Final Report
October 2006

The sexual health and relationships of young people in Glasgow

Prepared for
Young People's Sexual Health Steering Group

Contract No: 2653

Acknowledgements

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1 Introduction

1.1 Background

Glasgow City Council and NHS Greater Glasgow & Clyde jointly support a partnership approach to improving a range of issues relating to young people's sexual health and relationships. This work has two main strands: firstly, improving joint corporate responses to sexual health improvement for Glasgow's adolescent population and improving supports for young parents and secondly to identify gaps in current provision. Sexual ill-health and its various outcomes, including teenage pregnancy, are closely associated with health and socioeconomic inequalities, and consequently this work is rooted within the national and local agendas on community regeneration and social inclusion.

All the major Council and NHS services that have an interest in young people's sexual health and well-being are represented on the Young People's Sexual Health Steering Group (YPSHSG), which is the main mechanism for planning and co-ordinating work of this type in Glasgow City. It is chaired by the Deputy Leader of the Council and its work is supported by the post of Strategic Manager – Young People's Sexual Health.

In October 2005 the YPSHSG launched a consultation programme with Glasgow City's teenage population to find out their views on a range of sexual health issues. (This consultation complemented an earlier similar piece of work conducted with parents in Glasgow). The YPSHSG commissioned FMR Research, an independent social research company based in Glasgow, to undertake the analysis of the data gathered, and report the findings.

This questionnaire was but one strand of the consultation being undertaken with young people in Glasgow City. A separate qualitative research programme was also conducted by another independent company... This has been reported on separately.

1.2 Objectives

The research objectives were:

- to analyse and report the findings of the quantitative aspect of the October 2005 young people's consultation on sexual health;
- to place the findings in the context of wider research, existing literature, and previous consultations in both Scotland and the UK; and
- to make recommendations to the YPSHSG on the findings.

2 Method

2.1 Consultation process

The quantitative part of the consultation sought to gauge young people's views and experiences of a range of sexual health issues including:

- self-perception, control and self-esteem
- perceptions of school-based sexual health and relationships' education
- sources of information on sexual health and relationships
- experiences of parental/carer support on sexual health and relationships
- behaviours in terms of sexual health and relationships
- attitudes to sexual health and relationships
- young people's perceptions of their own skills in dealing with sexual health and relationships
- general demographics including deprivation category, ethnicity and religion

The self-completion questionnaire was designed by the YPSHSG and was distributed via the following channels:

- secondary schools
- social work services
- other statutory services
- youth groups
- other community groups
- online
- postcards in various public facilities e.g. sports centres/libraries

A total of 2,774 questionnaires were returned and the information input into SPSS by an independent company, overseen by NHSGGC's Research and Evaluation team (all questionnaires were double keyed for quality assurance purposes). Young people were able to complete the questionnaire either on paper or online: 2,509 young people completed it on paper and the remaining 198 did so online.

The analyses presented here have a maximum base of 2,707, with 67 questionnaires being excluded from the analysis as the respondents' postcodes fell outwith the Glasgow City boundary. Responses where the respondent failed to give a valid postcode were assumed by the research steering group to fall within Glasgow City boundaries, and are therefore included.

The majority of responses came via secondary schools. All secondary schools were asked to distribute the self-completion questionnaires to two S3 classes, two S4 classes, one S5 class and one S6 class. Parents/Carers were lettered to advise them about the consultation with the option of removing their child from the survey. Denominational schools were notably less consistent than non-denominational schools in administering the consultation. At the start of the process, denominational schools took the decision to issue questionnaires to sixth year pupils only and this only happened in some rather than all denominational schools. In addition rather than opting out, parents/carers had to opt in to allow their young people to take part. Further, the section on sexual behaviours and young people's reflections on these (Chapter 7) was removed. Additionally, in all schools, all pupils in year groups S3 – S6 who were not asked to complete a questionnaire in school should have received a postcard notifying them of the consultation and asking them to complete it online in their own time. However, it is not known how many postcards were issued.

Respondents were invited to make any comments on either the consultation process or sexual health and wellbeing issues. The majority of young people did not make any comment (90%, 2411 respondents). However 34 young people praised the questionnaire, 33 felt that the questions were too personal or intrusive, 16 felt the

questionnaire was too long or boring and 10 felt the questionnaire was pointless or a waste of time. A hundred and sixty seven respondents expressed other views that could not be readily categorised.

2.2 Analysis & reporting

The report highlights the key findings from the consultation. Differences in response between groups (e.g. gender, age group, etc.) are reported where these are statistically significant. Statistical differences have been tested mostly using the Chi-square test (in addition to t-tests, ANOVA and regression). In general only the p-value has been quoted for improved readability. A p-value of less than 0.05 is taken to be statistically significant.

2.3 Interpretation of findings

As a consequence of the decision taken by denominational schools with respect to the consultation, denominational school pupils are underrepresented by a factor of four in this consultation exercise, and this must be borne in mind when any of the findings are being interpreted or reported elsewhere. In addition questions were asked about postcode, ethnicity, faith and disability. Analysis has been done using these variables; however many people did not complete the first part of their postcode, and the numbers in relation to ethnic minorities, Muslims and disabled people are small. Therefore, this should again be borne in mind when interpreting or reporting the findings.

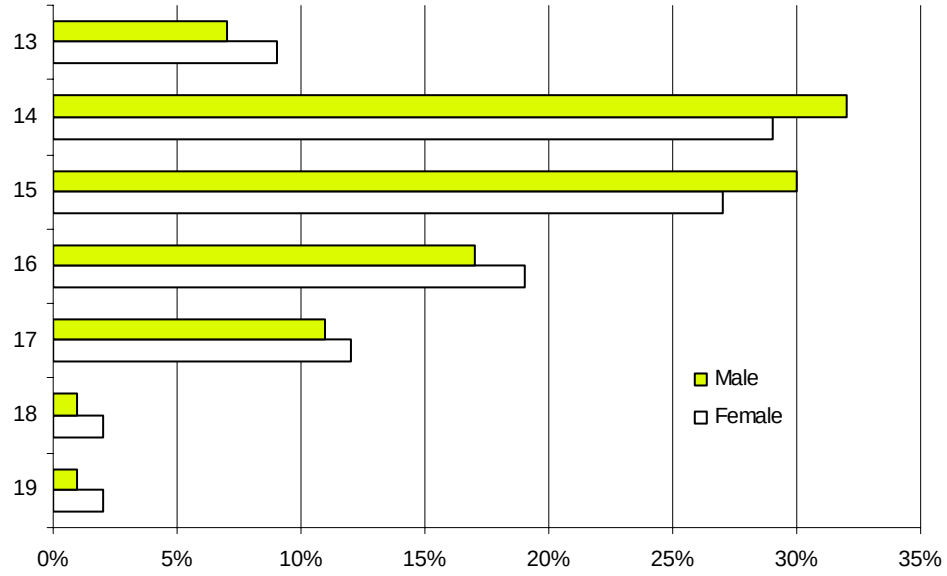
3 Profile of respondents

This section reports on the demographics of respondents in terms of their age, gender, occupation, ethnicity, religion, practice of religion, family living arrangements, disability and sexual orientation.

3.1 Age and gender

The chart below shows the breakdown of the sample by age and gender. Over half of the respondents were either 14 or 15. When age is grouped as 13-15 and 16+ it was clear than significantly more females over the age of 16 answered the questionnaire than males (p=0.014)

Figure 1 Respondent profile by age and gender



n=2,569

3.2 Mode of completing the questionnaire

Those who responded online were more likely to say that they: attend/attended denominational schools; were Catholic or Sikh/Hindu/Jewish/Buddhist faiths; were aged 16 plus or were recorded as non-heterosexual.

3.3 Occupation

Ninety-five percent of respondents (2,443) described themselves as school pupils while 3% (70 respondents) were full-time students and 1% (35 respondents) were full-time employed. A very small proportion of the sample (0.8% in total, 21 respondents) described themselves as either part-time employed, unemployed, or other.

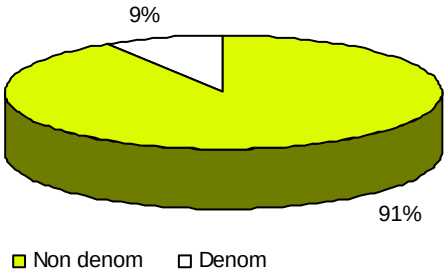
3.4 Type of school attended

When asked about the school they attended, or last attended, just 1% of the sample responded that they attended private schools, while 97% indicated that they attended a local authority school (94% were inside Glasgow, 3% were outwith Glasgow). Two percent of the sample described their school/last school attended as 'other'.

The chart below shows that the vast majority of the sample attend or attended non-denominational schools (91%, 2208 respondents), while 9% (229 respondents) attended denominational schools.

The majority of those respondents who stated that they attend/attended denominational schools did not give their views via schools; only 50 or so questionnaires were returned from denominational schools. Of those who said they attend/attended denominational schools most were of Catholic or Sikh/Hindu/Jewish/Buddhist faiths.

Figure 2 Type of school attended



n=2,437

There was a significant difference when the type of school attended/last attended was analysed by age group ($p<0.001$), with a higher than expected proportion of older respondents attending denominational schools. This is reflective of the age group of young people to whom the questionnaire was given in denominational schools and also the profile of respondents who completed the questionnaire online.

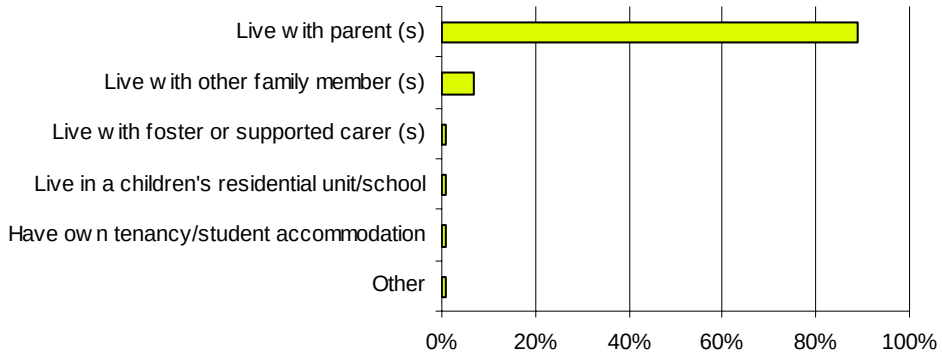
Those attending denominational schools were significantly more likely than those attending non-denominational schools to live in the most deprived areas ($p=0.001$) (64% of denominational school pupils lived in depcat 7 areas in contrast to 48% of non-denominational school pupils). Depcat 1 represents an area of low deprivation, whereas 7 represents an area of high deprivation.

3.5 Family living situation

Respondents were asked how they would best describe their living situation. The majority (89%, 2,263 respondents) lived with their parents, while 7% (185

respondents) lived with other family members, and 1% nominated each of the other four options shown in the chart below.

Figure 3 Respondents living situation



n=2,536

Area of deprivation was grouped (grouped as depcats 1 & 2, depcats 3, 4 & 5, and depcats 6 & 7) and analysed by living situation. There were significant differences between the living situations of those from the least deprived areas and those from the most deprived areas when living with parents was compared to all other categories. Those from the least deprived areas were significantly more likely than those from the most deprived areas to live with their parents ($p<0.001$).

The percentage of young people living with other family members increased with increasing levels of deprivation; from 2% in the least deprived (most affluent) areas to 8% (123 respondents) in the most deprived areas.

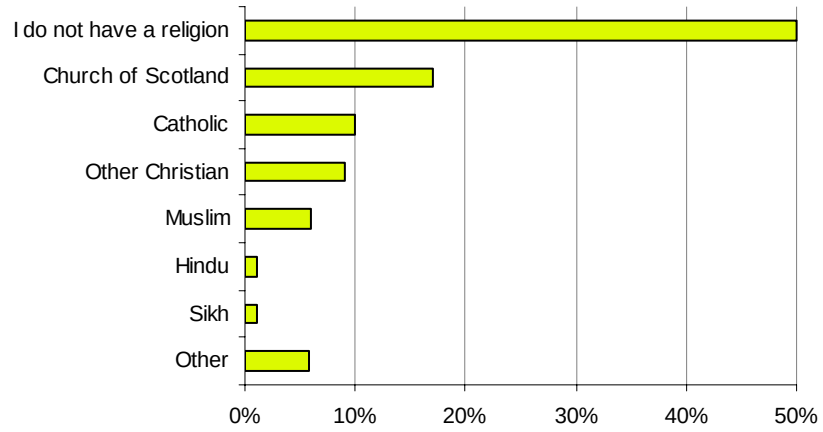
3.6 Respondents' status as parents

There were some inconsistencies in the findings in this section and therefore, because of this and the small numbers involved, this variable was excluded from further analysis.

3.7 Religion & practising a faith

In response to the question as to whether young people identified with a particular religion, 50% (1,261) of respondents stated that they had no religion. Of those who did identify with a particular religion (49%, 1,222 respondents), the highest response was for Church of Scotland (17%, 421 respondents). Sixteen percent (125 respondents) in the 16+ age group were Catholic in comparison to just 8% (125 respondents) in the 13 to 15 age group. This is likely to reflect the way in which questionnaires were distributed in denominational schools. There were significant differences when stated religion was analysed by age group however, the higher proportion of Catholic respondents in the older age group will have a large bearing on this.

Figure 4 Religion



n=2,502

Of those who identified with a particular religion, 28% (342 respondents) said that they regularly attended their place of worship.

The table below shows the percentage of young people who practise their religion: Church of Scotland, Catholic and Other Christian respondents are less likely to be practising than Muslims or young people belonging to another faith group ($p<0.001$).

Table 1 Percentage of respondents belonging to each religious group who practise their religion

Faith group	Total	No. practising	% practising
Church of Scotland	408	81	20%
Catholic	255	53	21%
Other Christian	209	41	20%
Muslim	155	109	70%
Sikh/Hindu/Jewish/Buddhist/Other	144	46	32%
Total	1171	330	28%

Seventy percent of respondents (109) who stated they were Muslim also stated that they regularly attended their place of worship.

Church of Scotland, Catholic and Other Christian respondents were less likely to be practising their religion than Muslims or young people belonging to another faith group ($p<0.001$).

There were significant differences when this question was analysed by depcat with respondents living in the least deprived areas more likely to be attending their place of worship in comparison to those living in the most deprived areas ($p=0.001$).

Of the 330 respondents who said that they had a religion and regularly attended their place of worship:

- 33% (109 respondents) were Muslim
- 25% (81 respondents) were Church of Scotland
- 16% (53 respondents) were Catholic
- 12% (41 respondents) were from another Christian group
- 14% (46 respondents) belonged to another religious group

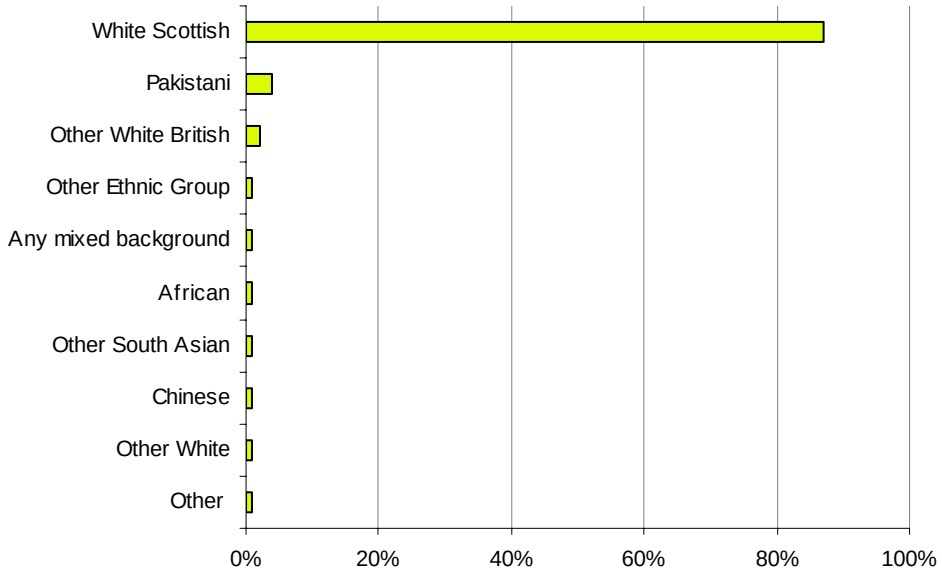
Practice of religion is included in various analyses later in this report, with three groups being compared: those who attended their place of worship; those who indicated that they belonged to a religious group but did not attend a place of worship; and those who indicated that they did not belong to any religious group.

3.8 Ethnicity

The chart below shows the ethnicity of respondents, with the majority of respondents identifying as 'White Scottish'. There were significant differences when ethnicity was analysed by school type, depcat, and sexual orientation. Those who were White Scottish were more likely to attend a non-denominational school ($p=0.034$), be from more deprived areas ($p=0.05$) and report to being heterosexual ($p<0.001$).

- 88% of respondents attending non-denominational schools described themselves as 'White Scottish', in comparison to 82% of those attending denominational schools.
- 88% of respondents who were coded as heterosexual were 'White Scottish' in comparison to 80% of those coded as non-heterosexual.
- 88% of those living in the most deprived areas (depcat 6 & 7) were 'White Scottish' in comparison to 79% of those living in the least deprived areas (depcat 1 & 2).

Figure 5 Ethnicity

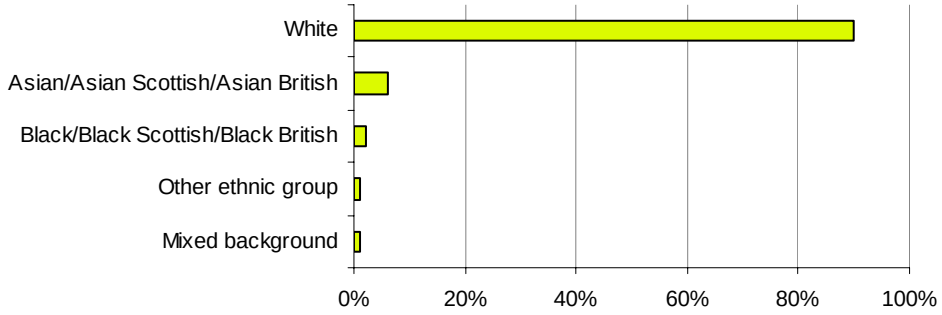


n=2,482

(It should be noted that although a complete list of ethnicities was available to respondents, the table above shows those groups with frequencies of less than 0.5% amalgamated as 'other'. The 'other ethnic group' category differs from 'other' in that the former was a specific category for respondents to choose. Respondents choosing this category were not asked to specify their ethnic group).

Ethnicity was also recoded into five broader categories, the data for which are shown in the chart below.

Figure 6 Ethnicity (recoded)

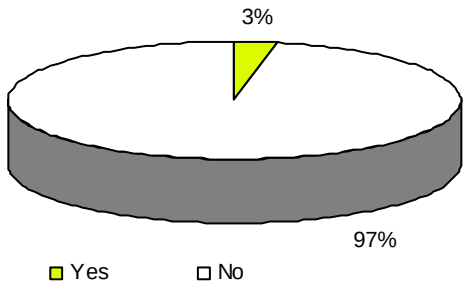


n=2,482

3.9 Disability

Overall, just 3% (68 respondents) stated that they had a disability.

Figure 7 Disability



n=2,525

There were significant differences when this was analysed by:

- gender (p=0.018). Respondents reporting having a disability were more likely to be male than female (60%, 39 respondents versus 40%, 26 respondents).
- school type (p<0.001). Respondents attending denominational schools were more likely than those attending non-denominational schools to state that they had a disability (7%, 15 respondents versus 2%, 46 respondents).
- depcat (p=0.042). Respondents reporting a disability were more likely to live in areas of high deprivation (depcat 6 & 7) than the least deprived areas (depcat 1 & 2).
- sexual orientation (p<0.001). A higher proportion of people reporting a disability also reported being non-heterosexual compared with those who did not report a disability (26%, 17 respondents versus 11%, 266 respondents).

The base, however, for all this analysis was low.

3.10 Sexual orientation

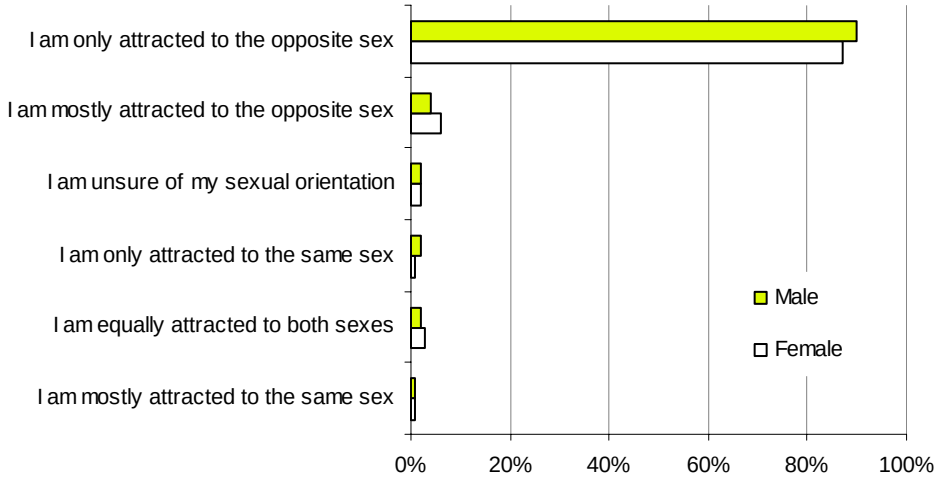
Monitoring questions were asked relating to sexual orientation to ensure that the consultation met YPSHSG standards around tackling inequalities, and to address the known specific sexual health challenges faced by young people in relation to sexual orientation.

Given the age of young people who participated in the consultation, and the formative nature of sexuality at this age, it was felt that it would be more helpful to avoid asking

young people to identify with very defined sexual orientations such as heterosexual or gay, and instead to measure their feelings on a 5 point scale (with an option for those who were unsure).

The chart below shows responses to this question according to gender. Eighty-eight percent (2,203 respondents) stated that they were only attracted to the opposite sex. A further 5% (127 respondents) said that they were mostly attracted to the opposite sex, whilst 2% (57 respondents) stated they were equally attracted to both sexes and 3% (55 respondents) were mostly or only attracted to the same sex. Two percent (50 respondents) stated that they were unsure of their sexual orientation.

Figure 8 Sexual orientation



n=2,492

While it was useful for basic information to separate individuals out according to the 5 point scale, because of the small numbers it was preferable for the purposes of further analysis to group young people as heterosexual if they were only attracted to people of the same sex (88%, 2203 respondents) and as non-heterosexual if they demonstrated any feelings that were not exclusively heterosexual (12%, 289 respondents). There is the caveat however, that young people themselves may not have selected the dichotomous variable assigned to them on the basis of their response if given the choice.

Those categorised as non-heterosexual were significantly (all $p<0.01$) more likely to:

- be older (16 years and over) (14%, 119 respondents)
- attend denominational schools (17%, n= 8)
- have completed the questionnaire online (24%, n=28)
- be disabled (26%, n=17)
- not be living with their parents (20%, n = 52)

Non-heterosexuals were no more likely than heterosexuals to report having no religion. In addition, of those respondents who identified with a particular religion and were practising (13.8%, 342 respondents), non-heterosexuals were marginally more likely to report practising their religion than heterosexuals ($p<0.04$).

With regards to ethnicity, the proportion of those from Asian backgrounds who were non-heterosexual was significantly higher than expected (22%, 31 respondents, $p=0.002$). Although the numbers of respondents in the various categories of religion and ethnic origin were comparatively small, and the results may not be reliable, these findings indicate that non-heterosexual young people are likely to be represented amongst all ethnic minority groups and faith groups.

3.11 Chapter Summary

In terms of the profile of those responding to the survey, the preference would have been for a slightly more diverse sample in order to better understand the issues and canvass the views of as wide a group of young people as possible. However, there were respondents from most of the demographic categories included but those attending denominational schools, ethnic minority backgrounds, faiths other than Christian, and disabled young people were under represented and this may have had an impact on some of the findings in subsequent chapters.

Generally the majority of those who responded were: either 14 or 15 years of age; school pupils; mainly attending or having attended a non-denominational school; White Scottish; living with their parents; non-disabled, and heterosexual.

Half of the young people who took part in the consultation stated that they did not have a religion. Of the 49% who did identify with a particular religion, just over a quarter actually said that they regularly attended their place of worship. Those who were of a Christian faith were the least likely to be practising when compared with Muslims and those who were categorised as Sikh/Hindu/Jewish/Buddhist/Other. Interestingly, of those who were practising their faith, non-heterosexual young people were slightly more likely to be practising than heterosexuals.

4 Self-esteem, control & relationship with parents

The findings in this section represent a series of questions relating to respondents' 'sense of self', key relationships in their lives and who they receive support from. Research has indicated that positive responses to these issues can act as 'building blocks' from which young people can develop a sense of well-being and the necessary skills to make safe and confident choices regarding their sexual health and relationships.

4.1 Self-esteem

The questionnaire began by asking respondents to indicate their agreement with a series of statements, which taken together allow a judgement of respondents' self-esteem to be made. These were included because self-esteem has been shown to be an important factor in young people's attitudes and decision making in relation to sexual behaviour. For example young women with low self-esteem are more likely to consent to unprotected sexual intercourse[1]. The series of statements were adapted from Rosenberg's Self-Esteem Scale.

The scale used in this consultation comprised ten items, each with a four point response scale ranging from 'strongly agree' to 'strongly disagree'. Items were scored (1, 2, 3 or 4) such that a higher score represented higher self-esteem, and the scores for all ten items were added together. The overall mean self-esteem score for the young people responding was 30.55 (S.D. =4.31, n=2,470), with individuals' total scores ranging from 14 to 40. A significant gender difference was found ($p<0.001$), with males gaining higher scores than females: the mean score for males was 31.91 (SD=3.91, n=1,083), while the mean score for females was 29.42 (SD=4.28, n=1,285).

4.1.1 Interrelation between self-esteem and key descriptor variables

In the first instance, an analysis was conducted to determine which key descriptor variables were significantly associated with self-esteem scores. Given the significant gender difference in mean scores noted above, analyses were also conducted separately on the scores of male and female respondents. Many of the variables associated with self-esteem were themselves significantly related to one another. In order to clarify which factors were independently associated with self-esteem, three multiple regression analyses were conducted (using the whole sample, and using male and female responses separately).

Table 2 Overview of results of hierarchical multiple regression analyses of self-esteem scores

variable	Total sample	Females	Males
Online versus paper	ns	ns	ns
Gender	< 0.001	-	-
Worship			
-religion, not practising	ns	ns	ns
-no religion	ns	ns	0.036
Disability	ns	ns	ns
Sexual orientation	<0.001	0.05	< 0.001
Closeness to mother/female carer			
-close	0.002	0.007	ns
-quite close	<0.001	ns	0.001
-distant/NA	< 0.001	0.002	<0.001
Closeness to father/male carer			
-close	0.017	ns	0.012
-quite close	0.002	0.046	0.023
-distant	0.006	0.028	ns
-not applicable	ns	ns	ns
Control over life-path			
-some	< 0.001	< 0.001	0.049
- a lot	< 0.001	< 0.001	< 0.001
Control over health			
-some	< 0.001	ns	0.008
-a lot	< 0.001	0.027	< 0.001
Satisfaction with appearance			
-happy	< 0.001	< 0.001	< 0.001
-not happy	< 0.001	< 0.001	< 0.001
-extremely unhappy	< 0.001	< 0.001	< 0.001

The analysis based on the total sample provided a significant solution, explaining 48% (adjusted) of the variance of self-esteem scores ($F_{20, 2,242} = 105.5$, $p<0.001$).

When examining the whole sample, those with higher self-esteem scores were more likely to be:

- male
- heterosexual
- very close to their mothers and to their fathers
- perceive some or a lot of control over the way their life was going and over their health (compared with those who perceived little or no control),
- very happy with their appearance.

The separate analyses for female and male respondents provided similar results, although some specific differences were noted. Although satisfaction with appearance was a significant predictor of male self esteem, it made a far greater contribution in explaining differences in females' self-esteem. Sexual orientation explained more of the variance of male self-esteem than it did of female self-esteem. Non heterosexual males reported lower self-esteem than heterosexual males. What these findings perhaps highlight is the role that gender conditioning may have in shaping how young people feel about themselves.

Although not a significant factor for females, males who attended their place of worship and by extension religious category and ethnic origin[1] gained higher self-esteem scores than did males with no stated religion, although the effect was comparatively small.

[1] Given the overlap between ethnic group, religious group and practice of religion and the potential problems in relation to the small numbers in these categories the decision was made to use religious group (Church of Scotland, Muslim, Catholic, Other Christian, other religion, no religion) or practice (attend place of worship, have religion but not attend, no religion).

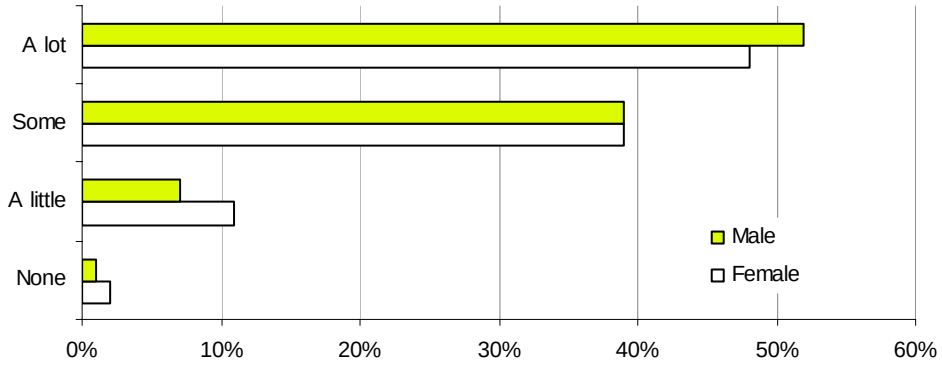
4.2 Perceived control over way life is going & general health

Young people were asked about the extent to which they felt they had control over the way their life was going and the amount of control they felt they had over their general health.

Half of the sample (50%, 1,334 respondents) reported that they had a lot of control over the way their life was going, while a further 39% (1,040 respondents) perceived some control over their lives. The remaining 11% (302 respondents) felt they had little or no control over their lives.

The figure below shows the response frequencies to this question split by sex. There are significant differences between the sex's (p=0.003), and as the chart shows, males are slightly more likely than females to feel that they have a lot of control over their life while females are more likely than males to feel they have little or no control.

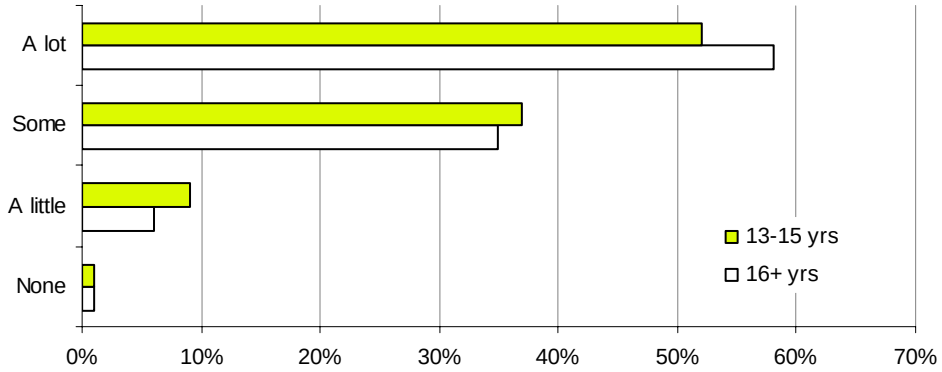
Figure 9 How much control do you have over the way your life is going?



n=2,676

Perceived control over health was significantly related to age group as illustrated in the figure below, with older respondents more likely to report 'a lot' or 'some' control.

Figure 10 How much control do you think you have over your general health?



n=2,685

Those living away from home perceived less control over their health than those living at home (p=0.016).

No significant difference on control over health was noted with regard to religious group in general. However Muslim respondents were significantly more likely than other religious groups to indicate that they had 'some' control over their life (p=0.019) but were no different on any of the other scales (e.g. a lot, a little etc).

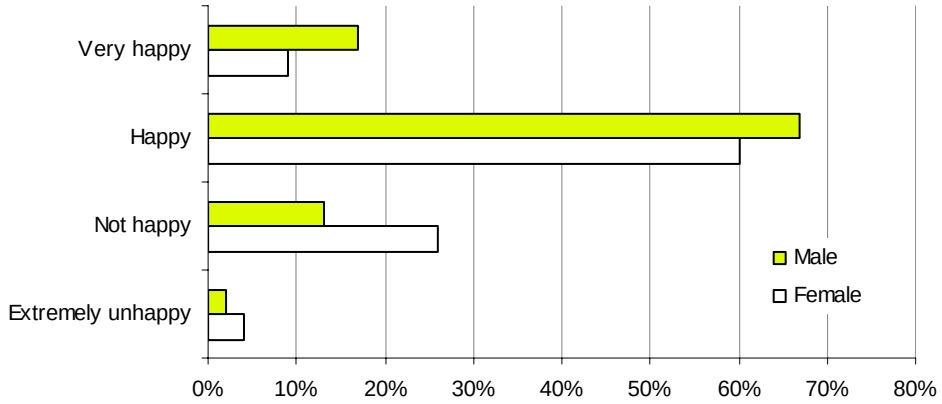
Those who were disabled were more likely to perceive little or no control over both the way their life was going (p=0.045) and over health (p=0.001). A similar finding was identified in relation to those coded in the non-heterosexuals category (p<0.001 in both cases).

Responses for both questions concerned with control were significantly related to one another ($p<0.001$) with 67% of those who indicated that they had a lot of control over the way that their life was going also indicating that they had a lot of control over their general health.

4.3 Satisfaction with appearance

Three-quarters of respondents (76%, 2,042 respondents) were happy to some degree with their appearance. As might be expected, a significant gender difference was found ($p<0.001$), with females likely to be less happy with their appearance than males.

Figure 11 How happy are you with the way you look?



n=2,677

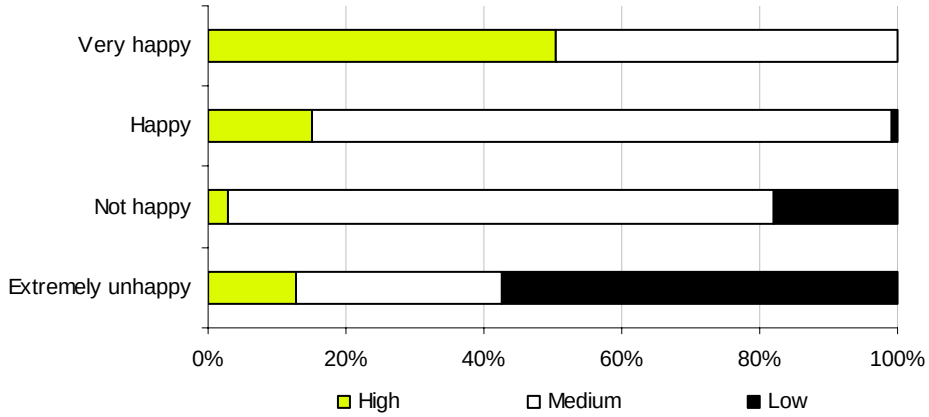
Muslim respondents were found to be happier with their appearance than those of other religious groups ($p<0.001$), as were those who attended their place of worship ($p<0.001$) when compared to those with a religion but not practising and those with no religion.

Young people who stated they had a disability, and those who were not heterosexual, were less happy with their appearance ($p<0.001$ in both cases) than those with no disability and heterosexuals respectively.

Those who completed the questionnaire on paper when compared to those who completed online were significantly happier with their appearance ($p=0.002$). Responses to the two items on control were highly related to satisfaction with appearance (both $p<0.001$), with those who perceived more control being more satisfied with their appearance.

As might be expected given the previous findings on determinants of self-esteem, there were significant differences when young people's satisfaction with their appearance was analysed by their self-esteem scores ($p<0.001$). Half of young people who were very happy with their appearance also had a high self-esteem score with the other half having medium self-esteem scores. The majority of those who were extremely unhappy with their appearance also had low self-esteem scores.

Figure 12 Satisfaction with appearance and self-esteem (high, medium or low)



n=2,452

4.4 With whom is free time spent

Table 3 With whom young people are spending their free time with

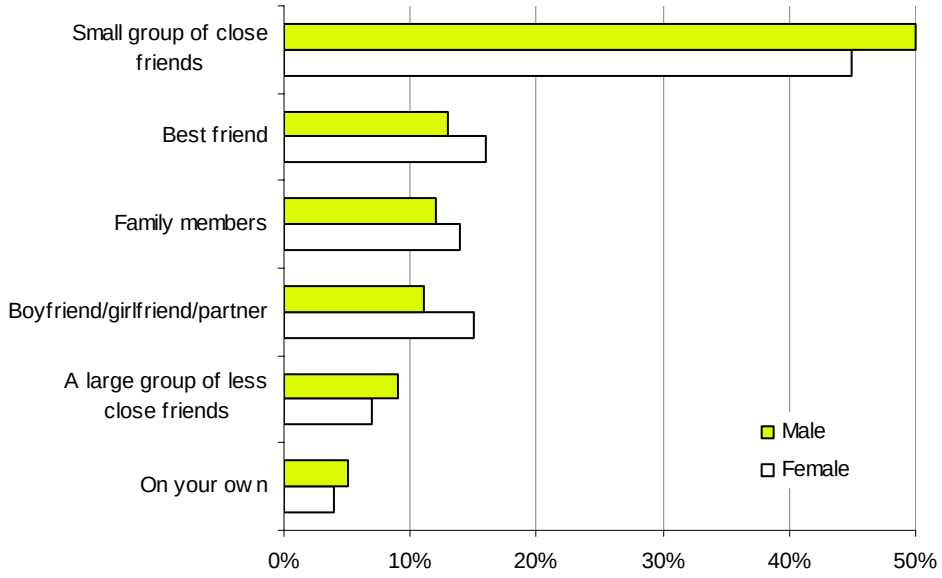
Whom	Frequency (numbers)	Percent
Boyfriend/Girlfriend/Partner	367	14%
Best friend	371	14%
Small group of close friends	1,218	47%
On your own	119	5%
Family	333	13%

The vast majority of young people in this consultation spent most of their free time outwith the family with only 13% (333 respondents) spending free time with their family. Findings as to whom young people spent their free time with were:

- 47% (1,218 respondents) spent most of their free time with a small group of close friends,
- 14% (371 respondents) with their best friend
- 14% (367 respondents) with their boyfriend/girlfriend/partner
- 13% (333 respondents) with their family
- 5% (119 respondents) spent most of their free time on their own.

There were significant differences between males and females in terms of the people they spent their free time with ($p<0.001$). For both sexes, the majority favoured spending their free time with a small group of close friends, although males were more likely to give this response. Females were more likely than males to report spending their time with a best friend or partner.

Figure 13 With whom ho do you spend most of your free time?



n=2,613

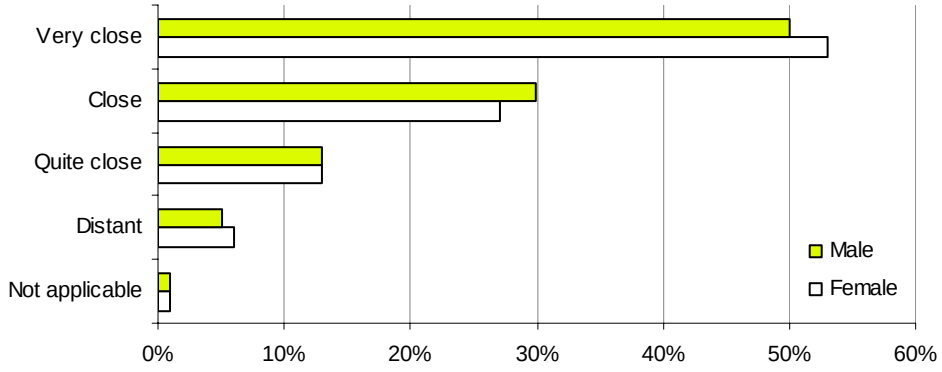
Those who reported spending time with family members were more likely to be those who attended their place of worship in comparison to those who said they had a religion but did not appear to be practising and those with no religion. They were also more likely to be Asian as opposed to any other ethnic group: and be Muslim rather than any other faith group. Given the small numbers in relation to ethnicity, faith and religion these findings may, however, not be reliable.

4.5 Closeness to parents/carers

4.5.1 Closeness to mother/female carer

Young people were asked to rate the extent to which they were close to their mother or female carer: very close; close; quite close; distant; or not applicable. Just over half (52%, 1,358 respondents) perceived themselves to be very close to their mother or female carer and a further 28% (745 respondents) to be close. Only 5% (142 respondents) considered themselves to be distant.

Figure 14 In general, how close are you to your mother/female carer?



n=2,627

Those who completed the questionnaire online were more likely than those who completed a paper version to be distant from their mother/female carer ($p<0.001$), which may be a result of a response bias in terms of the profile of those answering online. There were no significant differences in the extent of closeness to the mother according to sex, age, school, depcat, ethnicity, disability or religion. However, there

was an indication that those who practised their religion were more likely to be closer to their mothers (p=0.032): 59% (201) of those who attended their place of worship indicated that they were very close to their mother, compared with 52% (458 respondents) of those who indicated that they had a religion but did not attend their place of worship, and 50% (628 respondents) of those who had no religion.

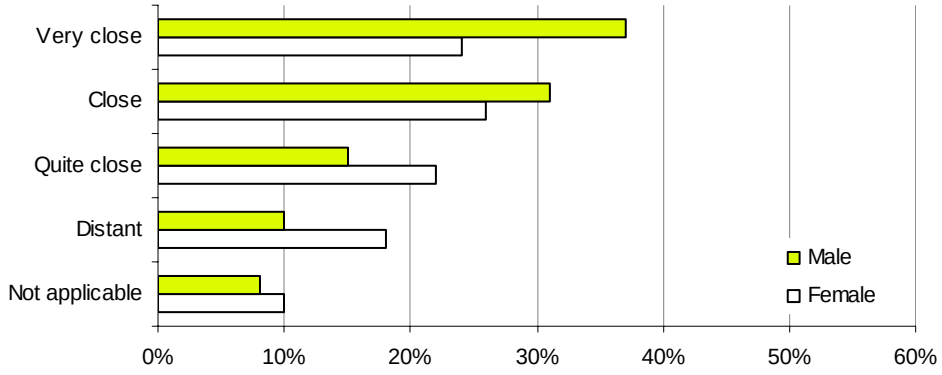
Several other significant findings in relation to closeness to mother/female carer were noted. First, as might be expected, young people who did not live with their parents were less likely to be very close to their mothers (p<0.001): 40% (108 respondents) of those who did not live with their parents indicated that they were very close to their mothers, compared with 53% (1,198 respondents) of those who lived with their parents. Around double the proportion of those living away from parents indicated that they were distant from their mothers (or that they did not have a mother or female carer) compared with those living with parents: 12% (32 respondents) compared with 6% (132 respondents). The second significant difference concerned sexual orientation: young people coded as non-heterosexual tended to be less close to their mother/ female carer than young people classed as heterosexual (p=0.011).

Those who were closer to their mothers were also more likely to have higher self-esteem, more perceived control and be happier with their appearance (p<0.001 in all cases).

4.5.2 Closeness to father/male carer

In general, it was found that fewer young people had a close relationship with their fathers than had indicated so with their mothers. Just under 30% (763 respondents) indicated that they were very close to their fathers, and a further 28% (721 respondents) to be close.

Figure 15 In general, how close are you to your father/male carer?



n=2,585

As with closeness to the mother, young people who responded online were more likely to be distant from their father/male carer (or to indicate that they did not have a father or male carer) than those who completed the questionnaire on paper (p<0.001).

There were no significant differences in closeness to the father/male carer according to religion, practice of religion, or ethnicity. However, closeness to the father varied significantly according to gender (p<0.001), age (p<0.001), depcat (p=0.001), disability (p = 0.045), living arrangements (p < 0.001) and sexual orientation (p=0.008), with the direction of trends as follows:

- male respondents were closer to their fathers/male carers than female respondents
- younger respondents were closer to their fathers/male carers than older respondents

- respondents living in more affluent areas were closer to their father/male carer than those living in more deprived areas, while those in more deprived areas were more likely to indicate that they did not have a father or male carer

- respondents coded as heterosexual tended to be closer to their father/male carer than respondents coded as non-heterosexual

- young people who stated that they had a disability were somewhat more likely to be distant from their father/male carer than those without a disability

- respondents who did not live with their parents were significantly more likely to indicate that they did not have a father or male figure than those who lived with parents (18%, 47, compared with 8%, 179)

Closeness to fathers was related to control over life ($p<0.001$) and control over health ($p = .001$), with those who were closer reporting that they had more control (or alternatively those who were less close, reporting having less control). There was also a relationship between closeness to father and satisfaction with appearance and self-esteem, both $p<0.001$, such that those who were closer to their father were happier with their appearance and had higher self-esteem.

4.6 Chapter Summary

Within this section young people reported on a range of factors that may act as 'building blocks' from which young people can develop a sense of well-being and the necessary skills to make safe and confident choices regarding their sexual health and relationships.

One of the most important findings from this section is the one that highlights the potential benefits of having a close relationship to one or both parents. Those who were closer to one or both parents had significantly higher self-esteem, perceived themselves to have more control over their life and health and were happier with their appearance. Although most young people reported being very close or close to either parent, only 13% of young people were spending most of their free time with their families, with most young people, particularly young males, spending most of their time with small groups of close friends. Young females were more likely to report that they spent their time with best friends or partners.

Other findings worthy of note were around self-esteem and gender. The young males in this consultation were significantly likely to have higher self esteem levels than the young females. Given that it is already known that self-esteem is potentially an important factor in young people's attitudes and decision-making in relation to sexual behaviour, strategies/programmes that aim to build the self-esteem of young people, particularly young women, could be useful in relation to sexual health outcomes. From this consultation, such an approach may also help young people to feel more in control of their lives generally and of their health. The second finding in relation to gender differences and self-esteem was the impact that gender conditioning and societal pressures may be having on young people. For females, satisfaction with appearance was having a far greater impact on self-esteem than it did for young men and it may be that young women to a greater extent than young men feel pressure to look a certain way. For males, sexual orientation had more impact on self-esteem than it did for young women. Being gay is often perceived quite negatively in terms of masculinity, with gay men being stereotyped as weak and lesser males than the heterosexual male. It could be that the pressure to fit the male stereotype may be negatively impacting on those young men who perhaps do not fit this image. Work with young people around gender and gender stereotypes may positively impact on young people's self-esteem.

5 Information sources

Young people were asked a variety of questions which provide information on the different ways young people receive information about sexual health. This chapter outlines the findings in relation to general sources of information, parents as a source of information and schools.

5.1 General sources of information

Respondents were presented with a list of 15 possible sources of information on sexual health and relationships. They were first asked to tick all that applied to them, and then to list the three from the list that had had the most influence on them.

5.1.1 All sources

When asked generally where they received information about sexual health and relationships, the most commonly cited sources for all respondents were:

- school PSE lessons (78%, 2,070 respondents)
- friends (59%, 1,567 respondents)
- mother/female carer (56%, 1,481)

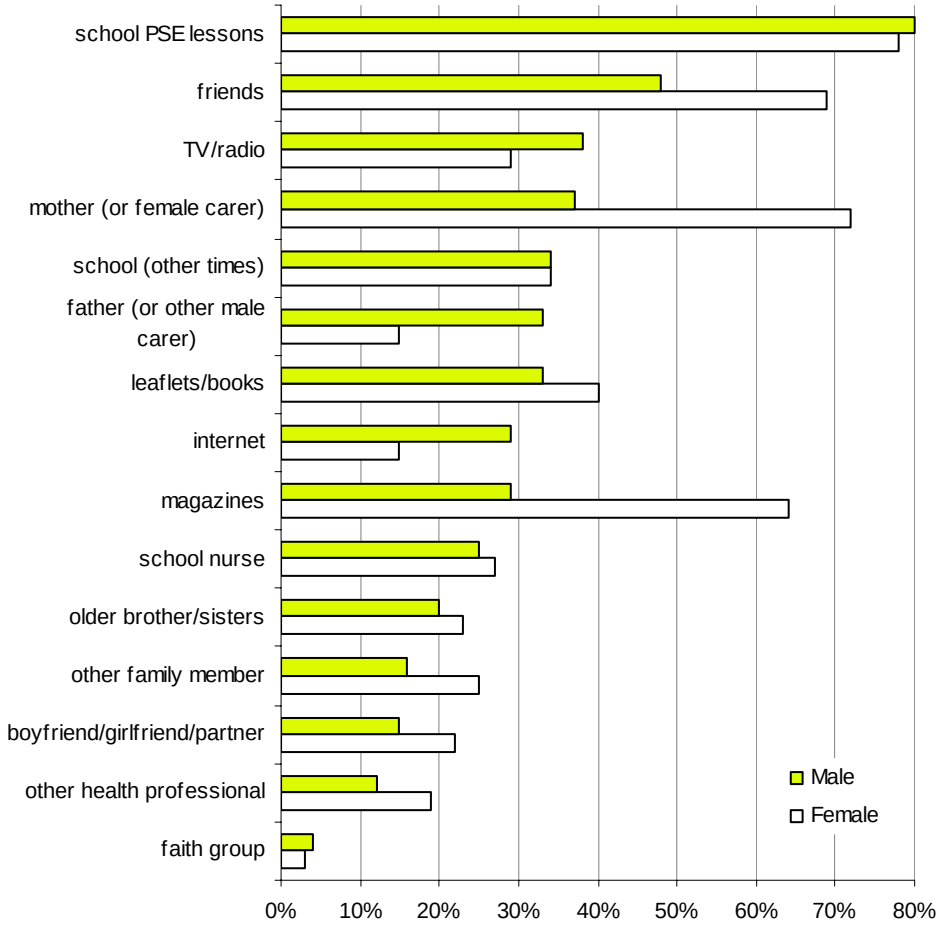
Within these responses, there were differences between the sexes. For females, the four most popular sources for information were PSE, their mother/female carer, friends and magazines whereas the four most popular choices as reported by males were PSE, friends, TV/radio and their mother/female carer. Females were twice as likely as males to obtain information from their mother/female carer and magazines and were also more likely to cite friends as a source.

Although male respondents were twice as likely as females to cite their father/male carer as a source of information, they still cited mothers/female carers more often than they cited father/male carer. For males, TV/radio was cited third highest and they were also twice as likely as females to cite the internet as a source.

Respondents attending denominational schools were less likely than those attending non-denominational schools (82%, 1,797 respondents) to cite school PSE lessons (52%, 117 respondents) as a source of information.

It should be noted that it was not possible to determine anything about the content or the quality of the information received by young people from their responses.

Figure 16 Sources of information on sexual health and relationships (multiple response question)



n=2,652

5.1.2 Most influential sources

For young people as a whole, the three sources most likely to be named as influential were:

- the mother/female carer (50%, 1,176 respondents)
- friends (48%, 1,130 respondents) and
- school PSE lessons (43%, 994 respondents).

The next most influential source was magazines (21%, 477 respondents), followed by father/male carer (18%, 413 respondents).

The three sources least likely to be named as influential were:

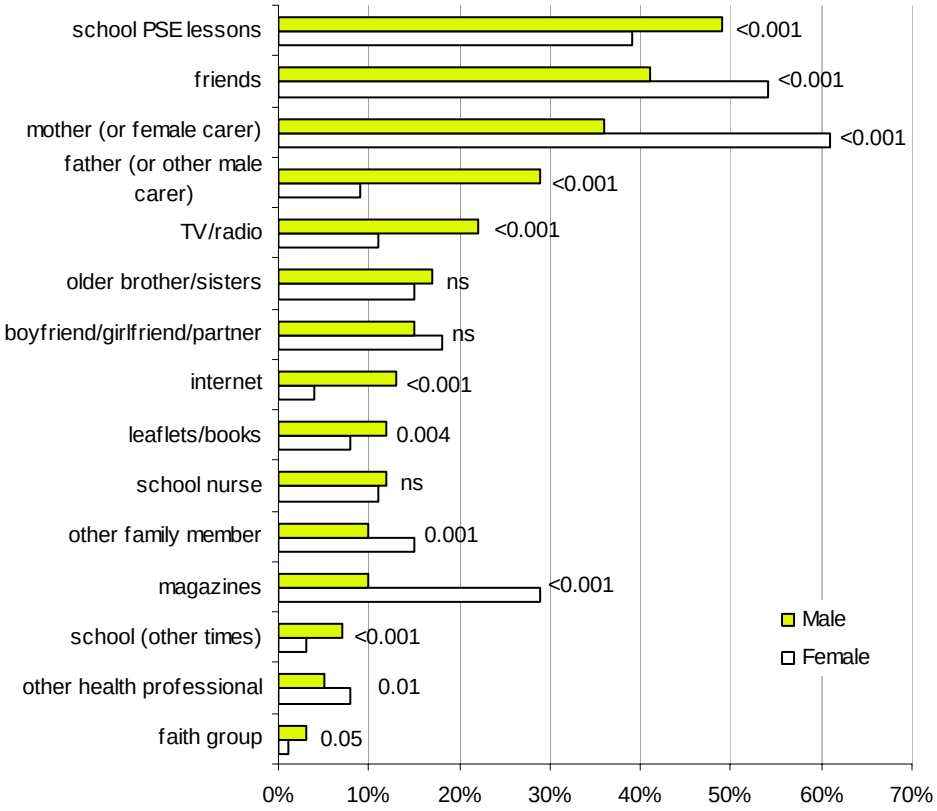
- faith group (2%, 46 respondents)
- school sources other than PSE or school nurse (5%, 123 respondents) and
- health professionals (7%, 162 respondents).

Gender, living arrangements & influential sources

Females were significantly more likely than males to name their mother/female carer, other family members, friends, other health professionals, and magazines, while males were significantly more likely than females to name their father/male carer, school PSE lessons, school sources other than PSE/school nurse, leaflets/books, and the internet.

As might be expected, young people who did not live with parent/s were less likely to cite their mother/female carer as an influential source, and more likely to cite another family member, than those who lived with parents. Those living away from parents were also more likely than those living with parents to cite leaflets and books.

Figure 17 Which three sources of information on sexual health and relationship issues have had the most influence on you?



n=2,343

Control, self-esteem & influential sources

When the relationships between control, self-esteem and influential sources were examined a key findings was that those who perceived having more control were more likely to be influenced by one or other parent.

Those who named their fathers/male carers as influential tended to perceive more control over their life and also to have higher self-esteem. Those who named their mother or female carer as an influential source tended to perceive more control over their health, although, there was no relationship with self-esteem. Although health professionals were generally not one of the most commonly cited influential sources (7%) in addition to mothers, health professionals were one of the most commonly cited sources amongst those who perceived themselves to have control over their health.

In terms of media sources, those who cited TV/radio were more likely to have higher self esteem than those who did not, while those who cited magazines tended to have lower self esteem. Although one might expect this last finding to be related to the fact

that females were both more likely to name magazines, and to have lower self-esteem, the effects were in fact independent of one another.

Schools, religion, ethnicity & influential sources

Due to the small numbers in some religious categories and in order to allow further analysis the different religions were recoded into the following six categories:

- Church of Scotland
- Catholic
- Other Christian
- Muslim
- Sikh/Hindu/Jewish/Buddhist/Other
- No religion

Generally those attending denominational schools and non-denominational schools and those of different religions and ethnicities cited similar sources as being influential. However there were some differences:

- Catholics, and those attending denominational schools, were significantly less likely than other respondents to cite school PSE lessons as influential, while those with no religion were more likely than those with a religion to cite this source of information.

- Those who practised their religion, Muslims, and those from an Asian background, were more likely to name their faith group as an influential source; although the numbers citing this source were small and other faith and ethnic groups were also represented among those who cited this source.

- Muslims or those in the Sikh/Hindu/Jewish/Buddhist/Other category, and those from Asian or mixed ethnic backgrounds, were less likely to cite their mother/female carer as an influential source. However, this finding can be explained by the fact that there were differences between those from different religious and ethnic groups in the extent to which they talked to their mothers about sexual matters (see section 5.2): those who talked less to their mothers about sexual matters were of course less likely to name her as an influential source of information.

- Those who practised their religion were more likely than other respondents to name TV/radio as an influential source, as were those from Asian, Black or mixed ethnic backgrounds.

- Those who practised their religion were also rather less likely to name health professionals as an influential source, a finding which might be explained by the fact that those who practised their religion were less likely to have had sexual experiences (see chapter 7).

Other findings

Those who completed the questionnaire online were less likely to cite their father/male carer, other family member, and school PSE lessons. They were more likely to cite their boyfriend/girlfriend, friends, health professionals, and, as might be expected, the internet. While the difference on the citing of health professionals was due to age differences between those who completed the questionnaire online and other respondents, the other findings were not so easily explained.

5.2 Parent as sources of information

5.2.1 Dialogue with parents/carers around sex

There have been various programmes in the US and UK (e.g. Healthy Respect, Let's Talk, SpeakEasy, Parent to Parent), which have looked at encouraging parent-child and parent-parent dialogue around sexual health and relationship issues. Although there are challenges involved in getting parents (especially fathers) to participate in such programmes, there is evidence that including teenagers' parents in information and prevention programmes can have a range of beneficial effects, some of which go beyond specific sexual health issues. In addition, it has been found that young people whose parents discuss sexual matters with them are more likely to use contraception at first intercourse.

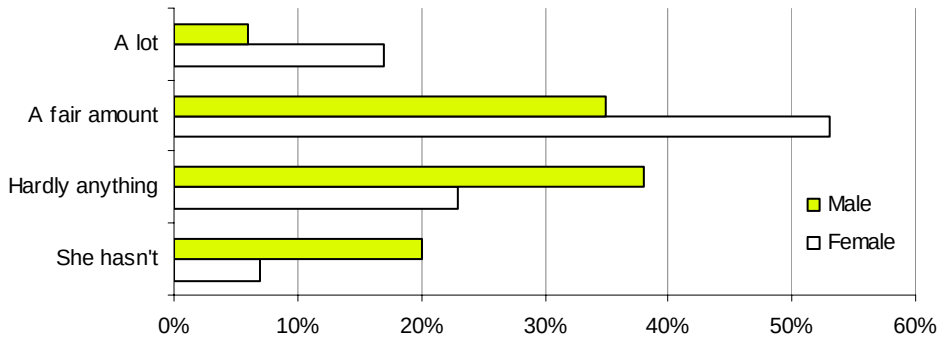
Dialogue with both parents/carers

Overall 2,230 respondents responded to the question about mothers/female carers and fathers/male carers and provided information about their own sex. Of these 2,230, 1,189 (53%) were female and 1,041 (47%) were male. Fourteen percent (146 respondents) of males and 6% of females (67 respondents) reported that neither parent/carer had talked to them about sexual health and relationships, with a further 16% of males (169 respondents) and 5% of females (64 respondents) reporting that their parents/carers had hardly said anything to them about sexual health and relationships

Dialogue with mother/female carer

Young people were asked about the extent to which their mother/female carer had talked to them about sexual health and relationships. Overall, 57% (1,454 respondents) responded either 'a lot' or 'a fair amount'. However, 43% (1,104 respondents) said 'hardly anything' or 'not at all'.

Figure 18 How much has your mother/female carer talked to you about sexual health and relationships?



n=2,558

As would be expected, a highly significant relationship was found between closeness to mother/female carer and the extent of talking to her about sexual health and relationships ($p<0.001$): those who had talked more to their mother/female carer were closer to them than those who had talked less. However, as will become apparent, being close to their mothers did not automatically mean that they had talked to their mother/female carer about sexual health and relationships, or conversely, that those who were less close to their mother/female carer had not.

Young people who lived with their parents were more likely to report that they had talked to their mother/female carer when compared with those who did not live with their parents ($p=0.037$) and those who talked more to their mothers about sexual matters, perceived more control over their life and health than other respondents (both $p<0.001$).

There are clear gender differences when looking at the data generated about dialogue with mothers/female carers. Young women were significantly more likely ($p<0.001$) than young men to have had more dialogue with their mothers/female carers on this topic (70%, 951 females responding a lot or a fair amount; 41%, 473 males). This finding is consistent with the finding reported in the previous section, where young women were significantly more likely than young men to name their mother/female carer as an influential source of information.

In addition those who were from more deprived areas (depcat 6 & 7) were more likely than those in the least deprived areas to have talked to their mother/female carer about sexual health and relationships ($p=0.037$) and perhaps not surprisingly those who were older were more likely to have engaged in dialogue with their mother/female carer than younger respondents ($p=0.027$).

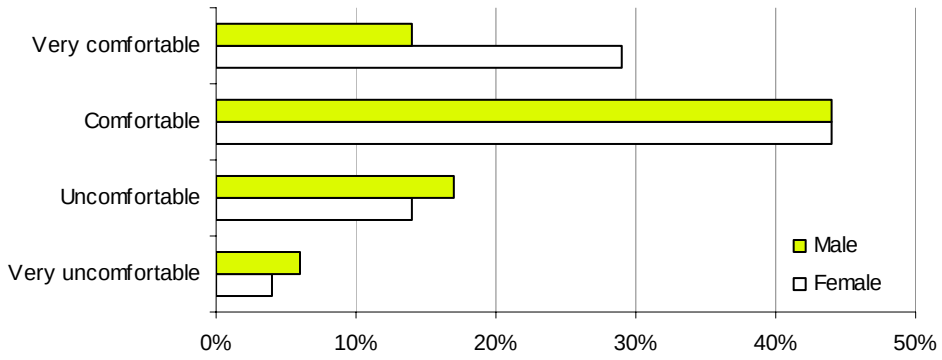
In terms of ethnicity, compared with those from white backgrounds, young people from other ethnic backgrounds were all more likely to say that their mother/female carer had not discussed sexual health or relationships with them. Similarly, those who identified themselves as Muslim, and those who practised their religion, were more likely to say that their mother/female carer had not talked to them about sexual matters. However, the lack of discussion about sexual health matters was not related to closeness. Those who practised their religion were actually closer to their mothers than other respondents. This highlights the point above, that although those who had talked to their mother/female carer a lot about sexual health were closer to them than those who had not; being close to mother/female carer did not automatically mean that they would have discussed sexual health and relationships.

How comfortable mother/female carer was

Following on from this, young people were asked how comfortable their mother/female carer was in talking to them about sexual health and relationships. Two-thirds felt their mother/female carer to be comfortable to some degree (67%, 1,467 respondents), 20% (439 respondents) to be uncomfortable and the remainder were unsure (13%, 291 respondents).

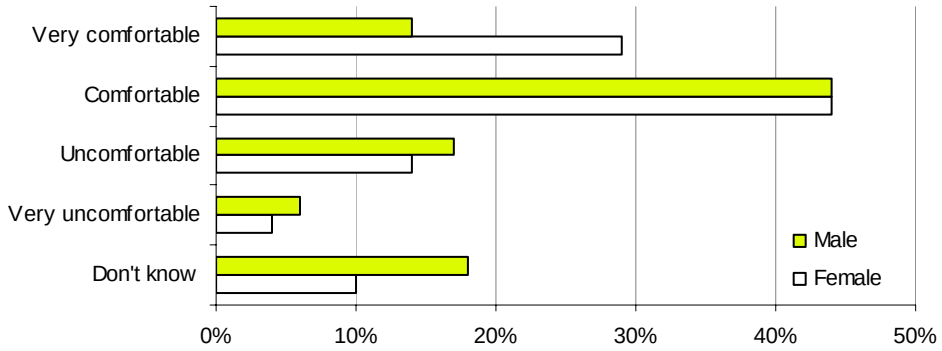
Young people were then asked to comment on how comfortable they were in discussing these issues with their mother/female carer. Just over half (54%, 1,187 respondents) were comfortable or very comfortable with this. Responses to both questions differed significantly by gender ($p<0.001$), with young women more likely to perceive that they and their mothers were more comfortable talking about sexual health issues.

Figure 19 How comfortable do you think your mother/female carer was in talking to you about sexual health and relationships?



n=2,197

Figure 20 How comfortable were you in talking to your mother/female carer about sexual health and relationships?



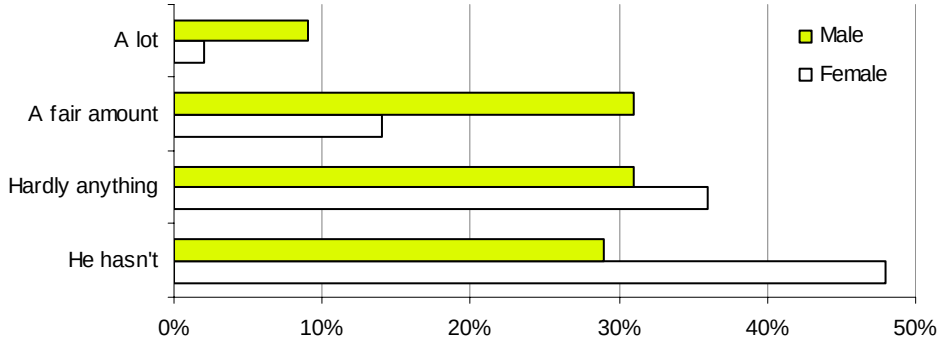
Closeness to the mother was related to both aspects of comfort with talking about sexual health and relationships. Those who were closer to their mother felt that they and their mothers were more comfortable talking about such issues. Similarly, those who felt that they and their mothers were more comfortable perceived themselves to have more control over their life and health and to have higher self-esteem.

With regard to religion and ethnicity, significant findings were noted that were consistent with those found in relation to the extent of dialogue with the mother. Thus, those from non-Christian and non-white backgrounds were likely to perceive that they and their mothers were less comfortable talking about sex (or to indicate that the questions were not applicable), suggesting that they were much less likely to have such discussions with their mothers.

Dialogue with father/male carer

Overall, 73% (1,689 respondents) said that their father/male carer had not talked or hardly talked to them about sexual health and relationships, with females significantly less likely than males to have had dialogue with their father/male carer around this topic ($p<0.001$). As might be expected, those who were closer to their fathers/male carer talked more to them about sexual health and relationships; those who talked more, and those who were closer to their fathers/male carer, had higher self-esteem, and perceived more control over life ($p<0.001$ in both cases). These findings differ slightly to those found in relation to dialogue with mothers/female carers. No relationship was found between self-esteem and talking to mothers/female carer about sexual health and relationships, whereas with fathers/male carers there was. In addition, those talking to their mothers/female carers perceived significantly more control over their health than those who did not, but there was no corresponding relationship in relation to talking to fathers/male carers.

Figure 21 How much has your father/male carer talked to you about sexual health and relationships?



n=2,314

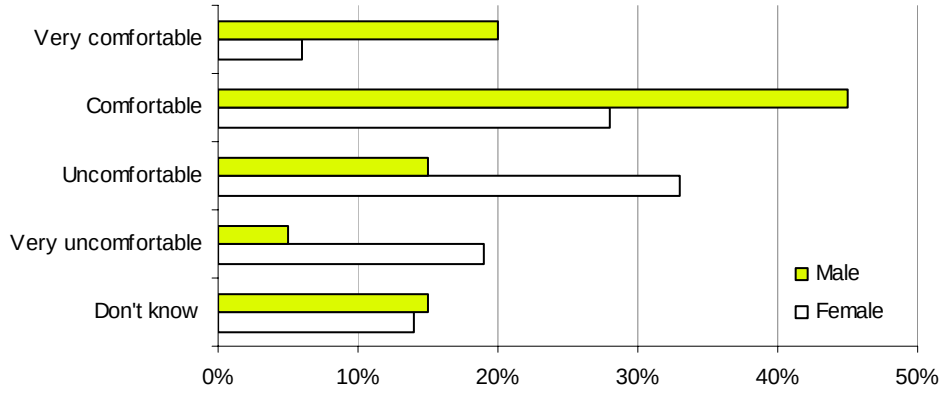
Similar findings were established with regard to religion and ethnicity as were noted in relation to dialogue with the mother/female carer. Muslims, those who practised their religion, and those from non-white backgrounds, were all more likely to indicate that they had had no dialogue with their fathers/male carer about sex. Young people who reported having a disability were more likely to have talked to their fathers/male carers about sexual health and relationships than young people with no disability ($p<0.001$).

Comfort with talking with the father/male carer

Those respondents whose fathers/male carers had spoken to them about sexual health and relationships were asked how comfortable they perceived he was in discussing these things. Half (50%, 705 respondents) considered him to be comfortable or very comfortable, whilst 35% (487 respondents) perceived him to be uncomfortable to some degree. Similarly, around 50% (685 respondents) who had discussed sexual health and relationships with their father/male carer felt comfortable in doing so.

There were significant differences between male and female respondents, with young men, more so than young women, perceiving that both they and their fathers were more comfortable talking about sex.

Figure 22 How comfortable do you think your father/male carer was in talking to you about sexual health and relationships?



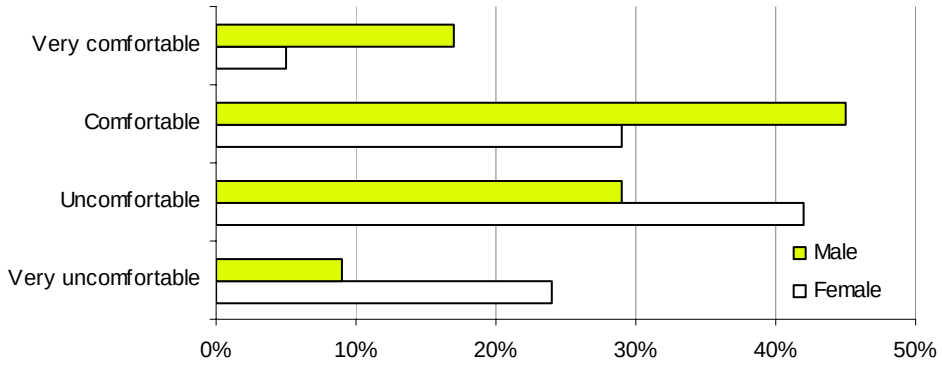
n=1,400

Those in the older age group (16+) were slightly more likely than those in the younger group to have indicated that their fathers were uncomfortable talking about sex while the younger respondents were slightly more likely to have indicated that they did not know whether their father was comfortable or not ($p=0.036$). Age did not appear to affect how comfortable respondents felt in talking to their fathers/male carers; however those from the least deprived areas (depcat 1 & 2) were slightly less comfortable than those from depcat 3,4 & 5 and 6 & 7 ($p=0.042$).

Denominational pupils were more likely than those attending non-denominational schools to feel comfortable talking to their father/male carer about sexual health and relationships ($p=0.028$).

There was a relationship between level of comfort and sexual orientation with non-heterosexual young people more likely to feel very uncomfortable discussing sexual health and relationships with their father/male carer ($p=0.019$).

Figure 23 How comfortable were you in talking to your father/male carer about sexual health and relationships?



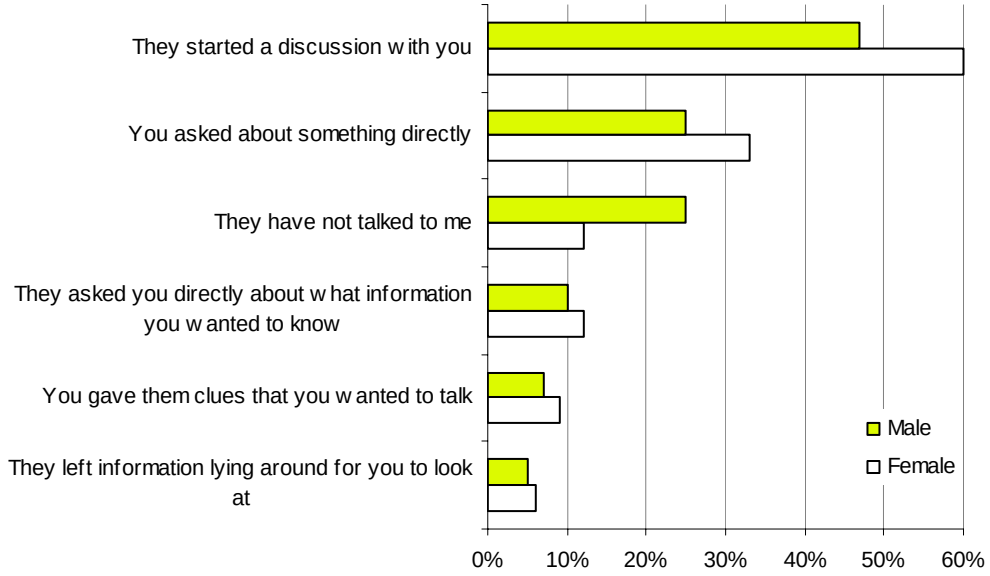
n=1,382

Young people therefore perceived their mothers/female carers to talk to them more about sexual health and relationship issues and to be more comfortable in doing so than their fathers/male carers.

How dialogue with parents/carers was initiated

All young people were asked how discussion with their parents/carers about sexual health and relationships had been initiated, and had the option of responding that this discussion had not taken place. The chart below shows that parents/carers are more likely to initiate a discussion about these issues with young women they care for, and that young women are more likely to ask their parents/carers direct questions. Young men were more likely to say that their parents/carers had not talked to them about sexual health and relationships. There was little differentiation in response by other demographic grouping.

Figure 24 If your parents/carers have talked to you about sexual health and relationships, was this because….

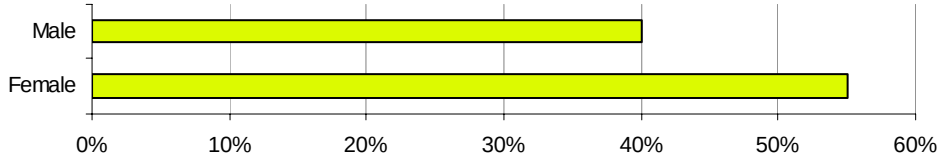


n=2,514

Respondents' wish for more dialogue with parents/carers

Finally for this section, young people were asked if they would like to be able to speak to their parents/carers more about sexual health and relationship issues. Overall, 48% (1,231) of young people said that they would like to have more discussions of this nature. Young women were significantly more likely to answer yes to this question than young men ($p<0.001$), as were young people living in higher depcat/more deprived areas ($p=0.034$). There were no significant differences in terms of age, school type or sexual orientation.

Figure 9 Would you like to be able to speak with your parents/carers more about sexual health and relationships? (those responding 'yes' are shown)



n=2,550

The main reasons given for not wishing to speak more to parents about this issue were: it's too personal/awkward/they're my parents (43%, 498 respondents); know enough already (27%, 317 respondents); and talk to them enough already (11%, 131 respondents).

5.3 School education

The previous section indicated that PSE classes were identified as both a popular source of information and an influential source of information. This section of the young people's questionnaire focused on young people's experiences of sexual health and relationships education (SHRE), its delivery, content, and when different elements were taught.

5.3.1 Perceptions of SHRE

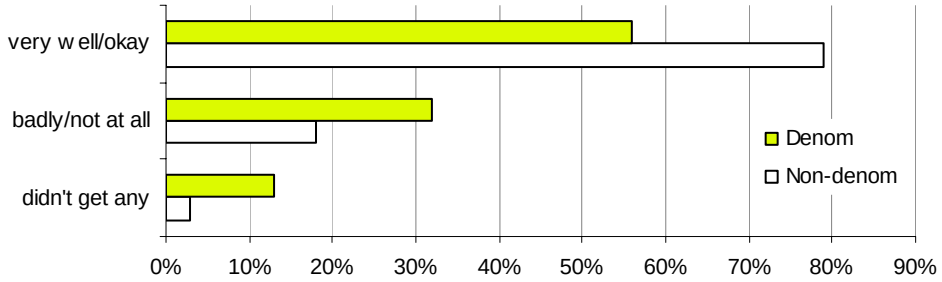
Young people were asked how well they thought SHRE at school had prepared them for dealing with sexual health and relationship issues. Overall, 76% of young people

(2038 respondents) responded positively to this question. Sixteen percent (419 respondents) indicated that school SHRE had prepared them very well and 61% (1,619 respondents) that it prepared them 'ok'. In contrast, 19% (524 respondents) negatively rated its ability to prepare them, with 10% (275 respondents) rating it poorly and 9% (249 respondents) stating that they hadn't been prepared by school at all. Notably, 4% (98 respondents) stated that they did not get any sexual health education at school. Catholics and Muslims were more likely than the other religious groupings to have reported not having received any SHRE.

Those who felt badly prepared or not at all prepared by school SHRE were more likely to feel that they had little or no control over the way their life was going ($p<0.001$), and to a lesser extent, little or no control over their health ($p<0.036$). Similarly, those who felt badly prepared by school SHRE had lower self-esteem ($p=0.021$) than those who either felt well prepared or those who had not had any teaching.

The factor which seemed to have the biggest impact on how young people rated their SHRE in this section was school type. Those who rated the SHRE they had received more negatively (or who indicated that they did not receive SHRE) were significantly much more likely to report attending or to have attended a denominational school.

Figure 26 How well do you think SHRE at school has prepared you for dealing with sexual health and relationship issues? (by type of school attended/last attended)



n=2,426

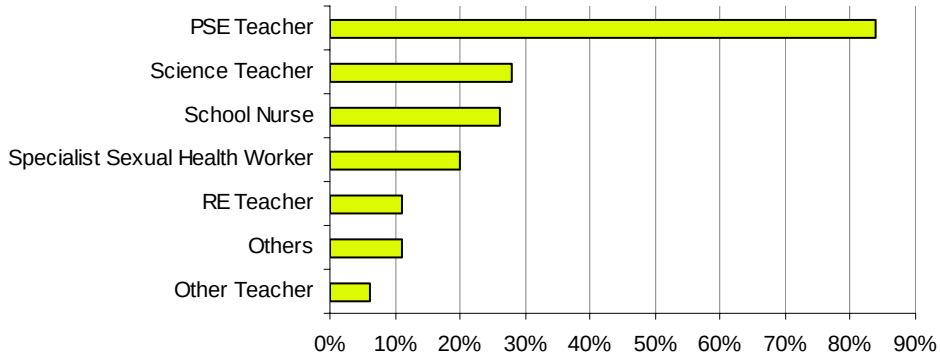
Other factors which were related to stating that the SHRE they had received had not prepared them well or that they had not received any at all were:

- being older-16+ ($p<0.001$)
- living away from their parents ($p=0.001$)
- being from less deprived areas ($p=0.006$)
- having completed the questionnaire online ($p<0.001$)
- having a religion (compared to those with no religion) ($p=0.002$)

5.3.2 Who teaches SHRE

Young people were asked who taught them SHRE at school. The most common response was their Personal and Social Education (PSE) teacher (84%, 2,108 respondents), followed by their science teacher (28%, 705 respondents) and then the school nurse (26%, 639 respondents). One in five (20%, 509 respondents) had been taught by a specialist sexual health worker.

Figure 27 Who teaches/taught you SHRE at school? (multiple response)



n=2,504

For males and females, the deliverer of SHRE differed significantly with females much more likely to have received SHRE from a school nurse than male respondents ($p=0.001$) which may reflect school practice in primary schools around menstruation. Older respondents, those aged 16+, were more likely to have received their SHRE from a specialist sexual health worker than younger respondents who were more likely to have received SHRE from either a PSE teacher or "others" ($p<0.001$).

Respondents attending denominational schools, were much more likely than those attending non-denominational schools to have had RE teachers (33%, 64 respondents vs. 9% 192 respondents) or science teachers (37%, 71 respondents vs. 28%, 577 respondents) deliver their SHRE. Those attending or having attended denominational schools were also much less likely to have reported PSE teachers and school nurses as deliverers of SHRE than those attending non-denominational schools ($p<0.001$).

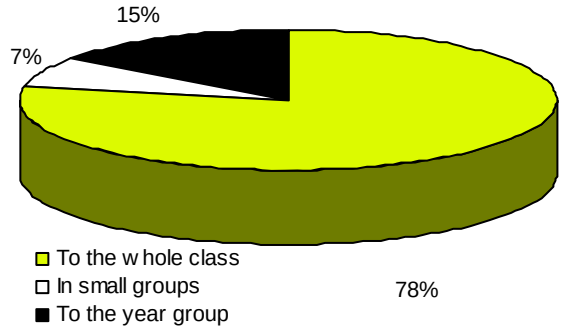
There were some significant differences between young people from different religions with regard to the person who taught SHRE (e.g. young people belonging to the Church of Scotland were more likely than those who were Muslim to report that they had been taught by a PSE teacher). However this is likely to be a consequence of the fact that those of different religions attended different types of school.

Those who had been taught SHRE by a PSE teacher or by a school nurse were significantly more likely than those who had ticked any other category to have felt that their SHRE had prepared them very well or okay. Being taught by any teacher other than those on the list (i.e. not a PSE, Science or RE teacher) did not have a positive outcome in terms of the perception of the quality of the SHRE. These respondents were more likely to indicate that their teaching had badly prepared them for dealing with sexual health or not prepared them at all.

5.3.3 How SHRE is delivered

Young people were asked about the manner in which SHRE was mainly delivered: for the majority (78%, 1,934 respondents) this involved the whole class.

Figure 28 How is/was your sexual health and relationships mainly delivered?



n=2,486

There was a significant difference in terms of school type (p=0.031), with denominational pupils slightly more likely to receive SHRE as a year group than non-denominational pupils (19% compared to 15%), but also more likely to receive this in small groups (10% compared to 6%) and less likely to be taught as a whole class (71% compared to 79%).

Young people from more deprived areas were more likely to have been taught SHRE in small group settings than whole class settings, in comparison to respondents from more affluent areas (p=0.034).

The majority of SHRE was delivered in mixed sex classes (86%, 2,129 respondents), as indicated by the chart below. This was significantly different for denominational schools (p<0.001), where 24% (47 respondents) received sexual health education in single sex classes.

Figure 29 In what class type was SHRE delivered?

n=2,490

A logistic regression analysis was conducted to determine the relative importance of teacher or source of SHRE, the size of group and being taught in mixed or single sex groups in determining level of preparedness. When the source of SHRE was accounted for, no significant difference was found between those taught in single or mixed sex groups or according to class setting. However, those who felt more prepared had been taught by a PSE teacher or by a school nurse (both p<0.001).

5.3.4 SHRE differentiation for gender and religion

Young people were asked if they felt that young men and young women should be given the same information about sexual health and relationships: overall 94% (2,487 respondents) felt that this should be the case.

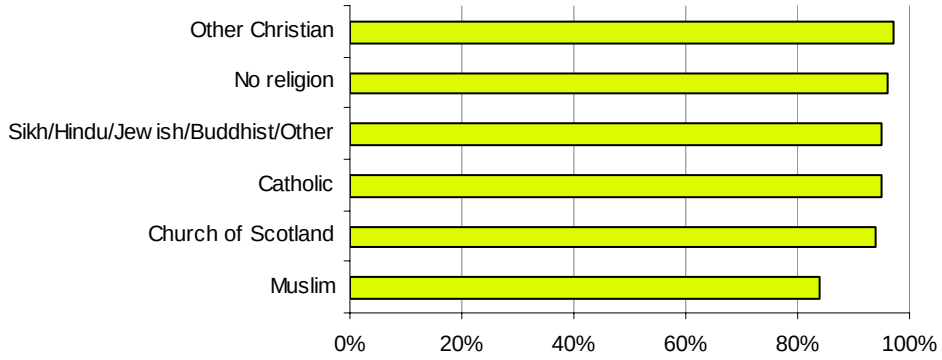
Parents were asked this same question, and 90% (947 respondents) felt that young men and young women should be given the same information about sexual health and relationships.

Respondents were also asked if they felt that young people of all religions should be given the same factual information about sexual health and relationships in the school setting. Overall, 95% (2,483 respondents) felt that this should be the case and there were no differences between those attending denominational and non-denominational schools. Parents were asked a similar question in the parents consultation mentioned previously, i.e. if the factual content of SHRE should be the same for denominational and non-denominational schools. Ninety-three percent (967 respondents) agreed that this should be the case.

Young people's responses to the question about giving the same factual information in the school setting irrespective of religion were analysed by their stated religion. There were significant differences according to religion ($p<0.001$), with Muslim young people being much more likely to disagree that young people of all religions should receive the same factual information about sexual health and relationships in school.

Responses to this question also differed by practice of religion: those who practised their religion were more likely to feel there should be differences in the factual information given to young people of different religions ($p<0.001$) but this is to be expected given that Muslims were also the most likely to practise their religion.

Figure 30 Percentage of young people who agreed that all religions should be given the same factual information about sexual health and relationships in the school setting, by religion (recoded)

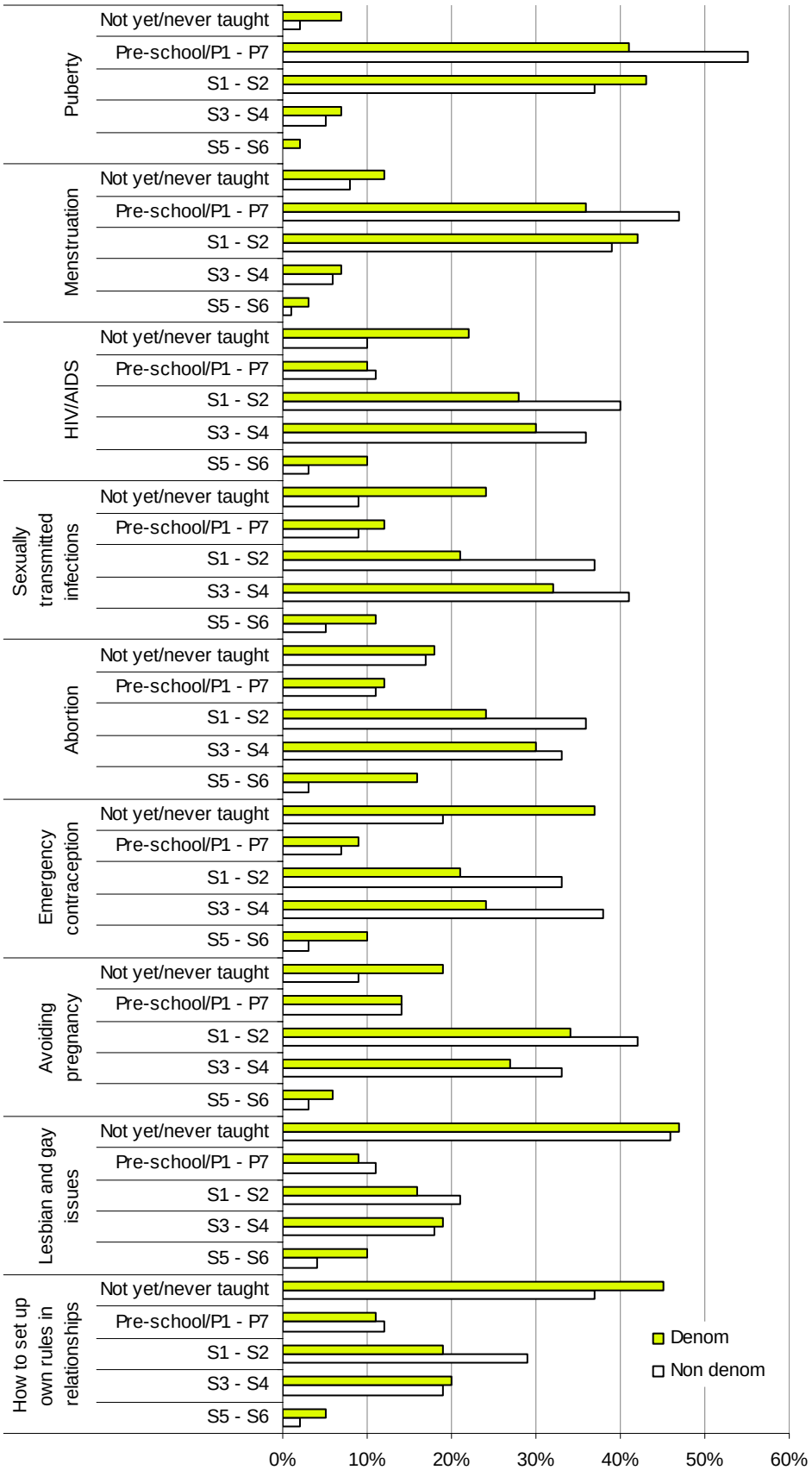


n=2,458

5.3.5 Age/stage at which SHRE elements are delivered

Within the questionnaire young people were presented with a list of 15 specific topics and asked to indicate when these topics were taught to them. The data for nine of these topics are presented in the chart that follows, with the data grouped according to whether the respondent's school/last school attended was denominational or non-denominational. It should be noted that some, but not all, of the 'not yet/never taught' responses will be because the respondent was not yet of the age when that particular topic was scheduled to be taught as part of their curriculum.

Figure 31 At what stage were these topics taught at school



n=2,465, 2,452, 2,446, 2,439, 2,441, 2,446, 2,431, 2,443, & 2,442 from top to bottom

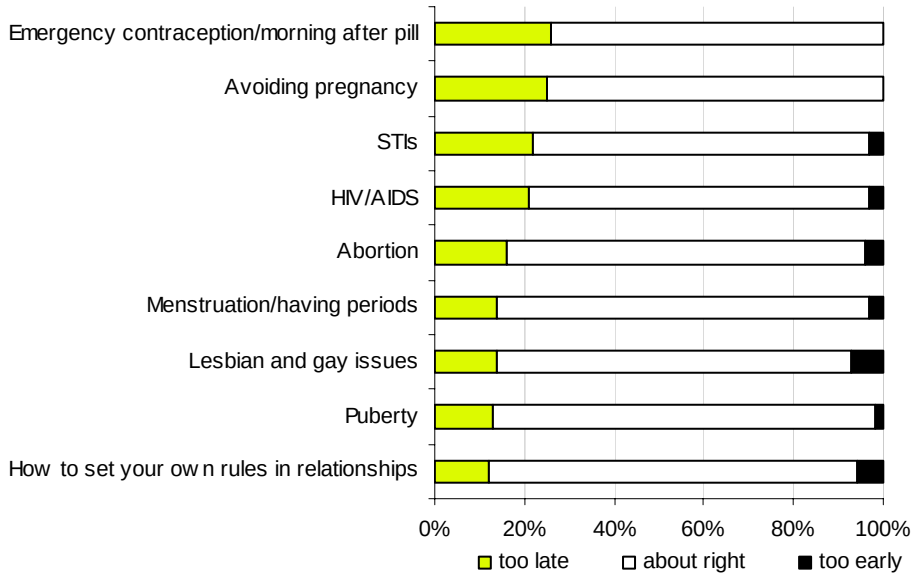
The Report of the Working Group on Sex Education in Scottish Schools (commonly referred to as The McCabe[2] Report) discusses the appropriate stages at which different topics should be taught. The table below compares the recommended stages for the nine topics shown above to the stage at which respondents *most commonly* reported they had been taught the topic.

Table 3 Stage at which SHRE topics are taught: recommended versus actual

Topic	Recommended stage (McCabe 2000)	Non-denominational	Denominational
Puberty	upper Primary	Primary	S1-S2
Menstruation	upper Primary	Primary	S1-S2
HIV/AIDS	mid to upper Secondary	S1-S2	S3-S4
STIs	mid to upper Secondary	S3-S4	S3-S4
Abortion	early Secondary	S1-S2	S3-S4
Emergency contraception/protection	not specified	S3-S4	Not yet/never taught
Avoiding pregnancy	early Secondary	S1-S2	S1-S2
Lesbian & Gay issues	early Secondary	Not yet/never taught	Not yet/never taught
How to set your own rules in relationships	early Secondary	Not yet/never taught	Not yet/never taught

Having been asked about the stage at which various topics were taught to them, young people were asked if they believed this was the right stage in their schooling. For all 9 topics at least three-quarters of the young people (74%, 1,354 respondents) felt that the timing had been about right. Whilst all issues were perceived to be covered too early by some respondents, it is more concerning to see up to 20% of respondents stating that issues like emergency contraception (17%, 393 respondents), avoiding pregnancy (18% 423 respondents), STIs (20%, 456 respondents) and HIV/AIDS (18%, 411 respondents) were covered too late in school sexual health and wellbeing education.

Figure 32 For each of these topics, was it taught at the right stage in your schooling?



n between 1,227 to 2, 257

In order to carry out further analysis the topics above were combined as follows:

- feelings and emotions; body parts; how babies are made
- puberty; menstruation
- boyfriends or girlfriends; long term relationships; rules in relationships
- avoiding pregnancy; emergency contraception; abortion

- HIV and AIDS; STIs
- parenting
- lesbian and gay issues

Although the majority of females felt that topics had been taught at the correct time, females were generally more likely than males to feel that most topics had been taught too late. The finding in relation to young women is consistent with Buston & Wight's research[Error! Bookmark not defined.], which found that young women commonly felt that school SHRE had been delivered too late in relation to their personal development. In this consultation, males were much more likely than females to report that many of the topics asked about had not been taught to them at all.

Other than in relation to the topic group covering feelings/emotions etc, older respondents were more likely than younger respondents to say that the rest of the grouped topics had been taught too late. The responses of those with a disability did not differ from those without disabilities, other than in relation to the feelings/emotions/how babies made category. Those coded as non-heterosexual were more likely than heterosexuals on all topics bar one (parenting) to indicate that they had been taught too late.

Significant differences were found according to school type on perceptions of the following topics: feelings and emotions; body parts; how babies are made ($p=0.001$); puberty; menstruation ($p=0.006$); HIV and AIDS; STIs ($p<0.001$); parenting ($p=0.010$). On these topics those from denominational schools were more likely to indicate that topics had been taught too late or that they had not been taught at all. Significant differences were also found according to religion, practice of religion and ethnicity. These differences tended to be in line with those found according to school type, with those who were Catholic or Muslim somewhat more likely to indicate that topics had been taught too late or not at all. Similarly those who responded online (who were likely to be older and to attend denominational schools) tended to indicate that topics had been taught too late or not at all.

Comparisons were made between those who felt topics had been taught at about the right time (or too early); those who felt topics had been taught too late; and those who indicated that they had not been taught the topics at all. Those who felt that they had been taught about feelings, body parts and how babies were made at too late a stage, or not at all, were likely to feel less control over their life or general health than those taught at the right time/too early (both $p<0.001$). They also had lower self-esteem scores than those who felt that the topic had been taught at the right time/too early ($p=0.014$). Similarly, those who felt that puberty and menstruation had been taught too late or not at all were likely to feel less control over their life ($p=0.038$) and health ($p<0.001$) than those who had been taught at the right time/too early However those who indicated that they had not been taught about puberty and menstruation, had significantly higher self-esteem scores than those who had been taught about the right time/too early or those taught at too late a stage ($p=0.009$). Further analysis indicated that this was because males, who have been shown already to have higher self-esteem scores, were significantly more likely to have reported not having been taught about puberty or menstruation. One other topic was related to self-esteem: those taught too late about parenting had significantly lower self-esteem scores than those taught at the right time/too early, or those not taught at all ($p=0.026$). Again, there were indications that this finding was due to gender differences in self-esteem.

As would be expected, those who felt that topics had been taught too late or not at all were much more likely to indicate that the SHRE they had received had prepared them badly or not at all to deal with issues relating to sexual health and relationships.

The numbers were too small to conduct any meaningful analysis on the data relating to those who felt they had been taught topics too early.

5.3.6 Perceived quality of SHRE

Young people were asked to rate how well the SHRE they had received had covered the variety of topics asked about previously. Topics deemed more suitable by the McCabe guidelines for teaching at primary school age were generally perceived to have been covered better than LGBT issues or relationship issues which were more likely not to have been taught at all.

For 11 of the 15 topics asked about, those who were attending or had attended denominational schools were more likely than their counterparts in non-denominational schools to have responded that the topic had been covered badly/very badly or (despite being of the appropriate age/school stage according to McCabe guidelines) not at all. These differences were noted on all topics except maintaining long-term relationships/marriage; how to set rules in relationships; abortion; and lesbian/gay issues.

As noted above in section 5.35, the topics were combined into 7 topic groups. For 5 of the 7 topics (with the exception of puberty/menstruation and gay/lesbian issues), those who felt that they had been taught very well or okay were more likely to have indicated that they felt a lot of control over the way their life was going. Similarly for 5 of the 7 topics (with the exception of relationships and gay/lesbian issues) those who felt that they had been taught very well or okay were more likely to indicate that they felt a lot of control over their health. The results with regard to self-esteem were more mixed. Those who felt that they had been taught very well or okay had higher self-esteem than those who felt that they had been taught badly on two topic groups: relationships and parenting. However those who indicated that they had not been taught about emotions/body parts/how babies made and avoiding pregnancy/contraception/abortion had higher self esteem scores than other respondents. In this case, the findings could not be explained by the preponderance of males having high self-esteem scores.

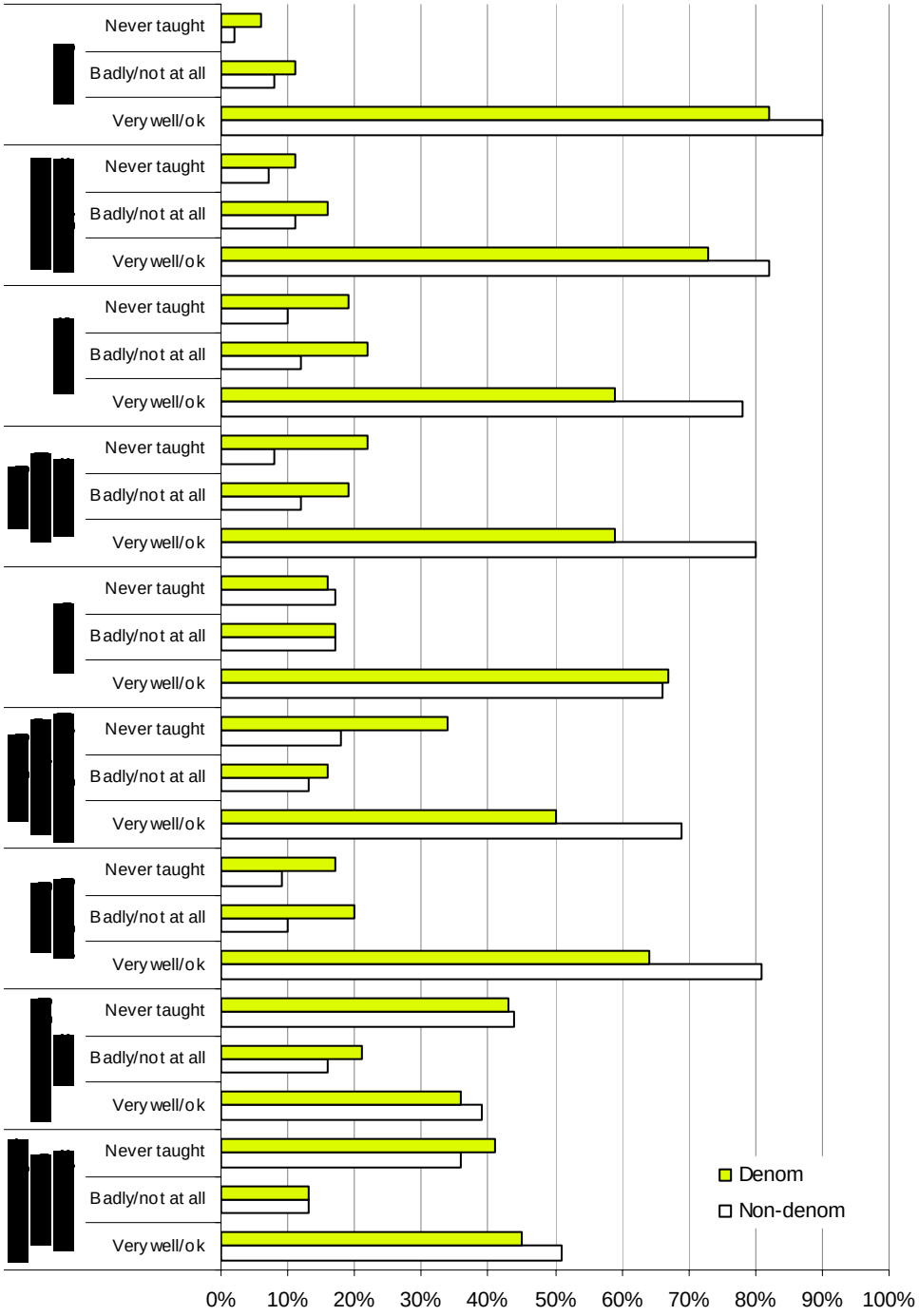
On four of the topics (feelings/emotions/body parts/how babies made; puberty/menstruation; avoiding pregnancy/contraception/abortion; and lesbian/gay issues) females were more likely than males to indicate that the topics had been taught very well or okay.

A number of differences in perception of quality of topics were noted with regard to age, school, religion and ethnicity, all of which were in themselves related. On all topics, those who were older were less likely than younger respondents to say that they had been taught very well or okay and those who completed the questionnaire online were less likely than other respondents to indicate that they had been taught very well or okay. Similarly, on all topics except lesbian/gay issues, those who attended denominational schools were less likely than those attending non-denominational schools to indicate that they had been taught very well or okay. With regard to religion, it appeared that those who were Catholic or Muslim were less likely than those in other religious groups to indicate that they had been taught very well or okay.

Those who were disabled were less likely to feel that they had been taught very well or okay about emotions/body parts etc while those who were not heterosexual were less likely than those who were heterosexual, to indicate that they had been taught very well or okay on four of the topic groups (emotions etc; puberty/menstruation; relationships; and lesbian/gay issues).

As would be expected, strong relationships were found between the perceptions of timing and the quality of the teaching of topics: those who felt that they had been taught very well or okay tended to feel that they had been taught topics at the right time. Perceptions in timing and quality were strongly related to the overall measure of feeling prepared by SHRE. It is not possible to link the perceptions of timing and quality of individual topics to the teachers who taught those topics, or to the way those topics were taught, however: generally speaking, those who had been taught SHRE by a PSE teacher tended to be more positive about the timing and quality of individual topics.

Figure 33 How well do you feel the following topics were covered in your school sexual health education (including primary and secondary)?



n between 2,549 and 2,573

5.3.7 Are there topics that should not be taught?

To complete this section, young people were asked if they felt any of the topics should not be covered in schools: 88% (2,219 respondents) of respondents said 'no', and only 12% (292 respondents) answered yes. The most common issues nominated by this subset of young people were lesbian & gay issues (68%, 186 respondents), abortion (9%, 26 respondents), followed by maintaining long term relationships/marriage (8%, 22 respondents).

The bases were small except for the topic of lesbian and gay issues. This was significant by gender (p=0.002), and sexual orientation (p=0.031). Male respondents were much more likely to cite Lesbian, Gay, Bisexual and Transgender (LGBT) issues (76%, 117 respondents) than females (58%, 63 respondents), as were those coded as

heterosexual (71%, 161 respondents) compared to those coded as non-heterosexual (52%, 16 respondents).

5.4 Chapter Summary

The purpose of this chapter was to look at the different mediums through which young people receive information generally about sexual health and relationships, and specifically in relation to parents and school based SHRE; the way these mediums are perceived and any impact they may be having on their lives.

The consultation carried out with parents/carers published in August 2005 asked parents and carers who they felt should *mainly* be responsible for educating children and young people about sexual health and relationships. The majority of parents/carers (70%, 739 respondents) saw this as a role shared by themselves and by teachers and for the majority of young people these two sources, to an extent were commonly cited as an influential source of information about sexual health and relationships.

Those who named one or either parent as an influential source of information were likely to perceive themselves as having more control. Those who cited their father as influential were likely to perceive more control over their life and have higher self-esteem: those who cited their mothers were more likely to perceive themselves as having more control over their life and health. Although both parents/carers were named as influential sources, fathers/male carers were so to a lesser extent than mothers/female carers with young people perceiving their mothers/female carers to talk to them more about sexual health and relationships and be more comfortable in doing so than fathers/male carers.

Despite parents/carers, particularly mothers/female carers being named as an influential source, 43% of young people (1,104 respondents) reported that their mother/female carer had either hardly spoken to them or not spoken to them at all about sexual health and relationship issues. Almost three-quarters of respondents (73%, 1,689 respondents) reported the same in relation to their fathers/male carers. Overall, 30% of males (315 respondents and 11% of females (131 respondents).reported that neither parent/carer had talked to them or hardly talked to them about sexual health and relationships. Interestingly, almost half of young people (48%) wanted to have more dialogue with their parents/carers on these matters. Young women were significantly more likely to want such dialogue as were young people living in more deprived areas.

In terms of school based SHRE, although this was named as an influential source for both males and females, males were significantly more likely than females to indicate that a number of topics had not been taught to them at all. Those who perceived their SHRE education to have prepared them well to deal with issues relating to sexual health and relationships, were far more likely to have higher self esteem and perceive more control over their life and health. Feeling more prepared was related to an extent to:

- the type of school the young person attended. Those attending non-denominational schools felt more prepared than those attending denominational schools
- the provider of SHRE. Those who were taught by a PSE teacher or school nurse were significantly more likely than those taught by anyone else to have felt prepared by the SHRE they received
- the perceived quality of the SHRE. Those who perceived that certain topics had been taught well were more likely to feel prepared.

The vast majority of young people felt all the topics asked about should be covered in school based SHRE and that that school based SHRE should provide the same information to males and females and those of different religions.

Friends and popular media sources were often cited by young people as a source of information about sexual health and relationships. There appeared to be a negative relationship between magazine reading and self-esteem and while there is absolutely no way to know which or what types of magazines are being read , it does suggest that sexual health and relationship programmes should build in work around self-esteem and ensure that young people receive accurate messages to combat any negative messages they may receive through popular mediums.

6 Attitudes to sexual health and relationships

6.1 Attitudes & relationship to behaviour

Young people were asked to signal their level of agreement to a number of attitudinal statements based around sexual health and relationships. Possible responses included 'fully agree', 'mostly agree', 'mostly disagree' and 'fully disagree'. The table below outlines the percentage of young people who either agreed or disagreed with each statement (fully agree and mostly agree have been amalgamated as have mostly disagree and totally disagree).

Table 4 Attitudinal statements and percentage of young people agreeing or disagreeing

Statement	Percentage Agree + (n = respondents)	Percentage Disagree + (n = respondents)
I think you should only have sexual intercourse if you are in a long-term relationship	61%	39%
	(1,624)	(1,019)
I think people should be married before they have sex	14%	86%
	(371)	(2,291)
I think it's more acceptable for young men to sleep around than young women	24%	76%
	(647)	(1,981)
I think it's OK to be a virgin	84.5%	15.5%
	(2,225)	(408)
I think it's OK for gay and lesbian people to raise children	62%	38%
	(1,630)	(1,013)
I think it's the young woman's responsibility to ensure there is contraception/protection	25%	75%
	(641)	(1,964)
I think it's important that abortion is available	76%	24%
	(1,988)	(632)
I think giving young people access to condoms encourages them to have sex	38%	62%
	(1,002)	(1,646)
I think using sex to keep a boyfriend/girlfriend is wrong	71%	29%
	(1,894)	(760)
I think prostitution is unacceptable	70%	30%
	(1,817)	(773)

The NATSAL study (2000) found that whilst sex before marriage was generally accepted by the respondents who took part, women and young people did not view having sex outside of a regular stable relationship positively[6]. A similar finding is evident from this consultation. The vast majority of people disagreed that people should be married before they have sex: however, people generally agreed that you should only have sex if you are in a long-term relationship, with females much more likely to agree with this statement than males. Those who were more likely to agree that people should be married before they have sex were female ($p<0.001$) and to an extent those in the older age group ($p=0.002$). Perhaps, not surprisingly, those who practised their religion were far more likely than those who did not practise a faith to agree that sex should happen after marriage. Muslims and those from ethnic minorities were also more likely to agree with this statement than those from other religions or ethnicities respectively. Most young people from denominational schools disagreed that you should be married before having sex. However they were

significantly more likely to agree with this statement when compared with those from non-denominational schools.

Most respondents disagreed that it was more acceptable for young men to sleep around than young women. Those more likely to agree with this statement were mostly male, from more deprived areas, perceiving little or no control over their health and indicating that they received no SHRE at school ($p<0.001$).

A positive finding was that 84.5% of young people felt that it was okay to be a virgin. Those less likely to agree with this statement were generally male, heterosexual, close to their fathers, with have high self-esteem and reporting that they had not received any school based SHRE. The finding relating to self-esteem reflected the fact that males had higher self-esteem and were also more likely to disagree with the statement.

Those who were more likely to disagree that it was okay for gay and lesbian people to raise children were male, heterosexual, practising their religion or from a minority ethnic background ($p<0.001$).

About a quarter of young people agreed that it was a woman's responsibility to ensure there is contraception/protection, most of whom were likely to be male, to have a disability, be from the younger age group, be practising their religion and be from a minority ethnic background ($p<0.001$). Those who felt well prepared by their sex education at school were somewhat more likely to disagree ($p=0.032$).

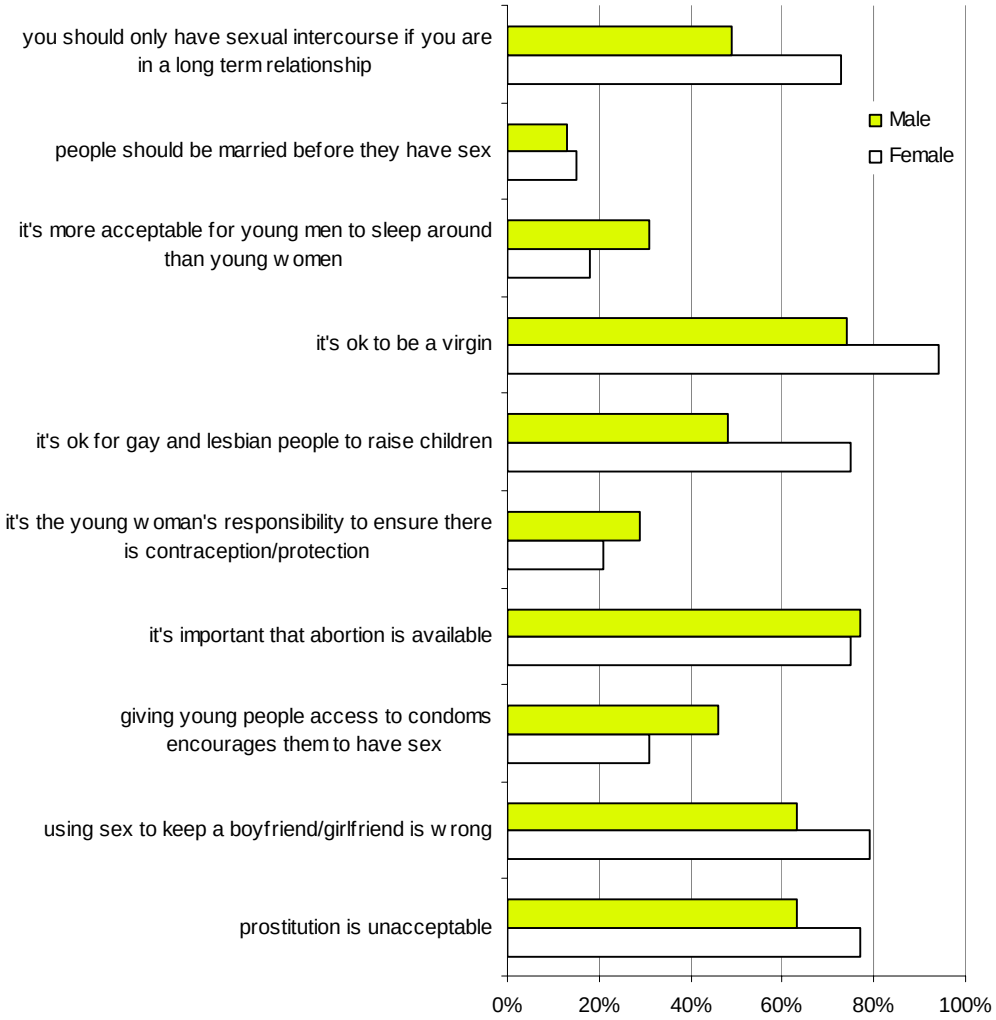
Responses to the statement about the importance of the availability of abortion/termination did not differ amongst the sexes. Those agreeing with the statement were more likely to attend non-denominational schools ($p<0.001$), be non-heterosexual ($p=0.19$) and be from less deprived areas ($p=0.001$). As would perhaps be expected, those who practised their religion were more likely to disagree as were those from minority ethnic communities ($p<0.001$).

Those who reported that they practised their religion were more likely than those not practising or with no religion to agree with the statement that giving young people access to condoms encourages them to have sex. Those from minority ethnic communities were also more likely to agree with this statement, as were young men and those in the younger age groups (all $p<0.001$).

Just less than 30% of young people disagreed that using sex to keep a boyfriend/girlfriend was wrong. Males and those with high self-esteem were more likely to disagree, but again the finding related to self-esteem lost significance when gender was controlled for in the analysis. Those more likely to agree that it was wrong were female, from the older age group (both $p<0.001$), living with their parents ($p=0.017$) and practising their religion ($p=0.013$).

Females were more likely than males to agree that prostitution is unacceptable as were older respondents ($p<0.001$) and those who practised their religion ($p=0.26$). Heterosexuals ($p=0.014$) and those who felt well prepared by their SHRE ($p<0.001$) were also more likely to agree.

Figure 34 How much do you agree or disagree with the following? (fully agree and mostly agree responses have been amalgamated and are shown in the chart below)



n between 2,590 and 2,662

6.2 Chapter Summary

Overall there were general levels of agreement with regards to most of the statements, with smaller numbers holding slightly different views to the majority and the factors determining this varied on most statements. Overwhelmingly however on all of the statements other than the one relating to abortion/termination there were gender differences with males much more likely than females to disagree that:

- you should only have sex within a long-term relationship
- people should be married before they have sex
- it is okay to be a virgin
- it is okay for gay and lesbian people to raise children
- using sex to keep a boyfriend/girlfriend is wrong
- prostitution is unacceptable

and more likely than females to agree that:

- it's more acceptable for young men to sleep around that young women
- it's a woman's responsibility to ensure there is contraception/protection
- that giving young people access to condoms encourages them to have sex

These results indicate that Programmes around sexual health and relationships need to consider gender differences and therefore may need to adopt specific approaches.

7 Sexual health and relationships - behaviour

7.1 Introduction

The purpose of this section, was not only to find out about when and what activities young people are engaging in, but also to gain a better understanding of young people's overall reflections on these behaviours. By so doing, the more holistic aspects of sexual well-being e.g. levels of regret, readiness, and pressure were gathered, to be used alongside more medical measures such as teenage pregnancy rates and STIs.

For the purpose of the study, the questionnaire defined sex as full intercourse with penetration, and defined 'other sexual experiences' as activities such as heavy petting or oral sex (but not just kissing).

7.2 Young people's engagement in sexual activity

There is evidence to suggest that young people are engaging in sexual intercourse at earlier ages now than in the past.

In this consultation over half of the sample (56%, 1,424 respondents) stated that they had engaged in some form of sexual activity, with half of under 16's also saying that they had done so (51%, 840 respondents). For each of the activities individuals were asked at what age they had first taken part. The following figures are the average age at which young people first engaged in these activities.

- Heavy petting or sexual touching = 13.80 (1,274 respondents)
- Oral sex =14.28 (668 respondents) (younger age taken when ages for giving and receiving provided)
- Full intercourse = 14.39 (785 respondents)

7.2.1 Key determinants of sexual experience

Demographics & sexual experience

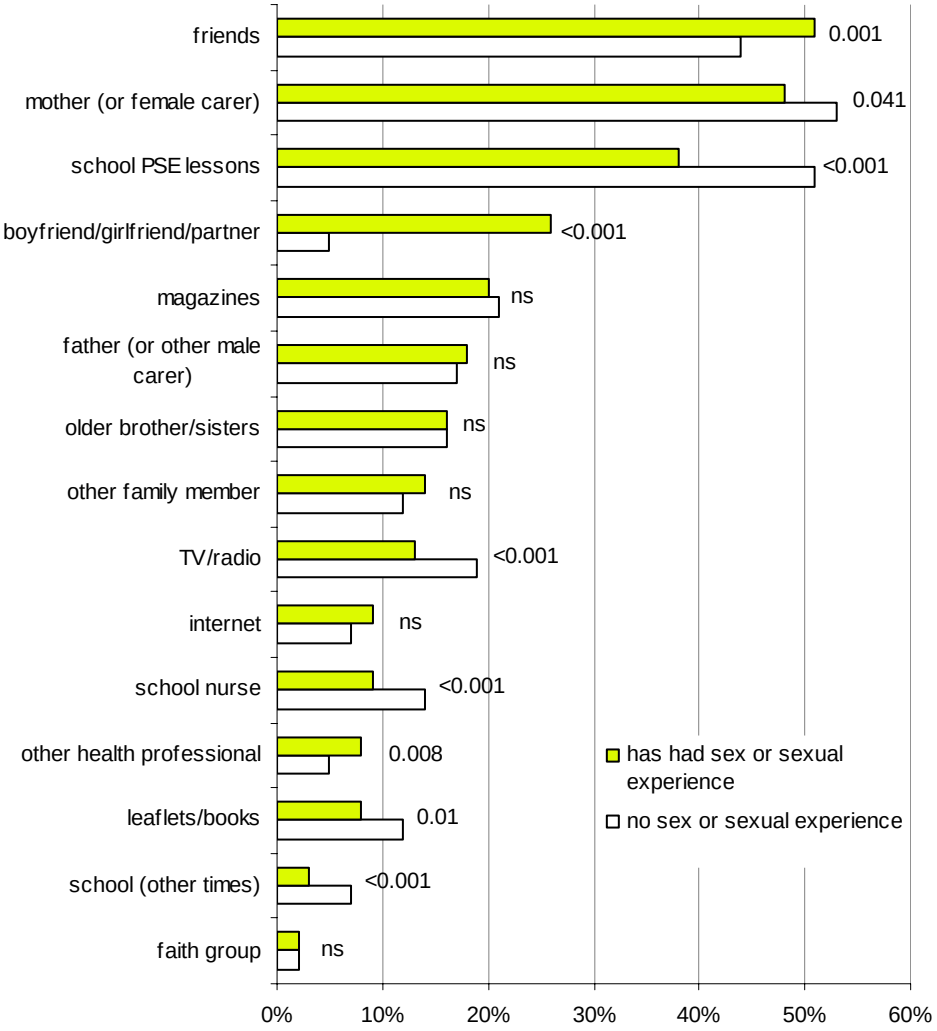
Analysis was carried out to see what the key differences were between those who had experience of some form of sexual activities and those who did not. It should be noted that a significant difference does not imply that a causal relationship exists.

Those who had experience of some form of sexual activity were likely to be older ($p<0.001$). With regards to religion and ethnicity, Muslims, those who practised their religion and those from non-white backgrounds were less likely to have had any sexual experience (all $p<0.001$). Those who lived away from their parents were more likely to have had a sexual experience, as were those who answered online ($p<0.001$).

Information sources & sexual experience

With regard to influential sources of information, those who had engaged in some form of sexual activity were less likely to cite their mother ($p=0.041$), PSE classes or other school sources (both $p<0.001$), the school nurse ($p=0.001$), TV or radio ($p=0.001$) or leaflets/books ($p=0.010$). They were more likely to cite their boyfriend or girlfriend ($p<0.001$), friends ($p=0.001$), or other health professionals ($p=0.008$).

Figure 35 Most influential sources of information and respondents' sexual experience



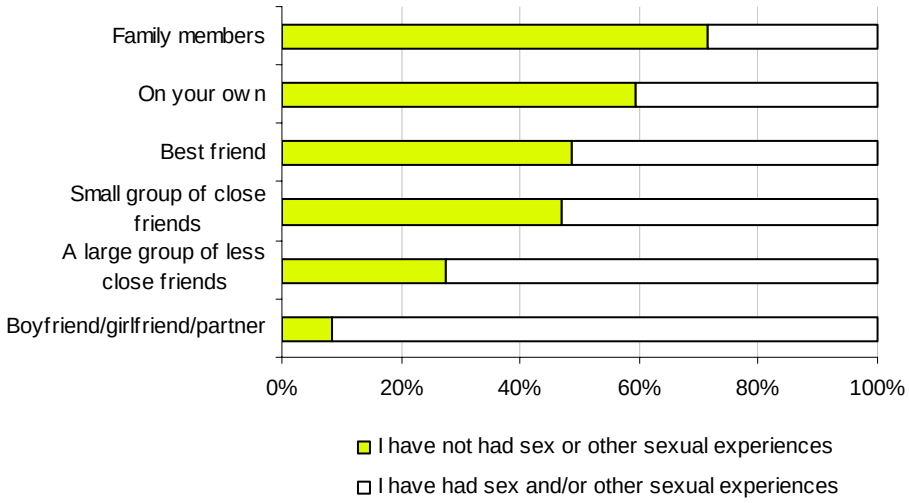
n=2,343

In terms of school based SHRE, those who had some type of sexual experience were likely to feel less prepared by school SHRE ($p<0.001$) and feel that a number of topics had been taught to them too late i.e. puberty/menstruation ($p=0.001$); boyfriends/girlfriends and relationships ($p<0.001$); avoiding pregnancy, contraception and abortion ($p<0.001$); HIV/AIDS and STIs ($p<0.001$); parenting ($p<0.001$), and gay and lesbian issues ($p=0.009$). They were also likely to perceive a number of topics as having been taught badly i.e. puberty/menstruation ($p=0.006$); avoiding pregnancy, contraception and abortion ($p=0.011$); HIV/AIDS and STIs ($p<0.001$); and parenting ($p=0.008$).

Those who had some type of sexual experience were less likely to be very close to their mothers ($p<0.001$) or fathers ($p<0.007$), were less likely to spend free time with parents and much more likely to spend it with a boyfriend or girlfriend ($p<0.001$). They were also less likely to cite their parents as one of the most influential sources. It was found that those who had had a sexual experience, were more likely to have talked to their mothers/female carers and fathers/male carers about sex ($p<0.001$) and had parents/carers who were comfortable in doing so. What this consultation is unable to clarify is the direction of the relationship found, and whether the discussion came before or after the involvement in sexual activity occurred. Those who had had a sexual experience were more likely to have had parents start the discussion ($p=0.018$) and therefore it may be that parents of the young people who had experience of sexual activity talked to them subsequently as a result of being concerned: however it is impossible from this consultation to know. Further, nothing was known about the nature of the conversation the young people had had with their parents about sexual

health and relationships, therefore no firm conclusions can be drawn with regards to this finding.

Figure 36 Who do you spend most of your free time with and sexual experience



Attitudes & sexual experience

With regard to attitudes, those with some type of sexual experience were significantly more likely to disagree (all $p<0.001$) than those who had no experience:

- that you should only have sexual intercourse if in a long term relationship
- that people should be married before they have sex
- that it is OK to be a virgin
- that giving young people access to condoms encourages them to have sex
- that using sex to keep a boyfriend/girlfriend is wrong
- that prostitution is unacceptable

They were more likely to agree that (both $p<0.001$):

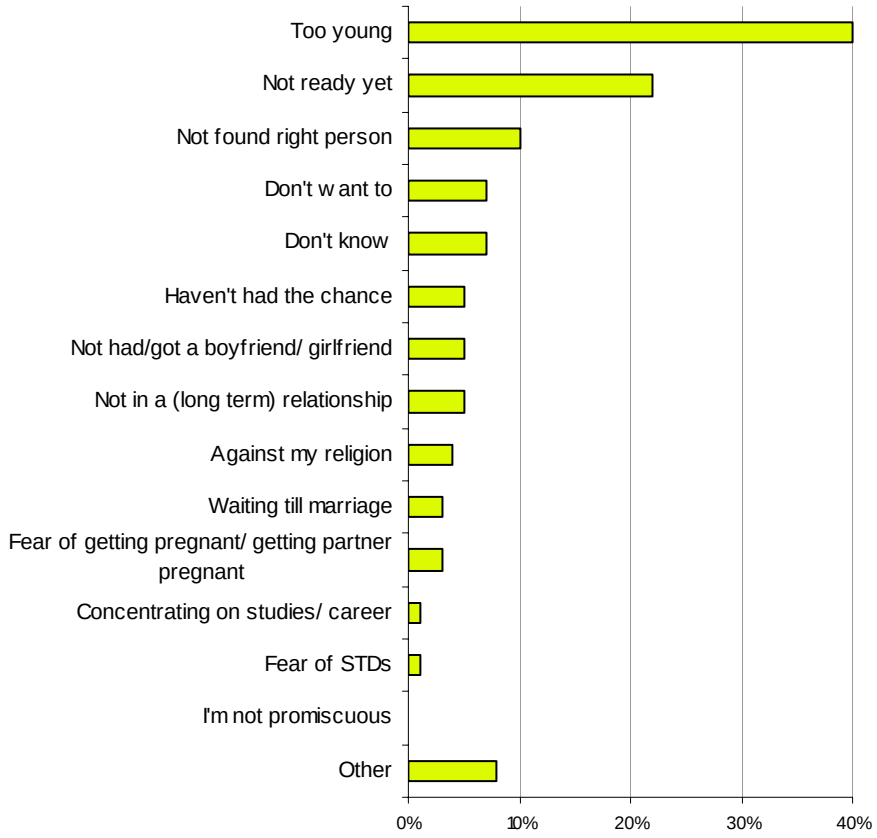
- it is more acceptable for young men to sleep around than young women
- abortion should be available

7.2.2 Reasons for not engaging in sexual activity

Those who had not engaged in any form of sexual activity were asked their reasons for this and these are shown in the figure below. The three most commonly cited reasons were:

- too young (40%, 337 respondents)
- not ready yet (22%, 181 respondents)
- not found the right person (10%, 81 respondents)

Figure 37 What were your reasons for deciding not to engage in sex or other sexual activities?



n=1,015

Females were more likely than males to say they weren't ready yet ($p<0.001$) and as might be expected younger respondents were more likely to give being too young as a reason for not having engaged in sex or other sexual activities ($p<0.001$). Interestingly older respondents were more likely to say that they didn't feel ready ($p<0.001$).

Although the numbers were low, those of Muslim faith were much more likely ($p<0.001$) than any other to cite their religion as a reason for not engaging in sexual activity.

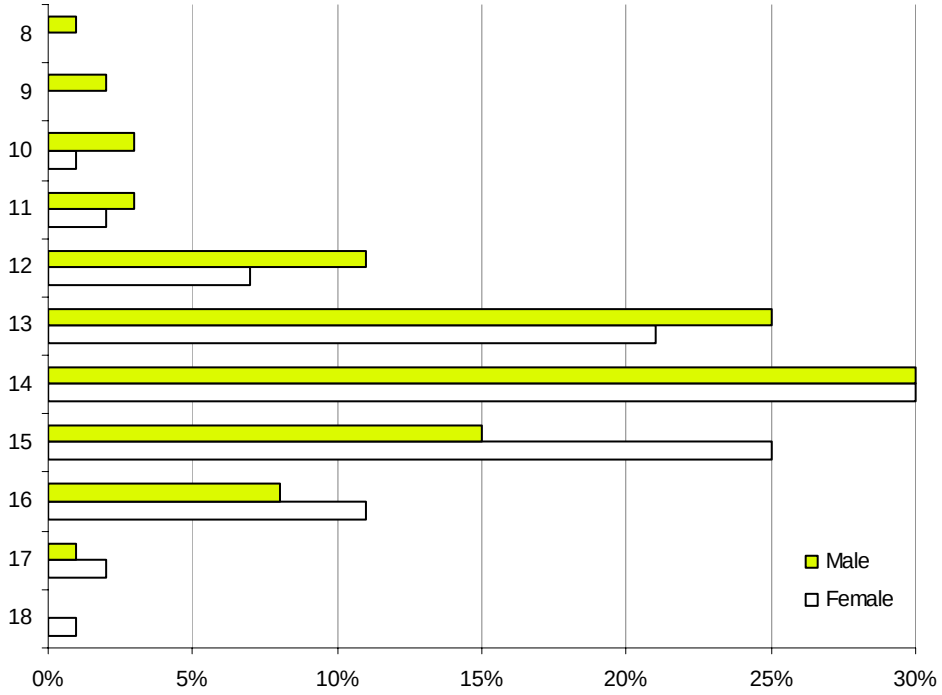
7.3 Heavy petting or sexual touching

Experience of heavy petting or sexual touching

Young people were next asked questions in relation to heavy petting and sexual touching with another person, and their age when this occurred. Overall, 50% of the entire sample had taken part in heavy petting or sexual touching. In the 13 – 15 age range, 48% (787 respondents) had done so. As would be expected, almost all (96% 1,274) of those who indicated that they had taken part in sexual activity had also taken part in heavy petting. The factors that differentiated those who had experience of heavy petting from those who had not were therefore identical to those which discriminated between those who had experience of sex or other sexual activities and those who had not.

Although the average age at which heavy petting first occurred was 13.80, the chart below indicates that males were more likely than females to report earlier experiences of heavy petting or sexual touching. The average age for males to experience heavy petting was 13.50 (584 respondents) and the average age for females was 14.07 (661 respondents)

Figure 38 Those who had taken part in heavy petting or sexual touching by age when first experienced



n=1,280

Reflections on this first experience of heavy petting or sexual touching

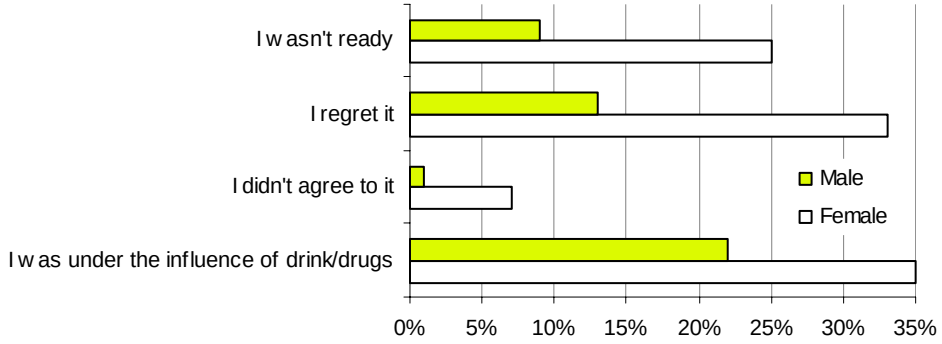
Respondents were asked to reflect on their first experience of heavy petting or sexual touching in terms of whether or not they felt ready, felt regret, had agreed to the activity, or were under the influence of drink or drugs. Whilst the majority reported their experiences in positive terms when asked specific questions:

- 17% (191 respondents) reported that they were not ready for their first experience
- 24% (226 respondents) said that they regretted it
- 4% (37 respondents) that they did not agree to it
- 30% (268 respondents) said that they were under the influence of alcohol or drugs.
- 2% percent (28 respondents) indicated that they had put pressure on their sexual partner
- 10% (135 respondents) said they had experienced pressure from their partner.

There were significant differences in terms of gender, with females less likely to have felt ready, more likely to feel regret, more likely to say they had not agreed, and more likely to have been under the influence of drink or drugs ($p<0.001$ in all four cases). Similarly, most of those who indicated that pressure had been put on them were females, while most of those who had exerted pressure were males. However in relation to pressure and agreement, the numbers were small and the results may therefore not be reliable.

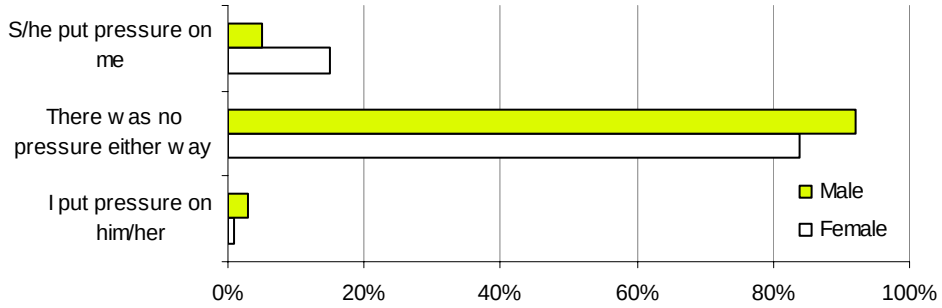
The data for gender are summarised in the chart below.

Figure 39 Looking back on your first experience of heavy petting or sexual touching…?



n=1,104, 933, 885, & 901 from top to bottom

Figure 40 Which of the these best describes your first experience of heavy petting or sexual touching



n=1,316

Readiness for first heavy petting

Those young people who reported not being ready on their first experience were more likely than expected to:

- attend or have attended a denominational school in comparison to those from non-denominational schools (p=0.016)
- be younger at time of first experience of heavy petting compared to those who were older at the time of first experience (p<0.001)
- have lower self-esteem (p<0.001) in comparison to those who felt ready
- feel less in control over the way their life was going in comparison to those who felt ready (p<0.001)
- be distant from their fathers (or to indicate that closeness was not applicable) than those who felt ready (p=0.003)
- have completed the questionnaire online (p=0.009)
- be non-heterosexual (p=0.001)

Regret of first experience of heavy petting

Respondents who regretted their first experience of heavy petting or sexual touching were more likely than expected to:

- be younger at the time of their first experience than those who did not regret it (p=0.001).
- perceive little or no control over the way their life was going in comparison to those who did not regret their first experience (p<0.001)
- be distant from or only quite close to their mothers in comparison to those who did not regret it (p=0.006)

Agreement to first experience of heavy petting

Only 37 respondents indicated that they did not agree to their first experience of heavy petting and to characterise these respondents is likely to be unreliable. Having said this, those who did not agree to their first experience of heavy petting or sexual touching were more likely than expected to:

- have lower self-esteem scores than those who said they did agree (p=0.004)
- perceive themselves to have less control over their life (p<0.001) and health (p=0.007) than those who did agree
- be distant from or only quite close to their mother/female carer (p=0.021) than those who agreed
- to report practising their religion (p=0.001)
- be from a minority ethnic background (p=0.004)
- be non-heterosexual (p=0.023)

Sober/not during first experience of heavy petting

Young people who said that they were not sober at the time of their first experience of heavy petting or sexual touching were more likely than expected to:

- have lower self-esteem scores than those who were sober (p=0.005)
- perceive themselves to have less control over their lives (p=0.024) and health (p=0.003) than those who were sober

7.4 Oral sex

7.4.1 Experience of oral sex

Forty percent of the entire sample (all 2,707 respondents) reported that they had taken part in oral sex. In the 13 – 15 age range, 34% (585 respondents) of the entire sample said that they had engaged in such behaviour. When looking at all those young people who said they had had some type of sexual experience, 71% (1,089 respondents) said that they had either given and/or received oral sex.

A number of those who indicated that they had taken part in oral sex did not give sufficient detail to determine whether they had both given and received or only given or only received. Of those did give sufficient details, the proportions of males and females with experience of oral sex were comparable to the proportions of males and females in the sample as a whole. Females were rather more likely than males to indicate they had both given and received oral sex (64%, 179 female respondents) or to have given but not received oral sex (60%, 110 female respondents) but much less likely than males to have to have only received oral sex (28%, 51 respondents). There were therefore gender differences with regards to oral sex with females more likely than males to be involved in the giving and receiving and less likely to be only receiving. Males were significantly more likely than females to have been engaged in oral sex at an earlier age. Males were on average 14.04 when they first experienced oral sex, and females were 14.43 years of age, and these two groups differed significantly from one another (p=0.001, based on the continuous age variable).

Those who had engaged in oral sex tended to have higher self-esteem scores and perceived more control over their life and health when compared to those who were sexually active but had not engaged in oral sex.

7.4.2 Reflections on first oral sex

Respondents who said that they had engaged in oral sex were asked to reflect on their first experience of it. It was found that:

- 19% (121 respondents) regretted it
- 3% (17 respondents) reported that they did not agree to it

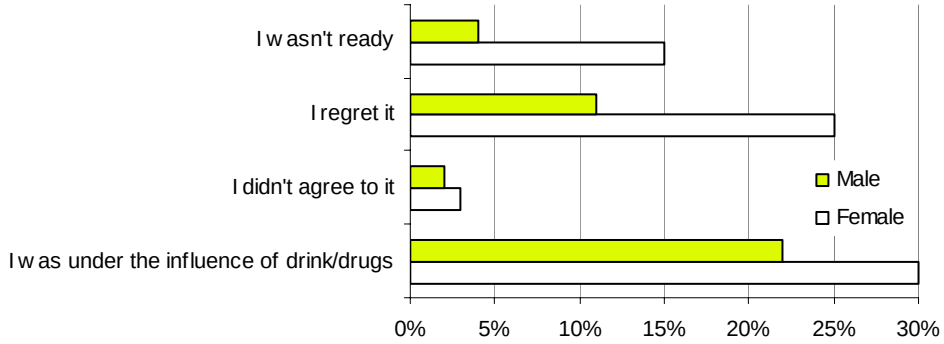
- 27% (168 respondents) reported that they under the influence of alcohol/drugs.

Although most said there was no pressure either way:

- 10% (92 respondents) said pressure was involved with
- 2% (20 respondents) reporting exerting pressure and 8% (72 respondents) reporting having experienced pressure.

As with heavy petting and sexual touching, there were gender differences in relation to first experiences with females significantly more likely than males to say they weren't ready ($p<0.001$), that they regretted it ($p<0.001$), that they were under the influence of alcohol/drugs ($p<0.001$) and that they had experienced pressure ($p<0.001$).

Figure 41 Looking back on your first experience of oral sex…?



n=757, 634, 620, & 628 from top to bottom

Readiness for first oral sex

Those who expressed that they had not been ready for oral sex at the time of their first experience were more likely than expected to:

- be female ($p=0.001$)
- be non-heterosexual ($p=0.048$)
- have had their first experience at an earlier age than those who were ready ($p=0.001$)
- have lower self-esteem scores than those who were ready ($p=0.001$)
- have reported being distant from their father/male carer or reported that closeness to father was not applicable ($p=0.001$)
- to perceive some (as opposed to little/none or a lot) of control over health ($p=0.041$)

Regret of first oral sex

Reporting regret over first experience of oral sex was associated with:

- being female. Females were more likely than males to regret their first experience of oral sex ($p<0.001$)
- being younger at first experience. Young people who regretted their first experience of oral sex had the first experience at a younger age ($p=0.011$)
- having lower self-esteem scores. Young people who felt regret had lower self-esteem scores ($p<0.001$) than those who did not regret their first experience
- being from a minority ethnic background ($p=0.036$)
- being distant from mothers ($p=0.011$) and fathers ($p=0.001$), or to indicate that closeness was not applicable

Non-agreement to first oral sex

Bearing in mind that only 17 respondents indicated that they had not agreed, those who had not agreed to their first experience of oral sex were more likely than expected to:

- be non-heterosexual ($p<0.044$)
- have lower self-esteem scores ($p<0.001$) than those who did agree
- be younger at age of first experience ($p=0.022$)
- perceive less control over the way their life was going in comparison to those who did agree ($p=0.001$)
- be distant from their mothers ($p=0.001$)
- be practising their religion ($p=0.002$)

Sober/not during first oral sex

Those who had not been sober during their first experience were more likely than expected to:

- be female ($p=0.020$)
- have lower self esteem scores ($p=0.016$)
- be younger at age of first experience ($p<0.001$) and currently in the younger age group ($p=0.005$)

7.5 Sexual intercourse

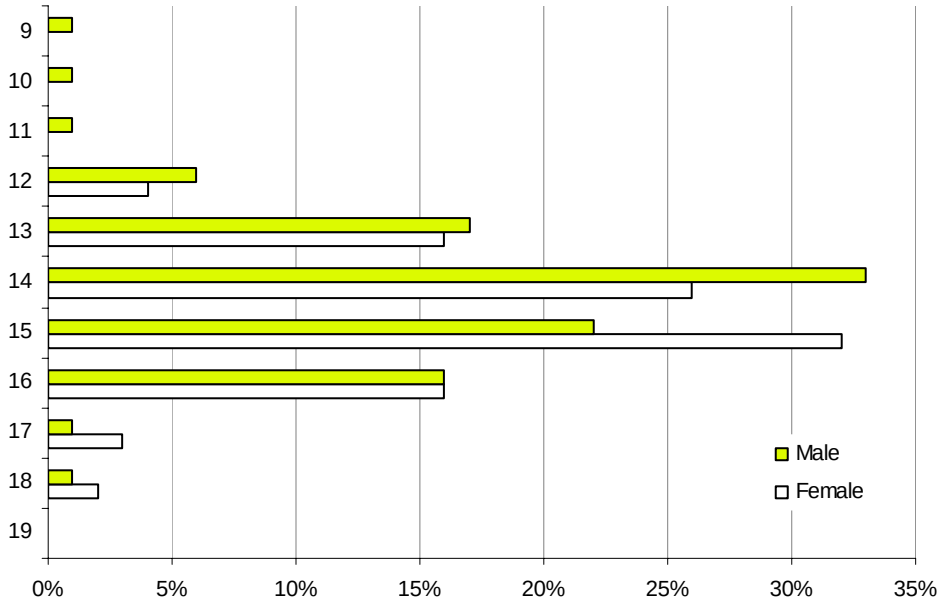
7.5.1 Number who had experienced sexual intercourse

When asked if they had experienced sexual intercourse, 31% (839 respondents) of the whole sample and 27% (439 respondents) of the 13 – 15 age range said that they had. Of all those that had engaged in some form of sexual activity, 62% had taken part in sexual intercourse.

7.5.2 Age at first sexual intercourse

The average age at which respondents first reported sexual intercourse was 14:39 however, there was a significant difference in age of first sex according to gender with a mean age for males of 14.2 years and a mean age of 14.5 for females ($p=0.003$).

Figure 42 What age were you when you first had sex?



n=791

7.5.3 Determinants of sexual intercourse

Analysis was carried out to establish which factors discriminated between those having had intercourse and those who had not and then between those who having had intercourse and those having sexual experience short of intercourse.

Two variables were used in the detailed analysis around experience of sexual intercourse. The first discriminated between those who had had intercourse and those who had not and the second discriminated between those who had had intercourse and those who had had sexual experience short of intercourse. First, an analysis was conducted to determine which profile and descriptive characteristics (or factors) significantly discriminated between the groups. Since many of these factors were themselves significantly related to one another, logistic regression analysis was conducted. This analysis took into account the inter-relationships of factors and highlighted the more important factors. An overview of the results is presented in Table 7.

Table 7 Results of regression analysis exploring factors associated with having had intercourse

Variable	Had intercourse v not had intercourse	Had intercourse v had sexual experience short of intercourse
Online v paper	ns	ns
Gender	ns	0.024
Age	<0.001	<0.001
School type	ns	0.021
Living arrangements	<0.001	0.006
Worship		
Religion, not practising	<0.001	ns
No religion	ns	ns
Self-esteem	ns	ns
Sexual orientation	ns	ns
Closeness to mother/female carer		
Close	ns	ns
Quite close	ns	0.047
Distant/NA	0.015	ns
Closeness to father/male carer		
Close	ns	ns
Quite close	ns	ns
Distant	0.014	ns
NA	ns	ns
Dialogue with mother/female carer		
Fair amount	ns	ns
Hardly anything	ns	ns
Not applicable	ns	ns
Dialogue with father/male carer		
Fair amount	0.003	0.042
Hardly anything	0.001	0.036
Not applicable	<0.001	<0.001
Control over life-path		
Some	ns	ns
A lot	ns	ns
Free time spent with….		
Boyfriend/Girlfriend	<0.001	<0.001
Best friend	<0.001	ns
Small group close friends	<0.001	ns
Large group friends	<0.001	ns
On own	ns	ns
Prepared by school SHRE	0.005	ns

ns= not significant

Compared with those who had not had intercourse, those who had engaged in intercourse were older, living away from home, not practising their religion, talking a lot to their fathers about sex, spending free time away from family and feeling badly prepared or not at all prepared by school based SHRE. They were to a lesser extent likely to be distant from their mothers and their fathers.

Compared with those having had sexual experience short of intercourse, those who reported having had intercourse were older; attending or have attended a denominational school; living away from home; talking a lot with their fathers about sex; and spending free time with their boyfriend or girlfriend rather than with family. To

a lesser extent those having sexual intercourse were likely to be only quite close, rather than very close to their mothers.

When compared to those who had not had intercourse, those who had, were mostly likely to name boyfriends/girlfriends ($p<0.001$), their fathers ($p=0.049$) and health professionals ($p<0.001$) as an influential source. Similar findings were noted in relation to those who reported having had intercourse in comparison to those who reported an experience short of intercourse. Those having sex were less likely to name school based SHRE lessons ($p<0.001$) in comparison to the two other groups.

Looking at school based SHRE lessons those who reported having had intercourse when compared to those who had not were more likely to feel that all the topics asked about had been taught too late (all $p<0.005$) and that the topics relating to contraception/abortion, HIV/AIDS and STIs, parenting, and gay/lesbian issues had been taught badly (all $p<0.05$). When comparing those who reported having had intercourse to those who reported a sexual experience short of intercourse, those who reported having had sex were more likely to feel that topics related to contraception, and gay/lesbian issues were taught too late ($p=0.001$ and $p=0.015$) and more likely to think that topics relating to STIs had been taught badly and that gay/lesbian issues had not been taught at all.

7.5.4 Attitudes & sexual experiences

As mentioned previously, two variables were used in the detailed analysis around experience of sexual intercourse. The first discriminated between those who had had intercourse and those who had not and the second discriminated between those who had had intercourse and those who had had sexual experience short of intercourse. With regard to attitudes, a similar pattern emerged in both analyses. In comparison with both other groups, those who had had intercourse were significantly more likely to totally disagree:

- that you should only have sexual intercourse if in a long term relationship (both $p<0.001$)
- that people should be married before they have sex ($p<0.001$ and $p=0.014$ respectively)
- that it is OK to be a virgin (both $p<0.001$)
- that giving young people access to condoms encourages them to have sex (both $p<0.001$)
- that using sex to keep a boyfriend/girlfriend is wrong (both $p<0.001$)
- that prostitution is unacceptable ($p<0.001$ and $p=0.006$ respectively).

Compared with those who had not had intercourse, those who had had intercourse were more likely to fully agree:

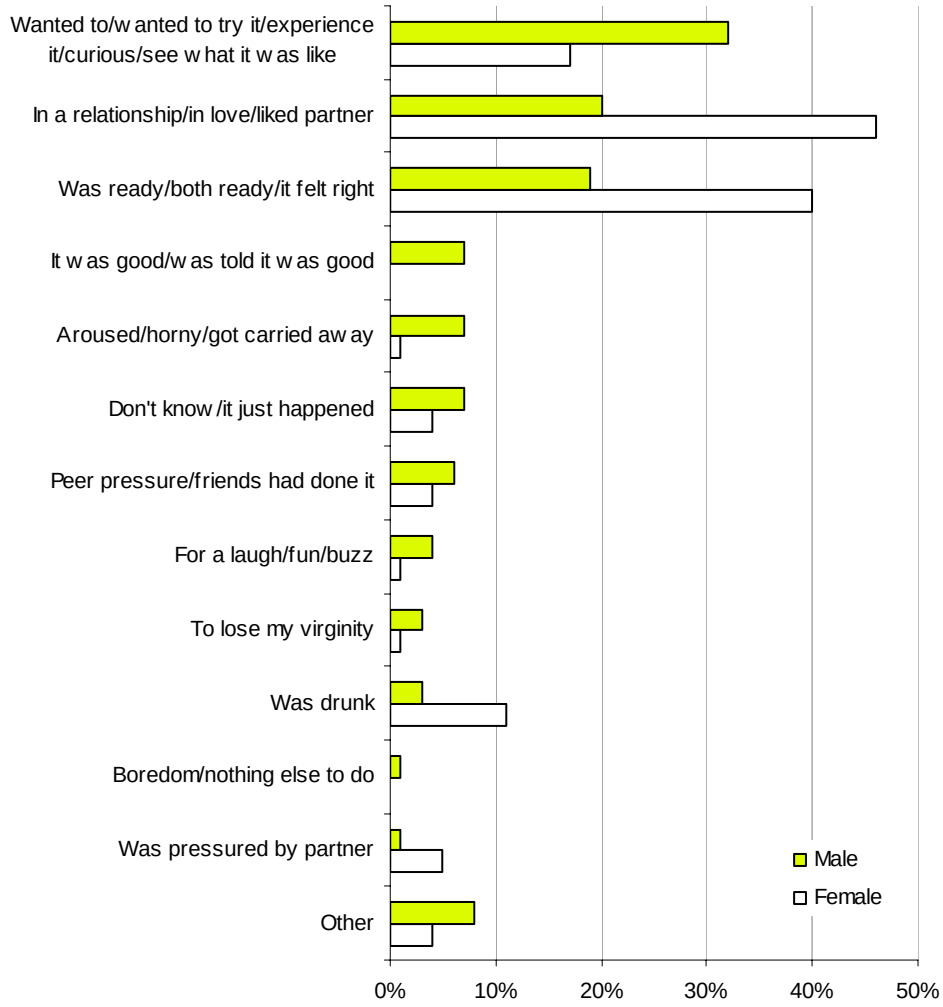
- that it's more acceptable for young men to sleep around than young women ($p=0.003$)
- that abortion should be available ($p<0.001$).

Responses to the latter also varied between those who had had intercourse and those who had had an experience short of intercourse ($p=0.011$), but those who had had intercourse were rather more likely to select fully agree or totally disagree.

7.5.5 Reasons for having intercourse the first time

Young people were asked what their reason was for having intercourse the first time they did so. The top three reasons given were being in a relationship/in love (34%, 239 respondents); being ready for it (30%, 211 respondents) and being curious (23%, 163 respondents). The most distinctive differences in response are by gender, which are shown in the figure below.

Figure 43 What were your reasons for first having sex?



n=700

7.5.6 Reflections on when respondents first had intercourse

The National Survey of Sexual Attitudes and Lifestyles (NATSAL 2000)[3] suggests that 20% of young men and almost 50% of young women wished they had waited longer before becoming sexually active, figures which doubled if the respondents had been younger than 15 years when they first had sex.

In this consultation, respondents who said that they have had sexual intercourse were asked to reflect upon that first experience. Whilst 839 respondents said they had had intercourse, not everyone answered all the reflective questions:

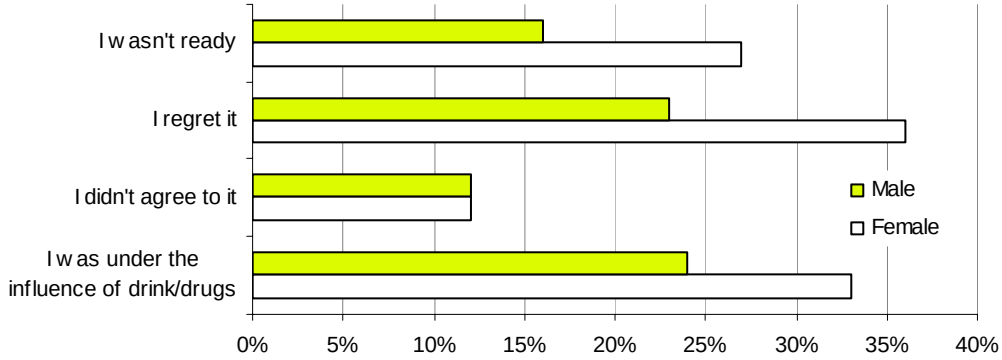
- 562 answered the question about agreeing/not agreeing
- 570 answered the question on being sober/not
- 582 for the question on regret
- 715 answered the question on ready/not ready
- 829 answered the question on pressure

Whilst the majority said that they had felt ready, there was still cause for concern as 23% (162 respondents) stated that they weren't ready and although the majority reported not regretting their first experience, 31% (183 respondents) did. Although 88% (494 respondents) agreed to their first experience of sexual intercourse, 12% (68 respondents) didn't agree to it; and 29% (165 respondents) stated they were under the influence of alcohol or drugs. Although the majority (83%, 691 respondents) felt no

pressure, 9% (72 respondents) felt pressured by their partner and 8% (66 respondents) had exerted pressure on their partner.

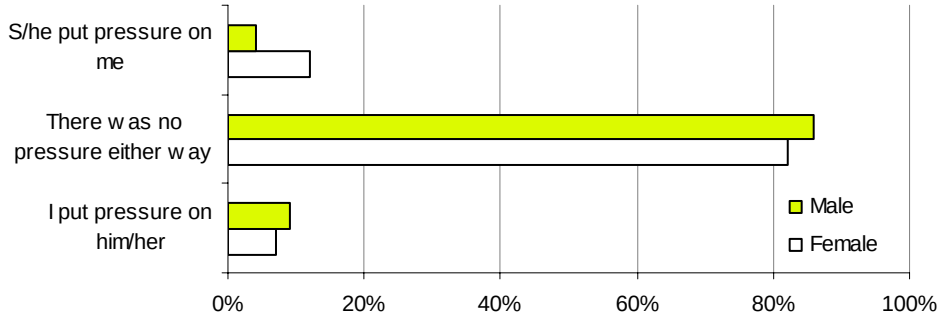
The following figure illustrates the responses according to gender. It is interesting to note there were significant differences by gender in respect of all questions except the one relating to agreement (all of which are discussed in detail in the sections that follow).

Figure 44 Looking back on your first experience of sexual intercourse…?



n=715, 582, 562, & 570 from top to bottom

Figure 45 Which of these best describe your first experience of sexual intercourse?



n=829

Because of the small numbers of young people in some of the religious categories and ethnicities, the analysis that follows relates only to the practice of religion and white vs. all other ethnic groups.

Readiness for first experience of sexual intercourse

Compared to those who said they were ready, those who said they were not ready at their first experience of sexual intercourse were more likely than expected to:

- be female (p=0.001)
- attend or have attended a denominational school (p<0.001)
- not be heterosexual (p=0.003)
- have completed the questionnaire online (p<0.001)
- have lower self-esteem scores (p<0.001)
- feel badly prepared by their SHRE (p <0.001)
- indicate that first sex had happened two or more years ago (p<0.001)

Regret of first experience of sex

Those who regretted their first sexual experience compared to those who did not regret it were more likely than expected to:

- be female (p=0.001)

- have completed the questionnaire online (p<0.001)
- attend or have attended a denominational school (p<0.001)
- practise their religion (p=0.050)
- have lower self esteem (p<0.001)
- feel badly prepared or not prepared at all or didn't get any SHRE (p=0.003)
- indicate that first sex had happened two or more years ago (p<0.001) when compared to those who had experienced sexual intercourse more recently.

Did not agree to first sexual intercourse

Only 68 respondents indicated that they had not agreed, and therefore the results are likely to be unreliable. However those young people who had not agreed to their first experience of sexual intercourse were more likely than expected to:

- attend or have attended a denominational school (p<0.001)
- be from a less deprived area (p=0.045)
- not be heterosexual (p<0.001)
- have completed the questionnaire online (p<0.001)
- not be living with their parents (p=0.012)
- feel badly prepared by their SHRE or didn't receive any (p<0.001)
- indicate that first sex had happened two or more years ago (p<0.001) when compared to those who had experienced sexual intercourse more recently.

Sober/not during first experience of sexual intercourse

In comparison to those who were sober those who were not sober during their first experience of sexual intercourse were more likely than expected to:

- be female in comparison to male (p=0.026)
- be younger at first intercourse (p<0.001)
- have lower self esteem (p=0.033)
- be distant from their mother/female carer (p=0.011)
- have completed the questionnaire on paper (p<0.001)

7.5.7 Sexual competence at first intercourse

NATSAL reports on a measure called sexual competence such that a person is taken to be sexually competent for a particular sexual encounter when both parties are equally willing to participate, the individual is not under the influence of drink or drugs, protection is used, and there are no feelings of regret.

Where the full data existed to enable sexual competence at first sex to be calculated, 46% (229 respondents) could be classified as sexually competent with 54% (266 respondents) not competent. However, it should be noted that 40% (344 respondents) of those who had had sexual intercourse did not complete all the items necessary to assess sexual competence. This group of respondents were significantly younger than other respondents at the time of data completion, and at the age of first sexual intercourse. Fifty-two percent were male. The fact that these respondents were not represented in the following analysis must be taken into account when interpreting the following findings.

Analysis found that sexual competence varied significantly according to mode of questionnaire completion (p<0.001), sexual orientation (p=0.001), disability (p=0.034), self-esteem scores (p<0.001) age at first intercourse, and perceived control over life (p=0.038) and health (p=0.006). The directions of these relationships are outlined below.

- those who were sexually competent tended to be older at age of first intercourse compared to those who were not competent.
- respondents coded as heterosexual were also almost twice as likely to be sexually competent in comparison to respondents coded as non-heterosexual (50% versus 28%)
- those who completed the questionnaire online were less likely to be classed as sexually competent than those who completed the questionnaire on paper
- young people with a stated disability were less likely to be sexually competent while those with no disability were more likely to be competent
- young people who were sexually competent had higher self-esteem scores than those who were not competent.
- those who were sexually competent tended to perceive greater control over life and health.

There were no significant differences in sexual competence by gender, current age, practice of religion, ethnicity, living arrangements, and closeness to parents or on talking to parents about sex.

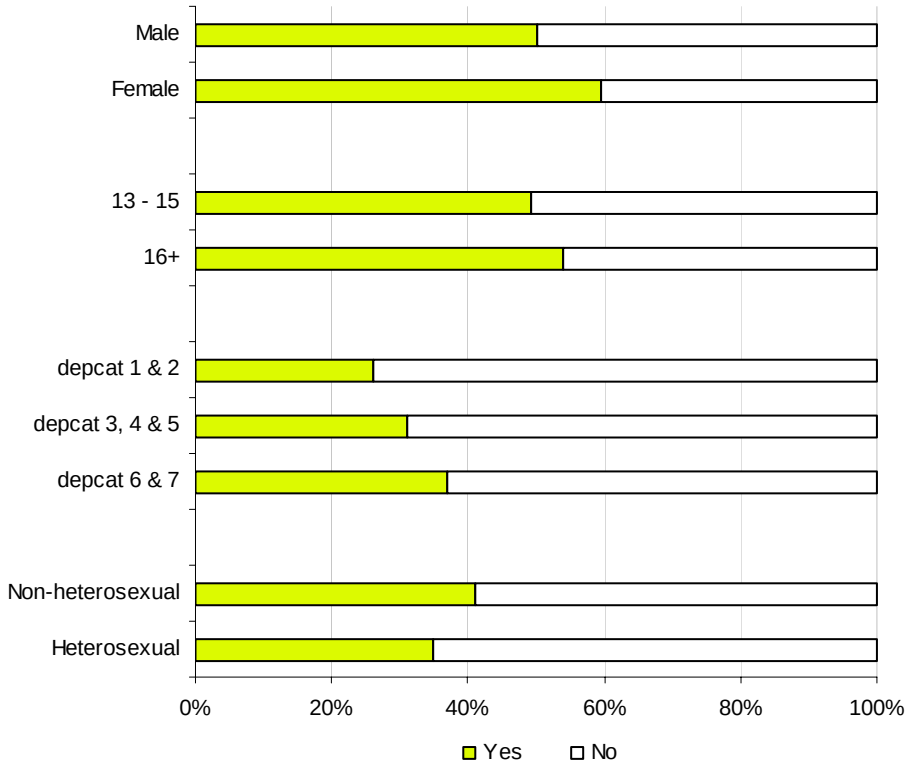
7.6 Respondents' relationship status

7.6.1 Current relationship status

All young people, irrespective of their sexual experience, were asked if they were in a relationship at the time of completing the questionnaire: 35% (889 respondents) stated that they were. There were significant differences in terms of gender ($p<0.001$), age ($p<0.001$), and depcat ($p=0.008$), but none in terms of school type, or sexual orientation.

Females were more likely than males to say they were in a relationship, and respondents aged 16 years plus were more likely than younger respondents (13 to 15 years) to be in a relationship. In terms of depcat, the trend was for the likelihood of the respondent saying they were in a relationship to increase with their level of deprivation.

Figure 46 Are you currently in a relationship?



n=2,525

Respondents' relationship status also varied by ethnicity: White young people were more likely to be in a relationship than all the other ethnic groupings and Asian young people the least likely ($p<0.001$). Muslims were the religious group least likely to report being in a relationship ($p<0.001$).

Relationship status did not vary with living arrangements, disability, age at first full sexual intercourse, or self-esteem score.

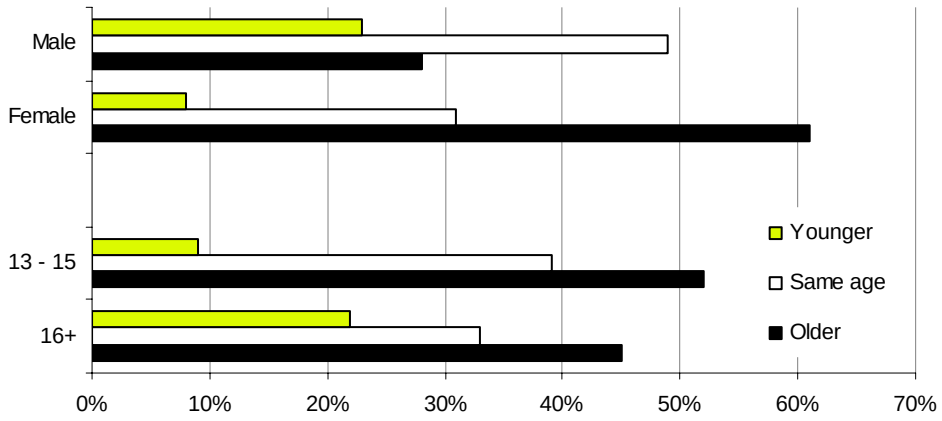
7.6.2 Age of boyfriend/girlfriend

Respondents who stated that they were in a relationship were asked the age of their boyfriend or girlfriend. For the purposes of this analysis, the age of respondents' partners has been recoded as younger, same age and older.

There were significant differences in terms of gender ($p<0.001$) and age ($p<0.001$).

The chart below shows the directions of the differences in terms of gender and age of respondent. Males were more likely than females to have boyfriends/girlfriends who were younger than they were and females more likely than males to have partners who were older than they were. Respondents who were over 16 years of age were more likely than those in the 13 to 15 year age bracket to have a partner who was younger than they were.

Figure 47 What age is your girlfriend or boyfriend?



n=842

The age of a respondent's boyfriend/girlfriend/partner in comparison to their own age (i.e. younger, same age or older) did not vary according to practice of religion, religion, ethnicity, living arrangements or disability, but it did vary according to the respondent's age at first sexual intercourse: those with an older boyfriend/girlfriend/partner being those who tended to be younger at first sex and those who had a younger boyfriend/girlfriend/partner tended to be older at first intercourse (p=0.014).

In terms of self-esteem, respondents with an older boyfriend/girlfriend/partner had the lowest self-esteem scores while those with a same age or younger boyfriend/girlfriend/partner had higher (and almost identical) mean self-esteem scores (p=0.002).

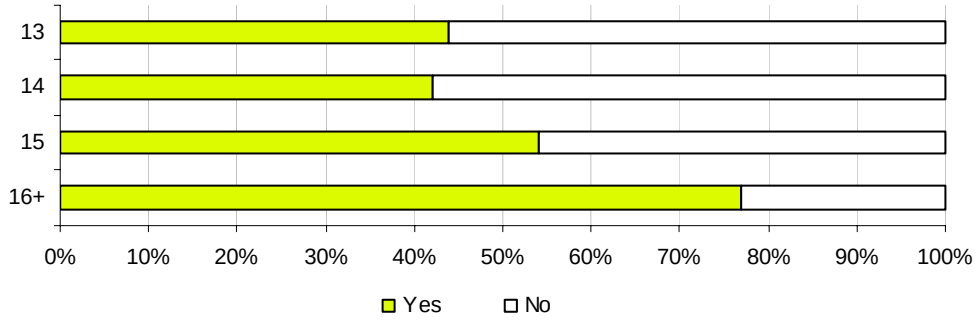
7.6.3 Sexual status of relationship

Young people who had a boyfriend or girlfriend were asked if their current relationship was a sexual one, which was defined as involving any type of sexual activity.

Overall, 59% (515 respondents) of those in relationships said it was a sexual one.

There were significant differences in terms of age (p<0.001), with those in the older age bracket (16 years and older) more likely than younger respondents to be having a sexual relationship.

Figure 48 Sexual status of relationship according to age



n=876

There was no relationship between this variable and practice of religion; however it did vary by religion. Young people (in a relationship) belonging to the Church of Scotland and Catholic Church were more likely to be in a sexual relationship, while Muslims, young people of other religions and those with no religion were less likely to be in a sexual relationship (p=0.014).

White young people were more likely to be in a sexual relationship and those from minority ethnic backgrounds less so (p=0.004).

Young people who lived with their parents were less likely to be in a sexual relationship, while those who lived with other relatives or had other living arrangements were more likely to be having a sexual relationship (p=0.008).

The sexual status of relationships did not vary according to closeness to the mother/female carer but did according to closeness to the father/male carer (p=0.028), with those who were close or very close being more likely to be in a sexual relationship than those who were quite close or distant.

There were significant differences in the status of young people's relationships in overall terms with respect to the most influential sources of information that they cited (p<0.001). Young people who cited the following as most influential sources were more likely to be in a sexual relationship:

- other health professional
- boyfriend/girlfriend/partner

while those who were in relationships that were not sexual were more likely to cite:

- mother/female carer
- school PSE lessons
- school nurse.

7.6.5 Sexual activity outside of relationships

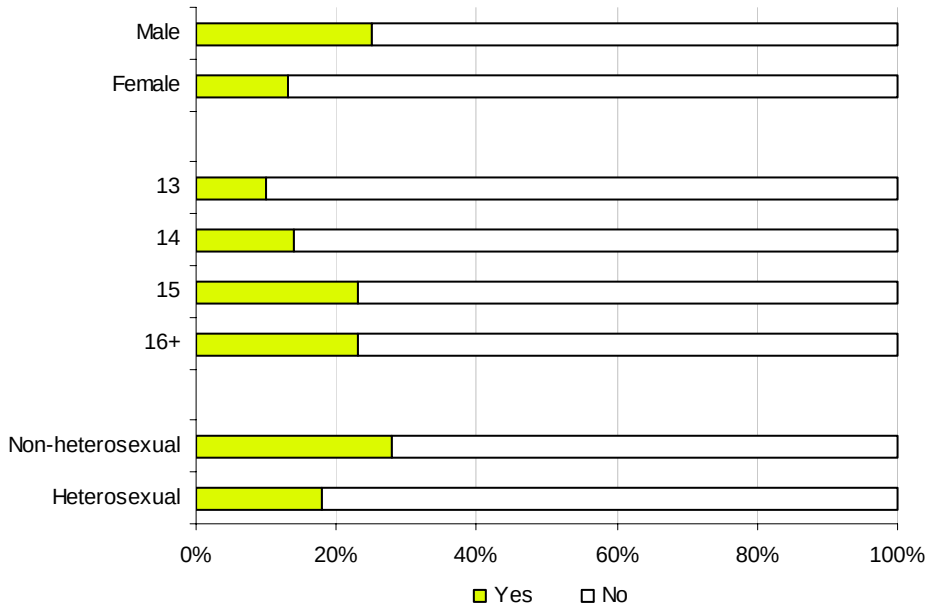
Respondents who were not in a relationship were asked if they were sexually active at the time of the study: 19% (280 respondents) said that they were. Those who were sexually active outwith a relationship were more likely to:

- be male as opposed to female (25%, 183 respondents versus 13%, 93 respondents, p<0.001)

- be older. Respondents aged 16+ were more likely than those aged 13 to 15 (23%, 103 respondents versus 17%, 174 respondents, p=0.009)

- have been coded as non-heterosexual. Non-heterosexuals were more likely than those coded as heterosexual to be sexually active at the time of the study (28%, 42 respondents versus 18%, 220 respondents, p=0.01).

Figure 49 Are you currently sexually active (not in a relationship)?



n=1,454

7.7 Contraception/protection

Those young people who reported having had intercourse were asked a series of questions regarding their use of contraception/protection: at the time of first intercourse, within sexual relationships, and for those who were sexually active outwith relationships. For the analysis the choices of contraception were grouped and categorised as follows: condoms; pill/jab/implants; withdrawing/ natural methods/others

Contraception/protection & first intercourse

Three-quarters (621 respondents) of the young people who had experience of sexual intercourse said that they had used contraception/protection on their first occasion, the majority of whom (94%) had used condoms. Although condoms were the preferred method for both younger and older respondents, those who were older were more likely than younger respondents to report hormonal contraception use which was categorised as pill/implants/jab. Those who were younger were more likely to have said that they had used withdrawal/natural family planning etc. Those from denominational schools were less likely than those from non-denominational schools to use condoms and more likely to use hormonal methods e.g. pill/jab/implants.

The main reasons given by those who did not use contraception/protection on their first occasion was not having any (39%, 74 respondents), followed by being drunk (15%, 28 respondents) and being spontaneous (14%, 27 respondents)

In comparison to those who did use contraception, those who did not use contraception/protection at first intercourse:

- had lower self-esteem scores
- had less perceived control over their life and also their health
- were more likely to have stated that they had a disability compared to those who did not
- were more likely to have cited, magazines, and friends as their influential sources about sexual health and relationships
- less likely to have cited father/male carer as influential source

Contraception/protection within sexual relationships & outwith relationships

Those young people who had stated that they were currently in a relationship that was sexual (sex or other sexual experiences) were asked questions in relation to their use of contraception/protection within that relationship.

Overall around 80% (402 respondents) said that they were using contraception; however 1 in 5 of those young people in a sexual relationship were not using contraception/protection. Those who were using were most likely to report that they were doing so was to avoid pregnancy (44% 156 respondents) with a smaller proportion saying to avoid STIs/STDs. Twelve percent (42 respondents) of those who were not using contraception/protection said that this was because they were not having penetrative sex: however as they indicated they were in a sexual relationship they may have been having oral sex where protection is also important to prevent the transmission of STIs.

Those who were mostly likely to be using contraception in their current relationship were:

- those who were older at age of first intercourse
- more likely to be classed as heterosexual compared to non-heterosexual
- more likely to cite their boyfriend/girlfriend/partner as an influential source information

Although it did not reach statistical significance ($p = 0.054$) there was a trend for those using contraception within relationships to have slightly higher self-esteem scores than those not using contraception within relationships.

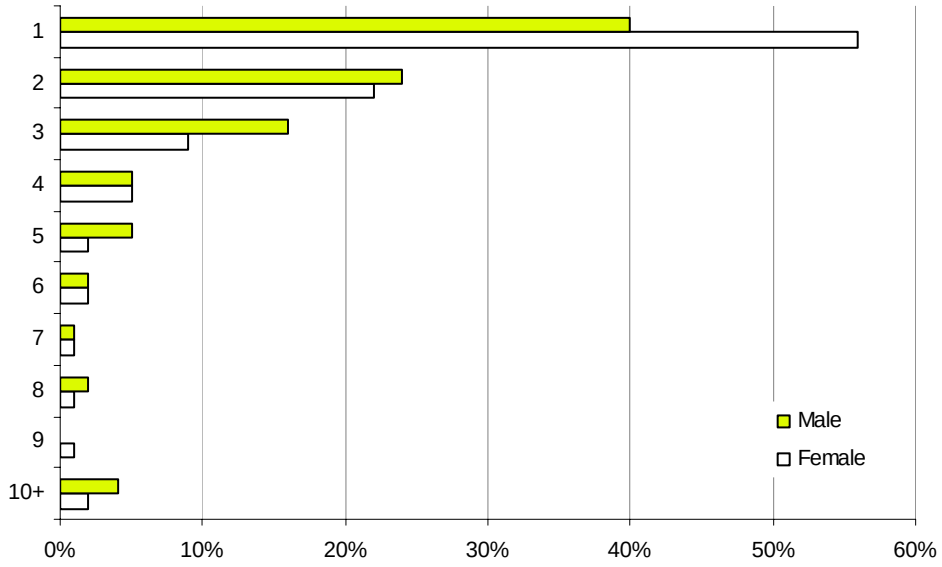
Condoms were the preferred method of contraception/protection for those young people having intercourse within a relationship and outwith. Although favoured by both those under 16 and those over 16, those who were older were less likely than those who were younger to cite condom use and more likely to cite hormonal contraception such as the pill. Nine percent (52 respondents) of those having sex within or outwith a relationship said they favoured withdrawing/natural family planning.

7.5.7 Number of sexual partners in last year

As well as having sex at an earlier age than in the past, the literature shows that young people (aged up to 24 years) also have a high turnover of sexual partners and are more likely to be involved in more than one sexual relationship at a time.

Young people who had had intercourse were asked about the number of partners that they had had in the year preceding the consultation. The most common response was one, for both males (40%, 125 respondents) and females (56%, 229 respondents). However there were numbers of young people who reporting having had multiple partners in the last year. The figure below shows the number of sexual partners in the past year according to gender. In the analyses that follow, the number of sexual partners has been recoded into three categories: 1; 2 to 4; and 5 or more.

Figure 50 How many sexual partners have you had in the past year?



n=732

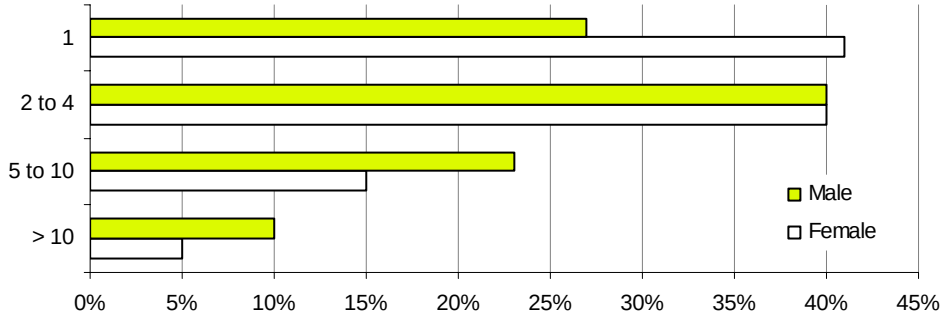
Forty-nine percent of those who answered this question (358 respondents) indicated that they had had one sexual partner in the preceding year; 22% (165 respondents) had had two sexual partners; and 29% (209 respondents) had had three or more sexual partners in the preceding year. Numbers ranged from 1 to 20, although only three respondents in total indicated that they had had more than 14 partners in the preceding year.

7.5.9 Number of sexual partners in lifetime

Young people were also asked about the number of sexual partners they had ever had. There were significant differences in terms of gender ($p<0.001$), school type ($p=0.006$), and sexual orientation ($p < 0.001$). There were no significant differences in terms of age or depcat.

Males were more likely to report greater numbers of sexual partners than females which supports findings from NATSAL 2000; respondents who attended denominational schools were more likely to report greater numbers than non-denominational school respondents, and respondents coded as non-heterosexual were more likely to report greater numbers of sexual partners than respondents coded as heterosexual. However, it should be noted that the analysis was based only on those who were sexually active, and the numbers attending denominational schools and the numbers who were non-heterosexual were very small. The analysis may therefore be unreliable.

Figure 51 How many sexual partners have you ever had?



n=725

The mean number of sexual partners in the respondents' lifetime was 3.3 for females and 5.1 for males. Once again there was a significant difference between the two groups ($p<0.001$).

Of the 725 respondents answering this question, 35% (252 respondents) indicated that they had only ever had one sexual partner. A further 19% (136 respondents) indicated that they had had two sexual partners, 14% (101 respondents) that they had had three, and 8% (56 respondents) that they had had four. The remaining 25% of those who answered this question (180 respondents) gave numbers ranging from five to 36.

7.8 Chapter Summary

Over half of the sample 56% (1,341 respondents) said they had experience of sexual intercourse or other sexual activities of whom: 96% (1,274 respondents) had engaged in heavy petting; 71% (1089 respondents) had experience of oral sex and 62% (839 respondents) said they had experience of sexual intercourse. Research has shown that the age at which young people are engaging in sexual activity is decreasing and the findings from this consultation would certainly support this with the average age at which most young people were engaging in some level of sexual activity being approximately 14 years of age. Fifty-two percent (439 respondents) of those who reported having experience of intercourse were 13-15 years of age.

Those who were not engaged in sexual activity were most likely to cite the following as reasons for not having done so:

- too young
- not ready yet
- not yet found the right person

Of those who had experience of sexual intercourse the top three reasons given for having sex the first time were:

- being in a relationship/in love
- being ready for it
- being curious

The research steering group was keen to look at the relationship between parents and young people's behaviours in addition to self-esteem and other outcomes examined in previous sections. The reason for this is that the role of connectedness to parents in reducing young people's risk taking behaviour is highlighted in a variety of research studies and there is evidence to suggest that parents and families are crucial in shaping the factors which influence sexual conduct. According to Ingham (2002), having emotionally available parents is important in shaping young peoples' attitudes to sexual relationships which is linked to delayed first intercourse and higher levels of discussion about and subsequent use of contraception. In this study there was evidence to support a relationship between closeness to parents and sexual activity. Those who were less close to one or both parents were more likely to have engaged in some type of sexual activity, as were those who spent less of their free time with their parents/carers and more time with boyfriends/girlfriends. Additionally when looking at reflections of first experiences, in relation to readiness and regret, those who were distant to one or other parent/carer were often more likely to have regretted their first experience or said that they were not ready. These findings would therefore suggest that there may be a positive relationship between connectedness to parents and young people's sexual health.

In terms of other information sources and the relationship between them and sexual behaviour: those who were less likely to cite school based SHRE and more likely to cite boyfriend/girlfriends as an influential source of information were more likely to have experience of sexual intercourse or other sexual activities. However although those who cited it as an influential source were less likely to have sexual experience, those who felt badly prepared by SHRE and felt that certain topics had been taught

badly were more likely than those who had rated their SHRE more positively to be involved in sexual activity.

Of those who had had some type of sexual experience most were relatively positive about this. However for a minority, reflections on their first experience were negative. There appeared to be some key factors which influenced whether or not young people who had experience were likely to perceive their first experiences positively or negatively. Whilst there were key influencers for each individual activity, generally the following applied to one or more of the activities in questions:

- Gender: females were generally more likely to reflect negatively than males
- Self-esteem: those who reflected negatively tended to have lower self-esteem scores than those who were more positive about their experience
- Age at first experience: those who were younger when the experience occurred were more likely to be negative about their reflection than those who were older when they first engaged in a particular activity
- Control: those who felt more negatively had less perceived control over their life and health than those who were more positive in their reflection.
- Closeness to one or other parent: those who were distant were more likely to reflect negatively on their first experiences.

Fifty-nine percent of young people (515 respondents) who said they were in a relationship said that it was a sexual one i.e. that it involved some sexual activity. Most of these respondents were in the older age bracket (over 16). A small number of young people (280 respondents) said that they were sexually active at the time of the study outwith a relationship.

In terms of the findings from this consultation in relation to contraception/protection use although most young people reported using contraception/protection on first intercourse a quarter of young people did not. Condoms were generally the preferred method of contraception/protection at first intercourse with 96% of those who said they used protection indicating that they had used condoms. Within relationships 1 in 5 young people were not using contraception/protection. Although some said this was because they did not need to because they were not having intercourse, a number of those who were having intercourse were not protected. Of those within relationships who were using contraception/protection, most again were using condoms. Although condoms were used by both age groups i.e. those over 16 and those under 16, the older age bracket were much more likely to report using hormonal contraception. Similar to the findings in The NATSAL Study, young people in this consultation were much more likely to cite protection against pregnancy as the main reason for using contraception/protection and to a much lesser extent Sexually Transmitted Infections (STIs) which could highlight a lack of awareness amongst young people about sexually transmitted infections and the risk of transmission and their vulnerability to infection.

8 Skills for dealing with sexual health & relationships

In this section, young people were asked about the extent to which they agreed with five statements concerning their empowerment around sexual health and relationships. There were gender differences in four of the five cases, with males appearing less skilled in dealing with sexual health and relationships.

This section presents an overview of the responses to each of the five separate items, followed by a detailed analysis of a sexual health skills (using a measure combining the five elements).

8.1 Overview of individual sexual health skill elements

Table 8 Extent to which young people agree with each sexual health skill element

Skill	Fully Agree	Agree	Disagree	Totally Disagree
I find it easy to say no to having sex	43% 898 respondents	38% 796 respondents	12% 256 respondents	7% 150 respondents
I find it easy to ask for help regarding sexual health issues	22% 517 respondents	42% 998 respondents	27% 649 respondents	9% 208 respondents
I find it easy to access information on sexual health	33% 790 respondents	48% 1168 respondents	15% 357 respondents	4% 97 respondents
I find it easy to understand information about sexually transmitted infections	45% 1097 respondents	46% 1116 respondents	8% 188 respondents	2% 41 respondents
I find it easy to ask for what I want in relationships	35% 788 respondents	46% 1026 respondents	16% 356 respondents	4% 82 respondents

For all of the skills other than the one relating to understanding information about sexually transmitted infections there were age differences with those who were older more likely to be able to say no to sex; ask for help regarding sexual health issues; access information on sexual health and ask for what they want in relationships.

Gender was influential in all but the skill relating to accessing information on sexual health, with young women being more likely than young men to be able to: say no to sex, ask for help regarding sexual health issues; understand information about STIs and ask for what they want out of relationships.

Sexual orientation was influential in relation to accessing information on sexual health and in asking for what they want out of relationships but in different directions. Those who were non-heterosexual were more likely to be able to access information on sexual health but less likely to be able to ask for what they want out of relationships.

8.2 Detailed analysis of combined sexual health skill measure

8.2.1 Method & rationale

The five items relating to skills for dealing with sexual health and relationships were scored such that a higher score indicated greater agreement and therefore greater skill. The internal consistency of these five items (Cronbach alpha) was 0.72, suggesting that it was appropriate to combine these items into a single scale. This was achieved by taking a mean of at least four of the five contributing items (i.e. by allowing up to one missing response). The mean was 3.10 (SD=0.57, n=2243), with scores ranging between 1 and 4.

8.2.2 Sexual health skills & demographics

Significant differences were found in relation to gender ($p<0.001$), age ($p<0.001$), religious group ($p=0.002$) and ethnicity ($p < 0.001$) as follows:

- females had higher sexual health skill scores than males
- those in the older age group had higher scores than those in the younger group
- Muslim respondents had significantly lower scores than those from the Church of Scotland and Catholic groups, and those of no religion
- respondents from minority ethnic communities had lower sexual health skill scores than white respondents

8.2.3 Sexual health skills, control & self-esteem scores

Those with higher sexual health skill scores were likely to feel that they had a lot of control over the way their life was going, over their health, and to have higher self-esteem scores (all $p<0.001$).

8.2.4 Sexual health skills & information sources

A number of relationships were found between sexual health skills and influential sources of information about sex. Those with higher sexual health skills scores were more likely to name their mother as an influential source ($p<0.001$), less likely to name the internet ($p=0.001$), TV/radio ($p=0.002$), magazines ($p=0.004$), school (other than PSE) ($p=0.010$), or faith group ($p=0.015$). They were also slightly more likely to name leaflets or books ($p=0.041$), and to name other family members ($p=0.050$).

Those who spent their free time with family members had significantly lower sexual health skill scores than those who spent free time with their boyfriends or girlfriends ($p<0.001$).

In terms of the relationship between sexual health skills and parents/carers, those who had higher sexual health skill scores had one or both parents/carers who talked to them a lot about sexual health and relationships, and were in situations where both they and the parent/carer were very comfortable talking about sex (most $p<0.001$, all $p<0.005$). With regard to initiation of conversations about sex, those with higher sexual health skills scores were more likely to say that they had asked something directly, or that parents had started the discussion, or parents had asked what respondents wanted to know (all $p<0.001$). Those who said that parents had not talked to them had significantly lower sexual health skills scores, as did those who said that they would not like to talk to parents more about sex or relationships (both $p<0.001$).

As might be expected, those with higher sexual health skills scores were more likely:

- to indicate that school SHRE had prepared them very well or ok
- to report that each grouped topic ((a) feelings and emotions; body parts; how babies are made; (b) puberty; menstruation; (c) boyfriends or girlfriends; long

term relationships; rules in relationships; (d) avoiding pregnancy; emergency contraception; abortion; (e) HIV and AIDS; STIs; (f) parenting; and (g) lesbian and gay issues) had been taught very well or okay.

Those who thought they had been taught too late or not at all in these topics (except lesbian and gay issues) had lower sexual health skill scores (all but HIV/STIs, $p<0.001$; HIV/STIs $p=0.031$)

8.2.5 Sexual health skills and attitudes

With regard to attitudes, those with higher sexual health skills were significantly more likely to fully agree:

- that you should only have sexual intercourse if in a long term relationship ($p<0.001$)
- that it is OK to be a virgin ($p<0.001$)
- that it is OK for gay and lesbian people to raise children ($p<0.001$)
- that using sex to keep a boyfriend/girlfriend is wrong ($p<0.001$)
- that prostitution is unacceptable ($p<0.001$)

They were more likely to mostly or totally disagree:

- that people should be married before they have sex ($p=0.012$)
- that it is more acceptable for young men to sleep around than for young women ($p<0.001$)
- that it is the young woman's responsibility to use contraception/protection ($p<0.001$)
- that giving young people access to condoms encourages sex ($p<0.001$)

8.2.6 Sexual health skills and behaviours

Those with higher sexual health skills were more likely than those with lower sexual health skills to have sexual experience and to have had sexual intercourse ($p<0.001$). As said previously this may in part be because these skills develop as a consequence of relationship experience. Those with higher sexual health skills were, however, significantly more likely to use contraception on first intercourse than those with lower sexual health skills. There was also a correlation between those with higher sexual health skills and age of first intercourse such that with increasing skill, age of first intercourse also increased.

Many of the factors that appeared to predict sexual health skills were in themselves related. In order to clarify the relationships, a multiple regression analysis was conducted. The following variables were included as predictors: current age, gender, self-esteem, religious group, ethnicity, closeness to the mother, closeness to the father, dialogue with the mother and dialogue with the father, with whom free time is spent, whether or not the mother is cited as an influential source of information, and whether or not sexual intercourse had taken place. In summary, the results indicated that those who had had more dialogue with their mother and, to a lesser extent, with their father, had higher sexual health scores, irrespective of all other factors.

8.3 Chapter Summary

In summary, a correlation was found between skill score and age of first intercourse, with those with higher skills being older at the time of first intercourse and those with lower skills being younger at first intercourse. The results also indicate that those who had had more dialogue with their mother and, to a lesser extent, with their father, had higher sexual health scores, irrespective of all other factors.

Those with higher sexual health skills were more likely to have had sexual experience or full sexual intercourse than those with lower sexual health skills. While there is no

way to know the direction of this relationship, it may be that these skills develop as a consequence of relationship experience rather than sexual experience being a consequence of higher skills in relation to sexual health. Regardless of the direction of the relationship, those with higher sexual health skills were more likely to make safer choices in relation to intercourse when it occurred, with those with higher skill scores significantly more likely to use contraception at the time of first intercourse than those with lower skill scores.

Those with higher sexual health skills were more likely to:

- cite their mother/female carer as an influential source of information about sexual health and relationships
- to cite that school based SHRE had prepared them well or okay and that each of the grouped topics had been taught very well or okay
- feel a lot of control over the way their life was going, their health and have higher self-esteem
- be female as opposed to male
- be in the older age bracket (over 16)

Those with higher sexual health skills were more likely than those with lower sexual health skills to agree that it was okay to be a virgin and that you should only have sex within a long-term relationship.

9 Conclusions

This consultation has produced an enormous amount of data on young people's perceptions and behaviour around sexual health and relationships in Glasgow, and the relationships among the factors is often complex. This section pulls together the key conclusions which can be drawn.

It should be borne in mind throughout that this was a consultation rather than a representatively sampled piece of research. Although the consultation was designed to reach as large a cross-section of young people as possible, some groups of young people were particularly under represented in this study. Further work may be needed with specific groups of young people (in particular those from ethnic minority communities, disabled young people and those from denominational schools) in order to understand what the important issues are for them in relation to sexual health and relationships.

Over half of the young people (56%, 1,424 respondents) who responded to the survey had involvement in some form of sexual activity of whom 59% (840 respondents) were between 13 and 15 years of age. One third of all those who answered the question (31%, 839 respondents) reported that they had experienced full sexual intercourse, of whom 52% (439 respondents) were 13-15 years of age. Those who were older at first intercourse were more likely to use contraception and be sexually competent at first intercourse (although 40% of young people not complete enough data to get sexual competence score) compared to those who were younger at first experience and were more likely than those who were younger at their first experience to reflect more positively.

A quarter of those who had experience of sexual intercourse did not use protection/contraception on first intercourse. Those using contraception/protection were most likely to cite 'to avoid pregnancy' as a reason for doing so and to a far lesser extent to protect against sexually transmitted infections (STIs) suggesting a need to raise awareness about the risk of STIs and how to protect against them.

Thirty-six percent of female respondents and 23% of males said that they regretted their first experience of sex. The figure for females is lower than the 2000 National Survey of Sexual Attitudes and Lifestyles (50%), while the figure for males is slightly higher than the National Survey figure of 20%. Thirty-percent of those who had sexual intercourse said that on their first occasion they were under the influence of alcohol or drugs, which was significantly more likely for females than males. As noted above females were generally more likely than males to reflect negatively on their first sexual experiences and more likely to report having experienced pressure. Throughout the report gender differences were apparent which would suggest the need for examining gender and gender specific approaches to work with young people around sexual health and relationships issues.

Young people received information about sexual health and relationships from a wide range of sources, however parents/carers, particularly mothers/female carers in addition to school based SHRE and friends were amongst the most commonly cited influential sources. Although parents were identified as an influential source, almost half of young people wanted more dialogue with parents/carers on sexual health and relationships and a number of young people reported that they had had hardly any or no dialogue with one or either parent/carer. Around 30% of the young men who answered both questions in relation to dialogue with mothers/female carers and with fathers/male cares reported that neither parent had talked to them or hardly talked to them about sexual health and relationships and young men were much more likely to report this than young women. In addition while school based SHRE was influential for

young men, young men were more likely than young women to report that they had received no teaching in relation to a number of topics asked about.

Sources of information on sexual health and relationships appeared to be important in relation to some of the outcomes for young people e.g. those who cited their father/male carer were more likely to perceive more control over their life and have higher self-esteem, whilst those who cited their mother were more likely to report having more control over their health and their life. The majority of young people reported positively on the school based SHRE they had received. They stated that the timings had been about right and that most of the topics had been taught well or okay. However, those who were badly prepared or not at all prepared by their SHRE were more likely to report little or no control over their life and to a lesser extent their health, and to have lower self-esteem. In addition those who were more likely to have experience of sexual intercourse and sexual activity were more likely to have perceived that their school based SHRE had not prepared them well, that topics had been taught badly or too late and were less likely to name it as an influential source.

The current consultation shows that young people who cite their friends as one of their most influential sources of information were also more likely to have engaged in sexual activity than those who did not. Research conducted elsewhere has also suggested peers as an important conduit for information. However it is recognised that the information through this channel can be inaccurate, and may reinforce peer pressures to engage in sexual activity. Additionally, young people who reported spending most of their free time with boyfriends/girlfriends as opposed to family were also more likely to have engaged in sexual intercourse or sexual activity.

Closeness to one or both parents was related to sexual experience, with those who were less likely to say they were very close to one or either parent/carer more likely to have experience. Those who were closer to their parents were more likely to have talked to them about sexual health and relationships and to feel comfortable in doing so but being close or distant in itself did not predict the likelihood of conversations about sexual health and relationships having taken place. Those who were closer to one or either parent were likely to have higher self-esteem, feel happier with their appearance and perceive themselves to have more control.

There is strong evidence from the present consultation of relationships between self-esteem and perceptions of control, and young people's sexual attitudes and behaviours, in particular that lower self-esteem and feelings of less control are related to sexual experiences, outcomes and behaviours that may be regarded as negative. One means therefore of improving the sexual behaviour and sexual health of young people would be to address issues of self-esteem, through, for example, confidence and assertiveness building, and to look at ways of empowering young people to take more control over the way their lives are progressing and their health. Given that females were significantly more likely than males to report lower self-esteem and that there were specific factors which played more significant roles in determining self-esteem in both males and females, a gendered approach, or consideration to gender (sex) differences, is warranted.

Differences and inequalities between the sexes were not just noted in relation to self-esteem; throughout this report significant inequalities and differences emerged between males and females. There were also significant inequalities and differences emerging in relation to school type and for those groups known to face greater inequalities in relation to sexual health for example non-heterosexual young people and those living away from home.

10 Recommendations

The key findings of the study and conclusions which have been drawn highlight a number of recommendations which we offer for consideration.

1. Almost half of young people who participated in the consultation said that they would like to have more dialogue with their parents/carers about sexual health and relationships. There is evidence from this consultation to suggest that dialogue with parents, closeness to parents and spending time with parents can affect attitudes, behaviours and outcomes around sexual health. This presents an opportunity for the YPSHSG to look at innovative ways of encouraging positive communication between parents and children, with Education, Youth Services and Community Health Care Partnerships likely to be able to play key roles in this. There is evidence of successful programmes to promote parent/child dialogue and connectedness around sexual health and relationships both in the UK and the US, and of programmes using parents as peer-educators to encourage other parents to engage more with their children around these and other matters. Given the low numbers of fathers/male carers speaking to their young people about sexual health and relationships, and the lower numbers of parents/carers talking to their young males, a specific emphasis to encourage fathers/male carers and parents of young males to engage in such programmes may be justified.

2. Those who felt badly prepared by their SHRE had lower self-esteem, perceived less control over their life and health and were more likely to report having experience of sexual activity. The message from young people is that there are variations emerging in relation to school type: those from denominational schools were more likely to say they perceived their SHRE much more negatively than those from non-denominational schools and were less likely to report that it had prepared them well to deal with sexual health and relationship issues. In some cases, despite being of an appropriate stage of schooling, young people reported that a variety of topics were never taught at all and other key issues being perceived to be covered too late. The YPSHSG should look at ways of ensuring consistency of approach, timing and quality across all schools in Glasgow, and in particular to address the apparent disparity between denominational and non-denominational schools. Although the vast majority (84%) of respondents said that SHRE had been delivered by a PSE teacher, there is a need to ensure that SHRE is consistently delivered by people who are trained for the role, in line with the National Strategy and Action Plan for Improving Sexual Health. The attitudinal differences revealed by this consultation (primarily by gender and religion) should also inform future educational work in this area.

3. A number of young people, particularly young women and those who were younger at their first experience, reflected negatively on their first sexual experiences. Although young women were generally more skilled than young men, programmes around sexual health should focus on skill based activities such as negotiating relationships; saying no to unwanted sexual behaviour and how and where to ask for help in relation to sexual health and relationships for both sex's with a specific emphasis on young males. With almost one third of respondents in this study reporting that they were under the influence of alcohol/drug, education around the effects and dangers of drug and alcohol misuse, in addition to what is already ongoing in Glasgow, needs to be to wholly integrated into existing work on sexual health and behaviour.

4. Low self-esteem was an issue for a small percentage (6%) of young people who participated in the consultation, more so young women than young men. While there are conflicting views on the relationship between low self-esteem and early sexual behaviour, self esteem in this study was related to perceived control; satisfaction with appearance; less negative reflections in relation to first sexual experiences; sexual competence at first intercourse (bearing in mind 40% young people did not get sexual competence score) and contraception/protection use at first intercourse. The idea of fostering self-esteem is a positive one and the YPSHSG should look at ways of integrating its work with other initiatives that seek to raise the confidence and aspirations of young people. Self-esteem programmes and programmes around sexual health and relationships should consider the gender (sex) specific approaches and the differences between males and females.

5. There were relationships found in this study between information sources and a variety of outcomes for young people. Friends were an influential source of information for young people on sexual health and relationships, as were magazines and the internet. Young people who cited friends as an influential source of information were more likely to have had sex or sexual experiences as were those who cited their boyfriend/girlfriend or partner. While other research has highlighted the potential of using peer groups to disseminate information, it also raises concerns about the messages and their accuracy. The YPSHSG should look at the type of information passing through peer networks and other popular mediums, and at ways these mechanism can be used to promote positive and accurate messages. The clear message is that SHRE provided by statutory services, particularly PSE classes in schools, in conjunction with programmes in informal/non statutory settings must be consistent and of high quality to combat any negative or factually incorrect messages young people may receive from elsewhere.

6. Twenty-five percent of respondents said that they had not used any contraception/protection on the first occasion they had sexual intercourse with most young people citing use of contraception/protection in relation to prevention of pregnancy rather than sexually transmitted infections. There is perhaps a need to ensure young people are fully aware of sexually transmitted infections, the risk of transmission and how to protect against them if sexually active.

Appendices

[1] Jayakody, A et al. Smoking, drinking, drug use, mental health and sexual behaviour in young people in East London. Prepared for the Teenage Pregnancy Unit.

[2] McCabe, M. Report of the Working Group on Sex Education in Scottish Schools. 2000

[3] National Study of Sexual Attitudes and Lifestyles 2000.