EXPLORING THE VIEWS AND EXPERIENCES OF YOUNG PEOPLE FROM BAME (BLACK, ASIAN, AND MINORITY ETHNIC GROUPS) BACKGROUNDS AROUND LOCAL SEXUAL HEALTH SERVICES

YOUTH CONSULTATIONS
SEPTEMBER - DECEMBER 2019

YMCA RIGHT HERE

Young people promoting health and wellbeing through education, campaigning and influencing

YMCA DOWNSLINK GROUP

Young healthwatch Brighton and Hove

CONTENTS

Executive Summary

What did we do ?

Healthwatch Brighton and Hove worked alongside Young Healthwatch to gather the views and opinions of BAME (Black, Asian, and Minority Ethnic groups) young people, aged 17-25 and living in Brighton and Hove around local sexual health services and STIs (Sexually Transmitted Infections). Young asylum seekers and refugees as well as young people living in the city temporarily to study English were also engaged around this topic.

Aims

The aims of this study were to measure knowledge and understanding of the following three areas:

1. What BAME young people know and understand about local sexual health services.
2. How BAME young people feel about accessing sexual health services locally.
3. What BAME young people know about Sexually Transmitted Infections (STIs).

To do this, we used a mixed method approach to cater for individual preferences for participating, including running a survey, conducting 14 1:1 informal interviews as well as 3 focus groups to collect both quantitative and qualitative data. Overall, we have consulted 71 young people in this study. Figure 1 is a breakdown of participants' ethnic backgrounds.

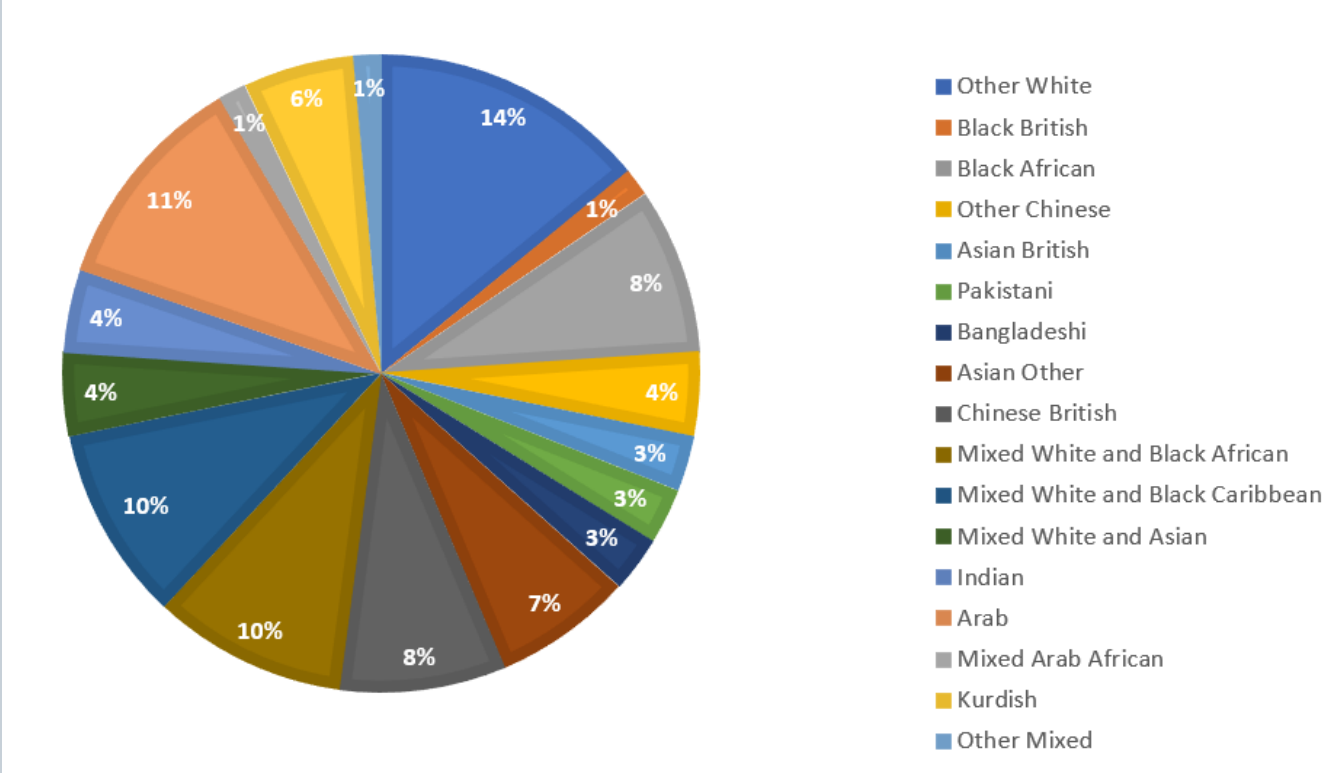


Figure 1

What did we find out ?

Through the study we were able to identify 4 main themes, which are set out below. A number of these key findings reinforce what we already know about accessing, and knowledge of, sexual health and related services; namely that common barriers exist which can prevent young people from using services. However, our study also identified that young people living in the city have good knowledge of services and sexually transmitted infections. This suggests there is a mismatch between understanding around sexual health and a willingness to engage with local services which should be addressed. More should be done to improve advertising and promotion (including offering these in different languages) and to tackle peer and familial pressures through increased promotion that services are confidential. Uniquely, our study highlighted that typical methods of engaging young people in studies such as this one do not work, and that adaptive and novel approaches are needed to ensure that young people are reached and their views factored into promotion.

Recruitment

Recruiting BAME young people was the main challenge in this study, especially when approval from youth group managers was required to organise focus groups or engage young people to complete the survey. Engaging with young people directly via informal and creative ways was found to be a more successful recruiting method than more traditional ways of recruitment. When taking part in this study, young people told us they felt listened to and empowered to get their voice heard to influence decision making.

Access to and perceived quality of local sexual health services

Young people had good knowledge of local sexual health services. Their experience using the services was mostly positive with many participants commenting on staff being welcoming and friendly and making them feel at ease. One of the common complaints was around waiting times being too long.

Barriers to accessing sexual health services

↘ **Language barriers:** language was a common barrier to access, especially for those who may have only recently moved to the UK and therefore had limited English skills.

↘ **Services' promotion and advertising:** young people felt lack of information and promotion around sexual health services is still a main barrier to access. Furthermore, promotional material was not seen as inclusive and representative of ethnic minorities living in Brighton and Hove, thereby making young people feel 'the services are not for them'.

↘ **Lack of family support:** young people shared a concern around confidentiality within services and a fear that personal information would be inappropriately shared with others, including parents. These worries were not based on any personal experiences but rather on preexisting beliefs. The fear of parents finding out, particularly, was perceived as a major barrier among many young people, especially younger participants (17-19) and those from Asian and Black African backgrounds. This was shown to have religious and cultural underpinnings, for example in relation to sex before marriage, sex being a taboo subject not spoken about within the family environment, and sex seen from parents as a main distraction from studying and focusing on academic achievements.

↘ **Issues with privacy and confidentiality:** young people said sexual health clinics are often not designed to be discreet and private. Patients may feel uncomfortable sharing private information and the reasons for their clinic visit upon arrival, especially if the waiting areas are busy or there are long queues where they feel they can be overheard. It was noted that typical seated cubicles on receptions lack robust privacy (1). Furthermore, some young peoples' worries around confidentiality are based on preexisting beliefs which can operate as a barrier. These are likely to be mitigated once they visit the clinic and confidentiality is properly explained to them by the service provider. There is ample evidence to show that issues with privacy and confidentiality are salient to all young people, and not just those from BAME backgrounds.

↘ **Peer influence**: peer influence was identified as both an enabler and barrier to accessing sexual health services. As a barrier, participants felt being seen in a sexual health clinic by another peer, especially when testing for STIs, may affect their social status and reputation; where a social media post from the wrong person could ‘out’ a young person as having an STI. There is evidence to show that ‘the fear of bumping into someone’ can prevent service access for all young people, not just those from BAME backgrounds. However, this barrier is likely to be most salient to young people from close knit communities where particular cultural and social norms strongly stigmatise being sexually active at a young age or before marriage. As an enabler, participants suggested accessing sexual health services with friends and peers may normalise the whole experience, making it more social and therefore less daunting.

↘ **Cultural and religious barriers**: religious beliefs were identified as a main barrier to access. We know that sex is still a taboo subject in some cultures and communities. Young people of faith may struggle with the internal conflict between their religion and being sexually active and consequently may not access services for the fear of being judged (by other people and peers at the clinic, but also by health professionals). The response of parents and carers was also flagged as the main reason for feeling embarrassed to communicate about sex, especially among younger participants from Asian and African backgrounds, ultimately preventing access due to the fear of parents finding out.

(1) Healthwatch Brighton and Hove has undertaken several environmental audits of the Claude Nicol Centre, the main sexual health unit in the city. Following each audit Health Watch has recommended to the Trust that the reception area needs to be redesigned to improve patient confidentiality. To date, only minor changes have been made which do not go far enough.

STI knowledge and awareness

Participants showed a good knowledge of Sexually Transmitted Infections (STIs) which they said to have acquired mainly through Education. They had a good understanding of what STIs are, including how these are contracted, common symptoms, and what the risks of asymptomatic undiagnosed STIs could be. Most young people had a clear idea of the process involved in getting an STI test, including options for both male and female patients. None of the participants commented on testing options for people identifying as transgender.

Some young people highlighted the stigma associated with STIs being a main barrier to testing, as diagnosis suggests engaging in unprotected sex, sex with multiple partners or sex with disreputable partners. Furthermore, absence of symptoms, the fear of reputation being ruined if seen going for a test, shame and embarrassment were identified as main barriers to testing. These issues have been shown to be salient to young people within the wider population as well. However, as mentioned earlier, the fear to be seen may be stronger for BAME young people living in communities where social, cultural and religious norms do not ‘allow’ young people to be sexually active.

Young people's main recommendations

After identifying some of the barriers considered to prevent access to sexual health services, young participants were asked to share their main recommendations on how to overcome such barriers and enhance service quality and accessibility. 5 main recommendations were made this way.

1 Improve sexual health services' promotion, information and engagement

a. Social media platforms such as Instagram and Facebook should be the main promotion channel to provide young people with information around sexual health and local sexual health service options. Possible ideas that young participants suggested included:

- **Short video clips** featuring young people sharing key information about services and personal stories around successfully using them. Young Healthwatch previously collaborated with Brighton & Hove Sexual Health and Contraception service (SHAC) to create the 'No Worries' campaign which featured youth-friendly video clips on what is like to get STI tested (find a clip example with this link: https://www.youtube.com/watch?time_continue=5&v=_nr8h0SYQVo&feature=emb_logo). Young Healthwatch would be happy to work with local services and commissioners to help develop more of these videos to best represent BAME young people and their specific needs.

- **Interactive Instagram 'swipe up' stories** to allow young people to quickly access external websites/resources, including online appointment booking systems and referral forms; interactive tools such as 'ask me a question' on Instagram, to allow young people to quickly and remotely ask questions around services and processes involved.

b. Leaflets and posters should continue to focus on representing young people from BAME backgrounds by including pictures and stories of people of colour and different ethnic backgrounds. Promotional materials should be translated into key languages to reach all young people, including those who speak limited English. They should also be 'visually catchy' and 'infographic style', with minimal wording and instead including more pictures/diagrams, especially when it comes to simple process explanations such as STI testing.

c. There should be more interactive and engaging ‘pop-up clinics’ around the city where young people can quickly and easily access key information, promotion material and freebies without necessarily interacting with professionals, ask questions if needed and pick up testing kits. Pop-up clinics mean young people can access them with other friends or peers, thereby normalising the experience by making it ‘more social’ and less daunting.

d. Prompts and reminders should be sent to young people regularly, either via text or email, around regular sexual health checks and STI testing.

e. Online campaigns to reduce the stigma around STI testing could be created to encourage regular check-ups throughout the year, to normalise the testing process as if it was a dentist or doctors’ checkup for all young people of age. Re-launching and updating the ‘No Worries’ campaign to better reflect the needs of BAME young people would respond to this suggestion.

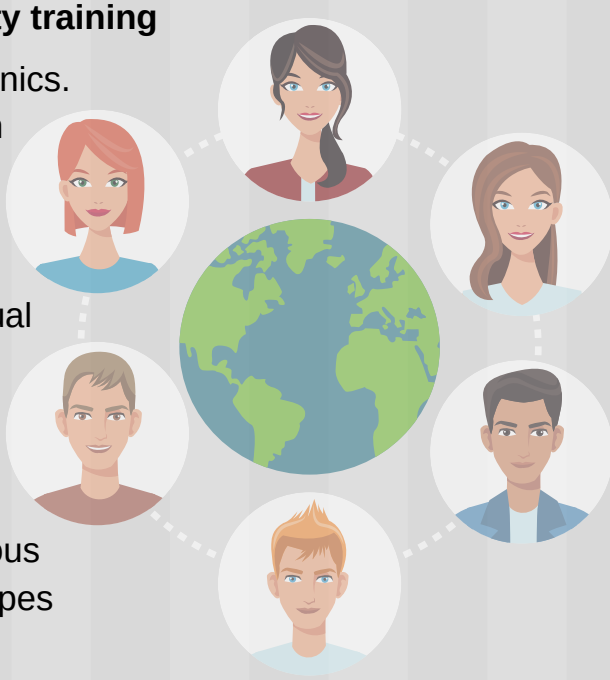
Education for parents and carers

Deliver targeted training for parents and carers to equip them with the knowledge and skills to best support their young peoples’ sexual health choices. This could include information of the services available locally and the professional framework and policies within which staff work, as well as interactive discussions with parents to listen to their worries and address them with explanations based on scientific research. It may be effective to involve BAME young people as well as faith leaders in the planning and delivery of these trainings to ensure sexual health messages delivered to parents are culturally appropriate and respectful of different cultural and religious norms.

Improve confidentiality and privacy

Promotional material should provide information about services’ confidentiality and privacy to reduce fear and stigma of access. We are aware that this is already being done and many of the SHAC services have improved this. Young people recommended that sexual health clinics should use online forms, via a tablet on reception, that patients can quickly fill in upon arrival. This could eliminate suggested discomfort around ‘explaining the reason for visiting’ and the fear of being heard by others in the waiting room.

4 Improve staff ethnic diversity and diversity training



Continue to ensure a diverse workforce in sexual health clinics. This would better reflect the existing ethnic backgrounds in local communities. Furthermore, in light of the identified cultural and religious barriers to access, diversity among healthcare staff is likely to make BAME young people feel more comfortable and understood when talking about sexual health.

Provide educational diversity training for all staff, including clinical staff and managers of youth groups/centres. Training could potentially be co-delivered by BAME young people, around cultural and religious understanding, religious celebrations or events, values, barriers to access, stereotypes and misconceptions.

5 Improve communication

Increase the provision of bilingual staff and foreign language interpreting services (including online translating services which already exist) to overcome linguistic barriers at sexual health clinics.

Background ans Aims

Healthwatch Brighton and Hove published a briefing paper in July 2019 (https://www.healthwatchbrightonandhove.co.uk/wp-content/uploads/2019/07/Healthwatch-Sexual-Health-briefing-report-July-2019.pdf) providing an overview of the pressures and challenges facing sexual health services both nationally and in Brighton and Hove, drawing attention to how funding and commissioning challenges may affect provision. The evidence used to produce this report showed that:

- Brighton and Hove has very high STI (Sexually Transmitted Infections) levels, with certain groups e.g., BAME young people and men who have sex with men (MSM) being disproportionately affected.
- There is high demand for services (which sometimes lead to long waiting times but despite this it is believed that service-user satisfaction levels remain high).

Furthermore, certain groups face additional barriers when trying to access services such as individuals with learning disabilities; whilst cultural, religious and other factors may mean that some groups are less likely to access mainstream services e.g., members of the BAME and trans communities. Therefore, commissioned services must meet these challenges, and Healthwatch Brighton and Hove has a valuable role to play in bringing the needs of these groups to the attention of local decision makers.

YMCA Right Here began operating in 2010 and is YMCA DownsLink Group's flagship youth involvement and influencing project. Right Here promotes the health and wellbeing of 12-25 year olds, with a particular focus on mental health. Right Here has won awards for good practice and innovative approaches and has been delivering a Young Healthwatch provision in Brighton & Hove for the past 3 years, ensuring the voice of young people is heard and influences decision making around local health services.

Given the experience that YMCA Right Here has with engaging and involving young people regarding Health and Wellbeing in Brighton and Hove, Young Healthwatch was commissioned by Healthwatch Brighton and Hove to deliver a project that explored young peoples' awareness and understanding of sexual health and related services.

The research aims for this project were agreed between Young Healthwatch, Healthwatch Brighton and Hove following a meeting held with Public Health Commissioners in August 2019. We wanted to gather the views and opinions of young people aged 17-25 from BAME (Black, Asian, and Minority Ethnic groups) backgrounds, including young asylum seekers, young refugees as well as young people living temporarily in Brighton and Hove to study English, to measure knowledge and understanding of the following three areas:

1

What BAME young people know and understand about local sexual health services:

- Knowledge of services available
- How young people hear about services
- Experience and satisfaction of using services, including peer experiences of using services

2

How BAME young people feel about accessing sexual health services locally:

- Barriers preventing access and use
- Recommendations to reduce barriers and ways to receive sexual health service information

3

What BAME young people know about Sexually Transmitted Infections (STIs):

- What they are and how you can contract them
- How to test for STIs
- What the symptoms are (if any) and how you can detect them
- Knowledge of risks related to untreated asymptomatic STIs
- Types of treatment and effectiveness

Following these initial stages Young Healthwatch started work on identifying key questions to ask young people in order to measure knowledge on the three main research areas, and planning recruitment methods to ensure a wide range of BAME young people would be consulted across the varying methods.

Methodology

A mixed methods approach was used to gather both quantitative and qualitative data around the research areas of interest outlined above.

Online survey

We used a survey to gather quantitative data around young people's knowledge of the services available, their experience and satisfaction of using these services, any barriers preventing access and use; as well as qualitative data, including recommendations to reduce barriers and improve service accessibility for BAME young people.

44 young people completed the survey which took on average 8 minutes to complete. 27.3% (12) were male, 63.6% (28) were female, 6.8% (3) were non-binary and 2.3% (1) preferred not to say. The survey was designed using Survey Monkey and tested by YMCA Right Here Youth Ambassadors and volunteers prior to publishing.

Informal 1:1 interviews

We carried out informal interviews with young people to understand more about the questions asked in the survey and to elicit more thorough discussions, including: perceived barriers preventing access to services, ways to overcome them, as well as preferred methods to promote sexual health service information among young people. 14 participants were interviewed. Interviews were on average 40 minutes long and took place in various settings, including YMCA offices at Reed House, local cafes, colleges, and youth groups. For practical reasons, some interviews were audio-recorded, transcribed verbatim and anonymised prior to analysis; whereas in other interviews, the interviewer took accurate notes which were later written up and saved anonymously. A semi-structured topic guide was used in interviews with 5 main guide questions. In some cases, extra questions were asked to explore in more detail responses from the survey. Interviews were co-delivered by a Young Healthwatch coordinator and a YMCA Right Here youth volunteer and/or a Healthwatch Brighton and Hove volunteer. All volunteers are aged 16-25, DBS checked and trained to co-deliver peer-led interviews or focus groups.

78.6% (11) of interview participants were female and 21.4% (3) were males.

Focus groups

We carried out 3 focus groups where participants were encouraged to discuss thoughts freely with other participants in a more interactive manner. The first focus group took place with a group of 4 young men outside Hove Park Cafe, Hove. This may not be an ideal focus group setting due to confidentiality. However, information sharing and confidentiality boundaries were discussed and agreed with the group, and participants filled in a consent form prior to starting the focus group. The second focus group took place at a college with 17+ year 2 students (3 female and 1 male). The third focus group was carried out at YMCA YAC (Youth Advice Centre) with a group of 5 young men with limited English-speaking skills who were currently involved with the YMCA WiSE ("What is Sexual Exploitation" - https://www.ymcadlg.org/what-we-do/support-and-advice/wise/) project around various sexual health topics.

Engaging techniques were used to ask different questions and start discussions. For example, participants were asked to position themselves on a continuum line depending on how good their experience was of using local sexual health services or to add branches to a tree with all the barriers they thought may affect BAME young people's access to services. Participants also could contribute to discussions through writing post-it notes if they were feeling uncomfortable sharing verbally. Like in interviews, often focus group discussions were based around issues raised in the survey (e.g., lack of family support, fear to be caught by parents etc.). More open and free discussions generated further ideas and provided a wealth of information which we will address in the Findings session.

Focus groups lasted on average between 50 and 60 minutes. 76.9% (10) of participants were male and 23% (3) were female.

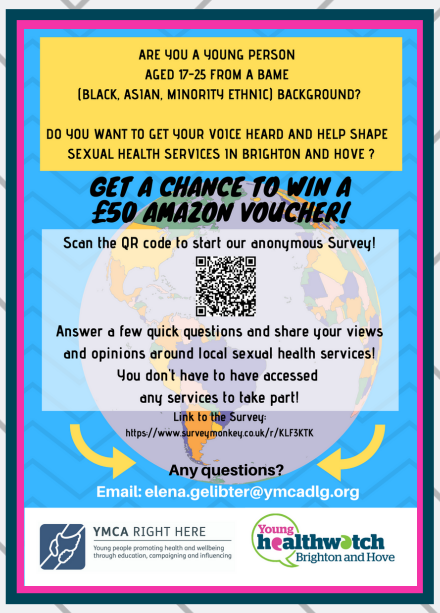
Full Demographic information for surveys, interviews and focus groups in Appendix 1.

Recruitment

We used multiple methods for recruitment, including:

1 Flyers and posters

We distributed a variety of 3 flyer and poster designs with key information and contact details around the city, including colleges, universities, youth groups and youth centres, cafes, pubs, language schools, gyms, barbers and hairdressers (posters we used to recruit participants in Appendix 4). Survey flyers and posters contained a QR code which young people could directly scan from their phone to access and complete the survey.



2 Social media

We shared the posters on our social media channels over the October-December 2019 period alongside key information on the project and how to get involved. We posted on Facebook, Instagram and Twitter, including relevant Facebook pages and groups such as Brighton Youth Opportunities, Family Black History Month event page, University of Sussex African Society, linking in with the Brighton University Chinese society president and more. Social media posts were then reshared by our contacts to promote the study. Brighton and Hove Healthwatch promoted the survey across their networks, including all the charitable organisations based within Community Base and members of the Health Promotion distribution email list.

3

Contacting and visiting youth groups and language schools

We emailed a long list of contacts with our study posters and included more detailed information on the project to ensure a diverse range of young individuals were consulted; including youth groups and centres that we knew worked with BAME young people (e.g., Hangleton and Knoll project, Terrence Higgins Trust, SHAC, BMEYPP, the Global Social Club, Brighton Table Tennis club, Pathways to Independence, University of Brighton Welfare officer, the Young refugee forum). We also contacted the English language schools and colleges in the city. We asked contacts to encourage young people to take part in interviews, focus groups or simply fill in the online survey. In some cases where we knew BAME young people already meet regularly, we asked group managers if we could 'come along' to one of those meetings and talk to young people in a more 'familiar' setting. We also directly visited young people's centres and language schools across Brighton and Hove we couldn't reach via email or phone, asking to speak to managers or youth workers.

For a comprehensive list of contacts that we approached and promoted the project to, see Appendix 2.

4

Outreach and direct engagement

We promoted the study on the street for 3 days to directly engage with young people in popular spaces of Brighton and Hove, including Churchill square, the pavilion gardens, outside universities and colleges, outside English language schools, outside/inside commercial coffee shops, within public parks as well as on city buses. We went to cafes and hairdressers known to be mostly frequented by BAME young people (e.g., Sushi places, Afro Hair Academy, Time for Kimchi) and also engaged with students at university and college freshers fairs.

5

Snowballing

This was also used, where initial participants were asked to recruit potentially interested friends.

All participants provided written consent to their participation before completing the survey, attending a focus group or completing an interview.
Participants were offered: £10 Amazon voucher to take part in a focus group or interview and the chance to win a £50 Amazon voucher for completing the survey. When engaging with people directly on the streets, young people were offered £5 Amazon vouchers as a further incentive for completing the survey 'on the spot'.

Young volunteers' involvement

We initially worked alongside YMCA Right Here young volunteers to carry out an initial literature review to identify previous research on this topic in order to find key questions to ask young people to meet the research objectives. Volunteers were involved in the design of the survey, design of the questions to ask in 1:1 interviews and also supported the design of more interactive activities to carry out during focus groups. YMCA Right Here volunteers as well as one volunteer from Healthwatch Brighton and Hove were encouraged to assist a Young Healthwatch coordinator before leading in interviewing or co-delivering a focus group. Volunteers also helped with the promotion and recruitment by sharing information about the project on their social media, putting posters around their local area, youth group, college or university, and recruiting friends from BAME backgrounds. Finally, a Healthwatch Brighton and Hove volunteer helped with data analysis and collating data for this final report.

Data analysis

Quantitative data from the survey was analysed using Survey Monkey analytical tools. Interview and focus group transcripts were analysed in conjunction, and quotations were sorted into themes and subthemes. The researcher read and re-read the transcripts drawing out themes. Where recording was not carried out for practical or ethical reasons, the researcher took detailed notes and these were summarised around a number of key themes which emerged as part of the discussions. Particularly, they focused on the barriers and reasons BAME young people may have for not accessing local sexual health services, including: language barriers, lack of family support and fear of parents finding out, peer influence, religious and cultural barriers, issues with privacy and confidentiality.

Findings

Recruitment

Recruitment of BAME young people was the main challenge in this study, but not in the way that we expected it to be.

'Sexual health' was often perceived as a triggering or sensitive topic by youth managers managing or working directly with BAME groups, resulting in a lack of further communication or simply a refusal to consider passing on information to young people who attend their service. This common theme for our study made it very difficult for us to 'get in' and organise focus groups within existing community meetings that we knew groups of young BAME people attended. We received many enquiries from youth group managers about the questions we would ask in the survey and/or focus groups and whether they would be 'personal' or 'triggering' in any way. For this reason, we decided to eliminate any 'personal' questions such as 'are you sexually active?' from both the survey and focus groups which would potentially make young people uncomfortable.

We were aware this would affect data analysis, but we decided to prioritise recruitment. Having edited our questions to eliminate any possibility of sensitivity from respondents around personal information, we found that youth workers/ professionals were still not willing to be involved or include their young people in this study. What has been interesting for Young Healthwatch is that not one of the young people we talked to mentioned, when questioned, any issue with the topic, in terms of it feeling overly sensitive or difficult. There may be a difference between what young people and what youth workers/professionals perceive to be sensitive topics, in this case sexual health.

It is worth noting that Young Healthwatch received some negative feedback around the topic of the study from youth worker professionals, labelling it as 'insulting for young people'. From our service perspective, this study gave BAME young people an opportunity to have their voice heard around services that matter to them. This perspective was reflected in the respondents' feedback to us following engagement.

This issue highlighted a concern for Young Healthwatch, that there may be an element of services becoming overprotective of their service users, unnecessarily.

In response to the initial recruitment difficulties, Young Healthwatch decided to rethink how we engaged with BAME young people, by taking a more informal recruitment method, such as speaking to people on the streets, outside colleges or (very successfully) engaging young people to sign up to be a part of the study whilst travelling on city buses. We found that this form of informal engagement was a very successful recruitment strategy and allowed us to promptly reassure young people about privacy or confidentiality around the study. Furthermore, since the demographic of the recruiting team was similar in age to participants, young people felt more comfortable speaking to them about sexual health services. As a result, participants were generally happier to engage in voicing their views and opinions on this topic and provided very positive feedback around questions and the informal, market research style methods we ended up using.

76% (54) of participants in this study fell within the lower age range (17-19). 72.7% (32) of survey participants were aged 17-19. 78.6% (11) of interview participants were aged 17-19. 92.3% (12) of focus group participants were aged 17-19. Find the age breakdown by method in Table 1 below.

This may be due to the successful recruitment process which took place in colleges, including BHASVIC and Varndean College, which included sharing posters, leafleting and whole-school emails sent by tutors. This may also show that younger individuals are simply keener to participate and get their voice heard, while older ones are likely to be busier with university or work, less interested in participating and rewards and therefore less easily engaged. Whatever may be the reason, it is important to recognise that the findings discussed below, and the resulting recommendations are likely to best reflect the views and opinions of younger BAME individuals.

Method used	17-19 years old	20-22 years old	23-25 years old	Average age
Survey	32	5	7	18.9
Interview	11	2	1	18.8
Focus group	12	1	0	17.6

Table 1

Using the recruitment methods outlined in the methodology, 14 participants were recruited to complete the survey and 14 participants to be interviewed. Young people were able to access and complete the survey by simply clicking on a link (e.g., included in Facebook posts) or scan the QR code from a poster or flyer, but had to contact Young Healthwatch directly to set up a suitable time and date for interviews. Young people were keener to engage with the survey or interviews (as compared to focus groups) in order to share their views around the topic of sexual health. This shows they may perceive these methods as more discrete and anonymous compared to focus groups where they would be involved in discussions with other young people who they may have never met before. Only 2 of the focus group members were recruited through the originally planned methods.

Furthermore, while for the survey and interviews most participants were female (63.6% and 75% in survey and interviews respectively), 76.9% of focus group participants were male. While this may suggest that interview and survey methods are more 'appealing' to young women than men, we cannot conclude that focus groups are a more 'appealing' method for young men just because most focus group members were male. Focus group participants did not proactively get involved in this study but were approached directly by Young Healthwatch and asked to participate in a 'spontaneous' focus group (e.g., 4 young men were recruited at Hove Park Café; 4 college students were asked to participate after a workshop delivered by YMCA Right Here as part of another project; 5 young men were asked to get involved at the beginning of a regular meeting delivered by YMCA WiSE around sexual health).

Access to local sexual health services

62.7% (27) of survey respondents could mention the name of at least one local sexual health service. 27.9% (12) could mention 2 services. 4.6% (2) could mention 3 services. The services most mentioned were: Practice Plus Brighton Station mentioned 14 times, SHAC Central (Morley street) mentioned 9 times, SHAC East (Claude Nicol Centre) mentioned 4 times, ''SHAC'' (non-specific) mentioned 4 times, and YMCA Youth Advice Centre (YAC) mentioned 2 times.

4 survey respondents mentioned the NHS when asked to write the name of a local sexual health service and 2 participants mentioned the GP.

The services most mentioned by young people interviewed were: Practice Plus Brighton Station Health Centre (mentioned 4 times); SHAC general (mentioned 3 times); SHAC Central (mentioned 3 times); SHAC East (mentioned 3 times); YAC (mentioned 2 times); Wish Park (mentioned 2 times).

Only 45.4% (20) of survey participants said they have accessed at least one local sexual health service in Brighton and Hove (see Figure 2).

71.4% (10) of the young people interviewed accessed at least one sexual health service (see Figure 3). Of the remaining 4 participants who have not accessed services, 2 were within the lower age range (17 and 19) and not sexually active. These two individuals gave the latter as a reason for not having accessed services yet.

69.2% (9) of the focus group participants accessed at least one sexual health service (see Figure 4). Of the remaining 4 who have not accessed services, 2 were young men from a Kurdish background and 2 were young women studying at college, all within the lower age range 17-19.

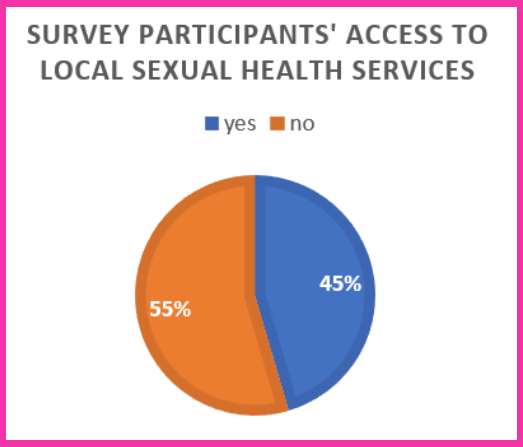


Figure 2

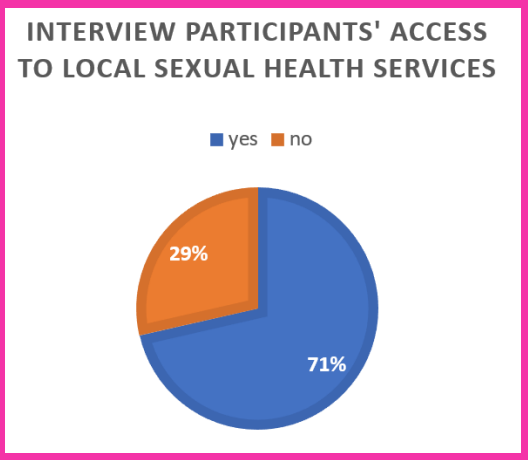


Figure 3

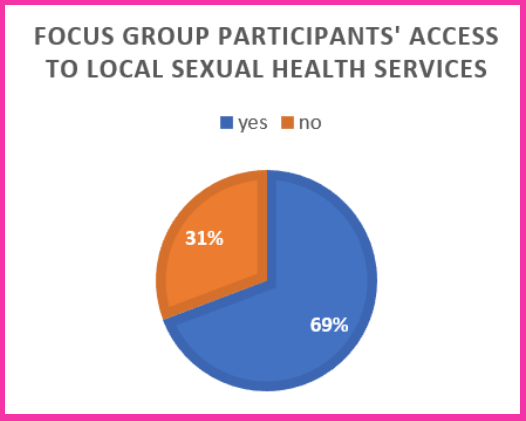


Figure 4

There is a notable difference between survey data and interview participants' data around how many young people have accessed a local sexual health clinic. This could be because young people who accessed services previously are more likely to volunteer to be interviewed and share their views and opinions; despite posters and promotional material clearly stating, 'You don't have to have accessed the services in order to take part!'.

Perceived quality of local sexual health services

Different measures were used, between the survey and interviews/focus groups, to evaluate participants' perceived quality of local sexual health services. In the survey, participants were simply asked to rate their experience on a sliding scale where 0 meant 'terrible', 50 meant 'satisfactory' and 100 meant 'excellent'. In interviews and focus groups, participants were first asked to stand on a continuum line to indicate their experience of using the services e.g., bottom corner if their experience was terrible. They were then asked to explain their rating, in terms of what did or did not go so well and discuss this with other young people if they were in a focus group. Following this discussion, participants were given the chance to 'reposition' themselves and give a final 'rating'. We recognise that, because of the different methods used to collect information, it is difficult to directly compare the experiences of survey vs interview/focus group participants. However, the more qualitative data collected in interviews and focus groups added important information, especially regarding the factors young people take into consideration when retrospectively evaluating their experience at the clinic.

Survey respondents who have accessed services gave an average rating for their experience of 66.3 out of 100 (more than satisfactory). Participants who have not accessed services were given the option to give a rating based on their peers' or a family member's experience; their average rating was 59 out of 100.

Young people who took part in focus groups and interviews seemed to rate the services more positively, with most participants positioning themselves on a continuum line somewhere between good and excellent.

The difference in experience ratings between interviewees/focus group members and survey respondents could be due to the methodology used. While in focus groups and interviews participants were given the opportunity to reflect and evaluate their experiences before deciding on a final 'rating', this was not the case in surveys. Survey respondents were first asked to give a rating and then explain the reasons for giving that rating. Therefore, such question order may have led to impulsive and inaccurate responses.

When asked to give reasons for their rating, many young people commented on staff, including reception and medical staff, being friendly and welcoming.

For example, some survey participants said:

Staff were understanding. I felt awkward going there but they made me feel very comfortable.

The staff were all very understanding and made sure to explain everything very slowly and carefully.

Staff were very nice, they didn't look down on me for doing what I wanted done. Nice environment, very welcoming staff!

One of the biggest complaints from young people was around waiting times being too long. A young person interviewed, for example, said:

> Bad! I went there with my girlfriend to ask to get tested as we'd both been sleeping around in the past and we had to wait for ages so that wasn't a great experience. There were loads of people in the waiting room looking really cross and bored, so we thought we'd leave it. Good my girlfriend booked an appointment for us both to go to the place at the hospital which was much better. We did have to wait ages though, like about 50 minutes after our appointment was booked for. Like I said I didn't care but my girlfriend was pranging about it!

A survey respondent commented:

> My biggest issue with the health services has been the waiting time. If you have an uncomfortable issue or you're very stressed/nervous sitting in a hot sticky room with 20 people isn't helpful. If you have a family that you don't want to find out this is also an issue of time and how long you'll be spending in these places.....

21.4% (3) of the young people interviewed and 13.6% (6) of the survey respondents, all in the higher age range (20-25) also pointed at the drop-in appointment system not being efficient with opening times that do not accommodate work commitments.

One young man said:

> We need more evening appointments. If you work full-time it's almost impossible to access the walk in and wait service as all appointments go before you can get there!

These findings follow trends from the wider population, with young people reporting long waits at walk in sessions and impractical opening times that do not take into consideration the needs or restrictions for young people (Samangaya, 2007; The International Planned Parenthood Federation IPPF, 2014).

Perceived barriers to accessing local sexual health services

A main aim of this study was to identify key barriers to accessing sexual health services that are specific to young people from BAME backgrounds living in Brighton and Hove. Some of the barriers identified are likely to be shared with white majority groups and, where possible, a link to previous research has been given to show this. To our knowledge, however, little or no research has been carried out locally around BAME young people' barriers to accessing sexual health services. Therefore, it was not possible to compare our findings with local previous data. On the other hand, several studies have been conducted nationally that focus on BAME young people more closely. Hence, a link to these data was made whenever possible and relevant.

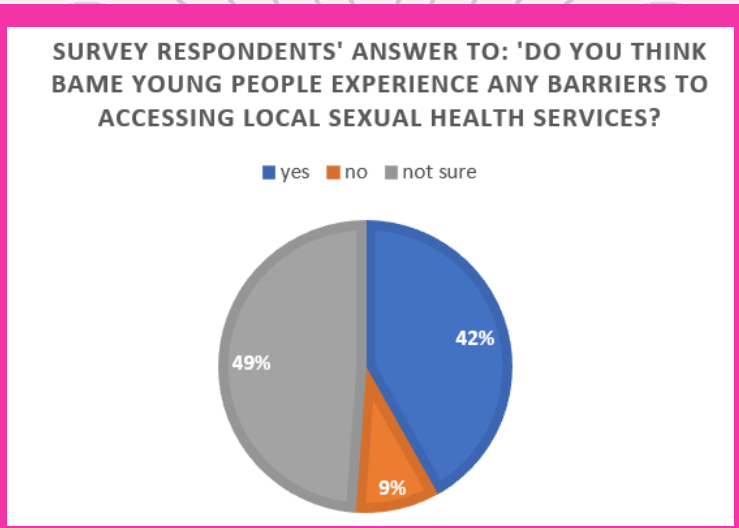


Figure 5

Young people completing the survey were first asked whether they thought BAME young people experience any difficulties (barriers) accessing the local sexual health services. 18 respondents said yes, 4 said no and 21 were not sure (see Figure 5).

Due to the nature of the survey question 'Do you think BAME young people experience any barriers to accessing local sexual health services?', it may be that young people did not understand the word 'barrier' and because of this answered 'not sure'. Alternatively, as mentioned above, it may be that in absence of concrete examples, participants struggled thinking of relevant answers, which could also explain the 'no' and 'not sure' responses.

Survey respondents were then asked to select from a list of options (see all options in the Appendix 3), and all the barriers they thought may affect BAME young people in the local area. An option to click 'no barriers' was included in this question, however none of the participants opted for this or skipped the question, showing that when giving examples of possible barriers to access, young people actually recognised the relevance of some of these for BAME young people.

The most 'rated' barriers respondents selected were: '**family not being supportive**' (selected by 28 respondents, 62.2%); '**cultural beliefs, values and attitudes**' (26 respondents, 57.8%); '**religious belief**' (27 respondents, 60%); '**not wanting to discuss my sexual health with others**' (26 respondents, 57.8%); '**stigma around accessing sexual health services**' (25 respondents, 56.8%); '**fear**' (23 respondents, 51.1%); '**judgment from the community (e.g., friends, family, peers)**' (20 respondents, 44.4%); '**language barrier (e.g., not being able to express myself properly/understand others**)' (21 respondents, 46.7%); '**discrimination, being treated differently**' (20 respondents, 44.4%).

We explored this question further in both focus groups and 1:1 interviews. The emerging themes for each barrier are detailed below.

Before delving into the barriers to access identified by young people it must be noted that analysis did not show any significant differences in responses to questions (in both the survey and interviews/focus groups) from young people of different ethnic backgrounds. However, some barriers were shown to be particularly significant to young people with specific ethnic backgrounds (e.g., fear of parents finding). Age also had an impact on which barriers participants identified, with clear differences between younger (17-19 years) and older (20-25years) participants. All these considerations are highlighted throughout the following sections in relation to specific barriers.

Language barriers

Language is a long researched and evidenced barrier to accessing health care services for people who speak English as a second language (e.g., Taylor et al., 2013; Woods et al., 2005; Memon et al., 2016; IPPF, 2014). Despite most of participants being either born in the UK or resident here since a very young age, they identified language as a major barrier preventing access for BAME young people.

In one focus group where participants had to use interpreters, young people emphasised the inability to effectively communicate and articulate their problems with healthcare professionals. After talking to two of the young men, an interpreter explained:

> They do not know how to explain what they need, that's why they don't want to go to services and never access them, that is the problem.

Quoting another interpreter on behalf of another young man:

> I know one friend, he struggled and struggled. He said what he could say but he had limited vocabulary, the real words he wanted to say to the nurse, he did not know the meaning of them in English. Then in the end they ended up getting the wrong treatment.

A participant interviewed also said:

> I've also been misunderstood for my accent, which isn't anyone's fault but it's difficult when it always happens!

Concerns were raised over inadequate provision of interpreters, but also the lack of translation when it comes to sexual health services promotion material, including posters, leaflets and websites.
Translated service leaflets could be designed bilingually so that young people can point to a service that they are hoping to receive and reduce incidents of miscommunication.

Services' visibility and promotional material

As outlined above in the 'Access to local sexual health services' section, most interviewees and focus group members said they have accessed local sexual health services before, whereas only 44% of survey respondents have. One of the reasons may be 'not knowing where to access sexual health services'. In fact, 31.8% (14) of survey respondents have identified this as a main barrier to access. Most of them were from an Asian ethnic background and within the lower age range (17-19) (See Figure 6 below for ethnic background and age of survey respondents who identified 'not knowing where to access services' as a main barrier).

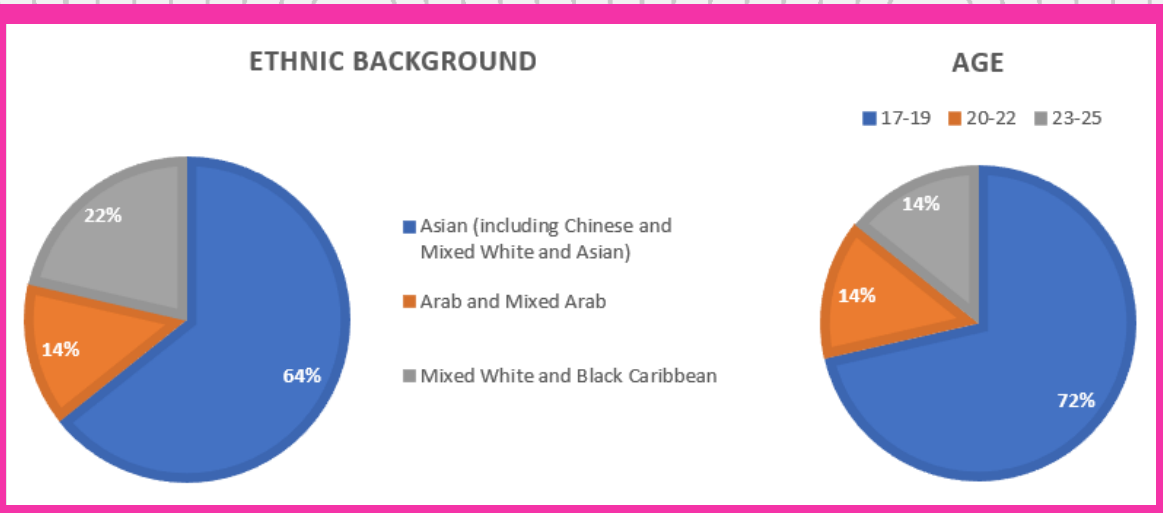


Figure 6

Interviewees showed more confidence in knowing where to access services and information. None talked about 'not knowing where to access services' being a barrier to access.

When our interviewees were asked how they have acquired information around sex topics and local sexual health services, 57.1% (8) of them said in school either through SRE (Sex and Relationships Education), or posters on the back of schools/college toilet doors. This follows national trends within the wider population (Tanton et al., 2015). The remaining 28.6% (4) and 14.3% (2) of the interviewees said they acquired information through reading leaflets and posters in GP surgeries, or through a 'quick research online', respectively. The latter two diverge from national trends, showing that BAME young people may prefer to gain information independently rather than asking parents or healthcare professionals. As we will further explore in the following 'lack of family support and fear of parents finding out' section, some participants have said they avoid talking to their parents about sex and relationships because of shame, embarrassment and the feeling they won't be understood. This could have cultural and/or religious underpinnings, especially for those young people who live in communities where sex is still a taboo subject and being sexually active at a young age and/or before marriage may not be accepted.

Despite the variability in data, between interviews and survey, around 'knowing where to access local sexual health services', most participants (74.1% (20) of the interviewees/focus group members and 70.4% (31) of the survey respondents) identified the need for more effective promotion and advertisement of local sexual health services.

In one focus group, for example, 2 participants (both aged 17 and female) found that they were playing 'hide and seek' when trying to access sexual health services, as they had to go searching for information they could not find and then gave up.

This finding is in line with previous research focusing on the challenges faced by adolescents in the wider population when searching for sexual health information on the internet. Patterson et al. (2019), for example, showed that limited awareness of specific, relevant and trusted online sources; difficulties in finding locally relevant information about services; and difficulties in navigating large organisations' websites are all practical barriers to accessing sexual health services.

One interviewee who has only recently moved to Brighton for a University placement said:

> I haven't accessed sexual health services here yet, but now that I think about it, nothing popped up on my feed either, ads and stuff like that, that's how I would remember to get a sexual health check back home....

Another interviewee said:

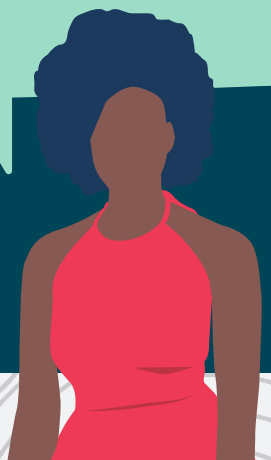
> With wellbeing I saw a Facebook advert of the burnt pier and I clicked through and made a referral. Why can't sexual health places do that?

Such findings highlight the need for more explicit advertisement of services, something that 'pops up' and catches young people' eyes, possibly on social media.

This way, young people may not have to actively search for services, something that all young people (not just BAME) tend to struggle with (Patterson et al., 2019). This is likely to be particularly helpful for young people who have only recently moved to Brighton who may not consider visiting the sexual health clinic as a big priority.

In interviews and focus groups young people were specifically asked what they thought about the current promotion and advertisement of local sexual health services and if there was anything they would like to change or improve. 81.5% (22) of the interviews/focus group members said that promotion material and advertising is still not currently representative enough of the ethnic minorities living in Brighton and Hove, thereby making BAME young people feel services are not for them. For example, one participant said:

> I haven't experienced anything negative to do with my heritage, but I have always felt like the services need to up their game on the posters and flyers. They don't represent a load of people who live here!



Another participant said:

> No wonder BAME young people don't want to access sexual health services, it's always white faces on posters and stuff, like hello! It's not that hard!

Therefore, while improving promotion and advertising of services to increase service access for all young people is and should remain a priority (Public Health England, 2015), our findings shows that working on creating promotion material that is as diverse and inclusive as possible of all the ethnic minorities who live in the community is paramount to ensure BAME young people feel represented and that the services are for them. Several recommendations were given on how to do this, which will be detailed in the 'Young People' Recommendations' section.

Lack of family support and fear of parents finding out

44.4% (11) of the young people who took part in either interviews or focus groups felt sexual health is not a topic they want to discuss with their parents. Of these 11 participants, 72.7% (8) of them said 'the fear of parents finding out' is an important barrier to access. 65.9% (29) of survey respondents also identified 'lack of family support' as a barrier. Furthermore, the theme of 'parents finding out' was brought up again by 27.3% (12) of survey participants when giving recommendations to improve services, specifically around perceived confidentiality (e.g., '…..and make young people know that their parents won't find out').

Of the 11 interviewees/focus group members who identified the fear of parents finding out as a main barrier to access, 63.6% (7) said they have not accessed sexual health services before. Furthermore, they were all within the lower age range (17-19). This suggests this fear may be stronger for younger people who are likely to still live with their family.

Lack of family support around sexual health could be due to restricting cultural and religious norms where sex is still a taboo subject and young people are not 'allowed' to have sex at a young age or before marriage.

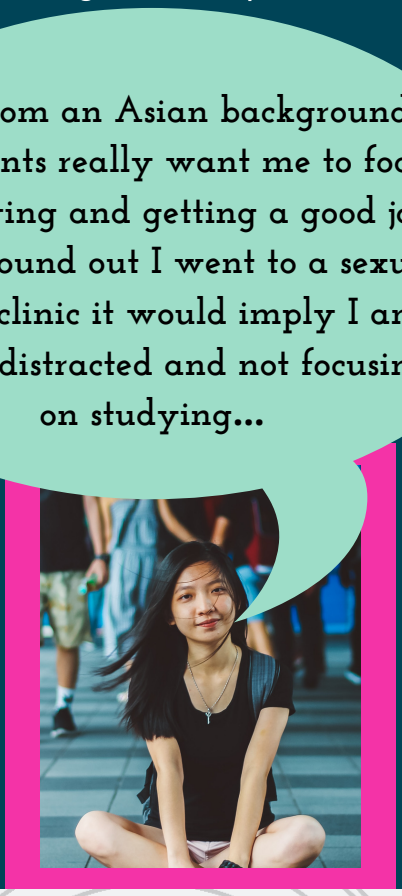
For example, one female focus group member, aged 17 and Muslim said:

> I have been with my boyfriend for 2 years now but I am not really sure my parents know I have had sex with him....like they probably suspect that but I know that if I made it official they wouldn't be understanding about it, they will just think sex before marriage is, like, so so wrong, religious stuff you know... I just don't wanna be in that situation, you know...sometimes I think it's ridiculous but the idea of my parents finding out or having to have that kinda conversation terrifies me....

Another interviewee, aged 17 and from a Bengali family said:

> You know...growing up in a strict family, sex is one hundred percent a taboo subject, no way we would talk about pregnancy, STIs...anything! Lots of my friends say they talk about relationships, boyfriends and so on with their mum but for me it's a no no! It would just be too awkward (referring to talking to parents around using sexual health services), like I wouldnt't even know where to start!

63.6% (7) of interviewees/focus group members who identified such barrier were either from an Asian or Black African background. This finding confirms previous research showing that that BAME young people from Asian and Black African backgrounds are more likely to feel that social expectations prevent any discussion or recognition of young people's sexuality and need for information or support. Furthermore, they tend to single out their parents/carers or community's lack of engagement in supporting young people around sexual health as a key factor in their life (Coleman and Testa, 2008).



Other more 'cultural' factors may also underpin young peoples' fear of parents finding out. One female interviewed, aged 17 and studying at college explained:

While the religious and cultural norms underpinning the fear of parents finding out are likely to be particularly relevant for BAME young people from close knit communities; there is evidence to show that this is an issue affecting all young people, especially younger teens (Carroll et al., 2012).

Previous research also shows that if young people do not discuss their sexual health with their parents, they are more likely to access information passed through word of mouth that is often laden with myths and misconceptions at a great risk to their health and wellbeing (Sau, 2018) (see examples of misconceptions in the later 'Knowledge around sexually transmitted infections (STIs) and diseases (STDs)' section. Addressing this barrier, therefore, is crucial.

The fear of parents finding out may extend to online contexts as well. Patterson et al. (2019), for example, showed that worries about 'being seen' by parents may affect young people's willingness to engage with online sexual health content, including visual and auditory content, sexual health information on social networking platforms or through smartphone applications. Our study confirms this.

One interviewee, female, 17, and from an Asian background said:

> Even googling stuff to find out where to go for is tricky for me, I am always scared my parents walk in and see what's going on or check my phone search history or something....

Issues with confidentiality and privacy

In some cases, the 'fear of parents finding out' discussed in the previous section may be reinforced by the lack of trust participants have around services' confidentiality and privacy. Young people's worries around breaches of confidentiality emerged in the survey with 34% (16) of respondents mentioning things like: '*make them feel like whatever they have to talk about will not go anywhere or anyone else'; 'greater emphasis on confidentiality and privacy'; 'make it confidential so parents don't find out*'; as part of their recommendations to improve local sexual health services.

It is worth noting that of this 34%, 68.7% (11) said they have not accessed services yet. As a result, their worries around breaches of confidentiality (which may in turn prevent access) are likely to be based on preexisting beliefs and alleviated once they visit the clinic for the first time.

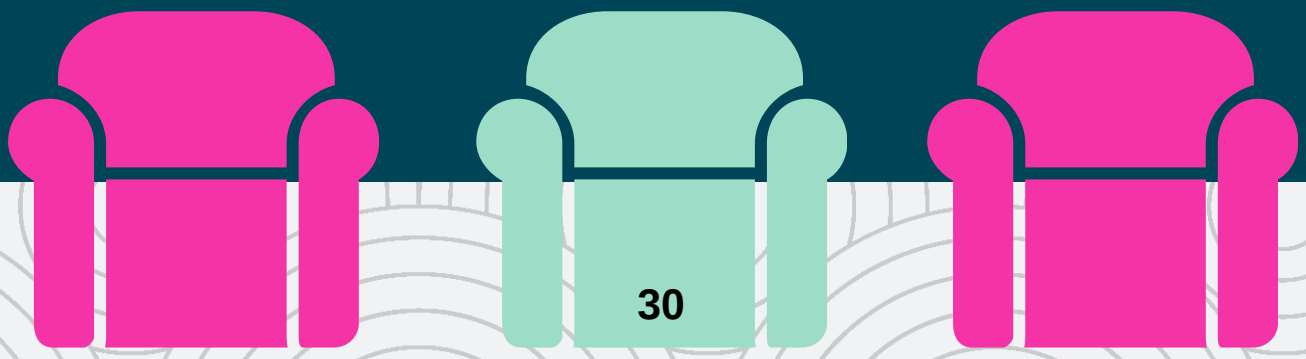
One interviewee illustrates this point clearly:

> I was scared information wouldn't be kept confidential and would have been passed on to my parents when I went to the clinic. The nurse then explained to me that wasn't the case, so I was fine, but I can imagine young people wouldn't even show up if they thought that was the case, you know...

There is previous evidence to show that young people do not tend to know about the duty of confidentiality properly until it is explained to them by the service provider and this may well operate as a barrier to access (IPPF, 2014; Beck et al., 2005; Samangaya, 2007).

However, issues with confidentiality and privacy are not limited to preexisting beliefs, but also stem from young people's negative experiences of using the services.

66.7% (18) of the young people who took part in interviews/focus groups and 34.1% (15) of survey respondents, suggested that sexual health clinics, especially the waiting areas, are not discreet enough which may make young people anxious and not willing to return.



One interviewee said:

You often get asked at reception What are you here for? And the room is quiet, and everyone is listening to you...like really? I have already explained to you what I needed when I booked the appointment on the phone...

Another member of a focus group said:

I hate seeing other people I know, especially if I am there for STI testing. I have had bad experiences before where they would say out loud that like I am there for an STI test. So like people in the waiting room could all hear that, and it just made me uncomfortable...

Regarding clinic waiting rooms not being 'designed' to be discreet and private, one young person commented that the:

> .... 'private' booths to sit and register in are bits of plywood and when it's busy people stand right behind you when you're explaining why you're there. I didn't care but my girlfriend hated it and felt like everyone was listening

Issues with confidentiality and privacy are likely to be of concern to all young people, and not those from BAME backgrounds. One interviewee clearly pointed this out:

> ...like I don't think this is about being BAME actually - I have lots of friends who hate it when they're asked what they are there for. My best friend, she is White British, she said she was blushing so much when she was asked to say the reason for her visit at reception, like well embarrassed!

Within the wider population, reluctance to use sexual health services has also been shown to be due to young people worrying about deliberate breaches of confidentiality, such as: services sharing personal information, contacting parents or GP; being seen by people they know; and open reception areas that don't give them any privacy to discuss sexual health issues and may encourage gossip of confidential issues (e.g., Carroll et al., 2012; Garside et al., 2002; Newby et al., 2017; Stone and Ingham, 2003; IPPF, 2014; Healthwatch Croydon, 2017).

To combat preexisting negative beliefs around breaches of confidentiality, it seems crucial to have this subject at the centre of any advertising and promotion material to ensure young people know what to expect and are aware of the processes and procedures around confidentiality prior to accessing services the first time. Furthermore, young people recommended different ways to make reception and waiting areas more discrete and avoid young people having to explain the reason for their visit in front of other patients which will be detailed in the 'Young people's recommendations' section.

Peer influence

Young people consulted in this study identified both the positive and negative influence of peers on their use of sexual health services.

a. Peer influence as a barrier and the fear to be seen

Especially for some of the younger participants consulted, the fear of being seen accessing services by their friends or peers may act as a significant barrier. This was largely related to the perceived stigma associated with attending sexual health clinics.

For example, college students who participated in a focus group felt concerned about seeing other students at the sexual health clinic, how this could impact their 'social status and reputation' or how they would be viewed among their peers. The fear of 'people finding out' was mentioned by students as a barrier to them accessing STI testing more specifically (perceived barriers to STI testing are later discussed in this report); expressing the view that young people with STIs can be stereotyped as 'a slut' or 'someone who has slept around so much that they have caught diseases'.

One college student interviewee also said:

> There is still loads of stigma around people accessing services and just young people being sexually active in my community, I am a bad Muslim by the way. I think when you have a place to go like a sex clinic, you always fear that you're going to bump into someone you know, and you never know how they're going to react and who you're going to see there. Most people would be cool, but you never really know, like you don't wanna be the guy with STIs you know...and it's about popularity really, like if someone more popular than you sees you at the clinic they may go tell everyone you have an STI and people will believe them!

Previous research shows that, especially in association with social status, popularity and reputation, the fear of 'bumping into someone you know' while accessing sexual health services and 'people finding out' is a common barrier among all young people, not just those from BAME backgrounds (IPPF, 2014; Cassidy et al., 2018; Garside et al., 2002). However, we argue that the fear of seeing other peers may be stronger for young people whose religion or culture does not 'allow' them to be sexually active outside marriage or long-term relationship, leading them to feel even more judged and embarrassed. Religious and cultural barriers will be discussed in the next section.

b. Peer influence as an enabler

Young men taking part in another focus group, all aged 17-19, who were also friends, talked about peer influence as a 'positive enabler' to accessing the services. They described accessing sexual health services as a social activity where they support each other by going together.

One young person said specifically:

> You know young people don't talk about sexual health, not even among themselves, especially young men, it's a super taboo topic I think, but one time, can't remember how we started chatting about it and we were like let's go together! It was a bit awkward at first, but we went to *name of clinic*, got tested and went out for a drink afterwards, it was part of a day out with your mates kinda thing and we did something that needs to be done, you know, not too bad!

Cultural and religious barriers

57.8% (26) and 60% (27) of the survey respondents identified 'cultural beliefs, values and attitudes' and 'religious belief', respectively, as main barriers to accessing sexual health services. To explore this area further, interviewees were asked the following question: 'Are there any cultural or religious barriers that may prevent BAME young people from accessing sexual health services?'. Community values around sex outside of marriage were important underpinnings in participants' responses to such question, confirming previous studies on the effect of cultural and religious beliefs on BAME young people' access to sexual health services (e.g., Samangaya, 2007; Beck et al., 2005; IPPF, 2014). As outlined above, in some cultures and communities, sex is still regarded as a taboo subject and therefore accessing services and talking about intimate details can be intimidating and require huge amounts of personal courage.

One young man interviewed, aged 19 and from a an Indian background, who said he has only recently accessed sexual health services for the first time, communicated his ongoing struggle with the internal conflict between his religion and family values and life 'outside' (including being sexually active). Such internal conflict has been shown to cause anxiety for many BAME young people (Coleman and Testa, 2008). This participant said he continued, for such a long time, to hold the perception that he would be judged negatively by health professionals if he accessed sexual health services. Furthermore, the fear to be seen by friends, peers or members of the community aggravated his negative feelings, '*stopping me from going in for at least a few months*'.

One young woman interviewed, aged 17, from an Arab background said:

> There is a real fear coming from my culture being considered a slut...like I don't fear God or anything, but if I see a peer or someone I know I would feel really embarrassed. Because of my religion I am not supposed to be sexually active before marriage...

Restrictive religious and cultural norms which strongly stigmatise young people's sexuality constitute a major barrier to access for young people. Such barrier is likely to be further reinforced by young people's concerns that their confidentiality may not be respected, since they are engaging in behaviour deemed to be dangerous and morally reprehensible (IPPF, 2014). This could instigate or aggravate their fear of parents, family members or peers finding out, which could lead to disappointment, shame, or a 'ruined reputation'. Therefore, at least in some communities, religious and cultural barriers, issues with confidentiality, the fear to be seen and of parents finding out are likely to be all interconnected and affecting each other. For this reason, when planning future strategies to improve young people's access to sexual health services, it may be useful to think of such barriers as a whole rather than separately.

Being treated differently

3 (21.4%) of the interviewees/focus group members said nurses and specialists are sometimes unable to understand or sympathise with the realities and experiences of those from a BAME background. They felt they had received inadequate or different treatment '*because of our skin or where we look like we are from*'.

For example, one interviewee expressed her frustration over her experiences in accessing treatment:

> I've been asked if I have ever been spoken to about female genital mutilation (FGM), which is great that people are doing something but when you see yourself as being the same as everyone else but your dark skin means you're asked extra things, I don't know it's weird. I'm from Brighton!'

Another interviewee said:

> I'm not going to speak for me because I'm cocky haha and I don't get nervous but for my other mates (who are BAME) they hate that kind of thing. You know I have a mate who had a fungal skin thing and it's really common for people of colour, it's like a thing that usual you know- and the doctor she went to didn't know about it, didn't have any clue it's just a common difference in pH levels or whatever and so made it into this big deal. When she (the friend) got home her mum was like, what? You just need some creme! So that wasn't cool, you know It's not like doctors need to know everything but clearly that doctor hadn't seen many people of colour and treated her in a weird way because of her tiny skin thing, which made her really not want to go back to a white doctor.

Knowledge around sexually transmitted infections (STIs) and diseases (STDs).

When asked to rate their knowledge of Sexually Transmitted Infections (STIs), survey respondents gave themselves an average rating of 66 out of 100 on average. Such a rating fell between 'neither bad nor good' and 'excellent' which would imply that most young peoples' perceive their knowledge of STIs to be 'good'. In interviews, the average rating was 75 out of 100 and in focus groups 65 out of 100.

Most young people could accurately explain what STIs are:

"Infections that can be passed on through sexual contact"

"Diseases that are caught or passed through unprotected sex or the transmission of bodily fluids"

"Infections spread through oral and penetrative sex"

81.7% (58) of all the young people consulted said they have learned about STIs either at school or college, the rest from either parents/peers or the internet.

There were a few misconceptions on the subject, specifically on how you can contract STIs. For example:

"Infection, bacterial or viral, that are caused by sexual activities, even kissing"

"Infections you get when you don't pee after sex"

When asked 'what are the symptoms and signs of STIs?', 61.4 % (27) of the online survey respondents could give several examples, including: discharge, odour, itchiness in genital areas, swelling, pain when urinating etc. 11.36% (5) of respondents did not know the answer and the remaining 27.3% (12) had more general answers, for example: '*symptoms can vary, it depends on the STI*', '*sometimes no symptoms at all*'.

In interviews, participants were asked more in-depth questions exploring their knowledge of STIs. 92.8% (13) of the young people interviewed could give examples of common STIs, including chlamydia, gonorrhea, syphilis and HIV as well as common symptoms. 85.7% (12) also recognised that STIs can be asymptomatic and that this is why it is crucial to still test for them; and 50% (7) also mentioned that untreated asymptomatic STIs can lead to long term effects, including infertility.

When asked the open question 'how can you prevent STIs?', 95.4% (67) of all the young people consulted identified using '*protection*' or '*wearing a condom*' as a main way to prevent STIs. 1 survey respondent also mentioned 'abstinence' and another '*dental dams*' to protect against direct mouth-to-genital or mouth-to-anus contact during oral sex. All participants in interviews and focus groups knew how to help prevent STIs.

When asked the open question 'How do you test for STIs?', 18.2% (8) of survey respondents were able to simply explain how to test for an STI. For example:

"Go to a sexual health clinic and do a test by peeing or swab"

"A swab, urine or blood test"

"Going to a sexual health clinic or doctors and completing a swab test, urine sample or examination"

Another 15.9% (7) only mentioned '*take one of those STI testing kits*' or '*ask for testing kit at clinic*', without specifying what the test actually involves. The remaining 65.9% (29) were either not sure or simply said '*go to the GP*'. However, because of the nature of the survey question young people may have thought they did not have to explain the process involved. During interviews and focus groups the interviewer had the chance to go into much more detail and adapt the question to ensure participants knew what they were being asked. 78.5% (11) of interviewees and 69.2% (9) of focus group participants showed a clear understanding of female and male testing processes.

14.3% (2) of interview participants described a lack of clarity around what STIs they are at risk of contracting or transmitting if they are from LGBTQ community.
One of them said:

> Sometimes people assume that like I know what I need to be tested for. Do you want to be tested for HIV? Do you want to do an STIs test?....and I am like, I don't really know what I need to be tested for. Especially because, like, I sleep with other women, it's like I am really not entirely sure. We don't really have a lot of LGBT specific education around what we could be exposed to, so I am just kinda like 'just test for what you know I should be tested for.... you know...

Given the young woman's lack of clarity around what she 'should be tested for', it would be expected that staff take the time to clearly explain available options and make a valid recommendation to the patient. Although from the young person's report it looks like this may have not been the case, there is also the possibility that she found the experience very stressful and was thus not properly listening to what she was told.

On the other hand, like the young woman here, many LGBTQ+ young people from BAME backgrounds have reported they feel they lack culturally appropriate information, safe spaces and social networks to meet their sexual health needs (Dougan et al., 2005). Lack of appropriate education and promotion around LGBTQ+ issues and sexual health needs is an issue that all young people, not just those from BAME backgrounds, feel needs improving. Findings from the latest national young people's RSE poll (2019) show that 18% of young people learnt nothing about LGBTQ+ issues at school, and a further 28% said they had not learnt all that they needed to about LGBTQ+ issues.

In interviews, participants were also asked what may prevent BAME young people from getting tested or bringing the test back to the clinic for analysis. Perceiving a low likelihood of infection with STIs tends to lead to low motivation to be tested.
For example, one participant said, referring to some peers:

> "They may assume you're just fine if you are not experiencing big symptoms, I have heard some peers who self-medicate by taking antibiotics just in case. Also, until you do it, you don't really know how easy it is to get it done so you may be put off doing it altogether".

42.8% (6) of interviewees highlighted the stigma associated with STIs being a main barrier to testing, as diagnosis suggests engaging in unprotected sex, sex with multiple partners or sex with disreputable partners. 28.6 % (4) reported they were anxious about their 'reputation being ruined' if they were seen going for a test. Other reasons given were the 'fear of finding out the test results'; 'awkwardness of meeting someone you know when picking up or dropping off the sample'; and 'fear of parents finding out', barriers which were already identified in previous questions.

These findings confirm those from a previous study conducted within the local wider population (275 young people living in Brighton, aged 17-25); with lower perceived risk, perceived norms, stigma, shame and embarrassment identified as main barriers to STI testing (de Visser et al., 2013). However, unlike de Visser et al (2013) results, none of our participants said 'not knowing how to go about testing' as a main barrier which is not surprising given their relatively good knowledge of the processes involved in testing for STIs.

Young peoples' recommendations

Through the survey, 5 main areas emerged that young people wanted to improve about local sexual health services, including: a) Advertising and promotion to young people, b) Diversity among staff, c) Confidentiality and Privacy, d) Education in schools and colleges, e) Education for parents and carers.

Interviews and focus groups confirmed these findings and allowed us to delve more into what the young people would do around these areas if they could shape their local sexual health services. The following recommendations should be understood as a reflection of respondents who took part in this study and, as such, they are reflective of the local BAME communities across Brighton and Hove.

1 Improving sexual health services' promotion among young people

When asked how to improve promotion of sexual health services to ensure it is most accessible to BAME young people, participants shared some innovative ideas:

Social Media

Young people would like to see more promotion of local sexual health services on social media, including Instagram and Facebook through promoted posts or adverts. When asked about what kind of content they would like to see, interviewees and focus group members said they would like the posts to be straight forward, honest and accurate without being 'preachy'. They should not be too serious and should not come across as 'sex education at school'. They would prefer content created in the voice of someone credible and knowledgeable but also someone they can relate to and respect such as an older friend. Suggestions from one focus group included short clips of young people sharing real stories on a range of issues and how they addressed them by accessing the right service. YMCA Right Here have already collaborated with Brighton & Hove Sexual Health and Contraception service (SHAC) in the past to create youth-friendly video clips on what is like to get STI tested (https://www.youtube.com/watch?time_continue=5&v=_nr8h0SYQVo&feature=emb_logo). YMCA Right Here would be keen to work with local services and commissioners to create more youth informed and youth developed content for the 'No Worries' campaign specifically for BAME young people. In terms of social media channels used, younger participants tended to prefer Instagram, whereas the majority of older participants said Instagram and Facebook.

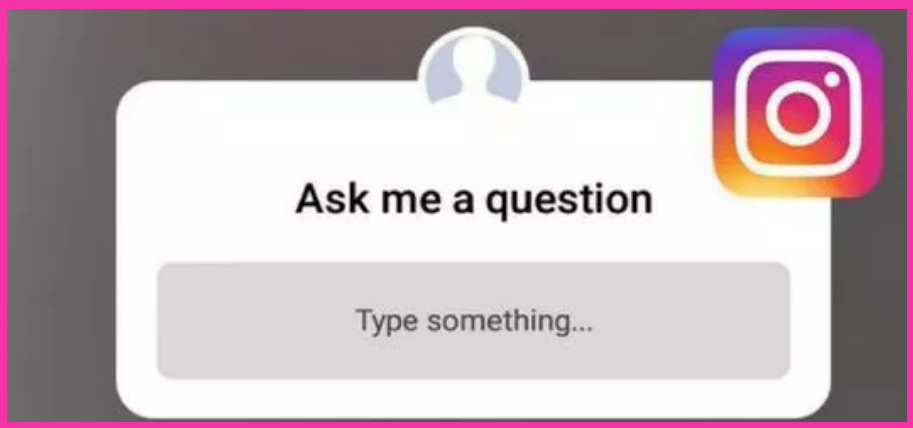
2 young people in a focus group also suggested promoting services on dating websites and apps such as Tinder and Grindr, especially regarding condom use, contraception and STI and HIV testing. We are aware this already happens, but young people's comments may suggest the current approach is not being effective.

It was also recommended to use innovative approaches that young people can engage with more easily, for example Instagram stories.

One person interviewed suggested:

"You know the 'swipe up stories', the ones you read about something, it's got to have a catchy image or GIF I guess, but then to find out more you swipe up and that it may link you to a website or blog - you know that'd be cool if you could book an appointment like that...."

Another young person also suggested including 'interactive tools' within Instagram stories, such as 'ask me a question' for young people to informally ask questions to services, or 'ratings' if services are interested in instant feedback from young people. Interestingly, these suggestions come in contrast with some previous research in which young people said images, videos and interactive content would exacerbate their worries about 'being seen' seeking sexual health information online (Patterson et al., 2019).



Our participants' recommendations are reinforced by previous research showing the positive effects of digital interventions on sexual health promotion (e.g., Bailey et al., 2015; Nadarzynski et al., 2019). Digital interventions have been shown to increase knowledge about STIs and boost STI testing and condom use (Bull et al., 2012; Jones et al., 2012; Gabarron and Wynn, 2016); and to be particularly effective if users are actively involved in the development process in order to increase engagement and persuasiveness (Nadarzynski et al., 2019). However, the majority of studies involving online social media for sexual health were mainly on STI health promotion.

To our knowledge, little or no research has been done to measure social media' effectiveness on promoting sexual health services or improving the appointment booking system (which is what the young people consulted here are suggesting). Furthermore, while the majority of previous research focuses on the use of Facebook, Twitter or Youtube, our participants were clearly keener on using Instagram, as this is the channel thought to be most popular among young people currently. Therefore, it is recommended to further explore these avenues.

Leaflet and poster material

Consultation with local young people is essential when developing any materials and deciding community settings for publicity. Young people felt promotion through leaflets and posters should be more representative of young people from BAME backgrounds as 'some BAME young people feel the services are not for them'. As a result, a common recommendation was having 'more people of colour in leaflets and posters' representing the different ethnicities living in Brighton and Hove.

Furthermore to make information more accessible to young people who have only recently moved to Brighton and Hove and whose English is still limited, leaflets and posters should be translated into different key languages (e.g., Arabic and Chinese were the two most mentioned languages). Translated service leaflets could be designed bilingually so that young people can point to a service that they are hoping to receive and reduce incidents of miscommunication.

35.7% (5) of interviewees said they would like leaflets to be in the form of a 'pocket guide', something 'small and foldable that can fit in your pockets and that you can take with you anywhere you go….you know if you get a big poster you just bin it straight away, you don't want other people to see you are reading a poster about STIs on the bus'. Pocket guides should contain key information on sexual health, names of services, contact numbers, what to expect from a sexual health appointment and common questions answered. YMCA Right Here has already produced 'pocket guides' information resources around 'self-harm' and 'suicidal thoughts' (see Figure 7) and could produce one around sexual health and STI testing.

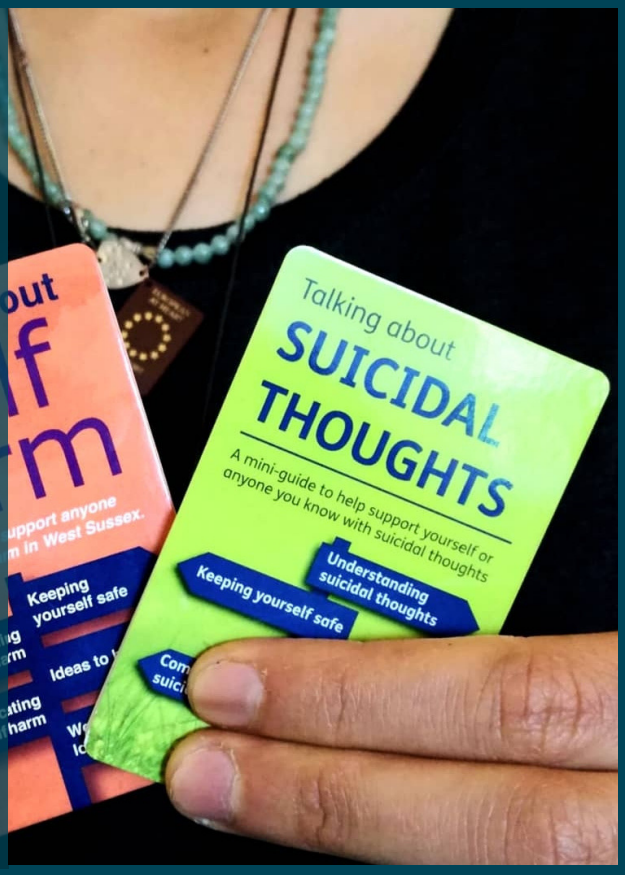


Figure 7

One young person interviewed decided to sketch a simple infographic (see Figure 8) when asked to describe what she thought getting an STI test involved.
Upon completion she explained:

> This is the kinda thing which would be accessible to anyone, you don't need a very good English to understand what's going on, a few nice and simple pictures and you really get how easy it is to get tested this way! You could make different ones for different services etc...

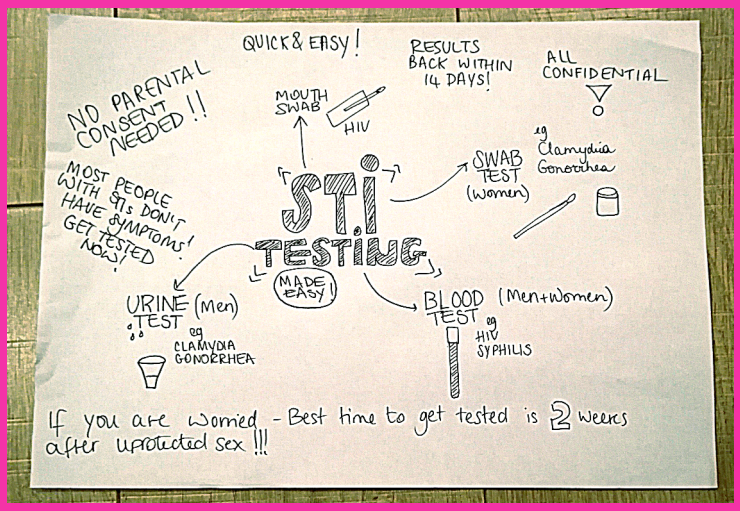


Figure 8

Several places were suggested for advertising sexual health services, including hairdressers and barber shops, taxis, buses, youth clubs and centres, pubs and coffee shops.

Engagement and Outreach

Many young people thought engagement and outreach activities are the best way to raise awareness among young people around local sexual health services and how to access them.

One young person said:

> I know I am old enough, I am at uni, but they all think you should know it all by then but actually I have just changed city and we are all experimenting loads, I feel we should be feeling like services are accessible and easy to access at this stage of our lives....I think there should be more mobile clinics around the city, you know a stall or something you can just go, pick up a condom or STI testing kit and you don't have to talk to anyone or explain what you are there for.

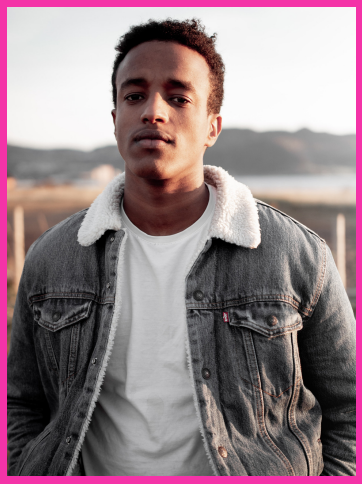
Similarly, in a focus group with college students the need was also expressed for more pop-up clinics where specialist sexual health promoters can answer questions, provide service information and talk about sexual health issues and possible solutions. One of the participants said:

> Last year they did it, but it'd be cool if they came more often. The lady was so nice, she answered all my questions, and was giving out free condoms and lubricant, you know everyone wants a freebie! It'd be great if they could make freebies which contain key information about services. You know, maybe one of those scroll up pens, what are they called? Ah banner pens with key info about local sexual health services, where they are and how to book an appointment? I think they would be very effective, people would love that!

Pop-up clinics would also allow young people to go as a group, thereby making the experience 'more social' and normalised.

One young person said:

> What I liked is that you could go to the stall with your mates, and that way it was not that awkward, there were loads of other people but I didn't care who saw me cause we were there as a group....I don't know, it was more like a social thing, you know, and not as daunting as going to the clinic alone to pick up a test or something...

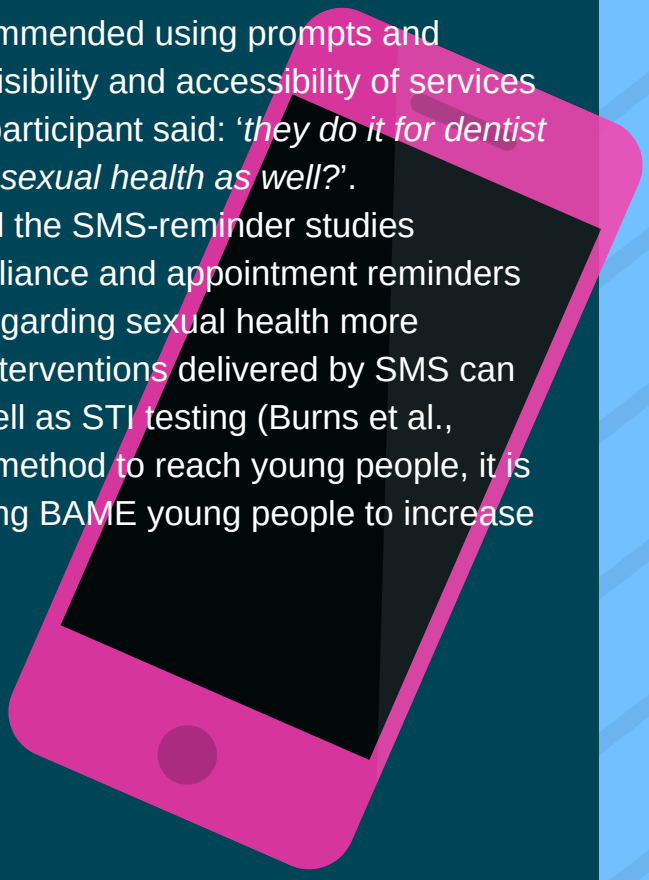


We are aware such pop-up clinics do exist and are delivered by services such as THT, but they are not currently well attended. This could be due to lack of promotion, or times and location not being accessible to young people, so further research may be required to identify and overcome these issues.

It was also suggested by 2 interviewees that more work needs to be done with local faith leaders to support services' understanding of faith communities and beliefs. It was recommended to involve faith leaders and community groups to support understanding within their communities by directly promoting sexual health information to reduce the stigma around regular testing or inviting specialists in to deliver information and answer questions. This approach is likely to enable the development of sexual health promotion that is specific to different communities' cultural norms. Furthermore, young people are more likely to positively receive messages around sexual health if these are delivered within settings that they are already comfortable and confident accessing. There is already ample evidence to highlight the importance of developing and testing intervention models that originate from community-based organisations to address complex and sensitive health issues among marginalised populations such as HIV prevention (Sau, 2018; Griffith et al., 2010; Ransome et al., 2018). In the UK, HIV Prevention England (HPE) has drawn a 2019/2020 strategy aiming to engage and collaborate with faith leaders, through the It Starts With Me campaign (link to the campaign: https://www.startswithme.org.uk/) and National HIV Testing week to reduce HIV stigma and help increase their participation in HIV prevention and testing. Therefore, it will be interesting to test similar models of health promotion more locally.

Prompts and reminders

Participants in one focus group especially recommended using prompts and reminders, either via email or text, to improve visibility and accessibility of services (e.g. when to get a sexual health check). One participant said: '*they do it for dentist appointments and stuff, why can't they do it for sexual health as well?*'.
A recent literature review showed that nearly all the SMS-reminder studies analysed helped improve patient medical compliance and appointment reminders (Schwebel and Larimer, 2018). Furthermore, regarding sexual health more specifically, there is evidence to suggest that interventions delivered by SMS can increase uptake of sexual health services as well as STI testing (Burns et al., 2016). As SMS are an easy and cost-effective method to reach young people, it is recommended to test this model locally, targeting BAME young people to increase access to local sexual health services.



2 Education in schools and colleges

It was recommended that information around sexual health should be more widely talked about in schools. A few young people said this should begin from primary school.

In a focus group, a participant said:

> We received information and learning in our upper six, but that should have been done earlier on to debunk myths and normalise the topic.

Furthermore, participants thought it was crucial for sexual education programs to be more LGBTQ inclusive, thereby increasing knowledge of gender identity, sexual orientation, examples of positive romantic relationships and families, protection; while dispelling common myths and stereotypes about behaviour and identity. LGBTQ+ young people often tend to report that SRE delivered in school does not provide them with information on sexual health issues that apply to them, and that SRE is based on the premise that all students are heterosexual (IPPF, 2014).

It has to be noted that in April 2019 with overwhelming support, parliament passed the new regulations for teaching RSE in England. This means that from September 2020, all secondary schools in England will be required to teach SRE and all primary schools in England will be required to teach Relationship Education (RE) (https://www.gov.uk/government/news/relationships-education-relationships-and-sex-education-rse-and-health-education-faqs). Importantly, the new guidance means that all secondary schools will have to teach LGBTQ+ inclusive lessons, including teaching about LGBTQ+ people and their sexual health needs, relationships and families, as well as covering other important issues like consent and online safety.

3 Education for parents

Some of the young people we consulted, especially the younger ones from Asian and Black African ethnic backgrounds said they don't discuss at all their sexual health with their parents. As previously discussed, such lack of communication is likely to be due to cultural and religious norms stigmatising sex at a young age and outside marriage. This means that some young people may decide not to access sexual health services for the fear of parents or community members finding out, especially if worry about services' breaches of confidentiality.

Of the 8 young interviewees who said 'the fear of parents finding out' is an important barrier to access, 5 of them suggested more education is needed for parents in order to break the stigma. Targeted training for parents and carers should aim to equip them with the knowledge and skills to best support their young people's sexual health choices. This could include information of the services available locally and the professional framework and policies within which staff work, as well as interactive discussions with parents to listen to their worries and address them with explanations based on scientific research. Taking up the young people's recommendation around involving faith leaders and faith organisations in delivering sexual health youth promotion (see previous 'Improving sexual health services' promotion and education among young people' section), it may be effective to adopt a similar approach when engaging with parents and carers. This would ensure the delivery of culturally appropriate sexual health messages which take into consideration, wherever possible, different cultural and religious norms that may affect discussions on sexual health matters and parents/carers' behaviour.

4 Improving confidentiality

18.2% (8) of the survey respondents said young people would feel more comfortable accessing or returning to sexual health services if they knew/were reassured that '*whatever they have to talk about will not go anywhere or to anyone else, like they always think information will somehow slip out and your parents will know*'. Interviews and focus groups strongly confirmed this finding and participants suggested promotional materials, whether it is posters, leaflets, websites/apps or social media posts, should provide information about services' confidentiality and privacy to reduce fear and stigma of access.

Furthermore, regarding clinic environments not being discreet enough and young people feeling uncomfortable disclosing their reason for visiting when other people can listen, participants recommended to use online forms that you can just fill in when arriving.

One person explained:

I went to my GP the other day and they had a little tablet that you needed to sign into upon arrival, I guess something similar could be used in sexual health clinics, like you come in, sign in and write a quick note about your reason for coming in...that'd be easy to do, right? those cubicles at *clinic* are ridiculous to be honest!

5 Improving ethnic diversity among staff and training

15.9% (7) of survey respondents identified the need to '*have more BAME staff, not just White British*' to allow BAME young people to feel more comfortable talking about sexual health and to be better understood when it comes to cultural, religious and values differences. 74.1% (20) of the young people taking part in interviews and focus groups recommended improving ethnic diversity among staff and wanted '*to see someone like me, someone who understands my culture who is going to be welcoming and get what I am saying*'.

Therefore, a common recommendation, and one that is likely to be salient to BAME young people specifically, was to improve the diversity of the workforce to reflect the existing diversity among local communities. This may help deliver more culturally sensitive interactions and services.

We asked those interviewees who recommended improving diversity among staff (11), how they envisioned this happening. While 63.6% (7) recommended recruiting more BAME staff that young people can better relate to; the remaining 36.4% (4) suggested closing the gap by providing formal training to existing staff, potentially co-designed and delivered by BAME young people, to further their understanding of cultural issues relevant to specific communities and the sensitive and diverse needs of BAME service users.

6 Improving communication

As well as producing promotional material in different languages as discussed above, young people emphasised the need to increase the provision of bilingual staff as well as foreign language interpreting services to overcome linguistic barriers. This may involve health workers receiving training in working with interpreters. Such measures would be especially effective for BAME young people such as refugees and asylum seekers, who have only recently moved to the UK and don't have a good level of English yet to communicate their needs effectively and there is evidence to show this (Burnett, 2001).

Extra recommendations from Young Healthwatch

1 Collaborate with local BAME young people to create a youth-friendly document to hand out to young patients prior to their visit at the sexual health clinic. This could include commonly asked questions, a short summary of 'what to expect' from the visit (e.g., timings, friendly staff, what does an STI test involve and how long until you get results), clear and concise information about privacy and confidentiality as well as a short section for young patients from the LGBTQ+ community including recommendations on appropriate screening tests. This document could be digitally shared using SMS, emails and social media, to alleviate some of the young peoples' worries and concerns which may prevent access. The same information could also be added to www.WhereToGoFor.co.uk , a health wellbeing service directory website run by YMCA Right Here where young people can search for the different services that Brighton and Hove has to offer. As discussed earlier, this information could be delivered alongside short youth-friendly and funny video clips such as those previously developed by YMCA Right Here in collaboration with SHAC on things like what is like to get tested for STIs, but this time specifically targeting BAME young people (e.g., by featuring actors from BAME backgrounds).

2 The findings relating to recruitment in this study suggest that some professionals feel that sexual health is still a sensitive and difficult topic for young people. However, judging from the positive comments and feedback from BAME young people participating in this study, this may not be the case. An idea would be to address such barrier via a BAME youth-led anti stigma campaign or training directed at youth workers and professionals who work with and manage groups of BAME young people to 'de-sensitise' the subject. This would not only help with involving more BAME young people in studies like this, but crucially equip youth workers and professionals with the right skills and confidence to address relevant sexual health matters and discussions with young people as part of their ongoing agenda.

Reflections

This study aimed at identifying key barriers to accessing local sexual health services that are specific to young people from BAME backgrounds. Our study confirms previous findings showing that language barriers as well as religious and cultural norms can prevent BAME young people from accessing sexual health services.

After reviewing the existing literature around perceived barriers to sexual health, we have also recognised that some of the barriers identified by our participants are likely to be common to young people within the wider population, including issues with service confidentiality and privacy, peer influence and lack of service visibility, promotion and advertising.

We have also argued that some barriers, such as the fear of being seen, although present within the wider population, are likely to be most concerning to BAME young people. This is because of restricitive cultural and religious norms that stigmatise being sexually active at a young age or outside marriage, causing young people to feel ashamed and embarrassed and that they would be negatively judged by peers and even by healthcare professionals for accessing services.

Finally, we have also shown that some barriers, such as the fear of parents finding out, are stronger for younger people (17-19) who are likely to still live with their families; as well as those from Asian and Black African backgrounds, who have been previously shown to struggle with communicating with parents around sexual health and often identify lack of family support as a major barrier to accessing services.

Locally and nationally BAME young people are disproportionately affected by STIs so it is crucial to combat the barriers that are currently preventing these minority groups from accessing services and getting the help they need. Even though some of the barriers and issues identified by our participants are not novel and may correspond to those affecting the wider population, we argue that some of the recommendations suggested by our participants are actually quite novel (e.g., regarding interactive social media promotion and advertising, diversity expressed in promotion material, online tools for patient sign ins to improve perceived confidentiality and privacy); and will provide commissioners with some fresh perspectives and innovative approaches to improve accessibility and quality of Brighton and Hove sexual health services for BAME young people.

Like other studies in similar settings, there is a possibility that the results could be affected by selection bias. For instance, if the study included participants who were particularly keen to discuss their views and perceptions and/or young people who have had negative experience of accessing/using sexual health services and therefore wanted to share these experiences. Considering the main aims of the study, the sample of participants and the quality of dialogue and analysis, we are confident the study achieved a sufficient level of information power.

This study was based in the community setting and addressed the local BAME population as a unified group, unlike some previous studies focusing on a particular sub-group of the BAME population (e.g., Samangaya, 2007 looking at young BAME males; Beck et al., 2005 looking at the Bangladeshi community in East London). This study heard the voice of 71 young people over the course of 3 months. The equality and monitoring information tells us that we spoke to a range of individuals from different ethnic backgrounds, thereby providing a comprehensive and practical discussion focused on the BAME population as a whole. The views and perspectives expressed reflect perceptions of barriers to accessing local sexual health services that are currently important considerations for improving equity in healthcare and reducing health inequalities.

Our initial plan was to use a ‘creative question tool’ other than a survey, such as a ‘scratch card’ style tool. This would have worked well with engaging large numbers of young people within youth groups, or from the Brighton and Hove Youth bus, which we had hoped to engage with as part of this study. Due to the recruitment issues via youth groups and services, this type of creative question tool was deemed unlikely to produce enough information to be useful for the study, as it would have been limited to around 3 short questions.

Reflecting on the challenges posed by recruitment, we recommend in later studies to explore more engaging and innovative methods for recruiting young people directly, without necessarily relying on ‘adult chains’. For example, rather than contacting youth groups managers and asking them to recruit their young people to take part in the study, it may be much quicker and more productive to approach young people on the streets, city buses, outside language schools or colleges, cafes and hairdressers.

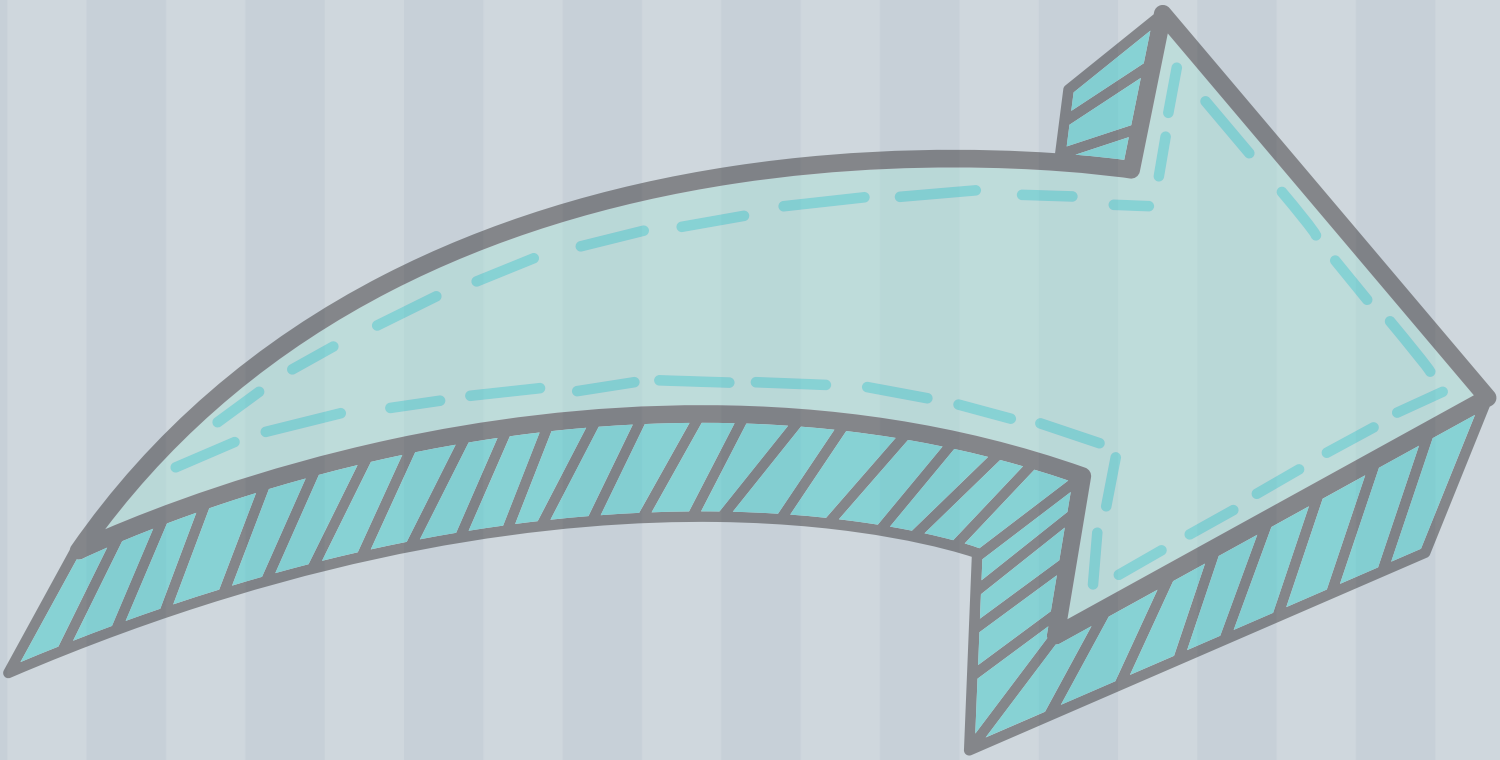
In this respect we found crucial to make potential participants aware that the questions they will be asked are not personal, and that data will remain anonymous and confidential. It is also good practice to reward participants for their contribution as close as possible to study completion, for example using vouchers, coupons etc.

As most participants in this study fall within the lower age range (17-19), it is important to reflect on what may be the possible reasons behind this. It may be that younger individuals are simply more easily engaged and keen to share their voice and opinions on services as compared to older ones who may be busier, less available or keen to give their time and participate. On the other hand, our participants' age may reflect the rather young BAME population residing in Brighton and Hove. As of 2015, the Brighton and Hove BAME population's age profile is younger than our White UK/British population. Mixed ethnic background residents have a very young age profile, with 50% (5218) of this community being aged 19 years or less (vs 22% of the general population being under 19). For Asian, Black and Arab residents the proportion is also higher than the 22% average (Brighton & Hove City Council Policy, Scrutiny & Communities Unit, 2015). Nevertheless, it may be useful in future studies to test a wider variety of methods of recruitment to ensure data is collected from a wider age range of young people. This would allow to make more robust comparisons between age groups and truly understand whether age specific issues and barriers exist and how they could be solved.

Next Steps

This report will be submitted to commissioners and any next steps will be discussed regarding which of the young people's recommendations will be taken forward and what resources will be required for this to happen. Furthermore, the report will be shared with all the young people involved in this project, including YMCA Right Here and Healthwatch Brighton and Hove volunteers.

Furthermore, YMCA Right Here is currently developing new sexual health pages (with the content produced by Public Health and SHAC) on the YMCA Right Here's www.WhereToGoFor.co.uk website which will support improved awareness and understanding of local sexual health provision. Therefore, learning from this study and report will be incorporated.



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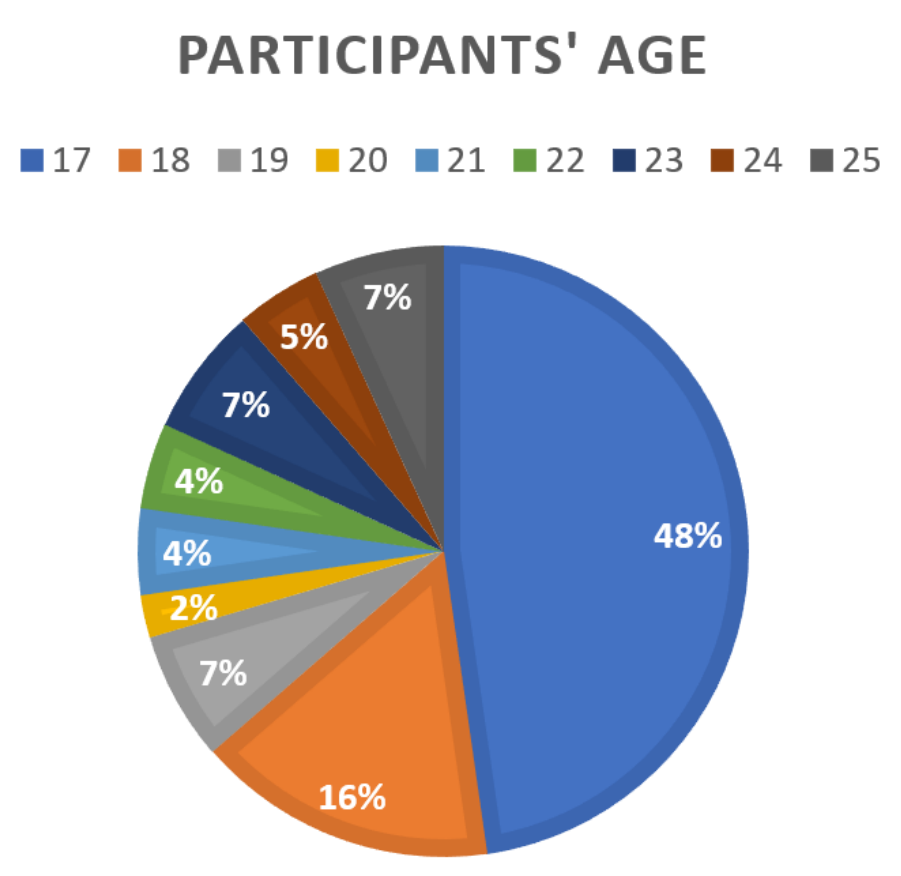
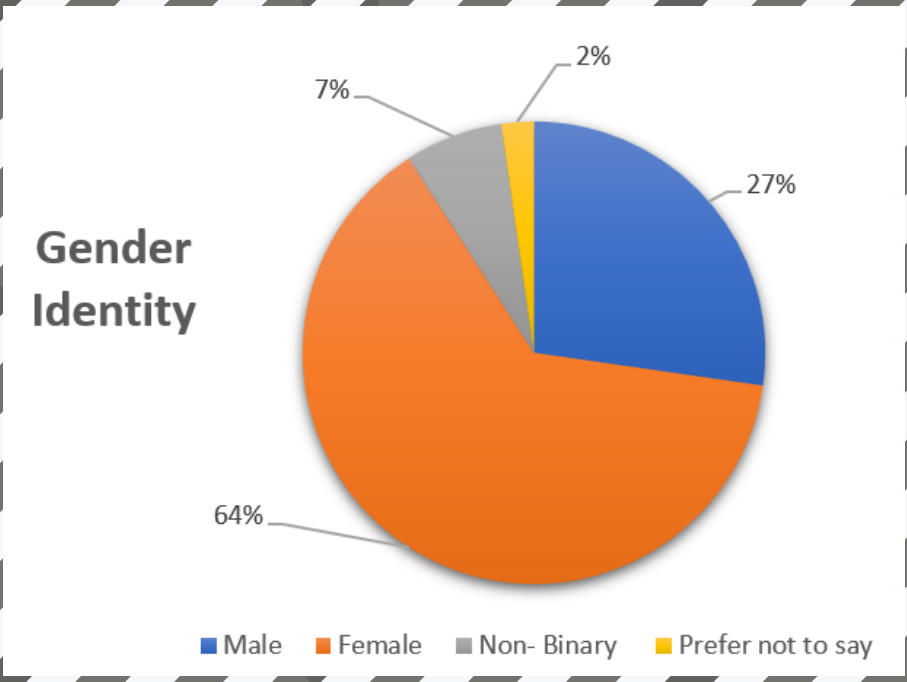
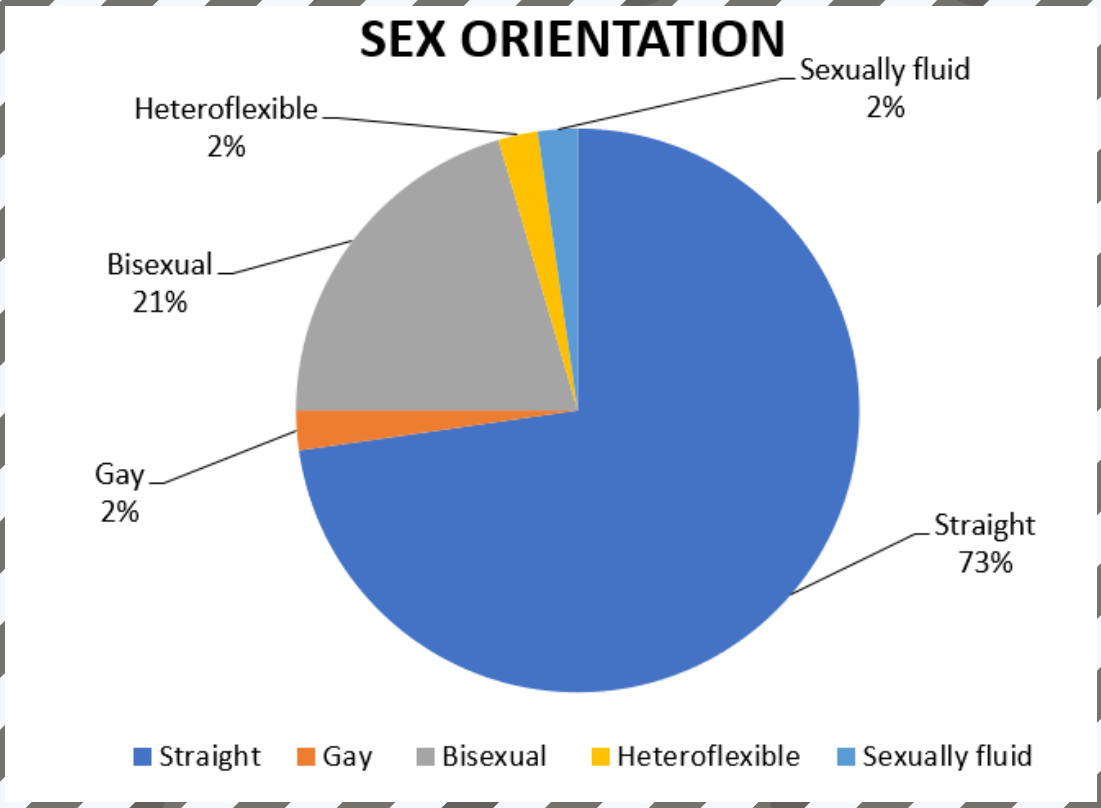
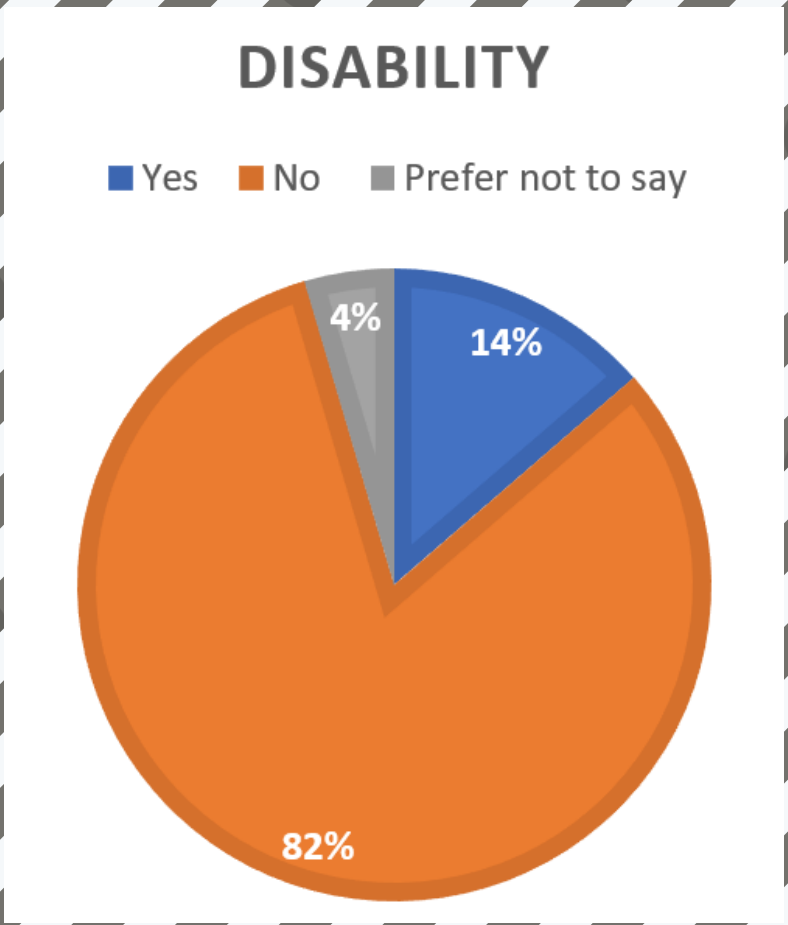
Appendix 1: Demographics

Survey Demographics

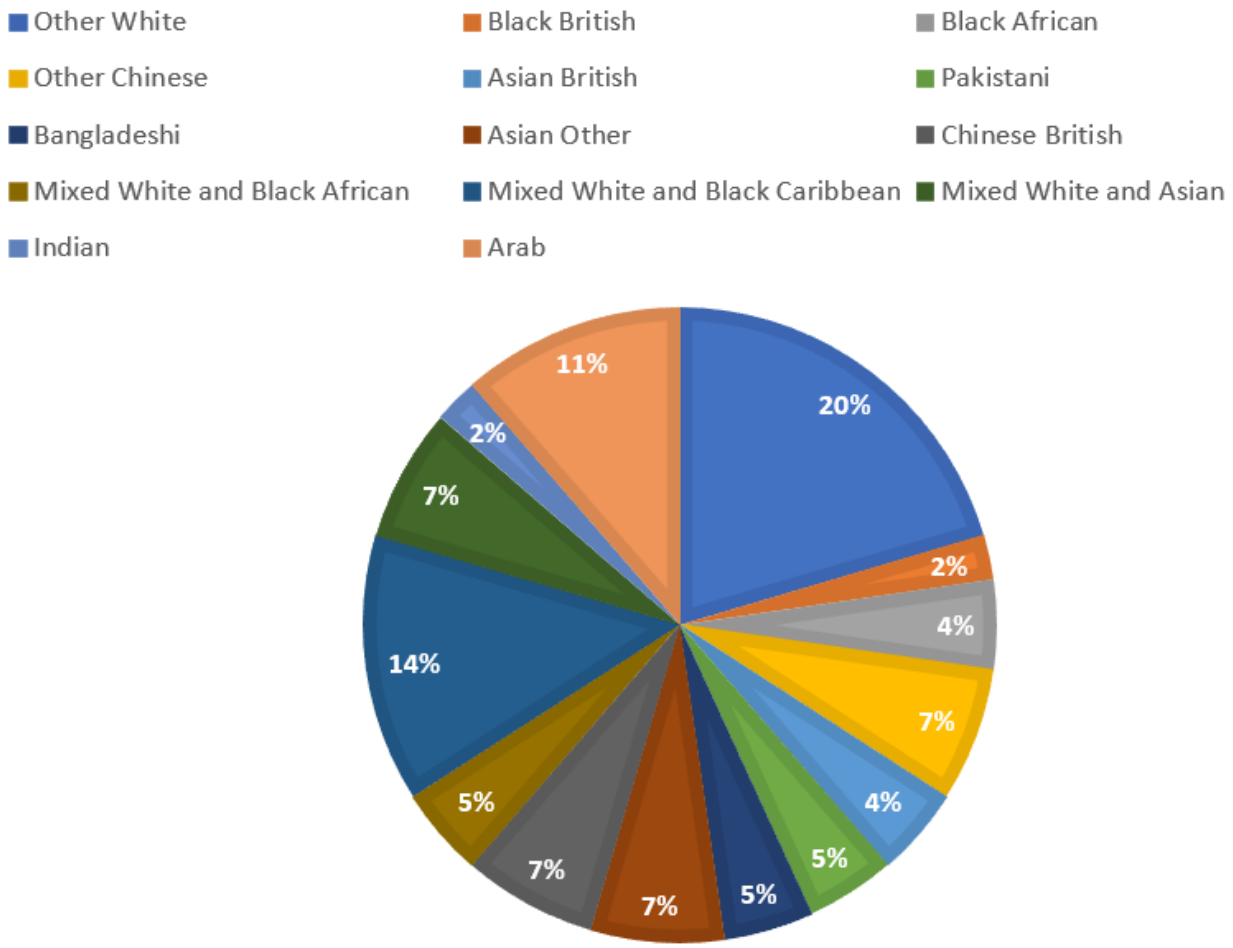




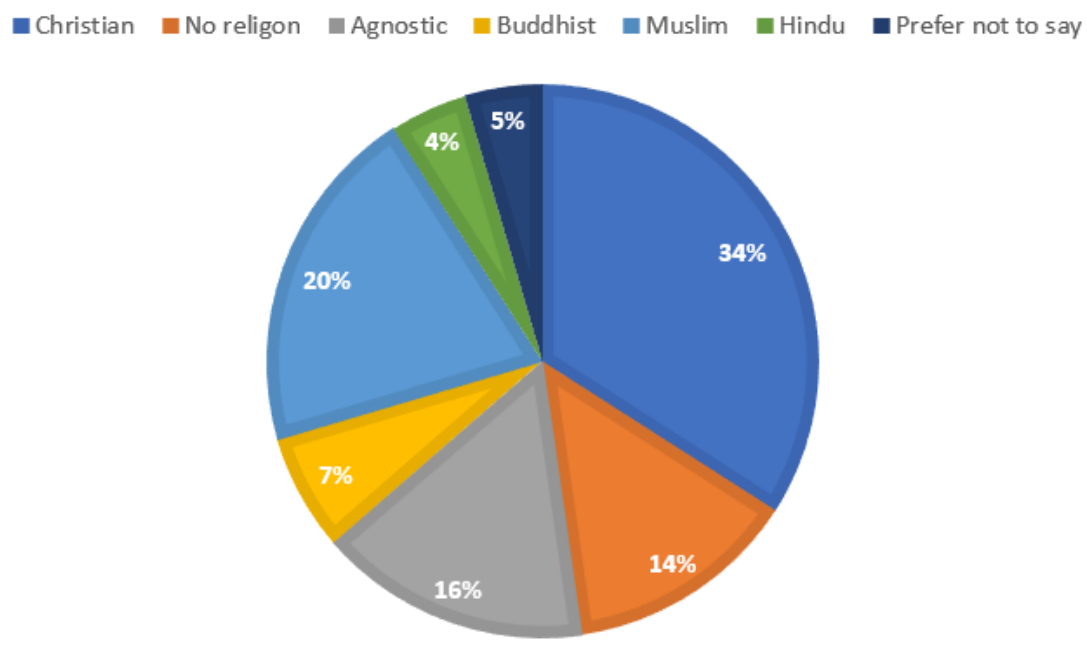

SEX ORIENTATION
Sexually fluid
2%
Heteroflexible
2%
Bisexual
21%
Gay
2%
Straight
73%
Straight
Gay
Bisexual
Heteroflexible
Sexually fluid


DISABILITY
Yes
No
Prefer not to say
4%
14%
82%

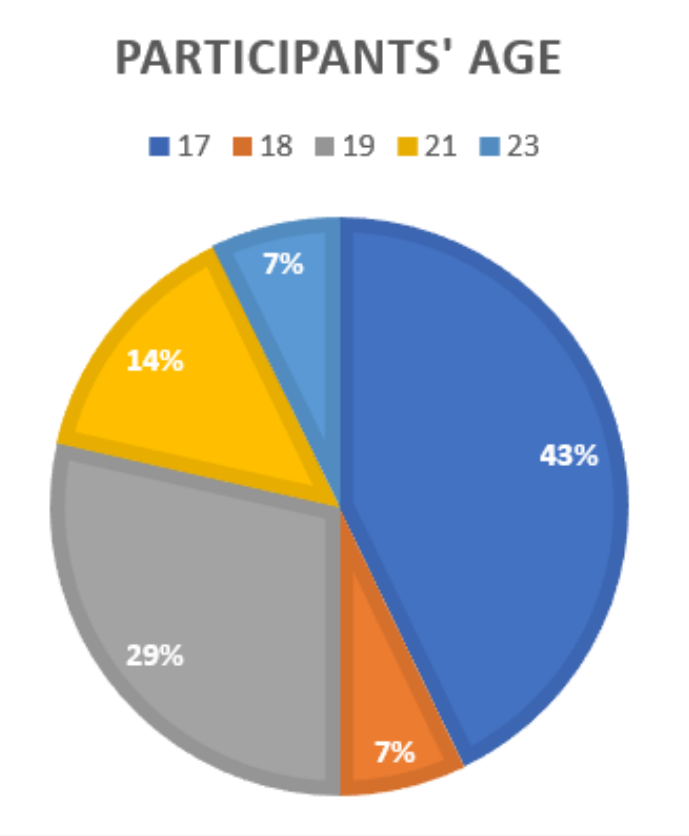
ETHNIC BACKGROUND

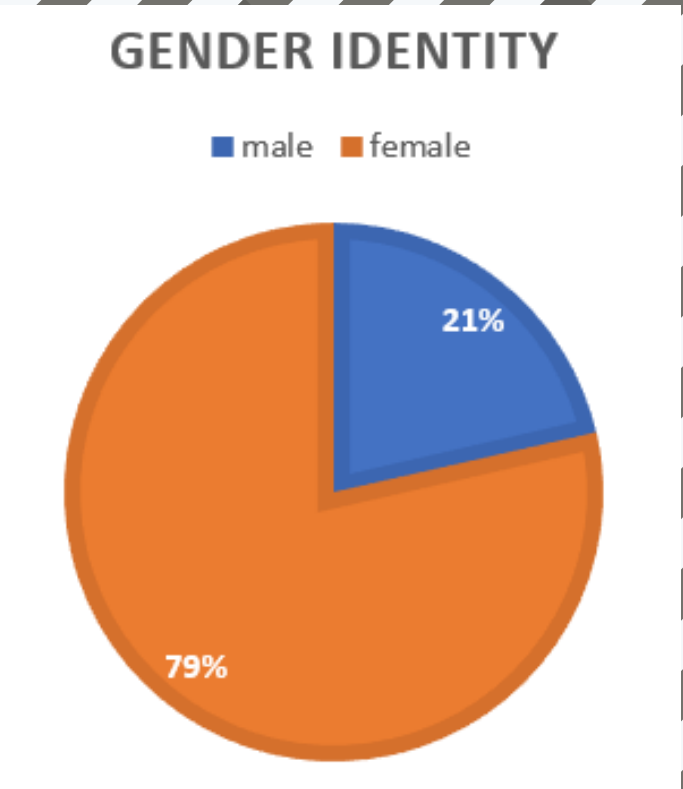


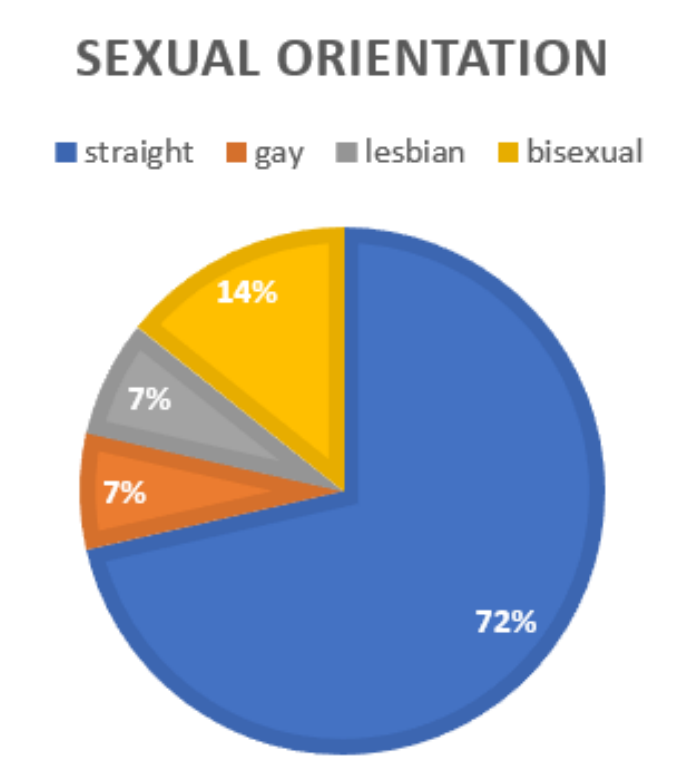
RELIGIOUS BELIEF

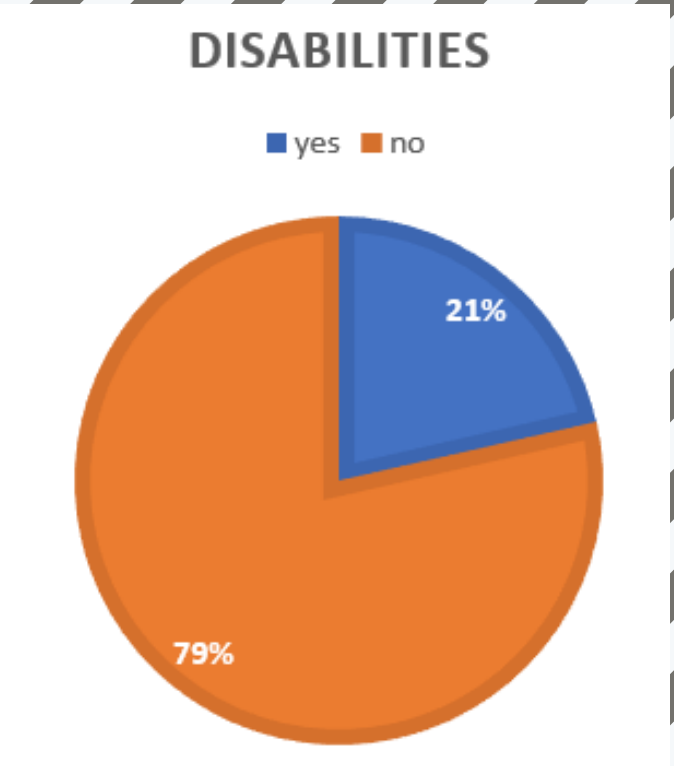


Interview Demographics









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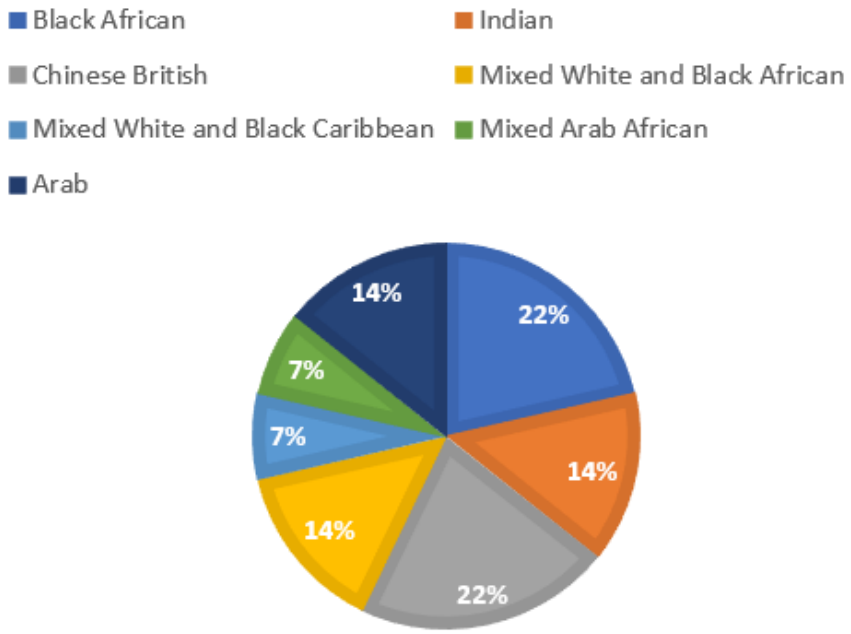

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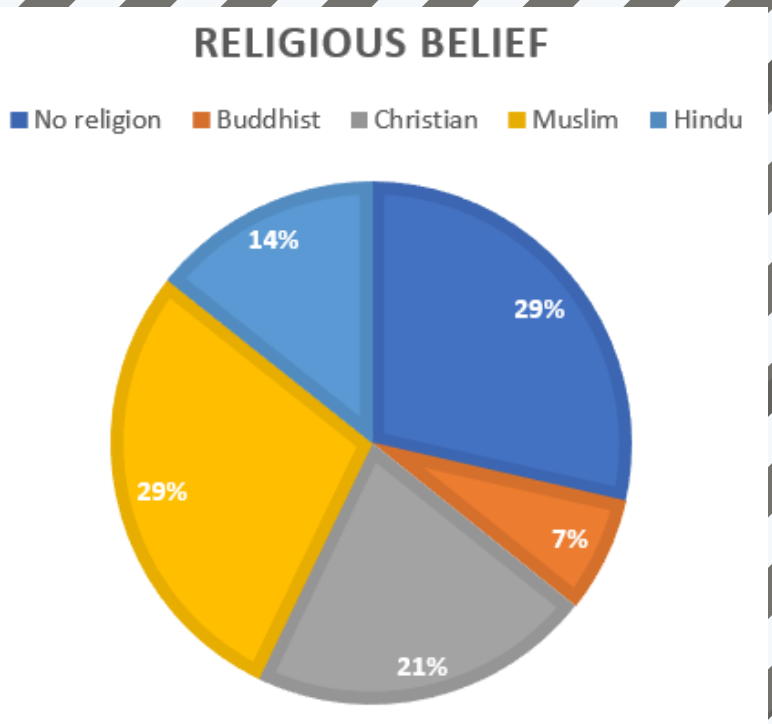
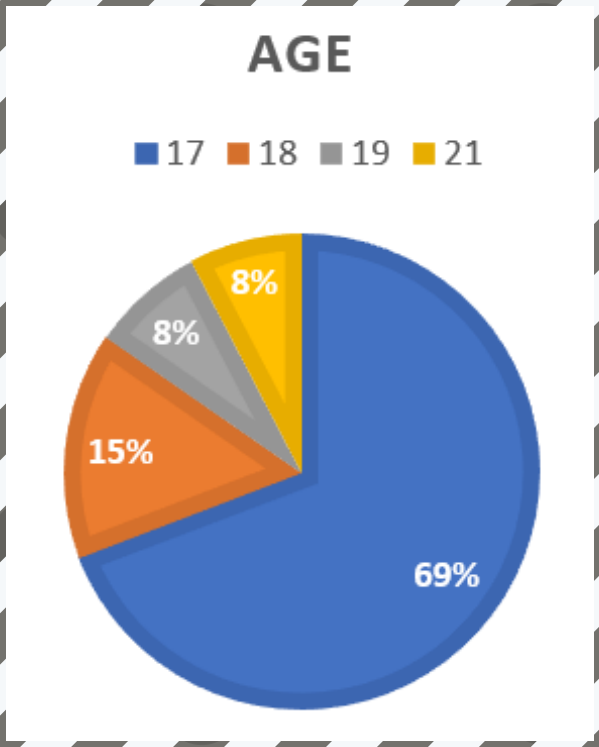
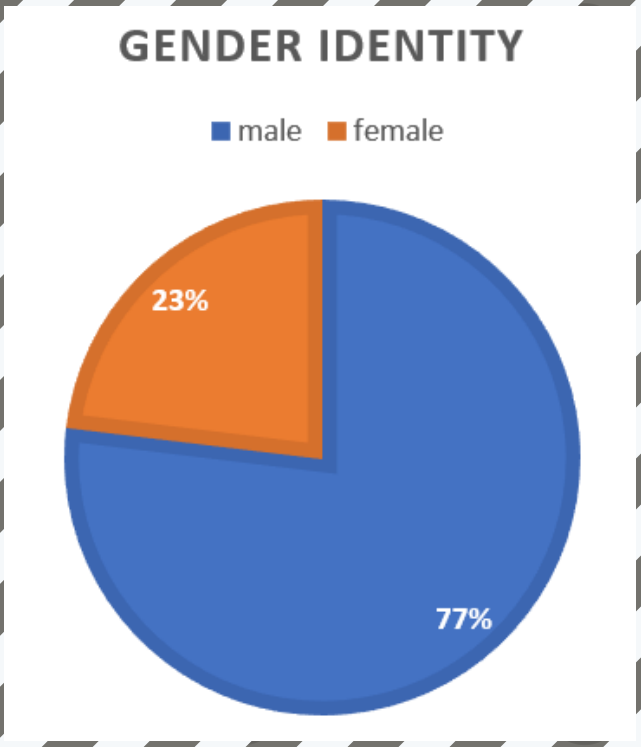
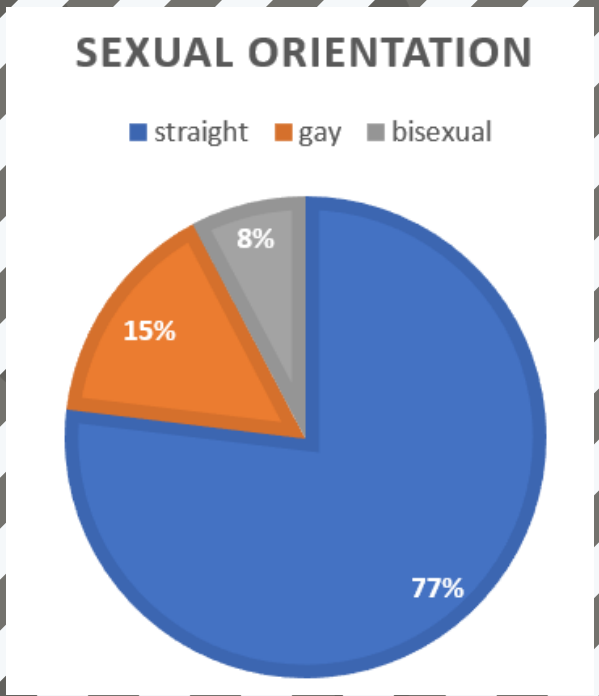
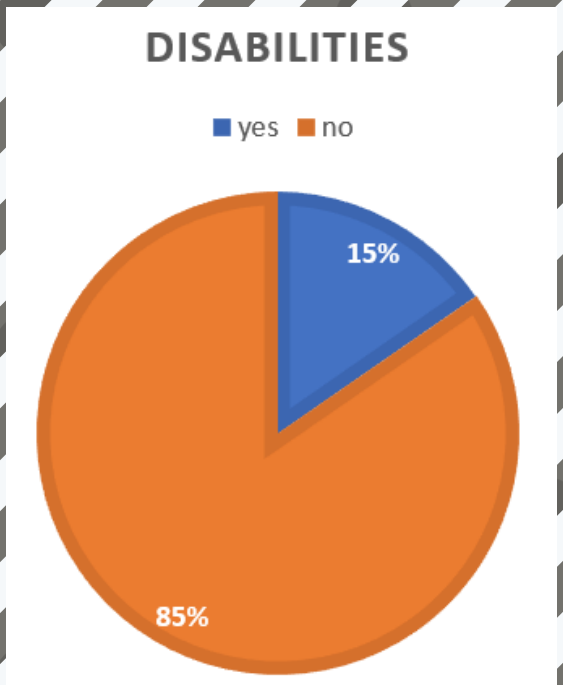


Focus group demographics









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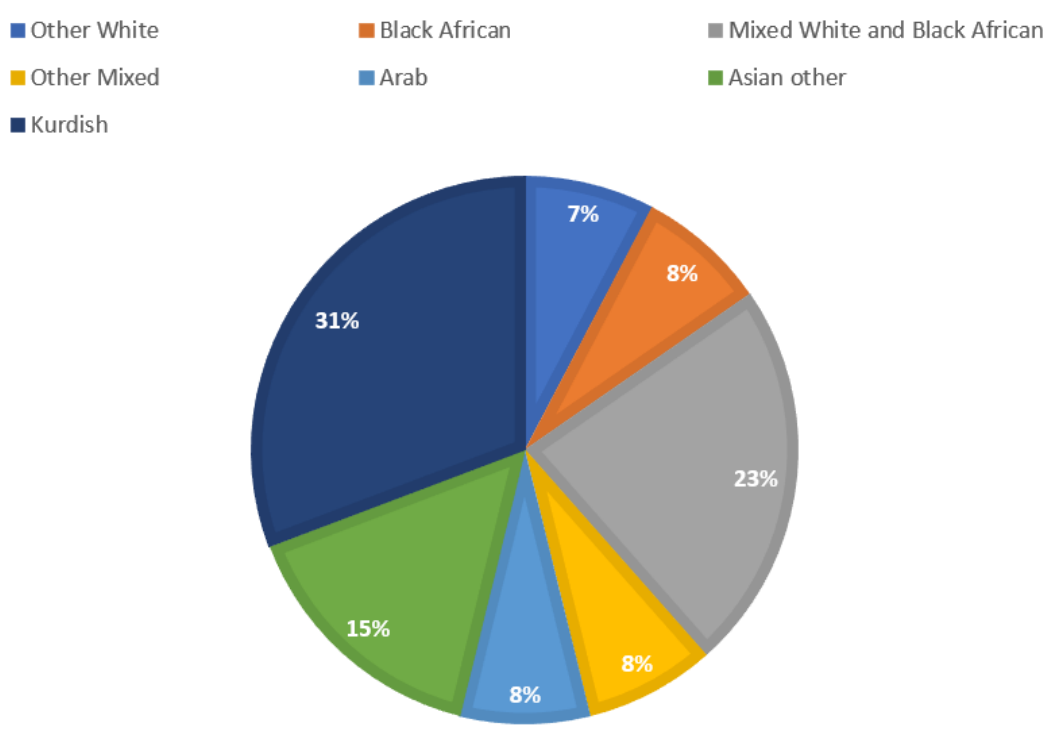

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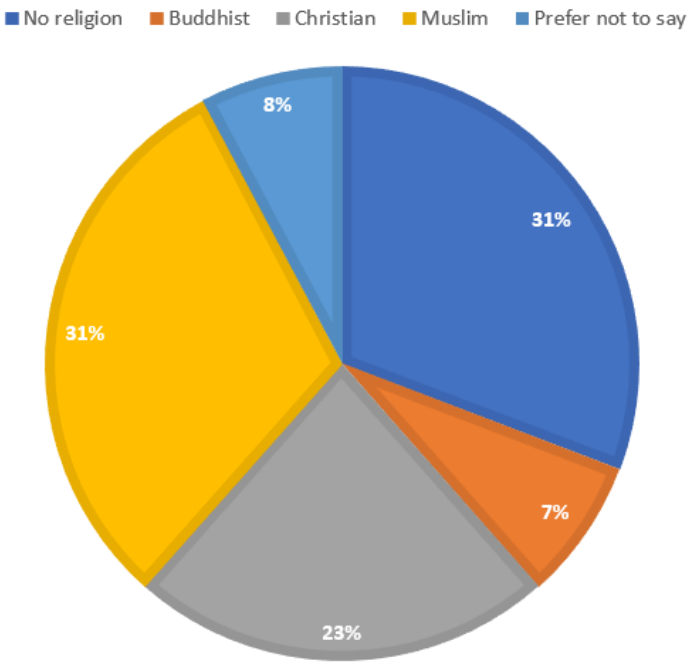


Appendix 2:
List of services contacted or visited

- Global Social Club
- Hangleton and Knoll project
- Brighton Tennis Club
- All Sorts
- University of Brighton Welfare officer
- University of Sussex Society and Citizenship officer
- Welfare officer at BHASVIC
- Brighton College refugees group
- Pathways to Independence
- Sussex University African and Caribbean Society
- Brighton Language college
- YAC in regard to free make up workshops for BAME young people
- Friends Centre
- Pastoral office for young asylum seekers migrants and refugees at GB Met
- The trust for developing communities
- Terrence Higgins Trust Black African and BAME project coordinator
- Migrant English project (MEP)
- BandBazi (Young people's support arts project)
- Unaccompanied asylum-seeking child team
- St Giles Brighton
- RASP - Refugee and asylum seekers project
- The English Language centre
- Interactive English language school
- SHAC
- Morley Street
- Claud Nicole
- Voices in Exile
- BMECP centre - The black and minority ethnic communities partnership
- Black and Minority Ethnic Young people's Project (BME YPP)
- ISE Brighton - ESOL provider
- EF Brighton
- Sussex Interpreting services
- Castle school of English
- Brighton Buddhist Centre
- Grapevine hostel
- EF language travel
- BIMM
- Young people's centre

The Cowley club

- Archipelagos
- Brighthelm Centre
- Olivet English Language school
- Taj the grocer
- Nail Garden and Spa
- Celly’s hair salon Brighton
- Brittania study
- Tookta’s Thai food
- Tortilla brighton
- Foodillic
- Brighton unitarian church
- St Giles school of English
- Brighton University
- Angelic hell tattoo
- Brighton make up school
- MET college
- Millwood community centre
- Arch healthcare, Homeless GP surgery
- Ebenezer reformed baptist church
- Planet india
- Brighton Oasis Project
- Phoenix art space
- New England House café
- The level café
- Park cresent health centre
- Swallow house
- Kicks martial arts centre
- AA charcoal grill
- Oriental takeaway (lewes road)
- University of sussex information centre
- The Martha Gunn
- Brighton Electric studios
- Coachwerks
- Rotunda café, preston park
- Preston fish bar
- Marvans news
- Whitehawk community centre
- Beaconsfield medical centre
- Beaconsfield dentists
- Filipino grocery store
- City academy whitehawk
- WASP
- Valley social centre
- Breadys delights jamaican food van
- Moulescombe library
- Hollingdean community centre
- Brighton open market
- Radio Reverb
- 1BTN
- La choza,
- Carlito burrito
- Komedia Brighton
- Theatre Royal Brighton
- Marwood coffee house and bar
- South portslade community centre
- Bamboo garden
- Juniper catering
- Mcdonalds
- Starbucks
- Café Nero
- Eastbrook manor community centre
- Adur Express community store
- Oxford International Brighton
- Whitehawk fc
- Hanover community centre
- Moulescombe the Bevy

Appendix 3: Survey questions

1. Have you ever used a sexual health service before?
a. yes b. no c. not sure d. prefer not to say

2. Do you know of any sexual health services in Brighton and Hove?
service 1 _____
service 2 _____
service 3 _____
service 4 _____

3. Have you accessed any of the local sexual health services you have listed in question 2?
a. none of them
b. service 1
b. service 2
c. service 3
d. service 4
e. all of them
f. prefer not to say

4. What was your (or your peers') experience using these services?
(Responses on a slider 0 to 100 (0 being very bad, 50 being neither bad not good, 100 being excellent)

5. Can you explain the rating you have given in question 4?
(When answering think about the following factors: are services well advertised and promoted? are they accessible? How are waiting times? Are appointment booking systems efficient? Are members of staff friendly? Is communication simple and clear? etc)

6. Do you think BAME young people experience any difficulties (barriers) accessing the local sexual health services?
a. yes b. no c. not sure d. prefer not to say

7. What do you think may stop BAME young people from accessing local sexual health services? Click all that apply.
a. fear
b. lack of information of 'where to go for' when it comes to sexual health
c. discrimination/being treated differently
d. stigma around sexual health
e. not wanting to discuss my sexual health with others
f. not trusting medical professionals here
g. staff not being friendly
h. lack of privacy (e.g., other people hearing what you say when speaking to reception staff about your visit)
i. lack of confidentiality (e.g., fear of personal information being shared with others)
j. not wanting to discuss my sexual health with a professional who is not from my ethnic background k. language barrier
l. health professionals being insensitive or dismissive
m. services not being inclusive
n. cultural beliefs, values and attitudes
o. religious beliefs
p. inefficient booking appointments and drop in systems
q. lack of understanding of the UK health system in general
r. family not being supportive
s. fear to be judged by health professionals
t. fear to be judged by the community
u. other - please specify _____

8. What do you think sexual health services should do to encourage BAME young people to access local sexual health services? How could the local sexual health services be improved?
Recommendation 1_____
Recommendation 2_____
Recommendation 3 _____
Recommendation 4 _____

9. How would you rate your knowledge of sexually transmitted infections (STIs). Use the slider to answer this question (0 being very bad, 50 neither bad not good, 100 excellent).

10. Can you tell us what you know about Sexually Transmitted Infections (STIs)? Answer each question using your own words:
a. what are STIs?
b. where did you learn about STIs?
c. what are the symptoms/signs of STIs?
d. how can you prevent STIs?
e. how do you test for STIs?
f. what are the treatments for STIs?

11. How old are you?

12. What is your gender identity?
a. female
b. male
c. non-binary
d. prefer not to say
e. other (please specify) _____

13. Is your gender identity the same as the gender assigned to you at birth?
a. yes b. no c. not sure d. prefer not to say

14. How do you prefer to describe your sexual orientation?
a. straight b. gay c. lesbian d. bisexual e. prefer not to say
f. other (please specify) _____

15. Do you consider yourself to have a disability?
a. yes b. no c. prefer not to say

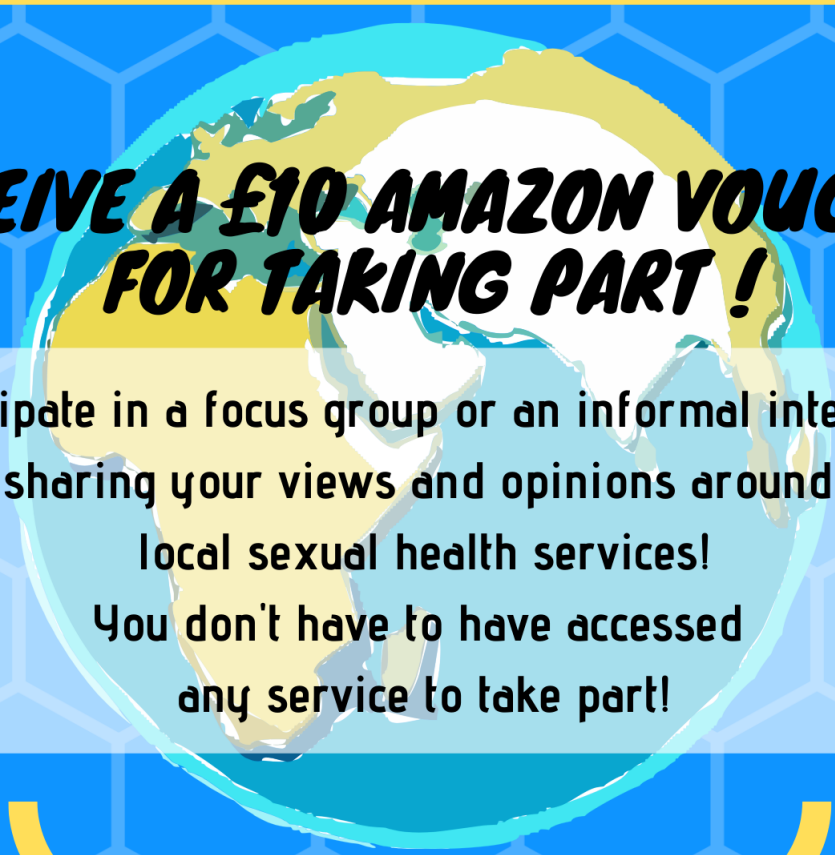
16. How would you describe your race or ethnic background?
a. White British b. White Irish c. Other White d. Black British e. Black African
f. Black Caribbean g. Other black h. Asian British i. Indian j. Pakistani
k. Bangladeshi l. Chinese m. Chinese British n. Other Chinese
o. Asian other p. Arab q. Mixed White and Black African
r. Mixed White and Black Caribbean s. Mixed White and Asian t. Other Mixed
u. Other - please specify _____

17. Do you have any religious belief?
a. No religion b. Agnostic c. Buddhist d. Christian e. Muslim f. Hindu
g. Jewish h. Sikh i. Prefer not to say j. Other - please specify _____

Appendix 4:
Posters and Leaflets

ARE YOU A YOUNG PERSON
AGED 17-25 FROM A BAME
(BLACK, ASIAN, MINORITY ETHNIC) BACKGROUND?

DO YOU WANT TO GET YOUR VOICE HEARD AND HELP SHAPE SEXUAL HEALTH SERVICES IN BRIGHTON AND HOVE ?



RECEIVE A £10 AMAZON VOUCHER FOR TAKING PART !

Participate in a focus group or an informal interview
sharing your views and opinions around
local sexual health services!
You don't have to have accessed
any service to take part!

INTERESTED?
Email: elena.gelibter@ymcadlg.org

YMCA RIGHT HERE
Young people promoting health and wellbeing through education, campaigning and influencing

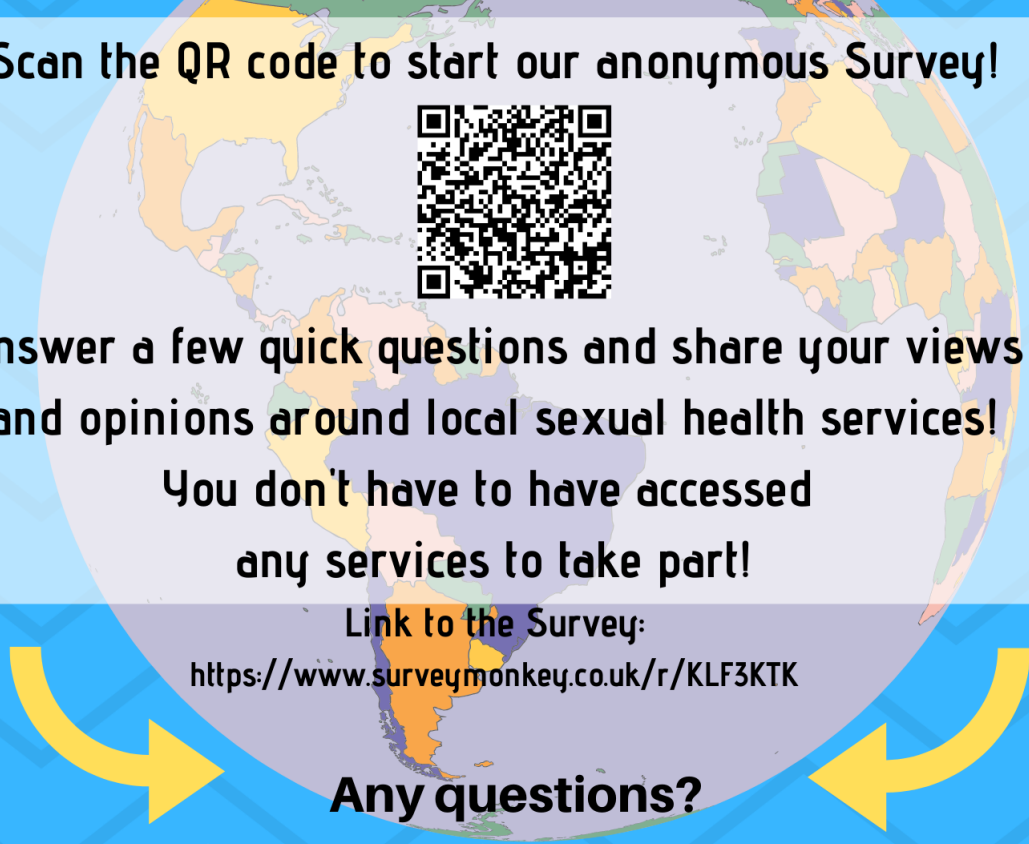
Young healthwatch Brighton and Hove

Appendix 4:
Posters and Leaflets

ARE YOU A YOUNG PERSON
AGED 17-25 FROM A BAME
(BLACK, ASIAN, MINORITY ETHNIC) BACKGROUND?

DO YOU WANT TO GET YOUR VOICE HEARD AND HELP SHAPE SEXUAL HEALTH SERVICES IN BRIGHTON AND HOVE ?

GET A CHANCE TO WIN A £50 AMAZON VOUCHER!



Scan the QR code to start our anonymous Survey!

Answer a few quick questions and share your views and opinions around local sexual health services!
You don't have to have accessed any services to take part!

Link to the Survey:
https://www.surveymonkey.co.uk/r/KLF3KTK

Any questions?

Email: elena.gelibter@ymcadlg.org

YMCA RIGHT HERE
Young people promoting health and wellbeing through education, campaigning and influencing

Young healthwatch Brighton and Hove