



# ICPD+15 – countdown to 2015



**ICPD+15 – countdown to 2015**

Published by

**fpa**

50 Featherstone Street

London EC1Y 8QU

Tel: 020 7608 5240

Fax: 0845 123 2349

**[www.fpa.org.uk](http://www.fpa.org.uk)**

The Family Planning Association is a registered charity, number 250187, and a limited liability company registered in England, number 887632.

© **fpa** 2009

Crown copyright material is reproduced under the terms of the Click-Use Licence.

# Contents

<b>Introduction .....</b>	<b>4</b>
<b>Summary of recommendations .....</b>	<b>5</b>
<b>The girl child .....</b>	<b>8</b>
<b>Male responsibilities and participation .....</b>	<b>11</b>
<b>Children and youth .....</b>	<b>13</b>
<b>Persons with disabilities .....</b>	<b>15</b>
<b>Reproductive rights and reproductive health .....</b>	<b>17</b>
<b>Family planning .....</b>	<b>19</b>
<b>Sexually transmitted infections and prevention of HIV .....</b>	<b>27</b>
<b>Human sexuality and gender relations .....</b>	<b>29</b>
<b>Adolescents .....</b>	<b>30</b>
<b>Women's health and safe motherhood .....</b>	<b>33</b>
<b>HIV infection and AIDS .....</b>	<b>35</b>
<b>References .....</b>	<b>39</b>

# Introduction

In 1994, the International Conference on Population and Development (ICPD) took place in Cairo, Egypt. During the conference, 184 United Nations Member States, including the UK, agreed an ambitious Programme of Action for improving sexual health and reproductive rights across the world. The goals set out in the Programme of Action must be met by 2015.

Since then, progress has been made in some areas of sexual and reproductive health, for example in access to services, the availability of testing and the variety of methods of contraception available. However, if all of the ICPD Actions are to be achieved in the UK there remains a great deal of work to be done.

For example, it is still the case that large numbers of young people do not receive high quality sex and relationships education at school and consequently are not able to develop the skills, confidence and knowledge they need to make informed choices as they grow up. This is partly because teachers are nervous about talking to them about sexual health. Young people's rights to access confidential sexual health services also need emphasising to ensure that young people, and the professionals who work with them, understand those rights.

Women in Northern Ireland are still denied access to safe and legal abortion. This is despite the 1967 Abortion Act which gave women in the rest of the UK access to these services over 40 years ago. This inequality needs to be addressed immediately. In addition, there continue to be problems with access to abortion services in Britain, which need to be addressed to provide women with an abortion service fit for the 21st century.

While there are 15 methods of contraception now available, many people are unaware of all of their options and unable to access the method of their choice. A great deal more effort needs to go into providing women and men of all ages with high quality information and investing in services to ensure they can choose the method of contraception which suits them and their lifestyle best.

In the last 15 years treatments for HIV have improved dramatically but people living with HIV continue to experience stigma and discrimination, which needs to be addressed, including changing the law on prosecutions for transmission of HIV and ensuring access to treatment free of charge for everyone in the UK.

Government also has a role to play in ensuring people in the UK are able to enjoy their sexual health free from prejudice and harm. This includes addressing issues such as female genital mutilation and forced marriage.

Over the next five years significant efforts are required to ensure that the UK Government fulfils its international commitments by 2015.

# Summary of recommendations

**fpa** urges the UK Government, the Scottish Government, the Welsh Assembly Government and the Northern Ireland Executive to:

## The girl child

- Ensure that high quality sex and relationships education (SRE) and personal, social, health and economic (PSHE) education are delivered to children and young people throughout their education and that teachers are suitably equipped to address and challenge values and attitudes around gender.
- Provide support to victims of forced marriages, including through the court service, and continue to raise awareness among professionals about forced marriage so that they can take appropriate steps to support victims as early as possible.
- Introduce legislation in Scotland similar to that in England, Wales and Northern Ireland to ensure that people who are at risk of being, or who have been, forced into marriage have suitable protection. We believe this must include provisions to allow people to act on a victim's behalf where the victim is unable to take the action themselves.
- Protect girls and women from female genital mutilation (FGM) both in this country and abroad. This must include efforts to prevent FGM, as well as making full use of the criminal legislation which exists to prosecute people who carry out FGM or aid and abet those who do.

## Male responsibilities and participation

- Ensure boys and men are equipped with the knowledge and skills to develop sexual behaviour which is safe and enjoyable for them, in part by ensuring that SRE meets the needs of boys and young men and that men-friendly sexual health services are available in all areas.

## Children and youth

- Issue and support the implementation of guidance which clarifies young people's rights to access confidential sexual health services to ensure that young people, and the professionals who work with them, understand those rights.

## Persons with disabilities

- Ensure that services are in place to enable people with physical impairments or learning disabilities to exercise their rights as sexual beings.

## Reproductive rights and reproductive health

- Continue to invest in contraceptive services to ensure that everyone has information about, and access to, the full range of contraceptive methods to enable them to choose the one which suits them best and consequently to avoid unplanned pregnancies.

- Encourage services to use innovative means of increasing access, for example by using community based settings or new technology to provide people with test results, to ensure that everyone is able to access the support they need to maintain their sexual health and that of their partners.
- Provide treatment for HIV free of charge to everyone, including failed asylum seekers to encourage people who have been at risk of HIV to come forward for testing.

## Family planning

- Ensure that all women and men of reproductive age have access to high quality, objective information about all methods of contraception and can easily access services to choose the method that suits them and their lifestyle best, acknowledging that this will be different for each individual and will change at different points in their lives.
- Ensure that sexual health services are open at times and in locations which are accessible to all who need to use them.
- Ensure that young people are able to access high quality, confidential sexual health services.
- Provide support for women in Northern Ireland to access abortion services in Britain and amend the law on abortion in Northern Ireland to recognise and give sufficient priority to the importance of women's health and wellbeing.
- Amend the 1967 Abortion Act to ensure that women across the UK are able to access an abortion service suitable for the 21st century.
- Remove all barriers to people accessing high quality contraceptive services regardless of their age or where they live.

## Sexually transmitted infections and prevention of HIV

- Ensure that training in sexual health is seen as a high priority and sufficient resources are allocated, including the provision of staff cover to ensure that professionals can take necessary training.
- Invest in national sexual health campaigns, which include messages around preventing all sexually transmitted infections (STIs) including HIV.
- Ensure that condoms are available free of charge from all healthcare settings, including general practice.

## Human sexuality and gender relations

- Ensure that children and young people at all key stages receive high quality, comprehensive SRE to equip them to make informed decisions as they grow up.

## Adolescents

- Provide the necessary investment to develop and sustain the services and joint working needed to enable young people to avoid unplanned pregnancies.

- Ensure parenting support is available, that it includes fathers as well as mothers and that it reflects the variety of people who carry out the role of parent, including grandparents and step-parents. The role of parents and carers in providing their children with information about growing up, sex and relationships should be recognised and supported.

## **Women's health and safe motherhood**

- Ensure that young people are equipped with the knowledge, confidence and skills they need to prevent pregnancies.
- Ensure that the social and cultural factors which have an impact on teenage pregnancy are addressed.
- Ensure that high quality, objective information is available to enable people of all ages to protect their sexual health.

## **HIV infection and AIDS**

- Ensure that comprehensive SRE programmes include discussions around preventing HIV and also tackle some of the issues associated with stigma and discrimination against people living with HIV.
- Ensure that suitable training is available for health professionals to enable them to talk to service users about sexual health and identify those people who may be at risk of an STI, signposting them on to further support where this is appropriate.
- Highlight the importance of HIV testing being widely available through the implementation of the UK National HIV Testing Guidelines and provide the necessary resources to ensure that testing services can be delivered in primary care locations.
- Ensure there is sufficient funding to provide local sexual health services and that these are seen as a priority by local commissioners. This must include providing the range of sexual health services, including contraception, genitourinary medicine (GUM), abortion, sexual health promotion, psychosexual and sexual dysfunction services and sexual assault referral centres.
- Make greater efforts to eradicate the discrimination faced by people with HIV, including providing training for professionals working in public services.
- Change the law on prosecution for transmission of HIV, except in limited circumstances, to reduce the stigma and fear that currently arise from such prosecutions.

# The girl child

**ICPD action:** Schools, the media and other social institutions should seek to eliminate stereotypes in all types of communication and educational materials that reinforce existing inequities between males and females and undermine girls' self-esteem.

There is more work to be done in the UK to tackle gender stereotypes. In June 2009, a report from the Equality and Human Rights Commission highlighted significant gender bias in the careers advice young people were given by schools. The survey of young people showed that the top three jobs girls believed they would be working in were teaching, childcare and beauty, and four times more boys than girls believed they would go into a career in engineering. Similar proportions of boys over girls chose careers in building, architecture, trade and IT.<sup>1</sup>

Schools could play a significant role in challenging some of these stereotypes, not only in the careers advice they provide to young people but also in delivering high quality personal, social, health and economic (PSHE) education incorporating sex and relationships education (SRE). PSHE education should provide an opportunity for young people to explore and challenge attitudes and values around traditional notions of masculinity and femininity, including within relationships. Such education can enable young people to place gender within a wider context and understand the impact that gender stereotypes can have on both men and women.

**fpa** welcomes the Government's commitment to make PSHE education a compulsory subject in England at both primary and secondary schools. This could be an excellent opportunity to provide young people with skills and knowledge to tackle gender stereotypes. However, this will rely on teachers having sufficient training and support to discuss these sometimes difficult issues. We are aware that, currently, many of the teachers delivering PSHE education have not had specific training to do so. While we welcome the Government's investment in the PSHE Education Subject Association and Continuing Professional Development accreditation scheme, there is a great deal more to be done to ensure that all teachers delivering PSHE education and SRE are comfortable doing so. It is also important to ensure that teachers in other parts of the UK can access similar support and training.

In Scotland, there is no national curriculum and so, although there is guidance from the Scottish Executive that encourages schools to provide sex and relationships education, there is no requirement for them to do so. The guidance from the Scottish Executive<sup>2</sup> requires sex education to present facts in an objective, balanced and sensitive manner within a framework of social values. However, sex education will vary between schools and it will depend very much on the willingness and ability of the teacher whether issues around gender are included in these discussions.

Sex education is part of the Basic Curriculum in secondary schools in Wales, which means it should be a compulsory part of the curriculum for all young people. However, the personal and social education (PSE) framework<sup>3</sup> in which sex education sits is not compulsory and so how sex education is delivered will vary from school to school. The PSE framework does address stereotypes but does not specifically mention gender as an issue to be covered. As is the case in England, there are significant problems with teachers not feeling they have sufficient training to deliver sex education and this is affecting delivery in Wales.

In Northern Ireland, relationships and sexuality education (RSE) is included in the school curriculum on a statutory basis through science and a learning area covering personal development. Through RSE young people should have opportunities to learn about the qualities of relationships and to explore the emotional, social and moral implications of early sexual activity.<sup>4</sup> However, the delivery of RSE is not uniform across Northern Ireland, and while some schools provide a well-planned and comprehensive RSE programme, this is not the case everywhere.

**Recommendation: fpa calls on the UK Governments to ensure that high quality SRE and PSHE education are delivered to children and young people throughout their education and that teachers are suitably equipped to address and challenge values and attitudes around gender.**

**ICPD action: Governments should strictly enforce laws to ensure that marriage is entered into only with the free and full consent of the intending spouses.**

The UK Government has made efforts to address issues around forced marriage. Within Government there is a Forced Marriage Unit, which is a joint initiative between the Foreign and Commonwealth Office and the Home Office. This Unit receives more than 1,600 reports of forced marriage a year. The Unit operates both abroad and in the UK trying to help victims of forced marriage, providing confidential advice and support and also providing training and information for professionals working in health, education and social services.

In addition, the Forced Marriage (Civil Protection) Act 2007 came into force in November 2008 and aims to provide protection for those who have been, or who are at risk of being, forced into marriage in England, Wales and Northern Ireland. The law means that anyone convicted of trying to force someone into marriage could be jailed for up to two years. It is also possible for victims, or someone acting on their behalf, to apply to the courts for a Forced Marriage Protection Order. These court injunctions forbid people who are trying to force others into marriage from actions such as taking people abroad for marriage, seizing passports or intimidating victims. The Protection Order could also require somebody to reveal the whereabouts of a victim. Penalties for breaching an order include up to two years in prison. This legislation is the first specifically to target the problem of forced marriage.

The Forced Marriage (Civil Protection) Act 2007 does not apply in Scotland. Although under Scottish law a marriage is void if either party was forced to marry against their will, and despite the Scottish Government having stated that forced marriage is a form of violence against women and a violation of human rights, there currently is not a law expressly prohibiting forced marriage in Scotland and it is not a specific criminal offence.

Following the introduction of the Forced Marriage (Civil Protection) Act 2007 in England, Wales and Northern Ireland, the Scottish Government conducted a public consultation about whether specific legislation on forced marriage was required in Scotland. The results of this consultation were published in June 2009<sup>5</sup> and showed that a large majority of those who responded did not think the existing civil provisions against forced marriage in Scotland were sufficient. In addition, a large majority of respondents believed that there were difficulties in accessing and using the existing civil remedies, for a variety of reasons including because of the cost to the victim, the need for action to be taken specifically by the victim and a lack of awareness and understanding of forced marriage and

the remedies available. **fpa** understands that the Scottish Government is considering the responses to the consultation and the possible options for future activity.

**Recommendation:** **fpa** urges the UK Governments to provide support to victims of forced marriage, including through the court service and continue to raise awareness among professionals about forced marriage so that they can take appropriate steps to support victims as early as possible.

**Recommendation:** **fpa** urges the Scottish Government to introduce legislation similar to that in England, Wales and Northern Ireland to ensure that people who are at risk of being, or who have been, forced into marriage have suitable protection. We believe this must include provisions to allow people to act on a victim's behalf where the victim is unable to take the action themselves.

**ICPD action:** Governments are urged to prohibit female genital mutilation wherever it exists and to give vigorous support to efforts among non-governmental and community organisations and religious institutions to eliminate such practices.

It is estimated that there could currently be as many as 20,000 girls under 15 years old at risk of female genital mutilation (FGM) in England and Wales.<sup>6</sup> FGM has been a criminal offence in the UK since 1985 under the Prohibition of Female Circumcision Act. In addition, the Female Genital Mutilation Act 2003 makes it a criminal offence for UK nationals or permanent UK residents to carry out FGM abroad or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where FGM is legal. However, to date there have not been any prosecutions under this legislation.

It appears that many professionals are still uncertain how to respond to FGM or how to protect girls and women at risk. There is a need for greater awareness about FGM among professionals working in health, education, the police, immigration and social services. In particular, services have a statutory duty to safeguard all children in the UK and this must include safeguarding girls against FGM. To achieve this, professionals need training to develop skills to address FGM, knowing who to refer concerns to when they are identified, and responding appropriately to cultural concerns.

**Recommendation:** **fpa** believes it is vital that the UK Governments make every effort to protect girls and women from FGM both in this country and abroad. This must include efforts to prevent FGM, as well as making full use of the criminal legislation which exists to prosecute people who carry out FGM or aid and abet those who do.

# Male responsibilities and participation

**ICPD action:** Special efforts should be made to emphasise men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning; prenatal, maternal and child health; prevention of sexually transmitted infections, including HIV; prevention of unwanted and high-risk pregnancies.

Official statistics show that the proportion of men attending community contraception clinics in England has increased in the last 15 years, from 63,000 in 1994–95 to 123,000 in 2007–08.<sup>7</sup> However, even this increased number is still only a very small percentage when compared with the 1.1 million women attending in 2007–08. In Wales, the number of men attending community contraception clinics has been falling in recent years and in 2007–08 was 3,600, compared to around 50,000 women in the same period.<sup>8</sup> Statistics on the use of community contraception clinics by both men and women are not collected or published in the same way in Scotland and Northern Ireland so it is not clear what trends there are in the numbers of men attending clinics in those countries.

Research into young men's use of sexual health services by the young people's sexual health charity Brook<sup>9</sup> has suggested that young men generally had lower levels of knowledge about sexual health clinics than young women as well as having less, and less accurate, factual knowledge about sexual health, in particular about contraception. In addition, there was a widespread belief among young men that services were set up primarily to treat illness and to provide contraception. Therefore, they did not view sexual health services as potential providers of advice or support.

Young men's willingness to use services can also be affected by perceptions that services are 'women-oriented'. In addition, for many young men the name 'family-planning' implies services which are for couples in stable relationships who are planning to have children, and therefore are not services that are relevant to them. Young men's understanding of masculinity and how they believe men should behave can also have an impact on their willingness to access sexual health services and to seek help of any kind.

Data from **fpa's** telephone helpline shows that around 20 per cent of callers are male. They are from a diverse range of ages and ethnic backgrounds. This suggests that a significant number of men are keen to find out more about their sexual health and will use a confidential advice helpline to do this.

Of the calls to **fpa's** helpline made by men, the majority (59.1 per cent) relate to sexually transmitted infections. Around 20 per cent of the calls from men are about contraception either on behalf of their partner or to find out more about it for themselves, specifically for advice on condoms or male sterilisation. This suggests that there are a significant number of men who are actively involved in decision making with their partner around contraception and other aspects of sexual health. However, these callers are still very much a minority.

To overcome some of the issues highlighted above, it is vital that school based sex and relationships education (SRE) meets the needs of boys and young men. For example, many young men report that the SRE they receive at school focuses almost exclusively on negative aspects of sex, such as unplanned pregnancies, or on female reproduction. There are also concerns that some forms of SRE collude with, rather than challenge, gender stereotypes and societal pressures around masculinity, or avoid discussing homosexuality.<sup>10</sup> In addition, it is important for teaching to respond to the different ways in which young men and young women process information and learn. In the absence of effective SRE that meets their needs young men learn most about sex and relationships from their peers, from the media or from pornography. Consequently, stereotypical views of what it means to be a man or to have a relationship can go unexplored and unchallenged.

Boys learn to be men in a society where it is rare for men to show their feelings openly, ask for help, admit that they do not know something or look after their health. They learn from an early age that boys need to be tough, and to conform to a specific model of masculinity which is often defined by the number of sexual encounters a young man has had, and his performance.<sup>11</sup> Parents can play a significant role in addressing some of these stereotypes. However, **fpa** is aware that many parents find it difficult to talk to their children about issues around relationships and sexual health. **fpa**'s Speakeasy programme aims to enable parents and carers to develop the skills, knowledge and confidence to talk to their children as they grow up. Part of the course specifically includes discussion of stereotypes and peer pressure. However, access to programmes such as this is not universal and many parents still struggle with this aspect of bringing up their children.

**Recommendation: fpa believes that boys and men need to be equipped with the knowledge and skills to develop sexual behaviour which is safe and enjoyable for them and for others and calls on the UK Governments to make efforts to ensure that SRE meets the needs of boys and young men and that men-friendly sexual health services are available in all areas.**

# Children and youth

**ICPD action:** Youth should be actively involved in the planning, implementation and evaluation of development activities that have a direct impact on their daily lives. This is especially important with respect to information, education and communication activities concerning reproductive and sexual health, including the prevention of early pregnancies, sex education and the prevention of HIV/AIDS and other sexually transmitted diseases. Access to, as well as confidentiality and privacy of, these services must be ensured with the support and guidance of their parents and in line with the Convention on the Rights of the Child. In addition, there is a need for educational programmes in favour of life planning skills, healthy lifestyles and the active discouragement of substance abuse.

fpa's community work has shown the importance of delivering a broad based sex and relationships education (SRE) programme, which, alongside providing young people with factual information, also develops their confidence and self-esteem. Programmes that enable young people to develop resilience in this way can support them not only to make responsible decisions about their sexual health but can also protect them against peer pressure around other issues such as smoking or alcohol. The quality of SRE continues to vary across the UK. Many of the teachers who are responsible for its delivery feel uncertain about their knowledge or skills, which means that the curriculum is often very heavily focused on basic facts rather than including skills or discussions around values and attitudes. It is important that this is addressed to ensure that young people are able to develop the skills, confidence and knowledge they need to make informed choices about their sexual health and relationships.

Concerns about confidentiality can be a significant deterrent to young people seeking help and advice from sexual health services. In recent years there have been some changes to the legislation relating to sexual offences in the UK. In England and Wales, the changes included in the Sexual Offences Act 2003 have led to confusion among professionals and young people about young people's rights to access confidential sexual health services. Both the law and professional guidance are clear that young people, including those under 13, are entitled to confidentiality when accessing sexual health services.<sup>12</sup>

In Northern Ireland, the Sexual Offences (Northern Ireland) Order came into operation in February 2009. This Order brought the legislation on sexual offences in Northern Ireland into line with the law in England and Wales, including lowering the age of consent to 16. Guidance produced by the Northern Ireland Office about the Sexual Offences Order states that "the law is not intended to criminalise mutually agreed activity between two young people of a similar age or understanding, unless it involves abuse, exploitation or harm".<sup>13</sup> It goes on to confirm that "young people will still have the right to access confidential advice on contraception, condoms and pregnancy, even if they are under 16".<sup>14</sup> However, services and professionals in Northern Ireland still have a mandatory duty to report all sexual activity involving young people under the age of 13.

The situation is currently different in Scotland. The Sexual Offences (Scotland) Act 2009<sup>15</sup> received Royal Assent in July 2009, but it is not clear when this law will come into operation. This law is very

similar to the legislation in the rest of the UK except that it creates specific offences relating to young people engaging in consensual sexual activity with another young person of a similar age also under 16. During the debates on these offences, concerns were raised about their impact on young people seeking sexual health advice and services, and in particular on young women who are pregnant as they will clearly have committed an offence. The Scottish Government tried to allay these fears by stressing that any cases brought under these offences would be likely to be dealt with by the Scottish Children's Hearing system rather than by the police. To date, guidance for professionals on how the law will affect young people and their rights to access sexual health advice and services has not been issued. The impact of this law on young people's willingness to come forward to seek help and advice is of grave concern.

If young people are denied access to confidential services, this will close off their opportunity to discuss sexual health and gain advice from trained health professionals, as well as making them more vulnerable to unplanned pregnancies and sexually transmitted infections. In addition, ensuring confidentiality means that those who are at risk or who are being exploited or abused can start to disclose these issues to a trusted professional who, with time, can help them to deal with the situation.

**Recommendation: fpa strongly supports the right of young people, including those under 16, to access confidential sexual health advice and services and we recommend that the UK Governments issue and support the implementation of guidance which clarifies young people's rights to ensure that young people, and the professionals who work with them, understand those rights.**

# Persons with disabilities

**ICPD action:** Governments at all levels should consider the needs of persons with disabilities in terms of ethical and human rights dimensions. Governments should recognise needs concerning, inter alia, reproductive health, including family planning and sexual health, HIV/AIDS, information, education and communication.

There has been some progress in recognising the rights of people with disabilities to have relationships, including sexual relationships. For example, the *Valuing people* strategy from the Department of Health in England includes a policy objective that 'people with learning disabilities have the choice to have relationships, become parents and continue to be parents, and are supported to do so'.<sup>16</sup> The *Draft action plan for adults with a learning disability in Wales* made reference to providing people with information about sexual health.<sup>17</sup> In Scotland, a review of services for people with learning disabilities, called *The same as you?* was published in 2000, which highlighted the importance of professionals and services recognising that people with learning disabilities have sexual needs and rights.<sup>18</sup> Similarly, in Northern Ireland, the *Equal lives* review of policy and services for people with a learning disability included an objective to 'enable people with a learning disability to lead full and meaningful lives in their neighbourhoods, have access to a wide range of social, work and leisure opportunities and form and maintain friendships and relationships'.<sup>19</sup>

However, it is not clear that Government guidance always translates into practice. In August 2008, **fpa** ran a Sexual Health Week campaign called 'It's My Right!',<sup>20</sup> which highlighted the rights of people with learning disabilities to have sexual relationships. For the campaign, **fpa** carried out two surveys, one with professionals who work with people with learning disabilities and one with people with learning disabilities. Although the survey samples were relatively small, they showed that 94 per cent of professionals thought there were barriers which prevented people with learning disabilities from having sex and relationships. In the survey of people with learning disabilities, 63 per cent said they wanted to know more about sex and relationships. It is vital that the rights of people with learning disabilities to have relationships, including sexual relationships, is acknowledged and respected. This must include ensuring that they are able to access sex and relationships education, and the information and services they need to make informed choices about their sexual health.

**fpa** believes that while the autonomy of individuals must be respected, there are circumstances in which people with disabilities may be vulnerable to, or may subject others to exploitative situations. Sexual health services should balance the individual's right to be a sexual being with the necessity to assess the risks for people with disabilities and those around them. **fpa** believes that an individual's consent to sex is crucial to his or her sexual wellbeing and to the formation of positive relationships. It is important that it is recognised that some people with physical impairments or learning disabilities may experience problems in communicating their needs and desires, but this does not necessarily imply a lack of capacity to consent.

**fpa** believes that service providers should be sensitive to the training and support needs of staff and those responsible for caring for people with disabilities. Training for those working with or caring for people with disabilities should include the physical and cognitive aspects of disability if and where

appropriate, but more importantly should address the social impact of disability, the barriers experienced and how they can be overcome. Training should seek to reassure staff, families and carers who may feel anxious or uninformed about the sexual health needs of people with disabilities, and enable them to address the sexuality of individuals in their care with confidence. It is also essential that professionals have clear and agreed policies, procedures and guidance for their work with people with disabilities in the field of sexual health.

**Recommendation: fpa urges the UK Governments to ensure that services are in place to enable people with physical impairments or learning disabilities to exercise their rights as sexual beings.**

# Reproductive rights and reproductive health

**ICPD action:** All countries should strive to make accessible, through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than 2015.

Access to sexual and reproductive health services has been variable across the country in recent years. For example, in England the focus on increasing access to genitourinary medicine (GUM) clinics means that, in April 2009, almost 100 per cent of those people attending a GUM clinic for the first time were offered an appointment within two working days,<sup>21</sup> compared with 49 per cent in 2005.<sup>22</sup> However, at the same time, contraception services in many areas have suffered from disinvestment and a lack of priority. A survey of contraception services conducted by the Faculty of Family Planning and Reproductive Health Care (now the Faculty of Sexual and Reproductive Healthcare) in 2006<sup>23</sup> found that more than 20 per cent of those who responded reported reductions to services because of budget cuts. Around 50 per cent of services reported restrictions on access to long-acting reversible contraceptives, with some citing issues such as a lack of funding and a lack of trained staff. An audit of contraception services carried out by the Department of Health in England<sup>24</sup> also found that the vast majority of primary care trusts that responded to the audit had not been able to commit money specifically earmarked for contraception in the *Choosing health* White Paper to increasing access to contraception services or to offering the full range of contraceptive methods. Research has shown that providing high quality contraception services which meet women's needs can save the NHS money.<sup>25</sup>

**Recommendation:** fpa urges the UK Governments to continue to invest in contraception services to ensure that everyone has information about, and access to, the full range of contraceptive methods to enable them to choose the one which suits them best and consequently to avoid unplanned pregnancies.

**ICPD action:** Innovative programmes must be developed to make information, counselling and services for reproductive health accessible to adolescents and adult men.

Access to services for young people has been improving with innovations such as school based sexual health services and services delivered in community settings, for example through youth outreach work. However, there is more to do to ensure that all young people are able to access sexual health services easily, particularly given the specific problems they are likely to have with transport and with accessing services outside school or college hours.

More efforts are needed to ensure that services meet the needs of men as, although more men are accessing services, they are still a minority compared to the number of women using sexual health services.

**Recommendation:** fpa urges the UK Governments to encourage services to use innovative means of increasing access, for example by using community based settings or new technology to provide people with test results, to ensure that everyone is able to access the support they need to maintain their sexual health and that of their partners.

**ICPD action:** Migrants and displaced persons in many parts of the world have limited access to reproductive healthcare and may face specific serious threats to their reproductive health and rights.

People seeking asylum in the UK are entitled to access NHS services free of charge, including sexual and reproductive health services, while their claim or appeal are being considered. People whose applications for asylum have been rejected or who do not have a right to remain in the country cannot access health services free of charge, with the exception of Accident and Emergency services and treatment for some specified infectious diseases.

Testing for HIV and associated counselling are free of charge to everyone, but treatment and care for people diagnosed with HIV is not free if their application for asylum has previously been turned down. This situation has the potential to have a significant impact on public health in the UK as it may deter people from coming forward for testing, even those who would in fact be eligible for free treatment. In addition, it could be placing extra burdens on the NHS as people who have HIV but fear they would have to pay for treatment will not come forward until they are extremely unwell at which point much more expensive emergency or life-saving treatment will have to be provided at the NHS's expense.

**Recommendation:** fpa believes that treatment for HIV should be available free of charge to everyone, including failed asylum seekers, to encourage people who have been at risk of HIV to come forward for testing. This change would also have a positive impact on public health by ensuring that people with HIV can receive speedy access to treatment and therefore reduce the risk of them passing HIV on to their partners.

# Family planning

**ICPD action:** Governments and the international community should use the full means at their disposal to support the principle of voluntary choice in family planning.

Government policy in the UK does appear to support the principle of voluntary choice in sexual and reproductive health. For example, efforts are being made at a national level to try to ensure that women are able to access the full range of contraceptive methods, with the Departments of Health in England and Scotland funding public awareness campaigns about long-acting reversible contraceptives (LARCs). In addition, the National Institute for Health and Clinical Excellence (NICE) issued guidance in 2005 which highlighted the effectiveness and the cost-effectiveness of LARCs and stated that: 'Women requiring contraception should be given information about and offered a choice of all methods, including long-acting reversible contraception methods'.<sup>26</sup>

However, policy documents have not always translated into reality for people accessing contraception services. Many services do not offer the full range of contraceptive methods and clear pathways to access all methods are not always available. Approximately 80 per cent of women access contraceptive advice through general practice. A survey<sup>27</sup> of sexual health service provision in general practice, conducted by the All-Party Parliamentary Pro-Choice and Sexual Health Group in 2007, found that provision of LARCs was patchy and in particular, that only a minority of practices were offering the contraceptive implant. In addition, in many areas there had not been an assessment of contraceptive provision through general practice.

It is vital that all services providing contraception can offer information about the full range of methods, and have clear pathways in place for service users to be able to access the method that suits them best. In many cases, this will require investment in resources and training for staff, and improved links between services. Adequate provision of contraception services is a key way to enable people to control their fertility and plan the timing and spacing of their children.

Failure to create close links between abortion and contraception services has meant that some women have not been able to access the contraception they would like to use immediately after an abortion and have therefore been at risk of a subsequent unplanned pregnancy. **fpa** welcomed the recent decision from the Department of Health in England to include a requirement that abortion providers offer all methods of contraception as part of the standard contract. However, it is vital that primary care trusts provide sufficient funding for abortion services to provide the full range of methods of contraception and that nurses and doctors conducting the consultations with women seeking abortion have sufficient training and time to talk to women about all of the options available to them so that they can make the choice that suits them best. **fpa** would like to see similar provisions made in abortion services provided in Wales and Scotland.

**Recommendation:** **fpa** urges the UK Governments to ensure that all women and men of reproductive age have access to high quality, objective information about all methods of contraception and can easily access services to choose the method that suits them and their lifestyle best, acknowledging that this will be different for each individual and will change at

different points in their lives. Correct and consistent use of contraception is vital to preventing unplanned pregnancies.

**ICPD action: All countries should seek to identify and remove all the major remaining barriers to the utilisation of family planning services**

Greater efforts still need to be made to increase awareness of contraception services. This is particularly an issue for community based services which are not open all of the time and which may be based within other services. It is important that service opening times and locations are advertised widely and clearly so that people can find the services they need. Increasingly, new technology can make this easier. For example, there are approximately 100,000 searches a month on the Find a Clinic search facility on **fpa**'s website.

In addition, there are particular issues for people trying to access services in very rural areas of the UK. In some cases people have to travel significant distances to access services. This can be a particular issue for young people or people from lower socio-economic groups as they are more likely to rely on public transport, which is often patchy in rural areas, and are also more likely to be deterred from accessing services by high transport costs. **fpa** recommends that steps are taken by Government at national and local levels to ensure that high quality sexual health services are accessible throughout the country.

It is important to recognise that there are specific barriers to young people accessing services, and these need to be addressed. In particular, young people are extremely concerned about whether services are confidential. A survey published in 2005 found that 64 per cent of young people would be less likely to access sexual health services if health professionals could pass on their details to social workers.<sup>28</sup> There remains significant confusion among professionals and young people about the confidentiality of services for young people under 16.

The law in the UK states that sexual activity with young people under the age of 16 is illegal. However, there is guidance in England, Wales and Northern Ireland that makes it clear that young people under the age of 16 have a right to access sexual health services and the law is not intended to criminalise consensual sexual activity between young people of similar ages.<sup>29,30</sup> This means that professionals do not automatically have to report sexually active young people under the age of 16 to the police or social services unless they have specific concerns that the young person, or someone else, is being abused or exploited. However, there is a mandatory duty to report all sexually active young people under the age of 13 in Northern Ireland. In Scotland, the Sexual Offences (Scotland) Act has been passed but as yet guidance has not been produced for professionals about their responsibilities under the law.

**fpa** is extremely concerned that young people are deterred from using sexual health services because they are worried about their confidentiality. This not only puts them at greater risk of unplanned pregnancies and sexually transmitted infections (STIs) but also means that those who are at risk or who are being exploited are denied an opportunity to start to disclose these issues to a trusted professional who, with time, can help them to deal with the situation.

**Recommendation: fpa urges the UK Governments to ensure that sexual health services are open at times and in locations that are accessible to all who need to use them.**

**Recommendation: fpa urges the UK Governments to ensure that young people are able to access high quality confidential sexual health services.**

**ICPD action: Governments should make it easier for couples and individuals to take responsibility for their own reproductive health by removing unnecessary legal, medical, clinical and regulatory barriers to information and to access to family planning services and methods.**

## Abortion in Northern Ireland

The Abortion Act (1967) which made abortion legal in England, Scotland and Wales does not apply in Northern Ireland. This means that women there are denied access to safe and legal abortion services in Northern Ireland and instead many women have to travel and pay to access a service. As a result, abortion services are only available to women in Northern Ireland who can afford them.

Official statistics<sup>31</sup> show that 1,173 women travelled from Northern Ireland to England to have an abortion in 2008. Other women will have travelled to other European countries such as Spain and Holland and would not therefore have been included in these statistics. **fpa** estimates that approximately 2,000 women a year travel from Northern Ireland to have an abortion. Despite being UK taxpayers, each of these women would have had to pay up to £2,000 for their travel, accommodation and abortion procedure while women in the rest of the UK are able to access abortion services free through the NHS.

**fpa** campaigns for the law in Northern Ireland to be changed to give women there the same rights as women in the rest of the UK. We also want to see the removal of the financial burden women from Northern Ireland face. These changes have been recommended by UN Committees. In 2008, the United Nations Committee on the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) recommended that the abortion law in Northern Ireland should be amended.

### **CEDAW observations and recommendations (2008):**<sup>32</sup>

- In line with its previous recommendation, the Committee reiterates its call to the State party to initiate a process of public consultation in Northern Ireland on the abortion law.
- In line with its general recommendation 24 on women and health and the Beijing Platform for Action, the Committee also urges the State party to give consideration to the amendment of the abortion law so as to remove punitive provisions imposed on women who undergo abortion.
- The Committee also encourages the State party to carefully monitor the delivery of health services in order that it may respond in a gender-sensitive manner to all health concerns of women and in this regard invites the State party to utilize the Committee's general recommendation 24 as a framework for action to ensure that all health policies and programmes integrate a gender perspective.

In 2009, the United Nations Committee on Economic, Social and Cultural Rights, which monitors the Convention on Economic, Social and Cultural Rights met in Geneva to examine the UK Government. In its concluding observations, the Committee recommended that the abortion law in Northern Ireland should be brought into line with the rest of the UK: 'The Committee calls upon the State party to amend the abortion law of Northern Ireland to bring it in line with the 1967 Abortion Act with a view to preventing clandestine and unsafe abortions in cases of rape, incest or foetal abnormality'.<sup>33</sup>

The UK Government has expressed reluctance to amend the law on abortion in Northern Ireland because they plan to devolve the responsibility for criminal justice, which includes abortion, to the Northern Ireland Assembly. This does not reflect the fact that the UK Government still currently has the power to amend the law on abortion and is leaving women's rights hostage to a parliamentary process. The process for devolving powers over criminal justice has now begun but this is not expected to be concluded before 2012, which leaves the law on abortion in Northern Ireland in a procedural limbo. In addition, this will create the peculiar situation whereby the law on abortion is devolved to the Northern Ireland Executive but not to either the Scottish Government or the Welsh Assembly Government.

The UK Government also claims to be concerned that amending the law on abortion in Northern Ireland does not have the support of the local community. This is despite the fact that other laws, notably on discrimination against people on the grounds of sexual orientation have been passed in the face of opposition from community leaders in Northern Ireland. It is also far from clear that the population of Northern Ireland is as strongly opposed to abortion as community leaders suggest. A poll conducted by **fpa** in 2008 found that nearly two-thirds of Northern Irish people thought that abortion should be legal in cases of rape and incest.<sup>34</sup> In addition, the fact that around 70,000 women are estimated to have travelled from Northern Ireland to have an abortion since the 1967 Abortion Act came into operation demonstrates that there is a need for abortion services in Northern Ireland. However, the official moral climate in Northern Ireland remains fervently anti-choice and the members of the Northern Ireland Assembly have perpetuated this. Of the 108 members of the Assembly, only two are publicly pro-choice. While others have privately expressed support for extending the 1967 Abortion Act to Northern Ireland, their party whips have prevented them from speaking out. This denies the reality of thousands of women who have sought an abortion following an unplanned pregnancy and maintains the culture of secrecy around abortion in Northern Ireland.

Women in Northern Ireland are being treated by the UK Government as second class citizens and denied access to the same services as women in the rest of the UK, solely on the basis of where they live.

**Recommendation: fpa urges the UK Government in Westminster to provide support for women in Northern Ireland to access abortion services in Britain. We urge the Northern Ireland Assembly to amend the law on abortion to recognise and give sufficient priority to the importance of women's health and wellbeing.**

## Access to abortion services in Britain

While women in the rest of the UK do have easier access to abortion than women in Northern Ireland, there remain unnecessary regulatory barriers, which can adversely affect their ability to access

services. In particular, **fpa** would like to see the 1967 Abortion Act amended to:

- remove the need for two doctors to approve an abortion
- enable suitably trained nurses and midwives to carry out an abortion
- extend the types of locations where abortions can take place
- enable women to take the second stage of a medical abortion at home if they choose to do so.

Currently two doctors are required to state that a woman meets the legal criteria to have an abortion; that continuing with the pregnancy would put her life at greater risk than having an abortion or that there is a severe fetal abnormality. For a significant number of women this can be a major barrier to accessing services. A survey conducted by Marie Stopes International found that around 20 per cent of GPs described themselves as anti-choice.<sup>35</sup> Therefore, there is a significant minority of doctors who would not sign a referral form, which can have an adverse effect on women's ability to access services. Research about women seeking later abortions found that for some women who waited longer than two weeks between first requesting an abortion and obtaining an appointment, obstruction from health professionals had been an important factor.

- For 7 per cent of women, the first person they spoke to about having an abortion made it hard for them to get subsequent appointments.
- For 4 per cent of women, the first person they asked told them they could have an abortion.
- For 4 per cent of women, the first person they spoke to told them they were opposed to abortion.<sup>36</sup>

This demonstrates the impact that having to seek the approval of two doctors can have on women trying to access abortion services.

The 1967 Abortion Act allows only registered medical practitioners (doctors) to carry out abortions. **fpa** is concerned that this regulation unnecessarily restricts access to abortion services. In practice, many medical abortion services are almost entirely delivered by nurses. In addition, international evidence demonstrates that, with appropriate training, nurses can carry out abortions just as safely as doctors.<sup>37,38</sup> Nurses already carry out similar procedures or ones that are more complex than early abortions and it is a professional's training and experience which should determine whether they are capable of carrying out a procedure, rather than their job title.

When the 1967 Abortion Act was passed, abortion was a major operation and therefore it made sense to restrict the locations where abortions could take place to hospitals and approved clinics. However, technology and practice has now moved on and it would be possible for abortions to be carried out safely in a wider variety of locations. Since 1990, the Secretary of State for Health has had a power to designate additional locations as suitable for providing abortions. However, this has never been used. This means many women have to travel further than is necessary to access services which could be provided more easily in community-based settings.

An evaluation commissioned by the Department of Health in England of two pilot sites that provided abortions in non-traditional, community based locations found that there were no discernible differences between the pilot sites and their matched comparator sites in terms of the safety, effectiveness or acceptability of non-traditional sites for the administration of early medical abortion.<sup>39</sup> When the evaluation was published the Department of Health noted that the study showed

that large community contraception centres, cottage hospitals and polyclinic-type settings could offer a safe, high quality service for women and that some women welcomed the informality and increased availability of staff support. This supported the findings of the experience in other countries that already offered early medical abortion in non-hospital settings.<sup>40</sup> Providing abortion services in a variety of settings would mean that some women would not have to travel as far, reducing the amount of time women spent travelling and visiting the clinics, as well as reducing the cost and inconvenience for them. In addition, waiting lists for abortions would be likely to be reduced, with the result that more abortions could take place earlier.

The way the law on abortion is currently interpreted in Great Britain means that women who have a medical abortion have to attend the clinic twice as there are two stages to the medication. In other countries, such as America, France and Norway, women are able to make one visit to the hospital or clinic, where they take the first dose of medication and then return home, where they are allowed to administer the second stage themselves. **fpa** believes women who choose to do so should be able to take the second stage of the medication at home. A pilot study was undertaken to assess the safety, effectiveness and acceptability of completing the second stage of a medical abortion at home in the UK.<sup>41</sup> This research found that 98 per cent of the women who took part were satisfied with taking the second stage at home and 93 per cent said that they would ask to take the second stage at home again if they needed to have an abortion in the future.

In 2007, the House of Commons Science and Technology Committee conducted an inquiry into the scientific developments relating to the 1967 Abortion Act including specifically the practicalities and safety of allowing the second stage of early medical abortions to be carried out at the patient's home. The Committee concluded that 'subject to providers putting in place the appropriate follow-up arrangements, there is no evidence relating to safety, effectiveness or patient acceptability that should serve to deter Parliament passing regulations which would enable women who chose to do so taking the second stage of early medical abortion at home, or that should deter Parliament from amending the Act to exclude the second stage of early medical abortion from the definition of "carrying out a termination"'.<sup>42</sup> **fpa** believes it is important that women are able to choose whether or not to return to the clinic, as some women will prefer to be in a clinic or hospital, but there should not be barriers for women to make that choice.

There are areas of Britain where it is extremely difficult for women to access abortion and they have to travel long distances to reach services. This problem is particularly acute in North Wales, where all women seeking abortion have to travel to England to access services. This has a particularly detrimental impact on young women and vulnerable women who are less likely to be able to travel for a variety of reasons, not least access to transport and the cost involved. However, this situation will have an impact on all women in North Wales as they are less likely to be able to have a medical abortion, even if this is what they would prefer, because of the additional clinic visit involved. Women in other rural parts of Britain will have similar problems. It is vital that efforts are made to ensure that all women have access to high quality abortion services regardless of where they live.

**Recommendation: fpa urges the UK Government in Westminster to amend the 1967 Abortion Act to ensure that women across the UK are able to access an abortion service suitable for the 21st century.**

## Access to contraception services

It is not only abortion services where there are regulatory and other barriers to people accessing services. For example, some primary care trusts have imposed age restrictions on access to community contraception clinics which means that in some areas anyone over the age of 20 is unable to access specialist community contraception clinics. This can have a significant impact on their ability to access the full range of contraceptive methods as not all GPs will be able to supply all methods.

There is currently a legal barrier to GPs providing condoms free of charge in the UK. When contraception was finally included in the NHS in the 1970s, condoms were not seen as medical enough to be included on the list of items GPs could prescribe. As a result, condoms are the only method of contraception which GPs cannot prescribe free of charge. Given the important role that condoms play in not only preventing unplanned pregnancies but also protecting against STIs, **fpa** believes it is vital that this situation is rectified as soon as possible.

**Recommendation: fpa urges the UK Governments to remove all barriers to people accessing high quality contraception services regardless of their age or where they live**

**ICPD action: Governments at all levels are urged to provide a climate that is favourable to good quality public and private family planning and reproductive health information and services through all possible channels. Finally, leaders and legislators at all levels must translate their public support for reproductive health including family planning into adequate allocations of budgetary, human and administrative resources to help meet the needs of all those who cannot pay the full cost of services.**

Securing sufficient resources for contraception services has been difficult in recent years, with significant disinvestment in many areas. Even money which had specifically been allocated for contraception services has not always been used for its intended purpose as it has not been ring-fenced. **fpa** very much welcomed the recent announcements of additional funding for contraception services in England and Scotland. However, it is vital that every effort is made to ensure that this investment does reach contraception services. We would also like to see specific investment allocated to contraception services in Wales and Northern Ireland.

We welcomed the campaign to raise awareness of LARCs in Scotland. It is important that women have information about all of the contraceptive options available to them. Research **fpa** commissioned for Contraceptive Awareness Week in February 2009 showed that around one in three women spent five minutes or less choosing their contraception.<sup>43</sup> Increasing women's knowledge of the variety of methods and their advantages and disadvantages can enable them to choose the method that suits them and their lifestyle best, which makes them more likely to use it properly. Correct and consistent use of contraception is crucial to preventing unplanned pregnancies. However, it is vital that services are available that can offer women the full range of methods to meet the increased demand likely to result from increased awareness.

In Wales, the *Draft working paper on sexual health and wellbeing 2009–2014*<sup>44</sup> includes a recommendation that provision of LARCs is reviewed with a view to making recommendations on

future action. However, a specific campaign to raise awareness of LARCs, similar to those in England and Scotland, does not appear to be planned and it is not clear how the Welsh Assembly Government will ensure that women and men in Wales have access to the full range of contraceptive methods. *The Strategy and action plan for promoting sexual health in Northern Ireland*<sup>45</sup> does not make any reference to ensuring that the full range of contraceptive methods is available. Although the strategy does include actions to make services more accessible the major focus is on preventing unplanned pregnancies in young women and the needs of women who are no longer teenagers do not seem to be included.

**Recommendation: fpa urges the UK Governments to ensure that all women and men of reproductive age have access to high quality, objective information about all methods of contraception and that there are sufficient services to meet demand for all methods.**

# Sexually transmitted infections and prevention of HIV

**ICPD action:** All healthcare providers, including all family planning providers should be given specialised training in the prevention and detection of and counselling on sexually transmitted diseases, especially infections in women and youth, including HIV/AIDS.

There are ongoing issues with access to training across the sexual health workforce, including being able to fit long-acting reversible contraceptives (LARCs) and around sexually transmitted infections (STIs), including being able to identify and address high risk behaviours. There are particular issues with the lack of awareness amongst GPs of HIV. A survey<sup>46</sup> of newly diagnosed, HIV positive Africans attending treatment centres in London found that 76.4 per cent of respondents had been to see their GP in the year prior to diagnosis. In addition, for 82.4 per cent of the people involved in the study, HIV testing had not been broached by their GP. Similarly, research<sup>47</sup> with people with primary HIV infection in Brighton found that in almost half (48 per cent) of symptomatic individuals who presented at a healthcare setting, a diagnosis of HIV infection was not made; 79 per cent of these missed opportunities took place in primary care.

It is vital that there is investment in training in sexual health for non-specialist professionals, particularly those working in primary care and general practice as they are effectively the gatekeepers for access to more specialist care in many cases. Ensuring that professionals are trained to take a sexual history, can recommend HIV testing in line with the UK National HIV Testing Guidelines and can identify people at risk of an STI and respond appropriately are key elements to improving sexual health in the UK.

**Recommendation:** fpa urges the UK Governments to ensure that training in sexual health is seen as a high priority and sufficient resources are allocated, including the provision of cover for posts, to ensure that professionals can undertake the necessary training.

**ICPD action:** Information, education and counselling for responsible sexual behaviour and effective prevention of sexually transmitted diseases, including HIV, should become integral components of all reproductive and sexual health services.

The National Institute for Health and Clinical Excellence (NICE) issued guidance in February 2007 on preventing STIs and under-18 conceptions, which recommended that healthcare professionals provide one-to-one advice to people identified as being at high risk of STIs and with vulnerable young people under the age of 18 to enable them to avoid unplanned pregnancies. It was recommended that these interventions included discussions around how to prevent STIs, all methods of contraception, how to access and use emergency contraception and reducing risk-taking.

However, this NICE guidance is not mandatory and is applicable in England only. Furthermore, fpa is concerned that many professionals do not have sufficient time to provide in-depth advice about sexual health to service users. In addition, there may be some healthcare professionals who are not

able to identify which service users may be at high risk of unplanned pregnancies or STIs and therefore do not offer additional information when it is required. Sexual health and wellbeing can have a significant impact on people's general health and wellbeing and therefore we would like to see more training for health professionals in sexual health so that they are confident in sexual history taking and in opening up conversations with service users about their sexual health and sexual risk-taking.

Since the 1980s, there has not been a generic HIV awareness campaign aimed at the whole population. Instead, efforts have been focused on targeting messages at groups of people seen to be at higher risk of infection, particularly men who have sex with men and people from African backgrounds. The Department of Health has also funded the Condom Essential Wear<sup>48</sup> campaign, which is aimed at 18–34 year olds and is intended to normalise condom use to reduce rates of chlamydia and gonorrhoea. In 2001, an ongoing STI awareness campaign was also launched in Wales. This was aimed at raising awareness of STIs, particularly chlamydia among people aged 16–30 and featured adverts in the toilets of pubs, clubs, universities and colleges throughout Wales.<sup>49</sup>

While these more specific awareness campaigns are welcome, it is important to recognise that some people will still be at risk of STIs, including HIV, even though they are not part of one of these groups. In addition, there is a risk that focusing campaigns too narrowly can stigmatise STIs and HIV as they become seen as things which only affect certain people.

**Recommendation: fpa would like to see investment from the UK Governments in national sexual health campaigns, which include messages around preventing all STIs, including HIV.**

**ICPD action: Promotion and the reliable supply and distribution of high quality condoms should become integral components of all reproductive healthcare services.**

The overwhelming majority of sexual health services in the UK will offer male condoms free of charge, and some services also provide female condoms. However, it is still not possible for GPs to provide condoms free of charge unless specific arrangements have been put in place by the local primary care trust. In 2007, **fpa** supported an effort in Parliament to change this situation but this was not successful due to lack of parliamentary time. Condoms are one of only two methods of contraception which can be chosen by men and are the only method of contraception which helps protect against STIs. Therefore it is crucial that access to condoms is made easier, including through general practice.

**Recommendation: fpa urges the UK Governments to ensure that condoms are available free of charge from all healthcare settings, including general practice.**

# Human sexuality and gender relations

**ICPD action:** Support should be given to integral sexual education and services for young people with the support and guidance of their parents and in line with the Convention on the Rights of the Child, that stress responsibility of males for their own sexual health and fertility and that help them exercise those responsibilities.

Analysis of the areas that have been most successful in reducing their rates of teenage conceptions shows that high quality sex and relationships education (SRE) linked to confidential sexual health services for young people was one of the key factors. **fpa** believes that it is vital that young people receive high quality, comprehensive SRE which enables them to make informed choices about their relationships and sexual health and also that they can access confidential sexual health services.

In some cases, schools continue to be nervous about delivering SRE or providing sexual health services in schools. However, in a 2005 survey, 86 per cent of all adults agreed that every young person should receive SRE in school as a compulsory part of the National Curriculum,<sup>50</sup> and 94 per cent of parents in a Health Education Authority survey<sup>51</sup> stated that they were in favour of schools providing at least part of their children's SRE. High quality SRE does not make young people more likely to have sex. In fact, it can lead to them starting to have sex later, especially when linked to confidential advice services.<sup>52</sup> Therefore, it is vital that schools engage parents as much as possible with the programme of SRE that will be delivered so that they are aware of the information their children will receive and can reinforce the messages for their children at home.

In England, the provision of SRE and personal, social, health and economic (PSHE) education have been reviewed. Following these reviews the Government in England announced its intention to make PSHE education, including SRE, a compulsory subject at all key stages. In November 2009, the Children, Schools and Families Bill was introduced including clauses to make PSHE education a statutory part of the curriculum. **fpa** supports these proposals as an important step forward in delivering young people's entitlement to information and education about sexual health and relationships. Although we are aware that many faith schools teach SRE extremely well, the measures introduced enable schools to deliver PSHE education in a manner that is appropriate to the religious and culture background of pupils. As these proposals are debated and implemented, **fpa** will continue to seek clarification that young people will have an entitlement to receive core information to try to avoid a situation where young people are simply told that contraception or homosexuality are wrong. In 2002, Ofsted published a report into SRE teaching which found that 'schools almost always set their SRE programmes within an explicit moral framework governing relationships and behaviour. They are often successful in giving pupils opportunities in SRE lessons to explore their values and attitudes and to consider how they and others are affected by them. Where lessons are less effective, this is most often because the teacher talks about what is considered to be the right attitude without giving the pupils the opportunity to debate it, to make their own views known and to explore contradictions and disagreements'.<sup>53</sup>

**Recommendation:** **fpa** urges the UK Governments to ensure that children and young people at all key stages receive high quality, comprehensive SRE to equip them to make informed decisions as they grow up.

# Adolescents

**ICPD action: Countries, with the support of the international community, should protect and promote the rights of adolescents to reproductive health education, information and care and greatly reduce the number of adolescent pregnancies.**

Following the publication of the Teenage Pregnancy Strategy in 1999, there has been progress in reducing rates of under 18 conceptions in England. Between 1998 and 2007, the rate of conceptions in young women under 18 fell by 10.7 per cent. In addition, the rate of conceptions for young women under 16 fell by 6.6 per cent.<sup>54</sup> Although this will not achieve the target of a 50 per cent reduction at a national level, the statistics show that there has been significant variation between local areas with some areas seeing a reduction in rates of around 50 per cent whilst others have seen an increase of almost 50 per cent in the same period.<sup>55</sup>

In 2006, the Teenage Pregnancy Unit published guidance for local authorities and primary care trusts on how to make progress in reducing teenage pregnancy rates.<sup>56</sup> This was based on a review of areas that had been successful in reducing rates in comparison with similar areas that had not been able to reduce rates. This review found that there were a number of key factors which were common to areas that were doing well but were absent in the areas that continued to struggle. Importantly, the Teenage Pregnancy Unit found that all of these factors needed to be present together to make the most significant impact.

These were:

- Active engagement of all of the key mainstream delivery partners who have a role in reducing teenage pregnancies (health, education, social services and youth support services as well as the voluntary sector).
- A strong senior champion who was accountable for and took the lead in driving the local strategy.
- The availability of a well publicised, confidential, young people-centred contraception and sexual health advice service, with a strong remit to undertake health promotion work, as well as delivering reactive services.
- A high priority given to personal, social, health and economic education in schools, with support from the local authority to develop comprehensive programmes of sex and relationships education (SRE) in all schools.
- A strong focus on targeted interventions with young people at greatest risk of teenage pregnancy, in particular with looked after children.
- The availability and consistent take-up of SRE training for professionals in partner organisations (such as Connexions personal advisers, youth workers and social workers) working with the most vulnerable young people.
- A well resourced youth service, providing things to do and places to go for young people, with a clear focus on addressing key social issues affecting young people, such as sexual health and substance misuse.

The Teenage Pregnancy Strategy is specific to England. The Governments in Scotland, Wales and Northern Ireland have set targets to reduce the rates of teenage pregnancies although they did not develop specific strategies for tackling teenage pregnancy. There has been varying success in reducing rates of teenage pregnancies in the rest of the UK.

In Wales, the 2000 sexual health strategy, *A strategic framework for promoting sexual health in Wales*, included an aim to reduce rates of teenage pregnancies.<sup>57</sup> Statistics show that while the rate of teenage conceptions in Wales fell between 2000 and 2005, there was an increase from 43.3 per 1,000 young women aged 15–17 in 2005 to 44.9 per 1,000 in 2006.<sup>58</sup>

In Scotland, the sexual health strategy *Respect and responsibility*<sup>59</sup> included a target to reduce the pregnancy rate in 13–15-year-olds by 20 per cent from 8.5 per 1,000 in 1995 to 6.8 by 2010. Statistics show that, within the under 18 age group, the pregnancy rate peaked in the 1990s with a rate of 44.9 per 1,000 in 1998 then there was a gradual decline to 39.4 per 1,000 in 2001. Since then there has been a slight increase to the present rate of 41.5 per 1,000 in 2006. The rate in the under 16 age group has also fluctuated, peaking in 1996 at 9.0 per 1,000. The lowest rate recorded was 6.6 per 1,000 in 2001. In the more recent years the rate has been around 7.0 per 1,000 with an increase in 2006 to 8.1 per 1,000.<sup>60</sup>

The Department of Health, Social Services and Public Safety in Northern Ireland has set a target to reduce births to teenage mothers under the age of 17 by 25 per cent by 2013.<sup>61</sup> Data on teenage conceptions are not available for Northern Ireland because there is incomplete information about women who have an abortion. Statistics show that in 2008 there were 1,426 births to teenage mothers. This was a decrease of more than 20 per cent from the high of 1,791 births in 1999, although it did represent a small increase on the 1,405 births in 2007.<sup>62</sup> According to official statistics, the number of women under 20 who travelled to England to have an abortion fell between 2000 and 2008 from 301 to 196.<sup>63</sup> However, these figures are likely to be underestimates of the number of young women who had an abortion as some travel to other European countries or give false addresses and are therefore not recorded in official statistics.

**Recommendation: fpa urges the UK Governments at national and local levels to provide the necessary investment to develop and sustain the services and joint working needed to enable young people to avoid unplanned pregnancies.**

**ICPD action: Governments and non-governmental organizations should promote programmes directed to the education of parents, with the objective of improving the interaction of parents and children to enable parents to comply better with their education duties to support the process of maturation of their children, particularly in the areas of sexual behaviour and reproductive health.**

The importance of parenting has been increasingly recognised at national policy level. In England, there is now a Department for Children, Schools and Families, and a Parenting Fund was established in 2004 to provide financial support for parenting and parenting organisations. In Wales, the Welsh Assembly Government launched a Parenting Action Plan in 2005 which set out a comprehensive approach to improving services and support for parents.

**fpa** is aware that parents and carers want to talk to their children about growing up, sex and relationships. However, in many cases there is embarrassment on both sides and parents worry about how to start the conversation and what to say. Our Speakeasy programme is a community based SRE project aimed at enabling parents and carers to develop the skills, knowledge and confidence to talk to their children. The programme lasts about eight weeks and covers factual information about puberty, contraception and sexually transmitted infections as well as strategies for identifying opportunities to talk to children, making conversations age-appropriate and keeping children safe from harm, including on the internet. The Government has provided some funding for **fpa** to deliver the Speakeasy programme in England. In other parts of the country it is funded by charitable funders or by local authorities. In addition, **fpa** makes efforts to train staff who work with parents to deliver the programme. However, access to Speakeasy is far from universal.

The Department for Children, Schools and Families in England has also funded a national campaign, Time to Talk, aimed at helping parents to tackle conversations about sex and relationships. This was delivered by the national voluntary organisation, Parentline Plus, and provided information to parents online and via telephone helplines about how to talk to their children about sex and relationships.

**Recommendation: fpa would like all parents to be able to access help and support from services such as Speakeasy. We believe that parenting support should be available, should include fathers as well as mothers, and should reflect the variety of people who carry out the role of parent, including grandparents and step-parents. The role of parents and carers in providing their children with information about growing up, sex and relationships should be recognised and supported.**

# Women's health and safe motherhood

**ICPD action:** Adolescent females and males should be provided with information, education and counselling to help them delay early family formation, premature sexual activity and first pregnancy.

There have been efforts to reduce rates of teenage pregnancies. **fpa** welcomes the recent Government announcement of the intention to make sex and relationships education (SRE) a compulsory part of the curriculum in England as it will enable young people to develop the knowledge and skills needed to make informed decisions about their sexual health and relationships.

As part of efforts to address teenage pregnancies in England, the Government funded two specific awareness campaigns: RU Thinking<sup>64</sup> and Want Respect? Use a Condom. RU Thinking is aimed at younger teenagers, promoting messages on delaying first sex and avoiding peer pressure. Want Respect? Use a Condom is aimed at sexually active young people. It promotes condom use by associating the use of condoms with behaviour that will earn young people respect from their peers.

It is important to recognise that teenage pregnancy is a complex social problem affected by a variety of factors including socio-economic deprivation and educational attainment. Efforts to ensure that young people continue in education, or are employed could be crucial to tackling rates of teenage pregnancy. Research with young people in Rochdale has shown that young people's aspirations are an important predictor of sexual activity. The research found that the sooner young people expected to leave education the more likely they were to be sexually active at age 14–15. The report concludes that 'this implies that increasing young people's self-confidence, sense of achievement and future aspirations could prove an effective way of reducing sexual activity at a young age'.<sup>65</sup>

**fpa's** community based projects are aimed at providing young people with factual information about sex and sexual health but also increasing their confidence and self-esteem. This plays an important role in enabling young people to make informed and confident decisions about their sexual health and relationships. Comprehensive SRE such as this has been shown to delay the age at which young people start having sex and make them more likely to use contraception when they do. It is crucial that a comprehensive approach is taken to ensure young people have both the knowledge and the confidence to make their own decisions as they grow up.

**Recommendation:** **fpa** urges the UK Governments to ensure that young people are equipped with the knowledge, confidence and skills they need to prevent pregnancies and to ensure that the social and cultural factors which have an impact on teenage pregnancy are also addressed.

**ICPD action:** All countries, as a matter of some urgency, need to seek changes in high-risk sexual behaviour and devise strategies to ensure that men share responsibility for sexual and reproductive health, including family planning, and for preventing and controlling sexually transmitted diseases, HIV infection and AIDS.

In recent years there have been a number of different sexual health awareness campaigns aimed at providing people with information to identify high risk behaviours and avoid sexually transmitted infections (STIs). For example the Condom Essential Wear campaign in England is aimed at young people aged 18–34 and is intended to normalise condom use specifically to reduce rates of chlamydia and gonorrhoea.

The majority of campaigns which have been launched have focused on condom use and have been specifically aimed at young people. Therefore, it is vital that more investment is available to ensure that awareness campaigns can be broader ranging and can be relevant for people in a variety of age groups. In particular, there is evidence that, although young people still experience the highest rates of STIs, the numbers of infections in people over the age of 45 are increasing. Statistics from the Health Protection Agency show that the numbers of new diagnoses in the UK of syphilis in men aged 45–64 rose from 13 in 1998 to 464 in 2007.<sup>66</sup> Although the numbers of older people diagnosed with STIs remain relatively small, efforts still need to be made to ensure older people have access to the information and services they need to maintain their sexual health, and that of their partners.

**Recommendation:** fpa urges the UK Governments to ensure that high quality, objective information is available to enable people of all ages to protect their sexual health.

# Human Immunodeficiency Virus (HIV) infection and Acquired Immunodeficiency Syndrome (AIDS)

**ICPD action:** Programmes to reduce the spread of HIV infection should give high priority to information, education and communication campaigns to raise awareness and emphasise behavioural change. Sex education and information should be provided both to those infected and those not infected, especially to adolescents.

School-based sex and relationships education (SRE) must by law include information about HIV as part of the science curriculum. However, this biological emphasis does not always address the wider sexual health and social issues associated with HIV. **fpa** welcomes the Government's intention to make personal, social, health and economic education, including SRE, a statutory subject in England. This should ensure that young people can access high quality SRE that provides them with the knowledge and skills to maintain their sexual health. **fpa** strongly recommends that similar measures are taken in Scotland, Wales and Northern Ireland.

To support teachers to deliver education about HIV, the National AIDS Trust<sup>67</sup> has developed a toolkit for schools. This includes lesson plans, statistics, PowerPoint slides and ideas for assemblies and other ways of providing young people with information. It is important that schools have access to resources such as this to make sure that young people receive high quality education about HIV, and understand that HIV is an issue in the UK as well as in the developing world.

**Recommendation:** **fpa** urges the UK Governments to ensure that comprehensive SRE programmes include discussions around preventing HIV and also tackle some of the issues associated with stigma and discrimination against people living with HIV.

**ICPD action:** Health providers, including family-planning providers, need training in counselling on sexually transmitted diseases and HIV infection, including the assessment and identification of high-risk behaviours needing special attention and services; training in the promotion of safe and responsible sexual behaviour, including voluntary abstinence, and condom use.

There are a variety of areas where more training for healthcare professionals is needed on sexual health, particularly for non-specialist staff such as those working in general practice. Wherever possible, healthcare professionals will talk to service users about their behaviour and making changes to reduce their risk of sexually transmitted infections (STIs). However, this requires sufficient resources in terms of time and also trained staff to deliver this service which is not always currently possible. In addition, these messages delivered by healthcare professionals

need to be backed up by messages from society and the media so that it is easier for people to make changes to their behaviour.

**Recommendation:** fpa urges the UK Governments to ensure that suitable training is available for health professionals to ensure they are able to talk to service users about sexual health and identify those people who may be at risk of an STI, signposting them on to further support where this is appropriate.

**Action:** Governments should develop guidelines and counselling services on AIDS and sexually transmitted diseases within the primary healthcare services.

The three main organisations involved in HIV testing have published UK National Guidance on HIV testing, which includes recommendations on testing in general practice.<sup>68</sup> However, there continue to be significant barriers to testing in primary care settings. These include confusion among professionals about the need for in-depth, pre-test counselling and concerns from service users about confidentiality. Greater training needs to be available for professionals along with the resources for them to be able to undertake courses.

The Royal College of General Practitioners has developed an introductory certificate in sexual health which provides a basic grounding in sexual health issues. The aims of the course are to:

- develop the knowledge, skills and confidence of generalists in general practice and enable them to practice at the generalist level in sexual health
- improve the care of people with sexual health needs in general practice
- improve and promote the diagnosis and care of people with HIV in general practice.

While this course and others like it are very much to be welcomed, they remain voluntary and therefore are only likely to be taken up by those professionals who already have an interest in sexual health issues. fpa would like to see greater emphasis on sexual health training in the core curricula for all health professionals so that it is seen as a central aspect of health and wellbeing to be considered in all interactions with service users and all professionals are confident in raising and addressing issues around sexual health, rather than it being seen as something only specialists can deal with.

**Recommendation:** fpa urges the UK Governments to highlight the importance of HIV testing being widely available through the implementation of the UK National HIV Testing Guidelines and provide the necessary resources to ensure that testing services can be delivered in primary care locations.

**ICPD action:** Wherever possible, reproductive health programmes, including family-planning programmes, should include facilities for the diagnosis and treatment of common sexually transmitted diseases, including reproductive tract infection, recognizing that many sexually transmitted diseases increase the risk of HIV transmission.

In many cases, integrated sexual health services offer contraception services alongside those dealing with STIs. In particular, in Wales, a process of sexual health service modernisation was specifically designed to merge contraceptive services with genitourinary medicine (GUM) services to ensure that people could access one service for all their sexual health needs. This made significant progress, with service redesign taking place across Wales and closer links between services now in place. In Scotland, the sexual health strategy, *Respect and responsibility* encouraged services to bring together contraception and GUM services wherever possible.<sup>69</sup>

In England, traditional divisions between contraception services, which are often more community based, and GUM services, which are often based in hospitals, continue. Attempts to integrate these services in England have been undermined by the fact that contraception services are funded in a different way to GUM services. Often GUM services are provided by the secondary care sector which means they are paid for through the Payment by Results tariff, which pays a certain amount for each activity. Contraception services, however, are not funded by Payment by Results but instead are still paid for in most cases through block contracts. A review of the *National Strategy for Sexual Health and HIV* in England found that 'Partial implementation of Payment by Results (PbR) for sexual health and HIV services, with the introduction of tariffs for some services and some settings, but not for others, has led to further disjunction between hospital and community services, presenting barriers to commissioning across whole pathways of care'.<sup>70</sup> While a pilot of an integrated sexual health tariff is underway in London, there is significant progress to be made to ensure that the funding of sexual health services is sufficient and does not create artificial divisions between services.

**Recommendation: fpa believes it is vital that there is sufficient funding to provide local sexual health services and that these should be seen as a priority by local commissioners. This must include providing the range of sexual health services, including contraception, GUM, abortion, sexual health promotion, psychosexual and sexual dysfunction services and sexual assault referral centres.**

**ICPD action: Government should develop policies and guidelines to protect the individual rights of and eliminate discrimination against persons infected with HIV.**

As a result of the Disability Discrimination Act 2005, a person living with HIV is considered to be a disabled person from the point of diagnosis for the purposes of the Act. This means that people living with HIV are protected against discrimination from service providers, such as restaurants, hotels or dentists as well as discrimination in education, housing and employment. In relation to services, discrimination would include:

- refusing to provide, or deliberately not providing a service
- providing a service of a lower standard
- providing services on worse terms, for example charging someone living with HIV more for a service.

In relation to employment, the law requires employers to make reasonable adjustments to remove substantial disadvantages that someone living with HIV might experience, for example flexibility to see a doctor. It also prevents employers discriminating against people during the recruitment and selection process. To date, not many cases of discrimination have been taken to court or tribunal, but

this legislation is very much welcomed as an important way of ensuring that people living with HIV are not discriminated against.

People living with HIV can also experience stigma on a daily basis and a great deal more needs to be done to tackle this. It is vital that comprehensive SRE teaches young people the facts about HIV and how to protect themselves. It is also crucial that they have an opportunity to discuss issues such as stigma, discrimination and attitudes, including towards people with HIV. There need to be greater efforts to reduce inaccurate reporting about HIV in the media and to increase the visibility of people living with HIV both in the media and more generally in public life. In addition, services such as health and education need to plan and provide resources for sustained training and education for staff to eradicate stigma around HIV from public service delivery.

Despite legislation being in place to remove discrimination against people with HIV, laws which prosecute the transmission of HIV also exist and these can add to the stigma associated with HIV. **fpa** is opposed to prosecution for transmission of HIV except in extremely limited circumstances. The current legal situation causes fear and confusion and can undermine effective public health activity by deterring people from accessing HIV testing. In addition, a review of police handling of criminal investigations relating to transmission of HIV in England and Wales found significant areas for improvement in investigations that had taken place.<sup>71</sup> In particular, officers' understanding of HIV was often limited which led to inappropriate management of some cases. In addition, in some cases even where there was no charge possible from the original complaint, police continued to seek other potential complainants. In the report's author's view, this caused fear among people with HIV about malicious or misguided complaints leading to wider disclosure of their status and disruption of their lives. These concerns could lead people to be reluctant about disclosing information about previous partners in a clinical setting where notes could later be required as evidence.

**Recommendation: fpa urges the UK Governments to make greater efforts to eradicate the discrimination faced by people with HIV, including providing training for professionals working in public services.**

**Recommendation: fpa is opposed to prosecution for transmission of HIV except in limited circumstances and therefore urges the UK Governments to change the law to reduce the stigma and fear that currently arise from such prosecutions.**

# References

- 1 Equality and Human Rights Commission, *Staying On: Making the Extra Years in Education Count for All Young People* (London: Equality and Human Rights Commission, 2009).
- 2 Scottish Executive, *Standards in Scotland's Schools etc Act 2000: Conduct of Sex Education in Schools, Circular 2/2001* (Edinburgh: Scottish Executive, 2001).
- 3 Welsh Assembly Government, *Personal and Social Education Framework for 7–19 year olds in Wales* (Cardiff: Welsh Assembly Government, 2008).
- 4 *Education (Curriculum Minimum Content) Order (Northern Ireland) 2007* <www.opsi.gov.uk> accessed 26 June 2009.
- 5 Reid Howie Associates, *Consultation on 'Forced Marriages: A Civil Remedy?': Analysis of Responses* (Edinburgh: Scottish Government, 2009).
- 6 Dorkenoo E et al, *A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales* (London: FORWARD, 2007).
- 7 NHS Information Centre, *NHS Contraceptive Services, England: 2007–08* (Leeds: Information Centre, 2008).
- 8 Statistics for Wales, *NHS Community Contraceptive Services in Wales, 2007–08* (Cardiff: Welsh Assembly Government, 2009).
- 9 Forrest S, *Boys, Young Men and Sexual Health Services: A Summary of a Review of the Academic Literature* (London: Brook, 2007).
- 10 Forrest S, 'Big and tough: boys learning about sexuality and manhood', *Sexual and Relationship Therapy*, vol 15, no 3 (2000), 247–262 and Hilton G, 'Listening to the boys again: an exploration of what boys want to learn in sex education classes and how they want to be taught', *Sex Education*, vol 7, no 2 (2007), 161–174.
- 11 Aggleton P, Oliver C and Rivers K, *The Implications of Research into Young People, Sexuality and Relationships* (London: Health Education Authority, 1998) and Forrest S, *Boys, Young Men and Sexual Health Services: a Summary of a Review of the Academic Literature* (London: Brook, 2007).
- 12 Home Office, *Working within the Sexual Offences Act 2003* (London: Home Office, 2004).
- 13 Northern Ireland Office, *Safer from Sexual Crime: Protecting Children and Young People* (London: Northern Ireland Office, 2009).
- 14 *Ibid*
- 15 *Sexual Offences (Scotland) Act 2009* <www.opsi.gov.uk> accessed 26 June 2009.
- 16 Department of Health, *Valuing People Now: A New Three Year Strategy for People with Learning Disabilities* (London: Department of Health, 2009).
- 17 Learning Disability Implementation Advisory Group, *Policy and Practice for Adults with a Learning Disability: Proposed Action Plan* (Cardiff: Learning Disability Implementation Advisory Group, 2008).
- 18 Scottish Executive, *The Same As You? A Review of Services for People with Learning Disabilities* (Edinburgh: Scottish Executive, 2000).

- 19 Review of Mental Health and Learning Disability, *Equal Lives: Review of Policy and Services for People with a Learning Disability in Northern Ireland* (Belfast: Review of Mental Health and Learning Disability, 2005).
- 20 **fpa**, '**fpa** publishes results from survey of professionals working in learning disability' <[www.fpa.org.uk](http://www.fpa.org.uk)> accessed 26 June 2009.
- 21 Department of Health, *GUM Access Monthly Monitoring, April 2009* (London: Department of Health, 2009).
- 22 Health Protection Agency, *A Complex Picture: HIV and Other Sexually Transmitted Infections in the United Kingdom, 2006* (London: Health Protection Agency, 2006).
- 23 Faculty of Family Planning and Reproductive Healthcare, *Community Contraceptive Services Faculty Questionnaire 2006* (London: Faculty of Family Planning and Reproductive Healthcare, 2006).
- 24 Department of Health, *Findings of the Baseline Review of Contraceptive Services* (London: Department of Health, 2007).
- 25 Armstrong N and Donaldson C, *The Economics of Sexual Health* (London: **fpa**, 2005).
- 26 National Collaborating Centre for Women's and Children's Health, *NICE Clinical Guideline 30: Long-acting Reversible Contraception* (London: Royal College of Obstetricians and Gynaecologists Press, 2005).
- 27 All-Party Parliamentary Pro-Choice and Sexual Health Group, *A Report into the Delivery of Sexual Health Services in General Practice* (London: All-Party Parliamentary Pro-Choice and Sexual Health Group, 2007).
- 28 Brook, *Wise Up! Survey of Brook clients* <[www.brook.org.uk](http://www.brook.org.uk)> accessed 29 July 2009.
- 29 Home Office, *Working within the Sexual Offences Act 2003* (London: Home Office, 2004).
- 30 Northern Ireland Office, *Safer from Sexual Crime: Protecting Children and Young People* (London: Northern Ireland Office, 2009).
- 31 Department of Health, *Abortion Statistics for England and Wales: 2008, Statistical bulletin 2009/01* (London: Department of Health, 2009).
- 32 Committee on the Elimination of Discrimination Against Women 'Fifth and sixth periodic reports, United Kingdom of Great Britain and Northern Ireland' CEDAW/C/UK/CO/6 <[www2.ohchr.org/english/bodies/cedaw/cedaws41.htm](http://www2.ohchr.org/english/bodies/cedaw/cedaws41.htm)> accessed 26 June 2009.
- 33 UN Committee on Economic, Social and Cultural Rights, 'Consideration of reports submitted by States Parties under Articles 16 and 17 of the Covenant: Concluding Observations of the Committee on Economic, Social and Cultural Rights – United Kingdom of Great Britain and Northern Ireland, the Crown Dependencies and Overseas Dependent Territories' <<http://www2.ohchr.org/english/bodies/cescr/cescrs42.htm>> accessed 26 June 2009.
- 34 **fpa**, '**fpa** survey confirms public support for abortion in Northern Ireland' <[www.fpa.org.uk](http://www.fpa.org.uk)> accessed 31 July 2009.
- 35 Marie Stopes International, *General Practitioners: Attitudes to Abortion 2007* (London: Marie Stopes International, 2007).
- 36 Ingham R et al, *Second Trimester Abortion in England and Wales* (Southampton: University of Southampton, 2007).

- 37 Goldman M et al, 'Physician assistants as providers of surgically induced abortion services', *American Journal of Public Health*, vol 94, no 8 (2004), 1352–1357.
- 38 Warriner I et al, 'Rates of complication in first-trimester manual vacuum aspiration abortion done by doctors and mid-level providers in South Africa and Vietnam: a randomised controlled equivalence trial', *The Lancet*, vol 398, (2006), 1965–1972.
- 39 Ingham R and Lee E, *Evaluation of Early Medical Abortion (EMA) Pilot Sites: Final report* (London: Department of Health, 2008).
- 40 Department of Health, 'Results of pilot study on early medical abortions in community medical settings published' <<http://nds.coi.gov.uk/clientmicrosite/Content/Detail.aspx?ClientId=46&NewsAreaId=2&ReleaseID=366752&SubjectId=36>> accessed 10 July 2009.
- 41 Hamoda H et al, 'Home self-administration of misoprostol for medical abortion up to 56 days' gestation', *Journal of Family Planning and Reproductive Health Care*, vol 31, no 3 (2005), 189–192.
- 42 House of Commons Science and Technology Committee, *Scientific Developments Relating to the Abortion Act 1967: Twelfth Report of Session 2006–07* (London: The Stationery Office, 2007).
- 43 **fpa**, 'Women spend up to five minutes choosing contraception despite almost half having pregnancy scares new **fpa** research shows' <[www.fpa.org.uk](http://www.fpa.org.uk)> accessed 26 June 2009.
- 44 Welsh Assembly Government, *Sexual Health and Wellbeing in Wales 2009–2014: Draft Working Paper* (Cardiff: Welsh Assembly Government, 2009).
- 45 Department of Health, Social Services and Public Safety, *Sexual Health Promotion: Strategy and Action Plan 2008–2013* (Belfast: Department of Health, Social Services and Public Safety, 2008).
- 46 Burns F et al, 'Missed opportunities for earlier HIV diagnosis within primary and secondary healthcare settings in the UK', *AIDS*, vol 22, no 1 (January 2008), 115–122.
- 47 Sudarshi D et al, 'Missed opportunities for diagnosing primary HIV infection', *Sexually Transmitted Infections*, vol 84, no 1 (February 2008), 14–16.
- 48 [www.condomessentialwear.co.uk](http://www.condomessentialwear.co.uk)
- 49 [www.wales.gov.uk](http://www.wales.gov.uk)
- 50 Brook, 'Poll Reveals Massive Public Support for Key Sexual Health Priorities in 2006' <[www.brook.org.uk](http://www.brook.org.uk)> accessed 26 June 2009.
- 51 National Foundation for Educational Research, *Parents, School and Sex Education* (London: Health Education Authority, 1994).
- 52 Swann C et al, *Teenage Pregnancy and Parenthood: a Review of Reviews, Evidence Briefing* (London: Health Development Agency, 2003).
- 53 Ofsted, *Sex and Relationships Education in Schools* (London: Ofsted, 2002).
- 54 Department for Children, Schools and Families, *Teenage Conception Statistics for England 1998–2007* (London: Department for Children, Schools and Families, 2009).
- 55 Department for Children, Schools and Families, *Under 18 Conceptions Data for Top-tier Local Authorities 1998–2007* (London: Department for Children, Schools and Families, 2009).
- 56 Department for Education and Skills, *Teenage Pregnancy: Accelerating the Strategy to 2010* (London: Department for Education and Skills, 2006).

- 57 National Assembly for Wales, *A Strategic Framework for Promoting Sexual Health in Wales* [Cardiff: National Assembly for Wales, 2000].
- 58 Welsh Assembly Government, Statistical Directorate, *Teenage Conceptions in Wales, 2006* [Cardiff: Welsh Assembly Government, 2008].
- 59 Scottish Executive, *Respect and Responsibility: Strategy and Action Plan for Improving Sexual Health* [Edinburgh: Scottish Executive, 2005].
- 60 ISD Scotland, *Teenage Pregnancy* <[www.isdscotland.org](http://www.isdscotland.org)> accessed 24 June 2009.
- 61 Department of Health, Social Services and Personal Safety, *Sexual Health Promotion: Strategy and Action Plan 2008–2013* [Belfast: Department of Health, Social Services and Personal Safety, 2008].
- 62 Northern Ireland Statistics and Research Agency, 'Seventeen year high in the number of babies born: Statistics press notice – births in Northern Ireland 2008' <[www.nisra.gov.uk](http://www.nisra.gov.uk)> accessed 24 June 2009.
- 63 Department of Health, *Abortion Statistics for England and Wales: 2008 Statistical bulletin 2009/01* [London: Department of Health, 2009].
- 64 [www.ruthinking.co.uk](http://www.ruthinking.co.uk)
- 65 Redgrave K and Limmer M, *"It makes you more up for it" School Aged Young People's Perspectives on Alcohol and Sexual health* [Rochdale: Rochdale Teenage Pregnancy Strategy, 2005].
- 66 Health Protection Agency, *Selected STI Diagnoses Made at GUM Clinics in the UK: 1998–2007* [London: Health Protection Agency, 2008].
- 67 [www.nat.org.uk](http://www.nat.org.uk)
- 68 British HIV Association, British Association of Sexual Health and HIV and British Infection Society, *UK National Guidelines for HIV Testing 2008* [London: British HIV Association, 2008].
- 69 Scottish Executive, *Respect and Responsibility: Strategy and Action Plan for Improving Sexual Health* [Edinburgh: Scottish Executive, 2005].
- 70 Medical Foundation for AIDS and Sexual Health, *Progress and Priorities – Working Together for High Quality Sexual Health: Review of the National Strategy for Sexual Health and HIV* [London: Independent Advisory Group on Sexual Health and HIV, 2008].
- 71 Terrence Higgins Trust, *Policing Transmission: A Review of Police Handling of Criminal Investigations Relating to Transmission of HIV in England and Wales, 2005–2008* [London: Terrence Higgins Trust, 2009].

# fpa supporting professionals

## fpa membership

Become a member of **fpa** and receive a range of benefits while supporting our vital work. The benefits include:

- a full set of **fpa** factsheets and booklets
- quarterly mailings, which include subscriptions to *Sex talk* and *In brief*
- discounts on **fpa** open training courses
- discounts on **fpa** publications (school and organisation members).

Choose from three membership packages – individual membership at £30 a year, school membership at £50 a year (includes universities, colleges, Connexions, youth organisations and Sure Start) and organisation membership at £90 a year.

*Sex talk* is **fpa**'s newsletter, keeping you in touch with **fpa** events, campaigns and our latest publications and resources. *In brief* provides the latest news and comment on contraception, sexually transmitted infections and reproductive health.

## fpa training

**fpa** provides high quality training in sexual health, sex and relationships, and sexuality. We offer:

- Open training: offered on pre-set dates and open to all.
- On request training: the same content and format as open training but delivered to a specific group or organisation.
- Tailor made training: specifically designed to meet a client's particular needs, and may offer a mix of training and consultation.
- Consultancy: **fpa** has a strong team of experts in all aspects of sexual health who are available to facilitate seminars or briefings, to provide specific advice and to assist with writing a relevant policy or guidelines.

**fpa** provides university accreditation for some of its courses.

## fpa publications

**fpa** offers a complete order service for health and education professionals and the public. Our extensive stock includes books, booklets and resources on sex and relationships education, learning disabilities, contraception, and sexual health.

For more details on membership, training or publications see [www.fpa.org.uk](http://www.fpa.org.uk) or call 020 7608 5240.



Published by

**fpa**

50 Featherstone Street

London EC1Y 8QU

Tel: 020 7608 5240

Fax: 0845 123 2349

**[www.fpa.org.uk](http://www.fpa.org.uk)**

The Family Planning Association is a registered charity, number 250187,  
and a limited liability company registered in England, number 887632.

© **fpa** 2009

Crown copyright material is reproduced under the terms of the Click-Use Licence.