Investigating sexual health services for young people in Stockton-on-Tees: a participatory approach

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Abstract

The project design aimed to recruit a number of young people in the Stockton-on-Tees area to research the sexual health services in whatever manner they wished to. The remit was purposefully broad so as to allow the young people involved as much autonomy and choice as possible. Participatory methods were the theoretical base, in order for young people to assess the sexual health services in the area in which ever way they felt was most appropriate. As a result of this research wider theoretical issues were addressed. The position of youth in research, society and in relation to sexual health is addressed, the marginalised situation of young people discussed and the way that social trends have radically altered the nature of youth in Britain today. The nature of participatory research, especially in relation to its use within a large bureaucratic institution, and including young people in relation to sexual health. The problems and issues that came out during the research period are explored and discussed in relation to the literature and the experience of a number of the young researchers. This research was successful in recruiting young men and made a large number of practical suggestions to improve the sexual health services in Stockton for young people.

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Section A

Section A.1 Introduction

A.1.1 Introduction

In the realm of health research it is especially important to hear the voice of the individuals being researched rather than the researcher. In order to provide health services that cater for the needs of the community rather than those needs as perceived or translated by others, the opinions and views of the communities need to be heard and acted on. This project is based on involving a group of young people who researched sexual health services in their areas in a participatory manner using a variety of qualitative methods. The participatory research method relies on the active involvement of people in the communities themselves. In this methodology "'outside' researchers and 'inside' respondents are partners, exploring topics of mutual interest together" (Martin, 1996: 83). This method allows people to ask their own questions and to express their own needs in ways they feel are important and that can lead to alterations. "A major objective of the PR process is to work towards reducing the power often held by researchers who come from outside the community to do research, and by elite groups within the community. The bias is towards marginalized groups in the community" (ibid. 83). This bias then is towards the communities being worked with rather than the institution that the researcher may be working for.

Teenage pregnancy has become a political and emotional issue. This is true in both Britain and America. "In the past decade this issue has become one of the most frequently cited examples of the perceived societal decay in the United States" (Coley and Chase-Lansdale, 1998: 152). This contrasts with the facts that the rates are actually lowering in the US

(ibid.) and in the UK. "Although the UK has the highest teenage fertility rate in Europe, the perception of teenage pregnancy as an increasing problem is false; the live birth rate to teenage women in the UK in 1987 was 30.9/1,000 compares with 49.7/1,000 in 1970" (Spencer, 2001). The issue then is not related to an increase in births in this age but is in fact a much more complicated issue relating to delay of marriage and other sexual health issues.

Sexual health among young people is a larger issue than just levels of pregnancies. Effective and consistent use of contraceptives, protection from disease and the ability to express their own sexuality are also at the heart of this matter. The provision of services and the policy that health professionals follow are important. From research carried out in both Britain and Germany among women of reproductive age it has been concluded that health care policy and the available facilities has a dramatic effect on contraceptive choice and use. In particular factors were "the organisation of contraceptive services, the type of providers involved, the considerable influence of provider preferences, and teenage sex education" (Oddens and Lehart, 1997: 432). This influence is obviously very important if we consider other elements that this research discovered such as German adolescents using oral contraceptives more frequently but condoms less frequently than British adolescents. Most worrying though is the more frequent use of British teenagers of either no contraceptive method or withdrawal than their German counterparts (ibid.). Thus it can be seen that the sort of services and the policy behind them is significant in looking at how young people control their own sexuality and how society views this.

At issue here is also the discourses in society about young people. How they are viewed in society is very important to the way that young people can fashion their own culture and behaviour. In relation to health this is especially important. Many health issues need to be viewed outside of a traditional biomedical sphere. "By its nature, public health dictates that

health problems be viewed behaviourally, as well as medically" (O'Reilly, 1991: 88). A large number of the health issues that affect young people are related to behaviour, these include sexual health, drug abuse, mental health and exercise. Previous views of young people and health behaviour seemed to view young people as performing risky behaviour that would stop if they were just told not to. This view has changed radically in many areas. There has been a realisation that young people and their behaviour need to be listened to and understood rather than lectured. "Patterns of teen behaviour must be understood in context, not simply labelled deviant and treated as an epidemic against which youths may be inoculated by health education messages" (Nichter, 1991: 10)

This project is based on research carried out in Stockton-on-Tees using participatory methods in order for young people to assess the sexual health services in the area. As a result of this research wider theoretical issues were addressed. The rest of Section A looks at youth in research, society and in relation to sexual health. The marginalised situation of young people is discussed and the way that social trends have radically altered the nature of youth in Britain today. In terms of sexual health, the literature regarding young people and sexual health in many Western societies is discussed, especially regarding contraceptive use, risk behaviours and how young people view teenage pregnancy themselves. Section B concentrates on the nature of participatory research and its use within a large bureaucratic institution, and including young people in relation to sexual health. The problems and issues that came out during the research period are explored and discussed in relation to the literature and the experience of a number of the young researchers. Section C relates the results of the research. The findings about the sexual health services in Stockton are viewed in relation to both the research and to existing recommendations from both government and academic research. In Section D the three sections are pulled together again and conclusions drawn about the nature of the research and methodology.

A.1.2 Description of project

The project design was to recruit a number of young people in the Stockton-on-Tees area to research the sexual health services in whatever manner they wished to. The remit was purposefully broad so as to allow the young people involved as much autonomy and choice as possible. I was appointed as a facilitator and would use the research as work for a masters in Anthropology. My role was to ensure that the work was ethically sound and also of significance.

After some initial meetings with groups of young people, in which methods, aims and practicalities were discussed, two main groups of long-term researchers were set up. One of these was based in Thornaby and the other in Egglescliffe. In the interests of broadening the research base some short-term work was set up in central Stockton where workshops were carried out with young Asian men and also young people involved with social services.

Throughout, the main purpose of the research was to allow young people in the Stockton area as much freedom as possible to find out what currently exists as regards sexual health services for young people and to make their recommendations as to changes that are needed in those services.

The research was carried out over a period of about four months in all and then written up over about a month. The young people involved gave recommendations, results of their research and their conclusions to the facilitator who then wrote these findings into the document here. In each section of this report the views and findings of the young people involved are put forward and then these are put into the wider context of recent research and policy.

A.1.3. Aims of the project

The initial aims of the project were to:

- have a range of young people from different sources investigate the sexual health services of Stockton,

- put the emphasis on young people setting the agenda regarding objectives and methodology,

- gain a view of what different groups of young people in Stockton think about the sexual health services in the area, and

- obtain recommendations from young people for changes in these services.

B.1.4 Stockton as research site

Stockton-On-Tees is situated in the Northeast of England and is part of the larger Teesside conurbation, consisting of Stockton, Hartlepool and Middlesborough. The population of Stockton is nearly 180,000. The overall unemployment rate for Stockton is 7.5%, as compared to 4.5% for the national average. The rate of under 18 conceptions for the period of 1995-1997 was 46.5 per thousand girls aged 15-17 which puts it 116th out of the 374 local authorities in England and Wales (Tees Health Authority). Looking at Stockton on a ward level it can be seen that there are very large variations between the different areas. The research carried out for this project attempted to reach young people from a variety of these areas. The main wards that were reached were Egglescliffe, Village and Mandale in Thornaby, and Central Stockton, consisting of Portrack and Tilery and

Parkfield. On a scale of inequality for the Tees area these cover from affluent Egglescliffe, through intermediate Village, to very deprived Portrack and Tilery and Parkfield (Tees Health Authority, 1998).

Egglescliffe is the most affluent area studied. It is situated on the outskirts of Stockton with a low unemployment rate, 3.1% overall, is overwhelmingly owner-occupied housing and the majority of heads of households are involved in non-manual work, 65.5%. The levels of teenage pregnancies here are among the lowest in Stockton. In the period 1995-1997 there were nine under 18 conceptions (Tees Health Authority). Also the 1995 Cleveland Health and Lifestyle Survey found that rates of cigarette smoking, high levels of alcohol intake and obesity are lower in this area than the average for Tees (Tees Health Authority, 1998).

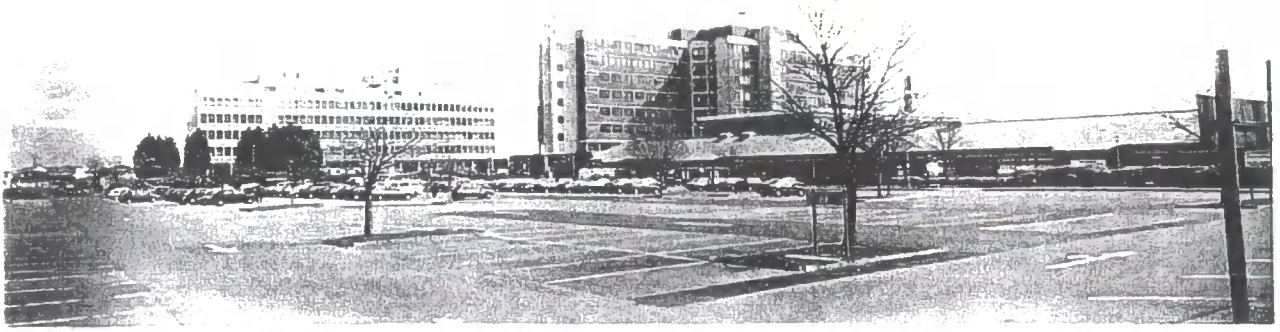
Village and Mandale are both part of Thornaby. This area is closer to Stockton centre than Egglescliffe and is a densely populated area. There are higher levels of council property in these two wards than in Egglescliffe, 32% for Village and 45.6% for Mandale. Also a majority of heads of households are involved in manual work, 60.7% for Village and 64.3% for Mandale. There are also higher levels of unemployment in this area, 7.4% for Village and 9.2% for Mandale (ibid.). Levels of teenage pregnancies are low and high intermediate, respectively, for the Stockton area. In the period 1995-1997 there were nine under 18 conceptions for Village, and thirty for Mandale (Tees Health Authority)

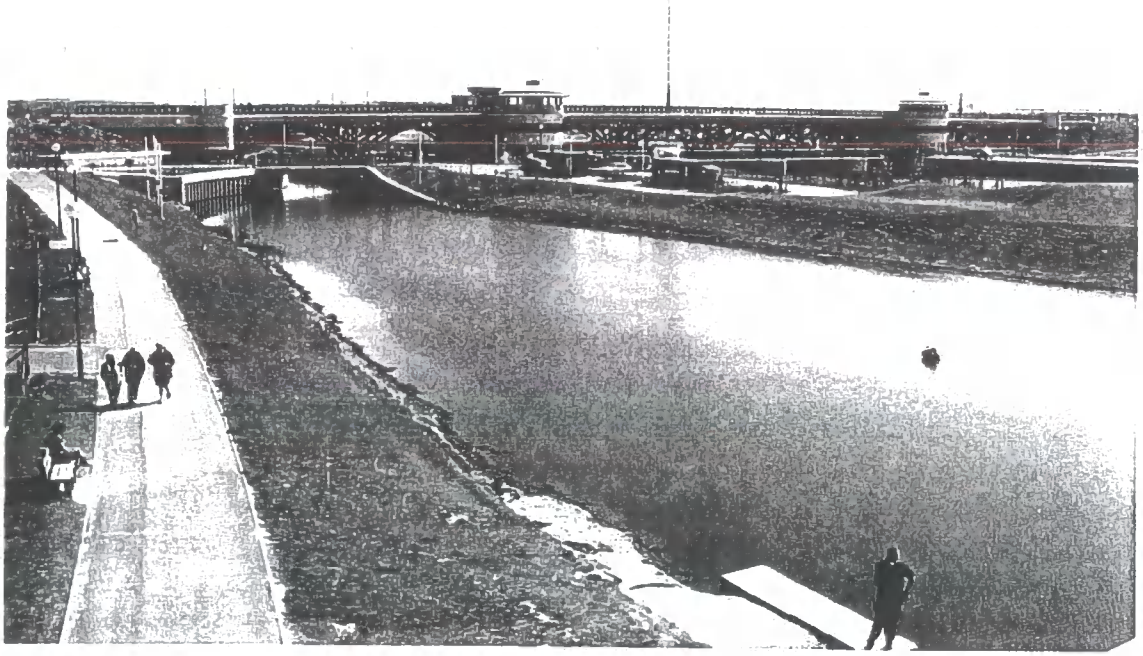
Portrack and Tilery and Parkfield are within the central Stockton area and both have very high unemployment rates, 19.1% and 19.5%. Both also have higher than average levels of ethnic minorities for Tees, 3.3% and 9.8% respectively. Portrack and Tilery has very high levels of council owned property, 58.6%, and Parkfield has a large number of properties rented from another source, 36.1% (Tees Health Authority, 1998). The levels of teenage

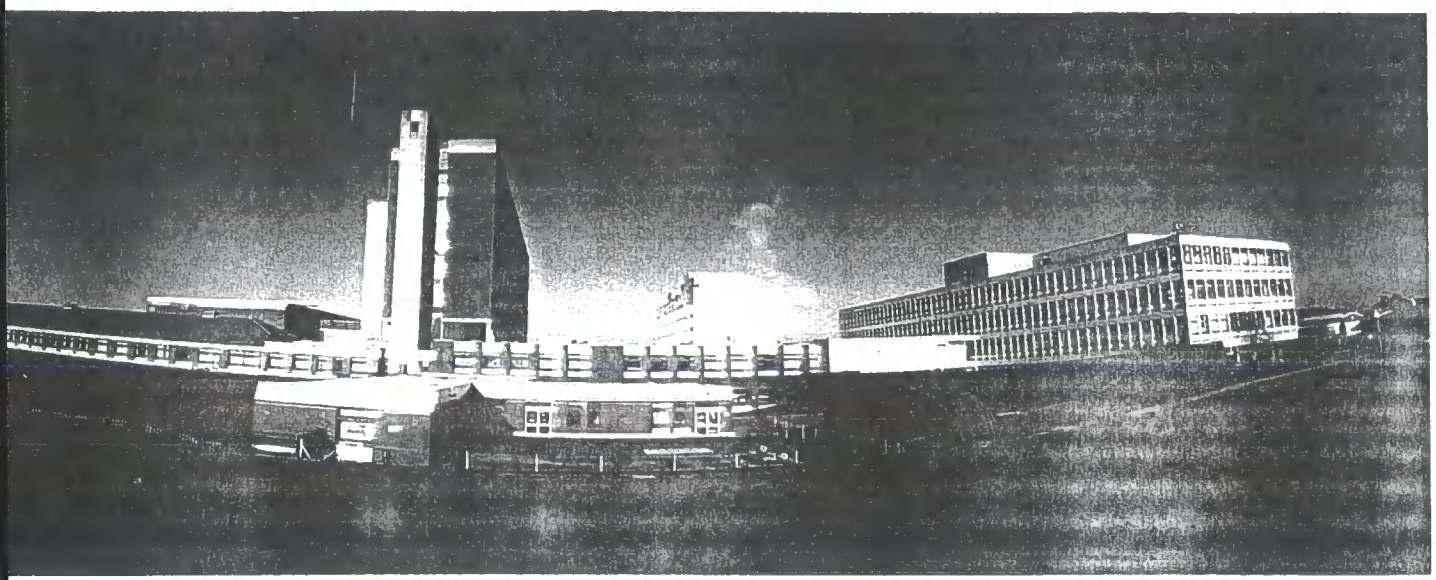
pregnancies for both of these areas are among the highest in Stockton. In the period 1995-1997 there were 39 under 18 conceptions in Portrack and Tilery, and 37 in Parkfield (Tees Health Authority).

As a research site Stockton is part of the wider Teenage Pregnancy Strategy to reduce under 18 conceptions. The area of North Tees and Hartlepool, which includes Stockton, has been targeted because, in pockets, this area has some of the highest rates of teenage pregnancies in England and Wales. This area also has some very high levels of social deprivation and unemployment. The wards in Stockton that consistently have among the highest levels of teenage conceptions generally have higher than average unemployment levels for the area, higher general fertility rates and higher percentage of single parent households (ibid.). There has been found to be a correlation between deprivation and teenage conception in this area (ibid.).

A.1.5 Photographs of Stockton-on-Tees







Section A.2 The position of youth in society

Adolescence, or youth, is a period of time in an individual development that is particularly difficult to define. This is because it is generally marked by being neither of two things. An adolescent is not a child, but neither is he or she an adult. Adolescence is, therefore, characterised by the ways that it is not childhood or adulthood. This usually comes to the main point that adolescents are partially independent, with some autonomy, but are dependent upon their family, or carers, for support, financial and otherwise. As a young girl who took part in the research commented:

> "You're in an independent world financed by your parents."

A.2.1 Youth and Anthropology

"The social spaces of difference are important because these sites are constituted by the presence and activity of people whose voices continue to be silenced" (Caputo, 1995: 19). These people include women and the young. Culture, if seen as a single coherent whole, can silence these voices, the voices of the less powerful. The culture of the young, because it is not mainstream adult culture, is ignored apart from considering its relation to adult culture. Youth have often been seen in anthropology only in terms of the relationships that the young have with adults, or in terms of training to be adults. "Youth (and children) still tend to be viewed as *incomplete adults*, not real, full persons who have understood what life is really about" (Wulff, 1995: 11). Thus their own contribution to culture, or their own culture in itself, is often overlooked as somehow less important, or less significant, than adult culture. Generally children and youths have been seen in ethnography but only as "appendages to adult society" (Caputo, 1995: 22) and their voices have not been heard. "From their relative positions of powerless, they have been kept silent" (ibid. 23).

One of the reasons why the voices of children and youth have rarely been heard, or given weight, is that "children's culture is connected conceptually to women, is the subject of everyday life, is not explicitly tied to political economy and, as such, retains a devalued status" (ibid. 32). The importance placed on public culture and on the political economic sphere means that youth and children, who are generally excluded from this arena, are outside of the central areas of interest. Thus their voices and culture are felt to be lesser, or are trivialised.

Generally anthropological research into young people has seen the period of youth as significant in terms of preparing for adulthood rather than as notable in its own right (Wulff, 1995). Studies of childhood and adolescence have often considered them as being deserving of interest because of their importance in forming adults for the future. It has been a "notion that children's lives are only significant in relation to some future state or in relation to adult cultures" (Caputo, 1995: 29). The nature of childhood and adolescence is conceived in terms of what is to come. The young are perceived in terms of societies' hopes for the future. The policies that are formed in relation to children are concerned with what they will become, they are concerned with constructing future adults rather than considering present youths. This can be seen in the way that worries about teenage pregnancies are expressed in America and Britain. The discussions are relatively unconcerned with the immediate consequences for adolescents but are worried about what sort of adults teen mothers will become and what adults their children will become in turn (Social Exclusion Unit, 1999). Each adolescent is only a youth for a certain time period and this has meant that youth and childhood are viewed from the perspective of a transition. This has resulted in this period of time as being seen in terms of what it leads to rather than what it is. It seems that "perhaps, like many other adults, anthropologists view youth as not to be taken seriously; occasionally amusing yet potentially dangerous and disturbing, in a liminal phase" (Wulff, 1995: 1).

One of the areas that has been given a lot of attention in relation to the young is the importance of rites to mark the attainment of full adult status in many societies. "No passage is so often and significantly marked as that which functions to signify the end of childhood" (Goodman, 1970: 146). In modern British society, though, this transition is not marked by any specific, universal, formal rite. There are a number of generalised changes that are considered to mark this transition. "A defining characteristic of the transition from youth to adult status is the progression from partial dependence on parents to independence, and a reliance by individuals on themselves (and their parents) for resourcing their daily living arrangements" (Irwin, 1995: 2). Malinowski in his definition of adolescence concentrated on the elements of the rites of initiation, and commented that "this is the period of complete emancipation from the family atmosphere" (Malinowski, 1927:15). He also comments that in certain tribes "it is the epoch in which tribal law and order lay their claim on the youth and the maiden" (Malinowski, 1995: 15). This brings attention to one of the major themes in the interaction between youth and adult society – the idea of control of the young by society.

There is a common perception that young people are empty vessels that are filled with adult culture. "Children, like youth, continue to be depicted as passive receptors of adult culture" (Caputo, 1995: 22). This view of young people as not being social actors themselves, merely being formed by society and having culture taught to them, has been widely used in many ethnographic works. This has been viewed now as being both a narrow viewpoint, and also an almost totally inaccurate portrayal of youth as experienced by the young. "Being a child is not longer, even it ever was, simply a matter of being shaped by adult-controlled institutions" (Prout, 2000). There has been a move in recent works to the view "young people are active agents – in different ways and with varying force – in the construction of the meanings and symbolic forms which make up their

culture" (Wulff, 1995: 1). The idea here is that young people are not the passive receptacles of adult society but are actively engaged in formulating their own culture and that this is of equal importance for investigation as adult culture. This move is potentially very controversial and significant. "The suggestion that children may have a different kind of knowledge, that they may be pre-occupied with things their adults are unaware of, may appear offensive to responsible parents and teachers" (ibid. 10). It also moves the focus of research from viewing young people in terms of how they are like adults, or what adults they will become. The new perspective allows research to discover what is important in youth culture and how this is formed and expressed.

A.2.2 Youth and social trends

Youth is a constantly changing concept, its boundaries being negotiated constantly. As a result "not only is 'youth' consequently a construction, as is the term 'children', but in fact so is 'adult' " (ibid. 6). The changes and shifts in how adolescence is experienced and defined have effects on both the young themselves, and adults. One of the main elements that have been effected is the boundary between youth and adulthood. Where this is drawn and how has ramifications for how adolescents are conceived, and how adults are defined. Adulthood has often been characterised by economic independence, marriage, and having children, while adolescence in contrast is related to at least a partial dependence on family for finance and support. With changes in employment, and the make up of the family these characteristics are being challenged and renegotiated. It is important to note though, that "young people in particular are not products of social change but actively engage with it in complex and often paradoxical ways" (Miles, 2000).

The last three decades have seen dramatic changes in the labour market for all ages. There was a massive increase in unemployment generally and in particular for young workers. The unemployment rate for young men aged 16 to 24 in 1974 was five percent and this had

increased to twenty-five percent by 1984 (Coleman, 2000). The number of young people in the job market has also decreased through the introduction of training schemes (ibid.). These schemes were designed to reduce young unemployment, but they have also served to delay young people from entering the labour market as full members. Also full time higher education has increased in popularity to the extent that now about seventy percent of young people go into a form of higher education (ibid.).

Another noticeable change in the labour market has been the shift from a manufacturing base into the services industry. Over the period from the 1950's to today the share that manufacturing has of the labour market has decreased from thirty-five percent to sixteen, while there has been a concurrent shift in the services share from eight percent to twenty-three percent (ibid.). This has great implications in that young men have lost their traditional employment sources whereas young women have gained opportunities (ibid.).

The main result of these changes is that "economic independence – a tangible sign of maturity – is delayed" (ibid. 232). The situation of young men as being able to bring in money to support themselves, and maybe a partner, has become increasing unlikely. The life course of leaving school, getting a job, marrying young and starting a family has been delayed and shifted and as such "the very nature of the adolescent transition from child to adult is altered" (ibid. 232). The importance of these shifts in employment trends is central in many ways. A key question is "how will young people define adulthood, or full autonomy, if they are unable to find employment which provides financial independence?" (ibid. 240). The traditional view of an adult as being financially independent and being able to thus control their own lives is under threat by these changes in the employment of the young.

As well as young people being effected by changes in employment, it has been contended that changes in the labour market also have an effect on the way that society views adolescents. When the labour market is buoyant and is in need of numbers of young workers, the young are viewed as self-sufficient and as being deserving of full adult status relatively young. When there is a depressed labour market with little need for young workers, the young are viewed as needing further education and as being near childhood for longer (Finn, 2001). Thus it has been illustrated that the way that society views the young is generally out of the control of the young themselves.

One of the other areas of change in modern society that has affected young people is the family. The nature of the family has changed radically in the last three decades. The divorce rate has increased radically and more children are being born out of marriage (Coleman, 2000). This has many implications for the lives of young people. There is more stress because of family breakdown and reorganisation. Also young people have to deal with stepfamilies and other extra family members. This all means that young people experience family life in a markedly different manner in this era than at previous times. Thus their expectations and desires for the future in respect to relationships and families are different as well (ibid.).

The way that people perceive themselves and their relationships to others is often closely related to their ideas of kinship. Who we are is often associated with who our families are, and where we come from. The changes in the family are linked to kinship in ways that are still being clarified. Kinship is a combination of biological and social elements. The biological parts include genetics and gestation, the social include household composition and marriage (Strathern, 1992). Recent shifts in society include changes in traditional sex roles, increases in divorce and other disturbances in the concepts and definitions of family and reproduction (Farquhar, 1996). There is a lot of anxiety in society as a whole regarding

these social changes. There have also been advances in the scientific technologies that are changing the landscape of reproduction and kinship as well as many social changes that have effected and changed these areas beyond recognition. The increasing divorce rate and acceptability of homosexual relationships have lead to the fact that "many will live long term in a 'family' setting, but with people who are not biologically related to them" (Ulanowsky, 1995: 1). So the concepts of kinship and relatedness have been subject to many drastic changes over the recent years.

Changes in sexual behaviour have also occurred that are a corollary of these changes in marriage and kinship. No longer is it expected that people should save sex for marriage. Also there is a concept that the reality is no longer to only have one sexual partner for life, but to have a series of sexual relationships, also known as serial monogamy. Changes in adult sexuality have a major influence on adolescent sexuality. Many young people now observe their parents having a number of relationships, and very probably having sexual relationships outside of marriage. As such the association of sex taking place within the context of marriage and only ever with one individual has been broken to a large extent. There has also been a trend for young people to initiate sex at an earlier age than in previous decades. "To have experienced intercourse at least once by age 18 or 19 is the norm rather than the exception in Western Society, for young men and women alike" (Moore and Rosenthal, 1993: 202).

There are many other social trends that affect young people in British society at this moment. These include the importance of socialising through drinking, club culture, football support and an apathy towards traditional politics (Bynner, 2001). Bynner comments that young people are deprived of an education in politics and it is as a result of this that they feel apathetic towards traditional politics. Most involvement that young people have in politics is related to protests relating to animal rights, conservation (ibid.)

and fears of globalisation. Bynner relates this lack of political education to an association made by the Thatcher government between such education and left-wing political indoctrination. As a consequence most young people do not have any contact with politics through the school curriculum (ibid.). There have been some moves under New Labour to rectify this with a commitment to encouraging active citizenship through education at schools (ibid.). An exclusion from politics, though, has meant that young people have little power over the way that politicians perceive youth, or over the policies that these politicians put into place.

A.2.3 Youth and control

One of the major themes to be considered when looking at the position of the young in society is the idea of control. The control of the young by society is of key significance when viewing the treatment by society of the young. "The sexual maturity of our children appears to represent to parents and other adults an enormous challenge. Above all it is symbolic of the moment when we finally lose control of our sons and daughters, and there is little doubt that the key issue between adults and teenagers is that of power and control" (Coleman, 2000:236). Here sexuality can be seen as a central area of concern. Moore and Rosenthal (1993) discuss Selverstone's work in which sexuality is seen as a part of the development of young people. It is an area that enables young people to disengage with the family and to move towards independence and an individual, self-realised identity. Thus sexuality is one of the main areas where young people assert their separation from their status as child, or dependant. This makes sexuality an area of much conflict and control between adults and adolescents. It is therefore particularly noticeable that there has been little heard on this subject from adolescents. "There is little analysis of sexuality from the adolescent's viewpoint – what it feels like, what beliefs and motives underlie experience" (ibid. 204). Our understanding of this significant portion of young people's

lives has been reached with little consultation to the experience of the young themselves in their own words.

Prout (2000) has considered that the treatment of young people in society is marked at the moment by the tension between two trends. One of these seems to control the private sphere and the other the public. In the private sphere young people are being seen as individuals with the ability for self-realisation and the right to some element of autonomous action (ibid.). In the public sphere, on the other hand, young people are being subjected to "practices directed at a greater surveillance, control and regulation" (ibid. 304). The public attempts at control are related with a desire to mould the future by moulding the adults of the future. Education is central in this attempt at control. This has lead to a greater centralisation of education in Britain, though such initiatives as a national curriculum, greater testing of children and the creation of school league tables (ibid.). "Public institutions are more and more concerned with the control of children, whilst the private sphere is constituted ... as the place where children are more allowed to express choice, exercise authority and work at their own individual self-realisation" (ibid. 311).

One trend in the interaction between the young and the public institutions that affect them is the substitution of the opinions of the young with the opinions and voices of their parents. Parents are given very high levels of import in institutions such as schools where they may act as school governors. This is in contrast to the lack of attention that the voices of the young themselves are given. The right of the parents to have a say in their children's education is given precedence over a child's right to have a say in their own education (ibid.). The control of the young in the public sphere can be seen as almost total because where influence is allowed on their behalf, this is to be expressed by their parents, not themselves.

Emler (1993) comments that adolescence is when individuals are first made aware of formal, public institutions that are aimed at control, such as the legal system, large-scale education, and health. During childhood it is the private sphere that is the main level of experience. Children are generally surrounded by family, friends and small-scale, personal encounters with education and health. When adolescence is reached young people are now in direct contact with large-scale institutions. Secondary schools are generally large, with young people having many teachers, rather than being taught by one familiar form teacher. Young people are now controlled by law directly, whereas in childhood it is their parents who acted as intermediary between the law and them. So adolescence is a period of life when the mechanisms of social control are brought to bear on the young, but it is still a time when young people have very little control on the mechanisms in return.

A.2.4 Youth and marginalisation

The discussion of youth seems to consider young people as all being subject to the same pressures and stresses. This is a false impression as young people are as divided by such social measures as class, gender, sexual orientation, race, and religion as adults are. Certain groups of young people are particularly vulnerable through these divisions. There has been a "construction of particular groups of young people as 'troubling' or 'troubled' in relation to specific social problems such as teenage pregnancy, youth crime, drug abuse and school dropout or exclusion" (Griffin, 2001: 149). The likelihood of any individual young person being considered in this way is affected by such characteristics as class and gender. This marginalisation of certain groups of young people extends into the treatment of young people by researchers. In fact it has been posited that youth research "tends to overlook or marginalise the perspectives of young women, young people of colour and other 'minorities', young people with disabilities, young lesbians, bisexuals and gay men, to name several overlapping groups which remain relatively underrepresented in contemporary youth research" (ibid. 166).

The attention that has been paid to youth has generally been focused on young men. The popular view of youth culture has been that of the male perspective. "Images of youth that emerged from poetry, literature, psychology, education, and sociology were ones of male adolescents or young adults and rarely included girls, let alone focused on them" (Lees, 1993: 4). The concept of youth culture was that the experiences of young women could be considered to be the same as for boys and so was not deserving of separate consideration. This has been seen to be untrue. Young men and women experience youth in different ways because of the different ways that society deals with them. For young women the concern that society views them is usually related to their sexuality. "One important theme was the central role of sexuality in the construction of young women as actively deviant or passively 'at risk', set alongside pressures to 'get a man' as a mark of 'normal' adult femininity" (Griffin, 2001: 152). In fact sexual promiscuity has "historically been a primary indicator of pathology in adolescent females though not identified as a problem when similar behaviour is evidenced by males" (Finn, 2001: 180). The existence of this double standard has long been commented on in British society and the radical changes in many attitudes towards sexuality seem to have left this cultural norm mainly untouched. It is still true that much of society holds the view that girls should not indulge in casual sexual encounters, and in fact should not want to. Boys on the other hand are thought, and expected, to have a strong sexual urge and are expected to have sex whenever possible. One of the ironies here is that "girls are sexually subordinate but it up to them to restrain boys from going too far too fast" (Moore and Rosenthal, 1993: 202). Susan Lees in her work with adolescent girls in London considered that "at the level of everyday lived experience, according to my research, their position is one of subordination" (Lees, 1993: 5). The features of this include fears about sexual violence, moral judgements regarding their behaviour and feelings of inadequacy. Lees contends that young women suffer a drop in self-confidence in adolescence because their identity is dependent upon their sexual

reputation (ibid.). It is important to note, as Lees does, that "girls do not passively accept their subordination" (ibid. 63). The problem can be that young girls who are attempting to form an identity are too constrained by the perceptions of society that they are unable to break free of the conventions that constrain them.

For young men the concerns of society are generally surrounding violence and crime, as opposed to sexuality. These worries have resulted in increasing amounts of policies that target young working-class men and control their activities such as curfews and school exclusions. These rest on the idea that these young men are a threat to society because of their behaviour (Griffen, 2001). The position of young men in society has been the subject of a lot of consideration during the 1990s. In fact it has been stated that the 1980s could be characterised by a concern about young women and the 1990s by a concern about young men (Coleman, 2000). The reasons for this include the removal of many of the employment certainties through the shifts in the labour market and the alarming trend in mental health problems for young men. The suicide rate for young men is three to four times higher than that of young women. In fact "in the UK as a whole a total of 547 young men between 16 and 24 took their lives in 1996" (ibid. 238). This statistic is very worrying in relation to the situation that young men are in within society. The traditional consideration of young men as being in positions of power may have to be addressed in order to understand this disturbing trend.

One of the major causes of differentiation amongst the young is the division of class and wealth. The young are not immune from the inequalities that are to be found in Britain today. "The position and opportunities of young people in society are ultimately shaped by relations of wealth and poverty" (Wyn and White, 1997: 1). The importance of such factors in young people's lives as their parents' class, income and position in society should be given appropriate weight. Wyn and White believe that this social inequality, and

subsequent sidelining of certain members of society, is an inevitable result of the capitalist nature of British society. "Marginalisation, for instance, is part and parcel of a social polarisation under capitalism which disadvantages some while at the same time privileging and advantaging others" (ibid. 145). They also hold that these inequalities are intrinsic and divisive in such a way as to make generalities concerning young people almost totally irrelevant. "These differences in circumstances and outcomes are so fundamental that the category 'youth' seems to have relevance only in the broadest sense" (ibid. 1).

One group of young people that are marginalised both by society and by other young people are young homosexuals. Lees' research found that a lot of young people felt prejudiced against young homosexuals and reported that they would treat them with either ostracism or violence (Lees, 1993). Though there has been little research into homophobic bullying in the UK some early research has found that seventy-nine percent of under eighteen year old lesbians and gay men had experienced physical homophobic bullying (Warwick *et al*, 2001). Thus young homosexuals often feel hostility towards them from other young people as well as society as a whole. In fact research in America has indicated that rates of attempted suicide were two or three times higher among young lesbians and gay men than other young people and that they possibly account for thirty percent of all suicides in the young (ibid.). Young lesbians and gay men can be seen as being specifically marginalised by society.

"Youth is a complex, shifting, and contradictory category that is rarely narrated in the dominant public sphere through the diverse voices of the young" (Giroux, 1998: 24). Giroux, in his look at the representation of young sexuality in American culture, comments on the silencing of the opinions and experiences of the young in public. The main point here is that though the young are silenced in public, they do speak about their lives. This is usually at the margins of society though. The young make use of such media as the

Internet, underground magazines and music to express themselves (ibid.). These forms of expression are not given weight by society though and so these voices are not given space in the public arena, though they may be spread in youth culture. The young do speak and give expression to their experiences "they are simply restricted from speaking in those spheres where public conversation shapes social policy and refused the power to make knowledge consequential with respect to their own individual and collective needs" (ibid. 24). They are not given weight where they would be able to affect their own lives.

Though the young are differentiated in many ways there are many ways in which they are treated by society that are very similar. "The experiences of youth are diverse and complex. Cutting across this variation, however, are significant social processes which are affected more and more people, young and old alike" (Wyn and White, 1997: 151). These include the social trends of employment and family composition discussed earlier. Young people have also been subjected to a perception in society that mirrors their silence in the work of social science researchers. Within the public sphere young people have very little control over the way that they are perceived and treated. The young are, as a group, marginalised by society. Their voices are unheard and their lives are controlled with little or no consultation.

Section A.3 Sexual Health and Young People

A.3.1 Sexual health in context

Considerations of sexual health and sexual behaviour of young people in Britain today must take into account the social context in which these occur. The influences that result from this context include gender roles, power relationships and perceptions of risk (Wight *et al*, 1998). Traditionally sexual expectations and experiences are different for boys and girls. Girls first experience sexuality through menstruation and sex with a partner. As such sex is associated with the risk of pregnancy and loss of reputation. This is in contrast with boys who generally first encounter sex through solitary experimentation. This associates sex with enjoyment and personal fulfilment. Generally sexual identities are formed within early teenage single sex peer groups. This means that mixed sex confrontations are stressful and intimidating. One way to deal with this would be to encourage mixed-sex discussions of contraception and other issues surrounding sexual identities (ibid.). In a Foucault inspired view of power relations based on what is valued and validated by society, men are viewed as sexually knowledgeable and powerful, whereas women are caught between a traditional view valuing passivity and a liberatory discourse encouraging sexual openness and availability (ibid.). These influences, combined with competing risk discourses regarding sex as either a dangerous risk to health or as a healthy pastime, have resulted in complex social norms that adolescents, and services designed to provide for them, must negotiate.

The association of sexual behaviour with risk is especially important with regards to adolescent sexual behaviour. This is because "experimentation with risk-taking such as unsafe sexual behaviours has been conceptualised as both statistically normative and

psychologically adaptive by developmental researchers" (Parsons *et al*, 2000: 378). This emphasis on risk-taking by adolescents means that the risk elements of sexual behaviour are especially attractive and complicate the context that sexual relationships are enacted. It has been put forward, though, that sexual risk-taking is unrelated to other risk-taking in adolescence (Flisher and Charlton, 2001). "There was no evidence that contraceptive non-use is associated with other general risk behaviours" (ibid. 240). This is because that failure to use contraception is a failure to act rather than a failure to refrain from acting and so is a different type of risk behaviour and must be looked at separately.

A.3.2 Young people and a different outlook on pregnancy

The reason put forward for the high level of interest in teenage pregnancies, from governments and other groups, is generally concern for the negative effects that such behaviour has on the individual girls and their offspring. "The high birth rate among American teenagers is a major source of social and political concern in this country because of evidence that childbearing during adolescence seriously jeopardizes the quality of life of most young parents and their children" (Stevens-Simon *et al*, 1996: 48). Some researchers have questioned this reasoning though. They have put forward that "recent research has indicated that many of the negative outcomes of adolescent motherhood, such as low educational achievement and poverty, precede rather than stem from early parenthood" (Coley and Chase-Lansdale, 1998: 155). The argument here is that "successful parenting is more dependant on adequate material resources and social support than maternal age" (Spencer, 2001: 5). In this view the main reasons for increasing concern with teenage pregnancy are that an increasing proportion of these births are outside of marriage and the fear of welfare dependence for the mothers and their offspring (Coley and Chase-Lansdale, 1998). An important factor to be kept in mind here is that high levels of teenage pregnancies indicate that a large number of young people are engaging in activities that put them at risk of STDs, notably HIV and AIDS (Jewkes *et al*, 2001).

This emphasis on teenage mothers as being unmarried may be in many cases looking at teenage relationships from the wrong direction. With the decrease in marriages and the increase in co-habiting and other long-term relationships the emphasis on marriage as an indication of relationship status is incorrect and a more accurate view of the situation of young pregnant teenagers would be gained by considering the duration and seriousness of their non-marital relationships (Smith, 1993).

The general emphasis on the prevention of pregnancy in teenagers seems to ignore the possibility that adolescents may wish to become pregnant, or at least have a positive outcome if a pregnancy were to occur. American research indicates that for many adolescents in the United States pregnancy is not necessarily an undesired outcome. In fact this research carried out by Stevens-Simon and colleagues among pregnant teenagers found that the most common reasons for the lack of consistent use of contraceptives prior to conception were related to positive or ambivalent feelings towards pregnancy (Stevens-Simon *et* al, 1996). They have also found that these ambivalent feelings towards conception are generally associated with adolescents no longer in full time education. "These studies indicate that the consequences of early childbearing are often less disturbing for teenagers who are doing poorly in school, because adult roles other than parenthood are usually perceived to be inaccessible" (ibid. 52).

As well as the possibility that pregnancy is not an unwanted situation for some adolescents there is some evidence, particularly from the USA, that pregnancy may not be treated as a negative situation if it were to occur. "Contrary to the commonly held notion that adolescent pregnancy is a doomed, hopeless situation, pregnancy may carry with it an opportunity and reason to be hopeful about the future" (Connelly, 1998: 205). Research also indicates that pregnancy in teenagers is not associated with low self-esteem. It has

been posited that "low self esteem may be associated with the adolescent becoming pregnant. Thus, the pregnancy serves as an esteem enhancer" (ibid. 206). In this view many pregnant teenagers are able to view their situations in a positive light, especially on a personal level. Thus the experiences of individuals undergoing teenage pregnancy may not fit into the general opinion held by society about this situation.

Research in Britain has also indicated that in some areas pregnancy is viewed as a positive experience for young people. It is thought to "provide access to a loving relationship, to social recognition and to a valued identity" (Thomson, 2000: 408). This means that the values adolescents aspire to are fulfilled, at least at that time, by early childbearing. This, though, may "close the door, or confirm that the door is closed, to educational and career opportunities" (ibid. 408).

A.3.3 Young people and sexually transmitted diseases

One of the other major indications used as to a level of sexual health of individuals and communities is that of sexually transmitted diseases (STDs). The lack of these diseases is a measure of a successful sexual health service and individual. Generally adolescents do not consider themselves at risk from these diseases and they were not considered at risk by the medical and research professions. This, though, has been reconsidered in the light of recent research. A British survey of 19,000 adolescents between 1990 and 1991 found that 75% reported having first sex with someone older and 51% of their partners were already experienced (Short, 1998). This is an indication of how sexually transmitted diseases can infect young populations. "Thus women may be the unwitting bridge between the sexually transmitted disease infected adult population and the uninfected adolescent cohort" (The Lancet, 1994). In the USA nearly a quarter of all cases of STDs are found in adolescents (Short, 1998). It can be seen then that adolescents are in need of protection against these

diseases, as they do not always have sex within uninfected groups and as such are at more risk than may be considered.

Perceived risk from HIV and AIDS is dependent on many things and, though the link between perceived risk and behaviour is controversial and discussed in more detail below, the interactions and influences on this view of risk are highly variable. Research in America in 1990 found that perceived risk of AIDS in adolescents is associated significantly with parental level of worry. "Parents and their teens reciprocally influence each other within the family system in their perceived susceptibility to AIDS" (Carroll *et al*, 1999: 178). The level of worry was also linked to worry about the safety in their neighbourhoods, though neither to income, nor actual location of family home (ibid.). This indicates the important role that parental feelings and influence can have on teenagers and their perception of the risks of AIDS, and possibly other STDs as well.

A.3.4 Young people and initiation of sexual intercourse

One of the other main factors aimed at in most conceptions of sexual health is a delay in initiating sexual intercourse. This is especially true in America where there are many initiatives relating to abstinence for teenagers such as PSI, a teaching initiative to promote abstinence which is often used in American schools (Loda *et al*, 1997). One problem with this that has been identified in America is that factors that lead to the delaying of intercourse also tend to make it more likely for non-use of contraception (Cooksey *et al*, 1996). This could be a major concern for education programmes as attempts to reduce the age of first intercourse could be associated with lowering the use of contraception. Research carried out by Karofsky and colleagues found that there was a correlation between the level of parent-child communication and abstinence. This was especially noticeable in that individuals that moved to having sex were more likely to have reduced communication with their parents (Karofsky *et al*, 2000). The possible reasons for this

include that the reduction in communication is causal and the young people then look elsewhere for intimacy and therefore this reduction should be considered as a problem in itself, or that the initiation of sex causes the reduction in communication. In this case it could be that young people keep this section of their lives private from their parents and so suffer reduced communication and in this case it is not the reduction in communication that needs to be considered but the reasons why young people do not discuss their sexuality with their parents (ibid.).

Other research shows that encouraging communication between parents and adolescents is important when sex has been initiated because consistent contraceptive users were more likely to be adolescents with frequent conversations with parents than non-users (Hacker *et al*, 2000). This association between contraceptive use and parental communication is unclear though as some research has found that "communication follows rather than precede contraceptive use" (Furstenberg *et al*, 1986: 238). Young people were more willing to discuss their sexual lives with their parents after they had made that sort of decision and as such then "communication with parents is not very significant in promoting contraception compliance among sexually active teenagers" (ibid. 240).

A.3.5 Young people and contraceptive use

The use of contraception is an important part of sexual health; both in terms of protection from pregnancy and disease and in terms of control over sexual identity and expression. In fact, in relation to teenage pregnancy, use of contraception at first intercourse has been recommended as a more appropriate outcome measure for services and programmes than the pregnancy rate in itself (Bigrigg, 1999). The use, and non-use, of different forms of contraception is a complex decision process with many influences. Many of these influences are not related to the actual practicalities of the contraceptive itself but are related to social pressures.

In the 1960s there was a perception that contraception was a vital and intrinsic part of women's liberation. Since the 1970s and 1980s, though, there has been an increase in concern among researchers and feminists about health risks and the possible lack of control that women have over their contraceptive choice (Hardon, 1992). In consideration of the role that self-esteem and decision making is felt to play in sexual health, the possibility that women may not have the choice of the contraceptive they require or desire is an indication of a lack of sexual health in these women. This lack of control can relate to the sorts of contraceptives that are available. The technologies that are being produced are chosen for many criteria and there has been a call for "women (and men) [to] participate in setting prerequisites for appropriate contraceptive technologies and in reviewing the consequences of existing methods" (ibid. 764). One of the problems with this is that there is a strong likelihood that any inclusion of general populations in the design and alteration of contraceptive methods is unlikely to involve adolescent populations, for either logistic or political reasons. This means that this group is unlikely to have control over the sorts of contraceptives that they have to choose from.

Non-use of effective contraception and protection from STDs has also been linked to negative life stresses. "It is thought that youth's likelihood of manifesting maladaptive behavioural and mental health outcomes increases due to the amount of stress they encounter via negative life events" (Arrington and Wilson, 2000: 223). As such the environment and experiences of young people are the context in which they make decisions regarding their contraceptive use and "youth's risk is increased when their environments make them vulnerable" (ibid. 224). This shows that contraceptive use must be considered in context and especially in terms of negative or destructive life events.

Other social aspects that are likely to affect contraceptive choice include religion. "The role religious customs and doctrines plays in the reproductive health care of women cannot be overstated" (Klima, 1998: 486). The Catholic ruling on contraceptive use and other religious prohibitions are important factors that individuals must absorb and consider in their contraceptive decisions. The Roman Catholic Church, for example, prohibits practising Catholics from using any form of birth control other than the rhythm method (Wellings *at al*, 1994). The National Survey of Sexual Attitudes and Lifestyles found a "continuing though weak effect of religion on contraceptive practice" (ibid. 342). This survey also found that religion was associated with age at first intercourse. Generally an affiliation with a Christian religion is related to a delay in initiation of sexual intercourse but Roman Catholicism is related to a slightly increased likelihood of sex before sixteen (ibid.). The relation between religion and sexual behaviour can be seen to still be evident, to some extent, in Britain today.

The lack of efficiency in condom use means that research has found that women who use condoms in Sweden are generally more positive about their partner's reaction to a pregnancy than those that used oral contraceptives (Lindell and Bergbom Engberg, 1999). This comparative lack of worry about pregnancy with condom use may be important when deciding on which method to use. This is important in relation to the use of condoms for STD prevention. Also important to consider in the use of condoms and their efficiency is that in order for the failure rate to be low they must be used correctly and that adolescents self-efficacy may affect their willingness to use the method (Elkins *et al*, 1998). Thus adolescents also consider the importance of the effective use of contraception and a lack of confidence in this area may be used as a reason for not choosing certain methods.

The perceived efficiency of different methods may not be the main focus when teenagers are choosing their contraception. Erickson (1997) found that in comparing Hispanic

adolescent and health provider priorities for contraceptive methods, while the health providers generally focused on the efficiency of the method, the adolescents were interested in many other factors. Thus adolescents may choose methods that are not very effective because other factors may be more important to them. Also the fact that different contraceptive methods involve very different skills should be central to education programmes. For example Kvalem and Traeen (2000) point out that the contraceptive pill and condoms are dependent on females in one case and males in the other, condoms are situation dependant but the pill is not. Factors like this make contraceptive choice a much more complicated judgement for young people than a simple weighing up of efficiency rates.

A.3.6 Young people and emergency contraception

The importance of emergency contraception for adolescents can be seen by the fact that they are thought to be, generally, less efficient contraceptive users than adults and so are likely to be in need of post-coital contraception after contraceptive failure. Research carried out in Devon with pregnant teenagers indicated that eighty-one percent of the 167 girls interviewed had heard of emergency contraception but that eighty-eight of these had not obtained it, even though many of them had realised that there was a problem with their contraceptive method on the occasion that they had become pregnant (Pearson *et al*; 1995). The conclusion drawn by the researchers here was that two of the most important things to be brought to the attention of teenagers are assessing personal risk and how to react to method failure (ibid.).

There has been some concern that emergency contraception may lead to less conscientious use of contraception because of the existence of a safety net mechanism. This has been investigated in relation to condom use in New York (Roye, 2001). The research there has preliminarily concluded, "that provision of emergency contraception may not have an

adverse effect on condom use, and may prompt teens to think seriously about their contraceptive behaviours" (ibid. 166). This was investigated by questioning how condom use and feelings about contraception changed after provision of emergency contraception.

A.3.7 Young people and use of the oral contraceptive pill

"New users of oral contraceptives are more likely to discontinue use within the first year, many because of side effects, such as breakthrough bleeding, amenorrhoea, and other medical problems" (Klima, 1998: 484). In work amongst adolescents in America Greenwald and Gold found that the main reasons for having stopped using the contraceptive pill were weight gain and altered menstruation. The other reasons mentioned included forgetting to take pills and nausea (Greenwald and Gold, 2000). Medical professionals often dismiss this emphasis by teenage girls on the effects that the pill has on weight and menstruation as something that, if explained to the individuals, can be ignored. This ignores the important cultural significance of both menstruation and body weight in Western society for young girls. For the pill to be used by young girls these effects must be given consideration. Research in Belgium found that young girls felt that side effects of the pill were very important to them, and they were very eager for more information on these effects (Peremans *et al*, 2000).

It has been posited by research in Britain and Germany that oral contraceptives fit into a life cycle view of contraceptive choice. This research found a general trend for individuals to move from condom use initially for their first youthful encounters, then a move to oral contraception with more experience and then after having had one child having an IUD fitted and finally sterilisation with final family size (Oddens and Lehert, 1997). Research in America also found this move from early condom use to oral contraceptives later on in adolescence (Everett *et al*, 2000). This view of certain contraceptives being associated with

certain times in lives seems to be reinforced and recommended by health professionals, thus often choice is limited by the age of the patient (Oddens and Lehert, 1997).

A.3.8 Young people and condom use

One of the problems facing young people in decisions about sexual health is that methods that protect well against pregnancy do not work to protect against sexually transmitted disease and vice versa (Stedman and Elstein, 1995). This has lead to the adoption of the method known as 'Double Dutch' (because of its origin in the Netherlands). This is the recommended contraceptive method for young people and consists of the use of condoms and also a hormonal contraceptive such as the oral contraceptive pill (Hanna, 1999). This means that the condoms protect against disease and the hormonal contraceptive is highly effective against pregnancy. This method may be recommended in policy now but its adoption has some problematic features. This is based on the fact that the use of condoms in this manner does imply an accusation of carrying disease to the partner, or a lack of trust in their fidelity. This means that the use of condoms in a relationship may put that relationship at risk by bringing an element of distrust into the situation.

There have been many different attempts made to increase the use of condoms by adolescents in order to decrease their chances of both getting pregnant and catching a sexually transmitted disease. These attempts to get young people to feel more positively about condoms have ranged in design. Often they involve direct interaction with condoms. Research by De Wit and colleagues found that a short direct physical interaction with condoms did not in itself improve feelings about condoms. "Research even indicated that a short physical interaction with condoms has a negative delayed effect on global attitude towards condom use and on the perceived attitude of peers" (De Wit *et al*, 1997b: 307). This same research did, however, indicate that interacting with condoms while concentrating on more positive or amusing feelings rather than rational assessment may

associate condoms with positive feelings (ibid.). Factors that are associated with condom use are enjoyment of condoms, feelings of self-efficacy in using condoms, perceptions of peer norms supporting condom use and communications about AIDS (DiClemente, 1992). One of the problems in associating condoms with such positive factors is that condom use is generally a negative action. The result of using condoms is the lack of disease, which is in itself a very distant reward (Arnold-McCulloch and McKie, 1995).

An attempt to associate condoms with positive feelings as well as simultaneously training people in their use was designed using American college students but has spread as far as Thailand (Elkins *et al*, 1998) and Stockton. This is the condom race and involves competition, reward, and feelings of achievement as well as experience in putting on condoms in a hurry in the dark. In Stockton-on-Tees it has been used in youth projects in order to get young people talking about condoms and also to have them touch and discuss condoms in a mixed-sex environment. It has been found to increase individuals' estimations of their own efficacy at using condoms as well as encouraging group discussions of condom use and access (ibid.).

Assertiveness has been found to be associated with condom use but not for other health risk behaviours such as smoking. This "reflects the interpersonal aspect of sexual behaviour compared with more individual behaviours like smoking, exercise etc" (Grimley *et al*, 1997: 66). This means that an emphasis is needed in condom interventions on assertiveness training and negotiation skills. Research carried out in Belgium concluded that programmes that are based on individuals do not work in relation to condom use because safe sex in not based on individuals decisions (Buysse and Van Oost, 1997). It is always necessary to remember, "whatever the attributes of the individuals involved, what happens in sexual encounters is largely the result of the interaction that takes place and context within which the encounter occurs" (Wight *et al.* 1998: 328). Work in America

found that patients at STD clinics were more likely to change their behaviour if they felt that their partner would react positively (O'Leary *et al*, 2000). Further work in America has found that it is usually women who initiate conversations with their partners about safe sex and that this was more likely to happen after they had started to trust them (Lock *et al*, 1998 and Woodsong and Koo, 1999). This implies that an important area of education would be to give women the confidence and skills to broach this conversation earlier in a relationship, preferably before unsafe sex has occurred. Thus young people must be given skills in order to negotiate condom use which is a highly "complex social and interpersonal behaviour" (DiClemente, 1992: 35).

A.3.9 Young people, relationships and sexual health

Research in Belgium found that "many adolescents tend to describe a partner as being a steady one, often after only knowing him or her for a couple of days" (De Wit *et al*, 1997a: 22). This is significant in the light of findings that "individuals were more resistant to using condoms with a main partner ... as compared to other partners" (Grimly *et al*, 1997: 64). This implies that greater interest must be shown into what adolescents consider to be a steady, main partner and how this impacts on their decisions to use condoms. Greenwald and Gold (2000) found that one of the main reasons for discontinuing condom use was being in a monogamous relationship and using other forms of contraception. Thus the definition for young people of a monogamous steady relationship is very important in relation to condom use.

As well as young people being less likely to use condoms with a steady partner they have been found to be less likely to use them with a very recent or casual partner (Coleman and Ingham, 1999 and Lindell and Bergborn Engberg, 1999). This meant that there is a small period of time in a relationship where condom use is practised. This is when a couple are

relaxed enough to discuss contraception but before they become close enough to assume fidelity.

Section B

Section B.1 Participatory Research

Social science research traditionally involves a researcher starting with a design and going into a community and using certain research techniques in order to ascertain a view of the community and their opinions, wants, or needs. This generally fitted into the view that a researcher can be objective and effectively not exist in the research situation. Thus the researcher could claim that they were not a contributing factor in the results. This idea was effectively challenged by the realisation that the researcher is as much a part of the research situation as the researched. This resulted in work that included the researcher in a more reflexive way. The feelings and relationships that the researcher took part in were central in many ways to the research. This greater realisation, that the relationship between the researcher and the researched is of importance, has been highly influential in anthropological studies. Also there has been a realisation that the sort of methodology used effects the results dramatically. Work by Helitzer-Allen *et al* (1994) with girls in Malawi in relation to sensitive information found that interviews gave a very different sort of result than focus groups with the same cohort. Findings like this have put focus onto the methods used to investigate groups and so there has been a move away from the idea that the methods and the researcher are just objective tools that do not affect the findings.

B.1.1 The basic aims of participatory research

In a way the development of a participatory form of research follows on from these previous changes in that it further builds on the idea of the importance of the relationships that the researcher and researched are involved in. Participatory research recognises that there is a power imbalance between the researcher and the researched community, or individual. In this the researcher holds all the cards. The researcher decides what aspect of

society should be investigated and the methods that should be used. The individuals to be considered are chosen, to a large extent, by the researcher and ultimately it is the researcher's analysis and opinion that is accepted as the results of the research and the 'truth'. The recognition that this relationship between the two sides of the research equation is not simple or separate from power inequalities has led to an attempt to find forms of research that contest this. "Participatory research attempts to redress the balance of power which traditionally exists between the researchers and the researched and to challenge in practice those processes that disempower people" (Dockery, 1996: 167). The roots of this form of research can be found in the desire to transform and find a 'truth' that is based on the researched rather than the 'truth' desired by the existing power structure or the researcher. "Participatory research is ... a personal and political process aimed explicitly at transforming current inequalities" (Cornwall, 1996: 95).

The main idea and impetus behind this form of research is "generating knowledge from the perspective not only of the researchers but also of the researched" (de Koning *et al*, 1996: 1). The methodology originally started in areas such as Latin America and Africa in work with marginalized groups in these settings. There was a "concern with persistent inequalities in the distribution of power and resources, and the processes which help to keep in place dependency and domination in the relationships between privileged dominant and marginalized groups of people" (ibid. 4). Thus participatory research was started with its emphasis on allowing communities and individuals to exercise power in their own research. The aim was, and is, for the researched to be able to set their own agenda, to ask their own questions.

A wider view of community participation is participatory appraisal. There are three elements to participatory appraisal: research, education, and collective action (Wotherspoon and Sellers, 1997). This then is aimed at a holistic view of community participation. In

practice many instances of participatory research involve these three elements in an integrated manner. "Participatory appraisal is described as a family of approached and methods to enable people to share, enhance and analyse their knowledge of life and conditions, to enable them to plan and act" (ibid. 19). The role of a researcher or research team is to make sure that all of these elements have community participation and are integrated into the project design.

There is another view of participatory research, which takes it as an ideal of democratic dialogue (Gustavsen, 2001). Here the emphasis is on communication. Each participant of the research process has the space to communicate his or her point and is listened to by every other participant. Every participant is equal but they must speak from their own experiences (ibid.). The aim of having equal and respectful dialogue within society is for social relationships to be transformed. "If our purpose is to build social relationships that can embody a principle of equality for all participants, the choices that offers itself is *democracy*" (ibid. 25). The importance participatory research then is to allow participants a space for dialogue.

B.1.2 The role of the researcher

The role of the researcher is central to the theory of participatory research in that the idea of the researcher as a neutral and passive observer has been shifted towards the view of the researcher as activist. There has been a movement from value-neutral academic work towards work that takes "a personal stand regarding the evolution of societies" (Fals Borda, 2001: 27). Researchers here act as activists that wish to find ways of actively changing their research field. The aim of the research is to find ways of transforming the study community and thereby addressing the inequalities that the community experiences. The researcher, then, has to abandon the previous anthropological ideal of cultural relativism

and the aim of neutrally reporting on the culture of a group. There are two major issues that result from this shift from researcher as value-neutral to researcher as activist.

The first issue is that of how academically important the work can then be. If the researcher is going into a society wishing to change it and to radically shift its power relationships then, as far as anthropology is concerned, is this work then of use? Is the researcher then going to be able to report on the society and the process of his or her work fairly? The work of R Cole (1991) in America looks at this issue. His work was in small group organisations and he played an active role in the organisations and actively undertook to alter their nature and course. He posits that this did not lead to his work being biased towards showing only his side of the argument and into emphasising only the changes that he agreed with because he limited his activities so as to minimise this and also generally the changes were not in line with his activities. As such Cole's work was not subject to this issue because he limited his activist role, and the role he did take was not very successful.

The second issue is that once a researcher has become an activist then how is the balance between activist and researcher reached? If there is a conflict between these interests then how is this to be resolved? Sergio Ruano (1991) comments on the problems of social science researchers working within a team carrying out applied work. Here Ruano considers that the danger is that social science workers will co-opt the work into a research project where the emphasis is on the research rather than on the results for the community. The significance of the work here is firmly placed on the activist role but the researcher themselves may find this emphasis more difficult to place.

There are a number of positive aspects that anthropologists in particular can bring to participatory research. These include the ability to communicate between the culture of a

development agency, or other large institution, and the culture of the community (Ruano, 1991). This means that each group's point of view can be made clear to each other and an acceptable solution can be found to any problems within the society. The anthropologist can put the needs and opinions of a community across to scientists, developers and other workers in a way that is acceptable to them, and also clarify information in the other direction. Whiteford puts forward that, unlike other workers in the area, an anthropologist is in a liminal position and that "in this liminal position he or she can assume multiple roles within an agency, or create a new role" (Whiteford, 1991: 121). An anthropologist is not constrained by existing networks or by specific skills. They are able to move into new, or many, different positions and so participate in an agency but still remain separate and flexible.

B.1.3 The role of the researched

The main feature of participatory research is the emphasis that is placed on the people that are being studied. There are two main considerations about the role of the researched in this study.

Firstly there is the interaction between the individuals that participate and the concept of community. Participation is described as though finding a community and defining it was obvious and without concern. Seeley *et al* (1992) stated that "Participation implies a local autonomy in which communities discover their options, make choices and thereby enhance their ability to manage their own development" (p. 1089). The concept of a community is a concern in itself, as a researcher must consider in what way to define the community being studied. Where should the boundaries be drawn? Is a community all the people that live within a defined geographical area, interest groups or other defining features (Woelk, 1992)? If geographically how is this area marked out? Is it a whole city or town, or a district, or is it an estate of houses? If it is defined by geography what about people who

travel in and out every day? Are these to be included? These sorts of problems can be deeply important when looking at participation. If looking at an area should people that only work or go to school there be included or are they part of a different community? Associated with this issue is the idea of representation. Do the participants in the research area have to represent their whole community rather than just themselves (Garratt and Chell, 1997)? In diverse communities how are all views to be considered and given space (Seeley *et al*, 1992)? As such are extreme, minority groups to be excluded from research in case they skew the findings? What about groups that do not want to take part, or that can't through time constrictions (Cornwall and Jewkes, 1995)? The idea that all members of a community are accessible, or want to be accessible, is unrealistic as all groups and individuals have their own priorities. Perhaps it is impossible to expect that research can pick its participants, instead the participants that come forward should all be included and effort made to recruit across all groups.

Secondly there is the issue of what is the aim of the participation of individuals. Is it their contribution to the work or is it about their empowerment? A research project may wish to look at this as a matter of some importance. Where the emphasis is put could be very significant for the research design. It is a corollary of the issue regarding whether a researcher should be an activist or researcher first and foremost. Within the research project should the contribution of the participants to the knowledge about the area be most important, or should the empowerment of individuals be foremost?

Another issue related to the role of the researched in participatory research relates to the importance put on 'local knowledge'. There is a perception that participatory methods reveal what people really think and feel and so their true needs are discovered and therefore can be met. Cooke and Kothari (2001) have reported one of the problems with this view. They comment that often 'local knowledge' is actually shaped by what communities

perceive is on offer, or what is possible. People seem to offer as solutions, that appear to be coming from the local communities themselves, only things that "could legitimately and realistically be expected to be delivered" (ibid. 8). This in itself would not be problematic but the findings of these pieces of research are generally presented as being what the local people need and not subject to limitations. For the significance of the findings to be looked at these limitations must be considered, whether they are imposed by local people on themselves or otherwise.

B.1.4 Empowerment

The definition of power has been discussed, refined and contested widely and it is unlikely to ever reach a firm solution. A good working view of power in this situation is the ability by an individual, or group, to meet their own fulfilment, material needs and interests (Servian, 1996). Thus a person who has power is able to fulfil all, or at least most, of their needs. In this view empowerment can be seen as people gaining the ability to fulfil their needs. One view is that " 'empowerment' may be best seen as 'moves towards autonomy'" (ibid. 8). This, though, ignores that fact that many forms of empowerment are very limited and delineated and as such are not really forms of autonomy (ibid.).

The basis of the concept of empowerment "suggests that some people have power and too much of it, other people have too little, and those who have too little should get more" (Gomm, 1993: 131). This should be achieved by those with little power being 'empowered' in some way. The way that this should happen, though, is some cause of concern especially in the realm of participatory research. The problem here is that to empower someone is to make "a gift of power" (ibid. 137) from someone who is powerful to one that is not. Can power really be something to be given as a gift rather than taken or exercised? Does this gift really emphasise the receiver or is it actually about the institution or individual that is giving out permission for power? Empowerment that is given rather than taken often

serves to increase the power of the giver in a number of ways. One of these is that "those people who say they are in the business of empowering rarely seem to be giving up their own power: they are usually giving up someone else's" (ibid. 137). This then keeps their own power in place and can in fact increase it by lessening others.

Maxine Molyneux defined a distinction between practical and strategic interests in terms of gender. Practical gender interests are those that make individuals better at performing their gender roles in society and strategic gender interests are those that aim at changing unequal gender roles. "In general, actions arising out of 'practical' gender interests have been perceived as less empowering than those which arise out of the more powerful analysis of gender which animates 'strategic' concerns" (Kaler, 2001: 784). An important dimension of a project design that aims at empowerment is whether the interests involved are practical or strategic.

One area of research that has been subject to a lot of interest in terms of empowerment is that of AIDS research. Here empowerment seems to have been reduced to an emphasis in being able to negotiate condom use (Giffin, 1998). The problem with this is that the expressed views of women in many countries are against the nature of condom use. Women across the world have emphasised sex as being with a loving relationship and being about trust and intimacy. Condom-use, in contrast, is associated with distrust, a lack of intimacy and multiple partners (ibid.). Thus in pushing condom-use to women rather than giving women the power to explore their own definition of sexuality this form of empowerment is actually disempowering in many ways. " 'Empowerment' in these terms represents a suppression of those positive values in sexuality which are being expressed by many women as subjects of research" (ibid. 154). In fact research has generally concluded that women's expressed link between sex and love and trust is confused, and in some way not valid (ibid.). Instead of attempting to give women the space and ability to challenge

existing power relations, this work is aimed at working within them. Here it can be seen that in one area of work at least work that is aimed at empowerment can actually result in perpetuating existing gender power inequalities by emphasising male aspects of sexuality.

Also Green *et al* (2001), in looking at vaginal products in South West Uganda, commented that even though the products gave more control to women over contraception their relative lack of power in the rest of their lives meant that their access to, and use of, the products was limited. As such attempts to empower people within the existing framework of inequalities may not be able to work at all because these inequalities are too limiting. Any empowerment, then, must be at a much more significant level. Women in developing nations are also at risk of their reproductive choices being affected by population policy. In this way their control over their own reproduction is taken further away from them (Garcia-Moreno and Claro, 1994). There has been a movement called the Women's Health Agenda that is aimed at giving women more choice than just which contraceptive to use to reduce the size of their families. Here the point is made that "women's health and empowerment are goals in their own right, not means to reduce fertility" (ibid. 53). This issue can be seen as being of relevance in relation to young girls in Britain and their pregnancy rates.

As well as empowerment working within existing power relations and so not really changing the position of people in society it can work to actually increase the power of the already powerful. This works because often attempts to empower individuals result in certain groups being disempowered and their power being appropriated by more powerful groups (Servian, 1996). This means that more people are powerless and power becomes more concentrated rather than less. In this way empowerment can be about exploitation rather than any real help to the powerless.

One interesting view about empowerment rests on the idea of who has power. Servian (1996), in his consideration of empowerment and people with learning difficulties, looked at who had the most power in the lives of these people. He found that the people with the most direct power were the carers and managers. These people, though, perceived themselves as having very little power at all. Thus only one side perceived the power inequality in that relationship. This lead Servian to conclude, "the lack of recognition by the powerful of their power may be as problematic as any deliberate disempowerment" (ibid. 57). A process of empowerment can only really occur if people are aware of the power that they hold, or don't hold. Individuals who feel powerless may actually have a lot of power over other groups without realising.

Empowerment is also problematic in that the idea of empowering groups carries with it the idea that these people must be changed and made to realise their situation. This contrasts with the idea that local people have expert knowledge of their situation. It leads back to a very colonial view where outsiders must go into a group and 'educate' them about the world and themselves. The idea seems to be not to empower people to do as they want to do, to fulfil their needs as they themselves see them, but to empower people to do as they should do according to development agencies, or to governments, or to researchers. Is this empowerment in any real sense, or is it really a form of silencing the real needs and wants of communities and individuals? This idea can be seen in work about empowering women. Here it is put forward that "women have been led to participate in their own oppression through a complex web of religious sanctions, social and cultural taboos ...[etc]" (Batliwala, 1994). As a result of this women are not able to change their own lives, or even realise that their own lives need changing. "The demand for change does not usually come from the condition of subjugation. Rather empowerment must be externally induced" (ibid.). Women in this view must be 'convinced' and persuaded to change for their own good. The aspect of empowerment that is generally associated with participatory research

is thought to be about people having the power to fulfil their own needs and that the people themselves are the best judges of this. This seems to have been transformed in some work into the idea that people don't know best about their own lives and so can't empower themselves.

B.1.5 Participatory research and health

> Surely we are a democracy and providing individuals don't break the law they can smoke drink and have unprotected sex whenever they want (Blinkhorn, 1995: 124)

When participatory research is used in health there are a number of specific issues that need to be addressed. Stone (1992) traced the thread in Primary Health Care (PHC) that is based on a strategy of community participation so that "communities identify their own health needs and assume responsibility for their own health development" (ibid. 409). The problem being that PHC has at its heart assumptions of how to meet people and parameters around possible health needs (ibid.). This means, "the essence of PHC can contradict the whole spirit of a genuine grassroots community participation" (ibid. 411). The concept of community participation should be based on finding what the members of a community really want and need rather than only allowing the answer to be within certain parameters.

This concern is related to an issue relating to health promotion. This questions the nature of health promotion and relates to the quote at the start of this section. The role of health promotion is not to make people act in certain approved ways, it is to provide people with the information to make informed decisions about behaviour that will affect their health (Blinkhorn, 1995). "Health promotion is, as the name suggests, promoting health, not

practising wholesale conversions of the general public" (ibid. 124). This view of the public as having the right to make their own health decisions is important in health research and promotion. It needs to be remembered that people can have behaviours and needs that do not fit into the parameters that health professionals may want. This does not mean that these behaviours are illegal or without legitimacy for the individuals. Why individuals participate in unhealthy behaviours and why certain groups are more at risk than others are significant areas of focus and enquiry but researchers and promoters and governments have to remember that individuals may choose to act unhealthily and that is up to them.

B.1.6 Participatory research and sexual health

The use of participatory research to investigate sexual health has the potential to be highly significant. The methods used to investigate sexual behaviour have been shown to have a noticeable effect on the findings. "The large number of studies of sexual behaviour which have employed diverse methods suggest that information about sex varies considerably depending on the research method used" (Green *et al*, 2001: 595). Thus allowing the people being studied control over the research process should allow for their needs in this area to come out more clearly. Sexual behaviour is an intimate part of an individual's life and as such questions about this are entering into a sensitive area. The way that questions are put, what the questions are about and who they are put by can have a very significant effect on the answers. "It is ... clear that sex talk is very context-specific and, language and content vary accordingly" (ibid. 595). As such having the communities being studied having an active input into the research process at all levels is vastly important.

Reproductive Health Awareness is a movement that attempts to introduce the participation of communities and patients into reproductive health (Marshall *et al*, 1997). Here an emphasis is placed on empowering people to have the knowledge and skills to choose and control their own sexuality. An explicit goal is "to empower people to understand and take

action to meet their own reproductive health care needs" (ibid. 318). The decision as to what forms the needs of individuals and communities is to be led by the individuals and communities themselves. In this view services and education exist to help people make their own decision rather than having people fit into existing parameters and expectations. The idea is also that by giving people control over their sexual health services, the services will be more effective. "Individuals are most likely to efficiently and effectively continue to use those services which are chosen by them rather than imposed by others" (Wilson, 1997: 339).

Section B.2 Carrying out Participatory Research in the NHS

B.2.1 Research in the NHS

There seems to be two conflicting ideologies relating to participatory research currently at work within the National Health Service. One is based on working in a more participatory style of health provision, where the control and provision of resources is based on community involvement, including individuals and minority groups. The other ideology takes the view that clinical control should be maintained. If there is participation it is in the form of highly structured traditional types of public involvement. Attempts to carry out participatory research on health service provision are often caught between these two conflicting views. Negotiation between them is confusing and complex as both ideologies are at work within the same institution and both views have valid and convincing arguments.

The use of research in the National Health Service in order to ascertain the sorts of products and care communities need has been thought increasingly necessary in the light of the new conception of the NHS providing a service to 'consumers' and the need to do this in a cost-effective and efficient manner (Dockery, 1996). This need to consult communities and individuals and to give them more power in determining services means there is a great importance in researching amongst these people. This can be done in two ways, both of which are based in the competing ideologies of the NHS. There is a traditional research method that is usually based on interviews or questionnaires that researchers control through choosing the questions used and the people asked. "In traditional research, both quantitative and qualitative, these two roles [researcher and researched] are distinct" (Tolley and Bentley, 1996: 50). There is also the participatory method that relies on the active involvement of people in the communities themselves. In

this methodology "'outside' researchers and 'inside' respondents are partners, exploring topics of mutual interest together" (Tolley and Bentley, 1996: 51). This method allows people to ask their own questions and to express their own needs in ways they feel are important.

B.2.2 Problems with using participatory research in the NHS

One of the problems in using a participatory methodology within the NHS that is based on involvement for communities can be found within the ideology that participatory research is based on. This is that research is to look at the disempowerment of marginalized groups by political structures and to look at ways that this can be altered (Dockery, 1996). Participatory research attempts to address and challenge the balance of power that is considered to exist between a researcher and the researched, thus it can be seen that it is embedded within a framework of change and transformation of society and its structures. These concepts are at the very heart of the methodology and the theory behind its use. The NHS, though, is a large bureaucratic institution and trying to use the potentially radical empowering ideals of participatory research within an institution that is in possession of much of the power. This could be viewed as a contradiction with many inherent obstacles, since the point of participatory research could be seen as essentially transforming the whole power basis of political and social institutions such as the NHS. The medical profession is generally felt by people to have knowledge and power greater than the members of the communities that it serves. The aim of participatory research is to challenge inequalities in power. In fact "a major objective of the PR process is to work towards reducing the power often held by researchers who come from outside the community to do research, and by élite groups within the community" (Martin, 1996: 83). "The bias is towards marginalized groups in the community" (ibid. 83). This bias then is towards the communities being worked with rather than the institution that the researcher may be working for.

The notion that people can be empowered by using participatory research set up by large institutions is quite problematic. These problems are based on the idea of empowerment. Through the use of participatory research some sections of the NHS wish to empower communities in relation to their health services but this is an example of power being given to a group rather than them taking it. In terms of the NHS this can mean that policy makers achieve the empowerment of communities through the removal of power from health providers. This power then may not end up being within the grasp of the communities, it can end up being given to managers or other individuals already in positions of power. The empowerment can be used in order to give more power to those already in charge.

Another potential criticism of the NHS and participatory research resides in the various meanings of the term empowerment. An important dimension of a project design that aims at empowerment is whether the interests involved are practical or strategic, according to the distinctions discussed earlier. When the NHS aims to empower young people in relation to contraception and sexual health services are they wanting to forward the practical or strategic interests of the young people involved? Do young people have a need for strategic interests at all? The analysis was originally intended for looking at gender and viewed women as having certain rights because they are women. "The idea of 'women' as bearers of rights had two key components – control and autonomy" (Kaler, 2001: 786). The question is whether young people have these rights. For the use of participatory research to be appropriate for young people there is an idea that young people have rights that they are not able to exercise. But is the NHS interested in transforming relations and giving young people the chance to empower themselves or are they interested in furthering the practical interests of young people? Or is their main emphasis on allowing young people to better fit into the existing framework preferred by the medical or local community?

B.2.3 Logistical issues in using participatory research in the NHS

The arguments for participatory research that involves active participation of individuals and communities to be used in assessing the health provision and promotion are extensive and compelling though. The problems inherent in the research are interesting but giving the people in the community the opportunity to have a voice within health provision seems important and desirable. The benefits for both health and the individuals connected with the research seem weighty and persuasive but the logistics are complex and can be seen as almost impossible to navigate. As Cooke and Kothari (2001) comment the ideals of participation are "constrained by institutional contexts that require formal and informal goals to be met" (p8).

In order to gain access to NHS resources and funds many forms and bureaucratic procedures have to be completed. These procedures are usually entrenched in the traditional ideology of the NHS and are based on quite strict ideas of power and control, as well as an emphasis on clinical or at least quantitative research. This is evident in items such as the ethics committee forms, which are based on a very strictly regimented view of research. This procedure is very useful in protecting the interests of individuals and communities but it is very difficult to adapt the process, when it has been designed for use with clinical or researcher-led projects, to more participatory-based designs. It has been commented that "applied medical anthropologists working in the public or private arena often confront unique ethical challenges because of the special nature of their research" (Marshall, 1991: 213). The ethics forms that are provided by the NHS have a very set and defined structure and, for example, use questions with yes or no answers. This does not allow for the sort of varied and complex ethical problems that qualitative, participatory anthropological research raises. A majority of the questions on these forms are related to clinical issues and statistical enquiries. Examples include the fact that question seven is

subjects, question eight is controls, question eleven regards radiation and wishes to know "if any form of ionising radiation is to be used" (North Tees Local Research Ethics Committee Form). Out of twenty-seven points only about half are appropriate for qualitative work and none are specifically aimed at this sort of work. A qualitative researcher gets the impression that their work is not within the remit of the NHS, and that maybe everything would be easier if they were radiating people and taking blood samples. As this is the form for all research within the NHS, most of the questions are specifically not aimed at qualitative research or the qualitative researcher. It has been pointed out that qualitative work "should not be evaluated against criteria appropriate to quantitative research but should rather be evaluated using alternative methods" (Yach, 1992: 605). Also working from a participatory research view is even more difficult as the forms require details of questions to be asked and what methods will be used. In participatory research contact and work with the study group needs to be commenced before such questions are considered. Then the only questions that are relevant to qualitative research are not relevant to participatory research. This is possibly inherent in the role of the ethics forms for this sort of research. The committee exists in order to protect patients from exploitation and unethical treatment. The procedure means that a committee of medical professionals must approve of any project carried out on any patient in order to protect their interests. Participatory research is about empowering patients or individuals and breaking down the barriers between researcher and researched. The paternalistic attitude of the ethics committee and the weight that it puts on the researcher as the qualified and responsible expert contrasts with the aims of participatory research.

The problems in carrying out this sort of work, though, are massive. Though the NHS wants to discover the opinions of the young people in the community there appears to be a lack of understanding or comprehension as to the techniques that this will involve. The use of young people in participatory research involves putting a lot of responsibility and

trust into the actions and views of young people. This seems to be treated with caution by many of the structures of the NHS. This includes the disinclination of NHS ethics committees to allow young people to talk to each other about sexual health services and other problems that will be discussed in detail later.

B.2.4 Government emphasis on participation

In the realm of health research it is especially important to hear the voice of the individuals being researched rather than the researcher. In order to produce health services that cater for the needs of the community rather than those needs as perceived or translated by others, the opinions and views of the communities involved need to be listened to. The government has issued statements and directives supporting this view including *The Health of the Nation* in 1991. This stated that health professionals must start "involving people more...at both strategic and operational levels in discussion and decisions about options and priorities, and through that involvement generating a shared commitment" (Dockery, 1996: 165).

An example of this emphasis on participatory research can be seen in such publications as *Positive Participation* by Cohen and Emanuel. The Health Education Authority in collaboration with Healthwise published this in 1998. It is a practical guide for workers involved in planning or running health projects for young people. This is aimed at getting young people into the planning and running of health projects through decision making, consultation and in some cases peer delivery methods (Cohen *et al*, 1998). It can be seen then that the current mood in the NHS is towards including patients in the design of services and their evaluation. This emphasis on patients having power and control over their health services needs to be thought out as it seems to clash at the moment with existing ideals of medical knowledge and status.

Section B.3 Carrying out participatory research with young people about sexual health services

B.3.1 Young people as a marginalised group

> I would there were no age between ten and three-and-twenty, or that youth would sleep out the rest; for there is nothing in the between but getting wenches with child, wronging the ancientry, stealing, fighting.
>
> (The Winter's Tale, Act III Scene III, William Shakespeare)

The use of participatory research as a tool for use with young people can be seen as being especially apt. Young people have been viewed as being marginalised in society. Some researchers have compared their position within Western society to the treatment and concept of non-Western societies in the nineteenth century. "Adolescents are the "new savages"... They are transitional, economically marginal, liminal, unorganised, acephalous, and politically powerless" (Ward, 1990: 27). This concept of young people as marginalised within society means that they fit within the framework of participatory research and its emphasis on empowerment of disempowered groups. There is an overwhelmingly negative aspect to the way young people and children are perceived by society as a whole. "They either need to be better protected (better policed from the evils of the adult world) or better controlled (because of the failure of certain families to police properly their children)" (Roche, 1999: 477). Being young is viewed as a risk factor in itself. Hill and Fortenberry (1992) consider that "adolescence has been 'medicalised' into a condition that is inherently pathological" (p. 73). There has been a call to escape these discourses and view children and young people with more respect and to include them in decisions about their lives. "We need to have proper regard to the contributions and insights of children in the here and now" (Roche, 1999: 486).

Young people are especially marginalised within the realm of their sexuality. Society as a whole seems to view them as being irrational and without any ability to control their own sexuality. "They are savages in that their sexuality is believed to be rampant and uncontrolled, a threat to the body politic" (Ward, 1990: 27). An example of the ramifications of this in health promotion can be seen in Ingham *et al* (1992). There it is claimed that using ideas of rationality in order to promote sexual health issues for young people is inappropriate. That young people, in particular, are irrational in terms of their sexuality and as such health messages must be tailored accordingly. Are young people irrational in terms of their sexuality and do they view their use of services and information as irrational? The acceptability of this opinion in terms of young people and their use of services and information needs to be looked at by the young people being discussed. Thus the investigation of young people and their use of sexual health services needs to be viewed from a participatory point in order to allow young people to challenge these discourses about themselves and to give over the information that they feel is important and relevant. This will be very significant in shaping and creating health services that fulfil the needs of young people as they see them, not as the researchers see them.

B.3.2 Young people as researchers in sexual health

The use of young people in investigating their own sexual health services has a number of points in its favour. The young people are the ones in the position of knowledge here and knowing what young people want and need is something that many people claim but very few seem to be able to get right. As Julia Hirst (1994) pointed out in relation to her work with young people in Sheffield "being a parent, teacher, youth worker, or having memories of one's own youth does not necessarily provide a truthful, uncensored insight into the lives of the current generation of teenagers" (p. vi). The accessibility and acceptability of sexual health services to young people is paramount in the North East, especially in terms

of the government's stated aim of reducing the rates of teenage pregnancy. There can be no better way in theory than actually utilising them to investigate the facilities and attitudes in an area than by having young people take the initiative and using the methods that they feel will be the most illustrative.

Participatory research, as well as being a very good way of giving a voice to people in communities and so making changes that are wanted and needed, has also been found to have an important effect on people who are involved in the research directly. In the health field, it has been found to give participants a greater sense of control over their health and their health services and to give them a general sense of self-control and importance. It has an educational effect in that it allows people to question relationships of dependence in their lives (Martin, 1996). This sort of "learning can lead people towards taking actions on their new understandings of the world" (ibid. 83). Within the work carried out in Stockton the mere act of talking to other young people about sexual health services, or of finding out about the services in their area seems to be of an educational and empowering value.

This is a very significant result of participatory research when working with young people and sexual health. Young people are considered to be at risk in life, especially in their sexual lives, usually because of feeling insecure and not in control of their lives. This involvement in participatory research in this field could then be very significant for the individuals concerned.

B.3.3 Research in Stockton

The research involved in this project was initiated by the local Teenage Pregnancy Co-ordinator, Tim Gristwood, for North Tees and Hartlepool. His position is part of a wider national campaign by the government to reduce teenage pregnancies. His emphasis is on working with local young people and finding out the best ways to prevent teenage

conceptions and other sexual health problems. As an individual he aims to get young people involved on all levels of work and he seems very aware of problems that are associated with this, such as tokenism and patronising behaviour. As part of his remit, he devised a project that would have young people investigating the sexual health services currently available. The main aim being that the young people would run the research themselves but would work very closely with a facilitator. The facilitator would have to ensure that the work by the young people was valid and ethically sound. He or she would also have to recruit and organise the young people involved.

At this point Tim Gristwood approached Dr Andrew Russell of the Anthropology Department at the University of Durham with respect to finding a facilitator. Dr Russell then approached myself as a third year undergraduate in the department. My undergraduate research had been working with teenage girls with regards to experiences of puberty and I had expressed interest in working with Andrew in the area of teenage contraceptive use. So I was brought onto the project as the facilitator with the responsibility of grounding Tim's design in participatory research aims in particular, and anthropology in general.

I spent the initial months living in Stockton-on-Tees and getting used to the area. This was very important as the area was unknown to me and it is part of a wider Teesside conurbation that even within itself is highly differentiated. The area is very urbanised with much heavy industry still in evidence, such as ICI, Teesside Power Station, and Corus. Teesside as a whole has suffered a lot from the reduction in the manufacturing base. High levels of unemployment are a result of this. Central Stockton and Hardwick suffer from high levels of deprivation and unemployment, Yarm is relatively affluent within the area and Central Stockton has high levels of ethnic minorities. After spending some time getting to know the area, some of the people and the methodology the young people

themselves were approached. Tim Gristwood, and the teenage pregnancy strategy as a whole, is aimed at accessing socially excluded young people. This includes ethnic minorities, young offenders, young people involved with social services, and young people with disabilities. There were a number of problems in incorporating these groups with the research design, as it was initially set. These are discussed in section B.3.4 below.

B.3.4 Problems with the research design

There were a number of problems encountered with the specific project design used with this research. The research involved a number of young people using their own initiative and time to investigate sexual health services in their area. The main problematic areas were in recruitment, attendance, and educational ability. The expressed aim of the study, as received from the Teenage Pregnancy Co-ordinator, was to recruit young people from youth projects in the Stockton area. This was found to be problematic. When a youth project for young people in residential care was approached the youth workers were quite enthusiastic but were unable to approach anyone that they considered to be capable of the unsupervised work or of the time commitment. A number of leaflets were left at the project for young people to look at but nobody was forthcoming. Maybe this lack of enthusiasm was related to some of the features of the project, such as the time commitment, the subject matter, or the link with the youth workers. A problem with using youth workers is that they can act as 'gate-keepers' of young people, becoming a barrier between young people and the research rather than facilitators. The young people would have to be chosen and approached by a youth worker, or at least the young person would need to approach a youth worker for further information. This leads to recruitment being dependent on the choices and opinions of a group of adult workers rather than young people themselves.

Another youth project was approached in relation to the research after this first recruitment attempt was unsuccessful. This was a project working with young people with disabilities. The Teenage Pregnancy Co-ordinator who had done work with them in the past mentioned it as an option. A long discussion was had with a youth worker here but again she had some major reservations. These related to the nature of the research, in that the youth worker felt that it would involve young people carrying out work and research which would cause them to feel inadequate, or insecure. Therefore it was decided that, for the good of the young people involved, the study was not suitable for disabled young people in the area. Again leaflets and information was left for other youth workers to consider but nobody was forthcoming with young people they felt would be suitable for participation in this research. Involving young people with learning disabilities in research relating to sexual health is an area that is in need of consideration as they are often ignored in considerations of this subject. Fraser and Fraser (2001) report that with a lot of preparation people with learning disabilities can be involved in focus groups successfully. This sort of discussion might be more successful at recruiting this group than long term participatory research.

Here were two projects that involve young people that are very much excluded from society and as such are of great interest as far as sexual health research goes. One of the major limitations of this research design is that it involves young people with a relatively high level of educational and time management abilities. As such youth workers in the area were unable to find young people that they dealt with to take part in this research. Other forms of participatory research would be highly appropriate for these groups and further research should be done with these groups using more suitable study methods. These could include short time scale participatory work, such as mapping, that involve young people in an active manner but do not require high levels of individual work or time-management.

A youth project in the centre of Stockton, Cornerhouse Youth Project, was itself very helpful and was able to find a number of young people who were willing to take part in the project. The young people were found to be willing to turn up to one or two meetings, especially when a youth worker that they were very familiar with was also attending, but they were increasingly less likely to turn up after this. There could be many reasons for this, such as being unused to attending set meeting times and the settings of the meetings (a local coffee house). The main reason expressed, though, was the changing nature of the young people's lives. The project design was such that it was to be carried out over a period of time but this meant that often the young people's situations had changed dramatically and so they were unable to take part. For example one young man was initially unemployed and was very willing to take part and attended a couple of meetings but then he became employed as a mechanic and so was unable to attend. This highlights the difficulty of working with young people who are not involved in set lifestyles, especially in projects that need an amount of time commitment.

The most successful attempts at recruiting young people were with young people through schools. These included young people approached by a youth council leader, and those approached by teachers. These young people were involved in full-time education and were picked by a teacher or youth worker as being able to commit to the time. The relative success of these recruitments could possibly be due to factors such as the institutionalised setting of the approach, the educational basis of their lives, and the stable nature of their lives. Adults that they treated with some respect in an educational facility generally did the approach and as such this lent the study an element of official endorsement, which was appreciated by these groups. In fact the young people involved from this area stated that they would not have taken part if the approach had not been made in this way. Also the young people here were used to carrying out tasks in their own time for an end goal in their

homework and as such it is probable that this research fitted into their lifestyles quite easily. Finally the young people here were in a stable environment, in that they were attending school for a set period of time and had quite well organised lives that didn't noticeably change over short periods of time.

This bias in the young people that were able and willing to carry out this form of research is limiting in that some of the most at-risk groups were not able to be included. This included groups such as young people in care, living in detention centres or suffering from other social adaptation difficulties. Research in Canada suggests that the intentions and behaviour of these young people "differ slightly from the factors in the general adolescent population" (Godin *et al*, 1997: 299). As such, research carried out by young people attending school with fewer of these social disadvantages may have less validity if generalisations are attempted to extend to other populations. Some changes were made in the research design in order to include some further marginalised groups. This is discussed in B.3.6 below.

B.3.5 Research regarding sexual health within a Catholic School

The use of respected youth workers was utilised in order to access a Catholic school in Thornaby. A youth council had been run in the school for a number of years and the youth worker involved, Mrs Morten, was well respected by the school. As a result of this through her I was able to access two boys from this school. The meetings were carried out both in the school and in a local coffee place. Being able to work with educated young people brought up within a religious atmosphere is highly significant as religion has an effect on the sexual behaviour and risk-taking of individuals. "The role religious customs and doctrines play in the reproductive health of women cannot be overstated" (Klima, 1998: 486). I was not in direct contact with any one from the school but they were kept up to date by the boys and also Mrs Morten. This seemed to work very well and I had no

problems working with the two boys. The parents had to sign a form allowing them to take part and the boys reported that their parents were very happy about doing this. In fact the boys commented that "they are happy that we're doing something useful for once." The anticipated problems in working with this group were all avoided. This might be because of a general liberalisation or because of using a youth worker to approach the school and the volunteers, or because the work was led by the boys themselves and so did not involve any intimate questions.

The school involved was quite small and situated next to a very large non-denomination school. The religious element was visually apparent to any visitor, or health worker. I found that going in to talk about contraception and sex was a little intimidating as I walked past a life-sized Saint Patrick in the entrance and then I waited next to the Chaplain's office under photographs from a school trip to Lourdes. This apparent orthodoxy in the visual displays upon entering the school did not mean that the school itself was particularly strict, though more than once I did walk though the hall during detention. The pupils themselves were loud and dressed as all young people in the area are, though within the confines of the school uniform. The boys that I was working with were in year 11 and as such were the oldest in the school. They seemed to be given quite a lot of freedom and were quite comfortable commandeering classrooms and hanging around after school. The worries that I had seemed to be unfounded in many ways. The boys themselves were not particularly embarrassed talking about sexual health or in talking about these issues with other young people.

Finding out what young people in Catholic education think about their sex education is very important. There have been reports that health visitors teaching sex education are constrained by the school in what they can say. In research carried out in a northern British town by Bloxham (1996) a youth and community worker commented, "Religious

views [constrain us] ... in a Roman Catholic school there are things we are not invited to do. Although in saying that, I think they're a lot broader than perhaps people who weren't involved in school would think" (Bloxham, 1996: 397). Also in talking informally to a number of youth and health workers there is a number of conflicting reports about Catholic schools that seems to result from different teachers in the schools having a variety of opinions about sexual health work. From the reports by the boys currently in education they felt that there was some information and this was a combination of scientific facts and religious advice. They did feel that the school should have much more sex education and they were also very unlikely to speak to their teachers about any problems they had.

B.3.6 Changes in research design

The research design as it stood seemed to have major problems in accessing, and keeping, disadvantaged young people. This seemed to be as a result of the emphasis on long-term commitment and work. In order to try and combat this, after the initial period of research involving young people from schools, workshops were carried out with two specific groups. These were a group of young Asian males from Cornerhouse Youth Project, and a group of young people involved with social services, accessed through Hartington Road Youth services.

The plan of the workshops was to allow young people to talk in groups about sexual health and sexual health services in their area. The group from Cornerhouse involved about ten young men and had a lot of help from a youth worker, Satnam. The use of a youth worker was particularly useful here. Satnam meets with this group of young men every week and has built up a lot of trust and rapport. When I arrived for the workshop he was running down the road to try and find a number of young men who should have been coming. Then the evening started with a little party for one of the young men's birthday. This was marked by cake, sandwiches and other food and by playing pool and listening to music.

The young men were all friends and Satnam seemed to be liked and respected by all of them. After this there was no real need for an icebreaker before the workshop and the workshop was held in the reception room of Cornerhouse. The young men and Satnam were all very familiar with each other, and each other's families. There was little difficulty making them talk though there was quite a lot of embarrassment and mocking amongst them. We initially discussed what sexual health was and what the services were. Then I separated them into two groups and got one group, which I sat with to draw a map of existing services, and the other, which Satnam sat with, to discuss what they would want in services in the area. This was quite successful but when Satnam was called away to drive some other young men from the area home, it was very difficult for me to keep the subject being discussed. I think that it is important that people that are well known and respected by the study group should carry out any work done with specific groups, especially if done in relatively large numbers. I am sure that the fact that I was neither Asian, from Stockton, male or known particularly to them meant that I was not immediately respected and it was in anticipation of this that the workshop was planned with Satnam as an integral part. Mainly as a result of his participation the workshop came up with a large amount of interesting recommendations and so was such a success. Julia Hirst (1994) mentioned that she felt that her work with young people in Sheffield was successful to some part because of the fact that she was from the area. "Being local and having some shared perception definitely enhanced relationships" (Hirst, 1994: 103).

The other workshop was carried out with five young people, three girls and two boys, from Hartington Road Youth services Drop-in. This was a very different experience from the previous workshop. The young people here all lived in some form of protective housing and were from the greater Stockton area. They had just been having some theory driving lessons before the workshop and were introduced to me by a social worker that worked with them during the drop-in, Julie. In a previous meeting planning the workshop she had

already commented that she felt uncomfortable talking to the young people about sex or contraception and so would prefer not to help with the workshop. This was mainly because she was the caseworker for a number of the young people and as such any information would be unlikely to be honest and it might have put her in a difficult position. This workshop was mainly hampered by the fact that the young people involved were much more interested in talking and interacting with me, as the facilitator, then discussing with each other sexual health services. Unlike the other group, the young people here were eager to disclose personal information and experiences. Two of the girls had babies and the other girl was also very open about contraception. The young men were less talkative here about sexual health and service use. The workshop plan, that had worked to an extent at Cornerhouse was impractical in this case and had to be abandoned fairly quickly. The young people were eager to talk about themselves to me rather than talk to each other about improvements. Also with a small group the more formal workshop format was unfeasible. The group ended up as an informal discussion with the young people about experiences with health services and their recommendations for change. The group was very differentiated with one of the girls being particularly mature and, in fact, she was already involved in a peer education programme as a young mother. The other young mother, in contrast, did not seem to be in control of her life. In fact this group seemed quite desperately in need of sex education as they did not attend schooling and two had already had a child. The youth worker mentioned this need to the Health trust but the emphasis did not seem on short-term education but on long-term prospects. This is in many ways a good thing but for the sexual health of the young people that I spoke to the important thing seems to be tomorrow, next week and next month, rather than looking at the next five years.

The main point about working with disadvantaged groups that seemed to come out of these workshops was that a lot of experience is needed and knowledge about the situations

that the individuals are living in. In the case of young people in care or otherwise involved with social services, there seems to be a real need for more attention to be given to them. They have a lot of experience of the negative sides of life and the group I spoke to were more than willing to talk about their experiences and opinions. The original research design was much too long term and based on a need for a stable lifestyle to appeal to this group of young people. One off work seems to be much more appropriate. Also one on one work might have been more successful as the young people put an emphasis on talking to me as individuals rather than a group, even in a group setting.

With any research design there is a need to be flexible. Here I found that the basis of participation was difficult for young people in disadvantaged situations. Their lives and abilities meant that long-term commitment and involvement was very hard for them to manage. As such then a drastic change had been required. The focus on long-term research and the giving over of research control to the youth involved was abandoned in this section and instead the emphasis had to be on short term, quite guided work. The information gathered in these sessions was very helpful and seemed to be quite honest but there was still the problem that this did not fit in with the original ideals of either participatory research, or with the research design itself. Carrying out participatory research about sexual health services with young people is very complex and needs a careful approach and maybe is not compatible with the lifestyles of the very young people that it is hoping to reach and empower.

B.3.7 Possible changes to be considered to further research

A further meeting was held with the two young men from Thornaby in order to ascertain their opinion on the research process itself. They had a number of comments to make about both the positive aspects and areas that could be changed. The areas that were thought to have worked well included the level of support and supervision, the approach,

the age group and the subject matter. The areas identified as possible areas of change included accessing different people through being bigger scale, timing being better and meeting up in larger groups.

The level of support and supervision was quite minimal for the long-term research groups. Meetings were every few weeks and there possible needs were discussed, work done so far and future work. This meant that any equipment, or information that the young people needed could be identified quickly. It also ensured that no unethical or unsafe research was being carried out. The meetings were such that the young people were left to decide what they wanted to do and what they felt was necessary. The young men from Thornaby commented that this approach meant that they felt that they could do what they wanted and they were supported in that. The young people also had a phone number on which they could contact me, and a trusted adult, either a teacher or a youth worker, was involved that they saw regularly.

The importance of using a one to one approach by a trusted adult has already been discussed above. The age-group involved, in this case year eleven at school, and the subject matter were thought to be very good as young people are interested in this area and are in the process of exploring sexual health any way. The age was also thought to be good, as it is old enough to have freedom to go and do research. They are also young enough to still have many of the restrictions that young people suffer, such as lack of money, lack of transport and also the need to inform adults of their whereabouts. The main problem this group did find though was that they had GCSE's to complete and so found their time quite constrained. The research could have been better timed for them, preferably either during the school holidays or at the beginning of the school year.

The small-scale nature of the groups involved was also an area that the researchers thought could have been improved. The young men from Thornaby worked in a pair and the young people at Egglescliffe worked separately as a group. This was from necessity as initial attempts to meet with groups of young people from different areas of Stockton were unsuccessful. It was found that the best way to meet up with the researchers was to meet them on their own grounds and so the groups were kept quite apart. In retrospect further efforts should have been made but after approximately eleven failed meetings I had concluded that the majority of the young people did not want them. The problems of getting large and differentiated groups of young people together are intense but it seems that it would be helpful to achieve this in future research.

Section B.4 Research involving young males and sexual health

One of the main areas where research is needed is in the field of young male use of sexual health services and their knowledge in this area. Young men are often excluded from a lot of sexual health research and from the services themselves, either on purpose or through inadvertent female-centred methods. There is a view, mentioned by all, and reinforced by some, of the young people involved in this research that sexual health and contraception is for women or girls to worry about. As one 15 year old boy commented – "more girls know about the services but I suppose that's a good thing. After all they need to know". Other young people thought that this should be altered and that boys should be focused on more by education, research and service provision. In research into knowledge of young people in relation to contraception there has been found generally a lack of knowledge amongst young men in comparison with young women. For example Graham *et al* (1996) found that in Lothian, Scotland 56.2% of sexually active 14-15 year old girls knew the correct time period for the use of emergency contraception compared with only 11.9% of sexually active boys from the same cohort.

B.4.1 Young men and this research project

Of the young people that this research managed to recruit, a very large proportion was young men. In view of the general difficulty in getting young males involved in research in this area this may be an interesting aspect of the research design to consider. Of the young people involved in all levels the proportion was about two young men to young women. This could be attributable to many different things. Options include the aspect of youth worker choice. As each young person was approached to take part there is a possibility that young workers chose more young men for personal reasons. If this is so the research itself was interesting enough for the young men to get them involved, and keep them that

way. From working with both young women and young men I feel that the reason is related to the aim of the work. Because the young people were recruited to find out about the services in the area, they were not required, or really wanted, to give any personal details about their own sexual experiences. A high proportion of the young women did this anyway. They also told more personal stories about their service use or their friends'. The young men did not do this at all. The research was such that the emphasis was on investigation and interviewing and not on personal revelation. In the sensitive area of sexual behaviour, this seems to have been very important in recruiting young men. So one possible way to get young men to take part in research is to make the research about more objective, investigative work rather than about asking them questions that are sensitive to young men whose status is often linked to sexual performance. This also moves away from the worry that young men will inflate their sexual experience. "Some young men over report their sexual activity to give the impression that they are conforming to what they think society expects of them" (Singh *et al*, 2000: 22).

B.4.2 Young men and other research

In research on sexual behaviour and fertility there has been an emphasis on women until the 1980's. This then changed with the advent of HIV and AIDS. The focus has begun to shift as the view has moved from female pregnancy towards disease that can be passed on and caught by both men and women. In this means that research into men's sexual behaviour has been increasing as is research into how women and men differentially experience sexuality throughout the world (ibid.).

Some findings from recent work with young men have found a number of factors that relate to sexual health. One important finding, especially for sexually transmitted infections is that sexual behaviour for young men especially is marked by short bursts of sexual activity and is normally with a number of different partners. "For never married young

people, particularly men, sexual intercourse appears to be very sporadic; therefore, it probably involves a number of partners over time" (ibid. 27). This is significant when it is combined with a relatively low use of condoms among young people, as it is in Britain.

Research in Scotland with boys and girls aged 14-15 years old found that generally the boys did have "a considerable sense of responsibility on sexual issues, although this is not as well developed as that of the girls" (Hooke *et al*, 2000: 485). In spite of this they found that more boys than girls considered there to be nothing wrong with casual sex and less boys than girls upheld value of commitment. Boys in this cohort also reported very high instances of alcohol use at time of first intercourse, about half of the group. Also use of alcohol at first intercourse was related to non-use of condoms. Thus young men are involved in sexual risk-taking more than the young women are. This emphasises the need for education and services to target young men.

A survey of 551 British men aged between 16 and 15 years of age focused on their sexual behaviour and considered factors that affected the number of partners in the last five years (Kupek, 2001). The main predictor of this was found to be the time since first intercourse and that this was in turn associated with permissiveness and number of partners overall (ibid.). One of the most interesting findings from this survey was that there was no significant relationship between sexual attitudes and number of partners. They were jointed predicted by a set of background variables, such as age and social class, but not directly linked (ibid.). This has implications for safe sex campaigns for young men in that possibly the focus should not be on changing attitudes.

B.4.3 Young men and sexual health services

Hacker *et al* (2000) researching in Boston, Mass., with young people, found that young men are less likely to use clinics because they are seen as female centred. This is a problem

because it seems that when young men use other health services their sexual is not being discussed. Research by Porter and Ku (2000) in America found that young men had a high use of medical services but these contacts were not used to provide sexual health help, or advice. "Despite this high level of medical contact, only a small minority of teenage males, including those who are sexually active, receive preventive reproductive health services" (Porter and Ku, 2000: 191). On anecdotal evidence this seems to be true of young men in Britain as well. A young man not involved in the research commented that his GP during a discussion of his health had said that he wouldn't embarrass him by asking about his sex life or behaviour. This opportunity of talking to a young man about condom use, contraception, and sexually transmitted infections was lost. It seems that if young men feel that clinics are not for them, and GP's do not discuss sexual health with them, then they are entirely falling through the net until they encounter a major problem.

Price (1997) reports on the setting up of a project in Brighton that aims to challenge the female orientation of family planning clinics. Here a male worker works with the local family planning clinic. He approaches young men in the waiting room, offering advice, some information, and access to free condoms. The young men then felt that their presence was acknowledged and appreciated. Also they had the opportunity to talk to about feelings, problems and any concerns they have. The family planning that was involved, like most others, had an all-female staff until this male worker joined. This helps to give the impression to young men that they are not welcome. "Young men often regard health service clinics as being 'women's places' and this can too often be reinforced by the provider" (Price, 1997: 105).

Another American research group (Everett *et al*, 2000), who worked with Youth Risk Behaviour Surveys from 1991 through to 1997, found that males reported a lower use by their partners of the contraceptive pill than females. They posit that this could be due to

males not knowing about their partner's contraceptive use. This is an interesting view and backs up a claim that young males seem to be excluded, by choice or otherwise, from contraceptive decisions and discussions. This has also been found in research among research with Swedish women about their partners. Of the women that were taking the contraceptive pill, forty-six percent of them reported their partner never asking them about it (Lindell *et al*; 1999). The women that used condoms reported a much higher amount of discussion about contraception with their partners. This is probably due to the fact that condom use needs constant decision making at each sexual encounter. For young men this constant discussion about contraception may be a barrier to condom use.

Research by Roberts *et al* (2000) in America with young men in a detention centre gives some indication of the attitudes of high-risk male adolescents. There were high levels of STD treatment and of reports of getting a girl pregnant, about a quarter of all respondents in both cases. One major attitudinal finding was that these young men "were more concerned about their own health rather than their partners" (Roberts *et al*, 2000: 300). This sort of finding is important and shows how groups of young people in different situations can have specific views on sexual health that could be highly significant for health messages.

B.4.4 Young men as fathers

"Many aspects of male adolescents' role in teenage births are not well understood" (Coley and Chase-Lansdale, 1998: 154). These include their role in abortion and adoption decisions. Generally there is little information regarding teenage fathering. Work by Dallas and Chen (1998) in America to research teenage fathers found that even finding them is difficult. Young mothers often do not name the fathers on birth certificates, and young fathers are often reticent at naming themselves for fear of being chased to give child support. They did manage to work with a number of young African American fathers and

they found that there was a feeling amongst the young men that they did not know a lot about fathering. In spite of this acknowledged ignorance the young fathers did not consider health care providers as a source of help or information (Dallas and Chen, 1998). This reveals that young men are being ignored by services even when they are fathers. There seems to be a real gap for more information to be given out to young men as fathers.

Work with young men is improving and they are increasingly included in considerations of sexual health. There is still a need though for young men to be reached more by education and services. Different groups have very different needs and it can be seen by a lot of the findings considered here that young men's needs are not being met and they are not being included very successfully in sexual health messages or services. The ability of this research to access young men and to discover the changes they would like to see in sexual health services is, therefore, highly significant.

Section C

C.1 Objectives decided on by the young people involved

The young people decided on three main objectives for their research in consultation with the facilitator. All of the young people agreed on these general objectives. They all also agreed that the best way to record their findings were through their own observations and through tape-recorded interviews. The objectives were as follows:

- Assess the services in the area. See what is available and how well it caters for young people. The most deeply important areas of investigation were thought to be looking at the services available, assessing them and considering how easy they were to access.

- Survey young people, by interviewing other young people, and find out what they know about the services and how they feel about them. Also check which services they would be willing to use and what they feel is important in sexual health services

- Assess the effectiveness of the information services available in the area. Services include media such as posters, television, radio and the Internet. The ease with which young people can find out about the services in their area is very important as well as the acceptability of national information services, such as websites attempting to give information about different contraception, abstinence or other sexual advice for young people.

C.2. Methods

C.2.1 Methods used in the project

The methodology was designed in order to involve young people in the research process as much as possible. This meant that a number of young people were recruited from local schools and youth projects to work in small groups together. They then set their own aims and objectives and worked out the best research methods that they could use to achieve them. The main emphasis throughout was on getting the young people to direct and carry out the research so as to get at what they felt was important and what they thought were the elements in the local and national services that needed changing.

The methods used in this project were designed in order to allow young people the most control over the research. Initial meetings were undertaken with groups of young people and the aims, and methods were discussed in these groups. Seven young people, between the ages of 15 and 17, were then able to dedicate further time to participating in long-term research. Regular meetings with the facilitator allowed them to explore their own research aims, and then how they would achieve these. These young people were given as much freedom as possible in this research, while still ensuring ethical and safe behaviour for them and other young people. The results of this research were conveyed either through written information or in conversation with the facilitator.

Some short-term research was also carried out. Workshops were carried out with a group of young Asian men from Cornerhouse, a youth project in central Stockton, and with a group of young people accessed through social services. The plan of this research was based in the initial aims decided by young people and they had an emphasis on participation. The young people drew maps of the area with services that they knew of

marked on them. They also discussed in groups the changes that they wanted to see implemented in these services.

The young people who became involved in the work were accessed through youth workers and teachers at school. The young people all volunteered. The parents of those involved in the long-term research had to sign a consent form that allowed their children to take part. The youth workers and teachers were all very enthusiastic and helped in reaching the young people and keeping them interested. As such, this way of accessing young people seems to be effective and though it may involve an element of 'gate keeping' it uses the trust already built up between young people and these workers. In fact a number of the young people reported that they would not have taken part if a respected adult had not approached them about it. The young people involved in this research have been mainly boys. This may be partially due to selection bias on the part of the youth workers but it seems to have some basis in choice by the young people involved. The appeal to males may be due to the fact that the research is based on action rather than talking about personal experience.

C.2.2 Methods decided on by the young people involved in long term research

In order to consider the services in the area the young people decided that the best way to assess them was to look at a number of them and visit some of them physically. This involved using either previous visits as evidence or making new visits to services and seeing what they were like for young people using them. This included thinking about location, atmosphere, staff and information available. A number of the young people chose to talk to the service provider in order to find out more information about the services.

In order to investigate the knowledge that young people had and what they thought of this the young researchers decided to conduct interviews with groups of young people. The

young people decided to conduct group, individual, or paired interviews with other young people, especially young people that they knew from the Stockton area. The fact that young people conducted these interviews should have allowed a greater openness and a new outlook onto the opinions of young people about these services. The young people chose to record their interviews either on tape, by hand, or through memory and then dictation to the facilitator.

The young people used search engines on the Internet to find and access information and judge how easy this was and how acceptably the information was presented. The Internet was thought to be a very important source and the sites found were assessed as to their ease of finding and how acceptable they were to both male and female users. Also the young people looked for other forms of publicity and information about sexual health and sexual health services in the mass media so as to see what information there is for young people.

Thus the young researchers planned to use these methods to investigate the accessibility and acceptability of services available to the young people in Stockton. The fact that these methods were decided on by a group of young people themselves indicates that these are important areas of issue for young people rather than externally perceived areas of concern.

C.3. Research Findings

C.3.1 Approach to Sexual Health

The young people worked with in this project considered the idea of sexual health and sexual health services to cover both the issues of pregnancy and disease, as well as wider concepts more embedded in a positive view of sexuality. The young men from the Cornerhouse youth project were particularly embedded in a more universal definition of sexual health. Sexual health here included being healthy, both physically and mentally, being free from drugs and alcohol abuse, and being able to talk to people about sexuality and other issues, as well as protection from pregnancy and disease. Other groups focused much more on the specifics of disease and pregnancy, though in every case there was an idea that young people need to be knowledgeable about sex and sexual health and that they should be able to talk to people about these issues in a safe environment. A safe environment would be one where they have the time, space and non-judgmental atmosphere. As such then a purely narrow definition of sexual health and sexual health services, merely taking in disease and pregnancy prevention, does not fill all the expressed recommendations of the young people involved. A wider and more holistic view is needed. The approach that young people want to be taken towards sexual health should affect the sort of information that is given out in posters, schools and other places. They felt that this information was often very instructive about what not to do and was very much about not having sex. It is generally a very negative and narrow approach. This was thought to be a waste of resources as young people are much more likely to listen to other sources about how they should act sexually. It was found a number of young people feel the same way as this particular interviewee:

> "Why would you listen to the government on how you should act when you have your friends telling you what to do?"

Peer pressure seems to be given much more weight on what young people think about sex and they recommended peer education and counselling as a method of reaching young people. This is discussed in more detail later.

It was felt that the information given by official sources should be more about what to do if you do decide to have sex and about giving young people all the information that they need and a place to go for advice. The information should include where to access sexual health services, the sorts of contraception available and what to do if anything goes wrong. One of the main things that these official sources should provide was felt to be contingency plans, i.e. a plan of what young people or their friends should do when they act in certain ways, or if things go wrong. Information should not be aimed at telling young people what not to do but rather on giving them information so as to make their own decisions and to follow through with these safely and comfortably.

Comparison with recent policy and research regarding approaches to sexual health

The concept of sexual health is one that refers to a variety of different ideas. Generally sexual heath has been defined in a negative manner. It is characterised by the lack of certain problems, for example disease and unwanted pregnancy. This definition has the advantage of being easy to assess and target. This negative definition has been criticised and challenged, though, by workers who attempt a positive definition of sexual health. This sort of definition includes the possession of high self-esteem and decision-making abilities in the area of sexual relationships, easy access to sexual health services and having the opportunity to discuss sexual issues with peers and adults (Bloxham, 1996). This view of sexual health tries to avoid considering possession of sexual health as merely the absence of risk behaviour or the avoidance of disease and pregnancy. This definition of sexual health is difficult to achieve and very difficult to assess. Thus most work on sexual health

services and interventions generally focus on the infections of disease, the numbers of pregnancies, the absence of early sexual intercourse and other quantifiable results. This project shows that young people in Stockton already view sexual health and their recommendations in this area within a wider, more positive setting.

The Governments new guidelines on sex education, as detailed in the Social Exclusion Unit's report on teenage pregnancy (1999), recommends that sex education should be linked to other related subjects such as alcohol, smoking and drugs. This indicates a view of sexual health that is taking a wider outlook and as such fits in more with the way that the young people in Stockton view this subject though there is still a danger of being part of a very negative standpoint.

The young people here felt that an emphasis on "just say no" campaigns is misplaced. This emphasis on abstinence is of particular note in America where the issue of political sensitivity has been of great importance especially in the area of programs and interventions involving teenagers and sexual activity. The provision of family planning advice, contraceptives and, most extremely, abortion are all areas that are considered to be politically very controversial and problematic in the U.S. and as such interventions involving other elements have been emphasised. These include pre- and postnatal care, the promotion of abstinence and a more general approach to raise the self-esteem of young people (Loda *et al*, 1997). It seems that, in America at least, political pressures and other factors have meant that programs and interventions are generally not paying attention to a main tenet of any work with people. "Planners will be faced with the fact that information and "just say no" programs do not work, requiring an assessment of cultural factors influencing behaviour" (Nichter, 1991: 9). This fits in with the results of this research, as the call is for accurate, practical information rather than an emphasis on "just say no".

Approaches to Sexual Health

- A wider definition of sexual health with greater importance being put on the ability of young people to make their own decisions and on giving them the information to do so.
- Information should be positive and should avoid telling young people what not to do.

C.3.2 Publicity for Sexual Health and Services:

One of the initial findings that the young researchers discovered was a lack of information or publicity regarding sexual health in their areas. They found that it was very difficult to find any real examples of sexual health information in the media or elsewhere. If you were very determined then the information was available but it was not to be easily found in the public arena. This was considered to be a problem for young people. The general feeling regarding publicity and the use of media for informing young people about sexual health was that there should be a major increase in this area. This increase should use all sorts of media and a variety of situations in order to keep good sexual health practices at the forefront of young peoples minds. The different forms of media mentioned included television, both adverts and within programming, radio, posters, and magazine adverts and articles. The places mentioned for poster use included schools (which are discussed later), buses, stations, toilets in social settings such as public houses and youth clubs, and also community buildings.

A lot of the information on television about sexual health and sex is aimed at adults and young people expressed feeling quite excluded from that. The programmes that deal with sexual issues and sexual health are normally aimed at viewers over the age of twenty at least. For young people watching television is a really good way to introduce sexual health into their everyday lives by associating good sexual practises with likeable characters and showing young people going through consequences of sexual behaviour. The young people involved in the research found that there has been an increase in information over the past few months. This was found to be especially true in soap operas on television. "Hollyoaks" was mentioned in particular as a source of information that put things in an acceptable manner for young people. Its current story line involving a young girl and her unintended pregnancy as well as discussions of teenage sex, school based sex education and

condom use are thought to be relevant and up to date for a young audience. This sort of programming could be used as a springboard for further details for young people in other advertising, or in more formal educational contexts.

An increase of the portrayal of sexual health issues on television is seen as a positive move. It means that information and discussions about sexual health are in the public arena and therefore this helps to lessen embarrassment and taboo surrounding sexual health. Some young people thought that it might be uncomfortable watching such programmes with their parents though and this is a consideration to be kept in mind by programmers.

The lack of publicity relating to sexual health was especially noted when compared to the amount of publicity regarding smoking and drug abuse. In fact one of the interviewees commented:

> "It should be like it is with smoking. There is stuff about that everywhere. After all, unlike smoking, this is really important and could affect your life now."

The young people had noticed a lot of information, posters, adverts and other media relating to smoking and drugs. This publicity is very much in the centre of public awareness and this reflects the unproblematic nature of anti-smoking and anti-drugs campaigns. Unlike sexual health campaigns the smoking and drugs publicity is related to not doing something. This is not very problematic in the eyes of the public, or schools, for example. Sexual health campaigns on the other hand need to be more about doing things, such as being aware of your sexuality, of the services available and of the need to protect yourself from pregnancy and sexually transmitted diseases. This maybe has meant that they have not been so public as the example of smoking. The young researchers felt that the same level of publicity is needed in this and that if the message is aimed correctly that publicity could be very effective. One group mentioned that services should clarify in their

publicity that the services are open to young men. It was felt that this would help to reassure young men that they were welcome at the services. It was thought that this would help get young men into the service initially.

In the case of a number of the youth projects providing sexual health services young people reported that they would not use them because they were unsure about how confidential they were. Publicity would be very helpful in these cases. A service should publicise its confidentiality policy widely as this is very likely to affect whether young people use it. Users of Cornerhouse, a youth project in central Stockton, reported that it was confidential and trusted. This meant that young people felt able to talk to the youth workers. Any publicity should include the confidentiality policy of the service.

There is information available and a determined young person can find out the information that they require but it was felt by the researchers that information should be much easier to get hold of and should keep the attention of young people. This could be achieved by using the whole range of possible media as mentioned above. They all need to be consistently used in order for information to be given and reinforced among each group of young people.

Comparison with recent policy and research regarding publicity for sexual health and services

The Social Exclusion Unit teenage pregnancy report (1999) details the outlook of the government as regards publicity of sexual health and sexual health services. There is a call here for services to be well publicised and for sexual health to be the subject of publicity campaigns. The researchers in Stockton found that at the moment the situation is improving as concerns publicity about sexual health in the media but there is still a way to

go. The publicising of services is not managing to reach all the relevant areas in this region because it does not give information to a wide enough catchment area.

The importance of publicising the confidentiality of services has been reported in the Teenage Pregnancy Unit's *Guidance for improving contraception and sexual health advice for young people* (2000). Here it is recommended that all publicity for services should emphasis that they are free and confidential. The information is also recommended to be available in places such as schools, bars, clubs and cinema's. This supports the requests made by the young people in Stockton. The report also mentions that, "all services providing contraceptive advice should have an explicit confidentiality policy which young people are made aware of" (ibid. 2). If worries about confidentiality stop people from entering a service then it is clear that such a policy needs to be made clear in publicity outside of the service itself.

As well as publicity for specific services there is also more generalised publicity for health promotion, or for services as a whole. In this area mass media can be very useful in reaching and influencing large numbers of people. There are a number of factors that mean that mass media is particularly useful. These include the large numbers that they can reach at one time, the fact that the messages can be repeated as programmes, magazines etc tend to have regular audiences and that mass media tends to initiate conversation and interactions between people (Romer and Hornik, 1992). These are all important in terms of young people. Young people tend to watch and read regular pieces of mass media and they also tend to discuss these within their peer groups. Another very important attribute that mass media possesses is credibility. Messages can cash in on the ready-made credibility of celebrities, programmes, etc (ibid.). There are a lot of worries about advertising or talking about sexual health on television or other forms of mass media. There was a mass media campaign in many major cities of America in the late 1990's, including Seattle, and

Philadelphia, that involved advertisements for contraceptives for television (Trussell *et al*, 2001). There was no outcry and this bodes well for other potential campaigns both in America as well as here, especially bearing in mind the conservative image America has in relation to Britain.

Publicity for Sexual Health and Services

- There should be increase in publicity about sexual health using all media. Aim at levels of information and publicity similar to those referring to smoking and drug abuse.
- Storylines in television programmes such as Hollyoaks are a good way to pass on information to young people.

C.3.3 Levels of Knowledge amongst Young People

The young people involved in long-term research reported that generally there was a low level of knowledge amongst their peers. They found that there was little knowledge about sexual health or sexual health services. One important differentiation in this was that girls tended to know more than the boys in the same area and age group. They thought this was probably a good thing as they felt that girls had to know about the services and general sexual health because they are the one's likely to get pregnant. The difference in levels of knowledge between the girls and boys could be due to the difference in the levels of information available to them. Generally the boys doing the research found that sexual health information in the mass media, whether on television, the Internet or in magazines, was aimed at girls and they felt quite excluded from it. They did use the information that was aimed at them, such as information in magazines such as FHM, but there was not a lot for them. This reinforces the idea that boys do not need to know about sexual health and that it is "women's business". Obviously FHM is a specific case and it is one of the very view magazines that gives health information about both men and women to men but it is aimed at a much older age group. It could be a possibility to have something similar for a younger age group.

In central Stockton there seems to be more knowledge about services, this was true of the groups from the Cornerhouse youth project and Hartington Road youth services. This might be related to the fact that there are more services in the vicinity. In the outlying areas the researchers found that more people had less detailed knowledge about services and that there isn't that many services close by to know about. Lawson Street clinic, a clinic offering a variety of services including a young person's clinic in central Stockton, is well known to the nearby residents down to details such as what is on offer on which nights. Young people living much further away mention that this is a main place on offer

to them and that they would or do attend. The problem with the users or potential users from further away is that they do not know the opening times or when specific services are on offer. They feel that the hours should be long to allow people to travel to it when they can and that these hours and other details should be well publicised in the surrounding areas of Stockton-on-Tees. The existence of family planning clinics in the area was known to some of the female population in outlying areas but the detail of knowledge was less widespread. This was thought to be an area that needed to be addressed through publicity and general education.

The lack of knowledge about both the services and sexual health in general is worrying especially where the research was carried out in schools. In schools now they are expected to provide a good sex education programme and the schools that this project worked with had strived hard in order to achieve this. In spite of this the researchers found that young people still did not have high levels of knowledge and it is a matter of concern that even in schools that have an active policy on sex education young people still do not possess the necessary information.

The young Asian men at Cornerhouse youth project were generally very knowledgeable about the services available in their area. They knew the location of services, what services were available and when. Their knowledge was detailed and related to how the services interacted in their own area. This may be partially related to the work that Cornerhouse does in the area, and partly because within the small geographical area of central Stockton there are a lot of services available. The young men at Cornerhouse had very good levels of knowledge and also were very confident in their personal knowledge of where services were and how you would use them.

Comparison with recent policy and research regarding levels of knowledge among young people

The Social Exclusion Unit report on Teenage Pregnancy (1999) identifies that "young people lack accurate knowledge about contraception, STI's [sexually transmitted infections], what to expect in relationships and what it means to be a parent" (p. 7). The report also comments that previous research has identified that a lack of knowledge about sex is "a key risk factor for teenage pregnancy" (p.8). Thus it can be seen that the lack of knowledge that the young people involved in this research have identified is part of a national problem and, also, a major aim for change. The high levels of knowledge about local services among the young Asian men from central Stockton is especially important in view of this and the positive steps that the Cornerhouse youth project undertakes are obviously working well.

Many services and educational projects are designed around a Health Belief Model. This model "proposes that individuals arrive at health-relevant decisions after taking due account of a number of factors" (Ingham *et al*, 1992: 163). These factors include the perceived costs and benefits of behaviour change, severity of illness, and how at risk the individual sees him or herself. This means that many projects and services believe that correcting false perceptions and giving accurate information will lead to a change in behaviour. The problem with this is that it has been found that the Health Belief Model is a poor predictor of behaviour. This is especially true of issues involving sexuality (ibid.). There are many reasons for this such as the mystique of sexual behaviour, lack of communication and perceived invulnerability (ibid.). Thus many services and projects that have been designed using the Health Belief Model may be unsuitable or ineffective for young people in this area of behaviour as "adolescents ... tend to engage in unprotected sex despite substantial knowledge regarding the dangers associated with their actions,

suggesting that factual knowledge concerning the health-related dangers of unprotected sex is an insufficient factor in promoting safer sexual behaviours" (Parsons *et al*, 2000: 379). However it has been argued that although perceived risk may not be enough to motivate behaviour change, without it behaviour is very unlikely to change at all (Carroll *et al*, 1999). As such then the conclusion seems to be that sexual risk related information and knowledge "is a necessary but not sufficient condition for adolescents adopting preventive practices" (Fisher *et al*, 1992: 118). Other researchers have come to similar conclusions (S⌐rensen *et al*, 2000, Coleman and Ingham, 1999, and Oakley *et al*, 1995) and so this must be behind any consideration of sexual health and young people. Services and information must be acceptable and accessible but young people also need to have the relative information in order to access them. As such then, raising levels of knowledge about sexual health among young people may not immediately lead to behaviour changes, but without it such behaviour changes are very unlikely ever to happen.

A low level of knowledge about sexual health has also been found among people in America. Research in America (Crosby *et al*, 2000) has discovered high levels of misinformation concerning STIs and their prevention. This research found that around half of the respondents from STI clinics thought that douching would protect against infection, twenty percent thought that oral contraceptives offered protection and thirty-nine percent thought that urinating after sex did (ibid.). Accurate knowledge about the prevention of STI's is, obviously, important and without it young people are lacking the information to protect themselves.

Generally it has been found that young men have lower levels of knowledge about sexual health services than young women (Sex Education Forum, 1997). This confirms what young people in Stockton found. The high level of knowledge about the services in their local area shown by the young Asian men's group is therefore very important. The

provision by Cornerhouse, the local youth project, and work of their specific youth worker has resulted in quite high levels of knowledge and a certainty about who to turn to for advice on sexual health questions. This contrasts to other young people who do not attend such a youth project and so provision of information should be considered in order to reach these other groups.

Levels of Knowledge amongst Young People

- Girls generally knew more than boys did and so it is proposed that education and publicity should aim to reach boys more effectively.
- Generally information in the media is aimed at girls, including magazines, leaflets, and websites. There should be more information aimed at male users.
- Specialised services should publicise their services in a wide area. Young people in outlying areas may wish to use them but are either unsure of their existence, unclear about the services on offer, or do not know the opening times.

C.3.4 The Role of Schools:

The role that schools can and do play in both sexual health education and service provision was deemed very important by many of the young people involved. School is somewhere where the majority of young people are for prolonged periods and, as such, it was felt that this is a real opportunity to allow large numbers of young people to have access to information, advice and even contraception provision. There was thought to be three main ways for schools to provide a service in this area. These are 1) the role of the school nurse, 2) the provision of sex education and 3) as a place for the advertising of services and issues.

1) The role of the school nurse was considered to be potentially very significant. There seems to be a lack of knowledge about the duties, hours, or place of work of the school nurse amongst pupils and even more importantly a number of young people did not know if their school, or college, had a nurse. This was thought to be the case of a real possibility missed. A number of the young people felt that they would very possibly go to a school nurse about sexual health as they were already in school and would not have to explain doctor or clinic visits to parents or make the effort to go to somewhere else.

There was a feeling that for school nursing to provide advice and other services for all the schools community then, for mixed schools, there should be both a female and a male nurse available at frequent and regular times for the young people to access. The young men involved in the research very much seemed to appreciate the advice and counselling of a man on these matters. Many of the young men from Cornerhouse mentioned that a male youth worker that they all worked closely with would be their first port of call for information and advice in relation to many matters including sexual health. This male source seemed to be lacking in other young men, outside of family members. It could be possible for a male school nurse to attempt, at least partially, to fill some of that role for

young men at school. As such then the recommended plan for schools is to have a male and female nurse on duty and that young people should have a choice as to which they wish to deal with. It should be made clear on any advertising for the service which nurse would be on duty. The importance of having a health professional to talk to that was willing and able to give the time and energy to counsel young people was emphasised by the drop-in group from Hartington Road. This role was thought to possibly be able to be filled by a school nurse, if they were properly trained for this role.

Some researchers also looked into the sort of work that a school nurse should carry out. It was thought that a school nurse should be available for drop in consultations and advice. Also it was thought that nurses should be able to make appointments for pupils at the appropriate agency, clinic or General Practitioners and that this service should be made known to all pupils. A number of young people also thought that school nurses should be able to give out certain forms of contraception, certainly male, and possibly female, condoms.

The researchers found that school nurses were not being used as a major source of information or support. This could be due to a lack of knowledge about where to find the school nurse and when they are available. It was concluded that school nurses should be available very regularly and as much as possible so as to enable young people to access them whenever they needed to. Better information for pupils on when and where to access a school nurse, and on what role a school nurse has, is needed.

2) Sex education in schools was also a major area of importance for the researchers. They reported that there was a focus on reproduction and the biology of pregnancy and not on the practicalities of negotiating sexual health as young people experience it. It was concluded that the scientific, biological information is necessary but that there should be an

emphasis on more practical issues such as obtaining contraceptives, negotiating their use, and how to actually use them. This practical information was thought to be more relevant and easily transformed into behaviour than more theoretical, or biological, details. Also young people felt that the information should be repeated and reinforced a lot more often. A lot of information is given but only once and generally that isn't enough to remember, or absorb, anything more than the very basic points. As well as this it was mentioned by young people that homosexuality was not covered by their sex education at all. The group from Hartington Road particularly mentioned that this is a major omission and that schools should teach and counsel about homosexuality within sex and relationship education. It was felt that this would help to reduce homophobia among young people and also help those that were wondering about their own sexuality. Generally the call was for a lot more sex education, for it to be given a practical emphasis and that it be given a lot more attention outside of science class.

One aspect of school-based services that was highly recommended by the young people was the use of outside visitors to give information and advice about sexual health rather than using teachers. The young people reported that their schools were already doing this to an extent and this effort was thought to be good and effective. The only complaint was that there should be more of this. The visitors should be young and good at dealing with young people. They were thought to be better than using teachers because visitors are unknown to the young people, have up to date knowledge and techniques, and are easier to talk to as they are outside of the school system. This is an area where the school nurse could also be used. This would make use of the expertise of the nurse and introduce him or her to the school population. Quite a few of the young people recommended a form of peer education to be used within schools. This is discussed further in the peer education and counselling section

The information in school should start young, according to the young researchers. Information about contraception, which a lot of the young people reported as being taught to them in and around year ten, should be initiated much earlier. Also there should be an increase in the amount of information and reinforcement in this period of school. It was thought that specific contraceptive information should be given to young people who are around twelve to fifteen and as such are felt to be old enough to need a lot of information and young enough to have probably not already got into problems surrounding sexual health.

The main conclusion regarding school based sex education was that everybody should be involved in giving out more information. Much more of an effort should be continuously given but the main area of focus for teaching and counselling should be on non-teaching staff and outside visitors. These are felt to be especially important and seem to provide an acceptable form of information for large numbers of young people.

3) Another use of school for giving out information was the use of schools for publicity surrounding sexual health. Posters around schools were thought to be a very good idea and can be accessed by young people when they are apart from family and with a peer group. Posters with general information, specific contraceptive information and those with advertising for services were all thought to be possibly very helpful in this setting. Specific information about opening times of services in the area, and of website addresses accessible in private areas of the school could overcome some of the problems that young people have in accessing services and information. The school is a building around which young people spent a lot of time and, as such, the walls themselves can be utilised to give out information about sexual health.

Existing recommendations regarding the role of schools

Sex education in schools is covered partially by the science national curriculum. The biology of reproduction and anatomy is part of this formalised teaching area and, as with each area of the national curriculum, there are recommendations as to what information should be known at what age. Every secondary school is required by law to provide sex education, and a policy on sex education is required by every primary school. In secondary schools this education must cover some information about HIV/AIDS and other diseases (DfEE, 2000).

Sex education is generally taught and covered within the teaching time designated Personal, Social and Health Education. This is an area of teaching where there is no specialist qualification and so teachers who cover this subject generally, and sex education in particular, are usually specialists in other subjects. The need for clear guidelines and training in sex education is clear. A report in 1991 by the Royal College of Obstetricians and Gynaecologists found that inadequate sex education was at least partly responsible for the high rates of unplanned pregnancies (Dillner, 1991). Also "the report expresses concern that sex education may focus on biology and not leave time for discussions about love and morality" (ibid. 303).

The Social Exclusion Report on Teenage Pregnancy (1999) indicates that many schools are nervous about sex education because of the possible reactions of the media and parents. This means that schools often do not advertise their sex education as a positive element of their school curriculum or try to innovate in this area. This issue needs to be considered because the young people involved in this work feel that sex education in schools is vital and needs to be emphasised.

The Social Exclusion report also details the new government recommendations on sex education. This has an emphasis on many of the areas that the young people in Stockton feel are lacking at the moment. This includes precise practical information as regards contraception and services, an emphasis on information for young men, and the use of outside visitors. The government, then, already supports many of the changes that the young people have put forward and as such local schools should feel confident in implementing them.

The new National Healthy School Standard (1999) is also relevant to these recommendations. In the outline to this scheme Tessa Jowell (Department of Health) and Jacqui Smith (Department of Education and Employment) stated, "We believe that schools are one of the key settings in which to promote the health of young people and the wider community" (DfEE, 1999). In Teesside there has been a local Health School award since 1990 but now that there are national standards to be attained it is hoped that the scheme will be more successful and high profile. This standard required schools to be pro-active in the realm of health, and this includes sexual health. There are a number of new initiatives in the area in relation to this, including the Sex Ed Roadshow. This fits in with the recommendations by young people that sex education should be more of a focus in schools and that outsiders to the school system should generally carry it out.

Teachers that are involved in delivering this education often complain that they do not have the relevant training or experience (Bloxham, 1997). The recommendation of using specialists such as youth and health promotion workers as visitors into the school to give out relevant, up to date information is one way to move from the problem of overstretched teachers and their lack of training in this area. Many researchers have recommended this (ibid.) but there are problems. These problems can be traced to worries by teachers and schools about controversy in this area. In order to trust a group of students to a visiting

speaker a teacher must be comfortable and willing to defend, if necessary, the information and advice given (Bloxham, 1996). This is especially difficult within a topic of such divergent views and political pressures as sex education. Thus there must be a level of trust built up between the outside speakers and the school. The calls from the pupils themselves indicates that this is important and effective area and, as such, this must be a matter for the attention of both schools and people who could act as outside support.

In rural America attempts to use schools as accessible and acceptable places to provide sexual health services have met with the legal barrier that they may not give out actual contraceptives in schools (Loda *et al*, 1997). Many school-based services have worked around this by having links with external clinics, though they have faced problems again when it comes to the controversial middle ground of school personnel making appointments for young people in these contraceptive-providing clinics. In the U.K. actually providing contraception on school property would likewise be highly controversial (Bloxham, 1996). School is important, as it is a place where almost all adolescents are for a large amount of time.

The Role of Schools

- School nurses should have a more clearly defined role, which is explained to all pupils and staff. They should be available frequently and regularly for both appointments and drop-in enquiries.
- In mixed schools there should be a male and a female school nurse.
- School nurses should be able to give out forms of contraception, such as condoms.
- There should be an increase in the amount and quality of sex education for young people.

- The sex education should generally involve non-teaching staff or external visitors, such as health promotion workers. Schools have been successfully doing this to an extent and these efforts should be continued and extended.
- Sex education still has an emphasis on reproduction and science, but it should provide practical information that young people can then apply in their lives, including how to access contraception, how to negotiate its use and how to use contraceptives effectively.
- Sex education should start earlier than it is currently, especially the more practical information. This is so that young people already know where to obtain contraceptives and are comfortable talking about them before they have to think about obtaining and using them.
- Schools should be used as a place to position publicity and promotion regarding sexual health. This should include posters on the walls, leaflets available to take away, and information regarding the opening times of services in the surrounding area.

C.3.5 The Role of the Internet:

The Internet was mentioned by most of the young people concerned as a major area for them to get information and advice about sexual health. One of the positive sides of the Internet that the young people were particularly aware of was that it is an anonymous source of information. Because of the anonymity associated with using the Internet it was able to get past a lot of problems that young people have in asking questions about sexual health. Young people felt that they could find out information about sexual health without having to talk to someone face to face, or that they could find out some basic facts anonymously before they did talk in person to someone.

There are a number of limitations to the use of the Internet by young people to access information and advice about sexual health though. These include that although there is a lot of information available, the style of sites was generally very female orientated. The boys looking at many of the sites felt that they were aimed at girls and so they felt excluded from accessing them. Other problems mentioned included the fact that access to computers is not widespread. Most of the young people worked with did have access to computers either at home, in school or college, or in a youth project.

In certain areas a lot of young people's main access to computers was at home but there was a worry amongst users that search and site histories told parents what information they had been looking at thus contradicting the main advantage of internet use. Some young people knew how to remove sites from their site histories but the use of "cookies" and other identifying software may mean that these fears among young people will only become more important. Either young people could be told ways of controlling their own site histories or ways in which to talk to their parents about the Internet as a source of information regarding sexual health. Other places where young people have access to

computers have different problems. These include only supervised use and the use of filtering software at schools. Schools generally use filtering software so as to prevent the computers being used to look up pornographic or other unwanted sites but this software also filters out sexual health sites which is a major barrier to use by young people whose only access to computers is through schools or colleges. There are some forms of controlling software available that do allow access to sexual health websites (NHPIS, 1998) and choosing this sort of filtering or blocking software would greatly improve many young peoples ability to use the Internet for sexual health information.

Another problem with the Internet that the young people found almost immediately was that the search terms that they used to look up about sexual health generally brought up a lot of pornography rather than information. This is a barrier for use by young people as they may be worried about parents thinking they were looking up pornography and also it made real information very difficult to find. Also, as well as pornography, as with any mass media there are many sites with their own agenda, such as anti-abortion sites, and anti-homosexuality sites. These may be of interest to young people but if they are wishing to obtain unbiased and accurate information accessing these sites may do more damage particularly if incorrect information is thought to be correct or expert.

Some solutions to this might include better advertising of sexual health sites so that the web addresses could be typed directly in so avoiding search terms at all. Another option could be a direct link on the home pages of search engines to "sexual health for teenagers", just as other options such as sport often do. This could then direct young people onto approved sites and avoid pornography and inaccurate or offensive sites.

Existing recommendations regarding the role of the Internet

Some other positive aspects of the Internet as a source of sexual health promotion are mentioned in the literature. These include that it can use graphics and audio in order to be understood by people with reading difficulties, and that the internet has an amount of credibility among young people that may be missing in other more traditional means of transmitting information (Fotheringham *et al*, 2000). This may be related to the novelty of the media and that young people generally are very comfortable using computers. Another important virtue of the Internet is that "information is accessible on demand and not restricted in terms of time or location" (ibid. 114). So that young people can access the information that they need when they need it rather than when a service can provide it.

Even with the problems involved it is clear that the Internet is an access area for young people that should be exploited and could potentially reach large numbers. Indeed it has been described as being possibly "the health promotion medium of the future" (Moore *et al*, 1996: 118). In America research in New York City found that Internet use was widespread amongst girls from a range of backgrounds and that it was very acceptable as a source of information about health, sexual health, and contraception (Borzekowski and Rickert, 2000). This seems to be true amongst young people of both sexes in Stockton as well. As such then the Internet seems to be both acceptable and increasingly accessible for young people as a source of information and advice regarding sexual health.

The Role of the Internet

- The Internet could be a major source of information and advice for young people about sexual health. More websites need to be aimed at young men though.
- Internet searches often bring up pornography or biased sites. To prevent this direct links could be used on search engine home pages or more advertising so that young people can just type in the web address of a site that they know.

- The use of protective software can prevent young people from being able to use schools computers to access sexual health information. It would be helpful if schools could find a way around this, perhaps by incorporating sex education into Internet information technology lessons.

C.3.6 The Style of Services:

The young people involved in both the long term and the short-term research discussed the style of the services on offer. The sort of people who deal with young people was felt to be very important. Some of the young people reported that General Practitioners, who are older and generally male, could be felt to be intimidating and thought to be less understanding. They were also perceived to have less time for young people and to be quite unfriendly. This put off quite a number of young people from asking their GP about contraception or other sexual health issues. Also the length of appointments was a matter of concern with young people and General Practitioners. Young people reported that they felt that they only had a few minutes and thought that this was not enough time. It is thought that young workers are more open to young people and listen more. The attitude and behaviour of all people involved in the health services is very important to the effective use of services by young people.

The group of young Asian males at Cornerhouse reported that they wanted all workers involved in dealing with young people to be able to deal with a wide range of problems. Wherever possible it would be helpful to have everyone able to answer queries and to be in possession of up-to-date training and information. This would mean that young people would be able to talk to whomever they felt most comfortable with and get the information that they required. Also recommended by this group of young men was that workers with young people should have more language skills to deal with multicultural groups. The use of posters in a variety of languages was thought to be very good. This would be very effective if carried through into face-to-face meetings. The use of medical, and non-medical, workers with language skills would make the services a lot more approachable and acceptable to different groups.

Many of the young people from more outlying areas found that the specific services, as opposed to general practitioners, are open at odd times. As such these services are more difficult for young people out of the immediate area to access. This was especially related to the clinic in central Stockton on Lawson Street, mentioned above. This clinic was well known locally and the young people knew quite a bit about its services and felt that it provided a good service. Those who lived in areas further away said that they would use it because it was offering a family planning clinic aimed at young people. As mentioned before, the main problem that they had was that the times of the services were very specific and not well publicised in their areas. This was an especial problem for these groups because of the distances involved. In order to visit this clinic they would need to take quite a lengthy bus journey and so would need to know the opening times and when the specific services were available. The main recommendation here is that these opening hours should be more general and that they should be well publicised in outlying areas. This could be done by having posters in private places such as toilet cubicles or by having leaflets given out for young people to keep and refer to.

There was a feeling that family planning clinics are aimed at female users particularly. While some young people thought that this was quite a good thing because they felt that girls were the most in need of the services, others felt that the clinics need to look to aiming at boys more. They should recruit more male staff in order for young males to have someone with whom they might feel more comfortable talking and also publicise the fact that they are open for access by young men. The young people thought that young males with questions about contraception, sexuality, or sexually transmitted diseases would not go to a family planning clinic at all. In the case of the young Asian males group they have a male youth worker that they feel able to talk to and are confident in. Other young males did not seem to have that option and some effort to integrate them into sexual health services must be undertaken.

The distribution of condoms was a matter of much discussion. A lot of young people are still not aware that condoms can be acquired free from health services and as such cost is an issue. With the added problems of family planning clinics being aimed at females and the problems that many girls feel about carrying condoms, there is a call for condoms to be available in different situations. The young people researching felt that social settings are a very good place to make condoms available. These could include public houses, clubs, cinemas, bowling and other places where young people 'hang out' such as cafés. They should be placed somewhere where it would not be public and embarrassing for young people to pick them up e.g. toilet cubicles. Another option was for a central location for condom distribution in a quiet, discreet area where young people can access condoms easily and within their usual movements.

If young people have to get up their courage in order to go to their doctors then they need the doctor to be confident in discussing these issues and willing to talk to the young people for an amount of time. The young people often felt that doctors, especially general practitioners, thought that young people were wasting their time with frivolous enquires. There needs to be comfort on both sides in order for honest information, advice and diagnosis to occur. As such the doctors and nurses dealing with young patients need to ensure that they do not act in a way so as to appear uncomfortable, impatient or disapproving. Other complaints about services included long waiting times. This meant that young people felt more uncomfortable and that they waited for hours and only got a few minutes of help out of it. Young peoples time is important and as such attempts to reduce waiting times would be a very good way to make services feel more approachable and easy to use. Another way to help with this situation is to make the waiting room more comfortable with a large number of comfortable chairs, magazines, and a television.

Existing recommendations regarding the style of services

The Social Exclusion Unit's report on Teenage Pregnancy (1999) also mentions many of the criticisms that were found amongst young people in Stockton. The location, opening hours and female bias are particular elements emphasised. The need for services that are easy to access through being either within a close walking distance, or a short bus ride is reported as is the need for services further away for young people who feel particularly worried about confidentiality. Also the atmosphere of services is discussed in the report as being centrally important. This was also found in the research. Young people were worried about services being female orientated, about being criticised and for being made to feel like they were wasting people's time. There are a number of other publications that place emphasis on the confidentiality of services, the Sexual Health Programme's *Evaluation Kit for Sexual Health Services for Young People* (2000) and The Royal College of General Practitioners and Brook's (2000) advice on *Confidentiality and Young People* to name two. This shows the importance that confidentiality should be given by services in their dealing with young people.

The Health Education Authority report *The implications of research into young people, sex, sexuality and relationships* (1998) also comments on the importance of different features of services. These include the problems young people have accessing GPs and family planning clinics, which includes the real or perceived disapproval by workers. The changes commented on here are the renaming of services to emphasise their youth friendliness, the changing of waiting rooms so as to provide a comfortable atmosphere, and making staff more approachable. The problems that the researchers in Stockton have found are often related to areas such as being made to feel uncomfortable using services, through either the buildings themselves, or by the workers.

The young people in Stockton report that there needs to be changes in the services in Stockton and many of the problems experienced, and recommendations mentioned, are in line with guidelines already issued by the government. As such then, these recommendations should be acted on as soon as possible.

The need for confidential means of accessing condoms, especially for young girls was emphasised in work done in rural Australia where Hillier *et al* (1998) found that young women did not buy or carry condoms because of fear for their reputations. This sort of danger, or difficulty in using services can be very important for young people and it is one that is often overlooked in project design.

The problems of accessing services because of confidentiality and reputation mentioned here have also been found in rural America. "Characteristics of rural life, including a lack of anonymity and stigmatisation of public assistance, contribute to adolescents' reluctance to use primary care and preventive services" (Loda *et al*, 1997: 165). This work supports these findings in Stockton, where it was also found that a lack of choice in services was a barrier as were deficiencies in transportation. This was mainly an issue in the outlying areas out Stockton itself. A possible solution could be that nearby urban centres can make sure that they are able offer well timed drop-in services that young people from out-of-town can access. An obvious choice in Stockton is the Lawson Street clinic, which was mentioned by young people from outlying areas already. One of the most important aspects of young people and their sexual health is that "it is of little use providing young people with an excellent education regarding their sexual health if they cannot easily access services to put into practice their learning" (Bloxham, 1997: 98).

The sensitivity that young people have about the way that health professionals treat them was addressed in an intervention in America which concentrated on the attitudes and aims

of providers rather than the patients (Dodge *et al*, 2001). The research gave health professionals in two primary health care clinics training in talking to patients about STIs and HIV. They were also given a lot of support and reinforcement for a number of months after the training (ibid). This was found to have a positive effect on the actions of the providers in that they did increase the amount of questions and advice they dealt with in relation to sexual activity. "This is a difficult area for many physicians, where only 62% report being 'quite comfortable' even asking about sexual orientation" (ibid. 182). This compares with the fact that about ninety-five percent of patients said that they were happy with having this sort of discussion with their health provider (ibid.).

One of the criticisms of sexual health services has been their fragmentary nature. Sexual health covers a wide range of possible need and so a large number of providers exist to supply those needs including: family planning, general practice, genitourinary medicine, and gynaecology (Stedman and Elstein, 1995). One of the problems for these different services is that they all concentrate on different sections of sexual health, such as family planning and pregnancy, and genitourinary and infection. This means that a young person may end up at a service that will not be able to provide them with the comprehensive service that they require. Stedman and Elstein (1995) recommend that there needs to be a more co-ordinated sexual health service especially between family planning and genitourinary. This relates to the recommendations mentioned in Stockton of having all workers dealing with young people being able to deal with all of their problems.

One way that services have been attempting to become more efficient and comprehensive is through inter-agency collaboration. Bloxham (1996 and 1997) has considered a case of this in the North of England. Here the main areas that collaborated were secondary school teachers, youth and community workers, health promotion officers, and staff working in community health services (Bloxham, 1997). This found that generally the goals of each of

these groups of people were very similar. "The stated aims of staff from the various organisations differed little" (Bloxham, 1996: 39). The staff all stressed "a non-judgemental and holistic approach to sexual health" (ibid. 395).

Allaby (1995) reviewed the sexual health services in the Oxford area. He found that "it seems that districts where clinics play a major part have a more effective service overall" (ibid. 1642). This was found to be most important in girls in the under sixteen-age range. Thus family planning clinics can be seen as an effective service for young people. This is especially relevant for the young people in the Stockton area who do not have easy access or information about family planning clinics.

Research carried out by Coleman and Ingham (1999) found that young people often did not discuss contraception with a partner and they were less likely to use contraception, especially condoms, if no discussion had taken place. The main reasons for this were that a discussion about using condoms would indicate that sexual intercourse was definitely going to happen and that mentioning condoms implied that they thought their partner had an STD. These reasons were made more problematic by other factors such as concerns for personal reputation, the hopes for future relationship, and the reputation of their partner (ibid.). They also found that the availability of condoms was an important factor as sometimes discussion would take place but then no condoms would be used because there were none available (ibid.).

The efficiency rates of contraceptives are dependent on correct and consistent use as well as the ideal failure rates of the actual contraceptive. It is this that means that methods that depend on the user heavily, such as condoms and oral contraceptives, have lower practical effectiveness than those that don't such as IUDs or Norplant (Klima, 1998). As research in America has found that fifty percent of all unwanted pregnancies in America are due to

contraceptive method failure (ibid.) this is significant element to contraceptive choice and to concerns relating to inexperienced adolescent use of contraceptives. It has been found that "adolescents ... tend to use contraception sporadically and ineffectively" (Coley and Chase-Lansdale, 1998).

An initiative that is been tried in the Hardwick area of Stockton is aimed at this problem. It is a card system of accessing condoms that ensures that young people are giving education about how to use condoms and how to use and access emergency contraception. This "C-Card" system has already been put into place in the Newcastle area and seems to address many of the problems that young people have with condom use. These include accessing condoms in a number of handy, easily identified places, having the necessary skills to use them, and knowing what to do if there is a problem. A youth worker involved with the scheme in Newcastle has set the scheme up in Hardwick and as such is very experienced. The scheme also offers other services such as chaperoning young people to health services. There has been a lot of publicity in the area and given the interest in condom distribution in other areas of Stockton it should be hoped to extend this service after an initial period in this test area.

The Style of Services

- The use of posters in many languages is thought a good initiative that would be helpful to extend to face-to-face meetings. Health workers and other people working with young people should have more language skills so that they would be able to deal with multicultural groups more easily.
- All workers should be trained to be able to deal with the vast majority of enquiries and problems. This would mean that whomever a young person felt most comfortable with could answer all their questions and provide the necessary service.

- Family Planning clinics are very much more accessible to female users and should try to be more attractive to male users. This should include employing more male workers.
- Condoms should be distributed in non-medical settings, such as social areas and schools. Placement is crucial so as to allow young people to access them without worrying about people noticing or judging them.
- Doctors and other workers in medical settings should be sensitive and make sure that they do not make young people feel as though they are wasting their time, or that the young person is being judged.
- An attempt should be made to reduce waiting times in health services as this increases the discomfort of young people. Also the waiting rooms should be made as comfortable as possible, with a lot of comfortable chairs, magazines aimed at young men and women, and television.

C.3.7 Peer Education and Counselling

A number of the young people felt that peer education and counselling would be an important way to reach young people. This was because young people already found out a lot of their information and advice about sexual health from each other and so were quite used to having such conversations in peer group settings. Also it was felt that the information would be less stressful and embarrassing for young people if given by someone close in age to them. The main proposal was for older young people to talk to others that are about two or three years younger than them so that their information and advice had some force behind it but they were still very much of the peer group generally. A number of young people had indicated that they would probably not go to any adults for information or advice but they would use friends and the advice of people of their own age. The use of peer educators would then meet the needs of this group of people and might make them more likely to go and use services recommended to them by experienced and knowledgeable young people.

The outside speakers involved with sex education in schools should possibly include invited young people that the pupils could feel an empathy with. It was recommended that young people who had personal experience of sexual health issues could be brought in to participate in talks in school. These could include pregnant teenagers, teenage mothers, and possibly young gay men and women. This would give a practical illustration of the issues surrounding sexual health and how they impact on young people. It was put forward that these young people should go and talk to pupils early on, preferably in year seven, as this would put the serious consequences of sexual health at the basis of their behaviour.

The recruitment of young people, maybe in their mid to late teenage years, from different areas and backgrounds in Stockton who are then educated and trained in good sexual

health techniques and practices seems to be a popular and possibly highly effective idea. Though the main focus with peer education and counselling is on using young people to work within their own age and subgroup this can be extended.

Existing recommendations regarding peer education and counselling

One of the major developmental processes in adolescence is to become a member of a peer group so as to explore individuality away from the family unit but still be accepted within a group. As such then, young people are used to acting in particular ways because of how they are expected to act by people of their own age. In fact, peer pressure is often thought to be a very negative influence as young people feel pressurised to perform risky behaviour in order to conform to group norms (Santor *et al*, 2000). This peer pressure effect could be used in a positive way though through the use of peer counsellors and educators. As some of the young people involved in the research said, they are much more likely to listen to their friends and people of their own age than the government or teachers. So if young people were to feel that people of their own age were giving them the information and reinforcing it then the processes that are already in place surrounding peer pressure would enforce good sexual health activities. Research in America has found that young people who think that other people of their age group are using condoms then they themselves are more likely to use them (Fisher *et al*, 1992).

In research carried out with women of reproductive age in Germany and Great Britain Oddens discovered that "contraceptive use seemed, partly at least, to be a social behaviour" (Oddens, 1997). This was especially true for use of the contraceptive pill. The behaviour of friends and the perceptions of friends of contraceptive pill use was a very significant factor (ibid.). Adolescents have been considered to be particularly liable to being influenced by group pressures. In fact "adolescents have been described as uniquely

susceptible to normative pressures" (Fisher *et* al, 1992: 120). Many young people do risky activities, such as unprotected sex in order to conform and show loyalty to their peer group (Santor *et al*, 2000). The effect of social groups on contraceptive use and choice seems to be very important and especially so for adolescents who are defining themselves through their peer group. This has prompted the call for community-aimed interventions and programs. If groups approved of safe sex behaviour then "adolescent HIV protection would increase dramatically because conforming to pro-prevention norms would be reinforced by the peer group" (Fisher *et al*, 1992: 119). This effect could also work for other contraceptive behaviours. In America, research in a midwestern women's health care clinic found that peer influence in relation to contraceptive choice was stronger in 13-25 year old women than in other age groups (Lieberthal and Beckmann, 1997). The importance of peer support for contraceptive decisions and other life choices can be seen in the effectiveness of interventions such as "The Second Chance Club" in America where peer group work and support was extremely successful in preventing further pregnancies in teenage mothers (Key *et al*, 2001).

With the introduction of the new medical course at UDSC then an idea from Australia would be a way of meeting this request by the young people. In Australia medical students went back to their old schools and gave sex education talks and other such advice (Short, 1998). This was very successful. Students at UDSC, Teesside University or other colleges in the area doing health-based courses could be recruited to give out information as well as other younger adolescents from schools. This would be especially useful if young people from the area studying in these courses could be recruited, as they would serve as good role models as well as informed young educators.

The idea of using young people within schools in order to give pupils a practical insight into the issues of sexual health was an important element of recommendations for schools.

The guidance for Sex and Relationship Education recommends that secondary schools should "use young people as peer educators e.g. teenage mothers and fathers" (DfEE, 2000: 10). This gives support to the proposals coming from the young people of Stockton. The use of peer educators in schools has both the approval of young people and of the government.

Peer Education and Counselling

- The use of peer education and counselling is recommended. This could range from very formalised use of trained young people giving sex education talks, to some one-on-one peer counselling, to educating groups of young people and them informally passing this information on to friends.
- Peer education and counselling should try to use young people who are slightly older than the groups they are dealing with, but who are from the same area, project, school, or background.

Section D

D.1 Summary of implications and recommendations from research

This research project found that the method of using youth workers in order to access young people was particularly effective. A number of the young people accessed for the long-term research reported that they only took part because they were approached about the project via a respected known adult. Using known, respected adults meant that the young people associated the project with an existing trusted network.

The number of young men is particularly interesting as many of the results indicated that young men generally feel excluded from sexual health services. The number of young men taking part might be partially due to the fact that the youth workers chose them but there does seem to be an element of young men choosing to take part in this research, and being involved with it over a period of time. The appeal to males may be due to the fact that the research is based on action rather than talking about personal experience.

One of the other main findings was that the young people in the city centre, who were in a deprived area, seemed to have better knowledge and access to services than young people from outlying, more affluent areas. This is significant when compared to the view that is generally held which characterises young people in affluent areas as being less in need of help in relation to sexual health. A change in focus seems to be needed in relation to the needs of middle-class young people in these areas.

It can be seen that the recommendations of these young people from Stockton fit in very well with policy and other research findings. This implies that none of the findings should be particularly difficult or controversial to implement.

Approaches to Sexual Health

- A wider definition of sexual health with greater importance being put on the ability of young people to make their own decisions and on giving them the information to do so.
- Information should be positive and should avoid telling young people what not to do.

Publicity for Sexual Health and Services

- There should be increase in publicity about sexual health using all media. Aim at levels of information and publicity similar to those referring to smoking and drug abuse.
- Storylines in television programmes such as Hollyoaks are a good way to pass on information to young people.

Levels of Knowledge amongst Young People

- Girls generally knew more than boys did and so it is proposed that education and publicity should aim to reach boys more effectively.
- Generally information in the media is aimed at girls, including magazines, leaflets, and websites. There should be more information aimed at male users.
- Specialised services should publicise their services in a wide area. Young people in outlying areas may wish to use them but are either unsure of their existence, unclear about the services on offer, or do not know the opening times.

The Role of Schools

- School nurses should have a more clearly defined role, which is explained to all pupils and staff. They should be available frequently and regularly for both appointments and drop-in enquiries.
- In mixed schools there should be a male and a female school nurse.
- School nurses should be able to give out forms of contraception, such as condoms.
- There should be an increase in the amount and quality of sex education for young people.
- The sex education should generally involve non-teaching staff or external visitors, such as health promotion workers. Schools have been successfully doing this to an extent and these efforts should be continued and extended.
- Sex education still has an emphasis on reproduction and science, but it should provide practical information that young people can then apply in their lives, including how to access contraception, how to negotiate its use and how to use contraceptives effectively.
- Sex education should start earlier than it is currently, especially the more practical information. This is so that young people already know where to obtain contraceptives and are comfortable talking about them before they have to think about obtaining and using them.
- Schools should be used as a place to position publicity and promotion regarding sexual health. This should include posters on the walls, leaflets available to take away, and information regarding the opening times of services in the surrounding area.

The Role of the Internet

- The Internet could be a major source of information and advice for young people about sexual health. More websites need to be aimed at young men though.

- Internet searches often bring up pornography or biased sites. To prevent this direct links could be used on search engine home pages or more advertising so that young people can just type in the web address of a site that they know.
- The use of protective software can prevent young people from being able to use schools computers to access sexual health information. It would be helpful if schools could find a way around this, perhaps by incorporating sex education into Internet information technology lessons.

The Style of Services

- The use of posters in many languages is thought a good initiative that would be helpful to extend to face-to-face meetings. Health workers and other people working with young people should have more language skills so that they would be able to deal with multicultural groups more easily.
- All workers should be trained to be able to deal with the vast majority of enquiries and problems. This would mean that whomever a young person felt most comfortable with could answer all their questions and provide the necessary service.
- Family Planning clinics are very much more accessible to female users and should try to be more attractive to male users. This should include employing more male workers.
- Condoms should be distributed in non-medical settings, such as social areas and schools. Placement is crucial so as to allow young people to access them without worrying about people noticing or judging them.
- Doctors and other workers in medical settings should be sensitive and make sure that they do not make young people feel as though they are wasting their time, or that the young person is being judged.

- An attempt should be made to reduce waiting times in health services as this increases the discomfort of young people. Also the waiting rooms should be made as comfortable as possible, with a lot of comfortable chairs, magazines aimed at young men and women, and television.

Peer Education and Counselling

- The use of peer education and counselling is recommended. This could range from very formalised use of trained young people giving sex education talks, to some one-on-one peer counselling, to educating groups of young people and them informally passing this information on to friends.
- Peer education and counselling should try to use young people who are slightly older than the groups they are dealing with, but who are from the same area, project, school, or background.

D.2 Conclusions regarding young people and participatory research

It seems clear that young people, or adolescents, constitute a marginalised group in society. They are subjects to discourses in society that they have no control over. These mean that popular views of the young in Britain are generally negative. The young either need to be protected from society or society needs to be protected from them. These views mean that young people are perceived as problematic in themselves and this has significant ramifications for their position in society. They are also viewed as being in a liminal phase, stuck between childhood and full adulthood. This means that there is a tension between the need to give young people the adult-like responsibilities and control they desire, and the need to control and protect the young from society. As well as being exposed to discourses over which they have no control young people are also excluded from other aspects of their lives. They are subjected to decisions over which they can offer no

influence. Until the age of 18 they have no vote, they are also not involved in other decision making, even in relation to issues that directly effect them. These include the curriculum that they study at school, the legal system that they are subject to, and other issues such as benefits, housing, and health.

Another important area where young people have been marginalised is in cultural research, including anthropological work. Young people seem to have been seen as somehow not full members of society and their contribution has been conceived purely as receivers of culture. They are educated about society and slowly learn about the cultural world that they will live in. The information has been viewed as purely one way. Young people receive culture but were not viewed as creators of culture. This has meant the contributions that young people, and children, offer to society have been devalued. Also the culture that young people have between themselves has been viewed as frivolous and unimportant, somehow not as 'real' as adult culture. This has been changing with a realisation in many disciplines, including anthropology, that youth and youth culture are important areas of study and that youth are full members of society.

As a marginalised group, young people are ideal people to involve in participatory research with its emphasis on transforming the power relations in research to order place the emphasis on the aims and opinions of the study group rather than the researcher. There is a concern though in involving different groups in participatory research. The majority of the young people that were able to get involved and keep going with the pure participatory research were mainstream youth that were quite middle-class. This is a concern as the research aimed to recruit a range of young people, and a number of projects working with disadvantaged groups had been approached. There is a possibility that the nature of long term participatory research does not attract disadvantaged groups, or, that is, doesn't fit

into their lives. This issue needs to be considered when other research is being designed that aims to recruit and involve disadvantaged youth.

Health is an area where young people really need to be able to have a voice, especially sexual health which touches on so many important issues for young people. The problem is that the large bureaucratic institutions in control of health in Britain are subject to the problems that all institutions are. They need to conform to very rigid rules and regulations, which makes any research that attempts to give the power to non-professionals difficult to carry out. This is particularly difficult in relation to young people because of the view of society that they need to be protected. Large institutions seem to act in a paternalistic manner and feel that they need to perform this role in order to keep young people safe from the world.

Health institutions have specific problems because they are based on a bio-medical view of the world. Doctors and other health professionals are seen as having better knowledge about health issues than non-professionals and because of this research that puts emphasis on what communities think and what they want is in a difficult and complex position. There is a danger that the research is really just there to give an answer that has already been chosen. For most health issues there is already a solution, or number of solutions, that health professionals and researchers have put forward. In research with young people there is a possibility that what is being required is for one of these solutions to be put forward rather than to find out what young people really want. Also young people are subject to similar pressures, and are acutely aware of issues such as money, cultural norms and society's expectations. This could mean that opinions and feelings that are not felt to fit into what is possible to achieve are not mentioned at all. In this research one major finding with the recommendations that are to be given to the NHS is that young people seem to agree with many existing recommendations. This could be because there is a

growing body of evidence that supports good and acceptable integrations of health and young people or that young people see these findings as fitting in with what is wanted. Within the research I tried very hard to give young people freedom and space to make up their own findings and to construct their own opinions so the work is legitimate. There is the proviso, though, that the young people could well have limited themselves because of their perceptions about what is available and acceptable to the NHS.

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