Sexual Health Knowledge, Attitudes and Behaviours among Black and Minority Ethnic Youth in London

A summary of findings

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Trust for the Study of Adolescence (TSA) and Naz Project London (NPL) 2006
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1. What is the aim of this report?

This report summarises a research project that identified and helped explain the sexual health knowledge, attitudes and behaviours among Black and Minority Ethnic (BME) youth in London. This research included quantitative (survey) and qualitative (in-depth interview) components. This summary includes an outline of why the research was necessary, which organisations were involved, the study objectives and the research methods used. The report summarises the findings from the research in the form of text and charts (presenting data broken down by sex). The summary closes by outlining the implications for practice and policy and looks at forthcoming developments connected to the research.

The full Technical Report, which includes a more extensive text and full tables is also available (see 12).

2. Why was the research undertaken?

The current climate of young people’s sexual health in the UK is of intense public concern (Tripp and Viner 2005). Teenage birth rates in England remain the highest in Western Europe (UNICEF 2001), and there has been a dramatic increase in new cases of Sexually Transmitted Infections (STIs) among young people (HPA 2005). To illustrate, from 1996 to 2004, new infections of chlamydia in the UK increased by 426% among young men and 240% among young women aged 16-19 years (HPA 2005).

It is acknowledged that certain young people are more at risk from poor sexual health. For example, higher teenage pregnancy rates are apparent among specific population groups such as looked after children and care leavers (Biehal et al. 1992), young offenders (Hobcraft 1998) and children of teenage mothers (Kiernan 1995, Ermisch and Pevalin 2003). There is also strong evidence linking teenage pregnancy to low educational attainment (Wellings et al. 2001, Cater and Coleman 2006) and high levels of poverty and disadvantage (Botting et al. 1998, Dennison 2004). In terms of STI, young people clearly show a greater likelihood of disease, with young gay men and young women being at greater risk (PHLS 2002, Fenton and Hughes 2003).

In addition, certain Black and Minority Ethnic (BME) groups have been identified as bearing a disproportionate burden of sexual ill-health (Berthould 2001, Fenton and Hughes 2003, Fenton et al. 2005, Sinha et al. 2005, Tripp and Viner 2005). For example, national surveillance data (Dougan et al. 2004, HPA 2004) and localised surveys within service settings (Shahmanesh et al. 2000, Hughes et al. 2001, Low et al. 2001, Low 2002) demonstrate higher numbers of new cases of STIs among Black groups, and lower numbers in Asian groups, compared to White groups.

It is widely acknowledged that few behavioural studies have been done to improve our understanding of these ethnic variations in sexual health (Bradby and Williams 1999, Santelli et al. 2000, Chinouya and Reynolds 2001, Low 2001, Fenton et al. 2005, Sinha et al. 2005). Although relatively comprehensive behavioural research has been conducted among White British youth (Wight 2000, Wellings et al. 2001, Henderson et al. 2002), the majority of studies among ethnically diverse groups have been conducted

3. Who was involved in doing the research?

The origins of this research stem from a need expressed by Naz Project London (NPL) to gain a fuller understanding of the sexual health knowledge, attitudes and behaviours of young people from BME groups. NPL is a unique multiethnic agency in London and the UK. It has a track record going back over the past decade as a leading sexual health and HIV service provider among BME communities. To support its work, NPL requires accurate and up-to-date data on the sexual health knowledge, beliefs, attitudes, lifestyles and behaviours of BME youth. At present NPL largely relies on surveillance data provided by the Health Protection Agency (HPA). However, these data focus on the surveillance of STIs rather than belief or attitudinal antecedents of risk behaviour crucial to the development of effective prevention interventions. Additionally, ethnicity data are not available for all the communities that NPL works with.

This report presents evidence derived from a two year research project, undertaken by the Trust for the Study of Adolescence (TSA), to support the work of NPL and others. TSA was founded in 1989 to improve the lives of young people and families. TSA’s work is derived from the belief that there is a lack of knowledge and understanding about adolescence and young adulthood. The Trust is trying to close this gap through applied research, training for professionals, and producing and marketing publications for parents, professionals and young people. Both authors of this summary report were present at TSA during the time the research was undertaken. The research was funded by the Big Lottery.

4. What were the research objectives?

The aim of the research was to identify the sexual health support needs of young people from BME communities. To meet this aim, the objectives were four-fold:

- To identify ethnic variations in sexual health knowledge, attitudes and behaviours.
- To identify specific preferences for Sex and Relationships Information (SRI), in terms of topics requested and preferred modes of delivery.
- To explore and help explain why some of these ethnic variations exist.
- To use the research data to generate implications for practice and policy.
5. What research methods were used?

This study adopted a mixture of research methods to help identify the sexual health support needs of BME youth, as follows:

Quantitative (survey) component:

A cross-sectional, self-administered questionnaire survey was performed among students attending secondary schools in Greater London. Schools were purposively selected among those where BME groups comprised at least two-thirds of the student population. To include reasonable proportions of different ethnic minority groups, schools were selected from all five London Strategic Health Authorities. Sixteen out of 30 schools approached agreed to participate in the study. The questionnaires were distributed and collected by a team of ethnically diverse fieldworkers under ‘exam’ conditions.

The sample consisted of all students in school Years 11 to 13 (aged 15-18), present in school on the day of questionnaire administration. The most appropriate interpretation of the survey data are that they represent students aged 15-18 in full-time education in London schools where the majority of students are from BME communities. Of the 3,026 students present in schools on the data collection days, including five who had been withdrawn by parents/carers, 3,007 (99%) agreed to participate.

Qualitative (in-depth interview) component:

The qualitative component used a semi-structured interview schedule to explore how sexual health knowledge, attitudes, beliefs and behaviours were shaped by family, community, culture, religion, and ethnicity. BME youth, in London, under the age of 25 were selected for interview from a range of community youth groups, youth sexual health clinics, and also volunteers from the self-completion questionnaires. In total, 50 in-depth interviews were completed. A male and female interviewer conducted the research.

6. Who were the people participating in the survey?

Three-quarters (74%) of the of 3,007 respondents were aged 15 or 16 years, reflecting the age of compulsory school attendance (up until 16). The gender split was even as expected. Most (77%) were born in the UK. Respondents were invited to state their ethnic background from 42 pre-coded groups, including an ‘Other’ response option.

In total, 80.9% of respondents reported being from BME backgrounds (defined as all groups other than ‘White British’). The percentage breakdown from the entire sample¹, is depicted in the following table and Figure 1:

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¹ 2926 out of the 3007 sample reported an ethnic background response.
### Table 1: Ethnicity, by sex

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>% of total sample</th>
<th>% male of total sample</th>
<th>% female of total sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>19.1%</td>
<td>9.9%</td>
<td>9.2%</td>
</tr>
<tr>
<td>White Other</td>
<td>8.7%</td>
<td>4.6%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>12.1%</td>
<td>7.3%</td>
<td>4.7%</td>
</tr>
<tr>
<td>Black African</td>
<td>12.0%</td>
<td>5.4%</td>
<td>6.6%</td>
</tr>
<tr>
<td>Indian</td>
<td>20.9%</td>
<td>10.7%</td>
<td>10.2%</td>
</tr>
<tr>
<td>Pakistani</td>
<td>4.1%</td>
<td>2.7%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>4.3%</td>
<td>1.9%</td>
<td>2.4%</td>
</tr>
<tr>
<td>All Other Backgrounds</td>
<td>18.8%</td>
<td>8.4%</td>
<td>10.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>50.9%</strong></td>
<td><strong>49.0%</strong></td>
</tr>
</tbody>
</table>

Figure 1 shows the ethnic profile of the survey respondents by numbers and percentages.

**Figure 1: Ethnic profile of the survey respondents**
(number and percentage of entire sample, n=2926)

The ‘All Other Backgrounds’ includes Black respondents other than Black Caribbean and Black African, and Asian respondents other than Indian, Pakistani and Bangladeshi (as well as all other ethnic groups). For information, the White Other were all from Eastern and Western Europe. As shown, the largest ethnic group within the sample was Indian at 21%.

The majority of respondents were resident within the North West Strategic Health Authority (47%) of London (Figure 2). Nearly one-half (45%) of the sample were resident in the upper quartile\(^3\) (25%) or most deprived areas in England.

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\(^2\) Percentage of males and females do not add up exactly to 100% due to rounding.

\(^3\) The 25% most deprived Super Output Areas ranked according to the Index of Multiple Deprivation.
Around a quarter of the respondents (27%) of the sample attended a church, synagogue, temple, mosque or religious class at least once a week. The most frequently reported religion/faiths were Muslim (24%) and Hindu (21%). Just over a third (36%) of the respondents did not report English as their first language. Eleven percent of the sample reported that they had ever felt attracted to the ‘same’ or ‘same and opposite’ sex or were ‘not sure’.

7. What were the main survey findings?

In line with the structure of the self-administered questionnaire, findings are presented for sexual health knowledge, sexual health attitudes, experience of sexual intercourse, sexual risk behaviour and outcomes, and preferences for learning about Sex and Relationships Information (SRI).

Findings are presented at three levels of detail as follows:

- Level 1 - The whole sample (BME and White British) with gender differences,
- Level 2 - across four main ethnic groups (White British, White Other, Black, and Asian) with gender differences,
- Level 3 - within Black groups (Black Caribbeans and Black Africans) and within Asian groups (Indians, Bangladeshis and Pakistanis) with gender differences.

In this summary report, the totals and male and female differences are age standardised and only include those respondents who recorded their ethnicity. These are occasionally one or two percentage points different to figures in the Technical Report where results from the entire sample, irrespective of a valid ethnicity response, are reported.

Due to the heterogeneity of the ‘All Other Backgrounds’ group, they are not included in this summary report but are detailed in the Technical Report.

The comparisons at Level 3, reporting the differences within the Black and Asian groups, do not include the 7 Black Other respondents (i.e. not Black Caribbean or Black African) and 219 Asian Other respondents (i.e. not Indian, Pakistani or Bangladeshi). However, in the respective charts, the ‘all Black groups’ refers to Black Caribbean, Black Africans and all other...
7.1 Sexual Health Knowledge

Females reported higher overall sexual health knowledge than males: mean scores were 18.5 (out of 25) among females and 16.6 among males. Young people were generally more knowledgeable about pregnancy compared to STIs. Knowledge gaps in both STI name and symptom recognition were evident - 37% of the entire sample and a notable 45% of males were unable to identify chlamydia as a STI.

Variations in the mean sexual health knowledge score across the four main ethnic groups and within the Black and Asian groups are shown in Figures 3, 4 and 5 respectively. These charts illustrate the particular knowledge gaps among White Other males, Black African males, Bangladeshi males, and Pakistani males and females.

![Figure 3: Sexual health knowledge score (out of 25), by ethnicity](image1)

![Figure 4: Sexual health knowledge score (out of 25), within the Black ethnic groups](image2)

Black groups that were used to compile the Black groups documented at Level 2 (when comparing across the 4 main groups). The same applies to the Asian groups. Also, due to the fact that relatively few Asians reported sexual intercourse, many of the sexual behaviour findings are unable to present comparisons by Indian, Pakistani and Bangladeshi groups.
7.2 Sexual Health Attitudes

Respondents were asked to what extent they agreed or disagreed with five statements used to measure their sexual health attitude. For illustration, one of these questions stated “it’s OK for me to have a one-night stand if I want to”. Those who agreed to this statement would be indicative of a more liberal sexual health attitude (and a higher mean score on the attitude scale). Males were generally more liberal in their attitude than females, reporting a higher mean score on the attitude scale (16.5 compared to 15.3 out of 30).

Variations in the mean sexual health attitude score across the four main ethnic groups and within the Black and Asian groups are shown in Figures 6, 7 and 8 respectively. These charts illustrate how the White British students were generally the most liberal, with the Black females and Asian females holding more conservative attitudes. The gender differences are most pronounced in the White Other and Black students, with males reporting more liberal attitudes. Females of Black African, Pakistani, and Bangladeshi ethnicity reported the most conservative attitudes of all.

These attitudes are interesting since they are not entirely indicative of the patterns of sexual behaviour that will be reported (in that respondents reporting more liberal attitudes were not reporting more experience of sexual intercourse and vice versa).
Figure 6: Sexual health attitude score (out of 30), by ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>18.1</td>
<td>19.2</td>
</tr>
<tr>
<td>White Other</td>
<td>16.8</td>
<td>14.7</td>
</tr>
<tr>
<td>Black</td>
<td>16.0</td>
<td>13.7</td>
</tr>
<tr>
<td>Asian</td>
<td>15.9</td>
<td>14.3</td>
</tr>
<tr>
<td>All groups</td>
<td>16.5</td>
<td>15.3</td>
</tr>
</tbody>
</table>

Figure 7: Sexual health attitude score (out of 30), within the Black ethnic groups

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black Caribbean</td>
<td>16.8</td>
<td>14.8</td>
</tr>
<tr>
<td>Black African</td>
<td>14.8</td>
<td>13.0</td>
</tr>
<tr>
<td>All Black groups</td>
<td>16.0</td>
<td>13.7</td>
</tr>
</tbody>
</table>

Figure 8: Sexual health attitude score (out of 30), within the Asian ethnic groups

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indian</td>
<td>16.9</td>
<td>14.8</td>
</tr>
<tr>
<td>Pakistani</td>
<td>13.7</td>
<td>12.5</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>14.6</td>
<td>13.0</td>
</tr>
<tr>
<td>All Asian groups</td>
<td>15.9</td>
<td>14.3</td>
</tr>
</tbody>
</table>
7.3 Experience of Sexual Intercourse

Two measures of sexual intercourse, defined as vaginal and/or anal intercourse, are presented in this report. Firstly, experience of sexual intercourse among all age groups (15-18) and, secondly, experience of sexual intercourse under the age of 16 among all 16-18 year olds. The inclusion of the latter measure of ‘early’ intercourse enables comparisons with other datasets, and has also been shown to be an indicator of poor sexual health outcomes (Wellings et al. 2001, Tripp and Viner 2005).

Of the 15-18 year olds surveyed, males generally reported more experience of sexual intercourse than females (38% compared to 24%). Variations in sexual intercourse across the four main ethnic groups and within the Black and Asian groups are shown in Figures 9, 10 and 11 respectively. These charts show the highest prevalence among Black male groups, especially the Black Caribbean males at 65%. Asians were generally the least likely of all groups to report experience of sexual intercourse, especially Asian females. Although less likely to have sex, among those Asians who did have sexual intercourse, 28% of Asian males reported experience of anal intercourse as did 19% of Asian females.

Just over one percent of the sample reported sexual intercourse with a person of the ‘same’ or ‘same and opposite’ sex (or 4% of those reporting ever having sexual intercourse).

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As Asians were the least likely to report sexual intercourse, it was not possible to report meaningful sexual behaviour findings individually by Indian, Bangladeshi and Pakistani respondents in this summary (other than experience of sexual intercourse).
Of those 16-18 year olds surveyed, 18% reported first sexual intercourse under the age of 16, with males reporting a higher prevalence than females (24% versus 13%). Variations in this measure across the four main ethnic groups and within the Black and Asian groups are shown in Figures 12, 13 and 14. These charts are comparable to the experience of sexual intercourse for the entire sample, with Black Caribbean males reporting the highest prevalence at 48% (compared to no Bangladeshi females). Previous research has showed that such ‘early’ experience of sexual intercourse has been linked to a greater likelihood of STI and pregnancy before 18 (Wellings et al. 2001).
Figure 12: Experience of sexual intercourse under 16 among all 16-18 year olds, by ethnicity

- **White British**: Male 25.6%, Female 26.7%
- **White Other**: Male 27.8%, Female 8.9%
- **Black**: Male 43.1%, Female 18.8%
- **Asian**: Male 11.7%, Female 4.4%
- **All groups**: Male 24.3%, Female 12.8%

Figure 13: Experience of sexual intercourse under 16 among all 16-18 year olds, within the Black ethnic groups

- **Black Caribbean**: Male 47.9%, Female 25.8%
- **Black African**: Male 38.0%, Female 11.6%
- **All Black groups**: Male 43.1%, Female 17.2%

Figure 14: Experience of sexual intercourse under 16 among all 16-18 year olds, within the Asian ethnic groups

- **Indian**: Male 12.1%, Female 5.0%
- **Pakistani**: Male 18.8%, Female 7.3%
- **Bangladeshi**: Male 7.1%, Female 0%
- **All Indian groups**: Male 11.7%, Female 4.4%
The remaining findings for sexual behaviour are derived from the 31% of the sample (38% males and 24% females) who reported sexual intercourse (Figure 9).

The survey recorded a number of events in relation to first ever sexual intercourse, such as reasons (e.g. ‘love’, ‘drunk’, ‘most people my age seemed to be doing it’), relationship, (e.g. ‘steady partner’, ‘met for the first time’), timing (e.g. ‘wished we had waited longer’, ‘about the right time’), willingness (e.g. ‘partner was more willing’, ‘equally willing’) and contraceptive use.

Variations for each of these five measures across five ethnic groups are shown in Figures 15 to 19. The young men generally reported circumstances at first sexual intercourse associated with higher risk than young women. Young men were more likely to report negative reasons for first ever intercourse, less likely to be in a steady relationship, to report intercourse that was of unequal willingness and without contraception. The ethnic groups most commonly reporting responses to these questions were as follows: White British males and White Other males reporting negative reasons for first intercourse, White Other males and Black Caribbean males not being in a steady relationship, Black African females and Asian females not considering the timing of this first intercourse as about right, and Black Caribbean males and females reporting unequal willingness.

Figure 15: First ever sexual intercourse: negative reasons, by ethnicity

![Graph showing reporting negative reasons by ethnicity and gender.](image)

8 The precise definition of contraception included the prevention of pregnancy among heterosexuals, and ‘precautions’ (e.g. condom use) among both heterosexual and same-sex relationships.

9 As a reminder, Asians were too few to make meaningful comparisons within this ethnic grouping. Hence the findings for Black Caribbean and Black African are presented alongside the other ethnic groups in a single chart.
Figure 16: First ever sexual intercourse: not in a steady relationship, by ethnicity

Figure 17: First ever sexual intercourse: timing was not 'about right', by ethnicity

Figure 18: First ever sexual intercourse: not equal willingness, by ethnicity
At first sexual intercourse, non-use of contraception (Figure 19) was most frequently reported among Black African males (32%), Asian females (25%) and Black African females (24%), indicating the possibility for unintended pregnancy and/or STI.

Taking these five measures into account, a measure of ‘sexual competence’ was derived, to illustrate the sexual health of this first ever intercourse. Only those reporting positive reasons for first ever sexual intercourse (such as for ‘love’ rather than ‘being drunk’), being in a steady relationship, thinking the timing was about right, being equally willing and using effective contraception were classified as sexually competent. As an example, if a person reported unequal willingness for first ever sexual intercourse they would be defined as not ‘sexually competent’ on this occasion, even if all other responses were ‘competent’. A comparable measure of ‘sexual competence’ has been used in previous research (Wellings et al. 2001).

Only 20% of the sample were ‘sexually competent’ on this occasion of first ever sexual intercourse (or 80% were not sexually competent on this occasion). Eighty-eight per cent of males were not sexually competent on the occasion of first ever sexual intercourse compared to 71% of females. Figure 20 shows proportion who were not sexually competent across these same five ethnic groups.

The most notable lack of sexual competence on this event are seen for Black Caribbean males (93%), White Other males (90%), Black African females (87%), Black African males (86%) and White British males (86%).
Moving on from events surrounding first ever sexual intercourse, Figures 21 and 22 show the proportion of young people reporting three or more lifetime, and two or more sexual intercourse partners in the last six months. Males generally report more lifetime and last six month sexual intercourse partners compared to females. In terms of lifetime sexual intercourse partners, the highest figures reporting three or more are White Other males (44%), Black African males (43%) and Black Caribbean males (40%). For sexual intercourse partners in the last six months, the highest proportions reporting two or more are White Other females (32%) and White British males (28%).
7.4 Sexual Risk Behaviour and Outcomes

Four measures of risky sexual behaviour were recorded, to include risk from conception and STI. Firstly, was young people’s experience of ever having sexual intercourse without using contraception (Figure 23). As can be seen, females were more likely to report this risk at 51% compared to 37% of males. Those reporting the highest prevalence of ever not using contraception were Black African females (65%), White British females (50%), Black Caribbean females (50%), and Asian females (48%).

Secondly, Figure 24 shows the proportion of young people who have ever not used condoms. Those reporting the highest prevalence of ever not using condoms were Black African females (72%), White British females (62%) and Black Caribbean females (58%). These patterns broadly follow experiences of ever not using contraception reported previously in Figure 23. Although this measure offers an indication of potential STI transmission, it may well be the case that instances of condom non-use may be occurring in monogamous
relationships where both partners are STI infection free, and where other forms of contraception are being used (in the case of heterosexual relationships).

The third and fourth measures provide a more detailed insight into the risk for potential pregnancy and STI. These two measures combine contraceptive and condom use with lifetime sexual intercourse partners. Respondents who reported experience of ever not using contraception, or ever not using condoms, with two or more sexual intercourse partners were defined as ‘higher risk’, relative to those not reporting such experience (Figure 25 and 26 respectively). In these cases, the absolute numbers reporting this risk behaviour were less than the ‘ever not used’ measures reported in Figures 23 and 24, so should be treated with a degree of caution.

For ever not using contraception with two or more sexual intercourse partners (Figure 25), there was little difference between males and females, with around one-in-ten of those having sexual intercourse reporting this risk behaviour. Notable exceptions were Black African females reporting the highest prevalence at 18%, and the White Other males and females both reporting the lowest proportions at around 5%.

For ever not using condoms with two or more sexual intercourse partners (Figure 26), females were more likely to report this at 16% compared to males at 12%. Notable findings for reporting this risk behaviour were White British females at 20%, Black African females at 18% and Black Caribbean females at 17%.

As an additional point, compared to events surrounding experience of sexual intercourse and events at first ever intercourse, these risk behaviours were more often reported by the young women in the sample.
Thirty-nine young women, or 12% of women reporting sexual intercourse, had experienced a pregnancy described as unintentional and/or STI. This compared to 35 or 7% of young men reporting sexual intercourse. Given the small numbers, any comparisons by ethnicity need to be interpreted with a high degree of caution. Fifteen per cent of Black females and 14% of White British females reported the highest proportions. Of interest, Black African females, at 24%, were more than twice as likely to report this risk outcome compared to Black Caribbean females (10%).

Taking the sexual intercourse, and sexual risks and outcomes data into account, three interpretations emerge from the data:

1. Males generally report more risk potential than females (e.g. more experience of sexual intercourse, more partners and lower sexual competence), although this is not the case in experience of ever not using contraception or condoms.
2. Black Caribbean males report the greatest potential for negative sexual health outcomes (e.g. highest proportions reporting sexual intercourse at 65%, sexual intercourse under 16 at 48%, and highest proportions not being sexually competent at 93%).

3. Although less likely to report sexual intercourse compared to Black Caribbeans, other groups among those who have experienced sexual intercourse, also report sexual risk events. Groups notably at risk are the White Other males (e.g. the highest proportion of all reporting three of more lifetime partners at 44%), Asian males (e.g. one-quarter reporting two or more sexual intercourse partners in the last six months), Asian females (e.g. one-quarter not using contraception at first intercourse and one-half ever not using contraception), Black African males (e.g. the highest proportion of all groups not using contraception at first ever intercourse at 32%) and Black African females (e.g. the highest proportion of all groups ever not using contraception and condoms at 65% and 72% respectively, and the highest reported risk behaviour of not using contraception and condoms with two or more sexual intercourse partners at 18%).

7.5 Preferences for Learning about Sex and Relationships Information (SRI)\(^\text{10}\)

These results are reported for all respondents, not just those who had sexual intercourse.

Compared to sexual health knowledge, attitudes and behaviour, there were generally fewer differences by ethnicity in young people’s ranked preferences for SRI. BME groups generally showed more preference towards their SRI compared to the White British who were more likely to report ‘no preference’. Preferences were recorded in three areas: preferred topics, preferred source of delivery (people and setting), and preferred characteristics of person delivering. Respondents could report more than one preference, so the percentages do not total 100.

**Preferred topics**

For the sample as a whole, the most preferred topics were grouped together as STIs (64%), sexual behaviour (60% - in particular ‘how to make sex more satisfying’), and emotions and relationships (55%). The preference for STIs ties in with the generally reported lower knowledge in this area (showed earlier). All the above were expressed evenly by gender, except for emotions and relationships which was mentioned more by females (61%) compared to males (50%). Females also expressed more interest in learning about contraception (55%), compared to 42% of males. The least preferred topic area was the ‘biology’ of sex and relationships.

There was generally minimal variation across the main ethnic groups and within the Black and Asian groups. For all groups, and for both males and females, STIs, sexual behaviour and emotions and relationships were the

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\(^{10}\) SRI refers to information about sex and relationships from school and other sources. Sex and Relationships Education (SRE) refers exclusively to school-based information.
three most preferred topic areas. The one exception was among Asian females who rated contraception one percentage point higher than sexual behaviour. A striking observation was the White British males, White Other males and White British females reporting the least preference for topics, although still rated these three topic areas higher than any others.

Figures 27, 28 and 29 illustrate the universal preference shown towards learning more about STIs, for the four main ethnic groups, within the Black groups and within the Asian groups respectively.
Preferred source of delivery (people and setting)

Similar to SRI topic preferences, there was remarkable symmetry across the ethnic groups in ranked preferences for delivery. School was ranked first among all groups (56% of males and 64% of females), followed by friends (36% of males and 42% of females) and family (21% of males and 25% of females).

However, there were variations by ethnicity in the degree to which school and family were preferred, as shown in Figures 30 and 31. The most noticeable findings were the greater preference reported by Asians for school-based information, contrasting to their lower interest shown towards information from the family home.
There were minimal differences within the Asian groups, however, Black Caribbean males and females reported a greater preference towards the family relative to other BME groups (Figure 32).

Preferred characteristics of person delivering

Both males and females rated a ‘sexual health professional’ of ‘similar age’ as the most desirable person to deliver sex and relationships information. Around 35% to 45% of all ethnic groups mentioned these two preferences. Females also expressed an interest in having the information delivered by someone of the same sex (50% of females compared to 25% of males). Someone of the same ethnic and cultural background was less frequently reported (25% and 22% respectively), as was someone of the same religion (17%).
Some notable ethnic differences were Asian males reporting ‘similar age’ more highly than other males (at 43%), and for Black males and females more frequently reporting interest in someone from the ‘same ethnic background’ (at 36% and 33% respectively).

Within the Black groups, a key observation was the Black Caribbean males showing more interest for someone of the same ethnic background (at 44%) compared to 25% of Black African males. Within the Asian groups, Pakistani males differed by reporting the least interest for a ‘sexual health professional’ at 22%, with more preference for someone of the ‘same religion’ at 42%. Interest for someone of the ‘same religion’ was echoed by Pakistani and Bangladeshi females (43% and 46% respectively), compared to Indian females at 19%.

8. Who were the people participating in the in-depth interviews?

The interview sample comprised almost equal number of males (n=24) and females (n=26) aged 16-23, the majority (70%) of who were aged 16 to 18. Their ethnic and religious details are presented in Figures 33 and 34 respectively. Most of the interviewees were Black, and of Christian religious affiliation. It should be noted that this was different to the survey respondents, who were most likely to be Indian, and of Muslim or Hindu faiths.

Twenty-two of the interviewees were attending school or college and recruited mainly from the self-administered questionnaires. However, unlike the survey respondents, a number of the interviewees were not attending school. Eleven were recruited from sexual health drop-in clinics, and the remaining 17 were recruited via various community-based organisations such as ethnic youth groups or LGBT (Lesbian/Gay/Bisexual/Transgender) groups. Four interviewees described themselves as gay, and five as bisexual.

![Figure 33: Ethnic diversity of interviewees (number and percentage of entire sample, n=50)](image)
9. What were the main in-depth interview findings?

In general terms, the findings from the interviews provided support to many of the issues raised in the survey. The key explanations behind the ethnic diversity in sexual health knowledge, attitudes, behaviours and learning preferences, were four-fold as follows:

9.1 Conflicting Sexual Norms and Values

BME adolescents reported experiencing dichotomous, and often conflicting, sexual norms and values between family and/or community, and life ‘outside’. This was the most significant finding that came out of the interviews. The pressures and values evident between the family home and outside environment caused a tension for some,

‘Mostly in my culture you’re not allowed to have sex, yeah - unless you’re married…first you have to bring the families together…it’s like, tradition, innit? That’s how the culture is, but I’m just enjoying my life, to be honest. As long as you say ‘no - I’m not gonna tell my dad, I’m not gonna tell your dad. You’re not going tell your mum - not gonna tell my mum, yeah?’ And you keep it. But if you spill it out, if someone tells you’re in big trouble ‘specially if you’re a girl and you’re a Christian or Muslim and your parents find out. They’re gonna be disappointed in you.’

Black African Muslim male, aged 17

‘The problem is…if I wanna carry [condoms] I still feel bad, cos I still got that Ghanaian mind in my mind.’

Black African Christian male, aged 18
‘After everything you do you have to look at your family, don’t look at yourself. That’s the problem...[appearing ‘clean’ in front of my culture] for the benefit of your family, not your own self. If it makes you feel happy, but then your family won’t be happy...you end up being ruled by your family, everything you do every day.’

Black African Muslim female, aged 19

As the majority of the sample were born in the UK, and are likely to have spent most of their life so far in this country, this tension reflects the ongoing process of acculturation. This acculturation and adjustment raises a conflict between traditional religious and family values within the home and the values and norms of the wider community,

‘If you learn things [about sex and relationships] from your parents and your religion...no sex before marriage and stuff, most of the time that can stay with you. But the environment that can kind of wear it [what you think about sex and relationships] off...So, at first I had it in my head, everyone has it in their head at first, but then it does kind of change sometimes with environment.’

Middle Eastern Christian female, aged 16

The conflicting norms and values experienced by young BME people had significant influence on a number of sexual health related behaviours, including an inability to discuss sex and relationships with family and community members. Some young people felt that social expectations prevented any discussion or recognition of young people’s sexuality, and need for information or support. Indeed, some participants singled out their parents’/carers’ or community’s lack of engagement in supporting young people around sexual health as a key factor in their life,

‘Our parents, they’re not teaching us [about sex]...so you go home and don’t think that way. We close part of us, and that’s the way they want us to act.’

Black African Muslim female, aged 19

‘The people in our community...they’re always pointing fingers. They’re like ‘Don’t do this and don’t do that. Get in the house...boys are like this.’ Yeah, thank you – I think I already know that!’

Indian Sikh female, aged 16

‘You’re more open [talking about sex with friends]...you can talk about anything, unlike the way you talk in a family. In my family I’m the last one, and everyone is grown up. Everyone is married with kids, and they all treat me like a baby, and they’re like, ‘Oh, she knows nothing.’ I’m like ‘I know nothing.’ That’s how I am, I think.’

Black African Muslim female, aged 19
'It's really strict [the community] plus we can’t go out with anybody – full stop. But I have been out with a few guys, and I’ve told my mum. But it’s really awkward when it comes to our [extended] family. They’re like ‘if she’s going out with a guy, this is gonna happen.’ If my [extended] family, like my grandparents, found out they would have a heart attack.’

Indian Sikh female, aged 16

As indicated in the survey findings, the Black Caribbeans are, by contrast, the most likely to feel comfortable talking to their parents about sex and relationships. This suggests that, for all BME groups, these conflicting norms are most apparent for Asian and Black African young people,

'It’s easy for me and it’s hard for them [Asian girls], because their parents are really strict. But my mum don’t really know what I get up to, but if I told her, I think she would be happy that I told her but in a way… She wouldn’t be happy that like, I’m having sex. But she would be happy that I had the courage to tell her.’

Black Caribbean Christian female, aged 16

9.2 Religion Versus Ethnicity as an Explanatory Variable

In looking for an explanation for this diversity in knowledge, attitudes and behaviours, religion seemed to play a more significant role than ethnicity (although they are commonly interwoven). For example, among Asians, the Muslims referred to religion and the Qu’ran frequently and explicitly when describing their personal or community views. Similarly, Christians of Black Caribbean, Black African, Latin American and Lebanese ethnicity illustrated their views and perceptions with reference to the Bible. Overall, young BME people’s experiences were better understood by religious context than by ethnicity. This may in part be due to religious principles being more tangible and clearly attributed since they are written in scripture, than non-religious cultural norms and values that are more frequently conveyed through social interaction.

Christian and Muslim participants in particular reported similar sexual attitudes across a number of topics including sex before marriage and same sex relationships. These participants included diverse ethnicities indicating that religion is an essential, if not more sensitive, variable to understand. For example,

‘It says in the Bible God destroyed Sodom and Gomorrah because they were gay…I find it disgusting that two boys or two girls are sleeping together. It’s in the environment that you become gay because no-one’s born gay - that isn’t possible. If you wanna be gay then that’s your problem. All I can do is pray for you and that’s it…You can’t do nothing about it in this society. We’re in the 21st century everyone does what they wanna do.’

Black African Christian female, aged 16
‘We’re Christians, and in the Bible, it says that if a man does that [have same sex relationship], then he should lay in his own blood. But I don’t believe that, as such. I just don’t tolerate it [same sex relationships], I don’t think it’s on.’

Black African Christian female, aged 18

‘I don’t particularly agree with it [sex before marriage], but some people might agree with it. It’s not as if we [students at school] argue about it. It’s just like, we sort of respect each other, in the sense that ‘Oh, you agree with that, and I agree with this.’ We just agree to disagree basically…because it’s down to religion.’

Middle Eastern Muslim female, aged 17

‘Well, my family doesn’t like it [being gay]…They don’t approve ‘cos it says in the Bible and stuff, that it’s not good…But I don’t think it’s a sin. It’s just a natural thing ‘cos when I was very young, about 6 or 7, I started getting attracted to men, so at that age, you feel it’s a natural thing.’

Black African Christian male, aged 19

9.3 Value and Necessity of Sex and Relationships Information (SRI)

Irrespective of religion or ethnicity, the vast majority saw the value and necessity of SRI. An appreciation and desire for good sexual health was universal among BME youth. Good sexual health education was expressed both in terms of avoiding physical outcomes such as unintentional pregnancy and STIs, in addition to psychosocial matters including being sexually responsible and resisting peer pressure to have sex.

A notable finding arising from the interviews was the gap in sexual health knowledge expressed by some people. This supports the survey findings, and may be partly a product of the conflicting norms outlined earlier. The following examples illustrate the need for improved SRI,

‘I know that condoms don’t really work, ‘cos they haven’t worked for my friends and they ended up getting pregnant.’

Indian Sikh female, aged 16

‘If someone got let’s say syphilis or HIV, they [community] always think of you as promiscuous…they always say, ‘Oh, she was promiscuous’. They will never think that you can get STDs through toilet seats.’

Black African Muslim female, aged 19

9.4 Preferences for School-based Sex and Relationships Education (SRE)

School was generally perceived as a credible and reliable source of impartial SRE information among BME adolescents. Even among young BME people who were critical of school-based SRE, the information was seen as being of
of some value. With many BME young people reporting a lack of information from home or the local community, they appear reliant on sex education at school. The conflicting norms outlined earlier illustrate the particular importance of school-based education for BME groups.

Interactive and non-judgmental SRE delivery by a slightly older peer was viewed as the ideal SRE delivery among BME adolescents. The preferred methods of SRE delivery focused on interactive and stimulating methods, particularly film workshops and discussions,

‘I think it [best SRE delivery] would be an interactive workshop… So I think what I would probably do is have a few drama exercises to kind of, wake them [young people] up and warm them up and then do like a few debates’

Latin American Christian male, aged 18

‘That could probably help… like a comedy something that they [teenagers] would remember like ‘Oh yeah, that happened’… I think that definitely could work, if you had the right cast.’

Black African Christian female, aged 18

‘[An ineffective way of delivering sex and relationships education is] A speech cos it’s boring, it’s condescending and it’s like, ‘So here’s what I’m telling you what you should do.’ I just don’t think it’s effective.’

Latin American Christian male, age 18

Although some young BME people found teachers approachable regarding sex and relationships, the majority of participants expressed a higher preference for an independent sexual health professional. Young BME people valued an objective and knowledgeable professional discussing sex and relationships, in addition to being more assured of confidentiality,

‘A teacher might just be talking about their own experiences, whereas a professional has dealt with situations, they know what they’re talking about. I think that a teacher would be biased.’

Middle Eastern Muslim female, aged 17

Although BME adolescents described conflicting sexual norms and values, only a few participants preferred SRE from a sexual health professional of the same cultural and religious background. Concerns over confidentiality and ‘being judged’ were raised,

‘Our community is small… they’ll say ‘Oh my God, she’s such a crook.’… Definitely you’re gonna think ‘Oh, she knows my family so she’ll go home and talk.’ So I’ll always be scared to talk to someone like that… I would like to be clean in front of my culture, to be treated as a good person.’

Black African Muslim female, aged 19
'I would personally rather speak to a white person about it than speak to a black, traditional, Ugandan woman about these issues...Maybe that's because I probably feel that they're judging me and saying 'that's not in our culture.'

Black African Christian female, aged 18

However, others were more positive about such ethnic and cultural compatibility,

'I'd feel happy [for someone of the same cultural and religious background to deliver SRE] 'cos they will know where I'm coming from more.'

Black Caribbean Christian female, aged 16

'In general, I don’t mean this in a racist way, but I find it easier to talk to people that are Christian [about sex and relationships], 'cos I am a Christian. I find it easier 'cos we share the same views and stuff.'

Middle Eastern Christian female, aged 16

10. What are the implications of the research?

In consideration of this research summary, the main implications for sexual health practice and policy\(^{11}\) are as follows:

- Young people are far from a homogenous group. There is clear diversity among young people in terms of their sexual health support needs. This research has reported distinct ethnic differences in sexual health knowledge, sexual attitudes, sexual behaviours, sexual health outcomes, and learning preferences. This demonstrates the importance of tailoring interventions to meet the specific needs of ethnic groups and, where appropriate, working with such groups individually.

- There is a need to promote a greater understanding of the conflicting norms faced by many BME youth – the values and norms apparent in the home and the local BME community, versus the values of the wider community. Young people in receipt of ‘mixed messages’ about sex and relationships has been acknowledged as a contributing factor to poor sexual health (SEU 1999). On the one hand, sexuality is explicitly presented in the mass media, which contrasts to the ‘silence’ apparent in the home/community. It is arguable that some BME youth, relative to White British youth, are likely to experience the most extreme mixed messages of all.

- There is tentative evidence from the interviews to suggest that Asians and Black Africans are the most likely to experience these conflicting norms and mixed messages, relative to Black Caribbean young people.

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\(^{11}\) Implications for research are outlined in the Technical Report.
• Relative to White British students, the lower levels of sexual health knowledge among BME groups represents a major cause for concern. Those most in need for improved knowledge are the White Other males, Bangladeshi males, Pakistani males and females, and Black African males. Knowledge gaps were greatest regarding STI name and symptom recognition and means of prevention.

• For such a school-based survey, the exclusion of young people outside of school is particularly pertinent to the interpretation of these findings. Previous research has shown that young people reporting higher educational achievement and leaving school later are less likely to have early intercourse, more likely to use contraception at first sex, and be ‘sexually competent’ at this event (Wellings et al. 2001). Among those in schools Years 12 and 13 (where school attendance is not compulsory), it is therefore possible that sexual risk behaviours identified in the survey are underestimated relative to the wider population of a young people.

• The greatest sexual health support needs are evident among Black young people, particularly Black Caribbean young men. This is based on their greater sexual experience relative to other groups (more likely to have experience of sexual intercourse and for this intercourse to occur under the age of 16) and fairly commonly reported risk behaviour (e.g. lowest level of ‘sexual competence’ at first ever sexual intercourse).

• Irrespective of sexual intercourse experience, the sexual health support needs of other groups must not be discounted. Although slightly fewer Black African young people report intercourse, they are more likely to report risk behaviour than Black Caribbean groups. Similarly, although the least likely to be sexually active, Asian young people who are sexually experienced also report distinct sexual health support needs (including the highest proportion reporting anal intercourse). White Other males also report evidence of risk behaviour.

• Irrespective of ethnicity, this research supports the need to focus sexual health promotion among young men in particular. To illustrate, the young men in our study, overall, reported a higher proportion of sexual intercourse, and a lower likelihood of using contraception and being sexually competent on the occasion of first ever sexual intercourse. In response, the search for innovative strategies to engage young men in sexual health promotion is critical. There is an obvious need to stress the confidentiality of sexual health services and counter the perceptions of embarrassment and fear that were been reported by some young male interviewees.

• Learning more about STIs was a high priority among all groups, and this concurs with poor knowledge in this area. Females were also interested in learning more about contraception, and emotions and relationships.

• Being the most frequent and preferred source of information on sexual matters, the content and delivery of school Sex and Relationships Education (SRE) within PSHE needs to be supported by guidance and legislation to improve its ‘patchy’ coverage (Ofsted 2002). This supports
the case for SRE, within broader PSHE, to be a statutory requirement for all schools. Extending SRE provision beyond the Science curriculum to PSHE is supported by this research, and this appears to be critically important for BME groups.

- Interactive SRE in school appears to be a particularly favoured approach, including drama and workshops, as well as more light-hearted group exercises.

- Training PSHE teachers in dealing with ethnic and cultural sensitivities must be considered as high priority, given the overriding preference for school-based delivery. Delivering this in a ‘culturally competent’ manner is the challenge.

- Learning this information from a sexual health ‘professional’ and someone of similar age were the most important preferences and, among females, a desire to receive this information from someone of the same sex.

- A professional of similar ethnicity, religion and culture was generally less frequently preferred. However, the exceptions to this were Black Caribbean males showing more than average interest for someone of the ‘same ethnic background’. Also, for Pakistani males and females, and Bangladeshi females, in reporting interest for someone of the ‘same religion’.

- In light of the above, there is a need at least to investigate the potential benefits of a professional from the same ethnic background who can appreciate cultural and religious circumstances and issues. Indeed, this may be more suitable than training teachers from outside the community to deal with cultural and religious sensitivities in an appropriate way. However, reassurances of confidentiality among sexual health professionals from the same cultural context will be required, as well as stressing that these professionals can be non-judgemental.

- Ensuring broader SRI is aware of religious and faith beliefs is critical. It is important to acknowledge that religion may well be more of a primary influence than ethnicity (although clearly interwoven).

- Informing parents/carers, other family members and community leaders of the importance of SRI, and assessing the possibility of their increased involvement is necessary.

- Working with parents/carers of Black Caribbean groups could offer an additional route for SRI, although the data suggest this may be less appropriate for some Asian families.

- If the above is not possible, the challenge remains to identify alternative routes for SRI to fill the gap exposed by some parents/carers and community leaders.
11. What next with the research?

The research data have been used to help inform a DVD resource which aims to promote better sexual health. This resource, developed by NPL, focuses on the sexual health needs of BME groups that have been explored in this research. For more information on the DVD resource, see www.naz.org.uk. This DVD and research findings are being comprehensively disseminated to practitioners, policy-makers and researchers.

In response to the findings of the research, NPL is also initiating a teen peer sexual health education project later in 2006. The project will help address the rising sexually transmitted infections and un-planned pregnancies amongst BME young people, by developing their sexual health knowledge and skills. Delivered by BME peers, the project will create greater awareness of safer sexual practices. Training events for parents and teachers will be crucial ingredients of this project.

A further output from the research is sexual health training developed specifically for professionals working with young people from BME communities. The one-day workshop will benefit voluntary and statutory professionals including those where sexual health is not an explicit remit of their work: youth workers, Connexions staff, counsellors, school nurses, PSHE teachers, supported housing staff and health service providers. The first workshop will run in 2006 in London with further workshops planned in other regions. For more information or to book a place on ‘What’s Ethnicity Got To Do With It? Sexual Health Training for Professionals Working With Black & Minority Ethnic Youth’ contact Jayne Hellett or Sarah Lee on 01273 771249 or jhellett@tsa.uk.com or slee@tsa.uk.com.

12. Where can I find more detail about the research?

The full Technical Report (Testa and Coleman 2006) is available from the Trust for the Study of Adolescence (TSA) – see www.tsa.uk.com. This technical report includes an executive summary and introduction to the research, alongside the complete findings presented in three volumes as follows:

**Volume 1 – Survey data**

Quantitative survey data presented for all respondents is outlined in the first chapter. Chapter 2 presents data for all BME respondents (i.e. all excluding White British). Chapter 3 presents data comparisons across five main ethnic groups (White British, White Other, Black, Asian, and All Other Backgrounds). Chapter 4 compares findings across the main religious groups (‘Don’t believe’, Church of England, Roman Catholic, Christian Other, Muslim, Hindu, and Other). Chapter 5 presents a conclusion to the findings in Volume 1.

All survey findings in Volumes 1 and 2 include text outlining the findings, a summary of key findings, specific ethnic or religious profiles, and the complete data tables from which the text is derived.
Volume 2 – Survey data

Volume 2 presents findings from a deeper analysis of the quantitative data. Chapter 1 reports findings within Black ethnic groups, by looking at the comparisons between Black Caribbean and Black African groups. Chapter 2 reports findings within the Asian ethnic groups, looking at comparisons between Pakistani, Bangladeshi and Indian groups. Chapter 3 presents a brief conclusion to the deeper level of analysis reported in Volume 2.

Volume 3 – Interview data

This volume presents findings from the qualitative interviews. This qualitative component helps to explain some of the findings derived from the survey, such as how ethnicity impacts upon attitudes and behaviours. Chapter 1 provides an introduction to the qualitative component, Chapter 2 presents the majority of the findings (including details of the sample), and Chapter 3 presents a discussion. This third chapter distils the key findings and examines some of the implications for policy, practice and research.

The Technical Report also includes appendices, such as a full copy of the questionnaire and interview schedules used in the research.

The authors of the report can be contacted for more information at: lcoleman@tsa.uk.com and adrienne.testa@hpa.org.uk.

In addition, a number of publications are available where further details of the research are presented (further publications are currently under review):


Finally, to obtain further copies of this summary report, please contact the Publications team at the Trust for the Study of Adolescence (TSA), at:

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