Sexual health behaviours

Health behaviours joint strategic needs assessment literature review

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Introduction

This short report on sexual health behaviours completes a suite of literature review documents around the seven health behaviours incorporated in the joint strategic needs assessment (JSNA).

It complements the secondary data analysis report which can be found on the JSNA publications page with final health behaviours report.

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Sexual health priorities

The reduction of sexually transmitted infections (STIs), pregnancy (in under-18s) and abortions (under-18s) through the promotion of safer sexual practices and increased knowledge amongst teenagers and young people have been priorities for public health policy in the UK for a number of years.

Outcomes of teenage sexual behaviour

These issues are important, particularly as teenage pregnancy may limit education and career/employment opportunities, whilst resulting in poorer life outcomes for teenage mothers and their children.[1] In relation to STI, chlamydia trachomatis is one of the most common sexually transmitted infections in the UK. It can have far-reaching consequences for women including infertility, ectopic pregnancy and cervical cancer.[2] The 'Unprotected Nation' report commissioned by the FPA (formerly the Family Planning Association) and the Brook sexual health charity estimates that if current access to sexual health services are maintained, the cumulative overall costs of unintended pregnancies and STIs in the UK between 2013-20 will be £84.4m and £126.6m.[3]

Factors for risky sexual behaviour

Evidence has shown the consistent risk factors for early pregnancy include a lower socioeconomic and educational status; areas with higher levels of deprivation tend to have higher rates of conception, with higher teenage pregnancy rates in more urban areas. Teenage girls who drop out of school early, or have lower levels of education are also more likely to become pregnant.[4]

Factors for risky sexual behaviours which result in an STI or pregnancy include having early sexual intercourse, having a greater number of sexual partners than the median, having sexual intercourse with someone an individual has just met, having unprotected sexual intercourse, having unprotected intercourse due to intoxication, taking a pregnancy test, and having a test for a sexually transmitted infection.[5]

The physical and social outcomes of risky sexual behaviour tend to be more pronounced for females. These can include becoming pregnant, the loss of their reputation, or the long-term complications of a STI. For males these outcomes are

fewer and tend to be less stigmatising. Amongst young people there can be the perception of increased status in having numerous sexual partners (for males). Young people often perceive parents and adults holding double standards with regards to their sexual behaviours – male sexual activity is seen as more acceptable, whilst female sexual activity is viewed as prohibited.[6-7] Whilst both sexes may experience issues accessing sexual health services – such as embarrassment, or concerns over confidentiality – females may feel more judged by the health professionals and have concerns with accessing forms of contraception which they can control.[8]

Younger people and adolescents (aged 16-24) years are at a higher risk of contracting a sexually transmitted infection, however there is evidence to suggest that having high levels of knowledge around STIs does not necessarily result in safer sexual behaviour amongst young people. Young people often show high levels of knowledge around other risky health behaviours and the health consequences such as smoking, drinking, using illicit drugs and tanning, but they continue to engage in them. One of the reasons may be the sense of invulnerability or perception of 'it won't happen to me', indicating that awareness and knowledge is not sufficient to encourage safer sex in young people.[9]

There is evidence to indicate the family is a key predictor to knowledge, attitudes, self-efficacy, and risk-taking behaviours. Involved parental control, effective communication between a parent and child, and a positive parent-child relationship has been shown to reduce risky behaviours. Young women who have an open, direct and receptive communication style with their parents are more likely to have a positive attitude and higher self-esteem, particularly with regards to their sexual behaviour. In addition, young women who feel close and connected to their parents are more likely to partake in responsible sexual behaviours.[10] The absence of a positive male role model may also affect adolescents' and young people's sexual behaviour and decision making. Particularly for young women, this manifests in the way in which they interact with men.[11]

There is a link between the socioeconomic status of young people and their sexuality and risk behaviours. Having a higher parental income is strongly associated with not having had intercourse, whilst an intact family and higher maternal education levels can be protective factors for early intercourse and having ever had intercourse.[12]

Links between delinquency, family structure (one- or two-parent families) parental socioeconomic status and education levels have also been established. Alongside low individual control, a lack of parental control is also associated with delinquency and sexual risk behaviour.[13] These are also associated with drunkenness and frequency of alcohol drinking amongst adolescents. Sexually active males who report binge drinking, smoking, violence or anabolic steroid use are more likely to have made their partner pregnant.[14]

Intoxication has been associated with an increased likelihood of risky sexual behaviour and young men who are drunk are more likely to engage in sexual practices such as not using a condom. It has been suggested that an individual's personality characteristics, such as low impulse control, may also lead to behaviours such as drinking to excess. Excess alcohol may increase the likelihood of risky sex, whilst the desire to engage in risky sex can also result in an individual drinking more. Individuals who have been drinking are potentially more likely to have alcohol-induced disinhibition, where rational assessment of costs/benefits of certain behaviours is less likely.[15]

An increase in the risk of chlamydia has been associated with the younger age at which women first drank alcohol, a higher number of lifetime partners and an increased amount of alcohol consumed on a heavy night of binge drinking (five or more units in one session, up to a maximum of 50 units).[16]

Whilst substance use (alcohol and drugs) can influence whether an individual has sex or not, other motives for sex can include using intercourse as a coping strategy, self-affirmation (for confidence), intimacy, and approval of others (friends or partners for example). These issues are confounded by other factors such as carrying and using condoms, which may have a stigma for young women and girls in particular. Other issues around condom use include negotiating their use with a partner, and using them correctly. Lack of access to services, embarrassment and lack of knowledge/skill can also impact on contraception use and safe sexual behaviours. The associations between sexual health knowledge, attitudes and accessibility of services appears unclear: improved services may not necessarily reduce conception or STI transmission rates.[17]

Other influences

Other factors which can influence sexual behaviour include parental expectations, gender roles, and religious beliefs.[18] This is important as emerging evidence suggests there is a wide difference between knowledge and behaviour of young people from differing ethnic background. Certain black and minority ethnic (BME) groups are at a disproportionate risk of poor sexual health. Although culture does play a role, other factors such as peer norms, religion, and inequalities in education and access to health care invariably will have an impact on the sexual health behaviours of young people.[19]

The table below summarises the factors linked to risky sexual behaviour. The more an individual engages in these behaviours or is exposed to the risk factors, the more likely they are to partake in unsafe sexual behaviour.

Table 1: Risk factors

Strong risk factors	Medium to low risk factors
Lower socioeconomic status. Low educational attainment. Younger age at first sexual intercourse. An increased number of sexual partners. Unprotected sexual intercourse or inconsistent contraceptive use. Low impulse control. Lack of parental control. Increased/excessive alcohol use. Use of violence/fighting (males). Injecting drug use.	Smoking. Alcohol use. Drug use. Engagement in other risky behaviours such as poor diet/nutrition or tanning. Low self-esteem. Incorrect use of contraception/poor safe sex skills. Poor communication skills (with sexual partners). Lack of access to services (particularly in rural locations). Incorrect beliefs about sexual practices.

Recommendations

Recommendations aimed at reducing the spread of STIs and teenage pregnancies have to take into a range of issues. There is a lack of evidence around what behavioural strategies (for example, promoting consistent condom use) are most effective. The relationship between risky behaviours is complex, there are many interrelated factors and it is not always possible to simply address single risk behaviours and see a reduction in STI infection or teenage pregnancy.

Sexual health services should be sited and delivered in a way appropriate to the area – for example in small or rural towns sexual health services could be delivered alongside other services for young people, rather than having a distinct separate service. In addition, training for health professionals (including pharmacists) should be comprehensive to ensure young people accessing sexual health services and emergency contraception are treated with confidence and in a non-judgemental way. Having open, direct and receptive communication between young people and service providers, covering a wide range of topics, can be beneficial. This is more powerful when the communication is also between young people and their families/parents.

Young people from different ethnic groups have specific sexual health needs and services and support should be tailored towards supporting these groups. Utilising all opportunities to work with young people from minority groups may also provide benefit. This also applies to other minority groups (for example, lesbian, gay, bisexual or transgender people). However making generalisations regarding typical behaviour due to a young person's religion, sexuality or culture can mask a diversity of attitudes and experiences within a homogenous religious or cultural group.

The table below summarises types of behavioural interventions for sexual health promotion.

Table 2: behavioural interventions

Examples of behavioural interventions	Features of effective interventions
Provision of factual information about sexual risk factors. Motivation building (including developing self-esteem, self-efficacy and communication skills). Education around safer sex skills. Promoting abstinence. Screening and treatment. Availability of resources (condoms).	✓ using theoretical models in developing interventions ✓ targeted and tailored (in terms of age, gender, culture), making use of needs assessment ✓ provide basic, accurate information through clear messages ✓ use of behavioural skills training

These have advantages and disadvantages and like other behavioural interventions can be delivered on different levels such as:

- personal (GP one-to-one consultation);
- group (school sex education);
- community (local campaigns); and
- socio-political (allocating resources to outreach services).

There are a number of wider interventions that can have a positive impact on teenage pregnancy rates, infection rates and risky sexual behaviour. These include:

- delivering national health promotion interventions/programmes;
- addressing socioeconomic deprivation; and
- increasing educational attainment.

Adult sexual health

Whilst younger people and adolescents (aged 16-24) years are at a higher risk of contracting a sexually transmitted infection there has been an increase in sexually transmitted infections amongst the over-45 age group, including increases in chlamydia, gonorrhoea, syphilis, genital warts and herpes. There has been an increase in the number of new diagnoses of HIV in people aged 50+ years (500 in 2003 and 990 in 2012) and approximately one in four adults aged over 50 years with a HIV positive status were accessing care in 2012: in 2003 this was one in eight. It has also been shown the most deprived areas in England have the highest HIV prevalence.[20]

For other STIs there has been the highest increase in the rates of syphilis and gonorrhoea with men who have sex with men between 2004 and 2013. The new diagnoses of gonorrhoea with men who have sex with men increased by over 10,000 cases between 2004 and 2013, whilst there were almost 5,000 diagnoses of chlamydia in men and women aged 45-64 years in 2012.[21] The reasons for the

increases have been attributed to divorce/separation rates (estimated at 42% of all marriages) and the resulting different lifestyles; the increased accessibility of new partners, for example, through dating sites and social media; and no requirement for contraception to prevent pregnancy (resulting in reduced condom use).

Conclusion

Sexual health remains a priority in Lancashire and a health needs assessment has been undertaken to inform future commissioning and service delivery. This will be available in spring 2015.

References

[1] Lancashire County Council, 2014. *Teenage pregnancy* [online], Lancashire County Council. http://www.lancashire.gov.uk/lancashire-insight/health-and-care/maternity-and-infancy/teenage-pregnancy.aspx

[2] NHS, 2013, *Sexually transmitted infections* [online] NHS.

[3] FPA, 2014. *Unprotected Nation: Cuts to sexual health services cost UK £136 billion (2013)* [pdf], FPA.

[4] Imamura, M., Tucker J, Hannaford, P., Oliveira da Silva, M, Astin, M., Wyness, L., Bloemenkamp, K.W.M., Jahn, A., Karro, H., Olsen, J., and Temmerman, M, 2007. Factors associated with teenage pregnancy in the European Union Countries: a systematic review. *European Journal of Public Health*, vol 17, no. 6, 630-636 [online].

[5] Jones, N., and Haynes, R., (2006). The association between young people's knowledge of sexually transmitted diseases and their behaviour: A mixed methods study. *Health, Risk & Society*, September 2006, 8(3): 293-303 [online].

[6] Bangpan, M., and Operario, D., 2012. Understanding the role of family on sexual-risk decisions of young women: A systematic review. *AIDS Care*, Vol.24, No. 9, 1163-1172 [online].

[7] Stanley, N., 2005. Thrills and spills: Young people's sexual behaviour and attitudes in seaside and rural areas. *Health, Risk & Society* 7(4): 337-348 [online].

[8] Ibid.

[9] Jones, N., and Haynes, R., (2006). The association between young people's knowledge of sexually transmitted diseases and their behaviour: A mixed methods study. *Health, Risk & Society*, September 2006, 8(3): 293-303 [online].

[10] Bangpan, M., and Operario, D., 2012. Understanding the role of family on sexual-risk decisions of young women: A systematic review. *AIDS Care*, Vol.24, No. 9, 1163-1172 [online].

[11] Ibid.

[12] Langille, D.B., Hughes, J., Tomblin Murphy, G., and Rigby, J.A., 2005. Socio-economic factors and adolescent sexual activity and behaviour in Nova Scotia. *Canadian Journal of Public Health;* 96/4; 313-319 [online].

[13] Lavikainen, H., Salmi. V., Aaltonen, M., and Lintonen, T., 2011. Alcohol-related harms and risk behaviours among adolescents: Does drinking style matter. *Journal of Substance Use*; 16(3): 243-255 [online].

[14] Imamura, M., Tucker J, Hannaford, P., Oliveira da Silva, M, Astin, M., Wyness, L., Bloemenkamp, K.W.M., Jahn, A., Karro, H., Olsen, J., and Temmerman, M, 2007. Factors associated with teenage pregnancy in the European Union Countries: a systematic review. *European Journal of Public Health*, vol 17, no. 6, 630-636 [online].

[15] Lyvers, M., Cholakians, E., Puorro, M., and Sundram, S., 2011. Alcohol intoxication and self-reported risky sexual behaviour intentions with highly attractive strangers in naturalistic settings. *Journal of Substance Use*; 16(2): 99-108.

[16] Valerie A McMunn and Woody Caan, 2007 Chlamydia infection, alcohol and sexual behaviour in women. *British Journal of Midwifery, April 2007, Vol 15, No. 4* (221-224).

[17] Imamura, M., Tucker J, Hannaford, P., Oliveira da Silva, M, Astin, M., Wyness, L., Bloemenkamp, K.W.M., Jahn, A., Karro, H., Olsen, J., and Temmerman, M, 2007. Factors associated with teenage pregnancy in the European Union Countries: a systematic review. *European Journal of Public Health*, vol 17, no. 6, 630-636 [online].

[18] Bangpan, M., and Operario, D., 2012. Understanding the role of family on sexual-risk decisions of young women: A systematic review. *AIDS Care*, Vol.24, No. 9, 1163-1172 [online].

[19] Sinha, S., Curtis, K., Jayakody, A., Viner, R., & Roberts, H., 2007. 'People Make Assumptions About Our Communities': Sexual Health Amongst Teenagers from Black and Minority Ethnic Backgrounds in East London. *Ethnicity and Health*, vol.12, No. 5, 423-441 [online].

[20] Gov.UK website, 2014. *HIV: surveillance data and management* [online].

[21] Gov.UK website, 2014. *Sexually transmitted infections (STIs): annual data tables* [online].