

SEXUAL AND REPRODUCTIVE HEALTH: QUALITATIVE INSIGHTS

Full Report

Qualitative Insight Team, Public Health – Wirral Council

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List of acronyms

AIDS	Acquired Immunodeficiency Syndrome
‘BAME’	Black, Asian and Minority Ethnic Communities ¹
HEP C	Hepatitis C
HIV	Human Immunodeficiency Virus
JSNA	Joint Strategic Needs Assessment
LD	Learning difficulties
LGBTQA+	Lesbian, gay, bi-sexual, transgender, queer, asexual
MSM	Men who have sex with men
PrEP	Pre-Exposure Prophylaxis

¹ The term ‘BAME’ is used in this report only when referenced by the research participants. In all other contexts, the term ‘ethnic minority communities’ is used.

Executive Summary

Background and methods

This research was carried out by the Qualitative Insight Team on behalf of the Public Health Team in Wirral Council.

This piece of qualitative research contributes to data being gathered around Wirral residents' sexual health outcomes and their experiences of using sexual health services. The Qualitative Insight Team were asked to gather qualitative insights into people's experiences and preferences around the following areas of sexual health service provision: STIs and STI testing, particularly Chlamydia; HIV; unplanned pregnancies and teenage conception; and cervical screening. In addition, the researchers were asked to focus on gathering insight from four key priority groups which were identified as at risk of poorer sexual health outcomes in the sexual and reproductive health Joint Strategic Needs Assessment (JSNA) and other key strategic documents. These groups are young people aged 15-24; people in the LGBTQA+ communities, with a particular focus on men who have sex with men; people living in deprived areas; and ethnic minority communities.

The findings from this research will help to ensure the voices of these groups shape the next commissioning plan for sexual and reproductive health services in Wirral. They will also aid the delivery of the Health and Wellbeing Strategy, particularly Priority 2, such as ensuring residents have easy and timely access to services shaped around them and addressing differences in health outcomes.

Between February and March 2023, the researchers spoke to 97 people using a variety of research methods. Table 1 below provides a breakdown of the number of research methods that were used to engage with different participant groups.

Table 1: Research activities.

Method	Number of times the method was used	Participant group
Focus groups	6	Professionals/ young people
In-depth conversations	8	Women involved in sex work/ women
Semi-structured interviews	2	Women in the LGBTQA+ communities
Informal conversations	34	All participant demographics
Research grids	17	Women and men
Participation observation	7	HIV Week events, support groups, and a women's health event for professionals

The researchers adopted a broad range of methods to make the participants feel as comfortable as possible given the sensitive/personal nature of the research topics.

Thematic analysis was used to identify themes within and across the participant demographics.

Summary of findings

Groups at a higher risk of poorer sexual health outcomes

The research findings complemented existing insights, particularly on groups identified in the JSNA as at higher risk of poorer sexual health outcomes. The JSNA and other official documents that laid the foundation for this qualitative piece had identified four groups: young people aged 15-24; people in the LGBTQA+ communities, with a particular focus on men who have sex with men; people living in deprived areas; and ethnic minority communities. The Qualitative Insight Team tested this supposition through interactions with professionals who work with different groups of people by asking them to identify who they consider to be 'underserved' or at risk of poorer sexual health outcomes. The professionals identified the four groups above, as well as five more groups: women engaged in sex work/drug use, women experiencing abusive relationships, refugees, people with learning disabilities and older people living with HIV.

STIs and STI testing, particularly Chlamydia

Most of the insights gathered on STIs were from young people and they reveal a gap between young people's knowledge of available services and their preferences. Young people are clear on their preferences of how they want to be engaged and where they would want to go for testing and to access services, but they do not feel confident in their knowledge of where to access those services. Beyond knowing their preferences, a shared sentiment among the young people was that they had limited understanding of the different types of STIs, symptoms, testing and treatment. It appeared there were factors that influenced their amount of knowledge, such as: access to sex education at high school, personal experience with sex and relationships, having family members in health care jobs, and relationships with parents and friends.

A case study of a young woman who had tested positive for Chlamydia was also a useful tool to illustrate some of the key themes around STIs. The case study demonstrates young people's lack of understanding of STIs and testing, misconceptions about how STIs are transmitted, the stigma around STIs, and preference for discreteness. It highlights how online information about STIs, and testing can be confusing. It also shows how young people can have a relaxed attitude towards testing after new partners. Older women and men also generally did not feel confident in their knowledge of STIs with regards to testing and resources/information available to them.

HIV

The research findings complement the findings in the JSNA which identifies low prevalence of HIV in the borough but relatively high incidences of late diagnosis. The engagement with the professionals echoed this and goes a step further by offering insights into why this is the case from their experiences of working in sexual health for years. Professionals working in sexual health across various organisations agreed that HIV treatment has advanced significantly in the borough. An organisation that focuses on pop-up clinics and STI and HIV testing reported that in the past 12 months, after testing hundreds of people, they have only come across two HIV positive cases. Reflecting on the numbers, one professional remarked: *“So, relatively low, but we know we’re bad for late diagnosis...Two in 12 months is amazing if you think about it. If you went back into the 80’s, it was scary.”*

The reasons provided for late diagnosis were quite varied. One of the key reasons identified was assumptions over knowledge. Professionals felt that people often assume they aren’t at risk of contracting HIV. There is a general assumption that certain groups of people with a particular sexual orientation are the only ones who can get the virus. Professionals working in the drugs and alcohol space described how they can often see this attitude among people who use steroids. Despite professionals' efforts to educate around the risks of using other people’s equipment or the wrong size needle, professionals find that some steroid users can be resistant to taking advice because of the perceived lack of risk.

An interesting finding with regards to HIV is that the young people engaged in the research didn’t seem to have much knowledge on HIV. When asked about HIV, including transmission, symptoms, testing etc., some young people didn’t feel able to answer. One group said they had *“no idea”* of the symptoms of HIV. Some were able to describe how it contracted/treated, such as that it’s *“treatable not curable.”* The young people often talked about HIV and AIDS together, suggesting a lack of understanding of the difference between the two.

Another key finding from conversations on HIV is that there is still stigma regarding HIV and people in the LGBTQA+ communities, particularly men who have sex with men (MSM). The stigma reflects a dearth in information and education when it comes to HIV. A GP communicated that people tend to assume that saying that these people are at a higher risk is often interpreted as stigmatisation, while in fact it is because anal sex poses a greater risk of tear and therefore contact with blood.

Unplanned pregnancies and teenage conceptions

The biggest issue that came up throughout the research around unplanned pregnancies and teenage conception was the issue of contraception. Women must contend with multiple challenges when it comes to contraception. Information was a prevalent theme in conversations around contraception, and women of different ages content with these issues in different ways. Young women between the ages of 15-24 perceived that there is inadequate information on the types of contraception available and their side effects, and they don’t feel confident making choices. When asked about their knowledge of

contraception, the young people could list a few contraceptive methods, but they could not break down what each of them entailed or how they worked. They had heard about them from social media, conversations with other women in their lives, and some classes from school.

Engagement with women over twenty-four revealed that these women also perceive there to be a lack of adequate information, but their experience is different from the younger women in that most of them know what contraception options are available, but the biggest hurdle is not knowing how to access the contraception. More than struggling with where to get condoms or other contraception methods, women struggle with booking appointments to discuss their contraception options. The theme of GP access and contraception came up a lot in the research. People perceived that this is due to the residual effect of COVID-19 and its impact on health services in general, not only sexual health. The commonly held view is that during COVID-19, GP practices *“... changed the way they work and never got back to pre-COVID working.”*

Professionals that work with people the LGBTQA+ communities said that the language around contraception options can be limited as its too male-focused with too much emphasis on male condoms, meaning *“women who sleep with women feel left out of the whole conversation”*.

With regards to abortion, women were not confident in their knowledge. A few sentiments that were shared across the different engagements were: *“I wouldn’t know where to go,” “I don’t trust the doctors to give me the right [contraceptive] pill, let alone go through an abortion.”* A Year 13 student commented *“Teach about abortion; where to go and how to get it safely. Too much stigma”*. A professional in youth sexual health services added that they’re seeing demand from young girls for workshops on pregnancy options (including termination). Social media was pointed out as a key theme in information/misinformation when it comes to abortion, such as it being presented as a joke on Tik Tok.

Post-natal contraception also stood out as a key theme in the research around unplanned pregnancies. Professionals from an organisation that supports families indicated that most women are not confident about the contraception available to them after they have just given birth. They said that contraception is *“the last thing people want to talk about after giving birth”*, but they cautioned that *“...this is also the period that they are very fertile”* and so awareness of fertility and contraception options is important. The professionals identified barriers preventing parent’s awareness of post-natal contraception, for example they noted that since COVID-19, there have not been antenatal classes at the local hospital, meaning that parents are not getting the same access to contraception advice as before COVID-19.

Smear testing (cervical screening)

The research found that there are a few barriers around smear test appointments, including waiting times, location, and cis-normative language in online booking systems. It appears that there is a small window of opportunity where women are motivated to book and attend an appointment, and so having to wait can be a deterrent. Several women communicated that waiting times add to their anxiety. The location of smear test appointments was identified as an important factor for making women feel comfortable. There was a consensus among sexual health professionals about the need to bring services like smear tests into the community spaces that people are familiar with. The research also revealed there are gaps in people's knowledge/ misconceptions around cervical screening.

Professionals working with people in the LGBTQA+ communities said that transgender people can be discriminated against during the online booking system for smear tests. Transgender people can struggle to access services for their gender assigned at birth. For example, a trans-male who was assigned female at birth can't book a smear test because once he selects 'male' as his gender on the form, smear tests are not listed.

Anxiety and discomfort stood out in the engagement as key barriers. The whole smear test process, including booking, waiting for the appointment, undergoing the procedure, waiting for the results and in some cases having to re-test, is an anxious time for some people. Women described how this anxiety can stem from the fear of the unknown, misconceptions, past negative experiences, or from stories shared by family.

Two case studies are used in the report to capture the knowledge gaps and misconceptions around smear tests. The case studies reveal that there is misunderstanding around who needs a smear test as well as what 'good' looks like in terms of vaginal health/sexual activity when it comes to smear tests. For example, Ann (a woman in her sixties) thought that sexual inactivity was a *"good thing"*. Another young woman was concerned that having a smear test would compromise her virginity, and she was unsure whether she even needed a test.

Sexual health education and awareness

A common theme that underlined all the focus areas was the need for continued improvement of sexual health education and awareness. Within each of the themes, you can see how lack of knowledge and perceived lack of information are posing barriers to people's confidence, empowerment, and ability to make informed decisions around sex and sexual health. Examples of perceived gaps in information discussed included: LGBTQA+ sex education, abortion and pregnancy options, the side effects of contraception, where affordable contraception can be accessed, options for post-natal contraception, the symptoms of STIs and HIV and how they're transmitted, what STI and HIV testing/treatment involves and where it can be accessed, where to access smear tests and who needs one. Sexual health knowledge was varied from individual to individual, while this may be down to the individual's willingness to talk about sexual health with the researcher, it was clear that people's access to sexual health education at home, at school, and in the community can hugely vary.

Overarching themes

Throughout the data, there were themes that cut across the different participant groups and the different areas of sexual health provision. These were:

- The need for sustainable sexual health services.
- The “*domino effect*” of COVID-19 on service provision and attitudes towards sex and relationships.
- The impact of negative experiences/perceptions of sexual health services on people’s confidence accessing support and ability to make informed choices about their sexual health.
- Gaps in knowledge and awareness of sexual health information/services.

For a detailed discussion of these overarching themes, see the conclusion to this report.

Project background

The project focused on understanding sexual health service provision in the Wirral with a focus on STIs, particularly Chlamydia; HIV; unplanned pregnancies and teenage conceptions; and cervical screening. The focus was streamlined to groups that were identified in the JSNA and other official documents as priority groups at risk of poorer sexual health outcomes. The identified groups included: young people aged 15-24; people in the LGBTQA+ communities, with a particular focus on men who have sex with men; people living in deprived areas; and ethnic minority communities.

Commissioning background

There are quite a few commissioned services that provide support for sexual reproductive health in Wirral. They provide services ranging from STI testing and treatment, STI pop-up clinics, HIV testing, HIV prevention and support, contraception, digital support, community outreach, GP and pharmacy support, and psychosexual therapy, among other services. However, the JSNA and other key strategic documents revealed there are certain communities in Wirral at risk of poorer sexual health outcomes. The sexual health commissioning team therefore wants to ensure that the voices of these identified groups contribute to shaping the next commissioning plan for sexual and reproductive health, in compliance with procurement regulations.

The commissioned contracts in place end in March 2024 and the new contracts must be in place by 1 April 2024. The Qualitative Insights Team were asked to gather insight from the groups identified to help inform the recommissioning of these services. The insight gathering had three main parts:

1. Gap analysis of available sexual reproductive health insights,
2. Qualitative Insight Team to gather insights from specified communities, and
3. Working closely with sexual health organisations that work on the subject areas and with the targeted groups to enhance our research approach, due to the deeply personal/emotional subject matter.

Key drivers for the project: Gap for qualitative insights

There is a wide range of available quantitative data describing sexual and reproductive health in Wirral in the JSNA and other key strategic documents. While they offer valuable insights into averages and aggregate experiences of Wirral residents, individual experiences are lost in the numbers. Capturing the voices of the identified groups requires further, in-depth exploration using a variety of qualitative methods.

The groups present considerable challenges of accessibility for research due to a few reasons (that have been identified in the qualitative team's work on different projects in the borough, from the gap analysis, and from the pilot conversations with the professionals). The reasons include but are not limited to; communication barriers with GP practices within some

members of the ethnic minority communities, fear of parents finding out among young people and the stigma surrounding topics of sexual reproductive health in general. These issues make the identified groups quite a difficult audience to reach particularly with quantitative approaches. However, a qualitative approach applied here offers greater opportunities to speak to people in greater depth, in interactive and people-focused ways, to gather evidence and understanding of their experiences of sexual health services.

Objectives

The Qualitative Insight Team aimed to draw on the experiences of individuals from the identified groups to get a more rounded understanding of people's experiences of sexual health to achieve two key objectives:

1. For services to be effectively commissioned:
 - It is essential that the available quantitative data is paired with the voices of Wirral people. This will ensure that service design and delivery is informed by an understanding of what people want from services, how they access services, and why they might not access services.
2. To explore what the barriers/enablers to accessing sexual health support are:
 - Insights will be gathered from the perspective of the individuals. Understanding their current needs will help the council design fit for purpose services.

Health and Wellbeing Strategy

The insights gathered from the project will also contribute to the delivery of the Health and Wellbeing strategy, particularly Priority 2. The priority has two major areas of focus:

1. Make sure that all local people have easy and timely access to health and care services shaped around them to screen, diagnose, treat, and prevent disease as early as possible through the Integrated Care Partnership and Wirral Place Plan.
2. Address differences in health outcomes by changing the way we deliver health and care services focusing on population health outcomes, with an understanding of needs within our communities and an emphasis on those who can benefit most.

Gap Analysis

At the onset of the project, the Qualitative Insight Team sent out a scoping email to approximately twenty-six organisations working with different communities in Wirral. The email invited the organisations to share any insights they might have on the identified themes and identified groups. A few organisations responded communicating that they either did not have the information, or they were not cleared by their GDPR policies to share the information. A handful did share some insights that ranged from a half a page document to ninety pages, including survey results, short reports, and PowerPoint presentations. The

information shared was wide ranging and, in some instances, did not mirror the identified project themes or research groups. Therefore, to pull themes and identify gaps and opportunities aligned with this research project an extrapolative analytical process was used to look at the 'scattered' data that was made up of mostly survey responses. For instance, the process involved examining how many times an answer came up in a survey, who answered the survey, what were the variations of similar answers, and synthesising the answers into a story and painting a picture of the recurring themes and the gaps.

Identified gaps

From the information shared, it was apparent that the most common method of collecting insights was surveys. Surveys offer valuable insights, but they do not offer in-depth insights into people's experiences or the opportunity to probe for further details, which are some of the key pieces of information required to understand people's lived experiences. At the outset, this offered an opportunity for the Qualitative Insight Team to complement the existing research with an exploratory approach.

Most of the surveys shared with the team were completed by health practitioners and service providers. Therefore, feedback gathered from professionals was significantly more than from service users. While this could have just been the nature of the information that was shared with the team, it does suggest that service users may not be keen on feeding back on their experiences. This was confirmed through pilot conversations with professionals which showed that people are not generally keen on completing surveys. This helped the research plan as the researchers had to brainstorm methods that would engage people who do not usually access services and those who access services but do not complete feedback forms and surveys.

Nearly all the surveys shared were completed after people had accessed the services. This suggests a gap in knowledge of what happens before the service is provided. The above listed are just a few examples of how the literature gathered was analysed and extrapolated to tell a story and establish a context for the Qualitative Insight Team to help the designing of methods, recruitment, and approaches for this project.

Project Methodology

The data collection for the project took place between February and March 2023. The research engaged a range of qualitative methods that included focus groups, in depth conversations, semi-structured interviews, informal conversations, research grids and participation observation (see Table 2). Prior to each engagement oral and/or written consent was sought and granted.

Data collection was carried out with eight research groups listed in Table 3, with a total of 97 participants. The specific participant groups are broken down in Table 3 and the different methods will be explored in further detail below.

Research participants were identified firstly through the organisations currently commissioned to provide sexual health services. The researchers were fully aware of the bias that might be present through this nature of recruitment where participants might feel obliged to speak positively of the organisation because they are accessing services. This bias had to be tolerated because due to the intimate nature of the research topic it would be difficult within the timelines of the project for the researchers to recruit people and build trust to a place of confidence to discuss such intimate issues. Secondly, the bias could be mitigated and countered through snowballing by the researchers after the initial introduction and conversation arranged by the organisation. As the research progressed, the researchers built relationships from those initial introductions, which they leveraged to recruit further participants that were not affiliated with the organisations and were not accessing services. This approach offered a nuanced picture of people's experiences with sexual health services in the borough.

Table 2: Research activities (repeat of Table 1).

Method	Number of times the method was used	Participant group
Focus groups	6	Professionals/ young people
In depth conversations	8	Women involved in sex work/ women
Semi-structured interviews	2	Women in the LGBTQA+ community
Informal conversations	34	All participant demographics
Research grids	17	Women and men
Participation observation	7	HIV Week events, support groups, and a women's health event for professionals

Table 3: Total number of people engaged in the research by participant group.

Participant group	Number of people
Professionals	22
Young women	14
Young men	12
Women	25
People in the LGBTQA+ communities	3
People from minority ethnic backgrounds	7
Women in sex work	5
Young mums	0
Male adult residents	9
Total	97

Methods breakdown

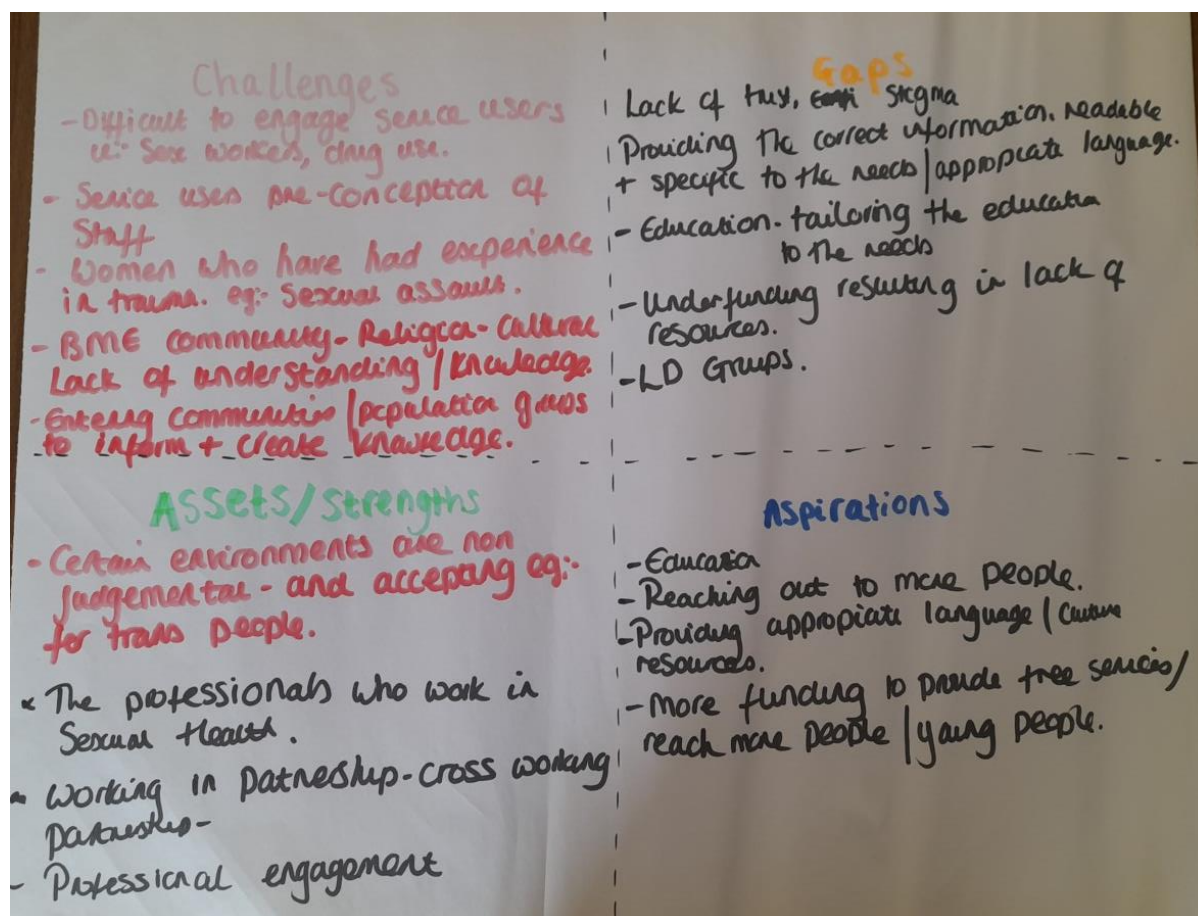
Focus groups

In total, the researchers held six focus groups for the project. Two focus groups with professionals and four focus groups with young people.

The first focus group with professionals involved five professionals from four organisations that offer sexual health services to young people, women, people dealing with drug addiction. The discussion was divided into four segments. In the first segment they were asked to brainstorm groups they consider at risk of poorer sexual health outcomes. In the second segment they were asked to brainstorm the challenges/barriers for the groups identified in the first segment. In the third segment they were asked to brainstorm the assets/strengths of existing sexual health services. In the last segment the discussion became more open-ended discussion on service provision and what they would want to see more of.

The second focus group with the professionals was held with professionals in an organisation that works with people in the LGBTQA+ communities with a close focus on HIV. The researchers sat down with four professionals. The discussion followed the plan of the first focus group where it was divided into the similar four segments.

Image 1: Brainstorm activity from a focus group with professionals.



The four focus groups with the young people were held at a local college. In total, twenty-four young people participated in the focus groups (six in each group). The focus groups were divided into four segments. In the first one they were asked to brainstorm their experience with sex education in school. In the second segment they were asked to brainstorm their knowledge of STIs, including types, symptoms, and testing. In the third segment they were asked to brainstorm their knowledge of contraception, including types of contraception, where to access it, side effects and support available. In the fourth segment they were asked to brainstorm their knowledge of HIV, including symptoms, transmission, and testing.

At the end of each session the researchers did a short exercise with the young people where they asked them to write anonymously on a piece of paper their concerns or scares around sex and sexual health. The scares they wrote down offered a lot of insights into the experiences of young people, which weren't discussed in the group setting. The young people's responses are shown in Figure 1.

Figure 1: List of sexual health scares identified by Year 13 students.



In-depth conversations

The researchers conducted eight in-depth interviews with women who are in different spheres of life, including women involved in sex work, mothers, and women experiencing menopause.

In-depth interviews were initially out-of-scope for the project, due to their time-consuming nature. However, as the project progressed, it became clear that some people's voices could not be captured on research grids or through informal conversations due to the multi-dimensional layers of their lives. In depth interviews were therefore conducted with women involved in sex work, women in menopause and women who are mothers and are contending with their sexual health and the sexual health of their children. The interviews offered an in-depth and nuanced view into the lives of women and their experience.

Research grids

The researchers designed a research grid. A research grid is a set of open-ended questions that are asked to glean opinions on topics without delving into the details. Usually, participants do not share their full names or identifiers other than basic demographic information such as age-range, sexual orientation, and location. A research grid is a great way to focus the discussion and keep the analysis focused on the original intent of the study.

The research grid designed for the project included questions such as: Do you know where to go for information for support on sexual health? Do you think people know enough about sexual health, like contraception, testing and safe sex? Are you comfortable talking about sexual health with others? Do you think you know enough about STI testing? Do you think you know enough about HIV testing? If you needed an HIV or STI test, how would you prefer to get one? Do you think you know enough about smear tests/cervical screening?

Seventeen people completed the research grids and the grids proved helpful for insights kick-starting conversations with residents.

Semi-structured interviews

All the semi-structured interviews evolved from the research grids. The researchers sat down with participants to complete the research grids and the conversations developed as the participants offered more information and details beyond the questions asked in the grids.

Participation observation

Participation observation offered the researchers a binary vantage point: to observe and to participate. This gives the researcher an opportunity to gather insights through observation of interactions and conversations with the benefit of seeking clarification afforded by being a participant as well. Participant observation further offers the opportunity for the researcher to recruit participants for engagement. The researchers attended five events as participant observers, including a women's health workshop for professionals, a support group for women who use drugs/are in sex work, a HIV testing event, a support group for men's mental health, and a listening event for new/expecting parents.

Participation observation reflections and impact on subsequent methods

There are a few key themes that emerged from the participation observation which are worth mentioning at this stage in the report. Since most the events occurred during the recruitment period of the project, these themes helped shape the design of the project. The events became a first point of contact between the researcher and Wirral residents' experiences with sexual health, and they offered a window into the narratives and conversations being held around sexual health. They also became an important opportunity for recruitment and further engagement.

At one event centred on women's sexual health approximately eighty professionals from different organisations and sectors attended. The professionals discussed their experiences of delivering sexual health services, as well as the experiences of the women they support. A general feeling was that sexual health services are currently better on the borough. The researcher observed that while it is important to organise events for professionals, it is also imperative to capture the voice of the service users, as representation can only go so far in capturing someone else's personal experience. The researcher observed that it is common to see the same faces/representatives at third-sector events, which also highlighted the need capture residents' views and experiences.

The researchers observed that the issue of funding is prevalent. Funding was mentioned at every event as a hurdle in sexual health services provision. The common phrase at events was *"everyone is underfunded."* One of the cervical screening events that the researchers were due to attend was cancelled because there wasn't a nurse available to do the tests. This observation gave first-hand insight into the challenges of sexual health service provision.

The researchers also observed that there is a hesitancy among people from ethnic minorities to engage in sexual health conversations. A researcher attended an event hosted by an organisation that supports women. The aim was to glean some insights on the general topics on sexual health using research grids which have yes/no/maybe/unsure questions that can be answered in less than two minutes. Most of the women were receptive and a few answered the research grid questions. The researcher approached a table where women of Asian descent were sat together and initiated conversation with them about the project, sexual health, and the research grid. Although they listened to the researcher, they declined to answer the research grid questions. The entire group of about seven-ten women were hesitant and not comfortable to answer the questions. When the researcher probed why they didn't want to answer the questions they indicated that it was not culturally appropriate for them to talk about such things. This indicated some mistrust and demonstrated how cultural differences can present a barrier to accessing sexual health services.

Data analysis

The data gathered through the various methods were analysed using a thematic analysis process. The researchers collated the different insights gathered and pulled the common themes, topics, ideas, and patterns. This was a systematic and reflexive process that enabled the researchers to find rich and useful insights and organize the data to see the broader context.

Names/pseudonyms/quotes

All the names of people used in the report are pseudonyms. No real names are used to protect the identities of the participants and the organisations that took part in the research. Direct quotes extracted from engagement are written in blue throughout the report.

Findings

The findings of the research are broken down into six sections: **Section one:** Underserved groups. **Section two:** STIs and STI testing. **Section three:** HIV. **Section four:** Unplanned pregnancy and teenage conceptions. **Section five:** Smear tests (cervical screening). **Section six:** Other themes (sexual health education and awareness). Each section concludes with insights into people's preferences and opportunities to improve sexual health outcomes in the borough.

1. 'Underserved' groups

The JSNA and other official documents indicated that there are four groups identified as being at risk of poorer sexual health outcomes: young people (15-24); people in the LGBTQA+ communities, with a focus on men who have sex with men; and people generally underserved by services on the borough, particularly ethnic minority communities and people from areas with high deprivation.

At the start of the project, the researchers tested out this premise through engagement with professionals working in sexual health. The professionals were asked to identify the groups they consider most at risk of poorer sexual health outcomes or 'underserved' by sexual health services based on their experiences. The researchers spoke to twenty-two professionals from seven organisations. The seven organisations work with women, young-people, people from the LGBTQA+ communities, men, people struggling with drug addiction, ethnic minority communities and people living and working in areas of high deprivation.

The professionals identified eight groups they consider 'underserved'. The eight identified groups overlap and expand on the four groups identified in the JSNA. This was a crucial finding for the research because it corroborated the work already being done by the JSNA, the intelligence department and the commissioning team. It was also a crucial finding as it provided a context for the research and offered a starting point for engagement and a deep dive into the issues the identified groups face around sexual health.

The following is a breakdown of the groups of people that were identified as 'underserved' with a brief description of why they have been put in that category.

Women

Professionals noted that women are fast becoming an underserved group in sexual health services. A professional stated that *"Women used to know where to go but now they don't know where to go...it is becoming more apparent that women are underserved as more and more services are commissioned."* According to the professionals, it has become difficult to identify what services are there for women specifically. They further posited that in the past few years funding and promotion has gone to other areas, such services for men or people in the LGBTQA+ communities, and so women are slipping through the cracks.

a. Women in sex work/ drug use

Women engaged in sex work and/or drug-use can struggle to engage in sexual health (and general health care) services for a variety of reasons, such as fear of judgement. They require consistency through seeing the same professionals and in most cases, this is not possible due to a shortage of professionals. This is further exacerbated by the women's complex daily routines, described by the professionals as 'chaotic', which can make engagement and outreach challenging.

b. Women experiencing abusive relationships

Women who are in abusive relationships or those who have survived abusive relationships can have difficulties opening-up about their experiences and being vulnerable to professionals because of the physical, mental and emotional challenges they have experienced in these relationships.

LGBTQA+

People in the LGBTQA+ communities were identified as 'underserved' mainly because of the exclusionary nature of language in sexual health. A professional commented that *"Most of the forms are cis-normative and the language is gendered...and most of it references to penetrative sex."* A challenge identified for trans people is that they cannot get access to services for their gender assigned at birth. For instance, a trans-male who is assigned female at birth cannot book an appointment for a cervical smear because once he selects 'male' as his gender on the form he cannot access cervical screening services. This gendered language makes people apprehensive when it comes to accessing services. The common feeling is *"I am not going to access that service if I am going to be told or made to feel that I am not normal."*

Ethnic minority communities

Professionals identified *"BAME communities"* as an 'underserved' group. According to the professionals this is mainly due to language differences. One professional remarked: *"It is quite difficult to have in-depth talks on complicated talks of sex, sexual health, STIs, contraception with someone who cannot understand what you are saying."* The presence of language barriers is exacerbated by cultural barriers. In some ethnic minority cultures, the subject of sex is rather a *"taboo"*, which makes it difficult to engage people on sexual health issues.

Young people

Professionals noted that a lack of resources affects young people's sexual health education. An example that stands out is that schools must pay for a sexual health organisation to engage a whole year group because the organisation can only offer smaller sessions as a commissioned project. This is explored further in Section six of this report.

People with learning disabilities

People with learning disabilities (LD) were identified as 'underserved' for many reasons. One of the main reasons is a lack of information that is readable and specific to the needs of people with LD. Professionals also highlighted that there are assumptions from parents/guardians that people with LD are not sexually active and therefore they do not expose them to information. Another key challenge is that certain services are not suited to meet the specific needs of people with LD. One professional recounted how they once had a client with LD who had to come in days before their appointment so that they *"...can see the chair they will sit at on the day of the appointment, the bed they will be laying on, the professional who will be attending to them, they were autistic, and this process was very important to them."* As such, consistency and familiarity were identified as important factors for engaging people with LD in sexual health services. However, professionals noted that these specific needs are quite difficult to meet in services that do not have the same staff every day or the ability to maintain the same set up each day.

Older people living with HIV

Older people living with HIV were identified as an 'underserved' group because according to the professionals there is limited support tailored to this group of people. Professionals described how older people living with HIV can be fearful of care homes, as they fear being judged or stigmatised. They can also fear that care home professionals will not be experienced to deal with their specific needs, in contrast to the professionals they have been in contact with throughout their lives.

Refugees

People who are refugees were identified as an 'underserved' group when it comes to sexual health for two main reasons. First, many of them are usually from ethnic minority communities and they contend with the challenges that these communities face. Second, they might be hesitant to access services because there is a fear it may affect their visa or immigration status.

2. STIs and STI Testing

This section discusses people's knowledge and experiences of STIs and their preferences around STI testing. Most of the insights gathered were from young people and they reveal a big gap between knowledge of available services and preferences. Young people are clear on their preferences, but they do not feel confident in their knowledge of where to access services. The centrality of young people and their experiences with STI accounts for the dedication of the bulk of this section to young people. The section then concludes with experiences of older men and women who responded to the research grids and shared insights that echo the views shared by young people.

2.1. Young people on STIs and STI testing

First, this section details the findings around young people's (17-25) knowledge of STIs and STI testing. It then explores their preferences around STI testing. It includes a detailed case study of a 23-year-old woman who tested positive for Chlamydia in 2023.

2.1.1. Young people's knowledge of STIs and STI testing

The overarching sentiment among the Year 13 students was that they had limited understanding of the different types of STIs, symptoms, testing and treatment. It appeared there were factors that influenced their amount of knowledge, such as:

- Access to sex education at high school
- Personal experience with sex and relationships
- Having family members in health care jobs
- Relationships with parents and friends

For example, students who had attended Catholic schools said they weren't taught anything about STIs and testing. Students who did not go to Catholic schools and who did receive STI education remembered having one-off half/full day workshops and they found that the amount of information was overwhelming. They said they would prefer for the learning to be reinforced throughout the years. Most students felt STIs should be taught about earlier than Year 10, but one student disagreed saying:

"In Year 7 me and my friends weren't thinking about sex, and we would have just joked about it...teaching about STIs too early will scare people and put them off having sex".

Professionals said that young people avoid testing because they can be scared of the test results (out of sight out of mind), showing that there are misconceptions about STI treatment. Other unhelpful messaging around STI's identified by professionals included:

“If you have an STI you are dirty or a 'slag' - this feeds into messages around the number of sexual partners someone has and it can lead to objectification, particularly for young girls.”

“Young people think you can tell if someone has an STI”.

“They think that you would know if you had an STI as they expect there to always be symptoms”.

Places where students said they'd look for STI tests or support included, Brook, their GP surgery, and the college. However, as discussed below, in reality young people are reluctant to access STI tests offered at the college. This shows there is a disconnect between what young people think is the 'correct' answer, and the actions they would actually take.

2.1.2. Young people's preferences for STI testing.

Overall, young people expressed a preference for discretion when accessing STI tests. For example, the Year 13 students said they wouldn't feel comfortable accessing the STI tests that are sometimes given out in the canteen space because everyone can see you going up to get one. As with accepting condoms, being seen to need an STI test or attending a voluntary STI talk would be a public declaration that you're sexually active, which students don't want others to know, including their friends. Needing an STI test or testing positive for an STI were things the students want to keep secret because of a fear of judgement and gossiping:

“You'll be looked at as dirty, which is stupid because you can't put shame on someone for following their natural instinct, but I'm not sure how you stop the shame”.

This backs up professional's observations that young people think that getting tested for an STI means you're dirty and that you must have an STI.

There were differences in opinion among young people about how they would prefer to access an STI test. For example, some would rather order a postal test as they knew or heard that the packaging is discrete, but for some the prospect of their parents seeing the package would be too awkward or could lead to conflict. There was a perception among young people that getting tested in person is more reliable: *“I'd go to Brook in person because it's going to be more correct”*. In addition, one young person said, *“I wouldn't go to a pop-up clinic for testing, I'd go to an actual clinic”*, which suggests there may be misconceptions about the reliability of pop-up clinics.

2.1.3. Young people and Chlamydia

The case below study details a 23-year-old woman's journey of testing positive for Chlamydia. It demonstrates the themes discussed above, including young people's lack of understanding of STIs and testing, misconceptions about how STIs are transmitted, the stigma around STIs, and preference for discreteness. It highlights how online information about STIs and testing can be confusing. It also shows how young people can have a relaxed attitude towards testing after new partners. Emily said that she'd only test for an STI if she had symptoms, which backs up professional's observation that young people assume there will always be symptoms.

Emily, aged 23, bi-sexual.

Attitude towards STI testing

- Emily doesn't feel the need to get tested after each new partner. She'd only test if she had symptoms: *"I've had partners in the past where nothing's happened, so I'm just like, meh. It crosses my mind, but I'm not worried. I'm not gonna die if I don't get a test"*.

Being told she may have an STI

- After being advised to take a test by a recent partner, Emily looked online for information on Chlamydia and Gonorrhoea. The information on the NHS website about how these STIs are transmitted was confusing, particularly around 'saliva'.

Ordering the test

- She thought she'd have to go to a hospital to get tested, but then saw she could order a test online, so she did.

Taking the test

- Emily found the 'two-week rule' confusing – she thought she'd missed the window where you need to test, but actually she had to wait two weeks to do the test. She kept 'googling', but it was confusing.

Packaging

- She liked that the packaging was discrete when it arrived. However, to send the swab back, she was given an envelope with 'human substances' written on it with and a big yellow exclamation sign, which she didn't like: *"I sent it through the letter box so I wasn't too bothered, but I wouldn't want to go to a post office with it"*.

Telling someone and feeling judged

- Emily felt she couldn't tell her mum she'd tested positive for Chlamydia: *"She'd judge me and think I'm dirty"*. *"I told my sister, but then she wouldn't even sit on my bed because she thought she might catch it from the bed sheets"*.

Misconceptions

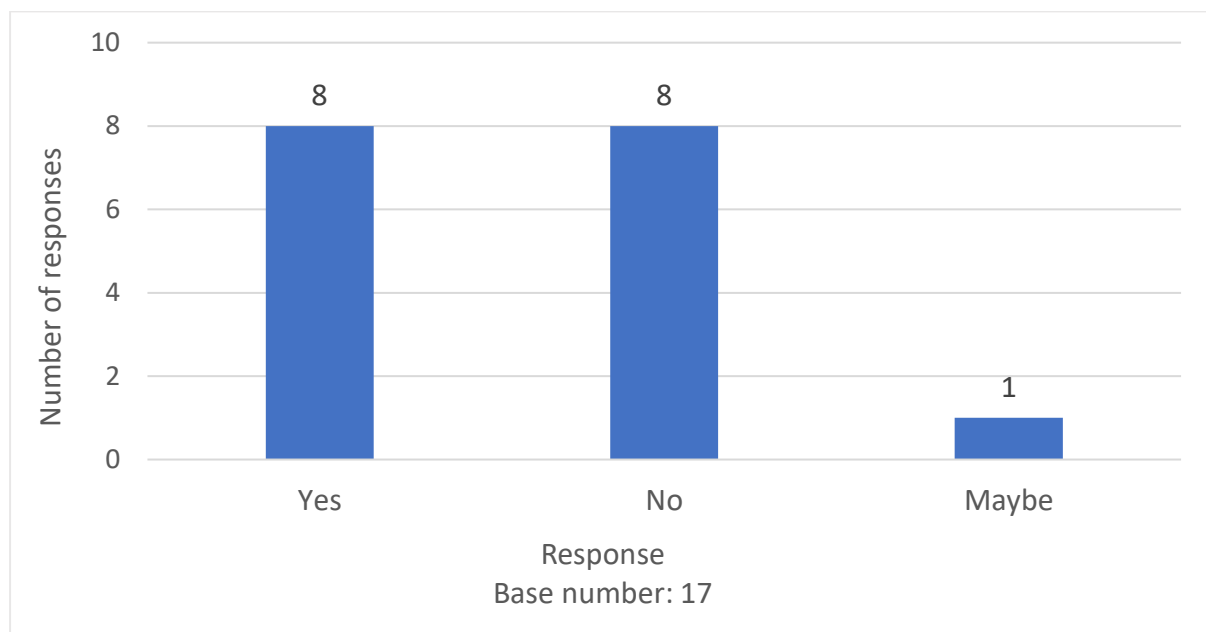
- Emily feels she and her friends don't know enough about STIs and testing, for example she said: *"One of my younger mates thought you had to be 18 to order an STI test, so she got someone else to order one to their house. She didn't want her family finding out"*. *"Another mate thought they had Chlamydia because someone with Chlamydia bit them"*.

2.2. Research grid results

The researchers also talked to adult women and men about STIs and testing using the research grids and informal conversations, the results of which are discussed below.

Using the research grids, the researchers asked 17 people if they thought they knew enough about STI testing. The response was divided, as shown in Figure 2:

Figure 2: Do you think you know enough about STI testing?

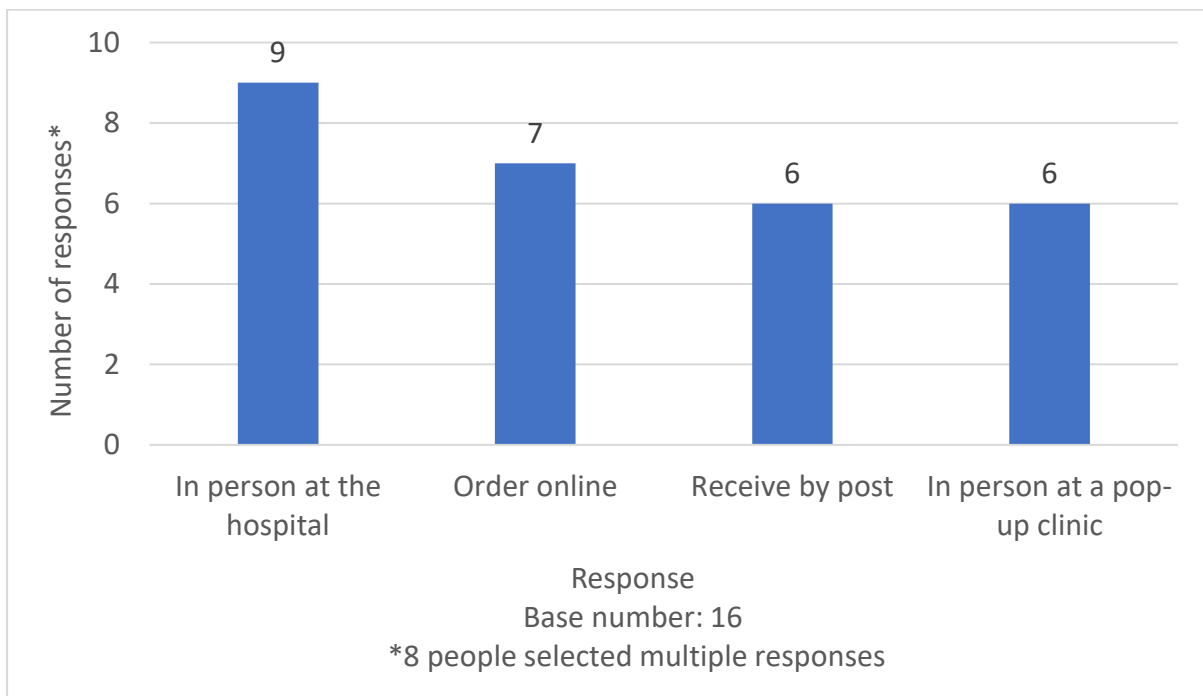


One woman who identifies as a cis-female lesbian provided her thoughts on how STI testing, and sexual health in general, is not a concern for her at this time in her life:

- As a lesbian in a long-term monogamous lesbian relationship, she doesn't feel that sexual health or STI testing is something she needs to worry about. She described how not having to think about STIs and sexual health is a perk of being in a lesbian relationship where both partners have been tested.
- She used to be a healthcare professional, so she has no trouble talking to her GP about sexual health if she needs to. However, she explained how at her age sex was not at the top of her priorities, and her health condition meant that sex was not desirable.

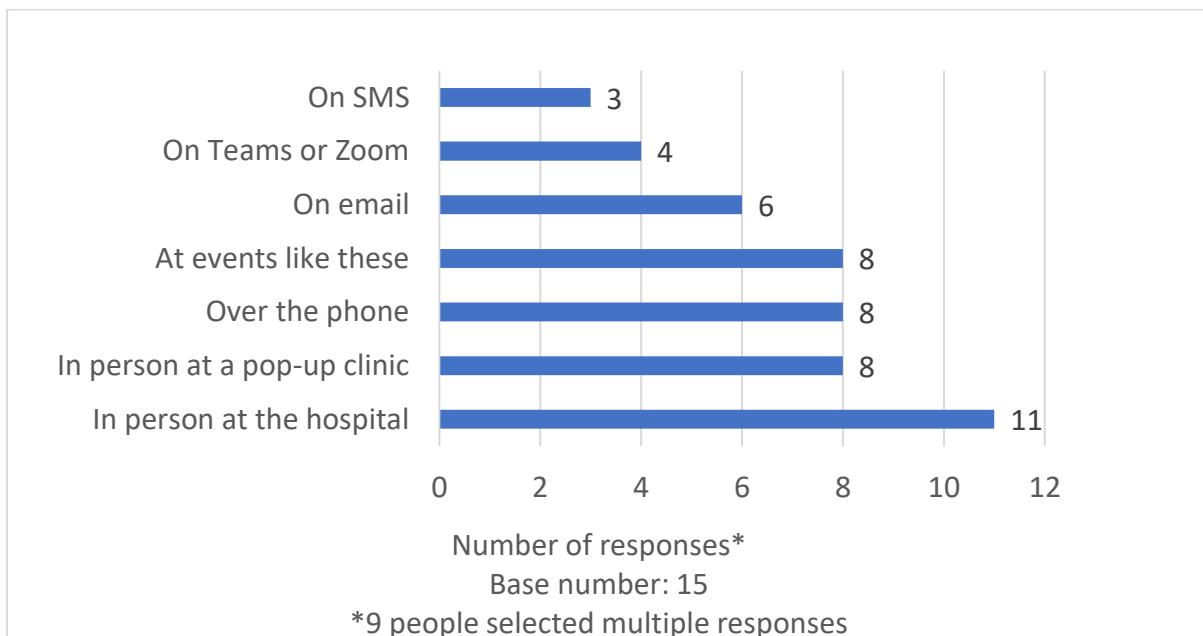
When asked how people would get a test if they needed one, the most popular response was in-person at the hospital (see Figure 3). Overall, in-person options were slightly more popular. As discussed above, there was a sentiment among young people that testing in-person is more reliable, and so this could also explain this finding. One woman said that *“pop-up clinics are a great resource”* because they're *“less formal settings”*.

Figure 3: If you needed an HIV or STI test, how would you prefer to get one?



Similarly, when asked which way(s) they would feel comfortable talking to someone about sexual health, most people preferred in-person options (see Figure 4). Less popular options included SMS and email where there would be no in-person conversation.

Figure 4: How would you feel comfortable talking to someone about sexual health?



It was clear that people know what their preferences are around testing and talking to someone about sexual health support, but they don't know how to source the testing, such as what websites to order home-testing from or where they could go for in-person testing. Therefore, it's important to raise awareness of organisations offering testing and different ways they can be obtained.

As with smear testing, professionals felt there are a lack of resources, restricting their ability to offer STI testing in the spaces they think will be approachable.

2.3. Opportunities and preferences

- Offer discrete and anonymous STI test distribution to increase the number of young people getting tested for STIs. This will offer confidence that their friends won't find out that they've accessed a service, or that they're sexually active.
- Improve awareness of different methods of receiving an STI test and ensure discrete packaging for at-home tests.
- Raising awareness of where testing is available, either online or in person.
- Provide education about the reliability of at home vs in-person testing.
- Provide regular education about STI symptoms and transmission throughout high school to consolidate knowledge and reduce misconceptions.
- *"Give people more tests and talk about it more" (woman aged '50-60').*
- *"Gender specific services, less formal settings" (woman aged 47).*

3. HIV

This section explores the themes that emerged from the engagements around HIV. The JSNA identifies that there is low prevalence of HIV in the borough, but that too many cases are diagnosed at a late stage of infection. The engagement with the professionals echoed this and went a step further into offering insights into why this is the case from their experiences of working in sexual health for years. Another key finding is that there is still stigma regarding HIV and people in the LGBTQA+ communities. The stigma reflects a dearth in information and education when it comes to HIV.

3.1. Low prevalence but late diagnosis

Professionals working in sexual health across various organisations agreed that HIV treatment has advanced significantly in the borough. An organisation that focuses on pop-up clinics and STI and HIV testing reported that in the past 12 months, after testing hundreds of people, they have only come across two HIV positive cases. Reflecting on the numbers, one professional remarked *“So, relatively low, but we know we’re bad for late diagnosis...Two in 12 months is amazing if you think about it. If you went back into the 80’s, it was scary.”* Granted the numbers of people testing positive are quite low there is still concern about the numbers of late diagnosis.

The reasons provided for late diagnosis are quite varied. One of the key reasons identified was assumptions over knowledge. There is a general assumption that certain groups of people with a particular sexual orientation are the only ones who can get the virus. This assumption was further demonstrated in the focus groups with young people. Students commented that HIV was *“associated with gay people”*, and some students mentioned a connection with Birkenhead, Liverpool and *“druggies”*. One young person recounts their experience:

“When I was in high school, HIV would only be thought of as a ‘gay’ thing, but anyone can get it. Also, a stigma around the spread of HIV, the fear around it etc. Less common now, but when I was young, I remember people referring to anything bad as ‘AIDS’ e.g., ‘that’s AIDS’”.

Lack of knowledge about HIV was reflected in the research grids and conversations held with older men and women who mostly communicated that they do not know enough about HIV, testing, symptoms and who is at risk.

Professionals felt that people often assume they aren’t at risk of contracting HIV. Professionals working in the drugs and alcohol space described how they can often see this attitude among people who use steroids. According to the professionals, steroid users can feel like they’re not vulnerable to HIV because they don’t feel associated with the stereotypical ‘drug addict’ profile: *“They’ll say, ‘I’m not a smackhead’ because they buy ‘reputable steroids’.”*

Despite professionals' efforts to educate around the risks of using other people's equipment or the wrong size needle, professionals find that some steroid users can be resistant to taking advice because of the perceived lack of risk: *"Even trying to tell a steroid user about the dangers of using other people's equipment, they'll say. 'Oh, no, no, no. I'm with John, he's spotless'."*

Organisations that provide support for people struggling with drug addiction also talked about how they provide support for blood born viruses associated with drug use. They have raised an alarm with concerns on increasing rates of Hepatitis C (HEP C):

"I can't remember the last time we got a HIV positive, but HEP C, every week. We're seeing positives for HEP C all the time... We do have people with HIV in treatment with us, but not... when I first stated there were people at end stages, but people are accessing the treatment much more now."

The increased concern about HEP C rather than HIV was a common theme in conversations with professionals. Another professional commented:

"HIV treatment has advanced so much now, it's amazing isn't it. The virus can become undetectable with compliance. But it's the HEP C we're more concerned about because that's the easier one to get."

Another factor that accounts for the low prevalence rate is the increased awareness in HIV prevention. Professionals are recording more instances of people asking for PrEP (pre-exposure prophylaxis), particularly people in their twenties and thirties:

"Another thing that we're finding is that a lot of the young people are asking, can I have PrEP. It's good, I know it sounds mad, but it's good because at least they're taking charge of their own... but it's just one of those where you're like, what are you expecting to actually do?"

This kind of proactive action shows that more and more people are taking charge of their health regarding HIV, which may be a contributing factor to the lowered prevalence rate of the virus.

3.2. HIV and the LGBTQA+ communities, particularly MSM relationships

While there is indication of a lower prevalence rate of HIV, there is still concern about the risk of HIV for the LGTBQA+ communities, particularly men who have sex with men (MSM). A GP communicated that people tend to assume that saying that this group is at a higher risk is stigmatisation, while in actual fact it is because anal sex poses a greater risk of tear and therefore contact with blood. This is because anatomically the anus is not as flexible as the vagina. The GP felt information is vital in the conversation of who is at greater risk, but often times it isn't communicated well and ends up sounding like stigmatisation. This misinformation gives heterosexual young people the false confidence that they are safe, and that HIV isn't a risk for them.

Another factor that makes it difficult to fully understand HIV prevalence among MSM is that many of them may not identify as LGBTQA+, so they might be going to services but don't appear in the data as LGBTQA+. As one professional said: *"the nature of most of these relationships is underground."* Professionals explained that men who have sex with men may have families and relationships they want to maintain in separate spheres of their lives, and so the discreteness of services is important for these individuals, as well as ease of access at different times of the day:

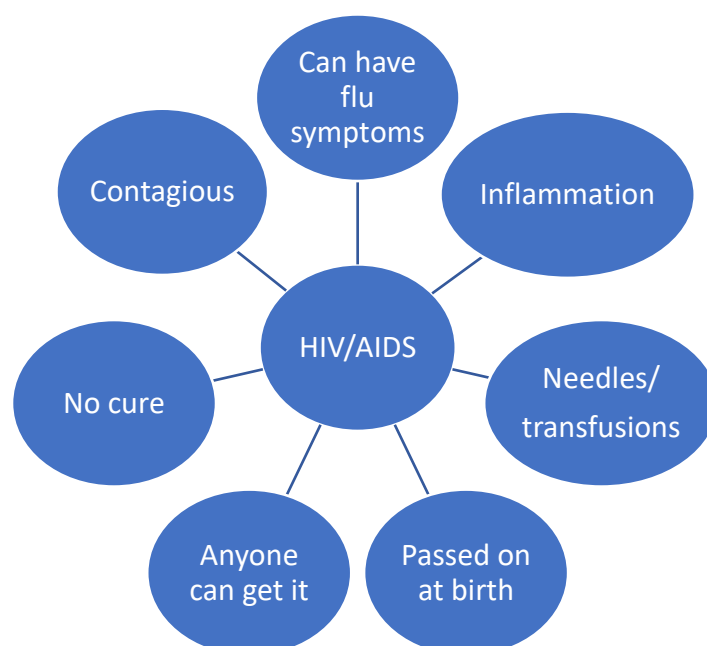
"A lot of the clinic is men who have sex with men who are essentially in quite stable heterosexual relationships... I think you just have to kind of really appreciate that the stress of trying to juggle your life, or bits of your life, and there's a real onus on the person to be discreet".

Professionals also observed that *"because they [MSM] feel that the Wirral is quite a small place, they're happy to come to the clinic to get tested, but then sometimes to get them into Wirral Sexual Health there's a fear that they'll know someone, or someone will know their partner"*.

3.3. Young people and HIV

The young people we spoke to didn't seem to have much knowledge when it comes to HIV. The researchers asked them about HIV, including transmission, symptoms, testing etc., and they were reluctant to respond. One group said they had *"no idea"* of the symptoms of HIV. Some were able to describe how its contracted/treated, such as that its *"treatable not curable"*. Some of the young people talked about HIV and AIDS together, suggesting a lack of understanding of the difference between the two. In one group, the researcher asked them to write down all the facts they know about HIV/AIDS. Figure 5 shows their responses:

Figure 5: Facts about HIV/AIDS identified by Year 13 students.



Reflecting on the brainstorm activity, one young person said: *“I barely know anything about HIV. That’s actually concerning”*. The students felt their limited knowledge of HIV/AIDS came from TV and popular culture, such as Grey’s Anatomy and Freddy Mercury’s death. One student said: *“wasn’t there a pandemic in the 80’s?”*. In terms of testing, they communicated that they wouldn’t know where to go besides their GP.

In an in-depth conversation with a young woman who recently contracted Chlamydia, she told the researchers that she doesn’t think she knows enough about HIV and HIV testing. She knows that an HIV test involves a blood test and that’s about all she knows and if she needed one, she would order it online.

3.4. TV/media raising awareness.

A recurring theme was the role that TV/media plays in information dissemination on HIV. One professional commented that *“Since the 80’s we’ve not heard much. There was a big promotion about HIV wasn’t there”*. However, professionals highlighted that TV shows like *It’s a Sin* and *EastEnders* have been helping to raise the profile of HIV more recently. For example, a recent storyline on *EastEnders* was of someone who has been sharing steroid needles and has contracted HIV: *“For us [as sexual health professionals], it’s really interesting that it’s on the TV now.” “There’s so much that’s gone into HIV advertising”. “For the young ones growing up now, they can see that, and they can hopefully see how much work has been put in, so I think it’s a really good advertisement.”*

3.5. National HIV Testing Week

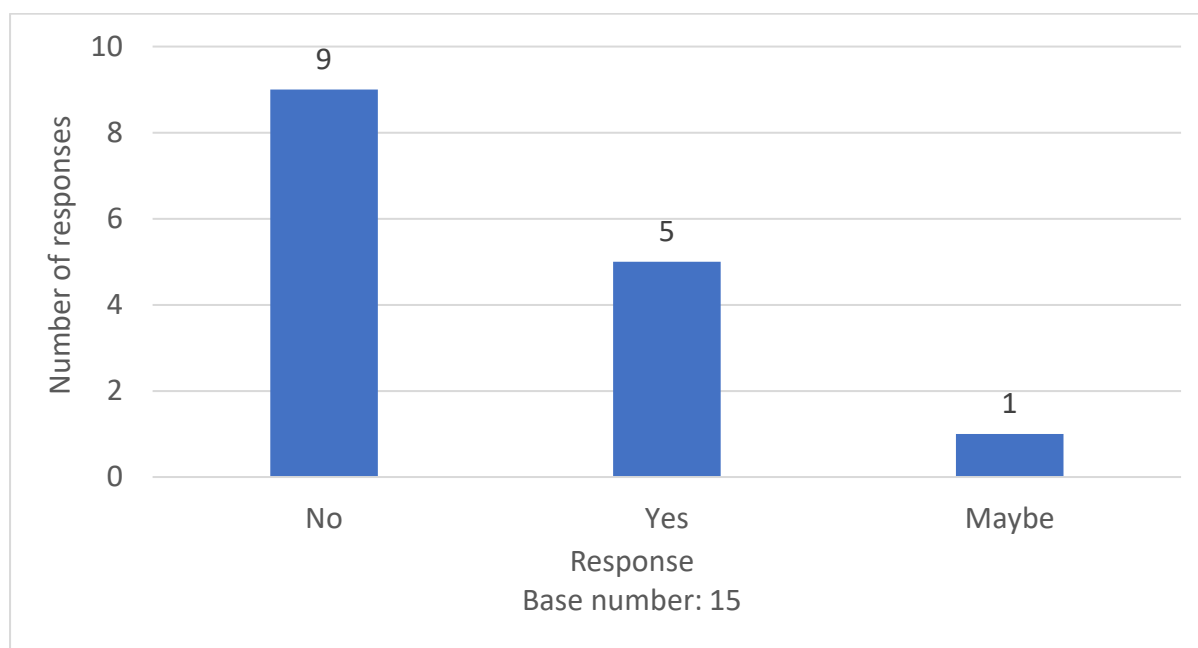
As part of the National HIV Testing Week in February 2023, the lead researcher attended a HIV testing event being delivered by two local services. However, the event was cancelled when the researcher arrived because there wasn’t a nurse available to do the HIV tests. As discussed in relation to smear tests, shortages of workforce are limiting people’s access to sexual health services.

3.6. HIV testing information and availability

As already observed in the STI and STI testing section, there is a gap in knowledge of sexual health services that involve testing. People do not generally know where to go to get tested for HIV, but they do know their preferences for tests should they require one. (See the STI section for more information.)

Using the research grids, the researchers asked 15 women and men if they thought they knew enough about HIV testing. The majority said no, as shown in Figure 6:

Figure 6: Do you think you know enough about HIV testing?



Another barrier to HIV testing identified by professionals is the lack of available resources. A professional from a women’s organisation described how their organisation currently doesn’t have a nurse, meaning they can’t offer STI and HIV testing. There is also the added challenge of reliance on volunteers within the charity sector: *“obviously everyone’s underfunded. We do rely on volunteers, and then that obviously means DBS and stuff.”*

3.7. Opportunities and preferences

- Improve awareness among young people and adults of HIV symptoms, transmission, treatment, what HIV testing involves and where testing can be accessed.
- Consider how misinformation and stereotypes around HIV can be addressed in sexual health and drugs education, such as addressing people’s perception of not being at risk.
- Need for more trained professionals available to deliver HIV testing to help avoid cancellation of testing events.
- As mentioned in the STI section, young people feel that discrete testing distribution will increase the number of young people getting tested for STIs and HIV because it offers confidence that their friends will not know that they accessed the service and that they are having sex.
- Discrete sexual health services for men who have sex with men, particularly those who are in heterosexual relationships: *“there’s a real onus on the person to be discreet”*.

4. Unplanned pregnancy and teenage conceptions

4.1 Contraception

The biggest issue that came up with regards to unplanned pregnancies and teenage conception is the issue of contraception. Women must contend with multiple challenges when it comes to contraception. A few themes emerged from the insights gathered are explored below.

4.1.1. Lack of information and information difficult to access

Information is a big theme in contraception and women of different ages contend with these issues in different ways. Young women between the ages of 15-24 indicated that some of their biggest challenges when it comes to contraception is the lack of information. This lack of information is multi-faceted. Young people perceive that there is inadequate information on the types of contraception available and they don't feel confident on the types of contraception available for them. For example, a bi-sexual young woman described how she would have liked to know more about different contraception options when she was younger because she felt the only options presented to her by her GP and family were condoms or the pill. She said:

"I feel like condoms and the pill were the only ones that were mentioned. I don't even know the difference between the different pills – I don't understand the different hormones. I've got mates that are using natural methods like the Flo app where they use a thermometer to track their cycle, but I don't think I could trust that myself".

A professional that works with people in the LGBTQA+ communities also said that the language around contraception options can be limited:

"I think that a lot of sexual health services seem to be tailored towards men. A lot of the language used is towards men, even like giving out condoms, they're for men and you know it's very rarely you see a condom for a woman. And I get asked for them all the time. But why are they hard to get?"

Although the professionals recognised that female condoms (femidoms) are more expensive to commission, and that for penetrative sex they are less recommended, they argued that *"it takes the choice away"* and adds to the stigmatisation of the femidom: *"there's a lot of light shown onto the condom"*. They also added that there is a lack of conversation about safe lesbian sex: *"I rarely see people talk about how if you use [sex] toys you should use condoms"* As a consequence, *"women who sleep with women feel left out of the whole conversation"*.

During the focus group with Year 13 students the researchers asked them to list the types of contraception they know, the potential side effects and where they can get them. Below are the findings from that exercise:

Figure 7: Types of contraception identified by Year 13 students.

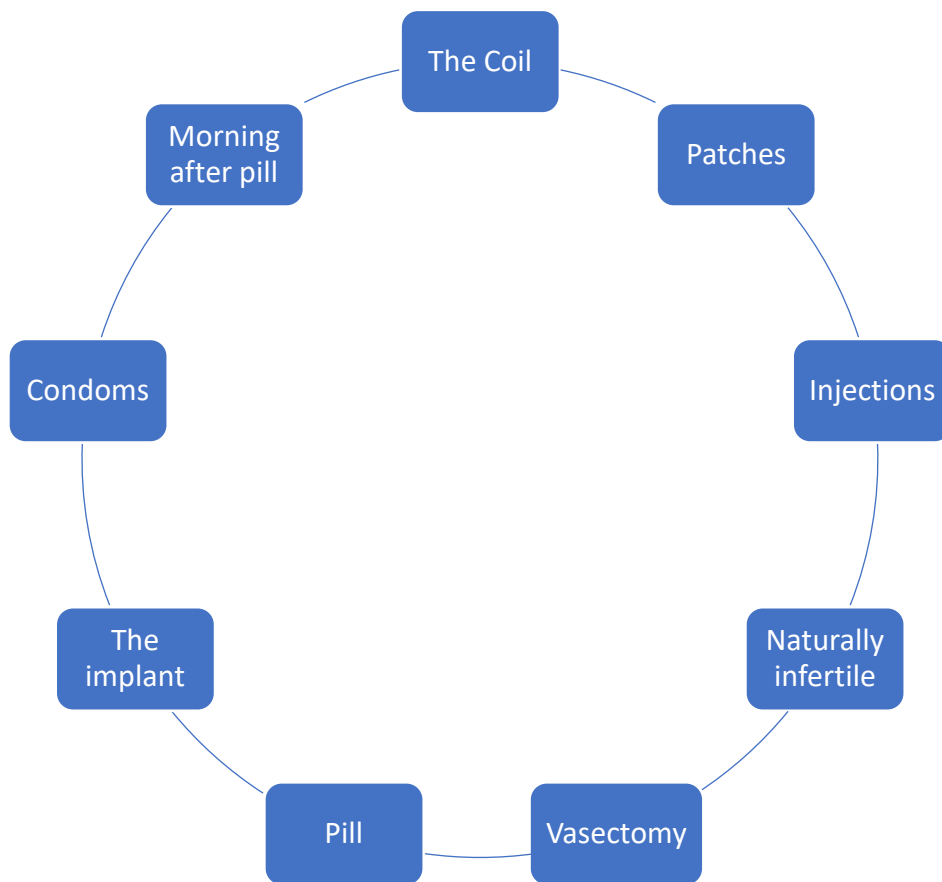


Table 4: Side effects of contraception identified by Year 13 students.

Side effects of contraception identified:
Moods
Infertility
Depression
Acne
Blood clots
Lower birth rates

Table 5: Places Year 13 students identified they could get a pregnancy test.

Where to get a pregnancy test:
Supermarket
GP
Pharmacy
Brook

The researchers have kept the original wording from the young people to communicate the nature of understanding they have on the subject. They could list a few contraceptive methods, but they could not breakdown what each of them entailed or how they worked. They had heard about them from social media, conversations with other women in their lives, and some classes from school. This shows the dearth of information when it comes to types of contraception, side effects and where to get them. This becomes a contributory factor to unplanned and teenage pregnancies. The students expressed fear around being pregnant or getting someone pregnant when asked to write down their sexual health concerns:

“I’m always fearful that I’ll get someone pregnant by accident”.

“Getting someone pregnant”.

“Being pregnant at this age”.

“Not knowing you’re pregnant”.

“Getting someone pregnant or being accused of something false”.

These quotes show there is a need to improve awareness of contraception among both sexes. As one male student said: *“Lads also need to know the benefits of contraception”.*

The students also perceived that there is a lack of adequate information in regard to the long-term side effects of different methods of contraception. This gap in knowledge sometimes makes the young women hesitant to use contraceptives and this can potentially result in unplanned pregnancies. A young woman raised her concerns regarding the long-term effects of contraception:

“Is there contraception that doesn’t have long lasting side effects? Some of the methods we use and that we have access to say that they could potentially cause long-term infertility. That is a big decision to make at this age. I just don’t want to get pregnant. I don’t know whether I want children in the future.”

Her views were echoed by many other women and present a barrier to contraception use, which could lead to unplanned pregnancies.

The Qualitative Insight Team spoke to Year 9 students about contraception in a previous focus group about risk-taking behaviours. The students hadn’t received PHSE lessons on contraception yet, but they felt they should know about contraception at their age. Like the college students, the Year 9s felt that PSHE and sex education is not taken seriously: *“most people joke about it”*. When asked where they’d go for support/advice on contraception, most students said *“online”* because they wouldn’t want to risk judgement or gossip from teachers, family, or friends: *“you’ll be judged for being too young”*. This shows there is a lack of confidence around contraception across a broad range of ages in Wirral.

Women that are over twenty-four also deal with the challenge of lack of adequate information.

Their experience is different from the younger women in that most of them know what contraception options are available, but the biggest hurdle is not knowing how to access the contraception. The case study below illustrates a woman's challenges accessing contraception.

4.1.2. Affordability of contraception and accessibility of services

Accessing affordable and timely contraception is an issue for a lot of women. The case study below shows the multiple barriers a couple faced when trying to access affordable and sustainable contraception. Helen's story shows that accessing free condoms is difficult for women over 24, echoing other women's feelings that there needs to be more support for people aged 24+. The case study also highlights how accessing contraception can even be difficult for people who have worked in the sector.

Case Study 2: Challenges of accessing contraception.

Helen, aged 33.

Helen has been with her partner for 15 years. In December last year they decided to go off the pill. After she got off the pill, she and her partner decided to use condoms. She went to the local supermarket and the brand of condoms she was looking for was going for £8 a pack. She realised that she couldn't afford them long term and she decided to go to a sexual health service that mainly supports young people. When she got to the service, she was told that she could not have condoms because she was over 24 years old. In her words she describes the experience: *"I have worked in the charity sector for more than three years and I am more knowledgeable than most women, but I don't know how to get support for sustainable sexual reproductive health...they also told me that they do not put the condoms in toilets because people will steal them, how about that for support!?"*

Young people (15-24) generally felt that sexual health resources are expensive. Condoms and pregnancy tests were described as expensive to be bought regularly and match the number of times they are engaging in sex. Therefore, young people may be engaging in unsafe sex because of the economic circumstances around them. When probed by the researcher as to why they will not go to organisations that offer free contraception, Year 13 students indicated that these services are located mainly in Birkenhead. Moreso, apart from being centralised in one area it appears that there is one main organisation that everyone relies on. According to the students, the monopoly held by this organisation limits their options for accessing contraception. The students indicated there is a need for more variety of organisations,

because apart from the one organisation they knew, they didn't know where else to go for support and services.

The professionals working with young people indicated that during condom and testing distributions they give out a feedback form which asks for age, postcode, school details, ethnicity, for mapping purposes.

Young people described completing forms and having to go to the canteen as *"off-putting"*. Professionals agree that these forms can be a barrier, however they do need to track condom uptake in case there's an STI flare up, or batch of faulty condoms. One professional commented on the dilemma this situation creates:

"These are young people, you don't want to have too many forms, they should be freely wanting to take condoms, instead of thinking I've got to take a condom and but then I've got to fill out this big, long form."

A professional also described the challenges surrounding their work distributing condoms to men who are refugees and living in hotels in Wirral:

"We're trying to find a way to get in there, to give them some type of testing and things like that. We brought things like condoms along, and they didn't want to go anywhere near them. So, you know, is it the lack of understanding what a condom actually is? Because obviously, for us in England its everywhere isn't it, but in those countries where they've come from, condoms aren't really advertised the same'.

As well as differences in awareness of contraception, the professional emphasised that language is a huge barrier, and so there is a dependence on interpreters. They also highlighted the need for appropriate representation in terms of gender and race when delivering sexual health support to people who are refugees.

"I couldn't take a woman clinician with me, that wouldn't work. So, I took a male clinician with me, who was actually from a BAME background, and it went down really really well because they can connect with it. You've got to think about the people going out and reaching out into the community as well."

4.1.3. Appointments for contraception: Residual Impact of COVID Lockdowns

More than struggling with where to get condoms or other contraception methods, women struggle with booking appointments to discuss their contraception options. A professional who supports women who are digitally excluded described how it is a *"nightmare"* to book an appointment for contraception with the GP. She recalls how one time when she called to book an appointment for one of her clients she was kept on hold and transferred so many times until she gave up. She reflects that *"The onus is put on the people. I tried getting an appointment until I just gave up...and it's my job to book appointments for people, how about*

someone who is not mentally or physically capable to endure the anxiety.” According to the professionals, the GPs put a disproportionate burden on the clients to monitor and follow up on appointments. Ordinarily this wouldn't be a problem, but the challenge becomes that the long waiting periods make it difficult for people to keep track of their appointments and *“Clients can't cope with the anxiety of waiting to access services.”*

The theme of GP access and contraception came up a lot in the research. People expressed that this is due to the residual effect of COVID-19 and its impact on health services in general, not only sexual health. The commonly held view is that during COVID, GP practices *“... changed the way they work and never gone back... they've stuck with the COVID ways.”* There is a common belief that GPs are sticking to appointment settings/processes that were meant for a health pandemic.

The already complicated appointment system is further complicated by digital literacy and digital inclusion: A lot of GPs are now employing systems where people can book their own appointments by completing forms online. This creates problems for people who do not have the digital literacy or access to the internet.

The ripple effect of people not securing appointments with their GP or sexual health clinics is placing demand on hospitals. According to a trainee doctor from a local hospital, the lack of available appointments for coil fittings in sexual health clinics is putting pressure on the hospital's obstetrics and gynaecology department. This takes away resources from people with urgent care needs. They asked for *“more appointments, please!”*.

4.2. Abortion

Women expressed that they are not confident in their knowledge on abortion. A few sentiments that were shared across the different engagements were *“I wouldn't know where to go”* and *“I don't trust the doctors to give me the right [contraceptive] pill, let alone go through an abortion.”* A Year 13 student commented *“Teach about abortion; where to go and how to get it safely. Too much stigma”*. A professional in youth sexual health services added that they're seeing demand from young women for workshops on pregnancy options (including termination).

Social media is a key theme in information/misinformation when it comes to abortion. A common theme is that abortion is presented as a joke on Tik Tok. One participant commented that *“More often than I would like, I see a coat hanger joke.”* The different platforms make light of the very real issues that people are contending with every day without providing any helpful information on the depth of the subjects. Due to the prevalence of social media in people's lives, people feel that there should be more services to counter this. Likewise, in previous engagements around risk-taking behaviours, the researchers found that Year 7 and 9 students were concerned about being pushed harmful content on social media and that they had little understanding about how algorithms work.

4.3. Support for parents of teenagers

Case study 3 below provides insight into a mother's concerns for her daughter around sexual health issues. She emphasised that both young people and parents need education around sexual health so they can both be empowered. She recognised that children do not always want to talk to their parents, and that parents aren't always the best source of advice. Therefore, she would like to see more age-appropriate and approachable places for young people of her daughter's age (11) to go for sexual and reproductive health education.

Case Study 3: Parenting sexual health.

Nikkita, aged 47, mother to an 11-year-old daughter.

Giving sexual health education

- Her daughter identifies as LGBTQ and learnt about sexuality when she was 7. Nikkita said that although she's open with her daughter, *"parents aren't always the best education"*. However, there aren't enough age-appropriate or approachable places to direct her daughter to for sexual health education: *"as a grown woman, I feel embarrassed, so how is a young person going to feel?"*.
- Nikkita is scared about her daughter getting pregnant. She thinks there should be more education about the consequences of having a baby.

Parent education/empowerment

"It's not just about educating the young ones... Parents need to be taught how to teach their children about puberty, menstruation and sex, like what size tampons they need".

Misogyny and harassment

- Nikkita's daughter is *"top heavy"*, and she worries about her getting unwanted attention: *"How can I protect her from that?"*
- Nikkita has received unsolicited nude images from men and she's angry that there's no regulation/accountability: *"Where's the protection from that? It's the same as being flashed in the street"*. She worries about her daughter having access to social/messaging apps.
- She's passionate about wanting to go into schools to teach about sexual violence and the dangers of social media influencers like Andrew Tate. However, she's found it hard to contact the Council: *"Someone needs to stand up and be heard"*.

4.4. Post-natal contraception and unplanned pregnancies

Professionals from an organisation that supports families indicated that most women are not confident about the contraception available to them after they have just given birth. They said that contraception is not at the forefront of parent's minds after giving birth: *"It's the last thing people want to talk about after giving birth"*. However, the professionals cautioned that *"...this is also the period that they are very fertile"* and so awareness of fertility and contraception options is important. The professionals identified barriers preventing parent's awareness, for example they noted that since COVID-19, there have not been antenatal classes at the local hospital, meaning that parents are not getting the same access to post-natal contraception advice as before COVID-19.

These professionals think it's important that conversations around post-natal contraception are happening throughout the pregnancy (*"drip feed it"*), as their own research has shown that women prefer to be given contraception advice at one of their midwife check-ups or later, rather than straight after birth. However, the professionals know that new parents have many competing priorities and so contraception can end up not being discussed. For example, they highlighted that aftercare GP appointments are approximately 15 minutes long, and there is so much to cover in the appointment that contraception can be forgotten.

The professionals also want to see more following up on women who are seeking out contraception. They feel that professionals should be booking these women into appointments or giving prescriptions there and then. They also said it would be beneficial to offer coil insertion at the time of birth. The professionals described how there is onus on the women to book and chase appointments, which can be challenging for people who've just had a baby. For example, one centre that offers contraception doesn't have waiting lists, so women have to keep ringing each day to get an appointment - this is a barrier for new mums with busy lives. In addition, going to the appointment can be a physical challenge *"especially if they've had a C-section"*. A professional recounted their experience of trying to access contraception during the COVID-19 pandemic after giving birth:

"It was really hard to get an appointment, I know myself personally, because I needed contraception during COVID. I'd just had a baby, so. It was a nightmare just having to get an appointment and attend the appointment".

These findings echo the themes that emerged in the gap analysis for the project. A large amount of the literature reviewed included surveys from mid-wives and professionals involved in post-natal care. The common thread in their opinions was that most women tend to fall pregnant unplanned after they have just given birth because *"...after giving birth every woman says they are never having sex again. Therefore, there is a need to train midwives in different approaches to speaking about the subject and having trained team midwives on site who can counsel, prescribe, and administer a wide range of contraception to postnatal women prior to discharge from maternity ward."* (Quote from survey results shared during the gap analysis).

A few suggestions for opportunities that would improve women's experiences emerged from the gap analysis, starting with the need for a small, laminated cards with pros and cons of each contraception. Alternatively, a simple leaflet of all methods available to give to women on discharge from ward after giving birth because they forget a lot of what they are told but if it's written down, they can refresh their memory when the time is right. The laminated card or the leaflet should also have clinic times and venues, phone numbers to book. Women are more likely to go if a place and phone number is provided. It would also be helpful if women are advised on how soon an IUCD can be fitted postnatally. These suggestions indicate the need for more information on postnatal contraception. Women need to know current availability, how to access, when and how to use, risk and benefits of all available contraception choices, and breastfeeding friendly contraception options.

4.5. Opportunities and preferences

- Ensure people feel aware of all the contraception options available to them and consider how male-centered language around contraception, such as the perceived focus on male condoms, can limit people's choices and be exclusionary for different sexualities.
- Young people and women want to know more about the long-term side effects of contraceptive methods: *"More information on the side effects of contraception and education on the impacts of having sex, including pregnancy"*.
- The students indicated there is a need for more variety of organisations that offer contraception.
- Improve awareness of safe sex around the use of sex toys.
- More age appropriate and approachable places for parents to send their children for sexual and reproductive health education.
- Consider how the necessary paperwork around condom distribution can be off-putting for young people.
- Address the waiting times and booking processes that are posing a barrier to people's access to contraception, particularly women aged 24+.
- Consider how GP and sexual health services could return to pre-COVID processes that align with people's preferences around accessing sexual health support, such as more in-person contact.
- Improve the availability of affordable contraception and pregnancy tests, and improve awareness of how to access free contraception, particularly among people aged 24+.
- Raise awareness of where and how people can safely access abortion services and address harmful social media content around abortion.
- Consider what appropriate looks like in terms of an offer around contraception and sexual health support for people living in Wirral who are refugees, considering language and cultural barriers and the need for representation within sexual health services. Continue to bring services to people: *"Promote education first. People need to be educated. They won't just come into your centres just like that... It's trying to get those communities into sexual health, getting them understanding what sexual health is all about"*

- For post-natal parents:
 - Earlier and more frequent conversations about post-natal contraception and post-natal fertility for parents who are pregnant, including which contraceptives are breastfeeding friendly.
 - Improved availability of antenatal classes post-COVID, where contraception advice can be given.
 - More hand holding and following up on post-natal women who are trying to access contraception and appointments.
 - Improve opportunities to offer contraception in a way that's convenient for the women, such as offering the coil insertion at the time of birth.

5. Smear tests (cervical screening)

This section discusses people's experiences of smear tests. Firstly, it looks at barriers around appointments, including waiting times, location, and cis-normative language in online booking systems. Secondly, it provides insight into the anxiety and discomfort that surrounds the whole smear test journey, before lastly looking at people's knowledge and misconceptions.

5.1. Appointments

The participants identified a few barriers around smear test appointments, including waiting times, location, and cis-normative language in online booking systems, explored in detail below.

5.1.1. Waiting times

Women described long waiting times to get an appointment and frustration with having to wait to see the nurse once they arrived at their appointment. It appears that there is a small window of opportunity where women are motivated to book and attend the appointment, and so having to wait can be a deterrent. For example, the researchers observed that women engaged in substance misuse and sex work have many competing priorities, and so smear tests can be the least of their worries. The work that professionals put into encouraging these women to agree to a smear test is then lost by the time the appointment comes around: *"They might say 'oh yeah, I'll book in with my GP' or 'yeah, I'll come to that pop-up'. It gets to that day, and they go 'oh no, I don't really want to'."* It's also frustrating for these professionals and women when pop-up smear clinics are cancelled last minute (due to a lack of available clinicians) after having waited and made the effort to attend, especially as many of these women depend on professionals for transport.

5.1.2. Location

"That's why we bring services to them."

The location of smear test appointments is an important factor for making women feel comfortable. There was a consensus among sexual health professionals about the need to bring services like smear tests into the community spaces that people are familiar with. This was highlighted as important for women who have experienced abuse: *"I know that a lot of women wouldn't want to go a different place, but because they feel safe in our environment, they will get a smear with us."* For women going through hard times, smear tests may not be on their radar, and so having them available in the spaces they use makes them more accessible. Having trusted professionals and familiar faces in the space also eases stress; for example, substance misusers/sex workers are reluctant to go to the GP because they feel judged for their lifestyle, line of work and drug use.

One woman described how the service she uses offers her human contact and people who care, as *“Outside, there’s only associates, not friends”*. A professional highlighted that in general, a GP surgery is not the most comfortable place to go for a smear: *“You’ll be seeing your same nurse for your asthma check a month later. You can understand why people would shy away”*. Professionals felt that people aren’t aware that smears are offered in spaces other than GP surgeries.

Unfortunately, some services don’t have the resources to deliver smear tests in spaces where women would feel comfortable, as one professional said: *“You’ve got to build some rapport and trust there to bring them in...It takes work. And at the moment we don’t have somebody in that role”*.

5.1.3. Cis-normative language

Professionals working with people in the LGBTQA+ communities said that transgender people can be discriminated against during the online booking system for smear tests. Transgender people can struggle to access services for their gender assigned at birth. For example, a trans-male who was assigned female at birth can’t book a smear test because once he selects ‘male’ as his gender on the form, smear tests are not listed.

5.2. Anxiety and discomfort

The whole smear test process, including booking, waiting for the appointment, undergoing the procedure, waiting for the results and in some cases having to re-test, is an anxious time for some people. We found that this anxiety can stem from the fear of the unknown, misconceptions, past negative experiences, or from stories shared by family.

Professionals described how anxiety is a particular barrier for people with learning disabilities (LD). For some people with LD, familiarity and consistency are important, and so its key that tailored support is offered. One professional recounted how they supported a young woman with LD by letting her attend the clinic days before her appointment so she could see the space and meet the clinician, as even differences to the colour of the bed covering could be triggering. From the service provider’s perspective, these specific needs are quite difficult to meet as services don’t have the same staff every day, or the ability to maintain the same set-up.

A professional emphasised that smear tests can be uncomfortable for people in minority ethnic communities and for people of certain religions due to cultural norms:

“It’s not that they’re underserved, it’s not the services, it’s just that being a BAME person, you don’t like to go in and talk about certain sexual things, as with certain religions as well. You know, a woman probably wouldn’t want to come in to get a smear test done, because obviously someone’s looking underneath and all that, and I think a lot of is a cultural thing.”

Women gave accounts of feeling uncomfortable during their appointments. For example, in one case, a trainee nurse carried out the test making the swab take longer, prolonging the woman's discomfort. A 29-year-old woman described how the speculum used during her first smear was too large, but that the nurse was unsympathetic when she voiced her discomfort. This test was unsuccessful, and she was asked to return, but she said: *"At that stage I couldn't be bothered...I couldn't go through that again"*. She did attend her next smear three years later, but her first experience left a lasting impression. She said:

"To be honest with you I was quite reluctant to return because the previous test had just been so horrible, but I did go, and it was better this time. People in healthcare need to understand how vulnerable and intimate that procedure is. Some women have been raped, some struggle with a lack of confidence in their bodies. The person doing the test should just show kindness to all women because they don't know what that person is going through. If it wasn't such an important procedure, I bet I wouldn't go back again."

Anxiety and embarrassment can lead to long-term avoidance and can make the build-up to an appointment a drawn out and fearful experience. During Cervical Cancer Awareness Week 2023, one service identified 15 women who hadn't had a smear test in over 20 years. Case study 4, below, demonstrates how anxiety and depression can impact women's confidence to attend a smear test appointment, and to return following an unsuccessful test. As above, the case study shows that when someone feels like their anxiety is not taken into consideration, it fuels their reluctance to return.

Case Study 4: Smear test experience.

Ann, aged 66.

Abnormal cells

- Ann contracted syphilis from her late husband, and a smear test revealed she'd been left with abnormal cells. Her GP told her she'd be required to have a smear test every year. However, over the years Ann has suffered from depression and anxiety and couldn't develop the confidence to go for the smear.

Recent smear test experience

- Recently, Ann *"finally summoned the courage"* to get a smear, but her experience was negative. She said:

"They knew about my anxieties; I told them how this was a big step for me, but when I got there, they kept me waiting. Eventually I was called in, the nurse doing my smear told me that I wasn't 'stretched' enough to have the test done. I'm a widow; I haven't been with a man in years. I thought this was a good thing. The nurse prescribed IMVAGGIS which no pharmacy has! I left the appointment feeling dreadful and hid away on my own all weekend just crying. I have cancelled the next appointment; I am not going back. So here I am stressed about not having had my smear and knowing that I don't have the confidence to go back there again."

5.3. Knowledge and misconceptions

The case study above illustrates the finding that there is misunderstanding around who needs a smear test as well as what 'good' looks like in terms of vaginal health/sexual activity when it comes to smear tests. Ann in the case study thought that sexual inactivity was a *"good thing"*. Another young woman was concerned that having a smear test would compromise her virginity, and she was unsure whether she even needed a test.

When we asked young students aged 17-18 if they knew what a smear test was, there was limited knowledge. A few people knew it was related to cervical cancer and that it was something they would need when they were older, but only one female student had discussed it in detail with her mum after watching a smear test story line on a TV soap. Some young people felt it should be discussed earlier than age 25.

5.4. Opportunities and preferences

- More resources to improve the availability and accessibility of smear tests, including:
 - Reduced waiting times.
 - Resources to ensure pop-up clinics are staffed.
 - More smear tests offered in community spaces, and training and upskilling so that non-sexual health staff working in women's spaces can offer support.
- Work towards reducing anxiety and stress throughout the smear test journey, including an offer of tailored support for people with learning difficulties.
- Improve awareness of cervical screening and where testing is delivered.

6. Other themes:

As stated in the project background section, four key areas of focus were identified for the project (STIs, with a particular focus on Chlamydia; HIV; unplanned pregnancies and teenage conceptions; and cervical screening). The data collected also offered insights into themes beyond the four focus areas. This section explores these themes.

6.1. Sexual health education and awareness

Throughout this report, it's clear that there is need to improve sexual health education and awareness in Wirral. Within each of the themes, you can see how lack of knowledge and information are posing barriers to people's confidence, empowerment, and ability to make informed decisions around sex and sexual health. Sexual health knowledge was varied from individual to individual, and while this may be down to the individual's willingness to talk about sexual health with the researcher, it was clear that sex education is not delivered consistently. People's access to sexual health education, at home, at school, and in the community can hugely vary.

Young people:

There was a difference between some young people and professional's opinion on the sex education students receive at school. On one hand, young people expressed that their sex education at school was *"rubbish"*, not memorable, an experience tainted with embarrassment and joking around, or non-existent. On the other hand, a professional working in young people's sexual health service said: *"I think its brilliant, its age specific, it's appropriate, it's all evidence based, it's clear in a language people can understand and relate to. There's a wide range of topics that we cover"*. Young people were more positive towards the sex education that is delivered by external organisations, but professionals described how limitations to resources are a barrier to sexual health education in schools. A professional described how the pandemic has impacted young people's access to 0-19 school nurses during school hours:

"It seems to be an issue now, since lockdown and things restarted, some schools may not want them [0-19 school nurses] in there. Or service pressure as well. So, you probably won't see school nurses as they were previously in the school, unless it's something that school is doing themselves".

Another professional emphasised that more funding is needed for young people's sexual health services to be able to reach more young people:

"One school has asked if we can reach a whole year group with what we call a carousel, and unfortunately, we can only offer that school half a day as a commissioned project. So then that other half a day, they have to pay for it (at a reduced price) if they want to reach the whole year group".

Topics that are taught during these carousels are chosen by the school. A professional described how the schools often opt for the free topics on offer, meaning that students can miss out on topics that may be more beneficial. For example, the professionals know from feedback forms given out at the end of the carousel days that students want more education on puberty, pregnancy options, and sexuality/gender identity. However, the schools don't have the ability to fund the service to deliver more sessions, so the schools say they'll concentrate on these topics themselves, but other priorities can get in the way. A professional highlighted that puberty is taught early on, and so when students are going through puberty, they don't have access to the relevant knowledge.

Another barrier described by the college students was the competing priorities that come with being in their second year of studies. They said that in first year of college they do receive PHSE and sex education during form time, and some voluntary drop-in talks are available, however, in second year their exams and university applications take priority. This was evident during the focus group, as some Year 13s asked if they could concentrate on finishing their course work instead of participating.

The college students told us how they would like to receive sex education:

- *"I would say make talks more frequent and reduce the group sizes in schools to 10 or less."*
- Less *"one-off"* sessions and more regular sessions to consolidate knowledge. As discussed in the STI section, the students can feel overwhelmed by full/half-day sexual health workshops, as it's too much information to process.
- More structured sex education in college, rather than voluntary sessions where it becomes obvious who is sexually active and seeking out support.
- Preference for external organisations coming into the school, rather than teachers as it takes away some of the embarrassment.
- Sex education in Catholic schools that goes beyond the basics of sex (within marriage)
- More education on puberty for parents

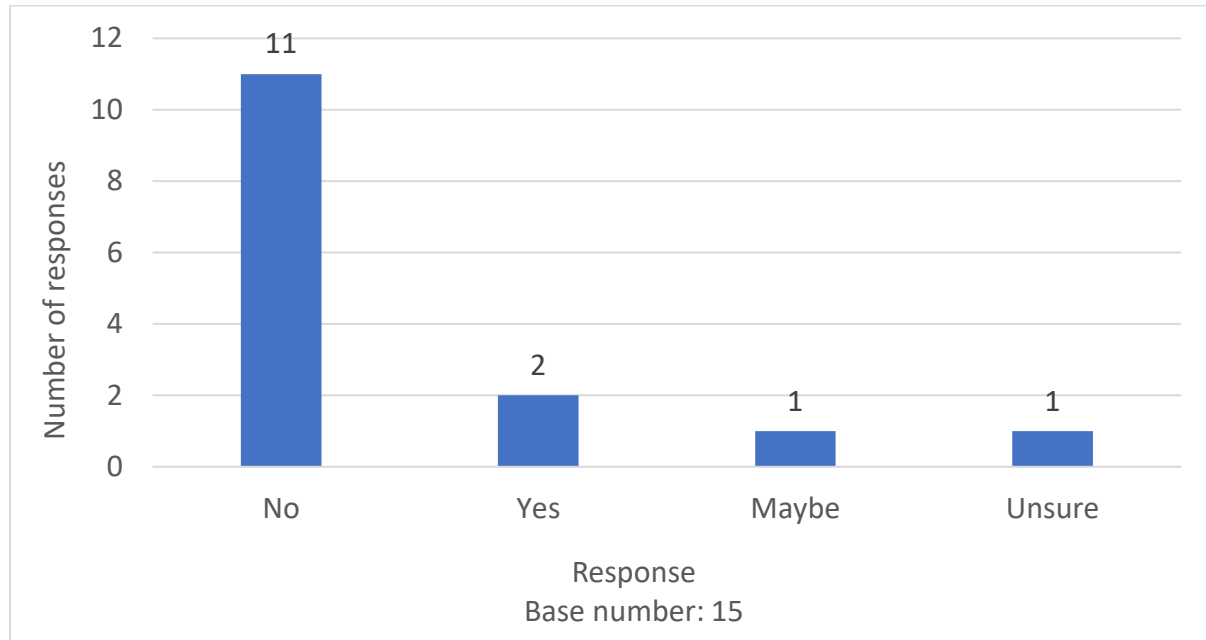
Although the students expressed a preference for smaller group work and for external organisations to deliver the sessions, a professional emphasised that the time and cost associated with this approach would be challenging for the school and the service.

The conversations with young people showed that relationships with family members can be an enabler or a barrier to young people's sex education. One student explained that they didn't have a good relationship with their parents, so they chose to educate their sibling on sexual health topics. A professional said: *"How can we expect young people to have conversations at home when the parents didn't get sex education themselves"*.

Adults:

The research grids showed that women and men also feel that there is not enough information around sexual health, as shown in Figure 8:

Figure 8: Is there enough information on sexual health?



In conversations, these adult women expressed that they'd like more information on sexual health and services. Therefore, there needs to be more opportunities for sex education outside of traditional education settings. As one professional said: *"I've got a background working with young people, so I know that education is in place for like Gen Zs, but for millennial upwards, where is the education?"*. Also, women's lack of confidence using their GP for sexual health information and services, shown throughout this report, should be considered. The women had the following preferences around sex education:

"Information needs to be more accessible in women only settings".

"More education and awareness. GPs aren't the best."

"Information easily available and accessible (where not judged)"

"Accessible education"

"Education for parents on puberty"

There was also emphasis on the need for sex education to be more inclusive, as one 23-year-old woman said: *"I would like to see a lot more education and inclusivity (for different age ranges and sexualities)"*. As discussed below, the women and students agreed that there should be more information about LGBTQA+ sex.

6.1.1 Sexuality and LGBTQA+ sex

Women:

The need for more education around LGBTQA+ sex and sexuality were raised by the women who completed the research grids. When asked what they'd like to see more of in sexual health provision, a 30-year-old woman said *"More teaching and empowerment for LGBT sex. Support needed for ages 24+"* and a 27-year-old said, *"LGBTQ education"*.

Young people:

One professional delivering support to young people said: *"the schools that I've seen, they're very open now, and accepting of diversity"*. Some of the college students agreed that there is more openness around sexuality and gender identity in schools and colleges, however, they felt that there is not enough information and detail included about non-heterosexual sex in PHSE and sex education. For example, they thought there should be more information and more detail about homosexual sex: *"It's important to teach it younger, even if people haven't come out yet"*.

The Qualitative Insight Team spoke to Year 9 students about sexuality and gender identity in a previous focus group about risk-taking behaviours. The students described how there is pressure to be heterosexual, which causes anxiety and bottling up of emotions:

"You could feel pressured to force yourself to like boys just because everyone else does. But that's you pretending to be something you're not, but you're too scared to open up".

Professionals:

Professionals said they are seeing a lot of young people and people with learning disabilities struggling with their sexuality and gender identity, and an increase in people identifying as non-binary. One professional said they have clients with learning disabilities who are confused about their sexuality and what different sexualities mean. *"Clients can change their sexuality day to day"*, and so the professional would like to offer a talk, but finding a suitable trained clinician to deliver the talk is a challenge.

6.1.2. Social media

Professionals perceived that young people learn about sexual health from social media and TV/film. Some of the college students cited TV programmes as their source of information, however, only a few students said they saw sexual health content on social media. One male student explained that *"social media is so tailored to you that you're not gonna see sexual health"*.

A female student explained that she does follow sexual health advice accounts because she didn't get any sex education at school, but they're American accounts, so although it's helpful for general information it doesn't help her know where to get support locally. The students understood how misinformation could easily be spread by influencers, but they didn't feel like they were victim of this.

Although students don't perceive that they're being influenced or educated about sexual health by social media, professionals and parents believe that attitudes towards sex and relationships are being shaped by social media influencers and pornographic content.

In the Qualitative Insight Team's previous work, the researchers also found that parents of young people aged 1-26 are concerned about young people's access to harmful content online, including pornography and paedophilia.

6.1.3. Sexual harassment

As shown in Case study 3, sexual harassment was a concern among some of the participants. There were concerns about young people's access to content online which normalises misogyny and violence towards women. One particular social media influencer causing concern at the time of the engagements was Andrew Tate. A professional explained that schools are asking for workshops on sexual harassment and consent:

"Like its Andrew Tate isn't it now, so a lot of the young boys, young men, are looking up to him and talking his language and advocating and thinking that he's really quite cool, so a lot of schools are concerned about that at the moment".

In previous engagements around risk-taking behaviours, the researchers were told by a professional working in sexual health that harassment can be a difficult topic to approach with young boys as they can sometimes feel accused and therefore unwilling to engage in the conversation.

6.2. Opportunities and preferences

People's preferences for sex education have been discussed throughout this section, but an overview of preferences and opportunities is given below.

- Young people expressed:
 - A preference for smaller group numbers for sex education lessons at school.
 - That sex education should be repeated throughout the years and that knowledge should be consolidated throughout the years. They also prefer to receive sex education from external organisations.
 - Young people who attended Catholic high schools would have liked to had sex education: *"Actually teach sex ed in catholic schools rather than just sex after marriage"*.
- Ensure that PHSE lessons, including sex education are continued into student's second year of A Levels, despite the competing priorities.
- Sexual health education for parents:
 - *"It's not just about educating the young ones... Parents need to be taught how to teach their children about puberty, menstruation and sex, like what size tampons they need"*.
 - *"How can we expect young people to have conversations at home when the parents didn't get sex education themselves"*.
- Age appropriate and approachable places for parents to send their children for sexual and reproductive health advice.
- Ensure that LGBTQA+ sex and relationships topics are included in sexual health education: *"More teaching and empowerment for LGBT sex"*.
- Ensure that professionals are trained and equipped to deliver support around sexuality and gender identity, particularly for people with learning disabilities.
- Ensure that people with learning disabilities have access to easy read sexual health information, and that assumptions aren't made around their need for sexual health advice and services.

Conclusion

This research provides valuable qualitative insights, which offer deeper understanding of people's knowledge, experiences and needs around sexual health support in Wirral. The report highlights the barriers and enablers to sexual health support that are perceived/experienced by young people aged 15-24; people in the LGBTQA+ communities; people living in areas of high deprivation; ethnic minority communities; women, including women in sex work and women who have experienced abusive relationships; and people who use drugs. In many instances the findings have complimented the existing data known about residents who are at risk of poorer sexual health outcomes, but they have also provided new perspectives and nuances straight from the voices of residents and the professionals who support them. The report has also presented themes beyond the original four research areas set for the project, such as sexual health education, social media, and the impact of COVID-19 on sexual health services/attitudes.

Overarching themes

Below is a summary of the overarching themes that emerged across the different demographics of participants and across the four areas of sexual health provision researched.

Sustainable sexual health services

The need for continuity of care was a key theme, particularly for women in sex work and people with learning disabilities where there was emphasis on the need for familiarity and consistency to build trust. Sustainable sexual health services look different for different people – some examples included:

- Greater provision of support for people aged 24+, particularly around access to affordable contraception.
- Improved access to appropriate sexual health information and support which is tailored to, and inclusive of, people's needs and identities. For example, easy read smear test information, post-natal specific contraception advice and *"More teaching and empowerment for LGBT sex"*. One woman said: *"I would like to see a lot more education and inclusivity (for different age ranges and sexualities)"*.
- Sex education in schools that is consolidated throughout the years through regular sessions rather than one-off half/full day workshops.
- Discrete services to cater for people who want to maintain their privacy.
- Need for approachable spaces where parents would feel comfortable to send their children for sexual health information and support.

Professionals emphasised the importance of tailoring support to people's needs and bringing sexual health services to people in the spaces they feel comfortable. They felt this approach helps overcome people's reluctancies, however, they identified that limitations in staffing, funding and time prevent services from being able to offer sustainable and flexible support.

For example, this professional explained how lack of staff prevents the outreach work that is necessary to build relationships with women who use drugs:

“You’re not going to just put a clinic on and they’re going to go ‘oh yeah, I must go for that smear’. It’s not going to happen. It takes work. And at the moment we don’t have somebody in that role.”

COVID-19 impact

Professionals described how the COVID-19 pandemic impacted people’s ability to access sexual health services, and how *“there’s been a domino effect”* on current service delivery:

“So, there were waiting lists, and ‘these people need to be seen first’. And while services were starting to open up face to face again, it was still actually, ‘you’re not on a priority list so you’re going to have to go elsewhere’, so you go to your GP but then you’re facing exactly the same challenge of filling out an e-consult and no one getting back to you.”

“Well, they’ve changed the way they work and never gone back. So, GPs never reverted back. They’ve stuck with the COVID ways.”

Continued difficulty accessing appointments was a theme that was prevalent in the conversations with residents about contraception and smear testing, and professionals themselves gave accounts of struggling to access appointments during and since COVID-19:

“It was really hard to get an appointment, I know myself personally, because I needed contraception during COVID. I’d just had a baby, so. It was a nightmare just having to get an appointment and attend the appointment”.

This research showed that women and men aged 23+ prefer in-person sexual health support and services, and so there appears to be a disconnect between people’s preferences and the booking systems/appointment types available to them since the pandemic.

Other examples of how services have not returned to pre-COVID service delivery include 0-19 nurses not being as present in schools, and antenatal classes in hospitals not returning. Both examples were described as barriers to people’s access to sexual health education and advice.

Professionals also highlighted how the COVID-19 pandemic changed attitudes towards sex and relationships:

“It felt like it was somewhat criminalised and frowned upon by the criminal system.”

“Some people were very scared that if it came about that people knew that they were having sex, that they’d be going against like rules and guidelines. So sexual activity kind of went underground bit.”

The impact of this culture around sex on people's confidence accessing sexual health support should therefore be considered.

Impact of negative experiences of sexual health services

This report has shown that people can have negative experiences and perceptions of (sexual) health care services, or reluctancies around accessing support. Fears, anxieties, embarrassment, and negative experiences of services can impact on people's decision making and sense of empowerment around sexual health. For example, women talked about how these factors have led to long-term avoidance of smear tests:

"I left the appointment feeling dreadful and hid away on my own all weekend just crying. I have cancelled the next appointment; I am not going back. So here I am stressed about not having had my smear and knowing that I don't have the confidence to go back there again."

Another example is when young people who attended Catholic schools talked about how the lack of sex education they received has negatively impacted on their knowledge and confidence to make informed decisions. Women also talked about their lack of confidence in their GP due to previous experiences of not feeling supported: *"I don't trust the doctors to give me the right [contraceptive] pill, let alone go through an abortion"*. Lack of confidence around accessing sexual health support was also a key theme among people from ethnic minorities.

Hesitancy to engage in health care services was also described by women who use drugs who said they can feel judged as *"second class citizens"* for their lifestyles. A professional that works with these women explained:

*"People have bad experiences of health professionals. So, a lot of people, not just the female sex workers, people in general in treatment for drugs and alcohol, **they're used to getting treated a certain way, or being judged, so they're more reluctant to engage**, or they don't prioritise their health and they miss appointments, so then they've got a bad DNA [did not attend] rate, and that also goes against them."*

The quote above shows the importance of not looking at sexual health in isolation when trying to understand people's reluctance or lack of confidence to access sexual health services: *"Sometimes people don't know the bigger picture behind why people don't engage"*.

Gaps in knowledge and awareness

As discussed throughout the report, the participants often expressed that they were unsure of where or how to access sexual health information or services. Participants gave examples of the gaps they perceived, such as LGBTQA+ sex education and empowerment, abortion and pregnancy options, the side effects of contraception, and how/where to access appointments for sexual health support. Participants also described how when they do find information it can be confusing, such as the *“two-week rule”* around Chlamydia testing, or inaccessible, such as not in easy-read format. There were also gaps in knowledge that became apparent to the researchers throughout the conversations, such as people’s misconceptions about HIV transmission and its perceived correlation to the LGBTQA+ communities, lack of knowledge of STI symptoms and transmission, and perceptions that at-home STI testing kits are less reliable than in-person testing.

The gap between knowledge and assumptions was particularly relevant to HIV, but it also played out in conversations around contraception and smear testing, such as the example given in Case study 1 of a young person thinking you have to be 18+ to order an STI test. Lack of knowledge was closely linked to people’s confidence around sexual health. For example, misconceptions about who needs a smear test and when, and the lack of knowledge that smear tests are available outside their GP surgery are stopping people from getting tested. Lack of confidence was also raised in conversations around parent’s ability/willingness to provide sex education to their children. As one parent said: *“It’s not just about educating the young ones... Parents need to be taught how to teach their children about puberty, menstruation and sex”*.

The role of social media, TV, and popular culture in providing access to harmful or misinforming content, particularly young people, was a reoccurring theme. The example given of a young person seeing abortion jokes on Tik Tok highlights the potential risks around people’s access to harmful messaging around sexual health topics. Interestingly though, most young people didn’t perceive that they see ‘sexual health’ content on social media. Social media is not a theme solely related to young people, as shown in Case study 3 where a mum described how she felt violated when she received unsolicited nude images on a messaging app. On the other hand, professionals highlighted the positive role some online/TV content has played in raising awareness about sexual health topics like HIV.

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About us

Qualitative Insight is a type of research that speaks to people to gather their thoughts, experiences, and ideas on particular subjects. The Qualitative Insight Team at Wirral Council work with residents to ensure that their voices are heard when informing council policy and decision making. The team supports the delivery of the Health and Wellbeing strategy, in which residents' voices are a key strand.