

When and Why Do Young People in the United Kingdom First Use Sexual Health Services?

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CONTEXT: Many young people think about and take steps to obtain adequate protection only after having sexual intercourse for the first time. Consequently, they are at increased risk of unintended pregnancy and sexually transmitted infections.

METHODS: Between June and August 1999, a self-administered questionnaire was distributed to attendees at UK youth-targeted sexual health services to investigate when and why they first use a sexual health service, reasons for delaying use, and sexual behavior and contraceptive practice before first use.

RESULTS: Of the 747 respondents, 29% had used a sexual health service before ever having sex, most commonly "to be prepared." In contrast, 61% of respondents had used a service after sexual debut; some of these had obtained condoms elsewhere (25% of women and 33% of men who gave a reason for delay) or had not known about services or their location (11–19%). Among the women, 20–24% had been embarrassed or scared, or concerned about confidentiality or age; 32% had visited a provider because they had had unprotected sex. Sixty-three percent of men who had delayed using a service reported that the ability to obtain free condoms had prompted their first visit. Only 43% of respondents who postponed service use had practiced contraception consistently before visiting a provider.

CONCLUSIONS: Young people need to be realistic about the possibility of having sex. Service use could be increased by providing more youth-specific services and by improving publicity and links between the youth, education and health sectors to dispel fears and myths about services.

Perspectives on Sexual and Reproductive Health, 2003, 35(3):114–120

For young people's sexual health services to be effective, they must be user-friendly, nonjudgmental, accessible, approachable and confidential.¹ They also must provide a range of services for both men and women,² and above all, they should be deemed appropriate and acceptable by young people in the locality.³ In the United Kingdom, youth-oriented sexual health services are often delivered from venues other than health care settings that are accessible and acceptable to young people, such as youth centers, general advice centers, town halls, schools and fitness clubs. Although they vary in their approach, such services offer contraceptive information, advice and products, and many provide specialized counseling services.

The number of UK sexual health services for young people has increased steadily over the past decade as a result of the government's 1990 Health of the Nation initiative, which aimed at halving the pregnancy rate among women younger than 16 by the year 2000,⁴ and the current gov-

ernment's 1999 plan to halve the pregnancy rate among women younger than 18 by 2010.⁵ Local audits have shown good client uptake,⁶ and evidence from the census ward level has revealed that youth-oriented services are effective in reducing the rate of teenage conceptions.⁷

In addition to specialized sexual health services for young people, generic family planning clinics, genitourinary clinics and general practitioners are increasingly serving young people. Health, education and social sectors also are collaborating to serve youth, in response to a government report in 1999 that stressed the need for an integrated approach to reducing teenage pregnancy rates.⁸

However, despite the wide availability of free and confidential contraceptive services to youth of all ages in the United Kingdom,* not all young people use contraceptives consistently.⁹ Although the first National Survey of Sexual Attitudes and Lifestyles (Natsal), conducted in 1990, revealed an increase in condom use at first intercourse among successively younger cohorts, preliminary findings from Natsal 2000 show that one in five sexually experienced people aged 16–24 did not use a condom at first intercourse.¹⁰ Furthermore, among sexually experienced people aged 16–24, only 39% of men and 24% of women reported condom use at last sex in Natsal 1990;¹¹ among those aged 16–44, 24% of men and 18% of women said in Natsal 2000 that they had used a condom during all occasions of in-

*Adults, defined as people older than 18, are usually regarded as competent in deciding their own treatment, and the Family Law Reform Act of 1969 gives the right to consent to treatment to anyone aged 16–18. A health care professional can also give contraceptive advice and treatment to someone younger than 16, if the professional is satisfied that the young person is able to understand fully what is proposed. Guidance on this policy was issued in 1985, following the House of Lords ruling in the case of *Gillick v. West Norfolk and Wisbech Health Authority and the Department of Health and Social Security*.

tercourse in the previous four weeks.*¹²

Adolescents, in particular, do not use contraceptives consistently. In a survey of students in higher education, one-quarter of sexually active 16–19-year-olds had never or only rarely used condoms with their current partner.¹³ In addition, a nationally representative study of men and women aged 16–55 who had ever had sex found that roughly one in five 16–17-year-olds had ever had unprotected sex with a new partner, thereby putting themselves at risk of both pregnancy and sexually transmitted infections (STIs).¹⁴ Identifying barriers to obtaining and using contraceptives among young people is thus important in promoting consistent method use.

For example, sexually active people younger than 16 are more likely than other age-groups to find obtaining contraceptives difficult.¹⁵ With an ever-increasing proportion of young people becoming sexually experienced before age 16, this problem cannot be ignored. In Natsal 1990, 16% of women and 25% of men aged 16–24 had had sex before age 16, compared with only 2% of women and 10% of men aged 45–59 at the time of interview.¹⁶ More recent estimates suggest that up to one-third of British 16–19-year-olds were sexually experienced before age 16.¹⁷

Understanding when and why a young person first uses a sexual health service could help in increasing contraceptive use, especially at first intercourse. Sizable proportions of young people in the United States have sex for the first time before seeking contraceptive help from a recognized source.¹⁸ Analyses of data from the U.S. National Survey of Family Growth revealed that just 24% of sexually experienced women interviewed in 1978 and 21% in 1995 had made their first visit to a family planning clinic before first intercourse. Furthermore, the median interval between first intercourse and first clinic visit among women who became sexually active between 1991 and 1995 was 22 months.¹⁹ In the United Kingdom, anecdotal evidence from the London branches of the Brook Advisory Centres[†] reveals that on average, women delay going to a family planning clinic for approximately six months after first intercourse. Additionally, data from a survey of attendees at young people's sexual health services in Southampton and Southwest Hampshire show that almost 80% of sexually experienced young men and women had first used a sexual health service for advice or contraceptives after they had had intercourse; the median delay was two months.²⁰

According to an analysis of personal accounts of sexual development, many young people initiate sexual intercourse but start to think about and obtain adequate protection only after accepting their new status.²¹ As a result of this delay, young people are at risk of unintended pregnancy: An audit at the London-based Brook Advisory Centres found that almost one-half of first-time clients younger than 16 obtained a pregnancy test or emergency contraceptives.²² In a more general survey among school pupils in the Lothian region of Scotland, one-third of sexually active women younger than 16 had ever used emergency contraceptives.²³

Although much research in the United Kingdom has ex-

amined contraceptive behavior among young people, little is known about their first use of sexual health services. It remains unclear if young men and women who delay obtaining services until after first intercourse do so out of a lack of knowledge about the availability of services, because of anxiety about visiting a provider or because they are using commercially available contraceptives and thus feel they do not need to see a provider. The aim of this study was to investigate when young people first use sexual health services, factors that prompt service use and, among those who delay use until after sexual debut, reasons for the delay, and sexual behavior and contraceptive use before their first visit.

METHODS

We used purposive sampling techniques to study current attendees at young people's sexual health services in the United Kingdom. After ranking health authority districts (administrative units of the National Health Service) by their rates of conception among women aged 13–15 during 1994–1996, we divided the districts into quintiles and used stratified random sampling by race and population density to select three districts from the first quintile and three from the fifth quintile that had comparable demographic compositions. The final sample included two rural and four urban districts; two of the urban districts had racially diverse populations.[‡]

Semistructured interviews were initially conducted with 41 people aged 21 or younger who had visited any of 12 randomly chosen sexual health services in the study districts (two in each district) between February and March 1999. Two researchers independently analyzed the survey responses and identified themes, which we used to design a four-page self-administered questionnaire; the questionnaire was approved by the National Health Service South and the West Multicentre Research Ethics Committee, as well as by the nine local research ethics committees that had jurisdiction over the study districts.

The questionnaire was distributed to all youth-oriented sexual health services in the six study districts—a total of 27 establishments. During a two-month period between June and August 1999, the receptionist at each service site asked all clients to complete the questionnaire on arrival, explaining that replies were confidential and that participation did not affect the provision of services. To maintain anonymity, participants were requested to place their replies in unmarked envelopes and to deposit them in reply boxes.

Attendees were asked to supply demographic information and to indicate whether they had been sexually experienced and, if so, how old they were at first intercourse, how long they had been seeing their first partner before inter-

*Natsal 2000 has yet to publish this figure disaggregated by age.

†The Brook Advisory Centres is a registered charity and the only national voluntary-sector provider of free and confidential sexual health advice and services specifically for people younger than 25.

‡Rurality is defined by population density; racial composition was determined using 1991 census data.

TABLE 1. Percentage distribution of attendees aged 21 or younger at specialist youth service sites, by selected characteristics, United Kingdom, 1999

Characteristic	% (N=747)
Gender	
Male	11.2
Female	88.8
Age	
<14	3.6
14–15	23.6
16–17	40.7
18–19	22.6
20–21	9.5
Receiving education	
Yes	71.5
Secondary school	31.6
Sixth-form college†	30.7
University	9.2
No	25.8
Employed	18.6
Unemployed	7.2
Other‡	2.7
Race	
White	95.4
Black	2.9
Other	1.6
Social deprivation of residential area§	
Very low	8.4
Low	7.5
Average	11.5
High	20.9
Very high	51.6
Sexually experienced	
Yes	90.1
No	9.9
Ever used a sexual health service	
Yes	89.7
After first sex	61.2
Before first sex	28.5
No	10.3
Total	100.0

†Institutions that specialize in the highest two grades of secondary school and vocational training. ‡Full-time caregiver or at home. §Among 651 respondents who provided a valid postal code, which was allocated a social deprivation score, on the basis of socioeconomic indicators of census wards.

course and whether they had ever used a sexual health service. The questionnaire also asked whether the first time they used a service was before or after first intercourse and what type of service provider was visited. Attendees who had ever used a sexual health service were requested to indicate the reasons for their first visit and the services they received, choosing from a list of responses or writing in others, as well as to recall the length of time between first intercourse and their first visit, or vice versa. Respondents who had first used a service after sexual debut were asked to report the reasons for not having used a service before first intercourse, again choosing from a list of reasons or writing in others. The questionnaire asked these respondents to indicate the number of times they had had sex before using services and how consistently they had used contraceptives.

Questionnaire responses were coded and entered into

a Microsoft Access database. We used SPSS version 10.0 to perform chi-square testing to determine whether the type of service provider seen at the first visit and reasons given for delaying their visit until after first sex were associated with the client's age.

RESULTS

Sample Characteristics

Because we deemed it unethical to collect information from attendees who chose not to participate in the study, we could not weight the dataset for nonresponse. In addition, the task of defining each establishment's catchment area and hence population served proved to be logistically very difficult. Nevertheless, the questionnaire was distributed at a variety of settings—youth centers, health centers and one-stop drop-in advice centers*—that provide sexual health services to diverse groups of young people within areas of varying levels of social deprivation.† We therefore believe that the sample represents a cross-section of attendees.

A total of 996 attendees returned questionnaires; 11% of the respondents were male and 89% female. Respondents' ages ranged from 11 to 39, with median and mean ages of 17 and 18, respectively. In an effort to reduce recall bias regarding the timing of, and reasons for, the first visit to a sexual health service provider, we excluded from further analysis respondents older than 21, as well as those who provided incomplete or inconsistent information about their use of a service. As a result, 747 respondents remained in the study sample. However, the exclusion of respondents did not affect the overall gender composition of the sample (Table 1).

The mean age of the attendees in the final sample was 17, with no significant difference between males and females (not shown). Twenty-seven percent were younger than 16—26% of females and 35% of males (not shown). Roughly three-quarters of respondents were receiving full-time education—32% at secondary school, 31% at sixth-form college‡ and 9% at university—and nearly all (95%) were white. About one-half of the 651 attendees who provided postal codes were living in areas classified as having very high social deprivation, whereas only 8% were living in areas with very low social deprivation.

The vast majority (90%) of respondents were sexually experienced—93% of males and 90% of females (not shown). Furthermore, nine in 10 respondents had ever used a sexual health service; the remainder had never used such

*Among the innovative approaches to delivering contraceptives and sexual health advice to young people in the United Kingdom, one-stop drop-in advice centers offer young people information, counseling and advice on a range of issues, such as housing, employment, addiction, relationships and sexual health.

†Levels of social deprivation were measured by assigning scores to census wards, on the basis of socioeconomic indicators from census data, such as unemployment levels, the number of households with no car and extent of overcrowding.

‡In the British educational system, sixth-form colleges are institutions that specialize in the highest two grades of secondary school and vocational training. (Most sixth-form college students are aged 16–18.)

a service but may have visited a facility to accompany a friend.*

When and Where Youth First Used Services

Sixty-one percent of the sample had used a sexual health service only after having had intercourse for the first time (Table 1). In contrast, 29% reported having visited a service before they had first sex—29% of men and of women (not shown). Younger adolescents were more likely than older youth to have sought help before sexual debut: Among respondents who reported having had first intercourse when they were younger than 16, 21% of those currently aged 18 or older used a sexual health service before first sex, compared with 24% of those aged 16–17, 26% of those aged 14–15 and 43% of those younger than 14.

Of the respondents who had ever used a sexual health service, 50% had visited a specialist youth-oriented service site on the first occasion, 33% a generic family planning clinic and 17% a general practitioner (Table 2). As the age at first visit increased, so did the proportion of respondents who went to a family planning clinic or general practitioner; however, the proportion who visited a youth-targeted service site decreased. Although these findings reflect the recent expansion in specialist youth services, they also suggest that young teenagers find these services acceptable.

Reasons for the First Visit

• *Reasons for visiting before first intercourse.* Of the 148 attendees (10% males and 90% females) who had first visited a service site before first intercourse and who indicated reasons for seeking help, 87% of men and 69% of women reported that they had wanted “to be prepared.” In addition, 36% of women had wanted “to obtain information and advice,” 27% had visited because they had planned or expected to have sex soon and 14% had attended “out of curiosity.” Among the men, 20% had visited because they were curious and 20% because they wanted information and advice.

Analysis of respondents’ reports of the length of time that they had been going out with their partner before having intercourse with that partner and the period between the first visit and first sex revealed that 70% of young people who had gone to a service site before first sex subsequently had intercourse with the partner they were seeing when the visit occurred. For 30% of the respondents, the relationship began after the visit.

A total of 203 people who used a service before sexual debut reported the type of service received. All 22 men said they had obtained condoms; one man had also received help and advice. Of the 181 women, 65% had obtained condoms, 51% the pill and 2% the injectable; 14% reported having received help and advice.

• *Reasons for visiting after first intercourse.* Among the 402 attendees (8% males and 92% females) who had delayed their first visit until after first intercourse and who indicated reasons for seeking help, men most commonly reported having wanted to obtain free condoms as the reason for

TABLE 2. Percentage distribution of youth who had ever used a sexual health service, by type of provider seen at first visit, according to age at first visit

Age	N	Youth service	Family planning clinic	General practitioner	Total
All	602	50.2	32.7	17.1	100.0
<14	81	60.5	24.7	14.8	100.0
14–15	279	53.4	33.3	13.3	100.0
16–17	199	44.7	34.2	21.1	100.0
18–19	43	34.9	37.2	27.9	100.0

$\chi^2=15.0^*(df=6)$

* $p<.05$. Note: Excluded are 58 respondents who did not report the service first used, four who had first used a service at age 20–21 and six who had visited a hospital emergency department.

their visit (cited by 63%); 10% had wanted “to be prepared” for sex with a new partner and 13% had been encouraged by others to attend. In contrast, women most commonly reported having visited a service site because they had had unprotected sex (cited by 32%); only 21% of women had wanted to obtain free condoms. In addition, 26% had wanted to switch methods, 25% had sought help because of contraceptive failure, 14% had been encouraged by others to attend and 12% had wanted “to be prepared.”

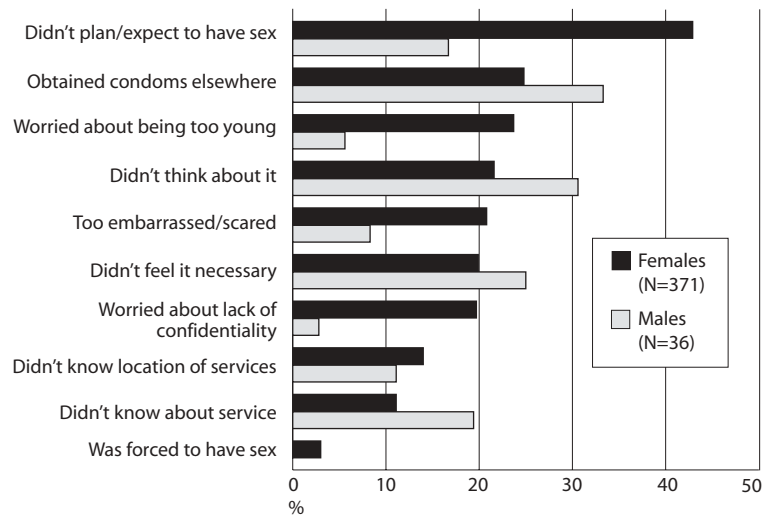
Twelve percent of women had visited a service provider to obtain a pregnancy test, including 19% of those who cited having had unprotected sex as a reason for attending. The proportion who had attended because of suspicion of pregnancy was significantly higher among those younger than 16 than among those aged 16 or older—16% vs. 7% ($p=.04$).

Among women whose first visit to a service site followed their initiation of sex, 40% had obtained emergency contraceptives at that visit, 37% oral contraceptives and 45% condoms. Women who had received emergency contraceptives included roughly two-thirds of those who said that unprotected sex was a reason for their first visit and roughly three-quarters of those who cited contraceptive failure. Further exploratory analyses of women who attended a service site for contraceptive failure or unprotected intercourse failed to reveal any significant differences for any of the indicators available between those who obtained emergency contraceptives and those who did not.

• *Reasons for not visiting before first sex.* In all, 407 respondents (9% males and 91% females) who used a service after first sex gave a reason for delaying their visit. The most commonly reported reason among the women was that they had not planned or expected to have sex (43%—Figure 1, page 118). One-quarter of women indicated that they had gotten condoms from places other than a sexual health service, and 20–24% reported that lack of confidentiality, embarrassment or fear, or young age had made them delay using services. In an analysis of reasons for delaying service use by client’s age

*The questionnaire read “Listed below are some of the sex advice services where you can get help about sex, contraception, sexually transmitted infections, etc. Which have you ever visited to get contraception and/or advice about sex for yourself (not just to accompany a friend)?” Respondents who had never used a service checked the option “I have never visited any service for contraception/advice for myself.”

FIGURE 1. Percentage of youth who had first used a sexual health service after first intercourse, by reported reasons for the delay, according to gender



(not shown), women younger than 16 were more likely than those aged 16 or older to report having not known about services (14% vs. 5%; $p=.04$). They also were more likely to cite concerns about age (34% vs. 5%; $p<.001$) and about confidentiality (25% vs. 12%; $p=.001$).

Men most commonly indicated that they had postponed using a sexual health service because they had obtained condoms elsewhere (33%), had not thought about using a service (31%) or had not felt it necessary to seek help (25%). These findings are not surprising, given that condoms are widely available from both commercial and non-commercial sources.

Both men and women who had delayed their first visit to a service provider until after first intercourse reported that they had lacked knowledge about services: Nineteen percent of men and 11% of women had been unaware of the services that were available, and 11% of men and 14% of women had not known where services were located.

Sexual and Contraceptive Behavior Before First Visit

Young people who had delayed their first visit to a sexual health care provider were asked to recall details about their sexual and contraceptive behavior between the first time

TABLE 3. Percentage distribution of youth who had first used a sexual health service after first intercourse, by contraceptive behavior before visit, according to number of episodes of intercourse before visit

No. of episodes	N	Never used	Used consistently	Used inconsistently†	Total
All	344	26.7	43.2	30.1	100.0
1	88	58.0	42.0	na	100.0
2-3	83	25.3	48.2	26.5	100.0
4-5	49	14.3	46.0	39.7	100.0
6-10	43	9.3	43.2	47.5	100.0
>10	81	11.1	37.9	51.0	100.0

†At least one episode of sex was protected and one unprotected. Note: na=not applicable.

they had intercourse and their first visit.

• *Extent of delay.* The interval between first sex and first visit for the 398 respondents who provided this information (of whom 9% were males and 91% females) ranged from less than one day to six years. One-fifth of the women had visited a service site within 72 hours of first intercourse; 77% of these had obtained emergency contraceptives because of contraceptive failure or unprotected sex. By one month, one-half of the women had used a service, and by six months, three-quarters had done so. Among male respondents, one-fifth had used a service within one week of first sex and one-half within four months.

• *Episodes of intercourse.* It is deceptive to just examine the time period between first sex and first visit to a service site, given that an individual may engage in first intercourse but no subsequent episodes thereafter. We therefore examined the number of acts of intercourse that occurred before the initial visit among respondents who had used a service after sexual debut. One-quarter of the 366 respondents who replied to this question reported having had sex only once before visiting a provider. A further one-quarter first visited a provider after having engaged in intercourse two or three times. In contrast, almost one-quarter of respondents had delayed visiting a provider until after engaging in intercourse more than 10 times.

• *Contraceptive use.* Of greater interest, however, is young people's contraceptive behavior between first sex and initial visit. Among respondents who had delayed visiting a provider, 344 gave information on contraceptive use before their first visit. More than one-half (57%) of these young people had had unprotected sex at least once—27% who had not used a contraceptive method before the first visit, which included 11% of those who had had intercourse more than 10 times, and 30% who had practiced contraception sporadically (Table 3). Four in 10 respondents had used a method for all episodes of intercourse.

DISCUSSION

The main study limitation is that we sampled only young people visiting clinics offering youth-oriented sexual health services. We recognize that other institutions and groups, such as schools and youth workers, provide general sexual health information and advice, as well as some forms of contraception, to young people. Furthermore, condoms are widely available and can be obtained easily. Hence, young people who obtain contraceptives from sources other than specialist youth services are underrepresented in the sample. Nevertheless, our findings shed light on an important and policy-relevant set of concerns. The majority of attendees at youth-oriented sexual health services had used a sexual health service after having had intercourse for the first time, commonly delaying the use of services by several months.

Having had unplanned or unexpected sex, embarrassment or fear, and concern about confidentiality and about being too young were common barriers among women who had delayed using a service, especially among those younger

than 16. Lack of knowledge regarding the location or availability of services was frequently mentioned by both men and women. These results highlight the need not only to provide greater information on the location of services, but also to reassure young people (particularly those younger than 16) of the usability and confidentiality of services.

As expected, both men and women reported that having obtained condoms from sources other than a sexual health service was a reason for not visiting a service site before first intercourse. Even though many sexual health care providers not only supply condoms and pills, but also provide a holistic service that includes education and counseling, young people may not rely on them as their first source of protection against pregnancy and STIs. Instead, many youth choose the easier and less-threatening option of using a vending machine or visiting a local store or pharmacy.

Our study also has shown that the supply of free condoms can influence first service use especially among sexually experienced men. In contrast, having had unprotected sex or experienced contraceptive failure (e.g., condom breakage or slippage) is a major trigger for sexually experienced women to visit a provider, probably reflecting their fear of pregnancy and infection. However, 23% of women who had visited a service site within 72 hours of sexual debut because of contraceptive failure or nonuse continued to be at risk of pregnancy because they did not obtain emergency contraceptives.

A prolonged delay in using sexual health services after first sex may represent a period of continued risk-taking behavior, of intercourse during which nonprescription methods of contraception are used effectively or of no further intercourse. Our findings indicate that when sex does occur again before service use, contraceptive use tends to be sporadic—57% of people who had delayed use had engaged in unprotected intercourse at least once.

There is some encouraging evidence that younger cohorts increasingly visit services before engaging in first intercourse, possibly because of the increasing availability of specialist youth services; it is, however, too soon to say if this trend will be sustained. Use of a sexual health service before intercourse is associated with increased contraceptive protection at first intercourse,²⁴ suggesting that increasing client uptake before first sex among younger age groups is key to decreasing teenage pregnancy rates.

Young people's use of sexual health services before sexual debut may be increased by providing more youth-specific services and one-stop drop-in advice centers. Furthermore, fears and myths regarding the use of services must be dispelled by media advertising (e.g., to raise awareness of confidentiality), increased community acceptance of young people's need for special services and strengthened links between the youth, education and health sectors. For example, visits to the local sexual health service could be incorporated as part of school sexuality education classes, or service providers might consider inviting a young person's drama or media group to produce an educational video to distribute to schools and youth groups in the neighborhood. Alternatively, schools and youth groups could

organize introduction days, when future users meet service personnel, including receptionists, thereby reducing concerns among younger individuals about the adults they are likely to meet.

However, embarrassment and fear about lack of confidentiality are sustained only through a social context in which young people's sexuality is stigmatized. Comfort in using services effectively will be fully achieved only when familial and social contexts change. For example, parents and other adults need to be realistic about young people's emerging sexuality. Early teenage years are a time for sexual exploration and experimentation: Young people are learning about their bodies and experiencing new sensations; often, only after having had sex do they think about the consequences. Parents may therefore benefit from guidance and advice on how to address the topic of sexuality with their children, and schools might consider holding discussions during sexuality education classes about the realities of sex—including that many young people do not anticipate having intercourse.

Comparative research on sexual and reproductive health among youth in different countries has clearly demonstrated that greater acceptance of young people's emerging sexuality is not associated with increased levels of sexual activity, but is associated with improved sexual health.²⁵ Removing some of the barriers to effective service use is as much a challenge to health care professionals as is improving knowledge and skills among young people.

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Acknowledgments

The authors thank the service personnel who found time in their busy schedules to distribute the questionnaires and the UK Department of Health and the Brook Advisory Centres for funding the study.

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