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### **SEXUAL HEALTH PROMOTION IN HIGH SOCIAL RISK ADOLESCENTS: THE VIEW OF ‘PROFESSIONALS’**

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## Sexual Health Promotion in High Social Risk Adolescents: The View of ‘Professionals’

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### Abstract

Teenage pregnancy rates and STIs have lately risen all over Europe. In Catalonia, figures have started to improve slightly because of a joint effort by all health and social agents involved in promoting healthy habits. Effective intervention must be accompanied by scientifically proven actions which must be present in educational curricula and in health plans and must also require family involvement. Our qualitative study aimed at exploring programmes and experiences targeted at young people as well as analyzing innovative proposals which would address teenagers’ needs; it also aimed at understanding weaknesses and strengths identified by professionals who work with vulnerable youths. We used 6 focus groups: 2 involved with immigrants, 2 from deprived areas and 2 from youth care homes with a total of 48 participants. They all stated the importance of combining initiatives within educational, community and health contexts. They also deemed necessary to come up with new organizational strategies which would facilitate coordination of services and resources available as well as the necessity to devise a common curriculum. They also believe in implementing more motivating and innovative strategies to attract teenagers and in the necessity for monitoring programmes in order to increase their effectiveness particularly those programmes aimed at youths who can’t access health or educational services.

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*Keywords:* Sexual health; teenage pregnancy; high social risk adolescents; effective interventions; prevention; health education.

## Introduction

Emotional and sexual health is a human right and as such, authorities worldwide should promote a responsible sexuality. The World Association for Sexual Health (WAS, 2008) identifies several stages towards a responsible sexuality: 1) Recognize, promote, ensure and protect sexual rights for all; 2) Advance toward gender equality and equity; 3) Condemn, combat, and reduce all forms of sexuality related violence; 4) Provide universal access to comprehensive sexuality education and information; 5) Ensure that reproductive health programs recognize the centrality of sexual health; 6) Halt and reverse the spread of HIV/AIDS and other sexually transmitted infections (STI); 7) Identify, address and treat sexual concerns, dysfunctions and disorders; 8) Achieve recognition of sexual pleasure as a component of holistic health and wellbeing. Educational programmes addressed to teenagers must include affectivity and sexuality as a given right so as to promote emotional and sexual health and avoid unwanted pregnancies and STIs. The Pan-American Health Organization (OPS in Spanish) (2000:29) identifies a holistic sexuality education as a vital process which provides knowledge, attitudes and values regarding sexuality and also sees sexuality education as one of the most valuable assets for society.

In spite of the international guidelines and of the universal recognition of the right to sexuality health, teenage pregnancies and STIs are a matter of concern worldwide. According to UNESCO (2012) the world fertility rate amongst teenagers is that of 48 per 1,000 women aged 15-19. In some European countries this rate has continued to increase since the late 70's in the 20<sup>th</sup> century. In Spain, according to basic demographic fertility and birth data for the years 2009-2011 - released by the National Institute for Statistics (INE in Spanish, as seen in June 2013, [www.ine.es](http://www.ine.es)), fertility rates increased compared to the previous decade. At the moment, fertility rates in Spain are to be found in a middle position compared to other European countries (12.2 per 1,000), with Sweden having the lowest rate (4.1 per 1,000) and Romania, the highest (39.3 per 1,000).

In Catalonia in 2001, the fertility rate among teenagers aged 15-19 was one of 8 per 1,000 and of 12.8 per 1,000 in 2008 showing a 60% increase in that age group. Equally, pregnancy rate in 2001 for young women aged 15-19 was 21.0 per 1,000 whereas in 2008 was 29.2 per 1,000, showing a 39.0% increase (Generalitat de Catalunya, 2011a). As far as abortions rate is concerned, in 2001 it was 13.0 per 1,000 whereas in 2008 it was 16.4 per 1,000 showing a 26.1% increase within that time span (Generalitat de Catalunya, 2011b).

2009 represented a turning point because of many converging factors such as the decrease in absolute figures and global fertility rates. Besides, the catalogue of interventions carried out in Catalonia together with a holistic approach to the issue and the cooperation of all health and social agents involved in promoting healthy habits and preventing unsafe behaviour showed the beginning of an improving trend in the figures.

In 2011 fertility rate among teenagers aged 15-19 in Catalonia was 9 per 1,000, showing a 29.7% decrease compared to 2008. Similarly, pregnancy rate in 2011 was 23.0 per 1,000 showing a 21.2% decrease compared to 2008. A 14.6% decrease in abortion rate also occurred during 2008-11, showing a ratio of 14 per 1,000 for young women aged 15-19.

In order to reduce such figures, effective action which must include educational programmes and health intervention with a cross-disciplinary approach, is required. Such action must promote emotional and health education, ensure access to health services and respect sex rights as well as addressing the social and economic factors which cause social and health inequality as seen by the WHO commission on social determinants of health (WHO, 2008). The decrease of social inequality partly depends on the efficiency of measures which promote healthy habits among the less privileged groups and, obviously on such measures reaching them. It is worth mentioning the lack of studies and reviews to analyze the possible impact of differences in measure efficiency depending on social groups as well as the lack of research on the relation cost-efficiency of interventions aimed at changing habits (NICE, 2007).

### **Emotional and sexual health programmes**

The “Documento de Consenso de Madrid” (Consensus Document of Madrid) signed by several international bodies specialized in sexuality education (Hurtado, Pérez, Rubio-Aurioles, Coates, Coleman, et al. 2012), sees sexuality education as based on scientific knowledge and as a universal right. Sexuality education programmes must be based on evidence and in order to be effective they must be designed taking into account the diversity and various needs of the population they are addressed to. On this line of thinking we must include UNESCO’s list (2010) of successful factors in sexuality education which was obtained from a case study per country which permitted to separate between general common factors and specific factors depending on the cultural and social environment we aim to intervene in.

Nowadays, it could be said that sexuality education helps improve teenagers’ emotional and sexual health, delaying the start of sexual practices and reducing the number of sexual partners and hence, contradicting some preconceived ideas

which believe sexuality education increases sexual activity and its risks (Kirby, Laris and Rolley, 2006; SAFE, 2006, Oringanje, Meremikwu, Eko, Esu, Meremikwu, et al., 2009). Contrarily, some studies suggest sexuality education helps reduce unprotected sexual activity and promotes the use of contraception to avoid pregnancies and STIs (Hurtado et al., 2012).

Although sexuality education is paramount to prevent AIDS/HIV infections, STIs, unwanted pregnancies and sexual abuse, it is not sufficient to have a positive impact on teenage pregnancies and it must be part of more comprehensive policies (Fletcher, Harden, Brunton Oakley and Bonnel, 2008; Harden 2009). It improves knowledge, rules, skills, attitude and sexual behaviour, but there is no substantial evidence that sexuality education helps reduce teenage pregnancy rate unless it comes with family and community action (Harden, Brunton, Fletcher, Oakley, Burchett and Backhans, 2006). Besides, measures aimed at promoting healthy habits and behaviour and at reducing risk practices must also be sustained in time in order to maintain reduced rate levels. Fertility rate in Catalonia in teenagers aged 15-19 was 9 per 1,000 in 2011, showing a 29.7% decrease compared to 2008. In 2011, pregnancy rate was 23.0 per 1,000 showing a 21.2% decrease compared to 2008. Abortion rate also decreased in the same period, showing a 14.6% decrease in 2011 when the abortion rate reached the figure of 14 out of 1,000 women aged 15-19.

### **Family, social and community intervention**

Family involvement is vital for a child to grow healthily (Molina, Pastor and Violant, 2011). Prevention programmes are more effective when it comes to reducing risk practices if parents are involved as well as when such programmes provide families with support and training to learn how to talk about sexuality issues since childhood (Blake, Simkin, Ledsky, Perkins, and Calebrese, 2001). Good communication delays the start of sexual intercourse and if it occurs, it is more likely to be safer, youngsters tend to have less sexual partners and they also increase the use of contraception in their first sexual encounters (Martino Elliott, Corona, Kanouse and Shuster, 2008; Swan, Bowe, McCormick and Kosmin, 2003).

Family education is an excellent tool and should be introduced in action plans to make plans more successful. Some cross-disciplinary programmes like Safer Choices, which include actions addressed to parents, have obtained positive results regarding the use of condoms after 31 months of monitoring; it was also observed that these programmes showed how the majority of psychosocial variables analyzed to be successful are mostly, knowledge, attitude, discipline, self-efficiency, risk perception and communication with the parents (Coyle, Basen-Engquist, Kirby, Parcel, Banspach, et al. 2001). Family intervention consisted of informing

parents about the educational programme itself, pregnancy, STIs, HIV/AIDS and about how to develop and establish a dialogue with their children. It has been equally observed that in order to reduce teenage pregnancy rate, more comprehensive actions than simply targeting small groups of youngsters are necessary or providing contraception solely. Those communities which have carried out multicomponent programmes have achieved positive results. Kirby's review (2007) of multicomponent programmes found that in 4 of the 7 reviewed programmes, the time for a first sexual intercourse was delayed, use of contraception increased and both pregnancy and fertility rate decreased. One of the most intensive and prolonged programme was the Children's Aid Society-Carrera Program, which provided services in different areas: family and sexuality education, general education, academic support, careers advice, self-expression through arts, individual sports, general health care and reproductive health. Harden, et al. (2006) recommends carrying out actions aimed at facing eventual unsafe situations through counselling, preventing domestic violence, improving the quality of child and youth care, expanding life ambitions and expectations, as well as training parents in conflict resolution.

The differences in sexual practices and the risk of teenage pregnancy among both ethnic minorities and majorities, lead to identifying the need for community groups to develop a personalized approach to cater for different cultures, and parents involvement to ensure community services adapt to the existing specific needs (Department for Education and Skills, 2006). However, it is also advisable not to exclusively aim programmes at youths at risk so as not to reinforce those social rules which don't favour prevention and on the other hand, so as not to reinforce prejudice; ideally programmes should be aimed at diverse groups of youngsters which live in different circumstances (Wiggins, Bonell, Sawtell, Austerberry, Burchett, et al. 2009).

In spite of the progress made, it is necessary to carry on researching on the impact of parental involvement to strengthen available evidence, and it is also vital to carry on researching on the effect of social support programmes to families, such as programmes for improving employability or to reduce teenage pregnancy (Kirby, 2007).

Within this context it becomes necessary to carry out research to know what the situation of sexuality education in Catalonia is, since health education is a competence of the regional local government. The present study is part of qualitative research done by the GRISIJ research group (Research Group for Social and Educational Intervention in Childhood and Youth in Spanish, formed by researchers at the University of Barcelona and Lleida who also collaborate with the Catalan Public Health Agency and the Catalan regional government Health Department.

This piece of research aimed at analyzing the needs that arise in dealing with sexuality, pregnancy prevention and STIs in vulnerable youths. The results presented refer to the following goals: 1) explore experiences, actions, proceedings and programmes aimed at young people 2) explore innovative proposals to cater for necessities identified among young people 3) understand weaknesses and strengths that professionals who deal with vulnerable young people and help them improve their emotional health and reduce unsafe sexual practices, may have.

## Methods

The research was based on participative action, taking professionals from different trades in the field of social intervention as key informers. This model intended, on the one hand, to develop the ability to build alternative action plans in collaboration with the professionals, and on the other hand, intended to be used as a training procedure and tool for professional performance reflection.

In order to gather information, focus groups of professionals working on three areas of youth work were created: professionals in child protection (Educational Action Care Homes – CRAE in Spanish- where children are looked after by the authorities whilst temporarily separated from their families), professionals in immigration and deprived areas. These professionals were selected by the local authorities and official institutions involved in each of the sectors so as to have a wide range of people with different profiles from health, educational and social work centres as well as members from associations involved in those same sectors. Two instruments were devised: a personal information sheet with the participants' social and demographic data and, a list of questions, based on the bibliographical review, for the focus groups which would facilitate obtaining a diagnosis, an evaluation and a prospection on: a) actions, proceedings and programmes aimed at promoting emotional and sexuality health and to reduce risky sexual behaviour in vulnerable youths b) training needs for professionals and members of the educational community so as to carry out actions, proceedings and programmes effectively. *Table 1* shows the general objectives of the study in relation with the specific objectives in form of questions posed to group informers.

Written consent was given by focus groups members who were audio recorded and their words transcribed for a later analysis. Each group was monitored by two members of our research group. The recordings were later transcribed and their transcripts analyzed using Atlas ti v.6 data analysis software and to analyze the participants' profile, the program SPSS 12.0 was used.

Table 1. Objectives included in question lists for focus groups

<b>Explore experiences, actions and proceedings in existing programmes</b>	Identify existing experiences, actions and programmes
	Gather detailed information about non institutional experiences, actions or programmes.
	Gather evaluations on existing experiences, actions and programmes.
	Explore innovative proposals to address identified needs.
<b>Explore innovative proposals</b>	Among innovative proposals, explore evaluations related to the use of the audiovisual media.
	Among innovative proposals, explore evaluations related to the use of ICT.
	Understand weaknesses among professionals and members of the educational community.
<b>Understand weaknesses and strengths professionals and member of the educational community may have in their work practice.</b>	Understand which weaknesses among professionals and members of the educational community are training needs.
	Understand strengths among professionals and members of the educational community.

After analyzing the bibliography, a first code was elaborated following codification guidelines using the “bottom up” method. Once significant paragraphs, fragments and quotes had been selected, a more conceptual analysis was carried out by creating codes and categories which allowed for any changes in meaning for each fragment or quote. *Table 2* shows the categories created to analyze the focus groups.

Table 2. Categories to analyze professionals' focus groups

<b>Category</b>	<b>Definition of the category</b>
<b>Promotion</b>	
Carried out promotion	Running programmes, actions and resources used in promoting emotional, sexuality and reproductive health.
Promotion to be carried out	Institutions, actions and programmes which have promote emotional, sexuality and reproductive health but have not been edited nor made public yet.
Professionals' profile	Profile of those professionals involved in promoting emotional, sexuality and reproductive health (training, experience, institution, etc)
Progress stage	Assessment of the adequate point to promote emotional, sexuality and reproductive health is
Area of promotion	Area(s) where promotion of emotional, sexuality and reproductive health is being carried out.
Method of promotion	Methods used to promote emotional, sexuality and reproductive health among teenagers.
Promotion and gender	Assess how gender may affect promotion of emotional, sexuality and reproductive health



<b>Category</b>	<b>Definition of the category</b>
<b>Running programmes</b>	
Successful actions or programmes	Assessment of successful running actions and programmes which promote emotional, sexuality and reproductive health.
Unsuccessful actions or programmes	Assessment and constructive criticism of programmes and actions that have been unsuccessful or poor in promoting emotional, sexuality and reproductive health
Why do they work?	Reasons for effectiveness of successful programmes or actions which promote emotional, sexuality and reproductive health.
Why don't they work?	Reasons for lack of effectiveness of unsuccessful programmes or actions which promote emotional, sexuality and reproductive health.
<b>Proposals</b>	
Proposals for actions, programmes and resources	Proposals for actions, programmes and resources that would improve effectiveness of promotion of emotional, sexuality and reproductive health.
Innovative proposals	Proposals regarding innovative actions, programmes and resources in promoting emotional, sexuality and reproductive health.
Professionals' profile	Profile (qualifications, experience, etc) professionals involved in promoting emotional, sexuality and reproductive health should have.
Proposals regarding age	Age considered by professionals as the most suitable to start promoting emotional, sexuality and reproductive health
Proposals regarding gender	Proposals regarding gender difference in promoting emotional, sexuality and reproductive health
Proposals regarding place of action	Places where emotional, sexuality and reproductive health issues should be discussed.
Proposes regarding methodology	Proposals and plans for work methods when working when youngsters so as to raise their interest in emotional, sexuality and reproductive health
<b>Weaknesses</b>	
Weaknesses which affect actions	Weaknesses identified in actions
Weaknesses which affect programmes	Weaknesses identified in programmes
<b>Strengths</b>	
Strengths which affect actions	Strengths when carrying out actions which promote emotional, sexuality and reproductive health
Strengths which affect programmes	Strengths when implementing programmes which promote emotional, sexuality and reproductive health

## **Participants**

48 professionals and community members participated, 75% were women and 25%, men. 6 focus groups were created, 2 from the immigration area (with 18 professionals) 2 from deprived areas (with 11 professionals) and 2 from CRAEs (with 19 professionals). 38.3 were over 45. 45% worked in the health area, 33.3% in education and 20% in social work. 58.2% held vocational qualifications and 43.2% held higher vocational qualifications.

## **Results**

### ***Actions and resources to promote emotional and sexuality health: main characteristics and process***

Professionals from the three areas agreed that the main actions they were carrying out were: workshops, in-schools programmes, training of community workers (in the case of the immigrant population) and of community health workers. These professionals highlighted programmes such as “health and school” and “young evening” which take place in local GP surgeries and sexual health clinics and aim at addressing young people’s needs by promoting healthy habits and behaviour as well as identifying unsafe behaviour.

*“We have four running programmes on Sexuality Education and STIs prevention: we aim for young people in extracurricular activities, young people with intellectual disabilities and we also deal with educating in equality and with youths at risk of social exclusion” (neighbourhood).*

*“The SiE (Salut I Escola, in English “Health and School”) programme was very good, it made it possible to make a connection between the health sector and prevention, to bring someone from the health sector in the educational sector” (immigrant).*

Educational Action Home Cares (EACH, CRAE in Spanish) are characterized for carrying out their actions depending on day to day reality and tutoring action and not on purposely done workshops.

*“We have a EACH for 16-18 year old girls; in July we came up with the idea of a “girl’s evening” ; we went to the cinema, it was a way of leaving the home care and speak freely amongst them and with the social worker so they can see themselves in other girls experiences and not feel judged; inevitably, at times, there were strong arguments but the girls valued it very positively and we are trying to make it standard practice” (EACH).*

In deprived areas, there is a vast variety of actions aimed at promoting sexual health: parents' schools, radio programmes made by professionals and youngsters in local GP surgeries, advice for teachers, in-service training for professionals and cooperation with health staff.

*“In the Raval area, there was a time when GPs made a radio programme together with local young people for a week; in the end they won an award for this project. They later came to our EACH to do a workshop and it went really well and was also very interesting” (immigrant).*

On the other hand, immigrants often claim they must deal with other basic social priorities (bureaucracy, language, access to school, etc).

*“I’m more worried about those teens with no information on sexual health available for them than about teens in school, which at least are, under the school umbrella” Immigrants.*

*“In our case, you can find all sorts of situations but the main problem is getting their residence, a work permit, because they are responsible for supporting their family back In Morocco, their families ask for money...for these teens, sexuality is a escape route, a way to have fun, when you ask them they always say, well it is a game, I don’t care if she gets pregnant or she falls in love with me, I have a family to support back home...” (EACH).*

As far as professionals dedicated to sexuality health are concerned, it is worth mentioning their wide variety: doctors, nurses and matrons; primary and secondary teachers and community social workers from EACHs; generally speaking they all mention a lack of training on health education. Participants in our focus groups agree that their training on this issue is not adequate, particularly members of the teaching community.

*“When it comes to training social workers there are two parts in their training, one being theoretical, since they have no medical background and know nothing about STIs but they should know which basic questions young people may ask them regarding STIs, what they are, how to prevent them, so these workers have to answer these questions and this is one of the aspects their training should go for” (neighbourhoods).*

*“As Social workers we intervene but have no specific plans, we are not medical professionals but we should definitely have health oriented programmes” (EACH).*

The key role of the so-called “paraprofessionals” is also mentioned, particularly since these community liaison agents are also young immigrants (equals) and receive some basic training on STIs and on how to prevent them.

*“Create support groups, support groups nets made by equals or others; it is important to do something about lack of action” (EACH).*

There is no unanimity of opinion regarding available resources; such diverse opinions seem to depend on the approach and motivation displayed by each professional.

*“Young evenings’ are run in the local GP surgery and I don’t like it. If you think of a ‘young evening’ you must come up with the right place, depending also on the area cause in some areas GP surgeries are not the best place, at least nor for me; teenagers associate GP surgeries with places where the elderly go to the doctor and for this reason, it is normal to change the location, in the town hall, at a shop...youngsters don’t see it as a surgery, with appointments, a certain service...” (neighbourhood).*

*“It is like a family planning clinic. When teens turn 16 we send them over there” (EACH).*

On the three key areas the age in which users start using these services is normally 14. Regarding gender approach it was unanimously said that there must be a separation between boys and girls because of the differences in attitude between sexes. Generally speaking, “romantic love” was seen as a risk factor in girls as well as the need to introducing domestic violence prevention measures in the programmes.

*“We are gradually incorporating domestic violence, we talk a lot about pregnancies and STIs but we are seeing a lot of violence, sexual relations without consent...we are seeing a great deal of it” (neighbourhood).*

*“We do it during class time, though we’d tried it before...we split boys from girls, also because of the high proportion of immigrants, and it was very positive since boys, when in a group, spoke nonsense but the girls didn’t get involved; after splitting them, over the 2 years we did it, both boys and girls asked many questions, they felt more comfortable and asked much more” (EACH).*

*“In mixed workshops both boys and girls speak less. On the contrary, in single sex workshops they all speak much more and in the presence of boys or girls they tend to talk about different things; some things they wouldn’t talk about in front of the opposite sex” (immigrant).*

There was also a general agreement regarding the importance of the school environment when dealing with emotional and sexuality health, particularly during tutorial times, since the school environment includes everybody in deprived areas, especially because teens are in their compulsory schooling years. However, the effectiveness of tutorial action regarding personal and social care depends greatly on the teacher's attitude towards these issues.

*“Our secondary school action programme is focused on helping teachers; we have had the material for a few years now, we pass it on to the teacher so he/she can work on one specific aspect and from there, he/she can suggest students to participate in certain campaigns” (neighbourhood).*

*“Sexuality health workshops are run in Y8 and Y11. We elaborate materials so teachers can work with them and every so often we may go to the school to support them” (EACH).*

Some professionals criticized the idea that emotional and sexuality health is not part of the National Curriculum, consequently such content is only partially approached and also depends greatly on the teachers' willingness to approach it.

*“I work in three schools and depending on the school sthings varyt, not because they are religious schools, funnily enough, in another school I had to ask for permission to the tutor, the tutor, to the Head of Studies, a week before my next visit, so I can see that if they had a problem they may not have it anymore cause they don't need me right now; I've tried sorting it out but I can see this is the way things are, and those who want to do things we do it little by little” (immigrant).*

*“I'm worried about teens we can fend for who are not at school, schools have the SiE itinerant programme at least, but those who don't go to school, what can they do, they are at the higher risk” (immigrant).*

The importance of parents working with children was highlighted by all, particularly when it comes to sharing experiences and opinions and to better understanding generational differences.

*“When we realized we were only working with parents we saw we were not doing the right thing since we had neglected the children. When you work on these issues, it must be done together, parents and children; there must be communication between them...” (neighbourhood).*

When talking about methodology, professionals highly value actions and programmes made by mixed methodologies, combining work in small groups with individual work. They also highlight the importance of comfortable and open

spaces, appealing to young people. “Door to door” approaches, which consist in going out in the street and attracting the young person, were seen as very effective as well as methods which mix formal and informal actions.

*“We, like MINERVA, work in health centres but tutorial work is very important because it is there where information and advice are given...it is more important because it is personalized and not for the group” (EACH).*

*“Group intervention: we make groups up in the classroom, we give each group a controversial issue (STDs, pregnancies, HIV...) and a time to discuss and then we all discuss it. It is at that point when they contribute and we contribute too but it depends greatly on the school. In the ‘young evening’ spaces the approach is more individual or reduced” (immigrant).*

Those professionals who work with the immigrant community highly value actions aimed at building role models within the community. Community liaison agents are normally young people who have been trained on prevention issues and are better communicators since they know the community from within.

*“It is important to build role models within the community (...). It is a learning process made up with these role models. The negative part is our dependency on public funding since we work with projects and programmes. When we work together with the immigrant community it is important to know the areas they go to. Models and community places of interest (virtual or physical)” (immigrant).*

Professionals working at Educational Action Care Homes highlight the importance of the role of a young positive leader among under 18s. Their significance doesn't come out of a planned strategy but they highly value the circumstances that have contributed to their existence.

*“Having a positive leader is extremely beneficial. It connects to what you were saying about the working with equals approach...working with families can be very positive but it needed very good coordination among professionals... working with equals or having other young people as liaison agents can be very effective: the emotional link and the age these youngsters arrived in the home, the amount of time spent in care...” (EACH).*

### ***Innovative proposals***

All professionals emphasized the importance of providing professionals who deal with young people, with training on emotional and sexuality health so as to be more effective when conveying the message and to find the best strategies to approach young people.

*“What we do as matrons is not enough so we feel like we could be doing much more, for instance, guiding those who work with the youngsters all year round. It’s a need we’ve identified but there’s nothing we can do about it” (neighbourhood).*

*“As educators, we need advice and guidance on how to approach certain issues and problems” (EACH).*

*“Training for those who work in the community, many of them can’t do much with what they have. Lifelong training” (immigrant).*

It is also suggested to aim programmes at younger ages, 14 is seen as too late and education should start in the family. Gender issues are persistent. It is also recommended to address masculinity and femininity since many risk attitudes are related to “romantic love” in the case of young women, or to ideas of female submission, low self-esteem, emotional deficiencies, etc. However, it is also recommended to create joint spaces to address emotional issues.

*“I think that (emotionality) must be addressed depending on gender, whether you are a boy or a girl you build your personality and develop differentiated relationships. Romantic love is also, from my point of view, a construct that emotional education must address since it can lead to tolerate certain kinds of abuse” (immigrant).*

From a social perspective, the need for networking and an increased coordination between social, health and community services is also emphasized, as well as the need for a more proactive approach, and the increase in community resources such as family meeting points or creating counsel and advice services for families.

*“Joint collaboration in the social environment. Local councils must have committed professionals in the different areas; they must work on coordinating all efforts that would be strength” (immigrant).*

The media were also mentioned. It was argued that publicists and marketers should also be involved so as to provide guidance and advice to professionals when it comes to making audiovisual materials and other kinds of resources.

*“We have to attract young people and we may only be able to do it via a good publicist, a sociologist or an anthropologist, so these young people can have a space to meet but wouldn’t know exactly what kind of space(...)” (immigrant).*

Most suggestions point at using on-line help lines, using drama or designing audiovisual materials to motivate teenagers, particularly vulnerable youths.

### ***Strengths and weaknesses identified by the professionals***

Generally speaking, the main weaknesses identified by professionals were related to the lack of training on sexuality health on the side of community workers, and of the lack of training on education on the side of health workers as well as the lack of coordination between health workers, social workers and educators which has an impact on their mutual understanding and results in a lack of knowledge of each other's actions.

*“Coordination between all of us. Shared information among professionals so we can know what resources we have, if the centre is crowded (...) if staff is overwhelmed (...)” (EACH).*

Another weakness they identify is the lack of funding and staff shortage as well as a lack of community resources. Consequently, there is a tendency to focus on working on the use of contraception neglecting emotional training.

*“It is purely sexual education we are providing, not emotional” (immigrant).*

*“I witnessed more unwanted pregnancies and STDs as a community worker than as a doctor (which is my current job) and that worries me because I think it is us doctors who can really help since community workers are not trained on health issues and health workers are not trained on social issues” (immigrant).*

Professionals who work in deprived areas particularly regret the lack of strategies to make sexual and emotional health more approachable to those youngsters who have no access to health services; they also regret the lack of monitoring of the services and actions as well as the lack of professional and academic recognition of their task.

*“We love talking about ideas but there is a clear lack of recognition and a lack of monitoring so we can value long and half term results, it wouldn't be necessary if we only wanted to find out how much youngsters know but if we want to know the impact, we can't see it as it is. I don't know what really works” (neighbourhood).*

The main strength generally identified was the motivation displayed by all professionals working in sexuality health. Their enthusiasm, empathy and creati-



vity to carry out programmes aimed at vulnerable groups were unanimously praised.

*“People who work closely with the youngsters are strength, you can see they have bucket loads of motivation and sometimes it is unfortunately wasted” (neighbourhood).*

*“I have been doing this job for a long time and it is nice to see how motivated people who work on these issues are, it is definitely strength (...)” (EACH).*

Professionals in Home Cares praise the trustworthy relationship between social workers and young people who see these social workers as role models. Everyday life provides them with plenty of opportunities to work differently and in varied informal contexts, emotional and sexuality health learning goals. On the other hand, the safe environment and the good communication between professionals in Care Homes are also seen as strengths.

*“The trust you establish with the young people is definitely a strength, cause you may sometimes be 4 years with a child or 4 days only cause he/she may run away; but because we are few, not like other centres where you may have up to 40 children, we can create a safe environment and we can work on many issues since they feel they can trust the Care Home workers and we know a lot about them” (EACH).*

In the case of the immigrant population, diversity is seen as strength; the experience for the host community to welcome immigrants and live with multiculturalism is also seen as positive. These professionals praise quality of education and primary health care in Catalonia where social and educational processes to work with both parents and youngsters are blooming.

*“Our society is truly prepared and made up with different cultures and we must make the most of this. We can learn from a lot of people and this is a powerful driving force” (immigrant).*

*“Background knowledge to be able to work with cultures” (immigrant).*

Professionals in deprived areas highlight the use of the “young web” since they feel more likely to ask questions using this resource.

*“Whether a user is online or not, resources are always available; we have a web on drugs and we get asked many questions related to sexuality” (neighbourhood).*

From a community point of view, schools are seen as a key strength to work with teenagers because they are a participative resource which allows teens to get involved in the issues, the resources and the local social agent.

## Conclusions

Professionals' perceptions regarding actions and resources is quite unanimous except in professionals from Care Homes since their work is based on day to day reality and their educational action can be more informal and more connected to a shared reality. The fact that actions carried out by professionals working with immigrants is very similar to those carried out by professionals working in deprived areas seen in our study, shows that vulnerability in such areas is associated to immigration.

Professionals group actions and resources used in promoting sexuality and emotional health into three main areas: the educational area ("Health and School", class tutorials), the social and community area (workshops, liaison officers, "young evenings") and the health area (primary health care, family planning). However, it appears it is necessary to come up with new organizational practices which enable coordination of services and resources between the three areas and also, to come up with a common curriculum.

Proposals for innovation emphasize the need to approach these issues from an individual perspective, as it was traditionally conceived. Beyond big changes, key importance is given to the ability to be empathetic, to create a safe environment, to guarantee confidentiality and to be approachable when working with teenagers. It would therefore, be convenient to consider the need for providing professionals with training on those skills which would help increase their social and communication skills.

From a methodological point of view, programmes must include more innovative and creative strategies to appeal to the young audiences; programmes must also be assessed and monitored to increase their effectiveness particularly those programmes addressed to teens who have no access to education or health.

Professionals also emphasize the importance of working with both parents and teenagers. Proposals for training parents and providing them with skills and knowledge to communicate with their children are sought by professionals; such communicative knowledge and skills help develop empathy which is paramount to be able to deal with such delicate issues with children and they are more important when it comes to vulnerable communities, with or without cultural barriers, since they tend to have more difficulties in talking about these issues.

Training for professionals involved in emotional and sexuality education is also persistently demanded. Although some health professionals may receive some training on STDs and their prevention, there is still a lack of effective strategies and dynamics that professionals can use when approaching these issues and basic aspects of sexuality and sexual health. It is necessary to point at the need to develop training programmes to educate on sexuality health and it would also be necessary to come up with a specific professional profile responsible for such tasks. Our study also identifies the need for a better coordination and for a multidisciplinary and collaborative approach between health, social and educational services on all levels.

The main strengths identified in our study which are also vital when it comes to innovating are: the powerful force that is motivation displayed by all professionals, the ability to empathize, their enthusiasm and their creativity.

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