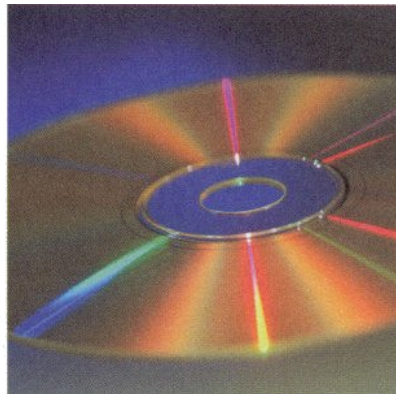


A Survey of Teenagers' Views of Sex
and Relationships Education and
Sexual Health Services in Kent

EXECUTIVE SUMMARY

September 2007



**Jenny Billings, Charlotte Hastie,
Linda Jenkins, Jan Macvarish**

**Centre for Health Services Studies
University of Kent**

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

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I 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 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

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.

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 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 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 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. 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.

3 Key Points

3.1 Sex and relationships education

3.1.1 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 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 said that they had learned only some or a little from this source.
- 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, a pattern that 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 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.

- The results of a knowledge quiz within the questionnaire 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. Less was known about the emergency contraceptive pill.
- Respondents from schools in more affluent areas were more knowledgeable with reference to the quiz than their counterparts in more deprived areas, despite having less sex and relationships input at school and drawing on fewer sources of information.

3.1.2 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. Wanting SRE to be taught in smaller groups was a recommendation.
- Most felt that the timing of SRE was right, although some felt that they had learnt about abortion and being a parent/childcare at an inappropriately early age.
- Most respondents said 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.

3.1.3 Teenagers' comments

'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'

'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'

'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'

'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!'

'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!'

'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'

'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'

'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'

'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'

3.2 Views and use of sexual health clinics

3.2.1 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. Many boys and girls were also worried about being medically examined.
- Embarrassment was reported or anticipated when accessing contraception from both health services or commercial premises, however once teenagers had accessed services their general opinion of them was favourable.
- A further issue of privacy and confidentiality was revealed in the concerns expressed 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.

3.2.2 Teenager's comments

'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'

'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.'

'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'

'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'

3.3 Attitudes and sexual behaviour

- 40% of teenagers said they had 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.
- 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.

- Being curious, a relationship progressing and being in love were the most commonly cited motivations for first sexual intercourse. 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.

3.4 General comments

- Some teenagers commented that more sex education was needed within the school; the timing of lessons and how and what topics were taught were also an issue. Others felt that sex education lessons were delivered too late, or they weren't learning anything new when they had further lessons.
- 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'.
- Further comments were made regarding provision of sexual health services for young people in addition to comments made earlier in the questionnaire. As before issues of awareness, advertising, accessibility, and embarrassment were mentioned.

- Issues of peer pressure around having sex were described in some of the comments. Some teenagers regret being 'pressured' into feeling like they have 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 was 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''

'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!'

'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'

4 Conclusion

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 would appear to be some positive educational examples, it would seem that the current sex and relationships education delivered in schools across Kent is, in general terms, 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 inhibits 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 around embarrassment and confidentiality surrounding how contraception is obtained also play a large part in the access process. Once 'over the threshold', services were favourably viewed by users, but it would seem that there is targeted work to be done in managing this process and overcoming anxieties. Initiatives such as the 'C Card' could play a significant role in facilitating this. Of note is the finding that 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.

5 Recommendations

5.1 Improving sex and relationships education

5.1.1 As the school arena remains the most important forum for sex and relationships education, agencies involved in teenage pregnancy prevention 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.

5.1.2 There are clear topic gaps in current provision. A greater focus should be given to informing teenagers more about 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.

5.1.3 There is a need to inform teenagers of relevant sexual health services at an early stage; this includes not only contraceptive services but also sexually transmitted infection screening. School nurses and sexual health outreach workers would be well placed to provide this.

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

5.1.5 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.

5.1.6 Consideration must be given to the methods by, and the 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.

5.1.7 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.

5.2 Improving sexual health services

5.2.1 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.

5.2.2 A review of methods to better manage the access process to sexual health clinics and contraceptive services should be undertaken. Central to this approach should be the 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.

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

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

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