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# **Seeking sexual health information? Professionals' novel experiences of the barriers that prevent female adolescents seeking sexual health information**

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## **Abstract**

**Objective:** Sexual health professionals are key in implementing sexual health intervention programmes, yet their views are largely absent from the literature. Sexual health professionals provide a unique perspective on teen sexual health issues as they engage in confidential discussions with a wide range of teenagers. This study aimed to provide an in-depth exploration of professionals' perceptions of teenagers' sexual health information seeking practices and barriers. Furthermore, the research provided a unique re-examination of key predictors of risky sexual behaviours, which have been highlighted by previous research.

**Method:** Nine semi-structured interviews were undertaken with sexual health professionals to explore their perceptions of teenagers' sexual health information seeking practises and barriers. Subsequently the professionals rank ordered the 57 factors identified in previous research in terms of their perceived importance in predicting risky sexual behaviours.

**Result:** Four themes emerged: "*society and media*"; "*environment and family*"; "*peer influences*" and "*the self*". The rank order task confirmed that 33 of the 57 factors were perceived as highly important by sexual health professionals.

**Conclusion:** Society, peers, environment and family are perceived as barriers to teenagers seeking reliable sexual health information, but these are dependent on the individual person. An individual with higher self-esteem is more confident in seeking sexual health information and applying this knowledge appropriately. Self-esteem was also identified as a key perceived predictor of risky sexual behaviours. Therefore, there is scope for intervention programs targeting self-esteem and knowledge, so teenagers have the confidence to seek out sexual health information and to make their own informed sexual health decisions.

**Keywords:** Adolescents; self-esteem, sexual health

## **Introduction**

The number of pregnancies and prevalence of sexually transmitted infections (STIs) in the teenage population are still high despite the development of numerous sexual health intervention programs (Health Protection Agency, 2010). Sexual health professionals are key stakeholders in implementing these interventions (Department of Health, 2013). Yet, the perceptions and experiences of health care providers are largely absent from the literature. It is vital to expand on previous research and explore the views of professionals who specialise in adolescent sexual health issues, due to their vast experience and knowledge in the area.

Previous research has noted a number of predictors of teenage sexual risk-taking; for example socio-economic status (SES), peers, personality traits, self-esteem, parental advice, support and guidance (For a full review see Buhi & Goodson, 2007). The majority of these findings have been derived from questionnaires and/or qualitative interviews with teenagers and parents. Yet, sexual health professionals are in a special and privileged position engaging with adolescents in an in-depth and confidential manner on the topic. Whilst GPs do not proactively address sexual health issues with patients (Gott, Galena, Hinchliff, & Elford, 2004), sexual health professionals are in a unique position to identify issues around information seeking practices and to highlight the factors that in their opinion lead to risky sexual behaviour, as they listen to the concerns and problems faced by teenagers during their discussions.

While first sexual initiation is a normal and expected aspect of adolescent development, early sexual intercourse, before age 15, is associated with sexual risk-taking behaviours which can result in unplanned pregnancies and STIs (Magnusson, Masho, & Lapane, 2012; McClelland, 2012). Research has identified female adolescents from low SES areas are more likely to feel pressure to engage in earlier sexual intercourse (Nahom et al., 2001). Early intercourse for

female teenagers can lead to negative influences on females' psychological wellbeing and their reproductive health (Olesen, 2012). Therefore, it is vital to understand the predictors of risky sexual behaviours for female teenagers and the barriers to seeking reliable sexual health information.

In summary, this qualitative study aimed to explore sexual health professionals' perspective on sexual health information seeking, through their unique position they are able to highlight the barriers to female adolescents seeking sexual health information. Also, the study re-examined the predictors found from previous studies with parents and teenagers to ascertain whether there is overlap between the views of sexual health professionals, parents and teenagers, particularly with respect of sexual health in female teenagers from low SES areas.

Therefore, the research had two aims: (1) to explore the sexual health information seeking practices and barriers for female teenagers from the point of view of sexual health professionals (through the use of semi-structured interviews); and (2) to re-examine the sexual health predictors suggested by previous literature (through the use of a rank order task). Understanding the perceived risk factors and the information seeking barriers from sexual health professional's perspective would provide a strong basis for an intervention programme.

## **Methods**

### **Participants**

A purposeful sampling method was used to recruit nine sexual health professionals. Participants were drawn from a range of allied health and other professions from both the private and public sector which involve provision of sexual health advice, including working with pregnant teenagers and teenage mothers. All participants were required to have at least

one years' experience working with female adolescents. See table 1 (below) for each participant's professional expertise.

INSERT TABLE 1 ABOUT HERE

### **Procedure**

The study received ethical approval from (Blank for review) Ethics Committee prior to the interviews taking place. The study itself comprised two parts. The first part comprised a semi-structured interview designed to explore the barriers to teenagers seeking sexual health information and the second part was a rank order task designed to confirm the perceived predictors of risky sexual health from a professional's perspective with female teenagers.

The interview schedule was formulated by creating open-ended and semi-structured questions grounded in current literature in order to keep on topic but allowing participants to provide further explanations and discuss their own experiences. Example questions on the interview schedule included: *"What are the main sexual health issues for female teenagers?"* and *"What are the main factors associated with unplanned teenage pregnancies?"*

Participants took part on a voluntary basis. All of the interviews lasted approximately 90 minutes and were carried out at the participants' workplace.

The rank order task comprised a list of 57 factors drawn from the current literature that have been found to predict risky sexual behaviours in teenagers (examples of the factors are; parents, peers and self-esteem). Each factor was typed on a small card. Participants were asked to arrange the cards in order from most important to least important in terms of the degree to which they believe that factor predicts risky sexual behaviours in teenagers. Participants were asked to "think aloud" as they completed this task and describe why they were putting the factor in that position. At the end of the task participants were asked to

summarise their choices and discuss whether any factors should be removed from or added to the list.

### **Analysis procedure**

Thematic analysis was used to analyse the data. This approach effectively allowed the exploration of participants' individual experiences in relation to adolescents' sexual health issues and the meanings they attach to them, whilst also allowing investigation of the influence of societal factors on sexual health issues. The data collected from all of the interviews was transcribed verbatim and initial thoughts and ideas were noted down. The main researcher then familiarised herself with the data by "repeated reading" (Braun & Clarke, 2006). The transcribed data was read and re-read several times and the recordings listened to in order to ensure accuracy of the transcription. The second stage involved identifying initial codes in the data. These codes were generated by building on the notes and ideas made during transcription. All of the codes identified features that were relevant to the research question. In the third stage similar codes were incorporated into a theme. However, to verify final themes the full research team reviewed the data and by use of constant comparisons agreed on the initial themes. Analysis of the interviews at this stage suggested that no new themes around professionals' perceptions of teenagers' sexual health information seeking practises were emerging. A thematic map was created to visualise the links between the themes and to ensure each theme had enough data to support it (Braun & Clarke, 2006). Coding was repeated to ensure no important codes or information had been missed out at earlier stages. Finally, stage five then involved naming and defining the themes.

### **The rank order task**

The main researcher noted and took photos of each of the rank order tasks on the interview day, to create a record of each participant's rank order. Using the photos and the think aloud

data in the transcripts, each factor was grouped in to one of three categories; low importance, medium importance and high importance. These categories were based on the rating of each factor provided by the majority of participants. Again to verify final categories the full research team reviewed the data and by use of constant comparisons agreed on the ranking of importance.

## **Results**

Four key themes emerged from the data: “*society and media*”; “*environment and family*”; “*peer influences*” and “*the self*”. These were viewed as essential to understanding the participant’s knowledge and attitudes towards information seeking practices and barriers.

### **Society and media**

This theme is defined by the way participants expressed that society and the media can heavily impact on adolescents’ understanding of sex and relationships. Participants described that there is a taboo around openly discussing sexual health information and this causes problems for sexual health workers. It is difficult for sexual health workers to get access to teenagers, because of the taboo in society. This also results in difficulty openly discussing sexual health information and becomes a barrier for adolescents seeking advice, making this group vulnerable and often confused.

*As the sexual health worker for children, and what was interesting there was despite the fact that they employed someone to do that role, I spent a lot of time explaining why that role was appropriate, and access to the under 13s was challenging. (Project worker)*

*Teenagers, particularly, feel really vulnerable coming in here. Because they don't know whether they are going to be judged (Midwife practitioner)*

Society also views sex differently for males and females this double standard can be a confusing concept for teenagers. Participants discussed how this issue can stop teenagers feeling comfortable accessing sexual health information or discussing what a healthy relationship is. Yet, even though it is not acceptable to speak openly about sexual health, sex is portrayed widely and negatively in the media.

*When I asked the students this morning if they thought teenage pregnancy was going down or up and a few of them said down but most of them thought it was going up. And that is because of the media. Because becoming a dad at 13 or whatever, that sells a paper. (Teenage pregnancy and adolescent sexual health co-ordinator)*

It was clear during the interviews that participants had negative views of the media. Participants became angry and defensive when discussing how sexual health is often portrayed. Participants believe the media normalises risky sex and objectifies women, which can be confusing for teenagers and ignores information on safe sex.

*There is no consent in porn, basically, in some porn they actually violate consent, where it is, there are rapes in scenarios, there usually isn't any protection involved, there usually isn't any talking about what people want and what is pleasurable. (Health improvement specialist)*

Therefore, pornography is easily accessible and can portray negative views of consent and contraception. Yet, this is easily accessible and more accessed than speaking about safe sexual health because of the taboo in society. The aspects of taboo and stigma within this theme lead on to the next theme of environment and family. Stigma exists for adolescents from low SES environments; however this stigma can also be reinforced by parents and linked to their family backgrounds.

### *Environment and family*

This theme is defined by the stigma around teenagers, pregnancy and sexual health information if they are from a low SES area. Sexual health professionals believe there is a societal preconception that low SES female teenagers want to become pregnant before age 16. This is not because they do not have sexual health education but because pregnancy is associated with perceived benefits such as social housing.

*Teenage mums, they are obviously going to be a bad mum, there are a lot of misconceptions about what is a teenage mum, she must have got herself pregnant, all she wants is her council house. (Sex and relationship outreach worker).*

The perception that they will be stigmatised can become a barrier to them seeking sexual health information. The professionals in this study believe teenagers feel that seeking advice will result in being labelled as ‘wanting to get pregnant’. Also, there are fewer opportunities in lower SES areas, less access to information and intervention programs and less access to abortion.

*It's likely they don't have access to, to services, like abortion clinics, sexual health advice because of the area they live in. (Midwife practitioner)*

Therefore, the environment in which adolescents live can become a barrier to seeking sexual health advice. Also, family can reinforce this barrier. Mothers can be excited for their daughters to become pregnant at a young age, due to norms surrounding teenage pregnancy in some low SES communities. This can lead to an inherent self-fulfilling cycle of teenage mothers that because of family influences, can be difficult to break away from.

*Working with quite a social deprived area and not in [...], in another area and some of the mums bringing along their daughters who were pregnant the mums were*

*delighted. For 16 year olds or younger, they are saying it is marvellous, they are so excited to be a grandma. (Teenage pregnancy co-ordinator)*

Teenage pregnancies can be the norm in certain areas and there can be a lot of pressure and expectations from families for their teenage children to have a baby. Professionals believe this could stop teenagers seeking sexual health advice because it lowers their aspirations and future plans if they do not have the support to aspire and achieve in their own lives. Teenagers need to see people achieving to see the benefits and rewards of it.

*Low socio-economic status, yeah, yeah I think your aspirations are going to be lower for some people I don't want to generalise it. But yeah I think if you are kind of bored and you are stuck in a rut and you feel like you have nothing to aspire to, then it could make you have more risky sex. (Client care co-ordinator)*

Therefore, their parents' attitude towards sexual health is important, especially in an environment that has a norm of young pregnancies. Family and environment are therefore interactive; if parents' attitudes are positive then this can overcome the environment they live in. If they can talk to their parents openly about safe sex then this can have a big impact on their own attitudes.

*That [SES] kind of doesn't really matter. Because if that is all negative, if parental attitudes towards sex is good, and influences and monitoring is good, if that is good or a positive then, the social and educational background doesn't really come into it. (Sex and relationship outreach worker).*

Parental attitudes can protect against the environment they live in, because living in a lower SES area can increase the prevalence of other factors such as negative parenting, norm of young pregnancies and reduced access to services. However, if these other factors are not

present and parental influences and attitudes are positive then environment on its own does not have a major effect on sexual health decisions. In the same way, teenagers that do not speak openly to their parents about sexual health decisions may be influenced more by their environment. Participants mentioned that many teenagers will not discuss sexual health issues with their parents.

*A lot of the teenagers that come here come without their parent's knowledge, they don't have to have their parents but they do have to have an adult with them, when they come for treatment but that adult doesn't have to be a parent. And we don't have to inform the parents. (Midwife practitioner)*

Environment and family support can influence information seeking practices, as the stigma in the environment can lead to teenagers having lower aspirations and motivation to seek sexual health information and advice. Parents can reinforce this stigma or have positive attitudes that can protect against the environment. This theme links onto the next theme of peer influences, as parents can shape teenagers' initial understandings and attitudes of sexual health but if teenagers choose not to talk to parents then peers can have a big impact and influence.

### **Peer influences**

Peers can become a major influence on teenagers' sexual health understanding as they are more likely to speak to their peers than anyone else. Participants discussed that teenagers are less likely to talk to their parents, especially about sex and relationships.

*[Peers] Quite a big influence, especially at that age because I think sometimes, that is where you are probably not going to listen to your parents because they know nothing. What do they know, they are old (Sex and relationship outreach worker)*

Teenagers feel more comfortable talking to their peers about sex and relationships, and seek sexual health advice from their peers. Peers can be a positive influence, as having a lot of friends and feeling connected to people can encourage teenagers to discuss sexual health issues. Participants discussed teenagers usually share information on sexual health information centres and can encourage peers to visit.

*Yeah, and there is a place, the teenagers all know about it, I know they do cause my daughter and all her friends know about it, it is specifically targeted for teenagers (Project worker)*

However, participants mentioned that teenagers who do not have a lot of friends to talk to can become isolated and this becomes a barrier to them seeking sexual health advice. Participants mentioned that a lot of pregnant teenagers feel they do not have anyone to speak to and this stopped them seeking sexual health advice before they became pregnant.

*Peer communication is quite a high up one I would say, we get a lot of pregnant girls who have been in who have felt that they do not have any friends and they are being bullied, stuff like that (Client care co-ordinator)*

However, participants noted that it can be problematic if peers become the main source of sexual health information because they are not a reliable source in comparison to parents or sexual health professionals. Therefore, their knowledge and understanding often comes from less reliable sources such as the mass media. Even though teenagers feel more comfortable talking to peers about sexual health issues, they may not be the most reliable or best source of sexual health advice.

*Adults might go to more reliable sources of information, children because they don't have that experience to source where is reliable or not, are going to maybe the loudest or most popular voice. (Project worker)*

There is also an element of pressure from peers associated with risky behaviours, especially alcohol and drugs, which can lead to other risk taking behaviours. Having a bigger peer group may lead to greater peer pressure. This peer pressure may be more influential if having sex at a younger age is seen as normal and expected within the individual's peer and sociocultural group. Therefore, while friends can be important in encouraging teenagers to seek sexual health information, pressure from peers can also act as a barrier in seeking sexual health information.

*There can be a lot of peer pressure, again a lot of myths, and misconceptions about the fact that if you are 16 and you haven't had sex you are an alien. (Sex and relationship outreach worker)*

### ***The Self***

Self is defined by the way participants expressed that seeking sexual health information is dependent on the individual person; including their self-esteem, self-standards, personality, self-resilience, self-regulation, attitudes, beliefs and self-efficacy. The influence of the other themes is dependent on these aspects of the self.

*If they have a lot more self-resilience and their self-regulation is a lot better, then obviously they are not going to need as much social support. (Health improvement specialist)*

Participants believe that self-esteem is highly important; low self-esteem will influence aspirations leading to more risky sexual behaviours. Also a person with a higher self-esteem

will be more likely to seek sexual health information and have the confidence to use the information.

*For girls who have low self-esteem, I think they look to heighten their self-esteem in so many different ways, and it can just lead to like, not good judgements really, you can end up doing things that are not, I just think it is such a shame*

(Support worker for teenage pregnancy)

*It's all due to self-esteem. Sometime it works like that, sometimes it does give them the push (Support worker)*

Therefore, self-esteem and personality traits are important to risky sexual behaviours. Participants discussed that because of this, it is important for adolescents to have a strong self-esteem to be able to make their own informed decisions. However, participants believe that current intervention programs concentrate on sexual health information and prevention methods, rather than empowering self-esteem. Participants discussed that this is a barrier to teenagers seeking sexual health information, as they may not receive the information that they want to know.

*They get so much information about, well don't get pregnant, don't get an STI, but they don't get a lot about what actually, you know having a good relationship with somebody (Sex and relationship outreach worker)*

Participants discussed that the main intervention programs target prevention strategies for STIs and unplanned pregnancies and that there is a lot of information available. However, fewer interventions target what a healthy and positive relationship is. Interventions need to target sexual health information that is important and appropriate for teenagers, so that they feel happy and confident with the information they have received.

### **Rank order task**

All 57 main predictors drawn from the literature were rated during the rank order task and none were removed from the list. Two extra predictors were added to the list by participants: consent and pornography. The factors were split into three categories of high importance factors, medium importance factors and low importance factors. Table 2 (below) shows that 32 predictors, identified in the literature, were perceived as highly important.

INSERT TABLE 2 ABOUT HERE

As shown in table 2 participants ranked that 32 of the 57 factors are highly important in predicting risky sexual behaviours for female teenagers. These core findings are important as most of these factors have previously been found in teenager and parent studies; however it is important to know that sexual health professionals who are implementing interventions also perceive these factors as important. Therefore, this confirmation of factors confirms that these high importance factors should be taken into consideration during intervention programs. Secondly, this rank order task highlights the importance of self-esteem. Sexual health professionals expressed the view that self-esteem is one of the most important factors that can predict risky sexual behaviours in female teenagers.

INSERT TABLE 3 ABOUT HERE

As shown in table 3 and 4 30 factors were rated as medium important and six factors were rated as low importance. These are still seen as important in predicting risky sexual behaviours as participants noted that they could not disregard any of these factors. However, while they have some degree of importance in predicting risky sexual behaviours in terms of implementing these factors in intervention programs, they are not perceived as important as the higher rated factors.

INSERT TABLE 4 ABOUT HERE

### **Discussion**

The findings of this study highlight sexual health professionals' perceptions of the barriers to female teenagers sexual health information seeking and the factors those professionals believe predict risky sexual behaviours for that same population. In terms of barriers, professionals believe that the double standard in society, whereby safe sexual health is not discussed yet risky sexual health is widely displayed in the mass media prevents teenagers seeking safe sexual health information. The increasing availability of pornography, made easier via the proliferation of smartphones (Mitchell et al., 2007; Owens, 2012), presents a very unrealistic and potentially harmful resource regarding sexual information (BBC, 2016). Whilst we know that large numbers of young people are accessing pornography (Penford, 2016) it is less clear as to whether teenagers are regularly accessing safe and reliable sexual health information. Certainly the sexual health professionals in the current study believe that teenagers are not being targeted with reliable sexual health information and as such there is scope for intervention programs to counter the misinformation provided by pornography and to promote safe sexual health as a more mainstream topic available for open discussion.

Secondly, professionals viewed family, environment and peers as barriers to seeking sexual health information. It is known that teenagers from low SES areas are more likely to become pregnant during their teenage years, especially those with a sister or mother who became parents during their teens (East, Reyes & Horn, 2007; Karakiewicz, et al 2008), however, this study has highlighted that because of this teenagers from low SES areas can feel stigmatised and are reluctant to seek sexual health information, in case they are seen by others as 'wanting' to become pregnant. Sexual health professionals also highlighted that parents can encourage their daughters to have a teenage pregnancy, as it is normal and expected in some areas. This presents a potential conflict for teenagers and can make it difficult for them to seek alternative, safe sex information. The professionals thought that as teenagers get older their peers become more of an influence. In early adolescence, individuals start to

emotionally separate from their parents and form strong peer identification (Macintosh, 2003). Peer influence has a strong influence on sexual health and seeking sexual health information seeking (Gillmore, 2002) and peer to peer resources are seen as increasingly important aspect of health information and communication (Ziebland & Wyke, 2012). Incorporating accurate, credible peer to peer resources into intervention programmes could thus provide a powerful tool for increasing safe sex knowledge and intention.

Finally, self-esteem was found to be a barrier to teenagers seeking sexual health information. Teenagers need to have the self-esteem and confidence to seek reliable sexual health advice. Interestingly, low self-esteem was identified in the rank order task as a strong perceived risk factor for risky sexual behaviours. Existing systematic reviews have found no evidence for self-esteem as a statistical predictor of sexual behaviours, attitudes or intentions (Goodson et al., 2006). However, this may reflect the complex nature of self-esteem development, which is known to interact with SES background, family and individual characteristics (Boden & Horwood, 2006). In early adolescence self-esteem is still developing, peer interest is strong and health risk behaviours such as sexual risk taking and alcohol use behaviours begin to emerge (Macintosh, 2003). The present study findings highlight the emphasis placed on self-esteem by sexual health professionals in accounting for adolescent risky sexual behaviour, despite a lack of evidence from quantitative studies that low self-esteem is a statistically significant predictor of sexual health information seeking in this group (Goodson et al., 2006). As mentioned above, self-esteem development in adolescents occurs amongst a myriad of other intrapersonal characteristics, which can make it's detection as a risk factor in quantitative studies difficult. The present qualitative work indicates the importance that sexual health professionals place on this key risk factor, which suggests that future intervention programs would benefit from focussing on improving self-esteem, despite a lack of quantitative evidence to support self-esteem as a significant predictor of sexual behaviours.

We know that knowledge based interventions on their own are not effective (Campbell, 2000) a point reiterated by the health professionals in their ranking task. However, there is scope for combined self-esteem and knowledge interventions. Teenagers may know about the importance of condom use; however they also need the confidence to insist their partner actually uses a condom. This type of intervention would overcome the barriers discussed, instilling in teenagers the confidence to deal with external pressures such as media, family influences and peers.

### **Future directions**

Sexual health professionals' provided an interesting perspective on information seeking barriers and practices in adolescent females. Gaining professionals' views on the existing factors that can predict risky sexual behaviours was also beneficial confirming that these factors are indeed viewed as highly important by the key stakeholders in intervention programs. Each participant had regular contact with a large number of adolescents, and, therefore, could provide an unbiased view of the risk factors which influence most teenagers. The North East of England is an area that has a high rate of teen pregnancy (McClelland, 2014) and further work is needed to validate the findings with a larger sample of sexual health professionals from different areas. Furthermore, mixed methods work would enable the qualitative findings to be corroborated with quantitative findings. This would be beneficial given the limited previous evidence for low self-esteem as a risk factor from quantitative studies.

### **Implications**

The findings of the current study indicate that sexual health interventions should aim to build self-esteem and address socio-economic stigma, so adolescents feel confident to make their own informed sexual health decisions. Peers were found to have a major influence on

adolescent sexual health information seeking decisions; therefore, intervention strategies should try to incorporate accurate, reliable information delivered via a peer channel (for example, videos in which teenagers discuss safe sexual health practices). This type of intervention would give adolescents both the knowledge and the skills to deal with pressures from their environment, family, peer groups and media.

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**Table 1: Professional expertise of study participants**

| <b>Participant – job title</b>   | <b>Years at job</b> | <b>Sexual health issues covered in job</b>  |
|--|---------------------|---|
| <b>1</b> – Health improvement specialist for the NHS                               | 11 years            | Trains sexual health workers who work with adolescents.   |
| <b>2</b> – Sex and relationship outreach worker for the NHS                        | 5 years             | Works with individual and vulnerable teenagers in schools, youth groups and shelters.   |
| <b>3</b> – Midwife practitioner for a private pregnancy advisory clinic            | 2 years             | Deals with pregnancy, terminations and post-operative care, for women of all ages starting at 13.   |
| <b>4</b> - Client care co-ordinator for a private pregnancy advisory clinic        | 6 years             | Works with pregnant teenagers and offers advice and counselling.  |
| <b>5</b> - Client care co-ordinator for a private pregnancy advisory clinic        | 12 years            | Works with pregnant teenagers and offers advice and counselling.  |
| <b>6</b> - Project worker for an individual charity                                | 7.5 years           | Works with teenagers and young adults aged 12-15 years, they have drop in sessions at their organisation – for individuals and groups. Covers all sexual health issues. |
| <b>7</b> - Volunteer and support worker for a teenage pregnancy team               | 3 years             | Volunteers with new teenager mothers, from the ages of 13-17 and offers advice and guidance.  |
| <b>8</b> - Teenage pregnancy and adolescent sexual health co-ordinator for the NHS | 10 years            | Co-ordinates sexual health and pregnancy services across the North East of England.   |
| <b>9</b> - Youth and school health worker for an individual charity                | 7 years             | Visits schools and youth groups offering sexual health services to groups of teenagers. Covers all sexual health issues.  |

**Table 2: Factors rated as high importance.**

| <b>High importance factors</b>         | <b>Previous literature</b> |
|--|----------------------------|
| Self-esteem                            | (20)                       |
| Belief in the future                   | (23)                       |
| Pornography                            | (11)                       |
| Media                                  | (24)                       |
| Consent                                | (25)                       |
| Alcohol                                | (26)                       |
| Drug use                               | (26)                       |
| Conforming to peer norms               | (27)                       |
| Self-efficacy                          | (28)                       |
| Knowledge                              | (29)                       |
| Age of partner                         | (30)                       |
| Low aspirations                        | (31)                       |
| Body image                             | (32)                       |
| Social norms                           | (33)                       |
| Not seeing the long term implications  | (34)                       |
| No direction                           | (3)                        |
| Self-standards                         | (35)                       |
| Believing peers have had sex           | (18)                       |
| Depression                             | (36)                       |
| Peers approval of sex                  | (37)                       |
| Coercion from sexual partners          | (27)                       |
| Connectedness                          | (38)                       |
| Beliefs and attitudes towards sex      | (39)                       |
| Personality                            | (40)                       |
| Low school aspirations and performance | (31)                       |
| Peers                                  | (25)                       |
| Peer pressure                          | (25)                       |
| Spontaneous sex                        | (41)                       |
| Peer communication                     | (42)                       |
| Social support                         | (32)                       |
| Self-determination                     | (23)                       |
| More ego-centric thinking              | (24)                       |

**Table 3: Factors rated as medium importance.**

| Medium importance factors                                     | Previous literature |
|---|---------------------|
| Sexual abuse  | (32)                |
| Parents   | (43)                |
| Role models   | (44)                |
| Fatalism  | (34)                |
| Poor self-regulating  | (43)                |
| Lack of awareness   | (3)                 |
| Family support  | (29)                |
| Parental influences and monitoring                            | (27)                |
| Culture   | (15)                |
| Negative parenting  | (45)                |
| Boredom   | (3)                 |
| Poverty   | (24)                |
| Age of first sexual intercourse                               | (46)                |
| Lower-socio economic status                                   | (24)                |
| Time spent alone at home                                      | (47)                |
| Intention or motivation to have sex                           | (18)                |
| Early physical intimacy experiences                           | (31)                |
| Age of puberty  | (48)                |
| Education and social class of parent                          | (46)                |
| Environment with no chance of social and economic advancement | (49)                |

**Table 4: Factors rated as low importance.**

| <b>Low importance factors</b>  | <b>Supported by Previous literature</b> |
|--------------------------------|---|
| Low awareness of contraception | (50)                                    |
| Parental attitudes towards sex | (51)                                    |
| Parents                        | (46)                                    |
| Younger parents                | (46)                                    |
| Love of babies                 | (52)                                    |
| Lone parents                   | (45)                                    |