and prevention.[219]

4.3.2. More specific national targets include:

- reducing the incidence of Gonorrhoea at PCT level
- securing an appointment within 48 hours to all those referred to at GUM clinics by 2008
- offering HIV tests to all new attendees of GUM clinics
- screening for Chlamydia at least 50% of the sexually active under-25 population in each PCT by 2007
- and offering all men having sex with men Hepatitis B vaccination on their first visit to GUM clinics.[220]

4.3.3. The National Chlamydia Screening Programme was originally planned in the Department of Health's National Strategy for Sexual Health and HIV. Ten pilot programmes were introduced in 2002 and other 16 were added in 2004. The current screening programme covers over 25% of PCTs in England.[221]

4.3.4. Phase 3 of the Programme consists of the introduction of another 50 sites. In 2006 full screening began in England with the aim of achieving full coverage of the country.[222]

4.3.5. In England, the Programme reported that, between March 2004 and April 2005, 60,698 opportunistic screening tests were taken in non-GUM settings from young people aged from 16 to 25 years. The great majority of tests was carried out on women (53,103 women against 7,596 men).[223]

4.3.6. Further national recommendations have also been made by several agencies.

4.3.7. The Health Development Agency, for example, has recommended partner referral for identifying new infections and school-based sex education to improve risky behaviour.[224]

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[219] Health Protection Agency (2006) "A Complex Picture: HIV and other Sexually Transmitted Infections in the United Kingdom", HPA.
[220] South East Public Health Observatory, Department of Health (2006) "Choosing Health in the South East: Sexual Health", Oxford.
[221] *Ibid*.
[222] *Ibid*.
[223] *Ibid*.
[224] *Ibid*.

4.3.8. The National Chlamydia screening programme has reiterated opportunistic Chlamydia screening when young people aged under-25 visit their GP for other reasons.[225]

4.3.9. The Medical Foundation for AIDS and Sexual Health has recently produced ten standards of sexual health and HIV services. These include the promotion of sexual health through the provision of information, support and opportunities to improve personal and social skills in an effort to enhance sexual health; prompt advice on and availability of contraceptive methods; rapid access to free and confidential pregnancy testing services, with same-day, and preferably on-the-spot, results.[226] Confidentiality seems to be a particularly important feature of sexual health services for teenagers.[227]

"Being confidential no one would like [their] parents or family to find out"

(Teenager, from Kent)[228]

4.3.10. It appears that the Chlamydia Screening Programme is more developed in East Kent than in West Kent. For example, a free and confidential home testing kit is established for under-25 residents in the East Kent area, while it is still developing in West Kent. The kit can be conveniently requested by phone and email.[229]

4.3.11. In the South East, the West Kent area was the last one to receive Government funding to establish a screening programme for Chlamydia. The National Screening Programme rolled out in West Kent in August 2006 to test young people aged from 15 to 25 years. The programme consists of 3 phases. In Phase 1, it is launched in Family Planning and Young People's Clinics. In Phase 2 it becomes available in GPs and Genito-Urinary Medicine Clinics, and in Phase 3 it is supplied in community locations, such as colleges, Connexions services, pharmacies and youth services.[230]

4.3.12. Those young people found to have contracted Chlamydia are also tested for Gonorrhoea and Syphilis. Tests tend now to be less intrusive, especially those for young men which only involve analysing urine samples.[231]

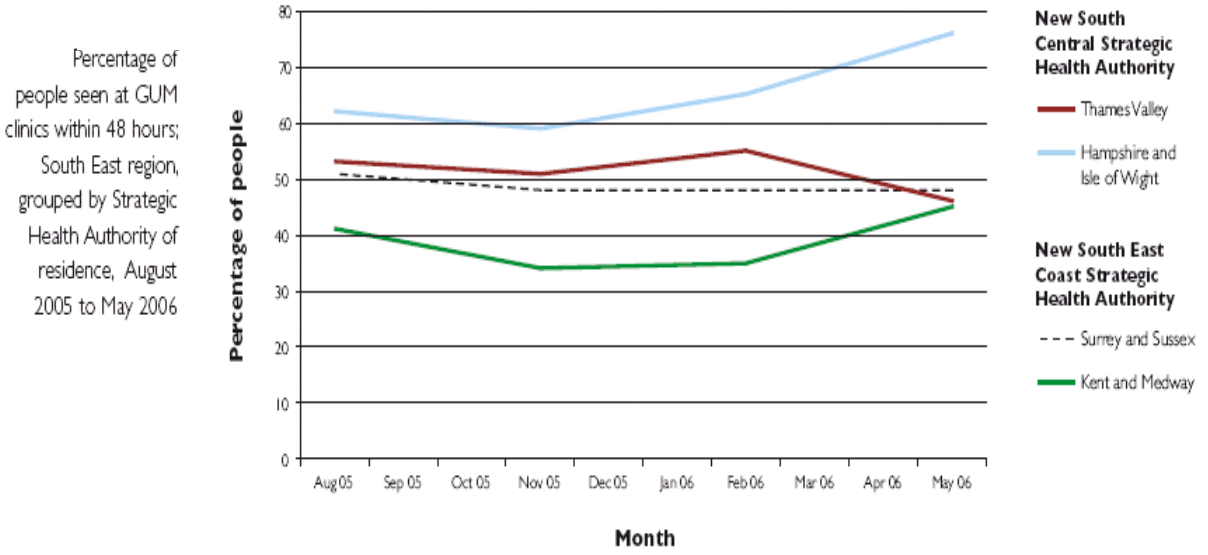
4.3.13. Service provision in GUM clinics in Kent can also be developed and improved. Data and statistics provided by the Health Protection Agency (HPA) about waiting times for patients attending GUM clinics allows the

[225] *Ibid*.
[226] *Ibid*.
[227] Jenny Billings (2005) *Service Development Programme: Maximising Life Opportunities for Teenagers*, CHSS, University of Kent.
[228] *Ibid*.
[229] Kent and Medway NHS (2007) "You and your health: Chlamydia screening", www.kentandmedway.nhs.uk/local_nhs_services/chlamydia.
[230] Janine Cooke, Children's Health Select Committee, 23 November 2006, Kent County Council.
[231] *Ibid*.

assessment of the percentage of people seen at GUM clinics within 48 hours, which is a NHS priority.[232]

4.3.14. In the South East, data grouped into Strategic Health Authority (SHA) areas shows that Kent and Medway are falling below 40% success in meeting the 48 hour waiting target. However, this can be explained to some extent by the logistic difficulty for some rural or partly rural PCTs in providing timely access to GUM services.

Figure 7: Percentage of people seen at GUM clinics within 48 hours, South East region grouped by Strategic Health Authority of residence, August 2005 to May 2006.



4.3.15. The supply of sexual health services in schools in Kent can also be improved. A survey conducted by the South East teenage pregnancy co-ordinators in 2005 illustrates that the percentage of secondary schools in areas, such as Bracknell Forest, West Berkshire, Reading and Portsmouth is above 25%. In Kent, there are currently only two established drop-in centres based in secondary schools, with two more planned for the future.[233] [234]

Source: South East Public Health Observatory, Department of Health (2006) "Choosing Health in the South East: Sexual Health", Oxford.

"I think there should be a service in school for free contraception and emergency contraception"

(Teenager from Shepway, Kent)[235]

[232] South East Public Health Observatory, Department of Health (2006) "Choosing Health in the South East: Sexual Health", Oxford.
[233] *Ibid*.
[234] Janine Cooke, Children's Health Select Committee, 23 November 2006, Kent County Council.
[235] Jenny Billings, Children's Health Select Committee, 20 November 2006, Kent County Council.

4.3.16. This reluctance can partly be explained by a general culture that tends to attach a stigma on young people seeking information about sexual health issues.[236]

Case Study

Bracknell Forest

Work to help teenagers avoid pregnancy has been spearheaded by Bracknell Forest Borough Council and Bracknell Forest Primary Care Trust. Initiatives have included drop-in clinics at all secondary schools, enabling teenagers to see school nurses and youth workers about health issues, including those related to sexual health and contraception. The success of the Healthy Schools initiative has been to help children think about health issues from an early age, preparing the way for discussions about relationships and sex.

The availability of advice and emergency hormonal contraception - the 'morning-after pill' - from high street chemists and the joint appointment of staff, bridging the gap between education, social care and health have also been key success factors. Further joint work will involve a conference for local health, council and voluntary staff on how to help teenagers delay having sex.

Department for Education and Skills (2006)

4.3.17. The steady rise of many sexually transmitted infections in the UK has become today a central national concern. Several strategies and initiatives have already been developed and implemented both at national and local level to deal with the increase of STIs. But more can be done to ensure a better quality of life for the young residents in Kent. The committee recommends the following:

Recommendation 5

The Committee recommends that all partner agencies involved must facilitate the expansion of the National Chlamydia Screening Programme, to ensure full screening coverage of all sexually active young people in Kent under the age of 25.

Recommendation 6

That GUM clinics must replace appointments with a “walk in” service. The Committee insists that the proportion of Genito-Urinary Medicine (GUM) clinic attenders offered an appointment within 48 hours of contacting the service must reach 100% by 2008.

[236] Janine Cooke, Children’s Health Select Committee, 23 November 2006, Kent County Council.

Recommendation 7

That the number of school nurses working in secondary schools in Kent be increased, and that the number of accessible, confidential and young people friendly sexual health clinics in all secondary schools in Kent be raised by at least one per cluster by 2008.

5. Personal, Social and Health Education (PSHE)

5.1. What is PSHE?

5.1.1. Personal, social and health education (PSHE) is the planned provision for emotional and social development in schools. It helps provide children and young people with the skills, knowledge and understanding they need to lead confident, healthy and independent lives.[237] [238] [239]

5.1.2. The provision of PSHE embodies three central aspects:

- The acquisition of relevant information on different topics, such as relationships, sexual health and substance misuse including alcohol.
- The development of values and behaviours that support self esteem and well-being.
- Learning of social and emotional skills for social interaction and the management of health and well-being.[240] [241]

5.1.3. According to the Office for Standards in Education (Ofsted), an encompassing and balanced PSHE curriculum over Key Stages 1 to 4 should include:

- Aspects of health, including SRE and Drug Education
- Education for sustainable development
- Economic and industrial understanding
- Career education and guidance
- Personal financial understanding
- Citizenship.[242]

5.1.4. In a legislative context, the requirements for teaching Personal, Social and Health Education are set out in a non-statutory framework for PSHE and Citizenship at Key Stages 1 and 2, and for PSHE at Key Stages 3 and 4.[243] [244]

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[237] The Independent Advisory Group on Teenage Pregnancy and The Independent Advisory Group on Sexual Health and HIV (2006) "Time for Action", IAG TP and IAG SH.
[238] Qualifications and Curriculum Authority (2006) "About personal, social and health education", www.qca.org.uk/7835.
[239] Jill Wiles, Children's Health Select Committee, 7 November 2006, Kent County Council.
[240] The Independent Advisory Group on Teenage Pregnancy and The Independent Advisory Group on Sexual Health and HIV (2006) "Time for Action", IAG TP and IAG SH.
[241] Allan Foster, Children's Health Select Committee, 3 November 2006, Kent County Council.
[242] *Ibid*.

[243] Qualifications and Curriculum Authority (2004-5) "Annual report on curriculum and assessment", QCA.
[244] Allan Foster, Children's Health Select Committee, 3 November 2006, Kent County Council.

[245] However, the effective delivery of PSHE helps schools achieve the five national outcomes for children, as required in the Children Act (2004). These are:

- Being healthy
- Staying safe
- Enjoying and achieving
- Making a positive contribution
- Economic well being.[246]

5.1.5. In addition, PSHE is also important in achieving the second aim of the National Curriculum:

"The school curriculum should aim to promote pupils' spiritual, moral, social and cultural development and prepare all pupils for the opportunities and responsibilities of adult life".[247]

5.1.6. Finally, PSHE is relevant to legislation and guidance on diverse, related issues including;

- Sex and Relationships Education Guidance (DfEE 2000)
- Healthy Schools (DfES and DH 2005)
- Drug Education Guidance (DfES 2004)
- Pupil Participation (DfES 2004)
- Teenage Pregnancy Guidance (DfES 2006).[248] [249] [250]

[245] Claire Stubbs, Children's Health Select Committee, 13 November 2006, Kent County Council.
[246] Clusterweb (2006) "Healthy Schools: National Healthy Schools Programme", www.clusterweb.org.uk/Children/hs.
[247] The Independent Advisory Group on Teenage Pregnancy and The Independent Advisory Group on Sexual Health and HIV (2006) "Time for Action", IAG TP and IAG SH.
[248] *Ibid*.
[249] Department for Education and Skill (2006) "Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies", Nottingham.
[250] Department for Education and Skill (2006) "Teenage Pregnancy: Accelerating the Strategy to 2010", Nottingham.

5.2. Why PSHE Is Important

5.2.1. It is important that children and young people receive support to help them develop emotionally and socially, in order to enhance their personal awareness and social skills, and ultimately to enjoy and manage their lives effectively.[251]

5.2.2. More specifically, evidence consistently shows that comprehensive PSHE can:

- Improve the engagement with learning, for example by fostering self esteem and improving behaviour
- Contribute to improving public health, such as sexual health and obesity
- Enhance pupils' ability to live in a multi-cultural, fast-changing society
- Promote social inclusion
- Help schools meet legal requirement, such as promoting race equality.[252]

5.2.3. In addition, an in-depth review carried out in 2005 by the Government's Teenage Pregnancy Unit concluded that a strong delivery of PSHE in schools was clearly related to decreasing teenage pregnancy rates.[253] [254]

5.2.4. This conclusion is also reflected in the Kent Teenage Pregnancy Strategy 2006 Annual Report, which recognises that there is a strong correlation between educational attainment and decreasing teenage pregnancy rates, and that the provision of Sex and Relationships Education within a regular timetabled Personal, Social and Health Education is essential for the Strategy's success.[255]

5.2.5. Indeed, the centrality of PSHE in education today is such that pressure is increasing to render the delivery of PSHE a statutory requirement and to make PSHE a foundation subject in the National Curriculum.[256] [257] [258] The recent creation of the first ever National Subject Association for personal, social and health education – bringing PSHE in line with other curriculum subjects – also reflects this increasing pressure.

5.2.6. Finally, it is perhaps important to point out that sexual health is not just about treating diseases; often ignorance and risky behaviour can have profound

[251] National Children's Bureau (2006) "A whole school approach to PSHE", NCB, London.
[252] The Independent Advisory Group on Teenage Pregnancy and The Independent Advisory Group on Sexual Health and HIV (2006) "Time for Action", IAG TP and IAG SH.
[253] *Ibid*.
[254] [254] Department for Education and Skill (2006) "Teenage Pregnancy: Accelerating the Strategy to 2010", Nottingham.
[255] Kent County Council(2006) The Kent Teenage Pregnancy Strategy Annual Report 2006, KCC.
[256] Qualifications and Curriculum Authority (2004-5) "Annual report on curriculum and assessment", QCA.
[257] The Independent Advisory Group on Teenage Pregnancy and The Independent Advisory Group on Sexual Health and HIV (2006) "Time for Action", IAG TP and IAG SH.
[258] National Children's Bureau (2006) "Urgent action on personal, social and health education", NCB.

consequences which can be prevented.[259] PSHE and SRE can help young people make informed choices about their lives.

5.3. Education and Services Out of School

5.3.1. Not all young people of compulsory school age go to school. Young people disengaged from education often are particularly vulnerable.[260] [261] Taking the issue of teenage pregnancy in particular, evidence suggests that areas with high level of absenteeism have higher under-18 conception rates.[262]

5.3.2. According to research conducted by the Teenage Pregnancy Unit (TPU), less than half young women interviewed attended school regularly before becoming pregnant.[263] [264] Teenage mothers are less likely to complete their education and are more likely to raise their children alone and in poverty.[265]

5.3.3. It seems therefore particularly important to help those vulnerable young people who are unable to attend school as a result of teenage pregnancy.

5.3.4. It is a statutory duty for local authorities to provide suitable education for all pupils for whom they are responsible, including pupils of compulsory age who become parents.[266] [267]

5.3.5. Schools would normally be expected to oversee the education of pregnant teenagers or teenage mothers. Depending on individual needs, the local authority may choose to provide a place at a Pupil Referral Unit (PRU) or other educational centre during absence from school, or could decide to provide home tuition.[268]

5.3.6. A girl is entitled to no more than 18 calendar weeks' authorised absence to cover the period just before and after giving birth. Sometimes pupils fail to return after this period, although they can still continue to receive support. Procedures are also followed in order to meet young fathers' needs.[269]

5.3.7. Nonetheless, the main objective is to re-integrate these young people into school, in order to ensure that – wherever possible - they complete compulsory education.[270] Indeed, it is one of the national central aims to

[259] Roger Street, Children's Health Select Committee, 17 November 2006, Kent County Council.
[260] *Ibid*.
[261] Bill Anderson, Children's Health Select Committee, 7 November 2006, Kent County Council.
[262] Department for Education and Skill (2006) "Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies", Nottingham.
[263] *Ibid*.
[264] Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council.
[265] *Ibid*.
[266] Department for Education and Skills (2001) "Guidance on the education of school age children", DfES.
[267] Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council.
[268] *Ibid*.
[269] *Ibid*.
[270] *Ibid*.

increase the participation of teenage mothers in education, training or work to 60% by 2010 to reduce the risk of long term social exclusion.[271]

5.3.8. According to the DfES, there is no evidence that keeping pregnant teenagers or teenage mothers in school will encourage others to become pregnant. In fact, effective PSHE can alert teenagers to the risks and realities of early parenthood.[272]

5.3.9. One of the services that a local authority can offer is the provision of advice on childcare. A "Re-integration Officer" and Connexions and Sure Start advisers are all able to supply young parents with information about accessing care for their children. Financial help can also be available, if the young parents' families are unable to help.[273]

5.3.10. In Kent, a range of services is in place to deal with social issues affecting young people. A well resourced youth service supports young people disengaged from education, for example by organising a wide range of social and educational activities aimed at raising their aspirations.[274] In addition, most of its youth workers have received training in sexual health and condom distribution.[275] [276]

5.3.11. The Kent Teenage Pregnancy Partnership collaborates with other agencies, such as the Learning and Skills Council (LSC) and the Open College Network to encourage the re-integration of young parents into education, by tailor making service provision to suit individual needs.[277]

5.3.12. A multi-agency Sex and Relationships Education Steering Group ensures that SRE in Kent is planned and delivered effectively focusing - amongst other aspects – on the delivery of SRE to those outside mainstream education.[278] Partners involved in the Group's activities include the Kent Teenage Pregnancy Partnership, KCC Education, School Nursing and Sexual Health Services.[279] A specific initiative includes multi-agency work to help young fathers through group work.[280]

5.3.13. A Re-integration Officer in Kent helps young people of statutory school age who left school as a result of pregnancy to return to education. The Officer can provide young people with advice and information about housing, benefits, childcare, funding and options available to complete education.[281]

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[271] South East Regional Public Health Group, Department of Health (2006) "Teenage Pregnancy", GOSE.
[272] Department for Education and Skills (2001) "Guidance on the education of school age children", DfES.
[273] *Ibid*.
[274] Mick Price, Children's Health Select Committee, 20 November 2006, Kent County Council.
[275] Kent County Council(2006) The Kent Teenage Pregnancy Strategy Annual Report 2006, KCC.
[276] Mick Price, Children's Health Select Committee, 20 November 2006, Kent County Council.
[277] Kent County Council (2006) Kent Teenage Pregnancy Partnership Information Update for 2006, Kent County Council.
[278] Kent County Council(2006) The Kent Teenage Pregnancy Strategy Annual Report 2006, KCC.
[279] Cathy Donelon, Children's Health Select Committee, 20 November 2006, Kent County Council.
[280] Kent County Council(2006) The Kent Teenage Pregnancy Strategy Annual Report 2006, KCC.
[281] Kent County Council (2006) Kent Teenage Pregnancy Partnership Information Update for 2006, Kent County Council.

5.3.14. The PSHE Advisor in Kent can help identify children at risk of teenage pregnancy. Indeed, it is possible to identify which children are at risk of unwanted teenage pregnancy from the age of 10.[282] However, PSHE is only one of three subjects the Advisor is responsible for, constraining the time that a demanding PSHE organisation requires, and reducing the time available to identify children at risk.[283]

5.3.15. A new advisor responsible for Religious Education (RE) and Citizenship should be in place from the beginning of 2007.[284] This should allow the PSHE Advisor to be fully devoted to supporting the PSHE programme in Kent.

5.3.16. These examples are only a selection of a range of activities showing that Kent is demonstrating commitment in re-integrating young people of statutory school age into education. It is important that this commitment is sustained in order to reduce young parents' absenteeism and its consequences.

5.3.17. Together with all these KCC initiatives aimed at providing education and services to vulnerable people outside the school environment, other programmes supporting young people also take place in the wider community. The Gr@nd, for example, is a "cyber-café'" centrally located in Gravesham that, amongst a wide range of facilities, supplies sexual health information and services for young people - including those disengaged from education.[285]

5.3.18. As Mr Britt - Public Health Manager in Gravesham Borough Council and heavily involved in the Gr@nd – points out, many of the young people The Gr@nd supports left education at the age of 11 and merely "brushed" against PSHE.[286]

5.3.19. Together with all the programmes implemented by KCC, The Gr@nd, which is completely externally funded by a range of partners including KCC - amongst many other programmes - helps those young people who have not completed statutory education and perhaps have not received satisfactory health education.[287] [288] There are another 300 Healthy Living Centres originally funded by the New Opportunities Fund like The Gr@nd.[289]

5.3.20. Services that The Gr@nd offers include free, drop-in confidential sexual health advice, information and support from youth workers; a free "active listening" service; and an open-access clinic visited by 450 to 500 different young people each year, that provides emergency contraception and Chlamydia testing – all in a completely non-clinical setting.[290]

5.3.21. Importantly, it seems that one of the reasons for The Gr@nd's success is that it is driven by what people want. For example, it was recognised that

[282] Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council.

[283] Allan Foster, Children's Health Select Committee, 3 November 2006, Kent County Council.
[284] *Ibid*.
[285] John Britt, Children's Health Select Committee, 27 November 2006, Kent County Council.
[286] *Ibid*.
[287] *Ibid*.
[288] Mick Price, Children's Health Select Committee, 20 November 2006, Kent County Council.
[289] John Britt, Children's Health Select Committee, 27 November 2006, Kent County Council.
[290] *Ibid*.

many young people did not wish to go to hospital or to their GP to confide in, and that a more friendly non-clinical setting was needed. Also, young people are asked what programmes and topics should be covered and are asked to evaluate its services.[291]

Case Study

Liverpool

Liverpool's Primary Care Trusts and Children's Services are working in partnership with the Local Authority, Connexions, Acute Trusts, and the voluntary sector to deliver targeted work with young people who are most at risk of teenage pregnancy, and universal work which aims to ensure sustainability through workforce training and community development. Focus has been given to the provision of consistent, high quality sex and relationships education in schools and non-school settings; and to sexual health training for professionals who work with young people. So to Speak, Liverpool and Sefton's Sexual Health Education Outreach Team, has been highlighted as an example of good practice in this area of work. Their aim is to equip young people with the information and skills required to make informed choices about their sexual health, while supporting professionals to understand the broader issues that impact on sexual health, and their role in addressing those issues. Other key objectives for the local strategy include raising young people's awareness of, and improving access to, the city's well-established, young-person friendly sexual health services such as Abacus and Brook, which have also been highlighted as examples of good practice.

Department for Education and Skills (2006)

5.3.22. It seems, then, that both KCC and the wider community can offer a range of sexual health services to young people disengaged from school. It also seems that the effective re-integration of these vulnerable people - including young mothers and fathers - into education is of the utmost importance to prepare them for the realities of adult life.

Recommendation 8

The Committee commends and supports all those working with disengaged, vulnerable young people, and urges the effective re-integration of more young mothers and fathers into school to complete their statutory education.

[291] *Ibid*.

5.4. The National Healthy Schools Programme and PSHE

5.4.1. Having briefly outlined the activities available to young people disengaged from education, the report will now focus on the provision of PSHE within schools' settings. It will begin by describing the role and importance of PSHE within the National Healthy Schools Programme.

5.4.2. The aim of the Healthy Schools Programme is to promote the health and well-being of children and young people through a well planned curriculum that encourages learning and healthy lifestyle choices.[292]

5.4.3. The Programme was launched in 1999 and was driven by commitments made in the Excellence in Schools White Paper (1997) and Saving Lives, Our Healthier Nation White Paper (1999). It is a joint project between the Department of Health (DH) and the Department for Education and Skills (DfES).[293] [294]

5.4.4. Following the publication by the DfES of the Healthy Living Blueprint in 2004 and the Public Health White Paper Choosing Health (2004), Every Child Matters and the Children Act (2004) the Government introduced more rigorous criteria for the Programme.[295]

5.4.5. As outlined above, Every Child Matters and the Children Act introduced five national outcomes for children. These are:

- Being healthy
- Staying safe
- Enjoying and achieving
- Making a positive contribution
- Economic well being.[296]

5.4.6. In order to reflect these five outcomes the original programme was revised to include four aims to be achieved for four core themes. The four aims of the Programme now include:

- To support children and young people in developing healthy behaviours
- To help raise pupil achievement
- To help reduce health inequalities
- To help promote social inclusion.[297]

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[292] Department for Education and Skills and Department of Health (2005) "National Healthy Schools Status: A guide for schools", Department of Health, London.
[293] Kent County Council (2006) "National Healthy Schools Programme", www.clusterweb.org.uk/Children/hs.
[294] Carol Healy, Children's Health Select Committee, 7 November 2006, Kent County Council.
[295] *Ibid*.
[296] *Ibid*.

5.4.7. Schools have to evidence how they are contributing to the five outcomes in order to realise the four aims and achieve Healthy Schools status.[298] Ofsted school inspections evaluate and monitor this evidence.[299]

5.4.8. The national programme provides direction and sets the standards for all schools and projects in England though a regional and local network.[300] All local education authorities have their own Healthy Schools Programme.[301]

5.4.9. The national targets set urged that:

- Half of all schools had to be Healthy Schools by December 2006
- All schools have to work towards being Healthy Schools by December 2009.[302] [303]

5.4.10. Although these targets appear to be challenging, evidence shows that there is a strong link between health improvement and educational attainment, and that schools involved in the National Healthy Schools Programme scored higher on 9 out of 11 Ofsted indicators and achieved higher SATs results in Key Stages 1 and 2.[304] [305]

5.4.11. Schools, as explained above, need to demonstrate evidence in the four core themes using a whole schools approach aimed at involving the whole community. Personal, Social and Health Education is one of these core themes, together with healthy eating, physical activity, and emotional health and well-being.[306] [307] (Please see Figure 10 in Appendix 3). Indeed, effective delivery of PSHE is one of the mandatory requirements necessary in order to achieve Healthy Schools status.[308] [309]

5.4.12. Eleven criteria need to be satisfied in order to demonstrate the effective delivery of PSHE. Criteria that a Healthy School must meet in this core theme comprise:

- The use of a PSHE framework to deliver a planned programme of PSHE
- Monitoring and evaluation of PSHE delivery

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[297] *Ibid*.
[298] *Ibid*.
[299] *Ibid*.
[300] Cathy Donelon, Children's Health Select Committee, 20 November 2006, Kent County Council.
[301] Carol Healy, Children's Health Select Committee, 7 November 2006, Kent County Council.
[302] Kent County Council (2006) "National Healthy Schools Programme", www.clusterweb.org.uk/Children/hs.
[303] Cathy Donelon, Children's Health Select Committee, 20 November 2006, Kent County Council.
[304] Kent County Council (2006) "National Healthy Schools Programme", www.clusterweb.org.uk/Children/hs.
[305] Carol Healy, Children's Health Select Committee, 7 November 2006, Kent County Council.

[306] Department for Education and Skills and Department of Health (2005) "National Healthy Schools Status: A guide for schools", Department of Health, London.
[307] Carol Healy, Children's Health Select Committee, 7 November 2006, Kent County Council.
[308] *Ibid*.
[309] Department for Education and Skill (2006) "Teenage Pregnancy: Accelerating the Strategy to 2010", Nottingham.

- A named member of staff in the school responsible for PSHE provision with status, training and senior management support

- The involvement of other professionals, such as school nurses and sexual health outreach workers

- The provision of PSHE professional development opportunities.[310]

5.4.13. Importantly, then, a Healthy School approach provides – amongst other aspects - a useful vehicle for the effective planning, delivery, monitoring and assessment of PSHE.[311] And, by fully engaging schools with PSHE, it would be easier to identify those young girls and boys slowly becoming disengaged with education, and implement preventative measures.[312]

5.5. The Kent Healthy Schools Programme

5.5.1. The Kent Healthy Schools Programme is accredited and is guided by the National Healthy Schools Programme. Locally, the main strategic partners are the Primary Care Trusts and the local authority, which is responsible for delivering the Kent Healthy Schools Programme.[313]

5.5.2. Together with these main partners, the National Healthy Schools Programme relies and depends on an encompassing web of support. Partners involved include Local Education Officers, PSHE Advisers, Educational Psychologists, Community Dieticians, Sexual Health Teams and the voluntary sector.[314]

5.5.3. Because of Kent's size and complexity, the Kent Healthy Schools programme is divided into three areas. These are East Kent, the North West Kent, and the South West Kent Healthy Schools Programmes.[315]

5.5.4. Each cluster in Kent is provided with a named Healthy Schools specialist, whose role is to support all the schools within the cluster in their efforts to achieve Healthy Schools status. Assistance may include help with auditing procedures, development of action plans and signposted partnership support.[316]

5.5.5. In Kent a softer target has been negotiated with Central Government within the Local Area Agreement, recommending that 50% of all schools be *engaged* in achieving – rather than *achieve* – Healthy Schools status by 2006, and with the rest working towards Healthy Schools validation by March 2009.[317]

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[310] Department for Education and Skills and Department of Health (2005) "National Healthy Schools Status: A guide for schools", Department of Health, London.
[311] The Independent Advisory Group on Teenage Pregnancy and The Independent Advisory Group on Sexual Health and HIV (2006) "Time for Action", IAG TP and IAG SH.
[312] Carol Healy, Children's Health Select Committee, 7 November 2006, Kent County Council.
[313] *Ibid*.
[314] *Ibid*.
[315] *Ibid*.
[316] *Ibid*.
[317] *Ibid*.

5.5.6. The Healthy Schools Programme, then, can help improve both educational attainment and well-being. Importantly for the context of this report, it can be one useful vehicle for the effective planning, delivery, monitoring and assessment of PSHE.

Recommendation 9

The Committee recommends that all schools in Kent work towards Healthy Schools validation by March 2009, through a process which is all inclusive to parents and governors.

5.6. Personal, Social and Health Education in the School

5.6.1. As explained in Section 5.1, the requirements for teaching Personal, Social and Health Education are set out in a non-statutory framework for PSHE and Citizenship at Key Stages 1 and 2, and for PSHE at Key Stages 3 and 4.[318] [319]

5.6.2. Perhaps one of the consequences of this lack of statutory status is that PSHE teaching remains characterised by general vagueness and inconsistency.[320] Ofsted reports extreme variations in the time schools allocate to PSHE, ranging from a relatively generous provision to no provision at all.[321] [322] [323]

5.6.3. In fact, PSHE has one of the lowest percentages of teaching time allocated to it – approximately 2.5% in years 7 to 9.[324] Ofsted maintains that the position of those (secondary) schools not providing PSHE in any form is "untenable", although the challenge of including another subject in an already "squashed" curriculum remains.[325] [326] [327] [328] [329]

5.6.4. A consistent, multi-agency approach to PSHE indeed appears to be effective. For example, in the Isle of Wight regular and systematic teaching, together with devoted multi-agency collaboration, have been key elements of the Island's successful PSHE delivery.[330] As a result, the Isle of Wight managed to reduce its teenage pregnancy rate from 40.2 per 1,000 girls in 1998 to 31.7

[318] Qualifications and Curriculum Authority (2004-5) "Annual report on curriculum and assessment", QCA.
[319] Allan Foster, Children's Health Select Committee, 3 November 2006, Kent County Council.
[320] *Ibid*.
[321] Osted (2005) "Annual Report: PSHE in secondary schools", Ofsted.
[322] Jill Wiles, Children's Health Select Committee, 7 November 2006, Kent County Council.
[323] Anna Pelham, Children's Health Select Committee, 27 November 2006, Kent County Council.
[324] [324] Qualifications and Curriculum Authority (2004-5) "Annual report on curriculum and assessment", QCA.
[325] *Ibid*.
[326] Allan Foster, Children's Health Select Committee, 3 November 2006, Kent County Council.
[327] Jill Wiles, Children's Health Select Committee, 7 November 2006, Kent County Council.
[328] Roger Street, Children's Health Select Committee, 17 November 2006, Kent County Council.
[329] Anna Pelham, Children's Health Select Committee, 27 November 2006, Kent County Council.
[330] Liz Phillips, Children's Health Select Committee, 13 November 2006, Kent County Council.

per 1,000 in 2004, achieving a reduction of 21.2% and exceeding its target.[331] [332]

Case Study

Hackney

An audit of schools in Hackney, as part of the Hackney Healthy Schools Programme, drew attention to the need for more consistency in the delivery of PSHE and Citizenship in schools and for support to further raise the quality of provision in this area. Therefore in 2000 all Hackney schools agreed to combine funding from their Standards Fund budgets to develop PSHE and Citizenship. Schools received advisory support and guidance known as "Pulling it Together", which was informed by the DfES guidance on SRE, including a scheme of work and lesson plans that had been shared and agreed. Hackney's teenage pregnancy rates have fallen by 10% between 1998 and 2004.

Department for Education and Skills (2006)

5.6.5. Generally, it appears that in Kent primary schools perform relatively better than secondary schools in their provision of PSHE, although secondary schools tend to be more complex organisations generally needing more support.[333] Nevertheless, it is in secondary schools that PSHE and sexual health education are needed most.[334]

5.6.6. It is important, then, to allocate more time in the weekly curriculum to PSHE and to raise its profile, as has been done successfully with healthy eating and obesity.[335] This objective is also strongly reflected in the Kent Teenage Pregnancy Strategy.[336]

5.6.7. This general inconsistency appears to be accompanied by weak assessment and monitoring systems. The 2005 Ofsted Report on PSHE in Secondary Schools states that "far too little assessment is undertaken of standards or progress in PSHE and, even where it is present, it is often poor".[337] [338] In fact, assessment seems to be the weakest aspect of PSHE in secondary schools.[339]

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[331] *Ibid*.
[332] Department for Education and Skill (2006) "Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies", Nottingham.

[333] Carol Healy, Children's Health Select Committee, 7 November 2006, Kent County Council.
[334] *Ibid*.
[335] *Ibid*.
[336] Kent County Council(2006) The Kent Teenage Pregnancy Strategy Annual Report 2006, KCC.
[337] Osted (2005) "Annual Report: PSHE in secondary schools", Ofsted.
[338] Qualifications and Curriculum Authority (2004-5) "Personal, Social and Health Education Annual Report", QCA.
[339] *Ibid*.

5.6.8. Just under two-thirds of schools in the country analysed by Ofsted claimed to assess pupils' progress and achievement in PSHE, citing teacher observation (80.6%), self-assessment (78.1%) and peer assessment (37.2%) as the main teaching methods.[340]

5.6.9. However, Ofsted reported that perceptions of assessment are "narrow, relating only to pupils' progress in developing their subject knowledge and understanding".[341] The report explains that not many schools evaluate changes in pupils' attitudes and learning, and few have data that could usefully be adopted to inform planning; much assessment still consists of informal reflection and is not recorded.[342]

5.6.10. A local initiative that can perhaps lead to more effective time allocation, planning and assessment, entails the involvement of the School Improvement Partnerships. The Partnerships could collaborate with schools when preparing their self-evaluation and they can assess evidence, adopting the role of "critical friends".[343]

5.6.11. Together with weak provision and assessment, PSHE is also affected by a shortage of specialist teachers prepared to cover the subject.[344] Although in Kent – as of November 2006 – 75 teachers were working towards a PSHE qualification, issues still existed around staff training.[345] [346]

5.6.12. The PSHE Certification for Teachers is a programme for continuing professional development (CPD) that has been running for four years and so far it has enhanced the knowledge, confidence and professional development of 5,000 teachers across the country. The programme is free to teachers as assessment costs are covered by the DfES.[347]

5.6.13. The certification process runs for up to 12 months and is taught by a combination of whole-day courses, twilights, telephone mentoring and residential courses. A portfolio of evidence of classroom practice must be produced and assessed in order to gain the certificate.[348]

5.6.14. Concerns arise not only because too few teachers decide to obtain the PSHE certificate, but also because, according to Ofsted, the majority of secondary schools do not allow those attending training sufficient opportunity to disseminate the knowledge and skills acquired.[349]

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[340] *Ibid*.
[341] *Ibid*, page 10.
[342] *Ibid*.
[343] Allan Foster, Children's Health Select Committee, 3 November 2006, Kent County Council.
[344] Anna Pelham, Children's Health Select Committee, 27 November 2006, Kent County Council.
[345] Allan Foster, Children's Health Select Committee, 3 November 2006, Kent County Council.
[346] Qualifications and Curriculum Authority (2004-5) "Personal, Social and Health Education Annual Report", QCA.
[347] Department for Education and Skills (2006) "DfES PSHE certification for teachers", DfES, London.
[348] *Ibid*.
[349] Osted (2005) "Annual Report: PSHE in secondary schools", Ofsted.

5.6.15. Nonetheless, it seems that one of the main reasons to explain teachers' reluctance to gain the PSHE certificate is that a non-statutory PSHE is not as desirable as other statutory subjects in terms of career development.[350] [351] [352]

5.6.16. Another reason is that PSHE is considered a "content heavy" subject, and that some teachers may feel uneasy about teaching some aspects of it – such as Sex and Relationships Education.[353] [354] [355] In addition, budgetary issues can put constrains on schools' capacity to release their staff for training purposes.[356]

5.6.17. But perhaps, precisely because some PSHE aspects are "content heavy", it is important that untrained teachers should secure the PSHE certificate. Indeed, Ofsted reports that the quality of PSHE teaching by specialist teachers remains considerably better than that of non-specialist ones.[357] [358] [359]

5.6.18. Another advantage of completing the certificate is that having members of staff trained to teach PSHE effectively is one of the criteria individual schools must meet in order to achieve Healthy Schools status (see also Section 5.4)[360]

5.6.19. Teachers, nevertheless, are not the only professionals who could teach PSHE at school. School nurses and members from voluntary sector agencies can and do teach PSHE in schools too, although some concerns have been raised about the number of external organisations offering their services, including private companies, charities and religious groups. [361] [362] [363]

5.6.20. Indeed, a DfES PSHE Certification for Community Nurses also exists.[364] The programme has been running for about two years and has trained about 900 nurses across the country. It is free to nurses, as training and assessment costs are met by the DfES and the DH.[365]

5.6.21. The relevance of nurses in PSHE teaching can perhaps be demonstrated by the diversity of sexual health related activities they are already involved in. For example, they conduct "healthy lifestyle days" where young people learn

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[350] Qualifications and Curriculum Authority (2004-5) "Personal, Social and Health Education Annual Report", QCA.
[351] Carol Healy, Children's Health Select Committee, 7 November 2006, Kent County Council.
[352] Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council.
[353] Qualifications and Curriculum Authority (2006) "Personal, Social and Health Education (PSHE) update", QCA.
[354] Anna Pelham, Children's Health Select Committee, 27 November 2006, Kent County Council.
[355] Qualifications and Curriculum Authority (2004-5) "Personal, Social and Health Education Annual Report", QCA.
[356] Carol Healy, Children's Health Select Committee, 7 November 2006, Kent County Council.
[357] Osted (2005) "Annual Report: PSHE in secondary schools", Ofsted.
[358] Roger Street, Children's Health Select Committee, 17 November 2006, Kent County Council.
[359] Georgie Lindsay-Watson, Children's Health Select Committee, 23 November 2006, Kent County Council.
[360] Department for Education and Skills and Department of Health (2005) "National Healthy Schools Status: A guide for schools", Department of Health, London.
[361] Carol Healy, Children's Health Select Committee, 7 November 2006, Kent County Council.
[362] Kent County Council(2006) The Kent Teenage Pregnancy Strategy Annual Report 2006, KCC.
[363] Jill Wiles, Children's Health Select Committee, 7 November 2006, Kent County Council.
[364] Cathy Donelon, Children's Health Select Committee, 20 November 2006, Kent County Council.
[365] Department for Education and Skills and Department of Health (2006) "DfES PSHE certification for community nurses", DfES and DH, London.

about sexual health and contraception; they teach SRE in schools; they offer support and advice to young people in school-based drop-in clinics on a range of sexual health related matters; and they provide support and advice to pregnant pupils and to teenage parents returning to education.[366]

5.6.22. The reluctance of teachers to specialise in PSHE and the reluctance of schools to allow specialised teachers to disseminate their knowledge, may be explained not only by a "squashed" curriculum, by budgetary issues and by uneasiness with the subject matter, but also by the concern of some parents that teaching aspects of PSHE can encourage sex amongst young people.[367] [368] Nonetheless, evidence suggests that these concerns are largely unfounded.[369]

5.6.23. A member of the Kent Youth County Council (KYCC) explained that it has been difficult to persuade her school to display leaflets concerning sexual health, pointing out that the attitude had been "not at our school".[370] In the Isle of Wight, in which an effective PSHE programme has contributed to one of the lowest reductions of teenage pregnancy rates in the country, all schools promote sexual health services.[371] [372]

"Co-operation from schools and more publicity and information about them for example, I don't know where the nearest family planning clinic is"

(Teenager from Ashford, Kent)[373]

5.6.24. This reluctance is perhaps also manifested by the installation by some schools of "firewalls" that deny pupils access to websites providing information about sexual health, such as the "foryoungpeople", "RUthinking" and "Frank" websites.[374] [375] School computers are the only ones that many young people are able to access; some young people may not own one, while others find it difficult to access SRE information through the home computer when this is not located in a private area.[376]

5.6.25. The lack of provision, or the disinclination to provide, young people with sexual health information can even be harmful; the absence of sensible and honest information can leave young people misinformed about sex and

[366] Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council.
[367] The Independent Advisory Group on Teenage Pregnancy and The Independent Advisory Group on Sexual Health and HIV (2006) "Time for Action", IAG TP and IAG SH.
[368] Roger Ingham, Children's Health Select Committee, 17 November 2006, Kent County Council.
[369] *Ibid*.
[370] Georgie Lindsay-Watson, Children's Health Select Committee, 23 November 2006, Kent County Council.
[371] Liz Phillips, Children's Health Select Committee, 13 November 2006, Kent County Council.
[372] Department for Education and Skill (2006) "Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies", Nottingham.
[373] Jenny Billings, Children's Health Select Committee, 20 November 2006, Kent County Council.
[374] Kent County Council (2006) The Kent Teenage Pregnancy Strategy Annual Report 2006, KCC.
[375] Children's Health Select Committee, 23 February 2007, Kent County Council.
[376] Georgie Lindsay-Watson, Children's Health Select Committee, 23 November 2006, Kent County Council.

relationships and can make them vulnerable to the consequences of unprotected sex.[377]

5.6.26. After this analysis, the Committee recommends the following:

Recommendation 10

The Committee strongly recommends a strategy for a more consistent and systematic Personal, Social and Health Education (PSHE) delivery, that is coupled with more robust assessment and monitoring methods, and that is adopted in all primary and secondary schools in Kent.

Recommendation 11

The Committee urges that the new RE and Citizenship Advisor remains permanently in place to ensure that one advisor is permanently and wholly responsible and accountable for PSHE in Kent.

Recommendation 12

That PSHE certificates for both teachers and nurses be widely promoted and supported. That each school cluster in Kent has a PSHE lead and each secondary school in Kent has at least one PSHE certified teacher. That PSHE awareness be raised through a countywide multi-agency conference, which includes all the decision makers, by March 2008.

Recommendation 13

The Committee strongly urges the County Council to press Government to make PSHE statutory and therefore part of the core curriculum, thereby ensuring that a selection of PSHE lessons are duly observed during inspections by Ofsted.

Recommendation 14

The Committee insists that all secondary schools in Kent ensure access to websites such as “foryoungpeople”, “RUthinking” and “Frank”, and that they provide permanent information on local sexual health services on a visible notice board.

[377] Jenny Billings (2005) *Service Development Programme: Maximising Life Opportunities for Teenagers*, CHSS, University of Kent.

6. Sex and Relationships Education (SRE)

6.1. What is SRE?

6.1.1. Sex and relationships education (SRE), which sometimes is called "sexuality education" or "sex education", is essential if young people are to make well informed and responsible decisions about their lives. Effective SRE helps young people learn to respect themselves and others, and move confidently from childhood through adolescence and into adulthood.[378] [379] [380]

6.1.2. The legal framework for SRE is contained in the Education Act (1996) and in the Learning and Skills Act (2000). Every local authority, schools and governing body has a statutory responsibility to provide SRE as specified in this guidance. However, SRE, together with Careers Education and Guidance, are statutory only at Key Stages 3 and 4. In addition, the specific content of lessons is largely left to schools.[381] [382] Only the biological component of SRE must be taught as part of the statutory National Science Curriculum (see also Paragraph 6.4.2).[383] [384] Parents have the right to withdraw their children from the non-statutory elements.[385]

6.1.3. In primary schools, headteachers and governors are responsible for deciding whether to teach SRE beyond the statutory requirements of the science programme of study.[386] They are also able to decide about the content of lessons and about how it should be delivered.[387] [388] [389]

6.1.4. In secondary schools, headteachers and governors are required to provide a programme of sex and relationships education to ensure that the needs of the pupils are met appropriately.[390] [391] Again, the school can decide the specific content of the lessons. A school can choose to cover only the biological and contraception parts and exclude the moral and relationships components.[392]

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[378] Qualifications and Curriculum Authority (2005) "Sex and relationships education, healthy lifestyles and financial capability", QCA, London.
[379] Avert (2005) "Sex education that works", www.avert.org/sexedu.
[380] Cathy Donelon, Children's Health Select Committee, 20 November 2006, Kent County Council.
[381] Sex Education Forum (2005) "Sex and relationships education framework", National Children's Bureau, London.
[382] Allan Foster, Children's Health Select Committee, 3 November 2006, Kent County Council.
[383] Sex Education Forum (2005) "Sex and relationships education framework", National Children's Bureau, London.
[384] Roger Street, Children's Health Select Committee, 17 November 2006, Kent County Council.
[385] *Ibid*.
[386] Qualifications and Curriculum Authority (2006) "What are the requirements for sex and relationships education?", www.qca.org.uk/15037.
[387] *Ibid*.
[388] Qualifications and Curriculum Authority (2005) "Sex and relationships education, healthy lifestyles and financial capability", QCA, London.
[389] Allan Foster, Children's Health Select Committee, 3 November 2006, Kent County Council.
[390] Qualifications and Curriculum Authority (2006) "What are the requirements for sex and relationships education?", www.qca.org.uk/15037.
[391] Qualifications and Curriculum Authority (2005) "Sex and relationships education, healthy lifestyles and financial capability", QCA, London.
[392] Allan Foster, Children's Health Select Committee, 3 November 2006, Kent County Council.

6.1.5. Together with the guidance outlined above, several sources agree and maintain that the most appropriate context for SRE provision is within a wider PSHE and National Healthy Schools framework.[393] [394] [395] [396] Effective delivery of SRE would then also be embedded in the requirements and standards of this framework.[397]

6.1.6. Nonetheless, the aim of sex and relationships education is to support young people through their physical, emotional and moral development. SRE is composed of three main elements:

- Acquiring knowledge and information
- Developing personal and social skills
- Exploring attitudes and values.[398] [399] [400]

6.1.7. The "knowledge and information" component can include understanding human sexuality, sexual health and reproduction, learning about contraception and related support services, and learning about the risks and realities surrounding unplanned pregnancy.[401]

6.1.8. By developing personal and social skills through SRE pupils can learn about managing emotions and relationships confidently, can develop self-respect, can learn to make choices based on an understanding of difference, and can gain knowledge on how to manage conflict.[402]

6.1.9. Through the exploration of attitudes and values, students can learn about the importance of moral considerations and of family and relationships related values, can be taught about respect, and can develop critical thinking.[403] [404]

[393] Department for Education and Employment (2000) "Sex and relationship education guidance", DfEE, Nottingham.
[394] Roger Street, Children's Health Select Committee, 17 November 2006, Kent County Council.
[395] Qualifications and Curriculum Authority (2005) "Sex and relationships education, healthy lifestyles and financial capability", QCA, London.
[396] National Children's Bureau (2006) "A whole school approach to PSHE", NCB, London.
[397] [397] Department for Education and Employment (2000) "Sex and relationship education guidance", DfEE, Nottingham.
[398] Department for Education and Employment (2000) "Sex and relationship education guidance", DfEE, Nottingham.
[399] Sex Education Forum (2005) "Sex and relationships education framework", National Children's Bureau, London.
[400] Cathy Donelon, Children's Health Select Committee, 20 November 2006, Kent County Council.
[401] Department for Education and Employment (2000) "Sex and relationship education guidance", DfEE, Nottingham.
[402] *Ibid*.
[403] *Ibid*.
[404] Roger Street, Children's Health Select Committee, 17 November 2006, Kent County Council.

6.2. Why SRE is important

6.2.1. Together with supporting young people with their moral, physical and emotional development, there are several other reasons to justify the importance of teaching effective SRE at school. Some of these reasons are listed below.

6.2.2. As the Report already explained, the United Kingdom has the highest rate of teenage pregnancy in Western Europe.[405] [406] [407] The rate of Sexually Transmitted Infections (STIs) in the UK is also the highest in Western Europe, with a staggering 10% of young people aged under-25 having currently contracted Chlamydia.[408] Half of sexually active young people aged under-16 do not use contraception the first time they have sex.[409] The media and advertising industries are sexualising children and young people at increasingly earlier ages.[410]

6.2.3. Although the reasons for teenage pregnancy and sexual health are complex and diverse, there is widespread agreement that SRE can help young people make informed decisions about their sexual lives and that, particularly when linked to contraceptive services, it can delay sexual activity and can reduce pregnancy rates.[411] [412]

6.2.4. Children today learn about relationships and sex from a very young age and sometimes from sources which are not accurate or honest.[413] For example, a member of the Kent Youth County Council (KYCC) reported that her younger sister displayed misunderstandings and incomplete knowledge by learning sex related matters from her friends.[414] As the DfES put it, "in a world where sex is used to sell things from food to fast cars, and celebrities' lives become everyone's business, we should talk to our children to help them make sense of it all".[415]

6.2.5. In addition, there continue to be calls for better provision of SRE; this increased awareness is not only characterised by a wide range of national initiatives, but it is also informed by strong support from both parents and

[405] Department for Education and Skill (2006) "Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies", Nottingham.
[406] Department for Education and Skill (2006) "Teenage Pregnancy: Accelerating the Strategy to 2010", Nottingham.
[407] Janine Cooke, Children's Health Select Committee, 23 November 2006, Kent County Council.
[408] *Ibid*.
[409] Office for Standards in Education (2002) "Sex and relationships", Ofsted, London.
[410] Jill Wiles, Children's Health Select Committee, 7 November 2006, Kent County Council.

[411] Qualifications and Curriculum Authority (2005) "Sex and relationships education, healthy lifestyles and financial capability", QCA, London.
[412] Swann, C et al. (2003) "Teenage pregnancy and parenthood: a review of reviews", Health Development Agency, London.
[413] Jenny Billings (2005) *Service Development Programme: Maximising Life Opportunities for Teenagers*, CHSS, University of Kent.
[414] Georgie Lindsay-Watson, Children's Health Select Committee, 23 November 2006, Kent County Council.
[415] Department for Education and Skills (2006) "Why does sex and relationships education (SRE) matter?", www.dfes.gov.uk/sreandparents.

young people.[416] [417] [418] For example, the Teenage Pregnancy Unit reports that a survey found that 88% of young people and 86% of parents believed that SRE would help young people be more responsible about sex.[419]

6.2.6. Also, SRE can help change peer norms. By contributing to the reduction of teenage pregnancy rates, SRE can ensure greater attendance and engagement at school.[420]

6.2.7. Finally, evidence tends to suggest that the view that increased provision of SRE increase the frequency of sex and the number of sexual partners is unfounded.[421] [422] [423]

6.3. Principles of Good Practice

6.3.1. Different settings and different sources can provide for opportunities for sex education. These can include parents, guardians, youth workers, television, magazines and friends.[424] [425]

6.3.2. While the home (especially mothers) and friends are key sources of information, it appears that the main source is the school. In Kent, for example, 58.5% of boys and 52% of girls suggested that they acquired "some" or "a lot" of information from teachers.[426]

6.3.3. Perhaps, as an Ofsted report suggests, nowadays many parents are absent from home, and the parental advice that young people may need is not available.[427] Also, they often feel ill equipped to talk to their children about sex education and the impact of drugs, believing that schools should cover these topics.[428]

6.3.4. Nonetheless, it seems that teachers are central in the provision of SRE to young people. A review by the Health Development Agency (HDA), and

[416] Qualifications and Curriculum Authority (2004-5) "Personal, Social and Health Education Annual Report", QCA.
[417] Sex Education Forum (2005) "Sex and relationships education framework", National Children's Bureau, London.
[418] Jenny Billings (2005) *Service Development Programme: Maximising Life Opportunities for Teenagers*, CHSS, University of Kent.
[419] Teenage Pregnancy Unit (2004) "Teenage pregnancy: an overview of the research evidence", TPU.
[420] Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council.
[421]Kirby, D. (2001) "Emerging answers: research findings on programs to reduce unwanted teenage pregnancy", National Campaign to Prevent Teenage Pregnancy, Washington DC
[422] Avert (2005) "Sex education that works", www.avert.org/sexedu.
[423] Roger Ingham, Children's Health Select Committee, 17 November 2006, Kent County Council.
[424] Jenny Billings (2005) *Service Development Programme: Maximising Life Opportunities for Teenagers*, CHSS, University of Kent.
[425] Georgie Lindsay-Watson, Children's Health Select Committee, 23 November 2006, Kent County Council.
[426] Jenny Billings (2005) *Service Development Programme: Maximising Life Opportunities for Teenagers*, CHSS, University of Kent.
[427] Office for Standards in Education (2002) "Sex and relationships", Ofsted, London.
[428] Jill Wiles, Children's Health Select Committee, 7 November 2006, Kent County Council.

evidence from practice, suggest that the planning and delivery of SRE following specific principles can is likely to be more beneficial for pupils.[429]

6.3.5. As with PSHE, in order to ensure a better quality of sex and relationships education, it is important that SRE is taught by teachers who are committed to SRE and who possess specialist knowledge and expertise.[430] [431]

6.3.6. The development of a clear SRE policy should involve consultation with both children and parents. This will ensure that the needs of young people are addressed.[432]

6.3.7. The provision of SRE should begin before the onset of puberty and of sexual activity, and should be structured as an ongoing programme.[433] [434]

6.3.8. The content of SRE lessons should be relevant and appropriate to the needs of pupils.[435]

6.3.9. The teaching environment should be one in which open, honest and non-judgemental discussions about sexual health and related subjects can take place.[436]

6.3.10. The privacy and confidentiality of pupils should be respected - within the boundaries of protection.[437]

6.3.11. Effective monitoring and assessment should be in place in order to record children's progress and understanding.[438]

6.3.12. Together with these principles of best practice in relation to planning and delivery, other principles related to the type of information and skills can be included. SRE lessons should cover the biological, emotional, legal and social aspects of sexuality and sexual health.[439]

6.3.13. The impact of ignorance, prejudice and stigma should be discussed, and advice and confidential support should be available.[440]

6.3.14. Children should be able to learn and practice skills including the ability to manage their emotions confidently and to empathise with others.[441]

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[429] Health Development Agency (2003) "Teenage pregnancy and parenthood: a review of reviews", Evidence Briefing, HAD.
[430] *Ibid*.
[431] Office for Standards in Education (2002) "Sex and relationships", Ofsted, London.
[432] Health Development Agency (2003) "Teenage pregnancy and parenthood: a review of reviews", Evidence Briefing, HAD.
[433] *Ibid*.
[434] Cathy Donelon, Children's Health Select Committee, 20 November 2006, Kent County Council.
[435] Health Development Agency (2003) "Teenage pregnancy and parenthood: a review of reviews", Evidence Briefing, HAD.
[436] *Ibid*.
[437] *Ibid*.
[438] *Ibid*.
[439] *Ibid*.
[440] *Ibid*.
[441] *Ibid*.

6.3.15. Importantly, young people should develop their negotiation skills, they should learn to resist peer pressure, to resolve conflict, and to ensure that they choose what is best for them.[442]

6.4. Areas for Improvement

6.4.1. Having considered the importance of SRE and its ideal content and delivery, the Report will now consider some of the areas that may need improvement in Kent.

6.4.2. In general, it appears that some of the issues affecting SRE in Kent result from the following factors. Its delivery is not consistent and the assessment is normally poor. A greater involvement in planning and feedback from both pupils and parents is needed. SRE is too "biological", and a greater focus on relationships and on young men is essential. Finally, SRE teaching should start and develop from an early age, and sometimes it should be delivered through single-sex lessons.

6.4.3. As outlined above, it is crucial that schools provide pupils with accurate and honest information. However, the Report already explained that many teachers have approached SRE with diffidence and reluctance because of its nature as a "content heavy" subject, resulting in a shortage of specialists.[443] [444] [445]

6.4.4. But, as with the general teaching of PSHE, it is essential that teachers delivering SRE have the necessary knowledge and capability to teach this demanding subject. Indeed, the Report has pointed out that completing a PSHE Certification improves both confidence and quality of SRE teaching.[446] In Kent, the take up rate for specialist SRE training, especially amongst secondary schools, is relatively low.[447]

6.4.5. Nurses should also be encouraged to study the PSHE Certification programme. Indeed, recent research in Kent suggests that teenagers are more likely to value information on contraception and STIs from school nurses and medical professionals.[448]

6.4.6. The delivery of SRE in Kent is limited and inconsistent. For example, a teenage witness reported receiving only one comprehensive SRE session in Year 6 (age 10-11), and no further teaching until Year 10 (age 14-15).[449] The

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[442] *Ibid*.
[443] Osted (2005) "Annual Report: PSHE in secondary schools", Ofsted.
[444] Office for Standards in Education (2002) "Sex and relationships", Ofsted, London.
[445] Georgie Lindsay-Watson, Children's Health Select Committee, 23 November 2006, Kent County Council.
[446] Osted (2005) "Annual Report: PSHE in secondary schools", Ofsted.
[447] Roger Ingham, Children's Health Select Committee, 17 November 2006, Kent County Council.
[448] Jenny Billings (2005) *Service Development Programme: Maximising Life Opportunities for Teenagers*, CHSS, University of Kent.
[449] Georgie Lindsay-Watson, Children's Health Select Committee, 23 November 2006, Kent County Council.

delivery of SRE in Kent schools is also very variable, involving teachers, school nurses, and also private companies, charities and religious groups.[450]

"We should have more sex education in school. I learned most of what I know from television and friends"

(Teenager from Shepway, Kent)[451]

6.4.7. However, some initiatives are demonstrating an effort to bring about positive change. For example, a partnership involving the headteachers of 10 high rated schools is assisting closely the implementation of SRE services. Also, an SRE group in one of the clusters is supporting schools in developing their SRE policies.[452]

6.4.8. Evidence suggests that weakness in teaching often relates to poor assessment. The findings of a report from Ofsted, although are applicable to the country, point out that one third of primary schools do not regularly assess pupils' knowledge and understanding. Another third uses discussion to establish what pupils know, and only a few schools adopt more formal and regular assessment methods.[453]

6.4.9. Secondary schools appear to use a wide range of methods, including questionnaires and written tasks. However, 60% of schools implement weak evaluation practices, while one fifth of secondary schools do not make any assessment.[454]

6.4.10. Young people in Kent appear to be generally involved in the planning of diverse initiatives, and Kent is making an active effort to develop this involvement.[455] For example, specific consultations regarding the direction the Kent Teenage Pregnancy Strategy take place with the Kent Youth County Council (KYCC) and district youth forums. Also, young people have been involved in the design of posters regarding confidentiality of sexual health services and the benefits for teenagers of delaying sexual intercourse.[456]

6.4.11. However, it seems that pupils in Kent schools should be more involved and empowered in planning SRE lessons and in evaluating their quality.[457] Young people interviewed in a survey carried out countywide were generally uncertain about their contribution in SRE. About a third were not sure whether they could ask questions during lessons, and over half felt they did not have any input in deciding the content of topics.[458] [459]

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[450] Kent County Council (2006) The Kent Teenage Pregnancy Strategy Annual Report 2006, KCC.
[451] Jenny Billings (2005) *Service Development Programme: Maximising Life Opportunities for Teenagers*, CHSS, University of Kent.
[452] Kent County Council (2006) The Kent Teenage Pregnancy Strategy Annual Report 2006, KCC.
[453] Office for Standards in Education (2002) "Sex and relationships", Ofsted, London.
[454] *Ibid*.
[455] Kent County Council (2006) The Kent Teenage Pregnancy Strategy Annual Report 2006, KCC.
[456] *Ibid*.
[457] Jill Wiles, Children's Health Select Committee, 7 November 2006, Kent County Council.
[458] Jenny Billings (2005) *Service Development Programme: Maximising Life Opportunities for Teenagers*, CHSS, University of Kent.

Figures 8 and 9: Involvement of students in sex and relationships education at school, Kent, 2005

Figure 8

During sex education I felt I could ask any question I wanted to					
	Strongly agree	Agree	Don't know/ uncertain	Disagree	Strongly disagree
Male (n=908)	10.5%	28%	28.5%	23%	10%
Female (n=1005)	4.5%	26%	32.5%	29%	8%
Total (n=1913)	7%	27%	31%	26%	9%

Figure 9

During sex education I had a part in deciding what things were taught					
	Strongly agree	Agree	Don't know/ uncertain	Disagree	Strongly disagree
Male (n=900)	3.5%	16%	27%	28.5%	25%
Female (n=995)	2%	12%	25%	37%	24%
Total (n=1895)	2%	14%	26%	33%	25%

Source: Jenny Billings (2005) Service Development Programme: Maximising Life Opportunities for Teenagers, CHSS, University of Kent.

6.4.12. The sample of young people investigated suggested that SRE is generally delivered at the right time. However, they maintained that information about the impact of alcohol and drugs should be delivered earlier.[460] They also felt that sex and relationships education should be an ongoing process and that it should be taught throughout their time at school.[461] [462] In addition, teenagers expressed the need to know about local sexual health services at an earlier stage.[463]

6.4.13. It is also important to ensure that sex education should begin early, before young people reach puberty and before they have developed rigid patterns of behaviour.[464] [465] [466]

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[459] Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council.
[460] Jenny Billings (2005) *Service Development Programme: Maximising Life Opportunities for Teenagers*, CHSS, University of Kent.
[461] Georgie Lindsay-Watson, Children's Health Select Committee, 23 November 2006, Kent County Council.
[462] *Ibid*.
[463] *Ibid*.
[464] Kirby, D. et al (1994) "School-based programmes to decrease sexual risk behaviours:a review of effectiveness", Public Health Report, 109, pp336-360.
[465] Schaalma, R. et al. (1993) "Determinants of consistent condom use by adolescents: the impact of experience of sexual intercourse", Health Education Research, Theory and Practice 8 pp255-269

6.4.14. In the Netherlands, where consistent, focused and open sex education has been taught from a very early age, teenage pregnancy rates have fallen in the last 20 years to become amongst the lowest in Europe.[467] [468] [469]

6.4.15. Although researchers and educationalists frequently debate about the relative merits of single-sex versus mixed group education, it has been suggested by the Committee that perhaps the teaching of particularly delicate aspects of SRE, such as periods for girls and wet dreams for boys, should be taught separately in single-sex groups.[470]

6.4.16. Crucially, evidence strongly suggests that the content of SRE lessons tends to be too "biological"; the importance of relationships and self esteem is generally neglected.[471] [472]

6.4.17. According to several commentators and professionals, sex education should not merely cover the biology of reproduction and sexually transmitted diseases. SRE needs also to help young people develop their social, negotiation, and communication skills, in order for them to make informed decisions that could affect the rest of their lives; SRE should focus on *relationships*. For example, it is widely reported that girls would like that SRE developed their assertiveness and taught them to say "no" when negotiating their relationships with their partners. [473] [474] [475] [476] [477] [478] [479]

"We didn't actually learn about sex. We just learned like about babies and how they were like made but nothing about the actual relationships or anything like that"

(Teenage girl aged 17, from Kent)[480]

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[466] Dickson, R. et al. (1997) "Effective health care: preventing and reducing the adverse effects of unintended teenage pregnancies", National Health Service Centre for Reviews and Dissemination, University of York.
[467] Roger Ingham, Children's Health Select Committee, 17 November 2006, Kent County Council.
[468] Ingham, R. and Van Zessen, G. (1998) "From cultural contexts to interactional competencies", paper at AIDS in Europe, Social and Behavioural Dimensions Conference, Paris, 12-16 January.
[469] Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council.

[470] Kent County Council, Children's Health Select Committee, 8 January 2007, Kent County Council.
[471] Jenny Billings (2005) *Service Development Programme: Maximising Life Opportunities for Teenagers*, CHSS, University of Kent.
[472] Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council.
[473] Bandura, A. (1992) "Self-efficacy mechanism in psychobiologic functioning, self efficacy: thought control of action, pp155-189, Hemisphere, Washington.
[474] Wight, D. et al. (1998) "Towards a psychosocial theoretical framework for sexual health promotion", Health Education Research, 13 pp317-330.
[475] Allan Foster, Children's Health Select Committee, 3 November 2006, Kent County Council.
[476] Jenny Billings (2005) *Service Development Programme: Maximising Life Opportunities for Teenagers*, CHSS, University of Kent.
[477] Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council.
[478] Bill Anderson, Children's Health Select Committee, 7 November 2006, Kent County Council.
[479] Anna Pelham, Children's Health Select Committee, 27 November 2006, Kent County Council.
[480] Jenny Billings, Children's Health Select Committee, 20 November 2006, Kent County Council.

6.4.18. For example, it has been pointed out that, unlike the rest of the European continent, English boys' attitude towards sex results more from peer pressure and from their desire to prove they are not gay, rather than out of love.[481] [482]

M: If they're like, really don't like girls and they're really into like…
F: Gay boys.
M: No if they're into other stuff like going out with mates and not having time for girlfriends they can choose that way can't they?
F: They sound proper gay.

(Teenagers aged 12 and 13, Kent)[483]

6.4.19. It has also been indicated that, although in Kent there are initiatives aimed at assisting young fathers – such as the "Supporting young Fathers" course, the focus of SRE tends to be on girls. Indeed, for example, even at national level very little research has been carried out on the characteristics of young men more likely to cause teenage pregnancy.[484] [485]

"…Boys pressure girls into everything – they should get the most education, because they won't talk about it and they get girls pregnant"

(Teenager from Swale, Kent)[486]

6.4.20. Nonetheless, in Kent young men tend to know less about contraception and STIs than girls.[487] It also appears that many tend to be reluctant to ask about sex related matters, accessing questionable knowledge through pornography instead.[488] It is important, then, to ensure that young men – especially those who are sexually active - receive effective SRE, so that they can understand the benefits of delay and the use of contraception.[489] [490]

6.4.21. Evidence also shows that programmes in Kent – such as "Speakeasy" - can help parents talk to their children about sex and relationships.[491] [492]

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[481] Roger Ingham, Children's Health Select Committee, 17 November 2006, Kent County Council.
[482] Bill Anderson, Children's Health Select Committee, 7 November 2006, Kent County Council.
[483] Jenny Billings, Children's Health Select Committee, 20 November 2006, Kent County Council.
[484] Department for Education and Skill (2006) "Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies", Nottingham.
[485] Kent County Council (2006) Kent Teenage Pregnancy Partnership Information Update for 2006, Kent County Council.
[486] Jenny Billings (2005) *Service Development Programme: Maximising Life Opportunities for Teenagers*, CHSS, University of Kent.
[487] *Ibid*.
[488] Liz Phillips, Children's Health Select Committee, 13 November 2006, Kent County Council.
[489] Department for Education and Skill (2006) "Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies", Nottingham.
[490] Bill Anderson, Children's Health Select Committee, 7 November 2006, Kent County Council.
[491] Kent County Council (2006) Kent Teenage Pregnancy Partnership Information Update for 2006, Kent County Council.
[492] Janine Cooke, Children's Health Select Committee, 23 November 2006, Kent County Council.

These programmes are vital, as research shows that many parents – and fathers in particular – find it difficult to talk to their children about sex.[493]

6.4.22. In addition, as with young people, it is important that parents can become involved in the planning of SRE. The teaching of some aspects of SRE may be a matter of concern for some parents.[494] Parents, then, need to be reassured that the values and beliefs that teachers hold do not influence the SRE framework. Sex and relationships guidance states that schools should always work in partnership with parents, consulting them regularly on the content of SRE Programmes.[495]

6.4.23. In Kent, several schools actively engage parents – who may feel embarrassed to come to school to talk about SRE[496] - in an effective manner, for example by inviting them to the school and by discussing with them their plans for SRE delivery. However, others appear to adopt less positive methods, for example by leaving the initiative to parents.[497]

6.4.24. Having considered the above evidence, the Select Committee commends the following recommendations.

Recommendation 15

The Committee recommends that school governors ensure that strong and consistent sex and relationships education within a PSHE framework is delivered. That SRE be taught appropriately from primary school and by specialist teachers.

Recommendation 16

The Committee strongly recommends that the "relationships" aspect of SRE be emphasised more than the biological aspect, and that, in order to reflect this emphasis, the name "sex and relationships education" be changed to "relationships and sex education".

Recommendation 17

That the nature of SRE lessons reflects equality of responsibility between boys and girls, and therefore that it has a stronger focus on young men and on their attitudes and responsibilities when negotiating sexual relationships. That it be considered to teach particular aspects of SRE in single-sex groups.

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[493] Department for Education and Employment (2000) "Sex and relationship education guidance", DfEE, Nottingham.
[494] *Ibid*.
[495] *Ibid*.
[496] Georgie Lindsay-Watson, Children's Health Select Committee, 23 November 2006, Kent County Council.
[497] Jill Wiles, Children's Health Select Committee, 7 November 2006, Kent County Council.

Recommendation 18

The Committee commends that schools encourage greater involvement of both pupils and parents/carers in the planning and evaluation of SRE programmes.

7. Conclusion

In October 2006 a select committee was established to consider the issue of children's health, focusing in particular on Personal, Social and Health Education (PSHE). The Review explored the extent to which education and health services met the needs and expectations of young people in Kent.

The Children's Health Select Committee received both oral and written evidence from a range of witnesses. The selection of witnesses included professionals working in the fields of PSHE and teenage pregnancy, clinicians, social workers, representatives of Central Government and young people.

Several recommendations resulted from this investigative process, aiming to form together a robust strategy that will reduce both the rate of teenage pregnancy and sexually transmitted infections (STIs) in Kent.

Dealing with teenage pregnancy and STIs is of the utmost importance; indeed the UK has the highest rates of teenage pregnancy and sexually transmitted diseases in Western Europe. But the purpose of the Committee was to focus not only on the effectiveness of sexual health services provided in Kent, but also to consider the role that education and schools in particular can play in tackling these issues.

Ignorance and risky behaviour when dealing with sexual relationships can have profound consequences for the lives of young people. Schools can help young people learn to respect themselves and others, can help them break a cycle of low aspirations, and can help them make responsible and informed decisions.

The sincere wish of all the Members of this Select Committee is that their work and dedication, and the work and dedication of all colleagues involved, will help improve the quality of life of young people in Kent.

7.1. Recommendations

Recommendation 1

That all those dedicated individuals working to provide young people in Kent with high standard sexual health services be commended. (See Section 3.6, p29)

Recommendation 2

The Committee urges that all key agencies be wholly committed and signed up to the Kent Teenage Pregnancy Strategy in an effort to decrease the rate of teenage pregnancy. (Paragraph 3.6.7, p31 to Paragraph 3.6.15, p32)

Recommendation 3

The Committee endorses and supports all the efforts of the Kent Teenage Pregnancy Partnership. It recommends expanding the Partnership's reach to all the young people in Kent by further promoting its sexual health services in places young people frequent. (Section 3.6, p29)

Recommendation 4

The Committee strongly recommends the broad production, promotion and distribution of discreet information on local sexual health services and support. (Paragraph 3.6.19, p34 to Paragraph 3.6.26, p37)

Recommendation 5

The Committee recommends that all partner agencies involved must facilitate the expansion of the National Chlamydia Screening Programme, to ensure full screening coverage of all sexually active young people in Kent under the age of 25. (Section 4.3, p43)

Recommendation 6

That GUM clinics must replace appointments with a "walk in" service. The Committee insists that the proportion of Genito-Urinary Medicine (GUM) clinic attenders offered an appointment within 48 hours of contacting the service must reach 100% by 2008. (Section 4.3, p43)

Recommendation 7

That the number of school nurses working in secondary schools in Kent be increased, and that the number of accessible, confidential and young people friendly sexual health clinics in all secondary schools in Kent be raised by at least one per cluster by 2008. (Paragraph 4.3.15, p45; Section 4.3, p43)

Recommendation 8

The Committee commends and supports all those working with disengaged, vulnerable young people, and urges the effective re-integration of more young mothers and fathers into school to complete their statutory education. (Section 5.3, p51)

Recommendation 9

The Committee recommends that all schools in Kent work towards Healthy Schools validation by March 2009, through a process which is all inclusive to parents and governors. (Section 5.4, p55 and Section 5.5, p57)

Recommendation 10

The Committee strongly recommends a strategy for a more consistent and systematic Personal, Social and Health Education (PSHE) delivery, that is coupled with more robust assessment and monitoring methods, and that is adopted in all primary and secondary schools in Kent. (Section 5.6, p58)

Recommendation 11

The Committee urges that the new RE and Citizenship Advisor remains permanently in place to ensure that one advisor is permanently and wholly responsible and accountable for PSHE in Kent. (Paragraphs 5.3.14 and 5.3.15, p53)

Recommendation 12

That PSHE certificates for both teachers and nurses be widely promoted and supported. That each school cluster in Kent has a PSHE lead and each secondary school in Kent has at least one PSHE certified teacher. That PSHE awareness be raised through a countywide multi-agency conference, which includes all the decision makers, by March 2008. (Section 5.6, p58)

Recommendation 13

The Committee strongly urges the County Council to press Government to make PSHE statutory and therefore part of the core curriculum, thereby ensuring that a selection of PSHE lessons are duly observed during inspections by Ofsted. (Section 5.2, p50)

Recommendation 14

The Committee insists that all secondary schools in Kent ensure access to websites such as "foryoungpeople", "RUthinking" and "Frank", and that they provide permanent information on local sexual health services on a visible notice board. (Paragraphs 5.6.24 and 5.6.25, p62)

Recommendation 15

The Committee recommends that school governors ensure that strong and consistent sex and relationships education within a PSHE framework is delivered. That SRE be taught appropriately from primary school and by specialist teachers. (Section 6.4, p69)

Recommendation 16

The Committee strongly recommends that the "relationships" aspect of SRE be emphasised more than the biological aspect, and that, in order to reflect this emphasis, the name "sex and relationships education" be changed to "relationships and sex education". (Paragraphs 6.4.16 and 6.4.17, p72)

Recommendation 17

That the nature of SRE lessons reflects equality of responsibility between boys and girls, and therefore that it has a stronger focus on young men and on their attitudes and responsibilities when negotiating sexual relationships. That it be considered to teach particular aspects of SRE in single-sex groups. (Paragraphs 6.4.18, 6.4.19 and 6.4.20, p73)

Recommendation 18

The Committee commends that schools encourage greater involvement of both pupils and parents/carers in the planning and evaluation of SRE programmes. (Paragraphs 6.4.10 and 6.4.11, p70; Paragraph 6.4.21, p73; Paragraphs 6.4.22 and 6.4.23, p74)

Appendix 1

Evidence

Oral Evidence:

1. Friday, 3 November 2006

- **Allan Foster**, Lead Curriculum Advisor, Curriculum Advisor for PSHE, Kent County Council
- **Ruth Herron**, Kent Teenage Pregnancy Partnership Co-ordinator, Kent County Council

2. Tuesday, 7 November 2006

- **Carol Healy**, Kent Healthy Schools Programme Manager, Kent County Council
- **Bill Anderson**, Director of Children's Social Services, Kent County Council
- **Jill Wiles** Acting Health & Youth Justice Commissioner/Policy Officer**,** Kent Drug & Alcohol Action Team, Kent County Council

3. Monday, 13 November 2006

- **Claire Stubbs,** Young People's Health Manager, Hastings and Rother YDS Eastern, East Sussex
- **Liz Phillips,** SRE and Teenage Pregnancy Co-ordinator, Isle of Wight

4. Friday, 17 November 2006

- **Prof. Roger Ingham,** Director of the Centre for Sexual Health Research, University of Southampton
- **Roger Street,** Regional Coordinator for the Health of Vulnerable Young People, Government Office, South East

5. Monday, 20 November 2006

- **Mick Price**, Head of Kent Youth Service and Key Training Services, KCC

- **Jenny Billings**, Research Fellow, Centre for Health Services Studies, University of Kent

- **Cathy Donelon**, Young People's Team Manager, Health Promotion Service

6. Thursday, 23 November 2006

- **Dr. Janine Cooke**, Lead Doctor for Contraception and Sexual Health, West Kent PCT

- **Georgie Lindsay-Watson**, Kent Youth County Council

7. Monday, 27 November 2006

- **John Britt**, Public Health Manager, Gravesham Borough Council

- **Sam Higgins**, Young Parents' Health Improvement Manager, Kent Teenage Pregnancy Partnership

- **Anna Pelham**, Oasis Esteem Educator

Evidence

Written evidence:

- **Maria Annecca**
  L8R Partnership Development Manager

- **Nicola Baboneau**
  Chair of City & Hackney's Teenage Pregnancy Partnership

- **Hayley Blackburn**
  Family Planning Association

- **Alison Hadley**
  Programme Manager
  Teenage Pregnancy Unit

- **Charlie Manicom**
  Assistant Director - Public Health
  South East Coast Strategic Health Authority, Kent

- **Dorothy Okotie**
  Teenage Pregnancy Co-ordinator
  Services for Young People
  Southwark Council

- **Terri Ryland**
  Family Planning Association

- **Norman Wells**
  Family Education Trust

Appendix 2

Glossary of Terms and Abbreviations

Terms:

Acquired immunodeficiency syndrome (AIDS)
An advanced stage of infection with HIV (human immunodeficiency virus), in which the person affected becomes more susceptible to illness because the immune system is weakened.

Chlamydia
A sexually transmitted infection (STI) that is often asymptomatic and that can lead to serious complications, including infertility.

Deep Dive Reviews
Studies by the Teenage Pregnancy Unit, resulting from visits to high performing areas and statistical neighbours, in order to find key common factors that decrease the rate of teenage pregnancy.

Ectopic pregnancy
A pregnancy that occurs outside the uterus, and usually in the fallopian tubes. It can result from untreated Chlamydia and Gonorrhoea.

Emergency Hormonal Contraception (EHC)
A treatment that can avoid pregnancy after unprotected sex or when other methods of contraception have failed.

Genital Warts
Warts in the genital area resulting from infection with subtypes of the human papilloma virus.

Genito-urinary medicine (GUM)
Branch of medicine concerned with sexually transmitted infections of the genitals and urinary system.

Gonorrhoea
A sexually transmitted infection that can lead to serious complications, such as infertility.

Genital herpes
A virus infection that can infect genitals and other parts of the body.

Healthy Schools Programme
A joint initiative between DfES and DH to improve health standards in schools

Kent Teenage Pregnancy Strategy
Long-term strategy aimed at providing young people across Kent with easy access to high quality sexual health services.

Pelvic inflammatory disease (PID)
A condition often resulting from untreated STIs that can lead to infertility and ectopic pregnancy.

Personal, Social and Health Education (PSHE)
A non-statutory school subject aimed at developing social and emotional skills of pupils.

Sex and Relationships Education (SRE)
A school subject and lifelong learning about sex, sexuality, emotions, relationships and sexual health.

Sexually Transmitted Infections (STIs)
Infectious diseases that are passed from person to person by sexual contact. STIs are sometimes called *sexually transmitted diseases* (STDs).

Syphilis
A sexually transmitted infection that, in its advanced stage, can lead to damage to the heart and to the nervous system.

Towards 2010
A four-year strategy whose wide objective is to improve the quality of life of all residents in Kent.

Glossary of Terms and Abbreviations

Abbreviations:

AIDS	Acquired Immunodeficiency Syndrome
DFES	Department for Education and Skills
DH	Department of Health
EHC	Emergency Hormonal Contraception
FPA	Family Planning Association
GP	General Practitioner
GUM	Genito-Urinary Medicine
HIV	Human Immunodeficiency Virus
HAD	Health Development Agency
HPA	Health Protection Agency
KCC	Kent County Council
KTPP	Kent Teenage Pregnancy Partnership
KYCC	Kent Youth County Council
LAA	Local Area Agreement
LAC	Looked After Children
LPSA	Local Public Service Agreement
NCD	New Deal for Communities
NCSP	National Chlamydia Screening Programme
NHSP	National Healthy Schools Programme
NHS	National Health Service
NSF	National Service Framework
OFSTED	Office for Standards in Education
PCT	Primary Care Trust

PID	Pelvic Inflammatory Disease
PRU	Pupil Referral Unit
PSA	Public Service Agreement
PSHE	Personal Social and Health Education
RE	Religious Education
SHA	Strategic Health Authority
SRE	Sex and Relationships Education
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TPU	Teenage Pregnancy Unit
WHO	World Health Organisation
4YP	Foryoungpeople

Appendix 3

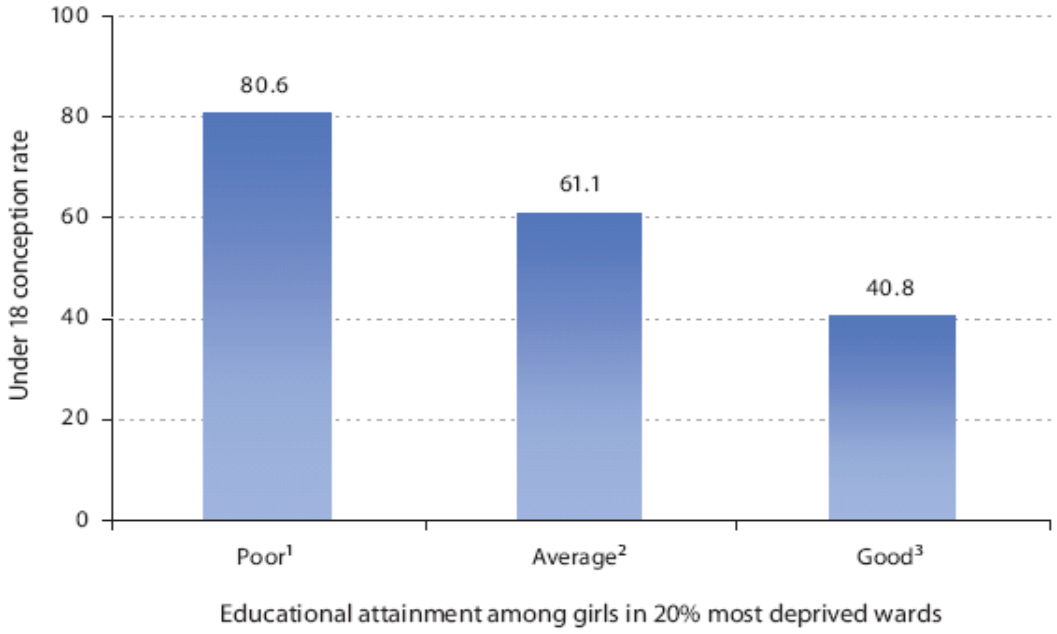
Tables and Charts

Figure 1: Percentages of first sex before age 18

country	year of birth 1932-41		year of birth 1972-73	
	males	females	males	females
Belgium	20	15	66	49
Denmark	37	40	57	72
Finland	31	26	68	68
France	42	12	68	49
West Germany	31	18	56	66
Great Britain	33	12	65	62
Iceland	52	39	73	72
the Netherlands	21	3	46	45
Norway	39	26	48	60
Portugal	78	6	68	26
Switzerland	30	19	46	41

Source: Roger Ingham, Children's Health Select Committee, 17 November 2006, Kent County Council.

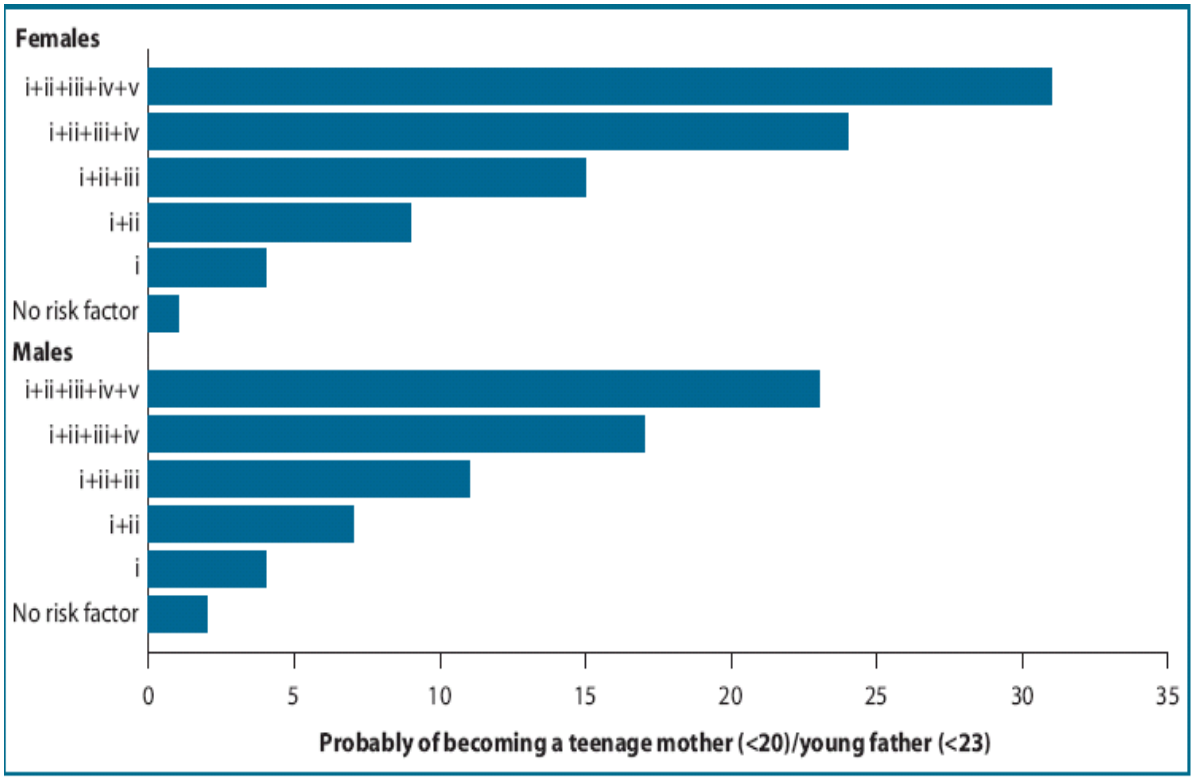
Figure 2: Under-18 conception rates and educational attainment in 20% most deprived areas



1 < 40% girls 5+ A-C GCSEs & > 10% no qualifications
2 40-60% girls 5+ A-C GCSEs & 6-10% no qualifications
3 > 60% girls 5+ A-C GCSEs & < 6% no qualifications

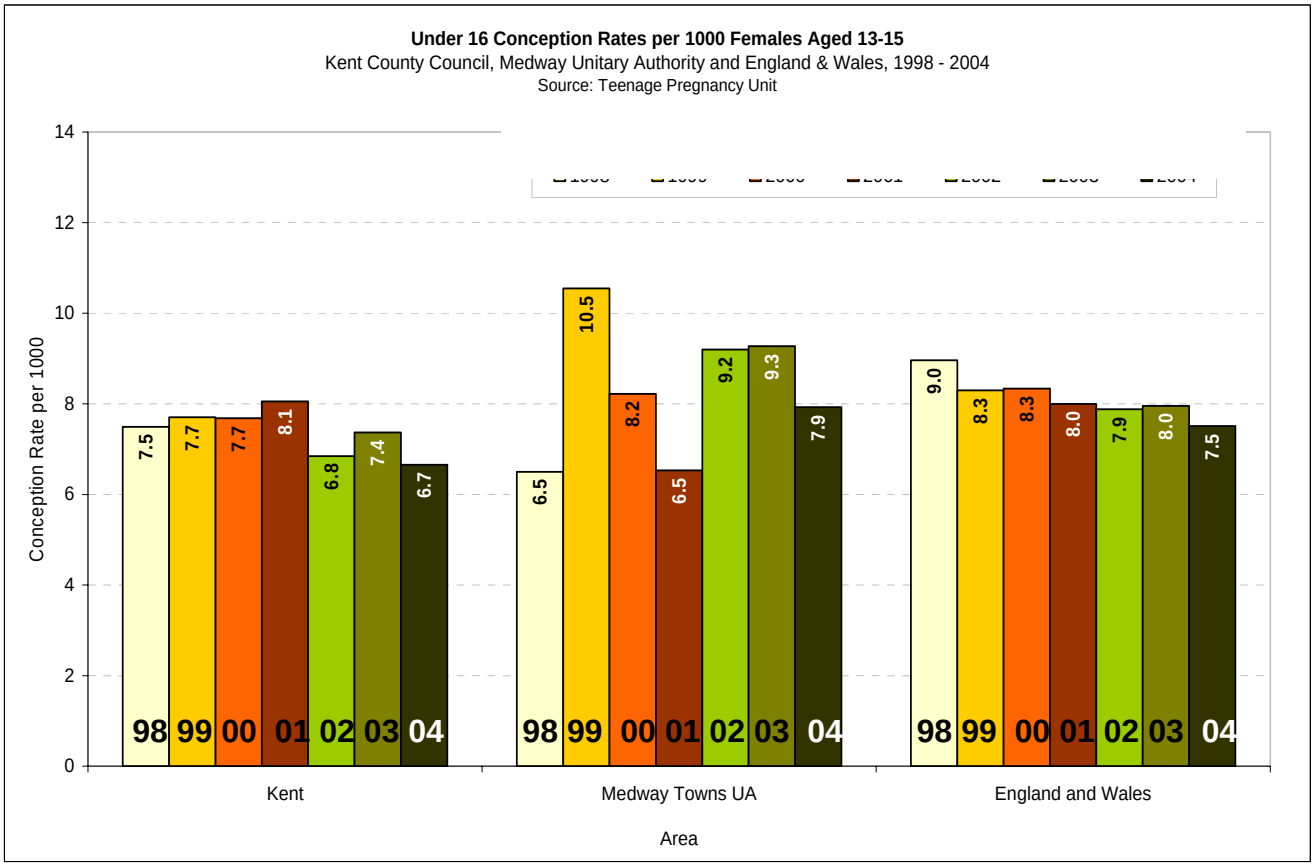
Source: Teenage Pregnancy Unit, 2006

Figure 3: Predicted probabilities of becoming a teenage mother (< 20 years) and young father (< 23 years) according to risk factors



Source: Department for Education and Skill (2006) "Teenage Pregnancy: Accelerating the Strategy to 2010", Nottingham.

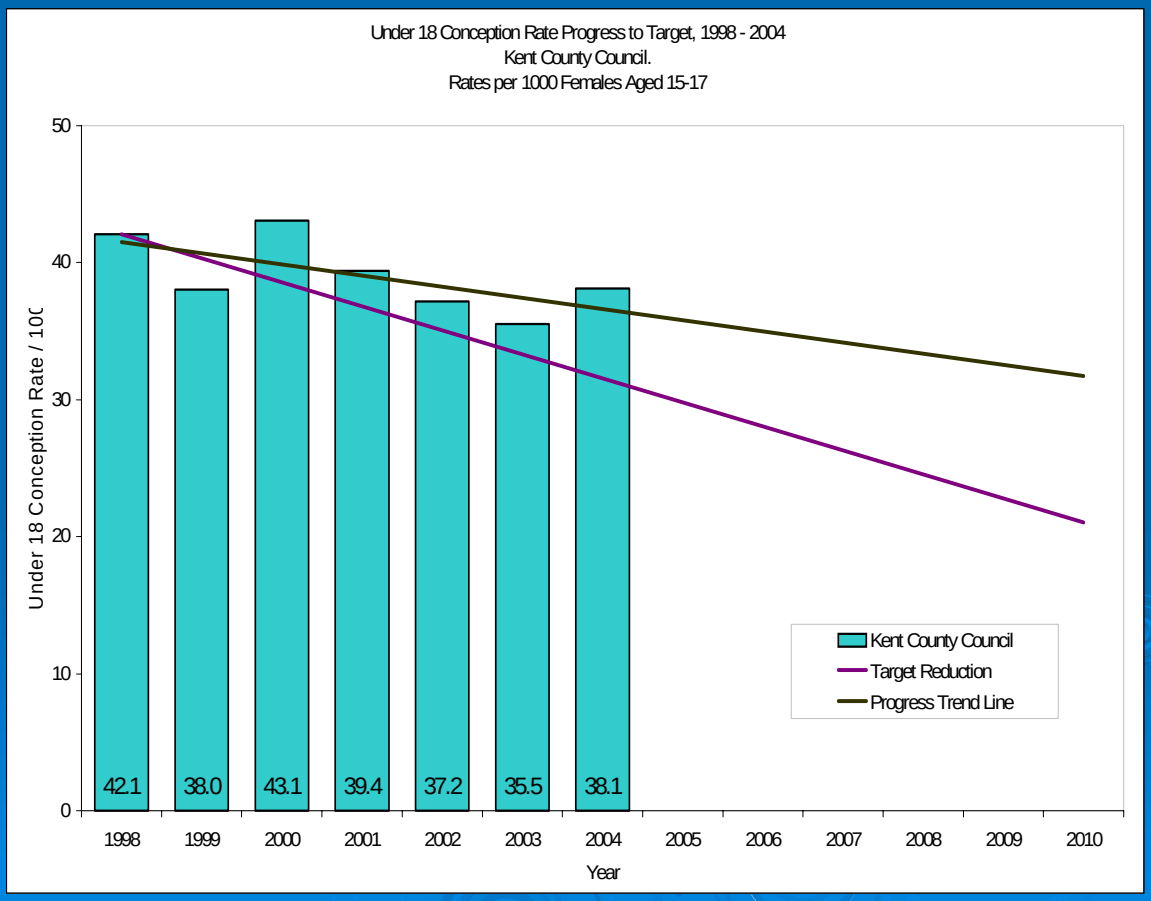
Figure 4: Under-16 conception rates per 1,000 females aged 13-15 Kent County Council, Medway Unitary Authority and England & Wales, 1998-2004.



Source: Teenage Pregnancy Unit (TPU) in Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council.

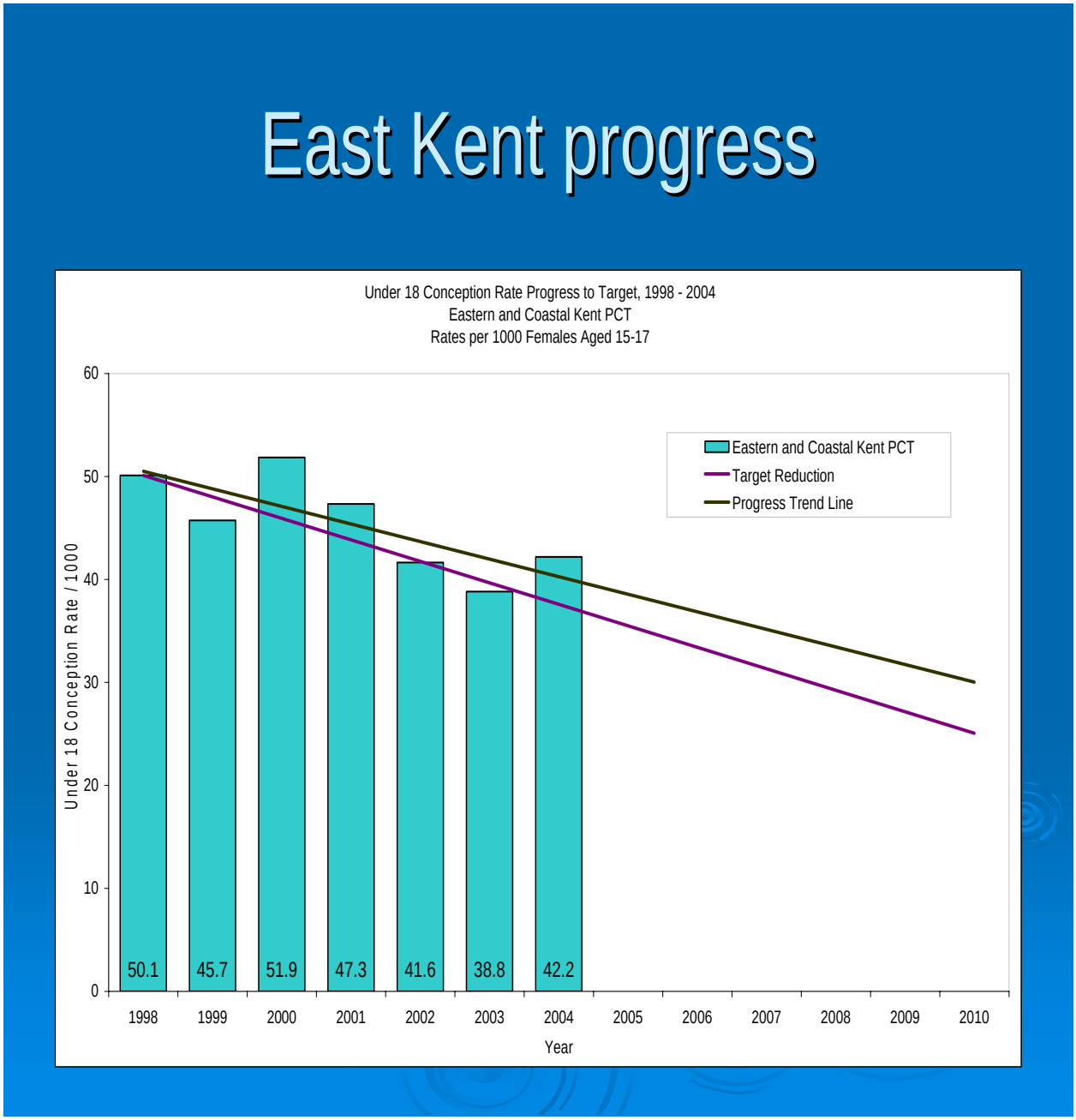
Figure 5: Under-18 conception rate progress to target, 1998-2004, Kent County Council. Rates per 1,000 females aged 15-17.

1998-2004 Kent progress



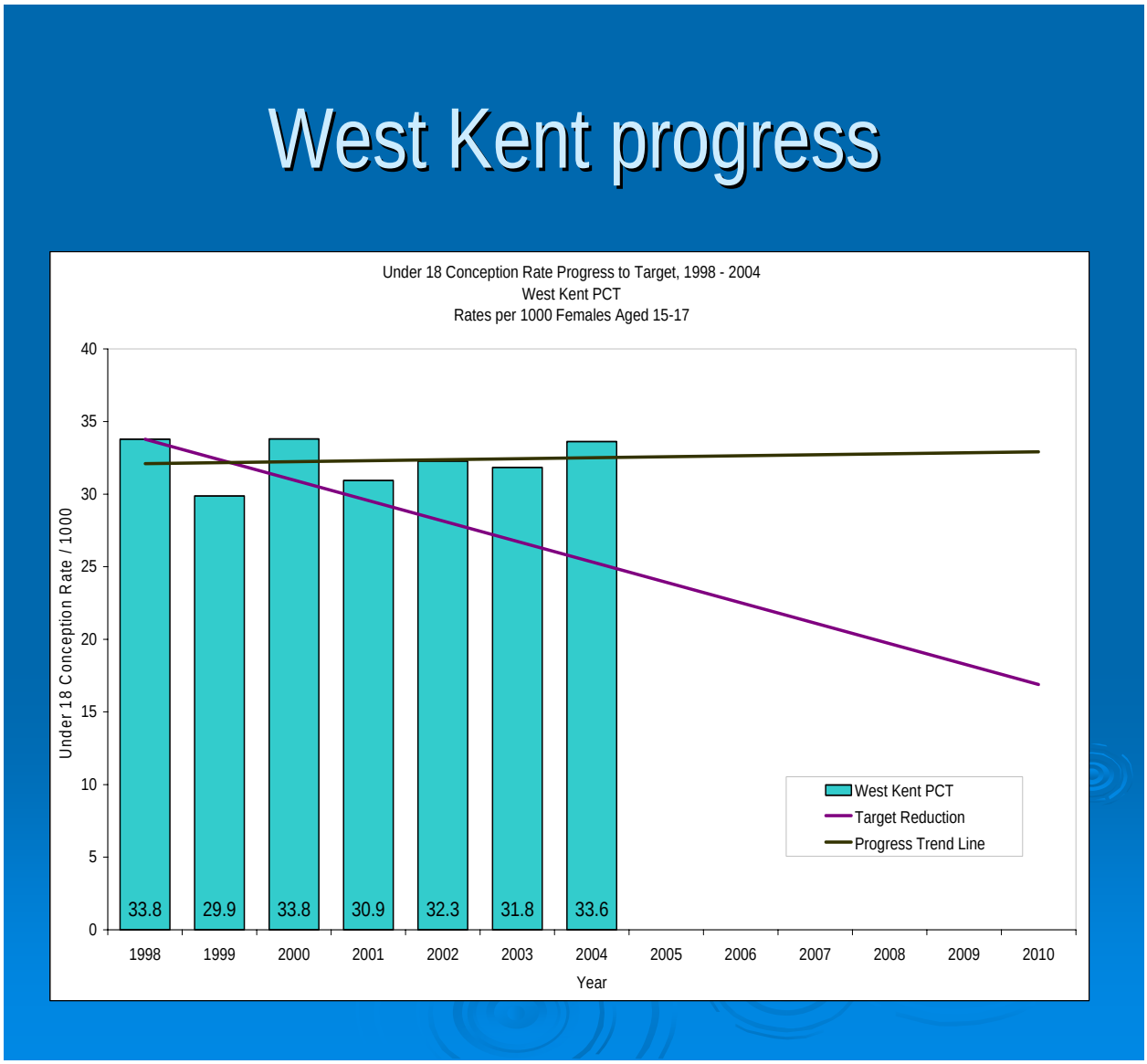
Source: Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council.

Figure 6: Under-18 conception rate progress to target, 1998-2004, Eastern and Coastal Kent PCT. Rates per 1,000 females aged 15-17.



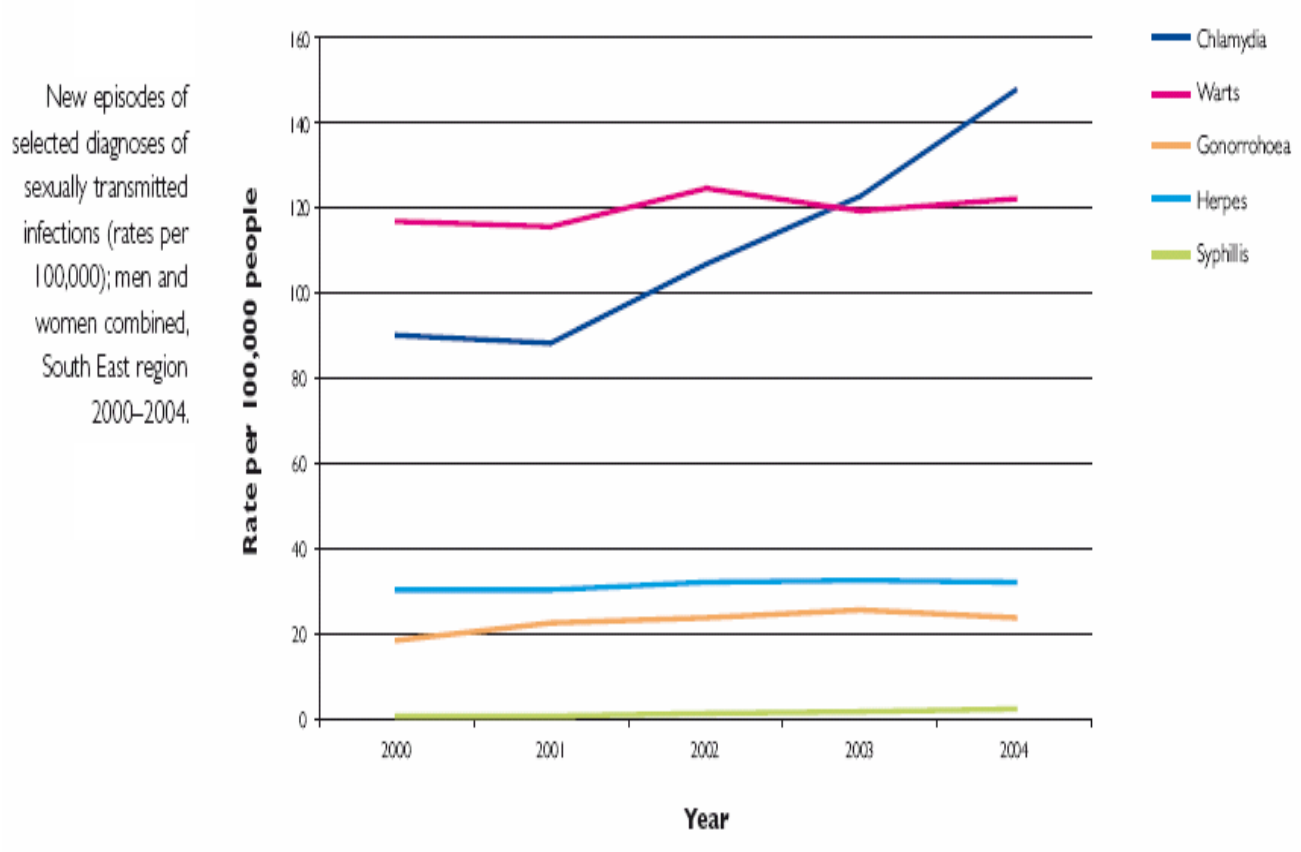
Source: Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council.

Figure 7: Under-18 conception rate progress to target, 1998-2004, West Kent PCT. Rates per 1,000 females aged 15-17.



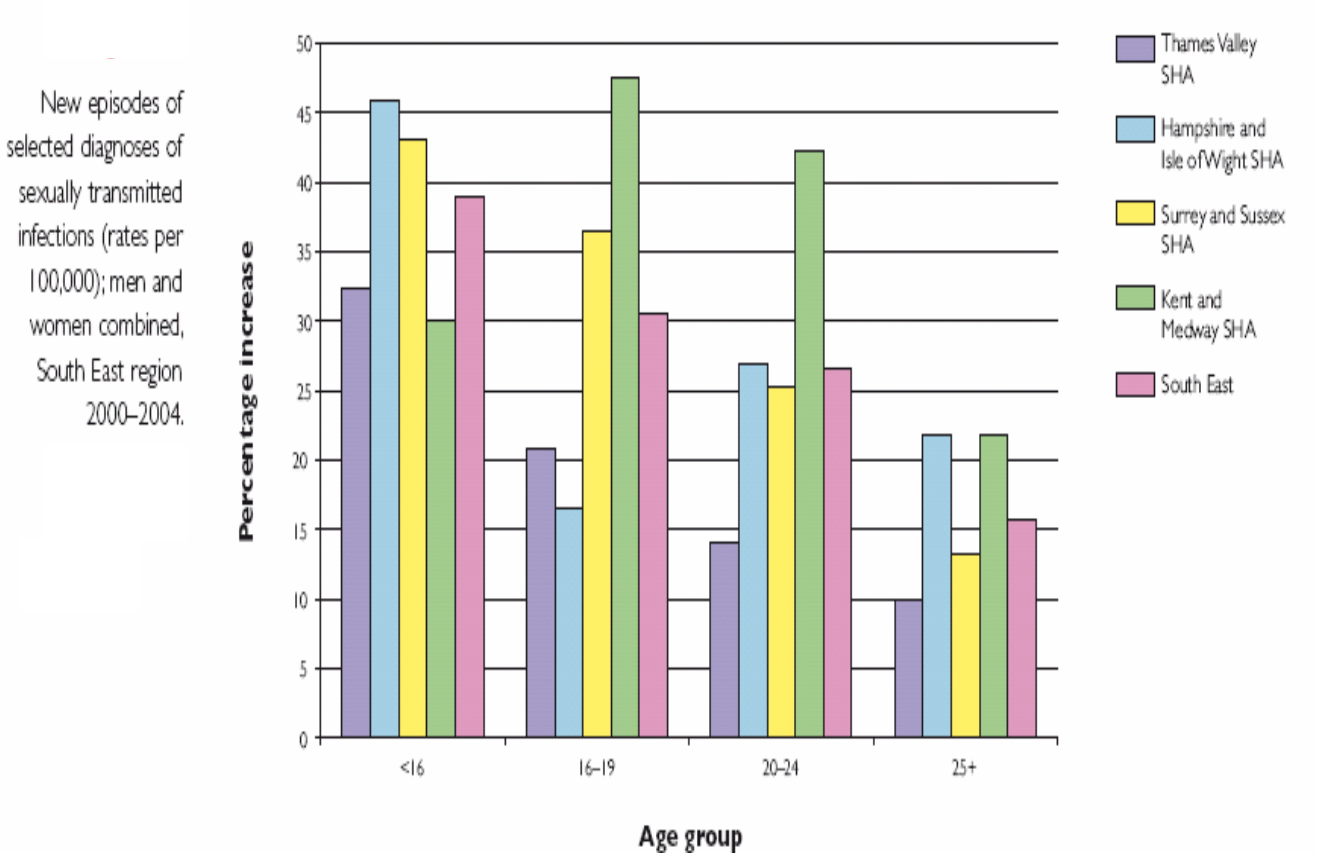
Source: Ruth Herron, Children's Health Select Committee, 3 November 2006, Kent County Council.

Figure 8: New episodes of selected diagnoses of STIs in males and females combined, South East region, 2000-2004.



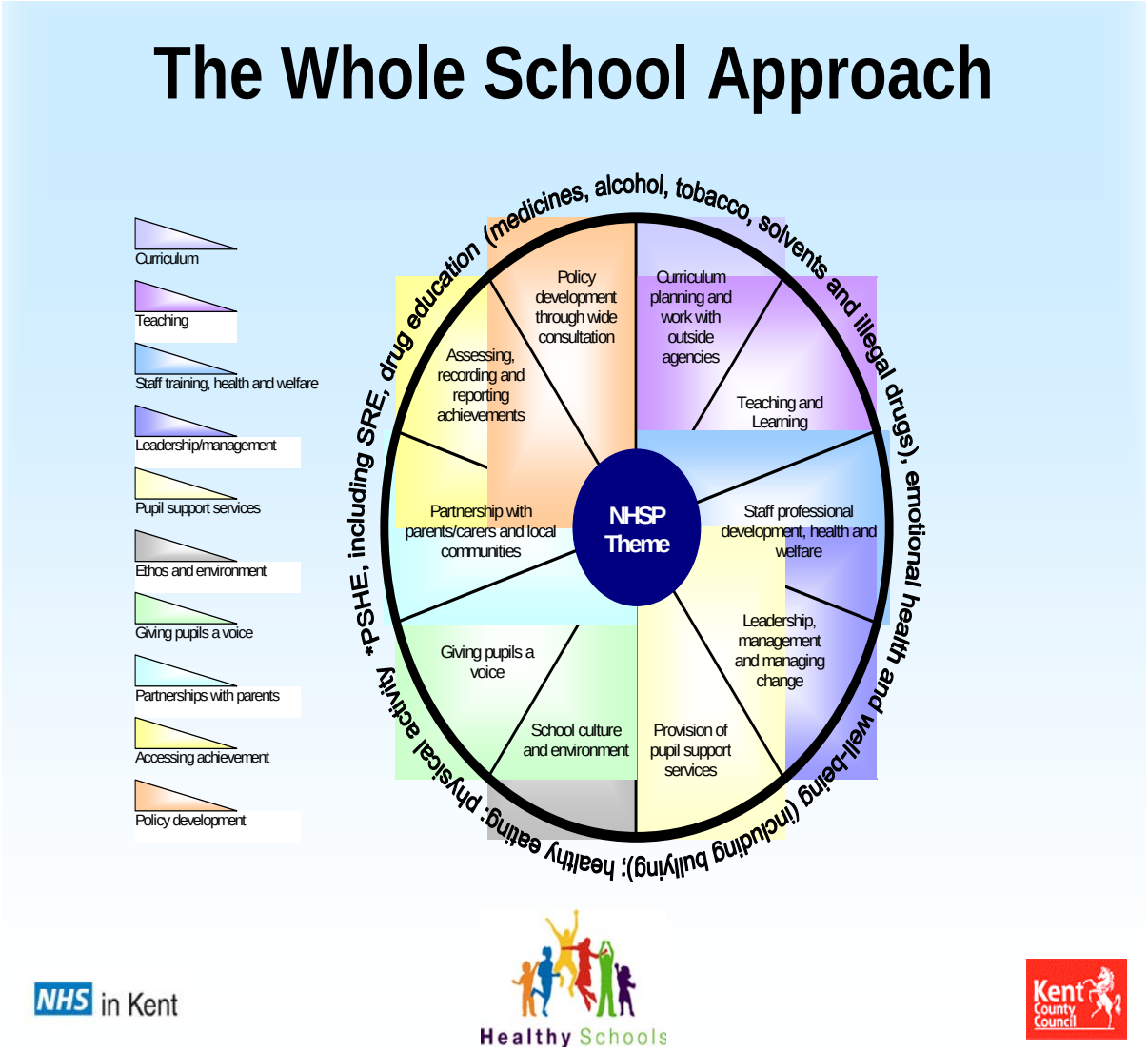
Source: South East Public Health Observatory, Department of Health (2006) "Choosing Health in the South East: Sexual Health", Oxford.

Figure 9: New episodes of selected diagnoses of STIs in Males and females combined. Comparative data of different age groups in different Strategic Health Authorities in the South East.



Source: South East Public Health Observatory, Department of Health (2006) "Choosing Health in the South East: Sexual Health", Oxford.

Figure 10: The Whole School Approach, National Healthy Schools Programme.



Source: Carol Healy, Children's Health Select Committee, 7 November 2006, Kent County Council.

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We would like to express our gratitude to all those who work every day with commitment and dedication to make Kent a great place for young people to live in.

The Children's Health Select Committee

March 2007