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A Survey of Teenagers' Views
of Sex and Relationships
Education and Sexual Health
Services in Kent

September 2007



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**Commissioned and Funded by:
Kent Teenage Pregnancy Partnership**

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Funding and acknowledgements

We would like to thank all the young people who took part in the research and all the head-teachers, teachers and school nurses who helped us to conduct the survey within the schools. Finally, we would like to thank the members of the project's steering group and the Kent Teenage Pregnancy Partnership for the funding.

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1 Introduction

Funded by the Kent Teenage Pregnancy Partnership, this survey was carried out as part of a broader programme of study into teenagers' views and experiences of sex and relationship education, sexual health services and family support services in Kent. The project was composed of three parts:

- Project One (the focus of this report) constituted the quantitative part of our research, which included two school-based surveys conducted between September 2004 and January 2006 with a total of 4000 15 to 16 year old school pupils;
- Project Two gauged the attitudes and experiences of looked-after children regarding sexual health education and relationships advice by conducting focus groups with 20 15 to 20 year olds (Billings, Hashem & Macvarish 2007);
- Project Three was a longitudinal qualitative study exploring the views of teenage parents during the antenatal (n = 38) and postnatal periods (n = 17). It was concerned with finding out their experiences of family support services, as well as obtaining their views on sex and relationships education and sexual health services (Billings & Macvarish 2007a&b).

This report provides the methodological outline and findings of Project One. The purpose of this project was to:

- describe how teenagers currently get information about sexual health and relationships and the value placed on these sources
- identify the nature, strengths and weaknesses of sexual health education received
- ascertain the up-take, strengths and weaknesses of any sexual health services used in the community
- describe the extent to which education and health services have prepared young people and whether they have influenced behaviour
- identify ways services can be improved

2 Method

2.1 Selection of Schools and Sample Size

Two 'waves' of survey data were collected from a variety of schools across Kent. The first 'wave' was collected in year one of the project between September 2004 and January 2005. A report on the year one data was then produced (Billings et al 2005). Following the same sampling technique, data was then collected in year 2. Different schools were targeted over the course of the two years data collection period. Year one and year two data were then merged into one large dataset that could be analysed.

The target sample, or number invited to take part, was 4,800 teenagers (2,400 in each year). Sampling for each year was organised by randomly selecting two to three schools from each of the eight Primary Care Trusts (PCTs) in Kent¹ and randomly selecting 300 teenagers in year 11 (aged 15-16) from each PCT area. Within the PCT areas the schools differed in the levels of deprivation in their intake population, in the mix of grammar, wide ability and high schools, single sex and mixed schools, and schools with a religious affiliation. Therefore schools were sampled in such a way to provide a broad overview of:

- socio-economic background determined by level of deprivation, using the Kent County Council Education and Social Deprivation Indices
- educational abilities, gender and religious belief related to type of school
- some comparison between Primary Care Trusts
- Kent-wide information

The measure of deprivation for the survey, the Kent County Council Education and Social Deprivation Indices² uses the Index of Multiple Deprivation (IMD) measure to identify the relative deprivation of each school's population. The IMD is available at electoral ward level. The postcode for each student at a particular school is mapped to the electoral ward they live in and thus mapped to a level of deprivation. The average level of deprivation for each school is then ranked, in order to produce a relative deprivation of all schools in Kent. Once ranked all Kent schools are divided into quartiles. Quartile 1 are the 25% most disadvantaged schools, quartile 2 are the next most disadvantaged, quartile 3 the next most, and quartile 4 are the least disadvantaged. These four deprivation levels were considered in the stratified sampling of the survey and in the analysis conducted. In analysis by

¹ From the 1st October 2006 the eight PCTs were reorganised into two PCTs: Eastern and Coastal Primary Care Trust and West Kent Primary Care Trust.

² Provided by the East Kent Coastal PCT, Health Promotion Service.

deprivation the split of schools remained as four categories related to the quartile that a school belonged to. The categories were: 1. 'most deprived', 2. 'deprived', 3. 'affluent', 4. 'most affluent'.

2.2 Access to Schools and Distribution

The Head Teacher was the first point of contact when trying to engage the schools in the research. This was in the form of a letter and followed up by a phone call a week later culminating in a face-to-face meeting if the schools were interested in taking part. The meeting enabled us to provide the school with further information on the project, identify a key staff member to support the project and for the school to advise on the best way to distribute the questionnaire in their school. In the majority of schools the questionnaire (which took approximately 30-45 minutes to complete) was filled in during a lesson. In most cases this was in a Personal, Social and Health Education (PSHE) lesson, as the questionnaire was about a relevant topic. In many cases all year 11 students from a school were invited to take part, or in larger schools classes were selected to cover a mixture of abilities. Some schools distributed the questionnaire themselves under the researchers' guidance; others preferred to have the project researchers in attendance while the questionnaires were being filled in.

All the students that were invited to take part received an information sheet seven to ten days before they were due to complete the questionnaire (Appendix A). At this time a letter was also supplied for parents and guardians informing them of the project, and enabling them to withdraw their teenager from the study if they wished (Appendix B). The students consented to take part in the project by completing the questionnaire.

2.3 Response

The total number of 15-16 year olds who took part in the survey across the two years was 4,053 from 37 schools across Kent. This includes:

- 19 High Schools
- 6 Wide Ability Schools
- 12 Grammar Schools
- 3 with a religious affiliation (2 Church of England, 1 Roman Catholic)
- 10 single sex schools (5 boys only, 5 girls only), 27 were mixed

The response rate overall was 84.4%. The response was also very similar for each of the two years data collection. The response rate in year one was 83.5% from 2,004 completed questionnaires, and the response rate in year two was 85.4% from 2,049 questionnaires. Table 1 below gives a breakdown of the overall response by Primary Care Trust. West Kent achieved a higher response (92.4%) compared to Eastern and Coastal (79.7%). The area of Ashford, within the Eastern and Coastal PCT, had the lowest response in relation to the target sample; this was because one school was unable to participate at late notice after agreeing to take part.

Table 1: Response by PCT

PCT (from 1st Oct 2006)	PCT (before 1st Oct 2006)	Returns	Target sample	Target response rate (%)
Eastern and Coastal Primary Care Trust	Ashford	430	600	71.7
	Canterbury & Coastal	439	600	73.2
	East Kent Coastal	553	600	92.2
	Shepway	460	600	76.7
	Swale	508	600	84.7
	Total	2390	3000	79.7
West Kent Primary Care Trust	Dartford, Gravesham & Swanley	547	600	91.2
	Maidstone and Weald	590	600	98.3
	South West Kent	526	600	87.7
	Total	1663	1800	92.4
Total		4053	4800	84.4

2.4 Key Access and Distribution Challenges

Timely access to the schools was hindered by a number of key challenges faced when negotiating with each school:

- ***Schools declining to take part*** meant that replacement schools needed to be invited to take part. Eighteen schools declined to take part over the two years of data collection (therefore a third of all schools contacted declined).

- **Communication with staff** sometimes proved difficult, as naturally they are teaching for the majority of the day. Therefore, even when preliminary agreement for the project was given it was hard to finalise arrangements, and staff that attended the initial meeting often required agreement from the Head teacher or other staff members. In one case this meant that one less school took part in the study than anticipated. An OFSTED inspection in one school also meant that the completion of the questionnaire was delayed.
- **Availability of students** affected the target response rate, particularly as some schools did not have 100 or 150 year 11 students. This has been compensated for by over sampling in schools with larger year groups, although in some cases numbers were reduced as students were on field trips or not informed of the project by staff.

Some of these issues were overcome with closer networking with key personnel in the second survey, including School Nurses, Connexions Workers, Local Education Officers and Sex and Relationships Education Local Implementation Groups. These professionals helped to anchor support for the project by negotiating access to schools.

2.5 Development of Instrument

The questionnaire was developed from a combination of widely used or validated tools from the following studies:

- Census 2001
- Health matters: Young people in West Sussex in the 1990s (Balding 1990)
- Kaiser Family Foundation: Survey on Teens and Sex: (PSRA 1996)
- ONS Health Education Monitoring Survey (ONS 1998)
- National Survey of Sexual Attitudes and Lifestyles 2000 (NATCEN 2000)
- ONS Omnibus Survey: Contraception and Sexual Health (ONS 2002)
- Survey by Centre for Sexual Health Research, University of Southampton (Clements et al 1999)
- Trent Young People's Lifestyle Survey 1994, University of Nottingham (Magowan and Roberts 1994)
- Teenage Sexual Health Project, conducted by Andrew Wilson in Leicester, 1995 (Wilson 1995)

A range of different question types were used including rating scales, closed and some open-ended questions to allow for expression. The use of rating scales was particularly important in order to measure movement in awareness, perceptions, attitudes and behaviour (Sonenstein 1997; Reininger et al 2002). The survey contained four main sections linked to the aims and objectives. Particular areas of questioning included:

- Where teenagers get their information from and what sources of information and support are most valued, such as formal over informal methods of information.
- Their views on the sex and relationships education they have received in school.
- Their opinions on sexual health services, how they are provided and how they should be provided.
- Questions testing their knowledge and understanding, such as whether teenagers have retained key messages in relation to issues such as the morning after pill and condom use, and their views on relationships.

Demographic details of the respondents were also recorded. In addition, some questions asked about sexual activity, as it is important to link these responses with knowledge, views and background to highlight specific areas where improvements are needed in service provision

Before access arrangements were negotiated with each school the survey was piloted with 24 members of the Kent County Council Youth Group, aged 13 to 19. Following this and feedback from the Steering Group alterations were made to the wording of some questions and the format of the questionnaire.

After year one of data collection, a number of amendments were made to improve the questionnaire to be used in year two (Appendix D and E). Preliminary analysis of the data was carried out to check for any differences between year one and year two. A report was produced which highlighted the questionnaire amendments and small differences between the two years data (Billings et al 2006).

2.6 Analysis

Following the preliminary analysis the two sets of data for year one and year two were merged into one much larger data set. Subsequent analysis (for this report) then concentrated on the results of all data, rather than comparing the two years data, which would not have detected any significant change. All the data was analysed using SPSS software, apart from the few open questions that required a written answer, which were stored and analysed in Excel. The data was analysed in relation to gender and level of deprivation (as described in 2.1).

Descriptive analysis was conducted and the results with the highest responses are reported. Adjusted standardised residuals were used to identify significant variations in the responses of boys and girls, levels of deprivation, and between any other groups used in the analysis. A residual of 3 or more was deemed worthy of comment in this report (Agresti and Finlay 1999). For the more qualitative open answers in excel, recurrent themes were picked out from the lists of comments recorded for each question. There were two open-answer questions in the survey, the first asked how they thought sexual health services could be improved for young people, the second was any general comments written at the end of the questionnaire.

2.7 Ethical Approval

Before any progress could be made on the research programme it had to receive research ethical approval, alongside sponsorship and indemnity from a Hospitals Trust. The research programme was granted ethical approval on the 16th of August 2004 from the East Kent Local Research Ethics Committee, and sponsorship and indemnity was granted by the East Kent Hospitals NHS Trust.

3 Findings

The findings are separated into the following sections that follow the sequence of the questionnaire

3.1 Demographic Data

- 3.1.1 Gender and ethnicity
- 3.1.2 Age
- 3.1.3 Religion
- 3.1.4 School area

3.2 Information, Education and Knowledge about Sex and Relationships

- 3.2.1 Sources of information: How do teenagers learn about sex and relationships?
- 3.2.2 Sources of information: Which do they most trust?
- 3.2.3 Sex and relationships education at school
- 3.2.4 Knowledge: Do they know the facts?

3.3 Teenagers' Views and Experiences of Sexual Health Services

- 3.3.1 Awareness and access to services
- 3.3.2 How satisfied are teenagers who use services?
- 3.3.3 Service preferences
- 3.3.4 How could sexual health services be improved for young people?

3.4 Sex and Relationships: Attitudes, Values and Behaviour

- 3.4.1 General attitudes and values
- 3.4.2 Attitudes towards safe sex
- 3.4.3 Sexually active teenagers

3.5 Teenagers' Comments

- 3.5.1 Sex and relationships education in school
- 3.5.2 Provision of services
- 3.5.3 Peer pressure
- 3.5.4 Why we have a problem

3.1 Demographic Data

3.1.1 Gender and ethnicity

The 4,053 survey respondents were quite evenly distributed between boys and girls. 1,959 (48%) were male and 2,093 (52%) were female. The vast majority of respondents were of white ethnic origin. Table 2 demonstrates that the sex and ethnic group breakdown of the teenagers is representative of the Kent population by comparing the survey data to the 2001 census data³.

3.1.2 Age

The majority of the respondents were aged 15 (84.6%; n=3429) and only 14.4% were 16 (n=583) at the time of the survey. All the survey collected data was from year 11 students, but the exact age of 41 students (1%) was unclear as they either did not answer the relevant question or they gave an answer saying their age was younger or older than 15-16 years old.

3.1.3 Religion

When asked 'What is your religion?' just over half of the respondents replied 'none' (56%; n= 2271). The majority of all respondents replied that religion was not important (72.6%; n=2942), and only 5.8% that it was very important. Of those stating a religion;

- 39% (n=1581) said they were Christian, of which 14% specifically said they were Catholic. Of other religions, only 1% (n=35) said they were Muslim, and less that they were Buddhist or Sikh.
- 2.4% (n=99) reported that they were 'other' religion.
- Only 10.6% (n=184) of those who identified with a religion said they thought it was very important to them, over half felt it was not important (57.5%; n=999).

3.1.4 School area

Due to the sampling techniques used there was an even spread of schools to represent the 'most deprived' 'deprived', 'affluent', and 'most affluent' areas in Kent. Table 3 outlines the characteristics of the 37 schools that took part in the survey. It describes the level of deprivation, PCT they are located in, the school type, number of schools that had these characteristics and the number of pupils per deprivation area.

³ 2001 Census data accessed via the NOMIS database online at: http://www.statistics.gov.uk/census2001/access_results.asp

Table 2: Sex and ethnic group – Kent population and survey comparison

		2001 Census (15-17 year olds)		Survey* (15-16 year olds)	
		N	%	N	%
Males	White	25013	94.3	1831	94.2
	Mixed	526	2.0	36	1.9
	Asian or Asian British	501	1.9	46	2.4
	Black or Black British	131	0.5	11	0.6
	Chinese or other ethnic group	368	1.4	20	1.0
All Males		26539	100	1944	100
Females	White	23787	95.0	1979	95.0
	Mixed	417	1.7	47	2.3
	Asian or Asian British	457	1.8	17	0.8
	Black or Black British	133	0.5	20	1.0
	Chinese or other ethnic group	243	1.0	21	1.0
All Females		25037	100	2084	100
All People	White	48800	94.6	3810	94.6
	Mixed	943	1.8	83	2.1
	Asian or Asian British	958	1.9	63	1.6
	Black or Black British	264	0.5	31	0.8
	Chinese or other ethnic group	611	1.2	41	1.0
TOTAL		51576	100	4028	100

[Numbers in the table are slightly lower than the total respondents because surveys with 'no answer' to the question about ethnic group were excluded from the analysis].

Table 3: Number of schools and pupils in the survey by deprivation level, PCT and School Type

PCT	School Type	Level of Deprivation				
		Most Deprived	Deprived	Affluent	Most Affluent	TOTAL
Eastern and Coastal (21 Schools)	High School	8	2			10
	Wide Ability	1	1	1		3
	Grammar –mixed sex			1	1	2
	Grammar – single sex			1	5	6
	PCT Total	9	3	3	6	21
West Kent (16 schools)	High School	3	3	3		9
	Wide Ability		2	1		3
	Grammar –mixed sex				1	1
	Grammar – single sex				3	3
	PCT Total	3	5	4	4	16
TOTAL Number of schools in each area		12	8	7	10	37
TOTAL Number of pupils in each area		1137 (28.1%)	976 (24.1%)	834 (20.6%)	1106 (27.3%)	4053 (100%)

3.2 Information, education and knowledge about sex and relationships

The survey included a number of questions to discover the range of sources of information teenagers had used to learn about sex and relationships. These sources included information available within school, from family and friends, the media, or from services like young person’s clinics or their GP. The survey also asked which of these sources they most trusted to give complete and reliable information on pregnancy and contraception, sexually transmitted infections and relationships. The following section explores the experiences and views of information sources and the knowledge the respondents demonstrated about sex and relationships.

3.2.1 Sources of information: How do teenagers learn about sex and relationships?

Teenagers learnt about pregnancy and contraception from a variety of information sources. Table 4 below highlights the proportion of young people who learnt a lot or some information from a particular source (if they were able to receive information from that source). The data is broken down by gender. Key points include the following:

- School was seen as an important source of education and information, with over half saying that they had learnt a lot/some from either teachers at school or from an outside visitor or speaker coming into the school;
- There were some significant differences within school between boys and girls, with girls more likely to have learnt a lot from outside visitors/speakers compared to boys, and boys more likely to say they had learnt nothing at all from outside visitors/speakers compared to girls.

Considering sources of information other than from school, the following was apparent:

- A high proportion of both boys and girls learnt a lot or some information from their mother and their friends;
- Use of the media for information on pregnancy and contraception was popular, particularly from watching TV or films, and reading magazines;
- Information from use of services was reported by the small minority of teenagers, especially boys. Family planning/young persons' clinics, and Doctor or Nurse in a GP surgery was the most popular option, particularly for girls;
- Very few reported using the 'foryoungpeople' website.

There was other variation between girls and boys in relation to the sources of information:

- Girls are more likely than boys to have learnt a lot/some information from their mother, sister, friends, magazines, books and pamphlets, family planning/young person's clinics, and a Doctor or Nurse in a GP surgery or hospital.
- Boys were more likely than girls to have said they learnt a lot/some information from their father, brother and websites.

Girls therefore appear to receive information from a broader range of sources than boys. A gendered distinction exists between who they talk to about pregnancy and contraception (girls talk to female family members and not their father; boys talk to male family members, as well as their mothers, but not their sisters) and there is also some distinction between the media sources used.

Table 4: Sources of information about pregnancy and contraception

Source	Boys	Girls	Total
School			
Teachers at school	1032 (55.8%)	1059 (52.4%)	2091 (54.0%)
Outside Visitors/ Speakers	843 (48.0%)	1094 (56.3%)	1937 (52.4%)
School nurse	391 (27.4%)	475 (29.7%)	866 (28.6%)
Family/Friends			
Mother	867 (47.4%)	1300 (64.1%)	2167 (56.2%)
Father	773 (43.9%)	440 (23.6%)	1213 (33.5%)
Sister(s)	230 (19.4%)	497 (38.7%)	727 (29.5%)
Brother(s)	281 (22.9%)	173 (13.4%)	454 (18.0%)
Other family	325 (20.4%)	379 (20.9%)	704 (20.6%)
(boy/girl)friend	579 (36.9%)	774 (46.1%)	1353 (41.6%)
Other friends	895 (49.9%)	1407 (69.4%)	2302 (60.1%)
Media			
TV shows or films	1012 (55.1%)	1058 (53.4%)	2070 (54.2%)
Magazines	690 (39.7%)	1294 (64.9%)	1984 (53.2%)
'For young people' website	38 (3.8%)	44 (4.4%)	82 (4.2%)
Other websites	372 (27.0%)	130 (10.3%)	502 (19.0%)
Books or pamphlets	324 (21.5%)	471 (27.1%)	795 (24.5%)
Services			
Telephone advice line	53 (4.9%)	54 (5.3%)	107 (5.1%)
FP/Young person's clinic	79 (7.2%)	339 (28.7%)	418 (18.4%)
Doctor/nurse at GP surgery/hospital	146 (11.6%)	269 (20.4%)	415 (16.1%)
Youth worker	95 (8.3%)	103 (9.8%)	198 (9.1%)
Chemist or Pharmacy	56 (4.7%)	106 (8.8%)	162 (6.7%)

There were differences in relation to **area of deprivation**:

- teenagers in schools serving deprived areas were more likely to say that they had learnt a lot/some information from teachers at school (61.9% [n=674]) compared to teenagers in schools serving affluent areas. (44% [n=474]);

- A similar trend appears in relation to receiving information on pregnancy and contraception from family members (mothers, fathers, sisters and bothers). 62.3% (n=675) of teenagers' in schools in the most deprived areas learnt a lot/some information from their mothers, compared to 46.6% (n=500) in the most affluent areas;
- Similarly 38.4% (n=382) in the most deprived and 22% (n=230) in the most affluent areas learnt a lot/some information from their father;
- Similar results emerged by level of deprivation for friends and (boy/girl) friends as sources of information. Teenagers talked to their friends and (girl/boy) friends about pregnancy and contraception just as little or as much whether they were from a school serving deprived areas or affluent areas;
- There was also no difference by deprivation related to sources of information in the media;
- Teenagers in the most deprived areas were slightly more likely to have information from a family planning/young person's clinic (n=153; 21.1%) Doctor/nurse in GP surgery (n=156; 20.1%) than those in affluent areas (n=74; 12.3% and n=58; 8.3% respectively). Later in the report, we will discuss possible explanations for this distinction.

3.2.2 Sources of information: Which do they most trust?

The sources of information the young people most valued and trusted were identified through four key aspects of sex and relationships education:

- complete and reliable information about pregnancy and contraception;
- HIV and AIDS;
- other sexually transmitted infections;
- relationships.

The results for this data will be presented by highlighting the top three responses for boys and girls for each of these aspects. The number of responses and percentage are also presented, as they are useful for comparison between boys and girls and across the three most trusted sources of information. It is recommended that these figures should be used in relation with each other only and not be considered in isolation as 'true' figures of trust, due to the changes in the question design (from more than one answer allowed in year one, to one answer only in year two [Appendix E]).

There are some interesting distinctions between the type of information and the sources that were trusted the most:

- For both boys and girls, family members, particularly the mother, were the most trusted source of information on pregnancy, contraception and relationships.

- Friends, other male family members for boys (father) and other female family members for girls (sister) were most trusted, particularly for relationships advice.
- Sexual health service providers were the most trusted for accurate information on HIV, AIDS and other sexually transmitted infections, particularly from a Doctor/nurse in a GP surgery or hospital setting.

Table 5: Most trusted sources of information

	Boys	n (%)	Girls	n (%)
Pregnancy and Contraception	1. Mother 2. Doctor or Nurse in GP surgery or hospital 3. Father	416 (21.2%) 328 (16.7%) 204 (10.4%)	1. Mother 2. Family planning/young person's clinic 3. Doctor or Nurse in GP surgery or hospital	640 (30.6%) 467 (22.3%) 371 (17.7%)
HIV and AIDs	1. Doctor or Nurse in GP surgery or hospital 2. Mother 3. Teacher at school	728 (37.2%) 198 (10.1%) 168 (8.6%)	1. Doctor or Nurse in GP surgery or hospital 2. Mother 3. Family planning/young person's clinic	868 (41.5%) 257 (12.3%) 218 (10.4%)
Other Sexually Transmitted Diseases	1. Doctor or Nurse in GP surgery or hospital 2. Mother 3. School Nurse	676 (34.5%) 179 (9.1%) 169 (8.6%)	1. Doctor or Nurse in GP surgery or hospital 2. Family planning/young person's clinic 3. Mother	737 (35.2%) 304 (14.5%) 239 (11.4%)
Relationships	1. Mother 2. Friends 3. Father	458 (23.4%) 409 (20.9%) 307 (15.7%)	1. Mother 2. Friends 3. Sister	837 (40.0%) 759 (36.3%) 189 (9.0%)

Given the higher proportions of girls reported in the top three most trusted sources in Table 5, girls appear to be more in agreement and certain on who they most trust compared to boys on these key topic.

- Girls rated family planning/young people's clinics in higher regard as a trusted source of information, compared to boys (similar to sources most learnt from in table 4).
- Boys regarded providers within school (teachers and the school nurse) as more trusted sources of information on sexually transmitted infections, although not as much as Doctors or nurses in a GP surgery/hospital setting, or their mother.

3.2.3 Sex and relationships education at school

This section presents further information on the teenagers' views and experiences of sex and relationships education received at school and explores the type of information learnt within school; how it was taught, its timeliness and what they felt they need to know more about as they approach the end of their school years.

For those teenagers who have received sex education within school, Figure 1 highlights how much they have learnt in relation to specific topic areas. In order to compare, figure 1 includes information previously shown on how much teenagers have learnt about pregnancy and contraception (see section 3.2.1). In addition figure 1 includes the information on how much they have learnt from teachers and lessons at school on HIV and AIDS, other sexually transmitted infections, and relationships. Key findings are as follows:

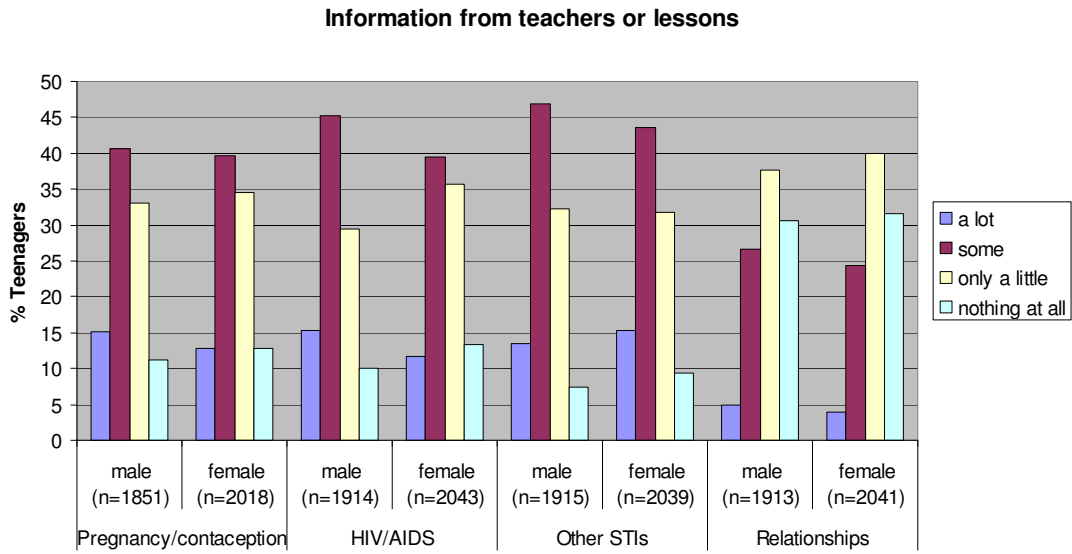
- Similar results were reported for boys and girls, with the majority saying they had learnt some or a little from teachers/lessons in school. Only a few teenagers said they had learnt a lot or had learnt nothing at all;
- With relationships however, a much higher proportion of boys (n=585; 30.6%) and girls (n=645; 31.6%) felt they had learnt nothing at all from teachers and lessons within school.

This indicates that the teaching and discussion of this aspect of sex and relationships education varies greatly between schools, and may need to be given further attention. Relationships were ranked highly as part of what teenagers said they would like to know more about.

The questionnaire asked in more detail about the topics teenagers had been taught in school and whether they were taught at the right time for them. There was little difference between the responses in relation to boys and girls.

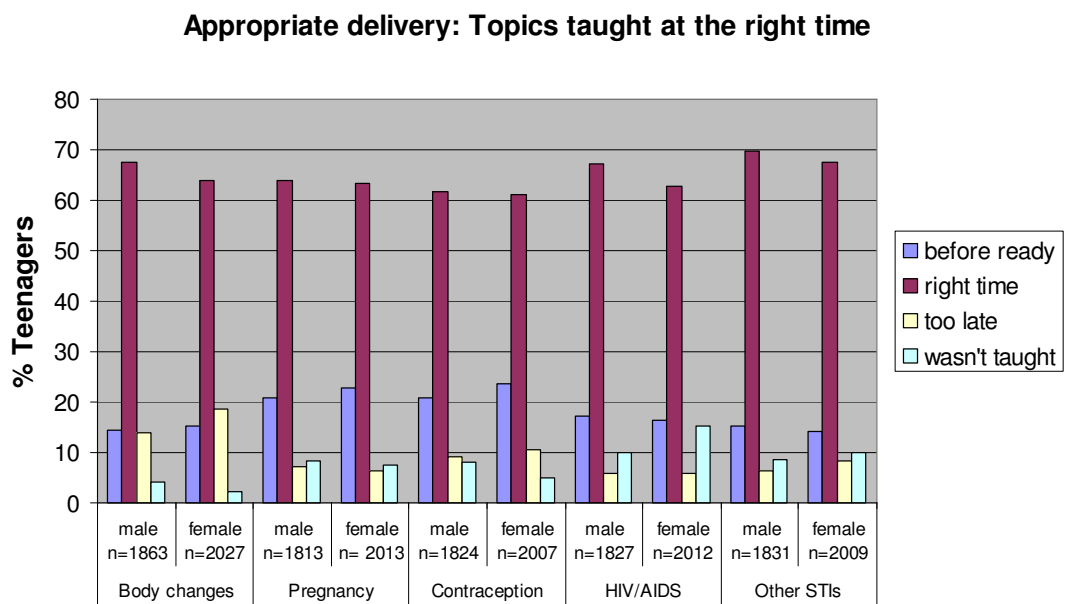
- Overall most teenagers felt that they had been taught the majority of the topics at the right time, particularly about growing up and changes in their body, contraception, pregnancy and sexually transmitted infections (figure 2).
- Just under a quarter of teenagers felt that at least one topic was taught before they were ready.
- Abortion and being a parent/child care were two main topics teenagers felt were taught before they were ready. 23.6% of boys (n=430) and girls 23.6% (n=473) felt they were taught about being a parent/child care before they were ready, and 23.1% (n=465) of girls and 19.6% (n=357) of boys felt they were taught about abortion too early.

Figure 1: Information from teachers or lessons at school by sex



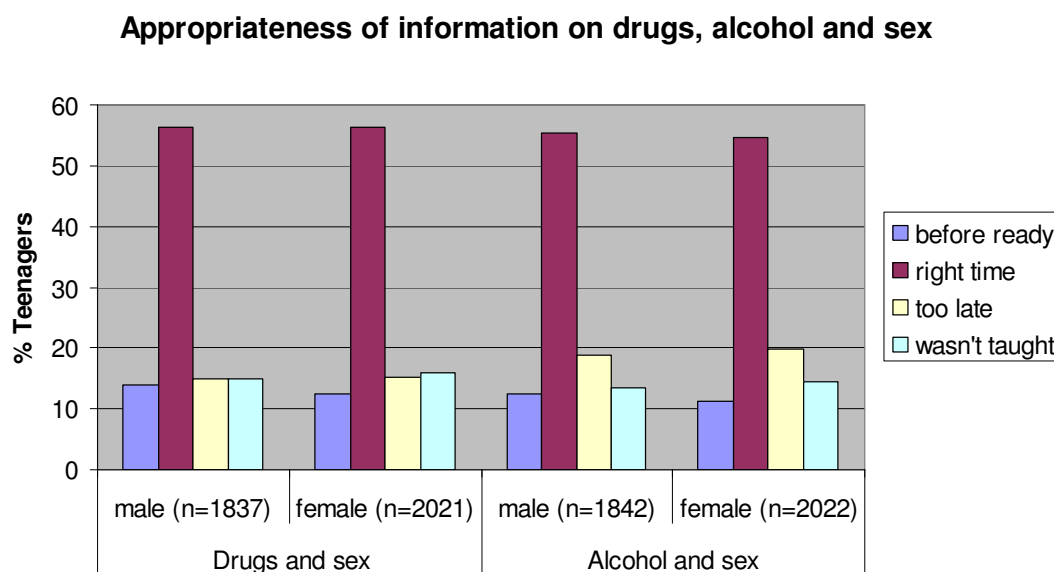
Although the majority of respondents claimed that the topics of contraception and pregnancy were taught at the right time, a significant minority said that they were taught too early (see figure 2). This is probably because as 'core' topics in the teaching of sex and relationships education, teenagers were less likely to say they had not been taught them.

Figure 2: Topics most reported to have been taught at the right time



The topics relating to issues around drinking alcohol and using drugs in relation to sex were more likely to be reported as either being taught too late or were not taught at all compared to other topics (figure 3). However, just over half of the respondents felt these topics were reported at the right time.

Figure 3: Appropriateness of information on drugs, alcohol and sex



Other relatively neglected topics were responsibility in relationships, information on sexual feelings and emotions, and information on being a parent/ child care (figure 4). More girls than boys reported that they had not been taught these topics in school. However around half of the teenagers recorded these topics as being taught to them and at the right time. Under half of the respondents reported receiving information at the right time concerning being a parent and child care (42.3% (n=769) of boys and 42.7% of girls (n=857)).

There were some differences regarding the timing of when specific topics were taught (if taught at all) and the **level of deprivation** of the school. As we have already shown, the majority of teenagers felt they were taught at the right time, but teenagers from schools in the more deprived areas were more likely to say they were taught certain topics before they were ready (figure 5) and those from schools in the more affluent areas were more likely to say they were not taught some topics at all (figure 6).

Figure 4: Appropriateness of information on relationships, emotional growth and parenting

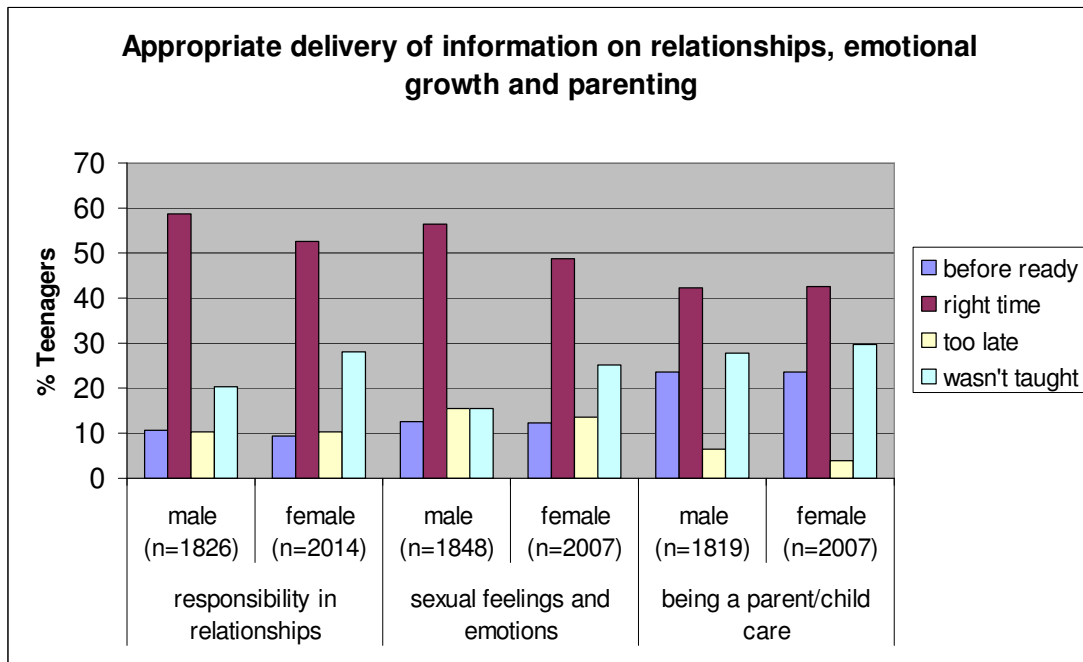


Figure 5: Response - Topic taught at school before ready, by level of deprivation

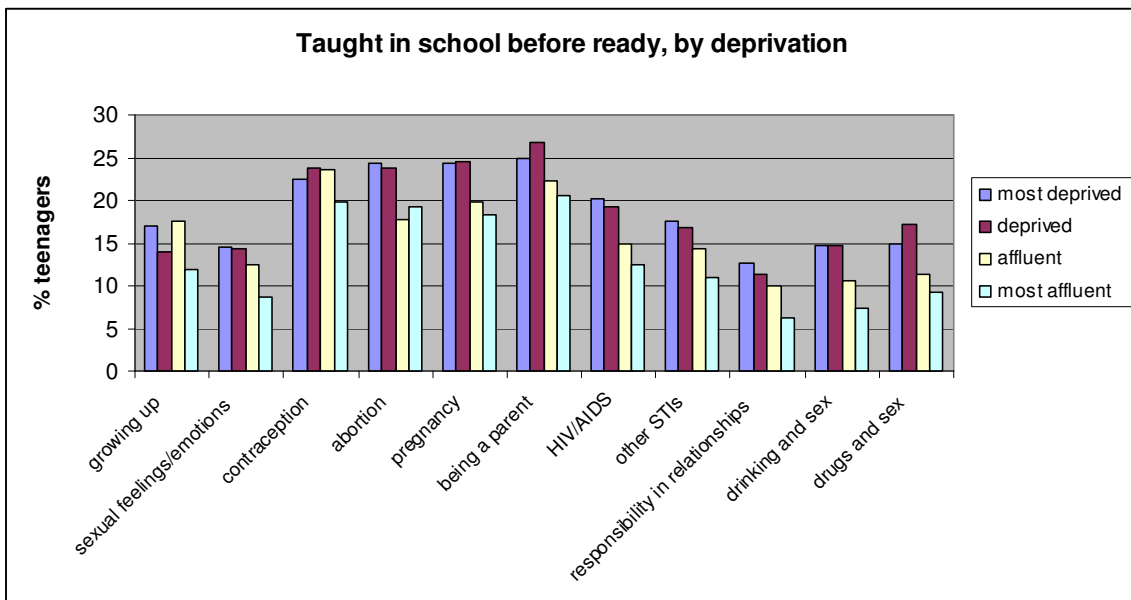
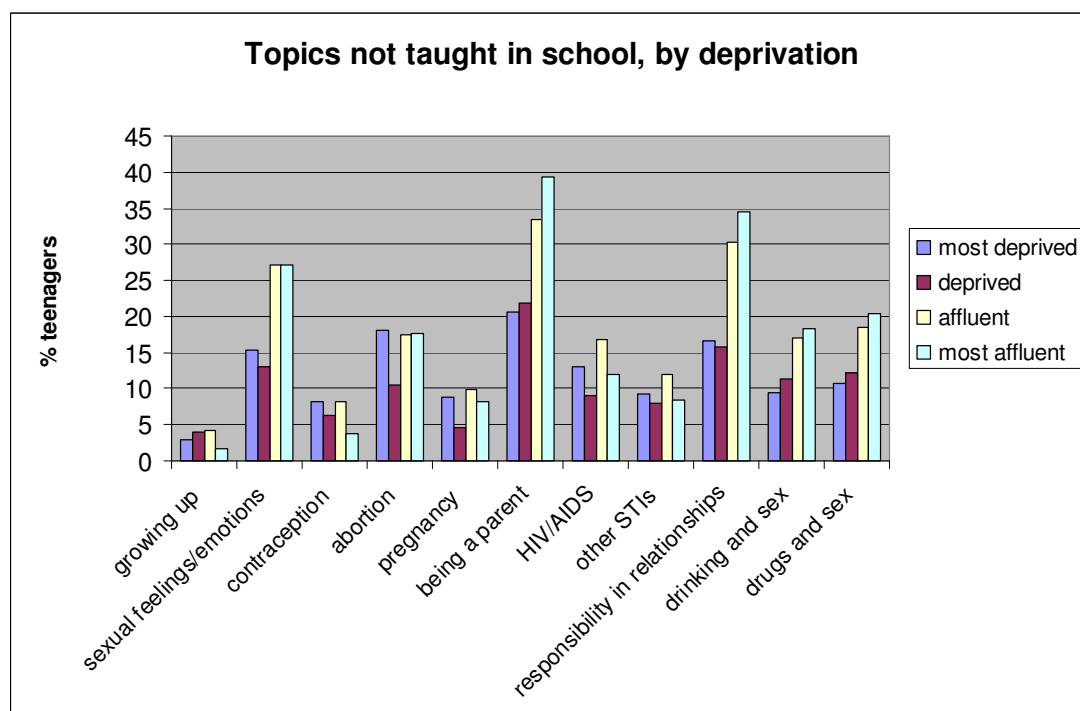


Figure 6: Response - didn't think the topic was taught to them at school, by level of deprivation



The survey included questions about how sex and relationships education was taught and the teenagers' views and experiences.

- A higher proportion of boys (n=765; 41.8%) compared to girls (n=642; 32.4%) felt that sex education taught in school was aimed equally at boys and girls,
- However more girls (n=813; 41.0%) than boys (n=405; 22.1%) felt that sex education was more aimed at girls than boys.
- A quarter of teenagers' responses indicated that they did not know whether sex education was the same for boys and girls, perhaps because they had only been to a single-sex grammar school.

Further questions in the survey included statements on how confident and comfortable the teenagers and the teachers were in the lessons, and how much involvement the teenagers had in discussions and planning of lessons. The teenagers had to say whether they agreed or disagreed with each of the statements. Table 6 presents the proportions of boys and girls who agreed to each of the statements.

- Over half of the teenagers said that they took their sex education lessons seriously in school (slightly more girls than boys).
- 19.1% (n= 355) of boys and 13.1% (n=262) of girls said they did not take the lessons seriously.

- The majority of boys and girls (just under 70%) said they thought the teacher appeared confident talking about the topics, but less (around 50%) felt the teachers/speakers made them feel comfortable talking about sex and relationships issues.
- There were similar results for boys and girls, apart from outside speakers where slightly more girls said they were made to feel comfortable in lessons compared to boys.
- Only a minority, 18.7% of boys and 11.7% of girls, agreed that they had a part in deciding what things were taught in their sex education lessons.

Table 6: Teenagers who agree to statements on sex and relationships education, by sex

Statement	Boys	Girls	Total
I felt I could ask any question I wanted to	700 (37.5%)	542 (27.0%)	1242 (32.1%)
Overall, the teacher(s) made me feel comfortable when talking about sex and relationships	886 (47.6%)	902 (45.0%)	1788 (46.2%)
Overall, the outside speaker(s) made me feel comfortable when talking about sex and related issues	856 (46.6%)	1122 (56.5%)	1978 (51.8%)
I had a part in deciding what things were taught	347 (18.7%)	233 (11.7%)	580 (15.1%)
I took my sex education classes seriously	1013 (54.6%)	1222 (61.3%)	2235 (58.1%)
The teacher appeared confident talking about the topics	1250 (67.3%)	1394 (69.6%)	2644 (68.5%)
The topics were discussed in small groups	525 (28.2%)	417 (20.9%)	942 (24.4%)
The topics were discussed among the whole class	1385 (74.5%)	1592 (79.6%)	2977 (77.1%)

The majority of teenagers (77.1%) said that the topics were discussed among the whole class, and only a quarter (24.4%) said that the topics were discussed in small groups. Slightly more boys than girls agreed that the topics were taught the latter way. Given that the majority of discussion on sex and relationships was among the whole class it perhaps not surprising that only 37.5% of boys and 27.0% of girls felt they could ask any question they wanted to (boys being slightly more confident to do so than girls).

The survey gave the teenagers the opportunity to express which topics they would now like to know more about. Table 7 highlights the top three topics for boys and girls, and there were some interesting differences:

- Girls were more interested in the emotional side of relationships and the worry of sexually transmitted infections and safe sex;
- Boys on the other hand were more interested in the physical side of sex and relationships.

This is not to say however that girls were not interested in these aspects, and boys were not interested in more information on the emotional side and sexually transmitted infections, as all of these aspects appear in the top five responses for both boys and girls. In general, it appears that girls were more interested in knowing as much as they could about a broader range of topics than boys.

Another topic that was important to our respondents was knowing more about being a parent (for a higher proportion of girls than boys). The importance of wanting to know more about this reflects what was reported earlier in this section where teenagers said that they had been taught less about this than about other topics.

The topics that the teenagers felt they needed to know the least about were how a baby is born and how girls' and boys' bodies develop. These aspects were probably more important to them in their earlier teenage years and they felt they already knew what was necessary.

3.2.4 Knowledge: Do they know the facts?

So far this report has highlighted teenagers' own perceptions of what they have learnt or have not learnt about sex and relationships from the school and other information sources. The aim of this section is to highlight the actual knowledge of the teenagers in relation to safe sex, contraception methods, and sexually transmitted infections.

A set of quiz style questions were designed and included in the survey to capture knowledge on these areas. The quiz included five questions.

- The first question asked whether a condom prevents pregnancy, sexually transmitted infection, both of these things, or neither of them.
- The second question was a similarly phrased question for the contraceptive pill.

- The third asked within how many hours the emergency contraceptive pill (morning after pill) must be used after unprotected intercourse. They were given the options of 12 hours, 24 hours, 48 hours, 72 hours or 120 hours.
- The fourth and fifth questions assessed knowledge of sexually transmitted infections by instructing the teenagers to identify the names of sexually transmitted infections (of which there were two) in a list of medical conditions, and then indicate how they thought such infections were contracted (two correct answers).

If the respondent answered all the questions correctly they would receive a maximum score of seven. The main findings were as follows:

- A high percentage of teenagers were knowledgeable about safe sex, contraception methods and sexually transmitted infections, and girls were more knowledgeable than boys.
- 82.7% (n=1674) of girls answered correctly that using a condom prevents both pregnancy and infections, compared to 73.9% (n=1368) of boys.
- More boys (n=205; 11.1%) believed that condoms prevented just pregnancy compared to girls (n=59; 2.9%).
- 93.7% of girls (n=1898) and 87.2% of boys (n=1594) answered correctly that the contraceptive pill prevents only pregnancy. The teenagers scored particularly high in these two questions.
- Their knowledge was less precise when it came to use of the morning after pill. Only 47.2% of girls and 21.7% of boys gave the correct answer of 72 hours. Nearly the same percentage of girls and the majority of boys believed that the number of hours the morning after pill could be used was less than 72 hours (figure 7).

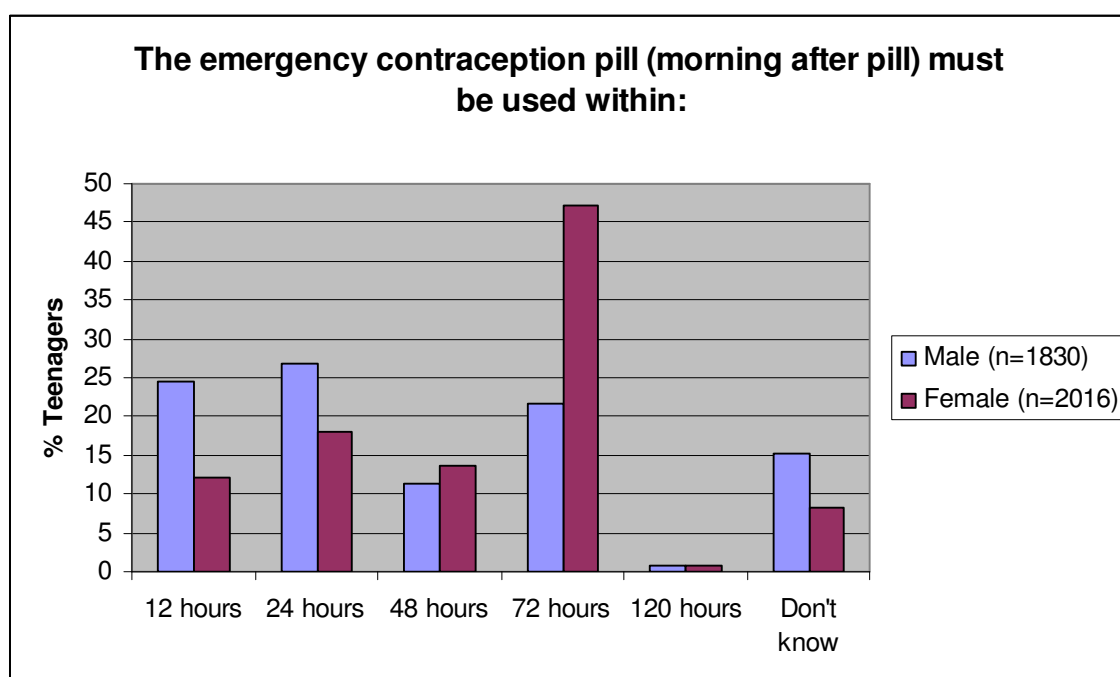
A similar pattern emerges with the questions on knowledge of names of and the contracting of sexually transmitted infections, with the majority demonstrating that they are knowledgeable, but girls more so than boys.

- 88.7% of girls (n=1857) and 64.8% of boys (n=1270) correctly identified Chlamydia as a sexually transmitted infection, and 73.2% of girls (n=1533) and 54.4% of boys (n=1065) correctly identified Gonorrhoea as a sexually transmitted infection.
- For contracting sexually transmitted infections the vast majority of girls (n=1986; 94.9%) and boys (n=1738; 88.7%) knew that people could catch sexually transmitted infections from vaginal sex.
- They were less aware that people could catch sexually transmitted infections from oral sex, with 61.7% of girls (n=1291) and 48.2% of boys (n=944) correctly identifying this.

Table 7: Topics teenagers would like to know more about

	Top 5 responses	n (%)
Boys	1. How to make sex more satisfying	986 (50.3%)
	2. Sexual intercourse	597 (30.5%)
	3. Being a parent	595 (30.4%)
	4. Sexually transmitted infections	582 (29.7%)
	5. Sexual feelings, emotions and relationships	575 (29.4%)
Girls	1. Sexual feelings, emotions and relationships	575 (42.7%)
	2. Being a parent	878 (41.9%)
	3. Sexually transmitted infections	790 (37.7%)
	4. How to make sex more satisfying	749 (35.8%)
	5. Contraception	627 (30.0%)

Figure 7: Knowledge on the emergency contraceptive pill, by sex.



The majority of teenagers, 66.5% of boys (n=1245) and 64.5% of girls (n=1319), got a score between 4-6 (meaning they gave between 4-6 correct answers out of seven). However a

higher percentage of girls (n=537; 26.3%) got all seven answers correct compared to boys (n=143; 7.6%) which indicates that girls have a better knowledge of safe sex, contraception and sexual transmitted infections than boys. A higher percentage of boys (n=484; 25.9%) got less than 4 answers correct compared to girls (n=188; 9.2%).

Table 8 takes the analysis a step further by outlining descriptive statistics of the teenagers average scores in the knowledge quiz by sex, level of deprivation and whether they have had sexual intercourse or not (this latter issue is explored in more detail later).

Table 8: Average scores on knowledge quiz, by sex, deprivation and whether sexually active

	N	Mean	Median	Minimum	Maximum	Standard Deviation
Boys	1872	4.47	5.00	0	7	1.588
Girls	2044	5.47	6.00	0	7	1.392
Most deprived	1078	4.72	5.00	0	7	1.615
Deprived	958	4.66	5.00	0	7	1.641
Affluent	782	5.05	5.00	0	7	1.637
Most Affluent	1099	5.53	6.00	0	7	1.234
Sexually active	1474	5.26	6.00	0	7	1.523
Not sexually active	2223	4.91	5.00	0	7	1.530

With regard to **levels of deprivation**, table 8 indicates a trend between knowledge on these areas and level of deprivation of the school. It shows that the more deprived the area of the school the less knowledgeable the teenagers and the more affluent the area the more knowledgeable the teenagers were in these schools. This is an interesting finding given that teenagers from schools serving the most affluent areas felt that they had learnt information about pregnancy and contraception from a narrower range of sources of information than teenagers in the more deprived areas.

Perhaps unsurprisingly teenagers who indicated they had experienced sexual intercourse were more knowledgeable than those who had not. As the range of scores was between 0 and 7 for each of these groups, this means that a small number of teenagers in all these groups gave all the correct answers, and a small number did not give any correct answers at all to the quiz.

The knowledge of the teenagers was also tested by a series of statements related to pregnancy and legal issues around sex and relationships, and they had to answer whether they were true or false⁴. Table 9 lists the statements and gives the percentage of boys and girls who answered the statements correctly. The majority of teenagers were aware of issues around pregnancy, and the legal issues around under-age sex, however girls were more knowledgeable than boys.

Table 9: Statements answered correctly, by sex

	Boys	Girls
It's against the law to have sex with a boy or girl who is under 16	1409 (71.9%)	1789 (85.5%)
If a girl is under 16 and is on the pill, her doctor must tell her parent	1396 (71.3%)	1699 (81.2%)
Even if contraception is used correctly, there is still a chance that a girl can become pregnant	1485 (75.8%)	1761 (84.1%)
You can't buy condoms if you're under 16	1617 (82.5%)	1795 (85.8%)
You can get pregnant having sex for the first time	1411 (72.0%)	1718 (82.1%)

For differing **levels of deprivation** a similar trend emerges with knowledge of pregnancy and legal issues, as it did for the knowledge quiz, with teenagers in schools serving the most affluent areas being more knowledgeable than those in the more deprived (table 10). These results are further broken down by whether they had had sexual intercourse or not. Interestingly, for all of these statements (apart from 'if a girl is under 16 and is on the pill, her doctor must tell her parent') the teenagers who had not had sex were more knowledgeable about these issues than those that said they had. However, the teenagers in schools serving the most affluent areas who had had sex were more knowledgeable than the most deprived who were not sexually active.

Summary

This section has identified the range of information sources teenagers use to learn about sex and relationships, how much they have used them and how much they trust them.

⁴ The questionnaire in year one asked if they agreed or disagreed with the statements.

It has demonstrated that teenagers use and trust a range of sources within the school, family and friends, the media and community services to increase their knowledge about issues of pregnancy and contraception. There is some distinction between boys and girls, for example the teenagers appear to have learnt from and trust family members of the same sex as them for advice, but the mother was very important to both boys and girls. In addition, girls appear to have received information from a broader range of sources than boys. There were also differences in relation to deprivation, more teenagers in schools serving more deprived areas said they learnt from their school and from their families about pregnancy and contraception, compared to teenagers from schools serving more affluent areas.

Table 10: Statements answered correctly, by level of deprivation, whether sexually active

Sexually Active	Level of Deprivation	It's against the law to have sex with a boy or girl who is under 16	If a girl is under 16 and is on the pill, her doctor must tell her parent	Even if contraception is used correctly, there is still a chance that a girl can become pregnant	You can't buy condoms if you're under 16	You can get pregnant having sex for the first time
yes	most deprived	353 (72.9%)	373 (77.1%)	367 (75.8%)	370 (76.4%)	369 (76.2%)
	deprived	322 (75.1%)	338 (78.8%)	338 (78.8%)	354 (82.5%)	323 (75.3%)
	affluent	217 (77.8%)	227(81.4%)	238 (85.3%)	225 (80.6%)	222 (79.6%)
	Most affluent	240 (82.5%)	228 (78.4%)	262 (90.0%)	269 (92.4%)	240 (82.5%)
Total		1132 (76.3%)	1166 (78.6%)	1205 (81.3%)	1218 (82.1%)	1154 (77.8%)
no	most deprived	436 (80.9%)	375 (69.6%)	425 (78.5%)	419 (77.7%)	423 (78.5%)
	deprived	409 (85.4%)	355 (74.1%)	378 (78.9%)	388 (81.0%)	363 (75.8%)
	affluent	385 (84.2%)	342 (74.8%)	388 (84.9%)	396 (86.7%)	378 (82.7%)
	Most affluent	677 (89.6%)	574 (75.9%)	695 (91.9%)	685 (90.6%)	646 (85.4%)
Total		1907 (85.5%)	1646 (73.8%)	1886 (84.5%)	1888 (84.6%)	1810 (81.1%)

The results confirm that the school is an important provider (along with other sources) for information on sex and relationships, however, pupils do not appear to be learning much from teachers. For the majority of teenagers it appears that sex and relationships education is being taught at the right time for a variety of topics and that their teachers were confident

about teaching it. However, only about half of the sample felt comfortable in the lessons and there was limited scope for discussion, perhaps due to the large classes. Also, information provided on some topic areas is not taught as much as the teenagers would like. For example the amount of information learnt within school on the topics of relationships and parenting and child care appears to be quite low and teenagers indicated that they needed to know more about them.

The rest of the section focused on the actual knowledge of the teenagers. The results indicate that the majority of teenagers are knowledgeable about issues of safe sex, contraception, sexually transmitted diseases, and under-age sex. However, overall girls were more knowledgeable than boys. When asked about the risks of becoming pregnant (such as whether you can get pregnant the first time you have sex) and the legal issues around under-age sex, teenagers who have actually had sex are not so knowledgeable, which reflects on the degree of preparedness of teenagers engaging in sex.

Level of deprivation appears to be a key factor in relation to knowledge as measured by the quiz, with teenagers in schools in the more affluent areas being more knowledgeable than those in more deprived areas. This is an interesting finding, given that teenagers in the more affluent areas draw their knowledge from a narrower range of sources and appear to learn less from teachers than teenagers from the more deprived areas. This may also be connected to the fact that teenagers from the more affluent areas are being taught less about sex and relationships, which may inform the emphasis placed on this aspect of the curriculum.

It does remain a concern however that teenagers from the more deprived areas feel they learnt more from a wider range of information sources, such as their school and families, but appear to know less of the facts than their counterparts in schools in more affluent areas. In addition, there appears to be a trend in that these teenagers were more likely to feel that they were being taught sex and relationships issues before they were ready.

3.3 Teenagers' Views and Experiences of Sexual Health Services

The aim of this section is to explore how aware all teenagers are of the services available to them, how to access them and to describe the characteristics of teenagers who have used sexual health services. It also outlines teenagers' preferences for how services should be run for young people, including opening times, who they would prefer to see, and what services they should offer. Further survey questions asked those teenagers who have used

services, such as family planning/ young person's clinics, whether they were satisfied with the services they have used.

3.3.1 Awareness and access to services

Sexual health services like family planning/young person's clinics, GP clinics, and pharmacists, are important for young people as a source of information and access to contraception in order for them to practice safe sex. However obtaining contraception appears to not be an easy prospect for some young people and many feel it would be an embarrassing experience.

- Less than half of the teenagers; 49.3% of boys (n=905) and 46.5% of girls (n=946) felt that contraceptives were easy for young people to get.
- A similar number also felt that they would be embarrassed to buy condoms in a shop, for girls (n=932; 45.7%) more so than boys (n=770; 41.6%).

Therefore appropriate services are important for young people to reduce the embarrassing process of getting contraception and provide them with important information.

The survey included questions on services the teenagers had used for contraception, GP, family planning/ young person's clinic, or chemist/pharmacy. In year two of the survey teenagers were asked additionally whether they had used a shop or a vending machine.

- Boys tended to use alternative ways of getting contraception. 36.6% of boys (n=369) said they had used a vending machine compared to 13.4% of girls (n=139) and 17.9% of boys (n=180) had used a shop compared to 16.7% of girls (n=174).
- Girls were more likely to say that they had used services like family planning/young peoples clinics, their GP or a chemist or pharmacist. However in year two girls (n=569; 54.7%) were more likely to say that they hadn't got contraception at all or by any of these means, compared to boys (n=449; 44.6%), which equates to half of the teenagers surveyed in year two.

The questions asking about services the teenagers had used were phrased differently in year one and year two (changing in year two to make it easier for the teenagers to answer, and to capture more information about alternative ways of getting contraception). However data for all teenagers surveyed has been merged to capture the information on who has used a GP, family planning/ young person's clinic, or chemist/pharmacy for contraceptive services (table 11).

- 27.9% (n=1130) of teenagers had used one or more of these services (22.8% of boys and 32.6% of girls). Girls had used them more than boys, as was indicated earlier (particularly family planning/young person's clinics and chemist/pharmacies).

Unsurprisingly both boys and girls who have had sex have used services more than those who haven't had sex.

It is interesting to note that the majority of boys and girls who said they have had sex had not used an individual service like their GP or young person's clinic. However the majority of girls (70.6%) who reported being sexually active had used one of these services, therefore indicating that sexually active teenagers vary in where they feel most comfortable about getting contraception and related advice.

Table 11: Use of services for contraception, by sex and whether had sexual intercourse.

Sex	Sexually active	GP	Family planning/ person's clinic	Chemist or pharmacy	Used any service
Boys	yes	104 (15.0%)	174 (25.0%)	162 (23.3%)	294 (42.3%)
	no	28 (2.7%)	59 (5.6%)	56 (5.4%)	119 (11.4%)
Total		142 (7.2%)	250 (12.8%)	223 (11.9%)	447 (22.8%)
Girls	yes	202 (25.6%)	294 (37.3%)	354 (44.9%)	556 (70.6%)
	no	33 (2.8%)	46 (3.9%)	47 (4.0%)	107 (9.0%)
Total		242 (11.6)	355 (17.0%)	408 (19.5%)	683 (32.6%)

In relation to **level of deprivation**, teenagers in schools serving the more deprived areas are more likely to have used one of the services compared to teenagers in the more affluent areas. The 'deprived' group had used services the most (n= 324; 33.2%) and the 'most affluent' group the least (n=248; 22.4%).

There are however potential barriers to access of sexual health service for users and non-users of services alike. Teenagers, in year one of the survey only, were asked what could potentially stop them from going to services like their GP, family planning/ young person's clinic or chemist to use contraceptive services.

- Worries about confidentiality were most likely to pose an obstacle of access to services for the vast majority of boys (n=698; 73.3%) and girls (n=866; 82.6%).
- Other potential barriers particularly identified were
 - lack of information (boys: n=690; 72.5%, girls: n=760; 72.2%),
 - worries of being medically examined (boys: n=643; 67.5%, girls: n=805; 76.5%)
 - embarrassment (boys: n=657; 69.0%, girls: n=805; 76.5%)

- transport problems (boys: n=618; 64.9%, girls: n=706, 67.1%),
- worries of being seen entering (boys: n=586; 61.6%, girls: n= 697; 66.3%)
- inconvenient opening times (boys: n=555; 58.3%, girls n=654; 62.2%)

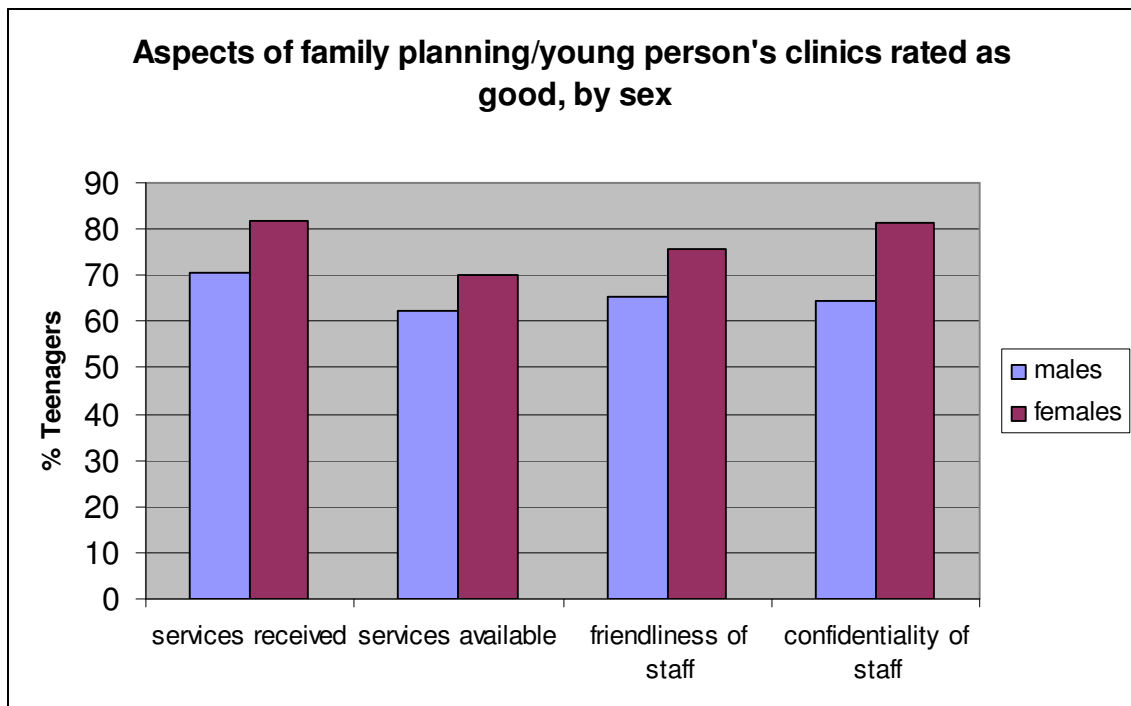
The least likely obstacles were for religious and cultural grounds.

3.3.2 How satisfied are the teenagers who use services?

Teenagers who had used family planning or young person’s clinics were asked what they thought about the service they received, the services available, the environment of the clinics in relation to the waiting areas and the friendliness of the staff, and also their thoughts on the clinics location, opening hours and waiting times.

The majority of users found some aspects of the clinic they went to good, particularly in relation to the staff and services on offer (figure 8). The services they received (n=300; 77.9%), the services available (n=260; 67.5%), the friendliness of staff (n=275; 72.2%) and the confidentiality of staff (n= 289; 75.7%) were all rated as good by the majority of users (more so by girls than by boys). Few found these services to be poor.

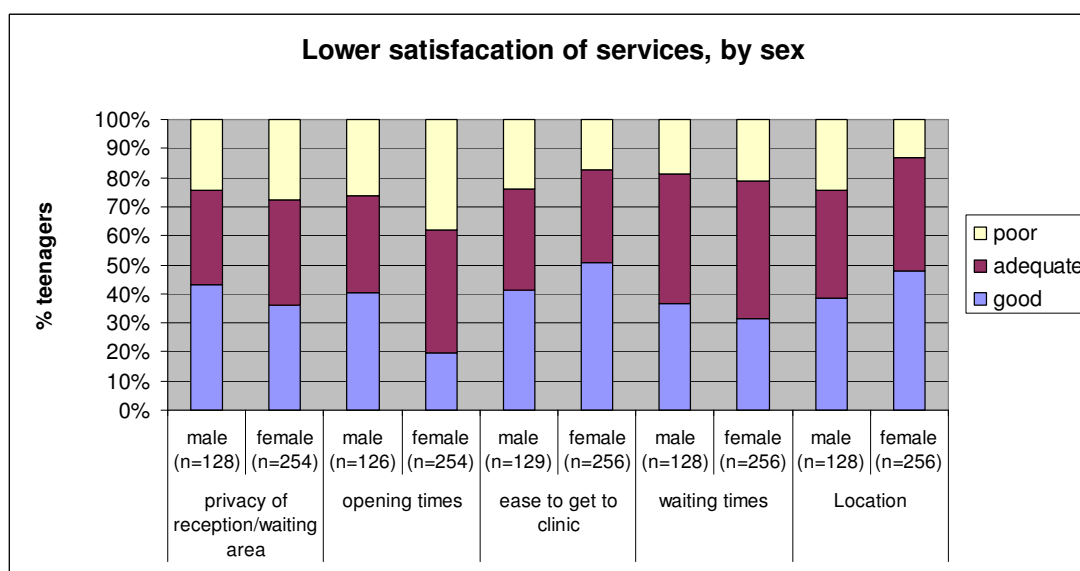
Figure 8: Aspects of family planning/young person’s clinics most rated as good.



The following aspects were rated as adequate or poor (figure 9):

- privacy of the reception/waiting area (n=147; 38.5%),
- opening times (n=101; 26.6%),
- ease to get to clinic (n=183; 47.5%)
- waiting times (n= 127; 33.1%)
- location of the clinic (n=172; 44.8%) .

Figure 9: Aspects of family planning/young person’s clinics with lower satisfaction



More girls (n=97; 38.2%) than boys (n=33; 26.2%) thought that the opening hours were poor (only 19.7% of girls felt the opening hours were good compared to 40.5% of boys). Boys were more likely rate as poor aspects like how easy it is to get to the clinic (boys: 24%; girls: 17.2%) and its location (boys: 24.2%; girls: 13.3%).

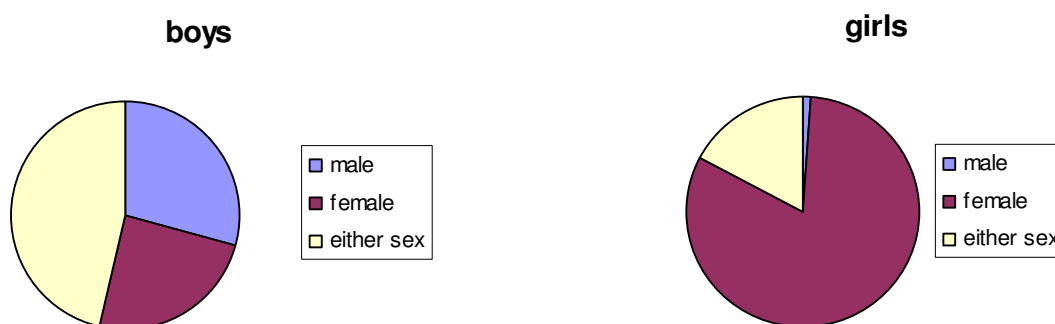
3.3.3 Service Preferences

Teenagers were asked their preferences for sexual health services, including the characteristics of the professionals they would go to see and seek advice from, what aspects of services are most important to them as young people, and where and when it is easiest for young people to use the services. The teenagers were also asked which professionals they would prefer to go to if they wanted advice from a professional about sex and relationships.

Which professional would they prefer to go to?

- The most popular choice for boys was their family doctor (n= 677; 37.3%) whereas this was the second most popular for girls (n= 416; 21.5%).
- Family planning/ young person's clinic was the most popular choice for girls (n=801; 41.3%) and the second most popular choice for boys (n=257; 14.2%).
- The third most popular choice for both boys (n=238; 13.1%) and girls (n=228; 11.8%) was a young people's advice centre.
- The remaining choices of school nurse (n=271; 7.2%), chemist/pharmacy (n=77; 2.1%) or other professional (n=89; 2.4%) were the least preferred options.

Figure 10: Preferred gender of person providing advice, by sex



Interestingly 24.4% of boys (n=443) and 13.2% of girls (n=256) said that they did not prefer to seek advice from any of these professionals. The reasons for this are unclear, however the results highlighted earlier also demonstrate the importance of family and friends as providers of information and advice on sex and relationships as well as professional groups.

The teenagers' preference for the gender of the person giving them advice tended to be their own gender, particularly for girls.

- The vast majority of girls said they would prefer the person to be female (n= 1701; 81.9%) and 17.1% (n=356) saying that they didn't mind if it was either sex.
- The response from boys was more mixed with just under half (n= 879; 46.5%) saying they did not have a preference, around a quarter saying they would prefer that

person to be male (n=551; 29.1%) and a similar proportion saying they would prefer them to be female (n=462; 24.4%).

What are the preferred locations for sexual health clinics?

The teenagers were asked where they think sexual health clinics should be held for young people.

- Just over half of girls (n=1117; 53.4%) felt that they should be located near their school or college, compared to 36.6% of boys (n=717).
- At the local health centre was the next most popular choice (n=1611; 39.8%), followed by near their home where there was some difference between boys (n=570; 29.1%) and girls (n=735; 35.1%).
- The least popular choices were at their local youth centre or club (n= 577; 14.2%) and in a mobile bus. There was some difference between boys and girls in response to the latter, with 13.8% of boys (n=271) and 9.7% (n=204) of girls choosing a mobile bus.

In relation to **deprivation level**, teenagers in the schools in the more affluent areas preferred young people's sexual health clinics to be held near their school or college, 57.6% (n=637). The response from the most deprived areas was more varied, but the local health centre was the most popular (n=492; 43.3%) followed by their school or college (n=437;38.4%).

What are the preferred opening times?

In addition to the location of services the teenagers were asked at what time of the day it is easiest for young people to use sexual health clinics. In year one of the survey the teenagers were given the options of the morning before school, lunch time, after school, evenings, and the option to give another answer. Results demonstrated that a number of teenagers used the option of 'other' and suggested that the weekend would be the most suitable time for young people to use sexual health services, so this was included in year two as an extra option. This change meant that the results for this question in year two differed to those in year one. Therefore only results for year two are reported here, which were deemed to be more accurate than merging the two years of data.

- In year two, provision of services at the weekend proved to be the most popular answer for the teenagers. 69.1% of girls (n=719) and 55.5% of boys (n=559) thought it was easiest for young people to access services at this time.
- The next most suitable time was in the afternoon after school for girls (n=584; 56.1%) and boys (n=375; 37.2%), followed by in the evening: 35.6% of boys (n=358) and 42.2% of girls (n=439).

- Lunch time (n=247; 12.1%) and in the morning after school (n=227; 11.1%) were the least suitable times for young people.

What are the most important features of the service?

Finally the teenagers were asked their views on a number of features or ideas about how sexual health clinics should or could be run for young people. The teenagers were asked to rate whether the features were very important, quite important or not important. Table 12 highlights the features that were very important or not important for boys and girls. The following were seen as very important functions of a sexual health clinic by the majority of participants in the survey:

- confidentiality
- having a friendly atmosphere with staff that are easy to talk to,
- to be able to go without an appointment,
- free contraception and availability of emergency contraception
- instructions on how to use contraception,
- pregnancy testing and unplanned pregnancy counselling
- testing for sexually transmitted infections
- general advice on sexual health

However more girls than boys felt these features and the remaining features were very important. Interestingly, the features that were seen as the least important were having people of their own age using the clinic and not telling their doctor about their visits to the clinic. Also it is interesting to note that even though levels of importance were high for both features more boys thought that availability of free contraception was more important than being told how to use it effectively. The opposite was true for girls.

3.3.4 How could sexual health services be improved for young people?

The teenagers were asked this open question in the survey, and so were given the opportunity to freely write down what they felt about the provision of sexual health service for young people. Content analysis was carried out on the answers to this question, and many underpin the statistical data earlier in this section and in the previous section on information, education and knowledge. There are three key over-arching themes that emerged from the data, which were the lack of information about services, accessibility and the role of the school. In addition there were comments on the practical side of delivery of services, and the information provided. The responses are related to affluence/deprivation levels to allow for comparison, although there were also similarities in experiences and views between the different areas.

Increasing awareness of services:

It was clear from some of the answers to the open question that teenagers felt that the services available need to be better advertised for young people. It was also apparent that some of the teenagers were not aware that such services existed for young people, nor were they aware of what they provide or where they are located.

They could be more advertised because no one knows where they are or what they do (Most Affluent, West Kent PCT)

Let us know where it is and more about it. I don't know where a young people's health service is (Deprived, Eastern and Coastal PCT).

Knowing whereabouts they are, they should be advertised more! I don't know where any are near me (Most Affluent, Eastern and Coastal PCT)

There should be more family planning or young person's clinics and they should be more 'out there (Deprived, Eastern and Coastal PCT).

I think teenagers, young adults, should be given more advice about where to go for support etc. For example I do not know where my nearest family planning/young persons clinic is (Affluent, West Kent PCT).

Suggestions about how the advertising could be improved for young people included distributing leaflets where young people can access them, such as in the school.

For me it would help if I knew where the service was available and perhaps given a leaflet giving information about the services at school (Most affluent, Eastern and Coastal PCT)

Get leaflets through the door (Deprived, West Kent PCT)

More information should be given out on leaflets that are placed around schools (Affluent, Eastern and Coastal PCT).

Table 12: Important features of sexual health services

	Very Important		Not Important	
	boys	girls	boys	girls
Confidential (all discussions in private)	1527 (81.3%)	1972 (95.1%)	52 (2.8%)	6 (0.3%)
Not likely to meet someone you know	827 (44.9%)	1058 (51.5%)	233 (12.6%)	206 (10.0%)
Not telling your parents	828 (44.9%)	1264 (61.4%)	340 (18.4%)	173 (8.4%)
Not telling your doctor	382 (20.7%)	480 (23.4%)	849 (46.0%)	647 (31.5%)
Only people of your own age using the clinic	359 (19.5%)	404 (19.8%)	777 (42.3%)	976 (47.8%)
Friendly atmosphere and staff easy to talk to	1426 (77.8%)	1875 (91.5%)	78 (4.3%)	27 (1.3%)
Someone else to talk to other than doctor/nurse	732 (39.8%)	943 (45.8%)	278 (15.1%)	228 (11.1%)
Being able to go without an appointment (drop in)	1022 (55.6%)	1442 (70.1%)	151 (8.2%)	64 (3.1%)
Having young staff	586 (32.1%)	710 (34.6%)	503 (27.5%)	508 (24.8%)
Free contraception	1270 (69.0%)	1508 (73.3%)	122 (6.6%)	86 (4.2%)
Emergency contraception (morning after pill)	1251 (68.4%)	1765 (85.6%)	124 (6.8%)	39 (1.9%)
Instruction on how to use contraception effectively	1075 (59.1%)	1557 (76.2%)	162 (8.9%)	48 (2.3%)
Advice on relationships	681 (37.1%)	837 (40.8%)	241 (13.1%)	142 (6.9%)
Gay, lesbian and bisexual issues	477 (26.1%)	667 (32.6%)	615 (33.7%)	415 (20.3%)
Pregnancy test/unplanned pregnancy counselling	943 (51.6%)	1617 (78.6%)	167 (9.1%)	21 (1.0%)
Support groups e.g. young Mums	742 (40.7%)	1302 (63.4%)	282 (15.5%)	76 (3.7%)
Tests for HIV and other STIs	1414 (76.9%)	1847 (89.7%)	79 (4.3%)	11 (0.5%)
General advice on sexual health	1035 (56.3%)	1392 (67.6%)	89 (4.8%)	24 (1.2%)
Advice on other health matters	777 (43.9%)	972 (49.6%)	199 (11.3%)	95 (4.8%)

Accessibility

Being able to find services in accessible locations emerged as the important priority for the teenagers in the survey. Another important factor was that although services should be easily accessible they should also be discreet, because of the fear of being seen by people they know. This meant that there were mixed views as to where services themselves are best located. Some teenagers quite positively suggested that they should be near school, in the town centre or near their home, others teenagers felt they needed to be somewhere else completely where it was unlikely they would be seen by people they knew.

By making it more obvious where they are so people know where to go, but not incredibly obvious (Most affluent, West Kent PCT).

More of them and less obvious to passers by. When I first went there for advice I walked straight past because of the huge sign 'family planning clinic' and I was embarrassed (Affluent, Eastern and Coastal PCT).

To have clinics around towns in less obvious places so that people are able to feel confident about going to them (Deprived, Eastern and Coastal PCT)

I think there should be clinics nearer schools so younger people can access them quickly and easily (Most Affluent, Eastern and Coastal PCT).

I think that they should be in more convenient places, as they are very difficult to get to (Deprived, West Kent PCT).

It could be easier to get to for others because it's quite hard to find, especially when you are young (Affluent, West Kent PCT).

Respondents also mentioned opening times and being able to 'drop in' to a clinic without an appointment. Ideally, and perhaps unsurprisingly teenagers suggested services could be improved for young people if services were open more often, for longer hours, and at times currently unavailable like weekends.

It should be easy to get to and it should be open at the weekends when teenagers are more likely to be out (Deprived, Eastern and Coastal PCT).

The opening times and accessibility should be more appropriate for the young people they supposedly provide for. I had to access the clinic after school but it was closed (Most Affluent, Eastern and Coastal PCT).

Opening hours should be more frequent, shouldn't need an appointment (Most deprived, Eastern and Coastal PCT).

Make better and more convenient opening hours, so there is more flexible time of going there (Deprived, West Kent PCT).

Role of the school

A number of the teenagers took the opportunity to suggest that they were more concerned with improvements to the amount of teaching and support within schools on sex and relationships education than with improvements of services for young people. However more links between schools and the sexual health services, and the setting up support networks between schools and services, were seen as desirable. More 'talks' from service staff within schools, and more advertising in school of the services available were suggested in order to 'reach' young people and make them more aware of what services are available to them. A few of the teenagers suggested increasing the availability of nurses, contraception and sanitary products in schools.

A better support system within the school with a full time nurse and free contraception within school if seen as necessary (Affluent, Eastern and Coastal PCT).

Sex to stop being such a taboo subject but more realistic cooperation from schools and more publicity and information about them, e.g. I don't know where the nearest family planning clinic is (Affluent, Eastern and Coastal PCT).

Not many people know about everything. There should be more people coming out to schools and talking about sex (Deprived, Eastern and Coastal PCT).

By having more info available at schools, more talks in small groups rather than classes (Deprived, West Kent PCT).

More nurses should come to schools to educate pupils about sex and STIs (Affluent, West Kent PCT).

Learn more about them in school so it doesn't seem so daunting (Affluent, Eastern and Coastal PCT).

Service delivery

Teenagers also commented on aspects of service delivery and how services are run. For example a number commented that confidentiality and privacy are important for young people. Although these principles are already part of services provided, some teenagers felt they could definitely be improved upon. Privacy in the waiting room and in the reception area was important and could be increased. There was the feeling that other people around knew the purpose of the visit when discussing the appointment with staff.

To be more accessible and private because others around you can hear and see you before you go in for an appointment (Most Affluent, Eastern and Coastal PCT)

Go straight through so you don't pass through the reception so you don't see anyone you might know (Most deprived, Eastern and Coastal PCT).

They could have more private waiting areas because when you go to the desk and talk to the receptionist everyone knows why you are there (Most affluent, Eastern and Coastal PCT).

Participants commented on the atmosphere of the clinics and the attitudes of staff. Some key terms used by the teenagers on how services and their staff should be were: understanding, friendly, relaxing, approachable, reassuring, more welcoming, more inviting, less intimidating, non-judgemental and less embarrassing. Whilst a number of the teenagers felt that services needed to concentrate on improving these areas, others felt that conveying reassuring messages about the positive character of services could help to allay anxieties and would encourage young people to attend. Another suggestion was the availability of (particularly younger) staff to talk to at clinics other than nurses.

Make it appear less intimidating a place that can be easily approached (Most Affluent, West Kent PCT).

Finding some way of making young people feel more relaxed and comfortable going to clinics because they can feel nervous, scared or edgy (Affluent, Eastern and Coastal PCT).

People feel embarrassed and scared, the environment should be as normal and welcoming as it possibly can. There is always room for improvement (Most deprived, Eastern and Coastal PCT).

Keep being friendly, do not make the person embarrassed or feel they are being judged (Affluent, West Kent PCT)

They could improve by making the waiting rooms, and/or get more staff so there aren't as many people. I felt very uneasy when it was crowded (Deprived, Eastern and Coastal PCT).

Have young members of staff that are not doctors or nurses, so people can just talk to them generally (Deprived, Eastern and Coastal PCT).

Some of the teenagers actually said that they thought service provision for young people was good enough already and it should stay the way it is.

I think it is all good for everyone. Don't think nothing needs to be changed (Deprived, Eastern and Coastal PCT).

I don't think they should [Improve] as it is very good in my opinion (Most deprived, Eastern and Coastal PCT).

I've never used the services but from what I've heard, they are very helpful and confidential (Deprived, Eastern and Coastal PCT)

At the moment I think that the sexual health services are very good. Confidentiality is very important (Most Affluent, West Kent PCT).

I think that there are good services, It's just people get embarrassed and scared to go (Most Affluent, Eastern and Coastal PCT).

Information

Some of the teenagers commented that they needed more information generally and there were particular subjects they felt they or, young people, need to know more about. The two subjects mentioned were more information on sexually transmitted infections and on relationships. A number of teenagers also commented on different mediums in which

services could provide useful information for young people, suggestions were leaflets through the door, television documentaries and the setting up of clubs or groups.

More detailed explanations to people wanting to know about sex and STD's. To ensure that they know all that is needed to know (Most deprived, Eastern and Coastal PCT)

There should be more emphasis on sexually transmitted diseases (Most deprived, Eastern and Coastal PCT).

They should give more information on sexually transmitted diseases and how to cure them if curable (Most deprived, Eastern and Coastal PCT).

More advice on actual relationships – “okay to say no” whatever and emphasizes people developing at different rates. Also emphasis on acceptance of other sexuality (Most affluent, Eastern and Coastal PCT).

Sexual health clinics for young people could be made better if maybe they could try to persuade people not to rush into anything instead of giving them free contraception (Most deprived, Eastern and Coastal PCT)

They should have some sort of like clubs for young people to talk about sexual health and stuff (Most deprived, Eastern and Coastal PCT).

Summary

Given the comments and issues raised about awareness and knowledge of sexual health services, it is perhaps unsurprising that the majority of teenagers surveyed had not used them. However use of the survey aimed to establish from users and non-users what the important aspects were of sexual health services for young people. The findings appear to demonstrate that gaining access to contraception and related advice can be an embarrassing time for young people, whether this is by visiting sexual health clinics or buying condoms from a shop. There was a gender difference in how teenagers chose to access contraception; girls were more likely to use family planning or young person's clinics, whereas boys were more likely to use other means like shops and vending machines, thus seeming to avoid the potential for embarrassment. Interestingly, teenagers were more likely to have used sexual health services if they were sexually active, or if they were from a

school taking students from more deprived areas which may be a reflection of the concerted efforts made by services in recent years to target these areas.

Generally the users of family planning and young person's clinics thought, in their experience, that the services on offer and the service they received were good. They also found staff to be friendly and respecting of the issues of confidentiality, which were rated as highly important aspects of service provision. Teenagers were however less happy with opening times and privacy of the reception and waiting areas. There were mixed responses about where they thought the best place for sexual health services for young people should be held. A small majority favoured a location near their school, whereas others preferred them to be in the town centre or near their home.

These results were confirmed in the responses to the open question of how services could be improved for young people. Issues around accessibility were particularly raised: having services located in places that were easily accessible for young people, but not too obvious, were very important. Awareness of services was also important. Some teenagers stated that they didn't know about sexual health services for young people, nor what help they provided or where they were located. The need for more advertising of services was clearly expressed in the community and through the school. In addition to advertising, a number of the teenagers also felt that more could be done through school to get advice and knowledge about the services available to them.

3.4 Sex and relationships: Attitudes, values and behaviour

This section explores teenagers' attitudes and values towards sex and related issues, and it investigates their actual behaviour, for example whether they have had sex, and whether they have used contraception.

3.4.1 General attitudes and values

Teenagers were asked about a number of general statements relating to sex and relationships issues. For some of the statements opinion was very strong for both boys and girls.

- 81.4% (n=3197) of teenagers disagreed with the statement 'You should be married before having sexual intercourse'. 5.1% (n=201) agreed with this statement.
- The majority of boys (n=1018; 54.6%) and particularly girls (n=1339; 65.2%) disagreed with the statement that they do what their close friends think is right.

- Similarly more boys (n=753; 40.8%) and girls (n=1404; 69.2%) disagreed that their friends make them feel as though sex is the most important thing in a relationship; however more boys (n=523; 28.3%) agreed that they were influenced by their friends in this way compared to girls (n=263; 13.0%).
- Just over half of the girls (n=1087; 52.8%) compared to 39.4% of the boys (n=737) agreed with the statement that you should be in love before having sexual intercourse with someone.
- 42.7% of boys (n=796) agreed that one night stands were okay compared to 16.4% of girls (n=336), 50% of girls (n= 1029) disagreed with this statement.
- Girls felt particularly strongly that girls who carry condoms do not sleep around (n=1592; 78.3%) compared to boys (44.5%; n=823).

In relation to **level of deprivation**, there were variations in attitudes between the teenagers from schools serving the more deprived areas and those serving the more affluent areas.

- Although overall the majority of teenagers disagreed with the statement that friends make them feel as though sex is the most important thing in a relationship, a higher percentage of teenagers from deprived areas agreed with this statement (24.7% [n=264], compared to the more affluent teenagers (12.7% [n=139]).
- Despite the more deprived areas having this perception of their friends attitudes to sex and relationships, they were more likely say they didn't want to do what their close friends think is right (n=674; 62.8%) compared to the most affluent (n=613; 55.9%).
- The most affluent areas (n=728; 66.8%) were more likely to disagree that girls who carry condoms sleep around, compared to the most deprived areas (n= 649; 60.7%).
- The most deprived areas (n=284; 26.9%) were more likely to think that using a condom reduces sexual pleasure and spontaneity compared to the most affluent group (n=207; 18.9%).

In addition to the general statements, the teenagers were asked their views on what they consider to be important in a successful marriage or long-term relationship. The aspects teenagers considered to be particularly important were faithfulness, mutual respect and appreciation (figure 11).

- 87.8% of girls (n=1765) and 76.4% of boys (n=1369) said faithfulness was very important;
- 81.4% of girls (n=1617) and 66.0% of boys (n=1166), felt mutual respect and appreciation was very important;

- slightly more boys (n=953; 53.4%) than girls (n=950; 47.7%) felt a happy sexual relationship was very important;

The least important aspects were having shared religious beliefs and an adequate income. Interestingly more boys felt an adequate income was very important compared to girls, who were more likely to think that it was not very important.

General attitudes and values: differences between boys and girls:

Boys are more likely to say:

- One night stands are okay
- Say their friends make them feel like sex is the most important part of a relationship
- Using condoms reduces sexual pleasure and spontaneity
- It is the man's responsibility to carry condoms

Girls are more likely to say:

- You should be in love before having sex with someone
- Girls who carry condoms don't sleep around

Although overall they had similar views, there are some interesting differences between the teenagers from schools serving different **deprivation levels**.

- Schools taking teenagers from more affluent areas were more likely to think that faithfulness, mutual respect and appreciation were very important aspects of a successful marriage or long term relationship.
- Although the percentage was small, the more deprived catchment areas were more likely to think that an adequate income, shared religious beliefs, a happy sexual relationship, having children, and sharing household chores were very important aspects of a successful marriage or long-term relationship (figure 12).

Figure 11: How important are the following to a successful marriage or long term relationship, by sex.

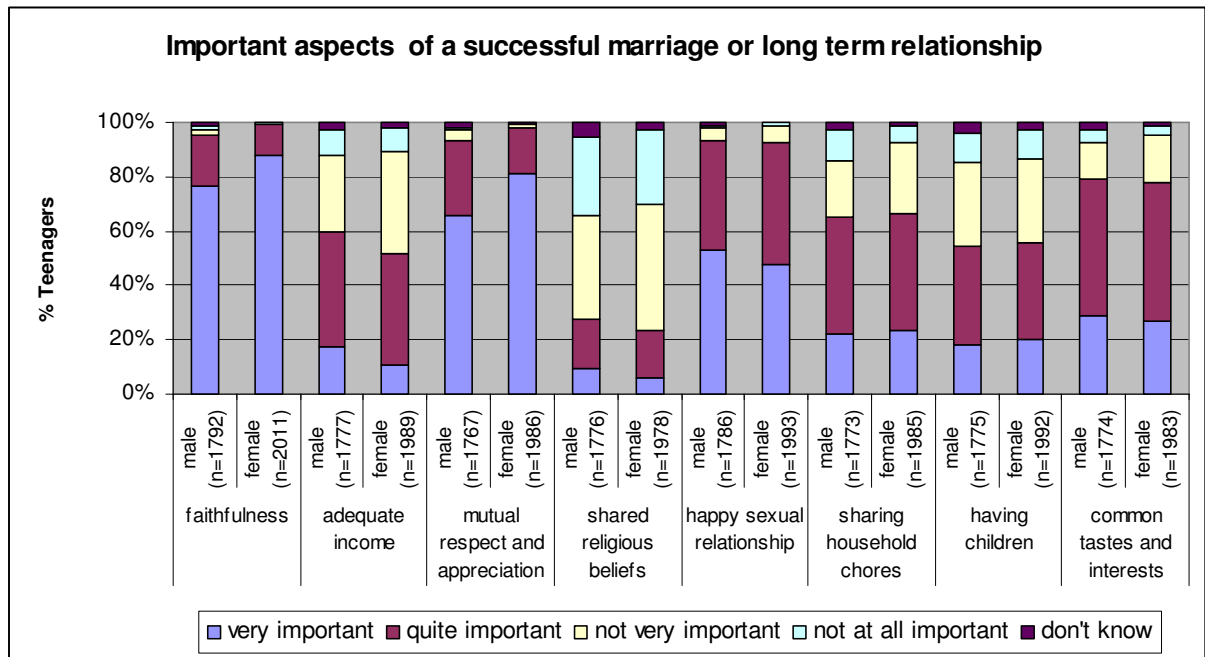
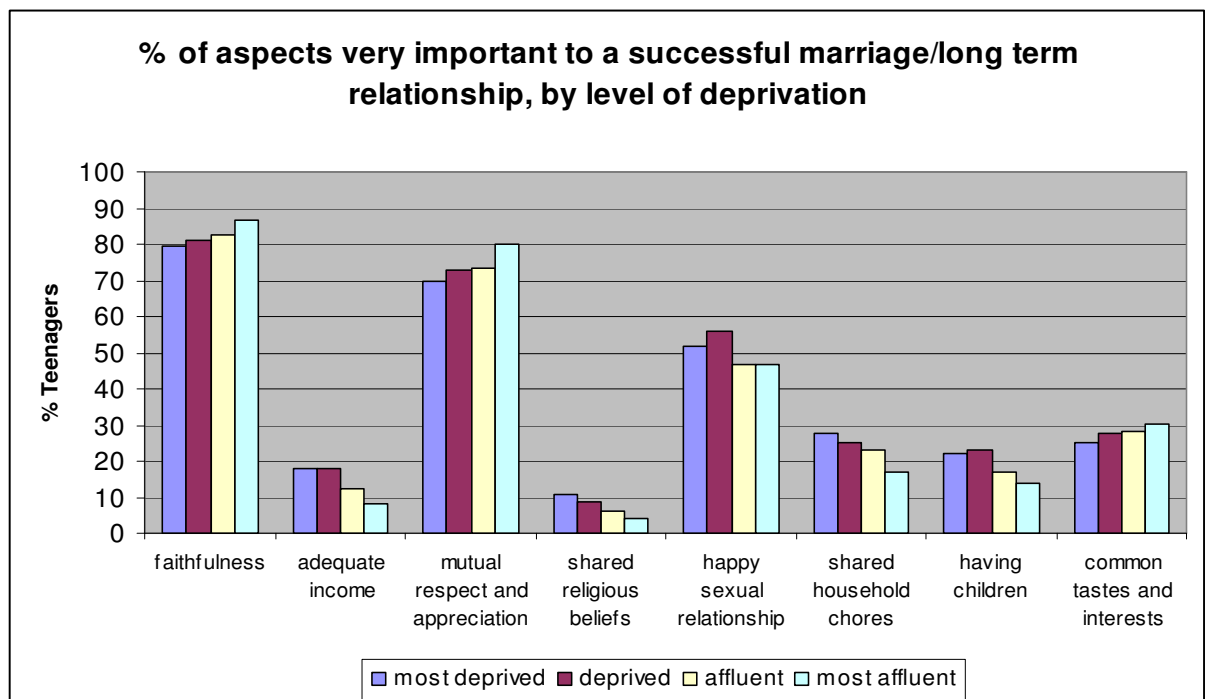


Figure 12: Percentage of aspects that are very important to a successful marriage or long-term relationship, by level of deprivation.



3.4.2 Attitudes towards safe sex

All teenagers were asked about their attitudes and views about a number of statements relating to safe sex. These include use of condoms, worries about pregnancy, and contraception more generally.

- The vast majority of boys and girls appeared to have a concerned and responsible attitude to safe sex; 88.2% (n=3475) said they intended to use a condom the next/first time they have sexual intercourse.
- Slightly less than this actually felt they could insist a condom was used during sex - more girls (n=1567; 76.9%) than boys (n=1274; 69.3%);
- Even fewer said they intended to discuss using condoms with their first/next partner before having sex - more girls (n=1228; 60.5%) than boys (n=876; 47.5%);
- Similarly more girls (n=1121; 55.2%) than boys (n=909; 49.4%) felt that they wouldn't be embarrassed to talk to a new partner about contraception.
- Girls (n=1257; 61.5%) were also more likely to think that people should refuse to have sex with someone who objects to using a condom compared to boys (n=813; 44.0%).

There are some interesting contradictions in these responses; although the intention is there, the actual negotiation of condom use remains less emphatic. This is particularly so with boys, who appear to be less insistent and talkative about it. However, boys and girls both worry equally (n=2579; 66.3%) about getting pregnant or getting a girl pregnant at their age. Also more boys (n=1438; 77.4%) than girls (n=1218; 60.1%) felt they knew how to use a condom properly. Therefore it may be that boys feel more confident in the use of condoms and feel discussion is not as necessary, or it could be that boys are just as worried as girls but are more embarrassed or anxious to discuss the issues of condoms and safe sex with their partner

Boys' attitudes towards not using condoms may also be more influenced by what their friends say. More girls (n=1632; 79.2%) than boys (n=1192; 63.9%) felt that most of their close friends think you should use condoms, although the majority of teenage boys and girls did say their friends thought you should use them.

Attitudes towards safe sex: differences between boys and girls:

Boys are more likely to say:

- They know how to use a condom properly
- They would be embarrassed to talk about contraception with a new partner

Girls are more likely to say:

- Their friends think you should use a condom
- They could insist a condom was used during sex
- They intend to discuss using a condom with their first/next partner
- People should refuse to have sex with someone who objects to using a condom

There were also differences in the **level of deprivation** in relation to what friends thought about use of condoms during sex.

- A larger majority of teenagers from schools selecting from the most affluent areas agreed that their close friends thought you should use condoms during sex (n=861; 78.5%) compared to those from the most deprived areas (n=727; 67.3%).
- A higher percentage of young people from the most deprived areas said they would be too embarrassed to talk to a new partner about contraception (n=212; 19.9%) compared to those in the most affluent areas (n=149; 13.7%)
- Participants in the most affluent areas were more likely to feel they could insist that a condom was used during sex (n=846; 77.3%) compared to those in the deprived areas (n=643; 68.8%).
- Those from the most deprived areas said they were more worried about getting pregnant/or getting a girl pregnant at their age (n=728; 68.5%), compared to those from the most affluent areas (n=669; 61.3%).

The increased worry about getting pregnant among the teenagers from schools selecting from the more deprived areas may come from their less stringent attitude to condom use demonstrated above and the more risky sexual behaviour among these groups demonstrated below.

3.4.3 Sexually active teenagers

This section outlines the behaviour and experiences of sexually active teenagers. It explores what contraception the teenagers have used, whether they have had unprotected sex, and how the issues of contraception and safe sex were negotiated before having sex for the first time. It also explores the reasons behind why they first had sex when they did, and reasons why they may not have used contraception.

Overall, 40% (n=1483) of teenagers (an equal percentage of boys and girls) said they had had sexual intercourse. With respect to **levels of deprivation**, there are significant differences between the more affluent and deprived areas.

- The most deprived groups were more likely to have had sexual intercourse (n=913; 47.3%) than the more affluent groups (n=570; 32.0%)
- A higher percentage of the most affluent group (n=625; 57.1%) said that most of their close friends had not had sex compared to the most deprived group (n=434; 40.4%), which confirms further a distinction in behaviour between teenagers in relation to area of deprivation.

Contraceptive use

- Two thirds of all sexually active teenagers (n=1141; 76.9%) used a condom the first time they had sexual intercourse, however 17.1% of boys (n=119) and 14.8% of girls (n=117) said they did not use contraception the first time they had sex.
- 11.8% (n=175) said they used the contraceptive pill, the majority of which used both a condom and the contraceptive pill together.
- 11.4% of girls (n=90) and 5.2% (n=36) of boys said they or their partners used emergency contraception the first time they had sexual intercourse.

In relation to **levels of deprivation**, teenagers from schools selecting from the most deprived areas were the least likely to have used a condom the first time they had sex, however a condom was still used by 70.9% (n=343) of teenagers in this group the first time they had sex. Interestingly the deprived group were the most likely to have used the contraceptive pill the first time (n=71; 16.6%), although a minority of teenagers had used this method the first time they had sex. There were no significant differences in relation to use of emergency contraception, but the most deprived group were the least likely to have used contraception the first time they had sex (n=104; 21.5%).

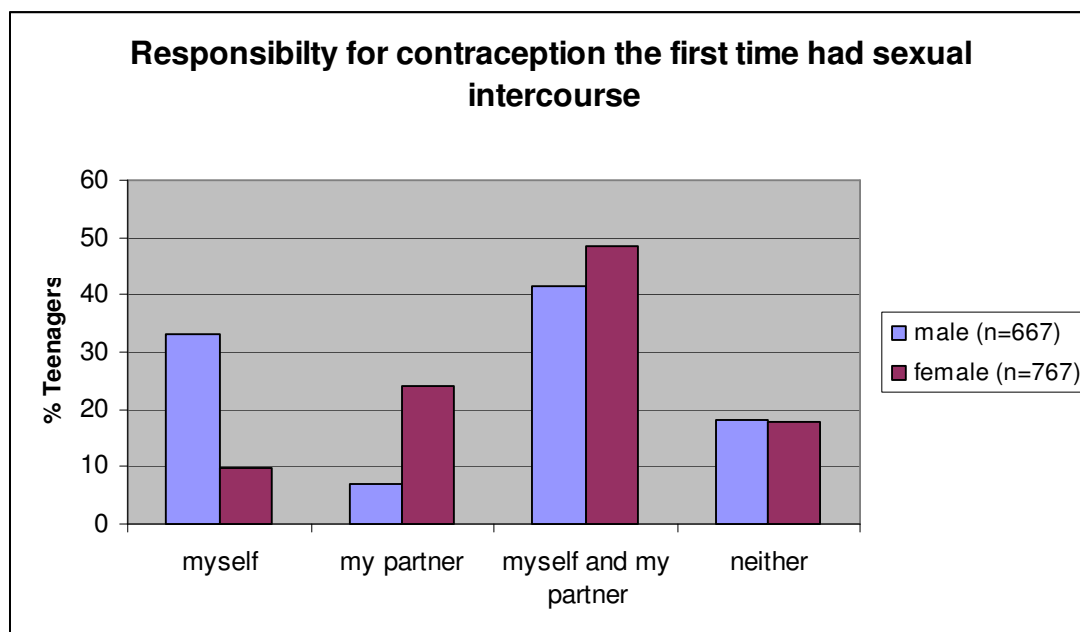
Negotiating contraceptive use

- Just under half of the teenagers said they discussed contraception with their partner before they first had sexual intercourse (n=686; 47.1%).
- A similar percentage said they did not discuss contraception (n=683; 46.9%) and 6% (n=88) said they did not know if it was discussed.
- 45.3% (n=649) of the teenagers said they and their partner were jointly responsible for ensuring contraception was used the first time they had sex (figure 13).
- Only one person in the partnership took responsibility for use of contraception for 36.7% of the teenagers (n=296). This person was more likely to be male rather than

female, with 33.3% of boys in the survey (n=222) saying they took responsibility themselves compared to 9.6% of girls (n=74)

- 18.0% of the teenagers said neither they nor their partner took responsibility (n=258).

Figure 13: Who took responsibility for making sure contraception was used the first time had sexual intercourse, by sex



Willingness and timing of first sexual experience

- Overall the majority of teenagers said they and their partners were both equally willing to have sex the first time - 82.8% of boys (n=557) and 72.8% of girls (n=561).
- However more boys were willing than girls, with 7% of boys (n=47) compared to 2.3% of girls (n=18) saying they were more willing, and 24.9% of girls (n=192) and 10.3% of boys (n=69) saying that their partners were the more willing.
- Just over half of the teenagers felt that the first time they had sex was the right time for them (n=803; 55.9%). However more girls (n=336; 43.6%) than boys (n=158; 23.7%) felt they should have waited longer before having sex. 17.4% of boys (n=116) felt they should not have waited so long compared to 3.0% of girls (n=23).
- In relation to **levels of deprivation**, the most deprived group was most likely to think they should have waited longer before having sex (n=189; 40.0%) and the least likely to think it was the right time for them (n=235; 49.8%).

Reasons for having sex

The teenagers were asked more about the reasons why they first had sex when they did and the relationship situation they were in at the time. It is recommended that these figures should be used in comparison with each other only and not be considered in isolation as

'true' percentages, due to the changes in the question design (from more than one answer allowed in year one, to one answer only in year two (Appendix E).

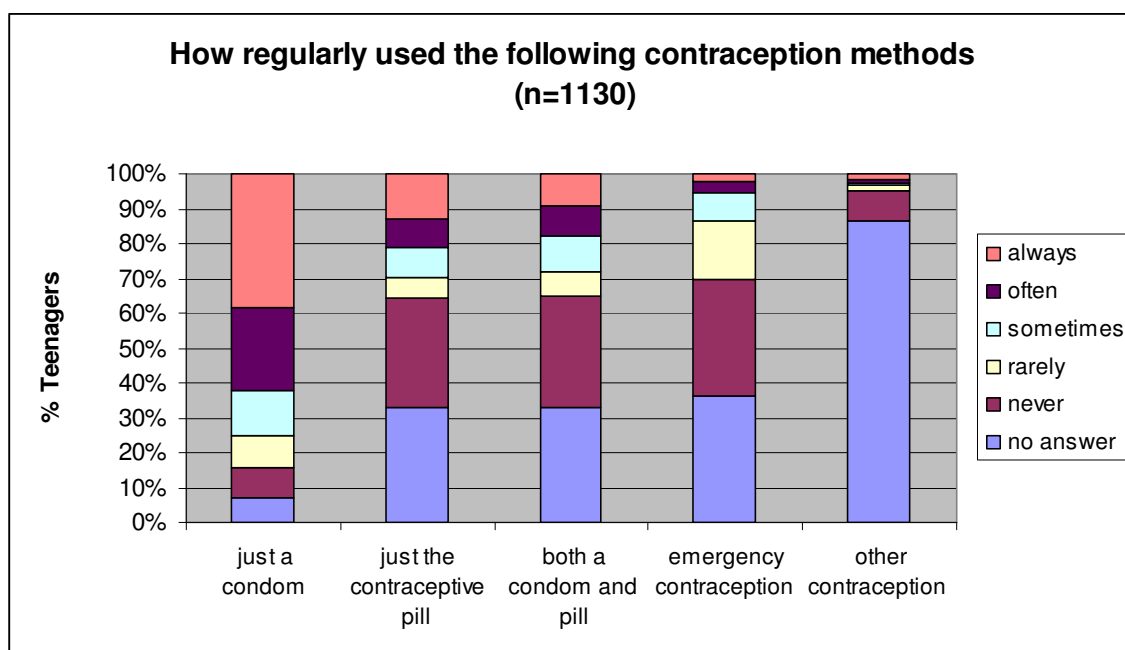
- 43.5% (n=645) were curious about what sex would be like.
- 31.3% (n=464) said sex felt like the natural 'follow on' in their relationship
- 30.8% (n=457) said they were in love. More girls (n=273; 34.6%) said they were in love the first time than boys (n=184; 26.5%).
- Boys (n=166; 23.9%) were more likely to say they wanted to lose their virginity than girls (n=110; 14.0%).
- 23.1% (n=343) of the teenagers said they were 'a bit drunk' and 21.7% (n=322) said they became 'carried away with their feelings', the first time they had sex.

Teenagers having sex more than once

83.1% of sexually active girls (n=636) and 74.1% of sexually active boys (n=488) said they had had sexual intercourse more than once, a total of 1130 teenagers. This group of teenagers were asked about their use of different contraceptive methods.

- There was no significant difference between boys and girls for contraception methods, apart from the contraceptive pill where more girls than boys said they had used it. This is perhaps unsurprising as the girl is the user of the method, the boy may be unaware that their partner was taking it.
- The majority of teenagers always used (n=433; 38.3%) or used often (n=272; 24.1%) a condom as the only method of contraception;
- Around a fifth of the teenagers said they used both a condom and the contraceptive pill often (n=99; 8.8%) or always (n=103; 9.1%) when they had sex.
- 3.5% (n=40) said they had used emergency contraception often and 2.0% (n=23) said they had always used emergency contraception when they had sex.
- Of concern is the finding that 8.7% (n=98) reported they had never and 9.4% (n=106) said they had rarely used a condom.
- Only 8.2% (n=8) of teenagers who replied that they never used just a condom, answered that they always use the contraceptive pill and a condom together instead.

Figure 14: If had sex more than once, how regularly used the following contraception methods.



Reasons for not using a condom

All sexually active teenagers were asked whether they used a condom during sex and if not, what the main reasons were. There were no significant differences between boys and girls, apart from girls (n=166; 21.1%) were more likely than boys (n=82; 11.8%) to say the reason for not using a condom was because they used a different method of contraception.

The most common answers were that they didn't use a condom because they were drunk or because they didn't have one (table 13). Both these situations increase the potential of the risky behaviour of unprotected sex.

Table 13: Main reasons why teenagers do not use a condom during sex

Top 5 responses	n (%)
1. A bit drunk at the time	301 (20.3%)
2. Didn't have a condom	299 (20.2%)
3. Knew partner well enough	276 (18.6%)
4. Used other method	248 (16.7%)
5. Very much in love	228 (15.4%)

The least common reasons for not using a condom were 'didn't discuss the question' (n=207; 14.0%), 'didn't think of HIV risk' (n=203; 13.7%), 'problem staying 'turned on'' (n=155; 10.3%), 'partner didn't want to use one' (n=151; 10.2%), 'difficult to raise subject' (n=116; 7.8%), and 'afraid might lose partner' (n=100; 6.7%).

Summary

There are variations in the attitudes, values, and behaviour of teenagers regarding sex and relationships, in relation to gender and level of deprivation. Generally speaking the girls believed that you should be in a loving relationship before having sex. Boys however were more likely to think that one night stands are acceptable, and think that sex is a more important aspect of a relationship. Boys were also more likely to be influenced by their peers in their attitudes towards sex and relationships. However the majority of both boys and girls believed that faithfulness, mutual respect and appreciation were the most important aspects of a long-term relationship.

The vast majority of teenagers intend to, and have used condom when they have sex. However there appears to be issues of embarrassment and reluctance to insist a condom is used among some of the teenagers, in particular boys and respondents from the more deprived areas. There are considerable contradictions in the responses between condom use intentions and actually negotiating use, and for boys there is the added pressure of the attitude of their peers around the issue of condom use.

It is important to highlight again that there is a small group of sexually active teenagers who used emergency contraception the first time they had sex or repeatedly when they had sex, and there are some sexually active teenagers who do not appear to have protected themselves adequately against pregnancy and infection at all.

Under half of the teenagers surveyed said they had had sexual intercourse, and the percentage was similar for boys and girls. However teenagers from schools serving more deprived areas, and their peers, were more likely to have had sex compared to the more affluent teenagers. There was also some variation in relation to deprivation and gender when the teenagers were asked to reflect on the first time they had sex. Girls from more deprived areas tended to wish they had waited longer and also to regret that their first sexual experience had been too early. However the majority of the teenagers felt that they had sex at the right time, took joint responsibility for contraception, and were equally willing for it to happen.

3.5 Teenagers' comments

The teenagers were given the opportunity to write down any further comments at the end of the questionnaire. The comments for year one of the survey were comprehensively reported in the year one survey report. Therefore this section concentrates on the comments of the survey in year two. In this report, comments from the specific question on improvement of services have been dealt with separately in section 5.4 (data from year one and year two were both described in this section).

For the general comments similar themes emerged from the data for both years. Again in year two many comments reflect some dissatisfaction with the provision of sex and relationships education in school, a number concerning the provision of services, peer pressure and sex, and factors impacting on why there is a problem of teenage pregnancies.

3.5.1 Sex and relationships education in school:

Some teenagers commented that more sex education was needed within the school; others expressed views about the timing of lessons and how and what topics were taught. A number of teenagers felt that the sex education lessons were delivered too late, or they were not learning anything new when they had further lessons.

'Teachers, parents, outside visitors are always talking about safe sex but I have had only 2 sex ed lessons in about 6 years. I don't really think that this is enough because at my age nearly all of the guys I know make a big deal about it and some people I know (including me) get a little worried about inexperience and not knowing what to do' (Most Affluent, Eastern and Coastal PCT)

'Sex ed is taught before most people are sexually active and is ignored as someone gets to the age when they are more likely to try it' (Most Affluent, West Kent PCT)

'Schools need to teach it more - not just the science side of sex education' (Most Affluent, West Kent PCT).

'Sex education is often the same thing repeated on different occasions. No new information has been given in the 3 sex education talks I have had' (Most Affluent, Eastern and Coastal PCT).

'I think sex education should be improved at school as I had to learn through other people when in fact I would liked to have had a professional teaching me' (Most Affluent, Eastern and Coastal PCT).

'I learnt most of what I know through friends and personal experience. I first had sex before I had sex education so the school have taught me nothing I didn't already know!' (Most Affluent, West Kent PCT)

'Sex is not talked about openly enough in school, we should be having more information about sex, contraception, STD'S and pregnancy in year 9 (when we got our tampon talk) and our tampon talk in year 7 or earlier. It is stupid that they wait so long to tell us these things and by then it is too late because in year 7 everyone had started their period and by year 9 some had sex without knowledge of the risks! ' (Most Affluent, West Kent PCT).

There were certain topics that some teenagers felt were more important to learn more about or they felt had been missing in their formal education. The topics mentioned in particular were sexually transmitted infections and the emotional side of sex and relationships. Suggestions for how topics should be taught were also given, like splitting into same-sex groups, more advice from health professionals within school, and the use of 'shock tactics'.

'I think that schools should definitely tell us more about sex because nearly all of the things I know about sex I learnt from my friends etc. When we have our sex education they should split the boys and the girls up because they would both feel more comfortable talking about things with people that are their own sex' (Most deprived, Eastern and Coastal PCT)

'I think that situations are so different it is hard to generalise with people aged 15/16, and even though I would never do something I didn't want to do sometimes I feel that the way people behave at this age can influence some people to believe that having sex is not a big deal. Even though nothing can be done to change the way people gossip in schools it is a great shame that people can become influenced. I think schools need to take more care in covering all possibilities to do with relationships and all kinds of physical interaction (Most Affluent, West Kent PCT)

'I feel that far too much emphasis is put on sex and not enough on relationships and how to deal with problems faced with people of our age and how you and your partner should have a good long relationship' (Most Affluent, West Kent PCT).

'I think that more nurses should come round schools and tell us more about how to use a condom etc, because I only found out when a nurse came round in yr 10 and may be too late for other people. My friend is 16 an she is pregnant' (Deprived, West Kent PCT).

'I would like to know more about sexually transmitted infections because until a few weeks ago I didn't know that you could get one from oral sex' (Deprived, West Kent PCT).

'Much more info needed about the effects of STI'S because nearly all teenagers haven't got a clue! Shock tactics real life cases should be used. For example photographs should be the main focus of sex education. I think people with these diseases should also tell teenagers to be more careful and talk about their experiences' (Most Affluent, West Kent PCT).

3.5.2 Provision of services:

Additional comments were made regarding provision of sexual health services for young people in addition to comments made earlier in the questionnaire. As before, teenagers mentioned issues of awareness, advertising, accessibility, and embarrassment.

'There needs to be more advertisement on all these clinics etc, young peoples clinic. There also should be more information given out because many young girls are getting pregnant at 15. But I was happy to fill in this questionnaire and I hope more help will be given out so more people think' (Deprived, Eastern and Coastal PCT).

'I think that unless you are a very confident person, it's hard to go and talk someone about sex. Its easier going to a sexual health clinic if you know that no one you know is going to be there and it is completely confidential and the staff will be nice. Same with buying condoms although that is easier' (Most Affluent, Eastern and Coastal PCT).

'When I needed the morning after pill, it took me 5hrs to get hold of one. It needs to be much more accessible to those who can't drive to a clinic and don't have £25 to buy it. I want the school to provide info on the local STI clinic so I can be checked' (Most Affluent, Eastern and Coastal PCT)

3.5.3 Peer pressure:

A number of teenagers reported factors relating to peer pressure and sexual experience and expressed regret at being 'pressured' into feeling like they have to have sex, others recognised peer pressure around them but felt that they were not influenced by it. Teenagers also felt that more help to overcome issues such as these were needed from services and schools.

'I think at this age we are getting too much peer pressure to have sex. We are made to listen to the ones who have had sex (e.g. close friends) and makes you feel bad although I would never cave to peer pressure others might. That's why most people regret their first time because they did it to make them look 'cool" (Most deprived, Eastern and Coastal PCT)

'I find being 15 quite hard because of the amount of pressure that is put on us to be sexually active. Myself will wait until I'm ready to be sexually active. Thank you for this useful survey' (Deprived, Eastern and Coastal PCT).

'I have never felt pressured into having sex but I know that a lot of people do and I think that it's not right and a lot of people end up doing things they don't want to. There should be more services around to help them' (Affluent, Eastern and Coastal PCT).

3.5.4 Why we have a problem

Some teenagers identified teenage pregnancy as a problem in our society, but they also described a variety of reasons why and how it could be tackled. Some reasons given for high levels of teenage pregnancy were that some young people are knowledgeable about safe sex but are choosing to take risks, whilst others felt that increasing levels of sex education, and at an appropriate time (e.g. earlier), would help the situation. Others thought that increasing provision of sexual health services and availability of contraception to young people (perhaps in schools) would help tackle the problem.

'I think most people my age ignore what they are told about sexual education and that's may be why there are so many teenage pregnancies or maybe they don't take it seriously. I have learnt a lot about sexual education and has helped me think twice about having sex at my age' (Most deprived, Eastern and Coastal PCT).

'Teenagers should be persuaded to tell their parents if they are going to have sex by clinics, teachers, school nurses. Getting contraception and hiding the fact you are having sex has been made too easy to avoid telling them' (Deprived, West Kent PCT).

'I think that if condoms were made available at school then there would be a lot less teenage pregnancies as I believe that if I had been able to get condoms from school then I would not have lost my virginity the way I did and I would be a lot happier now!' (Affluent, Eastern and Coastal PCT).

'I was never given sex education in school, given the rate of teen pregnancy in the area I think we should have received it, and probably about year 8! I also think that family planning clinics should have better hours after enquiring for a friend we found it was only open on Monday evening which wouldn't be helpful if you had sex on Tuesdays' (Affluent, Eastern and Coastal PCT).

I think there should be more sex education in school and should be done earlier. Speakers should be brought in to talk and advise people. If the government want to try to tackle teenage pregnancy they should start by actually making kids aware before they just do it to find out. Teenagers think that sex is so important that it almost becomes that you are sad if you are sexually active (Most Affluent, West Kent PCT)

4 Key Points

4.1 Sex and relationships education

4.1.1 Sources of information and advice

- In the school setting, all respondents felt that they had received more information about pregnancy, contraception, HIV/AIDs and STIs than they had about relationships and emotions. This was something they acknowledged was lacking and felt they needed to learn more about.
- Teachers and outside speakers at school, family, friends and the media were reported as more common sources of information about sex and relationships. Few respondents regarded sexual health services as their main source of information.
- Despite teachers being the main source of information, most teenagers described learning only some or a little from them.
- Girls reported gaining greater benefit than boys from outside speakers delivering SRE within school. They also reported a wider range of sources of information about sex and relationships, including family, health professionals, magazines and teachers. Girls also claimed to take SRE more seriously than boys.
- There appears to be a gender divide in that girls will seek out other females such as girlfriends and mothers for their information, but this pattern is not repeated for boys, who are not communicating with fathers, friends or uncles about sex. This means that boys are reliant on teachers, and hence learning little.
- Respondents from more deprived areas were more likely to say they had received information too early, whereas young people from more affluent situated schools were more likely to claim that they had not received any sex education.

- Pupils from more deprived areas were more likely to say that they had learnt from teachers, mothers and friends and were also more likely to have learnt from family planning clinics, young people's services or GP-based advice.
- Mothers and other family members were the most relied-upon sources of information regarding pregnancy, contraception and relationships. GPs were also considered to be a trusted source.
- GPs and, to a lesser extent, sexual health services were more trusted sources for more 'medical' information about HIV and STIs.

4.1.2 Delivery of sex and relationships education

- SRE was often delivered in whole class settings and this perhaps explains why only a minority of pupils, particularly girls, felt able to ask any question they wanted. Teenagers recommended SRE was taught in smaller groups.
- Most felt that the timing of SRE was right, although a minority felt that they had learnt about abortion and being a parent/childcare at an inappropriately early age.
- The majority of respondents reported that teachers had appeared confident in their delivery of SRE, however, half reported that as pupils, they had not been made to feel comfortable in SRE lessons.

4.1.3 Results of knowledge quiz

- The results indicate that the majority of teenagers are knowledgeable about issues about safe sex, contraception, sexually transmitted infections and issues around underage sex. Overall, girls were more knowledgeable than boys.
- Those who reported being sexually active were also more likely to answer the knowledge questions more accurately.
- More of the pupils from the affluent areas answered more questions correctly despite also claiming to have received information from a narrower range of

sources. In particular, their knowledge of the law relating to under age sex, confidentiality, the provision of contraception to young people and the effectiveness of contraception was more likely to be accurate.

4.2 Views and use of sexual health clinics

4.2.1 Accessing contraception

- The respondents reported significant barriers to getting contraception. Fewer than half of the teenagers felt that contraceptives were easy for young people to get.
- Fears about confidentiality constituted the most significant barrier for the majority. Our findings suggest that confidentiality should be understood in conjunction with issues of privacy, embarrassment and inhibition.
- Teenagers reported experiencing or anticipating feelings of embarrassment when accessing contraception from both health services and commercial premises.
- Many boys and girls were worried about being medically examined.
- A number of young people were concerned about being seen accessing contraception or sexual health advice by people they knew. It seems that they are not just worried about having their privacy protected from parents and other adults, but also from their peers. Lack of privacy in entering clinics, at the reception desk and while waiting to be seen was reported as a significant inhibitor.
- Lack of information about services and inconvenient opening times were other very significant factors impeding access to sexual health services.
- Girls were more likely to get contraceptives from clinics or GPs than boys. The majority (70%) of girls who were sexually active had visited a GP or sexual health/family planning services to access contraception.

- Young people from schools in less affluent areas were more likely to have used one of the services.
- The young people were asked to suggest their own improvements for sexual health services. The following were prioritised:
 - Advertising the location and opening times of services and familiarising young people with the services available.
 - Particular recommendations were to bridge the gap between school and services by bringing clinic staff in to SRE but also by taking pupils to visit clinics.
 - Ensuring discrete accessibility whereby services would be easy to use but where their privacy would be protected was also recommended.

4.3 Attitudes and sexual behaviour

- 40% of teenagers reported having had sexual intercourse. The most deprived groups were significantly more likely to have had sex than their most affluent counterparts (47% compared with 28%).
- Two thirds of sexually active teenagers said they had used a condom the first time they had sex. 12% had used the contraceptive pill. A similar proportion said they had used emergency contraception the first time.
- 17% of boys and 15% of girls said they had not used any contraception when they first had sex. The most deprived group were most likely to say they had not used any form of contraception the first time they had sex.
- There appeared to be a strong 'public' response in favour of using condoms that seemed to be at odds with the negotiation of their use. Girls felt that they could not insist on condoms being used and about half of respondents would be too embarrassed to discuss contraception use with their partners.

- Respondents from schools in more deprived areas were more likely to report peer pressure to be sexually active but were also less keen to use condoms. However, they were also more likely to say that it was important not to be overly influenced by their friends.
- The most common motivations for first sexual experience were being curious, a relationship progressing and being in love. Also common but less frequently, respondents claimed to have been drunk or 'carried away with their feelings'.
- The most common reasons for not using a condom were being drunk or not having one available at the time. However these apparently 'risky' scenarios of condom non-use were only marginally more numerous than more 'considered' scenarios such as knowing their partner well enough, using another method of contraception or being in love.
- Although most teenagers felt that they had had sex at the right time, girls were more likely to wish they had waited longer.

4.4 Comments from teenagers

- A number of teenagers commented that more sex education lessons were needed in school, the timing of lessons and how and what topics were taught also needed attention. A minority of teenagers felt that sex education lessons were delivered too late, or they weren't learning anything new as they progressed through school.
- There were certain topics that some teenagers felt were more important to learn more about or they felt had been missing in their formal education. The topics mentioned in particular were sexually transmitted infections and the emotional side of sex and relationships. Participants also provided suggestions for how topics should be taught, like splitting into same-sex groups, more advice from health professionals within school, and the use of 'shock tactics'.
- Additional comments were made in relation to the provision of sexual health services for young people as well as those made earlier in the questionnaire.

As before, issues of awareness, advertising, accessibility, and embarrassment were mentioned.

- Teenagers commented on peer pressure in relation to having sex. A number of the teenagers regretted being 'pressured' into feeling like they had to have sex, but others knew that peer pressure was happening around them but felt that they were not influenced by it. Teenagers also felt that more help to overcome these issues were needed from services and schools.

5 Discussion

This section provides a critical discussion of the findings focusing on sex and relationships information and education, use of the sexual health services, and attitudes and values. It will make comparisons between genders and areas of deprivation, and highlight salient differences between those who report being sexually active and those not. The section will conclude with a review of the strengths and weaknesses of the survey.

5.1 Sex and relationships information and education

While the school environment remains the main arena for sex and relationships information, there appear to be differences between the genders in relation to wider information seeking behaviour. Girls are using a variety of trusted predominantly female sources including mothers and friends, as well as magazines and clinics, and are perhaps as a consequence more knowledgeable about sexual health issues. Conversely, less than half of boys reported seeking information from male friends or relatives (preferring their mothers) men therefore, seem to play a smaller role in providing information. This reluctance in communicating with males is further demonstrated by the inclination of boys to get information by more solitary means through television or films and the web. Added to this was the finding that boys are less likely to take sex and relationships education seriously, which may be influential in their comparative lack of information seeking behaviour.

Other research has found that boys do not want to appear to be ignorant about sexual matters and the fear of ridicule among friends outweighs the desire to ask questions (Mitchell and Wellings, 1998a). Additionally, our finding that boys' friends are more likely to make them feel that sex is the most important part of a relationship, is suggestive that the nature of information sharing is more one of 'conquest bragging' than clarification and learning. Research by Thomson and Holland (1998) also suggests that boys feel under pressure from peers to have sex because they do not want to be seen as deficient in this area. However, the findings do raise questions about how and from where boys get information about sex and relationships. Our findings suggest that while peer pressure may have a part to play, boys seemed to attach greater importance to the physical side of relationships. They were more likely to think that sex was important in a long term relationship, that one night stands were ok and expressed a desire for more knowledge about the physical side of sex.

As reported earlier, along with girls, boys' main source seemed to be teachers. However, the adequacy of this source needs to be questioned from a number of angles. Firstly, boys were

less likely to get the knowledge questions right than girls, and did not seem to learn very much from teachers particularly about HIV/AIDS. Additionally, there were clear indications from both boys and girls that the classroom does not provide an encouraging environment for discussion, important for fielding frank questions and cementing understanding. Also, participants identified gaps in the type of education received, reporting a greater emphasis on physical aspects to the detriment of emotional issues, relationships and parenting. Even with this physical emphasis, there appeared to be more of a focus on bodily changes rather than sexual aspects. Although these findings relate to both genders, the reliance that boys may have on school-based education is of concern given that there seem to be some clear shortfalls in this method.

It is also important to note that while the school is a key source of sex and relationships information for most young people, half of the sample did not feel comfortable when being taught by teachers. In addition, there was a lack of small group discussion and most felt unable to ask questions in the sessions. Again, these factors are particularly relevant for boys. Most boys will not ask questions because they want to be seen to know it all (McNulty and Richardson, 2002) and they also find it difficult to discuss anything that makes them feel vulnerable (Mitchell and Wellings, 1998a). Consequently, these issues raise questions as to the adequacy of sex and relationships education in some areas.

Next it is logical to review the behaviour of those who report being sexually active. The difficulties boys appear to have in talking about sex are still evident. While both boys and girls do not seem to use boyfriends or girlfriends as a source of information, boys find it more embarrassing than girls to talk to a new partner about contraception. The boys involved in Mitchell and Wellings' (1998a) research also suggested that embarrassment was a key reason for not discussing condoms. This lack of communication can therefore easily translate to risky behaviour, particularly as overall, more boys than girls felt that casual sex was acceptable while also knowing less about sexually transmitted infections.

Despite girls knowing more about contraception and sexually transmitted infections than boys, the findings suggested that some girls might still lack the skills to negotiate safe or healthy sexual relationships. Approximately, a quarter of the girls wanted sex and relationships education to teach them more about being able to say 'no'. Clearly, an awareness of contraception and sexually transmitted infections does help to prepare teenagers for developing sexual relationships that they feel comfortable with; this is particularly relevant for girls, as negotiating safe sex can be guided by unequal gendered power relationships (Gelder, 2002). Our findings indicate that teenagers wanted and would benefit from talking more about the physical and emotional aspects of relationships.

With reference to other sources of information, it was disappointing that so few respondents use the highly publicised 'foryoungpeople' website created by the Teenage Pregnancy Partnership. Given the growing use of technology as a means of communication among teenagers, this method would seem in principle worthwhile, especially as there were clear indications in our findings that written information such as pamphlets are not used or valued. One explanation may be that access within schools or at home is restricted due to blocks imposed preventing access to websites of a sexual nature. However, further evaluation is indicated to discover how this could be improved.

Moving now to the timing of their sex and relationships education, although the majority of respondents felt that the range of topics that constitute such lessons were given at the right time, there was a noticeable disagreement with information about alcohol, felt to have been given too late. The links between sexual behaviour and alcohol are well documented (Nicoll et al 1999; Van Den Akker and Lees 2001) and the findings here may indicate a growing realisation of this, especially as a quarter of those who reported having sex for the first time cited alcohol as a contributory factor.

When considering the differences between deprivation levels, the differing priorities attached to parts of the curriculum may have a part to play in the findings that teenagers in the more affluent areas seem to draw their knowledge from a narrower range of sources and appear to learn less from teachers than teenagers from the more deprived areas. Also teenagers from the more affluent areas are being taught less about sex and relationships. For both areas, affluent and deprived, however, there was an over-emphasis on physical aspects and a scarcity of relationships education. It does remain a concern however that teenagers from the more deprived areas feel they have learnt more from a wider range of information sources, such as their school and families, but appear to know less of the facts than their counterparts in schools in more affluent areas. Also, this group of teenagers were more likely to feel that they were being taught sex and relationships issues before they were ready.

5.2 Use of sexual health services

When using sexual health services, teenagers identified the need for a friendly and private environment and free contraception mirrors surveys undertaken elsewhere (Mitchell and Wellings 1998; Stone and Ingham 2003). Most of the teenagers in our study had not used these services and when combined with their lack of knowledge of service availability and despite the potential challenges, calls for more information and collaboration with schools to

raise awareness. Blair et al (2001) also found that most boys and girls knew little about the roles of staff at sexual health services or their right to confidentiality when under 16.

Girls were more likely to use sexual health clinics to access contraception than boys, who were more likely to use shops and condom machines. Gelder (2002) and McNulty and Richardson (2002) suggest that sexual health services are mainly female staffed and some boys perceive services as 'women-only' (McNulty and Richardson 2002). However, the boys in this project were not concerned with the gender of the person offering them advice. This difference in the uptake of sexual health services by boys and girls may also contribute to the differences in their knowledge of contraception and sexually transmitted infections. For example, research by the Sex Education Forum (1997) argued that the gaps between boys and girls knowledge is because boys are less likely to receive information at home or from health care professionals, and this was certainly evident in our findings.

It was not surprising to see that the teenagers who reported having sex were more likely to have used a family planning or young person's clinic for contraceptive services, and this is reassuring. It was also of interest that teenagers were more likely to have used the service if they were from schools taking students from the more deprived areas. This is an interesting finding and may suggest that the targeted response of services to areas that are statistically more vulnerable to teenage pregnancy is working in that more young people are familiar with the service provision and using them.

Contact with these services might also have influenced the sources the teenagers trusted to provide them with reliable information on sex and related issues. For example, girls who reported having sex were more likely to trust sex and relationships information from a clinic than those who had not, moving away from mothers and friends as being the most trusted sources.

This movement towards services could link with the importance for service use to be anonymous, private and kept secret from friends and family members, which was a prominent finding in the study. It is well documented that gaps exist between parents and children with respect to sharing information on sex and relationships in this country (BMRB International 2003) and is often cited as a contributing factor towards high rates of teenage pregnancy. This is especially so when compared to other countries, who are seen as having a more open-minded approach (Berne and Huberman 2000) than the culturally reticent image of families in the UK. However, while greater parental involvement is often advocated (Walker 2004), there are contradictions about the extent to which this is possible in practice. A recent evaluation of the charity 'Parentline Plus' suggested that parents often feel ill

equipped to offer advice, and most teenagers surveyed found their parents embarrassing or unhelpful when it came to sex (Boddy et al 2004).

The teenagers' desire for sexual health services to be discrete and hidden away from people that they know contradicts with their desire for a service that is well publicised and easily accessible. The differing needs of teenagers present a number of challenges for service providers. Some want a service that is well advertised, centrally located or even provided in school. At the same time, others suggested that services should be discretely available to them in locations that only they would know about. There were also differing preferences within and between the areas surveyed. Health services need to be flexible, make use of pilot initiatives and have a range of different services if they are to be responsive.

The findings therefore on sexual health service use highlight clearly the importance of confidentiality and ensuring that service provision heeds the overarching 'embarrassment' factor felt keenly by our respondents. Overcoming the issues of embarrassment when accessing services is a major issue and could be assisted by greater linking of schools with providers, an aspect acknowledged by teenagers' comments. It is significant that the apparent lack of communication and linkage between schools and providers of services experienced in some areas could become more of an issue as the funding of these services is set to change. Teenagers in deprived and affluent areas have recognised that they need to know more about services and would welcome opportunities for outside speakers or school nurses to provide the information they need, albeit in the classroom setting or as outreach work – with young people visiting clinics. Advertising the service needs to be undertaken with caution and the right approach needs to be adopted. For example, leaflets are not viewed by many as useful means of communicating information, therefore more face-to-face methods could be more effective. Comments suggested that school nurses coming into schools could be instrumental in overcoming fears about embarrassment and being judged.

It was clear that, although the teenagers in the survey reported anticipatory fear and embarrassment associated with accessing sexual health clinics and contraceptive services, those who were using them viewed them as friendly and helpful. A positive outcome of this survey is the overall favourable opinion that users of the local sexual health services had in relation to range of services provided and the friendliness and confidentiality of staff. Again, this suggests that current users may continue to avail themselves of services when issues such as privacy and confidentiality are addressed. The key factor appears to lie in managing the processes that get teenagers 'over the threshold'. Comments did however reveal some

more discrete experiences that were not so favourable, such as judgemental attitudes and difficulties obtaining the morning after pill, that suggest there is room for improvement.

5.3 Attitudes and values

Despite the lack of educational input on relationships, sexual feelings and emotions there were some interesting and sometimes contradictory findings within these subjects. While respondents shared contemporary views on domestic equality in a relationship and having sex outside of marriage, they seemed to hold more traditional values such as faithfulness, mutual respect and having an adequate income highly. The teenagers were less sure about the appropriateness of casual sexual relationships. The findings identified a number of interesting and important differences between the genders, highlighting risky behaviours that could connect to information deficits. For example, more boys than girls thought that casual sex was ok, but only half of the boys felt that people should refuse to have sex with someone who objects to using a condom. While half of the teenagers felt that contraceptives were easy for young people to get hold of, half again would still be too embarrassed to buy condoms from a shop, especially boys. This reflects the teenagers' desire for their access to services to be hidden or discrete.

There are some further interesting contradictions that emerged in the attitudes towards safe sex among those teenagers reporting to be sexually active. As with previous research, most of the boys had sex because they were curious and the girls tended to have sex because they were in love (Aggleton et al 1998). There appeared to be a strong 'public' response in favour of using condoms that was at odds with the negotiation of their use. Girls for example felt that they could not insist on condoms being used and about half of respondents would be too embarrassed to discuss contraception use with their partners. Difficulties relating to embarrassment and negotiation seemed more pronounced among sexually active teenagers from more deprived areas and as these teenagers are also more worried about unwanted pregnancy it could indicate that they are taking more risks; this is supported by the finding that they are also less likely to have used contraception when having sex. Awareness of the risks yet inability to negotiate sexual relationships could be connected to the lack of relationships input that is apparent in current sex and relationships education. That girls tended to wish they had waited longer adds a further dimension and it is not surprising that the general desire among girls for greater input dealing with the emotional side of sexual relationships was a strong theme. These findings resonate with other studies (Wellings et al 2001) and also link back to the unequal gendered power relationships highlighted by Gelder (2002). Research by Freeman (2000) and Measor et al (2000) reported that male partners or friends sometimes pressure girls into sex. It is interesting that while controversy

surrounds the provision of sex and relationships education to young people (Spalt 1996) some of the girls actually suggested that they would have waited longer before having sex if they had been given more information. Putting these threads together, a picture emerges that further supports a targeted approach to sexual health.

5.4 Strengths and weaknesses of the study

Overall, the high response rate was encouraging and the relatively even gender split has enabled some sound comparisons to be made. Surveys to teenage populations generally have difficulty in attracting high male response (Darroch and Singh 1999; Kirby 2001). The demographic profile of the respondents is unsurprising and closely matches that of Kent as a whole (Limentani 2005).

The success of this survey has been largely due to the close networking of the research team with the participating schools and services associated with schools. The detailed nature of the questionnaire was both a strength and a weakness, permitting some in depth analysis of the study topics, but also having the potential to cause respondent fatigue due to its length.

6 Conclusion and Recommendations

This study has highlighted a wide range of issues that have revealed the nature of sex and relationships education and information, use of sexual health services, and attitudes and values around sex and relationships. In addition, comparisons between different groups have enabled some interesting differences to emerge.

While there appears to be some positive educational examples, it seems that the current sex and relationships education delivered in schools across Kent is, currently, not providing teenagers with the most inclusive educational experience, nor equipping teenagers with the knowledge levels they need. Teachers continue to be the main providers but, overall, our respondents were not learning much in the school environment, especially boys.

There appears to be too much emphasis on the physical side of sex and a lack of information about emotional and relationship aspects. This deficit is reflected in the contradictory nature of attitudes and values towards sex and relationships detected in our sample group, especially among sexually active respondents. Here, the ability to effectively negotiate contraceptive use is challenged and risk taking behaviours are apparent. This is particularly so among teenagers from schools that are situated in the more disadvantaged areas. In addition, curriculum delivery is impeded by large impersonal classes, an inability to address the differing gender requirements, and an embarrassment factor that militates against effective learning. There is a clear need for schools to take advantage of a more multi-agency approach using outside speakers from health and social care agencies in order to inject diversity and credibility into the general educational approach.

Access to sexual health services appears once more to be linked to information needs, as many respondents are not aware of these services. Fears about embarrassment and confidentiality surrounding how contraception is obtained also play a large part in the access process. Once accessed, services were favourably viewed by users, however, targeted work needs to be done in managing this process and overcoming anxieties. Initiatives such as the 'C Card' appear to play a significant role in facilitating this. Teenagers from schools within more deprived areas were greater users of these services, and given their apparently greater risk taking behaviour, the continued need to focus on services to these areas is justified.

One of the key findings of this report is that it may be unrealistic to identify a homogeneous set of needs and expectations that can apply to all teenagers. However, by exploring the most significant lines of differentiation, we can make recommendations that may help to tailor

services to individual needs in a way that maximises their reach and eases their use by young people. Our study suggests that gender, relationship with school, age at which sexual experimentation begins and levels of deprivation form the most consistently noticeable differences between the young people surveyed, however these are not always very large distinctions and individual circumstances and outlooks may be equally significant.

Recommendations

6.1 Improving sex and relationships education

6.1.1 As the school arena remains the most important forum for sex and relationships education, agencies involved in teenage pregnancy must continue to liaise with schools in supporting, developing and maintaining programmes. In particular, strategies for including those schools who provide less educational input (such as in schools situated in more affluent areas) must be developed and piloted, with greater cross-school learning regarding good models of practice. Schools in areas of deprivation should continue to be targeted.

6.1.2 There are clear topic gaps in current provision. A greater focus should be given to informing teenagers on the emotional side of their education, such as relationships and sexual feelings. Additional gaps include parenting, the emergency contraceptive pill, specific ways of contracting sexually transmitted infections and the legalities of sexual relationships.

6.1.3 Informing teenagers of sexual health services at an early stage is important, including contraceptive services and sexually transmitted infection screening. School nurses and sexual health outreach workers would be well placed to provide this.

6.1.4 The timing of sex and relationships education should be reviewed, particularly in relation to earlier delivery of drugs and alcohol and the frequency with which educational messages are given during the teenagers' school careers.

6.1.5 The issue of gender should be taken into account when planning sessions. For boys, practices should be reviewed to take into account their differing knowledge levels and information help-seeking behaviours. For girls, there is the need to develop more confident negotiation skills around the sex act, to avoid pressure to have sex and create an ability to say 'No'. Separate discussion groups may provide an initial forum through which to address these issues.

6.1.6 Connected to (ii), consideration must be given to the manner by which and environment within which SRE is taught, focusing more on small group discussions and innovative techniques, with greater use of outside speakers. In addition, a review of the training needs of school nurses and teachers should be undertaken.

6.1.7 Given the low use of pamphlets and web-based information, a more in-depth review of suitable methods to inform young people about sex should be undertaken. Alongside this, strategies that promote maximum learning opportunities should be identified.

6.2 Improving sexual health services

6.2.1 Proposals for developing and establishing alternative locations and user-friendly sexual health services should take place in areas where they are not available, learning from local and national pilot schemes currently underway. This should include drop-in young people's clinics in schools or other local easily accessible locations, with flexible opening hours.

6.2.2 A review of methods to improve the access process to sexual health clinics and contraceptive services should be undertaken. Central to this approach should be promotion of services in schools by health and social care staff, using strategies to counter embarrassment and fears, and promoting confidence among teenagers in the confidential nature of sexual health services. The continuation of the 'C Card' would appear to be justified here, enabling young people direct access to contraceptive services.

6.2.3 Agencies should continue to target areas of high deprivation where risk-taking behaviours are more pronounced.

6.2.4 There should be on-going assessment and training of staff working with young people in sexual health services to ensure a sympathetic attitude and approach to care.

6.2.5 Agencies should continue to promote the involvement of school nurses and outreach workers in sex and relationships education and support.

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APPENDIX A

Thinking about Sex and Relationships: Your Views on the Education and Services in Kent

We are a team of researchers at the University of Kent who have been asked to carry out a project on behalf of the Kent Teenage Pregnancy Partnership. We'd like you to invite you to take part in the project.

Before you decide if you want to take part or not, it is important that you understand what the project is about and what you would need to do if you take part. It may be helpful to talk about this with your friends, parents or carers.

What is the project about?

This project will find out what young people think about sex and relationships education, and sexual health services in Kent. Students across Kent will fill in a questionnaire, and their answers will help to make improvements to these services in the future, and so your views and experiences are important. The project is completely separate from the school and has nothing to do with your school work.

If I take part what do I have to do?

On the DATE a member of our team will be coming to your school and you will be asked to fill out a questionnaire with other students in your year. The project worker will be there to hand out the questionnaires and guide you through the survey. This will give you the chance to ask any questions about the questionnaire. It should take about 40 minutes.



The survey has four main parts to it that will look at things like where you get your information on sex and relationships from, what you think about your sex and relationships education and what you think about sexual health services in Kent.

What happens to the information?

We know that this information is private to you, and we are grateful that you may be willing to share it with us. I would like you to know that anything you tell us will stay with us, and your information will be completely confidential.

All the questionnaires will be anonymous, which means that your name will not be on it. When you have finished the questionnaire you will place it in a sealed envelope so only the project team will see the answers.



All the questionnaires will then be coded on to a computer so that no one can be identified. Once the project is completed all the questionnaires and computer data will be destroyed.

Do I have to take part?

It is up to you whether or not you take part, but if you don't want to take part, this will not affect you in any way. If you decide to take part but change your mind, you are free to do so, and this will also not affect you in anyway.

You can also change your mind while you are completing the questionnaire, as we can remove your questionnaire from the project and destroy it. Once the questionnaires have been collected your data cannot be removed as the questionnaires are anonymous.

How can I find out more?

If you would like to know more about the project or if there is anything that is not clear, you can ask (name of link teacher), or contact Jan Macvarish on 01227 823666 or via email at J.Macvarish@kent.ac.uk.

www.kent.ac.uk/chss

www.kent.ac.uk/chss

APPENDIX B

September 2005

Dear Parent or Guardian,

The Centre for Health Services Studies at the University of Kent has been asked by the Kent Teenage Pregnancy Partnership to find out teenagers' views and experiences of sex and relationships education and sexual health services across Kent. We are inviting young people in schools throughout Kent to take part in the survey so that the current services can be evaluated. We have been sending out an information sheet to tell them about the project and what taking part would mean to them.

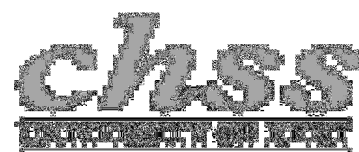
The project will involve a survey of teenagers' aged 15 and 16 in Year 11 and the Head Teacher has agreed to NAME OF SCHOOL taking part on DATE.

All students are given the opportunity not to take part in the project, and you can also withdraw your son, daughter or the child in your care from the project by completing the tear off slip below and returning it to the school.

If you need any further information about this project, please contact Jan Macvarish on 01227 823666.

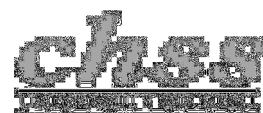
Yours sincerely

Jenny Billings
Research Fellow, Project Lead.



I would like to withdraw (insert name of student) _____
from completing the survey at NAME of SCHOOL on teenagers' views of sex and
relationships education and sexual health services across Kent.

Signed: _____ (parent/ guardian)



APPENDIX C

Participating Schools

Axton Chase Comprehensive, Dartford
Barton Court Grammar School, Canterbury
Bennett Memorial Diocesan School, Tunbridge Wells
Borden Grammar for Boys, Sittingbourne
Brockhill Park Performing Arts College, Hythe
Castle Community School, Deal
Clarendon Grammar School for Girls, Ramsgate
Christ Church CE High School, Ashford
Cranbrook Grammar School, Cranbrook
Dane Court Grammar School, Broadstairs
Folkestone School for Girls, Folkestone
Gravesend Grammar for Boys, Gravesend
Hartsdown Technology College, Margate
Harvey Grammar School for Boys, Folkestone
Herne Bay High School, Herne Bay
Hextable Comprehensive, Swanley
Highworth Grammar School for Girls, Ashford
Homewood School Comprehensive, Tenterden
Hugh Christie Technology College, Tonbridge
Minster College Comprehensive, Minster-on-Sea
Montgomery High School, Canterbury
Maplesden Noakes High School, Maidstone
Meopham High School, Meopham
Oldborough Manor Community High, Maidstone
St Edmunds Catholic Comprehensive, Dover
Senacre Technology College, Maidstone
Simon Langton Girls School, Canterbury
Skinner's Grammar School for Boys, Tunbridge Wells
Sittingbourne Community College, Sittingbourne
Thames View High School, Gravesend
The Channel School, Folkestone
The Community College, Whitstable
The Cornwallis High School, Maidstone
Tonbridge Grammar School for Girls, Tonbridge
Valley Park Community School, Maidstone
Westlands High School, Sittingbourne
Wilderness School for Boys, Sevenoaks