

Increasing use of condoms and sexual health services in Kent

Understanding people's attitudes, behaviours, beliefs, needs and preferences to improve sexual health outcomes

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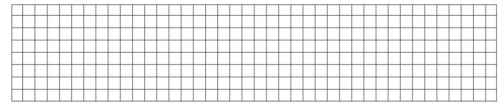
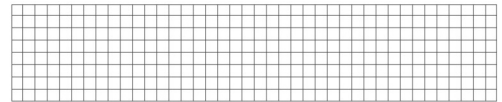
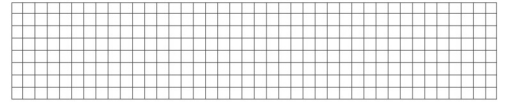


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1 Executive summary

1.1 Aims and objectives

The aims of the research were to gain insight into Kent residents' understanding of sexual health to identify what can be done to increase access to sexual health services and condom use, stimulating an improvement in sexual health in the population over the age of 35 and people from different communities across Kent.

1.2 Methodology

By using a mix of research methods – desk-based literature review, followed by qualitative primary research – we were able to triangulate the findings and gain a richer understanding of the issues from different angles. And by using an iterative process, we were able to review the findings at different stages and respond accordingly.

In total, 63 people from different backgrounds and from across Kent, were involved in the focus groups and creative workshops. The information from the primary research, focus groups and co-creation workshops, is qualitative in nature. It is not statistically significant but provides insight into why people behave as they do, their perceptions, capability and motivations around condom use and sexual health.

1.3 Key insights

What 'good' sexual health looks like to people

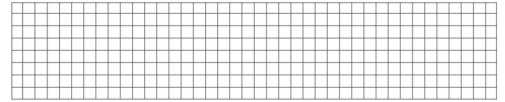
Although there is some variation between individuals, there is a consistency across all groups when considering what sexual health means to people.

Sexual health and wellbeing is seen to be important to everyone and something that needs to be safeguarded. "Good sexual health" covers more than physical health. It encompasses a wider wellbeing agenda including emotional health.

There is a general consensus that a more holistic view needs to be taken of what sexual health covers; that it is about the sexual health of the whole person, not just sexually transmitted infections (STIs) and contraception.

Sexual health means to all groups:

- Knowing and understanding the issues as well as having access to direct and practical services
- Being free of STIs
- Effective contraception
- The ability and capability to protect yourself from STIs and the knowledge, confidence and ability to access sexual health services if you have symptoms/suspect you may be at risk of a STI
- A better understanding of STIs, their symptoms and impact on health



- Both psychological/emotional *and* physical sexual wellbeing
- Keeping the sexual organs working and healthy – beyond the consideration of STIs
- The ability to conceive and have children

For women, in particular, the wider “wellbeing” agenda has more resonance as it includes a broader definition of physical health as well as emotional health. Women added that good sexual wellbeing included:

- Being in a safe relationship
- Being fully informed of options for, and easy access to, contraception and advice
- Good personal hygiene.
- Having easy access to smears / breast examinations
- Having access to emotional support to talk through difficult issues.

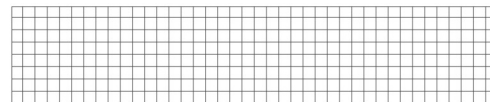
Behaviours relating to sexual health

- **Individuals do take positive steps to look after their sexual health:** Individuals take steps to ensure that they have “good sexual health” and look after themselves in a number of different ways, including:
 - o Using condoms as a contraceptive and to protect against STIs
 - o Having a check up after unprotected sex
 - o Keeping good personal hygiene
 - o Searching online for sexual health information
 - o Speaking to a friend or family member for general information and advice
 - o Having regular smears.
- **Good sexual health is not seen to be dependent on using condoms:** While the majority of individuals involved in the groups use condoms at some points in time and in some circumstances, almost no one talks of using condoms all the time.
- **Life stage, rather than ‘age’, dictates sexual activity:** Age is not a good indicator of whether someone is sexually active and/or has different partners. Participants in their sixties and younger all reported sex with different partners in the recent past.

1.4 Barriers to achieving good sexual health

There are significant physical and emotional barriers to achieving good sexual health, these include:

- **Knowledge barriers** – lack of knowledge about the risks of STIs, their symptoms, their potential risk to health, and ignorance of service available contributes to people not using condoms or getting tested
- **Communication barriers** – social and cultural norms, including feelings of taboo and shame, impact on people’s willingness to talk about sexual health issues, broaden their knowledge or seek out professional help
- **Behavioural barriers** – the mundane demands on people’s time prevents people attending healthcare appointments



- **Attitudinal barriers** – attitudes relating to embarrassment towards sex/sexual health, to perceptions of risk, and perceptions of availability all impact on condom use and uptake of sexual health services
- **Service barriers** – experience and perception about the quality of service, in particular difficulties with access and off-putting and unwelcoming services in specialist and primary care, impact on uptake of sexual health services.

1.5 Segmentation in the population

Variations in behaviours, needs, attitudes and beliefs were found amongst:

- Age – in general, the older someone is, the less salient they find sexual health messaging
- Gender – women in general pay more attention to their overall health and are more receptive to sexual health messaging; whereas men are more focussed on preventing and treating sexually transmitted infections.
- Ethnicity – people from South Asian communities in Dartford and Gravesend are much less open about discussing sexual health and in general have a much lower awareness of the risk of STIs, their symptoms or impact on their health.

1.6 Factors participants believe will increase good sexual health

A number of important motivators were mentioned by individuals of different ethnicities, ages and with different experiences of sexual health during the research. These include:

- **Importance of building knowledge** – insights into behaviours suggest that general education and information on good sexual health is not the answer. However, the research suggests that targeted interventions are needed to support the capability and motivation for the local population to change their behaviour
- **Key messages:** relate sexual health to a wider improvement in sexual wellbeing, relating positive messages to day-to-day experiences and targeting messages to particular communities
- **Changes to services** - individuals have very clear ideas on what constitutes an ideal sexual health service, the ways in which different services should be provided and how this would increase overall use by them and their friends

1.7 Actionable recommendations

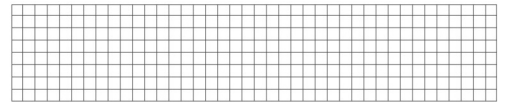
The table below summarises our recommendations.

Intervention	Gender		Ethnicity	
	Men	Women	White British	South Asian
Opportunistic screening, including as part of regular physical health checks	✓	✓	✓	✓
'Integrated' sexual wellbeing services	✓	✓	✓	✓



Use identified values to reform sexual health centres' customer service culture	✓	✓	✓	✓
Confidential helpline / online live chat	✓	✓	✓	✓
GP training	✓	✓	✓	✓
Improve access to sexual health services	✓	✓	✓	✓
Pop-up sexual health shops	✓	✓	✓	
Offer and promote self-testing kits	✓		✓	✓
Offer and promote emotional/psychological services	✓	✓		
Peer led discussion groups		✓	✓	
School education – lifetime risk	✓	✓	✓	✓
Rolling communications campaign	✓	✓	✓	✓

These recommendations are supported by a set of guiding objectives and key messages for development.



2 Introduction

2.1 Aims and objectives

The research aimed to provide insight into the barriers to condom use and identify what can be done to redress infrequent or no use of condoms, taking into account the differences in health beliefs between cultures and demographics (eg men who have sex with men (MSM), age, gender, geography and ethnicity).

The first wave of qualitative research into condom use, identified for both men and women resident in Kent, condoms and condom use are not identified as a single, stand-alone issue. But rather condoms are a part of a bigger, more holistic, picture that incorporates sex, sexual relationships and sexual health.

In addition, insight from wave 1 research indicated that people over the age of 35/40 have a lower awareness of the need to use condoms, combined with a low knowledge of sexually transmitted infections (STIs) and sexual health services.

2.1.1 Updated aims and objectives

In response to this finding, the aims of the research were altered to gain insight into Kent residents' understanding of sexual health to identify what can be done to increase access to sexual health services and condom use, stimulating an improvement in sexual health in the population over the age of 35 and people from different communities across Kent. This report is tailored to this latter aim.

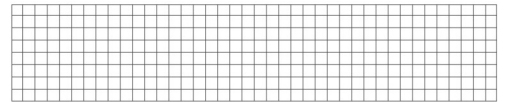
2.2 Background

Kent County Council Joint Strategic Needs Assessment (JSNA) chapter on sexual health (2013-2014) recommends that commissioners recognise the importance of prioritising the prevention of sexually transmitted infections. The JSNA acknowledges that building a sexual health culture with emphasis on behaviour change and prevention requires people to be motivated to practice safer sex, including the use of contraception and condoms.

In 2013 the Department of Health under the coalition Government published 'A framework for Sexual Health Improvement in England'¹. The framework set out the evidence base for sexual health and HIV improvement and provided information and support tools to enable everyone involved in sexual health to work collaboratively at local level to ensure that accessible services and interventions are available.

Contained within the framework are a series of ambitions the government set out to improve sexual health and wellbeing of the whole population in England. Ambitions include:

¹ 'A Framework for Sexual Health Improvement in England' Department of Health 15 March 2013.



- Building knowledge and resilience among young people aged under 16
- Improve sexual health outcomes for young adults aged 16 to 24
- All adults between 25 and 49 have access to high quality services and information
- People aged 50 and over, remain sexually healthy as they age.

The framework prioritises prevention, aiming to help people make informed and responsible choices, with an emphasis on making healthy decisions. Throughout the framework access to condoms is highlighted as a key component to reducing unplanned pregnancy, reducing transmission of STIs and preventing HIV infection.

2.3 Presentation and interpretation of the intelligence

The information from the primary research, focus groups and co-creation workshops, is qualitative in nature. It is not statistically significant but provides insight into why people behave as they do, their perceptions, capability and motivations around condom use and sexual health.

The research uses triangulation – a mix of research methods – to test and confirm the validity of what people are saying. Furthermore, across the eight different groups, there is a high level of consistency on the main insights and recommendations.

The qualitative approach method was designed to give deeper insights into people's personal and private relationships with sex, sexual health, condoms and sexual health services.

Throughout the report, verbatim quotes have been used to illustrate points. These quotes do not necessarily represent the views of all participants, but are representative of at least a significant minority of the participants.

2.4 Report structure

The report is organised into five main sections:

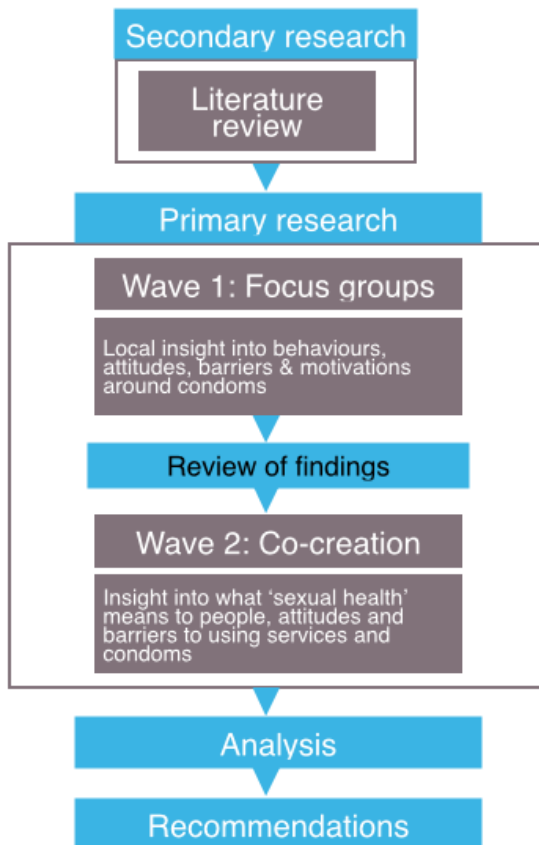
1. Methodology
2. Overview of key insights into condom use and understanding of sexual health
3. Differences between population segments
4. Factors likely to increase the use of condoms and use of sexual health services
5. Actionable recommendations.



3 Methodology

3.1 An iterative approach to qualitative research

The diagram below outlines our research method that was iterative in process. By using a mix of research methods we were able to triangulate the findings and gain a richer understanding of the issues from different angles. And by using an iterative process, we were able to review the findings at different stages and respond accordingly.

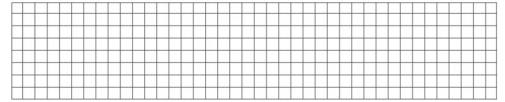


3.2 Secondary research

We carried out a desk-based literature review to explore the attitudes, beliefs and behaviours towards condoms.

Sources of information were derived through referencing the leading HIV and Sexual Health professional and academic institutions including:

- AIDS Map – National AIDS Manual (NAM): An independent agency supporting the fight against AIDS with independent, accurate accessible and comprehensive information.
- Brook: Brook is the UK's largest young people's sexual health charity.
- Department of Health England.



- Faculty of Sexual & Reproductive Healthcare Clinical Guidance (FSRH). The FSRH is a faculty of the Royal College of Obstetricians and Gynaecologists (RCOG).
- NHS Scotland
- Public Health England.
- Sigma Research a social research group specialising in the behavioural and policy aspects of HIV and sexual health, part of the Department of Social and Environmental Health Research at the London School of Hygiene & Tropical Medicine.

Other information was derived through an online search of published academic literature and grey literature. A variety of keyword descriptors were used in searching within the above-mentioned databases. Key words included attitudes to condoms, condom distribution scheme evaluation, motivations to use condoms, condom failure, women and attitudes to condoms, male attitude to condoms.

The review allowed us to place the research in context, generate hypotheses about what is happening in condom use in different population groups. These insights refined the direction of this research, helping us to produce the most relevant and actionable findings possible.

The report – *Condom use: A literature review into condom using behaviours and the barriers and motivations affecting different groups* – is available separately.

3.3 Primary research qualitative research: wave 1

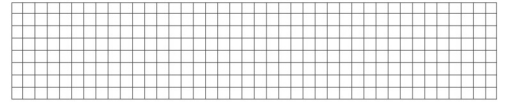
In order to support the development of solutions that could begin to address infrequent or no use of condoms, it is important to understand attitudes to condoms and their use, physical and emotional barriers to use and the extent to which this varies between ages, life stages, socio-economic groups and geographic areas.

Consequently a series of groups were put in place to identify and understand:

- Current attitudes to condom use and the extent to which these influence behaviours
- Cultural and religious influences on condom use
- The impact of education on condom use
- Physical and psychological ability to access condoms focusing on awareness and understanding of the benefits of using a condom
- Motivations for use including emotional response to using condoms
- Environments that inhibit or enable using condoms, including what a ‘good’ provision look like and how current materials measure up.

Four 1.75-hour groups were convened to understand condom use, comprising:

Where people live	Group type	Numbers	Age	Ethnicity
Margate/Thanet	Heterosexual	10	25 to 64	White British



	women			
Margate/Thanet	Heterosexual men	10	25 to 64	White British / Gypsy/Traveller
Tunbridge Wells	Heterosexual men mini-group	3	25-55	White British
Maidstone, Rochester	Men who have sex with men	10	25 to 68	White British / White other

All participants had had sexual relations in the past three months some with existing partners and others with new sexual partners. Within the groups there was a mix of employment status.

3.4 Primary research qualitative research: wave 2

In order to understand what ‘good’ sexual health means to local people in Kent and ways in which use of sexual health services could be increased, a number of co-creation workshops were run with people over the age of 25.

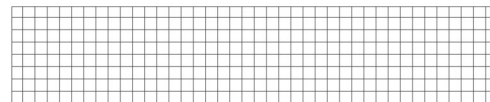
The aim of the workshops was to understand:

- What ‘good’ sexual health means to local people
- Local residents’ relationship to current sexual health services
- How people’s needs and preferences are currently being met
- What would need to change to improve residents’ overall sexual health.

Consequently, three 3-hour co-creation workshops were convened to understand use of sexual health services and condom use.

In addition, two 1.5-hour focus groups were put into place to understand the needs and priorities of the south Asian community in West Kent:

Where people live	Group type	Numbers	Age	Ethnicity
Margate/Thanet	Heterosexual women	11	35 to 62	White British / Black African / White other
Folkestone	Heterosexual men	8	35 to 56	White British / Black African
Ashford	Heterosexual women	6	37 to 69	White British / Black African (French)
Dartford/	Heterosexual	5	20 – 55	South Asian (Sri



Gravesend	women			Lankan & Indian)
Dartford/ Gravesend	Heterosexual men	5	30 to 41	South Asian (Indian)

All participants had had sexual relations in the past three months some with existing partners and others with new sexual partners. Within the groups there was a mix of employment status. Use of sexual health services varied across the groups.

3.5 Ensuring participation

For a project like this, discussing a very sensitive area, it was essential to incentivise participants in the primary research. Incentives act as a ‘thank you’ for the time that people give up and also highlight the value we attach to their time and importance of the research.

When recruiting ‘naïve’ participants – members of the public who have no previous connection to the project or the service – cash acts as the cleanest incentive. The following incentives were provided:

- Participants to the 1.5 / 1.75 hour focus groups: £40
- Participants to 3-hour co-creation workshops: £60

In addition, participants who lived in Gravesend were paid £5 to cover their travel expenses to the venue in Dartford.



4 Key Insights

4.1 What good 'sexual health' means to people

Although there is some variation between individuals, there is a consistency across all groups when considering what sexual health means to people.

Sexual health and wellbeing is seen to be important to everyone and something that needs to be safeguarded. "Good sexual health" covers more than physical health. It encompasses a wider wellbeing agenda including emotional health.

There is a general consensus that a more holistic view needs to be taken of what sexual health covers; that it is about the sexual health of the whole person, not just sexually transmitted infections (STIs) and contraception.

Although (being clear/preventing) sexually transmitted infections (STIs) are important to people, they are not necessarily the first issues that spring to mind when considering what is important to their sexual health.

Sexual health means to all groups:

- Knowing and understanding the issues as well as having access to direct and practical services
- Being free of STIs
- Effective contraception
- The ability and capability to protect yourself from STIs and the knowledge, confidence and ability to access sexual health services if you have symptoms/suspect you may be at risk of a STI
- A better understanding of STIs, their symptoms and impact on health
- Both psychological/emotional *and* physical sexual wellbeing
- Keeping the sexual organs working and healthy – beyond the consideration of STIs
- The ability to conceive and have children

For women, in particular, the wider "wellbeing" agenda has more resonance as it includes a broader definition of physical health as well as emotional health. Women added that good sexual wellbeing included:

- Being in a safe relationship
- Being fully informed of options for, and easy access to, contraception and advice
- Good personal hygiene.
- Having easy access to smears / breast examinations
- Having access to emotional support to talk through difficult issues.

There is a consensus that condoms are an important tool in ensuring sexual health, but only part of a wider tool kit

Sexual health can be maintained in a variety of different ways including regular check-up at a sexual health clinic, symptoms checking online and use of condoms. Consequently,



condoms are seen to be a “tool” that contributes to an individual’s sexual health and wellbeing, rather than as a standalone issue. This is true for both genders and all ages.

4.2 Behaviours relating to sexual health

4.2.1 Individuals do take positive steps to look after their sexual health

Individuals take steps to ensure that they have “good sexual health” and look after themselves in a number of different ways, including:

- Using condoms as a contraceptive and to protect against STIs
- Having a check up after unprotected sex
- Keeping good personal hygiene
- Searching online for sexual health information
- Speaking to a friend or family member for general information and advice
- Having regular smears

4.2.2 Good sexual health is not seen to be dependent on using condoms

While the majority of individuals involved in the groups use condoms at some points in time and in some circumstances, almost no one talks of using condoms all the time.

Condom use can be very subjective, and personal rules determine whether a condom is used. For example, there is no motivation for use if:

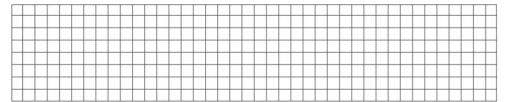
- Someone is in ‘steady’ relationship – although definitions of ‘steady’ can vary from person to person
- They have known the other person for some time prior to having sex
- The person is judged as ‘clean and respectable’
- Sex is taking place in the “heat of the moment”
- An individual hasn’t had sex for some time and feels that the offer may not come around again for some time
- Both partners have recently had a sexual health check
- One or both partners believe it’s okay to get a sexual health check-up the next day/later that week.

Other, more mundane, reasons can also conspire to condoms not being used such as use of alcohol and drugs, not having one at the right moment, not being able to open the packet, not being able to get an erection, loss of sensation.

4.2.3 Life stage, rather than ‘age’, dictates sexual activity

Age is not a good indicator of whether someone is sexually active and/or has different partners. Participants in their sixties and younger all reported sex with different partners in the recent past.

Whether someone is in a longstanding relationship or not is a better indicator about whether that individual will have sex with ‘new’ partners.



5 Barriers to achieving good sexual health

There are significant physical and emotional barriers to achieving good sexual health, these include:

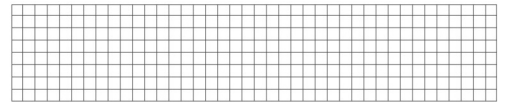
- Knowledge barriers
- Communication barriers
- Behavioural barriers
- Attitudinal barriers
- Service barriers

5.1 Knowledge barriers

- **Lack of awareness of the longer-term impact of sexually transmitted infections (STIs)** – The majority of individuals have a low understanding that some STIs have no symptoms – or symptoms that may only materialise years later. Additionally, participants were uncertain or did not know that STIs, if left untreated could lead to significant health problems in the longer term.
- **Lack of knowledge about the risk of transmission** – participants are generally unaware or at best unclear that if someone has an STI without symptoms they could pass it onto another partner. (This was particularly common amongst men, who had a common belief that women are the main transmitters of STIs)
- **Lack of awareness of availability of sexual health services** – The majority of individuals have a low awareness of what sexual health services are available to individuals, where they are provided, how to access them and who is eligible for different services. For example, what particular services are available at a pharmacist, GP, online or specialist clinic; how can they be accessed - when is a GP referral necessary; who are they available to (with a wide assumption that specialist sexual health services are only available to the under 25s).

5.2 Communication barriers

- **Taboos around sex continue to limit help seeking behaviour** - despite a more favourable attitude to sex and sexual health, there is a continuing sense of “taboo” that limits the extent to which individuals are willing to access sexual health services. This is especially true when services are focused solely on ‘sexual health’ (rather than incorporating a wider sense of ‘sexual wellbeing’).
- **Difficulty for different generations to discuss sexual health in south Asian populations** – although there is a perceived change in attitudes towards sex and sexual health throughout the community, participants are clear that sex and sexual health is not something that could be discussed between generations. There can even be difficulties in discussing it between genders.



5.3 Behavioural barriers

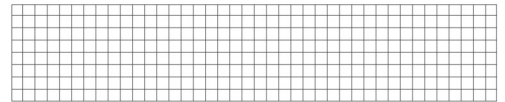
- **‘Day to day life can “get in the way” of good sexual health** - While good sexual health is very important to everyone individuals talk about a number of behaviours that do not necessarily support this statement. For example:
 - o **People act “in the moment” and do not always use condoms**, despite being aware of the risk of STIs This is often attributed to the tension between rational and physical drivers
 - o **Individuals will not always have an immediate sexual health check / get a test for an STI after having unprotected sex**
 - o **There is a reluctance to search for information** and participants frequently do not proactively seek out information on maintaining good sexual health, despite it being available online. This is partly put down to concerns over “diagnosis” on the internet.
- **Time is a major factor driving decision-making** – health-seeking behaviours, whether for physical or sexual health, are largely driven by perceived speed of being seen. People are very unwilling to have to take time off work for an appointment, particularly if they believe they will be made to wait unreasonably long times (eg for walk in services) or appointments will be late.

5.4 Attitudinal barriers

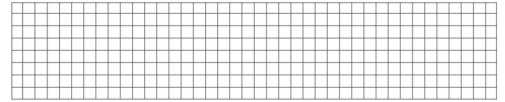
- **Low perceived risk of STIs in ‘older’ people** - There is an underlying perception that STIs are only a problem for people under 25, and that individuals in their late 30s, 40s and older are unlikely to contract an STI. This perception is reinforced with awareness campaigns and information frequently being targeted at under-25s.
- **Low perceived risk of STIs amongst south Asian people** – in particular Indian men are unaware that STIs are a risk to them.
- **Older females believe that condoms are no longer necessary** – as they are no longer at risk of becoming pregnant. They talk of enjoying a “new found freedom”
- **Individuals who have used specialist sexual health clinics comment that the majority of clinics cater primarily for under-25s**, with only a reduced service for older people (this manifests itself in limited opening times for people over the age of 25, including in Ashford for example, people over the age of 25 only being able to go to the service one day a week).

5.5 Service barriers

- **Individuals have difficulty in accessing sexual health services** - Individuals widely report their frustration in getting a sexual health appointment, both in general practice and at a specialist clinic



- In the case of GPs, there is a widespread perception that it is notoriously difficult to get an appointment with a GP. Added to this, is the fear and anger that receptionists will ask why you want an appointment.
 - There is widespread criticism of the difficulty of getting seen at specialist clinics, including opening times (not convenient for work), clinics only being open to people over the age of 25 on limited days, and the inability to book an appointment with the consequence of spending a whole day in a clinic with no certainty of being seen.
- **Individuals reported confusion on the names of clinics.** For example, not realising that a ‘family planning clinic’ would treat STIs or are suitable for men.
 - **Low levels of awareness of service availability** – this manifests as a general lack of awareness of what types of services may be available, to more specific barriers, including not knowing that there is a specialist sexual health clinic in the area, or which part of the health service offers which service.
 - **Mixed opinion of the quality of local sexual health services** – while some participants praise the sexual health service they have received, there are many individuals who feel they have had a mediocre or poor experience. This ranges from problems with access (see above – the most common problem), to general practice staff (in particular doctors) not proactively offering information on the range of services – such as contraception – on offer, to a general low level of compassion and enthusiasm amongst staff, which reinforces the taboos and stigma around sexual health.
 - **There is a strong desire for sexual health (and sex) to be normalised**, with individuals wanting sexual health services to lead the way. There is an almost unanimous desire amongst participants for sexual health and sexual health services to move out of the shadows and to become part of the regular health service. Some talked of the possibility of including sexual health checks as part of regular physical health checks
 - **Language barriers** – for first and some second generation south Asian people, not having information in Punjabi makes it hard for people to understand what services are available and where they can get help. This is particularly true for sexual health services, as people are very unwilling to talk about sex or sexual health so are unable to ask English speaking friends or family to help.



6 Segmentation in the population

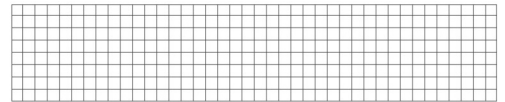
There are a number of differences between different segments that will influence behaviour change.

6.1 Age

- **Knowledge** – There was ignorance and surprise that there is an increase in prevalence in STIs among older (over 35s) population
- **Older preconceptions** – Both men and women from late 30s onwards felt that sexual health is aimed at younger people – teens and 20s. The perception is gained through advertising and messaging targeted at younger segments of the population.
- **Differences in knowledge** – heterosexual men and women over the age of 40 were less likely to be consistent about their use of condoms as they were less clear about the risks of sexually transmitted infections and sexual health in general. Some also had a lower awareness of the existence and availability of sexual health clinics.
- **Older preconceptions** – people over the age of 40 are less aware that the choice in condoms has increased, quality has improved and especially that condoms can now be a positive aid to sex (some of the younger women were keen about condoms that “sped the women up and slowed the men down”)
- **Taking every opportunity** – men and women (heterosexual and MSM) over the age of 40 were less confident about their sexual chances. As they get less offers for sex, they were more willing to have sex without a condom, rather than risk losing that opportunity.
- **MSM** – older men (40+) have stronger views and awareness of the need to use condoms than younger men.
- **Education supports condom use** – Younger men and women (heterosexual) have clearer views that individuals should use condoms – a message that has come through education at school
- **Life stage** - There were no clear differences in condom use between standard life stages although perceptions of what condoms are “like” vary. Individuals emerging from the “commitment” phase as the result of the break-down of relationships, are much more likely to view condoms negatively and to have “historic views” of what they are like which in turn influences use.

6.2 Gender

- **Men indicated a less worried attitude to STIs** and appeared confident that they would get treated and cured with medication.
- **Men specified more clearly** a need for more information to be made available more widely – ie beyond health settings such as pubs, newsagents, and barbers.
- **Less choosy men** – in general heterosexual men were more cavalier about condom use in the sense that any condom would do (the brand of the condom was

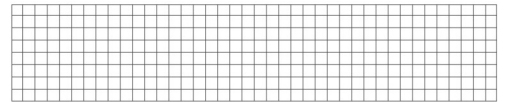


not important) and the source of condoms irrelevant with price being a factor in the decision to purchase

- **Women paid much more attention** – to their overall health in general and were particular about the brand (always Durex in this group) and the provenance of where they got it. The female participants highlighted that they would always use their own condom, rather than trust condom brought by the man.
- **'Morning after' use of sexual health clinic** – men (heterosexual and MSM) were more likely to access sexual health clinics immediately after a situation in which they have not used a condom. A quick check up was likened to the “morning after pill – just to make sure”
- **Gender perspectives** – heterosexual men and women both felt that the other gender were less responsible when it came to condom use. In particular the men held a view that women often did not have a condom available and were more willing to have sex without a condom. Women on the other hand talked of “being prepared” especially at home

6.3 Ethnicity (South Asian)

- **Women do not provide condoms** – it is expected that the man will buy and provide a condom due the perceived “shame” of a women being seen to buy them.
- **Men are embarrassed about buying condoms** – and would prefer to buy them from a shop out of their area and in a way that is as discreet as possible
- **There is a great taboo around sexual health and sexual health testing** – men will go to great lengths not to talk to healthcare professional about sexual health issues. If they have to they want to do so as discreetly as possible, and ideally not with a healthcare professional from their community due to perceived risk that people will find out.
- **There is a great deal of ignorance about STIs and sexual health services** – individuals are very unclear about the risk of STIs (in particular the men), that STIs may not have symptoms, and do not know what services are available.
- **Language is a barrier for the older generation** – first and some second-generation people struggle with information in English. In addition, they are more likely to use to consume non-mainstream media channels, such as Sikh TV.



7 Factors participants believe will increase good sexual health

A number of important motivators were mentioned by individuals of different ethnicities, ages and with different experiences of sexual health during the research. This chapter is a discussion of findings from the primary research, rather than a list of our recommendations.

This chapter is divided into discussion in three key areas:

- Importance of building knowledge
- Supporting messaging
- Changes to services.

7.1 Importance of building knowledge

Insights into behaviours suggest that general education and information on good sexual health is not the answer. However, the research suggests that targeted interventions are needed to support the capability and motivation for the local population to change their behaviour.

There are a number of key areas of knowledge which individuals thought would be useful in supporting behaviour change and improved sexual health outcomes.

Busting the myths that over 40s are not at risk of STIs

The older individuals are the more they believe that they are no longer at risk of STIs. During the primary research it was apparent that when groups/individuals understood that that risk of STIs has more than doubled for people in their 40s and over, the issue of condom use became much more salient, as did the necessity of getting tested.

STIs may not have symptoms

Most individuals are unaware that many STIs, such as Chlamydia, do not have symptoms. There is an underlying belief that people will be able tell when they have (or a partner) has an STI, in the same way that you can tell if someone has a cold.

You can't tell by looking

Related to the point above, many individuals (in particular heterosexual men) talk about deciding on condom use partly on whether they have known their potential partner for sometime or whether their prospective partner shows any outward signs of STI, in the mistaken belief that someone with an STI will always show outward signs of an infection.

Not getting treated is not an option

Individuals do not appreciate that STIs if left undetected and untreated could lead to serious health problems. And that in some cases the serious health problems could be the first sign that they have had an STI.



Sexual health services for everyone

Promoting the fact that sexual health services are available to everyone, no matter what age.

What sexual health services are available and from where

There is general confusion about what sexual health services are available and where to get them.

Promotion of specific services and where they are available from would be helpful for people to overcome confusion and uncertainty. For example, what services are available in general practice? Where can people get free condoms? Who are the services available to?

Information should be provided in simple language that does not use medical terminology or jargon, and does not create feelings of stigma, fear and apprehension.

Education targeting Indian and other South Asian communities

There is a need for education for everyone in the south Asian community. There should be education for parents and for young people about STIs, symptoms (or lack of them) and what services are available – and that these services can be used confidentially.

7.2 An approach to messaging to change behaviour

Underlying the specific areas of knowledge that individuals have identified, there is an approach to messaging to support behaviour change.

Everyday tone reflecting the realities of sex

Individuals in all groups are keen that 'sex', 'sexual health' and 'sexual health services' are normalised and relate to everyday experiences to remove the 'shame' felt by some of the public.

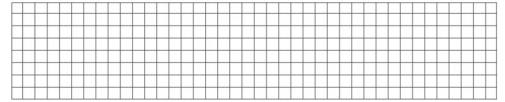
Individuals talk about sexual health information reflecting the new realities of life in Britain where sex is much more widely accessible both in terms of digital access (pornography, dating apps) and also in levels of sexualised advertising and media generally available in and out of the home.

Include wellbeing to neutralise emphasis on 'STIs'

Many people felt that the term 'sexual health' primed people to think about STIs only, rather than the wider aspects of sexual health. They suggested using the term 'sexual wellbeing' as a more inclusive term.

Sexual health information in everyday locations

Participants from all groups talk about the need for more promotion of information about STIs, the risk to over 25s, and availability of services in general. And that information and



advertising should be available in more every day spaces where they consume, travel and socialise.

Targeted information for different groups

All individuals feel that information and promotion should be targeted to them. Current messaging is too focused towards under 25s, and consequently everyone over that age switches off or worse, begin to believe that they are not at risk.

People are looking for messaging targeted to their age range, specific information for south Asian communities (eg the Indian Sikh community in Gravesend) and possibly gender.

Make safer sex, testing and condom use a 'sign of trusting relationship'

Many individuals felt that current messaging is weighted too much about risk and shame and felt that messaging should instead position safer sex and sexual health alongside caring for your partner – a sign of trust and affection.

Condoms as an aide to sex

Many older individuals were unaware of the range of condoms now available and how they have improved 'since their time'. Promoting condoms as fun and a positive part of sex is seen as a better option than making them out to be a 'unwelcome chore' that gets in the way of sex.

This ties into the general sense that sexual health messaging needs to align better to everyday experiences of sex; that it is fun, pleasurable and much more common.

7.3 Changes to services

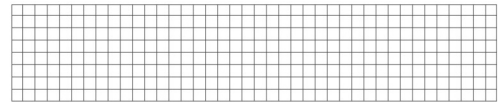
Individuals have very clear ideas on what constitutes an ideal sexual health service, the ways in which different services should be provided and how this would increase overall use by them and their friends.

(Where a service delivers real perceived value, people will engage with it and will go to efforts to use the service. French women regularly travelling back across France to see a gynaecologist for annual sexual health check-up is a good example.)

The most important consideration is that sexual health services should be more open and welcoming, so that people feel more comfortable about using them. In addition, they should be more inter-connected with general health services, and treat individuals with respect and as a whole person.

Key elements to be taken into account include:

- The range of services offered
- Accessibility and availability of support
- The values by which services are delivered



The range of services offered

A range of services is seen to be part of the ideal sexual health service, including:

- STI tests, with fast results
- Trusted and accessible information and education
- In depth, total sexual health checks
- Regular 'preventative' health checks, either provided at general practice (new registration or part of the NHS Health Checks for people over the age of 40) or at the sexual health centre
- Counselling with qualified counsellors / psychologists
- Comprehensive and personalised contraception advice (available from primary care, as well as specialist health centres)

There was also some interest in self-testing for STIs, particularly amongst the male participants.

The way in which different services can be delivered

Individuals recognise that there needs to be a mix of services available to cater for the different levels of sexual confidence amongst the population as well as different cultural needs (ie those who are more confident and open, and for those that still need to be discreet/secretive).

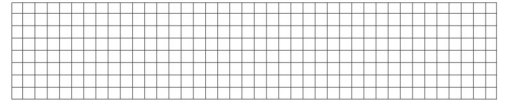
Sexual health services can be provided in a number of different ways through a number of different providers. Providers are not mutually exclusive and an integrated service is to be welcomed. Providers include:

- Sexual health clinics – offering a full range of services to maintain overall sexual wellbeing, including cervical smears, general gynaecological checks, and psychological support
- General Practice – not necessarily through doctors, but a service that is more responsive and easier to access
- Pharmacies – their longer opening hours and locations mean that individuals want to be able to access information, support and advice, and self-testing kits. However it is important that private consultation rooms are available.
- Online support
- Telephone helpline – preferably a specialist 'sexual health' telephone helpline, where it is possible to talk frankly without fear or judgement to highly informed staff.

The values by which services are delivered

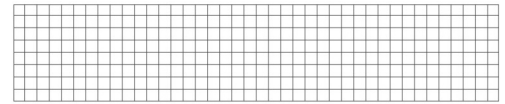
Whatever the actual service, it is really important that any services are delivered abiding by important core values:

- Ease of access – both in terms of getting seen quickly and good location
- Friendly, welcoming and comfortable
- Confidential and discreet
- Non-judgemental



- Respectful for the individual (paying attention to the individual, not the medical issue).

Mixing services together removes barriers of feeling embarrassed and makes them more accessible - Even those people who want core sexual health services to be more available and accessible (e.g. on the 'high street',) express the view that they would be would feel more comfortable if specialist services provide a wider sexual wellbeing service (eg cervical and breast screening and access to psychological support), rather than just GUM/STI services. Such services would avoid individuals being "labelled" as needing STI services.



8 Identifying actionable recommendations

Sustained behaviour change does not come about quickly, especially in a situation where emotion and libido can lead to spontaneous (often irrational) actions. It will only be achieved when interventions take a more holistic approach to sexual health. Consequently, behaviour change interventions will need to be embedded into current services, supported with a targeted behavioural marketing campaign to underpin the approach.

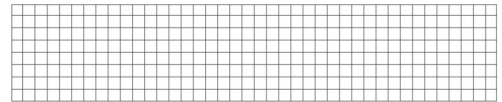
Social marketing national benchmark criteria emphasise the importance of a methods mix in behaviour change interventions. This involves a range of intervention (including upstream/service side change) and marketing methods to increase the likelihood of people changing relevant behaviours and avoiding a reliance on single methods or approaches used in isolation.

The aim of this section is to provide recommendations and guidance that are based on the primary research findings. This section discusses several key areas:

- A summary of guiding objectives that should direct any intervention developed
- Key messages for communication development, including message tone, types of messages and information required
- Recommended interventions
- Recommended approach to identifying and changing a specific behaviour

The table below provides an overview of the suggested interventions and target audiences.

Intervention	Gender		Ethnicity	
	Men	Women	White British	South Asian
Opportunistic screening, including as part of regular physical health checks	✓	✓	✓	✓
'Integrated' sexual wellbeing services	✓	✓	✓	✓
Use identified values to reform sexual health centres' customer service culture	✓	✓	✓	✓
Confidential helpline / online live chat	✓	✓	✓	✓
GP training	✓	✓	✓	✓
Improve access to sexual health services	✓	✓	✓	✓
Pop-up sexual health shops	✓	✓	✓	
Offer and promote self-testing kits	✓		✓	✓
Offer and promote emotional/psychological services	✓	✓		
Peer led discussion groups		✓	✓	
School education – lifetime risk	✓	✓	✓	✓
Rolling communications campaign	✓	✓	✓	✓



8.1 Summary of guiding objectives

There are a number of considerations and objectives that any intervention to improve sexual health, whether that is condom use or use of sexual health services, should be aim to achieve.

Make the risk of STIs more salient to people over the age of 25 and to different groups. Although people in Kent are aware of their sexual health and take steps to maintain it, the risk of STIs are perceived to be low to them personally. Because people do not hear about STIs, or only hear about them in connection with under-25s, there is an availability bias² in their decision-making. While awareness and information alone will not change all behaviour, without it there is little reason for people to take more precautions when having sex with a new partner.

Enable people to have more open conversations about sexual health. It is apparent that people are still uncomfortable talking about sexual health with their friends, family or even healthcare professionals. Enabling people – in particular women – to talk about these issues openly and normalising the issues within families and local communities is important in terms of encouraging those who are not accessing services or those who are unaware of the variety of condoms available.

Target people through their existing communications channels. Many people, in particular men and women who no longer require cervical screening, do not access health services regularly or frequently. Consequently, a reliance of information or promotion of sexual health/condom use will not reach these groups. In addition, first and some second generation people from South Asian communities in Gravesend and Dartford are less likely to access mainstream information services. Instead these groups need to be engaged using communication channels that make sense to their lives, for example information through community outlets (gyms, hairdressers, specialist channels, word of mouth, etc).

Aim to make sexual health testing and condom use as part of the ‘norm’ – a part of maintaining good overall health. Participants from all groups felt that it was important that sexual health messaging should be more positive, more upfront (less ‘hidden’ and ‘shameful’) and reflect that sex amongst all groups is part of normal day-to-day life. For example, individuals felt that public health messaging around condom use should focus on how they have improved over the past decades and can be sexual aide, rather than just a form of protection. In addition, people want to ‘see’ testing and use of sexual health centres as something that everyone – in particular, ‘people like them’ – does. From a branding

² Research on the availability bias demonstrates that estimates of risk are influenced by frequency that people hear of the risk. Additionally, the affect heuristic suggests that people make judgements and decisions by consulting their emotions. As they do not hear about cases of sexually transmitted infections amongst their community/peers there is little emotional concern about STIs, undermining their motivation to take steps to protect themselves. Tversky, Amos; Kahneman, Daniel (1973). "Availability: A heuristic for judging frequency and probability". *Cognitive Psychology* 5 (2): 207–232.



perspective, this suggests that sexual health and sexual health services should be actively transformed to instil the ‘Everyman’ brand archetype³ (ie “It’s perfectly normal to get tested and use sexual health services” – crafting messaging and experience as part of day-to-day life, rather than something unusual).

Build on what is already available. It is important to remember that most people do already act in ways to protect/maintain their sexual health, including using sexual health services and condoms. The recommendations proposed below do not mean starting from scratch therefore the existing methods of communication should continued to be used, either revised as we suggest or in partnership with our recommendations until interventions can be evaluated for their effectiveness.

8.2 Key messages for development

8.2.1 Message tone

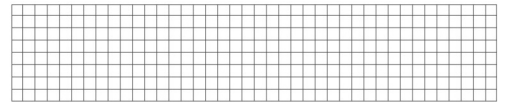
The tone of any messages that are communicated by Kent County Council or the health services, or any community based partner organisations and individuals, about sexual health should be in line with the following ideas:

- **Everyday** – taking care of your sexual health by using condoms and getting tested for STIs after a new sexual partner is a positive part of day-to-day life, something that everyone does – it’s just another part of our overall health
- **For everyone** – whatever your background or age, everyone should be using condoms / getting tested with a new sexual partner
- **Reassuring and respectful** – you will be treated with respect and with no-judgement. There is nothing to worry about.
- **Discreet** and confidential– you will receive advice, support and treatment in full
- **Speed and no fuss** – (as long as this is true) that sexual health services in Kent, whether from primary care or specialist services, will look after people with the minimum of fuss and results are speedy.

8.2.2 Types of message

- **Every time you have a new sexual partner get tested and use a condom**
- **Relate sexually transmitted infections to people over the age of 30.**

³ Based on Carl Jung’s 12 personality archetypes, ‘brand archetypes’ are a way for a service to ensure that all of its products, messaging, customer experience, etc are consistent.



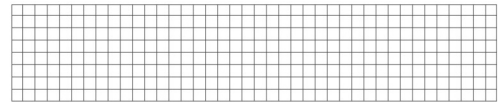
- **Tailor messages to particular groups – including age, gender and South Asian groups in Dartford and Gravesend**
- **Use positive real life stories to promote sexual health testing**
- **Relate use of sexual health services and the use of condoms to a positive and everyday aspect of caring for your health, and your sexual partner**

8.2.3 Information provision

Local people need to receive information that is tailored to them and in the right format, place and timing to motivate them to use condoms/use a sexual health service.

The following points should be considered:

- **Information needs to tackle the key gaps in knowledge:**
 - Bust the myth that STIs only affect people under the age of 25 – in particular responding to the perception that people (in particular men) 30+ know everything they need to about sexual health and are consequently 'closed' to learning more
 - The increased prevalence of STIs
 - The lack of symptoms of some STIs and the fact that symptomless STIs can still be transmitted
 - That STIs, even without symptoms, can cause long term and serious health problems
 - What sexual health services are available, where they can be accessed and who they are available for
 - Simplicity/ease of testing – tackling fear around pain or embarrassment of most testing.
- **Information should be available in simple (everyday) language** that does not use medical jargon, does not go into too much detail but rather focuses on giving people a simple set of beneficial and reasonable behaviours to follow (eg getting tested after every new sexual partner if you haven't used a condom)
- **Use technology to deliver information (and more) such as an app that would give information on STIs** – participants use apps for secure transactions such as banking, booking hotels, etc. Individuals believe an app would be ideal for sexual health issues as it could be secure, available to download over free Wi-Fi in sexual health centres / GP and could be used to provide detailed information, symptom checkers, location of sexual health services, used to book and check into appointments and also store personal data to be shared with healthcare staff.
- **Information should be available in different languages** for first and second generation south Asian people



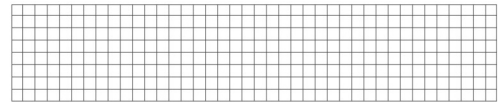
- **Multiple formats and communication channels** should be used to convey the information to reach the community and meet the people's learning preferences.

8.3 Recommended interventions

There are a number of recommendations based on the primary research. These are divided into two sections, service side changes and community-based interventions.

8.3.1 Service side changes

- **Use identified values to reform sexual health centres' customer service culture, including:**
 - o Speedy – getting an appointment and getting results
 - o Friendly, welcoming and comfortable
 - o Confidential and discreet
 - o Non-judgemental
 - o Respectful for the individual (paying attention to the individual, not the medical issue).
- **Opportunistic screening** by offering a sexual health test as normal when:
 - o People first register for a GP – in addition, provide new registrants with information about local sexual health services and the risk of STIs
 - o As part of the NHS Health Checks for people over the age of 40
 - o Alongside cervical screening.
- **'Integrate' other related services as part of sexual health clinics**, more of a 'sexual wellbeing' service, so that when people go to them they can get a full range of related services (eg cervical and breast cancer screening), so helping to reduce stigma around sexual health and normalising it, by establishing the notion of sexual health testing with the maintenance of good health in general
- **Improve access to sexual health services**, so that it is easier and faster for people to get an appointment and to get an appointment at a time that suits them (eg before or after work).
- **GP training** - this could include training in how to provide more simple information on sexual health (including the range of contraception), how to build rapport with patient, how to be opportunistic (ie suggest sexual health tests or condoms) and how to recognise when their manner impacts on their relationships with patients (eg referring women to their female nurses for advice if they feel unable to have conversations on this topic).
- **'Pop-up' sexual health shops** – pop-up shops or mobile sexual 'wellbeing' clinics could be provided on the high street or other locations (eg near supermarkets, workplaces to allow people to drop in when convenient to them. Tailored to older



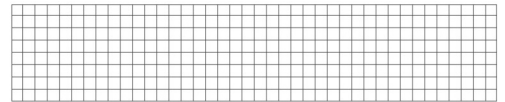
people, the 'shop's could offer information and advice, as well as testing. And could also act as base for outreach.

- **Offer and promote self-testing kits**, which people can either order online or take away with them from the pharmacy or GP. Men in particular spoke of the benefit of being able to test for STIs without human interaction, either with a kit or self-service booth in a sexual health centre.
- **Offer a confidential telephone helpline or online live chat** – where people can get information and advice on sexual health issues, as well as talk openly about their fears. The idea of a 'confessional booth' came up in a number of groups, where people could talk to someone without either party knowing the other – making it easier for the individual to talk more openly about personal and private issues.
- **Offer and promote emotional / psychological services** as well as physical sexual health services.

8.3.2 Community-based interventions

- **Peer led discussion groups** – white British women in particular expressed a demand for a discussion group where they could discuss sexual health issues in a safe space with other women. Facilitated by someone who is has been trained and is knowledgeable about sexual health, the agenda would be set by the group itself. A possible model for these groups is the *Talk for Health* programme⁴, whereby groups of people are taught the skills of managing a group. Along with train the trainer courses, this allows people to set up effective ongoing groups.
- **School education** – The messages and lesson learnt while at school seem to be retained amongst individuals, and are often the only source of sexual health understanding. Although some individuals thought their sexual education was good, the majority felt that it should be more comprehensive, and should highlight that STIs are an issue for all generations, not just the young.
- **Rolling communications campaign** – an integrated campaign across a wide range of media, to support a particular behaviour change message, this should be aimed and tailored at different groups, using appropriate communications channels and platforms. For first and second generation south Asians, information and advertising should be targeted at through particular channels and in their mother tongue (ie Punjabi).

⁴ <https://www.talkforhealth.co.uk/> Talk for Health is a social enterprise set up for people to deal with mental health issues through therapeutic talk



8.4 Recommended approach to identifying and changing a specific behaviour

While the above interventions and guidelines will help to increase condom use and sexual health services, our recommendation is to understand the problem in behavioural terms. And then devise an integrated mix (upstream and marketing) to support this.

The framework that we recommend is the Behaviour Change Wheel⁵ that was developed from 19 frameworks of behaviour change identified in a systematic literature review.

The framework is straightforward and systematic in its approach. The first steps are:

- a. Define the desired behaviour change
- b. Generate a list of target behaviours to bring about change
- c. Assess the intervention ideas based on practical criteria and select the highest scoring behaviour
- d. Specify the behaviour
- e. Identify what needs to change.

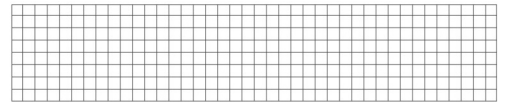
We have used this process to identify behaviours to change on condom use and increase in use of sexual health testing, using the method to test the intervention recommendations above.

The two behaviours identified are:

1. Condom use: **Always having a condom with you as part of 'going on a date' regime**
2. Sexual health testing: **For every new sexual partner, get tested**

An example of the Behaviour Change Wheel for arriving at the desired condom-behaviours is detailed in the appendix.

⁵ The behaviour change wheel: A new method for characterising and designing behaviour change interventions. Susan Michie, Maartje M van Stralen and Robert West. *Implementation Science* 2011, 6:42 doi:10.1186/1748-5908-6-42



9 Detailed findings – condoms (wave 1 primary research)

9.1 Overview of condom findings and insights

For both men and women resident in Kent, condoms and condom use are not identified as a single, stand-alone issue. This is a part of a bigger, more holistic, picture that incorporates sex, sexual relationships and sexual health. Condoms are merely seen as a practical part of sexual relationships and their use is either to be welcomed or to be ignored. This ambivalence is largely dictated by context. Overall there is a sense of self and willingness to take risks with coping mechanisms put in place to cope with the potential consequences when risks have been taken.

9.1.1 Behaviours

In terms of behaviours, while the majority of individuals involved in the groups use condoms at some points in time and in some circumstances, almost no one talks of using condoms all the time.

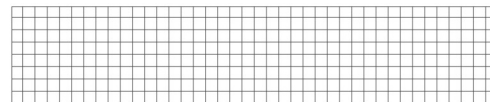
9.1.2 Motivations

Where condoms are used, the reasons and motivation for use include the need for contraception and the prevention of sexually transmitted infections / HIV as well as offering a basis for trust in a relationship that means individuals do not have to ask “difficult questions” of a partner.

At the same time, condom use can be very subjective and personal rules determine whether a condom is used. For example, there is no motivation for use if:

- Someone is in ‘steady’ relationship – although definitions of ‘steady’ can vary from person to person
- They have known the other person for some time prior to having sex
- The person is judged as ‘clean and respectable’
- Sex is taking place in the “heat of the moment”
- An individual hasn’t had sex for some time and feels that the offer may not come around again for some time
- Both partners have recently had a sexual health check
- One or both partners believe it’s okay to get a sexual health check-up the next day/later that week.

Other, more mundane, reasons can also conspire to condoms not being used such as use of alcohol and drugs, not having one at the right moment, not being able to open the packet, not being able to get an erection, loss of sensation.



9.1.3 Capability

There are relatively high levels of awareness of the reasons for the health benefits of condom use but physical and emotional barriers mitigate against their use in many situations.

Surprisingly, in all the groups, there was a mixed to poor awareness of the availability of sexual health/GUM clinics in Kent. Where individuals have used clinics after unprotected sex, they talk of using them as the “morning after pill” to check that all is well. Individuals have had mixed experiences of care.

9.1.4 Opportunity to get condoms

Condoms are bought in range of places with different criteria for choice including price, brand, shapes, sizes, colours and flavours. Women appear to be more quality conscious than men who tend to be more price conscious.

While free condoms from clinics are welcomed, there was some criticism over the “one size fits all” approach taken by clinics and a failure to recognise that condom use may increase if there is a greater choice including size, taste, colour, thickness.

9.1.5 The potential to increase condom use

Initial findings indicate:

- Behaviours around condom use are more likely to be effectively addressed as part of a wider focus on sexual health: helping local people manage their sexual health more confidently
- The population segment where there has been little attention paid, is heterosexual men and women over 40. In addition, this segment has lower awareness of the need to use condoms, along with a low knowledge of sexual health services and less likely to realise how much condoms have changed in recent years.



9.2 Heterosexual men based in Margate

Background

All of the individuals in the group lived in Margate and the surrounding area and were a mix of employed and unemployed. Margate is seen to be a difficult place in which to socialise with high levels of drunkenness and drug taking. Consequently socialising tends to be limited to their local area

“Too many people come just to get drunk / do drugs”

Behaviours

There is a general high level of interest in sexual health although individuals do not find it particularly easy to talk about – something that can be seen in the behaviours of a couple of individuals who would not seek help or advice.

“I would brush it under the carpet”

For the majority, if worried about something in particular, they would seek advice. However, advice seeking is a very personal thing and there was general agreement that social networks are not the right place to discuss sexual health issues or concerns

“I would talk to my mum – she always knows the answer”

“I would never talk to my mother. It is too embarrassing”

“I would always go to my GP”

“Talking to friends is good”

“I look on the Internet – it discreet”

“The one place I would not go is any social network”

Behaviours relating to condom use vary and reflect a range of different attitudes to the product itself and what it represents to individuals. Condoms are seen to represent safety and offer protection against STIs. However, condoms are also seen to be a part of a very intimate activity – something to be enjoyed. There is a feeling that condoms “get in the way” of this enjoyment and the use of condoms is affected by physical attributes (such as smell and difficulties of use) as well as the embarrassment factor of using them.

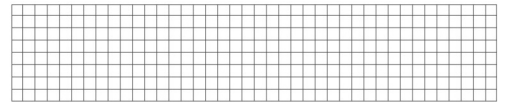
“It is so embarrassing taking them off”

These two opposing attitudes have a significant impact on behaviours and, with the exception of a younger member of the group, all talked of “sometimes I do and sometimes I don’t” approach to condom use.

However, within the group, there was a difference in the attitudes of older individuals (45+) towards condom use with that of younger participants (25+). The older individuals would rather not use condoms unless they “had to” while younger participants indicated that would always use condoms – unless they were in a situation where one wasn’t available as / when required.

“I never use a condom. It is just not the same” (Aged 45+)

“I always use condoms. I was just brought up that way” (Aged 25)



The younger member of the group had been “brought up” to always use a condom and “would never leave home without one”. This was attributed to successful education in schools as well as parental influence.

Motivations for use

Motivation for use is influenced by attitudes to “self-protection” as well as the nature of the relationship with the sexual partner. Individuals will use condoms:

- For my own protection
- To stop pregnancy
- For peace of mind
- If the girl asks me to – *“It shows she really wants me”*
- When I am with a prostitute
- When the girl has been around
- If I didn’t know the other person
- To relax me and make me confident - knowing that I will be OK

But there are a number of factors that mitigate against use . These include:

- I know the person and their background
- I am in a (regular) relationship
- We are trying for a baby
- We have both been tested and are OK
- When the condom falls off and you are hard and don’t want to put it on again
- When practising tantric sex
- If she is using contraception
- When I can’t be bothered with the hassle of putting it on
- We both lose sensation

It was also noted that while using condoms offers protection against getting STIs, this does act as a significant motivator as the majority do not see getting an STI as too much of a problem as most are “treatable”

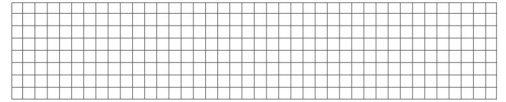
“Getting an STIs is not too much of a problem – they are all treatable”

Opportunities to source condoms

For this group, price is a significant factor in buying condoms and sources include ASDA, Tesco and the Poundshop. A number of individuals also talked of being able to obtain free condoms through sexual health clinics although this was not a widely used source within this group.

Changing behaviours

After discussing attitudes to and behaviours around condom use in some detail, the group believed that it will be difficult to get people to change their behaviours unless they are much more aware of the consequences of not using condoms and that these “outweigh” the benefits of condom free sex. They offered the following thoughts:

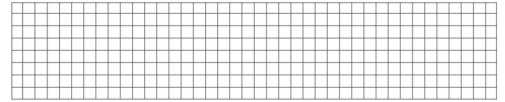


“The media has a role to make sure that people stop thinking they are invincible and that “nothing can touch them”

“There needs to be positive press about condoms being sexy. At the moment all the education stuff is about what condoms prevent not that they are fun”

“There needs to be a positive story about condoms and that they can be fun⁶”

⁶ (Reference to Big Poppa E and “How to make love” https://www.youtube.com/watch?v=4xss_K7-HJU)



9.3 Heterosexual women based in Margate

Background

The individuals in the group lived in Margate, Westgate and the surrounding area. The group was a mix of single mums, families and those with no kids. The nature of their family lives dictates the extent to which individuals go “out and about” in Margate.

“I just have an open door and everyone comes to me”

“As a single mum with family it is difficult”

“Need to look after the family”

“Depends on what you are looking for like to go out with friends for a drink and somewhere to dance”

However, even those who are able to go out and not worry about looking after their children, say that Margate is seen as quite a difficult place to socialise in as there is quite a lot of drunkenness and violence at night.

“Now my boy has grown up and I am more than I was when I was young”

“I go camping and fishing in Kent”

“Don’t go out in Margate. Tend to go to Broadstairs. It is safer”

Use of the internet and social media for communications by this group is limited as there are concerns over hackers – especially on Facebook.

“I worry about hackers on Facebook and the wrong people finding out things”

“Don’t use the internet unless it is to read things”

Behaviours

Individuals are concerned about their sexual health although it is not always something that is easy to talk about. While the majority of participants would seek advice in relation to a sexual health concern, opinions varied on the most appropriate / trustworthy source of information ranging from talking to friend to looking on the internet or going to the GUM clinic.

“I go to the GUM clinic for sexual health”

“My GP”

“Never look at the internet – you can’t be diagnosed over the internet – though once you know you have something it can be useful to find out more!”

“If it was minor I would talk to friends”

All of the group use condoms at some times but not others. This is the result of the context in which sex is taking place as well as attitudes towards condoms. On the one hand, condom are seen to represent safety and offer protection against STIs

“Safe and not comfortable”

“They are just necessary”

“I usually carry a condom with me – it shouldn’t be left to the man”

On the other hand there are a number of factor that affect behaviours and significantly limit use. These include:



- A physical allergy to condoms
- The fact that they can present a barrier in a relationship
"I don't want a barrier in the relationship – I want YOU"
- Religious convictions
- Drug abuse and drunkenness
- Sex is taking place "in the moment" and no condoms are at hand
- When the guy doesn't want to use one
- When someone wants to use a cheaper brand / unbranded product
- Physical reactions including "Brewers Droop"
- They are ugly, fiddly and not comfortable.

"No thanks in long term relationship"

"My partner says it feels like he is having a bath with his socks on"

"Sex should happen naturally and if you have to wait for them to put one on you have lost the urge"

"Bad for the man they can't feel as much"

"Cringe – the awkward conversation that you have to have"

Motivation

Individuals are able to identify a number of reasons and therefore motivators for using condoms. These are driven by the desire for "self-protection" and include:

- When you don't know your partner / a new partner
"I always use them with someone I haven't been in a relationship with"
- Contraception
"I don't want to get pregnant"
- Fear of HIV and STIs
"The diseases you have to live with for the rest of your life are really scary."
"Chlamydia ruins your insides"

At the same time, individuals talk of why they would not use a condom on a regular basis:

"I don't need to use one I have been with my partner for 15 years"

"When I am with someone I have known and that I know would be honest with me"

"When I or my partner has been checked out. All the youngsters go regularly"

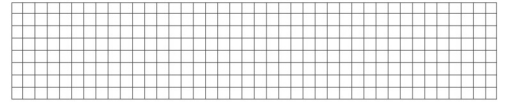
*"I am not used to it. It wasn't such a thing for my age group. What is the motivation?
(nearly 50)*

"Because I am allergic to them"

Sources of condoms

While condoms are bought from a number of different sources, there was a general concern over brand and for many there is a need to ensure that the condom that is used is Durex.

"Clinics though not all of the clinics have the full range of condoms"



“I wasn’t offered them when I was checked over – that would have been a good idea even if I didn’t want them”

“Tesco along with the groceries”

“Boots”

“Durex is important. The others seem to be thinner and break”

“NEVER go to the Pound Shop”

“If it’s not Durex I say we will use mine”

“Most guys buy Durex – if not Durex I want a named brand”

“Would never ask the guy where the condom came from”

Other thoughts from the group

After discussing attitudes to and behaviours around condom use in some detail, the group offered a number of thoughts of which the most important to them was the importance of being “checked out” at a sexual health clinic. In addition the group noted:

“There are a lot of older people who sleep around and need to be checked out and make sure they are careful”

“My views have changed. I take my sexual health much more seriously now that I am a mum. I have responsibilities”

“Condoms have changed and they are much better – colours, smell, taste. Important because it is part of sex and you can try different things”

“They should be available in pubs for free – and flavoured ones”



9.4 Heterosexual men based in Tunbridge Wells

Background

All of the group lived in Tunbridge Wells and the surrounding area and had lived there for some time. All are self-employed and enjoy living in the area. In terms of socialising they all prefer a quiet social place and commented that the Centre of Tunbridge is not so good given high levels of drunkenness and the absence of places just to sit and talk to people.

In terms of arranging to meet up with friends, none of the group uses social media – either Twitter or Facebook as they prefer to arrange to meet through phone calls and texting

Behaviours

There were varying levels of concern about sexual health ranging from one participant who went for a sexual health check every six months to one who didn't even really know about sexual health clinics and didn't worry too much about his health.

In terms of seeking advice for any concerns, individuals would consult their doctor or go to a walk in clinic for general health and go to the sexual health clinic for sexual issues. (It was noted that sexual health clinics used to be walk in too and that was "handy" but that is no longer the case.) Individuals may also consult friends but would definitely not turn to social networks

Condom use varied across the group with one individual always using condoms to another who sometimes used condoms. This difference was mainly an age difference. The older individuals would rather not use condoms unless they "had to" while younger participants indicated that would always use condoms – unless they were in a situation where one wasn't available as / when required.

"It was drummed into me at school as a normal thing to do"

"I usually plan to use one but this can be affected by the moment"

"If you have a one off chance – you don't think about it. Don't want to let the chance go"

"I always have a couple in my bag".

Where condoms are not used, this can be for a variety of reasons including:

"When I am in a relationship –

"When I / they have been tested though one participant had never had a test"

"It detracts from the moment do needs to be a part of the act. I always prefer the woman to put it on but some shy away – so I don't use it"

"I don't get many chances these days – and I know it is wrong but I will do it anyway"

"The gap of five minutes can ruin the moment!"

Use of condoms can be affected by the context and by the "moment"

"I always plan to use one but I don't like them so sometimes....."



“I am sometimes “persuaded” out of it – either by the other person or by an over-riding physical drive”.

“Most women don’t bring it up – say it is always up to the man”

“Older ones are the worst – they don’t seem to be educated in the reasons for using condoms and don’t want them”

Where condoms are not used for whatever reason, individuals put in place coping mechanism to ensure their sexual health:

“If I don’t use one then I am paranoid and get checked immediately”

Motivation

The key motivator for use is protection from both the risk of pregnancy and infection. Condom use is also seen to make people more relaxed

“If I use one because I know I will be all right but it does interrupt things”

“Would always bother – because you never know when STIs are going to come out”

[Younger guy]

However motivation can be affected by negative experience of condoms and their impact on enjoyment of sex.

“They are boring”

“The smell used to be awful

“They make sex “sterile”

“Rubbery and squeaky – and if too squeaky they hurt. There is friction”

Motivation can also be affected by experience

“My last two split which makes you wary”

“There are sensitivity issues on both sides Both sides would prefer not to”

Sources of condoms

Individuals buy condoms in a number of different places although the majority always bought a recognised brand. In terms of choice and acceptability, it was agreed that different shapes, sizes, colours and tastes make them much more acceptable

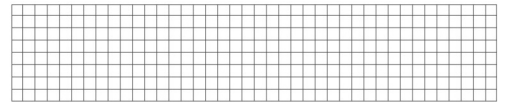
“Anywhere that is cheap”

“Always go to the clinic”

“I always buy Durex – are there any other brands? “

However, there was some criticism of the choice offered at clinics

“Most clinics need to have a greater choice. There is a belief that one size and one type fits all but that isn’t true”



9.5 Men who have sex with men (MSM)

Background

Living in Maidstone, Rochester and Chatham, one of them identified as bi-sexual, the remainder self-identified as gay. The participants largely socialise in: the Ship Inn (Rochester), the Riverside Tavern (Strood) and ME1 Sauna (Rochester). Other venues include Queen Anne in Maidstone and Coyotes in Chatham.

Grindr is widely used, as is Facebook. Apart from some monthly magazines such as *Attitude* and *GT* (Gay Times), none of the group regularly reads the gay press. This is due to availability as the local magazine, *M20*, has stopped publication and the free London magazines such as *QX* and *Boyz*, are not distributed to venues in Kent (they are only distributed to venues that advertise).

When looking to meet men for sex, while apps such as Grindr are used, participants will meet people in bars and saunas, the latter especially when travelling or in London.

Otherwise, the men keep in touch with events through friends (word of mouth), online news sites and blogs. Local printed papers are not widely read.

Behaviours

When concerned about their non-sexual health, most of the men go to their GP. Some will Google symptoms in advance.

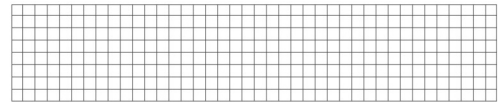
If concerned about sexual health, they seek advice from Google, national NHS websites (they were uncertain about the names), friends and sexual health clinics. Some of them would talk to their GP.

There was a surprising lack of awareness in the group about where specialist sexual health services/GUM clinics are located in Kent. There was much discussion about the services that other participants go to, their opening times, the individual's experience of the service, and what types of service are available at different venues.

There was discussion about the sexual health service that used to be based in Rochester and that it catered specifically for gay men. Since it closed the participants are less likely to get tested. Partly because of the distance to Medway Hospital, which is now the closest sexual health clinic. And also because of a perception that the service may not understand the needs and preferences of gay men so well.

The overwhelming majority of men in the group state that in most circumstances they use condoms for penetrative sex and have done so for most of the time they have been sexually active.

Condoms are only used for penetrative sex. (Some of the men have tried using them for oral sex, but found the taste unpleasant and also did not feel that the risk warranted it.)



Although the majority of the group profess to using a condom, most will not use a condom all of the time. Main reasons for not using a condom include:

- Availability
- Age (younger men less likely to do so)
- Alcohol and recreational drugs
- Problems getting/keeping an erection while using a condom
- In some circumstances, when their partner does not want to use them
- Reduced sensitivity undermining the pleasure
- Finding/opening/putting on a condom spoiling the moment
- Wrong size.

In addition, most of the participants will not use a condom when in a monogamous relationship, or when they “*know someone well*”.

(One notable exception, a man over 50, never uses condoms, as he could not get/keep an erection. His approach is to be “careful”, only having sex with men who he knows, as well as getting tested at a GUM clinic regularly and frequently.⁷)

Knowledge and capability

Individuals in the group are aware that condoms are the best barrier to STIs and HIV. (Overall, this group was much more knowledgeable and clearer about STIs and their symptoms than their heterosexual peers.)

The group was conscious that there is now little safer sex promotion (not just for HIV) on the gay scene or in gay media outlets (the older men could remember when it was pervasive). This is mirrored by the reduced availability of condoms.

While the group was confident about physically using condoms, some of the group acknowledged that condoms are hard to open during sex, in particular when fingers are slick with lube.

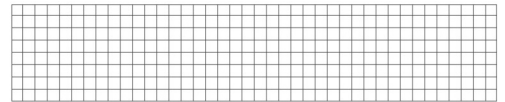
Everyone acknowledged that condoms reduced sensitivity, in particular for the active partner. And that reduced sensitivity is a barrier to using a condom.

“If [sex] was a non-event, no one would be fucking anyone.” [40plus]

HIV and HIV prophylaxis

There is a general acceptance that the threat of contracting HIV is no longer as potent as it once was due to the advancement of treatments. There was some discussion that it is now more comparable to other long-term conditions, such as diabetes. However, the older men

⁷ He was well aware of the risks of HIV and STIs and, despite this, had no intention of changing his behaviour.



in the group challenged this view, pointing out that the treatment for HIV is unpleasant. It was hard to gauge whether the younger men accept this point.

There was a general consensus amongst the group that gay men take the risk of being infected with HIV less seriously and that this has led to a drop in condom use. This is partly due to reduced fear of the consequences of being infected by the virus. But also a belief that HIV is harder to catch as treatments reduce the viral load of HIV positive men.

None of the participants had any first hand experience of using pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis (PEP) – either themselves or through a friend/partner. Participants were sceptical whether PEP/PrEP would be effective. The availability of PEP/PrEP had not changed their behaviour or the behaviour of their circle of friends. (Many of the group were unaware of PEP/PrEP, what it is or how/when to access it.)

Opportunity to source condoms

Condoms are believed to be much less available on the gay scene now than even a few years ago. Whereas condoms used to be universally available and free from gay clubs and bars this is not the case now.

The older men remember outreach teams handing out condoms at cruising grounds

“Use to have people wandering around there, like the ice-cream lady, giving out condoms.” (Over 50)

Most of the men buy condoms from supermarkets (eg Tesco) or community pharmacies (eg Boots). The participants generally have condoms and lube at home and some of them carry a condom in their wallet. (There was some discussion whether this is safe to do so and whether it would damage the condom or not.)

Only one of the men bought condoms online (from Freedoms). Most of the group were unaware that this was possible, despite most of the group being familiar with Freedoms as a brand via fee condom distributions on the gay scene.

Motivation

Despite being well informed about the risks of STIs and HIV, individuals do not use condoms in all circumstances

Older men (40 plus) have a much sharper awareness of HIV, as well as Hepatitis B, than the younger men, remembering the ‘Don’t die of ignorance’ TV adverts about HIV from the 1980s.

A few of the **younger men** were emphatic that they used condoms all/most of the time and put this down to the promotion of condom use during sex education at school. (All of the younger men were keen to point out that none of the sex education at school had included any reference to sex between, or safer sex, for men who have sex with each other. They are very critical of this.)



In the right context, the majority do not use a condom if their partner does not want to. This is not necessarily seen as 'undue' pressure, but just a reality of life and choice. That sometimes it is worth taking the risk rather than missing out.

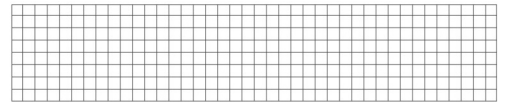
Factors such as alcohol, 'knowing' the other man and belief that "at my age" opportunities are less frequent, all increase the likelihood that they will accept not using a condom.

There is a consensus that condoms are expensive. (Some delight was expressed that condoms are available from the Pound shop⁸.)

About a third of the group regularly got condoms from the GUM clinic. But, most of the group were unsure whether they could get free condoms from the GUM clinic or whether there is an age limit.

Difficulty getting or keeping an erection due to a condom is a shared experience amongst most of the group. One of the men will never use a condom as he cannot get an erection with one.

⁸ Like their heterosexual counterparts, these gay men are less choosy where they get their condoms from than women. And also less concerned about brand.



10 Detailed findings – sexual health (wave 2 primary research)

10.1 Overview of findings

The key themes that emerged from the groups in wave 2, which focused mostly on sexual health services (and increasing their use) provide practical insight towards improvements in sexual health service delivery and access.

Desire for normalisation of sexual health - There is a shared view that sexual health is part of broader health and wellbeing and that it should be 'normalised' and brought into all aspects of life such as education, health checks, emotional wellbeing as well as physical health.

Inter-connected services for the whole person – Service provision that covers contraception, information leading to protection against STIs, emotional and psychological health services/therapy, information to help people stay healthy, and an inter-connected delivery among other health services.

Clear set of attributes - There is a general consensus that services should be more open and welcoming and that aspects of service to be promoted include: free, quick, confidential, discreet, accurate, for overall sexual health and wellbeing.

Based on values that are articulated throughout the customer journey - all groups articulated a common set of values that they want all sexual health services to demonstrate. These are: confidentiality, discretion, non-judgemental, welcoming and respectful, speed of access and results, and accuracy.

10.1.1 Behaviours

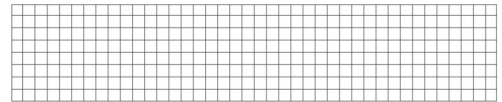
Many of the participants are single or only recently started to settle down with a partner.

Behaviours around taking care of their sexual health included using condoms, having a check up after sex, ensuring personal hygiene and using the internet to find out information (from trusted sources such as NHS or BBC sites).

Some of the groups cited difficulty in getting appointment, ignorance of where to go for sexual health (eg, check up versus treatment), embarrassment and fear of being noticed. These factors, alone or in combination, prevented access to services.

10.1.2 Motivations

On the whole people showed a genuine concern for their sexual health and a desire to maintain good sexual health. However motivations are hampered by lack of information



about service availability, low levels of awareness of STIs as well as barriers caused by embarrassment, fear of being noticed, and perceptions of an unfriendly service that is inaccessible or inappropriate for their age, or need.

10.1.3 Capability

Although there was a general awareness that STIs are not a good thing and that steps would be needed to protect oneself, there was evidence of a widespread lack of knowledge among the groups of the symptoms of different infections and ignorance around asymptomatic conditions and the consequences of leaving them unchecked. Importantly there was a lack of knowledge of where information about STIs or support and treatment could be found.

There was also some confusion around nomenclature – eg family planning, and where you would go for a check up versus treatment when showing symptoms.

General practice was cited as a place to go for tests and information but the perception and experience of *“doctors just don’t have the time and don’t tell you where else you can go”* along with widely held perceptions around difficulty in getting an appointment presented a significant barrier to accessing sexual health services in primary care.

Accessing dedicated sexual health clinics is hampered by beliefs that they cater predominantly for younger people (under 25s). This is compounded by a sense of embarrassment in accessing these service (primarily through feelings of shame, or fear of being noticed by someone you know).

10.1.4 Opportunity to increase access to sexual health services

Inter-connected and holistic - A clear opportunity for accessing services would be an ‘inter-connected’ service or holistic service offering that treated the whole person – this could include STI tests with quick results, counselling for emotional issues, general information about all aspects of sexual health (not just STIs).

Incorporate and demonstrate brand values - In addition to increasing the range of services provided, improved accessibility and availability, the values of the service provision should also be considered with key concerns around confidentiality, friendliness, being non-judgemental and respectful.

Positioning of services around ‘wellbeing’ emerged among all groups. This would enable a more open attitude around sexual health in general. This could include a movement towards a preventative service – eg, an annual ‘MOT’.

A dedicated and open service in general practice - GP practices could offer a dedicated (and advertised) sexual health service, provided either by the GP or practice



nurse. Integration with other GP services such as registration at a practice, and NHS health checks provide additional opportunities for increased awareness and service access.

Change in attitude of GP reception staff - Training of front line staff to be more friendly and not ask why the patient needs the appointment with the GP would be an obvious step to reduce people's reluctance to use GP service for sexual health concerns.

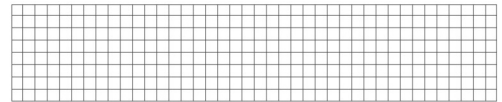
Increase awareness of location/signposting - There is a clear need to increase awareness of location and range of sexual health services in general.

A welcoming environment - Create a sexual health service that is welcoming, comfortable, conveniently located, publicised, well-designed (light, airy) with facilities such as free wi fi, refreshments, space for children, for men and women, young and old, spacious.

Pharmacies have a key role – through their convenient locations and longer opening hours are seen to have a key role in offering advice and information.

Online information is seen as important although trust of the source is an important consideration.

Self-testing services were mentioned and a dedicated (branded) helpline to give specialist advice.



10.2 Heterosexual women in Margate

Insights

- Sexual health is part of a much broader health and wellbeing agenda
- Sexual health needs to be “normalised” and made to be something that people talk about by bringing it into all aspects of life; education, general health checks and other aspects of “women’s health”. Make sure it includes the physical and emotional / psychological aspects of sexual health and that these are not swept under the carpet
- GPs are in a good position to raise issues around sexual health but do not take the opportunity. Health checks should include regular sexual health checks as a matter of course
- Sexual health clinics are good but do not cater for older people (over the age of 25). All of their services are focused on the young and you are expected to go along with this. They don’t seem to understand that “*older people still have sex*”
- Provision of services in a small community presents challenges and there are concerns around confidentiality and anonymity

Understanding of sexual health

While the detail of sexual health means different things to different people, there was general agreement that a more holistic view needs to be taken of what sexual health covers and the fact that it is about the sexual health of the whole person. Importantly sexual health means knowing and understanding the issues as well as having access to direct / practical interventions. Thoughts included:

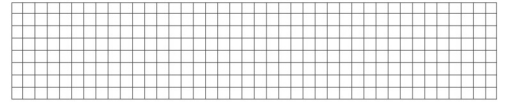
- Making sure you are protected and are “safe” in all aspects of sex. This includes:
 - o Contraception
 - o Protection against sexually transmitted infections
 - o Emotional health and psychological health
- Having information on all the things you need “to attend to” in order to stay healthy sexually
- Being safe in a relationship

Knowledge of specific aspects of sexual health - STIs

There is a widespread awareness that STIs are “dangerous” and of the need to take steps to protect yourself. The groups was also able to name a significant number of different diseases and an assumption that these are all transmitted through sex.

However there is a lack of knowledge of the symptoms of the different infections and of the extent to which they could apparently lie “silently” within the body. There was also a lack of awareness of the physical damage that can be caused by many of the different infections. This can be accompanied by a sense that people need to know

“We need to know what could happen. Where can I find that information?”



Taking care of my sexual health

Individuals take steps to ensure that they have “good sexual health” and look after themselves in a number of different ways including:

- Using condoms as a contraceptive and to protect against STIs
- Ensuring good hygiene at all times
- Having a regular check at the sexual health clinics – although not many women knew where the sexual health clinics were
- Making sure that physical health is good and will help to sexual “illnesses”
- Checking on the internet for “what I should do” in different situations

“I go to the GP though he doesn’t often have time”

“I go to the clinic and get checked out”

“I make sure I use protection even with a partner I trust”

An important consideration in taking care of sexual health, is the ability for individuals to access relevant information and support easily and in a “safe place”. This includes both information and the ability to get all relevant tests – not just be tested on a limited number of tests that the clinics think is appropriate.

“It is hard to know where to go. Doctors just don’t have the time and don’t tell you where else you can go”

“My doctors doesn’t really know me and my body. Where else can I go?”

“Clinics are OK but they don’t test for everything. They are also not open at the right time”

“Clinics focus on young people. It is really embarrassing walking into a clinic full of teenagers. But Vicarage Lane is only for teenagers”

“Many clinics only cater for young people and it can be very embarrassing to go and see your daughter’s friends”

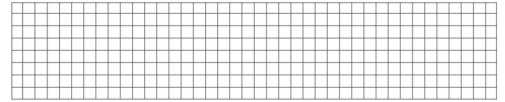
“I don’t want people knowing that I go somewhere because of my job. I need confidentiality so that makes it hard for me to get help”

Increasing use: the ideal sexual health service

Individuals have very clear ideas on what constitutes an ideal sexual health services and the ways in which different services should be provided. The most important consideration is that the services offered should be inter-connected and ensure that individuals are treated as a whole person. They need to show respect for the individual and give people confidence that they care. Key elements to be taken into account include:

1. The range of services offered
2. Accessibility and availability of support
3. The values by which services are delivered

The range of services offered



Based on the assumption that supporting an individual's sexual health requires holistic support, a range of services are seen to be a part of the ideal sexual health service. These include:

- In depth, total health checks
- STI tests with results while you wait
- Counselling with qualified counsellors / psychologists
- Contraception advice from either GPs, nurses or pharmacists
- Relaxation classes
- Helpline – telephone or on line to give help and advice
- General information about all aspects of sexual health

The way in which different services can be delivered

Sexual health services can be provided in a number of different ways through a number of different providers. Providers are not mutually exclusive and an integrated service is to be welcomed. Providers include sexual health clinics, GPs, pharmacies and online support

a) Sexual health clinics

Sexual health clinics should offer a full range of services appropriate to enable people to maintain good sexual health. These should include:

- Physical health checks including smears etc
- STI tests with results available while you wait
- Counselling services
 - “You need someone to talk to about facts and emotions you are going through. It is no good have all the facts if in too much turmoil”*
- Information through leaflets, screens and people to talk to
 - “They could have screens giving information as well as leaflets. Anything that helps to educate people”*

Clinics should also cater for different user groups with different clinics for age, gender etc.

Importantly sexual health clinics must be somewhere that people trust and that are confidential. They should:

- Offer the ability to remain anonymous or give your name – it's your choice
- Maintain privacy of personal details in public areas
 - “Don't do what they do in GPs and tell everyone your business”*
- Ensure that an individual is supported / looked after by the same member of staff throughout their visit
 - “Please don't pass me from one person to another”*
- Be open at hours that “suit individuals not the people delivering the service”. This includes evening and weekends and the potential for some to be available 24 hours.
- Offer services by appointment and through a drop in service



“There should be no appointments combined with short waiting times”

“Any check to be carried out by the same person throughout the process so that fears can be dealt with along the way”

“Evening and weekend appointments are a must”

“Drop in as well as appointments; couples or single appointments”

“When you are there, you should see someone of a similar age to talk your problems through”

b) GPs

GPs could offer sexual health checks as part of a regular health MoT. This could be provided by either the GP or a practice nurse.

“In an ideal situation, the GP would employ a sexual health nurse who could offer in depth advice, support and if necessary counselling”

c) Pharmacies

It was acknowledged that pharmacies have an important role to play and that they are more accessible than other services – with longer opening hours and located in places that are easy to get to. They are seen to have a key role in offering advice and information

“Use the pharmacy as a triage - and ask the questions you need to know. They could then sign post you to the doctors or clinic

“I think a section in a pharmacy would be a good start where you can get information on where to go or what to do. This is a perfect place to have leaflets and other information.

“The great thing is that they are open”

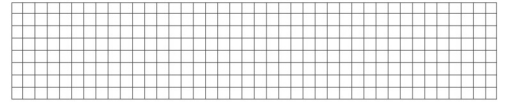
d) Online

While information that is accessed online needs to be considered with caution, it can also be used to provide information that can be trusted if offered by the appropriate / relevant organisation. Online should be used to provide additional information, support and signposting information

The values by which the services are delivered

Whatever the actual service, it is really important that any services are delivered by staff who know and care about what they do and show respect for the individual. In summary staff should:

- Be passionate about their work
- Ensure they provide accurate information and are honest
- Maintain patient confidentiality
- Care about what they do
- Be aware that they are also educators and that people need help and support to be in control of their sexual health
- Friendly
- Respectful



- Non judgemental
- Have a sense of humour

Other considerations

Make sure that sexual health is raised up the agenda for everyone! This could be done by:

- Providing more information on STIs – Google / leaflets
- Advertising on TV / through junk mail / billboards
- Better education in schools

The “perfect” clinic

The perfect clinic would focus on the needs of the individual and provide an appropriate environment in which to offer the right services:

- Everyone should have the right to anonymity
- There should be women only, and men only clinics and clinics for different age groups
- Individuals should have the choice of the gender of the doctor they see
- There should be a built in pharmacy to save the embarrassment of getting medication
- Everyone should have the ability to get test results while you wait

In terms of environment, the clinic should:

- Be clean not sterile
- Have WIFI
- Have lots Leaflets
- Have comfortable seating

“I would like it to be modern but resembling a relaxed comfortable environment with both male and female workers of various ages

“This clinic / health centre must offer all of the tests on site, maybe videos showing you what the more serious diseases look like and if possible wait on the result”

“Maybe have separate waiting rooms for younger people / older people / couples”

“Somewhere nice to wait for test results there are then”



10.3 Heterosexual men - Folkestone

Understanding of sexual health

While the detail of sexual health means different things to different people, there was a general agreement that a more holistic view needs to be taken of what sexual health cover. And that it should not be narrowed down to a single focus on sexually transmitted infection. The term 'sexual wellbeing' was suggested.

“When we mention those two words, sexual health, it always seems to narrow down to transmitted infections, rather than actually sexual wellbeing”

There was a consensus that it is time to change the culture around sexual health so that it is no longer seen as 'shameful', and that services are more openly provided and better communicated.

“What is the remit of 'sexual health' – if it's just badged as disease, then likely to remain shameful” – could it include testicular cancer?”

Importantly, sexual health means knowing and understanding the issues as well as having access to direct and practical services.

Thoughts about sexual health included:

- Better understanding of sexually transmitted infections
- Having information on safer sex to avoid STIs, even if you choose to have multiple partners (without judgements)
- Knowing what to do if you have symptoms/suspect you have an STI
- Access to counselling/psychological support

The group acknowledged that many men are less worried about catching an STI, confident that they can get it treated and cured with medication, possibly as a male 'right of passage'.

“Blokes... don't care. Just take a pill for that. Catching the clap is part of the process [for men up to the age of 30s]”

Finally, the group felt strongly that sexual health services and information are targeted at teens or 20-somethings and that consequently, people in their later 30s and up do not feel included.

“Part of the problem with sexual health is that it's aimed at youths – if you look at the advertising it's aimed at late teens and early 20s. But only have go out here on a Friday night and see the people stumbling out the pubs there's all ages.”

Knowledge of specific aspects of sexual health – STIs



There is a widespread awareness of STIs and that steps should be taken to protect yourself. The group was also able to name a significant number of different infections and an assumption that these are all transmitted through sex – however individually, there is a lack of confidence and knowledge.

There is a lack of knowledge of the symptoms of the different infections and of the extent to which they can exist without symptoms within the body. There was also a lack of awareness of the physical damage that can be caused by many of the different infections.

There was no knowledge of post exposure prophylaxis (PEP) for HIV amongst the group.

The group were surprised about the range of STIs around and that the prevalence of STIs has increased amongst over 35 year olds.

Taking care of my sexual health

Individuals take steps to ensure that they have “good sexual health” and look after themselves in a number of different ways including:

- Using condoms as a contraceptive and to protect against STIs
- Having a check up after sex (in particular after unprotected sex)
“Part of the culture now, it’s accepted that you’re going to catch it at sometime”

“I go to my doctor to check it out – for me I put my kids first. Always check my self out, if you don’t want to stick to one woman.”

- Ensuring personal hygiene
- Using the internet for information on STIs and symptoms – but only trusted NHS or BBC sites (although there was scepticism amongst one or two of the men about the quality of information online)

“I wouldn’t go on the internet, you can’t trust everybody on the internet”²⁵

Barriers to using sexual health services

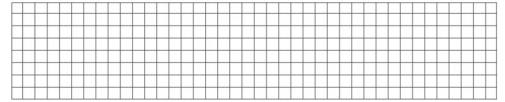
The barriers to using sexual health services include:

1. Lack of knowledge of specialist services locally and confusion between nomenclature

“A lot of people wouldn’t know where the local clinic was, there’s a problem with education. At work sexual health doesn’t tend to get a mention. I’m in my 40s, perhaps a lot of people don’t tend to talk about it.”

“I wouldn’t know the difference between the family planning clinic and the sexual health clinic. Why aren’t they the same?”

“If it’s more than disease, where do you go?”



“I wouldn’t make that leap: ‘Oh, I’ve got a sexually transmitted disease, I’d better go down to the one on Dover Road, as I just know that as the ‘Family planning’ clinic.”

“Family planning clinic, feels it’s more for women than for men, so already that’s a barrier for going. If [the name was different, or the centre offered more services] then I’d feel better to go”

“But actually not knowing where it is. I’d thought of using it, but don’t know where it is.”

“Also where clinics are based. They’re always down here or around there. They’re not clearly signed.”

2. Difficulty getting an appointment at the clinic

“I’ve been and they said ‘Sorry, wrong day, come back on Thursday’. Wait a minute! You expect me to wait from Monday to Thursday?! They said, ‘Go and see your GP’. But I couldn’t see my GP, coz I can’t get an appointment. They said ‘Go to emergency!’”

“Don’t want to take time off work”

3. Unwelcoming and ‘shameful’ feeling about services – “feels like the walk of shame”

“Midwifery units good example of what it could be like – free sandwiches and coffee – [sexual health services] should take cues from midwifery”

4. Problem of a provincial service – where there is a concern that you will see people you know, including staff. Or be seen going into the centre, when there’s only one reason to be going there

5. Difficultly getting an appointment with a GP (and fear that privacy will be broken by receptionist asking why you want to see the doctor)

“It’s very difficult to get a doctors appointment, easier to check things on the internet.”

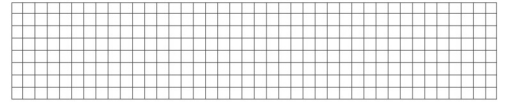
“If woke up with something wrong here... if woke up at 10am, then it’s too late to call the GP. Depends on the situation”

“I’d only call the GP if I had symptoms. If not symptoms, I’m not sure”

“I’d go to the doctor and expect to be referred”

Use of condoms

Condoms are used by most of the men, some of the time when with someone who is not their long-term partner.



“I only use them if I have to. If I’m being perfectly honest, only if she wants me to. You’ve got to understand that I know the girls I go with.”

Brand is not important. Condoms are mainly bought from supermarkets and chemists. One man buys his condoms online [no service name given]. And only one man gets free condoms from the sexual health clinic – *“Free party pack – condom and lube!”*

Increasing use: The ideal sexual health service

Individuals have very clear ideas on what constitutes an ideal sexual health service, the ways in which different services should be provided and how this would increase overall use by them and their friends.

The most important consideration is that sexual health services should be more open and welcoming, as well as being more inter-connected with general health services, and treat individuals with respect and as a whole person.

Key elements to be taken into account include:

- The range of services offered
- Accessibility and availability of support
- The values by which services are delivered

The key attributes of a sexual health service are:

- Free
- Quick (getting an appointment and also getting results)
- Confidential
- Discreet (this is not the same as hidden)
- Accurate
- For overall sexual health and wellbeing.

The range of services offered

A range of services is seen to be part of the ideal sexual health service. These include:

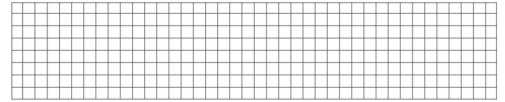
- Preventative health service – including a sexual health MOT to check that everything is okay and working as it should be
- Education and information about all aspects of sexual health
- Testing and treatment for sexually transmitted infections
- Emotional/psychological as well as physical health needs.

The way in which different services are delivered

To increase use of sexual health services, they would ideally be provided in a number of different ways through a number of different providers.

Providers are not mutually exclusive and an integrated service would be welcomed.

Providers include specialist sexual health clinics, GPs, pharmacies, online services and telephone helpline.



a) Sexual health clinics

Sexual health clinics should offer a full range of services appropriate to enable people to maintain good sexual health. These should include a full range of support, tests and treatment for STIs. They should link into other services so that it is not just a 'hall of shame', but integrates into other sexual wellbeing services.

The location of the service is important too, with a desire for choice of going to a more discreet service and also having clinics visible and on the high street.

“Sexual health shops as accessible as an optician, they shouldn't be hidden”.

“Key thing is to communicate that people do have that choice – about discreet or visible”

The service should ensure they cater for people over the age of 25. And also offer culturally tailored support for different groups too.

Clinics also need to become more welcoming and pleasant:

“Light, airy and welcoming service, as often they are a bit grim and depressing”

You should be able to book an appointment in advance or just walk in.

Opening times need to reflect people's difficulty getting time off work and desire to use services in the evening or at the weekend.

Sexual health franchises

Under the direction of the NHS, the reach of sexual health services should be extended by franchising outlets to private companies and sponsors, into leisure centres or large supermarkets – making it easier for people drop in.

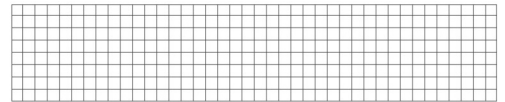
“Possible franchise attached to sports and leisure centre or Asda... vernacular to where people will go.”

b) GPs

The main barrier to using a GP is the difficulty getting an appointment and concern that the receptionist will insist on asking what it is you need an appointment for.

GPs should offer sexual health checks as part of the 'normal' health MoT, provided by the doctor or a practice nurse.

“When you register with a GP, they give you an initial appointment and assess your blood pressure. It's funny that nothing is done on the sexual health side.”



“It’s normal to get a dental check up, why not a sexual health check”

“Sexual health MOT, want it to be mandatory”

It should be possible to pick up a self-test kit to test for STIs from the GP.

c) Pharmacies

Pharmacies (chemists) have an important role to play because they are more accessible than other services – with longer opening hours and located in places that are easier to get to.

Pharmacies are seen to have a key role in offering advice and information (including awareness information on STIs and availability of services). They are also seen as an ideal place to drop off self-testing kits for STIs.

“Why isn’t information accessible at the pharmacy counter. Or at the Supermarket – where people actually go.”

d) Self-service

It should be easy to have a ‘self-service’ approach for testing for sexually transmitted infections. Either picking up testing kits from the GP/Pharmacist, or being able to get a totally self-service service at the sexual health clinic – where swabs, blood samples can be dropped off without an interaction with people.

e) App

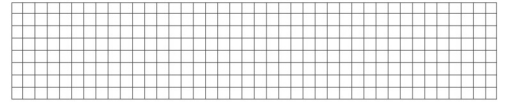
A sexual health app could have an important role in providing information and helping people identify symptoms. But also for booking appointments and keeping your own personal digital records of your sexual health.

“Apps with pictures, so you can self-diagnose early on”

“Face recognition technology, could be adapted for symptom recognition... if technology can provide it, then a demographic with a busy lifestyle [would want it]. Then worth investing in it”

f) Telephone helpline

A dedicated sexual health helpline could play a role in helping men decide what course of action to take and signposting people to services. There was some discussion about whether this could be part of NHS 111 and while there was some appetite for it, there was a clear preference for a dedicated brand, as people would trust it more.



“They do a NHS helpline, can’t they do a special sexual health helpline... I suppose I would be happy to call NHS 111, but prefer to have a dedicated one with specialist knowledge”

“I think I’d prefer to actually talk to someone, I’d prefer a dedicated line. Otherwise in my head, I’ve got a feeling that they are only Googling it anyway!”

g) Information, advice and communications

There is a demand for more information about sexual health in general for men. There is specific demand for information on sexual infections, the risk to men of this age and the symptoms (lack of symptoms). And also, on how condoms have improved in the past 10 to 20 years, especially for men in the 40s or older who may be coming out relationships.

“Would like to know more about condoms and how they’ve moved on”

Sexual health information should be made available where people go, including in clinics, GPs and pharmacies, but also in pubs, barbers, grocers and newsagents. Communications do not need to be ‘in your face’ but signposting people to the range of services available, for when you need them. As well as highlighting in general the risk of STIs and the need to get tested if you have a new sexual partner.

Advertising, should be in regular places where people don’t necessarily think of, like newsagents, barbers. Need for people to feel comfortable – needs to be de-stigmatised”

“You don’t want to see in your grocers, while you’re shopping for your veg, pictures of warts or a rash!”

“Advertise services that are on offer. So if you wake up one morning, it’s easier for someone to get the help that they need.”

Values by which the services are delivered

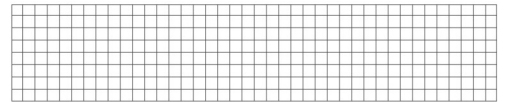
Whatever the actual service, it is really important that any services are delivered by staff that know and care about what they do and show respect for the individual. In summary core values are:

- Speed of access
- Confidentiality
- Respect for the individual
- Welcoming
- Non-judgemental

A good service is about honesty, listening, caring and acknowledgement

“They’re hearing what you’re saying”

“Makes you feel very good, they explained it very thoroughly to me”



10.4 Heterosexual women - Ashford

Understanding of sexual health

While the detail of sexual health means different things to different people, there was a general agreement that a more holistic view needs to be taken of what sexual health covers, that it is about the sexual health of the whole person. Importantly, sexual health means knowing and understanding the issues as well as having access to services or other interventions.

Thoughts about sexual health included:

- Being free of sexually transmitted infections
- The body working properly
- A good understanding and access to contraception
- Easy access (being invited to) regular sexual health checks
- Good personal hygiene.

Knowledge of sexually transmitted infections

Although there is a widespread general awareness of the dangers of STIs and the need to take steps to protect yourself, there was only a limited knowledge of details.

Between them the group was able to name a significant number of different infections and assumed that they were transmitted through sex.

There was a lack of knowledge of the symptoms of the different infection and of the extent that they could be symptomless. There was also a lack of awareness of the physical damage that can be caused by many of the different infections.

In addition, although some of the group believe infections such as Chlamydia were not around “*when we were teenagers*”, no one understood how much more common STIs are amongst people of their age.

“My husband had a Vasectomy, so I don’t have to worry about contraception. So nothing. I don’t know what’s out there for me, to be honest with you.”

Taking care of my sexual health

Individuals take steps to ensure that they have good sexual health and look after themselves in a number of different ways including:

- For information, Googling or looking online. In the main, an NHS logo was seen as a reliable kite mark, individuals will read a range of sites to get the information they need

“[NHS] more reliable than others, but look at all of them”

- Speak to a family member for general information and advice



- If symptoms are noticed, women would go to a sexual health clinic or go to a nurse at their GP. (Many in the group would not take a leaflet on sexual health at the GP surgery for fear that other people “*will see you picking it up*”.)
- Visiting a gynaecologist regularly for a sexual health check up (this was only available to the two French women when travelling back to France – although the English women were strongly in favour of having the opportunity to do something similar here)

“Every three months I go to see my gynaecologist – in France. Here, I go to see a doctor and he say ‘I don’t know’”

- For some, the smear test is the only form of sexual health care available to them.

“Go for Smear test, that’s it really.”

There is something of a cultural divide between the French and English women, with the former being more confident about their sexual health and more expectant to receive preventative and whole body care on a regular (and frequent) basis.

a) Knowledge of local sexual health centres

There was a mixed knowledge of what is available locally. Some participants knew about or had used the sexual health centre in Vicarage Lane and mentioned one in the hospital. Only one woman had used a sexual health clinic locally for her own needs. Most of the group were either unaware of its existence or thought it was not appropriate for them.

Amongst those that knew of the service, there was a strong and unanimous view that the service on offer is poor and does not meet their needs⁹.

“Didn’t even know there was one in Ashford”

“I only know [that there is a sexual health clinic in Ashford] because of my daughter.”

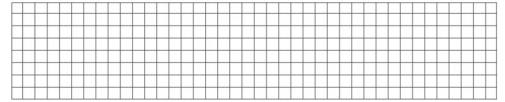
“I know [that there is a clinic in Ashford] helping a friends of my daughter to get the pill”

“[There is] nothing for over 25s!”

“What do they think, you reach the age of 21 and you stop having sex?!”

“Thought that Vicarage Lane was only for teenagers – for contraception or emergency contraception”

⁹ At the end of the focus group we asked the women who, at the beginning of the session, were ignorant of the clinic whether they would use it and they were clear they would not, unless they really had to. *“Wouldn’t want to go there as sounds dreadful, long waits and no certainty of being seen!”*



“Clinic... one day a week [for over 25s]. [You] just sit and wait”

“See information on the back of toilet of doors, but it’s all for under 25s”

“I had to go the day that it was open for you... you could be in that queue and they could say ‘right, we’re finishing now’ and you end up not getting your appointment and you could have sat there all that time. I ended up going two different weeks and I didn’t get seen, I got there at the beginning of the clinic and there was a queue out of the door. It was a worry [having to wait for two weeks]”

b) Views on local GPs

There was group consensus that it is difficult to get an appointment at a GP. And that it is terrible that receptionists ask you why you need to see the doctor – seeing this as an invasion of their privacy and overstepping of the receptionist role. Individuals are also disappointed that they are not able to see the same GP over the years and that this leads to a less personal service.

“When I ring up they want to know what the problem is before they make you an appointment to see a doctor, that’s disgusting. I don’t want to tell a random receptionist what’s wrong with me. I want to see a doctor”

“Every time you go to the doctor you see a different doctor... they don’t know me, they don’t know my body”

Increasing use of sexual health services

Individuals have very clear ideas on what constitutes an ideal sexual health service, the ways in which different services should be provided and how this would increase overall use by them and their friends.

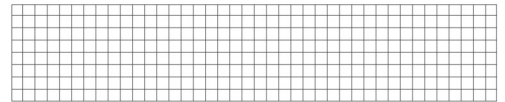
The most important consideration is that sexual health services should be more open and welcoming, as well as being more inter-connected with general health services, treat individuals with respect and as a whole person (including people’s emotional needs, not just physical).

The key attributes of a sexual health service are:

The range of services offered

A range of services is seen to be part of an ideal sexual health service. These include:

- Preventative health
- Treatment for overall sexual health and wellbeing
- Testing and treatment for sexually transmitted infections



- Education and information about all aspects of sexual health, in particular about the range of services available to local people.

Prevention

Prevention is seen as a particularly important service that is missing from the current sexual health service offering. The participants are very keen to be offered regular check up for the overall sexual health, which would help prevent problems and also reduce stigma around sexual health.

Ideally these checks would be offered on an annual basis.

“You get your bloods done, they check your heart, urine test, why don’t they include sexual health?”

“I had a hysterectomy at 29, so don’t get smear test, now I’m not getting checked for anything – 8 years ago was the last time I had a check. I couldn’t say there’s nothing going on”

“Once a year, a quick [sexual health] MOT, that’d be lovely.”

The way in which different services are delivered

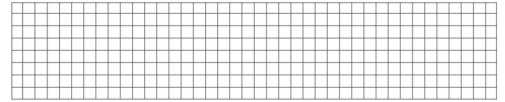
Participants in Ashford preferred that specialist centres deliver sexual health care, which are open six to seven days a week and are separate from GP surgeries.

This is not to preclude other providers supporting sexual health in the area, but that this would be a supporting role, signposting people to the main sexual health centre(s).

The perfect clinic

The perfect clinic would focus on the needs of the individual and provide an appropriate environment in which to offer the right services:

- Friendly and welcoming – no stigma or sense of shame – not feel like a ‘sex clinic’, but more of a ‘home, cafe or clubhouse’
- Centrally located, but discreet
- Passionate staff – friendly, straightforward and knowledgeable (male and female, and of various ages – for intimate examination of women, female staff)
- Not just about STIs, but all ‘sexual health’ and gynaecological issues
- Light and airy: clean but not sterile (and not shabby)
- Comfy seating (with absolutely no plastic) – dispersed through the centre, so not all sitting together (and not sitting with the men)
- Easy to get an appointment (no queues), but also able to walk-in at other times
- Able to bring young children – with a safe play area



- Computer terminals/kiosks available so easy to look things up privately
- Coffee and tea available, and free Wi-Fi
- Able to download and register on a free App (download for free at the centre, and then use it to get information on sexual health and also keep your information securely)

In addition:

- People need to know about it, so it needs to be well publicised
- Change the tone, so people are comfortable to go in for a regular 'sexual health' check up – for maintenance and prevention (ideally invited by their GP in a similar way that women are invited to cervical screening examinations)
- Use of light, large windows and plants (to break up spaces and give privacy to dispel the sense of shame/being behind closed doors)
- Men and women of all ages welcome – but genders discreetly separated by spread out seating areas (ie well designed interior).



10.5 Heterosexual South Asian women based in Dartford

Background to the group

The participants who were involved in the group all live in the Dartford and Bexley areas. In terms of country of origin, four individuals are of Indian origin with one having been born in Sri Lanka. All spoke favourably of life in the area and appreciate the fact that it is peaceful and quiet – but at the same time very friendly. However, while appreciating the area in which they live and work, there is a tendency for the group to socialise outside the geographic area and to go to other areas in which there are significant Indian / Sri Lankan communities – and in particular Wembley and Harrow. Here they will mix with friends and family as well as socialise with members of their wider community.

Cultural influences

All talk of the cultural challenges they face in everyday life – being Asian women. They talk of becoming a wife and mother and “leaving behind” other roles. It was agreed that there are particular problems for widows, especially in the Sri Lanka community where individuals are expected to “be in mourning” for the rest of their lives and to abstain from physical relationships and sex for the rest of their lives.

“When my husband died everyone expected me to wear black for the rest of my life; never to have a relationship. I told my children that I wasn’t going to be like that and that I wanted to meet someone else. They are used to the thought now!”

“Being Indian can mean that you are expected just to be a wife and mother. You are the quiet partner in any relationship”

Culture also influences the extent to which individuals will talk about sexual issues. The Sri Lankan women pointed out that if there had been anyone else from her community in the group, she would have felt much less inclined to talk so openly.

Communications

As a group, the main forms of communication with friends and family are a mix of phone / text and email. There is only limited use of social media with individuals indicating a preference for a more personal one to one approach.

Behaviours to physical health

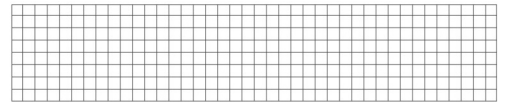
Individuals talk of a high interest and concerns in their own general health and wellbeing. However, in terms of help seeking behaviour, while a couple of participants would phone their GP for help and advice, others would search on line first and then go to either the GP or pharmacy to get appropriate medication.

“I would always phone my GP with a problem”

“I would search on line first. After all that is all that GPs do”

“I feel I have to search on line because it is so hard to get an appointment with a GP and then even when you do you get no time at all to talk”

“Appointments are at the wrong time. They don’t cater for people that work”



"I self-medicate and wait and see what happens. I have had bad experiences with GPs

What does good sexual health mean

While sexual health means different things to different people, there was general agreement that sexual health is "more than" sexually transmitted infections, HIV and contraception. It also includes:

- Contraception
- Check up for all matters relating to sex and sexual relationships
- STIs
- HIV
- Impotency in men
- Cervical smears / cancer
- Self-confidence and having esteem and self-belief that you are able to perform sexually
- Breast checks
- Childlessness
- Post-natal depression - which is seen to be related to the way you feel about yourself sexually and your body

"It is about all of me so that I am safe for my family"

"It is about emotion as well as physical health. The way you feel about yourself is important"

Behaviours towards sexual health

In terms of behaviours relating to sexual health, while only one individual (a student) had been to a sexual health clinic for a full health check, others had insisted that new partners should have a check-up before they would consider a physical relationship. It is interesting that the woman did not believe that she needed a check as *"I know where I have been"*.

"I had a check at university – blood, urine. All that stuff"

Two required their partners to have a full health before they agreed to have sex. The men agreed and the girls did not have checks. They knew that they were OK because they had always been careful and looked after themselves.

In terms of condom use, unless they are in a long term relationship, individuals always get partner to use a condom. However, they rely on the man to buy the condoms because of the perceived "shame" of being seen to buy them, especially if there is a danger that person is from your community.

"It is just too horrible – everyone would see you and think badly of you"

"People would "know""

"Not even in Boots where you can go to the self-check out"

"Buying condoms is a man's job"

"I am a widow and shouldn't even be thinking about condoms – but I want to have a relationship. I can't buy them because someone might see me and I would be "labelled"



in my community. But a friend has made up a “party pack” for me just in case. No one else can know!”

Motivation

The motivation to ensure that condoms are used is health and wellbeing. Despite the fact that individual do not like condoms as they take away sensation and are “clumsy” to use, they are seen to give a sense of protection against unwanted pregnancy and consequently take away fears. However, a number of things can prevent individuals using condoms which includes lack of availability and the age of the woman:

“When the man doesn’t have one and it really is up to him to get them”

“When the woman is older and there is no longer a need to use it for contraception.

Women feel there is a freedom in not having to use one for protection and they love that freedom!”

Sources of condoms

While condoms can be bought from a number of different sources, they are rarely bought by the woman. However, this was seen to be partially “an age thing” and there was agreement that condoms should be available for young people in pubs and clubs. In fact they should be available to young kids (say aged 14)

“It is best for them to know what they should do rather than find out the hard way”

“It would be good to have them in pubs and clubs”

The ideal sexual health service

The idea sexual health service is seen to be made up of a number of key elements:

Education

There is a need for education for everyone

“People don’t think it is a problem they think it won’t affect me. They need to learn”

There should be education for parents.....

“Older people (our parents) just won’t talk about these things - but they need to. They need to be aware and help young people to be aware. The trouble is we just don’t talk about sex”

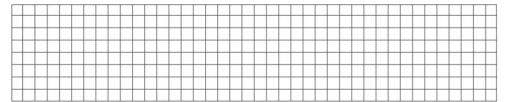
...and young people

Nurses should go into schools and be very clear about the dangers of not looking after your sexual health”

Information can be made available in convenient places - but don’t use leaflets to get the message across:

“The screens at surgery could show information, pictures of the symptoms of STIs on a rolling basis”

“People don’t read leaflets – don’t bother”



Education can be through talking:

“Find people from the different local community to act as Ambassadors – communicating in their own language and making sure that people understand”

“The ability to have open conversations with partners and getting agreement that you will both go for a health check would be a real help”

Advice services

There should be easily accessible advice and counselling services:

“Someone at the surgery who could offer counselling on a walk in basis. They could at least give advice on what to do and where to go.

“A sexual counselling service that helps you with the emotional side of sexual relationships”

Digital consultations

In the era of modern technology there was a call for digital consultation with a specialist. A “live chat” option was seen to be preferable to trying to get an “elusive” appointment with a GP who is by definition a generalist.

“They could even have computers in the health centres that you could use. But live chat with a specialist would help a lot”

Sexual health and wellbeing clinics

There is a perceived need for clinics offering holistic care and supporting sexual health and wellbeing.

“Health and wellbeing clinics that offer appointment and the opportunity to walk in”

“There is a need for something to suit everyone”

You could include support groups. Just to have the ability to talk to like-minded people about (e.g.) contraception. The doctor just tells you what to do but you need to chance to find out other people’s experiences. A support group would be great

Key points to consider

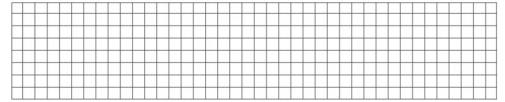
A number of key points were identified that would contribute to / diminish the ideal health service:

“You need to avoid the words sexual health. That will just put people off”

“Need to overcome the belief that STIs etc. are not a problem.

“Any place needs to be discreet, private and convenient”

“Online support would be a real help”



10.6 Heterosexual south Asian men based in Gravesend

Background to the group

All the participants in the group live in Gravesend. Their family's country of origin is India and they are all Sikh. All of them liked living in Gravesend, the main reason being that there is a strong sense of community with the biggest gurdwara (temple). There is also a sense that Gravesend is *"nicely integrated"*.

"It's a nice comfort knowing that you have family around you."

Although Dartford and Gravesend are geographically close, from a community perspective the individuals feel they are very different. Dartford, with a smaller South Asian Community is seen to be majority Indian and Sikh (with a temple), whereas Gravesend, more of a mix, with a Sikh temple and Muslim mosque. All of the participants were *"born and bred"* in Gravesend.

The participants, although they say they *"are not proper religious people"* will *"show their respect"* at their local temple.

Generally the group will socialise in Gravesend, although they will go out to other parts of London too. All individuals go the pub to relax after work, as well as family meals.

When going to the pub, although they will go with their male friends, they are just as likely to go to the pub with their wives and family.

"Occasionally take the family down to the pub for a football game."

"I'll go down [with my mates] if there's a game on."

"Take the missus out for a nice meal during the week to kill the day off"

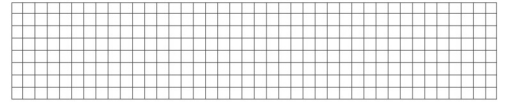
In addition to the pubs and meals, the group go the gym, keep up with cricket, shopping, cooking and see friends and family. *"Just normal life"*

Communications

Individuals stay in touch with people by texting, including apps like WhatsApp. All individuals read the free London papers, as well as national press such as the Mirror, TV news, radio, and online sites such as Ebay and AutoTrader.

All individuals also regularly read local press, the *New Shopper* and *Gravesend Reporter*.

Some of the individuals also read the *Sikh News* online, which is focussed on news in India.



“The family is always up to date with news from back home”

As well as English, all individuals can speak and understand spoken Punjabi, but they cannot read written Punjabi.

Behaviours around physical health

In terms of health seeking behaviour, their decision-making is largely based on reducing the impact of seeking help on their time, in particular avoiding taking any time off work. This means they avoid their GP wherever possible and use the pharmacy as the first port of call. All individuals find walk-in centres frustrating and would rather use A&E if their condition was ‘serious’ as they expect to be seen faster.

“Pharmacy, you can’t go wrong – even in Asda you can grab some food on the way home and pop into the pharmacy”

“GPs are a headache”

“GP, appointments, you have to wait a week. By then your cold or whatever is over”

“A lot of pharmacies have full a qualified practitioner there to give you the right medication and give you a quick examination”

“Walking centres are a myth, you go there and sit there in a queue, but anyone can walk through that door who is a registered patient and they’ll be seen before you. So if you go there and they’ve got an hour and half waiting time, it can turn into three hours – you might as well go to A&E”

“Why can’t you book online [for walk-in centre], rather than having to wait there.”

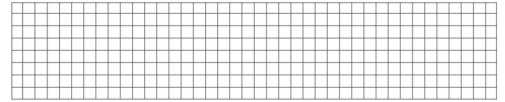
Individuals also go online first, and many of them have used NHS 111, in particular for their child, and have a high regard for the service.

“When you ring 111, it’s qualified nurses [you speak to]. 111 definitely works for me”

What does sexual health mean?

While sexual health means different things to different people, there was a general agreement that sexual health is focused around ‘sex’ and sexual function. It includes:

- Sex
- Penis and testicles - “Your bits”
- Sexual function
- Contraceptive protection (not protection against sexually transmitted infections (STIs))
- HIV and Aids
- Having children
- Education



- Testicular cancer

Behaviours relating to sexual health

This group did not spontaneously bring up STIs as an issue. And none of the group had spoken to a doctor or clinic about sexual health.

“If there was a problem there, if you get symptoms, then I’d go. But if I was feeling good and healthy then I wouldn’t talk about it.”

“If you ain’t got a cold, a sniffy nose, you don’t to a doctor. You don’t go and ask to check if you’ve got a cold.”

“I don’t think I even know any of my friends how have had one [STI test]”

The participants in the group were very unclear about STIs, the number or types of infections that could affect them, and the possible impact on their health. Individuals thought that STIs were more of an issue for women.

“A lot of them are linked to women. I bet you that women can have more than men.”

Although some individuals had a sense that STIs may not always have symptoms, there was no sense that they could have been exposed to an STI in the past.

“I’d assume that there would be symptoms.”

“I always thought if you ever got anything like that [STI] it would burn when you piss or something like that. You’d feel something.”

“I’ve just learned more here [during the discussion of STIs in the group] than I did in the whole of uni”

Individuals were uncertain about the process for testing with STIs, with an assumption that there needs to be a blood test. Only one individual had ever had a STI test, when his friend dared him to give a sample as a part of a Chlamydia outreach campaign at university.

Cultural influences

All individuals agree that sexual health and sex is a difficult topic for discussion in the local Indian community. Their fathers did not discuss sex education; rather they left it to the older brother to bring up or not at all. Advice on sexual health also focuses on not preventing unwanted pregnancy, not STIs. The older generation will need information in Punjabi. Because of the sensitivities in talking about sex and sexual health, participants would not have been comfortable to be so open if the group had been any larger.

“My brother said, ‘I hear you have a girl. Don’t fuck about, don’t get her pregnant.’ And I didn’t know how to put a condom on or nothing!”



“In the Asian community, people may have these diseases, but they won’t go to their GP to talk about their privates. Some people hurting down there won’t go to their GP, instead go online and try remedies.”

“My mates are proper jack the lads, definitely got something but won’t go to a GP. He got his uncle to talk to the GP and got a prescription from a different town.”

“If I had a urinary infection, I’d be a bit embarrassed, but would talk to my GP.”

“If there was another 3 or 4 us [in the group] I wouldn’t be this open. I wouldn’t talk about my family, my kids.”

There is a sense that the younger generations are changing rapidly.

“People look at certain races as in Muslim, ‘oh shit they’ve got to cover themselves up’, Indian ‘oh, woman stay at home’. The world out there now is so modernised that women and men are equal. Our parent’s [and] grandparents generations are realising that.”

“Things have changed. Women go to the pubs, the missus tells them [parents/grandparents] what the atmosphere is like.”

Condoms

Condoms are seen as a form of contraception, rather than protection from sexually transmitted infections.

Individuals do not use condoms now as they are in long term relationships. However, when they were single – at college or uni – they would use them, but not necessarily if the women was using another form of contraception.

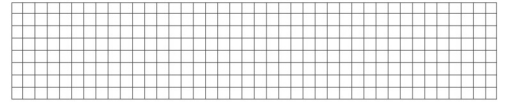
Individuals find the idea of buying condoms embarrassing.

“At uni we used to get free condoms. We used to make jokes about it in front of our mates. But really we were thinking ‘shit, who’s is going to buy them for me now”.

“If I had to go to a shop to buy a condom, I’d be thinking ‘bloody hell, that’s going to be awkward’. There’s a good chance the person behind the till will be an older generation so he feels a bit awkward.”

“It’s a bit embarrassing, you got eggs, you got milk, you got condoms! You try and hide it!”

“I wouldn’t [buy a condom from a corner shop]. I’d go a couple of streets up – wouldn’t go to my regular one.”



Most of the group were interested in the idea of buying condoms online, as long as it is discreet. Participants were keen to know that the condom was a good brand, but did not know much about what brands were available, apart from Durex. Participants had never used condoms as a sex aide.

The ideal sexual health service

Education

There is a need for more education for everyone, particularly in the local Indian community.

“It’s never too late to learn. I don’t think it’s [education] out there enough. I was never taught about it.”

“When I was a kid, I didn’t get taught sex ed until I was in year 9.”

There was a lot of discussion about when sex education should start. Some felt that 11 was too young, but others felt that it was appropriate to start so that they are prepared for secondary school.

“There’s a good chance that kids of 10 and 11 are looking at things on their phones”

There should be education for parents and grandparents in Punjabi and this would need to take into account the language barrier.

“Those Indians that don’t speak English, they’re not going to use internet”

“Need to advertise it on the Sikh TV channel”

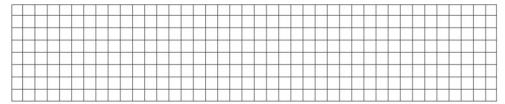
Online – ordering Self-testing kits and condoms

Individuals liked the idea of self-test kits because of the discretion and confidentiality that they could afford.

“You can go online and order Chlamydia tests straight to your door”

Sexual health clinics

Participants perceived the need for specialist clinics they can go to that are out of the area so that people can test for STIs without any chance of anyone from the community finding out. Ideally, the clinic would be available to the East of Gravesend, not further into London.



11 Appendices

11.1 An approach to identifying and implementing behaviour change

Following the Behaviour Change Wheel process to translate findings and insight into actionable recommendations.

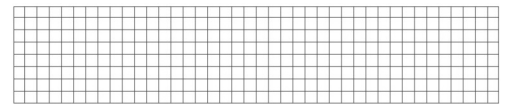
The process identifies the desired behaviour change, and from a long list of candidate interventions we are able to narrow down the selection based on practical criteria.

STEP 1 – defining the desired behaviour change

What behaviour?	Use a condom with every new sexual partner as a default action (whether known/unknown/perceived to be clean/respectable etc).
Where does the behaviour occur?	In personal spaces
Who is involved in performing the behaviour?	Target population: adults over 30 yrs in Kent

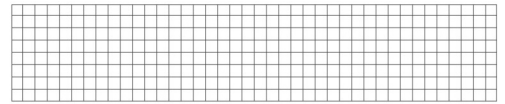
STEP 2 – Generate list of target behaviours to bring about change

Intervention designer response
<ul style="list-style-type: none"> - Buying condoms in advance - Having condoms on you - Having condoms at home - Negotiating with sexual partner prior to sex - Condom purchasing as part of 'going on a date' regime - Continued use of condoms with partner until both tested for STIs - Seek out condom availability late at night / last minute situations - Check with the other partner whether they have a condom - Make it known whether you have a condom or not - Buying condoms / having them available as a sex toy - Get condoms free from sexual health services (eg clinic) - Getting the right size of condoms / having a range of sizes



STEP 3 – Assessment of intervention ideas based on practical criteria and select highest scoring behaviour

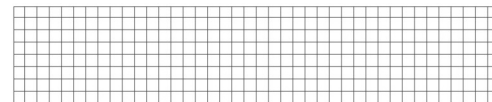
Potential target behaviours	Impact of behaviour change (unacceptable (0), unpromising but worth considering (1), promising (2), very promising (3))	Likelihood of changing behaviour (unacceptable, unpromising but worth considering, promising, very promising)	Spillover score (Likelihood that behaviour will have a positive impact on other behaviours) (unacceptable, unpromising but worth considering, promising, very promising)	Measurement score (how easy will it be to measure behaviour) (unacceptable, unpromising but worth considering, promising, very promising)	Score
Buying condoms in advance	Promising	Promising	Very promising	Promising	9
Having condoms on you	Very promising	Unpromising but worth considering	Very promising	Promising	9
Having condoms at home	Promising	Very promising	Promising	Promising	9
Negotiating with sexual partner prior to sex	Very promising	Promising	Very promising	Unpromising but worth considering	9
Always having a condom with you as part of going on a date regime	Very promising	Promising	Very promising	Promising	10
Continued use of condoms with partner until both tested for STIs	Very promising	Unpromising but worth considering	Very promising	Unpromising but worth considering	8
Seek out condom	Very promising	Unpromising	Very promising	Unpromising	8



availability late at night / last minute situations		but worth considering		but worth considering	
Check with the other partner whether they have a condom	Promising	Unpromising but worth considering	Promising	Unacceptable	5
Make it known whether you have a condom or not to the other partner	Promising	Unpromising but worth considering	Promising	Unacceptable	5
Get condoms free from sexual health services (eg, clinic)	Promising	Unpromising but worth considering	Promising	Very promising	5
Buying condoms as a 'sex toy' / for fun	Promising	Promising	Promising	Promising	8
Getting the right size condom / having a range of sizes	Unpromising but worth considering	Unpromising but worth considering	Unpromising but worth considering	Unpromising but worth considering	4
Record selected target behaviour here:	Always having a condom with you as part of going on a date regime				10
	This behaviour gained the highest score: 10 (out of possible 12)				

STEP 4 – Specify behaviour

Target behaviour	Always having a condom with you as part of 'going on a date' regime
Who needs to perform the behaviour?	Men and women, age 30+, living in Kent.
What do they need to do differently to achieve the desired change?	Always having a condom with you as part of going on a date regime
When do they need to do it?	Every time a date becomes an opportunity.
Where do they need to do it?	As they are preparing to go out / welcome a date / meet with



	someone on a date
How often do they need to do it?	Every time they prepare for a date
With whom do they need to do it?	Alone activity

STEP 5 – Identify what needs to change

COM-B Components	What needs to happen for the target behaviour to occur?	Is there a need for change?
Physical capability	N/A	
Psychological capability	<p>Educate target audience to understand the risk of STIs and that condoms are the best preventative measure to protect them and their partners.</p> <p>People need to understand that STIs often have no symptoms</p> <p>People need to know where to obtain condoms easily in Kent.</p> <p>People need to understand that condoms are not just for contraception.</p> <p>People need to believe that condoms are not a negative barrier to having fun.</p>	<p>Yes – our research demonstrates that this population does not necessarily perceive a risk of STIs to themselves.</p> <p>Yes - Education around lack of symptoms of many STIs leading to it not being possible to accurately judge whether an STI is present.</p> <p>Inform target audience where condoms are readily available.</p> <p>Yes - Importantly amongst some groups (women over 40) condoms are primarily considered a form of contraception.</p> <p>Need to shift perceptions around condoms as a barrier to / enhancer of good sex.</p>
Physical opportunity	Make condoms readily available.	No – condoms are already readily available through retail and health service providers.
Social opportunity	Lowering of social barriers (such as	Yes – a cultural shift towards condom

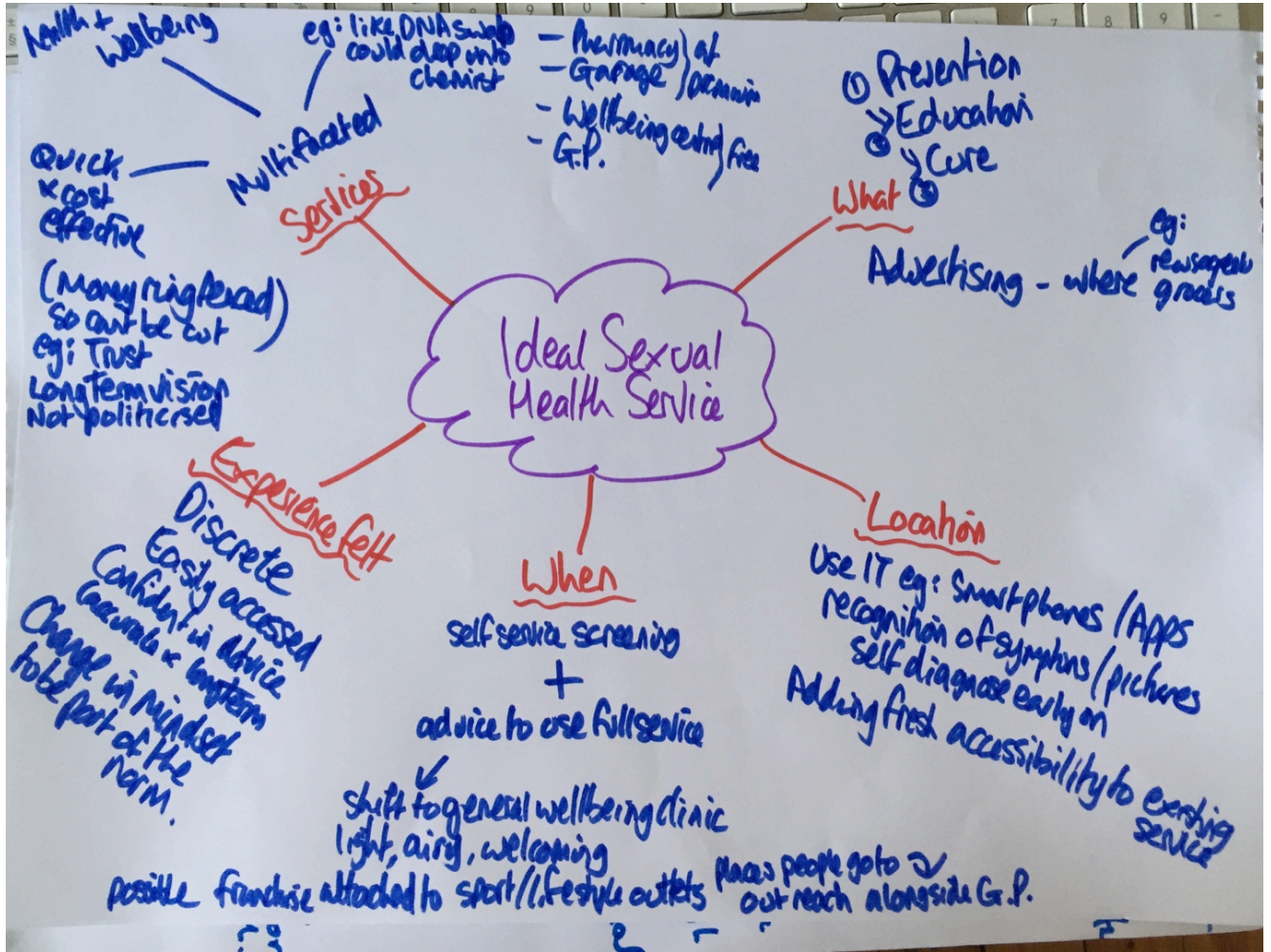


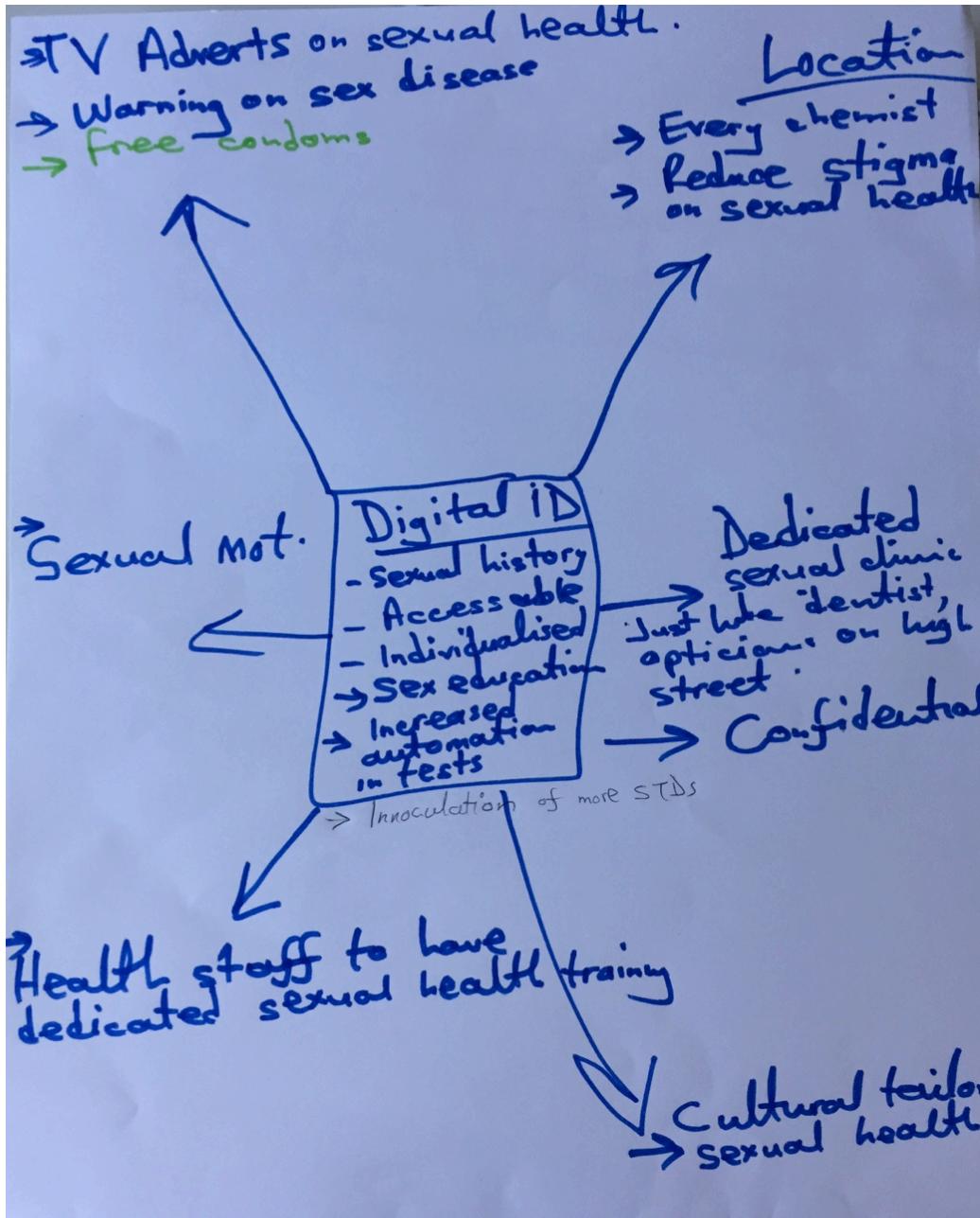
	embarrassment) to enable open conversation with social groups and partnership pairs/groups around condom use.	acceptability and value.
Reflective motivation	<p>Having a belief that STIs are a risk to me and that condoms are a reasonable method of protection.</p> <p>Positive attitude to condoms enhancing sexual experience.</p> <p>Altruistic attitude that condom use will protect my partner and is therefore an expression of care.</p>	<p>Yes – “STIs are a real risk to me, and condoms are the best and most effective forms of protection” (health belief model)</p> <p>Yes – people in the target age group are likely to be unaware that condoms have changed a lot in recent years.</p> <p>From literature review, and some focus group insight – there is an opportunity to promote a real shift in people’s view of condoms as a way of showing care for partner wellbeing.</p>
Automatic motivation	Condom availability needs to become part of people’s dating routine.	Yes – see above.

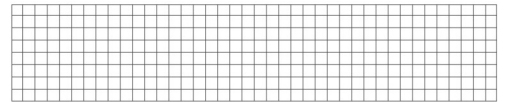


11.2 Images and notes from co-creation workshops

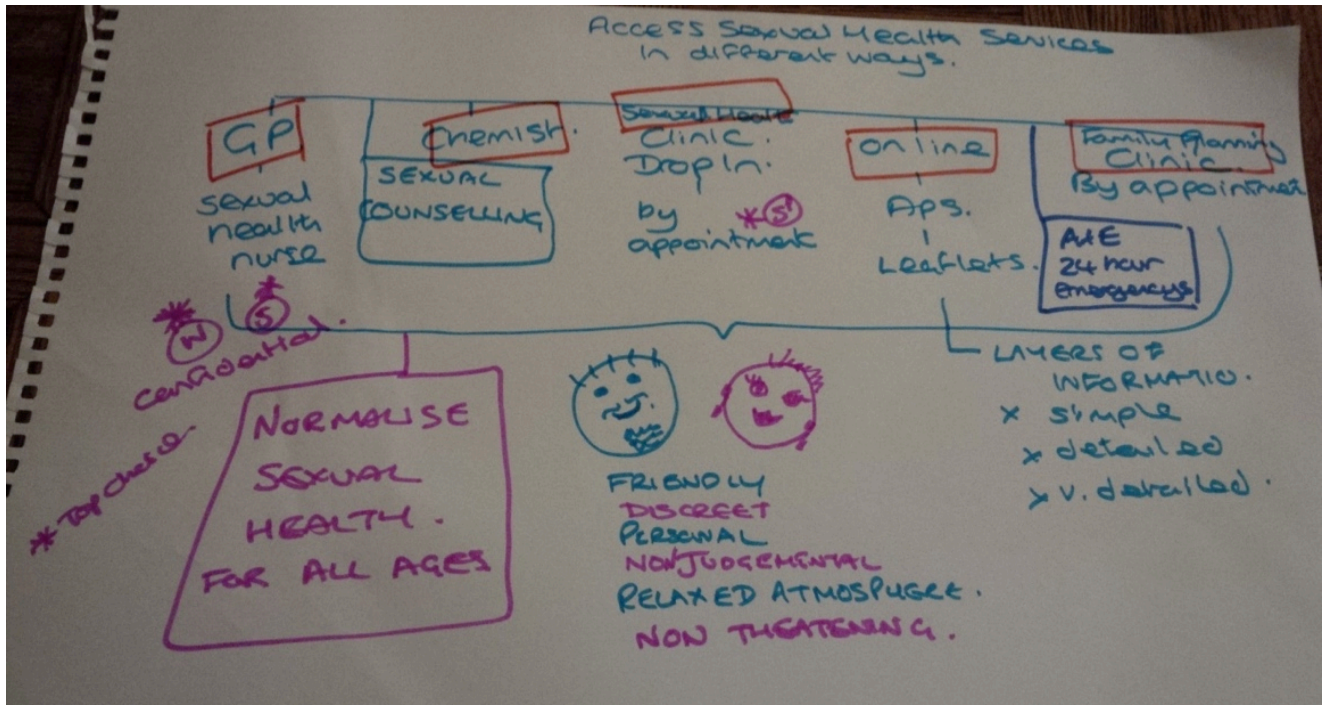
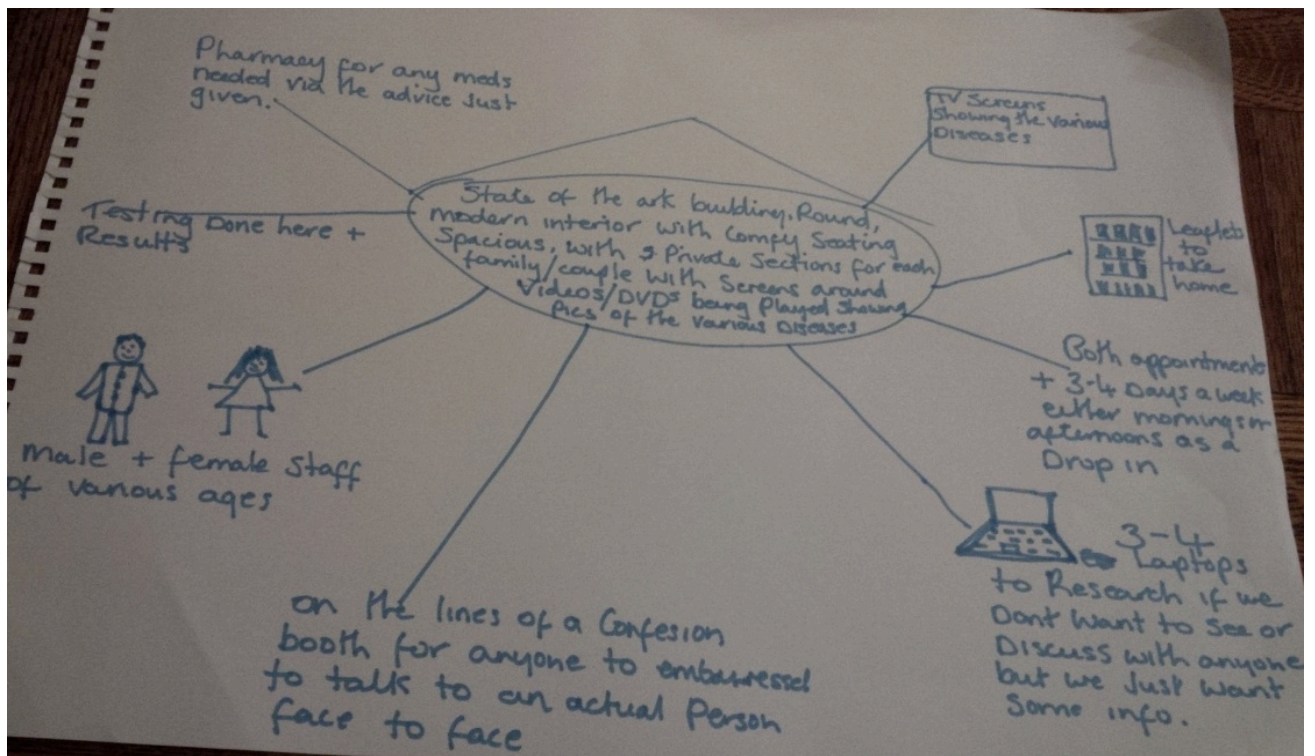
11.2.1 The ideal sexual health service – heterosexual men of Folkestone

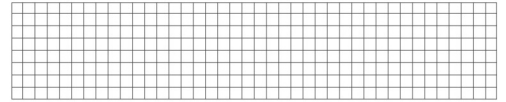






11.2.2 The ideal sexual health service – heterosexual women of Margate

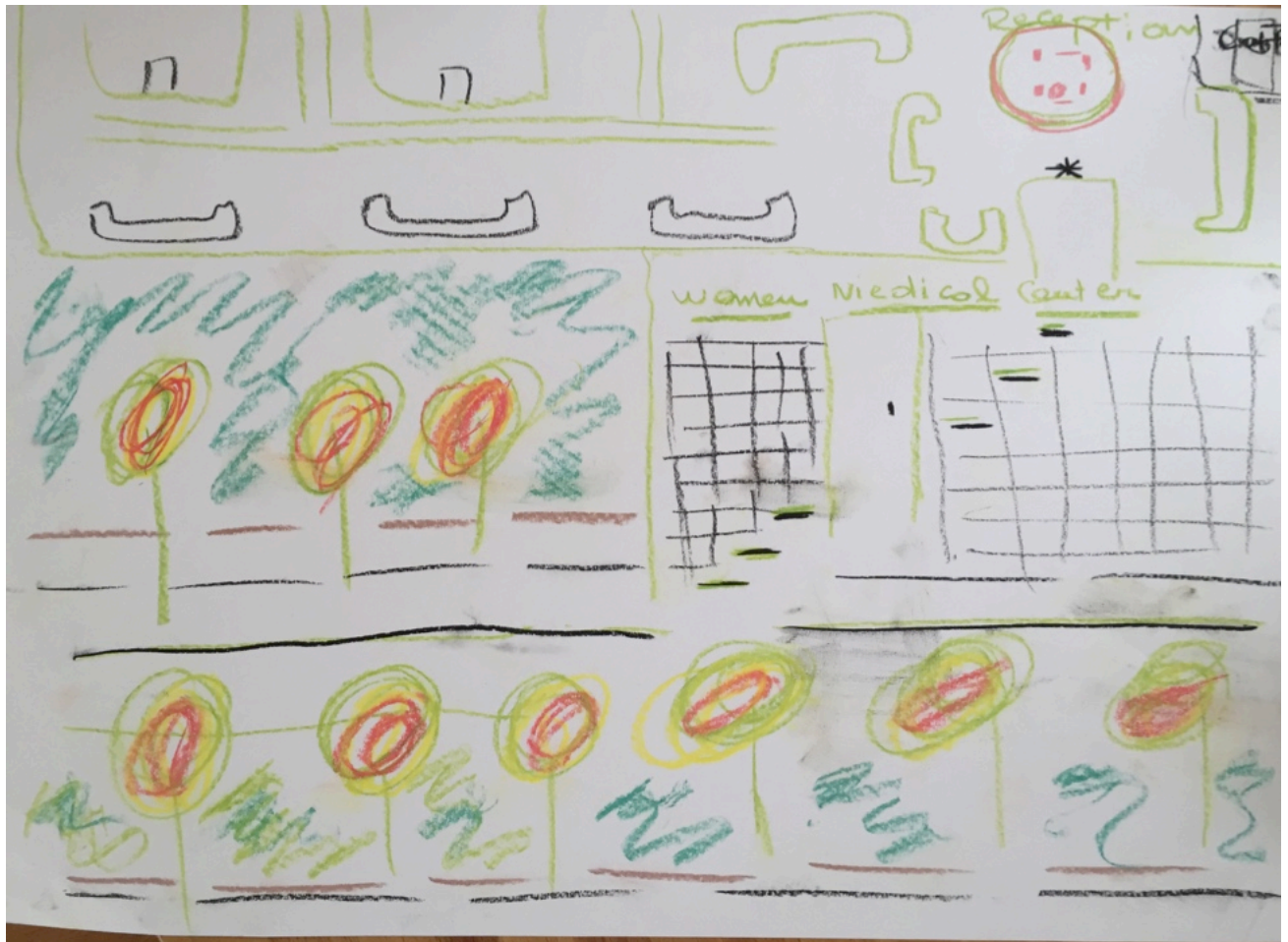




11.2.3 The ideal sexual health service – heterosexual women of Ashford

1 In their own words:

- Spacious
- Welcoming receptionist
- Specialised physicians available for rapid appointments
- Comfortable seats to wait and feel confident
- In town – easily accessible



Discussion

- Attractive environment on the outside – use of plants to make it attractive and also discreet
- Steps (or entrance) that takes you away from the street into a new environment – into the ‘Medical centre’
- Greeted by reception – who welcomes you when you ‘knock or ring’ – invites you to have a seat while you complete any paperwork
- Receptionist offers you a coffee or a tea “to help you to wait”
- Specialised medical centre with all the specialists available – to make it “an easy appointment” – not having to go to different places

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- Plenty of comfortable seating, not all together

No 2 – In their own words:

- Bright
- Comfy
- Welcoming



Discussion

- “Very bright, very welcoming, very comfortable”
- Music – so not quiet
- “Be able to buy chocolate... because women love a bit of chocolate, be able to get a drink of water”
- Very welcoming receptionist
- NO plastic chairs
- Different areas for different STDs



- “Smack bang in the centre of town... behind the Bingo hall is” where there is good parking and also good buses – should be in the middle of town, “easy access for everyone to get to”
- Can have both male and female in the centre, don’t want men & women sitting/mingling in the same area – as town is small and you don’t want to be sitting next to/opposite to the guy you’ve had sex with – same building, but not sitting in the same reception
- Of course, should be able to go with male partner

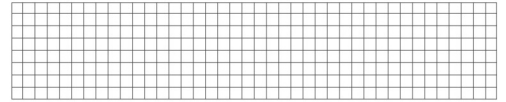
No 3. In their own words:

- If clinic looked more like a house, perhaps they would be more friendly towards women and girls, because younger and older people need to be able to access this service without feeling embarrassed



Discussion

- “More like a house, so it didn’t look so it didn’t look so much like a clinic
- Called the “Welcome Clinic”
- Phone up and make an appointment – “so not in a queue with loads and loads of people”



- Suppose okay for people to walk in as well – “should be able to allow for that on certain days”
- Don't want it to be embarrassing
- Really accessible to men and women

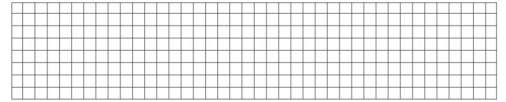
No 4 (two images)





Discussion

- Called "New Horizons"
- "In the town centre centrally, but not on the high street"
- "Not many people see you, unless they knew it was there – sort of disappear"

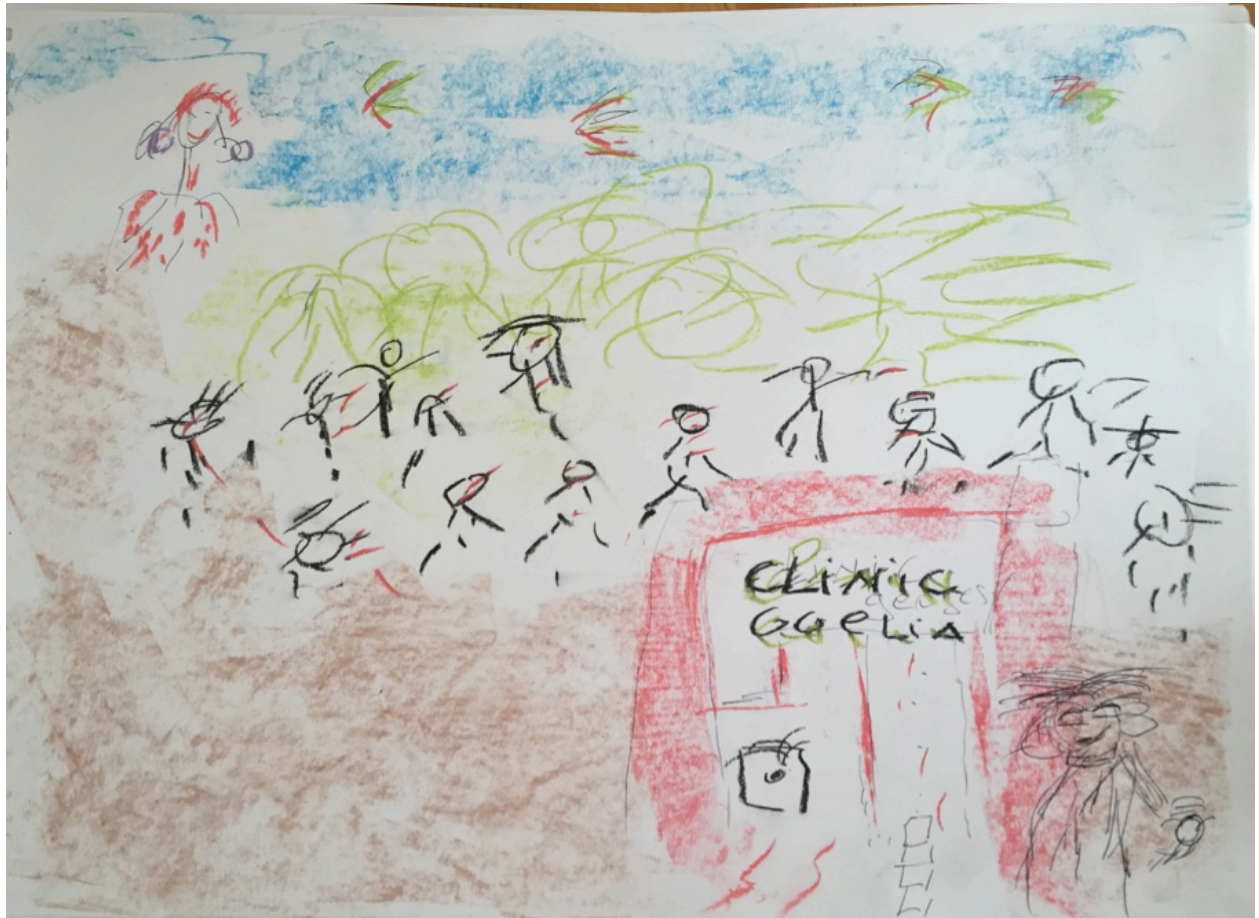


- “From outside, more like a coffee shop”
- Seating outside and play area for children (fenced off – so safe) – “in the middle of the week, when you’ve got your children, you don’t want to say to someone ‘would you look after the kids, I’ve got to go to the clinic!’ – so you can take your little children with you
- Inside: - coffee area
- Rather than having reception desk – more little points dotted around
- Sofas, chairs, play areas
- Individual rooms, so you can speak to people individually
- Male & female staff – young and old
- Open to young and old – different areas?
- Mix of appointments and walk in each day
- Wifi available – rather than a appointment form, have an app you can download over the Wifi – complete the registration – gives you security & privacy (for those without, got leaflets & forms – but covers are different – so if someone sees you reading it, don’t know what you’re reading)
- “All sexual health” catered for



No 5 - In their own words:

- Nice
- Life
- Green
- Sunshine
- Now
- Good health
- Nice clinic



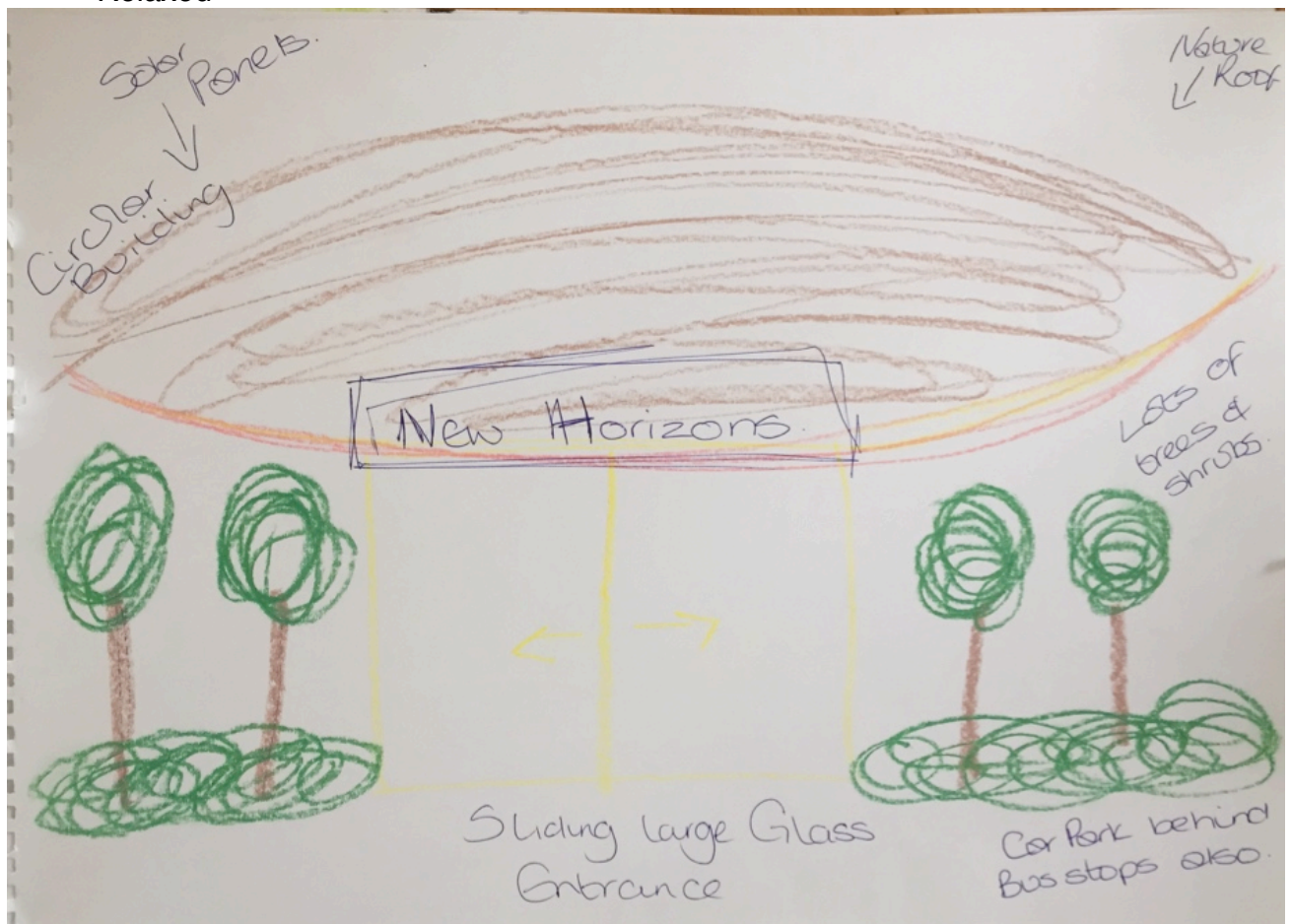
Discussion

- "This is my dream, when I close my eyes"
- Health – blue, sunshine, green – "health is inside of me"
- See the population of Ashford – men, children, women – everyone
- Start (top left) & finish bottom right – after going through the clinic
- Name of clinic: Clinic Gaelia
- One week in the clinic every year – "they look at everything; when doctor says: 'all alright', I'm happy"
- Like going on holiday
 - o "comme ca, is less price for NHS – they see very early [if anything broken inside], men, women, the babies, everyone



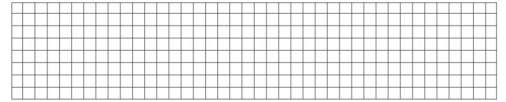
No 6 – In their own words

- Discreet
- Eco-friendly
- Welcoming
- Green & pretty
- Light & air
- Private
- Relaxed



Discussion

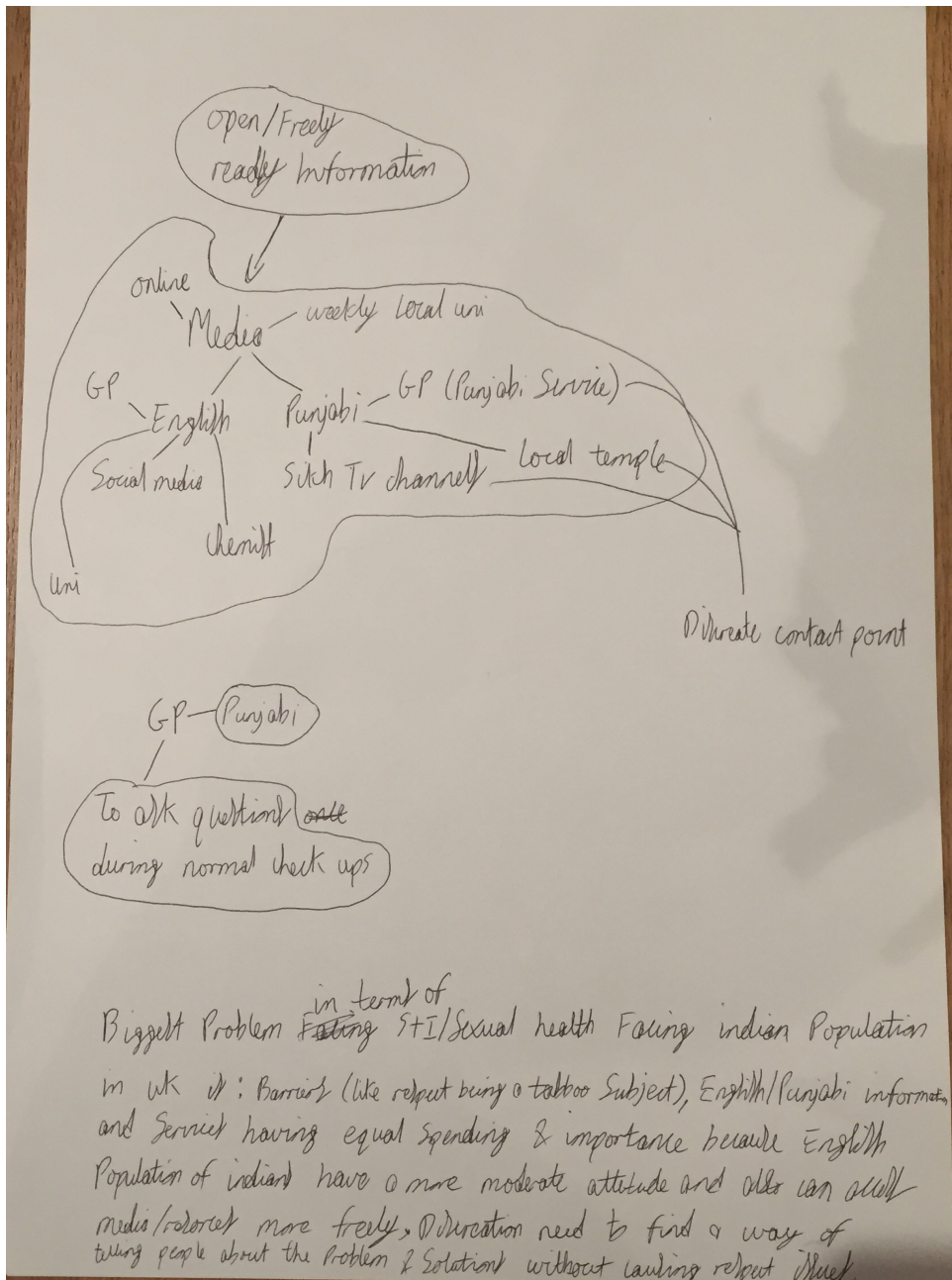
- Discreet and attractive – use of Trees/ shrubs to give privacy as well as attractiveness
 - o non-clinical – more green
 - o allows for the building to have lots of glass – privacy with plants
- Welcoming – large sliding glass doors
- Well connected by transport (both cars and public transport)
- Lots of comfy seating areas
 - o Seating areas split



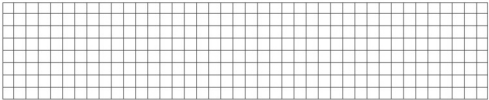
- Allows for men and women in separate areas [also different ages?]
- Place where children could be dropped off (safe and pleasant crèche)
- Booking & drop in area
- Consultation rooms off the central space



11.2.4 The idea sexual health service: South Asian men in Dartford



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