Teenage Pregnancy and Sexual Health Marketing Strategy

November 2009

Produced by Partners Andrews Aldridge and Fuel Data Strategies on behalf of the Department of Health and the Department for Children, Schools and Families.
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1. Executive Summary

1. Public information campaigns have traditionally played an important role supporting teenage pregnancy and sexual health policy and have no doubt contributed to the progress that has been made to date (for example reducing the under 18 conception rate by 10.7% and under 18 conceptions leading to birth by 23% since 1998, and significantly raising awareness of STIs and the importance of condom use).

2. However, teenage pregnancy and sexual health policies have evolved in recent years as more is understood about both the causes of the problems and the strategies that help to address them – for example, new policy initiatives include increasing investment in contraceptive services and choice, introducing the National Chlamydia Screening Programme, access to GUM clinics, supporting HIV programmes for the most at-risk population groups and strengthened joint working between Local Authorities and PCTs to implement teenage pregnancy and sexual health policy.

3. Consequently, a review of the relevant public information campaigns (Condom Essential Wear, RU Thinking and Want Respect) has been conducted in order to assess how communication can best support this new policy environment. Learning from behaviour change theory, research on risk factors, and the evidence on what works in practice have been used as the foundations of a new marketing and communications strategy. This sets out the implications for the public information campaigns supporting teenage pregnancy and sexual health.

4. Behaviour change theory highlights the many factors over and above personal attitudes and beliefs, which influence young people’s sexual behaviour. Social norms and peer pressure, perceived behavioural control (self efficacy) and risk images all play an important role in shaping both behavioural intention and, in young and/or inexperienced young people, behavioural willingness. These factors are, in turn, influenced by a wide range of ‘informants’ including parents and healthcare professionals, the media and society/culture in general. A key finding is that rather than influencing sexual behaviour directly, the impact of these factors is mediated by ‘preparatory sexual behaviours’, namely communication or talking with one’s partner, accessing free contraception and carrying condoms. Consequently, it is recommended that the marketing strategy focuses on influencing these preparatory behaviours rather than sex itself, and where possible, does so by influencing multiple factors. This will require an approach that reaches a broader audience than past campaigns have targeted, including not just young people but their parents, health care professionals, teachers and the wider youth workforce.

5. The evidence for what works in practice comes from three sources: studies of sex and relationships education programmes, international experience and some of the more innovative social marketing programmes taking place across the UK. The key conclusion from SRE is that successful programmes tackle multiple levers of influence and often engage multiple audiences (e.g. young people and their parents). The international evidence from countries such as the Netherlands, which has a strong track record in tackling the issues, highlights the role of creating open and honest discussion and building a culture that frames sexual behaviour among young people as a normal part of their development. Creating a fundamental change in UK culture will not be easy. However, by normalising safer sexual practices (and promoting open and honest discussion about them), a broader culture change could play an important role in tackling teenage pregnancy and poor sexual health in England. Finally, the success of some regional social marketing programmes
suggests the potential for local campaigns of this sort to reach at risk groups who are not easily engaged by more conventional forms of marketing and communication.

6. Further evidence for using more intense social marketing interventions to support the highest risk groups comes from closer analysis of their behaviours and attitudes. A number of different segmentations describe the at-risk audiences, and a clear finding from these studies is that the young people in these groups often present with multiple risk factors such as poor engagement in school, poor relationships with their parents and misuse of alcohol and/ or illicit drugs, in addition to risky sexual behaviours. These young people often require support in many areas of their lives and therefore interventions targeting high-risk young people are usually more intense than for other groups, and reflect their multiple vulnerabilities. Consequently, communication alone is probably unlikely to have a significant, direct influence on the sexual behaviour of the highest-risk individuals; rather it can be used to shape the attitudes of parents, teachers and peers, who have more power to influence the behaviour of the highest risk individuals.

7. Drawing together the insight from these multiple sources, it is recommended that the marketing and communications strategy aims to influence a wider audience, and address a broader range of factors relating to sexual behaviour, with the overall aim being to act as a catalyst for culture change: creating a more open, positive, supportive and respectful backdrop against which a range of policy interventions can happen.

8. In line with this overall aim, a new model for marketing and communications is recommended. It defines three complementary objectives:
   i. Communications can help prevent teenage pregnancies and poor sexual health by promoting the attitudes, knowledge and communications skills that make safer sexual practices more likely
   ii. Communications can help protect individuals from the consequences of risky sexual behaviour by encouraging protective behaviours (such as screening and more effective contraception methods)
   iii. Marketing can provide intensive support for the most vulnerable and at risk groups through marketing-led interventions designed around their specific service and communications needs.

9. To deliver against these three objectives, five campaign strands or work streams are proposed:
   • 'Knowledge and understanding' will focus on asserting social norms and promoting areas of consensus, e.g. the fact that the majority of young people are not sexually active before 16 and that both parents and young people broadly agree on an appropriate age for first sex. It will also give people the facts about sexual health and teenage pregnancy, and dispel some of the myths that currently exist
   • ‘Communication and negotiation’ will aim to promote more discussion between and within audience groups - for example, helping parents and children talk more effectively, and encouraging couples to talk more about contraception
   • A strand relating to chlamydia screening will promote the screening programme whilst continuing to reinforce the message that chlamydia is asymptomatic in many cases but has serious consequences
• A campaign around **contraceptive choice** aims to increase awareness of the range of effective contraceptives available to women, particularly newer and less familiar forms such as LARCs.

• Finally, **condom use** will be promoted as a secondary message in all communications and further supported through a below the line campaign to increase access to and carrying of condoms (e.g. by expanding the programme of partnerships).

It is envisaged that knowledge and understanding, and communication and negotiation will contribute to the 'prevention' objective, whereas the last three strands will contribute to the 'protection' objective. Mass market communication is unlikely to be used to support the third objective - delivering intensive support. The activity that contributes towards this objective is more likely to comprise very targeted campaigns that are experiential in nature, are integrated where possible with SRE in both schools and out of school settings, and including engagement with NHS services as a core part of the intervention.

10. The campaign will target multiple audiences. Young people and teenagers remain the most important audience - those under 16/not sexually active require an authoritative information source on all aspects of sex and relationships but especially one that stresses the importance of delaying early sex and of mutually agreed consensual sexual activity until they are ready, in conjunction with accurate information about contraception and practical help to resist peer pressure. Information about chlamydia screening and effective contraception use are key issues for those over 16/sexually active. In addition to young people, parents and carers are a critical audience given their influence over the younger age group. Their core need is for help communicating effectively and accurately about sex and relationship issues with their children. Finally, healthcare practitioners and other stakeholders in touch with young people, play a vital role in coordinating and delivering services, and are a critical audience to engage to ensure that there is consistency of message from campaign through to service delivery.

11. As well as conveying specific messages to relevant groups, communications can help create a 'sum of the parts' effect that will catalyse broad cultural change through the creation of a single campaign identity and information resource, which is accessible to all audience groups and promotes and encourages open discussion of the issues. The 'umbrella identity' will be based on the concept that **more talk = safer sex and better relationships**. By anchoring the campaign identity around 'talking', the aim is to encourage one of the key preparatory behaviours identified in behaviour change theory, and to promote discussion and debate among all audiences.

12. Creatively, this idea will be dramatised through conversations about topics relating to sexual behaviour to show that sex and relationships are **'Worth talking about.'** It is anticipated that this campaign idea will work in a way that is similar to Change 4 Life, carrying the multiple messages to different audiences and in conjunction with a range of different delivery partners (e.g. the NHS, LAs, Brook, FPA, Terrence Higgins Trust, and other relevant NGOs).

A revised channel strategy is required that makes the campaign more visible to a wider audience using the full spectrum of broadcast channels. In addition, there is also a need to deliver highly targeted messages to specific audiences through trusted and credible channels. This will be achieved through a three-staged process designed to increase the quantity and quality of conversations about sex and relationships - using a mix of broadcast (TV, radio, PR) and more.
discrete/narrowcast channels including digital advertising and search, and extensive partnership and stakeholder activities.

13. A full range of key performance indicators have been defined to enable comprehensive monitoring of the campaign’s progress and evaluation of its outcomes.

14. In summary, the revised marketing communications strategy for teenage pregnancy and sexual health sets out a vision for how communication can be used to shape an open, honest and respectful culture, in which multiple messages are conveyed using a new campaign identity to engage young people, their parents and stakeholders. Annual plans for the next three years will follow this strategy, taking into account policy priorities, and budget constraints. In so doing, communication will continue to play a vital role in supporting the Government’s teenage pregnancy and sexual health strategies.
2. Introduction

This document sets out the revised marketing and communications strategy for teenage pregnancy and sexual health. The first half of the paper (sections 3-7) set out the evidence on which the strategy is based, drawing on a wide range of sources from academic literature, international experience and stakeholder groups. Sections 8-14 describe the key elements that comprise the marketing and communications strategy: the objectives, roles for communication, audiences, campaign strands, channel strategy umbrella identity and evaluation proposals.

The aim is to set out the vision for the role that marketing and communication can play in supporting new policy initiatives and ultimately, in helping to meet the PSA targets.

3. The PSAs/ Policy landscape

In 1999 the Government launched the teenage pregnancy strategy, which set a target to reduce the rate of under 18 conceptions by 50% by 2010, in other words to reduce the rate of under 18 conceptions from 46.6 per thousand (measured in 1998) to 23.3 per 1000.

There are five key pillars to the strategy: sex and relationships education both in and out of school settings, supporting parents and carers to have open discussions about sex and relationships with their children, increased investment in high quality contraceptive services and access to sexual health services, supporting teen parents and providing a national information campaign to young people.

In 2001, the Department of Health published the country’s first sexual health strategy, which set out a vision for ‘holistic sexual health and integrated care based on patient need.’2

The strategy aims to reduce prevalence of all STIs by increasing access and capacity in GUM clinics, supporting HIV prevention programmes for the most at-risk population groups, introducing the National Chlamydia Screening Programme (aimed at screening the 15-24 year old population), better commissioning and increased support and training as well as reducing unintended pregnancies in all age groups.

3.1 The current situation

3.1.1 Teenage pregnancy

There has been slow but steady progress towards the teenage pregnancy target, with the latest figures showing a decline in the under 18 conception rate to 41.7 per thousand in 2007. This marks a decline of 10.7% from 1998 (the baseline year for the Strategy) and reverses the previous upward trend.3 Within the decline, there has been a significant reduction of 23% in under 18 conceptions leading to birth, with teenage births now at their lowest level for over 20 years. The 2.6% increase between 2006-07

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1 The figures for England only are a baseline of 46.6 (conceptions per 1000 15-17 year old females) measured in 1998 and therefore a target of 23.3
2 Department of Health, 2001 Better prevention, better services, better sexual health - The national strategy for sexual health and HIV.
3 A 23.3% reduction in under-18 conceptions leading to births has been achieved over the same period.
was entirely accounted for by an increase in conceptions leading to abortion, with the birth rate falling by a further 1%\textsuperscript{4}.

The latest data suggests the 2008 rate will return to the downward trend: Q1&2 2008 show reductions of 2% and annual abortion data for 2008 shows a 4.5% reduction. However, although some areas have achieved reductions of over 25%, progress nationally remains very significantly off trajectory for the 2010 target.

*Under 18 conception and abortion rate 1998-present and 2010 target.*

![Graph showing conception and abortion rates from 1998 to 2010.](image)

However, this national picture hides a far more complex situation regionally where there is significant variation in the declines achieved by different local authorities, with the best-performing achieving a decline in the region of over 25% and a minority seeing an increase of about the same magnitude.

\textsuperscript{4}Teenage Pregnancy Unit, DCSF. 2009.
Regional differences in change in teenage pregnancy rate 1999-2007

3.1.2 Sexually transmitted infections
The picture for sexual health is complex. Data from GUM clinics suggests increases in the number of diagnosed cases of chlamydia, herpes and warts among 16-24 year olds over the last few years. However, syphilis cases have decreased since 2005 and gonorrhoea cases decreased between 2003 and 2006 but showed a small increase in 2007. Based on GUM clinic data, chlamydia is by far the most prevalent STI among young people. However, far more people are now attending services for testing which may account for some of the increases.

HIV remains a serious problem for small pockets of the general population (notably men who have sex with men and the Black African and Black Caribbean communities), among whom far more cases of HIV are diagnosed. However, the evidence suggests that the majority of the sexually active population have a much lower risk of contracting HIV than they assume.

The number of diagnosed cases of chlamydia infections has increased significantly. Assessing chlamydia prevalence is complex and there is no current agreed measure for this but, the positivity figure published by HPA is 7.3% in NCSP settings.

As mentioned above, in an effort to stem the rise in chlamydia infections, the National Chlamydia Screening Programme was introduced in 2003-2004, providing opportunistic screening for 15-24s. The programme has rolled out in 3 phases, with screening rates in 2008/9 at 15.9% (the target for April 2008- March 2009 was 17% (excluding GUM clinics) and April 2009 – March 2010 is 25%).

5 This data probably overestimates the prevalence of chlamydia among the general population since it is based only on data from GUM and does not include data from NCSP settings. The latest published positivity rate from the NCSP is 7.3%.
The national picture hides a more complex picture locally, where some regions – e.g. London and Yorkshire & Humber – have achieved screening levels at or above target and others, which have joined the scheme more recently, are still some way behind.
3.2 The cost to society
Both teenage pregnancy and poor sexual health come at a significant cost both to the individual and to society as a whole. For example:

- Almost 40% of teenage mothers have no qualifications
- Only 30% are in employment, education or training compared with 90% of all 16-19 year olds
- Teenage mothers have three times the rate of post-natal depression and a higher risk of poor mental health for 3 years after the birth
- Teenage mothers are three times more likely to smoke throughout their pregnancy, and 50% less likely to breastfeed, with negative health consequences for the child
- The infant mortality rate for babies born to teenage mothers is 60% higher
- Children of teenage mothers have a 63% increased risk of being born into poverty, have lower academic attainment and are more likely to be unemployed aged 30 than children of non teenage mothers
- Overall, the cost – just to the NHS – of teenage pregnancy is estimated to be £63m a year\(^6\)
- It's estimated that between 5% and 30% of women with untreated chlamydia suffer from complications such as pelvic inflammatory disease, infertility and ectopic pregnancy\(^7\)
- Based on the likely incidence of PID and infertility the annual cost of the NHS in infertility treatment resulting from chlamydial infection is in the region of £21m, rising to £29m when treatment for PID and ectopic pregnancy is included \(^8\)

\(^6\) NHS cost in 2004 NHS review
\(^7\) HPA 2005
\(^8\) NHS reference cost 2008/2009
3.3 Conclusions: PSA and Policy landscape

Despite steady progress since 1998, the existing rate of decline in the under-18 conception rate will not be sufficient to meet the 2010 target. To accelerate progress, therefore, a number of new initiatives have been introduced including increased investment in contraceptive services and access and proposals for the statutory provision of SRE within PSHEE.

Marketing can clearly play a role in supporting these new initiatives and amplifying their impact.

Of all STIs, chlamydia presents the most immediate concern for public health: more cases are being diagnosed, and positivity data suggests it affects a much higher proportion of the population than other STIs. Like teenage pregnancy, chlamydia infection also has serious consequences, being a well-established cause of PID in women. Consequently, the introduction and roll-out of the National Chlamydia Screening Programme aims to reduce the prevalence of chlamydia infection, but must reach 26-50% of the 15-24 year old population to have maximum effect.

Again, there is a clear role for marketing in the roll-out of the programme and potentially also to support targeted interventions among communities at higher risk of contracting HIV.

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9 This includes screenings with GUM settings.
4. Why do we need a new marketing strategy?

Public information campaigns have traditionally played an important role supporting teenage pregnancy and sexual health policy. In the years since the strategies were launched, three different campaigns - Condom Essential Wear, RU Thinking and Want Respect – have been funded and have successfully raised awareness of some key sexual health issues, such as the risks associated with contracting STIs and the dual role of condoms in protecting against pregnancy and STIs.

However, as we have seen, teenage pregnancy and sexual health policies have evolved to meet the continuing needs of the wider population and new initiatives such as the increased investment in contraceptive services and access and the roll-out of National Chlamydia Screening Programme are not currently supported by any of the existing major campaigns.

Moreover, campaigns to date have been successful in increasing awareness and changing attitudes, but there is little evidence of real behaviour change outcomes.

Thirdly, there is also increasing evidence that highlights the multiple, complex factors influencing human behaviour beyond just attitudes and beliefs.

4.1 Conclusion: why we need a new marketing strategy

*We believe it is necessary to review the marketing and communications strategy for teenage pregnancy and sexual health. The aim of the review is to create a robust and evidence-based strategy, based on insights about who is at risk and what influences sexual behaviour, that is designed to complement policy initiatives, and to influence behaviour as effectively as possible.*
5. Who is at risk?

This section draws on the evidence from risk factors and a number of research studies to identify the groups most at risk of teenage pregnancy and poor sexual health.

5.1 Profiling at-risk audiences

There are some well-documented risk factors associated with both STI infection and teenage pregnancy:

- The most obvious and direct risk factors are **risky sexual behaviours** such as early onset sex (sex under the age of consent), poor or no contraceptive use, having multiple partners and prior chlamydial infection or conception.\(^{11}\)

- Engagement in **other risky behaviours**, particularly misuse of alcohol and/or illicit drugs

- **Poor engagement with school** is a widely cited risk factor, covering poor educational attainment, leaving school with no qualifications, dislike of school and truancy, and has been correlated with teenage pregnancy and/or risky sexual behaviour.

- **Parental engagement** is also a known contributory factor – children who have poor relationships with their parents, or who come from background where their parents have poor/low aspirations are known to be higher risk.

- **Demographic and social factors** such as deprivation/poverty, living in care, or being the daughter of a teenage mother are also widely researched risk factors for teenage pregnancy in particular.

5.2 At risk segments

A large number of studies – both qualitative and quantitative – aim to segment young people into groups, reflecting either common behaviours, attitudes or both in relation to sexual behaviour and teenage pregnancy.\(^{12}\)

Of these, the most useful is probably DCSF's children's and young people's segmentation, which clusters young people into seven segments based on a number of different dimensions including their relationship with the parents, their engagement in education and personal levels of confidence and aspiration. As such, it takes into account at least some of the risk factors identified above.

Three of the seven segments – 'Weakening Links', 'Breaking the Rules' and 'Exploring Independence' - display higher claimed rates of risky behaviour and therefore are likely to be those at greater risk from both STI infection and teenage pregnancy. However, as

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\(^{10}\) See for example the Teenage Pregnancy Strategy 1999

\(^{11}\) Analysis of NATSAL data (Haldane 2007) confirms the importance of risky sexual behaviour as a risk factor – for example individuals with multiple partners, or who have early sexual experiences are more likely to contract STIs

\(^{12}\) For example, Define Research's attitudinal segmentation, NATSAL reanalysis, Rosenblatt Research's teenage pregnancy typologies.

\(^{13}\) NB This DCSF segmentation only segments young people aged 11-19 – it does not extend to include 'older young people’ – i.e. those aged 19-24
the chart on the next page demonstrates, the underlying reasons/causes for their risk-taking may be very different.

<table>
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<th>Weakening Links</th>
<th>Breaking the Rules</th>
<th>Exploring Independence</th>
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<tr>
<td>- 13-15 years</td>
<td>- 13-15 years</td>
<td>- 15-18 years BC1</td>
</tr>
<tr>
<td>- 68% female</td>
<td>- 60% male</td>
<td>- Confident and independent</td>
</tr>
<tr>
<td>- Relationship with parents strained at home</td>
<td>- Poor relationship with parents</td>
<td>- Interests and friends outside home</td>
</tr>
<tr>
<td>- Aspire to leave home and get a job</td>
<td>- Low self esteem</td>
<td>- Unlikely to discuss issues with</td>
</tr>
<tr>
<td>- Risky behaviours more prevalent than average</td>
<td>- Disengaged from education</td>
<td>parents (but otherwise good</td>
</tr>
<tr>
<td></td>
<td></td>
<td>relationship)</td>
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<tr>
<td></td>
<td></td>
<td>- Recognise importance of</td>
</tr>
<tr>
<td></td>
<td></td>
<td>education</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Keen to travel/take gap year</td>
</tr>
</tbody>
</table>

There are strong similarities between these segments and some of those identified in other studies – e.g. research exploring young people's attitudes to sex and relationships by Define Research identified a group of 'Danger Seekers' who share similar attitudes and behaviours to 'Breaking the Rules' and Teenage Pregnancy research carried out by Rosenblatt identified two qualitative segments - 'Popular Hangers' and 'Shaggers', which probably overlap with Weakening Links and Breaking the Rules respectively.

Many research studies that look at these groups highlight that among the highest risk groups (e.g. Breaking the Rules, 'Shaggers' and 'Danger Seekers') risky sexual behaviour is usually only one of several problems and issues experienced by these young people. Typically, they present with multiple vulnerabilities – perhaps substance misuse and/or problems at school - and would benefit from support to deal with the full range of their issues.

Given the complexity of their problems, it is doubtful whether marketing communications alone can have a significant, direct influence on their sexual behaviour – these young people are likely to require a far more intensive intervention as well.

5.3 Segments at risk in the future?

The DCSF segmentation also identifies two further segments of note – 'Happier at Home' and 'Anxious and Unsure'. While not currently at risk (largely because they are too young), children in these segments betray some characteristics - such as lack of engagement in education, or low self esteem - that suggest that as they grow older they may be at risk.

5.4 Conclusion: who is at risk?

Based on the data presented here, our hypothesis is that we can identify two key groups who are risk:

- Those children and young people, who may be from more deprived backgrounds, exhibiting multiple risk factors such as poor relationships at home, lack of engagement in education and alcohol or illicit drug misuse. Such young people are likely to fall into a pattern of multiple risky behaviours at a relatively young age and present with multiple vulnerabilities. As a result, communication alone is unlikely to have a significant and direct impact on their sexual behaviour. Rather, communication needs to work through the adults and other young people who are best-placed to influence the most at risk, and in conjunction with other, more intense interventions.
The other key group is very different and comprises an older, more confident and better educated group of young people who are probably choosing to experiment with risky behaviours as a way of demonstrating their independence.
6. What influences sexual behaviour?

This section draws on a range of evidence from behaviour change theory to the more practical guidance provided by best practice in both sex and relationships education from international marketing. The aim is to provide a robust foundation for an evidence-based marketing and communications strategy.

6.1 Learnings from behaviour change theory

Most of the work on behaviour change and sexual health has focused on condom use and in particular the application of either the Theory of Reasoned Action or Theory of Planned Behaviour\textsuperscript{14} to explain the drivers of safer sexual behaviour. Also of note is Gibbons and Gerrard's Prototype Willingness model\textsuperscript{15} that aims to explain the influences that drive the initiation of risky sexual behaviour among young people. While these models tend to emphasise different influences, there are common themes and some key insights that we can draw from them that provide a rounded picture of different influences on sexual behaviour:

*Personal attitudes and beliefs*

This is a broad category of influence that includes perceptions of risk (e.g. the degree of perceived risk of catching an STI) as well as attitudes towards condoms (e.g. whether you believe condoms decrease sexual pleasures). All behaviour change models include provision for the influence of personal attitudes and beliefs but they differ in the emphasis given. For example, while they are a key component of the Theory of Planned Behaviour, in the Prototype Willingness Model, attitudes play a less central role, particularly for younger/less experienced young people.

*Social norms and peer pressure*

Models distinguish between two types of norm: descriptive norms (what I believe others around me are doing) and subjective norms (the beliefs of others and the degree of importance that I attach to them). In one meta-analysis\textsuperscript{16} of over 100 studies, the authors found evidence that descriptive norms have a stronger influence on sexual behaviour than subjective norms but both types of norm were stronger influences than one’s own personal attitudes and beliefs, highlighting the very important role that social influence plays in driving sexual behaviour. A good example of the dissonance between the descriptive norm and the real situation relates to the age at which young people first have sex. Only between a quarter and a third of young people have sex under 16, and young people and parents both agree that between 16 and 18 is the right sort of age for first sex, yet both groups also consistently overestimate levels of sexual activity under sixteen\textsuperscript{17}.

Despite the overwhelming evidence that there is for the role of peer pressure and influence there is relatively little work that aims to pinpoint the mechanism by which peer influence works. However, there are some interesting clues from some qualitative studies\textsuperscript{18}, which suggest that:

- friends are the most important source of information about sex and relationships (although not for contraception and STIs where schools and parents play an important role)

\textsuperscript{14} As described in the GSR behaviour change knowledge review
\textsuperscript{15} As described in the GSR behaviour change knowledge review
\textsuperscript{16} Sheeran et al (1999)
\textsuperscript{17} The average age at which young people first have sex is 16 and this has remain unchanged over the last six years.
\textsuperscript{18} See, for example, Rosenblatt (2004), Hatherall et al (2005)
- Peer influence is strongest among young age groups (12-15) and among children whose relationship with their parents or another responsible adult is poor.

- Peer influence is particularly strong when the relationship is between a dominant older youth and a younger, less confident individual (e.g. within a gang).

- There are some indications that there may be some gender differences in peer influence – for example, some research suggests that peer pressure tends to have a largely negative influence on boys (e.g. pressurising them into losing their virginity early and continuing to have regular sex thereafter) whereas among girls there can be a strong positive effect too (e.g. around contraceptive choices).

Self Efficacy or Perceived Behavioural Control
This set of influences concerns an individual’s perceived ease or difficulty of performing the particular behaviour. Within the context of teenage pregnancy and sexual health, it would include the degree of confidence an individual has in their ability to negotiate contraceptive use, whether or not they have access to appropriate contraception, and their confidence in their ability to use it effectively, etc.

Intention
In most theories, the factors described above together shape behavioural intention – i.e. whether or not an individual plans to behave in a certain way. Again most theories assume that intention is the direct precursor of the desired behaviour and when quantified there is good evidence that intention is correlated with the sexual behaviour among older/ more experienced individuals.

Preparatory behaviours
However, Sheeran et al (1999) in their meta-analysis of condom use, found that behavioural intention did not lead directly to safer sexual practice. Rather, condom use was mediated by what the authors term ‘preparatory behaviours’. They cite three key preparatory behaviours:
- condom purchase/ access
- condom carrying
- discussion/conversation about condom use

The authors found that while attitudes, norms and perceived behavioural control drove behavioural intention, perceived behavioural control could also directly influence preparatory behaviours, and that preparatory behaviours were better predictors of subsequent condom use than intention. Moreover, of the three preparatory behaviour identified, the strongest influence on behaviour was discussion/conversation19.

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19 The importance of conversation/discussion is also noted in other studies including Hatherall et al (2005), Marston et al (2006)
Model showing the mediating influence of preparatory behaviours on condom use, taken from Sheeran et al 1999

BEHAVIOURAL WILLINGNESS AND RISK IMAGES

In their Prototype Willingness model, Gibbons and Gerrard identify behavioural willingness as an important influence on the behaviour of young and inexperienced young people. They define behavioural willingness as the degree to which an individual is likely to behave in a certain way (rather than how they intend to behave). Behavioural willingness is, in part, driven by one’s perceptions of the people who indulge in a particular behaviour. So, for example, if I believe that people who do not use contraception are attractive or gain 'status' through their behaviour, I will have positive ‘risk images’ and high behavioural willingness. Gibbons and Gerrard have shown that behavioural willingness is a better predictor of behaviour among young and inexperienced young people than intention. (Among older / more experienced groups, behavioural intention becomes more important.)

PAST BEHAVIOUR

The Gibbons and Gerrard model also predicts that past behaviour has a strong influence on future behaviour. So, for example past condom use makes it more likely a condom will be used in future – a prediction that has been borne out in practice in several studies. Conversely, past use of the pill makes it less likely a condom will be used in the future.

INFORMANTS

Informants is a broad category of influences that covers the people, channels and places from which young people derive information (e.g. about risks or the strategies for minimising risk) that is relevant to their decision making. In the case of sexual health, this could include the media, internet, friends, parents, schools and health care practitioners. Hatherall et al (2005) documented the information sources used by young people and found that in general school, friends and parents are key sources across all issues20:

- Schools are the primary source of information for STIs and contraception
- Friends are the common source of information about sex and relationships
- Parents are important secondary sources for all topics
- Books/ magazines and other media play an important role particularly for STIs.

20 These findings are very similar to the pattern that emerges from other sources such as campaign tracking studies
Informants tend to shape attitudes and beliefs but can also drive the other factors influencing behaviour such as norms, perceived behavioural control and behavioural willingness. For example, Gibbons and Gerrard have shown that parents can have a very strong influence on their children's behaviour, and that this influence works by shaping both their children's attitudes and by decreasing behavioural willingness. Another example is the way in which the media can shape social norms and, by creating attractive 'risk images', increases behavioural willingness.

6.2 A generalised model of the factors influencing sexual behaviour

Pulling together all the factors that appear to influence and shape sexual behaviour, we can create a generalised model that identifies the key levers of influence. In the diagram below, two types of influences are identified: within the inner circle are those that relate specifically to sexual behaviour (e.g. attitudes to condom use or the perceived risks associated with contracting chlamydia). Those influences in the outer circle do not concern sexual behaviour specifically but are associated risk factors for teenage pregnancy and/ or STI infection.

This model identifies several new potential levers of influence – such as the role of risk images in driving behavioural willingness, the mediating role of preparatory behaviours and the potential to use parents as a way of influencing behaviour. Such levers have not been addressed to any great degree within the marketing and communication strategy to date (which has tended to focus more on changing attitudes and encouraging condom usage) but offer potential new opportunities to exploit in the future.
6.3 The evidence for what works in practice

While a theoretical model of behaviour change is a useful source of insight about what might work, international and regional experiences together with learnings from sex and relationships education provides invaluable evidence about what can work in practice.

**Sex and relationships education**

Good evidence for how the factors described above can be used to influence sexual behaviour comes from the ongoing studies in the US of the ‘ingredients’ of effective sex and relationships education. Kirby, 2007\(^21\) finds that the most effective approaches address multiple influencing factors and include:
- a strong message on delaying early sex together with knowledge about contraception and protection against STIs\(^22\)
- intensive support for those at risk
- good training and motivation for leaders
- a strong degree of participation/engagement
- strategies that address peer pressure directly
- modules that teach communications skills
- information that is tailored to reflect the age, sexual experience and culture of young people in the programme

**International and regional experience**

The experiences of other countries and regions in addressing both teenage pregnancy and STIs provide some interesting examples of how different strategies have been used to influence behaviour. The cultural and social context can differ widely, and needs to be borne in mind when making comparisons with the UK as a whole, but nevertheless there are some interesting observations that provide an indication of how different strategies might work\(^23\). Note that this is not an exhaustive review; rather a summary of some of the more interesting approaches adopted.

**The Netherlands**

The Netherlands is a much-cited example of a country that has successfully tackled both teenage pregnancy and STIs. According to a US review of European strategies\(^24\), one of the key (long term) drivers of success has been the creation of a culture of respect, openness and personal responsibility, where “The major public health goal is to ensure that everyone…has the necessary skills to behave responsibly when sexually active”. This culture can be contrasted with the prevailing culture in the UK, described by stakeholders as one of ‘stigma shame and embarrassment\(^25\)’. Sex and relationships education (SRE) plays an important part in delivering the strategy and at its heart is the belief that ‘teen sexual behaviour is … a developmental issue’\(^26\) (rather than a risky behaviour which is often how it is perceived in the UK). As such, SRE is delivered as part of the ‘Care’ curriculum and ‘the general philosophy is not to teach but to talk about sex. Teachers emphasise communication and negotiation skills\(^27\).

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\(^{21}\) Doug Kirby, Emerging Answers 2007
\(^{22}\) Kirby found that young people were able to take on board these message and did not perceive them to be contradictory
\(^{23}\) A more detailed project exploring the experience of other markets, notably the Netherlands, is being commissioned in order to better understand how to apply learnings to the UK’s situation.
\(^{24}\) Berne et al (1999)
\(^{25}\) Julie Bentley, Chief Executive, Family Planning Association, September 2009
\(^{26}\) Berne et al (1999)
\(^{27}\) Berne et al (1999)
New Zealand
The New Zealand campaign for teenage pregnancy tackles social norms head on with the campaign ‘Only when you’re ready.’ In doing so, it uses a delay message but put in the context of personal choice. The online resource that forms part of the campaign challenges the myths and misplaced beliefs that are common among young people further challenging existing perceived (descriptive) norms. In addition, the site has clearly signposted areas for both parents and teachers, which like in the Netherlands, helps to create the sense of an open and honest conversation about sex and relationships to which all parties are invited to contribute.

Massachusetts
The Massachusetts campaign focuses explicitly on the preparatory behaviour of ‘talking’ through the “Healthy Talk” campaign. A key learning from the campaign was that it isn’t sufficient to just tell people to talk; rather people needed to be taught ‘how’ to talk\(^{28}\). Consequently, some of the more successful executions features snippets of ‘overheard’ conversation that effectively ‘seeded’ appropriate language and conversation starters among the target audience. A key audience for the campaign was the Hispanic community, who are one of the ‘at risk’ groups within the US. (Interestingly this group shares some of the characteristics associated with groups known to be at risk in the UK.)

Advocates for Youth
Advocates for Youth is a US organisation that believes ‘all young people have the right to the reproductive and sexual health information, confidential, safe services and a secure stake in the future’. They run a number of different programmes including an extensive network of peer to peer educators involved in various activities including condom distribution and programmes aiming to increase self-esteem and confidence among minority groups. Advocates for Youth also provide very extensive and detailed resources for parents and teachers to help them communicate effectively with children and young people and cite multiple sources of evidence for the positive impact of good communication between parent and child.

Regional Initiatives
There are many examples of interesting approaches that have been adopted by SHAs and PCTs across the UK. In many cases, these approaches have yet to be fully evaluated, but they give a snapshot of some of the more innovative non communications-led approaches that are being piloted. For example:

- The DaSH project\(^{29}\) used social marketing principles to design a GU centre that was more appealing to a teen audience (and succeeded in driving additional footfall)
- COAST\(^{30}\) was a nurse-led chlamydia screening project in non-medical environments that successfully engaged young people
- MediVend is a pilot scheme to explore if strategically-placed vending machines/kiosks can be used to increase access to products such as condoms, pregnancy tests, etc.
- Condom card schemes\(^{31}\) (in which young people receive free condoms when they present a ‘C-card’ at participating venues) are one of the more established

\(^{29}\) Case study available via the NSMC database
\(^{30}\) Case study available via the NSMC database
\(^{31}\) A good example of one of the more established schemes is [http://www.ccard.org.uk/](http://www.ccard.org.uk/) which runs in Edinburgh and Lothian
approaches. Such schemes are well-received although it is hard to judge whether positive attitudes translate into measurable shifts in behaviour.

- Finally, one of the most interesting projects is “House” in Kent. This intervention (which was originally briefed as a communications campaign) had a broader goal, which was to engage teenagers in a dialogue across a range of risky behaviours. The insight behind it was that while there was no shortage of information or indeed of services accessible to young people, there was a shortage of channels that linked the two. The solution involved the use of ‘pop up venues’ in town centres, designed (by teenagers) to look and feel like ‘a mate’s house’ where they can access a range of services including sexual health, drug education and advice, etc. The approach has been deemed a great success and is due to be rolled out across Kent

6.4 Conclusion: what influences behaviour?

The review of behaviour change theory identifies that there are multiple influences on sexual behaviour which communication could seek to influence in addition to personal attitudes and beliefs. In particular, it is recommended that rather than seeking to address sexual behaviour directly, communication should aim to influence the preparatory behaviours that precede sex. These have been identified as communication with one’s partner, access and carrying of contraception, and could potentially be extended to included screening.

Evidence from current practice highlights the need for approaches that address multiple levers of influence (such as peer pressure and communication skills) and intense intervention for the most at risk. This adds further weight to the contention that communication may not be a sufficiently powerful tool to influence the highest-risk audiences, but that these groups can be engaged via marketing-led interventions such as those seen in some UK regions.

The importance of good communication between multiple parties is highlighted in overseas campaigns such as Healthy Talk and the work of Advocates for Youth. Together with the role played by ‘informants’ such as parents, peers and stakeholders identified in behaviour change theory, this suggests the need for a communications strategy that targets a much broader audience than those at risk and which raises the issue of communication and negotiation. In communicating with a broader and less vulnerable audience whose behaviour is easier to influence, there is potential for ‘trickle down’ to more vulnerable audiences through mechanisms like peer influence.

Finally, the experience of other markets, particularly the Netherlands, identifies the broad role of society and culture in shaping the way teen social behaviour is framed and responses to it. Whilst attempting to bring about a change in culture is a challenging objective for a marketing strategy, catalysing a more open and honest conversation at a national level about teenage pregnancy and sexual health could help to address them more effectively.

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33 The Sheeran et al (1999) study that identifies preparatory behaviours was based on studies of condom usage. However, the principle is extended here to include other forms of contraception.
7. The Social Influence Model

The review of behaviour change theory highlights in particular the influence of peer pressure and social norms on sexual behaviour. A social influence model was built to explore these influences further, and in particular, the mechanisms for how different communications strategies could work to affect health outcomes.

7.1 Model methodology

The social influence model is a multi-agent model. It simulates the individual sexual attitudes and behaviour within a simulated population of 4,000 people aged between 15 and 20. Each of the iterations of the model simulates 10 years of actual behaviour. Over 5,000 iterations have been completed during the development, fitting and exploration of the model.

The rules of behaviour and interaction for each of the individuals within the model were created based on academic research, the main sources being:

- NATSAL 2000 which was used to fit the frequency, length and distribution of sexual relationships within the model
- The mechanisms of influence on sexual relationships were based on ideas contained within *Chains of affection: the structure of adolescent romantic and sexual networks*, Bearman et al, American Journal of Sociology 2004
- The prevalence of different types of contraception was also fitted to NATSAL 2000
- Rates of screening were fitted to information from the HPA
- The rates of conception used within the model were based on research from the US including the National Survey of Family Growth which are cited in *Long-acting reversible contraception*, National Collaborating Centre for Women's and Children's Health/NICE 2005
- The epidemiology of chlamydia within the model was based on parameters published in "Developing a realistic network model of chlamydia transmission in Britain, Turner et al, Theoretical Biology and Medical Modelling 2006"
- Epidemiologists from the HPA were also consulted about the methodology used

7.2 Limitations of the model

The social influence model is highly complex however there are limits on its predictive capabilities due to a number of factors including:

- The main research study used, NATSAL, is nearly 10 years old and some sexual behaviours may have changed over that period. However, teenage pregnancy annual tracking surveys from the last five years show that the mean age for first sex has remained at 16, suggesting that significant changes are unlikely
- There is likely to be self-reporting bias in any research related to sexual behaviour
- There is variation in the provision of contraception and screening services which is difficult to quantify
- Qualitative and quantitative research on social influence related to sexual behaviour is very limited and consequently the mechanisms of influence within the model are extrapolated from a limited number of sources
- There are limits on the number of attitudes and behavioural rules and the size of the population which can be simulated within a realistic time frame

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34 TNS campaign tracking studies 2004-2009
As such all outputs from the social influence model should be interpreted alongside other analysis and in the context of the research foundations on which it is based. However it does provide a rational framework which can be used to assess the relative impact of different communications and policy approaches.

7.3 How and when conception and chlamydia infection occur

The model can be use to explore how and when both conceptions and chlamydia infections occur in the context of a relationship. Key findings are that:

- The probability of conception is lower for unprotected sex than most people realise at an estimated 0.71%

- Conversely the efficacy of both the condom and the pill is probably lower than commonly believed – the probability of conception being around 0.125% for the male condom and 0.066% for the pill. This is similar to the findings with the NICE guidelines that indicate a failure rate – driven by user error - of around 15% for the condom and 8% for the pill

- In comparison the chance of falling pregnant per sexual act with a LARC is estimated to be 0.0008%

Table showing the probability of conception per sexual act

<table>
<thead>
<tr>
<th>Contraception</th>
<th>Per sexual act chance of conception %</th>
</tr>
</thead>
<tbody>
<tr>
<td>No method</td>
<td>0.71%</td>
</tr>
<tr>
<td>Male condom</td>
<td>0.125%</td>
</tr>
<tr>
<td>Pill</td>
<td>0.066%</td>
</tr>
<tr>
<td>LARC</td>
<td>0.00008%</td>
</tr>
</tbody>
</table>

- However, the probability of conception is low enough to mean that, according to the social influence model, one night stands are probably not the main source of teenage pregnancies – the majority happen in relationships that are longer than a week’s duration

- Moreover, the modeling suggests that 64% of the pregnancies resulting from the modeled population are caused by contraceptive failure (probably as a result of user error), with only a third resulting from a lack of contraception

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35 NB the modeled population is of 15-20 year olds, not just under 18s.
Why conceptions occur

- The model estimates that probability of contracting chlamydia is around 5% per sexual act

- Consequently, the majority of infections are not a result of unprotected one-night stands. Rather, they are a result of people in slightly longer relationships (over a week in length) having regular sex with an infected individual

- The hypothesis, therefore is that chlamydia is often contracted when couples switch from using condoms to hormonal contraception when their relationship starts to become a little more established

The implications of these findings is that priority audiences for the sexual health campaign should include those young people in fledgling relationships who are already using contraception, albeit not very effectively, not just those who display the most risky sexual behaviours (i.e. multiple partners/one night stands/ no contraception).

7.4. Exploring the impact of different interventions

The social influence model can also be used to understand the interaction between attitudes, behaviours and outcomes and therefore to explore the potential impact of different potential communication themes.

First the model was used to explore the impact of communication about individual interventions such as contraceptive choice or chlamydia screening in order to understand both how such communication could work and the potential impact of it.

Once this had been established the model was used to understand how the different communications could work together to create maximum impact.

Each model run lasts a simulated 10 years, of which the campaigns are active for the first 5 years (indicated by the shaded areas on the graphs below). The outputs from the model are shown below where the conception levels and chlamydia infections are normalised with 1 as current levels.
7.4.1 The baseline and ‘current campaign’ scenarios
As part of this exercise a baseline was established for the likely trajectory for conceptions and chlamydia infections. These baselines are based on the assumption of no communications activity. In this scenario we still expect the uptake of LARCs and screening to increase due to higher levels of availability and increasing awareness due to social factors.

The model suggests that it is difficult to change overall condom usage through communications, and even if we could the impact on conceptions would be very low.36 As such we would expect the current communications mix, consisting of a major focus on condoms and regional activity supporting the National Chlamydia Screening Programme will have minimal impact on teenage pregnancy.

7.4.2 Potential impact of LARCS, chlamydia screening and condoms
The key to reducing conceptions seems to be getting young people to switch from forms of contraception that are subject to significant user error (such as condoms and the pill) to LARCs. Communications could play an effective role in raising awareness of more effective alternatives to the pill.

Potential impact of LARCS marketing spend on the teenage pregnancy rate in England

Condom campaigns have more impact on chlamydia prevalence. However the model shows that if investment is shifted from condoms to screening, prevalence will reduce even faster.

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36 This is because the model predicts that the majority of conceptions are caused by user error rather than a lack of contraception. So, increasing levels of condom usage without significantly increasing the quality of condom usage will not have a significant impact on conception rates.
7.4.3 Potential impact of increasing knowledge and understanding

The mechanisms for the potential impact of increasing levels of knowledge and understanding of sexual health-related issues are less well understood and so the model predicts their impact with a lower degree of confidence.

However, modelling indicates education is important in setting initial attitudes and will change overall behaviours as teenagers feed into the sexual population. However their good intentions will be moderated by the social influence of their older and more experienced peers. Consequently, interventions that increase knowledge and understanding work most effectively when efforts are made to change the attitudes and behaviour of the older peer group as well.

Increasing knowledge and understanding also plays an important long-term role in ensuring that behaviour does not return to pre-campaign levels as investment in marketing programmes stops.

7.4.4 Potential impact of communications and negotiation

Multiple sources of evidence point to the impact of improving communication and negotiation skills\(^{37}\) so the social influence model was used to investigate the potential impact of using marketing to fuel conversation and discussion.

The model predicts that while conversation *alone* does not have a significant impact on this, the strategy works hardest when used in conjunction with other strands and interventions.

It has more impact on Chlamydia infections than on conceptions, as the combination of assumptions within the model suggest a greater degree of social influence on an individual’s decision to accept a test than on their choice of contraception.

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Potential impact of combining LARCs, communication and negotiation marketing spend on the teenage pregnancy rate in England

Note: The model simulates a 5 year campaign. As shown in the graph above, the impact of communications eventually wears off and behaviour starts to return to pre-campaign levels.

Potential impact of combining chlamydia screening, communication and negotiation marketing spend on the chlamydia prevalence rate in England

In both cases increasing communication/negotiation seems to deepen and length the impact of the other programmes.
7.5 Optimum intervention strategies

The summary of these findings is that the optimum approach is to focus on LARCs and screening, maintaining some activity on condoms and making investments in education/knowledge and communication/negotiation.

Potential impact of optimum intervention strategy on . For consistency, we should use conceptions not pregnancy. teenage pregnancy in England
7.6 Conclusions: the social influence model

Developing a social influence model provides additional insight into how and when conceptions and infections occur, and also enables us to test the potential impact of different sorts of marketing intervention. It should be borne in mind that this is a theoretical model based on the available evidence for social influence on sexual behaviour. The data has been fitted to the best-available sources, but as with all models, includes some major assumptions and its findings should therefore be interpreted with some caution.

However, findings from the modelling suggest that:

- **The target audience for the campaign should include those young people who are already using contraception but may be using it poorly and therefore are at risk of conception and/or infection through user error**

- **The most effective individual strategies for addressing the conception rate and chlamydia infection rate are increasing LARCs usage and increasing chlamydia screening respectively. However, investment needs to be sustained otherwise behaviour quickly returns to pre-campaign levels**

- **However, condom use should still remain a core message within the campaign, given that condoms remain the only protection against other STIs, the most widely accessible form of contraception and the only contraception available to young men**

- **Increasing levels of knowledge and understanding should play an important role in the marketing strategy since it has an impressive, but longer-term impact and helps ensure behaviours do not return to pre-campaign levels**

- **There is also an important role for increasing communication among the key audiences. However, rather than working in isolation of other strategies this approach should be used to amplify the impact of other interventions since it appears to work by deepening and lengthening their impact**
8. Defining the roles for marketing and communication

8.1 Overall role

The overall aim of the marketing and communications strategy should be to act as a catalyst for culture change: creating a more open, positive, respectful and supportive backdrop against which policy interventions can happen.

Achieving this means not only raising awareness of these new initiatives, but challenging the existing culture of ‘stigma, shame and embarrassment’ that typifies attitudes towards teen sexual behaviour. It is therefore not only young people whose attitudes and behaviours we must change, but also their parents, and stakeholders such as health care practitioners. These groups must first recognise and embrace the role they can play in influencing behaviour and be confident they have the skills required to make a positive impact.

8.2 Marketing objectives

To achieve this overall aim, the strategy identifies three complementary marketing objectives:

8.2.1 Prevention: increasing the attitudes, knowledge and skills that make safe sex more likely

Activities that fall under this objective aim to influence the ‘longer and broader’ causes of teenage pregnancy and poor sexual health and will address needs of young people who are not yet sexually active.

8.2.2 Protection: encouraging protective behaviours that make sex safer

This activity aims to influence the behaviour of sexually active young people by encouraging behaviours such as contraceptive use and screening in order to make sex safer.

8.2.3 Intervention: providing intensive support for the most at risk

Activity that fulfills the third objective will be targeted at the most high risk audiences and should be designed around their specific needs. International experience suggests that such groups require extremely intensive support that combines all the protection and prevention approaches described above. Mass market communications is therefore
unlikely to be able to drive behaviour change directly. It is envisaged that social marketing approaches which provide access to tailored services in conjunction with specialist SRE are likely to make up the bulk of activity in this area.  

8.3 Campaign themes

For maximum impact, a number of different strands or themes are recommended:

- **Knowledge and understanding** will focus on giving people the facts about sexual health and teenage pregnancy, dispelling some of the myths and misperceptions that currently exist.
- **Communications and negotiation** will aim to promote more discussion within and between audience groups—e.g., helping parents and children talk more effectively and encouraging couples to talk more about contraception.
- A campaign focusing on **contraceptive choice, particularly LARCs**, is proposed to reduce the risk of pregnancy resulting from poor use of contraception.
- A campaign to **increase chlamydia screening rates** among 15-24s and therefore ultimately to decrease the prevalence of chlamydia within the population.
- Finally, partnership and stakeholder activity is proposed to **increase access to and carrying of condoms** particularly among younger audiences and those at particular risk of contracting some STIs (e.g., MSM groups).

Some or all of these themes will be integrated within interventions designed to offer intensive support to the most at risk (objective 3). It is likely that the activity that contributes towards this objective will be highly targeted, experiential, possibly integrated with delivery of SRE and include engagement with NHS services as a core part of the intervention.

8.4 Conclusion: the roles for marketing and communication

*The overall aim of the marketing and communications strategy should be to act as a catalyst for culture change: creating a more positive and supportive backdrop against which policy interventions can happen. This overall aim will be supported by three complementary objectives: to increase prevention, protection measures and to deliver intensive intervention against those most at risk; and by five campaign themes or strands: knowledge and understanding, communications and*

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38 Much activity of this nature is already carried out by Local Authorities and PCTs. This strategy formally recognises the valuable role that such activity plays.
negotiation, contraceptive choice, chlamydia screening and condom access and carrying.
9. Audiences for communication

It is important that a distinction is made between audiences that are most at risk of teenage pregnancy and STI infection (those described in section 4) and those that are the audience for communication.

While the most at risk audiences are a major priority for the strategy as a whole, the young people who fall into the highest-risk segments are likely to present with multiple vulnerabilities (e.g. drug and/or alcohol misuse, poor educational attainment, etc.). As such, communications is unlikely to be a major influence on their behaviour.

The key audiences for communication should therefore include a more mainstream audience who are easier to influence and parent/stakeholder groups who may, in turn, be able to play a more powerful role influencing the behaviour of those most at risk.

An additional priority for communication is to influence those young people who are not yet at risk (they are too young) but who may be vulnerable in the future.

In summary, then, there are four key groups that communication should influence:

9.1 11-16 year olds

The majority of under 16s are not sexually active, but are naturally curious about sex and relationships and highlight the provision of high quality information about sex and relationships as a key concern39. These years are critical for forming the attitudes that will shape their behaviour in years to come. As such, the key needs that communication must fulfill for this audience are to provide a source of authoritative and accurate information with particular emphasis on delaying early sex, and to build the confidence and skills required to negotiate safe sex when they feel ready for it. If and when sex and relationships education becomes statutory, much of this need can probably be met through excellent SRE delivery. However, a trusted, impartial, and comprehensive information resource will always be required to extend and support the work of SRE in schools.

The DCSF segmentation highlights two groups, which should be particular priorities:

- The Happier at Home segment, while having strong relationships with their parents and family, lack confidence, are less likely than average to enjoy learning and aspire to work rather than stay in education longer than necessary. These characteristics suggest that they may, as they get older, exhibit some of the underlying attitudes and behaviours that are known risk factors for teenage pregnancy.

- The key characteristic of the Anxious and Unsure segment is their lack of confidence and their vulnerability to peer pressure and bullying. There is also some suggestion that children in this segment may grow into teenagers exhibiting the behaviour and attitudes of 'Breaking the Rules'. Consequently, Anxious and Unsure children are a key focus and the key need that communication can help fulfill is to increase their confidence and skill in dealing with peer pressure.

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39 TellUs 3
9.2 16-34s

This older age group are sexually active and their key need is for strategies that can help them protect themselves better from STIs and the risk of pregnancy. Most will be using some form of contraception but may put themselves at risk by not using it adequately or by not taking sufficient protective actions (e.g. using hormonal contraception to prevent pregnancy and consistently using condoms to protect against STIs).

There is no single segmentation of this group on which we can rely for insight. However, a number of different studies highlight sub-segments of this age group who are particularly relevant for communication.

- **Exploring Independence** – the oldest of the DCSF segments, this group of BC1 15-18 year olds are confident and independent and choose to indulge in risky behaviour as a mark of their growing independence. They are relatively ambitious and recognise the importance of education, making them a lower risk group than others, but they may still put themselves at risk through careless use of contraception.

- **NATSAL segments ‘fledgling relationships’ and ‘high number of sexual partners’** - analysis suggests that these groups are at the highest risk of STIs. In the case of those in fledgling relationships this may be because of a shift from condom usage to hormonal contraception as the relationship progresses.

- **Risk challengers** – this is an attitudinal group defined by Define research during their study of contraception-related attitudes and behaviours. The typical risk challenger is beginning to settle into a longer term relationship and consequently is re-evaluating her contraceptive choice in line with her changing lifestyle. Risk challengers are probably the softest target for increasing usage of LARCs.

9.3 Parents

Parents play a critical role in influencing teen behaviour - in fact some commentators suggest that parents are the most important influence driving teen decision-making. Open and honest communication between parents and teenagers has many positive benefits is associated with avoidance of risky behaviour, positive influence over safer sexual behaviours and stronger aspirations to live up to parental expectations. Studies of effective SRE in the US have also demonstrated that engaging parents is a critical component of most successful programmes.

However, many parents admit to feeling ill-equipped to have conversations about sex and relationships with their children, lacking the skills and confidence to bring the subject up, know what information is appropriate for each age of child and to answer difficult questions. There is a clear role for communication, first to make parents aware of the positive influence they can have, and then to help them feel more confident when they do get involved.

9.4. Stakeholders

Stakeholders such as healthcare professionals, teachers and Governors play an important role in shaping the culture around teenage sexual behaviour. If these groups exhibit ‘stigma, shame and embarrassment’, they act as a barrier rather than an enabler of behaviour change.

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40 Advocates for Youth
41 Advocates for Youth
Health care professionals
Health care professionals such as GPs, practice nurses and pharmacists come into contact with young people and adults and have an important role to play in advising them on issues relating to contraception and STIs. However, almost all but the most experienced youth workers or sexual health specialists admit they find it hard to discuss issues relating to sexual health with patients, particularly if the initial reason for the visit/appointment was not related to sexual health. This manifests itself in a desire to simply administer contraception or a screening test, rather than discuss sexual history and other other factors influencing behaviour.

With HCPs communication can help by increasing the salience of the various issues, thereby providing the 'excuse' for the HCP to broach the subject of e.g. contraception or screening.

Teachers and Governors
Teachers and Governors have an important influencing role to play. Governors are responsible for setting the school policy on SRE and teachers will be responsible for delivering the subject in the classroom. Even among this generally well-informed audience there may be some misconceptions (e.g. incorrect beliefs that SRE can have a negative effect, actually fuelling the behaviour it aims to prevent) and a lack of awareness regarding newer forms of contraception and the chlamydia screening programme. Communication can help this audience by providing accurate and authoritative information, allaying concerns, etc.

Youth workforce
The wider youth workforce in touch with young people have a significant role to play in conveying accurate information, ensuring swift referral to contraception and sexual health services and encouraging open, honest and respectful conversations about relationships and sexual health. Many are working with young people at higher risk so play a critical role in supporting them to access specialist advice as needed.

9.5 Conclusion: audience for communication

Four key audiences are identified for communication: under 16s for whom the focus is on high quality provision of information about sex and relationships, 16-34s who need information on how to protect themselves adequately, parents, and stakeholders.
10 The campaign’s themes in detail

This section describes the key themes within the campaign in more detail and highlights some potential activities that could be used to deliver the campaign.42

10.1 Contraceptive choice

10.1.1 Background & rationale:
The most common forms of contraception used are condoms and the pill. However, these are only two of fifteen methods of contraception and are by no means the most effective. Used properly, both the pill and the condom are very effective but due to user error/carelessness the NICE guidelines suggest a failure rate of 8% for the pill and 15% for the condom. Moreover, continuing high levels of abortion indicates the significant proportion of conceptions that are unplanned and therefore need for improved knowledge of and access to the range of effective contraceptive choices.

Long acting reversible forms of contraception (LARCs) include the intrauterine device (IUD) and intrauterine system (IUS), contraceptive injection, patch and implant. These must be fitted by a healthcare professional but are by far the most effective form of contraception, with an 0.0008% chance of conception. They can last from 3 months (injection) up to five years (IUS/IUD) but may be reversed at any time.

Insight from the social influence model suggests that increasing the use of LARCs is likely to be the most effective short-term measure for decreasing teenage pregnancy and therefore raising awareness of LARCs within a broader campaign around contraceptive choice represents a key role for communication.

The overall aim of the contraceptive choice strand of communication should be help women make an informed choice about their contraception by increasing consideration of LARCs.

10.1.2 Potential activities and initiatives
- A mass market, multi-channel communications campaign that raises awareness among 16-34s of the benefits of LARCS (reliability and long-term use) and aims to make them feel like a more familiar form of contraception43
- An online resource/tool that enable women to explore their contraceptive choices and to assess which method is right for them
- A campaign targeting healthcare practitioners to raise awareness of the importance of contraceptive choice and to boost their confidence and skills in talking about LARCs, particularly the known side effects
- Content seeding and syndication – e.g. seeding storylines and content into existing trusted and credible platforms such as magazines, TV programming, etc., with the dual aim of reinforcing the efficacy message and boosting familiarity

10.1.3 Measures of success
The key measure of success for this activity will be levels of LARC usage. Leading indicators such as the number of women seeking more information about LARCS, and the proportion of contraception consultations where LARCs are discussed will also

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42 Budgetary constraints mean that is unlikely all proposed strands and activities can be supported in a given financial year. Budgets will be prioritized against activities that offer the maximum potential gain, or that support key policy priorities for the year.

43 The Define contraception research identified that ‘familiarity’ was key to driving usage of any form of contraception
indicate success. Measures that would indicate that the campaign is working in the way that is predicted it would include perceived familiarity of LARCs and their perceived efficacy versus user-dependent methods.

10.2 Chlamydia screening

10.2.1 Background & Rationale
Chlamydia is the most common sexually transmitted infection in the UK. In most cases, chlamydia is asymptomatic but although it has few symptoms its effects can be severe since left untreated, it can cause fertility problems in both men and women.

The National Chlamydia Screening Programme (NCSP) was launched in 2002. Its aim is to reduce the prevalence of chlamydia through a programme of opportunistic\textsuperscript{44} screening. Mathematical modeling has indicated that annual screening of 30\% of men and women under 25 years of age with 20\% partner notification would reduce the population prevalence of chlamydia by 29\% after one year, 65\% after five years and 82\% after ten years. Treatment of individuals who test positive for chlamydia and subsequent notification of their sexual partners is also an important part of the programme. Screening sites include healthcare-related sites such as GP surgeries and pharmacies, as well as non healthcare-related sites such as schools and colleges and army bases.

There is clear evidence from the social influence model that increasing rates of screening is the best strategy to decrease chlamydia infection in the population. However, there have been concerns in the past that a national campaign promoting the screening programme could overwhelm the system. However, a recent capacity analysis has indicated that the programme is sufficiently established to cope with significantly more screenings. Furthermore, analysis suggests sufficient 15-24s are already engaging with screening sites to screen 50\% of the target population each year. The key issue for the programme, therefore, is one of ‘conversion’ rather than driving additional footfall into screening sites.

The overall aim of communication about chlamydia screening should be to increase the proportion of 15-24s being offered and accepting a chlamydia screening test in NCSP screening sites.

10.2.2 Potential activities and initiatives
- A communications campaign that aims to increase the salience of chlamydia screening among both 15-24s and healthcare practitioners
- A ‘point of sale’ toolkit for screening sites which aims to increase the % of potential screenees who accept a test by providing clear and persuasive (but discreet) information about the benefits of screening for potential screenees. This could include posters, leaflets and filmed content (where services such as the Life Channel are available)
- A training toolkit for healthcare practitioners to boost their confidence in talking about screening with potential screenees
- A CRM programme for screening sites that maintains the salience and perceived importance of screening among HCPs and acts as a way to disseminate best practice

\textsuperscript{44}Opportunistic screening works by screening individuals who fall within the target group (16-24s) and who are already present within a screening setting – e.g visiting a GP for a consultation on another matter. Critically, it is incumbent upon the healthcare professional to identify potential screenees and ask them to take part.
- **Online/ easy access to self-administered screening kits** for those who are unable to access NCSP screening sites

**10.2.3 Measures of success**

The key measure of success for this strand of activity will be the increases in proportion of young people who are screened each year. We would also expect to see increases in the proportion of potential screenees who are converted at point of sale, and increasing rates of screening through existing sites.

**10.3. Condom access and carrying**

**10.3.1 Background and rationale**

The condom strand of activity presents a number of tricky issues and considerations within the overall teenage pregnancy and sexual health campaign.

The focus of most communications activity to date has been to try to increase condom usage and this is partly because there were few widely accessible alternatives. However, the advent of initiatives like increasing access to LARCs the roll-out of the chlamydia screening project provide sexually active young people with other protective strategies.

Insight from the social influence model suggests that the advent of these initiatives does not just increase choice, but also provides young people with more effective strategies from which to choose. With other easier and more effective options available, it is likely to be extremely difficult to increase existing levels of condom use.

This presents a major challenge since supporting condom use remains a policy imperative both because condoms remain the only way to protect oneself against STIs other than chlamydia and particularly because condoms are the most widely accessible form of contraception for young people, and men.

Consequently, it is recommended that condom activity focuses on maintaining condom use with a particular focus on key at-risk groups - in this case young people in hot spot areas, and population segments such as MSM and Black African and Black Caribbean communities.

**10.3.2 Potential activities and initiatives**

- **Reinforcing the role that condoms play** in protecting an individual from all STIs, and promoting the practice of using both hormonal contraception and a condom for maximum protection as secondary messaging in all communications
- **Stakeholder partnerships** that aim to increase access to and carrying of condoms. Good examples include initiatives such as ‘Queue Jump with a Condom’ which lets young people who are carrying condoms go to the front of nightclub queues

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45 Condom Essential Wear targeted 16-24s, and aimed normalise condom use as condoms are the only contraceptive method to protect against STIs. Want Respect targeted the most at-risk young people (deprived 16-18s in teenage pregnancy hotspots), and aimed to encourage condom use by associating use with increased peer respect. RU Thinking targeted under 16s and promoted condoms as the most widely accessible form of contraception and STI protection (among many other messages).

46 A key finding from the SIM is that increasing condom use has very little impact on pregnancy rates and only limited impact on chlamydia infections.

47 Albeit recognizing that other STIs affect a very small proportion of the general population although groups such as MSM and Black African and Black Caribbean communities have a higher than average risk of contracting HIV.

48 These preparatory behaviours are critical for driving condom use and are easier to influence than actual condom usage
- Support for schemes such as MediVend and C-card that increase access to condoms, particularly amongst at-risk audience in known hotspots. A recent pilot campaign in Liverpool has been successful in increasing carrying of condoms.
- Targeted communications campaigns such as the 'Jonny' campaign in holiday resorts which targets young people at a time/place when they are likely to put themselves at risk.
- A network of peer-to-peer condom distributors and/or educators in hot spot areas who can provide a regular trusted source of both condoms and advice.

10.3.3. Measures of success
Key measures of success for the condom strand of activity will include perceived ease of access to condoms and potentially the percentage of young people who regularly carry condoms with them. Given the proposed targeted nature of this strand of activity we would expect to see higher levels of access and carrying among targeted populations.

10.4 Increasing understanding and knowledge

10.4.1 Background and rationale
Providing accurate and authoritative information about a subject can be a powerful tool for shaping positive attitudes and beliefs, which in turn inform behaviour. In addition, such information can also be used to assert or challenge social norms, which as section 6 of this document highlighted, play a very important role in influencing sexual behaviours.

Moreover, because of the 'closed' and taboo nature of the subject some of the information that does circulate is ill informed or incorrect, creating the need for a credible information source with appropriate content, particularly for younger young people.

Earlier this year the Government announced its intention to make sex and relationships education statutory in schools, as part of PSHEE. Once consistent provision in all schools is established, it is likely that SRE will play a very significant role in increasing understanding and knowledge of sexual health. However, it is envisaged that marketing communication will continue to be important in supporting and supplementing SRE.

As well as the primary target of 11-16 year olds, the knowledge and understanding strand of communication has relevance to a much wider audience. For example, evidence from the States highlights the importance of educating parents as well as their children, and in particular helping them understand the positive and negative role that they play in shaping their children's attitudes towards sex and relationships. Experience in the UK demonstrates how important it is that those responsible for educating children – teachers and Governors - are well informed about these issues and their impact on society.

Therefore, the overall aim of this campaign theme is to arm young people with the information they need to make informed choices about when and how they have sex, and ensure they get the positive support they need from parents and teachers.

10.4.2 Potential activities and initiatives
- A communications campaign targeting young people and parents that asserts positive norms and highlights areas of consensus (e.g. the perceived 'right' age for first sex)
- A central information resource (online and/or offline) that provides the benchmark for accurate and authoritative information about sex and relationships
- **Engaging content and tools** then enable young people to assess what they know and rehearse how they should behave in certain situations.
- **Content syndication** – using stakeholders such as those that are part of the DCSF Parent Knowhow programme to distribute content via their own channels.
- A network of **peer to peer educators** who can be trained to provide a trusted and credible source of advice for at-risk young people.
- **Practical tips and tools for parents and teachers** that help them understand how they can positively and constructively influence their children's behaviour.

### 10.4.3 Measures of success

Since this strand of the campaign seeks to increase knowledge and shape attitudes and beliefs, its key measures of success should be based on attitude change. The social influence model suggests that changes of this nature will have an impact on behaviour over the longer term but we should not expect to see short-term changes in either claimed or actual behaviour. Rather attention should be focused on understanding of risks and consequences associated with teenage pregnancy and STIs, perceived trust and credibility in the campaign to deliver accurate and authoritative information, perceived social norms, behavioural intention and willingness.

### 10.5. Communications and negotiation skills

#### 10.5.1 Background and rationale

This is a new area of focus for the sexual health and teenage pregnancy campaign. The rationale for this strand comes from a range of sources:

- Academic literature, for example a study of the factors which predict condom usage, highlights that talking about condoms with one's partner is the strongest indicators of subsequent condom use.
- Evidence from the US which suggests that a critical component of successful SRE programmes is teaching communications skills to both children and parents.
- Experience in the Netherlands where the culture of open dialogue about teen sexual behaviour is widely cited as one of the drivers of their low teenage pregnancy rate (and is in marked contrast to the culture of 'stigma, shame and embarrassment' that exists in the UK).

Insight from the social influence model suggests that on its own this strand of communication will not work as effectively as other more immediate levers such as increasing LARCS usage or chlamydia screening. However, this strand appears to work hardest when done in conjunction with other strands of communication - its role being to amplify and maximise impact.

The key aim of this strand, therefore is **to get people talking more about sex and relationships.**

#### 10.5.2 Potential activities and initiatives

- The key proposed initiative is **the creation of a new campaign identity** that is rooted in the concept of talking and communication. This identity will be used to carry all the messages associated with the other strand of communication and is discussed in more detail in section 10.

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49 A relatively small-scale PR campaign entitled 'Time to Talk' was part of the previous campaign however.
50 Sheeran et al (1999)
51 Julie Bentley, Chief Executive, Family Planning Association, September 2009
- Insight from the Massachusetts 'Healthy Talk' campaign identified that people need to be shown 'how' to talk, not just told to talk. This learning suggests the need for resources that give people **practical tips and conversation starters** to enable them to have a responsible conversation about sex. Such resources could sit on the proposed information hub and should be tailored for different audiences including couple, peers, healthcare practitioners, parents and other stakeholders.

- The proposed **network of peer educators** could also be used to drive conversations about sex and relationships by priming them with relevant information and training them to initiate conversations between peers.

**10.5.3 Key measures of success**

The key measure of success for this strand of activity will be a claimed increase in the number of conversations about sex and relationships and perceived confidence – among all audience – to hold a conversation about sex and relationships. Given the importance of the overarching campaign identity recognition of this idea will also be an important gauge of the impact of communications.

**10.6 Intensive support for the most at risk**

**10.6.1 Background and rationale**

This strand of activity represents perhaps the biggest shift in focus for the campaign since it relies extensively on local networks and service to provide interventions ‘on the ground’ to the most at risk groups.

The rationale for this approach is the fact that many of the most at risk individuals (e.g. Breaking the Rules) will be engaged in risky sexual behaviours as a result of many contributory factors which could include drug and or alcohol misuse, truanting from school, poor relationships with parents/ family, etc. Consequently, communications is unlikely to have much impact on the behaviour of these groups. Therefore, a more appropriate approach is to build integrated services (perhaps comprising SRE, medical intervention if required, parenting interventions and confidence/ skills boosting initiatives) designed to meet the needs of specific groups.

Some good examples of the types of initiatives that are relevant were described in section 4, but of particular note are programmes like Kent County Council’s ‘House’ programme, DaSH and the current development of a social marketing pilot targeting repeat users of emergency contraception in the North West.

**10.6.2 Potential activities and initiatives**

The role for DH and DCSF marketing teams is probably not to deliver such interventions but rather to facilitate the creation and delivery of them by local stakeholders and partners. Therefore key activities could include:

- **Setting up a collaborative working party** comprising representatives from DCSF and DH, the National Centre for Social Marketing, stakeholders and key partners tasked with driving the development of this strand of activity

- Establishing some **clear evaluation principles** for interventions

- **Building a robust evidence base** for best practice in development and delivery of interventions

- **Sourcing ideas for interventions and working with partners and stakeholders to develop them** based on insights about specific target groups

- Working with partners to **pilot promising interventions**
10.6.3 Measure of success
Key measures of success for this strand of the campaign will be more concerned with the collection and effective dissemination of best practice in this area, than with the volume of young people engaged through initiatives delivered through marketing.

10.7 Conclusions: the strands in detail

It is proposed that the five campaign strands work as follows:
- Contraceptive choice will help women make an informed choice about their contraception by increasing consideration of LARCs and raising awareness of the potential failure rates of user-dependent methods
- Chlamydia screening will aim to increase the proportion of 15-24s being offered and going on to accept a screening test in core NCSP screening sites
- Condom activity will focus on universal promotion and availability of condoms to increase access and carrying – with a particular focus on at risk groups.
- Knowledge and understanding will arm young people with the information they need to make informed choices about when and how they have sex, and ensure they get the positive support they need from parents and teachers
- Communication and negotiation will aim to get people talking more about sex and relationships

A wide range of different activities and initiatives are proposed including mass market communications campaigns, stakeholder partnerships, a network of peer:peer educators and social marketing interventions.

However, budgetary constraints mean that it is unlikely that all the proposed strands and activities will be supported in a given financial year. Budgets will be prioritised against activities that offer the maximum potential gain, or that support key policy priorities for the year.
11. A single campaign identity

11.1 Background and rationale

As well as conveying specific messages to relevant groups, communications can help create a 'sum of the parts' effect through the creation of a single campaign identity. This will also help to ensure that the multiple messages that need to be conveyed do not become too disparate and fragmented thereby reducing the overall impact of the whole campaign.

The new campaign identity should work in a way that is analogous to Change 4 Life for obesity and which:
- Increases the salience and visibility of the whole campaign and therefore of teenage pregnancy and sexual health generally
- Have relevance and appeal across all target audience groups (children, sexually active adults, parents, health care professionals, etc)
- Create a property that can be used by delivery partners such as the Health Protection Agency, the Family Planning Association, Brook, SHAs and local PCTs
- Create consistent authorship and tone across the campaign

11.2 The strategic territory: talking

The recommended strategic territory for the campaign identity is ‘talking’. As we know from the academic and international evidence base presented earlier, good communication is a key preparatory behaviour and has been harnessed to good effect by other countries52.

Moreover, better communication plays an important role between numerous parties including sexual partners, children and their parents, teenagers and their peers, and health care practitioners and their patients, and can play an important role in driving a wide range of safer sexual attitudes and behaviours.

For these reasons it is recommended that the proposed sexual health campaign identity has at its essence the notion that 'more talk = safer sex and better relationships'.

11.3 Tone

As important as what the brand stands for is the tone of voice with which it is associated. Reflecting the nature of the issue, we believe that the campaign should communicate in a way that is grown-up, non-prurient, matter of fact, honest and respectful.

11.4 Creative interpretation

Creatively this will be brought to life through the thought 'Worth talking about'. The campaign will feature conversation about topics aligned to the campaign themes identified earlier such as contraception choice and chlamydia screening that are ‘worth talking about’.

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52 Notably the Netherlands where communication is the foundation of SRE in schools and there is a culture of openness and honesty around sexual health. In Massachusetts, ‘talking’ is at the heart of the ‘healthy talk’ campaign. Many studies also highlight the importance of talking for safer sex. See for example Sheerran et al (1999), Kirby (2007), Cho et al (2004), Hatherall et al (2005), Marston et al (2006)
11.5 Conclusion: a single campaign identity

*An umbrella campaign identity will be based on the notion that ‘more talk= safer sex and better relationships’. This thought will be brought to life creatively using a tone that is grown up, matter of fact, non-prurient, honest and respectful, by dramatising conversations relating to topics that are ‘worth talking about.’*

12. Channel strategy

12.1 Overall approach

The aim of the channel strategy is to encourage people to ‘open up’ and engage in more in-depth conversations, more frequently. Ideally, the campaign would be built around three stages of ‘opening up’:

12.1.1 *Start with ‘small talk’*

*Build awareness* of the need to ‘open up’ and talk by (a) getting talk on the agenda (b) introducing the key topics of conversation.

12.1.2 *Trigger ‘opening up’*

*Drive understanding and consideration* of need/opportunity to ‘open up’ by (a) providing support and guidance (b) demonstrating the benefit (c) signposting the opportunity to ‘open up’.

12.1.3 *Bigger and better conversations*

*‘Open up’ to more positive actions* (safer sexual behaviours) by (a) greater levels of understanding and consideration around contraceptive choice (b) higher acceptance of chlamydia testing as the norm (c) increased levels (rate and frequency) of carrying/using condoms as a key preventative of STIs and unwanted pregnancies (d) greater understanding and knowledge about sex and relationships amongst under 16s.

12.2 *Principles underpinning the channel plan*

A number of key principles underpin the channel plan for the campaign:

- Communications activity will be phased in line with period of key sexual activity peaks (Christmas, Valentine’s and Easter). For example, contraception activity will run before these times and chlamydia screening immediately afterwards.

- PR (and digital) will be used to build awareness of the need to talk and of the key topic of conversation.

- Digital and magazines (including advertorials) will be used to drive perceived momentum by driving greater understanding and consideration around a topic.

- Radio and TV will underpin this momentum and start to sign post key opportunities for talking.

- Stakeholder activity will underpin broadcast and look to drive deeper engagement (particularly in/around STI hotspots). In particular, partnerships and stakeholder activity will focus on converting awareness, understanding and consideration of the need to carry condoms into action.
Digital will have a key role in underpinning content of the main broadcast campaign, while also providing greater understanding and consideration.

12.3 Channel strategy: summary and conclusions

A three-staged process is recommended in order to increase the quantity and quality of conversations about sex and relationships. The channel plan is designed to maximise the reach of the campaign while simultaneously providing depth and support for at risk groups in hot spot areas. This will be achieved through a mix of broadcast (TV, radio, PR) and more discrete/narrowcast channels including digital advertising and search, and extensive partnership and stakeholder activities.
13. Evaluation /KPIs

As part of the strategy development process, a rigorous evaluation framework is proposed which will monitor the impact of the communications campaign on relevant attitudes, behaviours, health outcomes and their associated social costs and benefits.

13.1 KPI definition

Key performance indicators (KPIs) can be defined to help monitor the overall impact of the strategy as well as for individual campaign themes and an initial proposed set is outlined below\textsuperscript{53}. These have been chosen to reflect the way in which we expect the different campaign strands to work. So, for example, the campaign strand that concern protective measures like Contraceptive choice and chlamydia screening should be evaluated primarily in terms of the behaviour change that they drive. In contrast, the campaign strand that aim to work through longer-term preventative measures should be evaluated primarily in terms of attitude changes.

<table>
<thead>
<tr>
<th>Campaign objective/strand</th>
<th>Potential KPIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall impact of strategy</td>
<td>- Number of under 18 conceptions per 1000</td>
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<tr>
<td></td>
<td>- Positivity rate for chlamydia among 15-24s</td>
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<tr>
<td>Protective behaviours:</td>
<td>- % penetration of LARCs among 16-24s</td>
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<tr>
<td>- Contraceptive choice</td>
<td>- increase in information-seeking re LARCs</td>
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<td></td>
<td>- % GP/patient consultations where LARCs discussed</td>
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<td></td>
<td>- perceived familiarity with LARCs</td>
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<tr>
<td>Protective behaviours:</td>
<td>- screening rates among 15-24s and within settings</td>
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<tr>
<td>- chlamydia screening</td>
<td>- % conversion of potential screeness</td>
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<tr>
<td></td>
<td>- perceived normalisation of screening among 15-24s</td>
</tr>
<tr>
<td></td>
<td>- HCP confidence in suggesting screening</td>
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<tr>
<td>Protective behaviours:</td>
<td>- Perceived ease of access to condoms</td>
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<tr>
<td>- condom usage</td>
<td>- % young people carrying condoms regularly</td>
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<tr>
<td></td>
<td>- Claimed condom usage among key groups</td>
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<tr>
<td>Prevention activity</td>
<td>- Behavioural intention: agreement with ‘\textit{when I have sex I intend to use contraception}’</td>
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<tr>
<td>- knowledge and education</td>
<td>- Behavioural willingness: agreement with ‘\textit{when I have sex I think it’s likely I’ll use contraception}’</td>
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<tr>
<td></td>
<td>- Social norms: disagreement with ‘most of my friends are sexually active’ (among under 16s)</td>
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<tr>
<td></td>
<td>- Social norms: agreement with ‘my friends respect the choices I make’</td>
</tr>
<tr>
<td></td>
<td>- % young people citing campaign website/ resources as a key source for information</td>
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<tr>
<td>Prevention activity</td>
<td>- % claiming to have had a conversation about sex recently</td>
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<tr>
<td>- communication and</td>
<td>- Agreement with: ‘\textit{it’s important to talk about sex and relationships}’</td>
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<tr>
<td>negotiation</td>
<td>- Agreement with: ‘I feel happy and confident in the choice I make’</td>
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<tr>
<td></td>
<td>- Parents and stakeholders agreeing that ‘I feel confident talking to my children/ young people about sex and relationships’</td>
</tr>
<tr>
<td>Intensive intervention</td>
<td>- Outputs such as best practice guide to evaluation, number of interventions piloted</td>
</tr>
<tr>
<td></td>
<td>- Number of young people within key at risk segments reached via interventions</td>
</tr>
<tr>
<td>Overall culture change</td>
<td>- Perception of teen sexual behaviour as a normal part of development rather than as a risky behaviour</td>
</tr>
<tr>
<td></td>
<td>- Agreement that ‘\textit{it’s important to talk about sex and relationships}’</td>
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</table>

\textsuperscript{53} NB tracking studies and other data sources can be used to monitor many different metrics. Defined KPIs are those that represent the core metrics that will be used to judge success.
Data sources for many of these KPIs have yet to be established. However, it is envisaged that the three existing campaign tracking studies will be combined into one study that can be used to examine communications effects and, potentially less frequently, explore key attitudes and claimed behaviours. This will need to be supplemented with data from sources such as NCSP (chlamydia screening) and NHS prescriptions data that can indicate increases in the use of LARCs.

13.2 Reporting

To ensure a holistic approach to tracking and evaluation it is recommended that the key data sources are integrated into a campaign dashboard that enables multiple KPIs to be monitored simultaneously.

13.3 Understanding payback/social ROI

In order to understand the cost effectiveness of communications, data relating to campaign performance can be used within an overall evaluation framework which aims to calculate the impact of communications on health indicators – ie teenage pregnancy and STI rates – and ultimately the associated social costs and benefits.

The evaluation framework is represented diagrammatically below:

The social influence model (SIM) will play a key role in helping to quantify the impact of communication on attitudes, attitudes on behaviours and changing behaviours on the health indicators. At present the mechanisms of influence are based on insights from academic studies of behaviour change. However, as the campaign progresses, real data can be used to improve the validity of the model. It may also be beneficial to invest in additional market research that can assess the degree and nature of social influence in relation to specific relevant topics, e.g. contraception.
14. Summary and conclusions

Drawing on evidence from academic behaviour change literature, international experience, a social influence model and consultation with a wide range of experts, this new marketing strategy for teenage pregnancy and sexual health makes a number of recommendations that imply a significant change in the way communications are used.

- The role for marketing communication will be broadened, using it not just to influence sex-related behaviours directly (e.g. by encouraging the use of contraception and condoms) but also to influence behaviours and attitudes that are not sexually-related (e.g. communication and negotiation skills) but which are closely associated with safer sexual behaviour.

- However, the focus will be on influencing key preparatory behaviours (such as talking) and the factors that drive these (e.g. behavioural control, social norms) rather than trying to influence sexual behaviour directly.

- Teenage pregnancy and poor sexual health are driven by a wide range of social and cultural factors, as well as the behaviours and attitudes of young people. Therefore, to address the problems effectively we need to shape the attitudes and behaviours of a much broader audience including parents, health care professionals and other influencers such as teachers and the youth workforce, as well as children and young adults.

- Broadening the target audience for the campaign does not mean that the most at risk and vulnerable audiences will be ignored. However, mass-market communication alone is unlikely to have a significant and direct influence on the behaviour of the highest-risk audiences. Consequently, it is recommended that communication to these groups is used in conjunction with more intensive approaches, such as social marketing interventions, specialist SRE programmes and holistic services tailored to the audience's precise needs.

- The overall aim of the marketing strategy will be to act as a catalyst for culture change: creating a more open, positive, respectful and supportive backdrop against which policy interventions can happen. To do this, three new marketing objectives have been defined – prevention, protection and intensive intervention - together with five campaign strands or themes: contraceptive choice, chlamydia screening, condom usage, knowledge and understanding, and communication and negotiation. The following diagram shows how the different elements of the campaign aim to influence behaviour:
- As a result of broadening both the roles for communication and the audiences that are targeted, it is recommended that the channel strategy is evolved to reflect the changing nature of the campaign. The channel strategy should ensure that the campaign is more visible and ‘overheard’ by a broader audience, but will balance this with the need to deepen engagement in hot spot areas and among at risk groups.

- To increase the salience of the overall campaign, one umbrella teenage pregnancy and sexual health campaign identity has been developed, which will be used across all elements of the campaign, providing consistent authorship and tone and creating a greater sense of ‘openness’ about the issues. The new campaign is rooted in the concept of talking, and will dramatise conversations about issues related to sexual behaviour, with the endline ‘Worth Talking About.’

In summary, the revised marketing communications strategy for teenage pregnancy and sexual health sets out a vision for how communication can be used to shape an open, honest and respectful culture, in which multiple messages are conveyed using a new campaign identity to engage young people, their parents and stakeholders. Annual plans for the next three years will follow this strategy, taking into account policy priorities, and budget constraints. In so doing, communication will continue to play a vital role in supporting the Government’s teenage pregnancy and sexual health strategies.
15. Bibliography


11. BJ of GP (2004), Barriers to Opportunistic Chlamydia Testing in Primary Care, 54, 508-514.


24. Department of Health, 2001 *Better prevention, better services, better sexual health - The national strategy for sexual health and HIV*


32. Euro RSCG 4D Digital (2009), Google analytics Traffic figures reporting: 
http://www.ruthinking.co.uk/, Euro RSCG 4D Digital

33. Haldane A (2007), Sexual Health and Teenage Pregnancy Social Marketing Development: Results from NATSAL Reanalysis, COI.

34. Hatherall B, Stone N, Ingham R, McEachran J, The choreography of condom use: how, not just if, young people use condoms, The Centre for Sexual Health Research University of Southampton,


38. Lister T (2009), DCSF: Teenage Pregnancy. An insight into the profile of teenage pregnancy and its application to the DCSF Children and Young Person Segmentation, COI.


40. Marketing Intelligence Department (2008), Sti fact Book. Facts, figures and report extracts, Marketing Intelligence Department.

41. Marston C, King E (2006), Factors that shape young people’s sexual behaviour: a systematic review, Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, Lancet, 368: 1581–86.

42. Men’s Health Forum, Men and Chlamydia. Putting men to the test, Men’s Health Forum.


45. Naked Numbers (2008), Project Threshold, Naked Numbers


55. Teenage Pregnancy Unit (1999), *Teenage Pregnancy Strategy*


60. TNS Consumer (2008), *Sexual Health Post Wave Debrief 2008*, TNS Consumer.
