

# **Evaluation of Sexual Health Sheffield's Services in Community Settings: Perspectives from Young People aged 15-25 years**

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Members of the Sexual Health Network, Sheffield

## Summary of findings on community engagement services

This report details findings from an evaluation of Sexual Health Sheffield's (SHS) services in community settings (also known as **Community Engagement** services) from the perspective of young people aged 15-25 years. The evaluation was carried out during September 2014 to January 2015. Twenty nine young people aged 15-25 years who live in Sheffield or have used Sexual Health Sheffield's services participated in the evaluation via interviews and / or focus groups.

## Headlines

### 1. Sexual Health Sheffield's services in community settings are excellent

Characteristics of 'excellence' include informal professionalism, knowledge and advice that is reliable and easily understood, good communication skills and non-judgemental attitudes. For some, the service was described as a 'life saver'.

### 2. Unanticipated gains from involvement in SHS's services in community settings

Several young people said that involvement in sexual health services improved their levels of knowledge, with unexpected gains, such as, enhanced happiness, communication skills and confidence. Mental health was seen as central to sexual health. Positive impact was most evident among those who had had extensive sexual health input through their role as a volunteer or member of a group supporting young LGBT people and young people who had supportive parents.

### 3. Importance of supportive parents and school-based sex and relationships education (SRE)

Sexual health services are important but all participants said that on a day-to-day basis, parents and thorough SRE were most influential on feelings about oneself, sexual health and relationships. For individuals who did not have supportive or communicative parents and/or poor experiences of SRE, sexual health services in community settings offer a unique and vital source of support.

### 4. Restricted meanings of 'sexual health'

Some participants' descriptions of 'sexual health' were not as broad or positive as that said to be underpinning the strategy for Sheffield's sexual health services (and enshrined in the WHO definition of sexual health). For some, sexual health is conceived as not getting pregnant or contracting a sexual transmitted infection (STI).

## Key recommendations for sexual health services in community settings

### 1. Identity of the service

The SHS service identity (and brand) is in its infancy. Consider a consultation about ways of raising the profile of the service and communicating with a broader range of young people including those who are currently not accessing sexual health provision.

### 2. Positive and holistic sexual health, including mental wellbeing, self-identity and relationships

Services are underpinned by the WHO definition of sexual health that embraces a wide range of interrelated issues. Consider how to actively promote holistic sexual health that includes recognition of mental health (self-esteem and wellbeing) and support for affirming self-identity and relationships, as well as avoiding unwanted pregnancy or STIs.

### **3. Health promotion**

Consider sexual health promotion advertising and initiatives with a view to the services becoming more visible, inclusive of identities and practices, challenging stigma, and creating a reputation for public health interventions that are renowned for being delivered in a non-judgemental manner.

### **4. Sexualities and Relationships Education (SRE) and Personal, Social and Health Education (PSHE)**

School and college-based SRE is not offering universal access to SRE and support for sexual health. NHS based services are not sufficiently resourced to meet this deficit. Consider how NHS services can work productively with local authority, schools and colleges to address this.

### **5. Provision of free condoms**

Increase the availability, or at minimum, endeavour to maintain the provision of free condoms as these are imperative to young people's abilities (i) to protect their sexual health, and (ii) have some measure of control over their sexual practices and relationships. Condoms are also perceived as key to normalising sexual health and keeping sexualities and sexual practices on everyday agendas.

## 1. Introduction

This report details finding from an evaluation of sexual health services in community settings from the perspective of young people aged 15-25 years. The evaluation was carried out during September 2014 to January 2015.

Sexual Health Sheffield (SHS) is an integrated service comprising services in clinical and community settings and has been operational since April 2014. Prior to integration with clinical services, the community outreach service operated as the Centre for HIV and Sexual Health. The evaluation project was undertaken to produce evidence that could contribute to enhancing the effectiveness and responsiveness of this newly integrated and developing service.

Clinical services were not part of the evaluation, but most participants did not distinguish community and clinical services and commented on both. This might be expected given the relatively recent integration of services. The evaluation Advisory Group and SHS's senior management group unanimously agreed that insights on clinical services should be included in this report because they offer valuable insights relevant to SHS service developments.

Young people's generous participation in this evaluation highlights their willingness to talk openly and frankly about sexual health and sexualities, and issues they perceived as related, for example, mental health and sex and relationships education. Notably, most participants said they were happy for their name and disclosures to be identified (and did not require a pseudonym or other anonymising features) because they had 'nothing to hide' and had strong feelings about their views being heard. However, the ethics and governance of this evaluation require anonymity.

Others were less confident and surprised their views were sought, as reflected in comments such as:

*'I've got nowt of any use to tell'*

*'Nobody usually asks me what I think'*

This sense of lack of value or voice is all the more significant because these young people subsequently spoke of deprivations on many levels including poverty, limited or poor experiences of sexual health services and sex and relationships education at school and home. Self-perceptions of sexual health and self-efficacy were also least positive among this group. This highlights the importance of centralising young people's views in service developments and evaluations and ensuring that findings embrace the various contexts that frame experiences.

### 1.1. Methodological framework

Feminism and post-structuralism underpinned the evaluation. In practice, this meant that the evaluation paid close attention to how participants' experiences of the service related to their actual social realities and the mechanisms that might create gendered experiences (Ramazanoglu and Holland 2002). Post-structuralist positioning accepts that knowledge is socially constructed and permeated by values, historical influences and the workings and relations of power (Weedon 1987). Reflexivity is a necessary element within such research practice. Broadly, this means acknowledging my own position within the research and the effect on the evaluation process and participants, through careful attention to power, questioning assumptions and 'truths' (Letherby 2003) and unpacking disclosures in relation to specific contexts. These factors informed the evaluation design, approach to data collection and analysis (Kendall and Wickham 1999).

A quantitative approach to data collection was neither appropriate nor required given that the evaluation sought to capture qualitative data on young people's views and experiences, with in-depth, contextualised insights as the primary interest. Findings are intended to supplement quantitative measures routinely collected by the service.

#### 1.1.1. Method

The initial design of the evaluation was informed by research literature on young people's sexual health services and evaluation techniques and the author's previous research (for example, Hirst 2014a, 2014b, 2008; Ingham & Hirst 2010; Formby et al 2010a, 2010b, 2010c; Owen et al 2010; Formby et al 2009).

A number of consultations between the author and key stakeholders provided local intelligence. This included:

- SHS community engagement team
- representatives from Sheffield's local authority
- representatives from school and college based education and the *Healthy Schools* team
- representatives from public health commissioning
- the Sheffield Multi-Agency Young People's Workstream

The [Evaluation Steering Group](#) included representatives from SHS community engagement team. This guided pragmatic and organisational issues, consensus on the purpose of the evaluation, clarity on individual and agency responsibilities, operationalisation and communication of results.

The [Evaluation Advisory Group](#) offered valuable, impartial advice and assisted in ensuring the project's goals and expectations were met. Membership included:

- SHS (2 people from different tiers of the service)
- a youth service (local authority) representative
- a young people's representative who was also a member of the Sheffield Sexual Health Network
- a representative from sexual health commissioning in a neighbouring local authority
- an expert in research methodology and evaluation
- a doctoral research student (as observer)

Sheffield Teaching Hospitals [Clinical Effectiveness Unit](#) endorsed the final evaluation plan.

#### Recruitment

The evaluation was open to anyone aged 15 to 25 years who lives in Sheffield or used SHS services. All data were collected within the confines of Sheffield (including the city centre and outskirts of the city).

A recruitment flyer (see appendix 1) about the evaluation was distributed via local networks and stakeholders in community and educational settings. Potential participants then contacted the researcher directly or through link providers. An information sheet (see Appendix 2) providing more details on the evaluation was given to each potential participant before confirming their decision to participate. Prior to any data collection, the consent and revocation of consent form (see appendix 3) was issued to each participant, discussed for understanding of the evaluation process and right to withdraw, signed by the participant and researcher, with a hard copy for the participant and researcher.



Qualitative interviewing techniques were the main source of data collection. An interview aide memoire was designed by the researcher in consultation with the project Steering Group and piloted with 6 young people. Revisions were made as a result of the pilot study and the final aide memoire provided broad cues for interview questioning. In practice, the interviews were conducted as conversations and where possible, these conversations were led by the interviewee/s (Kvale and Brinkmann 2009). The participants could choose to be interviewed individually and/or in a small or larger group. Face to face interviews took place at a local university and community venues. At their own request, two participants responded by answering questions (based on the aide memoire) via email. In total, 29 young people volunteered their participation. There were 16 individual interviews, one small focus group (2 people) and one larger focus group (12 people). Two people participated both in a focus group and a subsequent individual interview.

All interviews were conducted, (digitally) recorded and transcribed by the report's author.

## 1.2. Analysis and reporting the findings

Interviews were analysed thematically (Bryman 2008). This type of analysis focuses on identifiable themes and patterns of experiences and views. Each individual interview was analysed independently and then compared across the whole cohort of participants and groups to identify patterns of experience, meaning, feelings and vocabularies, and areas of similarity and difference within the patterns.

Validity of the cross-cohort themes was tested through reference to wider literature and other related studies; this allowed inferences to be justified, and formulated with confidence, into the main conclusions and recommendations from the study.

Where possible, associations between different aspects of disclosures have been suggested, for example, associations between proximity to city centre and awareness of sexual health, but the small sample size limits the reliability of firmer correlations.

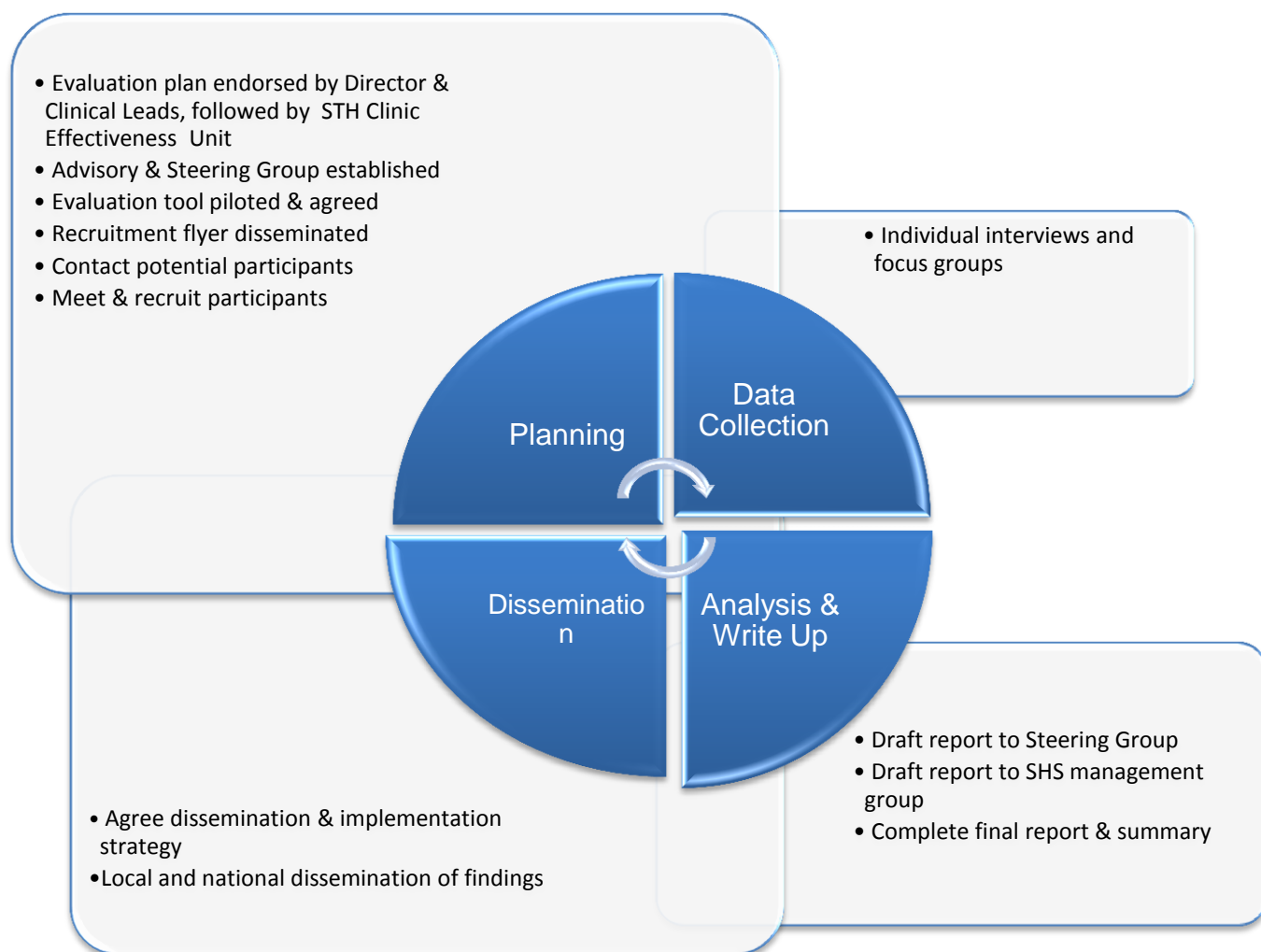
Findings are written up as key themes that are summarised in the third person, followed by illustrative extracts (verbatim quotes) from the data. Findings are reported in this document to reflect the key areas of conversations and questioning.

### 1.2.1. Limitations and reliability of the findings

Although the findings may not be generalisable to wider populations or different locations, they are representative of the young people that the evaluation sought to prioritise, that is, participants from a range of postcode areas (inner city, suburbs and outskirts) and those young people least represented in existing evidence bases. The reliability of the findings has been endorsed via dissemination to other groups of young people, youth and community workers, teachers, members of the steering group and advisory group, and NHS managers. As such, the evaluation findings are regarded as sufficiently reliable to have relevance for young adults in wider contexts and population groups.

The chart below summarises the process of the evaluation.

### Chart to summarise the evaluation process



### 1.3. Anonymised participants

To protect the anonymity of participants, verbatim extracts from disclosures are indicated by a pseudonym, an abbreviation for their self-descriptions of gender and sexuality, and their age. For example, Amy, F, PS, 17 depicts a female, pansexual, aged 17; and, Dan, M, G, 16 depicts a male, gay, aged 19. Postcode, ethnicity and disclosures have not been included in quotes as this might compromise confidentiality. Appendix 4 provides more detail.

#### 1.3.1. Key to abbreviations for genders

Genders	Abbreviation
Fluid	FI
Non-Binary	NB
Neutral	N
Trans	T
Female	F
Male	M

### 1.3.2. Key to abbreviations for sexualities

<b>Sexualities</b>	<b>Abbreviation</b>
Bisexual	Bi
Bi and Open	Bi & O
Pansexual	PS
Panromantic	PR
Asexual	A
Gay	G
Lesbian	L
Straight	St
Heterosexual	Het

This evaluation fulfilled its aim to capture the views of young people with a range of identities, abilities, backgrounds and experiences and met the goal of inclusivity regarding sexualities, genders and localities.

### 1.4. Order of the report

Section 2 offers a summary of participants' characteristics. Section 3 documents findings from settling-in conversations about participants' meanings of sexual health and sexual health promotion. This is followed by experiences of using the services (section 4), impacts of services (section 5) and contexts for the experiences disclosed (section 6). Participants' 'wish list' for future services concludes the findings in section 7. The author's recommendations for service development and research are summarised in section 8.

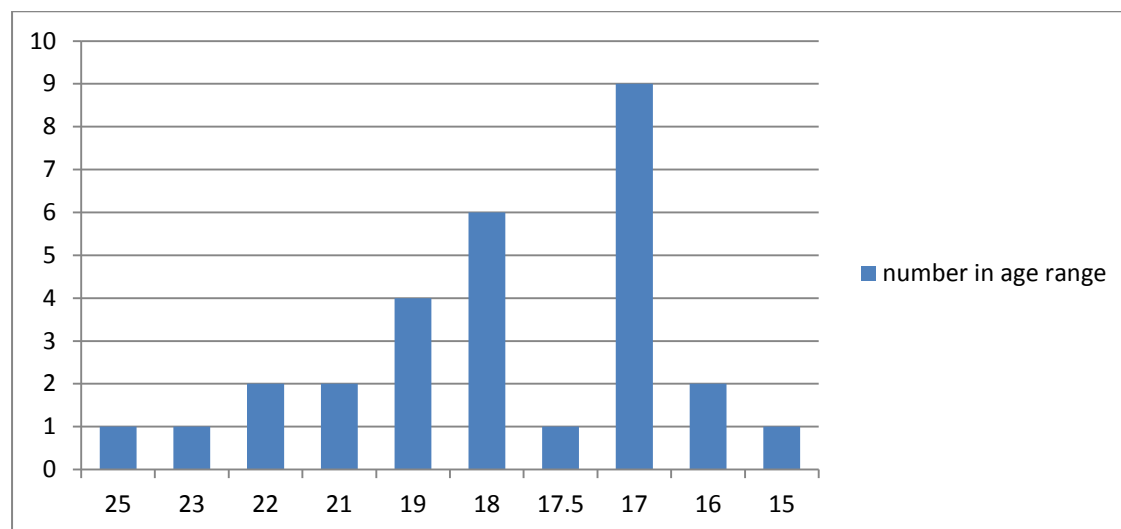
## 2. Characteristics of participants

Individuals described their gender, sexuality, ethnicity, first language and social class, and give their current age and postcode (first letter and number/s e.g. S14). The following charts summarise these features.

### 2.1. Age of participants

At the time of the evaluation, the youngest participant was 15 and the eldest 25 years, with the majority of participants aged 17 to 18 years. Nineteen participants were aged between 15 and 18, and ten were aged 19 to 25 years.

#### 2.1.1. Chart to depict age of participants (in years)

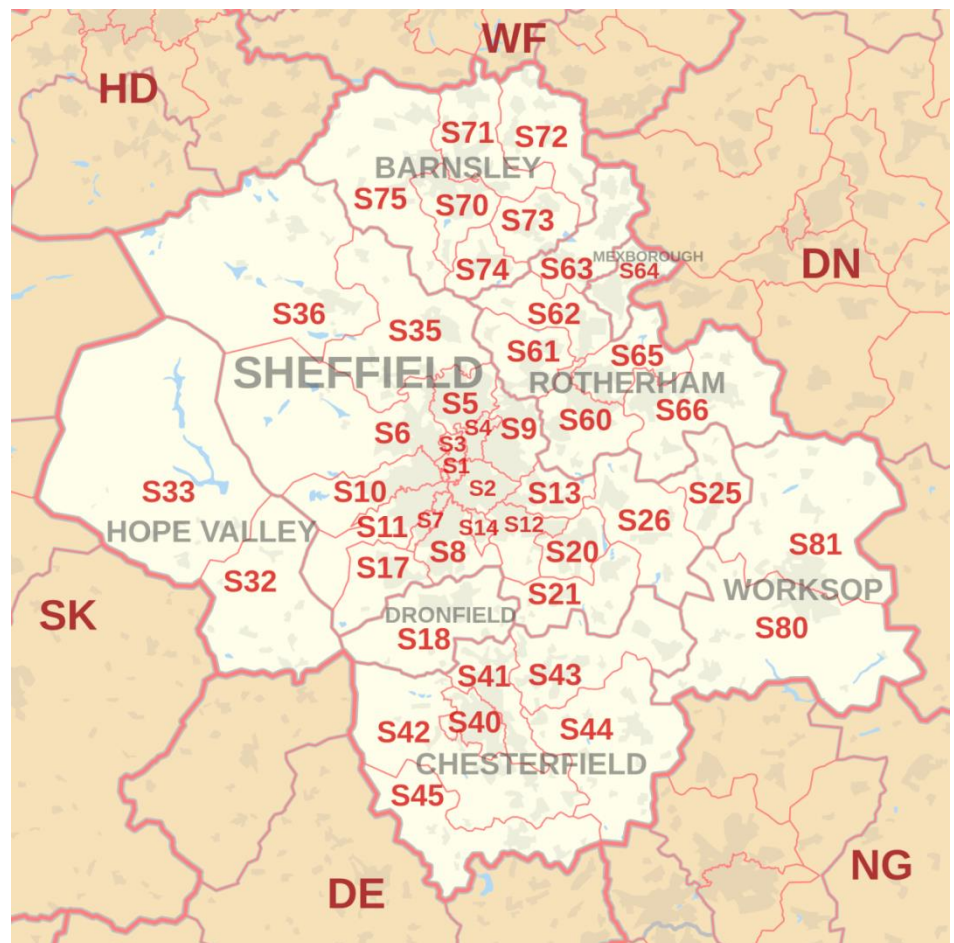


### 2.2. Primary place of residence

Most participants lived in central or suburban areas, within 3 miles of the city centre. A small number lived more than 15 miles from the city centre, and one person lived 37 miles from the city centre (but used the services in Sheffield).

### 2.2.1. Primary place of residence depicted by post code

Postcode	Number of participants living in postcode
S1	1
S2	2
S4	1
S5	3
S6	3
S7	3
S8	2
S9	1
S10	2
S11	5
S12	1
S26	1
S32	1
S36	3
DN6	1



### 2.3. Ethnicity and first language

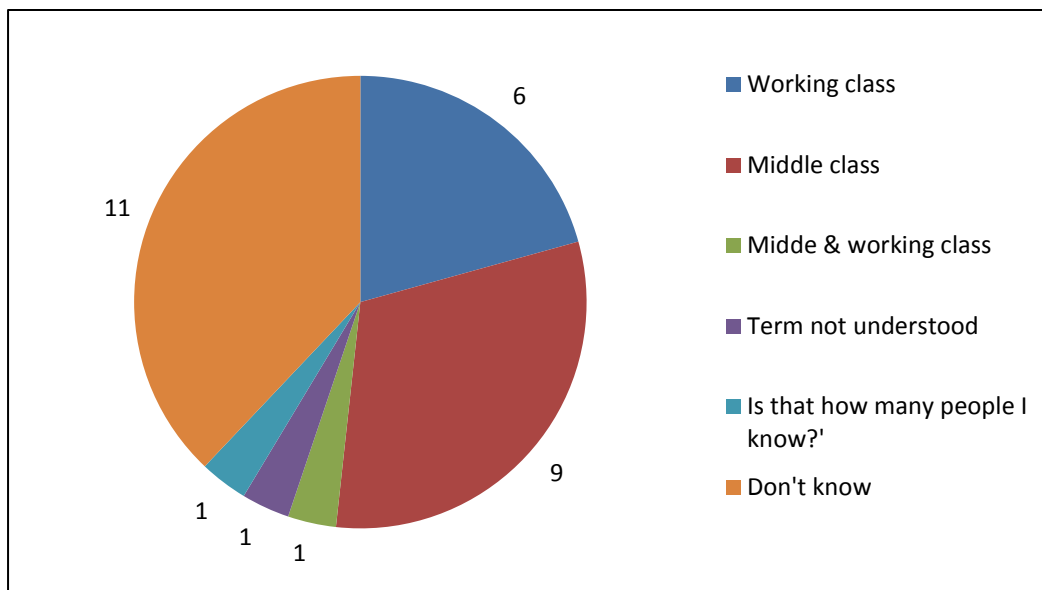
All participants' first language was English and ethnicities were described as black African (1 person), African (1), white mixed (1), mixed race (1) and white British (25).

### 2.4. Social class

Descriptions of social class proved less straightforward than anticipated. Sixteen young people answered 'working class', 'middle class' or 'middle and working class'. Eleven said they did not know their social class, weren't sure, or, didn't know how to describe it. One person did not know what the term meant and another asked, *'Is that how many people I know?'*.

As the chart below illustrates, in this sample, social class is not an identity characteristic easily described or understood. This contrasts with descriptions and understandings of genders and sexualities that were full and diverse (as discussed below).

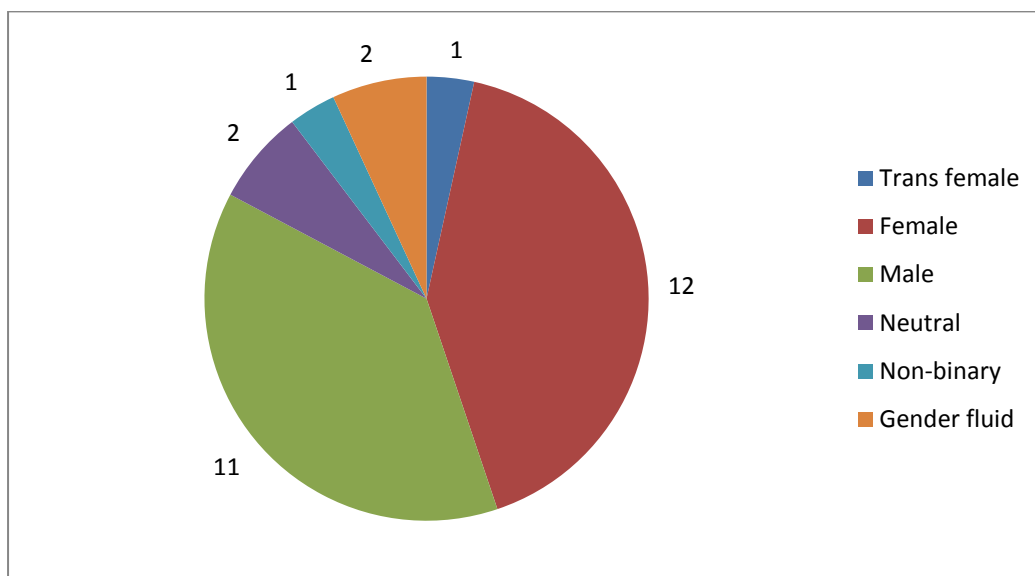
### 2.4.1. Chart to depict participants' self-description of social class



## 2.5. Genders and sexualities

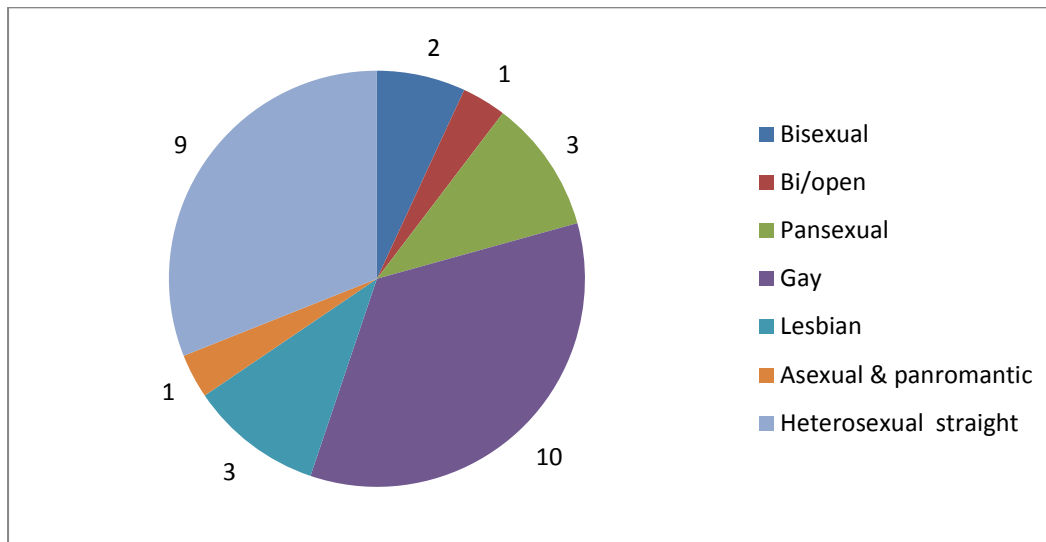
The request for self-description intended to be more inclusive than reductionist conceptualisation that segregate genders into female or male, or, three options of male, female or trans that incorrectly suggest that transgender people are a 'third sex'. Neither option embraces gender fluidity or neutrality. This is important, given that participants in this study described their gender as trans, female, male, neutral, non-binary, fluid.

### 2.5.1. Chart depicting participants' self-description of genders



Similarly, for sexualities, binary distinctions of gay-straight, or LGBT and Q would not have revealed the range of identities described by participants, that is, bisexual, bi and open, pansexual, gay, lesbian, asexual, panromantic, straight, heterosexual and 'heterosexual, for now'.

### 2.5.2. Chart depicting participants' self-description of sexualities



### 3. Participants' descriptions of sexual health and sexual health promotion

The Sheffield Sexual Health Strategy 2012-2015 (Sexual Health Network 2012, p.5) states that its vision for sexual health is *'built upon the belief that all people have the right to good sexual health, whilst acknowledging the complexities of sexuality and the integral part it plays throughout people's lives. Sexual health should not be solely concerned with disease or infection but with promoting good sexual health in a wider context. This is in line with the following WHO definition which reflects the thinking within this strategy:*

*Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. (WHO, 2002)*

#### 3.1. Sexual health

In light of this vision, and as an ice-breaker, participants were asked to share what they understood by 'sexual health'. All first responses described sexual health in terms of prevention and disease: 'preventing STIs or STDs', 'stopping you getting things', 'diseases and that'.

When specifically asked whether sexual health could be wider than STIs, other issues emerged:

*'Sexual health means being able to take care of yourself and being aware of the different kinds of sexual infections, diseases that are out there' (Tara, F, ST, 18)*

*'The physical wellbeing of your genitalia' (Tom, M, G, 18)*

*'Any personal problems to do with sex' (Ted, M, G, 17)*

*'Relationships and stuff' (Noah, M, G, 23)*

*'Looking after yourself and your partner' (Amy, F, St, 25)*

*'Sexuality, gender issues' (Ruth, F, Bi, 17)*

For some participants, the question was rephrased in an attempt to elicit broader descriptions:

**Interviewer: 'If you had 'sexual health', what would it be like?'**

*'I would be clean ... of any STIs. Just like, um, healthy sexually' (Jen, F, H, 18)*

#### 3.2. What does sexual health promotion mean to you?

First responses focused on models of health promotion concerned with knowledge and prevention:

*'Awareness of STIs' (Finn, M, G, 17)*

*'Making sure you have knowledge to prevent getting things' (Tom, M, G, 18)*

*'Alerting to services that can help with STIs. Learning how to protect yourself from*



*diseases'* (Ed, M, G, 17)

*'STIs and the different methods of contraception and where to go when you need information'* (Tara, F, ST, 18)

*'Making sure people are informed about contraception, STIs, pregnancy'* (Jen, F, het, 18).

More participants mentioned STIs, than pregnancy and/or contraception. Since less than half the sample was straight/heterosexual, this might reflect the sexual health priorities of participants or the focus of sexual health promotion they had received. Either way, inclusive sexual health promotion should include issues of pregnancy and contraception, irrespective of the sexuality of recipients.

As with sexual health (section 3.1) further prompting evoked more comprehensive descriptions:

**Interviewer: *'Is sexual health promotion broader than preventing diseases?'***

*'Safer sex'* (Ted, M, G, 17)

*'It's knowing what a healthy sexual relationship is'* (Kira, F, L, 16)

*'Yes, it's knowing about gender. Women need different things to men. Like I still don't really know much about periods and that'* Tom (M, G, 18)

*'It's about heterosexual and homosexual experiences'* (Will, M, G, 17)

*'It's about promoting and encouraging sex ... in a way that's informal, healthy, equal'* (Jon, M, St, 19)

*'.. the main way of making [people] aware of the different matters around the topic of sex, how to take care of themselves, what to do in different situations when you feel you're a risk and the different locations [where] you can speak to a specialist in confidence about your sexual health'* (Tara, F, ST, 18)

*'It's where you can be open and anonymous ... It's knowledge and the services to get help'* (Jen, F, St, 18)

HIV/AIDS was mentioned only once, by one person. Of course, this might be included in 'STIs' and 'safer sex' so does not necessarily equate with ignorance of HIV but it does suggest HIV is not on immediate agendas.

### 3.3. Pleasure

Pleasure was not mentioned in participants' descriptions of sexual health or sexual health promotion. But when asked (in line with the definition engendered by Sheffield's sexual health strategy) all those with broader understandings agreed that it was important. However, no one remembered any input on pleasure from school or services:

*'Yeah, course. Has to be in. But it's not'* (Cole, M, St, 21)

*'My mum goes on about it'* (Leah, F, St, 19)

*'Yes, pleasure. Well, it should. But not sure I remember anything on it'* (Eve, N, G, 18).

Those appearing to have least knowledge or understanding of sexual health could not comprehend why pleasure might be relevant:

*'No idea'* (Max, M, St, 16)

*'Eh? What? Where does that come in?'* (Kris, M, St, 18)

Subsequently, these two participants spoke very negatively about their experiences of SRE at school, as addressed in more detail below.

### 3.4. Summary

Although some participants widened sexual health and promotion (once prompted) to include gender, equality, diversity of sexualities and relationships, their sense of sexual health was not as broad or positive as that enshrined in the WHO definition or Sheffield's Sexual Health Strategy.

Wider understandings of sexual health were held by those who described relationships with parents as 'open' or 'liberal' and/or they were sexual health volunteers, and/or or attended city centre based youth groups. These responses embraced a diversity of identities and values, and more appreciation of links between sexual health, wellbeing and confidence. In comparison, questioning and probing of individuals who did not have this type of support suggested a sense of sexual health that was limited to prevention of STIs, pregnancy and risk. Participants invariably looked confused or answered *'what do you mean?'* or *'don't know'* to probing or more direct interview questions, such as, *'could sexual health mean more than not getting an infection or pregnant?'*

Other elements of the WHO definition that were not mentioned explicitly included dysfunction or infirmity, coercion, discrimination and violence. Again, these might be covered in other terms or comments such as *'healthy sexual relationship'*.

Overall, this does not lead to a conclusion of a lack of broader understanding of sexual health or sexual health promotion. Rather, it points to a need for further research or consultancy to assess how far the definition underpinning the strategy is conveyed or operationalised in practice.

## 4. Experiences of using the services

Those who had used SHS services described their experience/s as positive. Reasons given (from collective disclosures) include: *'professional'*, *'reliable knowledge'*, *'informal'*, *'good communication skills'*, *'easy to understand'*, *'non-judgemental'* and *'informal'*. Most of these general comments relate to a memorable experience of speaking to someone at a sexual health event, or stall, Chlamydia screening, peer education or training as a volunteer or peer educator (comments on specific services can be found in section 4.4).

Although most participants reported positive experiences, their comments (below) raise issues for consideration.

### 4.1. Sources of information

Participants found out about services through various sources, in the main from friends, *'friend of a friend'*, peer educators, teacher / mentor or *'leaflet'*:

*'I found out about C-card from my boyfriend at the time. It's the only thing I'd ever had on sexual health'* (Jo, NB, PS, 17)

*'Peer mentor sent me a link to Fruitbowl [youth group]'* (Will, M, G, 17)

None recalled hearing about services from school or college, though they said it may have been offered but it did not register.

Some participants felt that information on external services regarding sexualities was not readily accessible in schools:

*'It's hard if you're LGBT'* (Ruth, F, Bi, 17)

*'I found this weeny leaflet on a corridor at school'* (Finn, M, G, 17)

### 4.2. Contact with services

Contact occurred through various means, with most following up a referral or recommendation through a telephone call, text or email. Contact processes were viewed as *'easy'* and efficient:

*'Really easy. I emailed them (SHS) telling them why and they emailed me back'*  
(Amy, F, ST, 25)

*'The contact process was very easy because after I emailed them letting them know what I was interested in, they emailed me back'* (Tara, F, ST, 18)

### 4.3. Using services

Participants were asked to describe their experiences of using services, starting from first impressions. Their first responses were generalised and, as mentioned above, relate to services at events/stalls, Chlamydia screening, free condoms, peer education and/or peer support groups.

All said they had been able to speak honestly and openly and were given as much time as needed; sexual health practitioners were described as non-judgemental and communicated clearly:

*'I was made to feel really comfortable and the people are really friendly. I felt I could speak openly without any problems and without feeling shy'* (Tara, F, ST, 18)

*'Like a well-informed friend that you can trust..... It's kind of an informal professionalism. [...] No, no barriers. Kind of, barriers are intimidating, like when it's all scientific' (Jon, M, St, 19)*

*'They know what they're doing but they're not formal or intimidating' (Sam, M, G, 22)*

*'It's professional but informal. Like, like talking to your mates but they're a real professional' (Jen, F, St, 18)*

*'They're just really, really nice' (Jen F, Het, 18)*

*'Total accepting of where you are' (Noah, M, G, 23)*

*'... most of them are really open minded' (Kira, F, L, 16)*

*'It's confidential. Took me weeks of texting with [name of worker] til I finally got the confidence to show up. SO worth it' (Kat, Fl, A & PR, 15)*

*'Really welcoming. Nothing is a big deal' (Eve, N, G, 18)*

All participants said they got what were they were aiming for, or, seeking support for, and they would recommend the services.

#### 4.4. Views on specific services

Participants were then asked to comment specifically on component parts of community engagement services.

##### 4.4.1. Chlamydia screening

All participants had experienced, observed or heard about Chlamydia screening in school, college or youth centres.

*'I found out about Chlamydia at a stall. Ended up having a test and knowing all about it' (Finn, M, G, 17)*

*'They did Chlamydia screening in school and I remember they gave out little keyrings' (Jen, F, Het, 18)*

*'I use an online website that sends Chlamydia test directly to my house ... in a discreet package' (Tara, F, ST, 18)*

Chlamydia screening has become a familiar experience for most young people in this sample. All said they had or would willingly have subsequent tests based on their first experience. This is commendable feedback given that first experiences can deter future involvement.

Descriptions from four participants implied the service was primarily focused on screening and did not recollect a health promotion element.

##### 4.4.2. Peer education

Most participants recalled positive experiences of peer education sessions in school, for example:

*'Yeah, people came in to school about condoms. It was good' (Finn, M, G, 17)*

Those over 16 years (the majority) offered little detail as they couldn't remember it because it had taken place years previously. Others were volunteer peer educators for youth groups and very enthusiastic about the benefits of their involvement for themselves and their audiences, particularly in terms of knowledge, questioning assumptions and confidence (see more detail below, section 4.5)

#### 4.4.3. Events in community settings

When asked if they had experienced sexual health events outside school or college, some recalled seeing 'stalls' or 'pop-ups', *Sexual Health Saturday* and *Pride*.

#### 4.4.4. 'Open Doors' services (i.e. sexual health provision in schools, colleges, youth clubs and supported accommodation)

'Open Doors' is a programme of training and capacity building for sexual health practitioners or those with a more generic brief or involvement with young people. Participants had not heard of the services though might not be expected to know this term as it is the title of a programme used by staff.

#### 4.4.5. Provision of free condoms

Youth workers who provide and support young people on condoms may have been on an 'Open Doors' training programme though participants would not necessarily have known this.

All those who had received free condoms, with or without a C-card, were very positive. The provision of condoms was regarded as highly important. Participants seemed surprised when asked to explain the reasons:

*'What do you mean? It's obvious [quizzical look]' (Leah, F Het, 19)*

*'Sorry, I don't know what you mean? We need them [condoms]. We're adults, we have sex lives' (Jen, F Het, 18)*

*'Well you need condoms. Period [full stop]. You need free ones cos you can't afford to buy em' (Kris, M, St, 18)*

Free condoms were unanimously seen as axiomatic to sexual health, as highlighted in the following:

**Interviewer: 'What would happen if condoms weren't free?'**

*'That's just stupid. Wouldn't buy em' (Kris, M, St, 18)*

**Interviewer: 'Why?'**

*'What with? I would buy 'em [them] if I had owt' (Kris, M, St, 18)*

*'They're really expensive. You won't stop people having sex but you'll stop 'em using condoms. They'll get pregnant especially young ones' (Max, M, St, 16)*

*'Do they want 'em to get pregnant?' (Kris, M, St, 18)*

*'Would they really think about not giving them for free? It's so, like, important, and important to keeping in control. Getting them from someone who's really nice is dead important as well. Going to the chemist or supermarket, or whatever, it's embarrassing even if you're quite okay about those things'* (Jen, F, Het, 18)

In addition to seeming inconceivable that condoms would not remain free of charge, many requested more opportunities to pick them up, *ad hoc.*, and for more routine availability in youth clubs, pubs and clubs:

*'Think you should have them everywhere. No one ever died of having a condom on t'ready'* (Kris, M, St, 18)

Condoms were also seen as giving prominence to the importance and *normalising* of sexual health:

*'Get them [condoms] around everywhere. It's an important bit of sexual health on stalls or pop-ups. It normalises it as well. Like same as if you had your heart looked at on a market'* (Jon, M, St, 19)

#### 4.4.6. Information resources (e.g. Sexual Health Sheffield phone App, websites, social media, leaflets etc.)

To date, no one had used the SHS website, nor used or downloaded the SHS App, though some sexual health volunteers knew they existed. These participants, plus one other person, were familiar with SHS logo. Most felt they would 'probably' be able to find the website should it be needed.

One participant contacted the researcher after their interview to feedback that she was disappointed that appointments could not be booked on-line for the GUM clinic.

Other on-line resources used by participants include 'NHS website' and 'Laci Green' (this is a blog which offers information and advice on sexuality, sexual health, relationships etc.).

#### 4.4.7. SHS leaflets and posters

Participants were more familiar with leaflets and posters than on-line / social media resources. In particular, leaflets that signposted 'support for LGBT' were familiar to young people who attended city centre-based youth groups.

*'I know that Fruitbowl leaflet. That tiny, little one. Not very easy to find in our school'* (Mark, N, G, 17)

Others had picked up leaflets about sexual health services in the city centre. Notably, only those identifying as female or attended city centre youth groups said they had read leaflets after picking them up. Straight/heterosexual men were least likely to read leaflets. Reasons relate to seeking out support only when needed, for instance, for support for sexuality, a pregnancy 'scare', options for contraception or specifically locating a service. In these cases, participants said they had read a leaflet having been given it after confiding a 'problem' or issue to a teacher, mentor or parent, and that they were said to be useful, informative and easy to understand.

Those who had not read leaflets they had picked up or been given (heterosexual men), said they favoured face to face or verbal information. Those living a long distance from the city centre requested a Sexual Health phone line.

#### 4.4.8. Support for sexuality / relationships/ sexual feelings or experiences

Many participants alluded to this while referencing services mentioned above. Above all, those who were volunteers or city-centre youth group members had gained the most definable support from this service and the practitioners involved. Others said their *ad hoc* experiences had been very supportive but wished that support was more extensive or readily available.

Participants' 'wish' list for future services (see section 7) includes additional data that is relevant to the range of services, particularly, requests for sexual health services (including clinical services) to recognise emotional and mental health. This does not imply that support for emotional and mental health is not already an aim of and/or included in these services; rather, these young people do not get this sense of services across the range of provision.

#### 4.5. Sexual health volunteering, peer education and support

This section (4.5.) relates only to participants involved in volunteering and peer education. These services are provided by SHS, and community and voluntary organisations.

Without exception, there was huge praise and gratitude for the services. The relationship between knowledge, sexual health, confidence and communication was especially marked and mentioned several times:

*'Getting rid of my ignorance about sexuality and sexual health and stuff has made me so much more confident in every way. Like I can talk to my friends about anything. That wasn't how I was – the previous me'* (Dan, M, G, 21)

*'If you feel good about your sexual health then it's such a weight off'* (Tom, M, G, 18)

*'If you can talk about sex you can talk about anything'* (Lola, F, St, 17)

Related to this, and later on in the report, disclosures illustrate how a number of other participants felt that ease of talking about sex and, in some cases, good SRE, enhanced their broader confidence. This issue is addressed in more detail in subsequent sections.

##### 4.5.1. Motivations for becoming a sexual health volunteer

Motivations were variable, according to genders and sexualities. Those identifying as female and straight or bisexual had initially become involved because they wanted to extend their volunteering experiences to enhance their CV / eligibility for application to university. Having being trained as a volunteer, however, participants emphasised that the gains far outweighed this reason and they continue to be involved for broader reasons, primarily confidence, enjoyment and convictions about the importance of sexual health and helping others:

*'My motivation was gaining further knowledge on sexual health and to deliver sexual health talks to other young people. It was also an opportunity for me to develop my interpersonal skills and confidence in delivering presentations in front of people'* (Tara, F, ST, 18)

Those identifying as male, non-binary, trans, neutral and/or disclosing a disability or mental health issue had sought out the project/s themselves or via a supportive individual (teacher, mentor, social worker, housing support) or been recommended by a mutual friend, parent or partner. For example:

*'I just really needed help and someone to talk to. It was big stuff'* (Cole, 21, M, St)

*'My mum found out about it' (Dan, M, G, 21)*

*'After it all kicked off [came out as a woman] my teacher, the one in charge of detentions, but to be fair, got on line and looked what there was to help me' (Penny, T, L, 22)*

#### 4.5.2. Training involved in becoming a volunteer

Training was seen as invaluable:

*'It's had a massive impact on what I know. Having knowledge shapes you as a person ... just knowing how much better it is to be accepting and understanding where people are coming from. Makes me happier in myself' (Tara, F, ST, 18)*

*'It's so good in helping me to build my confidence' (Cole, M, ST, 21)*

*'If you can communicate about sex you can communicate about anything. I feel much more confident talking to my friends and I can always answer their questions. Before this [peer education group] I was the quiet one' (Tara, F, ST, 18)*

#### 4.6. Identity and composition of SHS service

To recap data discussed so far, all participants had experienced some of the services under evaluation, with some having had more experiences than others. In light of this, it is useful to consider disclosures on the specific identity and composition of the service. Aside from volunteers,

- Most were unable to name the service/s
- Most did not recognise the SHS (Sexual Health Sheffield) logo
- Most did not know about the SHS App.
- 'Sexual health services' was assumed (at the initial stages of interview) to mean clinical services.

Services were identified through description, request for elaboration, or my probing. For example:

**Interviewer: *'Have you experienced any of the sexual health services [interrupted]?'***

*'Yep I've been to the clinic' (Fran, F, PS, 18)*

**Interviewer: *'Apart from the clinic?'***

*'Ummm. Like what do you mean?' (Fran, F, PS, 18)*

**Interviewer: *'Things offered outside clinic settings ... support for your sexuality, peer education, leaflets and other resources about sexual health, Chlamydia awareness, free condoms ..'***

*'Yeah, yeah, I've had all those. Well, like, Chlamydia tests, seen the little leaflets at college, like, about Fruitbowl, and some sixth formers came into our class in about year 9' (Fran, F, PS, 18)*

*'Like, I don't know what it was called but it was good. Like they came into school and talked to us' (Mia, F, L, 17)*

*'I've done wazzing in a cup thing' (Kris, M, St, 18)*



**Interviewer: ‘What was that for?’**

*‘Don’t know but I’ve done it three times’* (Kris, M, St, 18)

**Interviewer: ‘Pee in a pot, was it? For Chlamydia?’**

*‘Yeah. Chlamydia that’s it. Clean [negative] three times’* [grins and punches the air triumphantly] (Kris, M, St, 18)

Kris could not remember whether he had received health promotion advice alongside Chlamydia tests. Similarly, getting hold of condoms seemed more important than who gave them or with what advice:

*‘I’ve got free condoms, from a pop-up in town ... but I don’t know who they were that gave them’* (Jon, M, St, 19)

*‘You can get free condoms at doctors. I don’t know where else from. [...] and you can go if you’ve got a disease’* (Max, M, St, 16)

*‘I’ve got a card thing for condoms ... is that it?’* (unidentifiable, focus group)

Although most participants answered ‘no’, ‘maybe’ or ‘not sure’ in answer to showing an image of the logo alongside the question, ‘Have you seen the Sexual Health Sheffield logo?’, some had seen the logo at the central clinic:

*‘I’ve seen it, yes ... at the clinic in town’* (Jen, F, Het, 18)

When asked the specific question, ‘what services does SHS include?’

- most stated that SHS services were made up of the central clinic and a (specific) NHS walk-in centre (see below for further discussion of the latter)
- no participant knew that the clinic at the Hallamshire (Hospital) was part of SHS
- participants viewed the (city) central clinic and ‘youth clinic’ as the same thing
- some thought the youth clinic had ceased to exist

Sexual Health Sheffield is a new brand, operating as an integrated service since March 2014 and officially launched on 17 October 2014. Hence, some of the above responses might be anticipated. Longer term, the importance (or not) of knowing the identity of services (notably, the specific identity of community-based services) and recognising marketing (logos etc.) is an issue for providers and commissioners of services to debate. However, the following might be considered:

- (i) an evidence base is more easily facilitated if the provider ‘brand’ is recognisable and identified with the service received
- (ii) highly corporate brands are readily recognisable and these companies are in the market for sexual health services that are up for tender
- (iii) members of city centre based youth groups or peer educator groups could readily name the group they were part of and directly attributed improved knowledge, skills, mental health and confidence to the support received from this ‘brand’

#### 4.7. Clinical services

Participants were keen to be heard regarding clinical services, as noted above. Some comments were prefaced with statements such as, *‘I know this isn’t about clinics and clinics are brilliant ....’* and

*'It's lovely, they're lovely ...'*, followed by personal experiences that felt important and relevant to the evaluation.

#### 4.7.1. Perceptions of provision

Remnants of the central clinic as a provider of 'family planning' services specifically for women persist, with young men more likely to have these views:

*'It's still mainly about family planning'* (Leah, F, Het, 19)

*'It's mainly for women and girls'* (Sam, M, G, 22)

Others thought clinical services were concerned with the prevention/treatment of disease:

*'I know it's not about this but it's the importantest thing I want to say ... I got really down, depressed. I was even going to the [central] clinic but I didn't know I could talk about anything except condoms'* (Cole, M, St, 21)

*'It's lovely, they're lovely and it's so much better than it used to be. But, it can be a bit, bit kind of robotic. Not with all of them. But, like, it's all about treatments. I don't know how to explain it ... like, "what do you need? Yes, we can do that"'* (Jen, F, Het, 18)

*'They sort of pay lip service to choice ... like I went to youth clinic to have a talk and see what was best for me. They gave out leaflet on contraception at the desk and I read it and I kind of made my choice or kind of nearly, in the waiting room, but I still wanted to talk about it. I went in and she just said, "Yes, we can provide that today". No talking. At all.'* (Jane, F, Bi, 19)

#### 4.7.2. Smoking

Unsolicited, two people referred to experiences of feeling judged:

*'I know this isn't about clinics and clinics are brilliant but if there's one thing I'd recommend in an ideal world [laughs], it's don't ask me about smoking. I'm already nervous about coming [to the clinic] in the first place. I don't need reminding about smoking, or being asked if I'm gonna give up. I know I need to. I just have to get the sex thing sorted, today'* (Leah, F, Het, 19)

*'They're a bit judgemental ... brought up smoking. It might be their job to get ticks on the smoking thing but it's hard enough as it is'* (Amy, F, St, 18)

These participants may have been caught up in the vestiges of 'Every Contact Counts'; they appreciated that mention of smoking was well intentioned, but, it is useful to consider the unintended impact.

#### 4.7.3. Location

The location of the central clinic was derided by all those who had visited. For example,

*'The [central clinic] building is seedy. Like I saw a programme on telly and there was clinics in Portsmouth, Leeds. Manchester. And they were like sooo nice. More like a posh shop kind of thing. Doesn't make you think you can be happy or proud walking in to that entrance [at central clinic]. It's dismal and they try to be welcoming but it's on a back street. And, well, ... it's not proud'* (Jaz, F, Bi, 19)

*'It's [clinic] not hidden but it's quite difficult to find unless you know what you're looking for' (Leah, F, St, 19)*

#### 4.7.4. Opening times

Some participants had found it difficult to access clinical services due to working late or shift patterns. Others requested Sunday opening:

*'Sunday is the most obvious time to go to clinic ... after a Saturday night' (Cole, M, St, 21)*

#### 4.8. NHS Walk-In

To reiterate an earlier point, some participants thought that the NHS walk-in centre was part of SHS. Two participants said they were directed to the Walk-in by central clinic staff. The association with SHS (mentioned above) is therefore understandable. Without any probing, these two participants described experiences of the walk-in that they wanted to include in the evaluation.

*'I got a right lecture. I went for morning after pill cos youth clinic was shut and they told me to go there. And I admit I was drunk during the sex. It was really preachy. I didn't need it. I know I drink too much sometimes. I know I shouldn't take risks. But, I've come for morning after pill ... I'm trying to address my actions. I don't need a lecture. AND. Don't assume I'm straight' (Fran, F, PS, 18)*

*'I got told to go there cos I couldn't go to the one at Mulberry Street cos it was closing. I told them I'd had unsafe sex but thought I might be pregnant but I was on my period, and could that be possible? She said "yes, it's possible". But she told me to go the walk-in place for a pregnancy test cos they were closing. So I did and told them I needed a pregnancy test and told her why and she said, "that's ridiculous. You can't get pregnant when you're on your period". I was really confused. Like, conflicting information like that (puzzled look)? So I had to go back to the clinic after the weekend and they gave me a test and it was negative. Thank god' (Jen, F, Het, 18)*

These disclosures highlight personal experiences that reflected on the quality of services and are particularly significant given the assumed connection with SHS.

## 5. Impact: knowledge, happiness, confidence, communication skills and mental health

Impact is difficult to measure because of the many factors which can influence outcomes and change. However, there is significance in the numerous responses asserting that involvement in sexual health services had improved levels of knowledge, with unexpected gains, such as, enhanced happiness, communication skills and confidence. These attributes are relevant to protecting sexual health and improving sexual competence (Hirst, 2008). Positive impact was most evident among those who had had extensive sexual health input through their role as a volunteer or member of a group supporting young LGBT people and young people who had supportive parents.

Improved emotional wellbeing was related to these outcomes with a number of participants emphasising connections between mental health and feeling better about sexuality and/or sexual health:

*'... it's like being happy and comfortable sexually, it's partially mental as well as physical happiness in sexual relationships ... like, almost, mental sexual health for your relationships, sexuality, whatever' (Jen, F, Het, 18)*

*'Most important thing is how it affects your mental health. Like, yes, physical health is important but the effect on your mental health is much more massive. I can't believe it' (Dan, M, G, 21)*

*'It's a no brainer. If you get rid of worries to do with your sex and that, then it's got to have an effect on your head' (Kris, M, St, 18)*

*'You can't function if you're worried about something that you daren't tell anyone about. An infection or other sex things... they're all a biggy. Talking to someone you can trust, absolutely trust .. (puts his head on table) ... it's so important' (Cole, M, St, 21)*

*'If it's been a big thing [issue about sexuality] for a long time, it's such a weight off, emotionally' (Jane, F, Bi, 19)*

No one said support for sexuality and sexual health could negatively impact on sexual health, and some were surprised by the question, for example:

*'No, it's obvious you'll have better mental health when you feel better about sexuality or sexual health' (Jaz, F, Bi & O, 19)*

Time was significant. Those having had reliable support sustained over time from parents, partner, youth intervention or outreach event were quick to cite these sources when asked to specify which services contributed to the improved mental health / wellbeing described above.

Those who did not refer to mental health were asked specifically whether sexual health services, events or outreach work could offer more support for mental health. Participants unanimously endorsed the potential for this, but, without exception, added a rider that lack of time might diminish the possibility:

*'Yes, definitely but there's nowhere near enough time. Nowhere near' (Max, M, St, 18)*

*'It's like sometimes you don't know what it is, like, that's bringing you down and you*

*can't like get all that out during peeing for Chlamydia or at a leaflet pop-up' (Jon, M, St, 19).*

*'But having said you're pushed for time, I think it's better to do it there ... like in schools or youth places than in clinics' (Noah, M, G, 23)*

One young woman said an ideal sexual health service would embrace mental health alongside clinical provision:

*'.. have a centre or a place where you can get your contraception and pregnancy stuff but another side that's emotional support for other things. Like, holistic, including mental health and other things about sexuality and relationships that you want to talk about' (Jen, F, Het, 18)*

## 6. Context: relationship to identities, circumstances and everyday experiences of living in Sheffield

Evaluation findings are more meaningful if appreciated in relation to the contexts that frame experiences. The request for contextual insights is also supported by its inclusion in SHS's vision and strategy.

Participants were asked:

***'Do you think your views on sexual health and experience of services (as you described earlier) are affected by who you are and your past and current circumstances?'***

Responses revealed aspects of participants' lives that had not been made known up to this point in the interview, focus group or questionnaire that are relevant to planning, prioritising and partnerships in sexual health. In this respect, the important point is that of all the issues listed below, parents and experiences of sex and relationships education in school were said to be the most influential on feelings about oneself, sexual health and relationships.

### 6.1. Parents ... who you live/d with

Responses spanned a spectrum from those with parents/grandparents construed as supportive to those who had difficult or no relationship with one or both parents.

Supportive parents were said to offer a safe space for discussion and advice that was much appreciated. They were described variously as *'liberal'*, *'open'*, *'treating me as an adult'*, *'respectful'*, *'protective'*, *'I can tell my mum anything'* and sometimes, surprising:

*'I really wanted to tell my mum and I knew she wouldn't throw me out or anything but I was just scared at what she'd say. Well, she said the best thing she could, "I've always wanted a gay son"' (Dan, M, G, 21)*

Some felt that supportive parents could not be replaced by friends:

*'Friends are great if you trust them but they don't know everything. Parents, especially my mum, knows what she's talking about. You can choose your friends but not your parents' (Jon, M, St, 19)*

*'I wouldn't want to not have the friends I've got now but it's not always been like that. I feel lucky that my parents are cool and okay about me being a sexual person. And when you really need it, like with a thing that happened to me [describes it]. They're the most important thing' (Jen, F, Het, 18)*

Protectiveness was valued:

*'My parents have affected me a lot because they regularly tell me to be safe and to be cautious of who I'm involved with' (Tara, F, ST, 18).*

Some people had ambivalent relationships with parents and described them as *'okay'*, *'all right'* but disappointing in relation to education and support on sexualities, relationships and sexual health:

*'I feel badly let down by school and my family. You're expecting THE talk. I got a book. They put it conspicuously on my shelf [laughs]. That was it. I mean, come on!' (Cole, M, St, 21)*

Experiences of a once-in-a-life time 'chat' during early teenage hood were commonplace:

*'No. NO. Can't talk to them about stuff like that [sex]. It's horrible. My mum tried to talk to me but I ... just put my head down. Horrible. ... I was about thirteen'* (Kris, M, St, 18)

**Interviewer: 'What sorts of things did your mum say?'**

*'She just asked if I knew about stuff and to be careful... it was horrible. Told her to shut up'* (Kris, M, St, 18)

**Interviewer: 'Seems like she tried though ...'**

*'Yeah but it's cos she couldn't cope if a lass got caught out [pregnant]'* (Kris, M, St, 18).

Talking about sex with parents was impossible for those with difficult or no relationship with parent/s. This was marked for those whose parents were not accepting of their sexuality and/or gender identity:

*'Eventually I told my dad I was gay and he said, "get out, you fat faggot". Not seen him since'* (Will, M, G, 17)

*'My mum doesn't want to see me. Doesn't see me. I texted my dad and told him I was trans. He texted back, "does that mean you want to wear women's clothes?" My grandma and granddad try to understand. They try and get my mum to see me. They're tolerant not accepting. [...] No. We wouldn't talk about sex or anything'* (Penny, F, Tr, L, 22).

Other participants shared stories of friends' distress when their parents were not supportive. These cannot be shared as the subjects of the stories were not part of the evaluation or given their consent.

Regarding parental support, age was also relevant and discussed in section 6.8.

#### **6.1.1. Locality, parental support and SRE**

Among this sample (and therefore, not generalisable), participants from areas of greater deprivation were least likely to ask their parents for support or guidance on sex, relationships and sexual health. This applied both to those still living at home and those over 18 who said they could not speak to their parents when they were younger and certainly would not seek parents' support having left home or been thrown out. This finding is echoed in other studies (see for example Jerman and Constantine, 2010).

Those from the most deprived areas (in this sample) described poorest experiences of SRE at school. Attending schools in other areas did not guarantee that SRE was reported as helpful, but, comments were more positive (see section 6.9).

It would be useful to develop data on this reported association between postcode, negative experiences of SRE and parents whom participants could not talk to about sex, in relation to data on teenage pregnancy and other indicators of sexual health.

## 6.2. Friendships

Friends were important with some participants serving as key sources of information for their friends:

*I'm lucky I've got good friends .. to tell me stuff or where to go if I needed a clinic or something ' (Jon, M, St, 19)*

*'I'm the type of person... when I learn something new, I'm most likely to tell them' (Tara, F, ST, 18)*

*'I'm like the hotspot in school! I answer everyone's questions on sexuality... everything' (Fran, F, PS, 18)*

As noted in 6.1 above, friends were valued but supportive parents were very important.

### 6.2.1. Perception that knowing someone socially is safe

Relevant to issues of safer sex, two participants who appeared knowledgeable, also assumed friendship offered safety:

*'I've always being careful with what I do and who I do it, I refrain from making any form of sexual contact with anyone unless in a relationship' (Tara, F, St, 18)*

*'I don't tend to go with [have sex] just anyone. I always know them first' (Jon, M, St, 19).*

These disclosures on familiarity are useful to safer sex education messages.

## 6.3. Social class

As noted in section 2.4. nearly half of participants did not know their social class or did not know the meaning of the term. Therefore, it is unsurprising that few participants mentioned social class as a mediator of experiences or views. This said, place (of residence/home) was cited as relevant with socio-economic district affecting availability of services, places to socialise and levels of happiness:

*'I know I'm lucky to live round here. Like it's not posh but people are nice and understanding and my school was good. Well, not all of it but they tried hard' (Leah, F, Het, 19)*

*'I hate it round here. It's miles from everywhere. There's nowt. You can't get to town centre. Don't know when I last went' (Kris, M, St, 18)*

*'Everything's shut down where I'm from. Everything. That's why I come to town, to here [name of youth group]' (Will, M, G, 17)*

*'There's just nothing to do. Nowt. Then they wonder why lasses get pregnant' (Max, M, St, 16)*

Some felt that living in poorer areas of the city had been problematic for gay friends:

*'I've got mates in other areas ... and even though they're really hard [tough] they've had a bad time with, with like sexuality and coming out' (Jon, M, St, 19).*



Given the association suggested above, between postcode, negative experiences of SRE, 'coming out' and parents whom participants could not talk to about sex, further exploration is recommended.

#### 6.4. Gender and Sexuality

As noted above (4.7.1), some participants thought that clinical services were perceived as more women-oriented. There was also a shared sense that women tended to be more informed about sexual health services than men, with one feeling very strongly:

*'Being a man is a disadvantage in getting to know about sexual health and like, your sexuality. I just didn't realise how much I didn't know. Women are way ahead of us'*  
(Cole, M, St, 21)

LGBT people across the age range had strong feelings about clinical services not being inclusive, assuming heterosexuality and using inappropriate categories in medical notes. For some participants, this was not as problematic as it had been previously due to support from youth workers but issues are raised in section 7.10. on fluid genders and sexualities that remain important to service developments and service users.

#### 6.5. First language and ethnicity

The first language of all participants was English and none had interpretation concerns. Only one person, of mixed heritage, said ethnicity was relevant:

*'My ethnicity does have an impact on what I do and the way I carry myself because growing up I was taught to respect myself and those around and to know my boundaries'*  
(Not assigned, might be identifiable).

#### 6.6. Faith / religion

Faith or religion had not affected most participants with 'atheism' or 'don't believe in god' offered in explanation. One person's faith was said to have only positive significance:

*'I'm a Christian but this doesn't impact on my beliefs about sexual health. Just about being kind and not judging people'* (Not assigned, might be identifiable).

#### 6.7. Disability

Disabilities disclosed by participants were dyslexia and mental health. Mental health had been a motivator for some becoming involved, or, being referred to, a support group. See section 4 for further discussion.

#### 6.8. Age

Questions about whether age was relevant to experiences led to 3 areas of response:

- age and sex education
- problems related to sexual health as a younger person
- age linked to lack of money and isolation.

These areas are developed below.

##### 6.8.1. Beginning sexuality education

It is interesting that when asked if age was relevant to their experience, all assumed this referred to sex education and proceeded to offer their opinion and/or shared experiences. There was

unanimous opinion (across classes, genders, sexualities and postcodes) that input on sexuality, relationships and sexual health should begin as early as possible, whether at school or in the home.

In accordance with international data (Ingham and Hirst 2010) starting too late or not at all were the most common responses:

*'Start as early as possible, if possible before young uns (ones) are sexually active. Make sure they know who's there to help. Too late when you're sixteen'* (Max, M, St, 18)

*'Teach it younger'* (Tara, F, St, 18)

Those who had parental input from an early age (a minority) welcomed it:

*'Start as early as possible. Like when you're little, like year 3 or something, well, it's embarrassing when you're talking about willies and vaginas but you laugh at it and it's okay. You think you don't want to know about it but it goes in subconsciously and then it's planted and you don't know, don't realise. Then when you get older, that stuff is already in there so when you start talking about it, the real embarrassment is over'* (Jon, M, Het, 19)

Age was also salient to those young people who felt more confident about protecting their sexual health through accumulating more knowledge as they grew older (see more in next section).

Some individuals felt 'sad' or 'upset' about how unhappy they had been as younger selves (see 6.8.2, 6.8.3 and SRE in 6.9)

#### 6.8.2. Problems (possibly dysfunction) related to sexual health as a younger person

No participants disclosed sexual dysfunction or overtly included it as an aspect of sexual health. However, some participants alluded to sexual difficulties, 'worries' or 'big stuff' that were resolved (or still in process) due to their involvement in youth groups.

Though no one disclosed or named a problem that might be considered a dysfunction, the data point to a total lack of awareness that support on sexual dysfunction is intrinsic to sexual health.

#### 6.8.3. Age, money and isolation

For some who were still at school and/or had no source of income, age was related to a loneliness, lack of money that maintained boredom, inability to cover the costs of a social life (other than 'roaming' about), leaving the area or going into the town centre.

*'I was very lonely as a kid. Bit naïve as well but I had no idea what was out there. I lived miles from the city centre. Hated my parents for moving out there'* (May, Fl, PS, 17)

*'I'm so glad I'm not my younger self. Awww. I was so on my own'* (Sam, M, G, 22)

*'Hate X [area]. Hate it. There's nowt. Nowt AT ALL to do. Nowt. If I have to live here for rest of my life ... Don't want to think about it'* (Kris, M, St, 18)

*'There's no service. There's your doctor but that's it'* (Max, M, St, 16)

*'You go in when none of your family are gonna be about'* (Kris, M, St, 18)

## 6.9. SRE at school/college

In echoing international patterns, SRE had not been universally available and models of practice varied (Ingham and Hirst 2010). Only two out of 29 participants commented positively on their SRE; these students had attended schools renowned for excellent SRE provision (MacDonald review of PSHE, 2009). An inclusive curriculum was seen as particularly important:

*'We had stuff on LGB and trans'* (Tom, M, G, 18)

Others emphasised negative messages and memories from school sex education:

*'If you have sex you're going to die'* (Eve, N, G, 18)

*'Don't have sex'* (Kira, F, L, 16)

*'We heard about STIs and that but I was struggling with some big stuff and I just didn't know what to do'* (Cole, M, St, 21)

*'Biology is worst ... sex education is really only about women as pregnancy machines'* (Kat, F, A, PR, 15)

On elaboration, most had not experienced SRE as part of the spiral curriculum (within PSHE). Some (who attended different schools / colleges) had occasional sessions and/or sexual health days or PSHE 'issues' on rotation:

*'[We had] pull-down days ... loads of stalls and stuff'* (Dan, M, G, 21)

*'It was just too much to take in ... you don't really get a chance to talk properly... like there's loads of people there'* (Kira, F, L, 16)

*'I basically missed out on when this LGBT lot came into our school but I missed out cos it was on a rotation and I was on PE (physical education)'* (Kat, F, A, PR, 15)

*'In year 8 when we were 13 or whatever, teacher said we're doing sex ed and everyone's giggling, like the boys most. And the teacher just says I'm not doing this. That were it'* (May, F, PS, 17)

*'I wish for sexual health being a part of the teaching that's done during school and not just being taught for a week or two like it's done in PSHE'* (Eve, N, G, 18)

Others commented that sexual health was an omission:

*'I just didn't think about sexual health at all until I came here [reference to support group]'* (Mark, N, G, 17)

*'In our college teachers do it but nothing in school. Nothing about where clinics are and that'* (Will, M, G, 17)

Some called for content that included broader education acknowledging gender differences and dynamics:

*'Even at my school, like PSHE was really good and I learnt that women could have pubic hair. And it's okay. But the boys didn't do stuff about the women, like nothing on periods and stuff and they should know' (Tom, M, G, 18)*

*'At school we don't talk about the vagina or proper names ... boys think it's just a hairless hole' (May, F, PS, 17)*

*'They try and make out it's the women's fault. They say, like Alice did this with so and so. Why is it her fault?' (Kat, F, A, PR, 15)*

One young man recalled that boys were not allowed to participate in the practical aspect of a session at school on 'how to put a condom on':

*'Lasses put condoms on a banana and a cucumber. Wouldn't let us have a go. Only lasses. I did it later [put a condom on a model] here [at youth group]' (Kris, M, St, 18)*

One person highlighted the importance of universal SRE and PSHE for challenging homophobic and sexist comments:

*'Teachers should do it cos it might be embarrassing and so they need help. Cos like if they don't do it, they get away with stuff. Like if you leave class with your bag, then the lads say stuff like "why you taking your bag? You on t'blob [menstruating]?" Like they didn't get same education and they're still immature about it. "Ooo are you on t'blob? Ugghhhh" and it's so embarrassing. And like, stuff like "oh, that's so gay." ' (Kat, F, A, PR, 15)*

As in past studies, participants were nevertheless sympathetic to teachers and offered explanations, such as:

*'It's not their fault', 'they're trying to do their best', 'they're not trained', 'they're forced to do it' (Focus Group)*

*'Our teacher didn't seem to know much about sex education' (Ed, M, G, 17)*

*'They aren't trained so you get all sorts of drama teachers and that doing it' (Fran, F, PS, 18)*

*'I think they are trying to include diversity. It's a lot better, but it's hard for them' (Tom, M, G, 18)*

Despite being critical of teachers - and echoing finding from previous studies - these young people maintained that school was the appropriate place for SRE and PSHE in order to reach most students, offer some continuity of input, and links to more readily available support. Finn summed up a collective request:

*'You just have to educate the teachers. It's the most important thing you can do for us as young people who want a good sexual health' (Finn, M, G, 17)*

And, perhaps a valuable distinction:

*'While biology is about physical things, P.SHEEEE [vernacular for PSHE] is a wisdom of some sort' (Finn, M, G, 17)*

#### 6.10. Internet and social media

All participants had or continued to use the internet as the key and first source:

*'Well yeah it's where you go first and there is information and stuff. It's not always reliable but it's better than nothing. But nothing is better than talking to a person' (Kira, F, L, 16)*

No one said they felt uncomfortable about using the internet and were aware of the potential for inaccuracies. NHS Choices (national) was named as a reliable source.

Social media was used by all participants, including Facebook, Twitter and numerous others. There seemed to be little interest in talking about the 'dangers' of on-line activity. One person said the over-emphasis or 'moral panic' on the dangers was anachronistic:

*'You'll be seen as a dinosaur if you go on about sexting' (Jon, M, St, 19)*

Jon also warned that the recent and enhanced emphasis on e-safety and grooming in politics and popular debate could monopolise PSHE education:

*'Sexual exploitation. That's all PSHE and sex ed will be about. Other stuff will get pushed out'*

All in all, although these media were said to have potential to inform sexual health, most preferred face-to-face work and would not want on-line resources to replace people, as illustrated in the quote at the start of this section.

#### 6.11. Television

Television was perceived as rather trivial and unimportant to sexual health or wellbeing. Participants were judicious in their viewing habits; some watched no TV at all, preferring on-line programmes, others named programmes they found helpful, such as, *Skins*.

When asked if TV could have negative effects on young people, some said their parents consumed more TV than them and this could have a detrimental effect:

*'With shows on TV like Jeremy Kyle telling you what's right and what's wrong ... it doesn't help parents to know what to do' (Kat, F, A, PS, 15)*

Participants were asked if television or other media coverage of sexual abuse in South Yorkshire (which occurred just before the evaluation took place) had affected them. Most said it had not.

*'No. I'm a bit embarrassed that I've not taken much notice of it' (Leah, F, Het, 18)*

*'.. it makes me as a young person feel unsafe within the system and the fact that people do these kind of things to children is repulsive and makes you wonder what actually goes on in certain people minds in society that would lead them to commit such a repulsive crime' (Tara, F, ST, 18).*

## 7. Participants' wish list for Sexual Health Services

Participants were asked, 'In an ideal world, what would sexual health services look like, what would you wish for?' The following issues were stated (in no order of priority):

### 7.1. More males

*'...aren't enough male volunteers or male workers even. Because young males won't exactly feel comfortable talking about sexual matters with a female, so I think it would be appropriate for them to do something to attract more male workers and volunteers'* (Tara, F, ST, 18)

*'It's not that the women (service provider) aren't good, they are. But, it's really hard approaching this stuff if you're the only bloke there. You need more male workers trying to get over that it's to do with men. They have to know. Like my mates, they all just don't know how important is. They haven't a clue. Especially in the clinics'* (Cole, M, St, 21)

### 7.2. 'Don't forget the obvious stuff'

*'Don't forget the obvious stuff! Lube! Nobody ever told me you need lube if you're having sex with a man. I didn't know that and it makes a big difference. I had a lot on preventing diseases and stuff but nobody ever mentioned lube'* (Dan, M, G, 21)

### 7.3. Extend services available

*'More of all of it'* (Mia, F, L, 17)

*'I know it's hard with cuts and stuff but it's so needed'* (Cole, M, St, 21)

*'Loads of services have closed down in my area over last years... there's nowt. That's why I come here (reference to city centre youth group)'* (Will, M, G, 17)

### 7.4. Sexual health and sexuality support line (telephone)

*'If I could have owt I'd have a service you could ring up and talk to someone so you don't have to go into town or talk to someone who's in a different place'* (Kris, M, het, 19)

### 7.5. Age and sexual health promotion

*'Start as early as possible, if possible before they're sexually active. Make sure they know who's there to help'* (Max, M, St, 18)

*'Teach it younger'* (Tara, F, St, 18)

### 7.6. Relationships

*'Really stress relationships. Offer relationships advice as well as sexual health advice to the young people'* (Leah, F, St, 19)

## 7.7. Advertising and health promotion

As earlier quotes suggest, participants asserted a need for bold and unapologetic advertising:

*'Bold, Get it out there. Everywhere. Like any other important issues. It should be [advertised] on buses' (Dan, M, G, 21)*

*'Make sure it's said really loud "you can talk to us about anything, not just STIs"' (Cole, M, St, 21)*

*'It [sexual health promotion] should be just there. Seen everywhere. Like everything else to do with your health and life' (Tom, M, G, 18)*

*'The Some People Are Gay, Get Over It [Stonewall campaign] really helped me. Like it's just there on buses and everything. Services should be advertised like that, so you think, hey it's quite normal' (Dan, M, G, 21)*

*'Just get it normalised. Informal pop-ups are best way of doing that. Like you're selling food or something' (Jon, M, St, 19)*

*'Usualise it! Like they say it's embarrassing but they advertise stuff about bowel cancer or prostate, or blood in your pee. Like cancer awareness. Why can't they do the same for sexual health? It's just as important.' (Jane, F, Bi, 19)*

In suggesting 'usualise' as preferential to 'normalise', participants were alluding to a sense of normalising as bringing marginalised 'other' into the advantaged circle of identities, practices and services. Heterosexuality as the unquestioned norm of sexual identity, for some, offers a good example.

*'I don't like norms or normalise. It's like saying, bring me in into what's normal for everyone else' (Kira, F, L, 16)*

*'You know what. Bottom line is all about communication and usualising if it's going to be a better world' (Eve, N, G, 18)*

'Usualise' is recommended as a more inclusive verb than normalise, and does not have connotations of Freudian distinctions of the normal and perverse, or, sexual health, sexualities and fluid genders positioned as an adjunct to norms for everyday life.

## 7.8. Home testing

*'Offer a test that people can do at home to check for STIs and STDs – not everybody feels comfortable going to the doctors' (Jon, M, St, 19)*

## 7.9. SRE in curriculum

*'I wish for sexual health being a part of the teaching that's done during school and not just being taught for a week or two like it's done in PSHE' (Eve, N, G, 18)*

### 7.9.1. A national curriculum irrespective of locality

*'Develop a scheme that is nationwide instead of just in Sheffield' (Tara, F, ST, 18)*

*'You miss out if you change schools ... they did sex education in year 6 in Cornwall and year 5 in Sheffield. I left Cornwall after year 5 and came to Sheffield to be in year 6, so I missed it'* (Jane, F, Bi, 19)

#### 7.10. Fluid genders and sexualities

Section 2 reported participants' genders as trans, female, male, neutral, non-binary and fluid, and sexualities as bisexual, open, pansexual, gay, lesbian, asexual, panromantic, straight / heterosexual.

There were emphatic requests for raising awareness of the fluidity of genders and sexualities:

*'Can there be more understanding of diversity?'* (Will, M, G, 17)

*'You need to know what different genders experience'* (May, FI, PS, 17)

*'What are the different genders?'* (Kat, FI, A & PR, 15)

*'Do you really know about trans? ... Teachers and people, and like our friends, need to understand there's a massive non-binary fluid spectrum'* (Jo, NB, PS, 17)

The questions above have implications for friends, family, teachers, and for commissioners and providers of services within and allied to SHS. Collecting identity characteristics or monitoring data that are self-descriptors has greater potential for:

- client inclusivity and equity
- services and providers' credibility
- avoiding inaccurate, incomplete case histories
- avoiding the alienation of service users and/or deterring subsequent use of services.

A service which is underpinned by understanding gender and sexuality as rich and fluid offers an inclusive model of practice which breaks with heteronormative and gender-binary conventions.

#### 7.11. Identity as un-extraordinary

For the future and notwithstanding the need for greater understanding, as one young man said, equity will be indicated when there is no need to state one's sexuality:

*'Hope the day will come when we don't have to come out. It just won't be an issue'* (Dan, M, G, 21)



## 8. Recommendations

### 1. Identity of service

The SHS service identity (and brand) is in its infancy; with time, the brand is likely to become more familiar. It is timely to consider the promotion of SHS and the range of services offered to ensure they are distinguishable and identifiable to users.

Consider a consultation about ways of raising the profile of services.

### 2. Holistic sexual health, including mental wellbeing

Services are underpinned by the WHO definition of sexual health that embraces a wide range of interrelated issues. Avoiding STIs and pregnancy dominate current consumer perceptions of sexual health and sexual health promotion. In parallel, improving mental wellbeing is a key goal of participants' sexual health.

Consider how

- (i) perceptions might be widened in order to be more representative of the current services
- (ii) to actively promote mental health /wellbeing, and
- (iii) to promote sex positive messages

This is reliant on all services and providers adopting a broader definition of sexual health. SRE teaching, teachers and parents/carers have a vital role to play in this respect (see also recommendations 12 and 13).

### 3. HIV /AIDS

HIV and AIDS did not appear to be concerns for interviewees insofar as it was only mentioned by one person.

Seek further data on young people's perceptions and meanings of HIV/AIDS, for example, prevalence, prevention, transmission routes, 'cures', treatments, PrEP (pre-exposure prophylactics) and PEP (post-exposure prophylactics) etc.

Consultation and engagement should be routinely embedded in services; ensure young people infected or affected by HIV/AIDS are included.

### 4. Provision of free condoms

Increase availability, or at minimum, endeavour to maintain the provision of free condoms as these are imperative to young people's abilities (i) to protect their sexual health, (ii) have some measure of control, and (iii) condoms are perceived as key to normalising sexual health and keeping sexualities and sexual practices on everyday agendas.

The impact of growing deprivation (Beatty and Fothergill, 2014) could prevent sexually active young people from buying condoms.

### 5. Health promotion

At a population level, sexual health is lower down the hierarchy than other health issues. But study participants view sexual health as equally important to other aspects of health (obesity, cancer, heart health etc).

Consider sexual health promotion advertising and initiatives that are equally bold, unapologetic and ubiquitous, with a view to

- (i) *usualising* the services
- (ii) making them more visible
- (ii) challenging stigma
- (iv) ensuring they are inclusive
- (v) creating a reputation for public health interventions that are renowned for being delivered in a non-judgemental manner.

## 6. Data monitoring

Consider strategy to increase awareness on fluidity of genders and sexualities and create inclusive data monitoring systems.

## 7. Socio-economic context

Participants from deprived areas had least knowledge, confidence and aspiration. Consider (i) how and why experiences of everyday living in the city and its outskirts affect uptake of services and potential for positive sexual health, and (ii) how services will acknowledge worsening socio-economic contexts in policy and processes. Specifically, (iii) explore association between postcode, limited understanding of sexual health, negative experiences of SRE, experiences of coming out and participants with parents that do not communicate about sex, in relation to data on teenage pregnancy and other indicators of sexual health, and (iv) consider how to enhance services for those living a distance from the city centre (and a majority of services).

## 8. Social class - relevant or not as a concept?

Given the health divide across Sheffield, social mobility at its lowest for decades, and Sexual Health Sheffield's aim to support those in greatest need, it could be useful to explore the finding that social class is not a concept that is familiar to under-25s. This is relevant because undiagnosed Chlamydia and other STIs are more prevalent among certain social classes.

## 9. Focused interventions

The evaluation did not capture the voices of many young people who may have different needs, for example, those new to Sheffield and/or whose first language is not English, young people infected or affected by HIV, and young people with disabilities. Consider strategy for inclusion.

## 10. Work with boys and young men

Universal service provision needs to continue, but, focused interventions with boys and young men are recommended to address comparatively poorer knowledge and confidence.

## 11. Sexual dysfunction

Explore how awareness of sexual dysfunction and referral to specialist services could be more effectively promoted in clinical and health promotion services.

## 12. SRE / PSHE

School and college-based SRE is not offering universal access to SRE and support for sexual health. NHS based services are not sufficiently resourced to meet this deficit.

Consider how NHS services can work productively with the local authority, schools and colleges to address this.

### 13. Working with parents and carers

Participants valued parents /carers who were informed and confident about sexualities, relationships and sexual health.

Consider how to support more work with parents/carers on the health needs and concerns of young people, for example, through 'Parent to Parent'.

### 14. Internet, social media and on-line sexual health

Young people do not want on-line resources and support to replace face-to-face interventions or speaking directly to a person via telephone. The internet (including Twitter, Facebook etc.) does not guarantee accurate or useful sex education or sexual health resources, but, it has the potential to enhance quality and access. Given that some parents and schools are not providing useful support or education and most young people are IT-skilled and often turn to the internet as a source of information, on-line, high-quality resources/websites and booking might contribute to some aspects of sexual health provision, signposting, and engaging a greater number of people. This applies particularly to young people living in remote areas of the region.

Consider strategy for:

- (i) platforms that support on-line booking of appointments
- (ii) promoting the SHS App.

### 15. Clinical services and allied services

Explore responses to reports of mixed messages, incorrect advice, judgmental and assumptive attitudes from clinical services and those allied to, but, not part of SHS service.

In particular, consider findings on

- (i) publicising the range of services (beyond STIs and pregnancy)
- (ii) perception of being female-oriented and not focused on boys/young men
- (iii) view that the Youth Clinic no longer exists
- (iv) referral to NHS walk-in
- (v) opening times (e.g. Sundays)
- (vi) smoking

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## Appendix 1: Recruitment flyer



### Evaluation of Young People's Sexual Health Services

**Are you aged 15-25 years?**  
**Do you want to help improve sexual health services for young people in Sheffield?**  
**We would really like to hear from you!**

Have you experienced any of the following sexual health services?

- Chlamydia screening (in community settings)
- Peer education (sexual health info sessions in schools)
- Outreach work
- Sexual health information stalls (festivals, community events)
- 'Open Doors' (sexual health services in schools, colleges, youth clubs)
- Access to free condoms
- Sexual health information resources (e.g. the SH app, websites, leaflets, social media)
- Support about your sexuality / relationships/ sexual feelings or experiences

We'd really like to hear about **your** experiences so that we can do our best to make sure we meet your future sexual health needs.

We'd also like to speak to you if you **haven't** experienced any of these services but have ideas about the way in which sexual health services are delivered out in the community.

Participation in the project will involve being interviewed (face to face or by phone) or taking part in a focus group discussion. The information that you share will be treated **confidentially** and you will not be personally identified in any publication. Participation **will not affect your future use of services**.

This project is being led by Dr. Julia Hirst, Sheffield Hallam University on behalf of Sexual Health Sheffield.

If you would like to arrange an interview or want more information about the project, please contact Julia by Wednesday 19<sup>th</sup> November 2014 on 07939 900138 (text or call and we can call you back) or via email [j.hirst@shu.ac.uk](mailto:j.hirst@shu.ac.uk)

If you have any questions about Sexual Health Sheffield contact Anthony Bains on 0114 305 4444.

## Appendix 2: Information for potential participants

### Sexual Health Sheffield

#### Participation Information Sheet

#### Evaluation of Young People's experiences of Sexual Health Sheffield Services

You are invited to take part in a service evaluation about young people's sexual health services in Sheffield. Please read the following information to help you decide if you would like to participate.

#### About the project

The aim of the service evaluation is to talk to young people in Sheffield about services provided by Sexual Health Sheffield in community settings (not those provided in clinics). These include:

- Chlamydia screening in outreach settings (e.g. colleges, youth centres, pubs and clubs)
- Peer education (information sessions provided by other young people in schools)
- Outreach in other community settings (e.g. community centres, gay pubs and clubs)
- 'Open Doors' services (sexual health provision in schools, colleges, youth clubs)
- Free condom schemes
- Information resources (SH Sheff phone app, websites, leaflets, social media)
- Support about your sexuality / relationships/ sexual feelings or experiences

Sharing your experiences and ideas will provide us with valuable information to improve sexual health services for young people in Sheffield and ensure we meet your future needs.

#### What does it involve?

Participation in this service evaluation is open to young men and women aged between 15-25 who live, work or study in Sheffield and have experience of the services referred to above or have ideas about sexual health service improvement and development.

If you decide that you would like to participate we will invite you to take part in an interview (face to face or by phone) and/or focus group to talk about your experiences and share your story with us. Interviews / focus groups will last approximately 30 – 60 mins and will be recorded.

#### Confidentiality

The interviews and focus groups will be confidential. Any information that you share that may identify you will remain confidential and will be disclosed only with your permission (except in exceptional circumstances as required by law). By signing this document, you give us your permission to use your experiences to inform this service evaluation. The findings will be disseminated via presentations, a report and journal articles. In any publication of the findings, information will only be shared in ways that do not identify you specifically. All personal information shared in interviews / focus groups will be changed or deleted. Only the lead researcher will have access to the transcribed interviews and focus group discussions. All material related to the study will be password-protected and safely stored.

**Feedback**

Feedback to participants about the results of the service evaluation will be provided by a report summary. You will be informed how to access these results when they are published. If you would like to receive them, please provide the interviewer with your contact details. These details will be kept separately and will not be linked to your interview data.

**Your consent**

Participation in the service evaluation is voluntary. If you decide to withdraw your consent after the interview / focus group (but prior to publication), please complete the 'revocation of consent form'.

**How to contact us**

If you have any questions about the service evaluation, please ask the interviewer. If you have any questions afterwards, please contact Dr. Julia Hirst by texting or calling on (mobile number) or via email [j.hirst@shu.ac.uk](mailto:j.hirst@shu.ac.uk)

The service evaluation has been approved by the Clinical Effectiveness Unit at Sheffield Teaching Hospitals NHS Foundation Trust. The evaluation will be conducted in line with NHS STHFT ethical principles and comply with STHFT policy and NHS guidance.

Please keep a copy of this information sheet for future reference.



## Appendix 3: Consent and revocation of consent form

### Evaluation of Young People's experiences of Sexual Health Sheffield Services

Lead investigator: Dr. Julia Hirst, Sheffield Hallam University

You are making a choice whether or not to participate in this evaluation of Sexual Health Sheffield's young people's services. Your signature indicates that, having read the information provided, you have decided to participate.

I have read and understood the information for participants provided about this evaluation. I have been informed about what is involved, including any known or possible inconveniences or risks. I understand that my participation in this study is strictly confidential. I also understand that participation in this study is completely voluntary and that I can withdraw my consent without prejudice.

Signature of participant

-----

Signature of Researcher

-----

Please print name

-----

Please print name

-----

Date

-----

Date

-----

Additional consent (optional and not required for participation in the study)

Please send me the report when it becomes available

Please tick box ☐

Email / Postal address:

-----

#### Revocation of consent

I hereby wish to withdraw my consent to participate in the service evaluation

Signature

-----

Date

-----

Please print your name

-----

*Note: Withdrawal is only possible prior to publication of results*

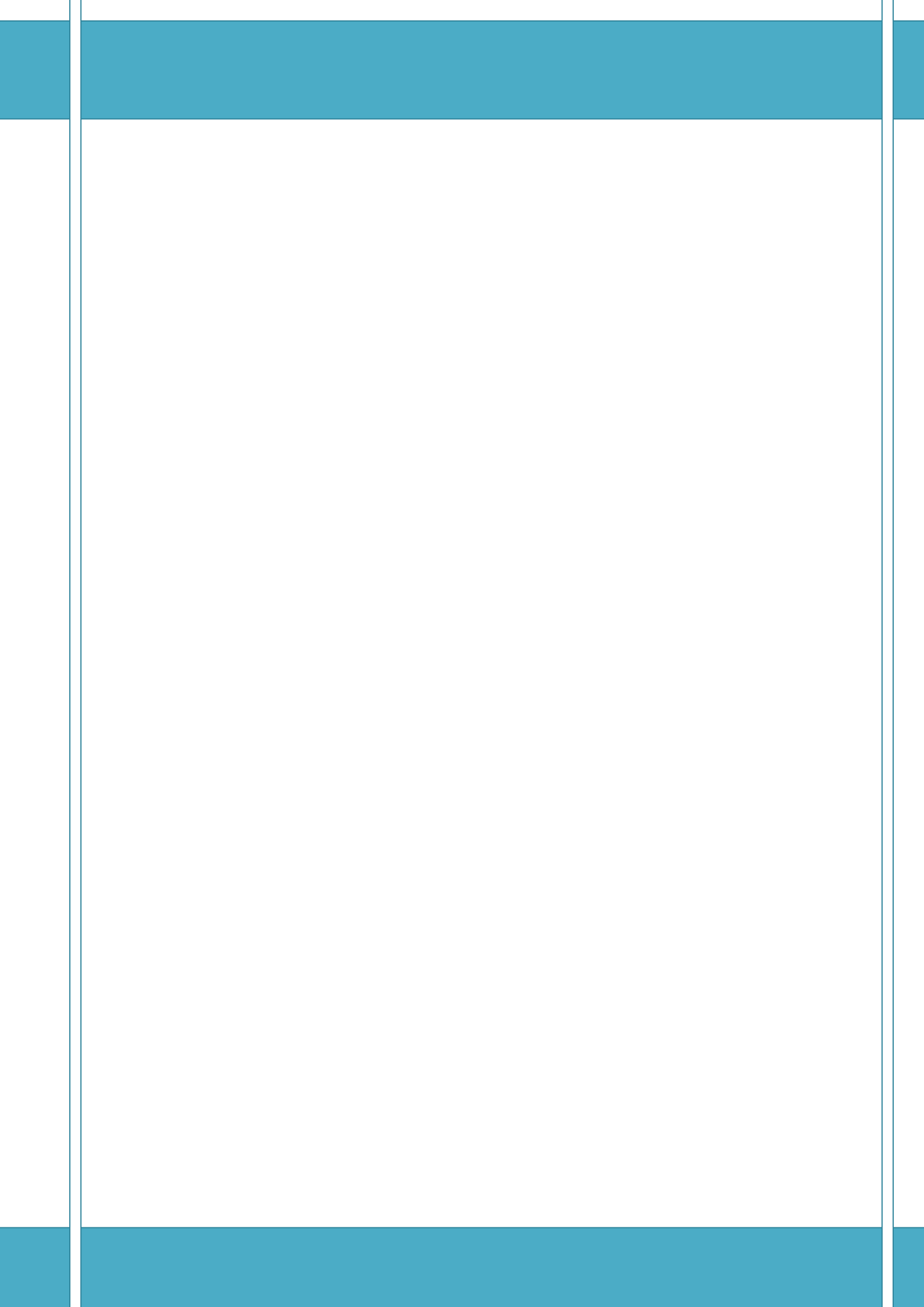
Return 'revocation of consent' to Anthony Bains, SHS, Central Clinic, 1 Mulberry Street, Sheffield S1

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## Appendix 4: Participants and method(s) of participation

Pseudonym	Age	Self-description of gender	Self-description of sexuality	Self-description of ethnicity and 1st language	Self-description of Social Class: Working Class Middle Class Don't Know	Post code	Service/s used: Chlamydia Screening Peer Education Free Condoms Outreach: SHS Stalls, Events SHS Resources Support for Sexuality etc	Mode of disclosure:  Individual Interview  Focus Group  Questionnaire by email	Member of a youth group, youth volunteer or peer education project
1. Amy	25	Female	Straight	White Mixed / English (E)	WC	S11	PE/S, FC	Q	No
2. Ted	17	Male	Gay	White British (WB) / E	Don't know	S5	CS, FC, SS	FG and I	Yes
3. Tara	18	Female	Straight	Black African / E	Don't know	S5	PE, S, E, R	Q	Yes
4. Lola	17	Female	Straight	African / E	MC	S4	CS, PE, FC, S, E, R, SS	I	Yes
5. Jon	19	Male	Heterosexual	WB / E	MC	S11	PE, S, E, FC,	I	No
6. Leah	19	Female	Heterosexual	WB / E	MC	S7	FC	I	No
7. Kat	15	Gender Fluid	Asexual & (pan)romantic	WB / E	WC	S9	PE, FC, R, SS	FG	Yes
8. Mark	17	Neutral	Gay	WB / E	Don't know	S5	PE, FC, S, E, R, SS	FG	Yes
9. Will	17	Male	Gay	WB / E	Don't know	S26	SS, R, SE	FG	Yes
10. Mia	17	Female	Lesbian	WB / E	WC	S6	CS, PE, FC, R	FG	Yes
11. Finn	17	Male	Gay	WB / E	Don't know	S2	CS, PE, FC, SS	FG	Yes
12. Ruth	17	Female	Bisexual	WB / E	WC	S6	CS, PE, FC, SS, R	FG	Yes
13. Jen	18	Female	Heterosexual	WB/E	MC	S11	PE, FC, R	I	No
14. Jo	17	Non-binary	Pansexual	WB / E	Don't know	S32	CS, PE, FC, SS, R, S, E	FG	Yes
15. Kira	16	Female	Lesbian	WB / E	Don't know	S8	CS, PE, FC, SS, E, SS	FG and I	Yes
16. Ed	17.5	Male	Gay	WB / E	Don't know	S6	SS, FC, E, R	FG	Yes
17. Tom	18	Male	Gay	Mixed Race / E	Don't know	S11	CS, PE, FC, SS, R, O	FG	Yes
18. May	17	Fluid	Pansexual	WB / E	Don't know	S10	SS, PE, S, E	FG	Yes
19. Fran	18	Female	Pansexual	WB / E	MC	S11	CS, PE, FC, SS, R, O	I	Yes

20. Sam	22	Male	Gay	WB / E	MC	S2	CS, PE, FC,	I	Yes
21. Noah	23	Male	Gay	WB / E	MC	DN6	SS	I	Yes
22. Dan	21	Male	Gay	WB / E	WC	S1	CS, PE, FC, SS, R, O	I	Yes
23. Penny	22	Female Trans	Lesbian	WB / E	Don't know	S8	SS, O, PE	I	Yes
24. Eve	18	Neutral	Gay	WB / E	don't know	S12	CS, O, R, SS	I	Yes
25. Jaz	19	Female	Bi / open	WB / E	Don't know	S36	CS, PE, E	I	Yes
26. Cole	21	Male	Straight	WB / E	MC/WC	S7	SS, CS, FC	I	Yes
27. Max	16	Male	Straight	WB/E	'Don't know what it is'	S36	R	FG	Yes
28. Jane	19	Female	Bisexual	White mixed /E	WC	S7	CS, PE, FC, SS, R, O	I	Yes
29. Kris	18	Male	Straight	WB / E	'Is that how many people I know?'	S36	CS, R	FG	Yes





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