Cragg Ross Dawson

ADULT SEXUAL HEALTH CAMPAIGN

Qualitative research among stakeholders

REPORT

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A. BACKGROUND AND OBJECTIVES

1. Background

The Public Health White Paper (November 2004) announced substantially increased investment commitment to improve sexual health in the UK. On the back of this announcement, the Department of Health is now planning to launch a major sexual health communications campaign in 2005.

In order to inform the development of this campaign, the Department commissioned a programme of qualitative research among Adult Sexual Health Stakeholders.

2. Objectives

The core objective of the research was to inform the development of the campaign and its delivery to the public. Specifically, the research set out to explore:

- what stakeholders would like to see from a sexual health campaign, with particular reference to their local population
- what consumer messages they feel might work among the target population
- how they feel about their capacity to deliver the campaign at a local level, including time and resources available
- what type of materials they would find most useful
- their training requirements
- their views on what type of support the Department of Health and campaign management could best provide
- their views on how the Department of Health should communicate with them about the campaign, including their response to potential ideas for stakeholder messages

B. METHODOLOGY AND SAMPLE

1. Methodology and audiences

The fieldwork comprised 44 depth interviews with Adult Sexual Health Stakeholders. The majority of these were individual interviews; two were paired interviews. Most were conducted in person, in respondents' places of work; three were conducted over the telephone.

The research was split into two consecutive stages, with different audiences in each.

Stage 1

Stage 1 comprised 20 interviews with core sexual health stakeholders. The audiences were as follows:

- GUM clinicians – a mix of health advisors and nurses/doctors/ consultants working in GUM clinics
- community contraception services – a mix of GPs and nurses
- Sexual Health Leads within PCTs
- Teenage Pregnancy Coordinators – a mix of regional and local coordinators

The fieldwork was conducted between 3rd February and 14th March 2005 in the following regions:

- London – a mix of locations, focusing on Tooting and Balham
- Leeds and environs – a mix of urban and rural locations
- South West
  - a mix of rural and urban locations in Devon
  - two rural locations in Cornwall, selected because of their participation in the local Chlamydia Screening Programme

Stage 2

Stage 2 comprised 24 interviews with secondary stakeholders, conducted between 4th and 22nd March 2005 . The choice of audiences was informed by a workshop convened by COI Strategic Consultancy. The audiences were as follows:

- school nurses/PSHE coordinators
- young people's services – services aimed specifically at young people, run by NGOs and charities; a mix of general services and dedicated sexual health services
- health promotion and communications contacts – working within PCTs and Strategic Health Authorities
- Directors and Senior Managers of Public Health – working within PCTs, Strategic Health Authorities and Regional Government Offices
- family planning clinicians – working within dedicated family planning clinics
- Chlamydia Screening Programme Coordinators

The fieldwork was conducted in the following regions:

- London – a mix of locations in North and South London
- Birmingham and environs – a mix of urban and suburban locations
- Manchester and environs – a mix of urban and rural locations

All fieldwork was conducted by Fiona Gillard, Tim Porter and Catherine Taylor. Presentations of the findings were given on 30th March and 6th April 2005.

2. Sample structure

The sample was structured as follows:

Stage 1

D1: GUM clinician – London
D2: GUM clinician – Leeds
D8: GUM clinician – Cornwall
D9: GUM clinician – Devon
D14: GUM clinician – Leeds/Yorkshire
D3: community contraception services (GP/nurse) – London
D4: community contraception services (GP/nurse) – London
D10: community contraception services (GP/nurse) – Cornwall
D15: community contraception services (GP/nurse) – Leeds
D16: community contraception services (GP/nurse) – Leeds
D5: sexual health lead – London
D6: sexual health lead – London
D11: sexual health lead – Devon
D17: sexual health lead – Leeds
D18: sexual health lead – Leeds
D7: regional teenage pregnancy coordinator – London
D12: regional teenage pregnancy coordinator – Devon
D19: regional teenage pregnancy coordinator – Leeds
D20: local teenage pregnancy coordinator – London
D13: local teenage pregnancy coordinator – Devon

Stage 2

D1: school nurse – London
D2: school nurse – Birmingham
D3: school nurse or PSHE coordinator – Manchester
D4: school nurse or PSHE coordinator – London
D5: provider of youth service – London
D6: provider of youth service – Birmingham
D7: provider of youth service – Manchester
D8: provider of youth service – Manchester
D9: communications lead within Strategic Health Authority – Birmingham
D10: health promoter/communications lead within PCT – London
D11: health promoter/communications lead within PCT – Birmingham
D12: health promoter/communications lead within PCT – Manchester

D13: director/senior manager of public health within Strategic Health Authority – Manchester

D14: director/senior manager of public health within Regional Government Office – Birmingham

D15: director/senior manager of public health within PCT – Manchester

D16: director/senior manager of Public Health within PCT – London

D17: family planning clinician – London

D18: family planning clinician – London

D19: family planning clinician – Birmingham

D20: family planning clinician – London

D21: chlamydia screening programme coordinator – Birmingham

D22: chlamydia screening programme coordinator – Birmingham

D23: chlamydia screening programme coordinator – London

D24: chlamydia screening programme coordinator – Manchester

The following abbreviations are used in these notes for ease of reference:

RTPC = Regional Teenage Pregnancy Coordinator
LTPC = Local Teenage Pregnancy Coordinator
SHL = Sexual Health Lead
DPH = Director (or Manager) of Public Health
CSPC = Chlamydia Screening Programme Coordinator

C. SUMMARY OF FINDINGS

1. Context

Discussion of the proposed campaign prompted strong views on the nature of sexual health in Britain. Many respondents perceived a need to overcome British coyness about sex. They felt that the current climate makes life difficult for young people because they are bombarded by messages about sex (and experience peer pressure) but have few places to turn for help and advice. Adults, including teachers and parents, were seen as not well equipped to talk about sex in a helpful way; and there were concerns that the language of sexual health made it seem remote and inaccessible. Senior health professionals wanted to see a shift in focus from sexual disease to sexual health – to normalise sexual health and position sex in a more positive light.

Other issues also came up in initial discussions. It was clear that many sexual health services were feeling stretched: they regarded themselves as under-funded and under-staffed, particularly GU and Family Planning services. GPs were believed to be insufficiently proactive about sexual health services and to be insensitive to issues of confidentiality. Consequently services were believed to be failing to provide young people with what they need. Many of those in senior positions also wanted changes to management structures in sexual health, to ensure that it is given higher priority both nationally by DH and locally by PCTs.

2. Current involvement with communications

Involvement in sexual health communications varied widely according to respondent's role, the nature of the local area and their own attitudes and degree of proactivity. Those working in strategic roles (SHLs and RTPCs) and also DPHs and communications leads, tended to be most involved with and to have the greatest influence on publicity coordination. CSPCs and LTPCs also had a significant role and were involved in ordering and producing materials.

Materials used included both externally-sourced and in-house items. External materials came mainly from DH; they were considered

generally well produced and clearly linked to national campaigns, but often expensive and not always well targeted. Locally produced materials were more precisely targeted but had lower production and design values.

3. General views on proposed campaign

The proposed campaign was widely welcomed, particularly by those in strategic roles. They regarded it as long overdue and saw it as a sign that the government was now taking sexual health seriously. It was also welcomed by those at grassroots level, though in more muted terms; they did not see it having a major impact on their day to day work and were concerned at the effect it might have on their funding.

The campaign was expected to have the potential to improve the nation's sexual health, but also to change the culture around sex and present it in a more positive light. Within this some felt it should focus on prevention – particularly using condoms – while others believed it should concentrate on publicising sexual health services, particularly testing for and treatment of STIs.

Concerns were variously expressed by those in different sectors that a campaign would prompt too high a demand for sexual health services; that focusing on STIs could suggest that these are all easily treated; or that communications should address sexual health in general rather than specific outcomes. Whatever its objectives, respondents felt that DH needed to be consistent in its messages about sexual health, and that it should ensure that the campaign was matched by increased accessibility to services.

There were also divergent views on the tone that a campaign about sexual health should take. Lessons from previous campaigns were perceived in different ways: some felt that the AIDS tombstone campaign of the 1980s had been effective in changing behaviour through sheer impact; others thought it had created a climate of fear. The Sex Lottery and RU Thinking campaign attracted less comment, but were thought to have lacked relevance to young people. The overall view was that communications had to be attractive and appealing to young people, explicit, direct and accessible in style.

In terms of media there was a widespread feeling that there should be a wide range used, including above and below the line communications. Respondents expected the campaign to use TV, radio (youth and including pirate stations), local press, leaflets, posters and other items such as credit card size information cards.

4. Target audience

The assumption was that young people would be the primary audience for the campaign: 15-25 year olds, possibly reaching down to 11-12 year olds. Older ages were also regarded as a risk group, particularly those in their 40s and 50s who were divorced and seeking new relationships. Some felt it should focus on C2DE social classes; others thought it should be more inclusive and cover the more affluent and well-educated.

Beyond this a number of niche groups were identified as in need of sexual health communications for a variety of very different reasons: African-Caribbean people; Asian women; asylum seekers; the prison population; and lesbian, gay and bisexual people.

There was some feeling that a national campaign should not try to cover too many different audiences, and that niche sectors needed to be targeted in different ways. On balance the general view was that it should concentrate on a core audience of young heterosexual people, provided other sectors were addressed separately.

5. Campaign messages

Within the overall objectives of promoting safer sex and encouraging use of sexual health services, and allowing for variations in communication according to age and sexual experience, the general feeling was that the campaign should stick to fairly broad messages. The most important were believed to be: STIs can affect anyone, not only high risk groups; STIs are common; sexual health services are available and some are intended specifically for young people; sexual health is part of general health; this is how to use a condom.

Other messages suggested were to do with: how to recognise STIs; making sex part of a relationship; delaying sex; ease of access to

services; prevention of pregnancy; links between alcohol and having sex.

HIV was generally regarded as a separate issue that would need addressing primarily among African-Caribbean people and gay men. Messaging about HIV was considered difficult; it was important to achieve the right balance between encouraging testing and promoting prevention.

6. Delivering the campaign locally

Expectations of involvement in the campaign reflected respondents' roles. Those in senior and strategic positions expected to have the greatest involvement; they wanted to be consulted on content at the outset, and in some cases prior to finalising campaign materials, and then to coordinate communication around the campaign in their area.

Those working in the field typically did not expect much direct involvement in the campaign, but imagined they would support it by using campaign materials in their work, provided these fitted with their audiences. A minority who were more highly motivated hoped for more active involvement, including input into consultation and planning of local campaigns.

Across the sample there were expected to be limits on the time and resources available to help deliver the campaign. Those in senior roles said that management time could be made available, but worried about how easy it would be to take the campaign out into the community. Those in the field generally felt they would be able to help deliver the campaign, if this meant doing what they did now, but with different materials. All respondents were concerned about funding for services, and the danger of stimulating more demand for them than could be met; there were many calls for increased funding to meet likely increased demand.

Views on training around the campaign reflected perceptions of training generally. A few areas were satisfied with the training currently available; many others felt the training they currently received was inadequate. The primary need was believed to be training updates for service providers to keep them informed about new statistics,

developments and clinical methods. Those most in need of training were believed to be school nurses, GPs and, if there was a drive for more community screening programmes, pharmacists and youth workers. The general feeling was that training was best organised through regional networks and held regionally or locally, including as part of workshops. A number of suggestions were made for ensuring quality and take up of training.

Timing of the campaign was considered a major issue. The key issue was allowing enough time between PCTs' budget setting and the campaign starting. Respondents at senior levels wanted sufficient time to plan for the campaign, flexibility in when they used materials, and delivery of materials in good time.

7. Format and nature of materials used

In relation to format of materials, tried and tested options were thought to work well, particularly leaflets, provided they were young people-friendly. There was also interest in small items, which were thought popular with young people because they were fashionable and discreet. Other formats that were expected to be effective were posters, especially in waiting rooms, more quirky give-aways such as key rings and mock credit cards, and electronic resources such as text messages, pop-ups on internet chat rooms, and CD-ROMs.

In terms of design and style, the general view was that materials needed to be bright, colourful, friendly and accessible, and that if possible young people should be consulted on designs.

There were varying opinions on whether national campaign materials should be adaptable for use at the local level. Most respondents felt that some element of adaptability was desirable: that national materials should stick to broad universal messages with the inclusion of details of local services. At the local level they wanted to be able to produce materials targeted at the local population but incorporating national design elements, such as logos and straplines. Some wanted national materials to be fully finished because they did not have the time or resources to make any adaptations.

8. Communicating with external stakeholders

Current communication channels with DH were generally believed to be effective, particularly by those who felt they needed closest communication – SHLs and DPHs. RTPCs tended to have good communication with the Teenage Pregnancy Unit but less close contact with DH. Communications leads and those working in the field also felt distanced from DH, though this did not seem to trouble most of them.

Onward communication was not consistent. Managers used established networks to cascade news and information to those in the field. These seemed effective in most cases, though some reported problems in receiving communications, particularly if they had limited access to IT.

There was wide variation in how those in the field obtained sexual health materials. Some had a dedicated resource centre; others ordered materials direct or via the SHL or TPC. Practices also varied according to the source of the materials and were influenced by funding issues. Those ordering materials from DH generally used the telephone order line, which seemed to function efficiently.

There was general agreement that once the campaign has been devised it would need to be launched to get health professionals on board. Suggestions for this were local workshops organised through SHLs, RTPCs and public health departments. In relation to ongoing campaign management the general feeling was that existing networks operated effectively.

The general preference was for electronic communication about the campaign, supplemented by hard copies posted and information in specialist press. Some were interested in having a named contact at DH with whom they get in touch with comments on the campaign. Ordering of materials from DH was expected to be done by ‘phone.

It was widely agreed that the campaign should also involve non-NHS stakeholders. The most important were believed to be schools and LEA; others considered worth including were NGOs and charities, youth organisations, clubs, gyms and cinemas.

9. Stakeholder messages

'This campaign is delivered as part of the government's commitment to sexual health in the Public Health White Paper and the national strategy for sexual health and HIV.'

The response to this message was largely positive, especially among senior management; reference to White Paper was effective shorthand for 'increased investment'. Those in the field were typically more familiar with the Sexual Health Strategy than the White Paper.

'This campaign is flexible and ready to adapt to your local needs.'

This statement was strongly welcomed, if it was true. There were some issues of credibility: people wanted to know how this would work in practice, and there were questions about resourcing.

'We're here to help you deliver the campaign in your local area.'

While there was some perceived value in the sentiment of this statement, the phrasing seemed to suggest direct intervention by DH at a local level, which was not credible. There was a perceived need to back this up with further information about what support was available.

'By working together we can prevent the spread of and reduce transmissions of STIs.'

The concept of working together in this statement was important, and was certainly plausible in terms of partnerships with local stakeholders – multi-agency working was a strong current trend. Some working in the field questioned the credibility of 'working together' with DH.

'Prevention is key. The campaign will help reduce pressure on GUM services.'

This was largely greeted with scepticism: although the campaign may ultimately improve sexual health and reduce the need for testing, the short term effect was expected to increase pressure on GU. Some respondents saw potential value in discussing this issue, but thought it needed careful handling.

D. CONCLUSIONS

1. There is considerable, widespread support for a new communications campaign around sexual health; indeed, such a campaign is often thought long overdue.

2. In the short term, sexual health professionals expect (and hope) that a campaign will increase demand on sexual health services. They believe it is vital that funding for these services is increased in order to meet this demand. In particular, they would like to see more use of community and outreach services, and to see these services designed to meet the needs of young people.

3. Opinions vary on what the campaign's priorities should be, but there is general agreement that…

   - young people should be the primary focus
   - there needs to be a balance between encouraging safe sex and increasing access to services
   - sexual health needs to be normalised, encouraging people to see it as part of health generally
   - messages about sexual health should be simple and unambiguous

4. Primary Care Trusts, Strategic Health Authorities and Regional Government Offices expect to be heavily involved in coordinating the campaign at a local level and want to be consulted as part of the development process.

5. As things stand, if the key individuals (i.e. Sexual Health Leads, Public Health managers, communications/health promotion leads and Regional Teenage Pregnancy Coordinators) are informed about the campaign, their current networks and resources will ensure reasonable roll-out at a local level.

7. Campaign materials are likely to be used in many service settings and the more proactive local areas would organise events and publicity to tie in with the campaign.

8. However, given the impetus provided by the White Paper, and the passion and commitment of some of the stakeholders interviewed in this research, we feel there is an opportunity for the campaign to achieve much more.

9. The impact of the campaign could be maximised by…

- using regional events to launch the campaign and engage stakeholders at both strategic and grassroots level
- providing guidance on the aims and objectives of the campaign and ideas about how these might be fulfilled; but also giving local stakeholders the freedom to innovate
- allowing stakeholders to adapt campaign materials to promote their own local services
- providing resource centres to allow easier access to materials
- providing easy access to information about the campaign via a campaign website and a named contact at DH

10. Some respondents also thought that improvements could be made to management structures within sexual health, perhaps using Teenage Pregnancy Coordinators as a model. Several suggested establishing Sexual Health Leads in every PCT and giving them a more clearly defined role and more resource.

11. In terms of campaign materials, the most popular formats are leaflets, posters, credit-card/mini-booklets and novelty items, and if budget is available high profile media such as TV and radio would be welcomed. Many would also like to use electronic resources more widely, although not all services have the necessary equipment in place at present.

12. Giving stakeholders sufficient notice of the impending campaign will be important in allowing them to plan and budget for materials and local events. Most would prefer to order materials by phone, either directly or via existing networks. An online catalogue would also be welcomed.

E. DETAILED FINDINGS

1. Contextual issues

Discussion of the proposed campaign in the interviews invariably involved prior comments by sexual health professionals on the current 'state of the nation' with regard to sexual health. Many respondents were keen to express their views on this before discussing the campaign.

At the broadest level, some of those in senior positions believed that British attitudes towards sex inhibit efforts to improve sexual health, and that a new campaign would need to take this into account. They perceived a mixture of reserve and hypocrisy in attitudes. They felt that the culture and media in the UK have become over-sexualised, and that this puts pressure on young people to be sexually active and confident; but that at the same time there is still a great deal of reticence to discuss sexual health.

These professionals identified a need to overcome the culture of British 'stiff upper lip'; to normalise sex and reclaim it as positive, healthy behaviour; and to encourage a grown-up discourse at national level. Some also believed that sexuality is now too politicised and not treated the classless way it should be. A specific issue here was concern about the influence of the US Christian right, and what they perceived as a worrying drive towards abstinence and ignorance; some respondents wanted the UK government to take a deliberate stand against this.

In terms of ways of tackling the issues, professionals wanted a shift of focus from sexual disease to sexual health; and for the approach to be proactive not reactive: more about prevention than about cure. They wanted a consistent sexual health message communicated over the long term, not the life of a parliament. They felt there was a need (and an opportunity) to win the argument about sexual health once and for all.

> *"The frustration comes from the fact that there is a mismatch between the timescales of the politicians and the timescales of the Public Health people, and neither of us are quite 100% right. The politicians want results and they want to see them now, they have discovered inequalities which have existed*

for 100s of years, and they want rid of them before the next election, whichever one it is; but equally it is not good enough for Public Health to say, 'Oh it will take decades to get rid of all this'."
Sexual Health Lead

"I read some work about what the Netherlands did 20 years ago where they used the media in a proactive way. We need to shift the culture. Sexual health is part of any aspect of health and we don't very often talk about sexual health as being a reproductive health right. It is a very important part of growing up and maturing. And also carrying on the species. We seem to have given rise to a disease-led sexual health as opposed to sexual health in the cultural context."
Regional Teenage Pregnancy Coordinator

Language was also considered an issue: professionals believed that some of the terminology around sexual health was indicative of these unhelpful attitudes. They felt that 'family planning' is irrelevant and outdated, and that 'genito-urinary medicine' is unfriendly, too medical and impenetrable. They thought both these terms seemed deliberately euphemistic, and demonstrated the need for more up to date language and labelling of sexual health as a whole, perhaps as 'sexual health services'.

School nurses and respondents working at senior, strategic levels emphasised the importance of sexual health education in schools. They regarded this as the starting point for sexual health as a whole, and believed that there is currently far too little too late. Many said they would support sex education starting as early as Year 3 or 4, with lessons around relationships, respect and body awareness.

"If you have information, not just for sex but also for things like tobacco, at an age when you are 8, 9, 10, when you are able to understand quite well but you are not driven by hormones and peer pressure and whatever quite so strongly, that can sometimes be a good foundation and protect you when all that starts to happen to you later."
Sexual Health Lead

There was some feeling that school governors and head teachers have too much control over whether and how sex education is taught, that it should be entrenched in the core curriculum. Some also believed that parents have too much influence over whether their children received sex education, and that they should not be able to withdraw their children from sex education classes. Rather, they perceived a need for

support for parents, to help them have conversations with their children about sexual health.

> *"We have got health professionals out there giving health education until they go blue in the face. You have got schools who can choose whether they have sex education within their school, i.e. the school governors decide so some children get sex education and some don't. That could be because it is a religious school or because they feel pupils in that school don't have sex, so it is very much a lottery of what the children get. Now when they are at home, it is whether parents decide to give sex education or not. Also parents can decide whether to pull children out of school, so parents can decide whether their children attend sex education lessons. That could be because of culture, religion, or just 'My Jenny doesn't have sex'."*
> Sexual Health Lead

> *"I go to private schools and to places like [X state school], and the issues are fairly similar. They're not immune from how society views sexual issues. On one hand we've got them watching on their mobile phone a man putting his head in a woman's vagina, and on the other hand the parents won't let them go to sex education. So they get all these messages but they're not getting messages about what is safe."*
> Family planning clinician

Among those providing sexual health services, there was a feeling that there had been under-funding over many years, and that this had caused problems, particularly in GU and family planning. In some areas services were reportedly in crisis and struggling to stay open; clinics were being overwhelmed by demand; and some services struggled to obtain basic items, such as supplies of condoms and communications materials.

> *"The trouble is, it is very easy to say that the Government are saying they want to address this issue but they need to do the walk rather than just the talk. I think people who have been working within that area for so long and have not had the resources are a bit sceptical."*
> Community contraception services (nurse)

Funding difficulties had also led to problems with staffing. Some respondents believed that it was becoming increasingly difficult to recruit and retain health professionals because pay was low, and that individual clinics and units could not afford enough staff. This resulted in piecemeal and unstable service provision.

> *"I think historically family planning clinics have been places where women have done it for pin money. They've done their evening clinics, or they've just done one clinic a week. In fact*

our consultant used that term "pin money" once and everybody just exploded. So obviously it's still got that mentality."
Family planning clinician

"We are staggering along in contraceptive services, with a skeleton staff. We are all immensely stressed and run off our feet. We love our job but we can't deal with the number of people we've got now. People are retiring, our managers won't employ anyone. Every clinic I work with we're short. I started off in one clinic and there was a doctor and 2 nurses then there were 3 nurses, now there are 2 nurses. But we're seeing the same number of people."
Family planning clinician

Related to this, there was some feeling that, family planning services in particular, had an ageing cohort of staff: many were approaching retirement, and no-one had been trained up to replace them.

Across the sample there were a number of concerns about the current provision of sexual health services. Many respondents felt there was still an over-dependence on hospital GU services, and that these were not welcoming to young people: they were unintentionally off-putting and difficult to access.

"I think the conventional model of consultant-led clinics in acute hospitals, delivering services in the way they traditionally have done is not necessarily the best way of delivering. [We need to] have services which are more locally based, potentially operated with more flexible staffing, doing different things. There is perhaps a sense that the White Paper does concentrate on GUM and acute-type services and perhaps it doesn't quite give the prominence to alternative ways."
Director of Public Health (RGO)

There was also a belief that GPs are not sufficiently engaged with sexual health issues. They were perceived as an important interface with the general public, even if they ended up referring patients on to specialist services, and were criticised by other health professionals for not being sufficiently proactive around sexual health. As an example it was said that GPs providing prescriptions for the Pill rarely offered women advice on other contraceptive methods (particularly) condoms, nor on STIs. Confidentiality was also believed to be a worry for young people: there was not enough consistency of confidentiality and this could deter young people from approaching their GP to discuss sexual health problems.

Consequently there were calls for services to be made more friendly and accessible for young people, and many saw outreach and community services as the solution. It seemed that efforts were being made to increase this type of service provision, including through Chlamydia Screening Programmes, but respondents felt that more needed to be done.

In addition to changes to service provision, many at senior levels also called for changes to DH/NHS management structure within sexual health. They felt there was a need to ensure that sexual health is consistently well represented in PCTs and SHAs; several suggested rolling out Sexual Health Leads nationally and giving them a clearer role and greater funding. There was also a demand for better communication between DfES and DH, to make more of the overlap of interests between sexual health, teenage pregnancy and education.

Calls were also made for a stronger central drive to make sure that sexual health is high on the agenda in PCTs. It was widely believed to be regarded within PCTs as a difficult and controversial area, and to cause headaches for senior management, who did not like dealing with it. Sexual health leads and communications leads wanted to ensure that it cannot be de-prioritised; perhaps by introducing more targets or framework agreements.

Finally, it is worth noting the significant differences between local areas, which were apparent even in the limited number of regions covered in this research. It was clear, for example, that rural areas have particular difficulties with access to services, confidentiality and anonymity, and providing services for small populations; some urban areas have very varied populations in terms of language and culture; and seaside areas have specific problems with mobile populations and hedonistic lifestyles.

2. Current involvement in communications

Involvement in sexual health communications varied significantly according to the respondent's role and the idiosyncrasies of the local area. Those with least involvement tended to be those working in the field who did not have a specific responsibility for sexual health: typically GPs, practice nurses, and some school nurses. These

respondents had access to leaflets about sexual health and contraception to use as and when needed, but were unlikely to have much involvement in sexual health communications beyond this.

Among others working in the field (e.g. family planning clinicians, GU clinicians, youth services) degree of involvement depended on respondents' own proactivity and the time and resources they had available. At a basic level, their involvement took the form of creating displays in waiting rooms and giving out leaflets and booklets to service users. Some were also involved in creating their own materials and in participating in events/publicity drives to tie in with national campaigns e.g. National Condom Week. However it was clear that these respondents saw their role as focused on delivering *services*, not communications; the communications materials they used were simply tools to help them do this.

At a strategic level, those most heavily involved in communications tend to be SHLs and RTPCs; others (DPHs, health promotion leads and communications leads) varied according to whether they had a specific responsibility for sexual health. They were typically involved in coordinating the organisation and publicity of local and regional campaigns and events (sometimes to coincide with national campaigns). They ensured that service providers knew about new developments and resources; in some cases disseminating materials to local services. They worked in partnership with other local agencies to coordinate events or campaigns, and produced materials at a regional level (e.g. booklet of all local sexual health services), sometimes organising consultation with young people to design materials.

CSPCs and LTPCs were also heavily involved in communications but spanned both these groups – they worked in the field but were also involved in strategy and coordination. Most of them used a combination of materials they had generated themselves and materials produced elsewhere. The latter largely came from DH – mainly disease leaflets (esp. GU), contraceptive method leaflets (especially family planning), RU Thinking materials and some Sex Lottery materials. Brook and FPA were thought to produce excellent resources for young people, sometimes preferred to DH materials. Some also used materials from other national providers such as THT, local

charities and youth organisations, and international providers (mainly based in the US).

They felt that materials generated externally had advantages and disadvantages. They tended to be well produced and to have high production values; and they tied in with national campaigns and so benefited from greater media spend. Against this they were often expensive to buy and they were not targeted specifically at the local community and so were not always appropriate.

Locally produced materials similarly had positives and negatives. They were regarded as vital for promoting local services, they could be used to tackle specific local issues and were designed to appeal to local people, taking account of local cultural issues. Also, they were sometimes cheaper to produce than external materials and could be produced on demand. The disadvantage of generating resources internally was that it involved time and effort, and the end result was typically something with lower design and production values.

Those in strategic roles tended to have some involvement in coordinating campaigns in local media, mostly local press and radio. This included not only advertising but also phone-ins, chat shows and other interactive publicity. Some areas also organised innovative outreach campaigns which combined service provision and communications, such as sexual health buses touring local communities, and 'pee in a pot' days at universities and colleges.

3. General views on the proposed campaign

3.1 Perceived need for a campaign

Support for a new communications campaign around sexual health was almost universal and the concept was often greeted with considerable enthusiasm.

Professionals in strategic roles tended to be particularly welcoming of the prospect of a new campaign. They felt that a national sexual health campaign was long overdue: the AIDS tombstone advertising from the mid 80s was, in their view, the last truly high-profile sexual health campaign; and the current generation of young people had missed out on those messages. Some felt that sexual health had been the poor

relation in terms of health publicity compared with smoking and drugs, which had been the subject of high profile advertising for several years. They hoped the campaign, and the White Paper generally, were signs that sexual health is turning the corner in the ways they wanted, and were keen to find out if the promised funding materialised.

> *"I think on the sexual health front, to see it given significant priority and see it being pushed up the political agenda was something that I am very pleased to see. I think there is quite a lot of good stuff in there."*
> Director of Public Health (RGO)

> *"From where I'm sitting it's bloody marvellous in terms of the money that is going to get pumped in to help us expand. It's a great idea. Reassuring it has been taken seriously, when for such a long time nothing has really happened."*
> Chlamydia Screening Programme Coordinator

These respondents tended to take a long-term, holistic view of sexual health and were enthusiastic not only because they wanted to see new advertising, but also because they saw a campaign as a sign that the government is committing to sexual health. The proposed campaign was also implicitly seen as an acknowledgement of the value of their roles and their work.

Those working in the field were not always aware of the White Paper, or did not appreciate its potential impact. When informed about the proposed campaign they tended to give it a more muted welcome, but were still positive about it. They felt that the more noise around sexual health the better – a campaign would help open doors and make it easier for them to promote sexual health; and that it would be useful to have new advertising and new materials to work with. However they imagined a new campaign would be unlikely to have a major impact on their day to day work; their key concern was funding for services, and they were concerned that a campaign might mask the need for greater funding.

> *"Part of me says: been there, done that. I would sooner have the money here where we need it."*
> GUM Clinician

A few feared that the renewed commitment to tackling sexual health was politically motivated and might be short-lived, whereas it would take years to achieve a significant impact on sexual health. There were also demands for resources to be directed into front-line services.

> *"I don't know what the aim of the campaign is. If it is to get people into clinics then we need the resources to meet that demand. We have doubled our numbers in the last 5 years. That is going to keep happening. What if people want to get checked out and have to wait?"*
> GUM clinician

3.2 Overall objective of the campaign

At a basic level the objective of a campaign was seen as self-evident – to improve the nation's sexual health. Some were of the belief that this could only be done by changing the whole British culture around sex and sexual health. They thought that a campaign could help to improve this by *normalising* sexual health: encouraging people to regard it as just another aspect of their general health, rather than as something slightly embarrassing or taboo.

They also pointed out that a campaign could also help to change the culture around sex by associating it with enjoyment rather than embarrassment or censure: it could reclaim the whole area of sex in a positive sense, encouraging people to make contraception and testing a normal part of a healthy lifestyle.

> *"I personally think the national campaign should be around breaking down that stigma. We need to get rid of the stereotypical views around clap clinics, and I still think humour is the only way we can change that."*
> Director of Public Health (SHA)

Others seemed simply to be keen to see the government making a noise about sexual health, bringing the issue into the light, and perhaps creating a new brand identity.

At a more specific level, there was some debate about what the main objective of the campaign should be, whether the campaign should seek primarily to increase access to services by encouraging people to get tested for STIs, or to focus on prevention by encouraging greater use of condoms. Though these two objectives are not mutually exclusive respondents differed as to where they thought the priority should lie.

The prevention message was universally acceptable and uncontroversial – but also less radical. Messages about condoms had been around for years and were considered unexceptionable. People

thought it was unlikely that this message alone would prompt a sea change either in behaviour or attitudes. Encouraging access to services was recognised as a newer and bolder message – often thought key by those in GU settings – but was not without problems and detractors.

Some pointed out the limited ability of services to cope with increased demand, with many already under severe strain. It was felt that a generalised encouragement to use services could result in an increase in the 'worried well' accessing them, as opposed to those who would really benefit. There was also some concern, backed up by scattered anecdotal evidence, that sending out the message that STIs were easily treatable could make people complacent about their sexual health.

Some respondents were unhappy with a disease-led approach. They thought that the focus should be on changing the way people view sex in a positive way, rather than on negative outcomes, which could risk leading people to switch off.

> *"It's an interesting point about getting the balance right. You want to raise awareness, you want people who may have a symptomatic disease to seek help, but you have got to be really careful that you don't overwhelm or annoy the people they will seek help from."*
> Sexual Health Lead

When thinking about the objective of the campaign, many respondents focused more on STIs than unwanted pregnancy. There were several reasons for this. First, STIs seemed to be regarded as the more urgent issue at present.

> *"[I'd like to see the focus on] HIV because it is so much more serious than anything else we deal with. It is a whole different cost, reckoned on a person's care – half a million pounds per person. It outstrips all the other infections."*
> GUM clinician

People also thought it was easier to convey single-minded messages about STIs. It was pointed out that a focus on pregnancy prevention did not provide a compelling argument for condom use, since the Pill was more effective in this respect. Some also felt that it was difficult to

talk about unwanted pregnancy without painting all pregnancy and parenting in a negative light.

> *"The fundamental thing we are all up against is the clash between what the educationalists would like to see in terms of messages, and what young people see as relevant messages for them, which can come across as very stereotyping, sometimes. You have to work from the reality of where they are. One example was a media campaign that was devised by young people and had some fairly tough messages, like, 'What would you rather be doing on a Saturday night, going out partying or staying in with a baby?'. That was frowned upon because it was giving a negative impression, and you have to strike a very careful balance if you're giving negative impressions about parenthood."*
> Regional Teenage Pregnancy Coordinator

Many professed to want the communications to talk about good sexual health and relationships in general, as opposed to focusing on specific outcomes. Sex and sexual health was felt to be about far more than simply the act of sex and its consequences, and where feasible it was hoped that a campaign would take this into account.

There were also varying views on whether and how a campaign should engage with the issues of abstinence and celibacy. On this aspect, views were divergent. The notion that young people should only become sexually active when they were ready emotionally was universally agreed with. All also agreed there was a need for better negotiating skills and more self-respect among young people to help them achieve this.

> *"It should be culturally diverse. We should be thinking about the message that sex is a normal part of being a human being. People may choose to have sex with one partner, others may choose to have more than one partner. They should know the consequences in terms of infections and diseases but also the pleasures and natural progression. I think it also needs to look at saying, 'You don't have to do it'. There is always the presumption that young people are having sex when over half of teenagers aren't. When they are ready, they need to be able to go and talk to somebody, go get some contraception, and to make sure they are tested if they need to."*
> Regional Teenage Pregnancy Coordinator

However, while some supported overt messages about delaying sex until later and restricting sex to loving relationships, others were very wary of straying into the territory of moral judgments.

> *"There does seem to be a backlash and a movement in schools about 'Just say no' which, looking at America, doesn't seem to have done a lot. It's a young person's choice... I think to promote abstinence on a national level is a step back."*
> Community contraception services (nurse)

There were two other general caveats on the potential success of the campaign which are worth noting. It was felt that it would be important for DH to stick to its guns on sexual health: some felt that pressure from the media and the public had inhibited policy and communications in this area in the past, and that this had had a negative effect on the success of past efforts.

> *"My first thought is that it's not what the target audience thinks, not what stakeholders in the field or the experts think, that matters most. The thing that matters most is the reaction from the Daily Mail. If [the campaign] wasn't afraid, then that would make me more excited by it. That would make me more confident in it; to believe it was more able to do what it set out to do. So take some chances."*
> Local Teenage Pregnancy Coordinator

It was also felt strongly that whatever the focus of the campaign it must ultimately be translated into increased accessibility to local services.

There were some more specific concerns among particular groups. GU clinicians, for example, tended to think in terms of a disease-led campaign, focusing on testing. This led to anxieties about the ability of services to cope with the consequent increase in demand.

> *"They are planning another campaign but they need to think about what effect that will have on us work-wise. We are stretched as it is now. I don't know how we would cope with this."*
> GUM Clinician

> *"My worry is that everything's got to be in place. Services have got to be in place. It's no good raising expectations, raising anxieties, and telling people, 'You must go and get checked out, you're putting yourself at risk if you have an infection', if when they do the right thing and go along for a check-up, you know, 'That magazine article told me to come for a check up, so here I am', if they then can't get an appointment."*
> Local Teenage Pregnancy Coordinator

TPCs tended to focus more on issues around prevention, condom usage and personal empowerment/self esteem. GPs and nurses were typically a little more traditional in their favoured messages. They

wanted to see sex back in the context of a relationship and wanted to encourage safer sex but also fewer partners.

> *"It is a good idea to reinforce the message on contraception, and that it is better to delay sex until you are in a relationship. It will not do any harm to reinforce that message. It is a reality that people are having sex underage so I do not think that it would do any harm to put that message across."*
> S2 D3: School nurse, Manchester

Among those working within PH, the STI issue was considered less thorny than the teenage pregnancy issue. For these people messages about wearing condoms and getting screened for STIs were uncontroversial, but they also identified a need to talk about raising the age of intercourse through empowerment, and this was of course much more bound up with moral judgment.

> *"To delay the age of sexual intercourse, because that does reduce the levels of certain STIs and other problems. To give people information so that they only have sexual intercourse when they want to, which means that abstinence and celibacy or saying no is part of the armoury, but accepting the fact that there are people who will not do either of those things, and therefore condoms is the next message."*
> Sexual Health Lead

This group could also identify problems with attempting to increase awareness of asymptomatic illnesses. They pointed out that it was difficult to tell people that 'you might have Chlamydia without knowing it', without making everyone think they've got it.

Sexual health leads felt that there was a potentially critical dilemma at the heart of any communication about STIs. This was that the more you encouraged people to get screened and tested, the more people would think STIs weren't a big deal – in trying to normalise and destigmatise them their potential seriousness could be correspondingly diminished.

> *"But if it's normalised and [the message is that] if you do have it you go for a screen, then it's just, 'Well, we'll take the risk and we'll go and get tested and get antibiotics and it'll all be sorted out, why use condoms?'."*
> Sexual Health Lead

3.3 Lessons from previous campaigns

Comment on previous campaigns tended to centre on the 1980s AIDS advertising. This was often mentioned unprompted. There were mixed views on the wisdom of this campaign and its success, and some sense that perspectives had changed with hindsight.

The 'traditional' view still held by some was that the campaign was excessive and inappropriate, that it created a climate of fear and demonised AIDS sufferers, while the real message was forgotten or ignored.

> *"The tombstones, HIV, 'Don't die of ignorance', shock horror stuff. There is a big debate about it, but generally it isn't felt to be very effective because it might catch people's imagination, but then some people might blank off, because it is too scary to contemplate, and other people might just remember, 'Ooh it's very scary', but don't remember anything about what the message was meant to be."*
> Sexual Health Lead

> *"Don't go for the fear. Don't go for the icebergs. That generates fear, not knowledge. Things which improve knowledge and understanding, things which give a realistic picture. And a way forward. The icebergs and crucifixes were about generating fear but they didn't say what to do or where to go or how to avoid it. Just be scared of it! Avoid that! If you need to generate a certain amount of concern in order to get people to act, that's fine, as long as there's a "And this is what you can do about it" bit as well."*
> Regional Teenage Pregnancy Coordinator

> *"As long as it is not managed like the government managed the iceberg campaign. About HIV where we all got a leaflet through our doors and it said don't die of ignorance. Scaremongering. Didn't do anything for anybody, just put the fear of god into people. Even now we are still undoing the damage that did, youngsters who are fearful of HIV."*
> Chlamydia Screening Programme Coordinator

However, others argued that at least the campaign was impactful; it raised the profile of sexual health overnight and put AIDS on the agenda. On balance, many thought it was better to create impact and risk over-hyping the issues than to rely on more subtle or localised communication and risk not creating any impact at all.

There was little feedback on the Sex Lottery campaign. This may be in part because usage of campaign materials seems to have been limited. Some thought that the design was not well liked by young people. One

or two felt it trivialised an important subject (while accepting that young people might see it differently).

The RU Thinking campaign was typically better liked, but not without reservations. Some felt that it had not had a great deal of impact. A minority reported that young people did not find the visual style appealing and that some executions were too complex.

Respondents' views on the overall learnings from previous campaigns were consistent but general. It was thought that materials must be attractive and appealing for young people (assuming they were the target audience) and that they had to be explicit, straightforward, colourful and accessible, without too much copy. It was also felt that in this area messages tended to wear out quickly and needed to be kept fresh. To have any significant impact, people thought it would be important for the campaign to be sustained over a long period.

It was also thought that in general the primary purpose of a campaign should be to provide knowledge and offer solutions. While they thought it was fine to generate some concern about sexual health, to generate fear at the expense of actionable advice was considered counter-productive and unacceptable.

3.4 Media

There was widespread feeling that a campaign about sexual health would have greatest impact if above the line methods of communication were employed as well as more traditional below the line methods.

Television, radio and outdoor advertising were considered sure ways to raise the campaign's profile and to help demonstrate government concern about sexual health. Owing to the perceived lack of publicity around sexual health since the AIDS tombstone campaign, several professionals said they thought a large part of the public now assumed HIV/STI's was no longer an issue.

Suggested ways of getting sexual health back to the forefront of the public conscious included: having a sexual health issue as a story-line in a popular soap opera (e.g. East Enders); devoting slots on young people's radio chat shows and 'phone-ins to sexual health topics.

Here, youth or pirate radio stations (e.g. Galaxy FM) were thought likely to be most effective – particularly if well-known DJs were involved because they were regarded by young people as cool, non-authoritarian, trustworthy information sources and were well-respected among hard to reach groups.

> *"I think [we need to use] the media that young people will actually see it in, like local radio. That's important because it gives it a certain credibility and consistency, so wherever young people are they're getting the same message. It's that sort of brand that they have to build up. I think [sexual health] is lacking a brand identity at the moment possibly."*
> Local Teenage Pregnancy Coordinator

Above the line methods were thought to aid more detailed communications such as leaflets, posters and other paraphernalia because the subject would already be raised in the publics mind. Discussion of sexual health on TV in particular would also help normalise it, encouraging people to discuss it more openly.

> *"TV tends to be ruled out because it is far too expensive. Even if you get a bit of public service broadcasting time, to really make the most of it with really good production values is horrendously expensive. But I personally think it's well worth it, because adverts get into language, like the parts others don't reach."*
> Regional Teenage Pregnancy Coordinator

4. Target audience and consumer messaging

4.1 Target audience

Most took for granted that young people would be the focus of any sexual health campaign. This group was widely believed to be where the real problem lay, and also to represent the best chance of improving sexual health in the long term.

'Young people' was typically defined as c. 15-25, though some thought that materials should also aim at 11-14 year olds, given that some are sexually active at this age. The purpose of aiming at 11-14 year olds was also to educate people in sexual health *before* they become sexually active and are exposed to other messages about sex.

Older people were also recognised as a risk group; typically those in their 40s and 50s coming out of marriages or long relationships. Many people in these groups had concerns which reflected the prevailing

climate before they had entered these long term monogamous relationships. Typically pregnancy was their main concern, and if this was taken care of (by the menopause or the Pill) then often little further thought was given to sexual health. There was also no culture of condom use (particularly among men) within this social group, since many of them had been insulated by their personal circumstances from having to engage with the notion of condom use to prevent STIs.

> *"Young people may be more open to sexual health messages and sexual health advice than older people, who may feel, 'I'm 50, I'm bombproof now'. But there's a lot of evidence that as people's relationships and first marriages have broken down, they've started new relationships and got back in the dating game. I think there's a feeling that they've got it sussed."*
> Regional Teenage Pregnancy Coordinator

Views differed on whether the campaign should target a specific social class. While the received wisdom was acknowledged to be that C2DEs were more at risk and less informed, some pointed out that it was dangerous to assume that the more affluent and well-educated were well-informed about sexual health; or that this translated into protecting themselves and accessing services.

In addition to these groups, respondents identified an array of niche audiences with specific issues around sexual health. Some of these related to various ethnic minority groups. Among African-Caribbeans HIV was seen as a major issue, especially in London; this was in part owing to cultural barriers to condom use, and in part because of the strong stigma held within this population around HIV and AIDS.

For Asian women there were clearly compelling cultural stigmas around issues relating to sexual health. It was pointed out that these people would rather go to specialist centres than to their GP and tended to present very late with symptoms.

Asylum seekers and refugees were generally considered hard to target and engage with, because of their diversity and transience. It was also felt that the prison population, especially young men, were often ignored, and that their low average reading age could make mainstream materials unsuitable.

> *"I am concerned that the traditional 16-24 year old target group, because they are the most sexually active group and*

> *therefore the one that is at greatest risk, tends to be the one that is concentrated on to the exclusion of lots of other groups. To an extent, things like prison healthcare and the links with drugs and alcohol, are the areas that we are particularly interested in, in addition to the normal groups. They tend to be the groups that have been marginalized and perhaps not recognised in the way they should have been."*
> Director of Public Health (RGO)

Lesbian, gay and bisexual people were also regarded as having particular needs in relation to sexual health information. Attention tended to focus mostly on gay men and HIV, but there were also believed to be issues for lesbian and bisexual people.

Most people believed, however, that a national campaign should not try to cover too many audiences. They pointed out that it would be impossible for the same set of materials to appeal to a variety of audiences, and if the campaign was not well targeted it would be unlikely to succeed with anyone.

It was felt that some audiences were unlikely to respond well to traditional advertising and materials anyway. While these groups might be the most vulnerable and important to reach, other approaches could work better for them.

> *"I am a bit sceptical about national campaigns, even if you spend quite a lot of money. I am not sure that there is much good evidence that publicity interventions really do change people's behaviours. You can provide information and you can beat people about the head with statistics until the cows come home, but unless there is something directly relevant to them which makes them think there is something in it for them to behave differently to how they do now, then I am not sure that the perspective of Joe Public isn't that this is just another one of hundreds of advertising messages that they see every day."*
> S2 D14: Director of Public Health, (RGO)

On balance, most people thought that the campaign should avoid trying to appeal to everyone because it would end up pleasing no-one. Instead, they thought it would be better to make a conscious decision to focus on a core audience of 'mainstream young people' – *as long as* dedicated work continued (and increased) among other groups.

Some however struck a note of caution about the homogeneity even of this 'mainstream' audience, noting that youth culture was diverse and amorphous, often for no apparent reason – what might appeal to a

young person in London would not necessarily appeal to someone in Leeds or Cornwall.

It would also be important for a sexual health campaign to talk people's language. This was considered particularly important with minority groups. It was acknowledged that this could be a problem for DH; in such cases it was suggested that communications should come from someone else (e.g. THT).

4.2 Consumer messages

As noted above, there was general agreement that a campaign would need to find a balance between two key messages: promoting safer sex, and encouraging use of services. Within these objectives, most felt that national advertising should stick to fairly broad messages, to appeal to the largest possible number of people within the core audience.

Several people noted, though, that different young people have unsafe sex for different reasons. One example was students, who tended to be basically well-informed and well-intentioned, and also easily persuaded into accessing services. For this group the main problem was drinking too much and forgetting/not bothering to use a condom. Another was younger and more vulnerable young people, who would often have unsafe sex because they felt unable to say no. If they suffered from low self-esteem and craved love and attention, they were easily pressured into unprotected sex.

It was also pointed out that people have different communication needs depending on their stage of sexual engagement. Those who were inquisitive or exploratory would not necessarily require or respond to the same messages as those who were already in sexually active relationships.

> *"A campaign can't target everybody who has unsafe sex. The vulnerable girl who wants to be loved, how can you target her with the same campaign as for a student going out on a Friday night? It's not going to be the same."*
> Sexual Health Lead

Another important issue was language. TPCs felt that a sexual health campaign would need to recognise how young people viewed

themselves in order to engage with them. They claimed there was often a difference between how educationalists wanted to address young people and how young people wanted to be addressed. Whilst they recognised that a balance would be needed, they suggested that getting through to certain groups of young people might involve using terminology that sounded demeaning (to educationalists) or un-politically correct.

Because of these factors, stakeholders tended to prioritise different messages depending on their local population. Some general themes did, however, emerge. Most agreed that an important aspect of the campaign would be to communicate the reality of the risk: to persuade people that STIs could happen to them. Among many people there was a sense of detachment from the issue of STIs, and it was common for people to feel that they were not relevant to them (*'no-one I know has had an STI'*). In order to penetrate this complacency, they thought it would also be important to make messages explicit and crystal clear – bearing in mind that people had a tendency to hear what they wanted to hear.

In general, the notion of high-risk groups (e.g. people who are promiscuous, and people who pay for sex) was thought unhelpful because this undermined efforts to drive home the relevance of the risks of STIs to more mainstream groups. It was considered more valuable to focus on risky *behaviour* – unprotected sex – for *everyone*.

It was acknowledged that sex had changed hugely for young people in recent years. In particular it had become much more casual and commoditised (examples were: sex offered for the return of a mobile phone, oral sex parties). Respondents felt it was important for the campaign to be underpinned by an understanding of the reality of contemporary sexual culture for young people. In order to encourage use of services it was also thought important to make young people aware that there were special services just for them and to emphasise confidentiality.

Other suggestions focused around making sexual health more mainstream and de-stigmatising the whole area. As well as having a more generalised target and getting away from high risk groups, people

thought that sexual health should be promoted as a normal part of general health.

> *"The DfES, it needs to log on to the importance of sex and relationship education as part of the national curriculum and as part of a normal healthy well being approach. I would put schools as the most important because unless we make this cultural shift amongst young people it will not work."*
> Regional Teenage Pregnancy Coordinator

The concept of a sexual health MOT was helpful here – encouraging people to take a more proactive approach to safeguarding their sexual health rather than only accessing services in a crisis. People also wanted a campaign to emphasise the importance of involving partners – and to make sexual health an issue for men as well as women.

There were also suggestions that the campaign should focus on and encourage *correct* condom use, and also let people know they had *choices* about sex, and what the consequences of those choices were.

> *"Correct condom use as well, because a lot of people do attempt to use condoms and they don't use them properly. I used to be a health advisor at a clinic, and you get young people coming in who've used them, but they didn't use them till the last minute, and as soon as the contact's made, the infection's already passed on."*
> Sexual Health Lead

Some professionals (especially those in GU and chlamydia screening) assumed that the campaign would be disease-led, probably leading on chlamydia, though other STIs were felt to be important, especially in certain areas. Its main purpose was expected to be to educate (and alarm) young people about specific diseases. They thought it would be important also to give people a better understanding of how to know if they had an STI, where they could go and what would happen when they got there.

Some of those who worked in teenage pregnancy, GP practices and family planning wanted more focus on appropriate sex – delaying sex, having sex within a relationship, empowerment and negotiation.

> *"We had a group of young girls here; these boys were nicking their phones and saying, 'You can have it back if you have sex'. They thought, 'I don't really want to but I might as well get my phone back because Mum will go mad if I don't come back with my phone'. They were absolving themselves. 'It was just sex, what the hell.' The consequences are dire.*

> *Pregnancy. Low self esteem. Chlamydia. When you separate it off it is meaningless. Just a way of getting a phone back. I want to put it back into a relationship, something which is important."*
> Community Contraception Services (GP)

Others tended to want more general, factual messages along the lines of: unprotected sex is risky, always use protection, if you think you might be pregnant or have an STI, access to services is easy, free and confidential – and here are details of your local service.

> *"People don't need to know the difference between warts and herpes, they just need to know that sex without a condom [is dangerous]."*
> Sexual Health Lead

Within this, there were some more specific issues that various stakeholders felt needed bringing to light. Some felt young people needed greater awareness of preventing pregnancy on the one hand and avoiding STIs on the other i.e. that condoms provided a barrier and the Pill provided contraception. They advocated promoting the double dutch method.

The crossover between sexual health and alcohol was also considered an important issue to tackle, especially in big cities. Some thought that the risk of drinking too much, having unprotected sex and the consequent risk of catching an STI needed to be made far clearer.

A few felt that young people needed shocking into protecting themselves: they suggested hard-hitting, graphic images of STIs, or advertising similar in style and tone to anti-smoking advertisements (e.g. the woman who has had a tracheotomy as a result of smoking). Some, however, felt that if sexual health advertisements were too shocking, people might be deterred from getting tested; overly dramatic advertising could also worsen embarrassment around sexual health rather than helping to normalise the subject.

Some, GU clinicians in particular, felt strongly that messages needed to be unambiguous, crystal clear. In their experience, people tended to focus – often inaccurately – on the messages they wanted to hear. For example, some thought – because they had read that the penetrated partner was more at risk of contracting HIV/STIs than the penetrating

partner – that if you were the penetrating partner during sex then you need not worry about protecting yourself.

> *"Some messages we don't want to hear. 'If you are the penetrated partner you are more at risk than the penetrating person if you are not using a condom'. So people equate that with 'the penetrating person is safe'."*
> GUM clinician

In this respect some leaflets targeting gay men were criticised for being too eager to keep their audience on their side and avoid being overly didactic. They sometimes colluded with the excuses some gay men used for not practising safe sex.

> *"Some of the gay men's stuff has been quite collusive. It will have things like, 'Most HIV positive gay men are having unprotected sex some of the time.' That is true. And then come up with a list of options which might reduce the risk which is not involving condoms. And at the bottom saying, "Don't ejaculate" or whatever. So we have moved the goalposts."*
> GUM clinician

HIV was often regarded as a separate issue. Whilst it was considered worth mentioning as one of the risks of unprotected sex, people thought that there would be a need for dedicated communications for gay men and the African-Caribbean community in this area. Of these it was considered an increasingly serious problem among the African-Caribbean population; unlike the gay community they tended to be poorly informed about the risks and less likely to come forward for testing.

Messaging around HIV was recognised to be difficult however. There was a fine balance between encouraging testing for HIV and emphasising the seriousness of HIV to promote prevention.

Suggestions for encouraging testing messages included: knowing you are HIV positive is better/more empowering than not knowing; if you know you are HIV positive then you can get treated and avoid getting sick; if you know you are *not* HIV positive then you can get on with your life without worrying.

There was, however, considerable feeling that the 'get tested' message was limited. GU clinicians reported that most HIV positive men had often had a negative test or tests before being diagnosed HIV positive.

Communications had therefore succeeded in encouraging testing but had not succeeded in bringing about sexual behaviour change. A more important HIV message was therefore thought to be that - HIV is really serious and you should take every possible step to avoid contracting it by wearing a condom.

5. Delivering the campaign locally

5.1 Expectations of involvement

People's expectations of their own likely involvement in the campaign reflected individual roles. Generally speaking, those at strategic and management level, with a specific focus on sexual health – SHLs, some DPHs, RTPCs, some health promotion and communications leads – expected to have the most direct involvement.

In terms of how they expected their involvement to unfold, in the first instance they hoped to be consulted on the content and perhaps design of the materials (some reported that this had happened on recent campaigns). How they expected this might operate in practice could involve them being perhaps invited to workshops to talk about overall direction and messages, and then to be sent 'work in progress' materials for debate and comment.

Some were very vociferous in their insistence on some kind of consultation process among appropriate health professionals (like themselves) prior to finalising any campaign materials. It was clear that these people would be annoyed if a catalogue of finished materials were to land on their desk without their involvement in their development.

They acknowledged the difficulty of involving everyone involved in sexual health services at all levels, but felt that it was important that consultation was at least seen to have taken place, particularly with respect to making materials relevant at a local level.

> *"[When you talk about] testing it out with people in the field first – it must be a bit depressing, the more you consult people, someone will say, 'No, it mustn't be purple it must be brown', and then somebody else will say, 'What on earth have you made it brown for? It should be purple'. But the more it is tested with people who are nearer to their own*

local populations, and have some expertise in getting health promotion messages across, that is worthwhile."
Sexual Health Lead

Some suggested local or regional coordination of consultation, perhaps via local panels.

Post-launch, these respondents expected to be involved in numerous ways. First, they would expect to be responsible for making sure all the relevant people in their 'patch' knew about the campaign – both those above them (e.g. PCT board) and those below them (GPs, nurses etc). They would also expect to talk to non-NHS partners and stakeholders about how they could work together with them to deliver the campaign. On a practical level, they saw themselves ordering and disseminating campaign materials (depending on the set-up in their area) and getting involved in decisions about which materials should be used in which settings, and perhaps organising regional communications, for example, placing ads on local radio or in pubs and clubs.

The issue of local media could be important: several complained that DH did not consult locally about which media to use but relied instead on media agencies (who used audience figures but didn't have local knowledge). When planning the local roll-out of the campaign most hoped for guidance from DH, but not a straitjacketed approach; they wanted to be given broad objectives but then be left to implement local delivery themselves.

"All of that. I mean locally, take it from a health promotion director's perspective. I would know my population, I'd know roughly what kinds of numbers of things I would want to reach my population, and where it's acceptable to put things, and what have you. I would know the most appropriate places locally, where other materials could go, that may be organised centrally. For example the TPU have had some back of the toilet door publicity things that they organised nationally, and the first we know, for example in xxxx [town], at the xxxx centre, was that these things appeared in the xxxx centre, in the ladies' toilets. I don't know whether they did in the men's toilets. That was the first I knew as the regional coordinator. The local coordinator would have been able to advise where the best place for that publicity would be, where the young people would hang out, and it wouldn't have been there, because there's a very ferocious attendant who doesn't allow young people to hang out! So sometimes it's very local stuff and they would know the best places to -. or they'd know the people locally who could have much more influence."
Regional Teenage Pregnancy Coordinator

Respondents working in the field generally did not expect to be 'involved in the campaign' – or, at least, they did not describe their involvement in these terms. Instead, they thought in terms of supporting the national campaign by using materials at a local level; although most were keen to do this, they were not prepared to give unqualified support. It was common for them to claim that they would only use campaign materials if they thought they were good and appropriate for their own population. They also pointed out that they had strict budgetary limits, which meant that their use of materials would depend on how much they cost.

Some respondents in the field hoped for more active involvement. These people typically were highly motivated individuals, passionate about sexual health, who would welcome a more strategic input in consultation and planning of local campaigns.

> *"I'd like to be consulted. There are groups consulting with them all the time. I know people who work at that level. It doesn't affect me or impinge on my work."*
> GUM clinician

> *"It would reinforce it if someone talked to staff about what the aims of the campaign are rather than just being given a wadge of leaflets and posters. If they wanted a really positive campaign they would have to get out there and tell people what to say and do."*
> Community Contraception Services (GP)

Among RTPCs it was pointed out that some good consultation work was already being done. A London sub-group had fed into the national RU Thinking campaign; they wanted to see this done on a new campaign as well, using regional coordinators.

5.2 Resources available and support needed

Respondents were of course limited in both the time and resources they had available to deliver a campaign locally but only a small minority felt they had no capacity to provide support. Most of those we spoke to at senior level said that management time, although stretched, could be made available. They felt that delivering the campaign would be a real priority, and they were prepared to make time to ensure successful local delivery – and to divert resource from local projects if necessary.

However, resource on the ground was much more of an issue; in particular, there was little or no resource available to take the campaign out into the community, as people would like – outreach work, running events, establishing new dissemination channels. Professionals working in the field did not think that getting involved in a new campaign would necessarily stretch their resources, as they would largely be doing what they were doing at the moment, but with different materials.

The most pressing concern, both at senior level and in the field, was about funding for services. People pointed out that there was no point in running a campaign if people could not then access services in response, and ideally they wanted funding to establish outreach services to relieve pressure on GU services.

> *"What worries me specifically about this, if it's a campaign, is that we haven't got the infrastructures to deal with any more people. We can't deal with any more people in family planning and they certainly can't deal with any more people at GUM. There needs to be a massive investment in contraceptive and sexual health services."*
> Family planning clinician

> *"The more advertising you do the more people will want screening. You have to have it set out so people have the facilities. There is no point in doing a campaign if you can't do the screening."*
> Community Contraception Services (GP)

Assuming funding for services was in place, it was expected that local delivery of the campaign could be supported by either free allocation of materials or more budget to buy them. People also wanted to receive extra budget and/or staff for coordinating local events and disseminating materials into the community *outside* the NHS, and budget for adapting materials (see below).

> *"I think where it's worked for teenage pregnancy is that they established local teenage pregnancy co-ordinators and regional teenage pregnancy co-ordinators, so there's a way they could speak to the regional co-ordinators. There was a teenage pregnancy website, discussion boards for the co-ordinators so they can find out [what's going on], so the whole discussion board was well thought out… If you take teenage pregnancy, they actually gave us money and we have a full time post to co-ordinate and a named lead. So are they going to give us extra money now so we're going to have a post that will help us on the campaign? Otherwise if they ask us to do something we have to build it into*

everything else we are doing. If money doesn't come with it, and I think it won't, it's very difficult to ask about the details of how we will get involved."
Sexual Health Lead

"There's not enough hours in the day to do my job. I can't imagine when I'd find time to wander about Wandsworth putting leaflets in pubs!"
Family Planning clinician

They expected it to be important to have sufficient funds to hire local marketing consultants and agencies to ensure sophistication of local delivery.

There was also a call for better and more consistent sexual health networks. An example of this was in the area of teenage pregnancy, where it was pointed out that the structure of regional and local coordinators reporting to TPU worked very well. In terms of the new campaign, as a starting point, it was hoped that there would be a dedicated Sexual Health Lead in every PCT.

5.3 Training

It was difficult for people to separate training needs specific to the new campaign from training needs generally. It seemed that current arrangements were variable.

A few areas were largely happy with the amount of training available to them and their staff, with very proactive organisation of courses at local or regional level, both for NHS workers and for others. RTPCs seemed particularly active in this area; they suggested SHLs could fulfil the same role.

Many others were much less satisfied with the amount and adequacy of training. Some believed there was a serious shortage of training available and very little budget to pay for it. Access to training was particularly difficult for certain respondents. Some charities (e.g. youth services) had very little budget available for training. Another problem was that some NHS service providers were quite isolated e.g. session workers who did not work within a GP or GU setting; these people often had little contact with their 'hub'.

In general terms, the main need identified was for training updates for service providers. These were thought necessary to inform about new statistics, new developments, new contraception methods etc, to keep service providers open-minded and in tune with current trends and issues. This need was not specifically connected with the new campaign, but it was pointed out that a campaign made it even more important that service providers were up-to-date.

It was also pointed out that if there was a drive for more community screening programmes, then more individuals e.g. pharmacists and youth workers would need sexual health training. Needs which would arise if the campaign was focused on young people might be centred around providing training on delivering sexual heath services in a friendly, accessible way.

Various different groups were believed to be in particular need of additional training. Some senior managers thought school nurses required more support and training; it was felt that some were uncomfortable with their remit and responsibilities in sexual health. Indeed the importance of schools in any sexual health campaign should not be underestimated. Even if their role is simply to refer children on to external services the way they deal with the issue will have a considerable influence on numbers of children accessing services. It was felt that schools needed to be better equipped to provide young-person friendly, confidential information giving children the confidence to use school as a first port of call for questions about their sexual health.

Others thought GPs needed more training. They thought that some didn't see sexual health as a core part of their remit, and were perhaps not comfortable with it; but still needed to provide services.

Many thought that training was best organised through regional networks and held regionally or locally – ideally in short (half-day) courses – though some wanted to see a central analysis of training provision to identify gaps.

Most of these training needs were generalised and few identified a need for specific training to deliver this campaign. However, many claimed that they would welcome local workshops to launch the campaign (see below), and they could envisage an element of training within this. A few also wanted to be given more access to training on media liaison and communications generally.

Depending on the focus of the campaign, some thought they might need more training to make them feel confident in delivering some of the content of the materials (e.g. training for school nurses in the correct way to use condoms). There was also an expressed need for guidance from DH about the campaign objectives, target audience, process and delivery of the campaign with some feeling that they had not been given enough direction for campaigns in the past.

One RTPC felt that training needed regional ownership, with specialist training given to those working with special groups. This RTPC organised regional training via 'gap analysis', working with social workers, youth workers and schools. She had found a significant lack of training among all these groups and felt this was something that DH needed to look into. She recommended conducting an audit of what was currently available to identify training gaps, and what was needed to fill these gaps, on a regional basis.

One suggestion was to introduce a quality kite mark for training, ensuring consistent, high standards nationwide. This would help to reassure those in HR that courses/events they booked for staff were reputable and recognised, and that their money was therefore being well-spent. Another stakeholder suggested linking sexual health training to funding. This would mean that a certain level of training in sexual health had to be reached in order to release funds, similar to the funding process for surgery with chronic diseases.

5.4 Timing

The timing of the campaign was a major issue, particularly for those at management level. The complaint that DH gave insufficient notice was widespread, although the situation was thought to be improving.

The key issue was funding: budgets were set at least a year in advance and any activity around a new campaign needed to be factored in at this stage. There were also issues around planning, with weeks' or months' notice needed to organise events to tie in with a key campaign date. It was felt that ideally there should also be flexibility in the timing of communications work. Obviously it would be important for this to tie in with the national campaign, but they also wanted to use the campaign materials to support local events and milestones.

Finally, materials needed to arrive in plenty of time, there were frequent reports of materials arriving late in the past, leaving staff insufficient time to disseminate them effectively.

6. Format and nature of campaign materials

6.1 Format of materials

There seemed to be little feeling that a radical rethink was needed in terms of resource *format*; tried and tested formats worked well, though some identified potential for much greater use of electronic formats. Currently, leaflets were still the default, particularly in the clinical setting, where it was pointed out that patients didn't take in everything they were told and needed information to take away with them.

> *"We can't function without leaflets because we haven't got the time to cover every single aspect. We can cover the major things but I think they need to have some written materials."*
> Family Planning clinician

> *"Leaflets are essential. When you talk you can watch their eyes glaze over, particularly the young. They can't concentrate or remember it all."*
> Community Contraception Services (GP)

The desire was for leaflets to be 'young person friendly' – colourful, strongly visual and with accessible language. However, it was pointed out that some service-users still wanted 'traditional' leaflets with more in-depth information.

There were also widespread calls for small materials – credit card format, or a similar sized fold-out or booklet – preferably with a display unit. Small-format materials were considered particularly appropriate for a young audience. They were thought to have greater visual appeal and to seem cooler, cleverer, and funkier than larger formats. Also they had the advantage of discretion: they were easy to hide in a wallet or pocket, with little risk of being found by parents or friends, and consequently a better chance of being kept rather than read once and discarded.

> *"If I was given a little card I could tuck it in my wallet. If I was given a big piece of paper I would put it in my handbag and throw it away a few days later because it was clogging things up."*
> Community Contraception Services (GP)

In terms of the role of small-format materials, the primary function was often seen as offering signposting to local services, with the potential also to convey key messages.

There was also some demand for display material (posters) which was considered useful for schools, waiting rooms, bill-boards etc, particularly if it could be used to include details of local services. Simple, striking, visual materials were considered most effective: these could be read at a glance, without having to stop and risk being spotted noting the information.

> *"If you name it you can talk about it. It is quite difficult to walk in and say, 'I might have been the victim of sexual assault.' But if you have seen a great big poster which says 'Are you?' it is much, much easier. Visual things do help."*
> Community Contraception Services (GP)

In waiting rooms in particular, there was a captive audience for such materials; waiting rooms were places were information could be easily and discretely absorbed. Less positively, it was pointed out that it could be embarrassing to jot down information in a waiting room; it was suggested that it would also be good to have posters on the back of toilet doors.

Quirky give-aways were considered always to be highly popular among young people, with kids keen to pick up anything free and the potential for brief crazes developing around particularly popular items. Examples included beer mats, mock filofaxes, key-rings, bus pass/condom holders and mock Visa cards.

> *"The 18-25 market is so sophisticated that people will know rubbish when they see it, and they're not going to pick up rubbish, and leaflets. For instance, for 25 year olds, leaflets are rubbish; it has to be something that looks like a visa card or a trinket."*
> Sexual Health Lead

> *"Anything with a novelty value is good for kids, anything that you can laugh at they love. They like key rings, they like promotions."*
> School nurse

> *"If it's advertised that if you do the Chlamydia test you'll get some sweets, they'll come for the sweets. They're quite happy to have a test once they get there, but they need a little something. You're talking about sexual health, about condoms and infections and stuff, there's got to be something in it for them."*
> Sexual Health Lead

However it was also thought to be very important to keep ideas fresh and innovative: kids were likely to reject anything deemed to be 'uncool' and quickly tire of items that were no longer new. Some thought that there was a danger that any materials which tried too hard to look up to the minute could quickly become dated.

> *"I think it is a bad idea in many ways to try and be trendy because young people are always changing and trends change. It is just giving the facts about it, and then there is more interest in it."*
> Youth services worker

There was less support for postcard-sized formats, which were thought to be disadvantaged by being neither one thing nor another: too small to display on a wall, but too big to be stashed discreetly in a pocket. They were also considered old hat: a format that had been done to death in the 90s, particularly for communications targeted at gay men.

Some respondents were starting to use electronic resources, and many thought that there was a lot of potential in this area; for example text messaging: this was currently used to remind people about appointments or to remind them to take their Pill. People thought that it could be used more widely to deliver sexual health messages.

> *"Things like texting and all that seems to be a good idea now. You can send them a text to remind them to take their pill. It is using technology and using stuff that young people use to get the message across."*
> Community contraception services (nurse)

Viral communications – messages and video clips passed on via 'mobile phones and e-mail – were mentioned by a few. They said that young people enjoyed communicating this way: viral was considered daring and unconventional because covert. If used correctly, viral might therefore be an effective means of reaching hard to reach groups. Here, the suggestion was for messages to remain unbranded for greater credibility and to avoid concerns that government was infiltrating 'underground' communication networks.

Another medium considered useful, particularly for the school environment were CD-ROMs and videos. It was also felt that the web could be used; waiting rooms were considered a 'lost opportunity', an environment where interactive materials could be usefully introduced.

> *"I feel the waiting room is a lost opportunity, especially for young people. Young people come in groups and that is about moral support, bringing their friends with them. So usually four people will come but only one is coming for an appointment, and I feel those other three are a lost opportunity… I would love some interactive CD ROMs that you could pitch to that group."*
> Sexual Health Lead

With regard to websites, some pointed out that the word 'sex' should be avoided in web-site titles: web-sites containing this word in the titles were often barred from computer networks to avoid users accessing pornography.

Internet chat rooms were also reported to be popular among young people: they allowed questions to be asked and feedback received anonymously; they were 'live' - constantly changing/being up-dated - and allowed young people to talk about what *they* wanted. A few were

using chat rooms on their own web-sites and suggested making these available on the campaign website.

Many respondents lacked resource and/or expertise to develop their own electronic resources, suggesting this would be a good area for DH to explore. Some respondents in strategic roles claimed that they would also like DH to issue ready-made press releases to accompany the campaign, which they could use with local press. It was suggested that these perhaps be made available on an ongoing basis via a campaign website.

6.2 Design and style of materials

There was little feedback on specifics of material design. The general view was that any resources for young people must be bright, colourful, friendly and accessible. Many suggested that young people themselves should be involved in the design of materials. There were some precedents for this. Several had involved young people in the design of local materials, and reported considerable success. In terms of how this could work it was felt that ideally young people should be involved early on in the design process, not just in pre-testing sample materials.

> *"Who are the materials aimed at? If it is the public then they should comment. If that is who they are for then they should be consulted. Campaigns we've done have only got as far as print when young people have agreed on the appropriateness of it. They've given choices about colours and what they have found most informative."*
> Regional teenage Pregnancy Coordinator

One respondent mentioned that the GLA were due to launch a major sexual health campaign and suggested consulting them about materials used: which were most effective and why..

6.3 Adaptability of materials

There was a broad spectrum of views on whether national campaign materials should be adaptable. Most thought, in principle, that some element of adaptability was desirable – primarily to allow the inclusion of local services.

> *"I think producing materials which can be over printed with local information is very, very helpful, because that means you can make the most of national campaigns locally."*
> Regional Teenage Pregnancy Coordinator

> *"it would be good if they came up with a basic template and there are bits of it that you could put a different cover on the front like that, that would be useful because that would save us from doing all the detail work which is then replicated time and time again across the country presumably so that would be really helpful actually."*
> Local Teenage Pregnancy Coordinator

It was widely felt that national numbers were off-putting and that young people were more likely to engage with materials if they carried details of local services. One or two reported having had bad experiences of national help-lines not directing callers to the most appropriate services.

A minority wanted more fundamental adaptability with the ability to change elements of the design and messaging to suit local audiences. They felt this was necessary to enable the materials to tie in with local youth culture and to avoid offending or excluding local communities. It was also pointed out that appropriate distribution would be critical in ensuring the campaign's success at a local level.

On the whole, respondents at a strategic level recognised that there could not be too much adaptation. They thought that it would be vital to direct the audience to local services and important to convey messages appropriate to the local population, but also felt that there was no point in having a national campaign if it didn't have consistency.

On balance, most thought that national campaign materials should stick to broad, universal messages, though having ability to adapt with details of local services would be welcomed. At a local level, more targeted materials could continue to be produced. However, they pointed out that it would be helpful to have certain elements of national campaign (e.g. logo, slogan) which could be imported into these.

> *"You could have a national campaign and you could have a buzz word, a title, a gimmick, a logo. For example, the Sex Wise logo – so whether it was on the TV or radio or whatever, Sex Wise would be mentioned or seen. Then at the local level we could have the flexibility to have a campaign to advertise our young people's services, how to access them, where to get screening, but what we would do*

is use the Sex Wise logo so people could relate the national to the local."
Sexual Health Lead

Among this sample, acceptable methods for adapting materials which were identified included: hard copies of materials which could be over-printed; electronic templates where some elements could be changed (though it was pointed out that they would need constraints to ensure quality of finish), and display material where phone numbers could be written in by hand (though this could look unprofessional). Some cited Information Revolution magazines (Fit, Prime etc) as a good example of national consistency with room for local adaptation.

In general, although adaptability was welcomed, it was also considered important to have finished materials available if desired. Several of these respondents lacked the time, resources or expertise to make changes to materials.

Some identified this as an area where DH could provide support in the form of funding and training. One further caveat was that DH must make it absolutely clear what type of adaptation was allowed – one or two reported having experienced problems in the past with the RU Thinking campaign.

"I think one of the difficulties with my own experience of the R U Thinking campaign was that it was very much, 'Local areas must not use these materials with anything on it that smacks of the NHS or anything at all'. All the things that might look authoritarian and put young people off. Very sound thinking behind it, but what it meant was that local areas backed right off and were anxious about whether they could put anything on the postcards. We were constantly trying to get answers to queries about, 'We are doing this work locally, can we use these campaign materials or can't we? What can we put in it and what can't we?'."
Regional Teenage Pregnancy Coordinator

Indeed one respondent who worked in health promotion felt that the process of local adaptation was as important as end result. She felt that there was much to be learnt from liaising and engaging with local agencies (e.g. advertising, design and research) who would gain knowledge and understanding of local populations and their specific communications needs in relation to sexual health.

7. Communicating with stakeholders

7.1 Communications from DH

On the whole, current communication channels were thought to serve their purpose adequately. Those who thought they needed close communication with DH – e.g. SHLs, DPHs and some CSPCs – generally felt they had this, and found a clear line of contact, often with the same person.

> *"There are several people we can speak to and they make contact whether it is email or every now and then I get a call. Just to catch up and see how things are going. They seem to be genuinely interested and not just lip service."*
> Chlamydia Screening Programme Coordinator

Communication typically took the form of: direct relationships with individuals in DH conducted via phone or email; regular email bulletins from DH; specific bulletins to Chief Executives of PCTs or Medical Directors which got passed on if relevant. Use of the website was also a significant channel.

The most important relationship in the context of sexual health was often thought to be that between DH and Public Health (including SHL); and between DH and Health Promotion, where this still existed as a dedicated department. In some cases communication between DH and Health Promotion was through somebody else rather than direct; and whilst this was not necessarily a problem, it was felt that the more intensive and reciprocal this relationship, the better.

Some communicated more via the Strategic Health Authority. Of those who did this, the feeling was that this channel worked well. However, there were others who felt that the role of SHAs was not clear and could serve to complicate the chain.

> *"On one hand you have the Department of Health at the top which disseminates stuff down to me but then every now and again for certain things the strategic health authority has to be involved and then you have to go on a curve."*
> Sexual Health Lead

In terms of the campaign, one SHA said that they would use a regional task group and regional networks to roll out the campaign, buying in people's time where necessary.

RTPCs reported especially good contact with the Teenage Pregnancy Unit; they believed this was a good model for DH's communication with sexual health stakeholders. They were uncertain, however, whether they would remain in position after 2006 owing to funding changes but recommended continuing this form of regional coordinator structure.

On the whole though, they felt somewhat distanced from DH; they claimed they would like more direct communication with DH as well as more resource and materials. In areas where there was no sexual health lead RTPCs had taken on part of the sexual health lead's role but did not feel they had sufficient back-up to fulfil this effectively. One RTPC felt that there was perhaps a capacity issue within DH.

Communications leads felt they had a less direct link to DH; some received emails and bulletins but claimed that they would appreciate a named contact to approach, particularly about any new campaign. Respondents working in the field also tended to feel distanced from DH; some complained about this.

> *"My only link with the Department of Health is with or through speakers at conferences, when you jump on somebody at the end, or through the internet, through using their website, or e-mailing somebody, but I don't have any direct link that I would contact. Any link would be handy, I think, especially for dealing with a campaign to check out stuff."*
> Sexual Health Lead

> *"It's a long way from me."*
> GUM clinician

However, most felt that they did not need direct contact, as long as they got the information they needed from somewhere (see below). Community nurses, as an example, did not have much contact with DH but neither did they want any; their primary interest was in receiving free leaflets and condoms.

7.2 Onward communications

Onward chains of communication were less consistent, but most at management level believed they had good or adequate systems in place. Typically they used established networks to cascade news and information down to people working in the field. These networks typically consisted of an SHL or DPH with an email list of GPs, nurses, GU clinicians, family planning nurses and others.

While most were largely positive, some admitted that the system did not always work. They acknowledged that they sometimes forgot to forward information to certain groups (e.g. GPs), and that it would not be guaranteed that the appropriate information would always be passed on in time.

Most of those working in the field were also fairly happy with the arrangements in place, though some reported problems. They did not feel that they always got sent information, or it sometimes arrived late. An example of this was that they had been known to read announcements in the media before they had heard them through the system, and could get caught out. Another problem for some was very limited access to IT; they felt that they got left out of the loop as a consequence.

> *"I access the Department of Health website a lot. I have to teach so I have to be knowledgeable. But I should imagine the general family planning nurse has no access, or no knowledge. I don't see anything that comes through at all, to us. Nothing is fed through to us directly."*
> S2 D19: Family Planning Clinician, London

When contact was instigated by those in the field, there was a more varied chain of communication upwards. Local TPCs tended to go to regional TPCs, but others did not necessarily go to SHLs; instead they would use whatever contacts they were most comfortable/familiar with.

7.3 Obtaining materials and resources

There was considerable variation in terms of how those in the field obtained sexual health materials. Some areas had a dedicated health promotion resource centre where people could look at and order materials; this seemed the most satisfactory arrangement. Otherwise, materials were ordered direct (e.g. GU clinics tended to have one person responsible for this); or via the SHL or TPC.

The process varied according to the provenance of materials – the main sources were DH, Brook and FPA, but others (local, national and international) were also used – respondents did not always know the provenance of the materials they used. Some providers had online catalogues, where respondents could browse and order materials; others sent unsolicited free samples.

The situation was further confused by funding issues. While some barely had any funding to buy materials and relied on small, ring-fenced allocation, others had more budget available but still needed to keep an eye on the amount they spent.

One SHL thought that it was harder for GU to get materials than GPs and nurses. In his area, those working in primary care had a resource centre but GU clinics only had access to a limited amount of materials.

It was apparent that when respondents ordered from DH, most used the telephone order line. Most reported finding this system satisfactory, although there were some complaints about limits on the number of copies they could order at once, and one or two had experienced problems with DH running out of materials.

One LTPC felt strongly that it would be helpful to give materials to campaign co-ordinators in pre-prepared, ready-to-send packs. This would save considerable time and money, and was preferable to receiving boxes of leaflets which would need collating and packaging before forwarding.

7.4 Promoting and managing the campaign

Once the campaign has been developed (in consultation with stakeholders), most agreed that some sort of launch would be helpful to get people on board.

It was clear that local workshops would be well-received. Ideally these would be half-day events with a chance to meet campaign managers at DH and see what materials were available. It was suggested that they could include a study aspect offering advice on who to target, how to roll out the campaign, promotion ideas etc.

The main local contacts for organising these workshops were expected to be SHLs, RTPCs and Public Health departments. All of the audiences in the sample expressed an interest in principle in such workshops – though some (esp. school nurses, family planning, youth services) seemed less sure they would have the time and budget to attend.

In terms of ongoing campaign management (passing on information, materials etc), most thought that existing networks worked fairly well. Some at grassroots professed to want to receive information direct from DH, but many worried about being bombarded and thought it best to channel information through PCT heads, SHLs, RTPCs and DPHs.

The majority would prefer communications in electronic form, because email was efficient and easy to cascade. A closed access point on a website was also welcomed; it was pointed out that this already works well on the TPU website.

> *"If it is general information there should be a website where documents can be posted and briefings put up there. We have quite a good website and the TPU, which has access for local coordinators to get more information, which highlights good practice and research. I think it is used fairly well but that is assuming all services have access to it."*
> Regional Teenage Pregnancy Coordinator

> *"I think one good thing they could learn from the Teenage Pregnancy Unit is that they have a website with an enclosed area where Teenage Pregnancy Coordinators can go in and access the message boards, they can share information, they can share good practice. That would be good for sexual health."*
> Sexual Health Lead

However, it was acknowledged that electronic communications also had significant limitations. Not everyone in the sample had access to internet and email – particularly those doing session work who did not have a fixed base.

> *"The DOH assume that people will have access to PC's and the internet at work we have not and we have to go to the library, what happens is our area manager will get a copy and we will see that one, you can download it but I do not want to be sat at home downloading it onto my computer."*
> School nurse

Some complained that they were bombarded with email, making it easy to overlook important communications. Another problem was the fact that a website relied on people proactively checking it; many thought that those in the field were unlikely to do this.

> *"But if you have got onto the website you are being proactive, you are already looking. You need to get people who didn't know they were looking but they are getting the message all the same."*
> Community Contraception Services (GP)

Other helpful forms of communication which were identified included hard copies of information sent through the post, information placed in relevant press e.g. Nursing Times, and communication via professional organisations. Some respondents were sharing information through journal clubs.

Text-messaging was not well-received as a method of communicating with stakeholders. It was not considered likely to be effective, since many did not use text messaging. Those who did considered the prospect of messages from DH inappropriate – too intrusive and personal. For ordering materials, most thought that existing arrangements worked well. Most wanted to be able to order from DH by phone, with a few preferring an online catalogue and ordering facility.

Finally, it was worth noting that communication should work in both directions – people thought it would be good to have a named lead at DH that anyone working in sexual health can contact about the campaign, or to nominate a local intermediary (ideally a SHL).

7.5 Stakeholder messages

It was thought important that communications from DH should be timely, supportive and practical.

> *"I feel quite lucky that I do have up to date information from the Department of Health. That is because I have attended a few meetings around sexual health. I am circulated information generally and attend twice a year. That said there is a capacity issue within the department of health, it is not a large department anymore. I suspect it could improve and will need to in order to make sure the information is timely and relevant."*
> Regional Teenage Pregnancy Coordinator

For respondents at management level, it was important that DH was seen to support but not to interfere. For those in the field, it was important that communications should seem practical and relevant: respondents did not want to be overtly 'enthused' about the campaign – just given the tools they needed to get on with delivering services.

'This campaign is delivered as part of the government's commitment to sexual health in the Public Health White Paper and the national strategy for sexual health and HIV.'

The response to this message was largely positive, especially among senior management. It was clear that for those who knew about it, the White Paper was a good button to push. It constituted a shorthand for 'increased investment' which was thought to give the campaign added kudos.

There was a strong welcome for the reference to the government's 'commitment' to sexual health. Many thought that there had been a lack of commitment in the past and welcomed this bold statement. There was also clearly a strong desire to hold DH to its promise, and a hope that it would 'put its money where its mouth is'.

> *"But it is people putting their money where their mouth is. We are not quite sure whether they have, we think they have but we haven't seen the evidence."*
> Director of Public Health (SHA)

Those in the field were typically more familiar with the Sexual Health Strategy than the White Paper. The Strategy was usually seen as a disappointment. It was felt that while much had been promised, little came to pass. Because of this, mention of the Strategy dampened overall enthusiasm.

In tone, this was seen as a little formal and 'governmenty', though it matched the content well. It was considered more appropriate for management than grassroots, because people in the field did not 'deliver campaigns' – they delivered services.

'This campaign is flexible and ready to adapt to your local needs.'

This message was strongly welcomed, if it was true. There were, however, issues of credibility with people wanting to know how this would work in practice, and there were also questions about resource – would DH provide extra funding for adaptation?

'We're here to help you deliver the campaign in your local area.'

While there was some perceived value in the sentiment of this statement, the phrasing prompted a negative response. It seemed to suggest direct intervention by DH at a local level. This was not credible. It gave an impression that people from DH were going to come and help deliver the campaign on a local level, which was not thought realistic or particularly desirable.

It was clear that there was a sense of territorialism at play here, with local professionals feeling they knew their own area better than DH did. It worked better to suggest that DH were available to support local delivery if needed. This was perhaps most effectively phrased as a question: *'what can we do to help you deliver..?'*

There was a need to back this up with further information about what sort of support was available.

'By working together we can prevent the spread of and reduce transmissions of STIs.'

The concept of working together was important, and was certainly plausible in terms of partnerships with local stakeholders – multi-agency working was a strong current trend.

Less positively, some working in the field questioned the credibility of 'working together' with DH, feeling that the Department was remote, in the role of a boss, rather than a partner. A minority thought that the phrase 'working together' had been over-used and was too New Labour.

The remainder of the statement generated little enthusiasm. The phrase about 'reducing transmission of STIs' was thought to be an unimaginative statement of an obvious objective, while 'prevent' was considered unrealistic. Some also commented that preventing 'the spread' and 'reducing transmissions' amounted to the same thing.

A minority of the people at senior level to whom we spoke thought that the statement was too disease-led and said they would prefer a broader focus on sexual health generally.

'Prevention is key. The campaign will help reduce pressure on GUM services.'

This was largely greeted with scepticism: although the campaign may ultimately improve sexual health and reduce the need for testing, the short term effect was expected to increase pressure on GU. Of course, this was not necessarily considered a bad thing since greater access to GU was seen as desirable as long as the resources were put in place to cope.

Some respondents saw potential value in discussing this issue, but thought it needed careful handling. They thought it was important to decide exactly what the objective of the campaign was, particularly with regard to encouraging people to access GU services: did they want more people accessing GU, or fewer?

GU clinics needed reassurance that they would be supported in the short term (by additional funding or more outreach services). They felt that only if this support was in place could DH say that, in the long term, pressure would reduce.

8. External stakeholders

Involving local non-NHS stakeholders was agreed to be vital to the success of the campaign; suggestions of who to approach were largely consistent. Among these, schools and Local Education Authorities were identified as probably the most important. Raising the profile of sexual health in schools was thought to be key, but not without its difficulties.

> *"The secondary schools are still very reluctant to tackle the issues. Even having a classroom session about putting on a condom is still a bit of a battle in some schools. Some sexual relationships programmes don't actually include that as part of their work so we have to add that on as an extra in the hope that schools might do it in smaller groups or even on a one to one basis."*
> Local Teenage Pregnancy Coordinator

It was acknowledged that it could be hard to get schools on board, particularly faith schools or those with conservative head-teachers or governors. It was deemed necessary to make a real effort with these audiences.

Apart from these, other important stakeholders identified included a wide variety of NGOs and charities, from Brook and Terrence Higgins Trust to small local charities. Youth organisations and youth workers and local councils were also considered significant. Secondary stakeholders were thought to include people running other local services such as clubs, gyms and cinemas who might have a role in displaying campaign materials.