Metro's Baseline Date Survey Analysis

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April 23, 2012

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Executive Summary:

1,023 young people (YP), aged 15-24, completed the Metro's Behaviour, Attitude, Skills, and Knowledge Survey between October and December 2011. After initial development and piloting, marking criterion and a correlated scoring system were developed to determine separate area and one composite score. Data shows clearly that attitude and knowledge scores are lower than behaviour and skills.

The data gathered from this survey is robust and the sample size was large. Statistical analysis would likely show small CIs and P-values. However, as with all sexual health survey tools, bias particularly sample, response, and social acceptability is an influencing factor, likely inflating scores.

Approximately 65% of 15-24 year olds have always used a condom, have never been sexually active, or have not been active in the last year. The most commonly sited reasons for not using condoms were using another form of contraception or being in a relationship. Factors dealing with impaired judgement or poor confidence in sexual negotiation skills impacted at least 6.5% of respondents. 20% of 15-17 year olds have accessed EHC, yet the vast majority of people having unsafe sex who do not use a backup method of contraception report never having used EHC despite its free availability through local pharmacies.

One quarter of all young people surveyed feel apathetic about, disagree or strongly disagree that safe sex is important. Contrary to popular belief, young men, and not young women, are more likely to report having sex to feel better about themselves. Males are also significantly less comfortable saying no to sex, perhaps resulting from asymmetrical focus on sexual negotiation and confidence education focused primarily on women.

Knowledge scores varied widely between 45-85% correct. Male respondents more than female knew where to get free condoms, however this does not necessarily mean that they are being accessed, used, or used properly. Some people wrote extra comments on their survey asking for information about where to get free condoms or re-iterating that they have unmet needs.

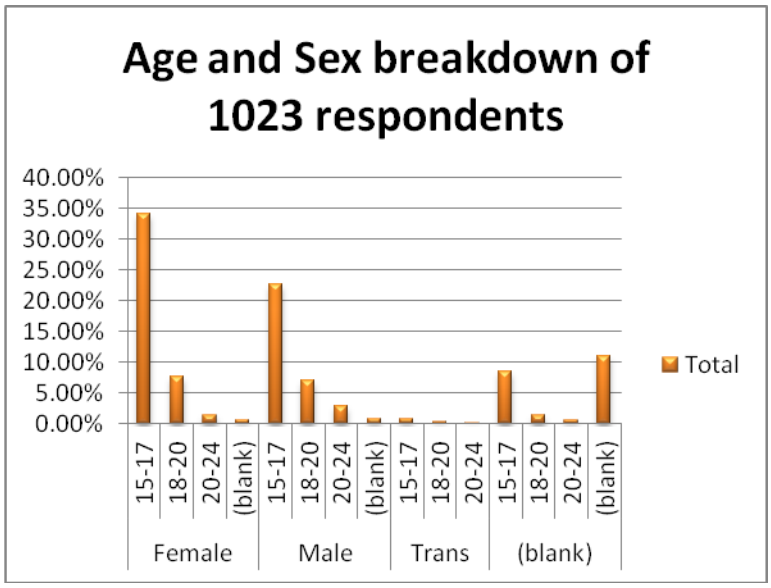
Based on available data, certain policy and programme changes can be made to decrease health inequities and improve sexual wellbeing throughout Bromley borough. These include,

- Clearer messages about EHC and contraception,
- Improved and innovative free condom distribution scheme, and
- Equitable and enhanced relationship education focusing on confidence, empowerment and sexual negotiation.

Introduction:

Metro's Bromley Young Persons' Behaviour, Attitude, Skills and Knowledge (BASK) survey was administered to young people (YP) aged 15-24 throughout the borough between October and December 2011. In all 1, 023 YP were surveyed. In addition to serving as detailed baseline data, the information gathered through the BASK tool can help target programming efforts and find the highest needs areas or demographics. Programmes can also focus on areas most likely to improve sexual wellbeing and close existing gaps in health inequity.

Demographics:



The age breakdown of respondents shows that young people have been intentionally over-sampled. Young people are a particularly useful demographic to analyze for manifold reasons. If they become teenage parents they are more likely to be forced out of education without receiving formal qualifications. As they were accessed mainly through schools, their answers may also reflect in some part the quality of Sex and Relationship Education (SRE) programmes. Furthermore, young people are learning sexual negotiation skills and are likely making their sexual débuts at this age. Early sexual behaviours and early début are both linked to set behavioural patterns and behaviours later in life (Ingham, 2010).

Sexuality	Percentage (and Number) of Respondents
Straight	73.31% (750)
Lesbian	1.76% (18)
Gay	1.08% (11)
Bisexual	2.83% (29)
MSM	0.59% (6)
(blank)	20.43% (209)

Ethnicity	Percentage (and Number) of Respondents
Asian British	3.32% (34)
Asian Other	0.68% (7)
Black British or mixed Black British, Caribbean and/or African heritage	4.29% (44)
Black Caribbean	1.76% (18)
Black African	2.54% (26)
White British	58.05% (595)
White Other	2.83% (29)
Mixed Ethnicity	5.66% (58)
Traveller	0.98% (10)
Other	2.15% (22)
Not Stated	17.76% (182)

Roughly 60% of the respondents identified as having a White British or White other background. 4% self-identified as Asian. 8.5% identified as Black British, Black Caribbean, Black African or a combination thereof. 5.5% selected more than one ethnic box or selected 'mixed' on the survey. 1% identified as traveller.

Ethnicity	Average Behaviour Score	Average Attitudes Score	Average Skill Score	Average Knowledge score	Average Score
Traveller	52.7%	39.5%	52.2%	42.9%	46.8%
(blank)	59.8%	42.7%	62.6%	45.1%	52.5%
Asian Other	57.1%	42.0%	65.1%	46.9%	52.8%
Black African	62.9%	63.2%	58.1%	44.2%	57.1%
White Other	63.9%	48.4%	69.7%	51.0%	58.3%
Black Caribbean	61.1%	55.3%	72.8%	54.0%	60.8%
Asian British	73.0%	60.4%	67.6%	48.7%	62.4%
Black British	68.2%	60.8%	78.0%	49.5%	64.1%
Mixed	70.4%	54.5%	76.2%	56.3%	64.4%

Other	71.9%	57.8%	72.7%	56.8%	64.8%
White British	72.1%	55.4%	77.3%	56.8%	65.4%
Average	**68.7%**	**53.3%**	**73.2%**	**53.4%**	**62.1%**

Of all the ethnic groups, travellers had both the lowest overall score at 46.8%. While their behaviour score just passed 50%, their attitude score, the lowest of any subset failed to reach into the 40th percentile.

Anecdotally, many respondents who elected to write in their ethnicity next to the 'other' box wrote ethnicities or nationalities from the Mediterranean or MENA regions. Scores from people who ticked 'Other' were second from the highest.

Notably, the one demographic whether separated by venue or ethnicity to have their best score in Attitudes are respondents who identify as Black Africans.

The Affects of Sample and Social Acceptability Bias

Biases' role in this reports' findings are significant and its impacts, both in terms of external validity and generalizability, need to be addressed prior to interpreting the data. This survey was administered in 22 sites in Bromley borough between October and December 2011. In total, 1023 young people between 15-24 years old filled in surveys in various schools, colleges, bars, pubs, and youth and leisure centres. Some young people took condoms, lube, or sperm shaped key chains as incentives. No incentives whatsoever were offered in exchange for "correct" or "acceptable" responses.

As the majority of respondents were accessed through schools a pattern of "response clumping" appeared sporadically, presumably when people would answer the questionnaire while sitting next to friends and all would share, copy or "correct" responses.

Sample bias specifically played a role in this survey as well. People are also more likely to fill in a sexual health survey if they feel they have some preparation to give proper answers. Because students were not significantly incentivised, students who elected to participate are more likely to feel they know something about sex. Students who approached the Bromley CRAASH Team were more likely to feel comfortable talking about sex and/or asking for more information.

Additionally, as with any sexual health survey, scores are likely to be inflated by social acceptability bias. Knowing that the people who administer the survey value sexual health and have a person stake in the tool, respondents are likely to feel compelled to give answers which they feel we are likely to want or give the "correct" answer, even when it is not true or applicable to them. For example, people tend to over report condom use and under report the

frequency of condoms slipping or breaking. This acceptability bias, like sample bias, artificially inflates scores.

Acquiescence bias is not likely to have a significant impact on scores as all leading questions were removed or restructured throughout the piloting process carried out in the first week in October.

The results presented below are useful as a guide to improving services and education aimed at young people across Bromley borough.

Summary Scores:

Row Labels	Average Behaviour Score	Average Attitudes Score	Average Skill Score	Average Knowledge score	Average Score
Goals North Beckenham	45.5%	26.4%	55.6%	55.4%	45.7%
Goals-Elmers End	59.5%	40.0%	70.7%	50.6%	55.2%
Kemnal Tech	69.2%	36.5%	66.2%	61.8%	58.4%
Ravens Wood School	67.8%	51.2%	65.2%	49.9%	58.6%
Lloyd's	65.5%	50.2%	62.8%	61.1%	59.9%
Bromley College	62.3%	52.0%	74.0%	52.1%	60.1%
Goals-North Beckenham	61.4%	58.2%	77.8%	44.6%	60.5%
The Spa Leisure Centre	63.8%	52.6%	72.2%	56.9%	61.4%
Bishop Justus	72.1%	54.0%	71.4%	50.8%	62.1%
Hayes	81.8%	12.3%	83.3%	75.0%	63.1%
Slug and Lettuce	61.8%	39.8%	80.0%	71.4%	63.3%
BullersWood School	70.5%	58.3%	74.0%	52.9%	63.9%
Capel Manor College	65.8%	62.6%	74.6%	55.4%	64.6%
Police Cadets	78.4%	52.9%	77.4%	50.7%	64.9%
Walnuts Leisure Centre	75.5%	56.7%	76.7%	51.1%	65.0%
Orpington College	68.7%	51.6%	81.6%	61.7%	65.9%
Darrick Wood	76.5%	57.8%	76.5%	53.8%	66.1%
Star and Garter	74.9%	59.8%	76.2%	56.4%	66.8%

Capel Manor	63.6%	42.0%	91.7%	71.4%	67.2%
Beaverwood School	72.9%	57.8%	83.2%	58.3%	68.0%
Harris Academy	77.3%	62.5%	79.0%	56.7%	68.9%
Mean Average	68.7%	53.3%	73.2%	53.4%	62.1%

*Lowest scores are highlighted in red and highest scores are highlighted in green.

All questions in this survey seek to elucidate a behaviour, attitude, skill or knowledge relating to long acting reversible contraception (LARC), emergency hormonal contraception (EHC) or general sexual health and wellbeing. The behaviour score is a composite from their reported use of contraception (excluding condoms), their sexual risk profile, use of EHC, and the frequency of having unprotected sex. The attitude component is derived from their responses to situations when it is alright to not use a condom, under what conditions they have not used a condom, if they feel that having safe sex is important, and whether or not they have had sex to feel better about themselves. Skills are based on the frequency of condoms splitting or slipping and they ability to say no to having sex. Their knowledge score is based on knowing where to get contraception, knowing about sexual health services available to them, basic information about EHC, and true or false questions testing the knowledge around conception, STI transmission, and HIV.

There is a clear divide in the scores between their behaviour and skills, which are comparatively high and their knowledge and attitude scores which are comparatively low. This potentially indicates that while young people have good behaviours surrounding sex and relationships, they lack the basic information to make informed choices and cope intelligently with the consequences of being sexually active and/or being in relationships. Overall, respondents have reported a strong skill set but their attitudes vis-á-vis sex and relationships remains around than 50%.

Behaviour:

In the last year, the reasons I've had sex without a condom were (in descending order of always/often frequency)	Always/Often	Occasionally	Rarely/Never	Always use a condom or not sexually active
Because I/my partner am/is using another form of birth control	21.7%	3.0%	13.0%	62.2%
Because I am in a relationship	19.2%	4.6%	12.8%	63.4%
It feels better to me	16.8%	4.0%	14.4%	64.8%
Because I knew the person	16.6%	3.5%	15.2%	64.7%
I didn't have a condom	9.5%	6.1%	19.2%	65.2%
I didn't want to use condoms on this occasion	9.2%	5.6%	18.1%	67.2%
Because my partner didn't want to use one	9.0%	4.3%	20.7%	66.0%
I had been drinking / I was drunk or high	8.0%	6%	23.8%	62.2%
My partner didn't have any condoms	7.7%	5.6%	20.5%	66.2%
My partner asked me not to*	6.6%	3.2%	23.3%	66.9%

Approximately 65% of respondents did not answer this question either because they have never been or are not currently sexually active or because they have not had unprotected sex in the last 12 months. The most common explanations for having unprotected sex are 'using another form of birth control (which will not prevent STI transmission), 'being in a relationship', or 'it feels better to me.' Being in a relationship and using another form of contraception were most often ticked together and are the two options most likely affected by social acceptability bias.

The role of sexual negotiation is elucidated somewhat by looking at 'because my partner didn't want to use one' and 'my partner asked me not to.' Overall, the impact of gender was negligible-as 7.9% and 7.2% of males and females respectively, always or often don't not use condoms because of their partner preference. However, the overall scores mask differentials within the data set. For example, at one sixth form school (where students were between 15-17 years old), no males reported always or often having sex without a condom because their partner asked them not to. All respondents who said they had had sex without a condom at their partners request were either

female or declined to give their sex. At the same school, of the people who reported their sex, only males reported never having had sex without a condom at their partner's request.

This asymmetry in negotiation skills at this age could be associated with female's poor confidence in sexual communication, sexual acquiescence, socialization to be polite, or over-trusting in partner's communication skills.

Percent of People who Use Only Condoms	**53.2%**
15-17	38.9%
18-20	6.6%
21-24	1.3%
No age given	6.4%
Percent of People who Use Another Contraception Method	**37.8%**
15-17	21.6%
18-20	9.2%
21-24	3.7%
No age given	3.3%
No Answer Given	**9.0%**

It is encouraging that 38% of women report using another form of contraception in addition to condoms. However, the method which she has elected to use may not be as effective if based on her compliance (for example, the pill or patch). Once follow-up surveys are collected, we will be able extrapolate more on their elected methods of contraception.

EHC use, broken down by age			
Age	**Never used EHC**	**Have used EHC**	**Did not Answer Question**
15-17	76.1%	20.1%	3.7%
18-20	64.9%	29.8%	5.4%
21-24	46.2%	50.0%	3.8%
No age given	60.2%	20.3%	19.5%

Of the 1,023 respondents, 97 people had engaged in unprotected sex and were not using another form of contraception. Sex is defined as unprotected when either no condom was used or because the condom failed. Of those 97 respondents, 57 were between 15-17 years old and only one sough EHC. 17 respondents aged 18-20 and seven 21-24 year olds also had high-risk sex and none of them reported seeking and taking EHC. Sexual risk in this survey is determined using an algorithm based on the respondent's answers to questions about having unprotected sex, frequency of condom failure, and the use of a backup method of contraception.

As the data clearly shows, there is an elevator effect being displayed by age groups. As the question asks whether or not the respondent has *ever* used EHC, a positive response does not necessarily, although it can, correlate with the respondent's present age group.

Attitude:

When do you think it is alright to have sex WITHOUT a condom? (In descending order of frequency)	✔
If we have both been tested	**46.8%**
Never – I always use a condom	**38.34%***
When I know the person	**16.0%**
When I don't want to use one	**13.7%**
When I am in a relationship	**9.0%**
When my partner asks me not to use one	**9.0%**
When I don't have a condom	**8.4%**
When I'm drunk / high	**7.6%**
When my partner doesn't want to use one	**7.4%**

*Many respondents who ticked that they always use condoms also ticked another answer, leading to contradictions within the data.

When respondents who ticked "Never-I always use a condom" and another answer are removed, only 27.4% of respondents remain. The greater than 10% difference should be kept in mind when interpreting answers which may be impacted by social acceptability bias.

This question is designed to reflect attitudes (and not actualized behaviours) and many respondents, some of whom have not been sexually active, are guessing at what their behaviours and attitudes will be once they become sexually active. This self-perception bias may lead survey respondents to over report low-risk and under report high-risk behaviours.

The factors which were reported least frequently are most reflective of impaired judgment and poor negotiation skills. All potential situations were ticked by at least 7% of the sample, which, as discussed earlier, is a conservative estimate. Given the frequency of safe sex messages which promote the empowerment model as a way to combat being pressured into having sex, this number is likely an underestimation of the real impact of those factors.

I think it's important for me to practice safe sex.				
Sex and Age	**Strongly disagree/Disagree**	**Neither Agree nor Disagree**	**Strongly Agree/Agree**	**No Answer Given**
Female	**7.6%**	**15.0%**	**75.0%**	**2.5%**
15-17	8.0%	17.8%	71.6%	2.6%
18-20	5.1%	5.1%	87.2%	2.6%
21-24	7.1%	7.1%	85.7%	0.0%
Male	**5.5%**	**18.7%**	**73.5%**	**2.3%**
15-17	6.1%	21.6%	70.1%	2.2%
18-20	5.5%	12.3%	78.1%	4.1%
21-24	3.3%	10.0%	86.7%	0.0%
Trans	**53.8%**	**15.4%**	**30.8%**	**0.0%**
15-17	37.5%	12.5%	50.0%	0.0%
18-20	66.7%	33.3%	0.0%	0.0%
21-24	100.0%	0.0%	0.0%	0.0%

Male and female respondents offered surprisingly similar responses regarding the importance of safe sex-the responses all falling within 3% of each other in all columns. Still however, one quarter of all young people surveyed feel that practicing safe sex is either unimportant, very unimportant or are apathetic to its significance. Age also appears to play a factor with older respondents valuing safe sex more than younger respondents, except in the transgender community where the opposite appears to be true. Given the small sample size and the probability that at least some of the respondents ticked being transgender for its perceived humour, the results need to be interpreted with caution.

I have had sex to feel better about myself				
Sex and Age	**Strongly disagree/Disagree**	**Neither Agree nor Disagree**	**Strongly Agree/Agree**	**No Answer Given**
Female	**72.5%**	**13.4%**	**10.3%**	**3.8%**
15-17	73.9%	12.6%	9.5%	4.0%
18-20	66.7%	17.9%	11.5%	3.8%
21-24	64.3%	14.3%	21.4%	0.0%
Male	**51.0%**	**26.5%**	**17.2%**	**5.2%**
15-17	50.2%	28.6%	15.2%	6.1%
18-20	53.4%	20.5%	21.9%	4.1%
21-24	53.3%	23.3%	23.3%	0.0%
Trans	**53.8%**	**7.7%**	**23.1%**	**15.4%**
15-17	50.0%	12.5%	12.5%	25.0%
18-20	66.7%	0.0%	33.3%	0.0%
21-24	50.0%	0.0%	50.0%	0.0%

Men are 7% more likely to have sex to feel better about themselves than women. Men are also 21% less likely to disagree with the statement that they have had sex to feel better about themselves. Generally, we assume that women are more likely to seek validation through sex, however this data indicates that this idea is misguided. Males, not females are more likely to have sex to feel better about themselves. Bearing in mind that the question is not time bound, the older the female respondent is, the more likely she is to agree with the above statement. Perhaps younger female respondents are taking on the empowerment model while older women do not have a common venue or means of receiving and enforcing the same messages.

Skills:

In the last 12 months, how many times has a condom slipped off or broken?						
Age	**0**	**1-2**	**2-3**	**3-4**	**4-5**	**5+**
15-17	71.2%	9.2%	3.3%	0.8%	1.3%	8.4%
18-20	69.0%	15.9%	1.5%	0.0%	1.7%	9.4%
21-24	62.5%	12.4%	5.6%	0.0%	1.4%	16.1%
Mean Average	**67.6%**	**12.5%**	**3.5%**	**0.3%**	**1.5%**	**11.3%**

Remembering that the less sex one is having, the less likely one is to report condoms breaking (simply because of decreased sexual activity) the numbers here reflect a frequency rather than a proportion of unsafe sex.

I feel comfortable saying no to sex.				
Sex and Age	**Strongly disagree/Disagree**	**Neither Agree nor Disagree**	**Strongly Agree/Agree**	**No Answer**
Female	**6.0%**	**7.4%**	**84.8%**	**1.8%**
15-17	6.0%	7.4%	84.5%	2.0%
18-20	3.8%	7.7%	87.2%	1.3%
21-24	21.4%	0.0%	78.6%	0.0%
Male	**20.7%**	**28.3%**	**48.4%**	**2.6%**
15-17	19.5%	29.9%	48.5%	2.2%
18-20	23.3%	24.7%	47.9%	4.1%
21-24	23.3%	20.0%	56.7%	0.0%
Trans	**69.2%**	**7.7%**	**23.1%**	**0.0%**
15-17	50.0%	12.5%	37.5%	0.0%
18-20	100.0%	0.0%	0.0%	0.0%
21-24	100.0%	0.0%	0.0%	0.0%

On average, 12% of young non-transgender people report feeling uncomfortable or very uncomfortable saying no to sex. Men however, appear to be particularly disadvantaged when negotiating sexual contact, as only 50% feel comfortable or very comfortable refusing sex. Messages focusing on sexual communication and negotiation tend to target women and girls and

men and boys may be excluded. Additionally, the pressures to live up to male sexual stereotypes may enforce views that men would never want to refuse sex. Females, who have received messages about sexual negotiation may also be overestimating their confidence and skills in sexual and relationship mediation. Both these factors may contribute to the significant gender disparity.

Troublingly, the transgender community reports particular difficulty in negotiating or refusing sex. Once again, while the sample is small, the differential is significant at over 50% from their non-trans peers.

Knowledge:

The correct answer has been marked with an (X) for clarity

Oil-based lubricant will damage latex condoms	
TRUE (X)	44.6%
FALSE	22.4%
NOT SURE	29.9%

Over half of people do not know that oil-based lubricants will damage latex condoms. They may also be unaware of how common many oil-based products are, including lotions and sunscreen.

You can get an Sexually Transmitted infections from sitting on a toilet seat	
TRUE	23.7%
FALSE (X)	51.5%
NOT SURE	22.0%

More than 55% of students still believe that or are unsure about STIs -transmission via toilet seats.

You can tell if someone has an STI by how they look	
TRUE	7.3%
FALSE (X)	82.7%
NOT SURE	7.5%

15% of YP answered the question incorrectly or left the question blank indicating their lack of confidence in their knowledge.

You can't get pregnant if he pulls out	
TRUE	14.8%
FALSE (X)	73.9%
NOT SURE	8.6%

Approximately three quarters of YP know that a woman can become pregnant from pre-ejaculatory fluids.

Only gay men and Africans get HIV	
TRUE	7.4%
FALSE (X)	86.8%
NOT SURE	3.3%

87% of young people understand that the belief that only gay men and Africans get HIV is false and based on stereotypes.

Being HIV+ and on treatment makes me live longer than being HIV+ and not on treatment	
TRUE (X)	50.6%
FALSE	17.8%
NOT SURE	27.4%

Half of respondents do not appear to know about improvements made in HIV treatment and the impact it can have on quality of life and life expectancy.

Do you know where to get free condoms in Bromley?			
Sex and Age	**No**	**Yes**	**No Answer Given**
Female	**55.6%**	**42.0%**	**2.5%**
15-17	55.6%	41.3%	3.2%
18-20	56.3%	41.0%	3.0%
21-24	62.5%	37.5%	0.0%
Male	**55.7%**	**41.4%**	**2.9%**
15-17	56.4%	43.6%	0.0%
18-20	50.7%	46.6%	2.7%
21-24	33.3%	66.7%	0.0%
Total	**55.6%**	**39.3%**	**5.1%**

Only 40% of young people know where to get free condoms in Bromley, which given their often prohibitively expensive costs, is particularly concerning. The price differential between individual consumers and large buyers operating under an economy of scale is significant. Condoms at popular high street chemists like Boots cost roughly £1.00/condom, while when purchased in bulk are roughly 5 pence/condom. Additionally, economically disadvantaged, young and socially excluded people are most price-responsive and would benefit most from easy access to a borough wide condom distribution scheme-potentially improving health equity in the borough.

Anecdotally, when asked if they knew where to get free condoms, some students circled numerous times or underlined “No” repeatedly and one student wrote, “Not in Bromley!”, clearly indicating a strong desire to access free condoms.

Furthermore, simply because a young person knows where free condoms are available does not mean that they actually choose to access them. The knowledge-attitude-behaviour change model here may not sufficiently capture the reality of condom use amongst young people in Bromley.

There is also a strong age/gender dynamic. Free condom schemes tend to target young people in schools, which might be one contributory factor for why women 21-24 years old do not know about free condoms schemes. Men, who are traditionally seen within heterosexual coupling as

the partner responsible for condom provision, seem to have better retained knowledge of where to access free condoms.

Potential Directions for Future Programmes and Demonstrated Areas in Need of Change:

	Average Behaviour Score	Average Attitude Score	Average Skills Score	Average Knowledge Score	Average Score
Mean Average	68.7%	53.3%	73.2%	53.4%	62.1%

This survey shows that young peoples strengths lie in their overall sexual skills, while their attitudes remains their weakest area. Taking into account the score inflation discussed in the introduction, the results here are likely to be an overestimation of the YP's actual sexual well-being. Survey respondents are at widely different levels of sexual understanding and involvement yet educational and health promotion messages are able to target diverse audiences with quality information and knowledge support to reinforce previous learning. Both factual (toilet seats are not transmitters of STIs) and practical knowledge (where to get free condoms) are lacking and we are therefore able to direct programming to be more efficient and effective. Attitudes, which were also poor, are important to examine as they may be indicate future behaviours and associated physical, social, sexual, educational, and economic ramifications.

Specific interventions may include:

- Clearer messages about the use and availability of contraception and EHC,
- More continually enforced condom education and safe sex training,
- Appropriate provision of condoms through various channels including school, pharmacy, and public venue distribution and encouraged participation in free condom schemes,
- Equitable relationship education focused on sexual negotiation, and
- Increase health promotion messages advertising available services and addressing commonly held misconceptions.

In addition to implementing more classroom-based or extra-circular activities confronting sexual health and wellbeing, engaging school's policies to provide comprehensive sexual health messages and information may improve young people's health. This could include authorizing the school nurse to provide free condoms and further encouraging student enrolment in borough-wide free condom schemes.

School administrators might also consider creating partnerships with other health groups or charities so that students feel like they have a knowledgeable person outside their nuclear peer-group that they can talk to about healthy sex and relationships.

Sexual health, like other arenas of young people's educational growth can be improved with solid information and opportunities to develop a sense of agency and autonomy. Whether learning how to properly put on a condom, electing to self-test for Chlamydia, or accessing information on contraception, services throughout the borough are available to improve the sexual well being of young people in the borough.