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## David T Evans and Paul Watson

# Spotlight on sexual health and education for Military, Veterans and Families

Sexual health and well-being is an intimate and integral part of what it means to be human and as such needs to be the business of every health care professional. This may sound like 'wishful thinking', but, essentially, if we do not include the sexual health dimensions of our client's lives in our health and educational service provision for them, then we are clearly not addressing them holistically (Evans, 2013). To adapt a popular phrase: "there's no health without sexual health". Those who provide education and skills for the improvement of life, including personal/self and relationship development, likewise share in crucial opportunities to assist individuals not only for staying (sexually) well and averting many preventable problems, but maximising the client's self-esteem and resilience in so doing.

Sexual and relational health and well-being concern more than just the young, 'fit', able and glamorous. This is an important point to emphasise, especially in times of heightened awareness of both physical and mental trauma affecting many military personnel, veterans and their respective relationships (Fossey, 2012). Considering persons with physical and/or mental health challenges is often contrary to popular media representations portraying what they consider sexy and sexually healthy.

There are a lot of definitions about what sexual health actually is, and probably a good exercise for individual teams to consider their own definition, to ensure they capture the full gamut of local life. A formal definition, from the World Health Organisation, states that sexual health is ...

*"...a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual*

*relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled" (WHO, 2006).*

If sexual health, in the holistic sense, affects everyone across all ages, genders and sexualities, then why the need to focus this article not just on children and young people (CYP) but more specifically in relation to the British Military and CYP of military personnel and veterans' families? The answer to this question is two-fold. Firstly, people are more at risk of many of the usually preventable problems 'when things go wrong' with sexual health at a young(er) age; secondly, serving military personnel, military and veterans' families, overwhelmingly fit into epidemiological categories for when things more-often-than-not tend to go wrong, more so than at other times of life. Some readers might bemoan "the youth of today", but we need to remember the youth of every other day. This article is therefore focused primarily on one age group (under-25-year-olds) but that in no way implies that people in other age categories are any less important or without their own sexual health needs and concerns.

### How many are we talking about?

Her Majesty's Armed Forces are some of the biggest employers of under-25 year old people in the UK, in addition and more than 85,000 CYP in military families. It is difficult to gather accurate numbers of how many CYP there are in veterans' families, but few schools or General Practices would be without any, and some areas and demographic populations are more highly represented than others. Public Health England's Sexual Health Profiles provide a clear simple-to-use on-line guide, comparing a range of local sexual health indices

(teenage conceptions; sexual infections and HIV) with wider personal (risk) demographics (<http://fingertips.phe.org.uk/profile/sexualhealth>). Addressing sexual health with supporting services and education is therefore crucial for the promotion of personal, holistic health and well-being, including healthy relationships (Hadley and Evans, 2013).

*"My girlfriend doesn't know that I 'played around' when I was on deployment and I was too embarrassed to get condoms beforehand. My fault! When I 'caught a dose' and had to go to G.U.Med, my sergeant even asked me where I was going - and why - in front of all the lads! I didn't know whether to 'fess up and say the truth or hide my red face under my cap!"*

Young recruits, especially in some parts of the Services, are particularly vulnerable to having grown up with misinformation about sexual health and lack abilities on how to protect themselves and partner(s). Many of these young people are equally prone to suffering stigmas associated with certain sexual activities and life styles, including the embarrassment of talking about sex with healthcare professionals (Clever and Rich, 2005).

### KASH for C&SH

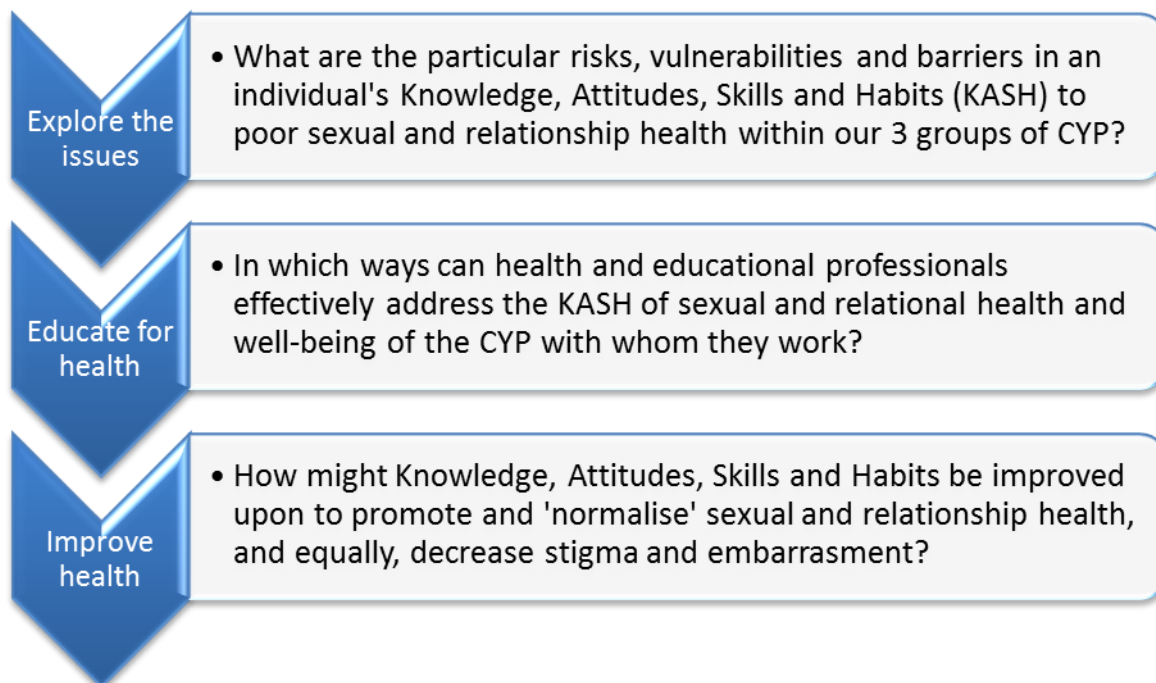
As Contraception & Sexual Health (C&SH or CaSH) services know well, health education is wider than information-giving; knowledge alone is merely one element. Equally important to knowledge-sharing are the skills and the resources to practice safer sex. Griffith and Burns (2014) expand the concept of education, claiming that to be truly effective it must address and

promote Knowledge, Attitudes, Skills and Habits (KASH). Once the particular issues, including personal and structural barriers facing these young people's sexual wellness, are explored, and deficits in their KASH identified, then it becomes imperative to be open and honest in clarifying which of these deficits or issues can be improved through our particular professions, be they in education, health and/or welfare. The goal of Figure 1 (below) highlights the culmination of an approach which effective KASH education can have on promoting the client's good or improved health and well-being.

The three activities in Figure 1 relate to the key populations of this article, i.e. young people serving in Her Majesty's Armed Forces; military families' children and young people, and CYP of those who have now left regular/active service (veterans' families). The three activities are: Exploring the Issues; Educating for Health, and ultimately Improving Health. Joining up these activities is important, not least because the individual needs of each person across, and often-times, between, these population groups are different and yet similar. The starting point must be to actively and proactively address sexual health and associated education: put it on the radar. The process of exploration then begins with clarifying the issues of sexual health and well-being for each of our population groups, followed by the role that positive, effective, education can play to improve, maintain and promote positive sexual health and well-being.

Clearly, as health and educational professionals,

Figure 1. Three key activities: Explore, Educate and Improve Sexual Health



we also need to ask ourselves what role we have in providing effective (health and education) services for these young people to stay/become sexually healthy and even enjoy the sexual well-being (Philpott, 2006; CHIV, 2009).

### **Poor KASH**

Debates still rage around the UK concerning a lack of equal and efficient provision of Sex and Relationship Education (SRE) in many schools, especially SRE which develops personal skills and esteem and effectively bolsters consensual sex. Many young people likewise bemoan a lack of provision of safer sex resources such as condoms to prevent against infections and contraception/Emergency Contraception to protect against unplanned and unwanted conceptions. Parents, too, are often reported as feeling ill-equipped to deal with sexual (health) discussions with their children. Yet the lack of truly effective SRE for all CYP – inclusive of all genders and sexual orientations – potentially fuels the high numbers of unplanned conceptions and abortions in the UK, as well as the ever increasing numbers with sexually acquired infections (SAIs) including HIV.

A number of specific predisposing risk factors facing our three target populations include the personal impact reduced sexual and relationship health might have on all individuals concerned. This impact can cause wider, holistic, problems with a person's mental and emotional health and well-being too. The heightened risk factors for poor sexual and relationship health effecting the three key populations in this article are exacerbated by the impact of:

- deployment, especially to areas of the world poor in sexual health resources and high in risk potential
- improved finances and living away from home
- younger age and in a predominantly younger age environment
- availability and cultural acceptability of alcohol consumption (sometimes problematic in itself)
- fears of what the future might hold, given the ravages of conflict and war
- stigma of (discussing) sexual health and accessing services, both in the military setting or outside, and especially whilst on

deployment or otherwise away from familiar home territory

- And conversely, a challenge for those who see acquiring an infection, such as Chlamydia, as a 'badge of honour', for bravado or rite of passage.

### **'Beer pressure' and other risks**

There is an abundance of evidence from civilian research showing the link between a higher risk of unplanned conceptions and sexual infections when alcohol is part of the equation. Given alcohol's availability and usage within the Armed Forces, there would be no reason to consider it less of an issue here despite robust research to demonstrate otherwise lacking.

The problematic use of alcohol (and sometimes illicit/recreational drug use), deserves special mention. Whilst these issues are more widely discussed in civilian research and publications, the easy and customary access to alcohol is of particular relevance to the Armed Forces. Drink-fuelled sex increases potential for abuse, regret at the sexual encounter, and incidence of unprotected intercourse. 'Unprotected' refers to both condomless sex, so opening up vulnerability to sexually shared infections, as well as without effective contraception leading to unplanned and unwanted conceptions. Alcohol is also sometimes used as a psychological support; evidence from USA military sources highlight an association with other risk taking behaviours, due to poor underlying emotional stability. As Conibear (2015: 11) states: "Underage drinkers, who consume alcohol regularly, are also more likely to smoke and engage in other risky behaviours such as drug taking and unprotected sex."

### **Access to services**

Provision of contraception and sexual health (C&SH) services, including free access to condoms, is relatively routine for civilian populations across the UK. However, some of the risks, vulnerabilities and barriers to poor sexual and relationship health within our three groups of CYP that need further consideration include the transient nature of the military populations. For this reason alone, many CYP can drift in and out of vulnerability, with additional increased risk taking behaviours due to poor attachment and emotional health and well-being (EHWB) (Iversen et al., 2007). Just

when a young person becomes accustomed to 'the way things are' in one placement, that does not mean things will be the same elsewhere, especially abroad. There are also problems with inequalities in transition if services are not available at the new location. This is particularly so for the provision of free condoms, the wide range of contraceptives, emergency contraception and allied sexual health e.g. testing, treatment and counselling services. Vulnerabilities even go so far as highlighting that military children are potentially more at risk of maltreatment when a parent is away, due to stay-at-home parental stress. Addressing such stress requires the need for enhanced and customised support for stay-at-home parents, especially those new to the role, feeling isolated and/or experiencing additional stressors (Lester et al., 2010).

### Improving sexual health

The first point of access a majority of young people encounter for various sexual health/education, safer sex (condoms) and other resources will be via various generic or mainstream services. DH (2011) emphasises that welcome, respect, trust and confidentiality, within a friendly environment, are essential for CYP. Front line services might be schools, general practice, pharmacies, military health fairs and emergency facilities. Effective education which addresses Knowledge, Attitudes, Skills and Habits, therefore needs to start with these front-line service providers, including ways to promote their provision of safer sex and contraceptive resources in line with their level of expertise and commissioned requirements. First-access services can provide clear referral pathways to more specialist facilities, such as advanced contraception, genitourinary health and emergency contraception.

Sexual health and supportive educational provision are rightly the duty at first access to services many individuals make. These first access services and their personnel include teachers, welfare staff, school nurses, primary care and emergency health staff, often accessed before more specialist Genito-Urinary healthcare, contraception services and sexual assault referral centres (SARC). But barriers to accessing particular specialist services, especially whilst on deployment, may be compounded by a lack of their local provision as well as from other

cultural and institutional barriers which prevent an individual attending in a timely way. Remember: any delay can be truly detrimental to health. Whilst confidentiality is a key element across sexual health services, this can be compromised in military settings, as with any small or local community, when privacy is lacking or the service one attends is staffed by people known to the individual. Building trust, and demonstrating it, is a key element underpinning the promotion of positive education for Knowledge, Attitudes, Skills and Habits for good sexual health most especially to CYP.

A crucial element improving sexual health is optimum mental health. There are numerous ways in which mental health is challenged, in military personnel past and present, and their families. Although a community or family ethos is a closely guarded aspect of military life, poor mental health not only leads to poor decision making/increased risk taking, but is an added burden for those who strive to portray a strong, resilient, persona. The stigmas often associated with poor mental health, right through to substance dependence, homelessness, criminal activity etc. are compounded for those who also feel they are 'weak' when they are expected to be 'strong'. An expected 'strength' of Armed Forces personnel, an onerous burden for many, is bolstered by a machismo (hyper-masculinised) culture, which, in itself, can have detrimental effects on the individual, their feelings and emotional well-being, as well as in the way they treat people of other genders and sexual orientations. In military and veterans' families, the impact of a 'stiff upper-lip' mentality can start young, even with little boys in the family being expected to 'be the man of the house' to prove their strength. Needless to say, this can have a devastating impact on young children who grow up not wanting to follow their parent's footsteps, or if they consider themselves to be a 'failure' for not matching up to what is (often, unfairly) expected of them. A case in point, hopefully well in decline since the Armed Forces' esteemed record as *Stonewall Diversity Champion* partners ([www.stonewall.org.uk](http://www.stonewall.org.uk)), would be with sexuality-related bullying. The characteristics of gender and sexuality-based bullying, abuse, violence and coercion are outside the scope of this article, but intimately entwined with the

sexual, physical and mental health of victims and perpetrators alike.

## Improving health – making a difference

In concluding this article, the focus has been on a number of crucial sexual health themes relevant to young people in the Armed Forces, and CYP in military families both past and present. After encouraging you to explore specific needs of these demographic populations, we explained how an educational approach which improves not just Knowledge, but Attitudes, Skills and Habits (KASH) can be usefully employed. Suggesting a few more resources to promote greater sexual health for your clients will ensure you are able to truly make a difference to local populations (DH, 2013). The list of resources and suggestions include, but are not limited to:

- more freely and widely available condoms, with suitable training on effective use
- clear signposting to venues for contraception, Emergency Contraception, sexual health screening, and sexual assault referral centres/pathways
- greater awareness of abuse/non-consensual sex, drink-fuelled and problematic sex
- increasing the number of primary health care staff with appropriate sexual health education
- ensuring confidentiality and freedom to attend sexual health services of choice and without personal or institutional interference
- greater educational provision to various front line (first access) health and educational professionals, supplied by specialist sexual health workers, focusing on promoting clients' holistic KASH, in regards to safer sex and improved sexual well-being.

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### Resources

A free e-learning course, on sexual, reproductive and mental health can be found at:

<http://www.scie.org.uk/publications/elearning/sexualhealth/index.asp>

For details on Sexual Health Skills e-learning course, "top up" BSc(hons) sexual health, and masters and doctoral studies in sexual health, contact [D.T.Evans@greenwich.ac.uk](mailto:D.T.Evans@greenwich.ac.uk)

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