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# Sex and relationships education, sexual health, and lesbian, gay and bisexual sexual cultures: Views from young people

FORMBY, Eleanor <http://orcid.org/0000-0003-4137-6592>

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**Sex and relationships education, sexual health, and lesbian, gay and bisexual sexual cultures: Views from young people**

Eleanor Formby, Centre for Education and Inclusion Research, Sheffield Hallam University, Sheffield, UK

**Abstract**

This article draws on three small-scale studies with young people in two cities in the UK, which sought to gather views on sex and relationships education (SRE) and sexual health, and included those who self-identified as lesbian, gay, or bisexual (LGB). Participants were involved in detailed self-completion surveys and/or in-depth interviews/focus groups. Each project elicited data about respondents' views on SRE (at school) and how this included/excluded LGB young people.

The article also looks at influences on sexual activity, conceptualisations/understandings of sexual health and 'safe sex', and expectations in relation to safer sex. This aids understanding about the existence of dominant 'sexual cultures' and their influence on young people's attitudes towards sexual health, including views on/experiences of 'risk behaviours', and (unequal) access to services. The article concludes with recommendations for good practice, and future research, highlighting the importance of an equalities and human rights foundation for learning about sex and relationships, for both young and old, and people of all sexual identities/experience.

**Introduction**

This article draws on three studies of young lesbian, gay and bisexual (LGB) people's views of sex and relationships education and sexual health, providing a perspective on the sexual cultures inhabited and experienced by young LGB people in the UK. The term 'sexual cultures' is used to describe how people learn about, discuss and practice sex, as well as how they engage with sex in the wider society. As Wilson (2009, 298) notes, 'Sexual culture is a group's worldview regarding normative sexual behaviour and sexuality...to understand a group's sexual culture is to examine the ways people speak about sex and sexuality, as well as the messages they report hearing from various institutions (e.g. family, school, religion)'. It has been argued that every culture makes 'who' and 'how' restrictions upon sexuality: as Weeks (2003, 21) describes, drawing on Plummer, "Who restrictions' are concerned with the gender of the partners... 'How restrictions' have to do with the organs that we use, the orifices we may enter, the manner of sexual involvement and sexual intercourse'. An exploration of LGB young people's experiences of learning (or not) about sex through school sex education, and their views on sexuality and sexual health more broadly, sheds light on the degree to which their sexual cultures are informed by these external factors. A dominant (heterosexual) sexual culture permeating health and education contexts can influence the sexual cultures of LGB young people, and thus affect their sexual behaviours and take-up of health services, which this paper will go on to examine.

Sex and relationships education (or SRE as it is widely known) is often a 'hot topic' amongst policy makers, practitioners and educators, the media and general public, parents, and of course young people themselves. This is evidenced by the recent attempt at a policy shift in this area by the Labour government in 2008 (and the media interest that followed), which tried to make Personal, Social, Health and

Economic education (PSHE) - under which non-biological school SRE falls - statutory[1]. Whilst the needs or views of young LGB people have seldom been well-represented in these debates, there is now a small but growing body of research aiming to address this void.

Drawing on this literature, and new empirical data, four inter-related themes are examined in relation to young LGB experiences of SRE and sexual health: invisibility and marginalisation, conceptualisations and understandings of sexual health, influences on sexual activity, 'risk assessment' and safer sex, and access to services.

**UK policy and research context**

Whilst little research with young LGB groups has examined views on sexual health specifically, a body of work sets out the wider social context for young people who identify as LGB. Research has described LGB experiences of schooling, identifying homophobic bullying and poor or inadequate responses from some schools (McNamee, Lloyd and Schubotz 2008; Warwick et al. 2004), discriminatory attitudes among some staff, and lack of reference to sexuality issues across the school curriculum (Ellis and High 2004; Hunt and Jenson 2007). It has also documented higher incidences of poor mental health, self-harm, 'self-destructive behaviours', depression and/or attempted suicide among young LGB people compared with their heterosexual counterparts (Fish 2007; McDermott, Roen and Scourfield 2008). They are more likely to suffer poorer physical health arising from higher incidences of alcohol, drug and/or tobacco use (Fish 2007; McDermott, Roen and Scourfield 2008),

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[1] This was subsequently unsuccessful with the relevant clauses of the Children, Schools and Families Bill withdrawn during the 'wash-up' period prior to the UK general election in 2010.

and may have poor experiences and/or a lack of access to appropriate health care or advice (Buston 2004).

Young people, regardless of their sexuality, are one of the groups most 'at risk' of being diagnosed with a Sexually Transmitted Infection (STI). According to the Health Protection Agency (HPA), young people (aged 16-24) accounted for just under half of all STI diagnoses in GUM clinics in the UK in 2007, including 700 new diagnosed cases of HIV, three times the level reported in 1998; 48% of these were infected through sex between men (HPA 2008). The rise in HIV diagnoses among young Men who have Sex with Men (MSM) is part of a general increase in STI transmission among MSM in the UK (The UK Collaborative Group for HIV and STI Surveillance 2007). Whilst increases in STI diagnoses could be due to rises in testing (Dougan et al. 2007), it might also be linked to an increase in so-called 'risky' sexual practices (Hart and Williamson 2005; Hickson et al. 2007). Though there are not equivalent figures for sex between women, it would seem that sexual ill-health, as measured by STI rates, is a significant backdrop to this paper.

Recent years have seen consistent debate and argument for improved SRE (The Independent Advisory Group on Teenage Pregnancy and the Independent Advisory Group on Sexual Health and HIV 2006; Ofsted 2007; UK Youth Parliament 2007). Current provision in schools has been widely demonstrated to be inconsistent (Alldred and David 2007; Formby, Hirst and Shipton 2009; Martinez and Emmerson 2008b), and often viewed by young people as 'too little, too late and too biological' (Blake 2008, 37), whilst LGB experiences of SRE are almost unanimously poor.

Current SRE guidance stresses the importance of (by definition, heterosexual) marriage for child-rearing and 'family life' (DfEE 2000, 4), implicitly criticising LGB identities and practice. Though there is mention of including all young

people, in reality there is little evidence that this happens. There is growing evidence of the dearth of information on homosexuality and/or LGB sexual health provided in schools (Forrest et al. 2004; Martinez and Emmerson 2008b). It is not surprising, therefore, that research on SRE has identified that LGB young people feel excluded, for example by language use or the discussion of sexual activities that render homosexual practices invisible (Buston 2004). The assumption that marriage is superior to other relationships discriminates not only against LGB young people, but also those raised by unmarried or single parents. Schools can therefore serve to regulate sexuality through the existence or promotion of a 'dominant' sexual culture which undermines young people's sexual agency, and limits sex education's 'effectiveness' (Allen, 2007).

Research has demonstrated that alternative sources of information about sex, sexuality or sexual health for many young people include family members, media sources, and friends, which all inform the development of sexual cultures. The media and other cultural texts, for example, can be informative in the absence of other sources (Formby, Hirst and Owen 2010), or potentially detrimental to the provision of sexual health related education or services, through adopting a hostile, sensationalist or protectionist stance (Owen et al. 2010). Similarly, family and friends have been identified as inadequate, unreliable or uncomfortable sex educators for some young people (Hirst, Formby and Owen 2006; Powell 2008). Sexual health provision for young people has been described as most 'effective' when it explores these media and peer influences on sexual behaviours, suggesting the importance of such factors within any sexual culture (Owen et al. 2010). Where mainstream sexual culture ignores or rejects homosexual identities and practices, this is a key influence on emerging LGB youth sexual cultures.

**Method and participants**

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This paper draws together findings from three small studies recently completed in England. The first project was undertaken in an ethnically diverse city in the Midlands (City 1), and was an audit of young people's views on their experiences of SRE. The study used a short self-completion questionnaire for young people aged 13-20, which was available online and in hard copy, and advertised and distributed through schools, colleges, and other services for young people, such as Connexions and local authority youth participation workers. There were 199 responses. This was supplemented with qualitative data from three focus groups in the same city, involving 32 young people, and including a group based at an LGBT centre.

The second and third projects took place in a city in the North of England (City 2), both commissioned to inform future service developments in the area. One was a consultation aimed at men who self-identified as gay, bisexual, or MSM, about their experiences and views in relation to sexual health. The sister project to this involved self-identified lesbians, bisexual women, and women who have sex with women. Both projects involved detailed self-completion surveys, available online and in hard copy, which were advertised in the local press, and distributed and disseminated through local LGBT networks and on the commercial gay scene. The men's project received 90 responses, and the women's project 54. In addition, the men's project allowed for a small number of follow-up individual in-depth interviews. Quantitative survey data was analysed using SPSS, and qualitative interview/focus group data was subject to thematic analysis.

In City 1, survey and focus group participants were both male and female, with ages ranging from 13-23, and including a range of ethnic backgrounds. In City 2, by contrast, the majority of participants described their ethnicity as white. The projects in City 2 were not targeted at young people specifically, but the majority of

respondents were aged under 35, and thus talking about current or recent experiences of being a 'young person'. All extracts included here are from these participants, though statistical survey results presented include those from above this age range. Illustrative quotes are taken from the survey, interview and focus group data, and anonymised throughout.

**Findings**

The findings presented here focus on four themes which emerged during the research: invisibility and marginalisation, conceptualisations and understandings of sexual health, influences on sexual activities, and access to services.

*Invisibility and marginalisation*

A common theme across the projects related to LGB invisibility, marginalisation or exclusion, most notably within school SRE. In City 1, many respondents identified sexuality, same-sex relationships, and homophobia as excluded from their experiences of SRE. Open-ended responses in the SRE audit (City 1) suggested that young people would like information and discussion on same-sex relationships in SRE, to aid 'awareness', address homophobia, and/or offer support for young LGB people.

'They don't mention anything about same sex relationships or homophobia, I think they should so more people are aware' (City 1, survey respondent)

No members of the LGBT focus group in City 1 had learnt about their local LGBT centre through SRE, though this was a potential source of support and guidance that local schools could have promoted.

The exclusion of LGB relationships from SRE met with a range of responses from participants; whilst some seemed resigned, others were angrier at the lack of support and/or the one-dimensional SRE they had received.

'There was nothing about gay people, I switched off' (City 1, survey respondent)

'They shouldn't just teach this dogmatic view about straight people in a marriage with two kids' (City 1, focus group participant)

Participants also noted that discussions of safer sex focused on heterosexual sex, leaving LGB sexual health issues un(der)explored. One young man had taken from his lesson that:

'…if you're gay you're gonna get AIDS, quite scary, I was quite traumatised by that' (City 1, focus group participant)

Conversely, another participant reported that he had not known what HIV was until he was diagnosed as HIV positive before the age of 16.

A young woman noted that:

'… they didn't say anything about lesbian and bisexual women at all so it was just like kind of giving the impression that they're immune or they didn't exist' (City 1, focus group participant)

Many participants suggested ways to improve provision, including well-informed external speakers rather than 'straight teachers with no experience', and learning about same-sex relationships from an earlier age, in order to 'normalise'

them. They also wanted information on dental dams, and local 'gay-friendly' sexual health services, not just 'family planning services'.

### *Conceptualisations and understandings of sexual health*

A definition of sexual health used by the World Health Organization states that:

'Sexual health is a state of physical, emotional, mental and social well-being in relation 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. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.' (WHO 2002, 5)

This understanding is not currently supported by much current UK health promotion or SRE, however, which tend to adopt a more medical and/or disease prevention understanding (Bourne and Robson 2009; Stone and Ingham 2006). It is not surprising, therefore, that a common thread in participants' responses expressed a largely biomedical conceptualisation of sexual health, focusing on the avoidance of infection or 'disease'. In City 2, for example, the majority of men related 'safer sex' to using a condom. As this indicates, their focus was on the prevention of fluid exchange, rather than broader notions, such as physical safety or harm. Understandings of sexual health that focus on issues such as the avoidance of infection, neglect a more holistic view of sexual health. They may also restrict discussion of wider issues, such as sexual pleasure, and what constitutes 'healthy' relationships. This in turn may relate to a British culture that stifles our ability to talk about sex openly, comfortably, and without embarrassment (FPA 2007; Hirst, Formby and Owen 2006).

***Influences on sexual activity, 'risk assessment' and safer sex***

When influences on decisions about sexual activity and 'safer sex' were explored, a number of shared issues were raised by men and women in City 2, with some men explicitly using the term 'risk assessment'. Alcohol/drug consumption was the factor many participants identified as most influencing their sexual decision-making, but choice of partner, communication, and access to safer sex supplies were also raised.

Assumptions about potential partners were key in decision-making about safer sex among City 2 participants. Such decisions were often based on the level of previous acquaintance or social network links, where or how they met, or on perceptions connected to appearance, such as age or ethnicity. Choice of partner, often related to notions of 'promiscuity', appeared more influential than decisions about actual sexual activities. As one participant noted:

'I would never ever have anal sex with someone who I met in a sauna just because I would be under the assumption that they were probably quite riddled'

(City 2, male interviewee)

Familiarity (Bourne and Robson 2009) and/or 'looking healthy' (Adams and Neville 2009, 1674) have been shown to be used as part of 'risk management' strategies. This suggests that the stigma concerning the visibility of sexual ill-health, or potential sexual 'dirt', remains prevalent, drawing on a long history of associations between dirt, 'otherness' and sexually transmitted disease or infection (Piercy 2007), and more recently, assumptions made about AIDS in the early 1980s, then known to some as 'the gay plague'.

Similarly, assumptions related to the concept of 'risk' demonstrate worrying beliefs about the ability to 'see' or prevent sexual ill-health or 'risk', largely based on how well someone 'knows' a potential partner, and/or their perception of likely sexual 'risk'. There was also some evidence that 'otherness' was associated with sexual risk, with assumptions made about the likelihood of HIV prevalence in relation to both age and ethnicity.

'You automatically kind of gauge a level of risk and I think there's several factors come into play there. I think race is a factor… You would perhaps synonymise a black gay man with HIV more than a white gay man and pretty much the same… with an older gay man than a young gay man' (City 2, male interviewee)

The female participants in City 2, whilst less explicit about their 'risk assessments', also appeared to make decisions on the basis of appearance and choice of partner, rather than sexual practices. Other reasons given by female participants for not practicing safer sex included 'trusting' partners, and being in long-term or monogamous relationships. In contrast to the male participants in the same city, some women reported that having sex with a new or unknown partner was less likely to lead to safer sex.

These decisions may relate to a general belief about a lower risk of STI transmission from sex between women, possibly due to greater levels of publicity and health campaigns about STIs among MSM. As Wilton (1997, 49) wrote in relation to HIV specifically, 'neither statutory nor voluntary/activist health education interventions have succeeded in identifying and meeting the needs of lesbians'.

'There should be more information for women on STIs. From my experience they don't think they can catch anything because we're a low risk group. This also means that most won't get tested for STIs because they think they're invincible' (City 2, survey respondent)

In addition, participants commented on the 'unsexy' or 'unromantic' nature of safer sex resources such as dental dams or gloves, which may discourage their use among lesbian and bisexual women within a social context that often emphasises women's passivity specifically and/or spontaneity in general (as opposed to risk-minimisation) in relation to sex.

'Who the hell are going to use gloves? It has some form of clinical/diseased connotation to it. I think if I ever pulled these gloves out on someone they would run a mile' (City 2, survey respondent)

As Wilton (1997, 48-9) suggested, 'Within the AIDS crisis... some lesbians, assuming that woman-to-woman sexual transmission was impossible... represented HIV as something associated with dirty, unpleasant practices which lesbians were unlikely to get up to... For lesbians, then, identity and a sense of community have not supported the development of a confident safer sex discourse as has been the case with gay men'.

Some participants also explained that their decision not to practice safer sex related to their inability to communicate about safer sex without embarrassment. Confidence and oral communication skills have been described as important for negotiating safer sex in both heterosexual and homosexual sexual encounters (FPA 2007; Bourne and Robson 2009). This was also discussed by the participants.

'It's awkward, it can be awkward… you don't know how they're gonna take it

[mentioning safer sex]' (City 2, male interviewee)


Research has documented the potentially negative effects of alcohol or drug consumption on safer sex (Adams and Neville 2009; Keogh et al. 2009). In City 2, alcohol and/or drug use was the most common factor identified by participants, particularly men, in increasing the likelihood of unsafe sex, but it was also seen as something that could facilitate more confident communication around safer sex.


Ambivalence or anxiety about discussing an 'awkward' or 'touchy' subject such as safer sex was also present:


'If you've say been on one or two dates with someone and you've already got a rapport, you can converse, you don't just like each other when you're drunk then you're more likely to bring up something a little bit touchy like safe sex'

(City 2, male interviewee)


Similarly, there was some reticence about buying or carrying condoms for use in potential sexual encounters. Participants suggested embarrassment, lack of confidence, and not wanting to appear to be 'planning' for sex (which might damage reputation) as reasons for their reticence. It would seem that this element of young LGB sexual culture is shared with many young people: that it is not always easy to talk about sex (Buston 2004). Given a British schooling system that does not prioritise SRE, evidence that many parents feel ill-equipped to discuss sex with their children (Goldman 2008; Ingham 2005), and an increasing focus on protecting young people's sexual 'innocence' (Moran 2001) within a sexualised society (Attwood 2006; Smith 2009), it is perhaps not surprising that young people lack confidence to clearly

communicate about sex. Difficulties are compounded for LGB youth by the widespread invisibility or marginalisation of their sexual identities within much SRE and sexual health provision.

**Access to services**

In relation to services and support, participants raised issues relating to the availability of appropriate sexual health information, access to safer sex supplies, and barriers to service provision.

There is a wide variety of information regarding sexual health aimed at MSM available on the internet, though only recently have organisations such as Stonewall and the Lesbian and Gay Foundation provided sexual health information for lesbian and bisexual women. Nevertheless, the internet was described as key for accessing sexual health information by both men and women in City 2, though its use raised two issues. First, male participants reported contradictory and/or confusing information based on their reliance on non-specialist websites or search engines (e.g. Wikipedia, Google), particularly in relation to the 'safety' of oral sex. Second, a possible 'false confidence' in the availability of local services was also evident.

Whilst men in City 2 reported gay bars and clubs as sources of sexual health information, perhaps not surprisingly given the focus of much health promotion aimed at gay men, women in the same city did not find it easy to access information about sex and relationships between women. The majority said they did not have enough information, and were unaware of specific local and national leaflets aimed at lesbian/bisexual women.

'Basic information about what sort of sex transmits what sorts of infections between

women would be a start! Alongside what actually IS safe sex between women'

(participant's emphasis, City 2, survey respondent)

A common complaint made by the women in City 2 related to the lack of visibility of LGBT patients in health materials. Whilst men reported the local GUM clinic as the most common source of information, women more often suggested other sources provided relevant information for their needs, such as books, friends and television.

There was some evidence of gaps in women's knowledge about sexual health in City 2. A minority demonstrated some misperceptions about STI transmission, with 11% saying they did not know or thought there was no risk of STI transmission from sex between women, and 26% reporting that they could not get any or many STIs or HIV through having sex with women. This confirms other research which identifies that many lesbians have a (mis)perception that they are 'immune' or at a very low risk of any sexual health related infections/problems (Hunt and Fish 2008; Richardson 2000). As Wilton (1997, 102) argued, 'there is almost no support within lesbian communities for the practice of safer sex'.

For the men in City 2, the prevalence and nature of health promotion in commercial gay venues or publications was raised as an issue, suggesting that sexual health workers have a hard balance to strike in relation to the provision of information on the scene. Perhaps unsurprisingly, some participants did not like the intrusion of health promotion into their socialising space.

'This is something I've always been struggling with, obviously the reasons that these

things are there is because statistically you're more likely… but the fact that it only

happens to one group and that's gay people, and not others is something I find a bit

strange… people have sought me out as a gay person to give me free condoms… I

don't want to just be gay and be sought out for that, I just want to be'

(City 2, male interviewee)

Access to condoms where men meet men was also highlighted as important by male participants in City 2, with a range of desired locations identified on the gay scene, at public sex environments, and in other pubs, bars and clubs. The majority praised the accessibility of supplies provided through a free local condom distribution scheme targeted at MSM. The women in City 2 were not afforded this luxury, and the majority said they did not find it easy to get safer sex items locally that were suitable for sex between women, though the vast majority said that they would like to be able to, for example, in local shops, bars and clubs.

Whilst inadequate sexual health information and/or supplies were highlighted by some participants, it was the implicit or explicit barriers to service access that often generated the most data. The women in City 2 reported wanting their sexual health needs met more effectively through increased understanding and knowledge about their experiences amongst local health staff.

'Doctors should have more information on the subject. I have come across doctors

who seemed to assume STIs cannot be transmitted at all between women'

(City 2, survey respondent)

Most women felt that their experiences of health services could be improved. The majority had been assumed to be heterosexual by health workers, which elicited various feelings, from anger to upset or embarrassment. Less than half of women respondents in City 2 reported receiving appropriate sexual health information or advice suitable for their needs as lesbian or bisexual women. Just under half also

reported concerns about confidentiality when 'coming out' or disclosing themselves as gay in a health setting or to a health worker. The most commonly reported barrier to accessing sexual health care or advice was fear and/or previous experience of 'ignorance', 'judgemental attitudes', or 'homophobia' from health care staff. This made some women reluctant to seek health care advice or treatment, and some reported delaying obtaining medical attention because of their sexuality.

The men in City 2 reported similar barriers to accessing sexual health care or advice:

'I don't think they're closed, but it's just like you've got this kind of heteronormativity or whatever in greater society and that just influences and trickles down into health settings too. It would be great to think that, to not walk into a hospital and have it assumed that you're straight' (City 2, male interviewee)

More practical barriers included lack of awareness about local services and service delivery. Suggestions for improvements to services related to this often focused on the timing or location of services.

'When I had my first STI scare and I didn't want to tell anyone… I was worrying, absolutely shitting myself that I'd caught something… I just didn't do anything about it and then I got crabs… I got a full check-up and that was fine… things that would have perhaps encouraged me to go would be being open on a weekend so I didn't have to skip school' (City 2, male interviewee)

Broader changes suggested by both men and women often related to staff attitudes or general demeanour, with participants explaining that more comfortable staff put patients at ease, and help them feel more able to talk about their health/sexuality.

**Discussion and conclusion**

Whilst the findings above are small-scale and therefore not generalisable, they do add weight to a growing picture of young LGB experiences of sex education and sexual heath, and aid our understanding of both a dominant sexual culture constructed by health and education providers, and the sexual cultures of LGB young people themselves. The former is characterised by high levels of invisibility and marginalisation prominent in LGB accounts of schooling, with health service access issues also raised by LGB participants. These included inadequate information and safer sex resources/supplies (particularly for women), and barriers to seeking medical care, often relating to staff attitudes/behaviours, or broader fears of mistreatment/discrimination. At present, not all young people are given enough information to maintain good sexual health, with LGB sexual cultures demonstrating questionable beliefs about choice of partner in relation to safer sex (based on assumptions and perceptions of risk), with decisions sometimes made solely on the basis of appearance, age, or ethnicity. However, there appears to be clear support for same-sex relationships to be included in future SRE, which could attempt to tackle these issues.

Whilst wider-scale research is still needed on young LGB experiences of SRE and sexual health, from this data and elsewhere, the key issues that appear to be important for LGB young people's future sexual health include the ongoing fear and/or stigma attached to using sexual health services; concerns about confidentiality and/or disclosure; workers assuming heterosexuality in health encounters; the lack of visibility of LGBT patients in health materials; poor supply of suitable safer sex items, such as dental dams; and fear of judgement, discrimination or homophobia. This sheds light on the degree to which LGB sexual cultures - and

sexual health - are informed by LGB youth experiences of a dominant sexual culture in wider society, particularly the education system and health care services. An analysis of this social context is therefore key in thinking about individuals' experiences of 'sexual health', whatever that may mean to them. Whilst a holistic definition of sexual health may be used by WHO this does not appear visible in a dominant UK sexual culture which focuses on penetrative heterosexual sex and/or protecting young people's 'innocence' at the expense of LGB young people's health education, and understandings of safer sex.

If talking about sex is often allied with notions of embarrassment (FPA 2007; Independent Advisory Group on Sexual Health and HIV 2007) and/or privacy (Fish 2006) for many people, but particularly for young people (Aggleton, Warwick and Boyce 2006; Buston 2004), then this can only be compounded for those young people growing up in a society that many of them experience as stigmatising, marginalising or rendering invisible their developing sexuality. Their sexual culture is currently defined as 'other' within school SRE that seeks to 'promote' marriage, and thus, even if only implicitly, heterosexuality (DfEE 2000; DCSF 2010). As Donovan and Hester (2008, 285) argue, 'The danger is that for many young people considering same-sex relationships, the contexts in which they might be expected to pick up information about the kinds of relationships they want might be unsympathetic at best or hostile at worst'. An analysis of these contexts, and the dominant and sub-cultural sexual cultures to which they contribute, is essential if we are to improve the current sexual health statistics for young people, LGB or otherwise: 'any analysis of sexual risk and sexual negotiation is enriched by an understanding of social interaction and social norms' (Keogh et al. cited in Adams and Neville 2009, 1674-5).

There is a need to further understanding and knowledge about the needs and experiences of LGB young people among both education and health staff, and to increase sex and relationships information materials and resources that are aimed at, and suitable for, LGB young people. Sex educators and sexual health services are in an ideal position to address some of the knowledge and information gaps in relation to LGB sexual health needs, particularly for young women. They should also attempt to encourage and increase safer sexual activity among LGB young people, drawing on a broad definition of sexual health, and particularly targeting beliefs based on stereotypes about sexual risk, and the visibility of 'risk'. Moreover, they could begin to challenge some of our reticence to talk about sex openly and honestly, and help wider advertising of suitable health and information/support services available locally, for all young people. Whilst acknowledging the time and financial constraints many health/education workers operate within, as well as research which suggests that sex educators often feel under-skilled or lacking in training (Formby, Hirst and Shipton 2009; Martinez and Emmerson 2008a), LGB awareness courses are available – if practitioners are willing and/or able to attend (Hinchliff 2005). Often a simple change in pronoun would make current provision more inclusive ('they'/'partner' rather than 'he'/'she'). Even within a narrow view of sexual health judged purely on STI rates, service providers should be seeking to include LGB young people.

For SRE to be truly inclusive of all sexual behaviours and/or identities, an equalities and human rights foundation to all learning and advice about sex and relationships must first be adopted. This should explicitly foreground the right to sexual health and pleasure for both young and old, and people of all sexual identities and experience. As the singer-songwriter Billy Bragg (1991) sings, 'safe sex doesn't mean no sex, it just means use your imagination'. It should not require much imagination to think we should equip LGB youth to have sexually healthy futures just as much as we should equip our heterosexual youth.

## Acknowledgements

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