Happier, Healthier and Better Informed

Bromley CRAASH Young Person's Survey

Qualitative Data Report

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Contents

Background

Between October and December 2011 1024 young people between 16 and 24 completed BASK sexual health questionnaires in Bromley. Young people were also given a sexual health presentation as part of outreach by the Metro centre. The questionnaires completed during the outreach sessions measured behaviour, attitudes, skills and knowledge in relation to sexual health and were administered in various locations such as colleges, schools and youth groups. Statistical analysis was completed on the sexual health questionnaires and published in a report by the Metro centre in April 2012. The report made certain policy and programme recommendations aimed at reducing health inequalities and improving sexual health well-being on young people in Bromley. This completed the first stage of the project.

The second stage of the project was a follow-up with young people who completed the original sexual health survey to assess retention of knowledge and behavioural changes in the year since the questionnaire was administered and to provide a short sexual health intervention, as discussed in the methodology. In addition, qualitative data was collected to complement the quantitative data from the first stage of the project. As other research has shown, a qualitative approach is useful in sexual health work in order to capture the complex motivations for sexual behaviour and decision making. Qualitative research can glean a deeper understanding of the thoughts, feelings and emotions related to sexual health. Indeed, Mulholland and Wersch (2007) criticise current sexual health approaches which neglect 'the subjectivity of human experience' and demonstrate how qualitative research can identify embarrassment, confidentiality and anxieties that a statistical approach would fail to capture. Through conducting qualitative research to supplement the quantitative data collected this report enables a more complex picture of young peoples' sexual behaviours in Bromley.

Aims

The overarching aim of the second stage of the Bromley CRAASH project is to better understand the nature and understanding of sexual behaviour by young people in the borough through taking a qualitative approach. This encompasses the following interlinked research goals:

- To better understand the sexual behaviour of young people in Bromley
- To gain an overview of their feelings, thoughts and aspirations in relation to sexual health.
- To highlight barriers to safer sex.
- To increase understanding of the motivations of sexual health choices made by young people.
- To illustrate the attitude and knowledge young people in the borough have.
- To make recommendations to help ensure young people make better sexual health choices in the future.
- To provide a short, targeted sexual health intervention through the research conversations.

Through focusing on the above goals this project not only seeks to further our understanding of the behaviour of young people in Bromley, but also to improve the well-being a sexual health outcomes of those involved in the project. With this aim in mind the report makes concrete recommendations to do this at the end of the report. In this vein, one of the main goals of the project was to use the telephone conversations as an opportunity for a short, targeted sexual health intervention. It provided the interviewee an opportunity to ask any questions they had and for the interviewer to provide information regarding safe sex, testing and contraception related to the participant's situation and signpost to appropriate services. In this way the conversations can be viewed as having had a dual role: to gather research data

and, just as importantly, to allow a participant-centred sexual health intervention. Together, an overarching objective was to improve the sexual well-being of study participants and provide information for young people to increase their autonomy in their sexual behaviour.

Methodology

Attempts were made to contact 364 participants who had completed the sexual health BASK survey in summer 2012 by telephone interviewers. The participants who answered the telephone and were willing to participate were asked a series of semi-structured interview questions (see template in appendix) related to the original BASK and the conversations were generally between 5 and 10 minutes. The questions were also used to determine whether there had been changes in behaviour, attitude, skills and knowledge since the original surveys were conducted. Due to the semi-structured nature of the interviews the question wording and order were not identical and the number of questions varied depending on the conversation. Interviewers were encouraged to probe participants' responses and to follow the flow of the conversation, rather than to read through a list of pre-determined questions. This was preferable as it enabled rapport to be established and allowed for a more natural conversation which increased the likelihood that participants would feel comfortable to talk openly about their sexual health. Consequently, taking a semi-structured, relatively informal and fluid interview approach was crucial for the key aim of this report – to increase the understanding of sexual behaviour and decisions made by young people.

Of the list of 1024 participants, attempt was made to contact 364 (see figure 1). A significant proportion of these participants (88) had given us invalid telephone numbers or e-mail addresses that did not work. As a result, contact (verbal, voicemail or e-mail) was attempted with 276 participants whose details were functioning and participants were contacted up to 3 times in an attempt to do the telephone interviews. In total, of the 276 people whose details were correct, 81 successful telephone interviews were conducted. Contact was attempted through e-mail or voicemail with 189 participants who did not reply and, subsequently, were not interviewed. In addition, 6 potential participants answered the telephone but refused

to be interviewed. Of the 81 participants who completed telephone interviews 42 identified as male and 39 identified as female. Nobody identified as trans. The fact that slightly more men than women took part in this study should be viewed positively, especially given the reluctance of many men to discuss their sexual health and the relative lack of sexual health work targeting men (particularly those identifying as heterosexual/straight) as highlighted in other sexual health studies.

Figure 1: Table to show BASK completion and contact attempts

Total attempted to contact	**364**
Invalid contact details	88
Attempted to contact (valid details)	276
No reply (to e-mail/voicemail)	189
Declined to participate	6
BASKS completed	**81**

Although telephone interviews were conducted with 8% of those that had completed the original survey, and this might seem low at first sight, this can be explained by the high amount of invalid contact details and the very low reply rate to e-mails/voicemails/texts. Thus, despite what might appear a low number of interviews completed, the data collected is useful as it furthers understandings of the sexual behaviour of young people in the borough in a way that statistical data does not, as explained below. In addition, while statistical approaches might require a high number of participants of validate data, this qualitative based stage focuses on particular cases, personal stories and individual experiences of sexual health, which this report illustrates. The aim of this stage is to better understand these individual situations, rather than to make generalisations for young people in Bromley.

Interviewers made notes based on the telephone interactions which were typed up and coded, taking a grounded theory approach (Miller & Salkind 2002). This enabled

key themes to be drawn form participants' comments, rather than beforehand, and ensured that the study was participant-focused. After being coded, key topics were identified and included in the following section of the report. Overall, feedback from participants related to the project was positive – many participants thanked interviewers for giving them the opportunity to talk openly about their sexual health and behaviour and were grateful for the chance to ask any questions they might have during the course of the interview. Importantly, and beyond the immediate objectives of this study, 18 participants were signposted to other services – such as free condoms and sexual health testing – which meant that in addition to collecting data the conversations also often served as an effective short sexual health intervention. Overall, telephone interviews were successful in illuminating the sexual behaviour of participants in different and complementary ways to the statistical first stage of the study. They allowed for a more in-depth and individual focused understanding of the motives for (not) having protected sex and established a picture of participant understanding of areas such as sexual risk, testing and contraception in ways that extend our knowledge of young peoples' sexual behaviour in Bromley and beyond.

Results

The first section of the report has highlighted the background, aims and execution of the qualitative research section of the project. The following sections will discuss some of the key findings that shed light on the sexual behaviour, knowledge, attitude and skills of young people in the borough of Bromley beginning with comments related to the initial talks/presentations given by Metro in the Autumn of 2011.

Metro Talks

As an opening to interview questions participants' were reminded that they had completed a survey with a Metro centre employer during talks/presentations. Overall, the majority of participants remembered these talks with many commenting that they 'vaguely' or 'kind of' recollected the sexual health presentations and original questionnaire. Participants were positive about the talks and many said that their knowledge has increased as a result of the interaction as the following quotes show:

> **Interviewer:** Do you think oil-based lubes will damage condoms?
>
> **Interviewee:** I remember when you were talking about that when you came and said things like lotion would, so yeah that's true.

> **Interviewer**: You have good knowledge about lube and STIs
>
> **Interviewee:** Yeah, I remembered quite a few of the answers from last time when you came in.

> **Interviewer:** Can you get an STI from sitting on a toilet seat?

Interviewee: I know there are a lot of myths about things like that....that was one of the things the Metro team did, dispelling some of these myths about sex and HIV so I know you can't.

Participants frequently commented that as a result of the original conversations they now knew where to get free condoms, emergency contraception and get tested in Bromley. Some participants even drew direct links between the sexual health talks and positive changes to their behaviour. This included, making sure they wore a condom, going to get free condoms/lubricant, being more assertive with sexual partners. For example, one participant commented that as a result of the first presentation she is 'more knowledgeable in terms of STIs' and feels that she 'would be safer with her sexual partners now'. Other participants stated that they went to get tested after conversations and have changed the lubrication/size of condoms they are using.

The comments made in relation to the conversations show that although few participants could remember the Metro talks/presentations in great detail, most of the participants retained some of the advice and could recall some of the details of the conversations they had with staff. The talks improved knowledge and in some instances directly impacted on behaviour between the first and second sections of the study. Thus, the outreach work conducted by the Metro centre appears to fall into what Oakley (1995) what determine a successful sexual health intervention which effects behavioural change.

Key finding: Participants found the sexual health presentation useful and it often resulted in improved knowledge and safer sexual behaviours.

Recommendation: Future sexual health initiatives which involve an initial presentation and a follow up to assess knowledge retention and behavioural change.

Behaviour

In the previous section reference was made to behavioural change between the first and second sections of the study but what are the sexual health behaviours that participants engage in? How was this changed specifically and what factors influence the sexual behaviour of study participants? These questions will be answered through focusing on responses to several of the questions asked by interviewers.

Sexual behaviours participants are engaging in

When asked whether it was important to have safe sex all participants bar one responded saying they 'agree', 'strongly agree' or that it was ' (very) important' .Of the participants that discussed the nature of their sexual behaviour the vast majority were engaging in protected sex, except those that were in long term relationships. When asked when, if they would ever have unprotected sex, the most common response was only when in a long term relationship. Most of those that gave this response, or who were in long term relationships and having unprotected sex commented that it was important to ensure that they and their partner had been tested before starting to have unprotected. However, it appeared that whilst some participants recognised that testing before having unprotected sex in a relationship was important this was not necessarily the situation with their current partners for all participants and for some it was more an indication of their intended behaviour with future partners. Some respondents commented that although neither they nor their partners had been tested the fact that they were in a monogamous relationship meant that they felt safe not using protection. Several participants linked this to trusting their partner like the following participant who said that he made the decision whether he would have unprotected sex based on how well he knows the person.

One participant commented that she would need to know her ‘partner really well, for every a year’ before having unprotected sex. This was reiterated in comments by another interviewee:

> **Interviewee**: You need to know the person well enough...like in a relationship, then you don’t need a condom, innit?
>
> **Interviewer:** So, is it about trust?
>
> **Interviewee**: Yeah, you need to trust the person

One participant commented that she would have sex without a condom if she was taking the pill and did so ‘maybe three times’ at the start of the year and only participant answered the question saying that they had unprotected sex with a casual partner in the last year. She stated she’d had sex without any form of contraception 3-10 times in the last year.

Condom Use

Broadly speaking comments made about ‘protected’ or ‘safe sex’ were in keeping with those made about condoms and indicated that using protection was a priority for most participants. For virtually all participants it was important to use condoms and for the majority it was the preferred form of contraception. Indeed, many of those who talked about ‘safe’/’protected’ sex conflated it with using a condom indicated that they were often perceived as the same thing. The only exception was one participant who stated ‘To be honest....I’m not all that fussed about it’ when discussing the importance of condom use. When asked about frequency of condom use the most common responses were that condoms were used ‘all the time’ or ‘always’ with casual partners, with one participant stating that he used condoms ‘without fail’. Several participants commented that they only use condoms ‘some/most of the time’, ‘rarely’ or ‘never’. The most common reason for this was

that participants felt that there was no-need if they were in long term committed relationships. This was reiterated by comments from several participants starting that condom use had decreased as their relationship became more serious. One participant said that when she first ‘got together’ with her ex-boyfriend they would ‘always use condoms’ they started using them ‘less and less frequently’ as the relationship progressed.

Other than being in a relationship, participants gave many other reasons for not using condoms. The most common were that they were seen to interrupt the spontaneity of sex, with several participants saying they can ‘ruin the passion’, or that they reduce sensation when having sex. Some interviewees commented that, because of this, condoms made sex less enjoyable and, in some instances, uncomfortable. One participant complained that condoms ‘take the fun out of it’ and ‘ruins the sensation of sex’ and another said condoms give him ‘toothpaste dick’, which he described as making his penis ‘tingle...which feels weird’. An additional reason for not using condoms, mentioned by a handful of participants, was alcohol consumption. One participant stated at the beginning of the interview that she had protected sex ‘all the time’, before going on to describe how alcohol had a ‘big effect’ meaning that she ‘didn’t know what she was doing’ and made her ‘more vulnerable’ and resulted in her having unprotected sex on one occasion. Another participant described how she had to use the EHC (morning after pill) twice and that on both occasions it was because she ‘was drunk’ and no condom was used. Other participants were a little less clear but still described a link between alcohol and condom use as in the case of one participant who said that while ‘I’m not one of those girls who gets out of control when I drink, it has influenced me a bit’ and went on to describe one incident of unprotected sex she had had while drunk. The data collected suggests that whilst the proportion of participants always using condoms when they have sex is high, it is important that barriers such as alcohol and loss of

sensation are considered if the amount of young people having protected sex is to be increased.

Other types of contraception

Although the condom was the most commonly used contraception, the pill was also commonly used, often in conjunction with condoms. Approximately half of those taking the pill were doing so because it was recommended by their GP and the GP was also the main means of acquiring the pill. Compliance was good for all but one respondent and many participants commented that convenience of taking a pill, being easy to access, was its main draw. Several participants also commented that the pill helped to alleviate heavy and painful periods. Those taken the pill long term also noted that they did not have any side effects. Conversely, 9 participants who tried the pill but who do not currently take it said they experienced negative side effects. This included putting on weight, headaches and having irregular periods. When asked why they did not want to take the pill participants complained that it made you 'fat and spotty', gave you 'mood swings' and 'messed up your periods'. One participant commented that she had to stop taking the pill because she kept forgetting to take it. Only a handful of participants reported using other forms of contraception such as the implant, patch and injection. The implant appears most popular of these and those that were fitted were positive because of the lack of side effects and the fact that you do not have to consciously remember to do anything once it is fitted. As one participant commented 'once it's in, it's in you don't have to do anything else'. Another participant disagreed and said that she prefers the pill, commenting 'the thought of anything inside me just makes me cringe'.

Overall, condom use was the most widely used contraception and the implant and condom were viewed as the most convenient and easy to use. The pill was used less than the condom and the side-effects appeared the main barrier to use. Although most participants used a single contraceptive, several said that they used

two or more concurrently. This was most commonly the case with the condom and the pill and was done to be safer. Nevertheless, most participants relied on using the condom alone and use was generally frequent and consistent with alcohol, knowing the other person and lack of sensation identified as impediments to use.

Motivations for sexual behaviour

In order to improve sexual health and well-being in the future it is important to consider the motivations for safe/unsafe sex. The main drivers to have safer sex were to avoid getting pregnant or to avoid getting STIs as seen in the interaction below:

Interviewer: Can you tell me a bit about why you said it was 'very important' to have safe sex?

Interviewee: Yeah, I do anything to stop having babies at a young age!

Interviewer: Is that the main reason?

Interviewee: Yeah definitely

Interviewer: What is safe sex? What does that mean to you?"

Interviewee: Using any type of protection.

Interviewer: Do you think it's important?

Interviewee: Yeah, of course

Interviewer: Is your motivation for using condoms so you don't get pregnant or is it more about STIs?

Interviewee: Equally for both, I don't want to get pregnant but I don't want diseases or anything, obviously.

Interviewer: Is it important for you to have safer sex?

Interviewee: Obviously, it stops you getting pregnant and getting STIs.

Another participant commented that she was having unprotected sex last year but she got pregnant and has since had a baby and, as a result, now would only have protected sex to avoid getting pregnant. In the data gathered there appears to be a gender difference with females referring to both pregnancy and STI avoidance as motivations for safer sex, whereas males would generally refer to solely STI avoidance. Data collected seems to mirror Ekstand et al's (2009) conclusions that pregnancy prevention is the women's responsibility and implies that more effort needs to be channelled into work promoting it as a joint responsibility and to include men in prevention. If sex was unprotected the main reasons identified were alcohol use or being in a long term relationship, as discussed above. Overall the results for this section complement the phase 1 report which shows condom use as the most prevalently used contraception, but expands on the report's conclusions by emphasising some of the motivations as to why this is the case.

Key findings

- Most participants are having protected sex and place importance on having safe sex.
- Condoms were the preferred method of contraception and were used by most participants.
- The main barriers to condom use were: being in a relationship, reduced sensation and alcohol consumption.
- Reasons for having unprotected sex were generally: being in a long term relationship, trusting one's partner, alcohol.

- Reasons for having protected sex were either to avoid STIs and to avoid getting pregnant/getting one's partner pregnant.
- Data implies that pregnancy avoidance was seen as a female responsibility.

Recommendations

- Sexual health work must look at the connection between unprotected sex and alcohol and the effect alcohol has on decision making regarding safe sex.
- To increase knowledge of contraceptives other than the pill or condom that might be more convenient for some participants e.g. the implant, patch etc.
- To include men in pregnancy prevention programmes and to promote pregnancy prevention as a joint responsibility.

Attitude

When asked when (if ever) was it OK to have sex without protection the most common responses were when in a long term relationship, as highlighted above. The second most common response was when in a long term relationship and we have both been tested and the third most common response was never – protection is always used. It should be noted that in a minority of cases participants answers showed contradictions and this was most common when an answer was give that it is 'never' OK to have sex without protection, but later they talked about instances where they had engaged in unprotected sex. Whilst there was consensus in the data that unprotected sex should only take place in a relationship there were a wide range of answers as to how long the relationship should be from comments that it should be a 'serious relationship' to answers of 'after a few months' and 'at least year'. Most participants did not make reference to monogamy; rather context implied that a long term relationship could be equated with a monogamous one. One participant commented that he had been in a relationship for 1 year and they have both tested and for this reason they have unprotected sex, adding that he would have unprotected sex in the same situation in the future.

When asked whether they have ever had sex to feel better about themselves the majority of participants said that this has never happened. A handful of participants said that this was the case and this often seemed to follow relationship break-up as illustrated in the following quotes.

> **Interviewer:** Have you ever had sex to feel better about self?
>
> **Interviewee:** 'Yeah well I broke up with my ex and I was feeling a bit down and I just went out and had sex.

Interviewer: Have you ever had sex to feel better about yourself?

Interviewee: Yeah, I'd say yes

Interviewer: When was that?

Interviewee: After we broke up for a bit then got back together again…I wasn't feeling great and you know...

Interviewer: You were feeling down?

Interviewee: Yeah a little bit and the sex made me feel better

In terms of having sex to feel better about themselves – all participants that said yes were males. Although the reasons for this were unclear one participant's response provides a possible answer. He said the having sex made him feel better because it was 'a bit of an ego boost with the mates'. Connell and Meerschmidt (2005) have suggested that privileged forms of masculinity include having sex and being in control over sexual activity. This appears to be mirrored in the data collected for this study and implies that through having sex and having it when they want, some males are able to gain kudos from their social peers.

Key findings

- Unprotected sex was seen as OK as long as both partners were in a serious relationship and, by many participants, as long as they had both tested.
- Sex to feel better about oneself was not evident amongst women but prevalent (but uncommon) amongst men.

Recommendations

- Increased focus on the importance of continuing testing even when in relationships.

- More exploration of the possibility of gender influencing attitudes towards sexual behaviour.

Skills

The skill or ability to have safer sex is important as it can often prevent safe sexual behaviour even when the desire to do so is evident. In general skill had improved since the Metro presentations and participants felt more comfortable in their own ability to have protected sex as a result. The majority of the 12 participants that were asked if condoms had broken or fallen off in the last year said that they had. For most participants this has happened 2-3 times in the last year and all but one of the participants did not know why this was the case. They were informed by the interviewer about condom size, correct use and correct application of lubricant. Several participants were surprised when they were given this information and one participant said 'I didn't know that, I'm thick for not knowing that ain't I?' The comments around effective condom use show the usefulness of the interviews as a short sexual health intervention.

All 32 participants who discussed their ability to negotiate sex felt comfortable saying no to sex if they did not want it, this was irrespective of their gender identity or sexuality. When asked whether she felt comfortable refusing to have sex one participant responded 'Yeah, still totally comfy saying no when I don't want to. But I normally do!'. Participants felt that their partners would respect their decision and said that they would respect their partner's decision not to have sex. One participant, whose comments were typical of many others, commented that he felt he could say no to sex if he wants to, specifically if his partner wanted sex and he did not. This was reiterated in the following exchange:

> **Interviewer:** So, do you think he would be OK with you saying no?
>
> **Interviewee:** Yeah, he would listen

However, one participant commented that he would pressurise his partner to have unprotected sex until 'she eventually says yes'. Apart from this comment, discussion

around negotiating *sex* appears encouraging, but it should be recognised that this does not necessarily mean that individuals feel comfortable discussing *safer sex.* A handful said that they do not feel able to discuss safe sex and using contraception with their partners:

> **Interviewer:** Do you guys talk about when you are going to use them [condoms] and when you aren't?
>
> **Interviewee:** No we don't really talk about it

This difference is important because an ability to negotiate sex, but an inability to discuss safer sex leaves young people at higher risk of acquiring STIs/HIV and can lead to unwanted pregnancies. The data suggests the importance of ensuring that young people are comfortable talking about contraception use with a partner rather than simply feeling empowered to decline sex when they do not want to have it.

Key Findings

- Skill in relation to condom use appeared low amongst respondents with frequent condom breakage and slippage.
- All participants felt comfortable negotiating sex.

Recommendations

- Focus on effective condom use with particular attention to appropriate lubrication use and condom sizes.
- Approaches which increase young peoples' comfort discussing safer sex/contraception, rather than simply on negotiating sex.

Knowledge

Condom use and testing

The majority of the 43 participants who were asked whether they knew where to get free condoms reported that they did and many commented that they remembered this information from the first Metro presentations/talks.

> **Interviewer:** Do you know where to get free condoms?
>
> **Interviewee:** Yeah at a place I go for other services….Bypass in Bromley for people affected by alcohol and drug abuse. Yeah, they have condoms

Several participants commented that they would prefer to buy their condoms rather than going to get them for free. One participant commented that he did this because it is more convenient than buying condoms, commenting 'I'd just buy them and save the hassle of having to pick them up'. Another stated that he had heard that used condoms were being re-packaged and re-distributed when they were given out for free and this was corrected by his interviewer. Although most participants knew where to get condoms 7 said that they were unsure or did not know, including one participant who responded saying that she had 'no idea'. All participants who did not know where to go for free condoms they were signposted and given information of a variety of clinics in Bromley (and elsewhere where appropriate), such as Eldred drive and Mottingham clinic.

The vast majority of participants said that they knew where to get a sexual health check up. Of the 42 who were asked, 36 knew and 6 were unsure. Most participants stated that they would go to their nearest GUM clinic, but one participant said he would go to an alcohol support service where he felt safe because they have the 'same testing kits as you guys use!'. Again where participants did not know where to get tested they were given contact details verbally or via e-mail, including one participant who complained that it would be complicated for him to get tested

because he would have to go to his GP first to obtain a list of testing places close to him.

There was an observable gender difference in terms of knowledge related to testing locations. Although the vast majority of females knew where to get tested, only about half of men interviewed and were aware of testing locations. The reasons for this were unclear, but one possible explanation could be better overall sexual health knowledge and awareness of infection risk as highlighted in other research, such as Robertson et al's (2006) study. Lear (1995) comments that this could be the result of societal pressure on women to demonstrate they are less promiscuous than men. However, rather than providing clear explanations for gender differences in testing knowledge it illustrates the need for more research into this area.

Lubricant, STIs and pregnancy avoidance

48 participants were asked whether oil based lubricant damaged condoms. In-keeping with results from the first phase report the majority of participants (36) knew that this was true, whereas 12 were unsure and said it was false. One participant was unsure about the exact situation when this could occur, other than applying the wrong lubricant for oral sex and this was clarified. A couple of participants knew the correct answer but were unsure which were oil based lubricants. Several participants commented that they remembered this question from the Metro presentation/talk. Overall, participants felt comfortable using the correct type of lubricant with condoms.

Participants' knowledge around STI appearance was generally good. Most participants knew that it was impossible to get an STI from toilet seat (36 of 49 respondents) and that someone may have an STI without any visible symptoms (18 of 20 respondents). In relation to catching STIs from a toilet seat one participant who gave the wrong answer thought it was possible because 'you still put your bits on it

don't you?'. Several participants commented that they knew the correct answers this time, but when they completed the questionnaire they were unsure and said commented that they know the answers because of the presentations given by Metro last year. 10 participants were asked about whether there was risk of pregnancy even if their partner pulled out before ejaculating. 1 participant was unsure, but 9 knew that this was still possible. In addition, all respondents asked were knowledgeable in terms of what the morning after pill and the 72 hours that you had to take it. For example, when asked if he had heard of a time limit to take emergency contraception one participant commented 'I know that the level drops down, its effectiveness goes down after 72 hours doesn't it?'. The majority of participants knew where to acquire the morning after pill, but several were not aware that it could be prescribed at a pharmacy. Finally, all participants who were asked about the window period had heard of it and new how long it was. On the whole participants had good knowledge in terms of lubricant, STIs and pregnancy avoidance. For each question there were several participants who felt that their knowledge had improved in the last year and had participants identified the Metro presentations as a main source of information regarding these topics.

Service knowledge and referrals

Knowledge of sexual health services varied, as highlighted above, but generally participants knew where to get tested and obtain contraceptives. The most commonly mentioned locations were GUM clinics (of which Mottingham and Orpington were mentioned specifically, pharmacies, GP clinics, youth centres and colleges. One participant also mentioned Bypass alcohol and drug support. Other sexual health services were not discussed. Overall participants' answers showed awareness of a wide range of locations to get tested and acquire condoms across South London including sexual health and non-sexual-services. Interviewees did not generally make any comments related to their experiences of sexual health services.

This absence might be read positively as it is likely that if there were problems they would have been raised in the conversations.

Where participants had a lack of sexual health service knowledge interviewers often made referrals into appropriate services, including 22 of the 81 participants who were given the details of sexual health services. 13 of these were testing locations and 9 were places where free condoms could be acquired. These were predominantly based in London, but in 2 instances participants were provided with information about services outside London – in Watford and Norfolk – where participants were now residing. In London referral locations included Beckenham Beacon, Mottingham clinic, Eldred Drive clinic, Orpinton Ramsden clinic, Bromley GUM clinic and the Metro centre. Often participants were also provided with the link to the NHS choices website where they wanted to know where to get tested or were unsure about opening hours. A handful of participants were referred to services that they had already heard of. These were not included in the referral numbers above.

Key Findings

- The majority of participants knew where to get free condoms from and where to get tested.
- However, there was a gender difference in terms of testing knowledge: Most women were aware of testing locations, compared with half of men.
- Most participants knew that oil based lubricant is not suitable to use with condoms, but some participants were unsure about what oil based lubricant was.
- The majority of respondents had good knowledge about STI appearance and transmission risk. Including the window period.

- Most participants realised that even after pulling out there was still risk of pregnancy and knew what the morning after pill was.
- Some participants were unsure where to obtain the morning after pill.
- The Metro centre presentations were a key source of increased sexual health knowledge over the last year.

Recommendations

- Future work must ensure that young people are aware of examples of oil based lubricants and where to acquire the morning after pill.
- Further research must pay attention to the reasons for a gender difference in testing knowledge and sexual health campaigns must seek to address this through relating testing promotion to male lack of knowledge.
- Continued focus informing young people about condom provision and testing locations as young people were knowledgeable about this.
- Metro sexual health presentations and testing are a useful approach to increase sexual health knowledge and should be continued.

Young Person's Sexual Health in Bromley: The Way Forward

The data collected for the qualitative stage of the study has helped to increase understanding of the sexual behaviour of young people in Bromley. It has highlighted that respondents generally have protected sex and that the preferable choice of contraception for young people in the borough is condoms. Through telephone conversations there the report has also illustrated the thoughts, feelings and opinions of a group of young people in relation to areas such as safe sex, STIs/HIV, testing and contraception. It has shown that young people are generally concerned about having safe sex and generally feel comfortable negotiating sex with sexual partners. The report also suggests that whilst young people are at ease refusing sex, they are less comfortable insisting on safer sex. In addition, the report has highlighted the motivations behind young peoples' sexual behaviour. The key drivers of young peoples' sexual behaviour appear to be the concern that they or their partner could become pregnant or get an STI. The former appears to be a motivation for female, but not male safe sexual behaviour. Alcohol also appears to be a key factor in terms of whether participants engage in protected sex and must also be considered as a reason for putting oneself at risk. Finally, the report has demonstrated that the sexual health presentations by the Metro centre had a tangible impact on the knowledge and behaviour of young people in the region and helped to improve young peoples' sexual health awareness and enabled participants to engage in safer sexual behaviour.

On the whole, the report has suggested that participants were happier, healthier and better informed as a result of the original Metro presentation and the following subsequent telephone interview than they were before participating in the study. However the conclusions that the report has elicited are useful in planning future

sexual health work in the borough, which have been highlighted in recommendations throughout the report, to improve the well-being of young people in the borough. The current sexual health approach appears to be successful in terms of ensuring young people have good knowledge of sexual risk and engage in protected behaviour but there are specific changes that could be made to improve the sexual health of young people in the borough. Firstly, the report suggests that more attention must be paid to the effects of alcohol consumption on sexual behaviour and, also on the importance of sexual health testing even in relationships. Secondly, young people must be made more aware of contraception options and, specifically, the benefits of using methods of contraception other than condoms and the pill and where to obtain the morning after pill. Thirdly, the report highlights two important gender-related areas that require more attention, namely, male responsibility of pregnancy avoidance, knowledge of STI testing locations and on how gender influences having sex to improve one's self-esteem. Fourthly, the report suggests that safe sex work could be more beneficial if more attention was paid to increasing knowledge about condom sizes and lubricants, especially given the high proportion of participants using condoms as a form of contraception. An additional suggestion the report makes is that attention is paid to negotiating *safe* sex rather than simply negotiating sex in order to empower young people to make healthier sexual choices.

If a similar research study was completed in the future it would be useful to increase the number of participants included in the telephone interviews as this was significantly lower than those that took part in the first phase of the study (for reasons discussed in the methodology). Ways to do this could include giving business cards on first meetings, sending a reminder e-mail/giving a reminder telephone call between research stages and ensuring that participants were aware of the importance of taking part in the qualitative section of the study. That aside, the qualitative section of the study is a valuable and illuminating addition to the first section of the study. Through exploring the feelings, emotions and thoughts of young

people in Bromley the report has successfully furthered our understanding of sexual health behaviour in the region and has provided concrete recommendations which will help to ensure that young people within and outwith the borough are even happier, healthier and better informed in relation to their sexual health in the future.

Appendix

Below there is a template of typical questions asked during the telephone interview. When reading the questions it is important to remember that they were not treated as a list of prescriptive questions, but as prompts and subject areas to be discussed where they were appropriate to the interviewee's situation and in a manner that best fitted the natural flow of conversation.

Interview Template

Opening

Hello X, my name is Y and I'm calling you because you answered a Bromley Young Person's sexual health survey with one of my colleagues at Z last year. Do you remember that? OK, great, I'm calling to ask you some questions related to that to get an understanding of your sexual health situation now and in the time since then.

Are you happy to take part?

General Questions

So, what is you current situation in terms of sexual health?

What does safe sex mean to you?

What's been happening in terms of the sex you've had since then?

Do you feel comfortable saying no to sex?

General Knowledge

Do you think you can get a sexually transmitted infection from sitting on a toilet seat?

Can you tell if someone has an STI from their appearance?

Do you know what oil based lubricant is? Do you think it can damage latex condoms?

Safe sex

How safe would you say the sex is that you're having and why?

Have you had unprotected sex in the last year? How often does this happen?

What is the situation when you're having unprotected sex?

Do you feel that you're taking risks sexually?

Do you feel comfortable talking about safe sex? Why/why not?

Contraception

Do you ever use condoms when you're having sex? Do you know where to get free condoms from?

Are there any reasons why you don't use condoms (etc.)?

Do you use any other methods of contraception? Do you know where to get these from?

Do you/your partner ever have any side effects when using this? Is there anything you like/don't like about this?

Testing

Do you know where to get tested? Can you remember when you last tested?

How did you find it?

What are the reasons why you don't get tested?

Closing

Overall would you say you have concerns about your sexual behaviour? If so, why?

Is there anything else you would like to add about your sexual health?

Do you have any questions for me about your sexual behaviour

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