

# COULD I JUST ASK YOU A FEW QUESTIONS AS YOU HAVE SEX ON THIS PARK BENCH ...?

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## INTRODUCTION

*The National Strategy for Sexual Health and HIV* (Department of Health, 2001) marked a major milestone when it was published, placing sexual health and HIV firmly on the national priorities agenda. It established a 10 year commitment to tackle sexual ill-health and to modernise sexual health services in England.

This paper details a research journey which was undertaken in 2008 and was linked to the above objectives. The Central Office of Information (COI) is the centre for marketing and communications excellence in UK Government. On behalf of the Department of Health, COI commissioned Define Research and Insight to accumulate an evidence-base which would facilitate social marketing interventions in Sexual Health across the United Kingdom.

Our journey included the following steps:

1. Identifying the research challenges in approaching the audience for sexual health services.
2. Moving towards a process of audience segmentation.
3. Developing the methodological approaches necessary to access valuable, legitimate data and to help respondents start the process of solutions to this tricky problem.
4. Analysing that data in order to search for inspiration on which to start building interventions.
5. Developing a 'co-creation' methodology that would allow the target audience to refine social marketing interventions.

The details of that journey are set out below. Particular focus has been placed on the use of innovative methodology – without which, the study would not have been possible.

## A PICTURE OF SEXUAL HEALTH

In the United Kingdom in 2000, the National Survey of Sexual Attitudes and Lifestyles (National Centre for Social Research, 2001) provided important insights into the extent of British sexual ill-health. In particular, the study highlighted an increase in the reported incidence of sexually transmitted infections (STIs) compared to results of the same study conducted in 1990.

Crucially, the increase seemed to be linked to higher levels of "risky" sexual behaviour; the increase was consistent with changing marriage, divorce and cohabitation patterns also seen in the United Kingdom during this time.

The key behaviours identified were an increase in numbers of sexual partners together with an increase in numbers of men paying for sex. These behaviours are associated with increased risk of HIV and STI transmission.

In light of such results, the first National Strategy for Sexual Health and HIV was formulated by the Department of Health in July 2001. This is a strategy that "aims to modernise sexual health and HIV services in England" and to "address the rising prevalence of sexually transmitted infections (STIs) and of HIV, and to put these in a broader sexual health context".

As part of this programme of work, DH commissioned a safer sex communication campaign – *Condom Essential Wear*. This campaign aims to generate awareness in England amongst the target audience (aged 16 - 35 years overall as prevalence is particularly high amongst this demographic, and they are most at risk of catching an STI). The campaign wanted to embed the risks in their consciousness in order to facilitate behaviour change over the long term. The campaign aimed to normalise condom use, to change the culture around unprotected sex, to support the social conversation about discussing safer sex and to break down STI taboos.

As the campaign has progressed, *awareness* of key messages around sexual health has increased but there is a need to help the young target audience (16-35 years) to *change their behaviour*.

The adoption of social marketing principles and practices to inform new and existing programmes of work is one way – amongst others – of doing this. *It's our Health* (National Social Marketing Centre, 2006) was commissioned to review the role that Social Marketing could play in driving this performance improvement.

## RESEARCHING THE TEEN SEXUAL HEALTH QUESTION

The Department of Health needed to find effective ways to understand and help curtail upward trends in both STI transmission and teen pregnancy – a particular challenge for the United Kingdom.<sup>1</sup>

As mentioned above, the journey of this research programme involved several steps.

A large-scale desk research programme was undertaken by COI to interrogate the initial data available – epidemiological data about STI rates and incidence, geographical risk clusters, social survey data, anecdotal evidence and reports on best practice from a number of different sources.

From this, the desk research team were able to begin a process of audience prioritisation, with identification of particular population groups having high incidence

of STIs or teen pregnancy, particular behaviours which put them at high risk or have other attitudinal or demographic characteristics linked with STI or teen pregnancy risk.

Groups identified as high risk were further investigated via a range of sources including previous primary research conducted by COI and published sources ranging from articles in *The Lancet* to the *British Medical Journal*. The reports were reviewed to identify any attitudinal factors associated with high prevalence/risk, information on how associations are formed, how they interrelate, whether they are a consequence/driver of risk behaviour. Qualitative commentary was plotted onto an analytical framework<sup>2</sup> derived from behavioural model and associations.

With comprehensive desk research behind the team, hypothesised audience segmentation was sketched out to enable the team to focus clearly on retaining the key drivers that would need to be addressed through the intervention.

## TOWARDS A PROGRAMME FOR CHANGE

The hypothesised segmentation fixed the known risk elements of the target audience of UK young people – including pre-identified demographic, socio-economic, attitudinal and behavioural characteristics for high STI incidence and teen pregnancy.

However, the objective behind the overarching DH work programme was to move this audience towards behaviour change.

- Primary qualitative research was needed to evaluate the hypothesised segmentation and to identify key insight – either behavioural, cultural or attitudinal – that would provide levers for interventions.
- Following on from this insight-gathering stage, a programme of intervention could be developed in collaboration with the target audience, and piloted.
- A final stage for evaluation would be commissioned once the intervention pilot had been running for an appropriate period, to be determined once the nature of the intervention pilot had been established through the above.

Clearly, of course, this programme for behaviour change hinged on one thing: accessing honest and reliable sexual health data from young audiences in an ethical and intelligent way. Understanding the barriers to researching teen audiences in any subject, but especially one as sensitive and as private as this, the primary qualitative research task was viewed with some trepidation.

### TOWARDS A SAMPLE AND METHODOLOGY

The project aims were bold: to segment audiences effectively, inspire interventions for behaviour change and then deliver effective pilot interventions – all on a foundation of knowledge about teen sexual behaviours and attitudes.

Accessing that foundation of knowledge would be the first task.

The desk research pinpointed lots of different groups who were likely to be higher or lower risk in relation to their sexual health and behaviours. This included individuals with high numbers of sexual partners, individuals from particular gender or ethnic background, individuals who were condom averse, those for whom contraception is taboo, or those for whom teen pregnancy is not a disastrous outcome.

The qualitative research needed to explore these groups in depth; each of the areas of detail required their own particular 'live' sample in order to be able to confirm or correct the hypotheses.

In building a sample, there were clear directions for groups of teens to include.

The hypothesised segmentation set the framework for inquiry as males and females, aged 16 - 29 years, including multiple ethnic groups (Black African, Black Caribbean) and covering a wide socioeconomic range from BC1 through to C2DE.

The qualitative sample was constructed to include all these demographic variables as well as pertinent behavioural variables: these included length of time of current relationship and 'type' of current relationship (committed,

relaxed and open or non-committal). The qualitative sample also controlled for those who were more or less sexually experienced or those who had had greater or fewer numbers of sexual partners (concurrently or consecutively).

Framing such intimate questions for the purposes of in-street recruitment took a large amount of time and attention; care was taken to ensure that any possible judgmental tone was avoided. Language was kept as informal as possible and recruiters were briefed to approach the questions confidently and in a relaxed manner (rather than in an overtly 'private' way). A series of scenarios (e.g. *Karen and Darren are in x type of relationship and do a, b, c*) was used to allow respondents to see that we were looking for a wide range of behaviours and attitudes from both parties with regard to "normal" sexual encounters). Overall, the whole tone of the recruitment process was designed to encourage openness about sexual practices.

Recruiters were of course briefed to appreciate that there could be a high level of "up-selling" of behaviours and attitudes: however confident, respondents were not likely to be wholly honest with recruiters on the basis of a short questionnaire. The main task for recruiters was to gather the widest range of respondents possible. The exact mix of attitudes and behaviours was less important than that range.

Moving from sample design to research methodology, a key question underpins all research, but is particularly pertinent both to sexual health research and to sensitive research topics with young people: how to access accurate and honest data?

In designing the study, there were a number of key elements which needed to be handled. The first was that, at some point in the process, data would need to be transferred from the young people themselves to an adult research team. Getting close to the actual essence of the experience of teen sexual behaviour and attitudes in order to identify motivations and barriers to behaviour would not be easy.

Exploring the world of teenage sexuality means, for most researchers, a trip back to memory lane. However, times have changed, and what we knew then is perhaps no longer relevant for today's 'market'. Terminology has changed, mainstream practices have changed and facilities and expectations (of both genders) have changed – to some extent.

The ethical implications for adult researchers investigating teen sexuality – how to gather data, how to frame questions, how to probe for detail, how to respond to perceived sexual exploitation or underage sexual encounters – were central to the methodology chosen.

Rejecting the traditional data gathering options of focus groups or depth interviews, it was felt that the approach needed something more. A methodology was needed that would place the teen sexual experience – and the teens who recounted their decisions in relation to it – at the centre of the discussion. Room would be given to spontaneous data, and probing would follow the flow of the respondents' conversation. As far as possible, respondents would determine the direction of the dialogue.

As has already been discussed, the research task was double-barrelled: to validate the segmentation and refine it as appropriate, and to find ways of inspiring and shaping interventions which would make a difference to teenage sexual health and teenage contraceptive effectiveness.

It was deemed most appropriate to "layer" methodologies and to use research several techniques to approach the challenge.

A plan of investigation was set out over three phases:

- Phase 1 would gather a wide range of "quasi-ethnographic" data (personal stories about sexual health experiences) as well as some initial sketched-out ideas for intervention.
- Phase 2 would allow respondents to interrogate the data to find deep meaning and would also ask them to refine intervention ideas in light of their understanding.
- Phase 3 would allow respondents to shape an intervention in detail. They would be facilitated to ensure that

it fitted need as far as possible, taking into consideration all elements of execution including marketing and presentation.

## RESEARCHING TEEN SEXUAL HEALTH: METHODOLOGY IN DETAIL

Before we consider researching teen behaviour, it is important for the research community to understand how teens see us. However cool, trendy or compassionate to their situation we consider ourselves, for teens, we are decades away from them – we are *other*.

Thus, throughout this project, we needed methodologies that helped to legitimise us as adult researchers – to give us an appropriate role and status – in order to gain admission to the teen world.

The methodology in each of the three phases was tailored so that the adult researcher could approach the world of teen sexual behaviours and attitudes in an ethical, respectful and creative way.

In Phase 1, the method of research was labelled *Creative Conferences*. The Phase 2 approach was based on an innovative technique called *Gallery*. The Phase 3 research objectives were approached via a method that was called *Development Days* – a process of formative research. All three methodologies are outlined below with the key insights at each stage.

### Phase 1 Method: Creative Conferences

Teenagerhood contains a number of contradictions. Many teens strive for attention and the chance to be centre stage; the same teens are desperate not to draw scrutiny and can become openly hostile to any event which they experience as exposing themselves or their life choices. The "group identity" offers a shelter, as it provides a normative framework which minimises the chance that the teen will be personally challenged. The technique of *Creative Conference* harnesses the power of normative group behaviours to facilitate discussion about sensitive topics.

Creative Conferences are, in essence, three traditional focus groups – of six teenage respondents each – taking

place in the same room at the same time. Each group is moderated by a different member of the research team. (For the purposes of this project, the Conferences were single-gender only but were able to include a wide range of respondent variables).

Creative Conferences set a normative baseline for respondents: seeing other groups of teens talking and laughing with their group leader (not necessarily on subject) helps teen respondents to open up. It becomes more 'normal' to talk.

Normative baselines for language and for key questions were also loosely set at the start of the conferences (respondents tend to be inhibited where they think they might offend the researcher, and in this topic, some of the data which was eventually revealed was quite shocking). Therefore, the research team began each Creative Conference with a short film, a recorded compilation of interviews from key stakeholders in the area of sexual health, such as clinic nurses, academics and marketers. These stakeholders spoke about the problems they were facing as professionals, and the teens were able to hear the kinds of vocabulary that adults might use, and the kinds of quite graphic detail that they were used to.

Thus, the process rules were set up with minimal overt control from the adult researchers. Respondents were then tasked to work in their group to create a collage, which would be a group view of their individual experiences around sexual health, sexual behaviour and barriers to safe experience. As they debated and discussed their choices of pictures or words to go on the collage, the groups revealed their personal stories – often in high detail and with much humour. The adult researcher was able to listen in, probing for further explanation or detail where necessary from a low-key, non-threatening role. Some of what we heard would have been hard to access otherwise: stories about drunken sexual activity, about using sex to get alcohol and about the issues or problems of contraception in a gendered world.

Once collages were completed, the groups of 'artists' shared their thinking behind their work to the wider conference, who were able to comment and ask questions,

to challenge or to add their own thoughts. It was at this stage that some of the detail and colour around common experiences emerged, offering key points for 'mass market' communications and interventions. Here too, some of the particular differences between teen experiences also emerged.

Following this, respondents were given stimulus materials and facilitation techniques in order to help them generate solutions; respondents were urged to consider what they would do to help other people like themselves to have better sexual health and safer sexual experiences. They were encouraged to think about the whole range of ideal behaviours such as using condoms, seeking screening, avoiding regretted sex and so on. Again, different ideas were explored in the smaller discussion group and commented on by the wider group.

Posthoc analysis of these 'inventions' by the research team generated a number of core inspirations for intervention.

### **Phase 2: Gallery methodology**

Keeping the teen respondents at the heart of the research and allowing the teen sexual experience to drive the parameters of enquiry, it was decided to approach the next phase of the research through a *Gallery* methodology.

Eight artworks<sup>3</sup> (from the Creative Conference collages) were placed in a large hall. A fresh sample of respondents was walked round the artworks individually and in pairs: they were asked to respond to the images.

They were told by the adult researcher that the images had been created by young people like themselves, and that these young artists had been trying to express some element of the problems and challenges they face as teens having sexual experiences.

The respondents were invited to respond spontaneously and promptly to the artworks – thinking about what the artist was trying to say, whether that was a niche or a mainstream problem or issue, what they themselves had experienced in relation to the topic and how they felt/dealt with or avoided such challenges.

As well as spontaneous and prompted data, non-verbal data were collected during the interview. Where the researcher noticed contradictions between what was said and what was demonstrated through body language, such differences were explored by means of projecting negatives back onto the artwork. This approach yielded a large amount of in-depth and very detailed data in terms of power relationships between genders, behaviour expectations in relationships, parental influence over contraception usage, knowledge and understanding gaps and a raft of information about cultural and language issues in the area of teen sexual health.

Once the eight artworks had been explored, solutions were investigated. A short-list of Phase 1 respondent-generated inventions, supplemented with some additional ideas, was also considered in depth.

Critical points were revealed including the issue of *language* (how can teens, particularly teens who are talking romantically, start to discuss practical details about condoms between themselves), *imagery* (what images build a feeling of empowerment, especially amongst young girls, which allows them to insist on protection during intercourse – and how can images of female nakedness be subverted to create confidence when and where it's likely to be needed), information (how can information and sexual health services be made acceptable in a country where sexual activity is still somewhat of a taboo, especially for females) and *consequences* (the real hierarchy of perceived consequences, especially for males who can be unmoved by many of the currently publicised consequences of unprotected sex, such as STIs and unwanted pregnancy).

The findings from Phase 1 and Phase 2 were analysed together to deliver a clear segmentation of the audience and some detailed inspiration for interventions, founded on a basis of in-depth knowledge of how teen sexual encounters currently work (or do not work).

### Phase 3: Development Days

The hypothesised segmentation from the desk research included demographic, relationship and attitudinal clusters. It was explored qualitatively to deliver detail.

Whilst the broad umbrella categories were supported, the research indicated that there was a high level of sophistication, particularly underneath the attitudinal clusters and that these were perhaps the best way of considering a nation-wide segmentation of young people.

A final segmentation was therefore drawn up which was based on two axes. The first was *sexual behaviour* (relationship status and number of partners) and the second was *factors which drive behaviour* (attitudes, self-efficacy/confidence, level of control within the encounter and perceptions of social norms).

The umbrella categories<sup>4</sup> produced followed those which had been hypothesised as:

- *Thoughtless*: Although they have the capacity/self-efficacy to make positive sexual health decisions, social norms or their attitudes do not support this.
- *Low Risk*: Have positive/protective attitudes, have sufficient self-confidence/self-efficacy to enable them to manage a relationship and articulate their preferences, and believe in social norms which promote sexual health.
- *Disengaged*: Having attitudes and social norms which do not support positive sexual health, and lacking in the self-efficacy needed to bring about change.
- *Vulnerable*: Lacking in self-efficacy and not supported by social norms, making it difficult for them to make positive choices about sexual health despite their positive attitudes.

The four umbrella categories (Thoughtless, Low Risk, Disengaged and Vulnerable) tend to be ordered according to a gender key: *Thoughtless* clusters tending to include more males, *Vulnerable* clusters tending to include more females.

Based on the in-depth “quasi-ethnographic” detail which was afforded by the Phase 1 and Phase 2 methodologies, detail was added underneath these categories and some of the findings are highlighted in the following section.

At the final analysis, however, there are nine attitudinal clusters which cover the sexually active UK teen population, weighted from largely male clusters through to largely female clusters.

The nine clusters are as follows:

1. *Thoughtless*: Single Focus (sober)
2. *Thoughtless*: Single Focus (drunk)
3. *Thoughtless*: Danger Seekers
4. *Low Risk*
5. *Disengaged*: Disconnected (males)
6. *Disengaged*: Disconnected (female)
7. *Vulnerable*: Denials
8. *Vulnerable*: Disempowered
9. *Vulnerable*: Unguided

Of course, segmentation and clusters in sexual health must be viewed as a series of fluid positions – they are not a rigid taxonomy. During the course of a six-week period, an individual might go from Single Focus Sober to Low Risk, and then to a higher risk category again. It is important to realise that young people are not ‘of one type or another’, and to appreciate that all teens should be equipped with the same levels of information and preparedness in order to avoid situations which could arise in their futures.

Following the Phase 1 and Phase 2 findings, DH agreed that an intervention should be piloted which focused on the three clusters that make up the *Vulnerable* category.

The Phase 3 co-creation was conducted via extended groups (Development Days) of eight new female respondents convened over four hours. It was felt that a longer period of time to discuss, including breaks for moving outside the research room and some time for lunch, would help the most vulnerable respondents gather their thoughts, get beyond their initial embarrassment, build a strong rapport with the researcher and the other members of the group and see the problem from a number of different angles.

The teen respondents were recruited to be somewhat ‘more creative and more expressive than their peers’ – although given the cluster to which they belonged, they were not all excessively boisterous.

As indicated, the Development Day method included the teens being able to leave the research room and

walk with the moderator around the community where the intervention was planned to take place.

The respondents were asked to walk around the shops and the high street and to look for images and ideas relevant to the design of the intervention. They were asked to go shopping with the researcher and to help buy things that could be incorporated into the intervention in some way. Their shopping choices and the ‘outside world’ elements that they drew into the project in this session were highly illuminating (both in terms of illustrating their comments and in terms of making the intervention more suitable for the target audience). Respondents were taken for lunch as part of the research process. Again, their behaviour and interactions at this point were observed and used as data within the project.

## TOWARDS FINDINGS: GENDER RULES (OK)

Teens in the UK are operating under a series of ‘*hidden rules*’ (which exist across many areas of society but which are particularly important when interpreted in the area of teen sexual health).

These rules are created from:

- the ‘groups or societies’ in which the respondents live/work/learn;
- the media (with its normative frameworks for drama and sexual attractiveness);
- parents (who communicate normative frameworks for their children, for each gender and for sexual behaviour in general);
- church or other moral compasses (who deliver patterns and norms for ideal, living, good living, right living – much of which is directly addressed at the area of sexuality and sexual expression); and
- schools and educational materials (which approach the subject of sexuality to deliver information, rather than to enlighten or empower students).

Some of these rules conflict with each other. Many agree in one respect at least: that sexual behaviour is not acceptable for the young and only acceptable for females under certain conditions.

Irrespective of where the rules are coming from, gender rules around passivity and activity tend to be reinforced – females being passive and males being active. The gender discourse of 21<sup>st</sup> century Britain would still seem to be the single key operating principle which underpins all sexual health behaviours, attitudes and expectations.

*Younger girls feel disgraced about going to the clinic ... but at the end of the day you choose when you have sex, but no one should judge you for it. You shouldn't be made to feel bad about going.* Female, 16, South

Females express their gender role by not asking questions and by avoiding control. In certain circumstances, it is important for the female gender role for them to be ignorant of the fact that sexual activity is likely to take place (overt innocence).

*We have strict rules about talking about sex, it is shyness and forbidden to talk about it. If you are underage like 18 you cannot talk about it ... if you are not married you cannot talk about it either.* Female, African, 20-24, South

*I went to a Catholic school so all I got was don't do it and told when you're married you do the rhythm method!* Female, 25-29, South

In contrast, males express their gender role by being sexually active and more control focused in regard to sex (rather than sexual health overtly). For them, the challenge is to negotiate through the displays of overt innocence and to get the female towards “unexpected” sexual activity – without either of them having to discuss it.

In thinking about the attitudinal clusters, the differences between Single Focus (Drunk) and Single Focus (sober) show how the hidden rules about alcohol come into play. In the United Kingdom, alcohol is deemed to ‘absolve’ the individual of responsibility to make choices. For girls in particular, this is seen as an advantageous route (towards overt innocence), allowing them to move beyond the regulated behaviours of their gender (passive and non-sexual) into more active sexual expression without breaking their gender rules.

*Alcohol is sometimes used as an excuse ... it makes you feel safe when you're not ... invincible ... but you still know what you're doing ... like an out of body experience.* Female, 16-17, South

Single Focus Drunk are therefore, whether really or pretending to be drunken, unable to broach the subject of condoms or sexual health; the intoxication that makes sex accessible, puts sexual health out of reach.

*This plays in the back of your mind. It happened to us both – got pissed up, shagged a girl (and got her pregnant).* Male pair, 25-30, South

By contrast, Single Focus Sober are those, usually males, for whom the sexual event is of ultimate importance. For this group, sex can occur at any time of the day or night and in any location. These are the ‘players’, notching up conquests.

Although they are unlikely to initiate condom usage (because of ‘gender rules’, their female partners cannot become ‘aware’ of sexual activity), they are likely to accept condoms if the alternative is not to have any sex at all. In this respect, the implications for empowering females to insist on condoms are clear.

Danger Seekers as a cluster belong largely to religious or ethnic communities where sexual activity is sinful or taboo in some way; in such communities, gender is likely to be prominent across a number of facets of the society. Young males, therefore seek sexual encounters as an adrenalin rush. They approach sexual activity as an act of danger – often seeking unprotected, homosexual or paid for sex at the same time as they are holding down a more mainstream relationship.

One of the main challenges is the level of exposure to STIs for the female in the primary relationship.

*Every time I'm in the pub and see a woman I never think about a condom! Might have a dance buy her a drink, just thinking about pressing.* Male pair, BME/ Caucasian, 25-30, North

The Thoughtless clusters can, of course, be either male or female. However, they are pro-active in pursuit

of sexual activity which leads them to tend to include more males.

For such males, the main negative consequence to be avoided is that of becoming a father at an early age. Teen males tend to assume that their female partners will take steps to avoid becoming pregnant; reminding these young men that they could – as they see it – lose everything in an instant by trusting a young female is a powerful prompt to take greater care of themselves by using condoms.

*Cos I don't wanna have no baby at the age of 16.* Male, Black African, 16-17, North

As the clusters which are pro-active in pursuit of sexual behaviour are more likely to include young males, so the clusters which embody more passive responses to sexual activity and sexual health tend to include the young females. The three clusters (Denials, Disempowered and Unguided) tend to include patterns of relationship to one's own sexuality which significantly impede appropriate and effective sexual health.

For Denials, there is a hidden rule about sex and purity which translates roughly as 'nice girls don't have sex'. Thus Denials tend to include the higher socio-economic groups and to have parents for whom family reputation is important. Denials may avoid sexual behaviour or any associations with sex until they are out of secondary school; in that respect, they may be slightly older than the average when they lose their virginity. However, they are likely to be lacking in preparation and education about sexual health, and to be inexperienced in terms of discussing it. Their frozen approach to engaging in their own health needs can lead to unplanned pregnancies and STIs from relatively late sexual engagement and relatively few partners. For Denials, a programme of empowerment and enlightenment around gender may be particularly effective as they already possess resource and education.

Disempowered are a more extreme version of Denials. Like the male Danger Seekers, the Disempowered belong to a cultural or ethnic group where sex is taboo

for females. In that respect, the cluster is characterised by fear of being exposed as a sexually active female. The penalties of being a teen female who is having sex are reportedly severe: respondents talked about being sent 'back home' to the country where their parents were born, or even of being physically punished if their parents found out.

The challenge for the Disempowered is that – being in such a vulnerable position – they have no leverage via which to insist on condoms. They cannot use the contraceptive pill because they might be found out; therefore they have to rely on their male partners being willing to agree to wearing a condom in order to avoid pregnancy and STIs. Unfortunately, many of the males with whom these teen girls are sleeping are Danger Seekers, interested in unprotected sexual activity. Some of the respondents in the Disempowered cluster reported that their boyfriends removed the condom during sex against their will. Female condoms may have an interest for these girls where they are not considered for other groups.

The Unguided are the final cluster which make up the Vulnerable category; again, they are likely to be female. They are characterized by having lost their virginity at a very young age to an older male (possibly aged fourteen to a nineteen or twenty year old) and as such, they have relied on adult male expectations of appropriate sexual behaviour and protection. They may – as adult females themselves, and possibly with a number of young children – be very naïve and under-educated in terms of how to protect themselves sexually. The challenge is to know how to reach such adult females and to provide them with the basics without patronising.

## TOWARDS INTERVENTION

*Sex is promoted a lot in pictures everywhere yet sexual health isn't. They don't weigh up.* Male pair, 19 - 24, North

Throughout the process of research, the respondents talked about how few opportunities they generally have to discuss sexual health. For some, the process of research itself was an intervention. Respondents left the research

room in a very positive frame of mind. Many commented that they felt much more confident having been able to express themselves and having seen what the other gender really thought of the whole subject area.

Within Phase 1, a simple clash technique (taking two pieces of stimulus and finding a way of combining them to form a new idea) was helpful and useful in allowing respondents to develop suggestions for solutions. Such “inventions”, whilst not always sophisticated or even very practical, were analysed to provide insights.

One example was the *Condomino's Pizza*: respondents suggested a pizza delivery service which would include a condom in the delivery. The important fact was that respondents felt they would save face by having condoms delivered “without their knowledge”. In particular, this was felt to be important for both genders in getting beyond the “overt innocence” defences of the female. If the condom had been delivered, and the delivery boy had left, there would be no way of returning it – it might as well be used.

Similarly, the suggestion of a *Sex Haven*, a spa or gym would allow the topic of sexual health to be subsumed into a wider category of “whole body health”, with less shame connected to it as a result. Respondents felt they would be more able to visit such a venue – even if, once inside, they went straight for sexual health information and services.

Drawing from these findings, the Department of Health has put forward a proposed pilot intervention targeted at Vulnerable females. It will combine sexual health advice, a whole body health ‘wrapper’ and will include an element of confidence-boosting discussion and learning.

This intervention is still a work in progress and details are not available to share at this stage. However, it is to be hoped that such pilot intervention could reach and change the experience of young women and positively affect teenage sexual health in the United Kingdom. The process of co creation has helped to ensure that we have developed an intervention that is appealing and credible amongst the target audience.

The Department of Health has been very pleased with the outcome and are in talks with interested parties such as Primary Care Trusts and independent charities who want to implement the intervention in their local area.

## SUMMING UP: CREATIVE RESPONDENT-CENTRED RESEARCH

At the heart of this project – to tackle the challenge of teen sexual health in the United Kingdom – has been the quality of creative thinking from the research team. Such innovation has been instrumental in developing this social marketing intervention. It helped uncover insights that would not have been accessible through traditional methods due to the combination of the sensitive nature of the subject matter, the complexity of the project and the difficult research dynamics that were naturally present as a result of the topic.

Through a flexible and creative methodology, respondents were made to feel comfortable in talking openly about sexual health, especially in front of their peers where they may feel judged – and in front of an adult researcher, where they may feel exposed and insecure. The research tools and techniques were tailored to draw respondents into the heart of the process and to afford them maximum control over the experience. The data quality benefited from this approach.

While previous activity has helped raise the awareness of sexual health, it is time to go a step further in the United Kingdom and to help today's youths who have taken on board the message of the importance of sexual health. It is now a question of supporting them to put behaviour change into practice.

### Footnotes

1. Reference is made, for simplicity, to the Teen audience. Without complicating matters, the desk research found that there were few behavioural divisions to allow for an age cut-off across the audience: for some behaviours, risk remained high up until the late twenties, whilst for other behaviours, risk was defined by the age of the respondent (underage sex, teen pregnancy). Whilst “young audience” would be a more accurate description to include the upper age range, it also indicates those less than 16 years – who are explicitly not included in the study. The age range of the sample was 16 - 29 years.

2. PSI: Population Services International.
3. Either represented by one of the original (respondent-generated) artworks, or by a new work (created by the research team) which drew together and expressed a number of specific ideas more clearly.
4. The category and segment names are working titles only and are being reviewed in order to avoid negative connotations. Thoughtless, in this case, is intended to infer an overarching tendency to act 'without thought' rather than 'without care' in relation to sex and sexual health

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