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**ROCHDALE  
TEENAGE  
PREGNANCY  
STRATEGY**

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**“It makes you more up for it”**

**School aged young people’s  
perspectives on alcohol and  
sexual health**

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## 1 Executive summary

### 1.1 Background

Risky drinking and sexual behaviour among young people is seen as a particular problem by those working around teenage pregnancy, sexual health and alcohol. The high profile public debate about both sexually transmitted infection rates and underage binge drinking reflect broader public health concerns. This study was carried out by Katy Redgrave and Mark Limmer as part of Rochdale Teenage Pregnancy Strategy. It explores alcohol and sexual health and the links between them for 14-15 year olds. It identifies vulnerable groups based on important differences linked to ethnicity, gender, aspiration and deprivation. Questionnaires completed by year ten pupils highlight patterns in knowledge, attitudes and behaviour. Focus groups reveal some of their underlying expectations and attitudes about these issues.

### 1.2 About the study

2081 questionnaires were completed by 78% of year ten students, across all 14 high schools in Rochdale, in June 2004. 80% of the sample were white, with 17% of Asian origin (of whom almost three-quarters identified as Pakistani, and one in eight as Bangladeshi). The gender split was even and the average age was 15 years and 3 months. Six focus groups of females, males, Asian females, Asian males and mixed gender high and low academic achievers involved 67 young people.

### 1.3 Key findings

- Sexual activity and problematic alcohol use are clearly linked to young people's aspirations. Those with the lowest aspirations are more likely to have had sexual intercourse and to have been drunk more than once in the last month.
- Getting drunk is widely accepted as a normal way to have fun by most white young people. While the vast majority have been drunk at some point, a minority of one in five report binge drinking, defined here as getting very drunk more than once in the past month.
- One third of respondents report having experienced sexual intercourse. Young people in this group are more likely to be white, female and with low educational aspirations. They are also the most likely to report binge drinking.
- Alcohol is seen as playing both positive and negative roles in relation to sexual activity. One in five white females report going further sexually than intended because they were drunk.
- More than half of respondents report drinking outdoors. Hanging out in large groups on a Friday night is seen as an opportunity to get drunk and 'get off' with people or to have sexual experiences. Risks associated with these drinking sessions include 'going too far', getting into fights or being moved on by police.
- Although two thirds of respondents are not sexually active, ideas about gender differences relating to pleasure and consent are already developed amongst white and Asian young people of both sexes.
- Feeling in control about negotiating consent to sex is seen as very difficult, and made harder by the effects of alcohol. There is a lack of skills and confidence in decision-making relating to sexual activity among both males and females.
- There is a tension for young women between the pressure not to be seen to want sex, and a sense of obligation to have sex. They struggle to articulate what they actually want, for fear of being seen as a 'slag' or as 'frigid'.

- Female sexuality is widely seen in terms of sex as pain rather than pleasure. This contrasts with a view among a few males, at the other extreme, of young women as predatory man-eaters who get multiple orgasms.
- Pornography appears to have a strong influence on sexual expectations, with reported disappointment when the experience does not match up. It is seen as a direct source of ideas for what should be included in the sexual repertoire, leading to pressure on females to comply.
- Basic knowledge levels about sexual health are lower than expected for this age group. Messages about preventing pregnancy and infection continue to be missed by more Asian young people compared to white young people, and more white males than white females.
- Confidence in accessing support from services is low, especially amongst white males and Asian young people.

#### **1.4 Conclusions and policy implications**

- ✓ Services need to work more effectively with young people to raise their expectations of the quality of sexual relationships, whilst at the same time challenging negative attitudes and values. Young people should be encouraged to have the expectation that sexual relationships are healthy, safe, consensual and respectful.
- ✓ Given the prevalence of risky alcohol use and sexual activity, interventions should provide a balance of encouraging delay in embarking on risk behaviours and the development of the skills and values to negotiate risky situations as safely as possible.
- ✓ More effective ways are needed to target the most vulnerable groups (identified by gender, ethnicity, aspiration and deprivation), whose needs vary widely. There is evidence that basic information and services provided universally are not meeting the needs of all groups. Some young people are vulnerable as they are less likely to access services or pick up health messages. Others need different inputs that relate to their experiences of sexual activity and binge drinking from a relatively young age.
- ✓ There is a need for services to focus on the factors which influence risk taking behaviours, as well as responding to the outcomes of individual risk taking. This should include:
  - Challenging prevalent cultural attitudes towards gender and power relations, which shape young people's expectations of their own sexual relationships
  - Increasing aspirations
  - Improving self-esteem, assertiveness and decision-making skills
  - Increasing confidence in accessing a range of services for support
  - Increasing levels of accurate and consistent knowledge
  - Being aware of the impact that faith and culture have on young people's decision-making

## 2 Introduction

### 2.1 About the study

Risky drinking and sexual behaviour among young people is seen as a particular problem by those working around teenage pregnancy, sexual health and alcohol. The high profile public debate about both sexually transmitted infection (STI) rates and underage binge drinking reflect broader public health concerns. This study explores alcohol and sexual health and the complex links between them for 14-15 year olds. It focuses on an age group, in which a proportion are already sexually active and most are developing their personal attitudes, values and skills. It also builds on the findings of earlier studies of knowledge and attitudes to sexual health among the same age group in 2000 and 2002. Certain questions were repeated in June 2004 to assess change over time, while the scope was broadened to investigate the links between alcohol and sexual risk taking on a larger scale.

Quantitative and qualitative methods were combined in order to build up a fuller understanding of how young people perceive their choices relating to sexual health and alcohol. Questionnaires, completed by 78% of Rochdale's year ten pupils, highlight patterns in knowledge, attitudes and behaviour. Focus groups reveal some of their underlying expectations and attitudes about these issues. Vulnerable groups are identified based on important differences linked to ethnicity, gender, aspiration and deprivation, within a sample that represents young people attending school, therefore not necessarily the most socially excluded groups. The main purpose of this report is to inform the development of policy and practice to better meet the needs of young people across the country.

### 2.2 Context

The links between alcohol and sexual risk taking are acknowledged in government policy and elsewhere (Social Exclusion Unit, 1999, DfES 2003, Alcohol Concern 2002). There is a recognised need to build up best practice to help young people deal with these combined pressures, in what is seen as an underdeveloped policy area (Lynch and Blake, 2004). While alcohol and sex may often be linked in young people's experiences, they are frequently dealt with completely separately by education and other services.

International research is not conclusive about the exact nature of the relationship between alcohol and sexual risk taking. The association is often explained in two ways, firstly, as an increased likelihood to have unprotected sex or sex that is regretted while under the influence of alcohol (Ingham, 2001). One study showed that 40% of sexually active 13 and 14 year olds were 'drunk or stoned' at first intercourse (Wight et al., 2000). There is evidence of increasing alcohol use among young people in the UK, which was already greater than in many other European countries (DoH, 2001; Coleman, 2001). A recent survey on risky drinking highlighted unprotected sex as one of the consequences (Coleman and Cater, 2005).

Other studies explain the links in terms of more general 'risk takers', who are more likely to engage in both risky drinking and sexual risk taking, although not necessarily at the same time. It is clear that there is a need to explore how the two risk domains fit together in order to help young people develop skills and strategies to manage them (Ingham, 2002). Risk taking is a facet of adolescence that contributes towards the development of personal values and boundaries, and changes as societies change.

Addressing the influences on sexual behaviour is key to achieving reductions in teenage pregnancy and STI rates, which are currently major national priorities along with reductions in binge drinking (SEU, 1999; DfES, 2003; DoH, 2004). Britain still has the highest teenage pregnancy rate in Western Europe, although the national rate of under-18 conceptions has declined by 9% since 1998 - an encouraging trend, but one that must be sustained if national targets are to be met. Rochdale's rate has decreased by 15% but at 52.4 conceptions per 1000 women aged 15-17, it remains significantly higher than the national rate of 42.1. Rochdale, in line with the rest of the country, has seen steep increases in the rates of STIs, especially among young people (Health Protection Agency, 2005). There is a need to develop more effective strategies to prevent risky sexual and drinking behaviour. Working on these issues together contributes towards achieving all five national outcomes outlined in 'Every Child Matters' (DfES 2003), and particularly 'being healthy' and 'staying safe'.

This study was carried out as part of Rochdale Teenage Pregnancy Strategy, in response to local concerns about perceived links between alcohol, sexual health and under-18 conceptions. For many practitioners and policy makers, these concerns were based on anecdotal evidence of the results of sexual risk taking, witnessed in a wide range of services for young people including teenage parents.

Rochdale has a population of 203,000 (Census, 2001) and is situated ten miles north of Manchester. It is the 25<sup>th</sup> most deprived borough in the country, with all but one of its wards falling in the most deprived 40% of wards and 10 falling in the worst 20%, according to Indices of Multiple Deprivation. Rochdale ranks twelfth in the country for local concentrations of deprivation, indicating pockets of particularly severe hardship. The borough has been allocated resources through the Neighbourhood Renewal Strategy and New Deal for Communities, and saw a slight improvement in deprivation levels between 2001 and 2004. Fourteen percent of the population belongs to an ethnic minority, including mostly people of Pakistani (7.7%) and Bangladeshi (1.3%) origin. These communities are potentially more isolated than those living in more diverse metropolitan areas, where research with ethnic minorities is more often carried out.

## **3 Methodology**

### **3.1 Recruitment process**

In 2004, 2081 young people completed questionnaires, which equates to 78% of the Year Ten school population in Rochdale borough. This response rate was achieved through the participation of all fourteen local high schools. The researcher approached head teachers and personal social and health education (PSHE) co-ordinators, together with the education authority's lead officer for sex and relationships education (SRE). Schools were offered the chance to see the results for their school, to access training and support to follow up the findings and to contribute towards attaining 'Healthy School' status. As more schools agreed to take part, others seemed not to want to be excluded, and the project gained in momentum.

The three Roman Catholic (RC) schools agreed to take part, using modified versions of the questionnaire. One of these schools did not allow questions about sexual health knowledge. All three requested questions about sexual attitudes and behaviour to be removed; the sample was therefore 20% smaller for these sections (1657 respondents). However, the pattern of responses, including sexual health knowledge amongst pupils in the two RC schools that permitted these, shows no significant differences between these and pupils in other schools. This suggests that respondents in RC schools would have responded in similar ways to their peers to the rest of the questionnaire. Religion was not included as a variable in the questionnaire, an omission that should be rectified in future studies.

Sample information letters for students and parents were provided to schools, which they were responsible for adapting in line with their own procedures. It suggested inviting parents or carers to contact the school and/ or research team if they had any queries or did not consent to their child taking part. The research team gave a five-minute introduction to all young people prior to them completing the questionnaire, they were then required to give written consent before taking part. The introduction emphasised that responses were confidential, participation was voluntary and that they could opt out at any time. It further explained that respondents need not answer any question that they were uncomfortable with, and that the purpose of the research was to inform the development of sex and relationships education and young people's services.

Following the completion of the questionnaires focus groups took place in six schools, involving 67 participants. Teachers were asked to select a group of 10-14 students with mixed academic ability, ethnicity and gender unless specified otherwise. In the four 'mixed ethnicity' groups, almost all participants were white. The criteria for each group were as follows:

- females
- males
- Asian females

- Asian males
- low academic achievers (one of the most deprived catchment areas)
- high academic achievers (one of the least deprived catchment areas)

### 3.2 Data collection process

The research team administered the questionnaires and collected them in sealed envelopes to maximise confidentiality. Teachers supervised as students completed questionnaires, but were requested to keep a distance. Exam conditions were requested but not always enforced. Arrangements varied from school to school, including exam desks in the hall or separate classrooms. Half an hour was allowed to complete the questionnaires, although one or two groups had slightly less time.

It is acknowledged that the questionnaire was likely to be inaccessible to some young people with reading difficulties. Extra support was occasionally requested from teachers and the research team. While care was taken not to look at individuals' answers, particularly to the most personal questions, this may have inhibited some students' responses.

The questionnaire asked young people about their knowledge, attitudes and behaviour relating to alcohol and sexual health, as well as gender, ethnicity, age and postcode. While most of the 75 questions were multiple choice, three open ended questions provided an opportunity for participants to use their own words to describe the effects of alcohol, and any benefits or risks of drinking before anticipated sexual activity. The questions did not presume that respondents had experience of alcohol or sexual activity.

The topics covered:

- Knowledge
  - Differences in strength and effects of alcohol
  - prevention of infection and pregnancy (repeated from 2000 and 2002)
- Behaviour
  - motivations for drinking and sexual activity
  - age at first sexual or drinking experiences
  - drunken experiences
  - settings for drinking alcohol
- Attitudes
  - advice and support (repeated from 2000 and 2002)
  - perceptions of risks and benefits
  - gender
  - communication
  - peers

The focus groups were facilitated by the researcher, with no teachers present, and an observer took notes about non-verbal communication. This role was taken by a mixed race man in the male group and an Asian man for the Asian male group and a white woman in the remainder. The discussions were recorded on cassette and took place in a classroom, drama space, library, learning mentors room or meeting room.

Discussions covered the acceptability of drinking and sexual activity, motivations and influences and how to get information and advice. The facilitator asked young people to discuss their ideas using the third person, rather than referring to personal experiences. This method provided an opportunity to observe the discourse taking place in a peer group setting, reflecting some of the norms and expectations that influence individual decision-making (Grbich, 1999). While individual interviews were beyond the scope of the project, the data offered particularly useful insight into these accepted attitudes and boundaries.

Key themes included:

- when, where and why young people drink alcohol and have sex
- positive and negative aspects of different choices
- feelings, expectations and consequences
- communication about consent and condom use



- pressures and power in decision-making
- influences of gender, ethnicity, religion, family and peer group
- sources of information and main messages received
- advice for a friend seeking help

Participants completed four questions from the questionnaire relating to experience of drinking alcohol and sexual activity. This anonymous overview of experiences in each group provided a useful context for their comments.

At both stages of the research, contact details were distributed for the school health practitioner and other sources of confidential advice about alcohol and sexual health. Two RC schools adapted this list to exclude certain agencies. Another did not allow any contact details to be distributed, because of references to clinics which, it was felt, could be seen as encouraging contraception or termination of pregnancy.

### **3.3 Data analysis**

Questionnaire data were coded and analysed using a quantitative approach. The SPSS statistics programme was used to measure the frequency of responses and to calculate percentages and cross tabulations between different variables. The chi square test checked for statistically significant differences. The independent impact of key variables was checked by a statistician from Salford University, using logistic regression analysis.

Focus group data were transcribed and analysed using iteration, an interpretative/ interactive field based approach (Grbich, 1999). Emerging themes were compiled and coding categories developed to group together findings into frames, which were then refined to be written up. This follows the grounded theory method of qualitative data analysis.

Data from both stages of the research were compared to compose the full picture of the findings. This analysis was supported by a national advisory group with wide experience and specialisations in fields relating to young people and research, sexual behaviour, sexual health, ethnicity, alcohol and education. Rochdale Teenage Pregnancy Steering Group oversaw the research process and offered alternative perspectives in the interpretation of the findings.

## 4 Demographics of sample

### 4.1 General

The sample of 2081 respondents represents almost four out of five of all year ten students on the school roll in June 2004. 22% of year ten students did not participate because they were either excluded, absent from school or occupied with other school events. The vast majority of young people completed the questionnaires in full without problems, while approximately ten declined to take part and less than five questionnaires were spoilt. There was an even gender split among respondents.

A limitation of this study is that the views of groups of young people not in mainstream school are not represented. As such groups are typically more socially excluded, they are more likely to engage in risky behaviour relating to alcohol and sexual health than the general population (SEU, 1999). The sample can therefore be seen as presenting the knowledge, attitudes and behaviour of the majority of this age group, who were less likely to be involved in risk taking. This project complements other sexual health research in Rochdale, which focuses on the perspectives of socially excluded young people (Limmer, 2002; Redgrave, 2005).

It is recognised that a proportion of young people aged 14-15 are likely to identify as lesbian, gay or bisexual, or to be questioning their sexuality. While many of the questions relate to issues that may affect any young people, parts of the study focus specifically on heterosexuality, partly due to being driven by the Teenage Pregnancy Strategy. More research is needed to address the perspectives of young people who do not define themselves as heterosexual, which was beyond the scope of this study.

### 4.2 Age

All respondents were aged 14 or 15 when they completed the questionnaire in summer 2004. Their average age was 15 years and three months. Participants in the focus groups in autumn 2004 were approximately four months older. Questionnaire respondents had an average of nine more months before their sixteenth birthday. It is important to note that other research involving young people often refers to the age category of 'under-16,' which includes those who are older than the respondents in this study.

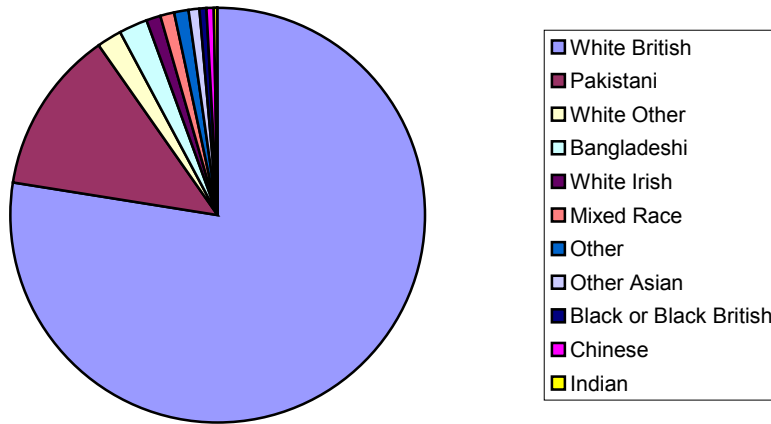
### 4.3 Ethnicity

In order to analyse data by ethnicity, the eleven census categories used on the questionnaire were collapsed into white, Asian and other, see Figures 1 and 2. This reflects the main ethnic groups, which were represented as follows: 80% of respondents identified themselves as white (British, Irish or 'other'). 17% identified themselves as belonging to an Asian ethnic group, including 13% Pakistani, 2% Bangladeshi and less than 0.5% each Indian and Chinese. The 3% of respondents who identified as mixed race, black or 'other group' were too few in numbers for useful statistical analysis by individual category. They were also too diverse to put together and comment on as a group distinct from Asian and white young people. These demographics broadly reflect those of Rochdale as a whole (Census, 2001).

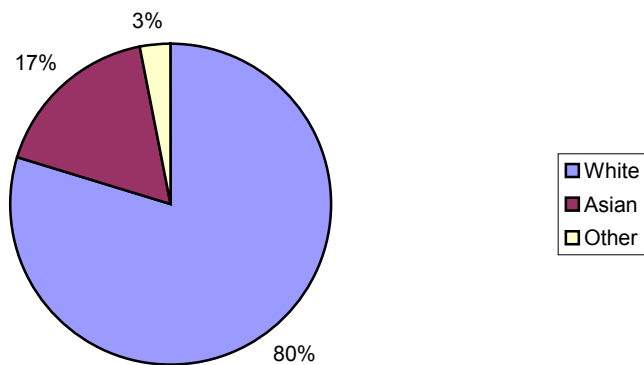
Within the Asian category, almost three quarters of the 349 respondents identified as Pakistani, and one in eight as Bangladeshi. While religion was not addressed directly in the questionnaire, the majority of Asian participants in the focus groups identified as Muslim. (Young people's religious heritage is likely to reflect the results of the 2001 census, where 9% identified as Muslim, and 71% as Christian).

The demographic composition varies widely between schools, reflecting the geographical spread of BME communities across Rochdale. There were eight schools with a minority of less than 5% Asian respondents. In three schools approximately half the respondents were Asian, and in other schools the proportion ranged from 10% to 30%. This is important when considering the differences in data from different schools, and in formulating policy responses that target specific geographical areas.

**Figure 1: Ethnic Origin**



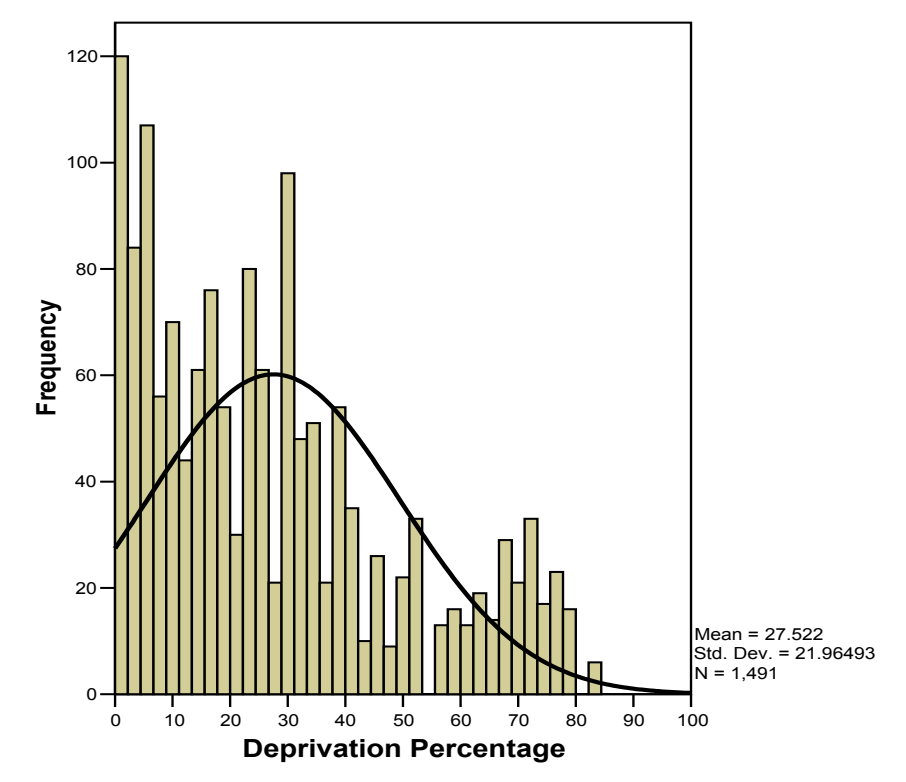
**Figure 2: Ethnic Groupings - Collapsed (%)**



#### 4.4 Deprivation

Respondents' postcodes were analysed using the national Indices of Deprivation 2004, which ranks deprivation levels as percentages, compared with the rest of the country, according to several criteria including income, employment and relative deprivation. The histogram in Figure 3 shows that deprivation levels among respondents range from the 1% most deprived in the country, to the 83% most deprived. The average rating is 27% most deprived, compared to the national picture. 45% of respondents live in areas below the threshold of 20%, commonly used to distinguish the highest levels of deprivation. However, 85% of Asian respondents live in the 20% most deprived areas, compared to 35% of their white peers.

**Figure 3: National ranking of respondents' postcodes according to Indices of Deprivation 2004**

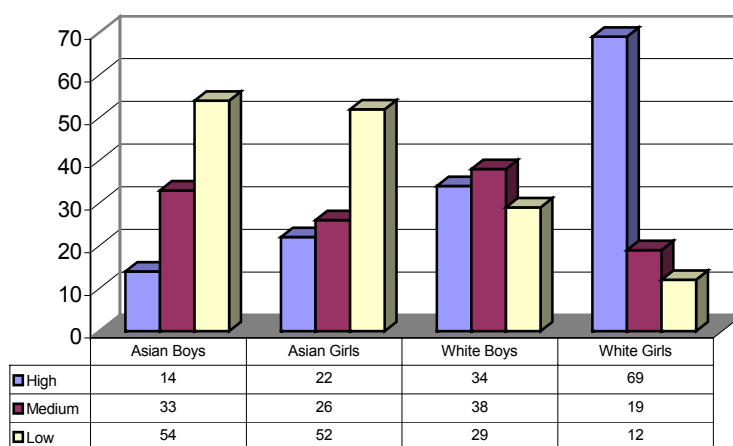


## Sexual Health

### 5 Sexual health knowledge

The questionnaire results suggest that sexual health messages are not being communicated equally effectively to all groups of young people. White males show far less awareness relative to white females. Asian young people's knowledge levels are much lower, yet they are more likely than their white peers to feel that they learn a lot from sex and relationships education (SRE). Figure 4 shows striking differences in the proportions of respondents scoring 'high', 'medium' and 'low' on questions that would have been covered in their lessons if the DfEE's SRE Guidance had been followed (DfEE, 2000). Respondents were asked about: identifying chlamydia as a sexually transmitted infection (STI), myths about preventing pregnancy, the possibility of STIs causing infertility, age limits on access to family planning clinics, methods of preventing infection, and where to get free condoms and free pregnancy tests.

**Figure 4: Sexual health knowledge rating by gender and ethnicity (%)**



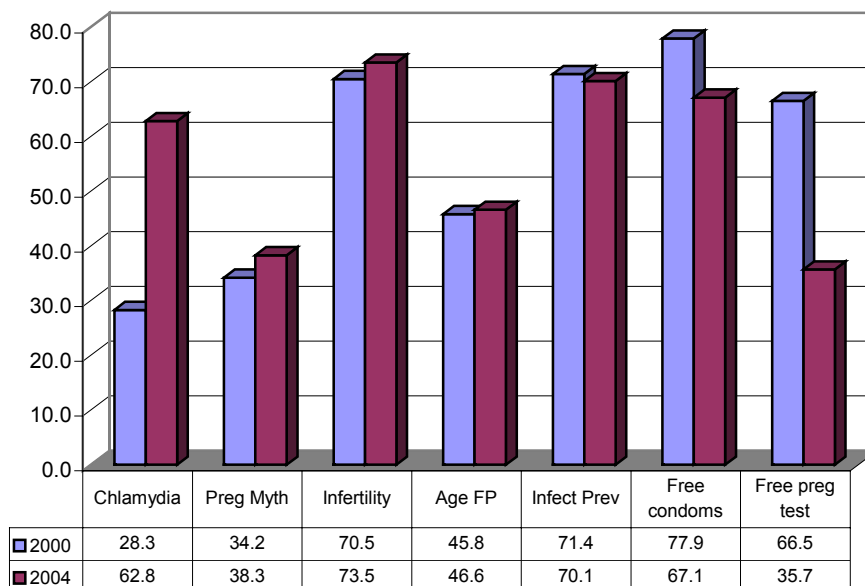
The same seven questions were asked to year ten students in 2000, 2002 and 2004. Earlier studies showed a similar pattern according to ethnicity and gender. Overall sexual health knowledge levels have decreased slightly in the past four years, especially on the questions of where to get free condoms and pregnancy tests (Figure 5). The only major increase since 2000 is in recognition of chlamydia as a sexually transmitted infection, which has doubled. This may reflect the specific campaign on this issue launched by the Government in 2003; however, some focus group participants said that they recognised it as an STI, but did not know anything else about chlamydia.

A basic level of sexual health awareness is important for young people before they become sexually active, so that they are more prepared for when the time comes to enter into sexual relationships. Comments from focus groups highlighted the importance of being taught about these issues. Although Asian females were the group least likely to be sexually active, their focus group emphasised the usefulness of sexual health information, whether for now or for later in a marriage context.

These findings suggest a clear need to improve consistency in the ways in which sexual health messages are promoted, in order to increase the accuracy of all young people's knowledge levels. A particular need emerges for targeted information that reflects the concerns of particular groups that may be vulnerable due to lack of knowledge. Sexual health messages should include Asian young people, and address the diverse influences of their peers, their faith and multiple cultures. Whilst this is clearly an agenda that should be

addressed more widely there is clearly scope to improve sex and relationships education in school. Findings about young people's attitudes towards accessing a range of sources of support provide further evidence of this (see Section 8).

**Figure 5: Sexual Health Knowledge - Correct answers 2000-2004 (%)**

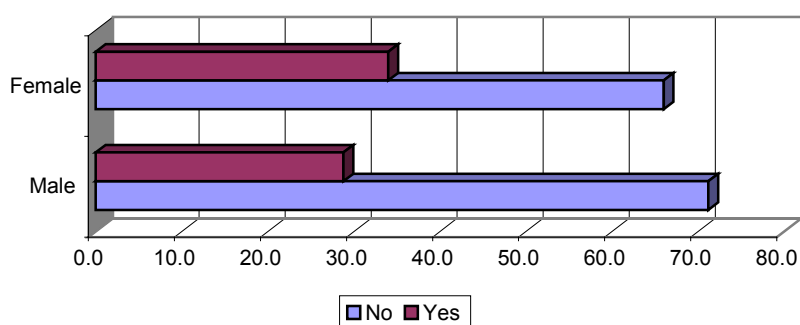


## 6 Sexual behaviour

### 6.1 Ethnicity and gender

While the majority of respondents were not yet sexually active, there were significant differences according to ethnicity, gender and aspiration. 32% of respondents reported having had sexual intercourse, which breaks down as 12% of Asian and 36% of white young people.

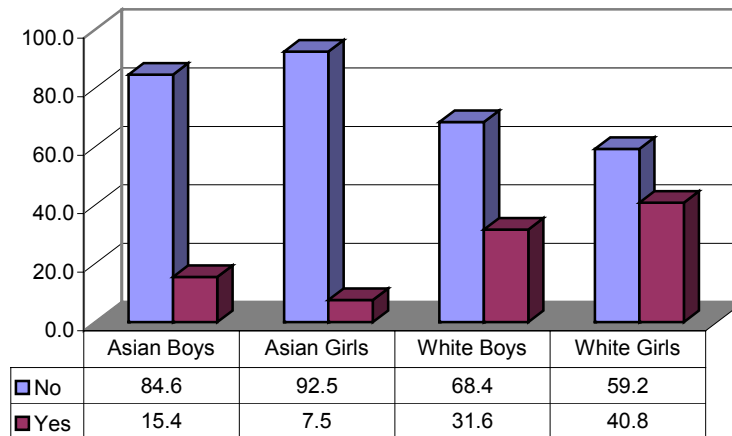
**Figure 6: sexual intercourse by gender (%)**



This rate is higher than in the national data from 2001, in which respondents in their late teens reported sexual intercourse at the age of 15 or younger (Wellings et al., 2001). Given that the national data was based on sexual intercourse up until the age of 16, a lower rate would have been expected among the younger cohort in this study. Figure 6 shows that the sexual activity rate among young women was particularly high compared to national data (34% compared to 26%), while it was slightly lower among young men (29% compared to 30%).

Figure 7 shows that white females are the group most likely to be sexually active by the age of 14-15, with 41% reporting sexual intercourse compared to 32% of white males. While Asian young people are less likely to be sexually active, there is still a significant minority who are. One in every twelve or thirteen Asian females (8%) reported sexual intercourse, as did one in every six or seven Asian males (15%). This minority appears vulnerable, given their far lower rates of sexual health knowledge and confidence in accessing advice from services among Asian young people.

**Figure 7: Sexual intercourse by ethnicity and gender (%)**

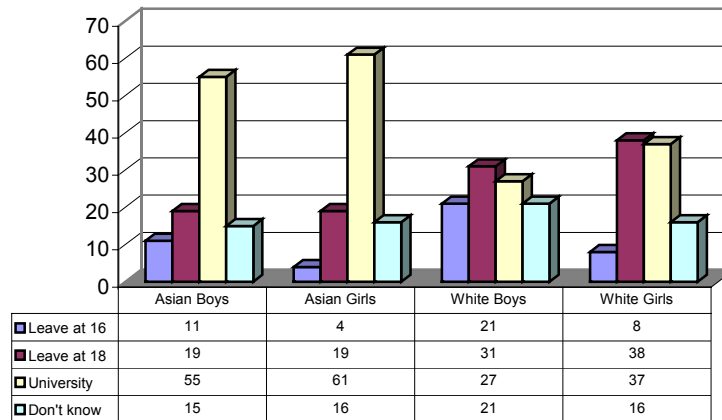


## 6.2 Aspirations

Figure 8 shows that a third of respondents expected to stay in education until 18, and slightly more expected to go to university. Nearly one in six expected to leave the following year (aged 16) and almost one in five didn't know. Asian respondents, however, appear to have much higher educational aspirations than white respondents. They were half as likely as white respondents to expect to leave education at 16, and almost twice as likely to expect to go to university. Within each ethnic grouping, males were nearly three times more likely to expect to leave at 16, and also less likely to expect to go to university. Asian females, overall, had the highest educational aspirations and white males the lowest.

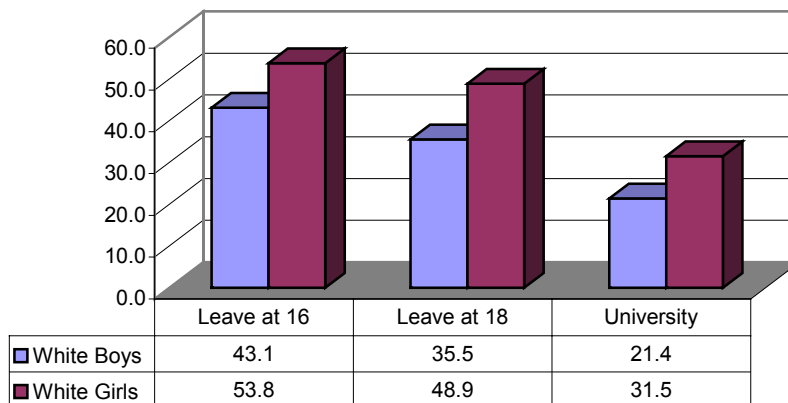
Figure 9 shows young people's aspirations to be an important independent predictor of sexual activity, based on regression analysis and controlling for gender, ethnicity and drunkenness. Aspirations were measured by the point at which respondents planned to leave education. The sooner they expected to leave education, the more likely they were to be sexually active at the age of 14-15. This heightened risk exists above and beyond the risks which are associated with females (compared to males), and with white respondents (compared to Asians). White females with low aspirations stand out as a group where more than half were already sexually active.

**Figure 8: Educational aspirations by ethnicity and gender (%)**



The impact of aspirations on sexual activity rates suggests that expecting to stay in education is a protective factor that prevents young teenagers from engaging in sexual activity. This implies that increasing young people’s self confidence, sense of achievement and future aspirations, could prove an effective way of reducing sexual activity at a young age.

**Figure 9: Sexual intercourse rates among white respondents, by gender and aspirations (%)**



This finding reflects other studies that have shown aspiration and attitude towards education to be important predictors of risky behaviour. Research with teenage mothers has found that significant proportions were already disengaged from school before they became pregnant (Dawson, 2004).

### 6.3 Sexual experiences

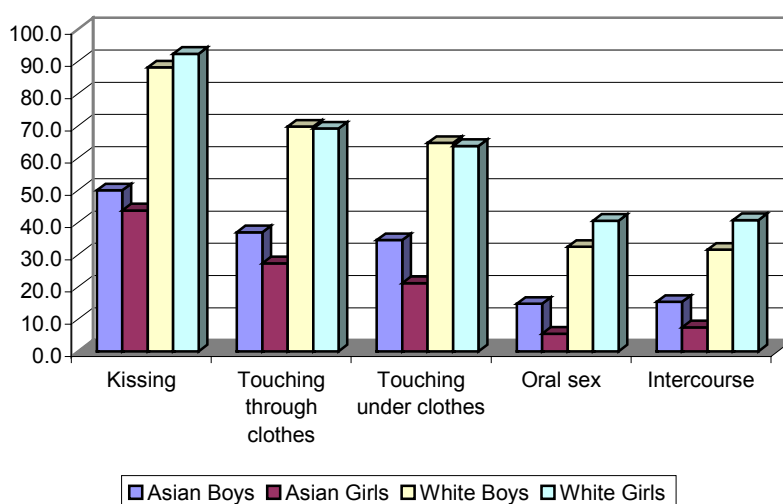
The question about sexual experience required respondents to indicate which activities they had experienced in a list ranging from kissing to sexual intercourse, or to indicate ‘none of the above’. This follows established methods for researching young people’s sexual experience, which avoid a simple yes/ no question about intercourse (Hutchinson, 2002) Those who have not had sexual intercourse may still tick other boxes, which should make it easier to leave blank the box next to ‘sexual intercourse,’ and therefore encourage more honest reporting. A single yes/ no question would not cover different types of sexual experience and may encourage respondents to respond positively even if they had not had full intercourse.



Self-reporting in anonymous questionnaires is as reliable a way to gain information on sexual activity rates as any available. There is no way for researchers to guarantee one hundred percent that all respondents' answers reflect their actual experience (Moore and Rosenthal, 1993). The methodology and the process of ensuring confidentiality, however, make this data on sexual activity rates comparable with other available data on the topic.

This question revealed that 34% of males and 26% of females had engaged in oral sex but not had intercourse. Meanwhile 33% of males and 27% of females had had intercourse but not engaged in oral sex. This implies that sexual health messages need to cover risks involved in oral sex, as well as in intercourse.

**Figure 10: Sexual experiences by gender and ethnicity (%)**



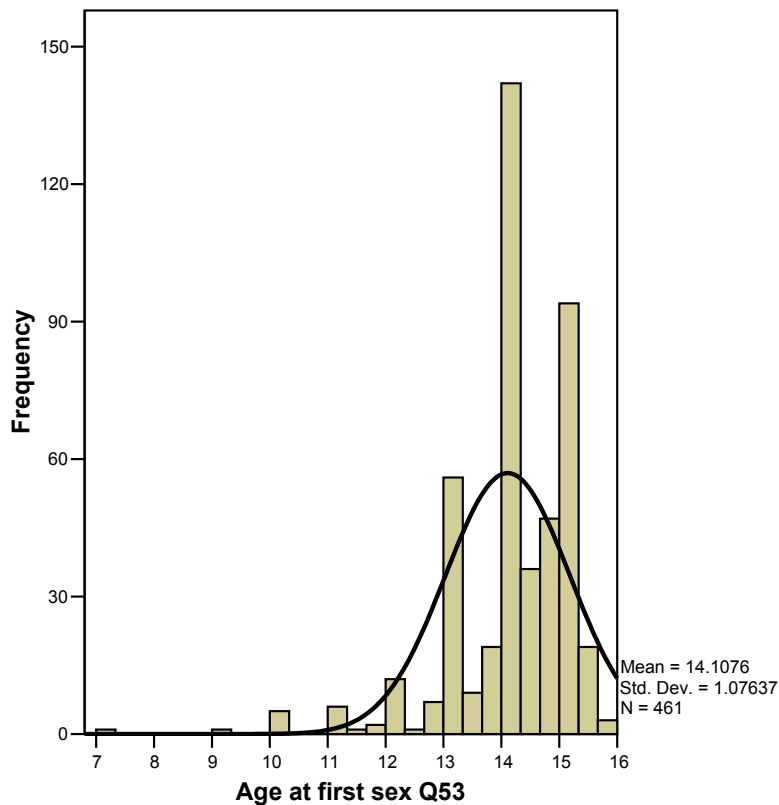
#### 6.4 Age of first sexual intercourse

Analysis of the age of first sexual intercourse shows that three quarters of sexually active respondents reported that they first had sex when they were aged 14 or younger; this is equivalent to a quarter of all respondents. Other studies have shown that the majority of young people who have sex aged 13 or 14 later express subsequent regret. Within this group 67% of young men and 84% of young women later wished that they had waited. (Johnson, Wellings et al, 2002). Factors influencing regret include having been put under pressure or putting the partner under pressure, and not having planned sexual intercourse with the partner (Wight, Henderson et al, 2000).

Approximately 16% of respondents first had sexual intercourse when they were 14, while around 6% did so aged 13, and less than 2% when they were aged 12 or younger. It should be noted that some participants had not yet finished being 14 or 15. The pattern of age at first sex is shown as a percentage of sexually active respondents and of all respondents in the table below, and as a frequency curve in Figure 11.

| Age at first sex | Proportion of sexually active respondents | Equivalent proportion of whole sample |
|------------------|---|---------------------------------------|
| Younger than 12  | 3.5 %                                     | Less than 1 %                         |
| 12               | 4.3 %                                     | 1 %                                   |
| 13               | 18.2 %                                    | 6 %                                   |
| 14               | 48.8 %                                    | 16 %                                  |
| 15               | 24.9 %                                    | 8 %                                   |

**Figure 11. Age of first reported sexual intercourse**

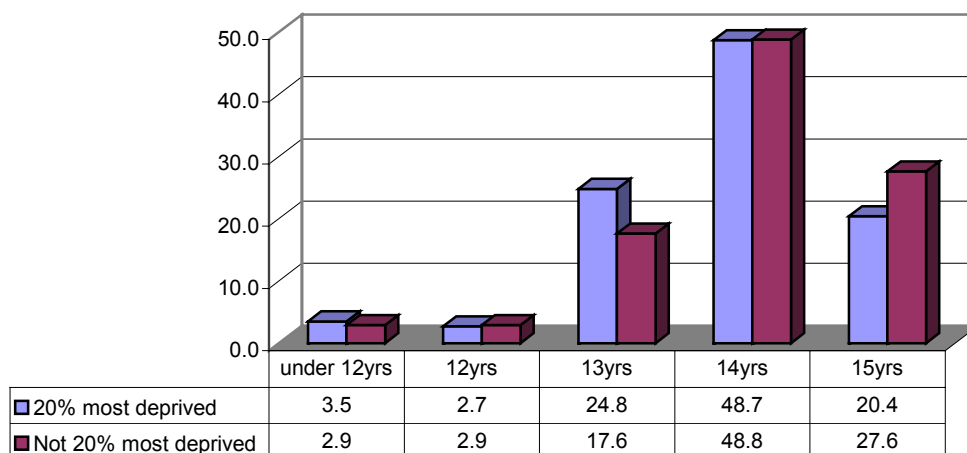


### 6.5 Deprivation

There is no statistically significant link between deprivation and the likelihood of respondents having had sexual intercourse by the age of 14-15. White respondents living in the most deprived areas, however, were more likely to have become sexually active at a younger age. Figure 12 shows that white respondents living in the most deprived areas were more likely to have had their first sexual intercourse at the age of 13, compared to their peers in less deprived areas, who were more likely to have waited until they were 15 before becoming sexually active.

Almost half of the sample lived in the 20% most deprived areas nationally, and the average deprivation level was 27% (see Section 4.4). Data from elsewhere about contraceptive use, conceptions and terminations shows that deprivation is linked with different aspects of sexual behaviour. Deprivation is clearly associated with lower rates of contraceptive use among young people (Wellings, 2001). Given the relatively high deprivation rates in Rochdale, it is likely that a significant proportion of sexually active young people do not use contraception. This is backed up by focus group comments about condom use and negotiation (see Sections 7.5 and 7.6). Young people living in more deprived areas are more likely to become pregnant before they are 18, and less likely to have terminations (Social Exclusion Unit, 1999, Clements et al., 1999, Lee et al. 2004).

**Figure 12: White respondents' age at first intercourse by deprivation level (%)**



### 6.6 Sexual activity rates in the context of STI and conception rates and deprivation

It is useful to look at the findings from this study about sexual activity in the context of data from other measures of related behaviour. The under-18 conception rate has declined by 15% in Rochdale since 1998 to 52.4 conceptions per thousand young women aged 15-17, but remains higher than the national average of 42.1. At the same time, sexual intercourse rates reported in this study are significantly higher than those reported in the NATSAL study (Wellings, 2001) (see Section 6.1). Given the time lapse between the two studies, this suggests that levels of sexual activity may have increased over time. An aim of the national Teenage Pregnancy Strategy was to encourage young people to avoid risky sexual activity and wait longer before becoming sexually active. Although there was no baseline for sexual activity rates in 1998, it appears that there is still a long way to go to realise this aim.

Sexually transmitted infection rates nationally and locally continue to rise among young people which suggests that safe sex, including condom use is not consistent (Wellings et al., 2001; Health Protection Agency, 2005). Emergency contraception, meanwhile, has become more widely available along with the contraceptive injection and implant (Rochdale Teenage Pregnancy Annual Report, 2005). This implies that the local reduction in conception rates may owe more to improvements in hormonal contraceptive provision than to a consistent uptake of broader safer sex messages, or to fundamental changes in risky behaviour.

Deprivation rates in Rochdale have remained high, and the four wards with the highest conception rates are among the top five most deprived in the borough. As deprivation is one of the underlying socio-economic factors related to teenage pregnancies, it is possible that conception rates will not decrease beyond a certain point, while a significant proportion of the population continues to live with high rates of deprivation and low levels of aspiration.

The implementation of the Teenage Pregnancy Strategy has seen increasing levels of information and services aimed at young people. It appears that the reduction in conception rates may be due in part to improvements in services to help young people who do not want to become pregnant, by increasing access to the contraceptive pill, injection and implant, and emergency contraception ('morning after' pill). Reducing the level of conception, however, among those who may be more ambivalent about whether they want to be pregnant could require a different emphasis in strategies. The emphasis may need to be on factors that influence some of the underlying behaviour such as raising self esteem and aspirations, as well as on reducing deprivation. To meet these aims would require going beyond responses to the outcomes of individual risk taking and specific education around sexual health.

## 7 Decision-making and expectations of sexual relationships

### 7.1 Acceptability of sex

Fifteen is not seen as too young to have sex by most white young people, particularly if both people want it and use contraception. The differences in sexual activity rates according to ethnicity are reflected in focus group comments about the acceptability of sexual activity. Asian participants highlighted the importance of diverse influences, including their peers, their Muslim faith and their parents, as well as messages from the media. The starting point for many was that sex before marriage was forbidden to them by their religion. However there was acknowledgement of advantages and disadvantages of sex before marriage. There were reports of pressure to keep relationships secret from families and communities, which could make it even more difficult to seek help and talk about sexual health issues. This further supports the findings that the Asian young people who enter sexual relationships may be particularly vulnerable due to lack of sexual health knowledge and advice.

*"I think that you should have sex before you are married because what if you get married to somebody that is really bad in bed, then you are stuck with them for the rest of your life." (female)*

Reasons given in focus group discussions for having sex include love or feeling close, which fits in with the view of sex as a positive choice within a 'good relationship.' By contrast, other motivations are the desire for a bit of fun, curiosity, or the notion of a physical imperative when hormones kick in. Having sex is also seen as a way to feel wanted or grown up, to avoid being dumped or to keep up with friends. This suggests that young people lacking self-assurance may see sex as a way to enhance personal self-worth and status in other people's eyes.

*"If somebody's like unhappy and they want to feel happy, then they might do it to make them feel better about themselves." (female)*

Experience in the Netherlands suggests that different cultural attitudes towards sex can be linked with later onset of sexual activity. SRE focuses more on gender there, and is part of the mainstream curriculum in primary schools, where children are given assertiveness training. Sex is seen more positively in terms of intimacy and taking responsibility, rather than as something dangerous and in conflict with morality (Adams, 2005). Comparative research shows that British young men are four times more likely than Dutch young men to cite peer pressure as a reason for first having sex, while Dutch young men are more than five times more likely than British young men to cite love and affection.

| Reasons given for first sex by young men | In UK | In Netherlands |
|--|-------|----------------|
| • Physical attraction                    | 45%   | 15%            |
| • Opportunity                            | 45%   | 30%            |
| • Peer pressure                          | 40%   | 10%            |
| • Love & Commitment                      | 10%   | 55%            |

(Ingham et al., 1998)

### 7.2 Attitudes towards power and gender

Although two thirds of respondents are not sexually active, ideas about gender differences relating to pleasure and consent are already developed amongst white and Asian young people of both sexes. Young people's expectations of sexual relationships appear to be shaped to a large extent by common assumptions about how men and women should be seen to behave sexually. This suggests that they have internalised certain cultural norms about sexuality, power and gender roles, and expect to reproduce these roles in their own early sexual experiences.

There was little expectation from males or females that young women would have pleasure from sex. In particular, females were clear that sex is painful at least the first few times.

*"Sex is a pain for a girl and a pleasure for a boy." (male)*

There was a tension for young women between the pressure not to be seen to want sex, and a sense of obligation to have sex. They were far more reluctant than young men to make positive comments about sex, although at the same time they said it was acceptable. They seem to struggle to articulate what they actually want, for fear of being seen as a 'slag' or as 'frigid'.

*"People think, oh yeah, look at her. She is well stiff, her. She won't even have sex with me." (male)*

On the one hand, young women were not expected to initiate sex, but to resist it. On the other hand, they were expected to 'give in' and fulfil the male's desires, often seeing a need to abdicate responsibility for this with the excuse of being drunk. In the Asian males group there was an acceptance of a theme of men being the initiators, with women likely to be passive until the point when they would say "no". There was no sense of negotiation or relationship in these exchanges, nor any understanding about why young women might want sex beyond "*hormones*". On the whole, females tended to characterise the opposite sex as rampant and with uncontrollable hormones.

In contrast with the general consensus, another male view of female sexuality saw females as having the upper hand, getting sex whenever they want and multiple orgasms.

*"Some are man eaters. Some are more into it. Some girls push you over and jump on you. It can be embarrassing for boys as well." (male)*

It seemed that many young women tended to buy into stereotypical gender roles to a large extent, and could not imagine being sexually assertive. Others, however, expressed alternative views about what they could expect from sex. Other research suggests that conventional gender relations still tend to prevail, while young people's attempts to redefine rules for themselves at a personal level may not be seen as legitimate in the wider social context. This is seen as leading to a pressure for heterosexuality to favour masculinity and jeopardise young women's sexual safety, despite more openness about sex and female sexual pleasure (Holland et al., 2004). One or two female participants suggested that some young women seek to enhance their social status through sexual activity, in a more traditionally masculine way.

*"Boys have competitions of who can sleep with the most people in like a week or something." (female 1)*  
*"So do girls." (female 2)*

There was a clear understanding that if a female did choose to sleep with different partners, this choice would be unacceptable to her male peers. One reason for the double standard that would allow young men, but not young women to sleep with different partners, was that there were no perceived consequences for them.

*"Girls have just got to be careful because if they go through a whole group of mates then you will get branded a slapper by all of them."*  
*[Boys who sleep around themselves] just think it is good cos they managed to get into them all... Boys can't get pregnant or anything can they, they just move on and think, 'oh, next one'."*

### **7.3 Engaging young people in discussions about gender and sex**

Generally, there was little acknowledgement that both sexes may have a range of feelings towards sex, including some desire and some hesitancy. There is a clear need to work with young people around relationships, to help them decide when they are ready to have sex and avoid being pressured into it either by a partner or by peers. This should involve promoting the idea that sex should be enjoyable and respectful, for both partners.

In the focus group discussions about gender, more exaggerated views of the opposite sex appeared to be reinforced in single gender groups, whereas in one mixed group (higher academic achievers), young men and women did explore different possibilities. Both sexes showed some ability to challenge each other's preconceptions and listen to each other, which also happened when discussing condom use (see Section 7.6).

*“Everyone says it’s lads always trying to get into them [girls], but it could be the other way round couldn’t it.” (male)*

*“You get really nice lads who are not just into that and do want to wait for you, but they’re not just thinking about sex.” (female)*

The way in which young people engaged with each other in the focus groups suggests that it may be useful to do some work in single gender groups, to build confidence, before engaging in mixed gender groups. The mixed focus group with lower academic achievers had more males than females, and males tended to dominate discussions. Some young people said that they would feel more comfortable in sex and relationships lessons without the opposite sex present. There was acknowledgement, however, of the importance of dialogue to improve communication and empathy, as it was widely acknowledged that males and females see sex in very different ways. The following comment about the focus group process was from the female group.

*“I think it is better if lads were here though cos then they would know what we think as well.” (female)*

#### **7.4 Influence of pornography**

Pornography was raised as an issue by all focus groups, and appears to play a significant role in shaping sexual expectations. It portrays strongly gendered roles, while satisfying curiosity as the only source of explicit information about sex.

*“If you watch a sex education videos and you think that’s boring, then you watch a porn movie and it is totally different, and you think ‘oh that’s good’.” (male)*

Pornography appears to directly influence young men’s ideas of what should be included in the sexual repertoire, and lead to pressure on young women to comply.

*“Makes you want to try new things... take it up a notch.” (male)*

*“They get really sick ideas from watching it, and if you don’t do it then they moan” (female)*

Concerns about the impact of pornography on behaviour and attitudes, particularly in relation to broadening the expected repertoire of behaviours to include anal sex has been picked up by both practitioners and in the research literature (Zillman, 2000).

There is some scepticism about pornography’s reflection of reality, and reported disappointment when the experience does not match up. A perceived consequence of males’ expectations is a lack of satisfaction for females, whether physical or emotional.

*“You watch a porn movie and think it is going to be like that but sometimes it’s not.... They don’t scream, do they.” (male)*

*“That is why they think sex is supposed to be so amazing for them, and then they are so disappointed after they have been watching that.” (female 1)*

*“And the girl is disappointed cos the lad’s crap.” (female 2)*

These comments suggest that there was an expectation or a hope among young women that they could get something out of sex, but there was resignation about the unlikelihood of this happening in most cases. There is a need to be aware of the significance of pornography as a source of information and influence and to challenge messages that it gives out.

#### **7.5 Negotiating sexual consent**

All focus groups felt that it was difficult to work out whether both people want to have sex. There was a severe lack of confidence and skills to talk about this question, especially outside a relationship. This is exacerbated by gender and power relations between the individuals, as discussed above, and by alcohol and peer pressure (see Section 13).

Many young people emphasised that both partners should agree and take responsibility for the decision.

*“The girl has obviously agreed to it, so why should the boy get in trouble.” (female)*

Further discussion revealed much less certainty about how easy this would be to achieve. More than half of questionnaire respondents agreed with the statement, "sometimes girls say no to sex when they mean yes" and there was no significant difference in responses by gender.

*"Yeah, but you don't know if you are ready or not, or you could be forced into it."  
(female)*

*"You don't know if the other person really wants it." (male)*

Refusing sex is seen as awkward, and young women feel a sense of obligation not to disappoint. Some young men appeared self-assured about pursuing sex, and expect young women to comply. There appears to be some blurring of lines between what either sex perceives as persuasion or coercion.

*"You just say come for a walk, and they say yes." (male)*

*"You feel more confident around the opposite sex [with alcohol]. Most of the time you get what you want because the girl likes you and doesn't want to let you down." (male)*

*"Like if a lad's basically made you do it and another lad comes near you, you get dead paranoid." (female)*

## 7.6 Condom use

There is awareness that condoms should be used to prevent infection and pregnancy, but acknowledgement that this does not always happen. 27% of questionnaire respondents reported that they would not always use condoms, although this is not, of course, a measure of actual levels of condom use. Some participants were clear that they would always use condoms, while others were much less sure. Amongst the latter group, some would proactively choose to avoid condoms to increase their pleasure (some males), while others felt that they may not have much choice (some females).

Problems with articulating personal boundaries also appear to come into play. Several participants in the female group felt strongly that once a young woman had signalled that she was ready to have sex, if no condom was available, it would be not just embarrassing, but impossible to change your mind and say no. It seemed that condoms were unlikely to be discussed beforehand (particularly outside a relationship) and were not seen as a valid reason to refuse sex at the last minute. One young woman challenged this consensus that females had little responsibility or control over condom use.

*"If they [boys] wear protection then it is stopping diseases and that. But some of them don't because they don't come prepared. Then you get all ready, and they're not prepared, so you just have to do it anyway." (female 1)*

*"It is a bit awkward to say no." (female 2)*

*"You are just stood there all naked and you go... [shrugs shoulders]" (female 3)*

*"No - if I didn't know them properly, I wouldn't [have sex without a condom], even if I was naked. I would say no if I didn't want to." (female 4)*

In a mixed group (higher academic achievers) there was some discussion between male and female respondents, after some young men had agreed that they worried about catching STIs.

*Why don't you [boys in general] use condoms then? (female 1)*

*We do. (male)*

*You're not always happy about it though. (female 1)*

*"Yeah, but some lads think of it as like, always having to keep a johnny in your pocket." (male)*

*"Yeah, but what if you forgot it and then you wanted to do it anyway, would you still do it?" (female 2)*

*"No - well I wouldn't anyway." (male)*

A common explanation for not using condoms was that some young people would prefer to have sex without a condom, rather than miss the opportunity for sex. The focus groups often saw sex without condoms as more enjoyable, particularly for males. A fifth of questionnaire respondents agreed with the statement that 'condoms spoil sex.' 14% of females agreed with this statement, as did 20% of white males and 40% of Asian males.

*"They might like it bare." (male)*

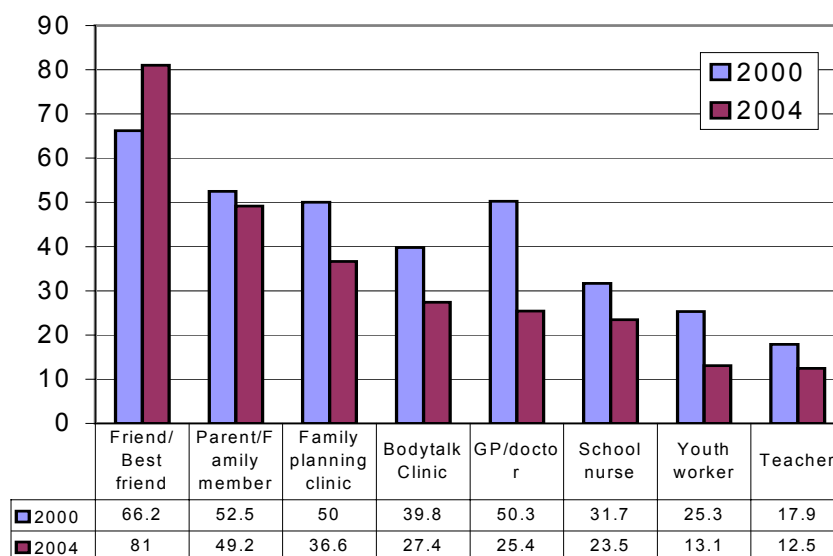
Other reasons given for not using condoms were hassle, not being able to afford them and not having one available when you needed it. 85% of questionnaire respondents thought that condoms should be more widely available, with white males most likely to give this response, (90%, compared to 74% of Asian respondents). One third of the sample did not know that free condoms are available from family planning clinics (see Section 5). Switching to the pill after a while was another reason, with the assumption that neither partner had a sexually transmitted infection. Asian females suggested that while a married couple may not use condoms if there was complete trust, they should use them if they do not want children and because they never know whether the other person has an STI.

## 8 Access to advice and support

### 8.1 Comparison with findings from earlier study

Young people's confidence in accessing confidential advice from services about sexual health and alcohol related concerns appears to have decreased over the past four years. Although the wording contained a slightly different emphasis from one study to the next, the gist of the question remained the same in the context of each questionnaire, and this apparent decrease in confidence cannot be dismissed.

**Figure 13: Who could you talk to.....? 2000-2004 (%)**



The general pattern has remained the same in both studies, in terms of the most popular sources of advice about concerns relating to sexual health and alcohol. Most young people cite friends as their first port of call, followed by parents, specialist health services, general and school health services, youth workers and teachers. Newer services such as Connexions and learning mentors were not listed as options in the questionnaire, but were mentioned by focus group participants.



There appears to be an important gap between knowing about a service, and accessing it. For example, the proportion of respondents who were aware that under-16s can access family planning clinics remained around 46% from 2000 to 2004. The proportion who would feel comfortable going to a clinic for advice, however, has decreased from 50% to 37%. Sexually active young people were more likely than their peers to say they would attend 'Bodytalk' young people's sexual health clinics (37% compared to 23%) or family planning clinics (51% compared to 31%). Those with higher overall knowledge of sexual health were also more likely to say they would attend both types of clinics. It should be noted that sexual health clinics in Rochdale are well used, but these results suggest that there may still be an unmet need among this younger age group.

Comments from the focus groups supported the findings about low levels of confidence in accessing services. They highlighted fears about disapproval and confidentiality as particular barriers, as well as embarrassment. While some of these expectations related to personal experience, the basis of young people's fears was not always clear, and appeared also to be linked to assumptions and hearsay. While many thought they could advise a friend to use services, few would actively seek help themselves. Yet some focus group participants could name long lists of services that were available to them. This indicates a need to go beyond informing young people of services' contact details and to develop more creative and targeted work, to build up trust and confidence.

## 8.2 Ethnicity and gender

There are significant differences in the pattern of responses to this question, based on ethnicity and gender. Figure 14 shows that white young people of both genders are more likely than their Asian peers to talk to parents/ carers, friends or family planning clinics. Asian respondents are more likely than white respondents to seek advice about sexual health or alcohol from a teacher.

**Figure 14: Which of the following would you talk to about concerns relating to sexual risks and alcohol, by ethnicity (%)**

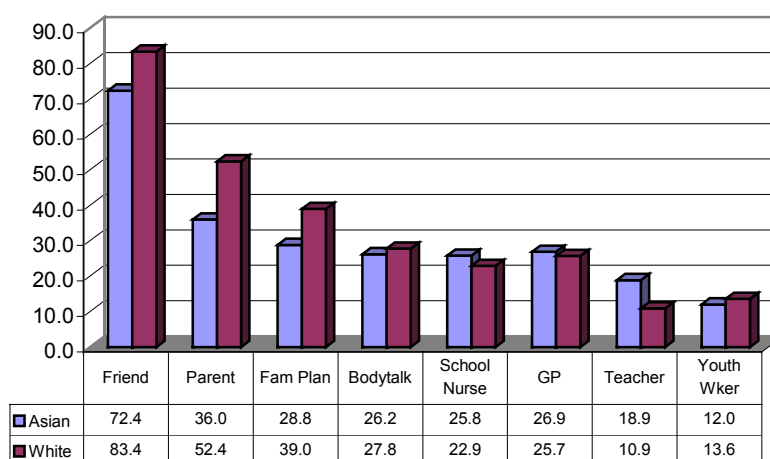
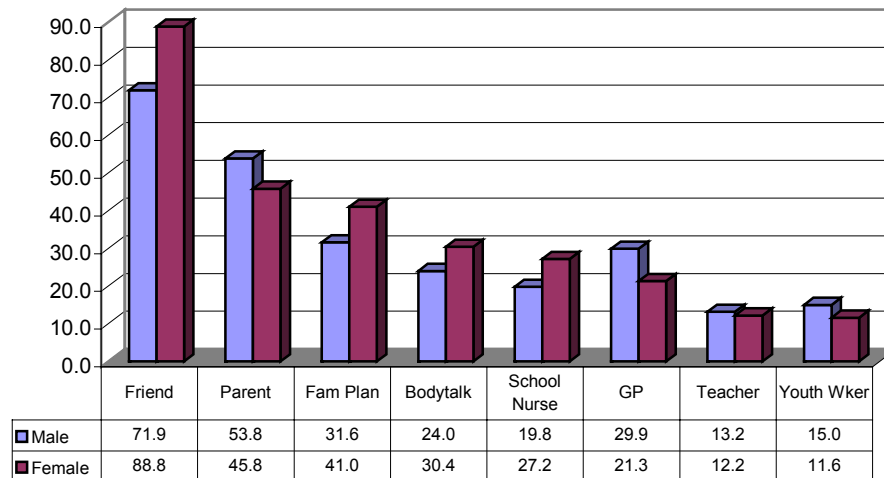


Figure 15 shows that young women of any ethnicity are more likely than young men to go to friends, family planning clinics or Bodytalk clinics and school health practitioners. Male respondents are more likely to talk about these issues to their parents/ carers, a GP or a youth worker, compared to female respondents.

**Figure 15: Which of the following would you talk to about concerns relating to sexual risks and alcohol, by gender (%)**



Overall, white young women appear to be most confident in accessing services. This picture fits in with the typical demographics of service users at clinics and health services (Cook, 2002). It could also reflect other cultural norms, such as the typical demographics of those who work in these professional roles. The focus groups suggested that young women may be more likely than their male sexual partners to feel a responsibility for dealing with concerns especially related to sexual health and pregnancy.

White female respondents were also the most likely to state in the questionnaire that talking about sex with a partner or friends would be easy, and that they had lots of people to talk to. They were also more likely to feel that they had learned more about sex from their friends than anyone else, and to have the perception that their friends are more sexually experienced than them. This suggests that they are more likely than other groups to have the language as well as the confidence to discuss sexual matters.

When these findings are turned around, it is evident that certain groups are more likely to miss out on the advice and support that should be equally available to all. Asian young men appear to be most isolated when it comes to having people to talk to about concerns relating to sexual health and alcohol, with white young men in a similar position. Asian young women also seem more likely to be isolated from many services, but appear more confident in talking to friends. The table below indicates which groups showed least confidence in accessing which sources for support around these topics.

| Source of advice       | Groups least likely to go there to talk about concerns re. sexual health/ alcohol |
|------------------------|---|
| Friend                 | Young men, especially if Asian  |
| Parent/ Carer          | Asian young people  |
| Family Planning Clinic | Young men and Asian young women   |
| Bodytalk Clinic        | Young men and Asian young women   |
| School Nurse           | Young men, especially if white  |
| GP/ Doctor             | Young women, especially if Asian  |
| Teacher                | White young people  |
| Youth Worker           | Asian young women   |

These findings suggest that different strategies need to be developed to encourage certain groups to feel more able to access services, should the need arise. Addressing sexual health and preventing under-18 conceptions are set out in the relevant strategies as objectives for all the services listed, and others (DfES, 2003; DoH, 2004).

To achieve these aims, all services need to target those groups that show a lack of confidence in them, to make themselves more accessible to all.

### 8.3 Attitudes towards services

Among the 67 participants in the focus groups there was a spectrum of positive and negative individual experiences of different agencies. In addition there were positive and negative attitudes which appeared to be based more on assumptions and hearsay. In studies looking at service experience it is often easier for respondents to focus on the negative, and this is particularly the case with young people where to criticise provision is more in keeping with group norm. Despite recognising this context, however, this data reflects a consistent dissatisfaction and lack of trust in all of the statutory services which should be addressed. Young people gave the clear impression that individual workers' personalities make a difference to how comfortable they feel seeking advice. Broadly, they valued support from teachers, youth workers and other professionals, if they would listen without judging, try to understand and give straight answers. Some specific points were raised, however, which highlight both barriers that young people perceive and some ways in which they are overcome.

#### Confidentiality

A small number of participants were able to clearly explain confidentiality and the duty to pass on information if a young person was at risk of harm. Some young people had an idea of these policies in relation to school health practitioners, doctors, youth centres, clinics or teachers and appeared to give them credit. On the other hand, participants often expressed a lack of trust, as they were concerned that professionals may tell someone else, particularly parents, if young people confided in them about sexual health issues. In the case of the doctors, for example, some participants associated them closely with their parents, visits when they were younger and ailments such as headaches, rather than sexual health.

#### Clinics

Clinics were frequently suggested as somewhere to go for help, but both male and female participants felt that embarrassment could discourage them. Within the females' focus group there was intense debate about experiences of sexual health clinics and the associated stigma. Some felt that if a young woman attended a clinic, this demonstrated responsibility, but that others would unjustly look at her as though there was something wrong with her or see her as a 'slag'.

*"It is like you are going there as a punishment and you are not." (female)*

There were young women who felt that there were more barriers to making an initial visit, which would then be removed if there was a next time.

*"Once you have been once you won't think it is as bad and you would go again." (female)*

Some others described negative experiences of the clinic service, which they said could put them off returning. They felt that clinic staff disapproved of them being sexually active before the age of 16. This sense sometimes appeared to be based on their worries and how they felt they were being looked at, particularly by older staff, rather than on specific comments. Some young women were offended by explicit questions which they thought staff asked to be nosy and to judge them. This suggests a need for staff to proactively reassure service users that they are not being judged, to ensure they understand the reasons for questions without assuming that they are accustomed to adult language and medical examinations.

*"They ask you if you had oral sex, 'Did you have it up your vagina, did you have it up your back passage? What drugs do you take?' What has that got to do with anything if you just want the morning after pill? I don't get that, me." (female)*

Some young people appeared to have difficulties understanding the term 'family planning clinic,' which was the most commonly asked question as they completed the questionnaires. This suggests a problem with the name of the service, as the concept of planning a family seemed to be quite distant to them. Opinions in focus groups were mixed, with some young people preferring more neutral names for such services.

### School health practitioners

On average, 24% of questionnaire respondents stated that they would go to a school nurse for support relating to sexual health and alcohol. The proportion of respondents who would do so was more than three times as high in some schools, compared to others (36% to 11%). This finding supports the experience of this study when telephoning school offices to ask for details of how students could contact this service (to be distributed to questionnaire respondents). Some schools struggled to provide any information at all about when and where the school health practitioner would be available, whereas others had clear protocols and information displayed for students. In those schools where young people were most likely to state that they would use this service, the school health practitioner had greater engagement with wider school health activities, than in other schools.

The male focus group were not sure how to access the school health practitioner, and saw problems with having to go through the school reception because they were not allowed to go there.

*"I think that they should come in front of the whole year and say, 'I am the school nurse, if you have any problems.' I didn't even know who the school nurse was. I had to get told about her." (male)*

Young men in some schools were more than 9 times more likely than in other schools to access their school health practitioner, with the proportion ranging from 38% to 4%. Some schools and school health practitioners have managed to develop a service that is relatively well known and well regarded, even among males, who are on average far less likely to access most services. This clearly implies that it is not impossible to achieve what is necessary to give young people confidence to attend services.

### Education

A few participants suggested that learning mentors could be easy to talk to, as well as 'the right' individual teacher. Most comments about experiences of sex and relationships education were fairly indifferent, although there was a sense that it is important. One group had missed out on any SRE and some were aggrieved about this, having heard about provision in other schools from their peers. The pros and cons of mixed gender provision were discussed, with Asian females feeling that they would be happy to talk like they did in the focus group in front of females, but not males. Suggestions for improvement included focusing more on relationships and both the positive and negative aspects of sex, for example feeling closer to a partner, rather than painting it as something bad. Some highlighted the difference between learning in a classroom environment and putting the knowledge into practice in a real situation.

*"They show you how to put a condom on a banana, it's nothing like that is it. ... it is there is front of you and it is easy to do it, but [not] when it is down there [points to crotch] and when you are drunk as well." (male)*

While the vast majority of school staff were extremely supportive of the research process, responses from a small number of teachers suggested difficulties with the climate for tackling these issues in some schools. One teacher told a male student that he did not need to know what a family planning clinic was, as it was only for girls, and said that she was reassured by his ignorance. One or two teachers made inappropriate 'joke' comments about individual students' sexual activity. While the majority of young people appeared relaxed about doing the questionnaire, some teachers introduced the questionnaires with great excitement and titillation.

### Other services

Participants were aware of a range of sources of advice including websites, and phone lines, as well as other services such as NHS walk-in centres. Fewer people commented on experiences of using these services. Some mentioned youth workers who they felt they would trust to talk to confidentially about sexual health issues or alcohol problems, whereas others knew one who they felt might not take them seriously. Some Asian females seemed to feel less able to talk to youth workers because they would not attend youth clubs where males were present, although single sex youth clubs were seen as more accessible.

Similarly, there were mixed attitudes towards talking to Connexions personal advisers about sexual health issues. Some positive feedback shows how professionals who are not sexual health specialists can put young people at ease, and benefit from opportunities to give support relating to this issue, as one among many others.

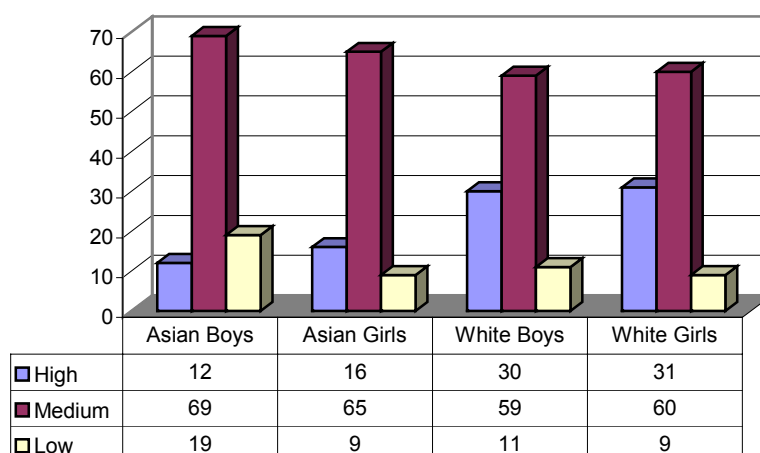
*“They’re good at Connexions... because they can help you with so many different things and they will sort anything out for you if you need anything sorting out. If you got an STI they would probably go to the clinic with you... [They normally ask you] about sex to make sure. Last time I went she asked me about everything not just the reason why I had gone.” (male)*

## Alcohol

### 9 Alcohol knowledge

White respondents scored more highly than Asians on questions relating to knowledge about alcohol, with no significant difference according to gender.

**Figure 16: Alcohol knowledge rating by gender and ethnicity (%)**



Respondents were asked about their knowledge of units, the relative strengths of different drinks, legal restrictions, the effects of alcohol and factors that change the effects. The results suggest that many young people have little awareness of units and the specific alcohol content of different drinks. Only a quarter of respondents correctly identified that the effects of alcohol depend on body size, age, type of drink and whether or not someone has taken medication or eaten.

Three quarters of respondents were unaware that a bottle of alcopop contains more alcohol than half a pint of standard strength cider or beer. Forty five percent were unable to correctly identify which drinks contain a unit of alcohol. This suggests that talking to young people about drinking in terms of units may be of limited use.

### 10 Alcohol behaviour

#### 10.1 Drinking and drunkenness

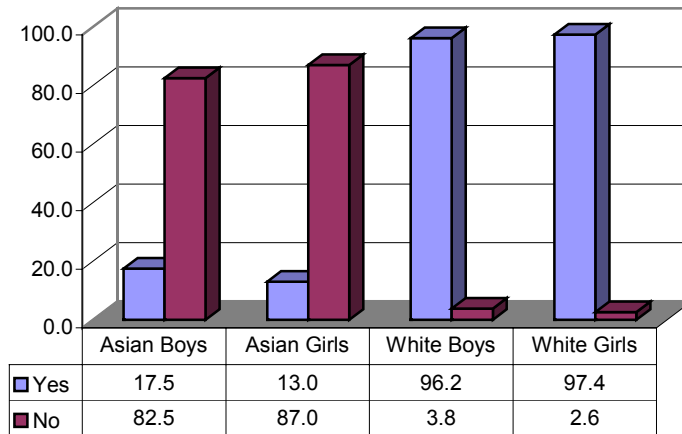
More than 80% of respondents reported having 'ever' drunk alcohol, the vast majority of whom had also been drunk. This suggests that there is relatively fast progression to drinking enough to get drunk. This is supported by focus group comments seeing, 'getting drunk', as normal. While almost a quarter of those who had tried alcohol had not drunk any in the previous month, one third had been drunk during this period, and a further 44% reported drinking alcohol without getting drunk.

There appear to be wide differences in the recent habits of young people. Frequent binge drinking was reported by a minority of one in five drinkers, who had been very drunk more than once in the past month. White young women and respondents with low educational aspirations were more likely to report drunkenness, as were those who were already sexually active.

## 10.2 Ethnicity and gender

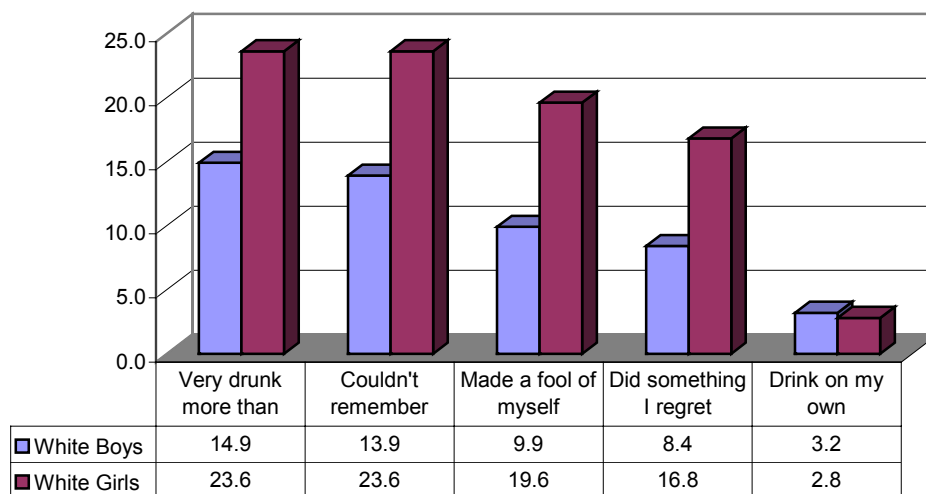
When these findings are analysed by ethnicity, it is clear that the proportion of white respondents who had drunk alcohol and been drunk was far higher than the average figures for the whole sample. They were six times more likely to have drunk alcohol than Asian respondents (97% compared to 16% on average for both genders). Among those who had tried alcohol, white respondents were also more likely to report having been drunk than Asian respondents (79% compared to 58%).

**Figure 17: Ever drunk alcohol by gender and ethnicity (%)**



The Asian respondents who reported having tried alcohol were more likely to be among the 15% minority of this ethnic grouping living in the less deprived areas of Rochdale (with postcodes outside the 20% most deprived according to the indices of deprivation). Bangladeshi young people were over twice as likely to have tried alcohol compared to Pakistani young people (19% compared to 9%). Asian young men were slightly more likely to have drunk alcohol than Asian young women. The numbers who reported drunkenness were too small to break down by recent drunken experiences.

**Figure 18: Drunken experiences in the last month amongst white respondents who have ever drunk alcohol (%)**



Among white respondents, there was a dramatic difference in levels of recent binge drinking and drunken experiences according to gender. While they were equally likely to have tried

alcohol, young women appear far more likely than young men to drink to the extent that they are at risk of losing control. Figure 18 shows that 24% of white females and 15% of white males had been very drunk more than once in the past month. Getting so drunk that they regret or cannot remember what happened appears to be a particular concern for white young women. This is supported by the finding that one in five white females reported having gone further sexually than they wanted or planned because of being drunk. Males were slightly more likely than females to report getting drunk on their own.

### 10.3 Settings for drinking alcohol

The most common setting for having drunk alcohol was at home, cited by 83% of those who had tried alcohol. This was closely followed by a friend's house or party, cited by 78%, while 56% had drunk outside on the street or in the park, and 52% in a pub, restaurant or nightclub. Drinking in unsupervised settings, particularly outdoors, is more likely to lead to harm than when there are adults around. Focus group participants talked a lot about the risks of drinking outside in a crowd of mates, compared to in a pub or while eating or watching television with family.

Among white respondents, females were more likely than males to report drinking outside (58% compared to 53%), at a friend's house or party (82% to 77%) or in a licensed venue (56% to 50%). Males were more likely to have drunk alone (23% to 15%) and there was no significant gender difference in drinking at home. This picture contrasts with a recent study which found males to be more likely to drink in unsupervised settings compared to females drinking in licensed venues (Coleman and Cater, 2005).

There is evidence from other studies that parents allowing teenagers to drink alcohol at home can benefit the socialisation process by modelling more 'sensible' drinking (Newburn and Shiner, 2001). This is supported by the finding that those who report often being drunk in the previous month were the least likely to report drinking alcohol at home (75% compared to 85% of those who reported occasional drinking without drunkenness).

Young people clearly receive mixed messages about alcohol, which is often not permitted to them and seen as 'deviant,' while at the same time playing a major role in the social life of the nation. Education about alcohol needs to help young people to manage the risks in a way that relates to their experiences, rather than portraying alcohol solely in a negative light.

## 11 Attitudes towards drinking alcohol

### 11.1 Motivations

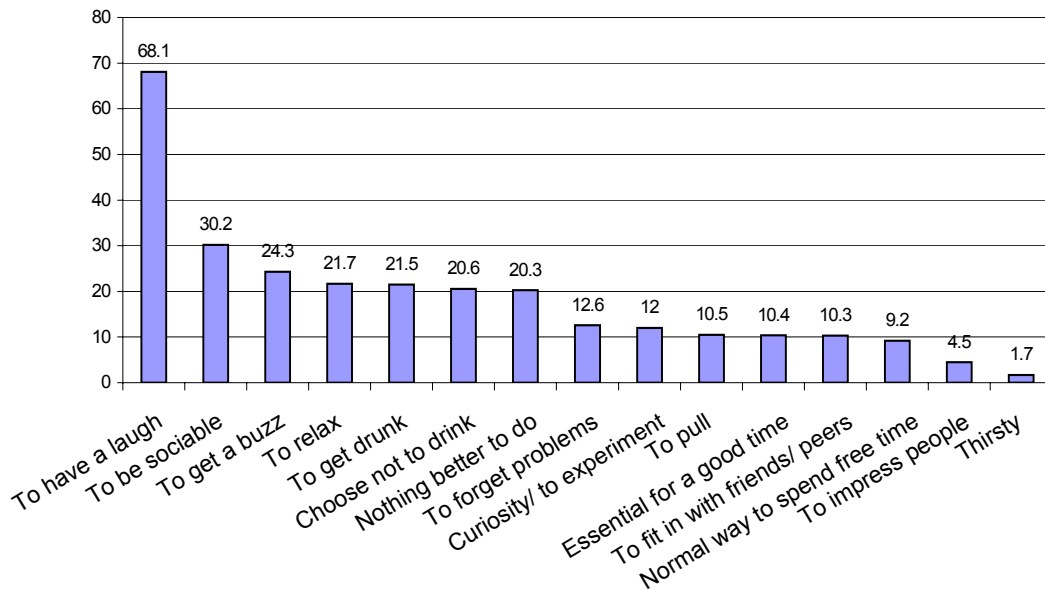
Alcohol is perceived as playing an overwhelmingly positive role for most white young people, which is evident from both questionnaire and focus group data. Asian respondents, on the other hand, show more negative and mixed attitudes, often starting from the perspective that alcohol is forbidden to them by Islam, but acknowledging that some Muslims do drink, even though they should not. This was seen as dependent on how religious they are, who they hang around with and whether or not their parents drink and how strict they are. The female group felt it was more acceptable on a special occasion such as a sixteenth birthday party. Two participants in each Asian group indicated (anonymously) that they had drunk alcohol, but not recently. The Asian female group resented peer pressure to drink, as illustrated by a comment from the (predominantly white) female focus group. The school year group was described as split into *"the geeks and the people who want to go out and get pissed."*

Getting drunk is widely accepted as a normal way to have fun. To have a laugh emerges as the most common reason for drinking alcohol, cited by more than two thirds of the sample, followed by being sociable, feeling a buzz and relaxing. Around a fifth of respondents felt that having nothing better to do was a reason to drink alcohol, while 13% would drink to forget problems.



**Figure 19. Main reasons for drinking alcohol (%)**

\*respondents could indicate up to three from list of reasons



More than half of respondents stated that their feelings or actions change when they drink alcohol. Again the most commonly cited changes were very positive, including confidence and happiness, as well as the ability to talk more openly and approach the opposite sex. Some written comments mentioned more than one effect such as feeling happy and then depressed.

*“I get on with people better, I relax, don’t care, I have a better night.” (female)*

*“I feel more sociable and flirty.” (female)*

*“Makes you feel really light and you think you can take on the whole world.” (male)*

*“Alcohol works better than an anti-depressant.” (male)*

*“Makes me feel very sick but really good at the same time.” (male)*

Focus group comments supported these findings by recognising the transience of the ‘buzz’ of getting drunk, and the progression to more negative effects such as getting emotional or aggressive.

## 11.2 Risk perception

Non-drinkers were more likely to identify alcohol with stupid or dangerous behaviour and losing control, especially in the questionnaire. By comparison, drinkers were more likely to state that alcohol makes no difference to their personal interactions and risk taking. This suggests a sense that respondents thought that they ‘could handle their drink’ and remain in control. It also fits in with typical patterns in attitudes towards drugs, whereby once young people have closer contact with a substance or others who use it, they are less likely to perceive it as wholly negative (Newburn and Shiner, 2001). In the course of focus group discussions, however, participants who indicated that they had drunk alcohol, openly discussed the risks that they perceived.

White young people talked about getting very drunk outdoors in groups of up to 30 or 50 as part of a normal Friday night. It was seen as an opportunity to get drunk and ‘get off’ with people. The problems that they identified include the cold and rain, regretted sexual experiences, fights and being split up or moved further out of sight by police.

*“Even though you haven’t done anything wrong... they [police] tell you to go away from like houses and stuff and big shops or whatever, so you go somewhere far away and they still complain to you.” (female)*

### 11.3 Managing risks

Some were resentful of the police dispersing them, and thus reducing their sense of 'safety in numbers.' Young people reported feeling threatened by other groups, for example from other areas. Some felt that there is acceptance of adults getting drunk in pubs, and hypocrisy in attitudes towards young people, who have nowhere to go. A suggested solution from at least two focus groups was to provide young people with somewhere to 'hang out', where they would be allowed to drink, with some adult supervision. Being indoors with some adults around is seen as conducive to calmer and more moderate drinking, whether at home, in a pub or in an alternative setting.

*"If people were sat in a room, just chatting and chilling, then they wouldn't do nothing. But when they are out on the streets and they are drunk they just tend to wreck everything." (female)*

This fits in with findings from other research about riskier drinking occurring in unsupervised venues, and a tentative recommendation to provide supervised venues where moderate drinking would be allowed (Coleman and Cater, 2005).

Comments from the focus groups reflect the questionnaire findings above about ignorance of the relative strength of different types of alcohol, unit measurements or recommended limits.

*"Most people don't know when to stop" (female)*

Participants described the difficulties of keeping check on the volume of drink consumed, for example when sharing a bottle of spirits. They appeared more likely to perceive and set limits on drinking based on physical symptoms, such as the inability to walk or vomiting. Although there was awareness of the effects of different levels of drunkenness, these comments imply little forethought about how to prevent reaching the stage of being sick. There was a suggestion that young people would be more likely to think more about such matters after having a "*bad experience*", for example, drinking to unconsciousness or going to hospital. There was evidence of some rationale relating to preventing risks, for example, stopping drinking an hour before going home, in order to be sober in front of parents. Other suggested strategies for managing risks included carrying condoms and asking a close friend to stay sober, although it was acknowledged that these were not always effective.

Specific interventions are needed to address the impact of inequalities on risk taking, rather than universal responses relating solely to alcohol. There is a need to better target risky drinking, making a distinction from occasional moderate drinking. This could involve finding more appropriate ways to conceptualise quantities that make sense for young people, and to communicate key messages effectively. Gender specific harm reduction activity is required, particularly relating to sex and personal safety. Meeting the educational needs of Asian young people is another priority. At the same time, there is a need to enable young people to achieve the perceived positive outcomes of drinking, in less risky ways.

## ALCOHOL AND SEXUAL HEALTH

### 12 Linking alcohol and sexual behaviour

Similar gender and ethnic differences are apparent in the patterns of alcohol consumption and sexual activity. At the same time questionnaire and focus group data highlights that consuming alcohol is directly linked with sexual risk taking. 1:6 respondents reported going further sexually than they wanted or planned because they were drunk. This rises to one in five white females. A third of respondents felt that drinking increases the risk of unprotected sex.

Young people who get drunk are more likely to be sexually active than those who do not. Young men who have been drunk are more than twice as likely to have had sex than those who have never been drunk. For young women the difference is even more striking with those that have been drunk being nearly ten times as likely to have had sex than the rest of their peers (see chart below).

|                 |     | Sexual intercourse |         |
|-----------------|-----|--------------------|---------|
|                 |     | Males              | Females |
| Ever been drunk | Yes | 39%                | 51%     |
|                 | No  | 16%                | 5%      |

Among white young people, who expect to leave school at 16 and have been drunk, 50% of males and 60% of females report having had intercourse. Meanwhile among those white young people who expect to go to university and have never been drunk, 13% of males and 4% of females report having had intercourse.

Logistic regression analysis shows that the effect of the socio-demographic factors on sexual activity rates is partly mediated through specific behaviour. For example, drunken behaviour has a major impact on the likelihood of intercourse. Young people who had often been drunk in the previous month were 6.7 times as likely to be sexually active than those who had not drunk at all. This drunken behaviour explains some (but not all) of the effects of educational aspirations and ethnic background on sexual behaviour. It also completely removes the earlier effect of female gender. Basically this means that factors such as education and ethnic background have effects on sexual activity which are both independent and mediated through drinking behaviour. Meanwhile, young women are more likely to be sexually active than young men, yet this apparent effect is not independently due to gender per se. Instead, this effect is associated with young women being more likely to report being drunk.

Having a positive attitude towards alcohol is also an independent predictor of sexual activity rates. Regardless of socio-demographics those who have a positive attitude towards alcohol are 1.4 times more likely to be sexually active than those who do not.

### 13 Sexual decision-making and alcohol

#### 13.1 Perceived benefits and risks

The relationship between alcohol, sex and risks is clearly complex. Alcohol is seen as playing positive as well as negative roles. Around a third of questionnaire respondents cited confidence as a benefit of drinking alcohol before having sex. Other perceived benefits include having an excuse, reducing pain and embarrassment and increasing sexual feelings.

*“If someone says why did you do such a thing, then you can just say because I was pissed, yes, and you have got a reason haven’t you.” (female)*

*“If you are drunk then a lad might take advantage, but it makes you feel more comfortable.” (female)*

Alcohol is seen as a disinhibitor, encouraging people to make decisions that they may not make while sober. At the same time there is concern about alcohol reducing people's capacity to say no. This is seen as leading to experiences that are later regretted, involving different levels of coercion.

*"If they are forcing it on you and you are wrecked out of your head, then you have got no energy in you, and you are struggling to get up." (female)*

### **13.2 Peer group influence**

Friends play an important role in sexual decisions. This involves both setting the boundaries for what is acceptable, and influencing the decision at the time. The focus groups suggested that this is closely linked with alcohol, describing situations that were part of a night out drinking. One reported strategy involved a young woman being asked to prevent her friend from going off into the bushes.

*"Don't let me walk off with him on my own." (female)*

There was a sense that despite not wanting to have sex, the young woman would not trust herself to keep within this boundary and anticipated that later in the night, once drunk, she may lose control and be persuaded or manipulated by a young man. She looked to a friend for protection, attempting to hand over the pressure of responsibility for the decision. However, participants felt that in the event, the friend would not have control over the situation either. The implication was that if sex occurred, then both young women would regret it and feel guilty.

*"When they're drunk you're best off leaving them cos you don't know what to do... Then you feel guilty in the morning for letting them ... like it's your fault." (female)*

Young men were more likely to report egging each other on, especially when drunk, and needing to impress each other in relation to sexual experience.

*"With lads it's like, 'I'm doing her.'" (male)*

*"You have got to show them (mates) who's boss... when it comes to sex." (male)*

*"If your mates are wrecked they motivate you and say 'get in there'." (male)*

### **13.3 Risk perception**

Young people identified positive reasons both for getting drunk and for having sex, which in many cases appear to outweigh the risks that they perceive. Rather than illogical decisions simply due to 'ignorance,' these activities fulfil functions in many young people's lives. There is a need to find effective ways to enable young people to achieve some of these perceived outcomes in less risky ways. This may include alternative activities, work around friendships and relationships and input relating to self esteem and mental health. Interventions need to relate to the range of young people's experiences, rather than portraying alcohol and sex solely in a negative light. This would enable them to explore their own boundaries and values while recognising both the risks and benefits of these experiences.

## Conclusions

### 14. Conclusions and policy implications

#### 14.1 Need for targeted responses

More effective ways are needed to target the most vulnerable groups, identified by gender, ethnicity, aspiration and deprivation. There is evidence that basic information and services provided universally are not meeting the varied needs of all groups. Some young people are vulnerable as they are less likely to access services or pick up health messages. Others need different inputs that relate to their experiences of sexual activity and binge drinking from a relatively young age. Even in a cohort not seen as especially vulnerable overall, there are factors which increase vulnerability:

- alcohol use
- lack of aspiration
- lack of knowledge
- poor negotiating skills
- low sexual and other expectations

#### 14.2 Variations in drinking and sexual activity

While the majority of respondents were not yet sexually active, there were significant differences according to ethnicity, gender and aspiration. Young people who reported sexual intercourse were more likely to be white, female and with low educational aspirations. They were also the most likely to report binge drinking. One third of respondents were sexually active, but among young people with all these characteristics, this figure rose to more than half.

While Asian young people were less likely to be sexually active or to drink alcohol, there were still significant minorities who did. They are likely to be particularly vulnerable given the far lower rates of sexual health and alcohol knowledge, and of confidence in accessing advice from services or parents, compared to their white peers. Interventions need to acknowledge the influence of faith and culture for young people, and prioritise Asian young people's educational needs in this area.

Getting drunk is widely accepted as a normal way to have fun by most white young people. While the vast majority have been drunk at some point, a minority of one in five report binge drinking, defined here as getting very drunk more than once in the past month. There is a need to better target risky drinking, making a distinction from occasional moderate drinking. Quantities of alcohol need to be conceptualised in more appropriate ways that make sense for young people, and to communicate key messages effectively. Gender specific harm reduction work is required, particularly relating to sex and personal safety.

The impact of aspirations on sexual activity rates suggests that expecting to stay in education is a protective factor, which is linked with lower levels of reported sex as well as of frequent drunkenness. Increasing young people's self confidence, sense of achievement and future aspirations could prove an effective way of reducing sexual activity and risky drinking at a young age.

White young people living in the most deprived areas were more likely to report first intercourse at a younger age than those in less deprived areas. However, they were equally likely to have become sexually active by the time of the study (when they were aged 14 to 15), regardless of deprivation.

Results show relatively high rates of sexual activity with increasing levels of STIs which suggests that the reduction in teenage pregnancy rates in Rochdale may be linked more to an increased use of hormonal contraception, than with consistent condom use or a genuine change in underlying sexual behaviour.

While a significant proportion of young people face deprivation, exclusion, low aspirations and a lack of self esteem there is a need to look beyond the provision of traditional, information-based education towards more creative ways of addressing these underlying factors.

### **14.3 Challenging attitudes relating to gender, power and sexuality**

Ideas about gender differences relating to pleasure and consent were already developed amongst white and Asian young people of both sexes, whether or not they were already sexually active. There is a tension for young women between the pressure not to be seen to want sex, and a sense of obligation to have sex. They struggle to articulate what they actually want, for fear of being seen as a 'slag' or as 'frigid'.

Female sexuality was widely seen in terms of sex as pain rather than pleasure. This contrasts with a view among a few young men, at the other extreme, of young women as predatory man-eaters who get multiple orgasms. Meanwhile, young men are expected to fit masculine stereotypes about virility. The higher levels of sexual activity and binge drinking among young women indicate some changes to traditional gender patterns, yet it seems that many lack a feeling of control or sexual assertiveness.

Pornography appears to have a strong influence on sexual expectations, with reported disappointment when the experience does not match up. It is seen as a direct source of ideas for what should be included in the sexual repertoire, leading to pressure on young women to comply. There is a need to be aware of the significance of pornography as a source of information and influence and to challenge messages that it gives out.

Feeling in control about negotiating consent to sex was seen as very difficult, and made harder by the effects of alcohol. One in five white females reported going further sexually than intended because they were drunk. There was a lack of skills and confidence in decision-making relating to sexual activity among both males and females. Many saw alcohol as playing both positive and negative roles in relation to sexual activity, by increasing confidence and serving as an excuse, as well as increasing the risk of doing something they would regret.

### **14.4 Managing risks and benefits of sex and drinking**

Young people identified positive reasons both for getting drunk and for having sex, which in many cases appear to outweigh the risks for them. Rather than illogical decisions simply due to 'ignorance,' these activities fulfil functions in many young people's lives. These may include increasing confidence, socialising, keeping up with peers, enhancing their reputation or forgetting about problems through drinking. Similarities exist with the purposes served by sex, which also included feeling wanted, pleasing or keeping a partner, feeling grown up and expressing closeness or love. There is a need to find effective interventions to enable young people to achieve some of these perceived outcomes in less risky ways. This may include alternative activities, work around relationships and input relating to self esteem and mental health.

Many young people were able to identify risks to their safety and wellbeing associated particularly with extreme drunkenness and unprotected or coercive sex. Hanging out in large groups on a Friday night is seen as an opportunity to get drunk and 'get off' with people or to have sexual experiences. Risks associated with these drinking sessions include 'going too far', getting into fights or being moved on by police.

Messages about risks appear to be getting through to young people to some extent at an intellectual level; the challenge remains to turn existing awareness into behaviour change. While risk taking is part of adolescence, there is a need to help young people to develop the skills and strategies to manage risks. Interventions need to relate to the range of young people's experiences, rather than portraying alcohol and sex solely in a negative light. This would enable them to explore their own boundaries and values while recognising both the risks and benefits of these experiences.

### **14.5 Increasing consistency in knowledge and trust in services**

Young people's knowledge levels suggest that sexual health messages are not being communicated equally effectively to all groups. They continue to be missed by more Asian

young people compared to white young people, and more white males than white females. The same groups with low knowledge levels about prevention of STIs and pregnancy were also less likely to feel confident accessing services for support and advice.

These findings suggest a clear need to improve consistency in the ways in which sexual health messages are promoted, in order to increase the accuracy of all young people's knowledge levels. A particular need emerges for targeted information that reflects the concerns of particular groups that may be vulnerable due to lack of knowledge. Sexual health messages should include Asian young people, and address the diverse influences of their peers, their faith and multiple cultures. They should also cover risks involved in oral sex, as well as in intercourse, as a significant proportion of young people had experience of one activity but not the other. There is scope to improve sex and relationships education both in school and in other settings through more creative approaches and utilising more informal opportunities with young people.

As well as informing young people about sexual health and sources of help and support, there is a need to break down other barriers that may prevent them from accessing services. There appears to be an important gap between knowing about a service, and accessing it, often due to an expectation that they might be judged or that confidentiality may not be respected. This indicates a need to go beyond providing contact details and develop more creative and targeted work, to build up trust and confidence. This could include arranging visits, use of videos and outreach work to help reduce fears about what to expect. Again, this work should reflect the reality of different young people's needs, specifically including young men and those from different ethnic backgrounds.

#### **14.6 Priorities for policy and practice**

Addressing the inequalities of risk taking is a priority. This means focusing on vulnerability and what underpins it, as much as on specific sexual health and alcohol issues. There is potential for services to focus on the factors which influence the behaviours, as well as responding to the outcomes of individual risk taking. This should include:

- Challenging prevalent cultural attitudes towards gender and power relations, which shape young people's expectations of their own sexual relationships
- Increasing aspirations
- Improving self-esteem, assertiveness and decision-making skills
- Increasing confidence in accessing a range of services for support
- Increasing levels of accurate and consistent knowledge
- Awareness of the impact that faith and culture have on young people's decision-making around sex and relationships and sexual health issues

Services need to work in partnership to increase young people's expectation that sexual relationships can and should be safe, consensual, respectful, enjoyable and thus healthy.

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**ROCHDALE  
TEENAGE  
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