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Glossary of terms

Healthy Respect One
Phase One of the National Health Demonstration Project called Healthy Respect 2001–2004.

Healthy Respect Two
Phase Two of the National Health Demonstration Project called Healthy Respect Two 2005–2008 (the subject of this report).

Internal Evaluation Team
A team of evaluators which were part of the Healthy Respect team and led by Ben Rowlands.

Intervention and comparison areas
Intervention area: Healthy Respect area chosen for the secondary school pupil surveys.
Comparison area: chosen as a comparator for the intervention area.

More affluent and less affluent young people
More affluent young people: those living in owner-occupied housing.
Less affluent young people: those living in social housing (rented accommodation, care/foster homes and emergency accommodation).

Providers
Those providing either sex and relationships education, other sexual health advice, or sexual health services to young people.

Partners
Those providers most engaged with Healthy Respect.

Sexual health services
Those services that provide sexual health advice and information alongside health technologies such as condoms.

Scottish Index of Multiple Deprivation
Developed in 2006 to measure level of deprivation on a scale of 1–5 (1 = least deprived and 5 = most deprived).
Executive summary

What is Healthy Respect?

The Healthy Respect National Health Demonstration Project represented the Scottish Government’s response to the poor sexual health of young people. It consisted of two phases and was implemented across Lothian including Edinburgh City. Healthy Respect One began in 2001 and ended in 2004, and Healthy Respect Two began in 2005 and ended in March 2008. This report contains the findings from the evaluation of Healthy Respect Two.

Healthy Respect Two aimed to integrate education, sexual health services and information for young people aged 10 to 18 years (although sexual health services were aimed at 13 to 18 year olds) across Lothian and was supported by an overarching communications strategy that included branding and media campaigns. The main components of Healthy Respect Two were:

a) Leadership and working with partners

The Healthy Respect team was hosted and based in NHS Lothian. The team identified and worked collaboratively with a range of professionals who were considered to be well placed to deliver education, information or services (or a combination of these) to young people and parents across Lothian. The professionals included teachers, school nurses, youth workers, social workers, community learning and development workers, and organisations within the voluntary sector.

b) Media campaigns, information and branding

Three high profile media campaigns were developed. The ‘Respect Difference’ campaign was implemented between August 2005 and February 2006 and aimed to broaden young people’s awareness and respect for themselves and others. The ‘Parents Campaign’ was implemented in 2006 and aimed to raise awareness of the health promoting benefits of quality family time and encouraged families to spend more time together. The ‘Access to Services’ campaign was implemented in 2007 and aimed to raise awareness among young people of the places that provided confidential information, sexual health services, and advice on relationships and other health matters.
c) Information for young people
A range of information products was produced specifically for young people, such as leaflets on chlamydia, promotional materials for sexual health drop-in services, confidentiality booklets, and Safe ‘n’ Sorted, a mini handbook on sexual health and relationships and a guide to services. Healthy Respect also provided a young person-friendly website with links to sexual health organisations.

d) Healthy Respect brand
Healthy Respect adopted, and continues to use, a non-profit partnership brand, the aim of which was to help build relationships with young people and provider organisations.

e) Education
Healthy Respect provided multidisciplinary training in two educational packages which were used in schools: Zero Tolerance Respect (primary schools) and SHARE (non-denominational secondary schools), and supported the development of Called to Love (Catholic secondary schools).

Zero Tolerance Respect
The Zero Tolerance Respect (ZTR) programme developed by the Zero Tolerance Charitable Trust provided a primary school foundation for the SHARE and Called to Love programmes. It aimed to equip primary school children (primary 7) with skills and knowledge which would help them to develop attitudes and relationships based on equality and respect. ZTR was introduced into 35 primary schools in Midlothian and was delivered by teachers and teaching assistants.

SHARE
Healthy Respect supported 16 non-denominational secondary schools across Lothian to deliver the SHARE programme to young people. SHARE is a research-based package aimed at students in years S2 to S4 (ages 14 to 16). It aimed to help young people build their practical sexual health knowledge, explore and reflect on attitudes, and develop practical life skills for sexual relationships.

Called to Love
Called to Love was a partnership initiative between the Scottish Catholic Education Service (SCES) and Healthy Respect, and was funded by the Scottish Executive (now Scottish Government) through the departments of Health and Education. It resulted in a package of materials being produced to support the teaching of relationships and moral education in Catholic secondary schools.
f) Parents
Specially designed leaflets were distributed to households to support the ‘Parents Campaign’. Parent information sessions were held in schools including a school for young people with learning disabilities. These sessions informed parents of the Healthy Respect activities and, where appropriate, the Home Activity Resource (HAR). The Home Activity Resource was developed by Healthy Respect and aimed to help parents engage with their children. One was designed for secondary schools and one for primary schools.

g) Drop-ins and other sexual health services
Healthy Respect established 24 sexual health drop-in services across Lothian which were situated in local settings (e.g. schools, health centres, or voluntary services) or in mainstream NHS services (e.g. well woman and family planning centres). They were designed to be young, people-friendly, and provided information and advice on all health issues alongside sexual health services. Additionally, drop-ins offered pregnancy and chlamydia testing as well as providing access to free condoms. They also offered access by referral to more mainstream sexual health services such as genito-urinary medicine (GUM) services and family planning.

h) Organisations in contact with vulnerable young people
The Healthy Respect team targeted young people who were at particular risk of poor sexual health by working with organisations who were known to be in contact with these groups of young people. The aim was to provide support and training to professionals to help them develop sex and relationships education which could be offered to young people.
Key findings from the evaluation

Did Healthy Respect engage effectively with providers?

Our findings suggest that partnership working was an important mechanism through which Healthy Respect linked with a large range of organisations. Healthy Respect’s leadership role was well recognised by local providers who viewed them as champions and helped to raise the profile of sexual health at all levels across organisations. This indicates that Healthy Respect’s influence was felt at a strategic and front line level within organisations. It should be acknowledged, however, that a close partnership was formed with approximately half of existing providers. Importantly, those with a good relationship with Healthy Respect benefited more from it, primarily in helping them improve their knowledge and ability to work with young people. Some organisations benefited less than others from Healthy Respect, typically those in the local authority sector, and specifically those working with vulnerable young people.

Those most engaged with Healthy Respect were from the NHS (including school nurses) and voluntary organisations which offered advice and contraceptives to young people. This may be relatively unsurprising given that the Healthy Respect team was based in the NHS and, as such, was able to form more natural alliances with other NHS services. However, it is extremely important to note that sexual health services occupied a dominant position in local networks of providers. Many providers linked with these services including secondary schools which offered SHARE. Thus, the Healthy Respect team established links with organisations that occupied a central position in local networks of providers which strategically represents the best entry point into a network, and one which was more likely to effect change.

There was a strong thread running through our findings that some elements of Healthy Respect One such as SHARE and the drop-in services were developed more fully during Healthy Respect Two, while some of the new components of Healthy Respect Two were less developed. Difficulties were experienced in new areas of work such as that with vulnerable young people, however, the input to one new area (Zero Tolerance Respect) was well implemented and well received by teachers and pupils.
Did Healthy Respect engage effectively with parents?

The Home Activity Resource was not well adopted by parents, particularly secondary school parents (5% vs. 37% primary schools). Thus it could be argued that the potential impact of Healthy Respect on family relations was low. The poor uptake among parents was due, in part, to the poor uptake among teachers, particularly secondary school teachers (20% vs. 53% primary schools). Lack of time was the main reason provided by secondary school teachers for not using the pack. In contrast to primary school pupils, secondary school pupils also expressed mixed views about whether the idea of doing homework with parents was a ‘good thing’ and this may have impacted on teachers’ decisions to use the resource.

There is also the issue of which family members to involve in discussions about sexual health and when. The response to our parent survey was low and probably completed by those most comfortable in discussing sex and relationships with their children. Most parents reported high levels of comfort when thinking about discussing sex and relationships with their children, although sensitive topics were less frequently discussed. This was particularly true for boys for certain topic areas (e.g. menstruation, puberty and pregnancy). Most parents indicated that it was either the mother, or mother and father jointly, who dealt with questions around sex and relationships education. Fathers were not seen as the main source of information by parents questioned.

Did Healthy Respect engage with young people?

The percentage of the population reached by Healthy Respect varied according to which aspects of reach are considered. Awareness of the Healthy Respect logo and literature was around 40%, with girls being more aware than boys. It should be noted that the tracking surveys commissioned by the Healthy Respect team suggest that the recognition of the logo was higher, at 66% of young people, however, these surveys were not conducted on randomly selected samples. Our secondary school surveys suggest awareness of anything other than the logo or literature was lower, around 25%, and this fell over time to around 17%, particularly among girls from lower social class. Other parts of Healthy Respect, such as SHARE, were not branded as Healthy Respect, and thus pupils may not have associated it with Healthy Respect yet we estimated that 90% of those in S2 to S4 across the 16 schools which offered SHARE were exposed to it. Furthermore, all primary 7 school children in Midlothian were exposed to Zero Tolerance Respect, but again none would have identified this as a Healthy Respect package because it was not branded as such.
At the end of the secondary school survey (2008/9) a total of 57% of girls and 65% of boys reported using sexual health services, including the Healthy Respect drop-ins. In both 2007 and 2008/9 service use was significantly higher among pupils who were less affluent. Significant improvements in service use were seen for all groups in the intervention area from 2007 to 2008/9, although the greatest improvements in service use were seen for boys (more affluent 42% vs. 62%; less affluent 54% vs. 71%). This is extremely encouraging and suggests Healthy Respect’s focus on targeting those from more deprived areas has worked, at least among those attending school. However, the difficulties encountered by providers in working with particularly vulnerable young people suggest that it is likely that some of these young people were missed by Healthy Respect. These included young people with poor literacy and communication skills or who had a background of abusive relationships. They may not attend mainstream school and were unlikely to appear in the school pupil surveys.

Did Healthy Respect have an impact on the sexual health and relationships of young people?

Primary school children
The Zero Tolerance Respect package was well implemented and well received by pupils and teachers, however, its impact in the short-term was limited. There was a slight improvement in boys’ attitudes regarding respectful relationships. Girls, on the other hand, reported high levels of respectful behaviour at baseline with little potential for improvement and thus no change at follow-up. There was very little evidence of discriminatory attitudes by race or gender among these pupils either before or after the package was delivered. However, over 55% of boys and over 25% of girls listed at least one age-inappropriate film (as classified by the British Board of Film Certificates (BBFC)) among their favourite three, and less respectful attitudes were strongly associated with the viewing of these films.

Secondary school children
The findings from our evaluation suggest that Healthy Respect benefited boys most while girls gained very little or experienced health losses. There was also evidence that sexual health inequalities remained across social class.
Boys
Healthy Respect had a significant and beneficial effect upon boys’ sexual health knowledge. However, sexual health knowledge was greater among more affluent boys than more deprived boys at the time of the first survey and, although there was evidence that improvements were made among less affluent boys, the gap in knowledge between both groups remained. Healthy Respect had significant and beneficial effects upon boys’ use of condoms at ‘most’ instances of penetrative sex. More affluent boys were nearly twice as likely than less affluent boys to have used a condom at most instances of sex. There was a significant increase in the use of services by boys in the intervention area and this was mirrored by a significant increase in service use by boys within the comparison area.

Girls
Service use significantly improved for all girls within the intervention area during the course of Healthy Respect and this was mirrored by an increase in service use by girls in the comparison area. Improvements in practical sexual health knowledge were mainly seen among more affluent girls. Although girls in the intervention area were as likely as girls in the comparison area to view condoms as protective, there was a significant shift at the end of the study among girls in the intervention area to view condoms as less protective. No change was seen in the intentions of girls (both more affluent and less affluent) to use condoms in protecting against pregnancy and sexually transmitted infections (STIs). There was no significant change in the use of contraception by girls over time. Finally, girls in the intervention area were significantly more likely to feel pressured into, and subsequently regret, their sexual debut. The last two findings were limited to more affluent girls. However, it is worth noting that the increased focus of SHARE on the quality of relationships may have sensitised them to the issues of pressure and subsequent regret.

Sexual health by social class
Compared with young people from less affluent areas, those from more affluent areas were more knowledgeable about sexual health, were less likely to have penetrative sex, used condoms more, and used services less.

Teenage pregnancy and chlamydia
Teenage pregnancy in Scotland among 13 to 15 year olds declined between 1994 and 2007. The rate of decline in Lothian of 1.15% per year was similar to that of Scotland (1.02% per year). If the trend continues, the NHS Lothian target of a reduction in the pregnancy rate from 9/1,000 (1994–1998) to an underlying rate of 8/1,000 in 2010 will be met. The target was based on that set in the national sexual health strategy Respect and Responsibility1, however, the deprivation gradient in pregnancies persists. The average rate
over the whole period for the 13 to 15 year old age group in Lothian varied from under 3/1,000 for the least deprived areas to over 16/1,000 for the most deprived.

Our findings do not provide any evidence that rates of testing or rates of positivity for chlamydia infection in young people in Lothian differ from those in the rest of Scotland. It is difficult to determine what effect Healthy Respect had on teenage pregnancy or chlamydia infection rates in Lothian. The trends in the rates for Lothian broadly reflect those observed elsewhere in Scotland. While these trends may be affected by the level of sexual health provision, it is also possible they are affected by changes in society, including cultural norms.

What parts of Healthy Respect will be sustained?

Our research suggests the integration of Healthy Respect into the activities of existing organisations after the demonstration period was achieved with little impact. However, it should be remembered that our research finished just as mainstreaming began (April 2008) and it was difficult to assess how organisations and staff within organisations would be affected in the longer-term. There were, however, some early signs of problems occurring among NHS staff who reported service closure or restricted service provision as a result of mainstreaming. This is of particular concern because Healthy Respect had established good relations with sexual health services in the NHS.

Healthy Respect is now integrated into NHS Lothian and continues to work in partnership with other agencies. It continues to develop its brand and information to young people via publications, local media campaigns and its website. It also operates the sexual health drop-in services, and continues to develop its work with vulnerable young people. SHARE training is now the responsibility of the Health Promotion Service, NHS Lothian, and the Home Activity Resource is still offered to schools engaged in SHARE and ZTR training.

There are parts of Healthy Respect which were not mainstreamed by NHS Lothian, namely Called to Love and the large media campaigns. As originally intended, the Scottish Catholic Education Service is responsible for implementing Called to Love in Catholic secondary schools across Scotland, and the Education departments in each local authority are responsible for implementing SHARE, Zero Tolerance Respect and the Home Activity Resource packs. The Scottish Government is responsible for future media campaigns.
The question of mainstreaming is not one which rests solely with the Healthy Respect team or NHS Lothian. The Scottish Government also has a major role in reaching a strategic decision about the future of sexual health provision in Scotland. Thus, while our evaluation comments on mainstreaming are aimed at a very local level and focus on the decisions made by the Healthy Respect team and their partner organisations, they do not account for the views of government and other national organisations in shaping the future of Healthy Respect and sexual health provision across Scotland.

**Has Healthy Respect informed the strategic development of sexual health provision in other areas of Scotland?**

Our research with strategists suggested that learning from Healthy Respect had taken place across Scotland. Perhaps most influential was Healthy Respect’s ability to form strategic partnerships with organisations which provided education, information, or sexual health services to young people. Healthy Respect was probably best known for linking education and sexual health services, which is perhaps unsurprising given the long history of this particular model which was introduced in Phase One in 2001.

The national sexual health strategy *Respect and Responsibility* was also influential in shaping local sexual policy and thus sexual health provision across Scotland. It is worth noting that much of the action plan outlined in *Respect and Responsibility* bears similarities to Healthy Respect Two. The development of the national strategy and the dissemination of Healthy Respect took place at the same time under the leadership of the same NHS Health Scotland programme manager for sexual health, and this led to the cross-fertilisation of these two initiatives. Thus, it is possible that Healthy Respect had a direct effect on sexual health provision in Scotland.

One commonly cited reason for not learning from Healthy Respect was the lack of research findings from the current evaluation. This is understandable and gives great optimism to those who think interventions should be informed by research. This report constitutes the formal release of the findings from the evaluation of Healthy Respect Two. NHS Health Scotland has the responsibility of disseminating the learning from these findings. Indeed, NHS Health Scotland continually disseminated the learning from Healthy Respect throughout Scotland during the demonstration phase through the WISH network. Given the importance of our findings, we hope that this dissemination will maximise the impact on the strategic development of sexual health provision across Scotland and strategic developments internationally.
Implications

Sex and relationships education and sexual health services

It is valuable to start by noting that, at the time of the secondary school survey, most young people (mean age 15 years, 6 months) had not yet had sexual intercourse. Approximately one-third of young people in the intervention area and comparison areas reported that they were sexually active. Most (approximately 70%) used condoms at first intercourse. This might suggest that the sexual health promotion these young people receive is, by and large, working. Thus the minority of young people with poor sexual outcomes are a residual group whose behaviour has been insufficiently affected by sexual health promotion. To change their behaviour is therefore a particularly challenging task.

It is extremely difficult to disentangle the exact impact of sex and relationships education and sexual health services on the sexual health outcomes in the Healthy Respect area. Both were delivered at the same time and it is possible that they acted synergistically to influence change, for instance SHARE might have had an important role in informing young people about their local sexual health services. Our data suggests that the impact of sex and relationships education was mainly confined to improvements in knowledge; there were no changes in the attitudes and intentions which, we anticipated, would lead to changes in behaviour. It is likely that the increase in condom use at most instances of sex among boys was due to sexual health services because these services provide the means to change behaviour. We therefore think Healthy Respect had a beneficial effect on the existing configuration of service provision in Lothian and there is a case to be made for its continuation, primarily because of the observed improvements among boys.

On the other hand, given the lack of impact of Healthy Respect on girls, we suggest that more targeted interventions are required for girls. There is the need to work more intensely with young people in helping them address some of the underlying issues which shape sexual health and this can be delivered through interventions in schools, sexual health services, further education colleges, and other local authority organisations. This might include helping them to develop more respectful attitudes, social skills, self-confidence and worth but, importantly, linking these to gaining educational qualifications and improving the opportunities to enhance their social and economic position. There is also the issue of working with the most vulnerable young people such as those in specialist education facilities and those cared for by the local authority. Mainstream interventions such as SHARE are not easily translated for use in these settings, and new approaches are required which better suit these populations. However, it is unlikely that these interventions alone will be powerful enough to address the deep
social and economic imbalances in society which give rise to sexual health and other health inequalities, and this limitation should be recognised by professionals working in the health, education and social sectors.

**Working with parents**

The poor uptake of the Home Activity Resource by teachers and parents was an issue. We know from our interviews with strategists across Scotland and from work carried out in other countries, that a number of methods are being tested which aim to improve parental engagement particularly among families from poorer areas. However, the evidence suggests that generic aspects of parenting (connectedness and regulation) are more important than communication about sexual matters, and that intervention in a child’s early years is more effective than in their teens. Future initiatives should also place greater emphasis on encouraging fathers and sons to engage in discussions around sexual health and relationships.

**New directions**

The findings from this evaluation suggest the need to reconsider more fundamentally how we tackle poor sexual outcomes among teenagers. Consistently, the evaluations of large scale sexual health interventions for young people have shown, at best, limited beneficial effects. While this evaluation does provide evidence of the benefits of high quality school sex education and the widespread implementation of sexual health services, it also shows that different approaches are required to achieve more substantial impacts on sexual health outcomes. Our evidence, and that from the wider literature, point to three radically different and potentially promising approaches. First, there is evidence that poor outcomes in teen years, including sexual risk-taking, are best tackled in the early years of a child’s life when their relationship with their parents is most malleable. Second, the clear social patterning of poor sexual health outcomes suggests that these are, in large part, the effect of underlying social and economic factors including poverty. These factors can only be tackled through government-led reforms which might include fiscal and welfare policies. Third, there is evidence from our research and others of the potential negative effects of exposure to images in the mass media and computer games. This would suggest the need for interventions to modify media content and exposure to negative sexual images. This might be achieved through a combination of editorial policy, censorship, and informing parents about the need to restrict their children’s viewing. A combination of these three approaches is likely to have a greater effect on sexual outcomes than the further improvement of sex education or sexual health services.
1 Introduction

1.1 Background

The Healthy Respect National Health Demonstration Project represented the Scottish Government’s response to the poor sexual health of young people. It consisted of two phases and was implemented across Lothian including Edinburgh City (Figure 1). Healthy Respect One began in 2001 and ended in 2004, and Healthy Respect Two began in 2005 and ended in March 2008. There was a transition period after Healthy Respect One in which the plans for Healthy Respect Two were devised and the evaluation tender specification was developed. Incidentally, the term Healthy Respect as used in the current report refers to Healthy Respect Two unless otherwise stated.

Figure 1: Geographical areas targeted by Healthy Respect

Healthy Respect One

The main aims of Healthy Respect One were to help young people in Lothian develop a positive attitude to their own sexuality and that of others, and a healthy respect for their partners, with the aim of reducing unintended teenage pregnancies and STIs. The programme aimed to integrate education, services and information for young people aged 13 to 25 years across Lothian and was supported by an overarching communications strategy that included branding and media campaigns. Healthy Respect One was evaluated by a research team from the University of Aberdeen.
Healthy Respect Two

Healthy Respect Two adopted the same broad aims as Healthy Respect One and was targeted at 10 to 18 year olds, although sexual health services were aimed at 13 to 18 year olds. However, following the findings from the independent evaluation (University of Aberdeen) and a review of the underpinning evidence, there was an explicit focus on a) tackling health inequalities and b) specifically targeting professionals working with young people who:

- were excluded, or at risk of exclusion from school, and in receipt of additional support
- were looked after and accommodated by local authorities
- had learning disabilities.

Healthy Respect Two also concentrated more effort in two geographical areas, Midlothian and north-west Edinburgh, to demonstrate implementation across a whole local authority and in an area of high deprivation respectively. However, the Healthy Respect team continued to work with providers in areas targeted during Healthy Respect One, namely, West Lothian, East Lothian and Edinburgh City. There were also new elements to the programme, namely, work with primary schools and Catholic secondary schools. Greater priority was given to working with parents in the second phase.

A key strategic objective was to create an environment that would lead to long-term improvements in the sexual health and wellbeing of young people. As with Healthy Respect One, this meant working with existing organisations which provided sex and relationships education, advice, or sexual health services to young people.

This report contains:

- a detailed description of the main components of Healthy Respect Two
- the key findings of the extensive evaluation conducted by a team comprising of Edinburgh Napier University, the MRC Social and Public Health Sciences Unit, and the Scottish Centre for Social Research.
1.2 Our approach to the evaluation

The external evaluation was commissioned by NHS Health Scotland at the end of 2005. The strategic direction for Healthy Respect had already been set by the Scottish Government, however, the proposal was refined to ensure that the final evaluation met the requirements of the commissioners and took account of how Healthy Respect was implemented. It also considered the needs of the Healthy Respect Two team; how timely and relevant data would be obtained; how this data would inform programme development and assist managers in making mainstreaming decisions; and how the evaluation would inform national and other local policymakers interested in learning which was applicable to the rest of Scotland. It was also important to ensure that the outcomes being evaluated were realistic in terms of what Healthy Respect was delivering and the timescales.

An Evaluation Advisory Group (EAG) was established comprising research experts, policymakers, senior representatives of the commissioning body, members of the Healthy Respect team, and the External Evaluation team. The final evaluation protocol was discussed with the EAG before formal acceptance. Any subsequent changes to the protocol were discussed and agreed by the EAG before being implemented. The external evaluation began in January 2006 and concluded in December 2009.

Healthy Respect was a complex intervention comprising a number of components (see next section). The evaluation consisted of a number of separate studies (Figure 2). The evaluation required three teams which led on assessing the delivery of Healthy Respect; the experiences of those receiving it; and the impact on young people themselves.
Figure 2: Healthy Respect evaluation components

**Delivery**
- Organisations working with Healthy Respect
- Routine attendance data collected by providers (2006–2008)
- Survey Wave 1 (2007)
- Qualitative interviews (2007)
- Survey Wave 2 (2008)
- Interviews with the Healthy Respect team (2008)
- Interviews with strategists across Scotland (2008)

**Recipients’ experience**
- Young people and parents
  - Parents survey Wave 1 (2007)
  - Parents survey Wave 2 (2008)
  - Interviews with parents (2008)
  - Interviews with young people (2008)

**Impact on young people**
- Secondary school survey
  - Comparison
  - First (2007)
  - Second (2008/9)
- Intervention
  - First (2007)
  - Second (2008/9)

**Zero Tolerance Respect trial primary schools**
- Comparison
  - Before (2007)
  - After (2008)
- Intervention
  - Before (2007)
  - After (2008)

- Pregnancies
- Terminations
- Chlamydia infections
The overall evaluation was informed by a logic model (Appendix 1) which illustrated the inputs and outputs which were identified by the Healthy Respect team as necessary to deliver the desired changes in outcomes. It was extremely useful in helping to identify areas upon which the evaluation should focus. The model highlighted the importance of building partnerships at strategic and organisational levels which, in turn, should have ensured the engagement of organisations that delivered sexual health advice, education or services to young people. Healthy Respect aimed to improve capacity and capability in these organisations. The final outcome was to improve the sexual health of young people.
1.3 How the findings are presented

The key findings from the evaluation are not presented as a series of separate studies (Figure 2). The technical reports from the individual components of the Healthy Respect Phase Two evaluation are available to download from the publications section of NHS Health Scotland (www.healthscotland.com) (Appendix 2). Instead, the final report is structured around the RE-AIM Framework (Reach, Efficacy, Adoption, Implementation and Maintenance) which takes account of the context in which complex public health interventions operate4.

The original RE-AIM framework was based on a quantitative approach to evaluation and assumes a straightforward model of intervention whereby service providers deliver a programme directly to recipients, with the aim of improving certain outcomes. This evaluation differs from this in two main aspects. First, the evaluation team used a mixed methods approach and, second, Healthy Respect was based on a partnership model whereby the Healthy Respect team worked through service providers to target young people which meant an added layer of complexity. Nevertheless, RE-AIM provided a useful structure for the present report.

The RE-AIM framework consists of five key elements which should be considered when evaluating an intervention. The findings are divided into six sections which together fit these elements. Each section has a summary of the key findings and is followed by a more detailed presentation of the findings.

The first section focuses on how the Healthy Respect team implemented Healthy Respect Two, particularly how partnerships were established. Second is adoption, which focuses on the uptake of the programme among those with whom Healthy Respect sought to establish collaborative partnerships, i.e. other organisations and parents. Parents are included in this section because they were viewed by the Healthy Respect team as a means by which to engage young people. The section also comments on the impact of Healthy Respect on these organisations and parents. The third section focuses on how the key interventions were implemented, namely the Healthy Respect drop-in services, SHARE and Zero Tolerance Respect, and the Home Activity Resource packs.

Fourth is reach, which relates to the number (and proportion) of young people who received or were affected by Healthy Respect. Fifth is effectiveness, which considers the impact of the intervention on the target population, that is, young people. Sixth is maintenance which considers the possible long-term impact of the intervention. This focuses on the impact on local providers but it also considers whether strategists across Scotland would adopt Healthy Respect.
2 The main components of Healthy Respect

2.1 Components

It is extremely important to note that Healthy Respect was not directly responsible for the implementation and delivery of all sex and relationships education and sexual health services in Lothian. Many existed before Healthy Respect began and were funded and managed separately. Thus, Healthy Respect sought to work with existing providers. Nevertheless, it sought to directly influence a number of targeted interventions, particularly drop-in services, sexual and relationships education in schools, and created information components including a website, leaflets, posters and media campaigns. Figure 3 outlines the main components of Healthy Respect. The Healthy Respect team consisted of one project manager and one lead for each of the following areas: education, information, communication and evaluation. Eight full-time and part-time staff provided further assistance including two administrators. The team was hosted and based in NHS Lothian headquarters.

Figure 3: Healthy Respect components
2.1.1 Leadership and working with partners
The Healthy Respect team identified a range of professionals considered well placed to deliver education, information or services (or a combination of these) to young people and parents in Lothian. These included teachers, school nurses, youth workers, social workers, community learning and development workers, and staff within the voluntary sector. The team then examined the role of these professionals and how they could be supported to deliver work on sexual health and relationships. To support local delivery, Healthy Respect provided a number of programme coordination functions including leadership, networking and support, Lothian-wide integrated communications work, training, monitoring and evaluation, and knowledge transfer through the national sexual health and wellbeing network which is now known as the WISH network (hosted by NHS Health Scotland).

2.1.2 Media campaigns, information and branding
Three specific high profile media campaigns were developed:
1. The ‘Respect Difference’ campaign was delivered in three waves between August 2005 and February 2006 and aimed to broaden young people’s awareness and respect of themselves and for others. The campaign was targeted at 16 to 18 year old males and females in lower socio-economic groups across Lothian.
2. The ‘Parents Campaign’ was delivered in 2006 to raise awareness of the health promoting benefits of quality family time and encouraged families to spend more time together.
3. The ‘Access to Services’ campaign (2007) was delivered to raise awareness among young people of the places that provide confidential information and services on sexual health, relationships and other health matters.

2.1.3 Information for young people
Safe ‘n’ Sorted, a mini handbook on sexual health and relationships and a guide to services, was delivered to all S3 pupils via schools. The handbook was revised in April 2008 and was accompanied by a flier and quiz to promote its use as part of sex and relationships education in either schools or youth community settings. Distribution continued beyond the demonstration period. Healthy Respect also provided a young person-friendly website with links to sexual health services and other organisations. A range of information and products were produced for young people, such as leaflets on chlamydia, promotional materials for drop-in services, confidentiality booklets, and rights and responsibilities cards. Specially designed leaflets were also distributed to households to support the ‘Parents Campaign’.

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2.1.4 Healthy Respect brand

Healthy Respect adopted, and continues to use, a non-profit partnership brand, the aim of which was to help build relationships with young people and provider organisations over time. A logo was used as part of branding and appeared on all Healthy Respect materials. Healthy Respect also sought to develop their brand which was based on four core values namely: respect, responsibility, inclusiveness, and partnership.

2.1.5 Education

Healthy Respect provided multidisciplinary training in two educational packages which were used in schools.

Zero Tolerance Respect (ZTR)

The Zero Tolerance Respect programme developed by the Zero Tolerance Charitable Trust (www.zerotolerance.org.uk/index.php) provided a primary school foundation for the SHARE and Called to Love programmes. It aimed to equip primary school children (primary 7) with the skills and knowledge to develop attitudes and relationships based on equality and respect. The Healthy Respect team provided support for teachers. This included training sessions, guidance on how to approach the package, and classroom support materials. ZTR was introduced into 35 primary schools in Midlothian and was delivered by teachers and teaching assistants. The introduction was staggered to allow for a randomised control trial of ZTR which was conducted by the evaluation team.

SHARE

Healthy Respect supported 16 non-denominational secondary schools across Lothian to deliver the SHARE programme to young people. SHARE is a research-based package aimed at students in years S2 to S4 (ages 14 to 16) (www.sphsu.mrc.ac.uk/studies/share/). It aimed to help young people build their practical sexual health knowledge, explore and reflect on attitudes, and develop practical life skills for sexual relationships. Schools could opt to deliver 22 sessions across either two or three years. SHARE was delivered throughout the demonstration period.
Called to Love

Called to Love was a partnership initiative between the Scottish Catholic Education Service (SCES) and Healthy Respect and was funded by the Scottish Executive (now Scottish Government) through the departments of Health and Education (www.calledtolove.org/what.html). It resulted in a package of materials to support the teaching of relationships and moral education in Catholic secondary schools. Called to Love sets relationships and moral education very firmly within a context of love, respect, responsibility and moral reasoning, placing great importance on the sacramental aspect of marriage in a manner that is fully supportive of church teaching. The guidelines produced by the Catholic Education Commission on relationships and moral education lay at the heart of these materials. Healthy Respect’s role was to comment on the educational materials as they were developed and it had no further input following the launch of Called to Love at the end of 2007. Roll-out and training was the responsibility of SCES.

2.1.6 Parents

A number of methods were developed to engage parents through educational settings. Specially designed leaflets were distributed to households informing parents of the media campaign and titled Parenting: A little guide to making a big difference. Parent information sessions were held in schools with the aim of consulting parents about possible service developments and/or educational programmes in their child’s school. One session was delivered to parents from a school for young people with learning disabilities.

Healthy Respect also designed two Home Activity Resources. One was distributed to secondary schools delivering SHARE throughout Lothian and one was distributed to primary schools delivering ZTR in Midlothian. It was based on a series of exercises that encouraged parent-child discussion around relationship issues (primary schools) and sex and relationship issues (secondary schools). Teachers were asked to explain the resource to pupils and encourage them to take it home. It was specifically designed to engage parents directly in a way which was not apparent in the other aspects of the Healthy Respect programme.

2.1.7 Drop-ins and other sexual health services

Drop-in services provided young people with what are known as low-threshold services, e.g. services that are within accessible distance and based primarily on self-referral and no appointment. These were situated in local settings (e.g. schools, health centres and voluntary services) or in mainstream NHS services (e.g. well woman and family planning centres). They were designed to be young, people-friendly, informal, and operated by
staff, typically school nurses and youth workers, who were experienced in working with young people. As a minimum, drop-ins provided information and advice on all health issues such as mental health and general wellbeing alongside sexual health services. Additionally, drop-ins offered pregnancy and chlamydia testing, as well as providing access to free condoms. By March 2008, 24 drop-in services operated throughout Lothian (Appendix 3). They also referred young people to more comprehensive services such as family planning and genito-urinary medicine.

The Healthy Respect team developed a set of standards titled *All I Want – LIVE* standards which all Healthy Respect drop-ins were expected to achieve. These were launched in 2005 and updated in 2007. A further development was the publication of *Healthy Respect Drop-ins: A Guide to Accredited Status and How to Achieve it* (2007), offering the Healthy Respect model to other existing or proposed services. An assessment workbook was developed which allowed for staff to review their progress against the standards with the aim of maintaining the quality and consistency of individual drop-ins and across the network of drop-ins.

### 2.1.8 Organisations in contact with vulnerable young people

The Healthy Respect team targeted young people who were at particular risk of poor sexual health by working with organisations who were known to be in contact with them. The aim was to provide support and training to professionals to help them develop sex and relationships education which could be offered to young people. Unlike other aspects of Healthy Respect Two, there was no specific intervention advocated. Training events were held for community learning and development workers, and social workers, and a Targeted Sex and Relationships Support Network (TSRSN) was developed to provide an opportunity of networking and support to those engaged with vulnerable young people. ‘Checking it out’, the Healthy Respect event for young people with learning disabilities, was held in December 2006 and focused on sex and relationships education. It was delivered to young people with learning disabilities who were about to leave secondary school education.
2.2 Mainstreaming

As planned, the Healthy Respect Phase Two demonstration period ended in March 2008. Healthy Respect is now fully integrated into NHS Lothian. NHS Lothian took the decision to mainstream some of the core activities through continued employment of some members of the Healthy Respect team. These core activities were:

- Coordination of the Healthy Respect programme (including partnership working) and the continual development and application of the Healthy Respect brand.

- Coordination of a network of 24 drop-in services for young people across Lothian with the overarching aim of providing a service in each locality and having services operate to consistent standards.

- Provision of training and professional support to ensure the delivery of high quality, educational interventions for young people at greater risk of poor sexual health outcomes. This was achieved via the Targeted Sex and Relationships Support Network.

- Production of resources, including print products, drop-in materials, a website and branded materials to support and promote partnership working within Lothian.

- Contribution to the delivery of SHARE, ZTR and other primary school relationships education, youth work training, and professional development for educational staff as part of the Healthy Respect network. It should be noted, however, that SHARE training became the responsibility of the Health Promotion Service NHS Lothian. The Home Activity Resource is still offered to schools engaged in SHARE and ZTR training. The local authority in each area became responsible for the delivery of SHARE, ZTR and the Home Activity Resource.

- Monitoring and evaluation of all activities, e.g. service and education uptake, service user feedback, and teenage pregnancy/STI data, to ensure effective performance management and contribution to the evidence base. This was conducted in partnership with Public Health NHS Lothian and NHS Health Scotland to support the post-demonstration dissemination. A temporary two-year post was set up in NHS Health Scotland to help disseminate the learning from Healthy Respect throughout Scotland as a major part of the WISH network.
Three-way partner agreements between Healthy Respect Lothian, Health Promotion Service NHS Lothian and the local authorities were arranged to give official recognition to the partnership approach in delivering education, information and services to young people. It established each agency’s contribution to the partnership including the delivery of SHARE, ZTR, drop-in services, evaluation and *All I Want – LIVE* standards.

In effect, mainstreaming meant continued emphasis on the developing networks, multidisciplinary professional training, support, and resources. Activities continued to be delivered by Healthy Respect partner agencies but without additional funding. There was also less emphasis placed on certain elements of Healthy Respect Phase Two, namely, the work with Catholic secondary schools (Called to Love), work with parents, and the large media campaigns. It should be noted that Healthy Respect had always intended to withdraw from Called to Love once the package had been developed. Future media campaigns are the responsibility of the Scottish Government.
3 Findings

3.1 How Healthy Respect Two was implemented by the Healthy Respect team

Qualitative research was conducted with the Healthy Respect team to gain some insight into how Healthy Respect was implemented.

3.1.1 Key findings

Partnership working was seen by the Healthy Respect team as a crucial mechanism to help improve sexual health provision for young people. This, together with the brand, helped to develop the team's relationship with organisations including those beyond Lothian. It was acknowledged that partnership working took a long time to nurture and required commitment at all levels within an organisation. The team recognised there were a number of issues which may have prevented the uptake of Healthy Respect among potential partners, including the difficulties in working with sensitive topics such as sexual health, not having dedicated time to work in sexual health, and a lack of a local champion to drive work on behalf of an organisation. Work with Catholic schools, with vulnerable young people and with parents was viewed as particularly challenging. All three were new to Healthy Respect Two and the difficulties and benefits are described below.

3.1.2 Detailed findings: Partnership working

The extent to which effective partnerships were developed was regarded by the team as an important outcome. The project’s goals were based on a clear understanding that sexual health was the business of a wide range of agencies and not just the preserve of health services. It was a pre-requisite for capacity building within and across different sectors. The Healthy Respect team members felt that their work in this area added to better understanding of how effective partnerships were created and nurtured.

The development and role of the Healthy Respect brand was important in helping the team to clarify the aims and objectives, and also developing its links beyond the project. The brand represented a set of core values. It encapsulated Healthy Respect's identity and acted symbolically to aid recognition among young people and providers.
While NHS Lothian had agreed to remove their logo from all Healthy Respect materials, some voluntary sector agencies were understandably keen to maintain their personal brand or image and did not want to share or supplant it with that of Healthy Respect. There was a view among the Healthy Respect team that although partners were involved in developing the brand there were some difficulties around ownership and maintaining each organisation’s identity. Often the work in building partnerships was viewed as a long-term development which required commitment at all levels within an organisation, that is, strategic, managerial and front line.

### 3.1.3 Other challenges

There were a number of issues which may have prevented the uptake of Healthy Respect among potential partners. These included:

- taking on work which might be regarded as sensitive and thus under the media spotlight
- professionals not having dedicated time to undertake work in sexual health
- the lack of a local champion to drive sexual health on behalf of organisations such as those in the local authority
- cultural and educational values held within organisations which conflicted with those held by Healthy Respect.

At a more general level, there was also the issue of helping service providers to challenge the cultural values around sexual health that existed within society. This was particularly important for non-NHS organisations which did not offer sexual health services.

Cultural and educational values were seen as extremely important by the Healthy Respect team. These were highlighted in two key areas – their work with Catholic schools and with vulnerable young people. The work with vulnerable young people involved dealing with particularly sensitive issues such as underage sex and abuse which are not easily addressed, particularly by providers who may feel poorly equipped to deal with such matters. The work with the Scottish Catholic Education Service, which was responsible for implementing Called to Love in Catholic secondary schools, was seen as extremely productive and an important step forward, but there was a clash of values between the organisations and a difference of views regarding sexual health education. This often led to compromise and a feeling within the Healthy Respect team that the work did not go as far as initially hoped (see also 3.6.2 on mainstreaming).
The work with vulnerable young people was seen by the team as particularly challenging. They originally planned to design an intervention which could be delivered to vulnerable young people, however, the team soon recognised there were difficulties in working with existing services in this area. These included reorganisation in social work services and the low priority given to sexual health by such organisations because of conflicting priorities. As a result, the team did not develop a specific intervention, but they devised methods to engage with and support existing services. One such method was the Targeted Sex and Relationships Support Network which aimed to share practice and identify the needs of those who worked with vulnerable young people (see section 3.2 on adoption of Healthy Respect by providers).

3.2 Adoption: The extent to which Healthy Respect was adopted by local providers and parents

Healthy Respect provided a range of resources and support to organisations. As outlined in the previous section, partnership working was viewed by the Healthy Respect team as extremely important in achieving their goals. Existing organisations were seen as a means to reach and work with young people. The partnerships were based on voluntary, rather than legal contracts. Healthy Respect also worked with parents as mediators through which young people were reached.

The findings in this section were derived from two surveys and qualitative interviews conducted with providers from organisations which delivered education, advice or sexual health services in the Healthy Respect area. Two surveys and qualitative interviews were also conducted with parents from secondary and primary schools.

3.2.1 Key findings: Providers

Partnership working was an important mechanism through which the Healthy Respect team linked with a large range of organisations. The Healthy Respect team’s role as leaders was well recognised by local providers who viewed them as champions and thought they helped raise the profile of sexual health at all levels across organisations. About half of the local providers were engaged with Healthy Respect. Engagement varied, with the highest levels of engagement seen among the NHS, including school nurses. There was evidence of successful engagement with voluntary organisations providing sexual health services to young people. Those working in organisations which were engaged with Healthy Respect reported help in
improving their knowledge and ability to work with young people. There was also evidence that those receiving help from Healthy Respect had stronger links with organisations in local networks. Organisations with particularly strong links in these local networks were sexual health services including school nursing.

Organisations in the local authority sector, particularly those working with vulnerable young people, did not gain as much from Healthy Respect. This occurred more often among local authority workers such as social workers, community learning and development workers, and those in special education settings. They reported a number of issues which made sexual health work particularly difficult. These included working with young people who had poor communication skills or a background of abuse, low priority of sexual health and organisational level, and poor relations with Healthy Respect. These views were not only held by those working in organisations which targeted vulnerable young people, indeed they applied to those working in some of the newly developed parts of Healthy Respect such as the Home Activity Resource.

3.2.2 Parents
Evidence from our surveys with parents suggested a relatively high awareness of Healthy Respect but low adoption. Primary school parents were more likely than parents of secondary school pupils to be aware of Healthy Respect (71% vs. 42%) and to engage with the HAR (42% vs. 5%). The difference in uptake was also apparent among teachers in secondary (20%) and primary schools (53%). The majority of parents (70%) saw sex and relationships education as a joint home/school responsibility, but despite this view did not engage with the Home Activity Resource. Many parents reported feeling comfortable about discussing sex and relationships with their children. However, more sensitive issues such as menstruation, puberty, and pregnancy were rarely discussed with boys. Mothers were seen as the main source of information on sexual health in the home. It is important to note that only 30% of parents responded to the parent surveys and they are likely to over-represent those who were already more motivated and more comfortable discussing sexual health and relationships.
3.2.3 Detailed findings: Providers

Healthy Respect aimed to achieve coverage of two geographical areas, namely Midlothian, which represented a whole local authority area, and north-west Edinburgh, which represented an area of marked social and economic deprivation. From the beginning of Phase Two, Healthy Respect worked with organisations across other areas of Lothian. This was due to the historical links with these areas which were established during Phase One and the mutual willingness to continue to work together. Approximately 45% of providers who were sent a questionnaire were from the two target areas, and the remainder were from West or East Lothian (20%) or Edinburgh City excluding north-west Edinburgh (35%).

A total of 529 individuals were targeted in the first survey (2006) and 687 individuals at the time of the second survey in 2008. There was a response rate of 69% for the first survey and 41% for the second survey. At the first survey, 33% of the sample worked as secondary school teachers, 10% were primary school teachers, 13% worked in local authority organisations (e.g. social work or youth work), 9% worked in voluntary organisations, and 35% were in the NHS (e.g. nursing, medical or other non-clinical occupations). The second survey contained more local authority staff and fewer NHS staff members, and reflected a change in policy by Healthy Respect towards agencies which worked with vulnerable young people.

Not all organisations engaged with Healthy Respect. The first survey indicated that 46% of those responding were engaged, 21% had some engagement, 14% were not engaged, and 13% had not heard of Healthy Respect. Adoption was influenced by Healthy Respect’s leadership and coordination functions. The qualitative research with providers suggested that members of the Healthy Respect team were viewed as champions of sexual health who helped raise the profile of sexual health across all levels (strategic, managerial and front line) within local organisations. Healthy Respect was also viewed as successful in developing links with primary schools, secondary schools, and drop-in services, but less so with other organisations such as those targeting marginalised groups. Incidentally these views were also shared by strategists in other parts of Scotland (see section 3.6.3).

Some of the constraints to adoption which were reported by providers related to the characteristics of the young people with whom they worked. This occurred more often among social workers, community learning and development workers, and those in special education settings, and was not restricted to any one geographical area. The young people included those with poor literacy and communication skills or who had a background of abusive relationships. Other constraints were more organisational in nature and included tension caused by a strategic commitment that wasn’t upheld.
by front line staff, organisational restructuring, and a reduction in the priority of sexual health at an organisational level. Some constraints also originated from the partnership with Healthy Respect itself, such as the perception among some providers that their relationship was based on an imbalance of power, with Healthy Respect having the upper hand. Healthy Respect was also viewed by some providers as being driven too much by goals and objectives.

3.2.4 Partnership working

Partnership working was assessed in different ways. First, it was possible to distinguish those who had a good working knowledge of Healthy Respect (those engaged) from those who knew little or nothing about it by examining responses to key questions in the survey. Those most engaged with Healthy Respect by the time of the end of the demonstration period (second provider survey) were mainly from the NHS and education sectors. A total of 83% of those from schools were engaged, and 80% of those in the NHS compared with 68% of those in voluntary agencies, and 30% of those in local authorities (excluding education).

Second, we devised a measure to assess the quality of partnership working with Healthy Respect among those initially classified as engaged. In general, Healthy Respect had good working relationships with these organisations at the time of the first survey and this did not change significantly at the time of the second survey (mean partnership score at first survey = 1.7; second survey = 1.8; range 1–5. A lower score indicates better partnership working).

Third, a more sensitive partnership score was devised at the time of the second survey to further assess the strength of the relationship between Healthy Respect and those who were classified as engaged. Evidence from other studies suggested that the commitment and the strength of relationship between partners are associated with the amount of support they received. This new score indicated that Healthy Respect had a stronger relationship with the NHS compared with the educational sector (mean partnership score NHS = 242.9; mean partnership score education = 114.6; p = 0.05. Please note that in this example a higher score indicates a stronger relationship). The relationship with the voluntary sector was similar to that of the NHS. Together these two sectors operate a number of sexual health services such as school nursing, drop-ins, family planning and GUM, and c:card services (condom distribution free at the point of contact).
Providers across Lothian also reported that their strongest links were with sexual health services. Figure 4, from work conducted by our PhD student, illustrates the links between the organisations in Midlothian where contact was made in relation to the sexual health of young people. The red dots are those who completed the questionnaire and the blue squares are the organisations they reported linking with. Two organisations in particular occupy a central position in the network – school nursing and a voluntary organisation which operates a sexual health drop-in service (Vol4). Different combinations of sexual health services occupied central positions in existing networks in other areas of Lothian. These included family planning, GUM clinics, school nursing and voluntary sector sexual health services. Healthy Respect had links with all of these services which means they were in contact with important organisations within existing networks. Figure 4 also illustrates a link between secondary schools and sexual health services, in particular school nurses and the voluntary sector drop-in services.
Figure 4: Network of sexual health providers in Midlothian

Respondents

Contact organisations

Service type key
CAMHS = Child and Adolescent Mental Health Services
C-card service = Condom distribution service
CHS = Child Health Services
CLD = Community learning and development
FP = Family planning
GP = General practitioner
GUM = Genito-urinary medicine
HS = High school
LA = Local authority
PS = Primary school
SN = School nurses
SW Team = Social work team
TOP Service = Support service for young people who have difficulty at school
Vol = Voluntary organisation
3.2.5 Benefits and limitations of working with Healthy Respect

Results from our first survey of providers suggested there were very clear benefits but also limitations for some organisations engaged with Healthy Respect.

- Approximately four-fifths reported that Healthy Respect helped them understand young people's sexual health, increased their confidence in approaching young people, and helped them share ideas about sexual health with other professionals.

- Over four-fifths thought Healthy Respect helped them improve the provision of, and access to, education and sexual health services. This was also supported by our qualitative work with providers which suggest that Healthy Respect had a positive impact on primary schools and secondary schools, including providing training in Zero Tolerance Respect (in Catholic and non-denominational primary schools), SHARE (non-denominational secondary schools) and Called to Love (Catholic secondary schools). Our qualitative work with providers also suggested that Healthy Respect’s involvement in Called to Love was viewed quite positively by some teachers in Catholic schools. Teachers in Catholic primary schools did not raise any objections to the introduction of ZTR. Healthy Respect provided an opportunity to work collaboratively on topics that were also of interest to non-denominational schools. Providers commented favourably on the Healthy Respect team’s work in establishing the All I Want – Live standards for sexual health drop-in services.

- About a quarter reported help with their administrative and/or general workload, although approximately half of the sample thought Healthy Respect made either or both of these things worse.

- Although two-thirds thought Healthy Respect had helped them focus on addressing unintended teenage pregnancy, the majority said it had only helped a little. Approximately half thought Healthy Respect helped them focus on improving support for parents, but the majority said it ‘helped a little’.

Three factors were associated with greater benefit from Healthy Respect: geographical area, managerial support for Healthy Respect within an organisation, and the amount of resources received from Healthy Respect.

Area

Compared with those in Edinburgh City, those in Midlothian reported greater help from Healthy Respect in focusing on the sexual health outcomes of young people. Good partnership working with Healthy Respect was also associated with those in Midlothian.
Managerial support
A high level of managerial support for Healthy Respect was associated with a greater impact on professionals’ knowledge and skills, improved support for parents, and an increased focus on sexual health outcomes for young people. Managerial support also helped to establish good partnership working with Healthy Respect.

Resources
Those receiving the most resources from Healthy Respect were more likely to report a greater impact on their professional knowledge and skills, and ability to focus on the sexual health outcomes of young people including unintended teenage pregnancy. A high level of resource was related to good partnership working with Healthy Respect and a small increase in organisational capacity. Those in the NHS reported a greater impact of Healthy Respect funding compared with those in local authorities, the voluntary sector and education.

Results from our second survey indicated a slight reduction in the impact of Healthy Respect in all areas between Wave one and Wave two. However, with the exception of reduced funding, none of these differences were statistically significant. Furthermore, two-thirds of providers said their manager supported Healthy Respect and this remained so at the time of the second survey. Nevertheless, there were areas where Healthy Respect had a relatively weaker impact in the first survey and these remained so in the second survey, namely, focusing on unintended teenage pregnancy, administration, workload and organisational capacity in general, and supporting parents.

3.2.6 Potential impact of Healthy Respect on existing networks of providers
A key question is whether Healthy Respect had an impact on existing networks of services. The first survey indicated that 67% of those engaged with Healthy Respect received help to link with other organisations. At the second survey this stood at 40%. The reduction could have resulted from less organisations requiring this type of help second time around.

We inserted questions into the second survey which allowed us to assess the strength of links between sexual health organisations across each area in Lothian. Those who said they received help from Healthy Respect had stronger links with other organisations (mean partnership strength score = 3.38 vs. 2.49 mean partnership strength score of those not receiving help; p< 0.05 – a higher score indicates a stronger relationship). It is feasible that those who received help from Healthy Respect to link with other
organisations were better networkers and thus more able to capitalise on any benefit which might accrue. It is possible that they gained from doing so, however marginal that gain was, and thus it is feasible that Healthy Respect had a positive impact on existing networks by helping to develop new links or strengthen existing links between organisations.

3.2.7 Healthy Respect brand
The Healthy Respect brand was viewed positively by both those involved with Healthy Respect and those who were not. This was also reflected in our qualitative work with providers who thought the brand helped raise the profile of sexual health and had a very human face behind it. In other words, members of the Healthy Respect team were available and visible. On the other hand, the Healthy Respect brand was also seen as supporting liberal values which might differ from those of other organisations and other sections of society. The difference in organisational values is raised again in the later section on mainstreaming.

3.2.8 Detailed findings: Parents
Healthy Respect attempted to work with parents as mediators through which young people could be reached. Evidence from our surveys with parents which were conducted in 2007 and 2008 suggested relatively high awareness of Healthy Respect but low adoption. However, it is important to note that only 30% of parents responded to these surveys and they are likely to over-represent those who were already more motivated and more comfortable discussing sexual health and relationships. The first survey showed that 71% of responding parents from primary schools were aware of Healthy Respect, however, only 37% had used the Home Activity Resource. A total of 42% of respondents from non-denominational secondary schools were aware of Healthy Respect, but only 5% used the HAR. This picture did not vary significantly at the second survey. Qualitative research suggested parents were largely unaware of, or at best were vague about, any sex and relationship work that their children may have brought home. Results from the parent surveys also suggest limited engagement with the Healthy Respect website, with only 3% of parents stating that they had used this resource.

It is difficult to tell exactly why parents of primary school children were more likely to have adopted the use of the HAR, but there are three possible explanations. First, the greater uptake could have resulted from our randomised control trial during which contact between the school and parents increased. We were obliged to notify parents of the trial via the school, and most schools held a meeting to discuss the materials with parents. Thus parents may have become more aware of Zero Tolerance Respect and the HAR.
Second, it is possible that uptake among parents may be due to the use of the resource by school teachers. A total of 53% of primary school teachers and 20% of secondary school teachers said they used the Home Activity Resource. Findings from qualitative research conducted as part of the randomised control trial of ZTR suggested that most primary school teachers were supportive of it. Parents were also informed of ZTR at parents’ nights. Encouraging secondary schools to implement the resource was difficult and meant synchronising it within the school timetable. Teachers were often concerned about asking parents to discuss sexual health in detail including topics such as the use of condoms, pregnancy, or parenthood. As such, the Healthy Respect team thought teachers adopted a cautious view of the HAR. In their view (and reflecting prior comments made about local champions), the resource was adopted by the most enthusiastic teachers. Managerial support was also seen as important.

Third is whether pupils supported its use. Findings from our qualitative work with pupils suggests that, in contrast to primary school pupils, secondary school pupils expressed mixed views about whether the idea of doing homework with parents was a ‘good thing’. This might be based on the relative difficulty of discussing sexual relationships with their patents than discussing relationships in general. This could have influenced teachers’ decisions to use the package.

School ethos and communication with parents was fairly good. At least 80% of responding parents from primary and secondary schools reported a positive school ethos. Many reported good communication between school and home although secondary school parents reported lower levels of communication and satisfaction with school specifically with regard to sex and relationships education. This is of particular concern as the majority (approximately 70%) of this group saw sex and relationships education as a joint home/school responsibility. Communication by newsletter between primary schools and parents was reported by 64% at Wave one and increased to 85% at the second parent survey. The increase in communication was also supported through our qualitative work with parents.

Our surveys and qualitative work indicate that approximately 90% of parents reported exercising high levels of monitoring with their children, and recognised and valued the importance of spending time together as a family. Approximately 90% of parents reported high levels of comfort when thinking about discussing sex and relationships with their children, although the more sensitive topics about which they were questioned were less frequently discussed. This was particularly true for boys in relation to certain topic areas (e.g. menstruation, puberty, and pregnancy). Furthermore 87% of parents indicated that it was either the mother, or mother and father jointly, who dealt with questions around sex and relationships education. Fathers were not seen as the main source of information by those questioned in the survey.
3.3 Implementation of key interventions for young people

We used routine data collected by providers to indicate how key interventions were delivered to young people. Qualitative interviews with pupils were also conducted to establish their views of these interventions. Given the strong link between secondary schools and sexual health services which was described in the last section, we focus here on the implementation of SHARE and the Healthy Respect drop-in services. Zero Tolerance Respect is also included because it was new and subjected to a randomised control trial, the results of which appear in section 3.5.2.

3.3.1 Key findings

The Healthy Respect drop-in services, ZTR and SHARE were well implemented and well received by young people. Pupils receiving SHARE reported improvements in their sexual health knowledge, confidence and communication rather than a change in behaviour. Pupils receiving ZTR reported improvements in their behaviour and that of others.

3.3.2 Detailed findings: Healthy Respect drop-in services

A total of 24 drop-in services had opened by the end of the demonstration period, March 2008 (Appendix 3). Eight were set up in schools, eight in health centres, seven in community settings and two in family planning/genito-urinary medicine. Thirteen opened in Healthy Respect One and 14 in Healthy Respect Two. All opened on weekdays. Twenty-one opened one day per week and three operated up to three days per week. Most (17) opened during lunch time (12.00 – 2.00 pm), four opened in the afternoon (3.00 – 5.00 pm) and three opened in the early evening (up to 6.00 pm). Some were closed during school holidays. One drop-in which was based in a secondary school in West Lothian was temporarily closed in 2007 and permanently closed in 2008 due to a change in the school nursing service.

The All I Want – LIVE standards were maintained through a joint assessment process which involved drop-in staff and members from the Healthy Respect team. Representatives from each completed a joint assessment workbook and worked together to address difficulties should these have arisen. Staff at the drop-ins were aware that if standards fell below an acceptable level, the service would not be supported by Healthy Respect. Assessments were conducted at three months, one year and thereafter every two years.
A client satisfaction survey of young people attending drop-in services was conducted by the Internal Evaluation team in 2007. The majority of young people (91%) were satisfied with the service they received and felt that they had been given the information they needed. Almost two-thirds (60%) of young people felt confident or ‘okay’ about attending the clinic, with approximately 15% feeling slightly or very anxious. Out of the 156 young people who answered the question, only four said that they would not use the service again, although the questionnaire did not determine whether this was because their needs had not been met or because they were dissatisfied with the service received.

3.3.3 SHARE

A total of 186 teachers were trained to deliver SHARE, including those in the target areas (Midlothian and north-west Edinburgh). Data were collected from 13 of the 16 schools throughout Lothian which delivered SHARE. Three made no returns in 2008 (Table 1).

<table>
<thead>
<tr>
<th>Time period</th>
<th>S2</th>
<th>S3</th>
<th>S4</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005/6</td>
<td>2,448</td>
<td>2,694</td>
<td>2,213</td>
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<tr>
<td>2006/7</td>
<td>1,968</td>
<td>2,701</td>
<td>2,493</td>
</tr>
<tr>
<td>2007/8</td>
<td>1,375</td>
<td>2,166</td>
<td>1,616</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5,791</strong></td>
<td><strong>7,561</strong></td>
<td><strong>6,322</strong></td>
</tr>
</tbody>
</table>

Teachers were asked to estimate what proportion of pupils attended all the sessions and reported that the majority of students had attended all of the sessions. Assuming 1,000 pupils were registered in each school and 50% of these attended S2 to S4, based on the data in Table 1, the uptake of SHARE in the 16 schools was 92% in 2005/6 and 90% in 2006/7.

Our qualitative research with pupils indicated a clear recall of some aspects of the following topics covered in SHARE: relationships, talking about sex, bodies and sex, sexual activity, pregnancy and contraception, sexual activity and STIs, condom use skills, and where to go for help. Some sessions on negotiation with a partner were covered with the older groups but there appeared to be no clear mention of the sessions which focused on negotiating safer sex with a partner. Most recalled sessions on ‘putting on condoms’.
Pupils were very much engaged with SHARE. They talked easily about the sex and relationships education they had received, articulated the key messages, understood and identified areas where they thought it had affected their knowledge, confidence and communication, but not their behaviour.

‘Got more of like the facts, like about pregnancies and STIs and stuff like that.’ (S4, mixed)

‘You’re more aware about like …what can happen if you don’t use a condom or anything like that. Like just things you never knew and sexually transmitted infections and contraception and that.’ (S2 Mixed)

‘It does kind of, cos it means if you’ve like talked about it in a class, then you’re more likely to go and talk to your friends about it because you see a teacher being relaxed and talking about it, and then so you’re not like as uptight to go and talk to your friends about it, and they won’t think it’s like so weird.’ (S4, mixed)

‘Yeah it looks at more about like the relationship side of stuff and emotions……. It’s just like when they show you how to you know how like if you had a partner how they would be feeling and how you’ve to respect what they want to do and everything.’ (S2, boys)

None suggested that sex education made them act differently.

‘Its just kind of like putting a message through to you saying if you don’t want to do stuff then don’t do it.’
3.3.4 Zero Tolerance Respect

ZTR was introduced into 35 primary schools in Midlothian and was delivered by teachers and teaching assistants. The introduction was staggered to allow for a randomised control trial of ZTR which was conducted by the Evaluation team.

Our qualitative work with primary school pupils suggested that pupils recalled, and were able to describe, the ZTR lessons. They particularly liked the small group activities as they provided an opportunity to meet new people and also provided a space for everyone to contribute. ZTR was evaluated very highly by pupils and they believed that they and their peers had learned more about respectful relationships. Unlike SHARE, pupils reported that it affected their behaviour and that of others (see also section 3.5.2).

‘... well when we play football sometimes we play just in our class and em, we sometimes play and X who is on our team, he sometimes he can like just stay up at the front on the other person's goals and he can .. he really can miss like really good opportunities and like I think before the Respect like everyone just shouted at him but now, like now I think because a lot of us just go up and say “good try” and pat him on the back and stuff.’

‘I think X in our class has kind if changed a little bit because em, he's kind of always been a bit rough and like kicking you and stuff but he's like, he's not doing that as much anymore.’
3.4 Reach: The extent to which Healthy Respect reached its key target group (young people)

The ultimate target group for Healthy Respect was young people between the ages of 10 and 18 years old, although sexual health services were aimed at 13 to 18 year olds. The findings presented in this section are derived from the secondary school pupil surveys (see section 3.5.4), and routine data collected from secondary schools.

3.4.1 Key findings

The percentage of the population reached by Healthy Respect varied according to which population and which aspects of reach are considered. Awareness of the Healthy Respect logo and literature, as measured by our secondary school pupil survey, was around 40% with girls being more aware than boys although awareness, as measured by research commissioned by the Healthy Respect team, was 66%. It should be noted, however, that the research commissioned by Healthy Respect was not conducted on randomly selected samples. Awareness of anything other than the logo or literature was lower at around 25%, and this fell over time to around 17%, particularly among girls from lower social class. A total of 16 schools in Lothian offered SHARE and approximately 90% of pupils in S2 to S4 in these schools were exposed to it. All pupils in primary 7 in Midlothian received Zero Tolerance Respect.

At the end of the secondary school survey (2008/9), a total of 57% of girls and 65% of boys reported using sexual health services, including the Healthy Respect drop-ins. Service use was significantly higher among pupils who were less affluent in both 2007 and 2008/9. Significant improvements in service use were seen for all groups in the intervention area from 2007 to 2008/9, although the greatest improvements in service use were seen for boys (more affluent 42% vs. 62%; less affluent 54% vs. 71%). This is extremely encouraging and suggests Healthy Respect’s focus on targeting those from more deprived areas has worked, at least among those attending school. However, the difficulties encountered by providers in working with particularly vulnerable young people suggest that it is likely that some of these young people were missed by Healthy Respect. These included young people with poor literacy and communication skills or who had a background of abusive relationships. They may not attend mainstream school and were unlikely to appear in the school pupil surveys.
3.4.2 Detailed findings

Estimating the proportion of young people who were reached by Healthy Respect depends on what is meant by the term ‘reach’. Reach could refer to young people’s awareness of Healthy Respect or it could refer to those who used educational resources or sexual health services.

Awareness of Healthy Respect

Evidence from the tracking surveys commissioned by Healthy Respect indicated that between 40% and 66% of young people were aware of Healthy Respect. It should be noted that the research commissioned by Healthy Respect was not conducted on randomly selected samples. The first schools survey (2007) places recognition at the lower end of the range, with 38% reporting they had seen the Healthy Respect logo. The level of recognition did not change significantly at the time of the second school survey (2008/9). Our qualitative work with young people in 2008 also suggested that there was a limited recognition of the Healthy Respect brand and logo.

Our data shows a clear gender difference in knowledge of the Healthy Respect branded literature and/or Safe ‘n’ Sorted leaflets with girls demonstrating more knowledge than boys. Knowledge decreased over time (boys 29% vs. 17%; girls 38% vs. 21%). The observed reduction may be due to the higher profile media campaigns coming to an end.

Pupils were asked in the secondary schools surveys to recall if they had seen or heard anything about Healthy Respect other than the logo. Girls were significantly more likely to report that they had than boys (20% vs. 15%). Between baseline and second survey, the awareness of Healthy Respect significantly fell among girls in the intervention area (25% vs. 17%), but not among boys (17% vs. 14%). The fall among girls was particularly noted in those living in social housing (30% vs. 15%) but not among girls living in owner-occupied housing (23% vs. 17%). There was no significant difference in the awareness of Healthy Respect among pupils who reported that they were sexually experienced and those who were not (girls: 21% vs. 19%; boys: 18% vs. 14%).
Of those pupils who reported that they had seen or heard something about Healthy Respect, the three most commonly cited places for obtaining information were school (53%), the media (23%), and services (10%). Between 2007 and 2008/9, there was a significant increase in the proportion of pupils reporting that they had seen or heard something about Healthy Respect through the media (girls 18% vs. 26%; boys 16% vs. 30%). This was an unexpected finding given that the Healthy Respect media campaigns were conducted between 2005 and 2007 and may partly reflect contamination from the Department of Health’s ‘Want Respect: Use a Condom’ campaign that was running on television, radio and MySpace during 2008/9.

Use of education or sexual health services
As indicated in section 3.3.3, an estimated 90% of pupils in S2 to S4 received SHARE. As determined by our randomised control trial, the Zero Tolerance Respect package was introduced into half of the primary schools in Midlothian and was delivered to 470 pupils. ZTR was introduced in all primary schools in Midlothian after the completion of the trial. The Healthy Respect drop-in services received 7,025 visits from young people aged between 13 years and 19 years between 2005 and 2007. Data from the secondary schools survey suggests that 46% of girls and 47% of boys in the intervention area had used a service in 2007. This increased to 57% of girls and 65% of boys by the second wave of the survey in 2008/9. Significant improvements in service use were seen for all groups in the intervention area from 2007 to 2008/9, with the greatest improvements seen among boys (20%). There was a 12% increase in service use among girls who lived in owner-occupied housing (more affluent girls) and 7% among girls who lived in social housing (less affluent girls). Incidentally there was also an increase in service use in the comparison area but this did not reach the level observed in the intervention area (2007: girls 29%, boys 15%; 2008/9 girls 47%, boys 45%).
3.5 The effect of Healthy Respect on young people’s sexual health and relationships

This section presents the findings from:

- a randomised control trial on the impact of the Zero Tolerance Respect package used in primary schools in Midlothian (P7)
- secondary schools survey measuring sexual health knowledge, service use and behaviour among S4 (15 to 16 years old) pupils

3.5.1 Key findings: Randomised control trial of ZTR

Pupils and teachers who used the ZTR package enjoyed and accepted its use as a resource, and there is some evidence that ZTR influenced the attitudes of primary school pupils. Girls reported high levels of respectful behaviour at baseline with little potential for improvement and no change at follow-up. Boys had lower respect scores at baseline and there was evidence of a slight improvement after ZTR had been delivered. This was particularly true for those boys who had the lowest respect scores at baseline. There was very little evidence of discriminatory attitudes by race or gender among pupils either before or after the package was delivered. However over 55% of boys and over 25% of girls listed at least one age-inappropriate film (as classified by the BBFC) among their favourite three. Less respectful attitudes were strongly associated with the viewing of age-inappropriate films.

3.5.2 Detailed findings: Randomised control trial of ZTR

The Healthy Respect team identified a package, Zero Tolerance Respect, to introduce in primary schools (P7, age 10 to 12 years). It did not address sexual issues directly, but was intended to introduce values of respect for others and respect for difference that would be a useful foundation to subsequent sex and relationships education.
Methods
Thirty four schools (952 pupils) were randomised to ZTR or control status. There was no comparable programme used in the control schools. However, there were other initiatives that affected all the schools in Midlothian. The programme ‘Keeping myself safe’ about avoiding unwanted harassment was used by P7 classes in all schools. At follow-up the pupils in all schools completed the following activities:

- An activity where pupils wrote about and illustrated their ideas of ‘respect’.
- An activity about gender stereotyping.
- A ‘respect score’ derived from the questionnaire.
- The pupils’ responses to a story that involved racial discrimination.

In addition, we obtained information from teachers about their views on teaching ZTR, their responses to the package and their use of the homework material.

3.5.2.1 Results
Pupils’ views of ZTR
Qualitative work with pupils suggested most had enjoyed ZTR and believed that they and their peers had learned more about respectful relationships. The practical sessions worked particularly well. The use of discussions and group work were also very popular. A few problems with individual sessions were highlighted and suggestions made. Pupils felt that teachers needed to reinforce the respect message in their own behaviour, particularly in relation to gender equality. Most pupils enjoyed ZTR and believed that they and their peers had learned more about respectful relationships. To quote one pupil:

‘I think the mood in the classroom changes, like, everybody’s... like before we did the respect package, well, it was just how we’d always, like, seen it. But afterwards, everybody just took more care with things and, you know, respected people more and, like, if anybody was going to do something, they’d be like oh, think about that before you do it. So I really enjoyed it.’

The homework pack was not mentioned spontaneously by many of the groups.
Teachers’ views of ZTR

Teachers in the intervention schools had very favourable reports of ZTR, particularly of the training and support materials provided by the Healthy Respect team. One teacher had a general criticism that the package did not ‘provide answers’ although most liked the discussion aspects. The majority (13/17) of ZTR schools used some aspect of the homework material but only one school used the material relating to sexual health. The teacher from this school reported very favourably on it.

‘They were all good – parents were waiting for the homework to arrive!’

The teachers from the 13 schools who used the ZTR homework assignments reported varying responses to them:

‘All the children completed it. All enjoyed talking to parents. One child said they never usually speak to Dad, so it was good.’

Comparing pupils who had ZTR with those in control schools

Overall we found that pupils in both intervention and control schools reported very little acceptance of disrespectful behaviour. Respect was seen to be largely about rules and manners, and disrespectful behaviour mainly about teasing and bullying – one aspect discussed specifically in the ZTR material. There were few differences between ZTR and control schools about how they viewed Respect after they had completed the programme. One small difference found was that boys in ZTR schools were more positive about educational programs like ZTR than those in the control schools.

The specific group activities intended to measure acceptance of gender stereotyping and racial discrimination found that all pupils were very well aware of these issues as problems and they reported that discrimination on the basis of either of these quite unacceptable. The results on racial discrimination differed from a similar study carried out in Scotland in 1995 where pupils were accepting of, and unsurprised by, a story that involved racial discrimination. In contrast, pupils in both ZTR and control schools challenged the racist behaviour described in the story and described how they might go about supporting the victims. However, knowing that something is not acceptable may be easier than acting out appropriate behaviour. While gender stereotyping was not seen to be acceptable, pupils’ reports of their own career ambitions were very heavily stereotyped by gender, with most boys aspiring to the male dominated profession or sports and girls, nurses, teachers or hairdressers.
The pupils’ Respect scores before the programme was delivered all provided very high levels of reported ‘respectful’ behaviour. The scoring included several questions that had been used in previous research carried out on behalf of the Scottish Executive\(^9\). We did not replicate their finding that pupils indicated a need for preventive work around this theme. Indeed the scores obtained, especially by girls, were very near the top of what could be achieved. However, at follow-up we did find an improvement in scores for boys in the ZTR schools compared to the control schools. This was particularly marked for boys who had the lowest scores at baseline and thus the greatest potential for improvement.

At follow-up, all pupils were asked to name up to three of their favourite films. The age-appropriateness of the films was sourced by cross-referencing titles with the certificates given to them by the BBFC and 795 pupils reported at least one certificated film title. Any film classed as suitable for age 15 or above was considered inappropriate for these 10 to 12 year olds. Over 55% of boys and over 25% of girls mentioned at least one age-inappropriate film among their favourite three. The respect score was strongly associated with the viewing of age-inappropriate films.

### 3.5.3 Key findings: Secondary schools survey

Healthy Respect had a significant and beneficial effect on boys’ sexual health knowledge, with boys who received SHARE more knowledgeable than pupils in the comparison area who received a standard sexual health education package. This finding was observed regardless of socioeconomic status. It is worth noting, however, that sexual health knowledge was greater among more affluent boys than less affluent boys at the time of first survey and the inequality gap remained over the course of the intervention.

In terms of behaviour, there was no significant change in the rates of boys in the intervention area having penetrative sex at the time of the second survey. Looking specifically at contraceptive use, there was insufficient power to detect changes in condom use at sexual debut. We did, however, have power to demonstrate that Healthy Respect had a significant and beneficial effect upon boys’ use of condoms at ‘most’ instances of penetrative sex. It is worth noting, however, that the inequality gap remained, with more affluent boys nearly twice as likely to have used a condom at most instances of sex than less affluent boys. Looking at service use, we found a significant increase in the use of services by intervention area boys during the course of the delivery of Healthy Respect and this was mirrored by a significant increase in service use within the comparison area.
For girls, the effects of Healthy Respect were more varied and distinctly patterned by socioeconomic background. Service use significantly improved for all girls within the intervention area during the course of Healthy Respect and this was mirrored by an increase in service use by girls in the comparison area. Improvements in practical sexual health knowledge were mainly seen among more affluent girls. Although girls in the intervention area were as likely as girls in the comparison area to view condoms as protective, we noted a significant shift at the end of the study among girls in the intervention area to view condoms as less protective. No change was seen in the intentions of girls (both more affluent and less affluent) to use condoms in protecting against pregnancy and STIs. There was no significant change in the use of contraception among girls over time. Finally, girls in the intervention area were significantly more likely to feel pressured into, and subsequently regret, their sexual debut. The last two findings were limited to more affluent girls.

Methods and statistical analysis
To measure the effect of Healthy Respect, pupils in S4 were asked to complete a questionnaire about their sexual health education, use of services, sexual risk-taking behaviour and family circumstances. Data were collected in the spring terms of 2007 and in 2008/9. It involved pupils from six schools delivering SHARE within Midlothian and north-west Edinburgh, and six schools in two local authorities that had similar levels of teenage pregnancy and terminations. The schools delivering SHARE are herein referred to as ‘intervention’ schools, and the schools they are being compared with ‘comparison’ schools.

All statistical analyses were conducted separately by gender and adjusted for those differences that were observed between the intervention and comparison areas in 2007; these differences mainly related to religion and affluence, with pupils in the intervention area being less religious and slightly more affluent than comparison area pupils. Additional adjustments were made for age at the time of interview, ethnicity, and clustering at school level. All differences reported as significant are at least at a 5% level, while trends (shown to give an indication of non-significant improvements/declines within areas) are reported at a 10% level. Finally, to determine whether any differences between areas over time could be attributed to Healthy Respect or to wider secular changes, an interaction was fitted between time (2007 vs. 2008/9) and area (intervention vs. comparison).
3.5.4 Detailed findings: Secondary school survey
The findings reported in this section:

1) explore whether Healthy Respect affected pupils’ practical sexual health knowledge, their knowledge of local sexual health service provision, and their attitudes towards and intentions to use contraception

2) examine whether Healthy Respect affected young people’s uptake of service provision, their use of condoms and contraception, and their sexual risk-taking behaviour

3) determine whether Healthy Respect was successful in reducing inequalities in adolescent sexual health.

3.5.4.1 Did Healthy Respect improve pupils’ knowledge and attitudes?

Schools in the intervention area delivered SHARE, to pupils in S2 to S4 (aged 13 to 16). Sexual health education was also delivered in the comparison area with each required to meet the standards set by Curriculum for Excellence Health and Wellbeing, Learning and Teaching Scotland (www.ltscotland.org.uk/curriculumforexcellence/experiencesandoutomes/index.asp).

In evaluating the impact of Healthy Respect, we looked at whether the following improved within the intervention area relative to the comparison area:

- Practical sexual health knowledge.
- Knowledge of sexual health service provision.
- Attitudes towards and intentions to use condoms/contraception.
- Attitudes towards forced sex and same sex relationships.

Table 2 summarises whether changes were seen for the above items between the first and second surveys. From this, it can be seen that the delivery of SHARE as part of the Healthy Respect intervention improved pupils’ practical sexual health knowledge compared to comparison area pupils. Interestingly, but not to detract from the key findings, we noted that there was a reduction in the practical sexual health knowledge of pupils in the comparison area between 2007 and 2008/9. This accentuated the effect of Healthy Respect on pupils’ knowledge within the intervention area.
Pupils in the intervention area were more knowledgeable than comparison area pupils at both time points (2007 and 2008/9). There was no additional effect of Healthy Respect on pupils’ knowledge of where to obtain free advice and condoms, with pupils in both the intervention and comparison areas more knowledgeable in 2008/9 than in 2007. These findings do not reflect a failure of Healthy Respect to improve young peoples’ knowledge, but rather indicate that improved awareness of service provision may be a more secular trend which could be related to the implementation of the national sexual health strategy across Scotland (see section 3.6.3).

The awareness of postal testing kits (PTKs) for chlamydia increased in the intervention area, however, this could be attributed to the longer-term effects of the first phase of Healthy Respect rather than Healthy Respect Two. In 2005, the PTKs developed during Healthy Respect One were mainstreamed and became the responsibility of the GUM clinic. In addition, GUM offered an outreach clinic at Caledonia Youth where treatment was offered.

Although girls in the intervention and comparison areas viewed condoms as protective against pregnancy and STIs, there was a significant weakening of this view among the intervention girls over time. One explanation for this may be that there was a shift towards the promotion of dual protection methods between 2007 and 2008/9 and this may have resulted in girls viewing condoms as insufficient protection against pregnancy on their own; however, we are unable to test this hypothesis using the data collected.
Table 2: Area changes in sexual health knowledge, awareness of services and attitudes between 2007 and 2008/9

<table>
<thead>
<tr>
<th>Boys</th>
<th>Intervention</th>
<th>Comparison</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Knowledge</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual health knowledge</td>
<td>↑</td>
<td>↓</td>
<td>HR2</td>
</tr>
<tr>
<td>Knows where to get condoms</td>
<td>↑</td>
<td>↑</td>
<td>secular</td>
</tr>
<tr>
<td>Knows where to get advice</td>
<td>↑</td>
<td>↑</td>
<td>secular</td>
</tr>
<tr>
<td>Aware of PTK for chlamydia</td>
<td>↑</td>
<td>=</td>
<td>HR1 legacy</td>
</tr>
<tr>
<td><strong>Attitudes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom norms (e.g. seeing condoms as protective)</td>
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<td>=</td>
<td>none</td>
</tr>
<tr>
<td>Intends to use condoms</td>
<td>↑</td>
<td>↓</td>
<td>HR2</td>
</tr>
<tr>
<td>Attitudes to forced sex</td>
<td>=</td>
<td>↓</td>
<td>secular</td>
</tr>
<tr>
<td>Attitudes to homosexuality</td>
<td>=</td>
<td>=</td>
<td>none</td>
</tr>
</tbody>
</table>
Table 2 cntd.

<table>
<thead>
<tr>
<th>Girls</th>
<th>Intervention</th>
<th>Comparison</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Knowledge</strong></td>
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<tr>
<td>Sexual health knowledge</td>
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<td>comparison area only</td>
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<tr>
<td>Aware of PTK for chlamydia</td>
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<td>HR1 legacy</td>
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<td><strong>Attitudes</strong></td>
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<tr>
<td>Condom norms (e.g. seeing condoms as protective)</td>
<td>↓</td>
<td>=</td>
<td>HR2</td>
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<tr>
<td>Intends to use condoms</td>
<td>↓</td>
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<td>HR2</td>
</tr>
<tr>
<td>Attitudes to forced sex</td>
<td>↓</td>
<td>↓</td>
<td>secular</td>
</tr>
<tr>
<td>Attitudes to homosexuality</td>
<td>↑</td>
<td>↓</td>
<td>HR2</td>
</tr>
</tbody>
</table>

1) Increases are identified using an upwards arrow while reductions are shown by a downwards arrow. Note a downward arrow for attitudes concerning forced sex and homosexuality indicate a worsening of these attitudes.

2) Where arrows are black they relate to changes significant at 5% level and, where grey, to trends at the 10% level.

3) The table also shows whether changes were potentially attributable to Healthy Respect Two, changes within the comparison area, or secular trends.
In the comparison area, where practical sexual health knowledge decreased, there was a significant (p<0.05) weakening of boys intentions to use condoms.

The focus of SHARE was on improving quality of relationships, however, there was no effect on pupils’ attitudes towards ‘forced sex’. Instead, there was a secular shift towards pupils in both the intervention and comparison areas becoming less certain about the acceptability of forced sex between 2007 and 2008/9. This is an issue given recent research findings that a quarter of 14 year olds report that they have been forced into doing something sexual that they did not want to do\textsuperscript{10} and the relationship between the experience of force at sexual debut and subsequent regret\textsuperscript{11}.

3.5.4.2 Did Healthy Respect change service use, sexual behaviour and contraceptive use?

We evaluated whether the following outcomes improved between 2007 and 2008/9 within the intervention area relative to the comparison:

- The use of sexual health services.
- Sexual behaviour and quality of sexual relationships.
- The use of condoms and contraception at sexual debut, and all other instances of sexual intercourse.
Table 3: Changes in service use, sexual behaviour and contraceptive use between 2007 and 2008/9

<table>
<thead>
<tr>
<th>Service use</th>
<th>Boys</th>
<th>Intervention</th>
<th>Comparison</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Used a sexual health service</td>
<td></td>
<td>↑</td>
<td>↑</td>
<td>secular</td>
</tr>
<tr>
<td>Sexual behaviour</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has not yet had penetrative sex</td>
<td></td>
<td>↓</td>
<td>↓</td>
<td>secular</td>
</tr>
<tr>
<td>Sexual debut at 14 years plus</td>
<td></td>
<td>=</td>
<td>↓</td>
<td>secular</td>
</tr>
<tr>
<td>Partner was same age or younger at sexual debut</td>
<td></td>
<td>↑</td>
<td>=</td>
<td>HR2</td>
</tr>
<tr>
<td>No regret at sexual debut</td>
<td></td>
<td>=</td>
<td>=</td>
<td>none</td>
</tr>
<tr>
<td>No pressure at sexual debut</td>
<td></td>
<td>=</td>
<td>=</td>
<td>none</td>
</tr>
<tr>
<td>Contraceptive use</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>All contraception at debut</td>
<td></td>
<td>=</td>
<td>=</td>
<td>none</td>
</tr>
<tr>
<td>Condom at debut</td>
<td></td>
<td>↑</td>
<td>=</td>
<td>HR2</td>
</tr>
<tr>
<td>Used condoms most times that they had had penetrative sex</td>
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<td>=</td>
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**Table 3 contd.**

<table>
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<th>Girls</th>
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<th>Comparison</th>
<th>Effect</th>
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</thead>
<tbody>
<tr>
<td><strong>Service use</strong></td>
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<td>Used a sexual health service</td>
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<td>secular</td>
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<tr>
<td><strong>Sexual behaviour</strong></td>
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<td></td>
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<tr>
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<td>=</td>
<td>=</td>
<td>none</td>
</tr>
<tr>
<td>Sexual debut at 14 years plus</td>
<td>↓</td>
<td>↓</td>
<td>secular</td>
</tr>
<tr>
<td>Partner was same age or younger at sexual debut</td>
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<td>=</td>
<td>none</td>
</tr>
<tr>
<td>No regret at sexual debut</td>
<td>↓</td>
<td>=</td>
<td>HR2</td>
</tr>
<tr>
<td>No pressure at sexual debut</td>
<td>↓</td>
<td>=</td>
<td>HR2</td>
</tr>
<tr>
<td><strong>Contraceptive use</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All contraception at debut</td>
<td>=</td>
<td>=</td>
<td>none</td>
</tr>
<tr>
<td>Condom at debut</td>
<td>=</td>
<td>=</td>
<td>none</td>
</tr>
<tr>
<td>Used condoms most times that</td>
<td>=</td>
<td>=</td>
<td>none</td>
</tr>
<tr>
<td>they had had penetrative sex</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1) An upwards arrow indicates the outcome changing in the intended direction (positive) while the downwards arrow shows changes in an unintended direction.

2) Where arrows are black they relate to changes significant at 5% level and, where grey, to trends at the 10% level.

3) The table also shows whether changes were potentially attributable to HR2, changes within the comparison area, or secular trends.
**Service use**
In the intervention area, Healthy Respect worked with existing service providers and there was a strong emphasis placed upon the provision of accessible youth-friendly services. In the comparison area, specialist sexual health services were primarily delivered through NHS services such as GUM and family planning facilities. However, in one of the local authorities, young people had to travel to the nearest city to access specialised facilities, a distance of up to 10 miles. Sexual health services were also available through general practitioners and pharmacies; c:card was introduced into one area in 2004 while in the other area it was introduced to schools in 2009.

The use of services was significantly higher in the intervention area than the comparison area in 2007 and in 2008/9. Service use was also significantly higher among pupils who were less affluent in both 2007 and 2008/9. Table 3 shows that there was a significant increase in service use within both the intervention and comparison areas between 2007 and 2008/9. Significant improvements in service use were seen for all groups, although the greatest improvements were seen for boys (more affluent 42% vs. 62%; less affluent 54% vs. 71%). The largest increase in service use was for boys in the comparison area which may reflect the introduction of c:card. That increases were seen in both areas suggests a wider secular trend towards improved use of services by young people; a significant interaction (p<0.05) fitted between time and area seems to further support this.

**Sexual behaviour and quality of sexual relationships**
Most young people (mean age 15 years, 6 months) had not yet had sexual intercourse. In the intervention area, 38% of young people reported that they were sexually active (girls 41% vs. boys 36%), while in the comparison area, 31% of young people reported being sexually active (girls 32% vs. boys 29%). It is worth noting that although sexual activity rates appear lower in the comparison area, adjusting for lower levels of both affluence and religious belief in the intervention area shows no difference in the rates of adolescent sexual activity. However, it is worth noting that boys in the comparison area were significantly more likely to have reported sexual activity in 2008/9 than in 2007. No changes were seen in the rates of penetrative sex for girls in either area over time.

Contraceptive use is less common and often used incorrectly when the sexual debut occurs at a younger age. Population rates of sexual debut prior to 14 years (most of this early sex was close to 14 years) remained stable for intervention area boys (8% in 2007 and 2008/9) but there was a significant increase in the proportion of boys in the comparison are reporting early sexual activity (8%, up from 3%). Although slight percentage increases were seen in both the intervention and comparison areas among girls, the difference was not statistically significant.
Given the strong focus in SHARE on improving the quality of relationships, we explored whether feeling pressured into having sex, or regretting sexual debut differed between young people in the intervention and comparison areas. No change was found in the feeling of pressure or regret for boys over time. However, a significant increase was observed in the reporting of pressure and regret by girls in the intervention area (pressure 16% vs. 26%; regret 35% vs. 49%); no change was seen for girls in the comparison area over time (pressure 30% vs. 28%; regret 44% vs. 49%).

Use of condoms and contraceptives
There was no significant difference in pupils’ use of condoms at sexual debut between the intervention and comparison areas at the first survey (girls 71% vs. 66%; boys 67% vs. 63%). We noted no statistically significant change in condom usage at sexual debut among girls or boys in the intervention and comparison areas. Condom use at sexual debut at the end of the study for girls was 74% (intervention area) and 58% (comparison area); and for boys 74% (intervention area) and 62% (comparison area).

It is worth noting that, in our initial power calculations, we demonstrated that we did not have sufficient power to detect changes within contraceptive use in the intervention area. This was due to the high levels of contraceptive use already demonstrated in 2007. To test whether an effect was seen on sustained contraceptive usage, we looked at the reporting of condom use at most instances of sex; the reason for this being that sexual debut may have occurred prior to engagement with Healthy Respect. There was a significant effect (p<0.05) of the intervention on boys reporting having used a condom ‘most times’ that they had had penetrative sex. No change was observed in condom use among girls over time.
3.5.4.3 Did Healthy Respect affect sexual health inequalities?

Four main outcomes were examined to assess whether Healthy Respect was successful in reducing sexual health inequalities: sexual experience, practical sexual health knowledge, use of services, and contraceptive/condom use. Due to the poor completion of postcode within the survey, a proxy variable for deprivation was used. There were two possible options: housing type and parental education, which are significantly correlated (p<0.001). Housing tenure had the lowest levels of missing data (6% vs. 20% for parental education) and, as a result, was used in our analyses. More affluent pupils were categorised as those living in owner-occupied housing, and less affluent pupils were categorised as living in social housing (rented accommodation, care/foster homes and emergency accommodation). An interaction between housing type and time was fitted to formally test whether there had been an effect of the intervention on social inequalities and a 5% significance level was accepted throughout. Table 4 shows the results of these analyses.

Healthy Respect had no impact on the gap in sexual activity between more affluent and less affluent young people. Pupils living in social housing were significantly more likely to have had penetrative sex than those living in owner-occupied housing at 2007 and 2008/9.

Healthy Respect had no impact on the gap in practical sexual health knowledge between more affluent and less affluent young people. More affluent pupils were significantly more knowledgeable than less affluent pupils in 2007 and 2008/9. Although sexual health knowledge for less affluent boys improved, this was matched by an equal increase in knowledge by more affluent boys. For girls however, knowledge only improved for more affluent girls, suggesting that the gap has widened.
Table 4: Deprivation related changes in sexual behaviour, knowledge, service use and contraceptive behaviour in the intervention area between 2007 and 2008/9

<table>
<thead>
<tr>
<th>Boys</th>
<th>Deprived</th>
<th>Affluent</th>
<th>Reduced inequalities?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has not yet had penetrative sex</td>
<td>=</td>
<td>↓</td>
<td>Yes but by increasing sex among the more affluent</td>
</tr>
<tr>
<td>Sexual health knowledge</td>
<td>↑</td>
<td>↑</td>
<td>No change</td>
</tr>
<tr>
<td>Used a sexual health service</td>
<td>↑</td>
<td>↑</td>
<td>No change</td>
</tr>
<tr>
<td>Contraceptive use at debut</td>
<td>↑</td>
<td>=</td>
<td>Non-significant decrease</td>
</tr>
<tr>
<td>Condom use at debut</td>
<td>↑</td>
<td>=</td>
<td>Non-significant decrease</td>
</tr>
<tr>
<td>Condom use at most instances of penetrative sex</td>
<td>↑</td>
<td>=</td>
<td>Non-significant decrease</td>
</tr>
<tr>
<td>No pressure at sexual debut</td>
<td>=</td>
<td>=</td>
<td>No change</td>
</tr>
<tr>
<td>No regret at sexual debut</td>
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<td>No change</td>
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## Table 4 cntd.

<table>
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<tr>
<th>Girls</th>
<th>Deprived</th>
<th>Affluent</th>
<th>Reduced inequalities?</th>
</tr>
</thead>
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<tr>
<td>Has not yet had penetrative sex</td>
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<td>=</td>
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<tr>
<td>Sexual health knowledge</td>
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<td>Non-significant increase</td>
</tr>
<tr>
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<td>↑</td>
<td>↑</td>
<td>No change</td>
</tr>
<tr>
<td>Contraceptive use at debut</td>
<td>↓</td>
<td>↑</td>
<td>Increased inequality</td>
</tr>
<tr>
<td>Condom use at debut</td>
<td>↓</td>
<td>↑</td>
<td>Increased inequality</td>
</tr>
<tr>
<td>Condom use at most instances of penetrative sex</td>
<td>↓</td>
<td>↑</td>
<td>Increased inequality</td>
</tr>
<tr>
<td><strong>No pressure at sexual debut</strong></td>
<td>=</td>
<td>↓</td>
<td>Yes but by increasing pressure felt by affluent girls</td>
</tr>
<tr>
<td><strong>No regret at sexual debut</strong></td>
<td>=</td>
<td>↓</td>
<td>No change</td>
</tr>
</tbody>
</table>

1) An upwards arrow indicates the outcome changing in the intended direction (positive) while downwards arrows show changes in an unintended direction.

2) Where arrows are black they relate to changes significant at 5% level and, where grey, to trends at the 10% level.

3) The table also shows whether changes were potentially attributable to Healthy Respect Two, changes within the comparison area, or secular trends.
There were many non-significant differences ($p > 0.05$) over time and across groups regarding contraceptive and condom use at sexual debut and most instances of sex (Table 4). Finally, looking specifically at pressure, we found in 2007, girls from less affluent areas reported that they had felt pressured into having sex than more affluent girls (18% vs. 14%). In 2008/9, this pattern was reversed with more affluent girls more likely to report that they had been pressured than less affluent girls (27% vs. 23%). An interaction fitted between time and area was significant suggesting that the gap in the experience of pressure had been reduced, but this was to the detriment of more affluent girls. Looking at the reporting of regret, there were significant increases in the reporting of this by more affluent girls only (44%, up from 27%). An interaction fitted between time and area was not significant, showing that the gap in the experience of regret by girls still existed after the delivery of the intervention (less affluent 58% vs. more affluent 44%).

3.5.5 Pregnancy, terminations 1995–2007 and chlamydia infections 2007

Teenage pregnancy data are taken as live births plus terminations and were derived by Information Services Division (ISD), NHS National Services Scotland, from civil registrations of births at GROS (General Register Office for Scotland) and Abortion Act returns to the Chief Medical Officer. Data on chlamydia testing are taken from records which are collated by health boards across Scotland. These data are held centrally by ISD Scotland.

3.5.6 Key findings

Teenage pregnancy

The teenage pregnancy rate in Scotland among 13 to 15 year olds declined between 1994 and 2007. The rate of decline in Lothian of 1.15% per year was similar to that of Scotland (1.02% per year). If the trend continues, the NHS Lothian target of a reduction in the pregnancy rate from 9/1,000 (1994–1998) to an underlying rate of 8/1,000 in 2010 will be met. The target was based on that set in the national sexual health strategy Respect and Responsibility.

The deprivation gradient in pregnancies persists. The average rate over the whole period for the 13 to 15 year old age group in Lothian varied from under 3/1,000 for the least deprived areas to over 16/1,000 for the most deprived.

There was a rise in rates of termination in Scotland including Lothian between 1994 and 2007. Termination rates are lowest in the most deprived groups. In the most advantaged areas, around 70% of all teenage pregnancies were terminated. The rates in the most deprived areas were much lower ranging from 20% to 40%.
Chlamydia
There have been several initiatives in Lothian which encouraged chlamydia testing during the life of Healthy Respect including PTKs and via Caledonia Youth (voluntary sector agency) and the Healthy Respect drop-in services. Overall the findings do not provide any evidence that rates of testing or rates of positivity in young people in Lothian differ from those in the rest of Scotland.

3.5.7 Detailed findings: Teenage pregnancies and terminations
The key teenage pregnancy target for NHS Lothian, derived from the national target set out in the 2005 sexual health strategy Respect and Responsibility was to reduce the pregnancy rate (per 1,000 population) by 20% in 13 to 15 year olds from 9.3 in 1995 to 7.4 by 2010.

Figure 5 shows the pregnancy rates among 13 to 15 year olds from 1994 to 2007 with 95% confidence intervals for individual years. The teenage pregnancy rate in Lothian for 13 to 15 year olds decreased from 9/1,000 in the five years from 1994–1998 to 8/1,000 from 2003–2007 and if the trend continues, it will fall below the target set by NHS Lothian for 2010. The decrease in rates of 1/1,000 is just significant at the 5% level.

The average rate of decline per year in the 13 to 15 year old pregnancy rate was 1.15% per year for Lothian, almost identical to the Scottish national rate of 1.02% per year. Due to the smaller numbers, the Lothian trend did not quite reach the 5% significance level from no change over time, but did for Scotland (p =0.07 for Lothian and p<0.01 for Scotland).

Figure 5: NHS Lothian teenage pregnancies 13 to 15 year age group, upper and lower confidence limits and Lothian target with trend to 2010.
Figure 6 shows the Lothian numbers and rates for the three teenage groups along with the trend line for Lothian and the trend line for the rest of Scotland, omitting Lothian, as a comparator. As indicated in the previous figure, the similarity of the trends for Lothian and the rest of Scotland in the youngest age group 13 to 15 years are evident. For the 16 to 17 year age group the rates for the rest of Scotland show almost no trend, while those for Lothian show a slight decline. However, the Lothian trend is not significantly different, implying no evidence of a real decline and it is also not significantly different from the trend for the rest of Scotland. For the oldest group of teenagers, however, rates for the rest of Scotland show a small increasing trend of +0.6% per year (p<0.001) while that for Lothian is lower at 0.1% per year and the difference in these two rates is close to reaching conventional levels of significance (p=0.06). There are reasons to be cautious in interpreting this as evidence that Lothian differs from the rest of Scotland. Over the period 1994 to 2006 the population estimates for young women in Lothian aged 16 to 19 increased by 15%. Thus the trends that we are seeing in Figure 6 are driven as much by changes in the population denominators as by the numbers of pregnancies. Population numbers for these age groups are known to be difficult to estimate due to problems with population movement in relation to education, and the unreliability of data on migration. An investigation of trends in other parts of Scotland for the larger health boards showed considerable variation by area. The lack of an increase in the rates for 18 to 19 year olds was not unique to Lothian, with Greater Glasgow health board showing a very similar trend.
Figure 6: Teenage pregnancies in Lothian (rates per 1,000 per year) and regression lines for Lothian and the rest of Scotland.
Teenage pregnancy and deprivation

It is very well established that the deprivation of an area has a major influence on teenage pregnancy rates. Lothian includes fewer deprived areas than the rest of Scotland. The data are categorised by the deprivation of the area of the mother's home address measured by the Scottish Index of Multiple Deprivation, 2006 (SIMD). The least deprived category includes 36% of the population of teenage girls in Lothian compared to only 17% in the rest of Scotland. Conversely, the most deprived category includes only 14% of teenage girls in Lothian compared to 24% in the rest of Scotland.

Average rates for Lothian over the whole period from 1994 to 2007 varied from under 3/1,000 for the least deprived areas to over 16/1,000 for the most deprived areas. At older ages, the differences by deprivation are even more marked: for 16 to 17 year olds, 21/1,000 in the least deprived and 123/1,000 in the most deprived, and for 18 to 19 year olds, 28/1,000 in the least deprived and 181/1,000 in the most deprived areas.

The numbers in the youngest age group are too small to investigate time-trends by deprivation. For the two older age groups there appears to be a greater decline in pregnancies in the most deprived areas and this is particularly true for 18 to 19 year olds. This decline is not seen in the less deprived areas. The pattern for Lothian was similar to the Scotland average. Data was provided by ISD Scotland giving pregnancy rates by health board area and deprivation. This showed that there was considerable variation in trends by health board. These data need to be interpreted with caution because the denominators on which they are based may be unreliable because they are dependent on poorly estimated changes in population over time. We must await data from future years to see if these trends are indeed proven to be genuine effects.

Termination rates also vary by deprivation category with the highest rates seen in the least deprived areas. In the most advantaged areas, around 70% of all teenage pregnancies were terminated at each of the three age groups. The rates in the most deprived areas were much lower ranging from 20% to 40%. All deprivation groups showed termination rates increasing over the years from 1994 to 2007.
3.5.8 Chlamydia

Because of its known prevalence in young people under 25 years of age, chlamydia has been regarded as a key public health ‘marker’ condition for Healthy Respect. During Healthy Respect One, postal testing kits for chlamydia were developed and many were distributed in various settings across Lothian. Unfortunately there is no obvious way to assess the proportion of the population affected by chlamydia since only a small proportion are tested, and the proportion of positive tests may bear little relationship to the proportion of the population infected. A high rate may only reflect the fact that the testing is being offered only to those who are likely to be infected because they are symptomatic, are contacts of those already diagnosed, or those responding to media campaigns which encourage sexually active young people to come forward for testing.

Testing rates for Lothian between 2005 and 2006 are higher in women than in men and among younger people. In Scotland, for those aged 15 to 24 years, testing rates were 69/1,000 for men and 243/1,000 in women yielding respectively 17% and 10% of positive tests. The rates for Lothian are comparable to those for Scotland as a whole for women, but for men the testing rates are somewhat higher in Lothian, especially for older men. For younger men the testing rate in Lothian is higher at 79/1,000, but the yield of positive tests is lower at just 13%, lower than any other health board.

It is difficult to know how to interpret these data without information on the reasons for testing since a low positivity rate may correspond to either a lower prevalence in the population or a wider testing pattern that brings lower risk individuals in for testing. There have been several initiatives in Lothian that may have influenced this. In 2005, the PTKs developed during Healthy Respect One were mainstreamed and became the responsibility of the GUM clinic. In addition, a special session was arranged at Caledonia Youth where testing was offered. Testing was also offered at four Healthy Respect drop-in services and all offered testing through postal testing kits. During 2007, the total number of chlamydia tests carried out in Lothian for the 15 to 24 age group was 4,506 for young men and 7,511 for young women. In 2007/8, return of the postal testing kits resulted in 1,395 tests in those aged 15 to 25 (9.5% positive) and there were 1,192 tests in the 15 to 24 age group (6.7% positive) from the sessions at Caledonia Youth. A breakdown by gender is not available but the report comments on the difficulty in getting young men to report for testing.

Overall these data do not provide any evidence that rates of testing or rates of positivity in young people in Lothian differ from those in the rest of Scotland.
3.6 Maintenance: Longer-term outcomes for local providers or evidence that strategists across Scotland would adopt Healthy Respect

This section considers the maintenance of Healthy Respect. We will explain why certain parts of Healthy Respect were mainstreamed in Lothian and examine its impact on local providers. We will also comment on whether strategists across Scotland might adopt Healthy Respect.

The findings in this section are based on data collected from strategists in five local authority areas across Scotland. Strategists from the NHS, local authority and voluntary sectors were chosen from each area. The areas include two cities, one remote and rural, and three which are a mix of urban and rural. The findings on mainstreaming in Lothian are based on the second survey conducted with providers.

3.6.1 Key findings

Mainstreaming Healthy Respect was constrained by a preset timetable and the lack of available findings from the evaluation at the time the decision had to be made. Decisions were influenced by the Healthy Respect team’s experience and learning from delivering the programme. Other criteria were important. Some elements of the programme, such as the work with vulnerable young people, were still regarded as being in the demonstration phase and therefore needed more time to mature.

Most (77%) of those providers engaged with Healthy Respect at the end of the demonstration period said mainstreaming did not give rise to any problems. However, there was some indication of problems reported by those in the NHS such as reduced service or service closure. This is important given the close ties between Healthy Respect and other parts of the NHS, and the central position of the NHS in local networks. It should be remembered that the second survey was conducted just as mainstreaming began and it is difficult to assess how organisations and staff within these organisations will be affected in the longer-term.

Research with strategists suggested that learning from Healthy Respect had taken place across Scotland. Perhaps most influential was Healthy Respect’s ability to form strategic partnerships with organisations. Healthy Respect was probably best known for linking education and sexual health services, which is perhaps unsurprising given the long history of this particular model which was introduced in Phase One in 2001. All strategists commented on the difficulty in working with faith groups in general. None suggested Healthy Respect had addressed this issue, but its work with Catholic schools
was noted as innovative and provided insight into how organisations might engage with religious groups. Finally, the idea of a brand was viewed as a powerful tool in attracting young people to a service; something young people would recognise and know what to expect. There were, however, a number of factors which act against the potential adoption of Healthy Respect in other areas of Scotland including providers’ response to the national sexual health strategy and the lack of findings from the Healthy Respect evaluation.

3.6.2 Detailed findings: Mainstreaming Healthy Respect

As planned, the Healthy Respect Two demonstration period ended in March 2008. Interviews with the Healthy Respect team provided some insight into why some elements of Healthy Respect continued while others did not. At the time of these interviews, mainstreaming was underway and this was occurring within a context in which the external evaluation findings were largely unavailable. Thus, the team tried to draw evidence together from a number of sources including those that relied on practical experience and learning. It was not an exact science and often relied on a process of collective deliberation. The following examples illustrate some of the decision-making around mainstreaming.

There was reflection about the extent to which demonstration had or had not been achieved. It was acknowledged that drop-in services and SHARE were developed over a longer period of time and were therefore more mature. There was less certainty about the work with vulnerable young people. Some doubted whether the work with vulnerable young people was sufficiently developed and there was an appeal to continue with this work on the grounds that it would take more time to mature to the level of older elements of the programme.

‘And the way to answer the other question is probably to think about if someone else was going to start it and they were asking you how to do it, would you be able to tell them what to do? And I think we could tell them what to do with formal education, drop-in services, and communications, but I don’t think we could with objective two. So I don’t think objective two has achieved demonstration.’ (‘Objective two’ is Healthy Respect’s work with vulnerable young people).

Healthy Respect team member.
'Yes I do think it's a time thing. It's just one of those things. It's almost like where we were with the schools in the early days. It wasn’t until the end of Phase One that schools were really accepting of SHARE. It was still quite disparate so I feel as though objective two is in the same position.’
Healthy Respect team member.

It could be argued that the work with the Catholic Church was at a similar stage to that of vulnerable young people. It was a new development and there was no available evidence to suggest it had an impact on young people and no research planned as part of the evaluation of Healthy Respect Two. A decision was made at the very start of Healthy Respect to mainstream it through the Catholic Church. This indicates a different set of criteria, which in this example includes ideological differences.

‘I think we took it almost as far as we could, the absolute limits of where it could go to. I think there were some things obviously from SCES’s perspective that are immovable and always will be.’
Healthy Respect team member.

‘And in terms of what young people will actually experience, I think the programme came on in huge strides in terms of how things are delivered, and putting the kind of principles and the Catholic teachings to one side, things like participatory methods and you know…the ways in which teachers who have been asked to deliver this were quite a departure and quite different, so there has been a huge influence from this side of things on all of that as well.’
Healthy Respect team member.

Impact of mainstreaming on providers in Lothian
The results from the two provider surveys suggested a tailing off of resources received from Healthy Respect over time, including funding, but there was little evidence that this resulted in a reduced impact on professional knowledge and skills, focus, or impact on organisational capacity as compared with the first wave.
Questions on mainstreaming were asked in the second provider survey. Most (77%) said that mainstreaming did not give rise to any problems in their organisation. Of the 33 reporting problems, 18 were from the NHS, 10 from schools, three from the voluntary sector and two from a local authority. Seven reported service closure (four from the NHS); 19 said their service operated without funding (15 from the NHS); and 17 said their service was inadequately funded (13 from the NHS). Thus it can be seen that more problems were reported by those in the NHS.

We asked respondents to indicate how mainstreaming might affect organisations throughout the Healthy Respect area, i.e. Lothian. Responses to a number of questions ranged between 25% and 40% of those who thought there would be a general increase in activity throughout Lothian as a result of mainstreaming. Between 8% and 15% thought there would be a general reduction in activity. Between 20% and 27% said that there would be no change, and between 30% and 45% said they didn’t know.

Overall the results of the second wave survey suggest that in the short-term the impacts of mainstreaming appeared minimal. However, it should be remembered that the second survey was conducted just as mainstreaming began and it is difficult to assess how organisations and staff within these organisations will be affected in the longer-term. There were some early signs of problems occurring among NHS staff who reported service closure or restricted service provision as a result of mainstreaming.

3.6.3 Potential adoption of Healthy Respect across Scotland

A sample of 16 high level managers in health and local authorities and the voluntary sector who made a significant contribution to the local sexual health strategy were interviewed in five Scottish local authority regions.

This research suggested that learning from Healthy Respect had taken place across Scotland. Perhaps most influential was Healthy Respect’s ability to form strategic partnerships with organisations which provided education, information, or sexual health services to young people. Healthy Respect was probably best known for linking education and sexual health services, which is perhaps unsurprising given the long history of this particular model which was introduced in Phase One in 2001. All strategists commented on the difficulty in working with faith groups, and the greatest issue from their perspective was ensuring young people had equal access to information and sexual health services. None suggested Healthy Respect had fully addressed this issue, but its work with Catholic schools was noted as innovative and provided insight into how organisations might engage with religious groups. Finally, the idea of a brand was viewed as a powerful tool in attracting young people to a service.
There were, however, a number of factors which acted against the potential adoption of Healthy Respect in other areas of Scotland. Understandably, other regions did not operate in a vacuum while the demonstration occurred. These regions were influenced by other factors, including the national sexual health strategy, the need to act while awaiting the findings from the Healthy Respect evaluation, designing local services for local needs, the scientific and professional literature, and models of service provision from other areas of the UK. The lack of evidence from the evaluation of Healthy Respect Two was also seen as a barrier. Thus, although there was evidence to support the transfer of learning from Healthy Respect to other regions in Scotland, the picture is more complex in that local strategy and thus service delivery are probably shaped by a number of influences, only one of which is the National Health Demonstration Project, Healthy Respect.
4 Discussion

4.1 Did Healthy Respect engage effectively with providers?

Sexual health provision in Lothian predated Healthy Respect One (2001) and included c:card, voluntary sector sexual health services, NHS family planning services, and HIV services. These were funded separately and were not managed directly by Healthy Respect. This was also true of Healthy Respect Two. Leaving aside the 24 Healthy Respect drop-in services, many organisations already existed across Lothian and were set up through different funding mechanisms. Healthy Respect therefore sought to work collaboratively with existing organisations. They provided training, support, and advice with the aim of helping these organisations to improve their sexual health work with young people.

Our findings suggest that partnership working was an important mechanism through which Healthy Respect linked with organisations. Healthy Respect’s leadership role was well recognised by local providers who viewed them as champions and helped to raise the profile of sexual health at all levels across organisations. This indicates that Healthy Respect’s influence was felt at a strategic and front line level within organisations. A close partnership was formed with approximately half of providers. Those with a good relationship with Healthy Respect benefited more from it, primarily in receiving help to improve their knowledge and ability to work with young people. Other organisations benefited less from Healthy Respect, typically those in the local authority sector and specifically those working with vulnerable young people.

Those most engaged with Healthy Respect were from the NHS (including school nurses) and voluntary organisations which offered sexual health services to young people. This may be relatively unsurprising given the Healthy Respect team were based in the NHS and, as such, were able to form more natural alliances with other NHS services. Sexual health services occupied a dominant position in local networks of providers. Many providers linked with these services including secondary schools which offered SHARE. Thus, the Healthy Respect team established links with organisations which occupied a key position in local networks. Strategically this represents the best entry point into a network and is more likely to affect change.

There was a strong thread running through our findings that some elements of Healthy Respect One such as SHARE and the drop-in services were developed more fully during Healthy Respect Two, while some of the new
components of Healthy Respect Two were less developed. One new area of work, Healthy Respect’s input into primary schools (Zero Tolerance Respect), was also well implemented and well received by teachers and pupils. Interestingly, strategists from across Scotland also thought Healthy Respect’s strength lay in their ability to work with schools and sexual health services. It takes time to fully develop relationships with providers; an argument which was advanced by the Healthy Respect team and is also evident in the literature\textsuperscript{13}. The argument was also advocated by the team that conducted the evaluation of Healthy Respect One. Their report suggested that long-term growth was required to help develop the focus and maximise the potential of Healthy Respect One.

4.2 Did Healthy Respect engage effectively with parents?

The Home Activity Resource was specifically designed to engage parents directly in a way which was not apparent in the other components of Healthy Respect, including the parent initiatives developed in Healthy Respect One. Given the relatively low levels of adoption among parents, particularly secondary school parents, it could be argued that the potential impact of Healthy Respect on family relations was low. The poor uptake among teachers, particularly secondary school teachers explains, in part, the poor uptake among parents. Lack of time was the main reason provided by secondary school teachers for not using the pack. It is interesting to note from our qualitative work that in contrast to primary school pupils, secondary school pupils expressed mixed views about whether the idea of doing homework with parents was a ‘good thing’. This could have influenced teachers’ decisions to use the resource.

There remains the key question of whether the HARs were powerful enough to improve family engagement with a view to improving sexual health. Our surveys and qualitative work with parents indicated that most of them recognised and valued the importance of spending time together as a family. As previously noted, the parents in the surveys and the qualitative research may represent an enthusiastic section of the community with extremely high levels of family engagement that would be difficult to enhance. The issue then becomes how best to improve family engagement among families who are less enthusiastic or do not have the means available to them to improve their family relations, what is technically termed ‘family social capital’. This is extremely difficult because ‘family social capital’ is dependant upon changing cultural values that are often reinforced by community norms which, in turn, are deeply engrained within communities\textsuperscript{14}. 
There is also the issue of which family members to involve in discussions about sexual health and when. Many parents reported feeling comfortable about discussing sex and relationships with their children. However, more sensitive issues such as menstruation, puberty, and pregnancy were rarely discussed with boys. Most parents indicated that it was either the mother, or mother and father jointly, who dealt with questions around sex and relationships education. Fathers were not seen as the main source of information by those questioned.

4.3 Did Healthy Respect engage with young people?

The percentage of the population reached by Healthy Respect varied according to which aspects of reach are considered. Awareness of Healthy Respect was restricted to the more visible parts such as the media campaigns and literature which contained the logo. Awareness of the Healthy Respect logo and literature is probably around 40%, with girls being more aware than boys. However, it should be noted that the tracking surveys commissioned by the Healthy Respect team, and not randomly selected samples, suggests that the recognition of the logo was higher, at 66% of young people. Awareness of anything other than the logo or literature was lower at around 25% and this fell over time to around 17%, particularly among girls living in social housing. Other parts of Healthy Respect such as SHARE were not branded as Healthy Respect and thus pupils may not have associated it with Healthy Respect, yet we estimated that 90% of those in S2 to S4 across the 16 schools in Lothian were exposed to SHARE. Furthermore, all primary 7 school children in Midlothian were exposed to Zero Tolerance Respect, but none would have identified this as a Healthy Respect package because it was not branded as such.

At the end of the secondary school survey (2008/9) a total of 57% of girls and 65% of boys reported using sexual health services, including the Healthy Respect drop-ins. Service use was significantly higher among pupils who were less affluent in both 2007 and 2008/9. Significant improvements in service use were seen for all groups in the intervention area from 2007 to 2008/9, although the greatest improvements in service use were seen for boys (more affluent 42% vs. 62%; less affluent 54% vs. 71%). This is extremely encouraging and suggests Healthy Respect’s focus on targeting those from more deprived areas has worked, at least among those attending school.
The difficulties encountered by providers in working with particularly vulnerable young people who were not in mainstream schools, suggests that it is likely that some of these vulnerable young people were missed by Healthy Respect. These include young people with poor literacy and communication skills or who had a background of abusive relationships. There were a number of reasons why work with these young people was difficult, including organisational priorities and issues around partnership working with Healthy Respect. Further work in this area is likely to be resource intensive and raises the question of whether a public health intervention such as Healthy Respect should allocate disproportionately more resources in reaching and working with young people who are socially deprived. This dilemma is faced by other public health interventions whereby the potential benefit to a small but needy section of the population takes precedence over the majority.

4.4 Did Healthy Respect have an impact on the sexual health and relationships of young people?

4.4.1 Primary school children
Zero Tolerance Respect was well implemented and well received by pupils and teachers, however its short-term impact was limited. There was a slight improvement in boys’ attitudes regarding respectful relationships. Girls on the other hand reported high levels of respect at baseline with little potential for improvement and thus no change at follow-up. There was very little evidence of discriminatory attitudes by race or gender in these pupils either before or after the package was delivered. However, over 55% of boys and over 25% of girls listed at least one age-inappropriate film (as classified by the BBFC) among their favourite three, and less respectful attitudes were strongly associated with the viewing of these films.

This was the first time a primary school education package on relationships was subjected to a randomised controlled trial. However, we did not assess the impact on behaviour which is probably more difficult to change and more difficult to assess. There is the additional question of whether these types of educational package have a long-term impact on attitudes and behaviour.

4.4.2 Secondary school children
It is worth noting, at the time of the secondary school survey, most young people (mean age 15 years, 6 months) had not yet had sexual intercourse. Approximately one-third of young people in the intervention and comparison areas reported that they were sexually active. Most (approximately 70%)
used condoms at first intercourse. This might suggest that the sexual health promotion these young people receive is, by and large, working. Thus, the minority of young people with poor sexual outcomes are a residual group whose behaviour has been insufficiently affected by sexual health promotion. To change their behaviour is therefore a particularly challenging task.

**Boys**

Healthy Respect had a significant and beneficial effect upon boys’ sexual health knowledge. However, sexual health knowledge was greater among more affluent boys than less affluent boys at the time of first survey and, although there was evidence that improvements were made among less affluent boys, the gap in knowledge between both groups remained. Healthy Respect had a significant and beneficial effect upon boys’ use of condoms at ‘most’ instances of penetrative sex. More affluent boys were nearly twice as likely to have used a condom at most instances of sex than less affluent boys. There was a significant increase in the use of services by boys in the intervention area and this was mirrored by a significant increase in service use by boys within the comparison area.

**Girls**

Service use significantly improved for all girls within the intervention area during the course of Healthy Respect and this was mirrored by an increase in service use by girls in the comparison area. Improvements in practical sexual health knowledge were mainly seen among more affluent girls. Although girls in the intervention area were as likely as girls in the comparison area to view condoms as protective, we noted a significant shift at the end of the study among girls in the intervention area to view condoms as less protective. No change was seen in the intentions of girls (both more affluent and less affluent) to use condoms in protecting against pregnancy and STIs. There was no significant change in the use of contraception among girls over time. Finally, girls in the intervention area were significantly more likely to feel pressured into, and subsequently regret, their sexual debut. The last two findings were limited to more affluent girls.

**4.4.3 Possible mechanisms**

There are four possible explanations which might account for the differences in outcomes between young people in the intervention and comparison areas. First, these were due to sex and relationships education. Second, was that sexual health services influenced young people’s sexual health. Third, is that both sexual health services and sex and relationships education acted synergistically to influence young people’s sexual health. Fourth, is that other factors influenced the findings.
Sex and relationships education

The theoretical basis of SHARE\textsuperscript{15} which was partially supported by findings from the SHARE trial\textsuperscript{16}, suggest that SHARE should lead to an improvement in knowledge, attitudes and intentions which, in turn, should lead to less unprotected or unsafe sex and a reduction in regret and coercion (Appendix 1). This evaluation found a marked improvement in knowledge for all groups except less affluent girls, but virtually no change in attitudes, intentions, or behaviour. Indeed, girls’ attitudes and intentions deteriorated thus any beneficial impact of SHARE was largely confined to knowledge.

Sexual health services

Given that sexual health services provide the means of reducing risk (e.g. condoms) then the outcomes might be more behavioural in nature. There was an increase in service use by both girls and boys in the intervention area and the control area, suggesting that there were marked improvements in service provision in both areas. It is also important to note that service use was greater in the intervention area. Given the failure of SHARE to affect the intermediary outcomes between knowledge and behaviour, and since the main use of services was to access condoms, it seems more plausible that boys’ increased condom use is attributable to service provision, rather than to sex education.

Sex and relationships education and services

In reality it is extremely difficult to disentangle the exact impact of sex and relationships education and sexual health services. Both were delivered at the same time and it is possible that they acted synergistically to influence change. Following the results of the SHARE trial it was assumed that improved sex and relationships education might reduce teenage sexual risk-taking if it was combined with high quality service provision\textsuperscript{17,18}. Although our data suggests that sex and relationships education made a limited contribution to the improved sexual health outcomes, it might have had an important role in informing young people about their local sexual health services.

That service use in the intervention area remained higher than in the comparison area supports the argument that long-term investment in youth-friendly services is beneficial in engaging young people. Healthy Respect One did not influence the sexual health outcomes of young people and this was thought to be related to the underdeveloped focus of the project. We also know from the evaluation of Healthy Respect One that the popularity of sexual health drop-in services increased after the intervention. We therefore think the value which was added to the existing configuration of service provision in Lothian by Healthy Respect accounted for the improved outcomes among boys.
Incidentally, this does not mean that the configuration of sexual health provision in the comparison area was ineffective. There was a secular increase in young people’s knowledge of where to obtain advice, and girls in the comparison area were more knowledgeable about where to obtain condoms. It demonstrates that the responses taken by the comparison area had an effect upon young people’s service use. As noted in our research with strategists, there was an expressed need to improve sexual health provision in other areas of Scotland and a requirement to respond to the national sexual health strategy, *Respect and Responsibility*, which might account for the change in service use in the comparison area. Financial support was also available as part of the strategy to support youth-friendly services.

**The impact of other factors**

Of course it is possible that influences other than sexual health provision could account for the differences between young people in Lothian and the comparison area. Given that the data from secondary schools were derived from a series of cross-sectional samples, there remains the possibility of underlying changes in the samples. These might include strong social or cultural beliefs and changes in demographics resulting, for instance, from migration in the local population. However, every effort was made to account for these differences by matching the intervention and control areas, and taking account of sample characteristics when analysing the data.

**4.5 Effects on sexual health inequalities**

Boys in primary and secondary schools benefited most and this is encouraging since they are traditionally excluded from home-based discussion about sexual health and conversations about sexual health with their peers. The improvement among boys is also encouraging given that a recent UK trial of a peer-led sex education programme (RIPPLE) reported no differences between boys and girls and no improvement on sexual risk behaviour or relationships per se. Our results also challenge the more negative findings from the evaluation of the Teenage Pregnancy Strategy in England where a reduction in the use of contraceptives among young men was reported.

The increased pressure and regret felt by more affluent girls is difficult to explain. It is possible that the increased focus of SHARE on quality of relationships may have sensitised them to the issue of pressure and subsequent regret. In addition, these girls are more likely to have educational aspirations that would be negatively affected by an unintended pregnancy and, as such, they may regret having risked that future. The finding that girls are less influenced by interventions and more by their social environment
(e.g. individual and neighbourhood poverty), and boys’ knowledge and contraceptive use are influenced by sex and relationships education and services replicates previous findings\textsuperscript{22}.

It is perhaps difficult for a public health intervention to equalise sexual health outcomes which reflect the fundamental divisions in society and therefore Healthy Respect’s inability to narrow these inequalities is unsurprising. Changing the socioeconomic conditions which give rise to these inequalities will take a longer duration and a strong political desire. However, there are a number of steps to help counter some of the effects of social inequalities and these are highlighted in the section on implications.

### 4.6 Teenage pregnancy and chlamydia

Teenage pregnancy in Scotland among 13 to 15 year olds declined between 1994 and 2007. The rate of decline in Lothian of 1.15% per year was similar to that of Scotland (1.02% per year). If the trend continues, the NHS Lothian target of a reduction in the pregnancy rate from 9/1,000 (1994–1998) to an underlying rate of 8/1,000 in 2010 will be met. The target was based on that set in the national sexual health strategy \textit{Respect and Responsibility}.

The deprivation gradient in pregnancies persists. The average rate over the whole period for the 13 to 15 year old age group in Lothian varied from under 3/1,000 for the least deprived areas to over 16/1,000 for the most deprived. Overall, the findings do not provide any evidence that rates of testing or rates of positivity for chlamydia infection in young people in Lothian differ from those in the rest of Scotland.

It is difficult to determine what effect Healthy Respect had on teenage pregnancy or chlamydia infection rates in Lothian. The trends in the rates for Lothian broadly reflect those observed elsewhere in Scotland. While these trends may be affected by the level of sexual health provision, it is also possible they are affected by changes in society, including cultural norms. Given the similarity of trends between Lothian and other areas of Scotland, it is unlikely that Healthy Respect had more of an impact on these trends than interventions in other areas.
4.7 What parts of Healthy Respect will be sustained?

Overall the results of the second provider survey suggested that, in the short-term, effects of mainstreaming on organisations appeared minimal. However, it should be remembered that the second survey was conducted just as mainstreaming began and it was difficult to assess how organisations and staff within these organisations would be affected in the longer-term. There were, however, some early signs of problems occurring among NHS staff who reported service closure or restricted service provision as a result of mainstreaming. This is of particular concern because Healthy Respect had established good relations with sexual health services in the NHS.

Healthy Respect is now fully integrated into the NHS. SHARE training is now the responsibility of the Health Promotion Service and NHS Lothian, and the Home Activity Resource is offered to schools which are engaged with SHARE and Zero Tolerance Respect training. It continues to develop its brand and information to young people via publications, local media campaigns and its website. It also operates the sexual health drop-in services, and continues to develop its work with vulnerable young people. If Healthy Respect Lothian can help to maintain sexual health provision through working with existing providers and the operation of Healthy Respect drop-in services; can continue to influence the existing network of services through its leadership and training; and continues to inform young people about service provision, then it is possible that the benefits to young people will be sustained. However, if it succeeds in doing only this, then the disparities in sexual health between boys and girls and across social class may continue.

There are the parts of Healthy Respect which were not mainstreamed by NHS Lothian. Essentially the NHS cannot be responsible for secondary school education. As originally intended, the Scottish Catholic Education Service is responsible for implementing Called to Love in Catholic secondary schools across Scotland. Education departments in each local authority in Lothian are responsible for implementing SHARE and Zero Tolerance Respect and the Home Activity Resource packs. The Scottish Government is responsible for large media campaigns in the future.
The question of mainstreaming outwith Lothian is not one which rests solely with the Healthy Respect team or NHS Lothian. The Scottish Government also has a major role in reaching a strategic decision about the future of sexual health provision in Scotland. Thus, while our evaluation comments on mainstreaming at a very local level and focuses on the decisions made by the Healthy Respect team and their partner organisations, it does not account for the views of government and other national organisations in shaping the future of Healthy Respect and sexual health provision across Scotland.

### 4.8 Has Healthy Respect informed the strategic development of sexual health provision in other areas of Scotland?

Our research with strategists suggested that learning from Healthy Respect had taken place across Scotland. Perhaps most influential was Healthy Respect’s ability to form strategic partnerships with organisations. Healthy Respect was probably best known for linking education and sexual health services.

The national sexual health strategy *Respect and Responsibility* was also influential in shaping local sexual policy and thus sexual health provision across Scotland. It is worth noting that much of the action plan outlined in *Respect and Responsibility* bears similarities to Healthy Respect Two. That the development of the national strategy and the dissemination of Healthy Respect took place at the same time under the leadership of the same NHS Health Scotland programme manager for sexual health, ensured the cross-fertilisation of these two initiatives. Thus, it is possible that Healthy Respect had a direct effect on sexual health provision in Scotland.

One commonly cited reason for not learning from Healthy Respect was the lack of research findings from the current evaluation. This is understandable and gives great optimism to those who think interventions should be informed by research. The present report constitutes the formal release of the findings from the commissioned evaluation of Healthy Respect Two. NHS Health Scotland has the responsibility of disseminating the learning from these findings. Indeed, NHS Health Scotland continually disseminated the learning from Healthy Respect throughout Scotland during the demonstration phase through the WISH network. Given the importance of our findings, we hope that this dissemination will maximise the impact on the strategic development of sexual health provision across Scotland and strategic developments internationally.
5 Implications

5.1 For future interventions

Partnership working
We think the main driving force behind Healthy Respect was good partnership working. This may be unsurprising to many working in sexual health services and education because it has been advocated by policymakers for some time. However, evidence which supports its effectiveness is relatively rare. One of the key messages from our evaluation is that it takes time to build good quality partnerships and this should be factored into any new intervention which relies on partnership working. It is also crucial that in Lothian, Healthy Respect continues to develop its existing partnerships and strengthen those in their newly developed areas, which include agencies that work with vulnerable young people.

Historical development of sexual health provision
The historical development of service provision was also important in making both services and education accessible to young people. Lothian has a long history of sexual health provision. This pre-dated Healthy Respect One (2001). Healthy Respect also developed over a long period (eight years) and had a positive influence on existing provision. Although service provision improved in the comparison area, service use is likely to take longer to reach the level achieved in the intervention area. The development of service provision outwith Lothian needs to be considered alongside the differences in the impact of Healthy Respect between boys and girls and the lack of impact on the sexual health gap between social classes.

Working with parents
The poor uptake of the Home Activity Resource by teachers and parents was an issue. We know from our interviews with strategists across Scotland that other methods are being tested which aim to improve parental engagement and to work more intensively with parents, particularly those from poorer areas. Two initiatives were specifically mentioned by strategists, Talk2 and SpeakEasy. Both aim to help parents discuss sexual health and relationships with their daughters and sons and both involve direct contact with parents, rather than using an intermediary such as schools. However, data from the secondary school survey and the wider literature suggest that generic aspects of parent-child relationships, in particular connectedness and regulation, are more clearly associated with positive sexual outcomes than communication about sexual matters. Furthermore, intervening with parents in a child’s early years is likely to be more effective than in their teens. Future initiatives should also place greater emphasis on encouraging fathers and sons to engage in discussions around sexual health and relationships.
**Sexual health inequalities**

Little headway was made in addressing sexual health inequalities. There is the need to work more intensely with young people in helping them address some of the underlying issues which shape sexual health and can be delivered through interventions in schools, sexual health services, further education colleges, and other local authority organisations. These might include helping them to develop more respectful attitudes, social skills, self-confidence and worth but importantly linking these to gaining educational qualifications and improving the opportunities to enhance their social and economic position. Evidence suggests that these types of programmes may work, but again there may be differences in the effects between boys and girls. There is also the issue of working with the most vulnerable young people such as those in specialist education facilities and those cared for by local authorities. Mainstream interventions such as SHARE are not easily translated for use in these settings and new approaches are required which better suit these populations. However, it is unlikely that these interventions alone will be powerful enough to address the deep social and economic imbalances in society which give rise to sexual health and other health inequalities and this limitation should be recognised by professionals working in the health, education and social sectors.

**New directions**

These findings suggest the need to reconsider more fundamentally how we tackle poor sexual outcomes among teenagers. Overall, our findings suggest that a large scale, multi-component, multi-sector sexual health intervention for young people had limited beneficial effects. This is broadly in line with the rigorous evaluation of other sexual health interventions in the UK, such as RIPPLE and SHARE. While this evaluation provides evidence of the benefits of high quality school sex education and the widespread implementation of sexual health services, it also shows that different approaches are probably necessary to achieve more substantial impacts on sexual health outcomes. Evidence from this study and the wider literature point to three radically different approaches, each of which may be more promising.

First, there is strong evidence that many poor outcomes in teen years are best tackled in the early years of a child’s life when interventions are most cost-effective. In so far as sexual risks are part of a constellation of other risk behaviours, and therefore a reflection of more fundamental social problems, early interventions give the best chance of success because the changes in brain structure involved in social behaviour are most marked during the early years. Brain structure and function influenced by postnatal environmental factors and sensory inputs can be difficult to reverse later in life. Evidence that early interventions can have positive effects on sexual outcomes in late adolescence and early adulthood come from the Family Nurse Partnerships and the Abecedarian Project.
Second, the clear social patterning of poor sexual health outcomes suggests that these are, in large part, the effect of underlying social and economic structures. It is difficult to argue that these could be changed by the health, education and social care sectors. These sectors are unlikely to address some of the deeper structural determinants of sexual and other health inequalities, such as poverty, which can only be tackled through government-led reforms. These reforms might include fiscal policies which redistribute wealth and welfare policies which reallocate resources in society.

Third, over half of boys and over a quarter of girls in our research in primary schools listed at least one age-inappropriate film (as classified by the BBFC) among their favourite three, and less respectful attitudes were strongly associated with the viewing of these films. There is also evidence of the negative effects of exposure to sexual images in the mass media and computer games. If early findings from the USA, now confirmed in the UK, suggest the need for interventions that modify media content and exposure to negative images, this might be achieved through a combination of editorial policy, censorship and informing parents about the need to restrict their children's viewing.

5.2 For future evaluations

Interaction
This evaluation was highly interactive. It involved close communication between the evaluation team, the funders (NHS Health Scotland) and the Healthy Respect team. Each was involved in refining the evaluation protocol. We reported the findings to the Healthy Respect team and NHS Health Scotland as soon as these became available. We wrote a series of technical reports which provided the detailed methods and findings of each of the research components. The findings were also presented during specially convened feedback seminars with the Healthy Respect team, NHS Health Scotland and other stakeholders. An interim report was also published in 2008. This process of continuous feedback allowed the Healthy Respect team to consider how the findings might be used to inform the development of the programme during the demonstration phase. We also think this helped establish good working relations between each of the organisations involved. However, evaluators seeking to replicate this method of working should be aware of the considerable time and effort required in doing so and should build this into their protocol and costs.
Design
There are always ways in which to improve an evaluation. A randomised cohort study with longer follow-up would have been ideal, but this was not possible because the intervention area was already chosen and the follow-up was limited by the funding for the study. We thought the work with providers, parents and young people added depth to the analysis because it provided insight into the workings of the ‘black box’ and thus helped explain the effects and limitations of Healthy Respect. However, an important limitation is that we have limited data on what changes in the provision of services in the comparison area led to an increase in service use.

Economic evaluation
We did not have the resources to conduct an economic evaluation. Thus we do not know how cost-effective Healthy Respect was compared to other initiatives. This is important, because other policymakers need this information to help them choose how to allocate scarce resources. These choices will be increasingly difficult to make in light of the current financial climate and government spending review. Any discussion on cost should include the findings from this evaluation including the differential impact on young people. It should also consider the costs and effects observed in the comparison areas.

Evaluating pregnancy, terminations and chlamydia.
Given the small number of teenage pregnancies and termination and the width of the resulting estimates, it is extremely difficult to use these as ‘hard’ outcomes in evaluations of sexual health interventions. However, testing for chlamydia as part of research, rather than relying on routine testing data, might prove a better indicator of risk behaviour.

Assessing the sexual health of young people who are not at school
This evaluation focused on the impact of young people who attended mainstream schools and we know very little about those who may be in special education settings or care settings. There is the need for additional research to assess the sexual health of these young people and assess the impact of public health interventions on their sexual health.
Learning from the evaluation

Understandably, strategists in other areas of Scotland voiced some concern about the time taken to report all of the findings from the evaluation. This is understandable. The evaluation took a long time to complete (four years) and during that time other areas of Scotland developed sexual health provision for young people. As indicated, the national sexual health strategy, *Respect and Responsibility*, influenced this development. NHS Health Scotland also disseminated the learning from Healthy Respect during the demonstration phase. This raises an important question about the importance of evaluation in decision-making, particularly in relation to practical and political expedience. Pressure to act is understandable, but this leaves the difficult issue of using the results of this evaluation to inform a policy landscape which has developed, and probably differs, from that which existed at the beginning of the National Demonstration Project.

A key question is whether it is of value conducting longer-term evaluations like this one which assess the impact of interventions on health. Some might argue for a series of short-term evaluations which focus mainly on implementation and assessing need, but which fall short of telling us whether something worked. In reality both types of evaluations are necessary. However, over the coming years, government expenditure for health research is likely to reduce and thus deciding how to use scarce resources will become more difficult. It would be extremely discouraging if investment in these types of large scale evaluations of public health interventions was reduced in favour of short-term evaluations, particularly if the nature of the interventions were to change as indicated above.
References


Appendix 1
Healthy Respect logic model
<table>
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<tr>
<th>Inputs</th>
<th>Outputs</th>
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<tbody>
<tr>
<td>Resources invested</td>
<td>What we do</td>
</tr>
<tr>
<td>Budget</td>
<td>Advocacy and leadership (negotiation, meetings, policy development, conferences)</td>
</tr>
<tr>
<td>Staff time</td>
<td>Knowledge transfer (learning network activities, visits to and from projects and health boards)</td>
</tr>
<tr>
<td>Partners input</td>
<td>Monitoring and evaluation (information and data collection on population and uptake)</td>
</tr>
<tr>
<td>Materials, technology, IT</td>
<td>Marketing and evaluation (information and data collection on population and uptake)</td>
</tr>
<tr>
<td>Resources invested</td>
<td>Who we reach</td>
</tr>
<tr>
<td>Budget</td>
<td>Directors of Education; Chief Executives of local authorities and NHS; Scottish Executive (health and education); NHS Health Scotland; National Sexual Health Advisory Committee</td>
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<tr>
<td>Young people’s time</td>
<td>Scotland-wide sexual health and public health practitioners and service providers, community health partnerships and nursing directors</td>
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<tr>
<td>Parent’s time</td>
<td>Academic sector (public health)</td>
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<tr>
<td>Staff time</td>
<td>Lothian professionals/stakeholders and elected members</td>
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<tr>
<td>Partner’s input</td>
<td>Healthy Respect partners (delivery)</td>
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<th>Products</th>
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<td>Partners agreements</td>
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<td>Policy and strategy documents</td>
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<td>Briefing papers and presentations</td>
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<td>Professional guidance</td>
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<td>Integrated brand and communications strategy</td>
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<td>Self-assessment and audit tools</td>
</tr>
</tbody>
</table>

| Evaluation: focus-collect data–analyse and interpret–report–learn |
| Who we reach |
| Teachers in Healthy Respect One and Healthy Respect Two schools |
| Social work and youth work (north-west Edinburgh and Midlothian) |
| School nurses and NHS |
| Voluntary sector agencies (e.g. lesbian, gay, bisexual, transgender youth) |
| Community education |
| Parents of young people in Lothian |
| Healthy Respect Two partners |
| Young people aged 10 to 18 years in Lothian |

**Assumptions**

Teachers and other professionals will commit to attend five days training; children’s services departments will take on the role of working with hard-to-reach young people and parents; drop-in services will continue to attract hard-to-reach groups; young people and parents will respond positively to Healthy Respect social marketing campaigns; partners will sign up to partners’ agreements and shared goals; evidence from elsewhere can be adapted to meet Scottish needs; schools are ready and willing to engage in Healthy Respect and SRE; Healthy Respect is recognised as a key part of young people’s services in Lothian.
### Long-term impacts

- Environment that encourages positive sexual health & relationships
  - Social
  - Cultural
  - Tolerance
  - Reduction in stigma/discrimination
- % Reduction in STIs in 10-18 group
- % Reduction in pregnancy rates (10-18 including ‘deprived’ groups)

### Outcomes

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>What the short-term results are</strong></td>
<td><strong>What the medium-term results are</strong></td>
<td><strong>What the ultimate impacts are</strong></td>
</tr>
<tr>
<td>Engagement of partners in Healthy Respect Two</td>
<td>Influencing policy and practice relating to young people’s provision – Healthy Respect included in children’s services and health improvement plans</td>
<td>Provision of a coherent and multi-faceted intervention to create an environment that positively influences the cultural and social factors which impact on sexual health and relationships</td>
</tr>
<tr>
<td>Partners commitment to programme delivery (time, funding, resources)</td>
<td>Improved leadership for sexual health in Lothian (champions, coverage, integration into policies)</td>
<td></td>
</tr>
<tr>
<td>Provision of a multi-agency network to coordinate services to young people</td>
<td>Changes in practice regarding sexual health services, SRE and integration</td>
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<tr>
<td></td>
<td>Local finance secured for mainstreaming successes</td>
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<td></td>
<td>System in place to transfer national resources and learning</td>
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<tr>
<td></td>
<td>Seamless referral pathways between education and services</td>
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<td></td>
<td>Implemented SRE framework in all target schools and across Lothian</td>
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<tr>
<td></td>
<td>Increased professional capacity and confidence (knowledge, skills, networks)</td>
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<tr>
<td></td>
<td>Better links between services and home/school</td>
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<tr>
<td></td>
<td>Increased access to quality services (13 to 18 year olds and excluded groups)</td>
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<td></td>
<td>Improved referral and improved monitoring/evaluation in clinics/services</td>
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<td></td>
<td>Increased opportunities for STI testing (sexually active)</td>
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<tr>
<td></td>
<td>Increased brand awareness (linked to understanding of healthy respect values)</td>
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<tr>
<td></td>
<td>Reduced negative press coverage regarding sexual health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increased number/quality of press</td>
<td></td>
</tr>
<tr>
<td><strong>Young people</strong></td>
<td><strong>Parents</strong></td>
<td></td>
</tr>
<tr>
<td>10% improvement in knowledge, attitudes and intentions</td>
<td>Greater percentage of parents engaging with young people regarding sexual health and values</td>
<td></td>
</tr>
<tr>
<td>Reduced regret and coercion (sexually active)</td>
<td>Increased surveillance and monitoring by parents</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percentage reduction in STIs in 13 to 18 year olds (sexually active)</td>
<td></td>
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<tr>
<td></td>
<td>Percentage reduction in pregnancy rates (13 to 18 year olds including ‘deprived’ groups)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increased sexual competence (sexually active) 13 to 18 year olds and excluded groups</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reduced negative press coverage regarding sexual health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increased number/quality of press</td>
<td></td>
</tr>
</tbody>
</table>

**External factors**

- Life circumstances; levels of educational attainment and aspiration; organisational change; staff and partner agency personnel changes; media influence and coverage; financial pressures within NHS and local authorities; stakeholder expectations

**Evaluation:** focus-collect data–analyse and interpret–report–learn
Appendix 2
List of technical reports and contacts
Work with providers

Contact: Professor Lawrie Elliott
School of Nursing, Midwifery, and Social Care
Napier University
Comely Bank Campus
13 Crewe Road South
Edinburgh EH4 2LD

Tel: 0131 455 5304
Fax: 0131 455 5359
Email: l.elliott@napier.ac.uk

Reports:


Assessing the outcomes among secondary and primary school pupils: secondary schools

Contact: Dr Marion Henderson
MRC SPHSU
4 Lilybank Gardens
Glasgow G12 8RZ

Tel: 0141 357 3949
Email: marion@sphsu.mrc.ac.uk

Report:


Primary schools

Contact: Professor Gillian Raab (or Professor Lawrie Elliott)
Napier University
Comely Bank Campus
13 Crewe Road South
Edinburgh EH4 2LD

Tel: 0131 455 5357
Fax: 0131 455 5359
Email: G.Raab@napier.ac.uk

Reports:


Work with parents and young people (and the Healthy Respect Team)

Contact: Dr Claudia Martin
Research Director
Scottish Centre for Social Research
73 Lothian Road
Edinburgh EH3 9AW

Tel: 0131 221 2553 (direct line)
Tel: 0131 228 2167 (switchboard)
Email: claudia.martin@scotcen.org.uk

Reports:


Focus group discussions with P7, S2 & S4 pupils Technical Report.
Reports by the internal evaluation team and on the communication and brand tracking can be obtained from Healthy Respect.

Contact:  Ben Rowlands  
Healthy Respect Lothian  
NHS Lothian  
148 The Pleasance  
Edinburgh EH8 9RS  

Tel: 0131 536 9407  
Email: Ben.Rowlands@nhslothian.scot.nhs.uk
Appendix 3
Healthy Respect drop-ins in Lothian at March 2008
<table>
<thead>
<tr>
<th>No.</th>
<th>Drop-in Area</th>
<th>Open</th>
<th>Setting</th>
<th>Area</th>
<th>Services</th>
<th>Drop-in status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Armadale</td>
<td>Fri 1.00–3.00</td>
<td>NHS health centre</td>
<td>West Lothian</td>
<td>General and sexual health info, c:card plus point, emergency contraception, pregnancy testing and chlamydia postal testing kits.</td>
<td>Opened 3/2007</td>
</tr>
<tr>
<td>2</td>
<td>Boghall</td>
<td>Tues 11.50–1.50</td>
<td>NHS health centre</td>
<td>West Lothian</td>
<td>General and sexual health info, c:card plus point, pregnancy testing and chlamydia postal testing kits.</td>
<td>Opened Phase One</td>
</tr>
<tr>
<td>3</td>
<td>Deans</td>
<td>Wed 11.50–1.50</td>
<td>School</td>
<td>West Lothian</td>
<td>General and sexual health info, pregnancy testing and chlamydia postal testing kits. For pupils of school only.</td>
<td>Opened Phase One</td>
</tr>
<tr>
<td>4</td>
<td>Dedridge</td>
<td>Mon 11.45–1.45</td>
<td>School</td>
<td>West Lothian</td>
<td>General and sexual health info, pregnancy testing and chlamydia postal testing kits. For pupils of school only.</td>
<td>Opened Phase One</td>
</tr>
<tr>
<td>No.</td>
<td>Drop-in</td>
<td>Open</td>
<td>Setting</td>
<td>Area</td>
<td>Services</td>
<td>Drop-in status</td>
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</tr>
<tr>
<td>5</td>
<td>Strathbrock</td>
<td>Thurs 12.00–2.00</td>
<td>NHS health centre</td>
<td>West Lothian</td>
<td>General and sexual health info, c:card plus point, pregnancy testing and chlamydia postal testing kits.</td>
<td>Opened Phase One</td>
</tr>
<tr>
<td>6</td>
<td>Whitburn Health Centre</td>
<td>Mon 12.15–1.45</td>
<td>NHS health centre</td>
<td>West Lothian</td>
<td>General and sexual health info, c:card plus point, pregnancy testing and chlamydia postal testing kits.</td>
<td>Opened 8/2006</td>
</tr>
<tr>
<td>7</td>
<td>Whitburn</td>
<td>Mon 11.50–1.50</td>
<td>School</td>
<td>West Lothian</td>
<td>General and sexual health info, pregnancy testing and chlamydia postal testing kits. For pupils of school only.</td>
<td>Opened Phase One</td>
</tr>
<tr>
<td>8</td>
<td>Musselburgh Connect Health</td>
<td>Mon 12.30–1.30</td>
<td>Community</td>
<td>East Lothian</td>
<td>General and sexual health info, c:card plus point, pregnancy testing and chlamydia postal testing kits.</td>
<td>Opened Phase One</td>
</tr>
<tr>
<td>No.</td>
<td>Drop-in</td>
<td>Open</td>
<td>Setting</td>
<td>Area</td>
<td>Services</td>
<td>Drop-in status</td>
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<tr>
<td>9</td>
<td>North Berwick High School</td>
<td>Wed 1.00–1.45</td>
<td>School</td>
<td>East Lothian</td>
<td>General and sexual health info, c:card plus point, pregnancy testing and chlamydia postal testing kits.</td>
<td>Opened Phase One</td>
</tr>
<tr>
<td>10</td>
<td>The Pennypit Prestonpans</td>
<td>Fri 3.00–5.00</td>
<td>Community</td>
<td>East Lothian</td>
<td>General and sexual health info, c:card plus point, pregnancy testing and chlamydia postal testing kits.</td>
<td>Opened 5/2007</td>
</tr>
<tr>
<td>No.</td>
<td>Drop-in</td>
<td>Open</td>
<td>Setting</td>
<td>Area</td>
<td>Services</td>
<td>Drop-in status</td>
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<tr>
<td>13</td>
<td>Craigroyston</td>
<td>Fri 1.00–3.00</td>
<td>NHS health clinic</td>
<td>City of Edinburgh</td>
<td>General and sexual health info, c:card plus point, contraception, emergency contraception.</td>
<td>Opened Phase One</td>
</tr>
<tr>
<td>14</td>
<td>Dean Terrace Centre</td>
<td>Mon–Wed 3.30–4.30</td>
<td>NHS specialist sexual health</td>
<td>City of Edinburgh</td>
<td>All Family Planning services. General and sexual health info, c:card plus point, all forms contraception.</td>
<td>Opened 2001</td>
</tr>
<tr>
<td>15</td>
<td>South Queensferry</td>
<td>Thurs 12.00–2.00</td>
<td>NHS health centre</td>
<td>City of Edinburgh</td>
<td>General and sexual health info, c:card plus point, emergency contraception, pregnancy testing, chlamydia testing and treatment.</td>
<td>Opened Phase One</td>
</tr>
<tr>
<td>16</td>
<td>The Junction</td>
<td>Tues and Thurs 3.30–6.00 Fri 1.00–4.00</td>
<td>Community</td>
<td>City of Edinburgh</td>
<td>General and sexual health info, c:card plus point and chlamydia postal testing kits.</td>
<td>Opened 3/2006</td>
</tr>
<tr>
<td>No.</td>
<td>Drop-in</td>
<td>Open</td>
<td>Setting</td>
<td>Area</td>
<td>Services</td>
<td>Drop-in status</td>
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<tr>
<td>17</td>
<td>GUM YP Service</td>
<td>Tues 4.00–5.30</td>
<td>NHS specialist sexual health</td>
<td>City of Edinburgh</td>
<td>General and sexual health info, c:card plus point, contraception, emergency contraception, pregnancy testing and testing for all sexually transmitted infections including chlamydia.</td>
<td>Opened 12/2006</td>
</tr>
<tr>
<td>18</td>
<td>Wester Hailes</td>
<td>Wed 2.00–4.00 3.45–4.45 for c:card</td>
<td>NHS health centre</td>
<td>City of Edinburgh</td>
<td>General and sexual health info, c:card plus point, contraception, emergency contraception, pregnancy testing, chlamydia testing and treatment.</td>
<td>Opened Phase One</td>
</tr>
<tr>
<td>20</td>
<td>Newbattle (High School) Drop-in</td>
<td>Mon and Thurs 12.50–1.35</td>
<td>School</td>
<td>Midlothian</td>
<td>General and sexual health info, c:card plus point, pregnancy testing and chlamydia postal testing kits. For pupils of school only.</td>
<td>Opened Phase One</td>
</tr>
<tr>
<td>No.</td>
<td>Drop-in</td>
<td>Open</td>
<td>Setting</td>
<td>Area</td>
<td>Services</td>
<td>Drop-in status</td>
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<tr>
<td>21</td>
<td>Linlithgow Academy</td>
<td>Mon 12.45–2.00</td>
<td>School</td>
<td>West Lothian</td>
<td>General and sexual health info, c:card plus point, pregnancy testing and Chlamydia postal testing kits. For pupils of school only.</td>
<td>Opened 1/2008</td>
</tr>
<tr>
<td>22</td>
<td>West Calder High School</td>
<td>Thurs 12.45–2.45</td>
<td>School</td>
<td>West Lothian</td>
<td>General and sexual health info, c:card plus point, pregnancy testing and Chlamydia postal testing kits. For pupils of school only.</td>
<td>Opened 1/2008</td>
</tr>
<tr>
<td>23</td>
<td>Dunbar Medical Centre</td>
<td>Fri 1.00–2.00</td>
<td>NHS health centre</td>
<td>East Lothian</td>
<td>General and sexual health info, c:card plus point, pregnancy testing, emergency contraception and Chlamydia postal testing kits.</td>
<td>Opened 12/2007</td>
</tr>
<tr>
<td>24</td>
<td>TEN at Through Care &amp; After Care</td>
<td>Tues 1.00–3.00</td>
<td>Community</td>
<td>City of Edinburgh</td>
<td>General and sexual health info, c:card direct point, pregnancy testing and Chlamydia postal testing kits. For clients of through care and aftercare only.</td>
<td>Opened 8/2007</td>
</tr>
</tbody>
</table>