Young People and Sexual Health: Community Engagement Report

2019

healthwatch Devon

Contents

Registered Charity Number: 1155202
Healthwatch Devon CIO

1. Key Findings

1.1 Sexual Health Education

1. Overall, 22.2% of survey participants consider their sexual health education to be good or excellent, while 44.6% considered it acceptable. Conversely, 33.2% of participants considered their sexual health education to be poor or terrible.

2. Individual experiences of sex education vary considerably between and within schools.

3. Topics that can be categorized as 'biological' (which include puberty, pregnancy and STIs) were the main, and most frequent, focus of most current sex education. However participant comments suggest that these can have a lack of detail.

4. The most frequently selected topics which participants felt needed be taught more were: LGBTQ+ and sexual identities; Accessing sexual health clinics and other relevant services; Body image; Consent and abuse and/or exploitation within relationships.

5. LGBTQ+ and sexual identities was the topic that was most frequently selected as needing to be discussed more in schools. Responses suggest that LGBTQ+ and sexual identities are not covered enough, and a focus on 'heteronormative' sexual education can have negative consequences. Teaching LGBTQ+ and sexual Identities more in schools would reduce negative experiences for people individually who identify as LGBTQ+ and increase respect and understanding through school and society generally.

6. Accessing sexual health services was named second as a sexual health topic area which needs to be discussed more in schools. Participants explained that they felt with better and more frequent teaching about accessing sexual health services could prevent risks (STIs and pregnancy) by reducing the stigma of visiting a clinic and informing people on where services are, what they offer and when to visit.

7. Consent, healthy relationships and social expectations are topics that are currently taught in schools, but survey participants expressed the view that these topics should be covered further.

8. With a focus on biological processes and STIs sexual education can feel negative. Many participants expressed they felt a need for sexual health education to address the positives and pleasure of sex.

9. Qualit demeanor of the teacher/tutor, along with the class setting, had a large impact on the student's experiences. Discussions suggest an experienced, knowledgeable and comfortable teacher, creating a safe space and delivering memorable lessons is desired. Different strategies were suggested as to how to achieve this, such as being more conversational, using videos, or younger teachers.

10. Timing and frequency of sexual health lessons contributed to participants' views on the quality of their education. Many participants felt they had too few lessons related to sexual health. Some respondents thought topics were taught at too young an age, while some respondents thought topics were taught too late. This seems to be related to issues of puberty and becoming sexually active.

1.2 Sexual Health Services

1. Findings from the survey demonstrate that the internet is the most frequently used source for sexual health advice, followed by friends and family.

2. Workshop participants discussed how each source of advice is used for different reasons and priorities and they value GPs and sexual health clinics for their professional expertise and confidentiality. Pharmacies are seen primarily as places for collecting medicines and not as places for specialist advice, to change this perception, participants suggest that an emphasis on encouraging privacy and confidentiality would be required.

3. 8% of those who have visited sexual health clinics report having had negative experiences, with over 52.1% having good or excellent experiences. Those who had a positive experience report their needs being met, and having felt comfortable, supported, and not judged by staff.

4. 75.6% of those who have visited sexual health clinics travelled for less than 30 minutes to access the clinic While 19.1% travelled for 30-60 minutes and 5.2% travelled for over 60 minutes.

2. About this report

This work builds on two reports carried out by Healthwatch Devon (HWD) in 2015 and 2016 into the health and wellbeing concerns of children and young people. In both reports sexual health was a top three concern cited by children and young people and so this research was devised to explore further.

Desk based research into sexual health topics was carried out, in order to refine and define design of a survey. Sources included academic research as well as editorials and commentary articles. The research stage also drew heavily on youth engagement work by Healthwatch Essex, Healthwatch Lewisham and Healthwatch Sheffield to inform both the topics and engagement methods.

It was decided that research would look at both sexual health education and the provision and use of sexual health services.

Topics arising from the desk based research were piloted as part of pop-up consultation events at Exeter University and Petroc College of Further Education (Barnstaple). An initial draft of the survey was sent to youth workers, and a trusted selection of young people for feedback. The final online survey was then distributed via contacts at schools and youth organisations around Devon.

Due to the broad nature of the topic of sexual health, it was decided that the survey would cover 23 distinct themes, identified in the desk research, so as not to pre-determine the areas of importance to young people surveyed. Following the survey, the top findings were taken forward for further for detailed exploration of these key themes through workshops with young people.

2.2 Data Collection

The survey was live from 07.03.2019 until 25.03.2019 and was filled in by 545 people aged 16-20 (ages are shown in Chart 1 below), although not all respondents answered all questions. 439 respondents answered question 4; "In what school(s) or college(s) have you received your sexual health education?" shown in Chart 2 below, and translated into the region of Devon participants were educated in Chart 3 below. Chart 4 shows a breakdown of participants by gender, answered by 521 young people.

Chart one: Ages of participants

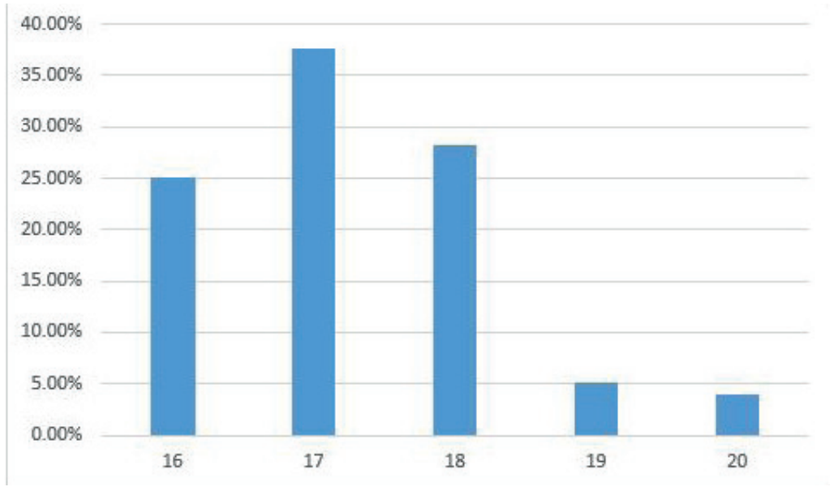


Chart two: Where participants had received their sexual health education

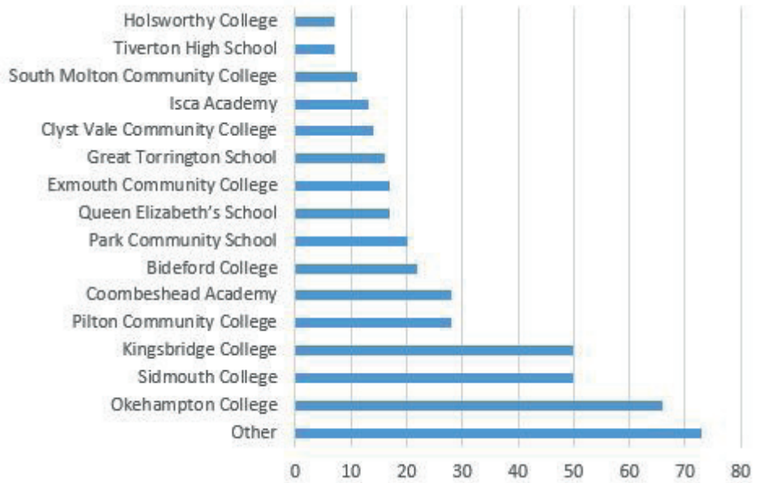


Chart three: Survey participants by area

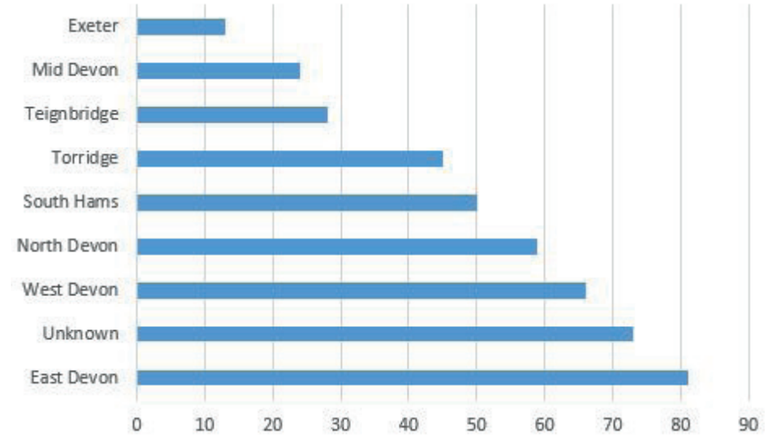
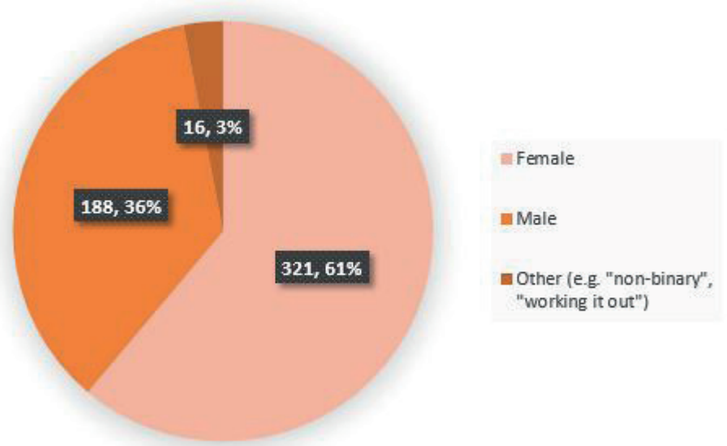


Chart four: 'What gender do you identify as?'



Following closure of the survey five workshops were held at Petroc College of Further Education on 01.04.2019 and 02.04.2019 by Healthwatch Devon staff, assisted by the presence of class tutors.

These took place in the course tutor groups for Hospitality and Catering; Outdoor Adventure; and Health and Social Care (x3) tutor groups. These workshops had a total of 72 participants and were divided so that 3 groups looked at Sexual Health education (47 young people) and 2 groups looked at sexual health services (25 young people). Ages and genders of participants in workshops were not recorded.

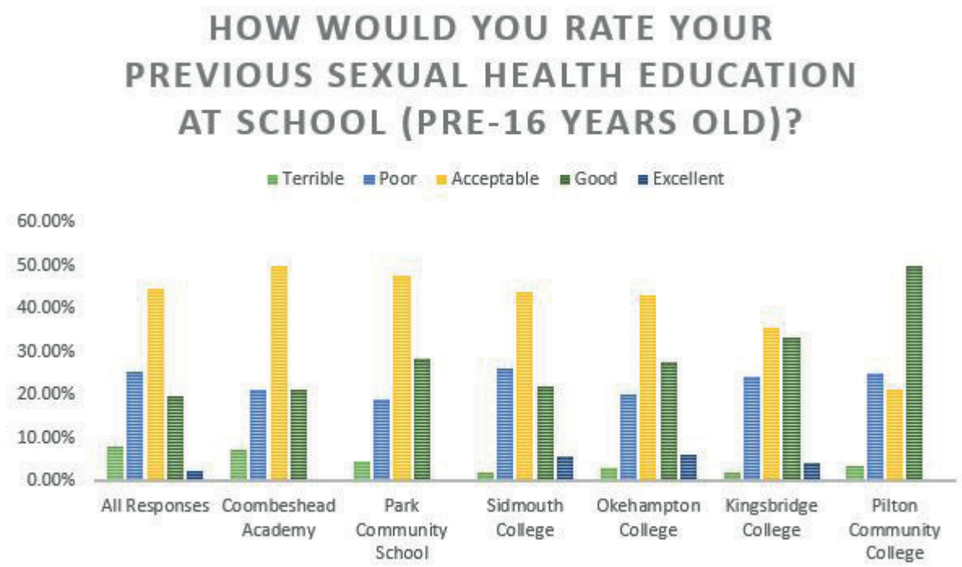
Workshops were designed to include class discussion but data was primarily collected using worksheets, which would help keep anonymity within the groups. Anonymous worksheets were shuffled and passed around to allow the attendees to still build upon each other's answers as if in conversation. These worksheets were subsequently coded.

All quotes in this report are drawn from the survey, unless explicitly named as coming from workshop participants.

3. Research Findings

3.1 Sexual Health Education

Chart five: responses to 'How would you rate your previous sexual health education at school?'



We asked – 'How would you rate your previous sexual health education at school?'

545 participants responded to this question of which 44.6% rated their previous sexual health education as acceptable, 33.2% of participants rated their previous sexual health education at school as poor or terrible While 22.2% rated their previous sexual health education at school as good or excellent.

The results in chart five above show the variation between schools (NB. only schools with 20 or more respondents have been included in this part of the analysis). It is clear that in all schools shown in the table that there is a significant proportion of students, approximately 25%, who considered their sexual health education poor or terrible. This suggests that whilst there is variety of experience across schools, there is also variety within schools and within the needs of individuals.

Participants were also asked to answer in a free text box: 'Any other comments on how you were taught at school (pre-16 years old)? (E.g. were topics covered adequately? Were there external teachers?)

261 participants responded. Following a process of qualitative coding, 143 of 261 open text box responses were coded as explicitly mentioning that their education was either not enough, brief or as having negative consequences. 17 of 261 responses were coded as holding an explicitly positive view from participants of their sexual health education. The remaining comments were descriptive and couldn't be given a value.

These responses can be thematically grouped as relating to the following:

1. **Quality of the Teaching**
2. **Content of the Lessons – Topics Covered**
3. **Timetabling of Lessons**

These will be discussed in further detail in the following sections, also drawing upon insight from workshop participants.

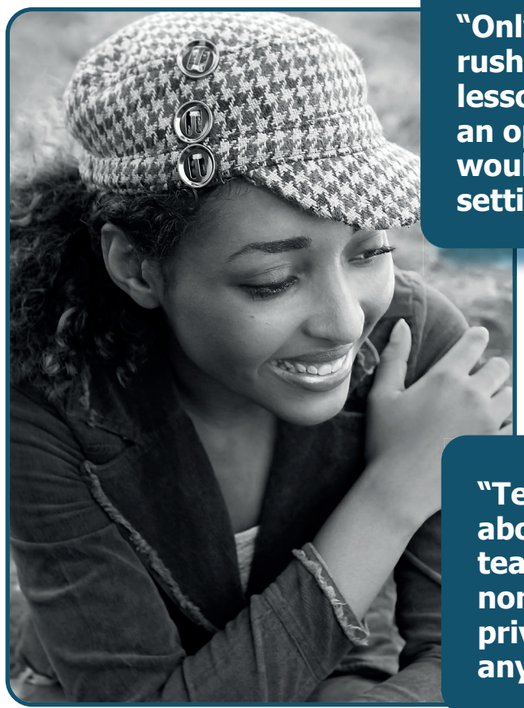
3.1.1 Quality of Teaching

79 of 261 responses in the survey's 'Any other comments', open text, question related to the style of teaching or classroom environment. Workshops further explored the topic of "How should sexual health education be taught?" with 47 workshop attendees.

Survey quotes, below, show that the quality of the education students felt they received, or desire to receive, is directly related to the knowledge and demeanour of the teacher or tutor, as well as the overall class environment created. Quotes show that the topic knowledge of the teacher and a comfortable/safe environment can overlap, and a comfortable and safe environment can be created by involving opinion, and space for questions or activities:

"The lessons that were taught were taught well because they would involve our opinions and some involved activities."

Conversely a negative environment could be created if teachers were not comfortable or knowledgeable enough about topics.



"Only 1 very untrained teacher, topics rushed and not taken seriously, lessons were uncomfortable so not an open space to ask questions- would have preferred more relaxed setting."

"Teachers seem awkward to talk about sensitive topics. Only one teacher was comfortable with the non-biology side of it. It was a private school and we weren't taught any of the social side of things."

The wrong teacher or environment could have direct and immediate negative consequences.

"There was no privacy, and the people who aren't popular wouldn't ask questions because the popular kids would have picked on them for it."

"The teaching was awful, it was by a PE teacher and everyone felt quite alienated. The education was focused towards straight relationships."

"We had an open questions box but the teacher stopped answering them because a few people messed around about it ."

Several survey quotes spoke about a desire for specialists to be brought in, or commented on the use of non-specialist internal teachers running classes.

"I think that there needs to be specialized educators in this area that come in to school, I do not think that this training should be placed on ordinary teachers. "

27 survey responses mentioned external teachers of some kind coming into their school. These included; junior doctors; a school nurse; 'external sexual health specialists'; external tutors, external companies; youth workers; 'people from the NHS'; and nurses.

The responses indicate that these were welcome but prone to many of the same general teaching and subject related challenges.

"External tutors came in. They were good but we needed far more contact time with them and they needed to broach the subject differently and cover more topics."

Workshop respondents agreed with comments from the survey and discussed how an experienced, knowledgeable and comfortable teacher, creating a safe space and delivering memorable lessons is desired. Different strategies were suggested by participants as ways to achieve this, such as being more conversational, or using videos (see appendix 1 for a list of workshop participants' recommendations)

A note on: Mixed Genders in the Classroom

The topic of gender in sexual health education raises points for discussion in relation to both classroom environment and regarding which topics should be covered by who (see quotes in the below 'LGBTQ+ and sexual identities' and 'Biology' sections for further discussion).

However, this topic was not explored in enough detail to reach any conclusions. Amongst the 47 workshop participants asked "How should sexual health education be taught?" 4 said they desired mixed genders in the same class, whilst 2 said they desired a gender split. 5 survey responses mentioned that their sexual health classes had been split into 'boy'/'girl' groups, with 2 of these responses in favor of mixing genders.

"The boys were taken away to one room and the girls another. I think it's important for male & females to learn about both."

3.1.2 Content of Lessons - Topics Taught

The discussion in this section draws upon 545 responses to two survey questions, with results shown in chart 6 below.

These questions were:

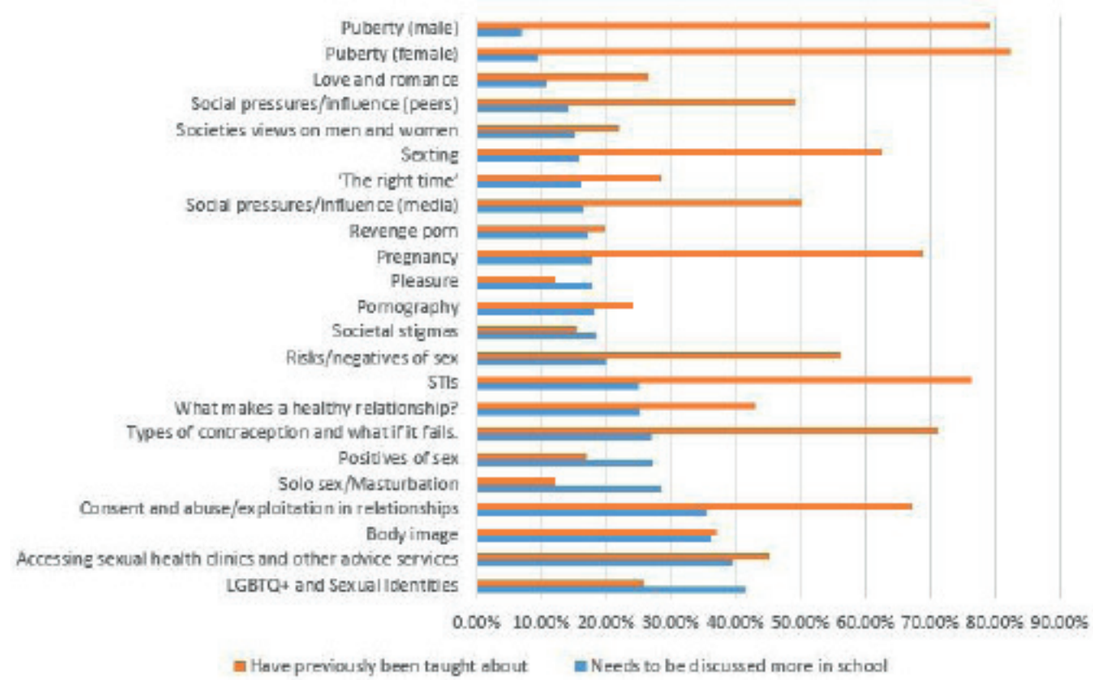
'Which of the following topics have you previously been taught about at school (pre-16 years old)?

'Which of the following topics do you feel, generally, need to be discussed more in all schools or colleges (pick 5)?'

Quotes are drawn from the surveys' free text responses which asked for further comments. Further information is drawn from workshop worksheets from 47 young people.

As explained in the methodology section above, the 23 subject areas asked in the survey and shown in chart 6 were compiled from desk research. Open text comments were free to discuss any aspect of their sexual health education. Workshop exercises were specifically on the topics of 'LGBTQ+ and sexual identities' and 'Accessing sexual health services', as these topics received the highest response in the survey as topics needing to be discussed more in schools.

Chart Six: 'Which of the following topics have you previously been taught about at school (pre-16 years old)? And 'Which of the following topics do you feel, generally, need to be discussed more in all schools or colleges (pick 5)?'



Key findings from this table show:

- **That for this sample of students; Biology - including Puberty (Male), 79%; Puberty (Female), 82.4%; STIs, 76.3%; and Pregnancy, 68.8%; as well as Types of contraception and what if it fails, 71% were the main, and most frequent, focus of most sex education.**
- **LGBTQ+ and Sexual Identities, was rated highest as an area students felt should be discussed more in schools with 41.6% of responses.**
- **Accessing Sexual Health Services was named second as an area which needs to be discussed more in schools with 39.6% of responses.**
- **The social aspects of sexual health education, including consent, healthy relationships and social expectations, like body image, are topics that are currently taught in schools, but the general view is that these topics should be covered further.**

Biology, contraception, STI

Biology (including puberty and pregnancy), contraception and STIs were remembered by students as areas they were previously taught about in sexual health education. Each topic receiving the highest responses to this question, each with over 69%. Chart 6 does not suggest that participants feel there is a particularly high need for more discussion on the subject of puberty (desired by less than 10% of responses). However, a number of research participants commented in free text boxes that despite this a lack of knowledge still exists in some cases.

17.6% of respondents desire more education on pregnancy, 25% desire more education on types of contraception and what if it fails, and 27% desire more education on STIs.

“We never talked about our bodies, I know many girls who I grew up with that still don't know their own anatomy, because it was never discussed in sex ed eg: not knowing the difference between the vagina and the urethra, unclear on the hymen, thinking its normal to bleed and hurt every time they have sex, getting infections and imbalances after sex and not knowing what to do about it.

"I also believe that boys and girls should both be exposed to learning about menstruation as it's important that not only girls know what happens to their bodies but also that boys are much more understanding and informed on the what over half the population go though.”

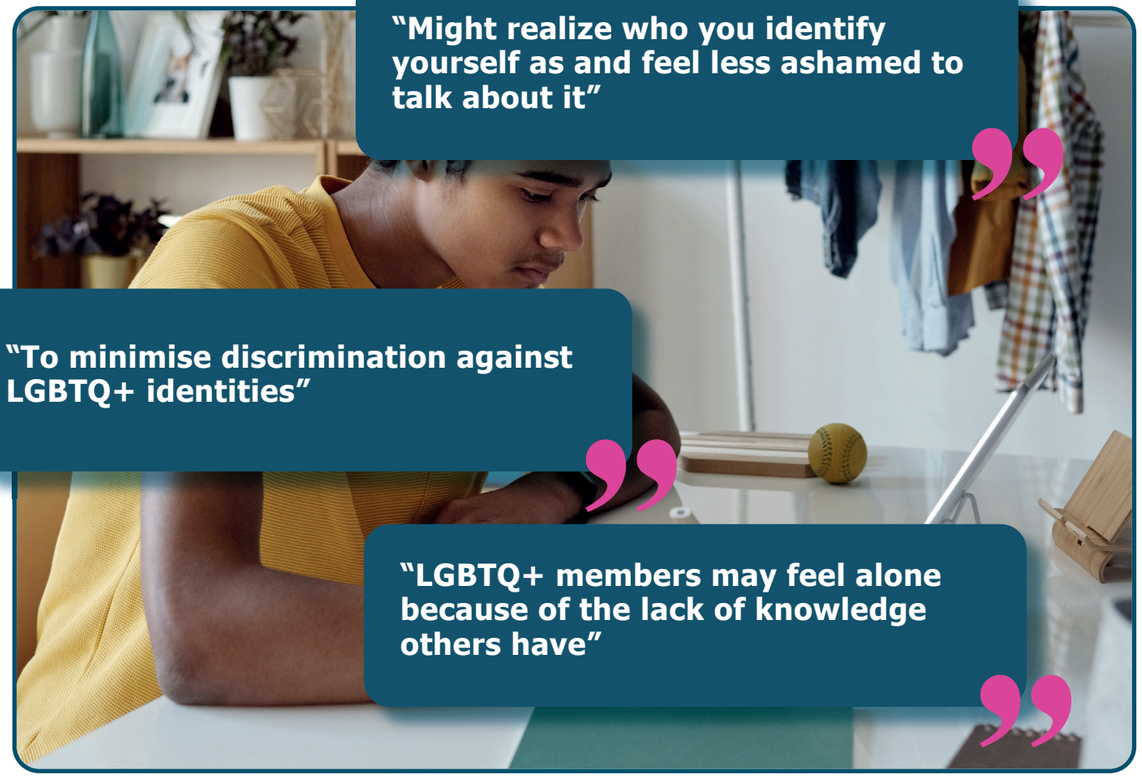
Lgbtq+ and sexual identities

25.6% of respondents said they have previously been taught on this topic but 41.6% of survey respondents felt that LGBTQ+ and sexual identities needs to be discussed more in schools. Free text responses in the survey discussed how they felt this subject was excluded and that a focus on ‘heteronormative’ sexual education was outdated and some felt this could even have negative consequences on individuals.

“My school was a faith school and they basically said that sex wasn't a good thing until we are married and then kept talking about hetro relationships and that same sex is abusive which made me feel shit as I'm gay."

"All we ever talked about was the biology of sex and about STIs. There was no discussion of asexuality which made my teen years incredibly confusing and very upsetting because I could not understand what was "wrong”. . . . Masculinity was not addressed in any detail, nor was the pleasure of sex. This solidified many young males views of sex as conquest and not pleasure, basing their ideals off each others conquests and off porn.”

As LGBTQ+ and sexual identities were rated in survey data as the main topic respondents felts should be discussed more in schools, this topic was therefore focused upon in workshop sessions, with an in-depth discussion amongst attendees (for full coding for this topic see appendix two). Participants in the workshop reinforced the survey findings with comments such as;



“Might realize who you identify yourself as and feel less ashamed to talk about it”

“To minimise discrimination against LGBTQ+ identities”

“LGBTQ+ members may feel alone because of the lack of knowledge others have”

Accessing sexual health services

Whilst 45.3% of respondents remember having been previously taught about Accessing sexual health services, 39.6% of survey respondents felt accessing sexual health services needed to be discussed more in schools.

As this was the second highest topic that survey participants felt required more discussion in schools, it was given further attention in workshop sessions (For full coding for this topic see appendix three). Participants in workshops discussed this and felt that 'Accessing sexual health services' being taught more in schools would prevent pregnancies and STIs, and their associated risks. This would happen by both providing the practical information needed, (i.e. informing students on where services are, what they offer and when to visit), and by reducing the current stigma of visiting a clinic.

"It could improve people's confidence intalking about sexual health issues and destigmatise sexual health."

"Individuals may not know where to go to find help"

Consent, healthy relationships and social expectations

Chart 6 (pg. 13) shows that these topics, which can be broadly grouped under the 'social side' (as opposed to scientific) of sexual education, are currently taught in many schools, with 'Consent and abuse/exploitation in relationships' being previously taught to 67.2% of survey participants. However, there was a feeling amongst participants that these topics should be discussed further in schools; with 36.3% of participants stating that they would like to further discuss body image, 35.6% of participants suggesting they would like to further discuss consent and abuse/exploitation in relationships ; and 25.3% wanting to further discuss the topic of 'what makes a healthy relationship?' Participants, via survey free text comments, felt that this was a gap in the content of their sex education;

"I think they missed a step, so they went straight to a full on relation and full sex, but not on building the relationship."

"We did not learn about relationships such as healthy relationships, red flags, abuse etc. All we learned was the biology of sex and what a tampon was, and don't pick your spots."

Positives/negatives/fear/pleasure

The focus on a scientific approach to sex, especially focus on STIs and pregnancy, means that there is a general view amongst participants that sexual education feels negative and many expressed a desire to focus and consider the positive aspects with 28.4% of respondents wanting solo sex/masturbation to be discussed more and 27.2% wanting pleasure to be discussed more.

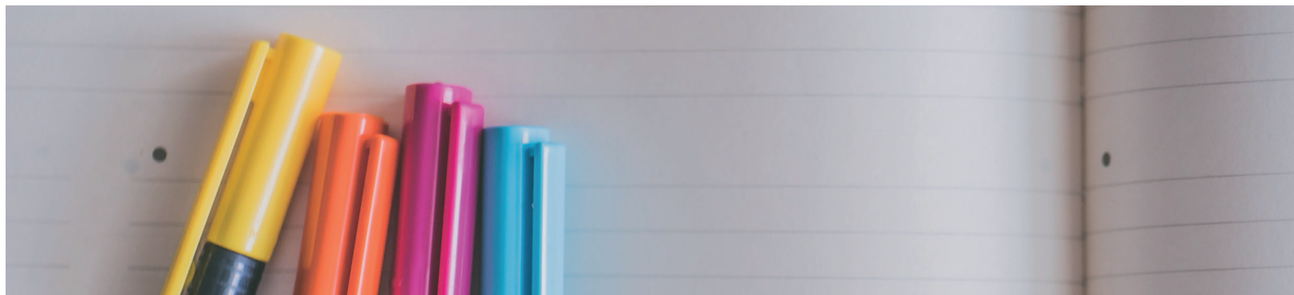
"I built up a phobia towards sex after only knowing the bad side of it"

"Watched a video in year 8 about pregnancy other than that every sex ed lesson was about sexting and paedophiles."

"There were external tutors. I kind of felt like the message of my sex ed was "don't have sex and if you do, don't get pregnant." which is perfectly reasonable advice to give a room of 13 year olds but it would have been nice to address sex more positively. Like there's nothing weird or awful about having sex or watching porn but they made it sound that way. It's not some big huge life decision (except maybe for the first time) and it's not something to be feared."

3.1.3 Timetabling of Lessons

Of the 261 responses in the survey's 'Any other comments', open text question 61 explicitly related to the timetabling of lessons. These comments made it clear that frequency and timing were contributing factors to whether sexual health education was adequate. They show a large variety in the approach taken by schools, shown in the examples on the next page.



"Covered the same thing every year e.g contraception and STIs but never anything like body image, romance etc."

"Only 1 hour sessions every so often but very informative."

"We had a week that had some focus on sexual health in year 10."

13 of these 61 comments explicitly name they had had 4 or fewer classes in their entire education.

"There was an afternoon workshop on it once in my whole time of education. Not good!"

13 survey comments explicitly related to the age at which topics were taught. With some respondents thinking the education was too early:

"I felt we were taught key info too early and it ended too soon. At our age when the information is most useful to us, we are taught nothing - we haven't had a sex ed lesson in 2 years."

"Taught too young- not when actually needed- not many people are sexually active in year 8."

And some thinking it was taught too late:

"In terms of period teaching, I was taught after I had started, we didn't learn till we were 14, some kids didn't realise what a period actually meant, and still to this day don't know that you can get pregnant whilst having one."

One participant, praised how their education developed:

" 'We have always been taught well about sexual health etc. and our lessons developed in content as we got older to ensure we are at the right age to be learning the content.'

To further understand the ages at which young people feel different topics should be taught 47 young people in two focus groups workshops were asked, via worksheet, 'What is the most appropriate age at which the below topics should be covered?' (NB. Same 23 topics as named in the survey). Participants were asked to select all the ages in which they felt each topic should be taught, with the percentage totals shown in Chart 7, below, reflecting how many of all participants answering this question felt that topic should be taught at that age. Participants could select multiple ages for each topic, implying the topic should be covered across age ranges.

This sample gives a consistent message that the most appropriate age to start sex education is between 9 and 11, with an increased need from ages 11-13, and that it needs to be a continuous process through to 16+.

Topics that participants felt should be addressed at an earlier primary school age were Love & Romance and What Makes a Healthy Relationship. Participants felt that issues around female and male puberty are important to start being addressed between the ages of 9 and 10 when young people are approaching this stage in their own physical development and then continued. Topics that participants deemed more suitable for teaching at an older age included pleasure and the positives of sex, and pornography which would generate more mature conversations.

Chart Seven: What age(s) should each topic be taught?

	Should not be taught	Ages 3-6	Ages 7-8	Ages 9-10	Ages 11-13	Ages 14-16	Aged 16+
Accessing sexual health clinics and other advice services	0%	0%	4%	11%	64%	70%	38%
Body image	0%	0%	11%	45%	57%	55%	34%
Consent and abuse/exploitation in relationships	0%	4%	13%	21%	64%	53%	47%
LGBTQ+ and sexual identities	0%	4%	17%	41%	59%	67%	50%
Love and romance	4%	9%	19%	36%	45%	49%	34%
Pleasure	6%	0%	0%	17%	36%	57%	47%
Pornography	9%	0%	2%	11%	38%	51%	47%
Positives of sex	2%	0%	0%	13%	32%	55%	55%
Pregnancy	0%	0%	11%	23%	60%	55%	49%
Puberty (female)	0%	0%	17%	61%	50%	48%	39%
Puberty (male)	0%	0%	11%	59%	57%	50%	41%
Revenge porn	11%	0%	2%	9%	41%	63%	52%
Risks/negatives of sex	0%	0%	2%	9%	66%	59%	52%
Sexting	0%	0%	4%	16%	58%	67%	51%
Social pressures/influence (media)	0%	0%	9%	30%	72%	65%	49%
Social pressures/influence (peers)	0%	2%	14%	29%	67%	69%	52%
Societal Stigmas	5%	2%	10%	31%	50%	69%	48%
Societies views on men and women	0%	2%	16%	40%	65%	63%	53%
Solo sex/masturbation	2%	0%	5%	14%	44%	63%	56%
STIs	0%	0%	5%	19%	70%	58%	51%
'The right time'	0%	0%	5%	25%	50%	64%	55%
Types of contraception and what if it fails	0%	0%	5%	14%	56%	67%	58%
What makes a healthy relationship?	0%	12%	16%	28%	65%	72%	53%

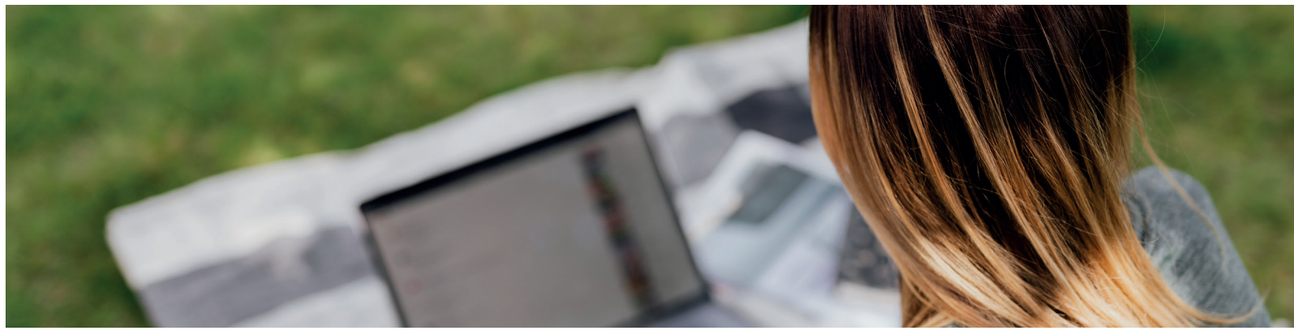
A note on: sex education outside the school gates

8 comments in free text survey responses found in that young people, feeling insufficiently informed by the education they receive, can often gain the majority of their sexual health education from sources outside school. For example, from parents, peers or personal research on the internet. This use of the internet is illustrated in the below quotes from the survey and matches with the findings shown in Chart 8 below, where people describe the internet as their main 'service' they use for sexual health advice.

"I was taught nothing useful - sexual education wise - at primary or secondary school, and would have been dangerously unaware of relationships/intimacy/sex if I hadn't had an open dialogue surrounding such issues with my mother, and then gone on to make an effort to self-educate."

"'Personally I learnt from external sources the main one being Hannah Witton on YouTube' "

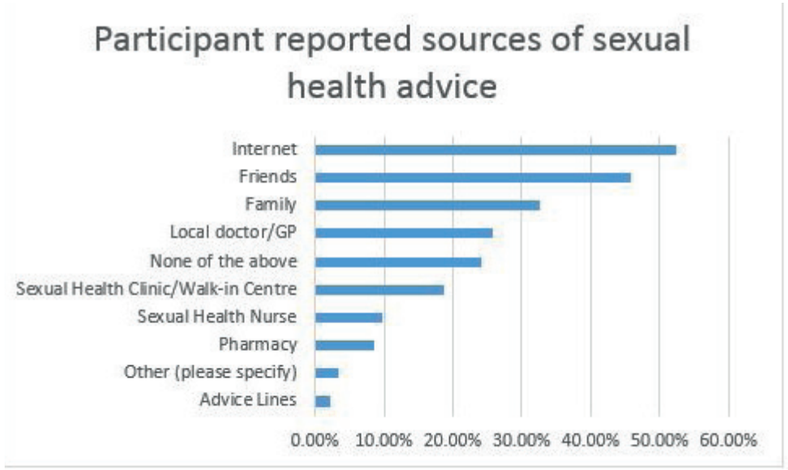
[NB. See recommendations section below for further information]



3.2 Sexual Health Services

In the survey we asked about sexual health advice and services. We wanted to explore where young people get advice and what they think about the services that are currently available. We asked respondents to 'Please tick any of the below which you have used for sexual health advice' and received 545 responses to this question with 'internet' being the largest category with 286 responses. 18 responses were named 'other' and these included youth centre; school teachers; and school clinic.

Chart eight: 'Please tick any of the below which you have used for sexual health advice'



The results to this question were explored further in workshops (say which) with 'X' number of young people, asked 'When/Why may you, or anyone, go to the following places for sexual health advice?' and 'How could the following services be improved for delivering sexual health advice/services?'

The summaries below combine insights from the survey and workshops.

Internet – is used for a combination of its ease of access and it's anonymity. Participants may not wish to discuss symptoms or other sensitive topics with people. There is some awareness that the information found may be false or misleading.

Friends and Family – are used as they are trustworthy and supportive, participants feel comfortable talking with people they know and can offer general advice, especially around the topic of periods and puberty. There is an awareness that this may depend on your family.

GPs – are visited when strongly concerned about an issue and professional, expert, advice is needed. GPs are also visited for prescriptions, such as for the birth control pill. It is valued that GPs are known to be confidential, but the service could be improved by having shorter waiting time for routine medicines (i.e. the pill) and with more comfortable settings, e.g. someone of a younger age group or providing a choice in the gender of the GP seen.

Sexual Health Clinics – are visited when professional, thorough, confidential advice is needed either for health emergencies/concerns or for advice on the types of contraception available. Clinics are also visited for STI testing. For further feedback on clinics see 'About Sexual Health Clinics' section below.

Sexual Health Nurse – There was some confusion related to what a sexual health nurse was, with some considering them to be clinic staff and others thinking them to be similar to school nurses and health visitors. Despite this confusion, answers indicated that they would be valued for their expertise and confidentiality. Participants suggested it would be helpful for them to be more easily accessible and know where they are available.

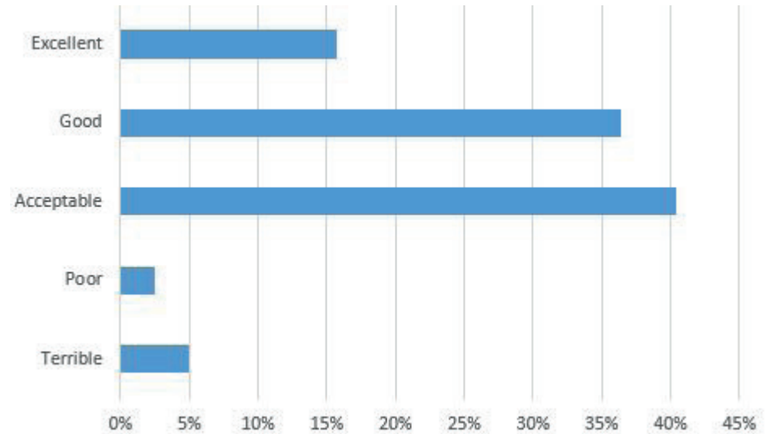
Pharmacies – The majority of participants saw pharmacies as a place to collect prescriptions and contraception. Some participants spoke of visiting the pharmacy for general information or 'if they couldn't get an appointment at the GP', but references to 'expert and professional' advice are noticeably absent from answers compared to visiting other services. It is valued that they are accessible and fast. There was also doubt about the confidentiality of a pharmacy. Providing a separate room or ensuring privacy was a major source named for improvement.

Additionally, a number of participants noted that they would like to be able to collect the birth control pill without a prescription from the GP – for example, if pharmacists could carry out blood pressure tests.

3.2.1 About Sexual Health Clinics

We asked in the survey 'If you have visited a sexual health clinic, how was your most recent experience?' The question had 277 responses, the results are shown in Chart 9 below. This chart shows that for those who have visited clinics, their experiences are more positive than negative.

Chart nine: 'If you have visited a sexual health clinic, how was your most recent experience?'



Respondents were also given the opportunity to expand on their answer in a free text box. Of the 73 participants who gave their comments 53 responses were coded as positive. These responses generally refer to needs/information being met, feeling supported, comfortable and not judged by staff.

"The doctor was informative and made me feel really comfortable (I was really nervous). They sent me information after my visit as a follow up which was great to be able to look over it in my own time."

"The first health professional that I saw at the clinic was beyond helpful, and even referred me to their onsite EMDR therapist, after I disclosed that I'd been struggling with sexual assault related PTSD (diagnosed)."

"They never judged me and helped me with whatever I needed. They gave me the correct advice and have helped me through 4 different types of contraception which suits me best."

17 responses were coded as describing a 'negative' experience. Negative comments generally refer to feeling uncomfortable, not listened to or judged by staff.

"One doctor didn't seem to listen to me or have time for me and talked over me a lot."

"Uncomfortable experience and felt more like an interrogation. Far too many irrelevant personal questions."

"Wanted to go with the support of my partner, was told had to be alone. Very rude and rough when taking my bloods (bruised my arm), made me feel uncomfortable and stupid. Went to a walk-in and was told that no one would see me"

3 answers referred to inadequate information being provided, one of these naming incorrect information:

"Unfortunately, after my check-up, I was directed to talk to another woman who worked at the sexual health clinic, who told me that I wouldn't ever need to go for regular smear tests once I reached the age of 21, because I'm not having heterosexual sex, meaning I wouldn't be at risk of cervical cancer. I wasn't sure that was right, so I checked with my doctor, who confirmed that I'd been misinformed. "

2 answers referred to negatives with the layout of the building itself:

"Very understanding staff who were incredibly accommodating, however the layout of the building and waiting areas etc. were not very calming/inviting or particularly discreet."

4. CONCLUSION AND RECOMMENDATIONS

Unique in its approach and findings this report provides the direct voices of 100s of 16-20 year olds across Devon. By combining a widely distributed survey and focused workshops, this report has gained insight into the broad needs and desires of young people, related to both Sexual Health Education and Sexual Health Services, exploring some of these needs in greater detail.
We hope this report has raised data to be used as a point of challenge and way to raise questions about the rationale in education and service design – not least related to the implementation of the new national Relationship and Sex Education curriculum, which is compulsory from September 2020.

Young People all develop biologically and socially at different times and this report shows how individuals' views differ widely, across and within schools, on what constitutes a positive education in terms of topic breadth/depth; timing/frequency; and format of classes – but it is clear that current Sexual Health Education in Devon, generally, is not 'good enough'.

The internet is now the main source of education for young people, to explore around the topics named in this report. This potentially alleviates pressure on schools to deliver complete, in depth education on all topics, to all young people of varying opinions and development - but the foundational knowledge and space for safe discussion is essential and achieved by

knowledgeable, comfortable teachers.

The strong desire for further education on Access to Sexual Health Services, and discussions around this, show how closely the actions of the health and education sectors are linked, ultimately relating to service use. This is supported by academic research (e.g. Palmer et al. 20191) which shows quality of Sexual Health Education is one key factor relates to overall 'sexual competence' and the associated ongoing health of individuals.

Experience of Sexual Health clinics is spoken of positively, with confidentiality and expertise being valued across all services.

4.1 Recommendations

1. Respondents show, when discussing Timetabling of Lessons, Sexual health education should be regular and ongoing education for each year group.

2. With different rates at which students experience puberty and become sexually active, schools could make clearer routes to accessing information outside SHE lessons.

3. Respondents often felt there was a need for better education on service provision. Access to services should therefore be incorporated into education, including practical notes on local services (location/opening hours etc).

4. The role offered by pharmacies; needs to be better taught and understood to be better utilised, one aspect that could particularly improve young people choosing to access advice from their pharmacy would be for pharmacies to promote their confidentiality.

5. There is a desire for knowledgeable, specialist teachers to visit schools. Close collaboration with sexual health services could meet this need. Internal and external teachers delivering Sexual Health Education should be fully trained, confident, and comfortable with delivering their topics and in creating a comfortable and safe space for discussion.

6. Far more attention should be given alongside the science, to healthy relationships, consent, social expectations, and body image.

7. The internet is relied upon heavily for sexual health education and advice. Schools could review their policy on which sites to block, or provide access to students as their age.

8. There should be opportunities for schools to share best practice and to level the quality of SHE to ensure all students receive equally high standards. This could be provided by using high quality external teachers.

5. FURTHER RESOURCES

1. Devon focused NHS Sexual Health Website (launched 2019): https://www.devonsexual-health.nhs.uk/
2. Outcome star framework for measuring young people and their sexual health: https://www.outcomesstar.org.uk/using-the-star/see-the-stars/sexual-health-star/
3. Statuatory guidance: Relationships education, relationships and sex education (RSE) and health education. https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education
4. PSHE Association's 'Preparing for statutory RSE and relationships education' https://www.pshe-association.org.uk/curriculum-and-resources/resources/preparing-statutory-rse-and-relationships
5. PSHE Association's 'Roadmap to statutory RSE' https://www.pshe-association.org.uk/curriculum-and-resources/resources/roadmap-statutory-rse
6. Rise Above – a website with online games and videos to get young people talking on PSHE topics https://riseabove.org.uk/about/
7. Hannah Witton – one of many Youtube and social media educators talking about sex and relationships. She has 596k followers. Short searches, especially on Instagram, on key words such as sex educators, body positivity or consent will reveal much high quality educational images and videos. https://www.youtube.com/user/hannahgirasol/videos?app=desktop
8. Ted Talk – How to talk to kids about sex in the time of #metoo by Christa Desir https://www.youtube.com/watch?v=CudqASUdCuQ&feature=emb_logo

6. APPENDICES

Appendix 1: Education Workshops – 'How to teach sexual health' – suggestions from participants

Main heading/code	Sub-code
Classmates	Both genders
Classmates	Genders split
Classmates	Familiar people/tutor groups
Memorable	Bring it into normal lessons
Memorable	Treat as a serious subject
Memorable	Have examples
Memorable	Have videos/virtual reality
Memorable	Practical demonstrations
Memorable	Body part models
Memorable	Both Negatives and positives
Memorable	Memorable way
Memorable	Fun
Memorable	Targeted
Safe space	Someone who understands it's embarrassing
Safe space	Relaxed/non-awkward
Safe space	Conversational
Safe space	No judgement/neutral
Safe space	Get stigma out of the way first
Safe space	Supportive enviro
Safe space	In a classroom
Safe space	Anonymous activities
Safe space	Safe space
Teacher experience	Someone with expertise
Teacher experience	Deep detailed knowledge
Teacher experience	Younger teachers
Teacher experience	Non-sciencey
Teacher experience	Up to date
Timing	Regularly
Timing	A whole day
Timing	Primary school
Timing	Every year

Appendix 2: Education workshop - 'Why teach LGBTQ+ and sexual identities?'

NB. Codes refer to responses and not participants. Participants each contributed multiple answers, and many answers could be coded for multiple coding categories.

To improve mental health and loneliness	31
Confidence in exploring identity and talking about it	27
Increasing equality, respect and reducing discrimination	35
For younger generations to understand	6
Understanding and awareness of the topic and language	28
Doesn't need to be taught more	5

Appendix 3: Education workshop – 'Why teach accessing sexual health services?'

NB. Codes refer to responses and not participants. Participants each contributed multiple answers, and many answers could be coded for multiple coding categories.

So people know where and when to go	25
Reducing stigma so people know it's ok to go	15
For safety - to prevent risks, STIs and Pregnancies	35
Contraception advice	9
To provide advice and support	24

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