Teenage Sexual Health Needs:
Asking the Consumers

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Executive Summary

At the beginning of 2003 a focus group study was conducted in schools in Cardiff and the Vale of Glamorgan to discuss the perceived sexual health needs of teenagers. Four single sex groups (two male and two female) were convened comprising 14-15 year olds and each group met for two one hour sessions.

Sex education was reported to vary considerably in quality and content both between and within schools. Participants felt that this was largely due to some teachers being embarrassed, which resulted in didactic delivery and lack of discussion. Most participants had been given very little information about sexually transmitted infections, including how they could be avoided or what to do if infection was suspected. The general message was that teenagers needed practical information delivered by an expert in the subject. Many felt that it would be useful to have an organised visit to a sexual health/contraceptive clinic as part of their PSE curriculum and that it would also be helpful if clinic staff contributed to their sex education.

The focus groups also carried out a critique of some currently available sexual health literature. Teenagers had very constructive views on what graphic style was most likely to convey the ‘healthy choices’ message effectively to their age group. There was a general consensus that two of the leaflets would be acceptable, but that neither was exactly what was needed. Participants felt strongly that people of their age throughout Wales should have a comprehensive sexual health booklet designed for teenagers and with their input. This should include local inserts giving details of sexual health services that they could access.

The outcome of this study was very similar to that of previous research conducted locally in 1996/7. Teenagers need more comprehensive sex education at an earlier age, delivered by individuals who are expert in the subject and comfortable in its delivery. Information alone is not enough but should be linked to accessible user-friendly services for contraception and general sexual health.
**Introduction**

The following report contains the views of secondary school students on their sex education and sexual health needs, derived from analysis of material from focus groups facilitated by Bro Taf Health Authority’s Public Health Directorate (now National Public Health Service for Wales). The study took place with year 10 students in Cardiff and the Vale of Glamorgan during February and March 2003.

**Background**

Sexually transmitted infections (STIs) can cause serious permanent damage to health if left untreated. Data collected by the Public Health Laboratory Service (PHLS) indicate that the incidence of gonorrhoea, syphilis and chlamydia in England, Wales and Northern Ireland more than doubled between 1995 and 2000\(^1\). The report states that the incidence of genital chlamydia rose by 20 per cent in males and by 17 per cent in females between 1999 and 2000.

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The figure below illustrates the local rise in chlamydial and gonorrhoeal infections in young women diagnosed at GUM clinics in the area covered by Bro Taf Health Authority until April 2003. The rise only became apparent between 1998 and 2000 when the number of infections diagnosed almost doubled (figure 1), but this may be partially attributable to improved diagnostic sensitivity and greater professional awareness leading to more opportunistic testing.

**Figure 1**

Chlamydia and gonorrhoea in females aged 16 to 19 years: Bro Taf GUM clinics 1995-2000

![Chlamydia and gonorrhoea in females aged 16 to 19 years: Bro Taf GUM clinics 1995-2000](chart)

Source: PHLS

Though the increase in both infections is of concern, chlamydia may be the more serious problem, as it is often asymptomatic and thus the reported figures are likely to mask a high number of ‘hidden’ cases. Opportunistic testing of teenagers attending local young persons clinics for contraceptive advice has produced rates of chlamydial infection of around 20 per cent, with one location having a rate as high as 50 per cent. A national chlamydia screening pilot for England (1999/2000) showed rates of 13.8% for those aged under 16 years and 10.5% for those aged 16-19\(^2\), but government policy is to target those over 16. These figures may represent a genuine increase in cases, or serve to confirm an existing high prevalence but, in either case, the public
health implications cannot be ignored. Chlamydia is now the most common sexually transmitted disease in the UK and known to be most common in sexually active women aged less than 20 years. It causes tubal infertility and ectopic pregnancy and it has been estimated that 60-80% of genital chlamydial infections are asymptomatic.\(^3\) Therefore many infections remain untreated and go on to cause serious reproductive problems some years later.

It is possible that easier access to emergency contraception may lead to increased prevalence of unprotected sex, thus adding to the risk of STIs. However, the rise in STI incidence began before ‘over the counter’ post-coital contraception became widely available. Birth rates in many western countries are already falling, probably by choice, and there are concerns over the potential imbalance between workers and pensioners. If the trend towards increased rates of STIs leads to an appreciable rise in infertility, the demographic imbalance is likely to become worse, with implications for the funding of pensions and the health service. This has serious public health implications and great potential to increase health inequalities. Prompt action is desirable, as these effects may only become apparent in the future, when women now in their teens attempt to become pregnant in their twenties and thirties.

A report published in February 2002 by the British Medical Association (BMA)\(^4\) suggests some possible explanations for the current high rates of STIs. Though there may be increased transmission, this possibility should be balanced against greater professional and public awareness, improved access to GUM services, and improvements of around 40 per cent in diagnostic sensitivity. The often asymptomatic nature of chlamydia enables rapid spread that can reach epidemic proportions. The BMA report suggests that contributory factors in the apparent rise in all STIs may be inadequate sex education in school and the absence of recent high profile campaigns to promote safe sex.

Sex education has been criticised as tending to remain largely static while societal norms have changed\(^5\). Recent figures show that approximately 26% of girls and 30% of boys have had sexual intercourse before the age of 16\(^6\). Courses have been criticised for being too late, too few and too general\(^7\). This view was largely supported by a 1997 study\(^8\), which concluded that sex education, information and service provision needed a holistic approach, rather than being treated as separate issues. This study identified that education on STIs was non-existent in some schools and very poor when it was taught. Curricula designed to help teenagers deal with social and peer pressure have had some success in tackling risk-taking behaviour\(^9\), and it is advisable to take teenage views into account when planning sex education\(^10, 11\). Adolescents themselves recommend that sex education should be more positive and that details of sexual health clinics should be advertised in locations frequented by teenagers\(^12\). Though this does now take place, younger teenagers who do not frequent pubs and clubs do not have access to such sources of information.

Most studies of teenage sexual health focus on unintended pregnancy rather than STIs, but some of their findings will also be relevant to the prevention of infection, for example, a review of interventions to prevent teenage pregnancy found that abstinence programmes showed an increase in pregnancies in partners of male participants\(^12\). This could mean that abstinence programmes discourage males from carrying condoms while sexual intercourse continues at the original rates. Thus
programmes advocating abstinence are also likely to lead to a rise in STIs. It can be demonstrated that sex education programmes improve knowledge\textsuperscript{13} but in well-conducted randomised controlled trials there is little evidence that interventions change behaviour\textsuperscript{12}.

Success is associated with broader interventions and those that take place at a younger age, for example disadvantaged children who receive day-care under the age of five years are less likely to have teenage pregnancies\textsuperscript{14}. This finding indicates that sexual behaviour is likely to be based on the individual’s self-efficacy engendered at an early age. Lessons from substance misuse programmes may also be relevant, where a combination of teaching social resistance skills and general life skills has been shown to be effective\textsuperscript{15}.

**Aims of the Study**

The study is based on the hypothesis that the current high prevalence of chlamydia in teenagers may be partially attributed to poor knowledge of sexually transmitted infections and inadequate use of condoms by sexually active young people. The intention was to examine issues associated with sexual knowledge, attitudes and practice in teenagers, an age group vulnerable to sexually transmitted diseases, particularly chlamydia. The proposed study involved adolescents aged 14–15 years and re-visits a local focus group study carried out in 1997. Following the original study, teenage sexual health clinics have been made more accessible. There has also been a new Sexual Health Strategy for Wales\textsuperscript{16}, which recommends that schools provide effective sex education within “environments that are supportive and safe for staff, visitors and pupils”. The Strategy recognised that education should be combined with good access to sexual health services. In maintained secondary schools, sex education must include information on sexually transmitted infections, but the document acknowledged that delivery is open to interpretation.

The objectives of the study were to identify:
- gaps in knowledge that could be remedied by improved school sex education
- problems of access to sexual health services
- sexual practices and beliefs that may increase the potential for sexually transmitted infections.

**Method**

**Sample**

Teenagers in year ten (aged 14–15 years) from three secondary schools in Bro Taf were invited to take part in the study. A high school in Cardiff that was involved in the 1997 study of teenage Sexual Health\textsuperscript{8} was included to provide comparative data. The second and third schools were single sex comprehensives in an area where a high prevalence of chlamydia in younger teenagers had been identified. The three schools tended to serve lower income areas. Sampling for this type of research should be theoretically driven rather than random, so schools were asked to select eight to ten pupils to take part in the research in single sex groups, based on their maturity, ability and willingness to take part.
**Study design**

Focus groups with a sample of students were convened to facilitate an in depth study of students’ knowledge, attitudes and beliefs regarding sexual health. Separate male and female groups were held, as evidence from the previous study in Cardiff indicated that students approved single sex groups, as this promoted greater openness. Methods were similar to the previous study, with two meetings convened for each group with an experienced but young facilitator who was familiar with the terminology used by teenagers, plus an observer. Focus groups were recorded, transcribed and analysed in terms of response to the core questions on which the discussion is based and using the principles of grounded theory.

Focus groups were semi-structured and based around the following questions:

**Session 1**
1. What do you think of school sex education?
2. How would you feel about peer-delivered sex education?
3. From where have you learnt most about sex in general?
4. From where have you learnt most about contraception?
5. What have you been taught about using condoms?
6. What is emergency contraception?
7. What do you know about sexual health services for teenagers?
8. Where would you go if you thought you might have a sexual health problem?

**Session 2**
1. Who should suggest using a condom?
2. What might stop people using a condom?
3. How would you feel about talking to your boyfriend/girlfriend about sex?
4. Do you think that there are pressures on teenagers to behave in certain ways?
5. What do you know about sexually transmitted disease?
6. Do you think that teenagers have an ‘it won’t happen to me’ attitude?
7. Opinions on currently available leaflets on STIs.

**Preparation for the study**

Heads of schools and PSE leads received a copy of the proposed questions, a draft letter to inform parents of the purpose of the study with the option to opt out, and a copy of the paper written as a result of our previous school sexual health study. Each pupil selected to participate was given a copy of the parental ‘opt out’ letter.

In addition, preparatory discussions with staff took place (face to face or telephone). There were no objections to the study, but one teacher (Vale girls) said that she would have preferred the study to have been later in the year, after she had delivered further time tabled lessons. It was explained that other schools might be in the same position, and it was advisable that all groups should take place within the same time frame. Some information given by school staff ran counter to pupils’ perception of the situation and this will be discussed later.

Both researchers gained police vetting prior to working with pupils.

**Analytical procedure**
In line with a qualitative methodological approach, the data from this study have been analysed throughout the research project. After each session time was spent discussing the content and formulating ideas about the research. This led to points raised in one session being further explored in the subsequent meeting and discussed with the other groups. The data has been analysed based on a ‘grounded theory’ approach. This means that theories develop inductively from the process of collecting and analysing data. The theories that are produced are therefore grounded in the data and the real experiences of participants\textsuperscript{17}. The constant comparison technique has also been used to analyse data. Initially this involved reading all of the transcripts to gain an overall ‘feel’ for the data\textsuperscript{18}. Categories were generally researcher led (based on the questions asked) and were interrogated until they reached theoretical saturation in the light of the study’s aims.

In reporting the results, the following abbreviations are used to denote the speaker when direct quotes are used: C = Cardiff, V = Vale, B = boys, G = girls. Also each participant is allocated a within group person number and sessions are numbered one and two. Thus, for example, CG1.4 would denote Cardiff girls first session, person four. The facilitator is Alexandra Allan (AA).
Results
Groups each comprised between six and nine participants. The first round of interviews lasted for approximately one hour each, but second round interviews were generally slightly shorter.

For ease of interpretation, comments are grouped under the core category (question) to which they most closely relate, together with discussion of the themes emerging for each. Some thoughts were expressed in direct response to the lead question whilst others emerged during broader discussions that developed from related topics.

What do you think of school sex education?

Students agreed with the present practice of year seven sex education concentrating on issues around puberty, but felt that this should move on to discussion of sexuality and relationships in years 8 and 9. They thought that sex education might be embarrassing for some pupils, but felt that an early start would make this easier to overcome and all groups believed that sex education had not started soon enough for them.

CB1.4: *I reckon we should be taught earlier on, ‘cos we could have a bigger bulk of knowing stuff.*

It is important to remember that a year group is by no means homogenous and children will vary in their abilities and needs. All groups appreciated the problems of differential maturity and hence the relevance of messages at different ages to different people. The extract also gives an indication of the willingness of participants to discuss the relevance of information to their own situation. On asking how useful sex education had been so far, the reaction was:

CB1.4: *I’m sure it will be, but it hasn’t yet.*

AA: *It hasn’t been? Why do you say that?*

CB1.4: *‘Cos I haven’t got there yet.*

This was quite typical of the participants’ view that sex education should be a practical tool for life. This is taken up later in their expressed need for practical information. Reinforcing this view, they believed that it was essential that sex education should be an ongoing process, delivered appropriately in each year: for example, lessons should be discussion-based for older pupils.

The reality of ‘under-age sex’ can be a difficult issue for teachers due to the legal situation. Participants felt that it was important that they should be taught about sex in school, but they wished to be treated with respect and not to be told how they should think and act:

AA: *Yeah, so you think it’s OK the way they treat you?*

VB2.1: *Not really...They just don’t seem to understand. They treat you like you’re in year 7 every year. Like that’s why we haven’t heard much about sex education ‘cos/*

VB2.2: *They treat you like five-year-olds like.*

VB2.1: *You come to this school and you can’t have sex at all!*

Style of delivery was obviously important, for example, pupils wanted lessons to be “less patronising” and more relevant to their own age. They did not consider them-
selves to be fully-fledged adults, but wished teachers to be sensitive to their increasing emotional and sexual maturity. Many participants held negative views about the way lessons had been conducted and this may have hindered their learning.

Among the Cardiff girls it was suggested that sex education was being modified to the intellectual capacity of the “less able” learners who were also “less mature”. Though they agreed that this was necessary, they were not sure that it was being implemented well. The result was that some of the “less able” were getting less sex education, but they felt that these were the very people who were most at risk of reckless sexual behaviour. This issue needs further investigation. As participants had been selected by their teachers on the criteria of ability and readiness to communicate, less able pupils tended to be excluded.

The immaturity and low ability of some pupils was recognised by group members as a barrier to good sex education, when the needs of less able teenagers were often the greatest.

**CB1.4**: See the bottom set is less mature about things and they mess about... With the lower set they have a narrower range of things they can do with the class before it breaks up.

and on the same subject:

**CG1.3**: I think that’s wrong ’cos the lower bands are the ones having the sexual relationships.

**CG1.2**: They are less informed and less mature

All groups reported variation in the quality and content of lessons within their own school and year group. They attributed this as sometimes due to the teacher’s poor delivery:

**CG1.1**: And it depends what teacher you get as well. Mr.--, he was all right talking about it, but say you had Mr.--, I don’t think he… he was too shy and that.

The Cardiff girls were keen to argue for a curriculum that would include the emotional side of sex, as they felt that this was missing in current teaching. All groups returned to the theme of the inadequacy of their current sex education, which left them with gaps in their knowledge. Contrasting her local sexual health clinic’s openness in providing information with that of her teachers, a pupil said:

**VG2.5**: …but in this school they leave bits out and to me that’s the most important things – the bits they miss out.

It was widely believed that some teachers were not comfortable with delivering sex education and this resulted in over concentration on textbook teaching and reluctance to answer questions or enter into discussion.

**VB1.4**: With the teachers you can’t have a discussion. It’s like a taboo or hush-hush subject.

On the other hand, however, some teachers were commended for their realistic approach and the practice of one teacher emerged from the Cardiff focus groups as a model of how both boys and girls would wish the subject to be delivered. This teacher’s methods were described as highly participatory with good control of the class:
The teacher attributes that students rated as important were:

- Comfortable with their own sexuality and relaxed attitude to sex education
- Trustworthiness and respect for confidentiality
- Ability and willingness to answer questions frankly.

Most thought that the personality and approach of the teacher was of overriding importance but a number also thought that age could be a contributory factor:

**VG1.3:** Well if you’re talking about sex, you don’t want to talk to old people about it do you?

Regarding teaching style, participants disliked role-play and didactic methods. Many considered that recall testing was unhelpful and inappropriate for this subject. Students complained of videos that were out of date and/or shown repetitively. Though many students expressed reluctance to watch sexual health programmes at home, they would welcome the recording of appropriate programmes for showing in PSE lessons. Those who had been given wallet-sized cards with contact numbers thought that this was a good idea. Three of the four groups said that they would like a facility for anonymous written questions to be answered in class and this had already been done with some success in the Cardiff schools.

In all schools students would welcome outside experts (for example, sexual health clinic staff) to take sex education modules in school and answer their questions. This method had already been tried in year nine in the Vale boys’ school:

**VB1.5:** We had someone come in and give us a talk on contraception and that and they gave us a card with all the numbers on and that. That was better…

**VB1.1:** And they didn’t dumb it down either.

**VB2.2:** Yeah, they were more straight about it.

**Themes**

Criticisms of teaching in this study were similar to those of previous local research, which found that sex education came too late and was inadequate. Teachers who are not comfortable delivering sex education usually do it poorly and this is apparent to pupils. The situation is made worse by inappropriate methods and materials, highlighting the need for expert input. Teenagers do not have sufficient information to protect themselves against STIs and this may apply disproportionately to lower ability pupils.
How would you feel about peer-delivered sex education?

There was some difference of opinion on the value of peer tutors for sex education. The Cardiff boys thought that being taught about sex by someone near to their own age would ensure that the information was relevant to their needs.  

CB1.4: ...You know you could trust them and see that they’re taking it from a true sense of view... If a peer comes in then you know your learning is relevant to real life.

One male group expressed a preference for being taught by someone more experienced and mature, believing that a tutor close to their own age would have problems controlling groups of teenage boys and would not be taken seriously. VB1.1: I think we need someone with experience and who’s more mature, but if it was somebody our age, they would mess about a lot.

The female groups were not happy to have peer tutors near their own age because some felt that they would lack credibility: VG1.6: No, say it was a fifteen year old girl in to teach, I wouldn’t listen to her. However, they thought that someone of 18-20 years would have empathy with pupils and would be listened to.

Themes

There was strong feeling that people who are just a few older that those they are teaching (tutoring) will have greater empathy with them, making the information they give seem more relevant and acceptable. However, participants were aware of potential discipline problem and lack of respect for people too near to their own age.

Some of these potential problems could be overcome by using a scheme such as APAUSE, devised by Exeter University. (This scheme is already in operation in some parts of Wales.) However, though such schemes are popular with participants and can increase knowledge, evidence is lacking as to their effectiveness in changing outcomes such pregnancy and STIs.
From where have you learnt most about sex in general?

Girls described social networks in which it was possible to test and discuss their views regarding sex. They also described helpful information from magazines. It is assumed in the current literature that girls find it easier to discuss matters in depth with one another due to the strong friendships they form. Indeed Hey\textsuperscript{19} suggests that friendships are a “defining female characteristic”. Some social networks included both sexes and some girls claimed to have learnt most about sex from older boys, in at least some instances, from practical experimentation.

Though boys are believed not to have as many opportunities for discussions with peers, some expressed the opinion that most of their information about sex came from friends. Boys picked up information in different ways from girls. Whereas girls talked with friends about information they had picked up from magazines, television and school, boys described a different type of interaction:

CB1.4: \textit{Yeah, you don’t just sit down and have a conversation and say that this is so and so, but you just mess about and things slip in.}

This description of how information is picked up informally can be related to later comments about leaflets for teenagers, where preferences for humour and cartoons were expressed.

There were no equivalent sexual information sources to girls’ magazines in publications aimed at boys. In fact, many of the boys enjoyed reading these sections in the girls’ magazines. Girls said that most of the information that had been given in school, they already knew from magazines. What they needed from school was better explanations about contraception and more on the emotional side of relationships.

Both girls and boys discussed sex with older siblings and found them a good source of information. Boys and girls alike stressed the importance of talking about sex in order to understand it better and thought that discussion based lessons might help to bridge the gender divide. Girls (particularly in the single sex school) thought that it would be helpful to talk to boys in order to encourage mutual understanding.

The Cardiff girls mentioned getting some information from television soap operas such as Coronation Street, but said that this could be embarrassing if parents were in the room. The Vale boys also mentioned picking up information on sex from TV story lines.

\textbf{Themes}

Social networks were important for gaining understanding by discussing information picked up from the media and from school. There was little mention of information from parents. Magazines, which were an important source of information, have been criticised by health professionals for giving partial or inaccurate information. A perusal of teen magazines was not part of this study, but there is no reason to believe that the this source is inferior to the very little sex education that seems to be available in school.
From where have you learnt most about contraception?

Girls and boys in Cardiff had learnt about contraception both from friends and from school, but most had very little of no input from parents. When parents had been involved, it was often in a negative way, including threats of what would happen if a girl were to become pregnant. Vale boys said that they had learnt most about contraception from school. There was some discussion about access to contraceptive advice via local ‘family planning’ clinic:

**AA:** Do you know where your local one is?
**CB1.4:** Well we do, but the school never taught us. I know where it is but I’ve never been there.

Incidentally, participants did not like the title ‘family planning’ as they felt that this implied that the service was not aimed at them. Throughout the discussions there was much emphasis on being ‘straight to the point’ and some thought that contraceptive clinic would be a better title.

Re-visiting the theme of different levels of information being given to different classes, it was said that:

**VG1.9:** Some of us aren’t being taught about contraception, but we’re also not being taught about emergency contraception. Some people just don’t have any idea what to do.

When asked what participants thought they should be taught about contraception, this was the response:

**VG1.5:** I just think we need to learn…to convince girls that they need to use a johnny.

**AA:** So you don’t get taught things like that then?

**VG1.5:** No!

**VG1.4:** Not at all!

Themes

For many of the participants, school had taught them the basic mechanics of contraception, but had given no practical information about services, which would help them to put this into practice.
What have you been taught about using condoms?

As previously mentioned, the Vale pupils had been told about their local sexual health clinic. Teaching again reportedly varied between classes, but participants of both sexes in this area were aware of a source of advice and free supplies. **VB1.1:** We get to go down there and get free condoms and useful information and stuff like that.

The Cardiff groups had been taught about condoms in varying degrees of detail, including how to put them on, and how to avoid damaging them, but none mentioned their role in protecting against STIs. Girls in the Vale again believed that some classes in their age group had been given more information than others. **VG1.4:** They get all shy about telling you things and we haven’t had that condom thing because he was too shy.

Each group thought that condoms were relatively easy to obtain and knew that they were free from clinics. Expense was not, therefore, a major issue, though several participants mentioned that condoms bought from a supermarket were cheaper than from vending machines, though machines were preferred for their privacy. Privacy appeared to be a very important motivator and clinics were generally preferred to shops for this reason. **AA:** Where would you prefer to buy them from? **CB2.3:** Private places. **AA:** What about getting them from the clinic…Would you get them from the clinic, or would you rather buy them? **CB2.4:** Probably from the clinic.

Themes

*Once more the factor of teacher embarrassment seemed to control the amount of information that different groups received. When more detailed teaching about condom use had occurred, it seems that the connection with protection against STIs had not been conveyed adequately. In the Cardiff school, the situation did not seem to have improved since the previous study.*
What is emergency contraception?

Some participants had been told about emergency contraception in school, some in PSE lessons only but others in Biology also. Again, some were adamant that the information had come too late:

CB1.4: Most girls have done it by now and they know it’s stupid… I’m gonna wait ‘til sixteen but it’s a bit late to teach you now about the morning after pill.

Cardiff girls had been told that they could go to the clinic for emergency contraception and that it could be taken up to two (sic) days after and, whilst not completely accurate, this demonstrated some knowledge. Vale girls had been given no teaching in school about emergency contraception, though they had picked up some information from other sources such as magazines.

Themes

As emergency contraception offers only a small window of opportunity for action, it is advisable that girls should have access information available before they are actually confronted with the situation. The discussions gave no indication that teenagers were relying on emergency contraception as a substitute for using condoms, so it is unlikely that wider availability of this method has played a significant part in the spread of infection.
What do you know about sexual health services for teenagers?

Knowledge
Cardiff students were unaware of the town centre young people’s clinic and said that, if they needed condoms, they would be more likely to use vending machines in public toilets. Some knew that there was a local clinic, but were rather unsure about details:

CB1.4: I know you can get some from the GUM clinic and I think there’s a clinic round the corner.

Cardiff girls expressed a preference for using a non-local clinic for reasons of confidentiality:

CG1.3: Yeah, ‘cos the clinic is by a café… and everyone goes there, don’t they?

Vale students were aware that they could access the local young people’s clinic, which users considered to be appropriate to their needs. They reported that clinic staff had a very relaxed attitude. Teenagers felt welcome at the clinic: a room was provided for socialising with tea and toast available, so they felt that it was good place to ‘just hang out’, even when they didn’t need advice.

VG1.5: It’s just nice to go up there, ‘cos you know you’re welcome there as well.

However, this clinic was open only at lunchtime and they were not ‘officially’ allowed out of the school grounds at this time.

VG1.6: But the school is like, you’re not allowed out of school premises, and then they’re complaining that the girls are getting pregnant.

In a preliminary interview with the boy’s school’s attached social worker, he had supported the aims of the clinic and said that he encouraged boys to go. He also worked in collaboration with the clinic, keeping supplies of condoms for distribution to boys who had been seen by clinic staff. His stated intention was to be as supportive as possible in matters of sexual health, but the boys mentioned his presence outside the clinic on some occasions as a deterrent. This demonstrates that people who work with teenagers need to be sensitive to the possibility of their actions being misunderstood by those they wish to help.

VB1.2: He would go down and stand outside and like look at who goes in and out… that’s a real problem.

VB1.5: Yeah, he checks on people.

The issue of embarrassment in connection with accessing services was raised by those who had not been given information about teenage sexual health clinics. Some mentioned lack of confidence to access the service and worries about what staff and others would think of them if they were seen at the clinic.

CG1.3: And ‘cos we don’t know very much about it, we would be stuttering and that and they would be talking about us, like that child, she’s just messing around.

The groups were asked if it would be a good idea for the school to organise a visit to a sexual health clinic, as is common practice in Holland. This received a positive response, illustrated by the following quotes:

CB1.3: I think it would be a boost in our confidence as well, ‘cos sometimes people don’t fancy going on their own.

CB1.1: I don’t think people would feel that embarrassed then, ‘cos I reckon people feel embarrassed otherwise, going to a clinic and asking for stuff. I think it would be
Other services mentioned by the Cardiff groups included leaflets distributed by youth workers, leaflets available in shops and cinemas, and telephone helplines.

**Preferences**
Participants expressed a preference for attending clinics with designated sessions for young people rather than services based at the GP surgery. However, many said that they might lack confidence to attend a clinic wherever it was based and would find it embarrassing. They would welcome a visit to a clinic included as part of the PSE curriculum, as this would make it seem less intimidating.

Most students did not wish to have condom machines in school toilets as they would be embarrassed to use them, but would welcome a confidential source in school, for example, a school nurse. Students thought that condom samples should be distributed in school and some believed that this happened in year 11.

**Themes**

The situation regarding the clinic near the Cardiff school may have deteriorated since the 1996/7 study. At the time of the previous study, most pupils appeared to know about the clinic’s services and opening hours. A number had either used the clinic themselves or knew someone who had, whereas during the current research none had used the clinic and information about it was very limited. Since the last study there have been staff changes both in the school and the clinic and these factors have probably contributed to lower awareness among pupils.

The previous research indicated that most participants would prefer to attend a centrally located clinic with services aimed at teenagers rather than a more local one. Since that time such a clinic has been established in Cardiff city centre, but none of the current participants knew about it. Although this provides a good example of services being responsive to consumer needs, it has not helped this group of teenagers because they have not been informed of its existence. If teenage sexual health services are to work effectively, a more holistic approach will be needed.

The situation in the Vale schools was in marked contrast to that in Cardiff. Pupils were aware of a local service where they felt ‘welcome’ because the service was aimed at their age group. However, although pupils have information, there remains a problem as pupils are forbidden to leave the school grounds at the time when the service is provided. Schools and health service providers should be encouraged to co-operate in order to improve access.

Once more, embarrassment was raised as a deterrent to accessing sexual health services and the suggestion that an organised clinic visit should be part of the PSE curriculum was universally welcomed.
What do you know about sexually transmitted disease?

The dominant attitude seemed to be that STIs were not likely to affect the people of their age and that the danger was at some undefined time in the future. It was therefore not worthwhile to think too much about the risks of infection. As stated previously, teaching on STIs was generally regarded as deficient or, in some cases, non-existent, so it is unsurprising that teenagers believed that they were not at risk. Girls in particular were keen to receive more information and believed that people would be more sensible if they knew more about the effects of these diseases.

The Cardiff groups appeared to have little information about chlamydia:

**CB1.4:** *I don’t know – it’s crabs innit?*

All groups agreed that they had been given very little (if any) information about chlamydia.

**CG2.1:** *We were taught, but she was embarrassed. We just don’t know like how it’s going to affect you.*

On the issue of chlamydia and infertility, some comments confirmed the suspicion that knowing about the connection might not be a deterrent:

**CG2.3:** *Well, most people think they wouldn’t want to get pregnant anyway, so they wouldn’t worry about that then.*

Vale boys had heard of the disease and knew that it could be asymptomatic, but were ignorant of the long-term consequences. Both boys and girls appeared to know more about HIV, but some teachers had reportedly said that it was not something that they should worry about. Any knowledge that the Vale girls had of chlamydia appeared to have come from the local sexual health clinic. Like those in other schools, they expressed a need for more information. Several participants mentioned the air of unreality that surrounded STI teaching:

**VB1.2:** *No, it doesn’t hit home at all. No, so you just think it happens to other people.*

**VG1.4:** *We’ve been told you can catch it from sex and things but we don’t know how to stop it, or what we could do.*

All groups said that if they had more information about the different diseases and their prevalence locally, the risks would become more real to them and they would take protection more seriously. The discussion that took place around knowledge of STIs demonstrated a consistent view among all groups that their understanding was inadequate. However, the belief that their behaviour would change if they knew more may be questionable. There are numerous examples of sexual health interventions with teenagers that demonstrate improvements in knowledge but no apparent change in behaviour, as measured by outcomes such as pregnancy rates. This follows a similar pattern to other health promotion interventions, such as smoking cessation and healthy eating, where it has been shown that knowledge alone fails to change behaviour. To facilitate change, good services and improved access have to work together with information.

Most would be willing to take a test provided that it was only a urine test, but they were very uneasy about anything invasive. This opinion is supported by a study by Moens and colleagues, who found that a cervical swab was unacceptable to a large...
proportion of younger women. There seemed to be some doubt among focus group participants about accepting opportunistic testing:

VB1.2: Well, if it wasn’t what I went down there for, I’d go home and think about it, but I wouldn’t have it done then.

GUM clinics are over-stretched and dealing effectively with STIs does not seem to be a political priority, so there will be capacity problems if more people are to be tested. Asymptomatic people who attempt to make an appointment because they believe that they have put themselves at risk may be asked to wait several weeks. This can result in non-attendance or further transmission during the waiting period. Furthermore, if people do accept testing for chlamydia, they will need to be aware of the implications. A qualitative study investigating the psychosocial impact on women of a diagnosis of chlamydia found that most women held stereotypical views of those at risk of STIs.

This resulted in anxiety following diagnosis, including fears about disclosure to partners. It was suggested that information should normalise and destigmatise chlamydial infection and promote GUM services. The authors concluded that support services should be in place for partner notification and to deal with uncertainties of future reproductive morbidity.

It seemed very important that the method of information delivery should be relevant to today’s teenagers. If pupils found the medium deficient in any way, they would be distracted from the message and concentrate on the deficiencies, a point that was also raised during the previous local study. The following is a criticism of a video shown during a sexual health lesson:

VG1.4: ‘Cos it had this sixties looking guy (general laughter) and he had VD and herpes at the same time.
AA: So you didn’t think it was particularly relevant?
VG1.4: No, I thought it was funny.

Themes

Teacher embarrassment was again cited as an important factor in participants’ lack of information on STIs. Videos which were out of date had also failed to get the message across and as the researchers said reporting the previous local study, “The effectiveness of sex education was felt to have been jeopardised by the use of old fashioned, out of date teaching materials – usually videos.” It seems likely that the very same video which pupils criticised as ‘old fashioned’ in 1996/7 is still in being shown!

It seems that opportunistic urine testing is largely acceptable and this has been the experience in local young people’s clinics. It is also apparent that chlamydia awareness is low and that, if this is improved, it is possible that clinics could be overwhelmed with requests for screening. Lothian Health Board has introduced postal urine testing as part of its ‘Healthy Respect’ sexual health programme and this may be a possible method of coping with raised demand.
Where would you go if you had a sexual health problem?

When asked this question, these were typical reactions:

**CB2.3:** Well, we haven’t got the confidence to get a contraceptive from the clinic, let alone go if you have a disease!

and:

**CG2.3:** …you wouldn’t go to the doctors and say, “I’ve got chlamydia” I can’t see myself doing that.

In this context, members of the group referred back to the discussion of an organised visit to a sexual health clinic, which would be good because:

**CB1.2:** It’s good to know that there’s someone there that you can talk to, like in the back of your head you know you can go there with a problem.

The clinic was considered to be more “confidential” than going to the GP and girls thought it was important to have a female practitioner. There was also some concern about the legal situation of those under 16 going to the GP for sexual health advice. Many people felt that embarrassment was a barrier to getting treatment for STIs:

**CG1.3:** I would probably keep it to myself ‘cos I would be embarrassed about it… I would be ashamed. I wouldn’t go (to the clinic) ‘cos I don’t like the thought of people examining me.

**Themes**

Embarrassment, lack of confidence and worries about the legal status of those below the age of consent were all factors that might prevent teenagers from accessing sexual health services. If transmission of STIs among the teenage population is to be controlled effectively, schools are an important part of the picture. Unless teenagers are given information about the services available to them, these services are unlikely to be accessed by some of those who are most at risk.
Who should suggest using a condom?

Both boys and girls agreed that the issue of contraception was generally something that was introduced by girls, though most girls said that they thought the boy should suggest it. Ideally both should be willing to raise the subject (“you have to be co-operative about it”), but this depended on the quality of the relationship. In general girls thought that boys were less mature and were less worried about the consequences of not using a condom.

**AA:** Who do you think would be most likely to suggest it?

**VB2.1:** The girl.

**AA:** Why do you say the girl?

**VB2.1:** They are the ones that are gonna get the worst of it. They are the ones that are gonna get pregnant.

Though participants thought that condom use was inconsistent among people of their age group, boys had a slightly different perception of why this might be.

**CB2.4:** We say it off and on (suggesting condom use), but most of the time girls don’t want to wait for their boyfriend to put a condom on. And you don’t want to say condom in front of them, unless you know they’re OK with it.

There was obviously some ambivalence around suggesting using a condom, which seemed to based on the fear of embarrassing or offending a partner, or possibly raising fears about one’s own disease status. Embarrassment was obviously a factor, as one girl said:

**CG2.5:** I don’t reckon I’d say it. I reckon I’d text it, I would.

Girls thought that they were more likely to suggest condom use because of the potential impact of pregnancy on their lives, believing that “75% of boys” would not want to share responsibility for a baby. It appears that these notions of responsibility are linked to wider discourses on gender and maturity. The idea that boys are immature at this age fits with a great deal of educational research. Francis found that boys took a “selfish” and “unsensible role” at school, whereas the girls were more likely to be “selfless” and “sensible”.

It was very apparent that any teaching on condom use that had occurred had concentrated on the risks of pregnancy and had not emphasised the role of condoms in preventing infection. Therefore boys were less likely to regard condom use as a matter of self-protection. There was obviously some confusion about the dual purpose of condom use.

**VG2.1:** Yeah you know when you’re on the pill, you don’t have to use a johnny do you?

**VG2.5:** Yeah, you have to use them to be safe. You don’t have to use them, but you have to, to stop getting things.

**AA:** Do you think if you just said to a boy, “Oh, I’m on the pill” do you think that would make a difference? Would they worry about it?

**VG2.1:** I reckon most boys would think it was better not to (use a condom).

This illustrates the overriding primacy of concerns about contraception over the risk of contracting a sexually transmitted infection. Though many of the participants claimed that they were responsible and talked about being “safe”, this was almost
always in terms of unwanted pregnancy rather than STI. This lack of understanding is supported by Welsh statistics that show that whilst rates of STI are rising, teenage pregnancy rates are falling and there has been a slight decrease in abortions in those aged under sixteen years. It would seem, therefore, that teenagers are increasingly protecting themselves against pregnancy, but failing to take precautions against infection. However, some boys were aware of the risks:

**VB2.2:** *The pill stops pregnancy, but there are still loads of other things to worry about.*

The role of condoms in preventing STIs seems to be a difficult message to communicate to teenagers. Researchers in Camden and Islington schools\(^\text{23}\) found that even after an intervention to improve knowledge of sexual health issues, some participants were still not aware that condoms were the only form of contraception that could prevent infection. The researchers concluded that greater emphasis should be given to this issue.

The question of girls carrying condoms was discussed and, whilst many thought that this was sensible and showed that they were in control, some felt that it “sent the wrong signals”. This idea links to a subsequent discussion regarding peer pressure where double standards for male and female sexuality seemed to be prevalent.

**Themes**

*There appears to have been much greater emphasis in teaching on the use of condoms for contraception rather than as protection against STI, resulting in low awareness among participants. This may have reinforced the prevalent traditional beliefs about female responsibility for ensuring condom use. If boys could be made more aware of the risks to themselves, they may become more pro-active in condom use.*
What might stop people using a condom?

Although most participants thought that condoms were readily available, there were still some barriers to obtaining them. Some believed that shops would refuse to sell condoms to people under the age of sixteen.

**AA:** Right, so what do you think might stop people using condoms?

**CG2.3:** Having to go to the shop and actually buying some…

**CG2.6:** It’s better though having them in the toilet than going to the shop.

**CG2.1:** It’s good the way they have them in the pub toilets and that like when you go out for meals.

It seemed that, once more, the embarrassment factor was paramount, with participants voicing the opinion that though condoms were cheaper in the supermarket and free at the clinic, many would prefer to buy them from vending machines.

**CG2.2:** In the toilets you would pay, ‘cos it’s less embarrassing.

Discussing access to condoms led to some comments around the random nature of unprotected sex, which could be brought about by seemingly trivial factors, for example:

**CG2.3:** …if you go to the toilets and you haven’t got change, then I think you’ll do it anyway.

Both boys and girls in the Vale schools knew that condoms were available free at the nearby teenage sexual health clinic, but this was open only at lunchtimes. They were not allowed out of school at this time, though some ignored this restriction in order to attend the clinic. The reality for many, however, was that they were denied access to a service that had been planned to meet their needs. This was likely to constitute a genuine barrier to condom use, as those who had used the clinic thought that it would be much more embarrassing to buy them from a shop.

**VG2.4:** Thing is, down the clinic you don’t get the funny eyes that they’d give you at the cash desk.

Groups discussed the feasibility of making condoms available in school toilets and though they thought that this would be a good resource, they were doubtful about the practicalities (“people would mess around”). Some suggested that parents or governors had already objected to the idea, and others said that some pupils were not mature enough to use the facility properly. Another suggestion was that condoms could be distributed in sex education lessons or could be available from the school nurse. Some girls suggested that teachers, especially younger women, could keep condoms for access on request. This is similar to the current practice in at least one school in the Vale, where the attached social worker keeps a supply of condoms for those who have already registered at the local sexual health clinic. However, it seems doubtful that teachers would be willing or able to take on this additional non-teaching responsibility.

Aside from purchasing condoms, every group mentioned that these might not be ‘comfortable’ and that sex was said to be better without a condom. Participants said that the effect of condoms on the sexual experience was discussed among peers in school and that many people held this view. Similarly, most groups mentioned that condoms could spoil the experience, as they took a while to put on, especially for the inexperienced and this would cause embarrassment.
A recent Health Development Agency review of interventions for HIV prevention identified a lack of skill in using condoms together with lack of skill in negotiating safer sex as important modifying factors in sexual behaviour. Health promotion interventions to change modifying factors will need to address the issue of lack of skills. A demonstration of condom use on a model is of some help, but to gain confidence, boys will need samples to try at home.

**Themes**

*Embarrassment was again raised as an important factor in decisions about whether or not to use a condom. This was important at two levels: firstly in accessing condoms and secondly during negotiations with partners. Teenagers are likely to be less embarrassed about access if they are taken to visit a clinic. Also, they would be less embarrassed about negotiating condom use if they had confidence in their ability to use the method effectively. The widely held belief that is sex better without a condom needs to be balanced against the very real risks of STI, and it seems that currently many teenagers are not making an informed choice.*
How would you feel about talking to your boyfriend/girlfriend about sex?

It was suggested that girls found it easier to talk about sex than boys did, unless it was in the form of sexual banter. Most girls believed that ideally it was not advisable to have sexual relations with someone with whom one could not discuss sex. Both girls and boys believed that they would be able to discuss sex with a partner but that communication depended on the maturity of the individuals. The following responses were typical:

VG2.1: Yeah, cool. Not a problem. Would depend on the boy but…
VG2.5: It depends if they’re mature enough. If they ain’t, then they’re not mature enough to have sex.

and

CG2.4: I wouldn’t be embarrassed, ‘cos at the end of the day, if you’re going to do it, then you should be able to talk about it.

Some of these responses expressed the traditional values around relationships that would support discussion:

CG1.1: If you were with them for ages and you have strong feelings for them, then I don’t think it would be hard.

Of course, this statement also implies the converse, that is many people who have casual sexual relationships that are not based on strong feelings find it impossible to discuss sex with their partner.

Themes

All groups thought that it was important for sexual partners to discuss the implications of their relationship. However, if people were immature or lacked commitment, this made communications more difficult. Young people’s perception of peer pressure, as discussed in the following section may affect their ability to discuss sex with a partner. The conflict between adult strictures to abstain and male peer pressure to be experienced may make it more difficult to have a rational discussion about how a sexual relationship should proceed. All groups said that the emotional side of sex had not been dealt with adequately in school.
Do you think that there are pressures on teenagers to behave in certain ways?

All groups thought that there was some peer pressure involved in sexual behaviour, but this did not generally cause anxiety. They were more worried by what they saw as over-emphasis on abstinence by teachers and parents, which they felt might be counter-productive. It is likely that this interpretation is valid, as there is evidence to show that a teenage sexual health intervention that advocated abstinence increased the pregnancy rate in partners of male participants. In the opinion of students, most adults failed to recognise their increasing maturity.

VB2.4: Some teachers find it hard to believe that you can act the same way that they can.

VB2.2: They treat us in the same way throughout the school, like if there’s one kid who’s immature or something, then the rest of us get tarred with the same brush. They find it really hard to believe that we’re nearly adults... Some of them treat us OK but some of them don’t. It’s those we have trouble with.

AA: And from what we were saying last week, do you think that goes into your sex education as well? They don’t treat you like adults then?

VB2.1: They just don’t seem to understand. They treat you like you’re in year seven every year. Like that’s why we haven’t heard much about sex education... You come to this school and you can’t have sex at all.

The discussions around negative pressures caused by parental attitudes extended to prohibitions affecting television programmes that might provide information about sex. Some participants believed that lack of knowledge might lead to experimentation.

CG2.3: They turn the channel over, so you want to know about it, so you go out and do it!

An issue that emerged in every group was gender-related pressure in relation to sexuality. It has been argued that all relationships take place within a “heterosexual matrix” where girls are expected to be feminine and fancy boys and boys are expected to be masculine and fancy girls. Behaviour did seem to be somewhat controlled by dominant heterosexual discourses, as participants reported specific ways in which each sex was expected to behave. This seemed to be the most important aspect of peer pressure. Girls in both groups felt that they were faced with a hard balancing act regarding their sexual identity, in that they were expected to be experienced, but not too experienced.

AA: What about in school, are there pressures to behave in certain ways or do certain things?

CG2.3: Some girls get taken the mick out of them.

CG2.1: It’s weird in this school... if you don’t do much you get called frigid. If you do too much, you get called horrible names.

Similarly, concerning theoretical knowledge:

CG2.1: ...and you get 100% on a sex education test and they’re like, “Ah, why do you know all that?”

CG2.3: It’s like with drugs, If you know all about that, then they say, “Oh look, she’s a druggy!”

It seems that the discourse that has been reported to control women for centuries is very much alive in contemporary culture and girls are still faced with sexual double
standards. The boys, on the other hand, reported very different experiences. The defining masculine characteristics of sexual objectification, banter and behaviour are still prevalent, as illustrated below:

**AA:** ‘Cos one of the things the girls were telling us… they said that they couldn’t know too much about sex and they can’t know too little. They said that on the one hand you get called frigid and on the other you get called a slapper. What do you think? Is it the same for boys?

**CB1.4:** No, this is where it’s good to be a boy ‘cos if you know too much then you’re a super-stud!….. You can never have enough experience when you’re a boy.

At the point where this was said, most boys in the group seemed to think that this was an advantage for them, but a later contribution shows the type of peer pressure that could result from this attitude:

**CB2.4:** It’s more like in the books they say that this person is saying so and so, that you should have had sex and they’re bragging about it. But it’s just underlying, that you know that everyone has, and you’re just there like, embarrassed.

The boys, therefore, could be openly proud of being sexually active, but this might exert pressures on the less experienced, perhaps leading to sexual relationships for which they were not ready. Of course not all boys are promiscuous and not all girls behave responsibly, but the data does seem to suggest that sexuality is controlled by dominant gendered discourses. The task will be to move beyond describing the situation to asking how it could be changed.

**Themes**

There is some divergence between adult and teenage perceptions on the source and nature of pressure. Traditional beliefs about male and female sexuality are still prevalent and these can result in pressure to conceal or exaggerate sexual experience. But teenagers feel that they are under even greater pressure due to the expectations of parents and teachers that people of school age should abstain from any sexual activity. This may contribute to delay in help seeking if a sexual health problem arises.
Do you think that teenagers have an ‘it won’t happen to me ‘attitude?

Pursuing the idea of invulnerability, there was some ambivalence, illustrated by the following:

AA: Do you think that teenagers have an attitude like that, “Oh it won’t happen to me. It’s not going to be a problem”?
VG2.3: Yeah, I’ve always thought that.
VG2.4: But we do think about it.

Many participants did admit having an ‘it won’t happen to me’ attitude, especially in relation to STIs, and thought that this was very prevalent in their schools. Referring to risk perception, a boy explained:

CB2.3: Some people know and they’ll still do it. But they think, oh it won’t happen now, but you know it will happen. Like smokers, they know it but they still carry on doing it. It’s like a drug.

There seemed to be two overriding reasons for this attitude of invulnerability. Firstly, girls explained that they were very aware of the need to avoid pregnancy, because it had consequences that were much more likely to affect their lives in the short term. Pregnancy could not be hidden. They had seen its consequences in their own age group, whereas they had never (to their knowledge) encountered anyone who had contracted a sexually transmitted disease. Secondly, there seemed to be a consensus that STIs were something that was not likely to affect them for some time, so there was no point in worrying now. Some thought that this was due to the way they were taught, but opinions differed:

VB2.2: That was what I was talking about. That’s the attitude that’s taught in this school. It’s as if they’re teaching us a fictional story, you know? This man got AIDS and he’s miles away and it’ll never happen to you.
VB2.4: …but I think they made it sound like it could happen to you. They tried to make it sound like a real possibility.

These statements may support the previously expressed belief that teaching is not consistent across schools and indeed across sets within schools. Teachers have a difficult task in striking a balance between giving enough information to encourage people to protect themselves and causing unnecessary fears. The boys pointed out that a balance of information was necessary in school. They needed to be more aware of STIs but not in alarming way.

There were some suggestions as to how these attitudes of invulnerability might be changed. Girls in particular were keen to have more information about STIs in their sex education lessons. Emphasising the long-term effects was too far into the future and information should concentrate on the more immediate effects. Many said that they would like local statistics on prevalence, so that they could relate this to their own lives. They also wanted more practical information about where they should go for help if they thought they might have put themselves at risk.

All groups considered that discussion based sessions were the best way to deal with these issues. Participants wanted their questions answered in a frank and honest manner, but this format may be difficult to achieve, given pupils’ comments about the
embarrassment of some teachers and uncooperative behaviour in some classes. Teachers have little training in the field of sexual health and, if this important topic is to be taught effectively, it may be necessary to bring in outside experts, sexual health clinic staff for example. In both this study and its predecessor, pupils said that they would welcome expert input and that this had been well received in the schools where it had happened.

**Themes**

*The attitude of invulnerability seems prevalent among this age group, especially where STIs are concerned. Participants did not appear to have been given enough information to understand the risks to which they are exposed and this must be a contributory factor. Some expressed a wish to have the local prevalence of STI explained to them and it might be helpful to encourage schools to publicise figures for teenagers. This age group has a much clearer idea of the risks of pregnancy and this may have helped to begin a reduction in rates among teenagers. By the same principle, there should be more openness applied to STI, which still seems to be a taboo subject for some schools.*
**Important factors which had not been adequately addressed in school**

All groups expressed the wish to be given written information on the location and times of teenage sexual health clinics, GUM clinics and outlets/services for emergency contraception.

Participants were concerned about their inadequate knowledge of sexually transmitted infections (STIs) and some were unclear about the ways in which infection could be prevented. They also wished to know about signs and symptoms (if any) of different STIs, the results of becoming infected and methods of treatment. No group had adequate knowledge of chlamydia, including modes of transmission, prevalence locally and long-term effects on fertility.

Both female groups wished to have more information about signs of pregnancy, abortion, and their legal rights of medical confidentiality. Similarly, they were concerned about whether they could confide in a teacher without their parents being told. The emphasis was again on the lack of practical information. Girls said that they had not been told that there was still a possibility of pregnancy when a condom was used. Also some had recently discovered from sources outside school that it was possible to be pregnant and continue to have periods and they believed that this should have been explained to them in school. They also complained that they had not been told what to do if a condom splits. This last expressed need may mean that perhaps too much is presumed by those providing sex education lessons. The young people do not wish to be treated like children, but they do feel a need for very explicit risk avoidance advice in order to prevent pregnancy and STIs.

The girls wanted information about abortion, but were reluctant to ask for this in school because they were worried about confidentiality, though they trusted clinic staff. The following exchange illustrates the sense of helplessness and isolation that some young girls in this situation feel:

**VG1.4:** More information on abortion, ‘cos some people may find themselves pregnant and not know what to do.
**AA:** But would you be able to talk to someone in school about it?
**VG1.9:** No, your teacher would tell everyone else.
**VG1.6:** You can’t trust no one.

**Themes**

Teenagers are expressing a need for a trustworthy and confidential source of practical information on the risks they may be taking and on sexual health services that are available to them. To some adults teenagers may seem brash and streetwise but this is sometimes a very thin veneer concealing their vulnerability.
Critique of locally available sexual health leaflets and booklets

Though it is not usual to include tables in reports of focus group discussions, pupils likes and dislikes about the written presentation of sexual health information can be summarised in tabular form:

<table>
<thead>
<tr>
<th><strong>Likes</strong></th>
<th><strong>Dislikes</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Colour</td>
<td>Black and white</td>
</tr>
<tr>
<td>Designed for teenagers</td>
<td>Pictures of ‘older’ people (25-35 years)</td>
</tr>
<tr>
<td>Attractive but discreet cover and title</td>
<td>‘Obvious’ or embarrassing covers</td>
</tr>
<tr>
<td>Pocket size</td>
<td>Too much writing/small writing</td>
</tr>
<tr>
<td>Cartoons</td>
<td>Text book style pictures and diagrams</td>
</tr>
<tr>
<td>Use of humour</td>
<td>Bilingual bound as one book</td>
</tr>
<tr>
<td>Factual and direct information</td>
<td>Illustrations of STIs</td>
</tr>
<tr>
<td>Contact numbers</td>
<td></td>
</tr>
<tr>
<td>Question and answer format/problem pages/hypothetical situations</td>
<td></td>
</tr>
</tbody>
</table>

Several leaflets and booklets, ranging from sheets printed from a website to quite substantial booklets (appendix 1), were discussed by the focus groups. The literature was placed in the middle of the table and participants invited to look through as many as they wished. Leaflets that were strongly disliked tended to be less colourful and have a greater amount of text relative to illustrations. The overall appearance of leaflets with these characteristics was described as “too formal”. Those which participants though were designed by or for older people were also disliked:

**CB2.4:** They’re made by 40 year old ladies who have no experience of sex.

**CG2.3:** These are designed by 40 year olds aren’t they? Sorry, 40 year olds don’t know what we want.

All groups expressed an interest in being involved in the design of booklets aimed at teenagers and, though they are unlikely to have the necessary design skills, they could be involved as a reference group to approve material before publication.

Two items emerged as the most popular in all four groups. These were a general sexual health information booklet entitled ‘Lovelife’ and a short chlamydia information leaflet. ‘Lovelife’ was chosen because it was small, colourful and well illustrated with plenty of information, which participants felt was presented openly
and honestly. (“Wow! It even talks about oral sex in this one!”) The title was quite non-specific and would not necessarily indicate that the booklet was about sexual health. It was suggested that covers needed to be attractive enough to make a teenager pick it up, whilst preferably avoiding specific references to sexual health. It was also popular because it was age-related, not patronising and contained problem pages similar to those found in teen magazines. Although the booklet was liked, it was suggested that it could be improved by using cartoons. The most important dislike was that, because it was bilingual, this made the booklet too bulky, so it was recommended that separate English and Welsh versions should be produced.

The small chlamydia information leaflet was in foldout format and looked very up to date. It was part of a set of publications that included a postal pack to submit urine samples for testing. The leaflet examined was for disease information only and had no reference to postal testing. There were no illustrations, but the colours (blue, purple and silver) and graphics were considered attractive, particularly by the girls. It was described as “short, snappy and attractive”. This is the type of leaflet that participants of both sexes said that they would be likely to pick up if it was available in clubs and cinemas. However, they stressed the need for two types of information. These were brief and “snappy” information leaflets to be distributed annually from year seven, and a comprehensive booklet which everyone should receive by year nine. Ref. Sefton health passport. Participants emphasised that all sexual health literature should tell the reader exactly what they should do if they suspected that they might have the problem being discussed. Local information on sexual health and contraceptive services available to young people should also be included.

**Making the leaflets available**

One male group thought that the leaflets should be available on a stand in school, along with leaflets on other subjects, so pupils could help themselves. The other groups disagreed with this method and thought that people would “mess around” if they were displayed in this way and some might be too embarrassed to pick up information leaflets in front of others. It was suggested that distribution should be a nation wide project, whereby everyone would receive a booklet with “all you’d ever need to know”. This went with the belief that if everyone was given adequate written information via distribution in class, this would be “fairer”, especially for those who were reluctant to be seen accessing information. Everyone would have a resource, which they could keep at home and used when the contents became relevant to their own level of maturity. One boy aptly described what was needed as a sort of ‘Hitchhikers’ Guide’.

**Websites**

The girls in particular seemed interested in finding information from websites. However, they said that this was very restricted in school, as all sites referring to sex had been filtered out and were therefore inaccessible. Sites were mentioned as giving good information that was relevant to teenagers, including ‘teenage health freak’ (teenagehealthfreak.org.uk). Few group members had internet access at home and some suggested that web access was not “private” enough, as people could walk past your screen and see what you were looking at.

VB 2.1: I don’t think I would go on a website about a disease and that people might look over your shoulder and see.
AA: No? So would you be more likely to pick up a leaflet?
VB2.1: Yeah.
VB2.2: I think you’d have to make a conscious effort to go on a website. You wouldn’t just be sat there going, ‘oh yeah, sexually transmitted diseases!.

The privacy concern also applied to television. Pupils would be unlikely to watch programmes about sexual health because of embarrassment when other family members were present. Written information which could be kept and read privately was therefore considered to be more useful than websites or television. There may be some scope, however, for exploration and research under supervision during sex education lessons or recording appropriate television programmes for showing in school. Providing videos for schools would be fairly expensive and this medium is likely to date more quickly than booklets. As the participants observed, teenagers may respond negatively to information that is not provided in a relevant and up-to-date format.
Conclusions

The dominant themes in this research are of sex education being patchy, too little, too late and too biological. These themes echo evidence of young people to the House of Commons Select Committee on Sexual Health\textsuperscript{26}.

Reports of PSE lessons appeared to be perceptive, with students able to discriminate between teachers who were respected for their competence and those who were reluctant or embarrassed to deal with the subject appropriately. However, the opinion in all groups was that they had not been given adequate information and that this was particularly true of STIs. Strong themes in these focus groups were variation in the content and quality of their sex education, embarrassment, lack of information on sexual health services and poor recognition by adults of the increasing maturity of students.

All would welcome leaflets which could be kept for future reference and most thought that a booklet giving comprehensive sexual health information should be given to all students in year 9 or 10.

Recommendations

1. Each secondary school in Wales should recruit an appropriate and committed individual to train as an expert teacher with responsibility for sex and relationship education.

2. Closer links should be developed between secondary schools and those providing sexual health services for young people. Providers should be invited to take part in schools’ sexual health education programmes. Groups of pupils should be taken to visit local sexual health services in order to ‘normalise’ protection and testing for STIs.

3. A user panel comprising members of the focus groups should be collaborators in producing appropriate sexual health literature for teenagers. A comprehensive sex education booklet, including inserts detailing local services, should be given to all pupils in year nine.

4. Videos that are used in sex education must be up to date and relevant to the target audience. A panel should be convened to view the BBC video ‘Dose’ to consider whether it would be suitable for showing to older pupils.

The above recommendations are compatible with the Review of Health and Social Care in Wales (Wanless)\textsuperscript{27}, which recommends an evidence based, upstream approach. The report recommends:

- Changing the focus to prevention and early intervention (p 51)
- Individuals’ acceptance of responsibility for health (p 53)
- Better use of media to inform and motivate (p 54)
- Much greater emphasis on children’s and young people’s health and greater partnership with the education system (p 54)
- Avoiding the need for more expensive care later (p 55).
References


Appendix:

Leaflets and booklets examined by the focus groups


Chlamydia. Healthy Respect, Lothian NHS Board.


HPV and genital warts: your questions answered. ECHPV (undated).


