"Sex in the Suburbs":

The Sexual Health of the Very Young and Vulnerable

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When we consider the very young and their sexual health needs, all subjects, including pregnancy, terminations and sexually acquired infections, are emotive. When talking about adolescents, we give most consideration to teenage pregnancy, its outcomes, and the various interventions (within the framework of our education system, at home and in society in general) that we might employ to try to prevent it. We talk of PSE programs in schools, of the influence of school nurses and teachers, of peer-led learning strategies, of lack of access to clinical services, of lack of knowledge among the very young about contraception and STIs, and of the poor communication between parents and children (especially fathers and sons).
If we look however at any statistical report on teenage sexual health we see that for a large proportion of our youngsters in Britain today, such strategies will be useless, as the children concerned are **"socially excluded"** and do not therefore come under the influence of any normal education or information policy. Many do not live at home, do not attend school, are already habitually using drugs and alcohol, and some are already selling sex, either to support their habit or simply to survive.
The following is taken from a recent report [1]
"Bristol is the largest urban conurbation in the SW region, with a sizeable population and large areas of inner city **deprivation.** There is considerable variation between wards with regard to teenage conceptions. Areas with high levels are generally found in the areas of high deprivation. Numbers of conceptions in girls under 18 ('95-'97) ranged from 4 in the relatively affluent wards.... to 60 in the deprived wards...a 15 fold difference.
A special focus on the inner city ward of Lawrence Hill enables the complex relationship between teenage pregnancy and deprivation to be explored in more depth. Although a number of young pregnant women and young mothers are rehoused in Lawrence Hill, it also has the highest conception rate within the city and consistently high rates of conceptions and terminations. It is a predominantly white working class area, which is **economically deprived, with a high prevalence of drug and alcohol problems.** It has also been noted that many young pregnant girls move into the area, to be rehoused in high rise council flats. However community services in the area are poor and many also believe the area to be unsafe and are fearful of being attacked. These issues suggest that the relationship between teenage pregnancy (*and the wider issues of adolescent sexual health**) and deprivation is both complex and mulitifactorial and that **social exclusion** is an important factor within this relationship."
The Department of the Environment has developed new indices of social deprivation and also provides an index of **child poverty** [2] which is being used across agencies to provide a robust and sensitive tool for highlighting areas for extreme concern. As well as large **urban areas** there are marked pockets of deprivation in **rural areas** where children are also facing lack of opportunities, impacting on their behaviour and sexual health. It is estimated that 1 in 3 children in the UK live in poverty.

Accessing children excluded from normal society necessitates a multi-agency approach- use must be made of the "at risk" register, and social services involved. There is a huge need however to offer complete **confidentiality** to children asking

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[1] *Teenage pregnancy in the South West of England* (1992-1998):
S.W. Public Health Observatory: May 2001

* Author's note

[2] Department of the Environment, Transport and the Regions. *Index of Deprivation 2000*
(www.regeneration.detr.gov.uk)

for help, but discussing concerns and issues within a child-centered **multi-disciplinary team** is often necessary. All sexual health providers must have a clear framework for dealing with the very young. They need to be able to offer advice and help to abused children and to those involved in coercive and commercial sex, for whatever reasons. They must have full knowledge of the **child protection policy** and be able to pull together a team of workers from allied fields (Child Health, Social Services, Drug Workers and others involved. Often the only way of providing services to the excluded, most vulnerable and most in need is to take the services outside the normal settings and "onto the streets". One such initiative is the Home Office funded "Pandora Project" in Bristol, a multi-agency group set up to provide services at point of need to under 16s. It involves Barnado's, Sexual Health providers, Social Services, drug workers and others. The needs of the very young are quite different from those of older groups and require a radically different model of service provision.

Patterns of **sexually transmitted infections** are often used as a proxy for sexual activity in the young. All indicators point to **a rising incidence of STIs in adolescents** with the highest rates in the youngest age groups. A rising trend in the number of reported cases of **chlamydia and gonorrhoea** has been noticed in recent years[3]. In men the commonest age for detection of either is 20-24, but in women it is age 16-19. Surveys in schools have shown

- **11% of the girls to be chlamydia positive**
- **3-6% of he boys**
- **> 90% asymptomatic**

20-30% of teenagers diagnosed as having an STI will be re-diagnosed during their teenage years. It is also a well-documented fact that re-attendance of teenagers after the first visit to a clinic setting is 10-15% only, and so their sexual health needs often must be met at a single visit. This requires a **fully integrated** and knowledgable and yet flexible approach.

Alcohol and drug use amongst teenagers are obviously great contributors to sexual ill health. We must attempt to ask, however, why growing numbers of our young are "users", and why it becomes a habit for so many. Is it just a part of the adolescent rebellion or due to peer group pressure? There is no doubt that for some of the very young users it is to escape their own nightmares and flashbacks usually indicative of childhood physical, mental or **sexual abuse**. Often they either cannot fall asleep, or are frightened to, because of persistent "night-terrors"- alcohol and or drugs become a coping mechanism. Some young people, girls and boys, become locked in to the spiral of using drugs and selling sex. Many are homeless and have often been abused. 43,000 children run away from home each year in Britain; 1 in 3 admit to having been abused. 95% of the **street prostitutes** age 16 and under seen by the Pandora team are heroin users. The sex they sell is high risk and unprotected, they are in the hands of their pimps and dealers and therefore still being abused. Their sexual and general health, and social needs are vast. Many end up in prison. They are suspicious of authority, and need understanding and a highly specialised approach.

As a society our **moralistic and judgemental approach** to teenage sexuality is now, rightly, under scrutiny as it has been responsible for failing to adequately provide for **the sexual health needs of our young people**. Nowhere is this more marked and dangerous than in our attitudes to the especially vulnerable very young.

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[3] Stuart et al. *Infectious Disease in South West England 1997-99.* Communicable Disease Surveillance Centre. Nov 2000.