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Understanding young people's use and non-use of condoms and contraception

A co-developed, mixed-methods study with 16-24 year olds in Scotland

Final report from CONUNDRUM (CONdom and CONtraception UNDERstandings: Researching Uptake and Motivations)

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#ProjectCONUNDRUM
@theSPHSU

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Foreword

I am delighted to welcome this timely and vital research, carried out by the MRC/CSO Social and Public Health Sciences Unit, University of Glasgow, and co-produced with young people, on their experience of using condoms and contraception. Condoms and contraception are essential foundations of good sexual and reproductive health and wellbeing for our young people, and understanding their views and attitudes toward them help us to better offer them the support that they want and need.

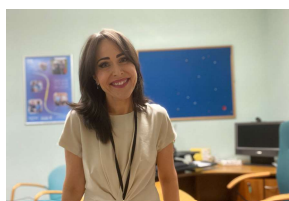
In Scotland we have much to celebrate in the good progress made over the last 10 years in our support for young people around pregnancy choices, and the positive impact this has made. However there is still much more for us to improve in relation to the sexual health of young people in particular. Increases in sexually transmitted infections such as gonorrhoea and chlamydia and socio-economic inequalities in relation to unplanned pregnancy and its outcomes remain of great concern. In this context it is notable that young people's use of condoms and the most effective methods of contraception have decreased in recent years. Understanding the reasons for these decreases is crucial to ensuring that we can shape service and information provision to best meet the needs of our young people and support their right to good sexual health and relationships.

This has never been more important as we work towards recovering sexual health provision from the impacts of the COVID 19 pandemic. This research was initiated in 2019 prior to the pandemic, and the research team have done an excellent job in adapting both the research methods and the content of the research to the current context of living with COVID 19, ensuring that young people's voices are still being heard.

As with many health services, COVID 19 has been the catalyst for significant and in some cases positive changes in service access models for providers of contraception and condoms such as sexual health services, pharmacies and GP practices. However, it has also highlighted pre-existing barriers to access which the pandemic has compounded, and we have much work still to do to address these.

To ensure we are fully supporting our young people, it's absolutely vital that their voices are heard and meaningfully acted upon. This research, which has been fundamentally based on the participation of young people, as well as stakeholders from policy and practice, provides rich and essential insights into the needs of young people. It has also helped us to better understand what value young people place on their sexual health and wellbeing, and how we can work with them towards improved engagement and progress in this area. Going forward, it will help us shape our services in a way that responds to what young people have told us about how contraception and condom services should be designed and promoted, and will be invaluable in shaping our Women's Health Action Plan, our Sexual Health and Blood Borne Virus (SHBBV) Recovery Plan and our next SHBBV Framework.

I commend this research and would like to thank all of those involved, but especially those young people who took part. Without your participation this would not have been possible, and we want to continue to work with you to build a better future for your sexual health and wellbeing.



Professor Nicola Steedman
Interim Deputy Chief Medical Officer,
Scottish Government

A handwritten signature in black ink, appearing to read 'Nicola Steedman'.

Executive Summary

Background

- This report presents findings from CONUNDRUM – a study commissioned in 2019 by three Scottish NHS health boards, in partnership with Scottish Government, to provide insight into the social context shaping use and non-use of condoms and contraception among young people in Scotland.
- In particular, study commissioners sought answers to two *conundrums* regarding sexual health among young people in Scotland: why has there been a decrease in use of free condom schemes in some areas, and a decrease in the use of certain forms of long-acting reversible contraception?
- Using a systems perspective, CONUNDRUM was designed to improve understanding of three levels of influence shaping young people’s experiences of condoms and contraception: 1) sexual partners; 2) wider social networks (e.g. peers, families, and online); and 3) sexual and reproductive health services.
- CONUNDRUM was co-developed with over 100 sexual health stakeholders – including young people – who contributed to shaping the study priorities, methods, and recommendations for future sexual health policy and service provision.
- A combination of workshops, an online survey¹, and small group discussions were used to explore views and experiences of over 2,000 young people aged 16-24.
- A diverse range of young people participated in the study, including young people living in a wide variety of circumstances and locations across Scotland, and with a range of sexual and gender identities.
- COVID-19 was declared a pandemic approximately halfway through CONUNDRUM, necessitating both a shift to virtual methods for the remainder of the study, and consideration of the post-pandemic context during the development of study recommendations.

Key findings

Sexual risk perceptions and use of condoms and contraception among young people

- In sexual partnerships where pregnancy is possible, unintended conceptions appear to be of greater concern than contracting a sexually transmitted infection (STI).
- More survey respondents reported feeling in control of their pregnancy outcomes than their STI prevention practices.
- A perception of insulation from STI risk is described as common among young people, and particularly among those who exclusively have other-sex partners.
- Most (93.3%) intercourse-experienced¹¹ survey respondents had used a condom at least once, although more than one third had not done so the first time they had intercourse with their most recent partner.

¹ The online survey used convenience sampling, meaning these data should be viewed as indicative, and not representative, of 16-24 year olds in Scotland.

¹¹ We use this term to refer to respondents who reported having experienced sexual intercourse. In the survey, intercourse was defined as “a penis going into a vagina or anus”.

- Among those who had ever used a form of contraception to prevent pregnancy, three methods (pill, condoms, and implant) accounted for the majority of use in the past year.
- “Pulling out” (i.e. withdrawal) was reported by many young people, despite widespread awareness that it is not an effective method of STI or pregnancy prevention.

Multi-level factors shaping condom and contraception use among young people include:

Sexual partners

- Fundamental elements of sexual risk negotiation between partners, including conversations about current contraception use and recent STI testing, appear to be far from normalised among young people.
- Negotiating condom use with new sexual partners is often described as difficult. Uncertainties in how and when to engage in these conversations lays groundwork for interactions fraught with possibilities of pressure and coercion to not use condoms.
- Where pregnancy is a possibility, conversations about contraception are characterised by young people as typically brief, often awkward, and primarily focused on ascertaining that a contraceptive method is being used so that condoms are not needed for pregnancy prevention.
- Some young women express frustration about gender inequities in the work related to choosing, obtaining and using contraception.
- Young people of all genders agree that contraceptive users should be supported by their partners in their contraceptive decision-making.
- There is scope for improving support and communication between sexual partners by increasing knowledge and understanding among young people of all genders, including young men, about different contraception methods and experiences.

Information and influence within wider social networks

- Young people engage critically with different sources of information about condoms and contraception (e.g. NHS websites, friends, unknown others on social media), yet describe challenges navigating the complexity of incomplete or contradictory messages within this information landscape.
- Young people appear to feel more confident about their abilities to find information about condoms and contraception than being able to accurately assess the quality of information.
- Young people describe inadequate education at school about contraception methods other than condoms as an important missed opportunity.
- While many young people reportedly turn to official healthcare sources (e.g. NHS websites, GPs, nurses) for accurate information on condoms and contraception, they do not always trust that they will receive the most honest input (e.g. on side effects) from these sources.
- Personal accounts of contraceptive experiences (e.g. from friends and unknown others on social media) are differentiated from scientific evidence, but are sometimes valued as an additional layer of information in a decision-making process.
- Young people want information about condoms and contraception that is easily accessible, scientifically accurate, and honest – especially about potential side effects of certain methods, and the fact that finding condom/s or contraception they are satisfied with may take time.

- Improving young people’s trust in information produced by ‘official sources’ (e.g. Scottish Government, NHS) would require more sophisticated use of social media platforms (e.g. Instagram) and digital formats (e.g. video blogs of contraceptive consultations) by these organisations.

Sexual and reproductive health services

- Almost half (46.0%) of survey respondents did not know or were unsure where to access free condoms in their local area.
- Young people’s use of free condom services is further impeded by embarrassment about face-to-face interactions, concerns about anonymity, a perceived lack of understanding about condom sizes and fit, and perceived lower quality of free products.
- Many young people indicate preference for free condom services that require minimal face-to-face contact, with online ordering of condoms posted home by far the favoured option across all genders.
- The majority of intercourse-experienced survey respondents had never tried to access STI testing at a GP surgery or sexual health clinic.
- Approximately 1 in 3 intercourse-experienced young people indicated difficulty getting an appointment for contraception or STI testing.
- Approximately one third of survey respondents who had used contraception (including condoms) had never spoken about the method(s) with a health professional.
- Major barriers to accessing sexual health services include: long waiting times for consultations, stigma about being known to use sexual health services, lack of clarity on which specific services are available in different settings, and an insufficient number of specialised sexual health clinics.
- Clear preferences for consultations about contraception with a healthcare professional include an online booking system, and in-person discussions within a specialised sexual health service setting. Very few young people report preference for accessing contraception consultations via pharmacy services.
- Despite clear preferences for consultations about contraception in specialist sexual health settings, three-quarters of contraception-using survey respondents had their most recent consultation at a GP surgery.
- Causes for dissatisfaction with contraceptive consultations include feelings of being pushed towards certain methods, not being heard or respected, dismissal of side effects, a dismissal of interactions between contraception, other medication and health conditions, and limited time given to discussions.
- COVID-19 has disrupted young people’s access to, and use of, free condom and contraception services, leading to changes in sexual risk-taking and preventive practices, unwanted changes in contraceptive use, unmet need for STI prevention, and switches from freely provided to commercially sold condoms and contraception.ⁱⁱⁱ

ⁱⁱⁱ The timing of the survey (June-July 2020) presented an opportunity to ask respondents about the impact of COVID-19 on their experiences of accessing and using condoms and contraception during the early months of the pandemic.

Recommendations

Recommendations for future sexual health policy and provision were co-developed with 31 sexual health stakeholders – including young people, sexual health clinicians, and people involved in planning sexual health services.

Recommendations are organised into two stages, reflecting consensus among stakeholders that priority should be given to improving sexual health services and information before investing in efforts to increase use of services and information.

Collaborating with a diverse group of young people to think through development and delivery of each of the below recommendations will be key in reaching successful outcomes.

First stage recommendations (developing and strengthening information and services)

1. **Establish structures that facilitate the meaningful and ongoing involvement of diverse groups of young people in high-level strategic planning regarding sexual health improvement among young people in Scotland.** Facilitating young people's involvement in strategic planning might include establishing new structures (e.g. a young people's sexual health collective, network or task force), or bringing young people into existing policy structures that support strategic planning.
2. **Invest in nationally-coordinated digital communications infrastructure and strategy for sexual health to lay groundwork for successful youth-focused sexual health promotion,** including building a trusted social media presence with a large following among young people on high-use platform/s (e.g. Instagram). Digital communications strategy should be co-developed with young people and adequately resourced, including a staff role for a specialist in digital communications/social media management.
3. **Establish a nationally-coordinated website^{IV} providing a digital hub for sexual and reproductive health in Scotland,** including functionality to order free condoms, digital tools to facilitate contraception decision-making and STI testing, and sign-posting to local services and information tailored to location of user. To ensure the website is trusted and widely used by young people, it should be co-designed with young people (among other key groups for targeted sexual health promotion), promoted via social media, regularly reviewed and updated, and potentially supported by an app.
4. **Involve young people in a review of current operation of free condom distribution schemes across health boards to inform development of core standards and modes of operation for local delivery.** Review should include consideration of range of products, distribution outlets (including online ordering), and advertising.

^{IV} A national sexual health website already exists in Scotland (www.sexualhealthscotland.co.uk), but few young people participating in this study appeared to be aware of this. Further discussions are needed to ascertain whether to review, refresh and relaunch the existing website or whether to create a new one.

5. **Enhance understanding and training among sexual health service providers**, especially in general practice, about young people's experiences of contraceptive consultations to improve quality of these interactions.
6. **Collaborate with young people to review and streamline young people's access to sexual health services providing condoms, contraception and STI testing**, including working to improve information advertising service availability in different settings (e.g. specialist clinics, GP and pharmacy), improve referral between services, reduce the complexity of appointment booking, diversify choice of appointment mode (e.g. video, phone), and potentially expand models of service delivery.
7. **Further strengthen in- and out-of-school education (e.g. in schools, youth work settings) and support regarding condoms, contraception and STI testing, including via the national RSHP.scot resource**, to ensure young people of all genders have the knowledge and skills to negotiate positive sexual interactions, and prevent STIs and – if desired – pregnancy. Young people should be involved in reviewing and enhancing existing content, and co-developing any new resources or materials.

Second stage recommendations (expanding use of information and services)

8. **Develop a nationally-coordinated sexual health campaign** to promote use of free condom schemes and understanding among young people of all genders, including men, about different contraception methods and experiences. Campaign strategy and messaging should be co-developed with young people, communicated via social media (among other modes), and broadcast with sufficient frequency to ensure reach to new generations of young people.
9. **Invest in development of new, and wider promotion of existing, sexual health decision aids** (e.g. Contraception Choices, those relating to STI testing) to support young people's knowledge and informed decision-making, and provide health professionals with practical tools to discuss sexual health, including contraception and STI prevention, with young people.

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- Castlemilk Youth Complex
- CERT (Contraception: Education & Reform Team), Buchanan Institute, University of Edinburgh
- Govan Youth Information Point
- Hype Youth CLD, Livingston
- Izone Youth, Greenock
- Landed Peer Education Project, Wishaw
- Queen Margaret University
- Sexpression, Glasgow
- TRIUMPH network Youth Advisory Group, UK

Stakeholders from policy and practice:

- Barnardo's
- Condom Distribution Scheme network, Scotland
- Family Nurse Partnership
- Health Protection Scotland
- Healthy Respect team, NHS Lothian
- LGBT Youth Scotland
- Public Health Scotland
- Scottish Government Sexual Health and Blood-Borne Virus Policy Team
- Scottish Government Women's Health Plan Team
- Sexual Health Lead Clinicians Group, NHS
- Waverley Care (including Sx)
- Young Scot

Colleagues at the MRC/CSO Social and Public Health Sciences Unit, University of Glasgow:

- Michal Shimonovich, Oarabile Molaodi, Enni Pulkkinen, Fiona Caryl, Gillian Bell, Raquel Bosó Pérez, Susan Patterson, Susie Smillie.

A note on terminology used in this report

- **Contraception use:** We use this term to refer to use of methods (e.g. pill, implant, injection) to reduce the possibility of pregnancy, rather than the variety of other reasons that people might use these methods (e.g. menstrual regulation, to reduce acne). The focus on contraception use specifically for pregnancy prevention (i.e. rather than other reasons) was developed through consultation with study stakeholders, and specified at the start of the survey questions about contraception use.
- **Contraception work:** We use this term to refer to the time, effort and anxiety related to choosing, obtaining and using contraception.
- **Gender-related terminology:** In order to be inclusive of all genders, we worked with our stakeholders, including young people, to develop the question wording used to measure gender within the survey (for further details, see [Appendix B](#)). We report our survey results by three categories of gender: Women (which includes trans women); Men (which includes trans men); and 'Identifies gender in another way', which includes young people who identified as non-binary, preferred to self-describe, and preferred not to say. Approximately 4% of our survey sample reported identifying as trans.
- **Intercourse-experienced:** We use this term to refer to survey respondents who reported ever having experienced sexual intercourse. In the survey, we defined intercourse as "a penis going into a vagina or anus".
- **Scottish Index of Multiple Deprivation (SIMD):** The Scottish Index of Multiple Deprivation is an area-based measure of relative deprivation. SIMD looks at the extent to which an area is deprived across seven domains: income, employment, education, health, access to services, crime and housing. SIMD ranks 6,505 data zones from most deprived to least deprived, and groups them into categories. To simplify our analysis, we use SIMD quintiles, with each quintile representing 20% of data zones.

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Study background

Sexually transmitted infections (STIs) and unintended conceptions remain high among young people in Scotland [1]. Condoms are a commonly used form of STI and (where relevant) pregnancy prevention, and are available free of charge to young people in Scotland^v. Over the last five years, however, there have been strong indications that fewer young people in Scotland than before are using condoms [2], and young people's uptake of free condom services has decreased in some health board areas [3]. National data also suggest a decline since 2013/14 in use of some forms of Long-Acting Reversible Contraception (LARC), such as the implant, among people under 20 [4].

These changes raise important questions. Have young people's attitudes towards using condoms and contraception changed in recent years, and if so, why? What matters most for young people in accessing free condoms and contraception, and are these priorities being met? And, as digital communication and social media continue to evolve, how do young people navigate the complex array of information regarding condoms and contraception?

CONUNDRUM (CONdom and CONtraception UNderstandings: Researching Uptake and Motivations) emerged from conversations about these questions between sexual health decision-makers in Scotland. To inform their development of policies supporting young people's condom and contraceptive use, three NHS health boards (Greater Glasgow and Clyde, Lanarkshire, Lothian) in partnership with the Scottish Government, asked University of Glasgow to explore the social context shaping use and non-use of condoms and contraception for sexual intercourse^{vi} among young people in Scotland.

Study design: a co-developed, systems-informed approach

Our approach to CONUNDRUM was informed by two overarching principles, namely that the evidence generated through the research would be richest if:

1. Co-developed with sexual health stakeholders, including young people;
2. Informed by a view of young people's sexual health as shaped by a *complex system*.

Co-developing the study

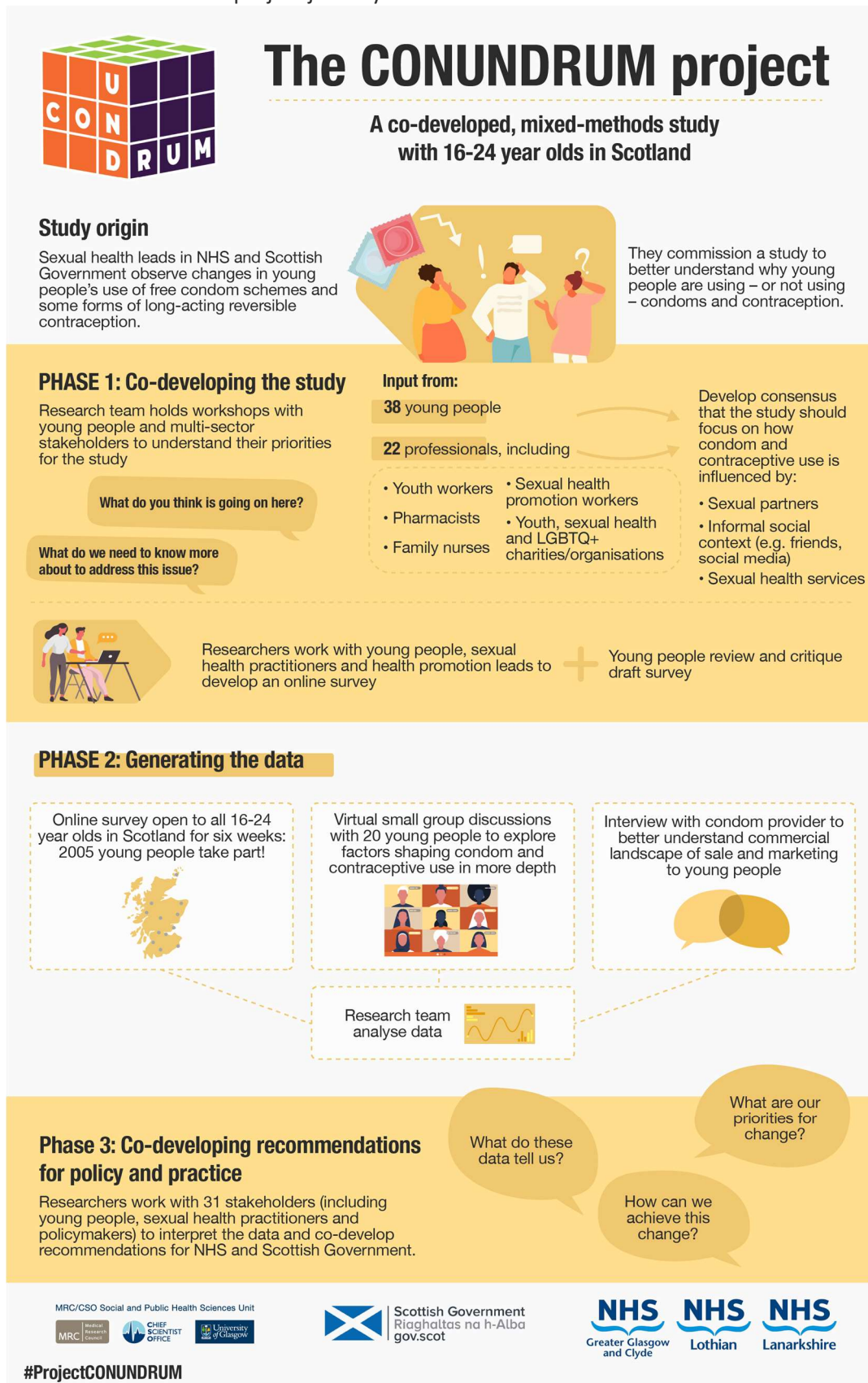
As a research team, we wanted to work *with* young people and other sexual health stakeholders (e.g. people who plan and provide sexual health information and services) to shape the study from start to finish. Therefore, we designed a multi-phase study that involved young people and other stakeholders in key decisions throughout, including working together to shape the study priorities, co-design research methods, and co-develop recommendations for future sexual health policy and service provision, based on the study findings. The CONUNDRUM project journey, including its co-development, is represented in Figure 1.

^v Service models for free condoms vary by health board across Scotland (e.g. options to access condoms by post are currently available in some health boards, but not others).

^{vi} As the study was initiated to inform policy development relating to STI and pregnancy prevention, study commissioners requested that the study focus on use of condoms and contraception for sexual practices carrying greatest risk of these outcomes (i.e. vaginal and anal intercourse).

Further details regarding these co-development processes and participants are provided in [Appendix A](#).

Figure 1. The CONUNDRUM project journey



A systems approach

Systems approaches are increasingly advocated as valuable frameworks for understanding public health challenges and evaluating their solutions because they “*encourage people to look at a bigger picture [...] by focusing their attention on how different agents - people, services, organisations, or whatever - interconnect and influence each other*” [5]. The emphasis is on understanding the system as a ‘whole’, rather than focusing exclusively on individual components [6].

Our use of a systems approach within CONUNDRUM is due to a basic, yet crucial, point: no one factor ‘causes’ young people to use or not use condoms or contraception. Rather, young people’s experiences in relation to condoms and contraception are dynamically shaped through their interactions with many different actors and contexts within a *complex system* that involves sexual partners, friends, families, education systems, health services, community and faith groups, digital environments, and so on. Not only does this complex system have many interrelated parts, it is also *continuously evolving* – whether that be due to social changes (e.g. changing gender norms regarding roles and responsibilities for sexual health), technological changes (e.g. development of new prevention technologies, growth of digital health services), political changes (e.g. cuts to funding for sexual health), global phenomena (e.g. COVID-19), and so on.

Building evidence and ways of working that allow us to engage with this complexity matter because “solutions” to improving sexual health are unlikely to be simple or located just in one part of a system. Improving relationships and sex education in schools, or innovating sexual health services, would – on their own – not be enough. Rather, assessing and rethinking the system in a way that better protects and promotes young people’s sexual health requires the action and collaboration of many different partners, and young people must be at the heart of these efforts.

As we wanted to develop evidence that could support systems thinking about young people’s changing use of condoms and contraception, our initial workshops with stakeholders (including young people) focused on understanding different features of the system (see Figure 5 and Figure 6 in [Appendix A](#) for a summary of stakeholder understandings). In these workshops, stakeholders identified questions about which they wished to know more, or believed evidence was lacking (see Figure 2 below). These questions were organised into three broad groups, including those relating to:



1) Sexual partners



2) Information and influence within the wider social context (e.g. peers, families, interactions online)



3) Sexual and reproductive health (SRH) services.

The consensus developed through the workshops was to focus the study on improving understanding of factors operating *within* and *across* these three levels of influence.

Figure 2. Stakeholders' priority questions for the CONUNDRUM project



In relation to **sexual partners:**

- Do young people feel confident and equipped to discuss condoms and contraception with the person/people they are about to have sex with? If not, what would help?
- What are the main barriers to negotiating condom use with a partner?
- What are young people's expectations about sharing responsibility for contraception? Is there any sign that traditional gender norms (e.g. that pregnancy prevention is women's responsibility) are changing?



In relation to information and influence within the **wider social context:**

- Where or who do young people look to for information and support about condoms and contraception?
- What kinds of information do young people trust?
- What is the influence of friends and families on perceptions and use of condoms and contraception?
- How are young people's beliefs regarding hormonal contraception and LARC shaped by non-clinical sources of information?



In relation to **sexual and reproductive health (SRH) services:**

- How do young people feel about free condoms? Is 'free' seen as a good or bad thing quality-wise? Does the brand matter?
- Where and how would young people like to be able to access free condoms?
- How do young people feel about ordering condoms online versus picking up in person?
- What are young people's experiences of interacting with clinicians about condoms and contraception? Who is 'getting it right'? What lessons can be learnt from others?
- Are SRH services as accessible as they can be to young people? What are the main barriers to accessing SRH services? What would help young people access SRH services more? What would the ideal service look like?
- How can community pharmacies support young people's STI and pregnancy prevention?

Study methods

As shown in Figure 1, and below, we used multiple methods to better understand young people's views and experiences of condoms and contraception, including in-person interactive workshops using drawing activities to generate discussion, small group discussions, and an online survey. We also interviewed a condom provider in order to explore commercial factors relating to product development and marketing of condoms to young people.

Data were generated between October 2019 and October 2020. Approximately halfway through this period (March 2020), COVID-19 was declared a pandemic and the UK went into its first lockdown. Consequently, fieldwork that was originally intended to be conducted face-to-face (e.g. small group discussions, workshops to co-develop recommendations) was adapted to take place online.

Further details about the characteristics of the young people who participated in small group discussions and the online survey are shown in Figures 3 and 4.

More information about the workshops with stakeholders (including young people) at the start and end of the project is presented in [Appendix A](#). More detailed information about the online survey and small group discussions is presented in [Appendix B](#).

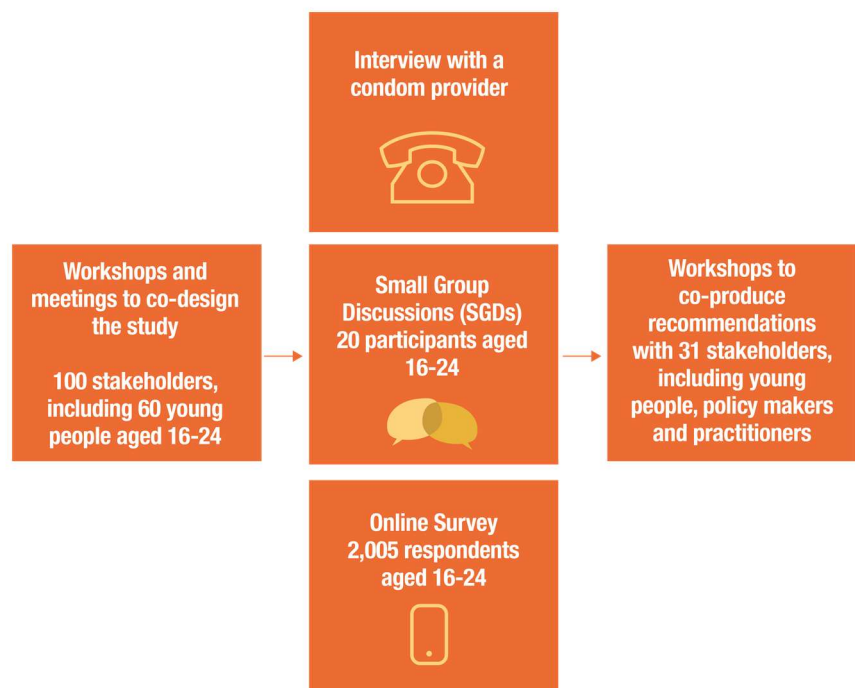


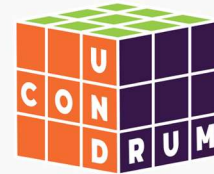
Figure 3: Key characteristics of small group discussion sample

SMALL GROUP DISCUSSION SAMPLE

- 5 online discussion groups
- 20 participants aged 16-24
- 4 mixed gender groups, 1 group of women
- 13 women, 6 men, 1 non-binary person
- Participants' self-reported sexual identities included heterosexual, bisexual, gay and queer

Figure 4: Key characteristics of online survey sample

The CONUNDRUM project: survey sociodemographics



Total survey sample:
2,005 young people aged 16-24 living in Scotland

HAVE YOU EVER HAD SEXUAL INTERCOURSE?*

- Yes 77%
- No 21%
- Prefer not to say 2%

AGE:

- 16-19 years old: 45%
- 20-24 years old: 55%

GENDER:

- Men (including trans men) 40%
- Women (including trans women) 56%
- In another way 4% (e.g. non-binary people, prefer to self-describe, prefer not to say)

DO YOU IDENTIFY AS TRANS?

- Yes 4%
- No 94%
- Not sure <1%
- Prefer not to say <1%

LIVING SITUATION IN LAST 12 MONTHS:

- With my family/carers (e.g. parent or guardian) 54%
- In a flat or house share 19%
- With my partner 12%
- In student accommodation 7%
- On my own 7%
- In supported accommodation <1%
- Experienced homelessness/ no fixed accommodation <1%

SEXUAL ORIENTATION:

- Asexual 2%
- Bisexual 16%
- Gay or lesbian 5%
- Heterosexual/straight 62%
- Pansexual 3%
- Queer 2%
- Multiple sexual identities** 6%
- Not sure 2%
- Prefer to self describe <1%
- Prefer not to say 1%

ETHNICITY:

- African, Caribbean, Black Scottish or Black British 2%
- Asian, Asian Scottish or Asian British 4%
- Mixed or multiple ethnic groups 3%
- Other ethnic group <1%
- White Scottish or White British 83%
- White but not Scottish or British 8%
- Prefer not to say/not sure <1%

DO YOU HAVE A DISABILITY, PHYSICAL OR MENTAL HEALTH CONDITION?

- Yes 21%
- No 73%
- Not sure 4%
- Prefer not to say <2%

PLACE OF RESIDENCE BY SIMD QUINTILES :

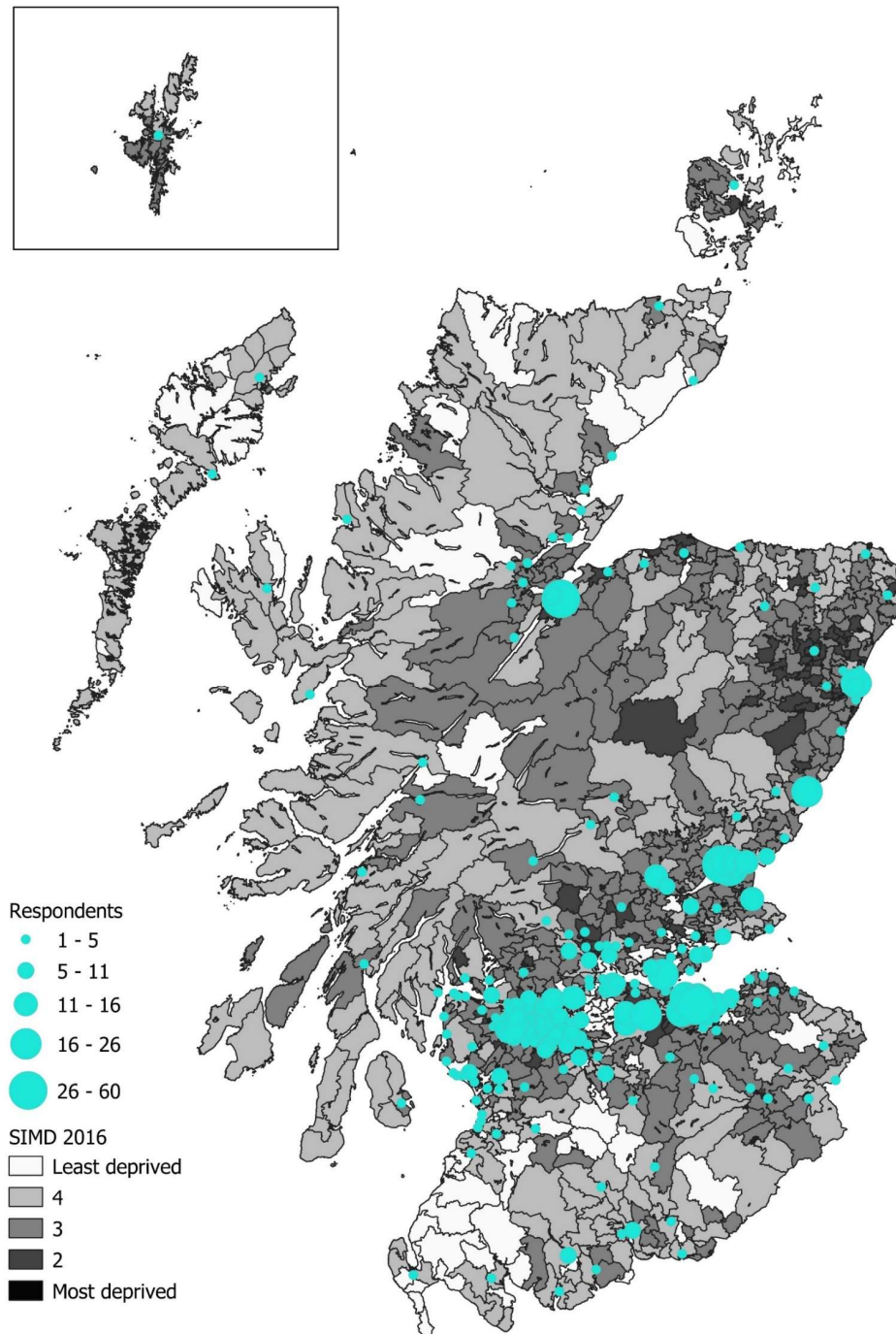
- SIMD 1 : 19% (most deprived areas)
- SIMD 2 : 18%
- SIMD 3 : 18%
- SIMD 4 : 20%
- SIMD 5 : 25% (least deprived areas)

*For the purposes of this study, we defined intercourse as "a penis going into a vagina or anus".

**Respondents that selected multiple options.

As seen in Map 1, young people from all over Scotland participated in the online survey.^{VII} Number of participants by health board area is presented in [Appendix B](#). Three of the four NHS health board areas with the highest number of survey respondents were those that commissioned the study (Greater Glasgow and Clyde, Lothian and Lanarkshire).

Map 1. Distribution of survey respondents across Scotland.



^{VII} Data shown here represents 82% of survey respondents (n=1646/2005) who were willing to share their full postcode.

Study findings

Findings are organised into four sections, which focus on elucidating: 1) general perceptions and experiences relating to condoms, contraception, and STI and pregnancy prevention; 2) partner-level factors shaping condom and contraception use; 3) the wider social context (e.g. peers, online) shaping understandings of condoms and contraception; and 4) SRH service-level factors shaping condom and contraception use.

Throughout these sections, insights gained through discussions with young people in the interactive workshops at the start of the study are presented alongside data from the online survey and small group discussions. This includes images that young people created in a “rich picture” exercise used in the initial workshops to stimulate reflection on why young people do or do not use condoms and contraception (see [Appendix A](#) for further details).

In our description of the online survey findings, we use the terms “intercourse-experienced” and “contraception-using” to identify the subgroups of young people to whom we refer.^{viii} Where not specified, our default group for reporting is all survey respondents. In some cases, findings from the survey are disaggregated by key socio-demographic variables. In many instances, small numbers in certain sub-groups (e.g. some sexual and ethnic identities) prevent separate reporting. In this report we therefore mainly report on differences by gender and age (categories 16-19 and 20-24).

^{viii} The survey was designed so that young people who reported experience of sexual intercourse (76.7% of our sample) were asked a greater number of questions about experiences of using or not using condoms and contraception than young people who said they had not experienced intercourse, or who preferred not to say. Intercourse-experienced young people who reported having ever used contraception to prevent pregnancy were also asked additional questions about these experiences compared to those who had not used contraception.

Perceptions and use of condoms and contraception: an overview

To provide context for understanding views and experiences among our sample, we asked survey respondents who reported having had sexual intercourse (n=1537) – referred to here as intercourse-experienced – about their use of condoms and contraception. As the online survey used convenience sampling, these data should be viewed only as indicative, and not representative, of 16-24 year olds in Scotland.

Condom use

Among intercourse-experienced survey respondents, most (93.3%) had used a condom at least once, although fewer than two-thirds (62.3%) reported having used a condom the first time they had intercourse with their most recent partner. These proportions were similar across age groups (16-19 and 20-24 year olds).

Contraception use

Among intercourse-experienced respondents who indicated that pregnancy was a possibility within their sexual partnerships (i.e. because they had intercourse with other-sex partners), a majority reported having used contraception to prevent pregnancy at least once (92.6%), with the highest proportion among young women (94.9%).^{ix} The vast majority of those who had ever used contraception had used a method in the last 12 months (95.8%). However, a limited range of methods accounted for the majority of contraceptive use in the past year, with the three most commonly reported methods being the contraceptive pill (53.9%), condoms (19.7%), and the implant (10.9%). Use of other methods were reported by only a small percentage: hormonal coil (3.5%) and non-hormonal coil (3.8%), injection (2.4%), hormonal patch (1.1%) and vaginal ring (0.4%).

Intercourse-experienced respondents who reported either that they had never used contraception with a partner or were not currently using a contraceptive method (n=149) were asked about their reasons for non-use. Respondents could select as many options as were relevant to them. Responses are listed in rank order.

1. Worry about experiencing side effects (23.5%)
2. Experienced side effects (18.1%)
3. Worry about longer term effects (e.g. on my body, fertility, health) (17.5%)
4. Don't like the idea of taking hormones (16.8%)
5. Have difficulties accessing contraception (e.g. problems getting an appointment, or getting to a clinic) (13.4%)
6. Would not want others (e.g. family or partner/s) to find out I was using contraception (12.8%)

^{ix} Questions in this section of the survey specified a focus on use of contraception to prevent pregnancy, rather than use of contraception for other reasons (e.g. menstrual regulation). Respondents could indicate (via a response option) that this question did not apply to them if they only had same-sex partners. The denominator for this percentage therefore excludes respondents who ticked: 'This does not apply to me'. Contraceptive methods included in response options were: Condom, Implant, Hormonal coil (IUS), Non-hormonal (copper) coil (IUD), Injection (sometimes called "the jag"), Contraceptive pill, Hormonal patch, Vaginal ring (e.g. NuvaRing). Respondents could select all contraceptive methods they had used with a sexual partner in the last 12 months (i.e. either their own, or their sexual partner's, use of a method within the partnership).

7. Not sure (12.1%)
8. It takes too much effort to use contraception (10.7%)
9. Have not found a method that works well for me (10.1%)
10. Want to have a baby (5.4%)
11. Don't know where to get contraception (5.4%)

Among intercourse-experienced respondents, sizeable proportions reported ever having used other methods to try to prevent pregnancy, including: 'pulling out' (withdrawal) (47.3%), emergency contraception (37.3%), and fertility/period tracking apps (21.6%).

During workshops and small group discussions, young people expressed the following views on these other methods:

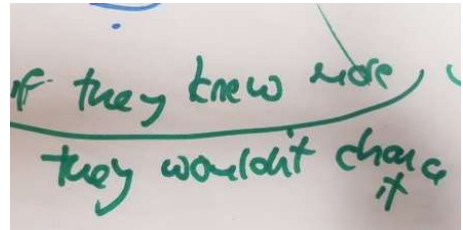


Image from a drawing generated by young people during a workshop.

'Pulling out' (i.e. withdrawal) was believed to be a very common strategy used by young people. Users of this method were described as either not knowing that pulling out was an ineffective contraceptive method, or, knowing its limitations, but assessing the risk to be minimal:

"I think a lot of the time people like see that [i.e. pulling out] as a viable and safe option, that that'll be okay because it's technically like you're not ejaculating inside. But obviously there are risks that come with pulling out as well. I think a lot of people either I think don't care or don't know, like just assume that it's going to be fine, because it's not happening inside of them unprotected".

(Woman, mixed gender group aged 19-23)

"I know a lot of girls who talk about pulling out and they either just do that and that's what they do and they're not bothered, or they do that and they get screened for STIs really regularly.

(Woman, mixed gender group aged 19-21)

Lack of education about the ineffectiveness of 'pulling out' was regularly mentioned as a shortcoming of school-based sex education:

"I remember from my sex education at school (...) they didn't really teach us about the pulling out method and how it's actually not effective because you can still get pregnant even if they pull out. And I think that maybe that would be like helpful to talk about that method maybe more".

(Woman, mixed gender group aged 19-21)

"I think it does come down to a lack of education. People just don't know. Like I genuinely at that age, at 15/16, had to be told. I went to a boy's school, a private boy's school, so whatever the standards of sex education round the UK was I didn't get that, I got something else. I'd never been told that pulling out wasn't safe and I actually at age 16 had to have my girlfriend explain that to me.

(Man, mixed gender group aged 19-23)

Fertility/period tracking apps were reportedly used by some, though these were mainly described as a digital tool to track menstruation, or an additional precaution used in

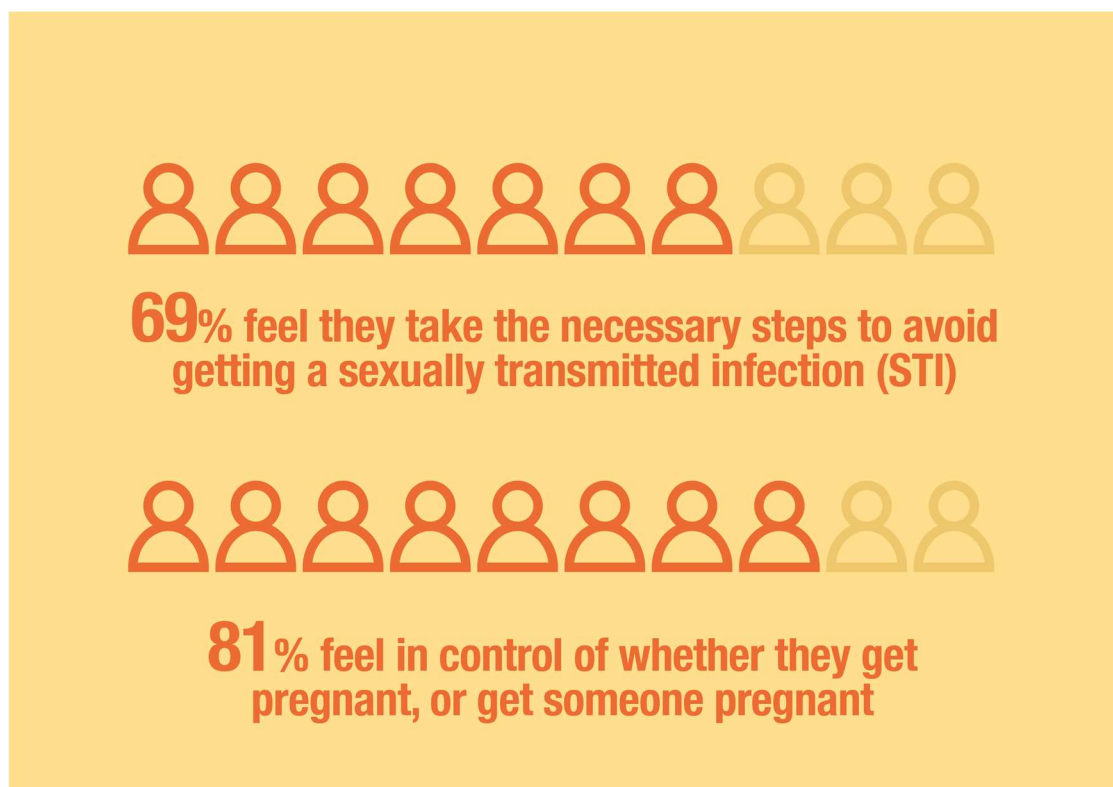
combination with another method to prevent pregnancy, rather than as a stand-alone contraceptive strategy.

Emergency contraception (the “morning after pill”) was perceived to be widely used by young people after unprotected vaginal intercourse between new sexual partners. It was not described by young people as a ‘regular’ form of contraception.

Self-evaluation of agency regarding STI prevention and pregnancy

We asked our intercourse-experienced survey respondents to self-evaluate their own agency in relation to STI prevention and pregnancy^x. In total, 68.9% indicated some level of agreement (either agreed or strongly agreed) with the following statement: *‘In my sex life, I feel I take the necessary steps to avoid getting an STI (sexually transmitted infection)’*.

Although responses were similar by gender and sexual orientation, a higher proportion of young people aged 16-19 evaluated themselves as taking the necessary steps to avoid an STI, compared to 20-24 year olds. Those who had never used a condom reported similar levels of agreement with this statement as those who had used a condom.



Among respondents who indicated that pregnancy was a possibility within their sexual partnerships (i.e. because they had intercourse with other-sex partners), a greater proportion indicated that they felt a sense of agency regarding their pregnancy outcomes than their STI prevention practices, with 81.4% agreeing or strongly agreeing with the following statement:

^x Respondents could indicate (via a response option) that this question did not apply to them if they only had same-sex partners.

“In my sex life, I feel I am in control of whether I get pregnant, or get someone pregnant”. Responses were similar across genders and age groups.

Young people elaborated on perceptions of STI and pregnancy risk in the small group discussions, adding further insight to these survey findings. A major theme conveyed within these conversations was a common perception among young people that they were insulated from STI risk:

“To be fair, I think it's a thing with like all kind of STIs. I feel like a lot of people just...it's just the assumption of like, oh, that'll never happen to me. Do you know what I mean? It's a lot of like people...I have friends that have a lot of sex or have enjoyed a lot of sex in their lives and are on the pill but still don't use condoms, and just are like it's fine, nothing will ever happen to me”.

(Woman, mixed gender group aged 19-23)



Image generated by young people to convey perceptions of insulation from STI risk.

Some young people commented that this sense of insulation from STIs, including HIV, was strongest amongst those who exclusively had other-sex partners; as one young woman noted: *“If you're just having like heterosexual sex a lot of people just don't see the risk [...] people just think that they're automatically immune to HIV and it feels very far removed from our like normal lives and stuff. It feels like a problem of the past and stuff”* (Mixed gender group aged 19-23).

However, this perception of insulation from STI and HIV risk (which was generally attributed to others and not to themselves) was challenged by young people in small group discussions:

“Like HIV is still a very, very real possibility if you're having heteronormative [sic] sex, without a condom obviously. And I think like it's just completely glossed over. I feel like people definitely still think that HIV is something you can only get if you're having gay sex, which just isn't true”.

(Woman, mixed gender group aged 19-23)

“Yeah, like I've got a lot of gay friends...in our friendship groups there's a lot of 'you're more concerned about STIs than you are getting pregnant'. I think that's the number one concern for me, yeah. So I think it's just different friendship groups”.

(Non-binary person, mixed gender group aged 19-21)

In contrast to accounts of perceived insulation from STIs, young people talked about pregnancy as a much bigger and more tangible risk within partnerships where this is a possible outcome; as one young man (mixed gender group aged 19-23) noted: *“I don't know if it's just our generation, but a lot of people think that the worst thing that will happen to you if you have unprotected sex is you will get pregnant”.*

Reflecting on sexual encounters between men and women, young women commonly expressed feeling that the burden of pregnancy prevention largely fell on their shoulders:

“...a lot of the time the boys don’t quite think [i.e. about using condoms] because they’re not going to get pregnant. So they’re not thinking ‘I’m going to get pregnant’ - it’s the girl that’s at that risk. I don’t think they always understand that or understand where the girl’s coming from.”

(Woman, mixed gender group aged 16-19)

Gendered inequities in perceived responsibility for pregnancy prevention are further explored in the next section.

Section summary: Perceptions and use of condoms and contraception

- ⇒ Most (93.3%) intercourse-experienced survey respondents had used a condom at least once, although more than one third had not done so the first time they had intercourse with their most recent partner.
- ⇒ Among those who had ever used a form of contraception to prevent pregnancy, three methods (pill, condoms, and implant) accounted for the majority of use in the past year.
- ⇒ “Pulling out” (i.e. withdrawal) was reported by many young people, despite widespread awareness that it is not an effective method of STI or pregnancy prevention.
- ⇒ In sexual partnerships where pregnancy is possible, unintended conceptions appear to be of greater concern than contracting a sexually transmitted infection (STI).
- ⇒ More survey respondents reported feeling in control of their pregnancy outcomes than their STI prevention practices.
- ⇒ A perception of insulation from STI risk is described as common among young people, and particularly among those who exclusively have other-sex partners.

How do young people negotiate condom and contraception use with sexual partners?

It is widely understood that communication with a sexual partner strongly shapes sexual experiences. Our stakeholders asked us to find out more about how young people in Scotland negotiate condoms and contraception with their sexual partners.

Sexual risk communication prior to intercourse

In the survey, we asked intercourse-experienced respondents whether they had discussed a range of topics with their most recent partner before having intercourse together for the first time. Responses indicate considerable variability in topics discussed. A majority said they had discussed whether to use a condom (75.4%). In instances where pregnancy was a possibility (i.e. intercourse with other-sex partners), two thirds (66.2%) reported having discussed whether either they or their partner was using contraception other than condoms^{x1}. However, other aspects of risk negotiation were reported by smaller proportions, with only half (50.4%) of intercourse-experienced respondents having discussed whether either partner was also having sex with other people, and only a third (34.4%) having discussed whether either partner had recently had an STI test.



In discussion groups, young people also indicated that conversations between new sexual partners about STI testing were far from routine. Barriers to mutual disclosure of STI status and recent testing history described by young people included:

- pervasive stigma associated with STIs meaning even being known to have been tested is cause for embarrassment:

"Either people don't think about it or, again, it's the kind of embarrassing aspect of, oh, you've been tested for an STI, like did you think you had one? So I would always ask but I don't think a lot of people do it, and that's both genders I think".

(Woman, mixed gender group aged 19-21)

^{x1} Respondents could indicate that this question did not apply to them if they only had same-sex partners. Denominator for this percentage therefore excludes respondents who ticked: 'This does not apply to me'.

- an implication that being asked about testing implies a lack of trust that the person would have self-disclosed if they had an STI:

“I feel like it would be kind of like an awkward conversation [...] I guess, there is a stigma with having an STI so, like, I’d feel like, [if someone asked about recent testing] even if I say I won’t be offended, like, I’d probably be a bit offended. But then there’s also that trust that they just don’t trust you enough that you’d tell them either, so they have to ask you, I guess”.

(Woman, all women discussion group aged 24)

- alcohol and/or drug use meaning discussion on STI status is not a priority:

“...if you’re out and you’re drinking and then you meet somebody you’re not going to be thinking ‘oh I wonder if they’ve got an STI?’ when you want to get straight to it”.

(Woman, mixed gender group aged 16-19)

Reasons for not using a condom

As reported earlier (p.9), only 62.3% of intercourse-experienced survey respondents told us that they had used a condom the first time that they had intercourse with their most recent sexual partner. Among those who said that they did not (36.5%, n=559)^{xii}, we wanted to understand more about why they had not used a condom on that first occasion. These reasons are presented in Table 1 (note: respondents could tick more than one item). By far the most commonly cited reason was feeling that other contraception was sufficient to prevent pregnancy (39.5%), while reasons relating to access (e.g. not having a condom, not being able to get a condom) were relatively uncommon (13.6% and 3.0% respectively). There were no significant differences by gender or age group.

Table 1. Reasons for not using a condom at first intercourse with most recent partner

<i>Why was a condom not used?</i>	Percent*	N (N=559)
We were using another method of contraception to prevent pregnancy	39.5 %	221
We were in a relationship where we decided not to use condoms	22.7 %	127
We got carried away and forgot to use one	22.5%	126
I/my partner do not like how sex with a condom feels	17.7 %	99
I/my partner pulled out before ejaculating	15.6 %	87
We did not have a condom	13.6 %	76
I/my partner had been drinking alcohol or using drugs	13.2 %	74
We were willing to take the risk	11.6 %	65
We had both recently been tested for STIs	10.2 %	57

^{xii} The remaining 1.2% of respondents answered ‘not sure’ to whether they had used a condom the first time they had intercourse with their most recent partner.

I was too embarrassed to ask my partner to use a condom	5.5 %	31
I/my partner was worried about losing an erection	4.7 %	26
I/my partner were not able to get a condom	3.0 %	17
Prefer not to say	2.9 %	16
I wanted to use a condom but my partner did not	2.7 %	15
I/my partner did not know how to use a condom	<1 %	2

* Does not tally to 100% as respondents could select all items that applied.

In workshops and small group discussions, young people shed further light on some of these reasons. As indicated in the survey, a commonly-expressed view was that the need to wear a condom related to the nature of the partnership, with young people typically noting that condoms were more necessary in one-off or casual encounters than in relationships where it was established that partners had sex regularly and exclusively with each other:

I think that it depends on the situation. I think if you're like monogamous and stuff and it's a discussion that you can have together, and you want to look into other forms of contraception together, I think that's like a pretty fair thing to say. Like in a relationship, it's like you're going to be having sex with each other a lot and things, I think that's quite common and quite normal for that to be a reason why. But I think if I was just like having a one-night stand and the lad said, 'well, I don't want to use a condom because it doesn't feel as good' I would literally just be like, well, thank you for your time, but I think that's it.

(Woman, mixed gender group aged 19-23)

The notion that condoms “don’t feel as good” (cited as a reason by 17.7% of respondents who had not used a condom at first intercourse with their most recent partner, see Table 1) was widely discussed and largely uncontested by young people in terms of its veracity, although some did question the legitimacy of this as an adequate reason to not use a condom.

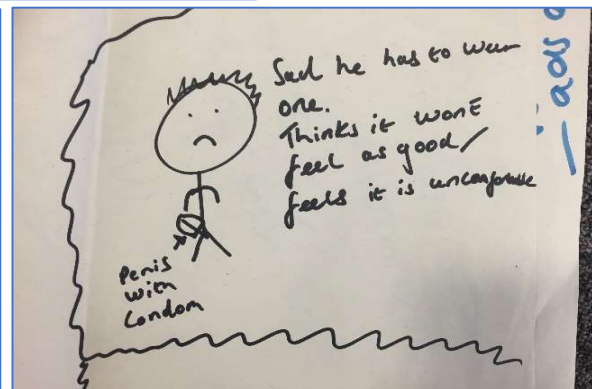
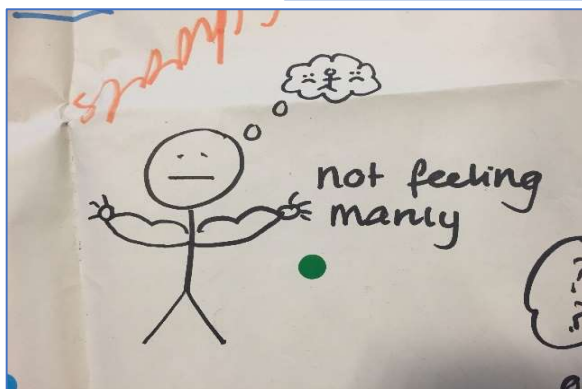
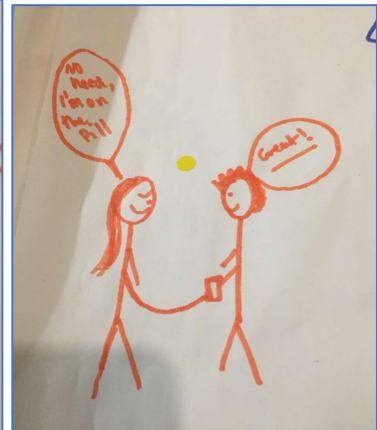
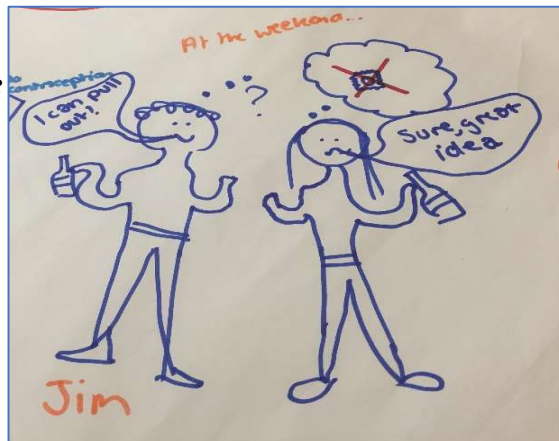
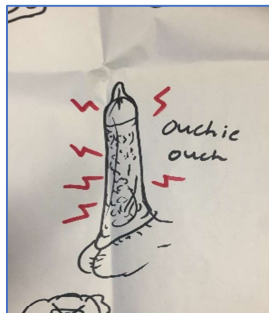
Young people more commonly characterised reduced sensation when using a condom as “a guy thing”. Some young women said condoms did not make a difference to their sensation, although others remarked that intercourse with condoms felt inferior, including talk about condoms “drying” them out (i.e. vaginally). Others noted that the intimacy-related, symbolic aspects of condomless sex were more important to them than the sensation: “I think as a female there isn't much difference with having a condom on and off. For me it's very much more like an intimacy thing. I think if you're monogamous with someone I think it does bring you closer in a strange way” (Woman). As discussed

It's definitely a valid concern. Like obviously it's never an excuse to not use a condom but when guys are saying that, obviously it's a shite reason, but it is true. I'd say that's not only a reason to not want to use a condom, for men that is the main reason to not want to use a condom, because it's about how it feels and it is completely different.

(Man, mixed gender group aged 19-23)

earlier (p.10) “pulling out” was perceived to be a widely practiced alternative to condom use, even though young people regularly indicated awareness that this was not an effective method of pregnancy or STI prevention.

Images generated by young people to convey why some young people do not use condoms



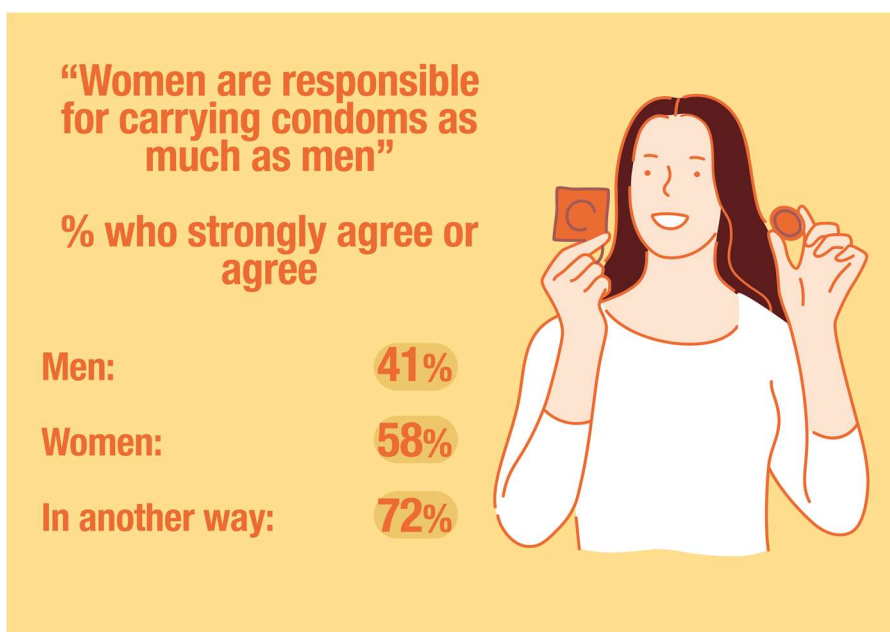
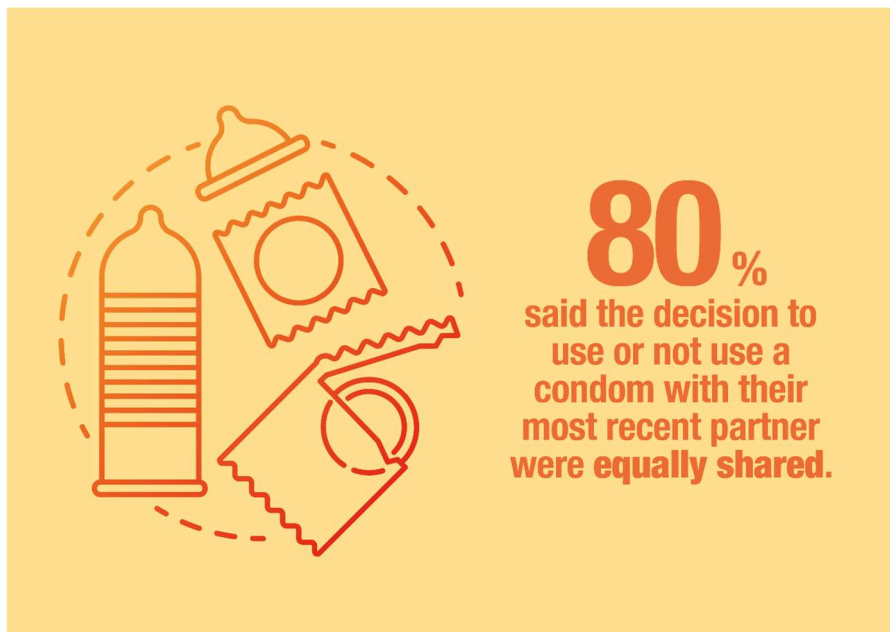
Negotiating condoms and contraception with a sexual partner

Throughout the study, young people repeatedly told us that negotiating condom and contraception use with a sexual partner could be challenging. In combination, our survey and discussion group data help shed light on why these dynamics between sexual partners can be complex.

Among our survey respondents, we found:

- **Condom use was not generally equated with mistrust of a partner:** Only 1.9% of all respondents agreed with the statement “Using a condom means you don’t trust your partner”.
- **Most reported being comfortable communicating about condoms and – where relevant – other methods of contraception with a sexual partner:**
 - ⇒ Four out of five intercourse-experienced respondents indicated some degree of comfort communicating about condoms with a new sexual partner.
 - ⇒ Among those who had used contraception at least once, 97.3% indicated comfort communicating about contraception with someone with whom they were in a relationship, and 82.4% were comfortable communicating about contraception with a new sexual partner.

- **Most reported some degree of agency in decisions about using a condom.** When intercourse-experienced respondents were asked how decisions to use a condom or not were made with their most recent partner, 80.0% said that the decision was shared equally. Some 11.3% said it was either more or only their own decision, and 8.7% said it was either more or only their partner’s decision.
- **There was lack of consensus about the gendered division of responsibility for carrying condoms.** Just over half (51.6%) of all respondents indicated some level of agreement (i.e. agree or strongly agree) with the statement: *Women are responsible for carrying condoms as much as men*. Notably, men were least likely to agree with this statement (41.3%, n=800) compared to women (57.6%, n=1123) and those identifying their gender in another way (72.2%, n=79).



While these survey data ostensibly present a generally optimistic view of communication between partners about condoms and contraception, a more complex picture emerged from young people's accounts within the workshops and small group discussions. *Note:* Despite diversity in participants' sexual identities, young people in these groups tended to mostly focus on sexual interactions between men and women, until prompted otherwise.

Young people told us that conversations about contraception were typically brief, one-off, and focused on simply determining whether a method was being used. Young women commonly characterised men's primary motivation to have these conversations as ascertaining that sex without a condom would not involve risk of pregnancy, rather than a fuller discussion about their experiences of using contraception; for example:

"Because a lot of the time the boys don't get...all they think about is 'oh sex won't feel good if I use a condom' and they don't think well the girl then has to put her body through different things in order to stop her getting pregnant. Because they don't really have to do anything, it's the girl that has to go to the clinic and take things or get an injection or whatever to stop her...because then if the girl ends up pregnant a lot of the time the boys would then take it out on them even if it was them from the beginning".

(Woman, mixed gender group aged 16-19)

"... a lot of boys see the morning after pill as a kind of 'get out of jail free' card in terms of pulling out and just, one, not considering the physical effects on the girl after it, the side effects of the morning after pill, but also it does alleviate responsibility from the guy's side, and I think that there's a lot of 'do I really need a condom? Oh, we can just do this', and there are lots of sort of points where the guy can be like, look, that's where you [i.e. women] need to do something..."

(Man, mixed gender group aged 19-23)

With respect to condoms, many participants talked about how difficult it is to raise the prospect of using a condom for the first time, with often-mentioned challenges including concern about being seen as too presumptuous, and also a perception that talking about condoms is not "sexy":

It's kind of like weird because it's definitely like if you are flirting, if it's flirty [...] I've found that means there's a fear of being assumptive, like, oh, we are going to have sex, we should have this conversation. So it removes all the nuance and flirting from it if you're like, will we use condoms, if we do, if we do have sex? And it's like that's not flirty, that's not sexy, but also that's why I have found the best time to have it is basically when you are getting into it and there is a point where you need to put on a condom.

(Non-binary person, mixed gender group aged 19-21)

Within heterosexual partnerships, young people typically expected women to be more likely to initiate discussions about condom use, and men to commonly assume that condoms were not necessary as they expected their partner to be using another form of contraception to prevent pregnancy:

I've had a similar experience of, like, you're about to...when you put the condom on, I guess, and I was like, let's use one. And he was like, what, you're not on the pill?

(Woman, mixed gender group aged 19-21)

- Man 1: *...often the responsibility of contraception is just placed on the woman, like it's just assumed that it's up to the woman to say, oh, you need to use a condom or... Because this might not be true for all, but a guy, especially if he feels better without one, he's not going to ask, he might not ask if a woman doesn't say anything.*
- Woman 1: *Yeah, like the winning move is not to ask and just...*
- Woman 2: *Yeah, that's it.*
- Woman 1: *...like he takes on very little risk by not using a condom.*
- (Mixed gender group, aged 19-21)

Possible scenarios if one partner refused to use a condom were commonly discussed. While some noted that they would easily just decline sex under those circumstances, others conveyed a sense that this would be challenging, setting the scene for coercion in which young people could be:

- Thrown into a dilemma about whether or not to have sex

"... like if you wanted to really get with, like, a random person, and then you're like, 'oh do you have a condom?', and they say, no, and then you're like, do I just say, like, well okay I'm not going to sleep with you, or do I just say, like, ooh okay? Like, if you're in a relationship, or if you knew the person then it would just be like, obviously it would be completely different".

(Woman, mixed gender group aged 18-20)

- Obligated to come up with an alternative method of protection

"Well if the boy's really dead set on not wearing a condom then it will be a case of, 'okay, well what am I going to do?' I don't know. A lot of people will go for the pull out method but I don't think that's very...and they might go for the morning after pill or something, but that can't be a constant thing".

(Woman, mixed gender group aged 16-19)

- Obligated to go along with it

"I know quite a few lads that have like bullied my friends into not using condoms. When you're like me you're vulnerable and already like ready and raring to go, it's kind of like a consent thing as well, I think a lot of lasses that once they've already started and you might have done bits of foreplay and stuff or you've already kind of indicated that you might want to have sex, if a lad says to me like I'm not going to have sex with you if you want to use a condom, a lot of lasses that I know and have done have just been a bit like, oh well, okay, I'm sure it'll be fine, do what you want, just because you're like vulnerable when you're like about to have sex".

(Woman, mixed gender group aged 19-23)

As seen above, some explicitly framed their understandings of such dynamics within broader notions of safety and consent, noting that it may be best for condom negotiations to take place prior to being "in the moment". In practice, however, this was felt to be challenging:

"I would say as a woman, I would feel safer having the conversation before anything happens. And it mightn't be easy, like especially if someone didn't want to use a condom you'd completely respect that. But as a woman, you just don't know if you get

into that situation and then you say, oh, we need a condom. And then they're like, no, and then you're like, am I completely powerless here? Is the situation going to change? I think I would feel a lot safer speaking about it beforehand, but again, it's that fear of bringing it up and ruining the moment or the dynamic changing."

(Woman, mixed gender group aged 19-21)

Importantly, while pressure to not use a condom was typically characterised as being directed towards women, pressures on men to not use condoms were also raised, both in sexual interactions between same-sex partners and between men and women:

"I think there can be pressure on both sides. I think sometimes women can also pressure men into feeling it's almost like emasculating if they don't want to have sex without a condom [...] I definitely have friends where like guys have said no [i.e. to sex without a condom] and the girls have like ridiculed them for not wanting to have sex and thought they were really weird for not wanting to have sex without a condom".

(Woman, mixed gender group aged 19-23)

Gender inequities in contraception work

Gender inequities between partners in the 'work' involved in choosing, obtaining and using contraception were a prominent theme in young people's accounts throughout the study. Young women expressed a strong sense of frustration that young men expect contraception to "just be sorted", leaving it to women to do all the work.



Image spontaneously generated by young people to convey frustrations relating to contraception work

I think they [i.e. men] just think 'oh well you're taking something or you've got the implant, you won't get pregnant'. I don't think they actually fully understand all the ins and outs and what it can do to your body and things.

(Woman, mixed gender group aged 16-19)

I feel like a lot of the time the boys just think well it's her that has to get it, just leave her to it. [...]. I think a lot of the time girls feel quite alone with making those decisions if the partner is maybe not as invested in it as they should be.

(Woman, mixed gender group aged 16-19)

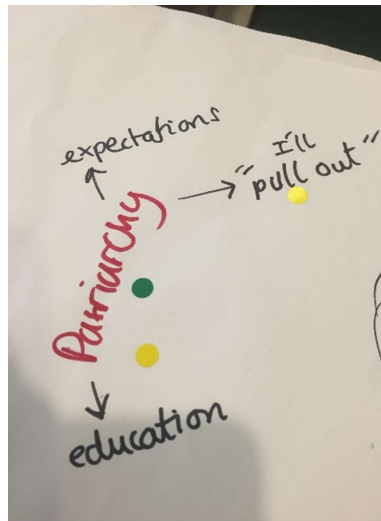
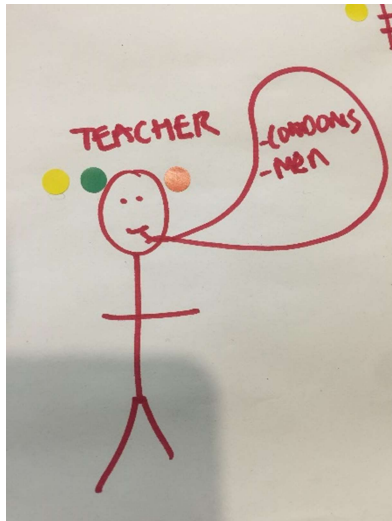
Contraception work described by young women included time, effort and stress related to:

- researching and making decisions about different methods;
- navigating often highly complex and inconvenient systems to gain access (e.g. finding out where preferred methods are available; booking and attending appointments, sometimes with long waiting lists and unsatisfactory consultations; visiting pharmacies to fill prescriptions);
- using method/s correctly (e.g. remembering to take a pill and get repeat prescription before running out; ensuring an implant is renewed within correct timeframes).
- managing and worrying about unwanted side effects attributed to their contraception, including low mood, weight gain, physical discomfort, and acne.

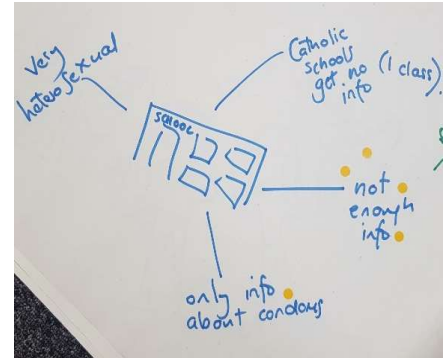
As one young woman in a workshop put it, “all the risks and responsibilities are on the girl” only then to be told by young men that they are “getting hormonal” if they express frustration or upset with the process.

Young people we spoke to commonly conveyed a view that young men’s knowledge and empathy relating to experiences of accessing and using contraception was inadequate. However, rather than blaming young men for this, some instead emphasised a wider system of influences at play at multiple levels of society (e.g. within families, schools, health systems) that conspire to create and reproduce this uneven burden on women. For instance, young people highlighted:

- **Families:** gender differences in messages about contraception that parents convey to their children (e.g. talking to girls about the contraceptive pill, but not boys);
- **Schools:** emphasis on condom demonstrations but little discussion on other forms of contraception; separation of pupils by sex within RSHP lessons reinforces the idea that men and women need different information; gendered language used by teachers and within textbooks that conveys a sense of women as sexually passive (e.g. “the man impregnates the woman”) and reinforces heteronormative ideas of gendered responsibilities for pregnancy prevention.
- **Health systems:** challenges securing appointments that are frequently required for some forms of contraception (e.g. regular BMI and blood pressure checks for the contraceptive pill) and time-consuming to attend; frustration about lack of scientific progress developing contraception options for men other than condoms.



Images spontaneously generated by young people during workshops to convey multiple influences shaping knowledge and understanding about contraception



In the context of these described gender inequities in contraception work, women often talked about wanting men to be more knowledgeable and sympathetic about contraceptive experiences – including how different methods work, the potential physical and emotional impacts on people who use contraception, and the time and stress involved in accessing and using contraception:

“I think it would be helpful for them [men] to know more, for sure, just so that they can understand your perspective and your decision and also what your body is going through and so they can have a bit of sympathy for you. And just, like, knowing the risks and knowing...yeah, just being more knowledgeable I think would be definitely helpful, at least in having those conversations too because if they don't know anything about it I feel like it'd be hard to have, like, a conversation about what method you would use or feel comfortable using”.

(Woman, all women discussion group aged 24)

“...like if you were to move forward from this I think it's important to start looking at how you could teach people together, if that makes sense? Taking both like males and females and teaching them responsibilities of things together rather than separately, so it's very much like we're kind of separated in that sense where like women are taught this one thing, and men are taught this other thing about how to protect themselves, but never taught how to like mutually do it together in like a partnership. And I think that if kids were...or young adults were to be taught that it could probably help a lot with that”.

(Woman, mixed gender group aged 19-23)

Some men also indicated their interest in knowing more about different contraceptive options, and being able to support not only sexual partners who used contraception, but also their friends. These expressions of interest in supporting contraceptive users were also borne out among survey respondents, of whom 93.1% indicated some level of agreement (either agree, or strongly agree) with the statement *“People who use contraception should be supported by their partners to choose a method that's right for them”.*

While choosing a method is just one element of contraception work, the high level of agreement with this statement, combined with perspectives expressed in discussion groups and workshops, indicates increasing men's knowledge and understanding relating to contraception may be a promising area for further investigation and development. However, young women also conveyed the delicate balance between wanting to feel more supported by young men regarding contraceptive experiences, while also protecting their right to reproductive autonomy:

Woman 1: *I'm feeling like you are welcome to, like, your opinion but I feel like at the same time, like if it's a woman's body and they're deciding to, like, say, use, like, the birth control pill. [...] I feel like they should have the final say, kind of, because it's their body.*

Woman 2: *I think so too. Like, if somebody tried to tell me...because I'm not on the pill but if somebody tried to say, you need to go on the pill, I'd say it's my decision, ultimately at the end of the day. Like, they can yeah obviously have opinions about it, you can have like a discussion but it's my body so I get to choose what I want to do with it".*

(All women discussion group, aged 24)



Section summary: Partner-level factors

- Fundamental elements of sexual risk negotiation between sexual partners, including conversations about current contraception use and recent STI testing, appear to be far from normalised among young people.
- Negotiating condom use with new sexual partners is often described as difficult. Uncertainties in how and when to engage in these conversations lays groundwork for interactions fraught with possibilities of pressure and coercion to not use condoms.
- Where pregnancy is a possibility, conversations about contraception are characterised by young people as typically brief, often awkward, and primarily focused on ascertaining that a contraceptive method is being used so that condoms are not needed for pregnancy prevention.
- Some young women express frustration about gender inequities in the work related to choosing, obtaining and using contraception.
- Young people of all genders agree that contraception users should be supported by their partners in their contraceptive decision-making.
- There is scope for improving support and communication between sexual partners by increasing knowledge and understanding among young people of all genders, including young men, about different contraception methods and experiences.

How do young people engage with diverse information about condoms and contraception?

Understandings about condoms and contraception are dynamically shaped through interactions with a multitude of sources of information and influence, including both formal (e.g. school-based relationships and sex education) and informal (e.g. via peers, families, online and digital platforms).

In the initial priority-setting workshops with stakeholders, a consensus was developed that school-based Relationships, Sexual Health and Parenthood (RSHP)^{xiii} education should *not* be a primary focus of exploration within CONUNDRUM for two main reasons: 1) a widely-held view that school-based education had received a greater amount of research focus than other contexts of learning about sex and relationships, and; 2) recent progress in Scotland in the development and implementation of a new, national-level RSHP teaching resource (RSHP.scot). Due to these factors, our stakeholders asked us to look beyond young people's views and experiences of school-based learning to find out more about engagement with information regarding condoms and contraception from other sources, including informal contexts. Nevertheless, the young people we spoke to spontaneously and repeatedly voiced their opinions on the perceived inadequacy of input on condoms and contraception within schools. We therefore start this section with a brief summary of these views expressed within workshops and discussion groups, before moving on to present findings relating to young people's engagement with other sources of information.

School-based information and support regarding condoms and contraception

While a minority of schools were described as “doing better” than previous eras, from the view of young people we spoke to, this was seen as largely dependent on individual school culture, and the skills and qualities of specific teachers, rather than systemic progress across the board. As such, the variability of young people's access to quality RSHP education was widely critiqued as unacceptable. Young people's characterisations of poor quality school-based education and support related to condoms and contraception included:

- Greater prominence given to discussion about condoms rather than other methods of contraception;
- Embarrassed or judgmental teachers;
- Perceived exclusion of content on contraception within some faith-based schools;
- Heteronormative focus of information, including either total lack of information on STI and pregnancy prevention that is inclusive of LGBTQI+ young people, or deprioritisation of this content (e.g. reports of teachers skipping over particular slides or examples within lessons). Young people also critiqued focus on some forms of diversity but not others (e.g. discussion about STI prevention between men who have sex with men, but not between women who have sex with women);
- Inadequate signposting to local services where young people can access further information and support (e.g. general mention of “clinics”, but not a specific list of local services).

^{xiii} Relationships, Sexual Health and Parenthood (RSHP) education is the terminology used in Scotland.

Finding, understanding, evaluating and applying information

We wanted to understand more about young people's own assessments of the ease with which they could find, understand, evaluate, and apply information about condoms and contraception – that is, their self-perceived critical sexual health literacy. Overall, our survey respondents painted a mixed picture of these skills. While most indicated that they found information about condoms or contraception either easy or very easy to find (80.5%), understand (82.8%) and use (78.4%), a smaller proportion found it easy or very easy to judge whether they can trust this information (65.3%).



Most likely sources of information about condoms and contraception

We asked all survey respondents where they would be most likely to go for information if they had a question or concern about condoms or contraception today (respondents could select up to three options). As the survey was conducted at a time of COVID-19 related disruption to daily life (June-July 2020), we asked respondents to imagine a scenario where everywhere is open and no social distancing restrictions were in place.

As shown in Table 2, official health websites (e.g. NHS, Healthy Respect) were by far the most popular place to seek information about condoms or contraception (74.5%), followed by a friend (34.8%), sexual partner (29.3%), sexual health clinic (28.8%) and GP/doctor's surgery (28.3 %). All other options were selected by 15% of survey respondents or fewer.

More young women than other genders identified friends and a GP/doctor's surgery as go-to sources for information (data not shown in table). By contrast, sexual partners were identified as a key information source by more men than women or those identifying their gender in another way.

Table 2. Most likely sources of information on condoms and contraception

<i>Imagine social distancing is no longer in place and everywhere is open. If you had a question or concern about condoms or contraception today, where would you most likely go for information?</i>	Percent*	N (N=1988) **
Official health websites (e.g. NHS, Healthy Respect)	74.5 %	1480
Friend	34.8 %	692
Sexual partner	29.3 %	583
Sexual health clinic	28.8 %	572
GP/doctor's surgery	28.3 %	563
Social media (e.g. YouTube, Instagram, Facebook)	15.3 %	305
Parent/carer or another family member	11.1 %	220
Pharmacy	8.1 %	161
Adult in school, college or university (e.g. teacher, counsellor, nurse)	2.3 %	46
Youth or support worker	2.3 %	45
Not Sure	1.9%	38
Books, newspapers or magazines	1.5 %	30
I would not look for any information	1.5%	29

* Does not tally to 100% as respondents could pick up to three answer options.

**Missing data: n=17.

As in the survey, young people in workshops and small group discussions also indicated that they engaged with a diverse range of information about condoms and contraception, with 'official' online sources often being identified as the first port of call if they had a specific question about condoms or contraception.

"I'd just go online [...] If I'm looking for, like, different types of contraception, I'd probably just google "different types of contraception" and then I'd go look at each of those types, just like the benefits or the side effects and things like that [...] I think for, like, just general information, I don't know what a website would be but like a trusted NHS kind of website, like that kind of stuff. You'd just choose the website that seems the most...with the best information".

(Woman, all women discussion group aged 24)

Trust in different sources of information

In addition to their most likely source of information, we also asked all survey respondents the extent to which they trusted four specific types of sources to give them accurate and honest information about condoms and contraception.

Table 3. Trust in different sources of information

How much would you trust the following to give you accurate and honest information about using condoms or contraception?					
	Don't trust at all	Don't trust	Neither trust nor don't trust	Trust	Trust a lot
Doctor or nurse at a sexual health clinic (N=2000)	0.2%	0.4%	1.7%	11.4%	86.3%
Doctor or nurse at a GP surgery (N=2003)	0.5%	1.2%	5.0%	21.8%	71.6%
Friends (N=1999)	2.6%	13.2%	39.3%	31.0%	14.0%
Sex education content online (e.g. YouTube, Instagram, Facebook) (N=1998)	6.7%	23.2%	36.5%	26.1%	7.6%

Denominators vary due to missing data (total sample=2005)

Clinical sources of information were rated as the most trusted by survey respondents. Doctors and nurses working in specialist sexual health clinics were trusted by 97.7% of our sample, with 86.3% indicating the highest degree of trust (i.e. “trust a lot”). Doctors and nurses working within general practice settings were trusted by 93.4% of our sample, with 71.6% of respondents trusting these professionals “a lot”. Notably, young women and those identifying their gender in another way trusted information from healthcare professionals in general practice settings to a lesser extent than men (data not shown in table; see pgs 41-50 for further discussion).

Less than half (45.0%) of respondents reported trusting information from friends, despite friends being the second most likely source young people said they would go to if they had a question about condoms or contraception today (see Table 2). A third (33.7%) of young people said they trusted sex education content online (e.g. YouTube, Instagram, Facebook), although only 7.6% indicated they trusted these sources “a lot”, indicating these platforms are prominent sources of information, even if young people reserve some degree of judgement over the veracity of information available in these contexts.

How trust shapes engagement with different sources of information

When asked how they evaluated the quality of online sources of information, participants in workshops and small group discussions distinguished between official sites from known agencies (e.g. NHS, third sector organisations) versus “random people” who “put up their opinions” online (e.g. via blog posts and social media). While the former was widely considered most likely to contain accurate scientific evidence, the value of learning online from unknown individuals’ experiences was not dismissed entirely. Indeed, young people were critical of information produced by official health sources for not presenting the “full picture” regarding negative aspects of STI and pregnancy prevention (e.g. discomfort of physical procedures, side effects of some contraception methods). In the absence of complete information, young people said they turned to informal sources – most notably online content and friends – for further input:

“When you speak to the doctor [...] even if what they were saying was the exact same thing that was on the internet, I'd like to find out myself, like, I want to double check everything. Which is probably the other way round, I should probably read it online, and then check with my doctor, but you know, it's 2020”.

(Woman, mixed gender group aged 18-20)

Young people talked about the reassurance of reading online content generated by people with similar experiences *“because it makes you feel like you're not the only one”* (Woman, mixed gender group aged 19-23). They also valued the candour of video blogs that people shared online, which they sometimes felt better prepared them for what to expect in relation to STI testing or contraceptive procedures:

Like if you were going to get a procedure done like get a coil fitted, there's like plenty of people on like YouTube and stuff will make videos like talking through the entire experience of what happens so that rather than going into it knowing like I'm going to turn up to the doctors and they'll probably talk me through it but I won't really know what's going to happen until it happens, you can sit and watch somebody talk through like everything that happened when they did it.

(Woman, mixed gender group aged 19-23)

These kinds of candid first-person accounts were likened to television programmes such as *Embarrassing Bodies* and *The Sex Clinic*, which were sometimes considered to present a more honest picture of particular procedures than NHS-produced information:

“The people on it when they get filmed and they're having these tests, they're honest, so if it's uncomfortable and it hurts you can see that and they're like saying, oh, that's not the most comfortable experience in the world. Whereas I feel like a lot of the time, especially NHS information, because obviously they want you to come and get tested for like public health and everything, they want you to be tested, so they're going to be like, oh no, it's fine, it doesn't hurt, you should just come and get tested, it's fine. Whereas if you see it on another person who isn't trying to get you to come and get tested then they're completely honest about like, okay, it does hurt a bit, but it's still worth it to know that you don't have an STI”.

(Woman, mixed gender group aged 19-23)

In the context of scepticism over the honesty of information gained through healthcare professionals and official health websites, young people talked about the significance of word-of-mouth stories as important additional sources of information. Young women in particular talked about how their understandings of contraceptive experiences were shaped through reading other people's social media posts (especially via Twitter, Instagram and Facebook). While they recognised and were critical about the greater likelihood of these posts focusing on “horror stories”, nevertheless these accounts were an additional layer of input that some young women felt shaped their consideration of different options.

“...even just like on Twitter, people post a certain pill: never go on this one, this happened to me, and blah, blah, blah, and then all of the comments are the same. So you wouldn't want to go on that one...”

(Woman, mixed gender group aged 16-19)

In addition to interacting with online content generated by unknown others, discussions with friends were also described as important inputs into the process of contraceptive decision-making. Indeed, discussing different contraceptive options was described as a generally acceptable topic of conversation between close friends, and – for the most part – friends’ opinions were trusted:

“I think close friends, yeah. A lot of that too is, like, discussions about different types of contraception. And just you trust your friends especially if, like, you know that they’ve done their research and they’ve figured out what works for them, it’s just another option for yourself. I’d trust a friend, yeah”.

(Woman, all women discussion group aged 24)

Some conveyed the added significance of hearing about negative experiences of someone known to them (e.g. a friend) versus unknown people online:

“I had a partner who... it was a long-term relationship and they were thinking about getting an IUD, but the big thing was they heard about one of our mutual friends got an IUD and was out of action for like two weeks. Just because of the pain and it’s just like the sheer amount of pain involved in getting that. And that was like the main hang-up for them it was just that one bad horror story they heard from a friend”.

(Non-binary person, mixed gender group aged 19-21)

Other young people described hearing about and discussing different contraceptive experiences with friends as a key part of the information-gathering process as they moved towards a decision about methods. Indeed, some conveyed that these conversations would pre-empt interactions with a health professional:

“You’re probably more likely to have a conversation with your friends about what you might want to get before you actually go see a nurse or doctor about it. I think you’re more going to have a big conversation before you go take action on that or speak to a medical person [...] and maybe if one of your friends have already had something they might be able to suggest that or suggest not getting that, which could be quite helpful. [...] If one of your friends had had like a really awful experience of say the pill or something, they’ll tell you that, they’ll tell you honestly. Whereas a lot of the time when you speak to a medical professional if you say ‘oh so and so had this’, they might be like, ‘no, no, no, it’s different for everyone’. They just make it seem okay when it might not be”.

(Woman, mixed gender group aged 16-19)

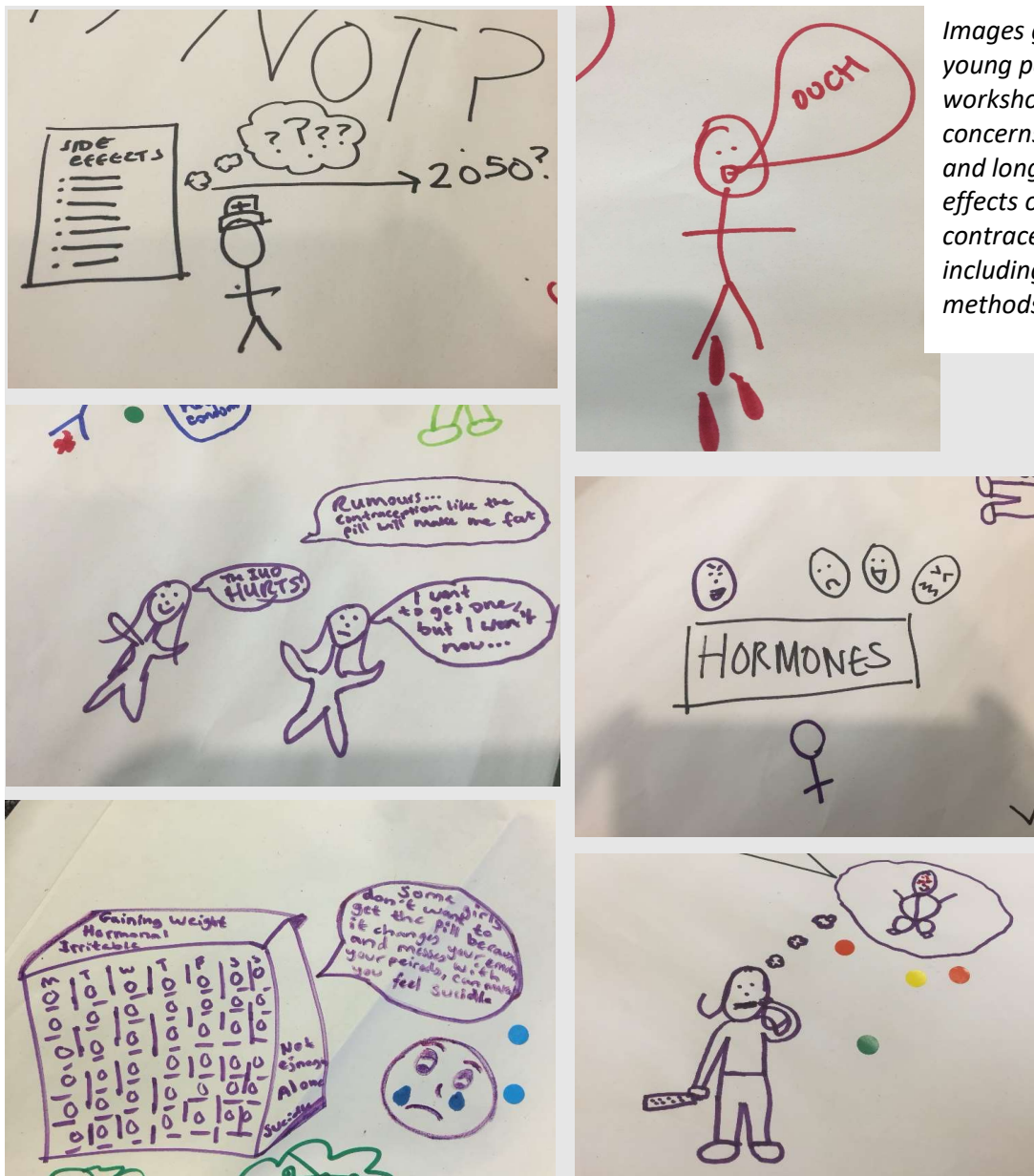
Again, the contrast between perceived honesty of information provided by friends compared to health care professionals is evident here. One suggested way of improving trust in information provided by healthcare professionals would be if greater emphasis were placed on conveying that finding an acceptable method can be an ongoing process:

“I think it’s weird that when people go to go on the pill they’re not really told it can be a really long process of finding one that really suits you. Like it’s, oh, here’s a pill and let’s see if it works [...] I think it is just people should be taught that it is more of a process of finding one that suits you instead of just going on one and seeing what happens”.

(Woman, mixed gender group aged 19-21)

Perceived influences on contraceptive choices

In our early workshops with young people, the potential side effects of different types of contraception, and particularly hormonal methods, were raised as a prominent source of concern, and a major factor shaping contraceptive choices (see images below).



Images generated by young people in workshops to convey concerns about short- and longer-term side effects of using contraception, including hormonal methods

Young women in particular told us that they often engaged with, and deliberated, input about side effects from a wide range of sources, including friends, family members and online content. However, they were not always clear which information was accurate, and which might be better understood as rumour and hearsay. Understanding the diversity of information that young people draw on to make decisions about contraceptive methods was identified by young people as a priority, and they helped us design a survey question to measure this among contraception-users in our sample (see Table 4).

Table 4. Influences on contraceptive decision-making among contraception users

Some people talk with others and share stories about the positive or negative side effects of different contraceptive methods. When you choose a contraceptive method, do you take into account any of the following:

	Women % (n=806)	Men % (n=502)	Identify gender in another way % * (n=41)	Percent **	N (N=1349)
Reading online/on social media about people's experiences of side effects	72.8%	48.6%	68.3%	63.7%	859
Discussions with a partner about side effects	56.2%	64.9%	65.9%	59.8%	806
Discussions with friends about side effects	70.22%	38.7%	48.8%	57.8%	780
Discussions with a doctor or nurse about side effects	72.1%	31.7%	65.9%	56.9%	767
Discussions with family about side effects	26.7%	10.4%	26.8%	20.6 %	278
None of these	1.5%	14.1%	0.0%	6.2%	83
Other	0.1%	0.6%	0.0%	0.7 %	10

**Data presented in this column should be interpreted with caution due to small numbers (n=41)*

*** Does not tally to 100% as respondents could pick multiple options.*

Among intercourse-experienced contraceptive users, reading online or on social media about other people's experiences of side effects was the most commonly cited source of input into contraceptive decision-making (63.7%), followed by discussions with a partner (59.8%), friends (57.8%) and doctor or nurse (56.9%).

Collectively, therefore, survey respondents indicated that they drew on multiple sources of information about condoms and contraception, with trust being highest for information from official health sources (e.g. discussions with health care professionals, NHS websites). When considering side effects of contraception, however, the views of a health professional were no more prominent than the accounts of others posted online and the views of partners and friends.



Section summary: Wider social context

- Young people describe inadequate education and support at school about condoms and contraception as an important missed opportunity.
- Young people engage critically with different sources of information about condoms and contraception (e.g. NHS websites, friends, unknown others on social media), yet describe challenges navigating the complexity of incomplete or contradictory messages within this information landscape.
- Young people appear to feel more confident about their abilities to find information about condoms and contraception than being able to accurately assess the quality of information.
- While many young people reportedly turn to official healthcare sources (e.g. NHS websites, GPs, nurses) for accurate information on condoms and contraception, they do not always trust that they will receive the most honest input (e.g. on side effects) from these sources.
- Personal accounts of contraceptive experiences (e.g. from friends and unknown others on social media) are differentiated from scientific evidence, but are sometimes valued as an additional layer of information in a decision-making process.
- Young people want information about condoms and contraception that is easily accessible, scientifically accurate, and honest – especially about potential side effects of certain methods, and the fact that finding condom/s or contraception they are satisfied with may take time.
- Improving young people’s trust in information produced by ‘official sources’ (e.g. Scottish Government, NHS) would require more sophisticated use of social media platforms (e.g. Instagram) and digital formats (e.g. video blogs of contraceptive consultations) by these organisations.

How do young people perceive and experience free condom and contraception services?

Use of, and satisfaction with, sexual and reproductive health (SRH) services are closely linked to health system factors, such as the availability, accessibility, acceptability, and quality of services. As such, stakeholders who took part in shaping this study asked us to find out more about how young people perceive and experience services providing free condoms and contraception.

Knowledge of free condom services

Condoms are available free of charge to any young person in Scotland via local service models across all health boards. Currently, young people can access condoms for free in a range of locations, including GP surgeries, sexual health clinics, community pharmacies, colleges and universities, and youth centres.

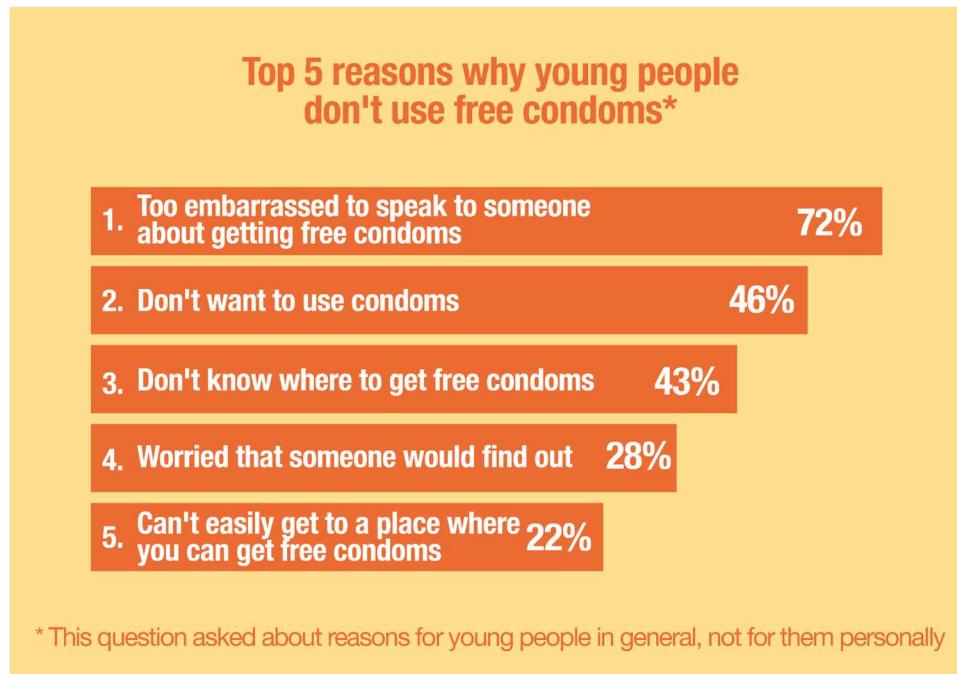
In the survey, we asked all respondents whether they knew at least one place in their local area where they could get free condoms. Just over half (53.8%) stated that they did know at least one place in their local area. Over a third (37.4%) did not know at least one place, and 8.5% were unsure. There were no significant differences in awareness of a local free condom distribution point by gender. However, more 20-24 year olds than 16-19 year olds were aware of points of access for free condoms (57.5% vs 49.8%, respectively).



In workshops and small group discussions, knowledge about services providing free condoms varied. Among those who were aware that condoms could be accessed for free, some noted that they had first heard about this while they were in high school, while others said they only became aware of these services in university or college (e.g. through outreach activities during Freshers' Week, discussions with new friends, etc.). Young people also described a lack of clarity about who free condom services were intended for (e.g. questioning whether they were mainly aimed at adolescents rather than young adults), and whether free condom services operated similarly across Scotland.

Perceived barriers to use of free condoms

We asked all survey respondents for their views on why some young people who have intercourse do not use free condoms. Respondents could select up to three reasons out of eight options. As with other survey items, this question and its response options were co-developed with stakeholders, including young people.



Responses highlight the predominance of stigma as a barrier to accessing free condoms, with almost three quarters (71.9%) of respondents citing embarrassment to speak to someone about getting free condoms as a barrier, and over a quarter (27.9%) believing worry about being 'found out' to be a factor. Other commonly cited barriers included lack of desire to use condoms (45.6%), lack of knowledge about where to access free condoms (43.4%), and poor accessibility to these services (21.6%). Relatively few respondents endorsed reasons relating to lack of choice or perceived inferiority in the types of condoms that are available for free. Results were similar across genders.

We further explored barriers to use of free condoms in workshops and small group discussions with young people, and in an interview with a representative from a condom company. The following themes were prominent in these conversations.

Fear of face-to-face interaction and being judged

As in the survey, embarrassment about having to ask for condoms in person and fear of being judged by service providers (e.g. for being sexually active) were predominant in young people's accounts. Being asked to reveal information about oneself or one's sexual behaviour in order to obtain free condoms (sometimes believed to be routine practice in areas where this was not the case) was commonly described as a deterrent. These fears spurred some young people to avoid using services where they could be seen by others, and where they expected to have to directly request free condoms in a face-to-face interaction (e.g. in a pharmacy). Those who did use service points requiring face-to-face contact noted that they tried to keep any interaction as brief as possible (e.g. by not discussing personal requirements, such as condom size or material).

I think if I went to a doctor's office, they might be like, 'oh, what size?' And then there's that whole thing, which is just like if you get the big ones, they'll think, oh, you're lying, you're just trying to make yourself look cool. But then what if you actually need them and then they won't fit and that's bad. That was something that really blindsided me the first time.

(Man, mixed gender group
aged 19-21)

The representative from a condom company also highlighted the importance of anonymity for many retail customers, which – alongside convenience – was identified as a key factor driving growth in online sales.

Branding and perceived quality of free condoms

Although the perceived quality of free condoms was only cited as a barrier to use by a minority of survey respondents (19.3%), perceived quality of different brands was regularly raised by the young people with whom we spoke. While some noted that they did not differentiate between brands, others said they viewed condoms that were available for free as lower quality than more widely known commercial brands; as one woman commented, *"...there's also that stigma around Durex or whatever being better than Pasante"*. Moreover, some expressed a view that accessing condoms for free (e.g. from sexual health clinics) was a practice associated with adolescents, and buying condoms was viewed as a rite of passage into adulthood. In the context of these perceptions, young people talked about stigma associated with using free condoms, which could risk those who used them being seen as immature, or a "cheap date".

"Yeah, I was seeing this guy and we were about to have sex and he pulls out a Pasante condom and he was like, 'oh God, I'm really sorry but it's Pasante'. I was like I don't care, it doesn't make any difference to me if it's Durex or Pasante as long as it's a condom".

(Woman, mixed gender group aged 19-23)

Stigma associated with the condoms distributed by NHS-funded schemes was also discussed in the interview with the representative from a condom company. While inferior product quality was discounted as a reality, its *perception* was acknowledged as an ongoing challenge to building trust in condoms that are available for free. Directly engaging with brand trust may, however, provide free condom services with a way to 'flip' this narrative, such that condoms that are effectively "NHS-endorsed" could be promoted as highly trusted products.

Alongside discussions about brand trust, packaging of free condoms was also raised as a relevant consideration. During workshops and small group discussions, some young people commented on different foils for free condoms that they had seen distributed in sexual health clinics and community settings (e.g. education settings, youth centres, nightclubs). While some designs were welcomed for their inclusivity (e.g. those using ‘Pride’ colours and symbols), others were critiqued for being “unrelatable” to some young people (e.g. messaging about love on a condom).

Variety and challenges finding the ‘right’ condoms

In small group discussions, some young people talked about the importance of experimenting to find condoms that suit different needs and preferences (e.g. fit, material), yet they believed awareness among their peers about the variety of condoms available was generally poor. Messaging about condom use in school-based sex education was described as simplistic (i.e. “use one”), and lack of more detailed discussion about variety and the process of finding the ‘right’ condom/s was seen by some as a missed opportunity. Some commented that they only discovered the importance of condom fit when they saw the variety on offer at a sexual health clinic.

For services providing free condoms to be appealing, offering a wide selection of condoms (fit, feel, flavour, material) to select from was identified by young people as key, as was guidance to support these choices. While some expressed frustration about receiving ‘variety packs’ which might contain multiple condoms they would not use, these were seen as a useful option for young people at sexual debut as they allowed for experimentation and discovery of what works for them.

“I think there wasn’t at the sexual health clinic but at the [name of university] ones they had a variety pack, which I think is brilliant. Because they always came in a pack of 20. I didn’t know what size I was and you don’t want to end up going out with three bags, one of every size. But a variety pack, for the first time you do it, you try it out, it seems like a solution”.

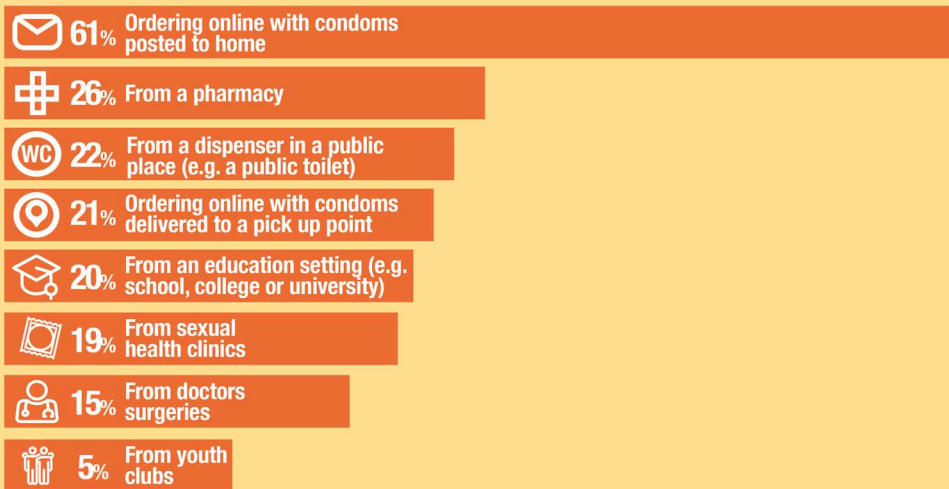
(Non-binary person, mixed gender group aged 19-21)

The representative from a condom company also emphasised the importance of finding the right fit and feel and viewed opportunities for young people to learn about different options as a key way to change negative experiences of condoms. Higher manufacturing (and therefore product) costs of some types of condom (e.g. those with thinner latex) were, however, recognised as a barrier to free condom services offering greater variety to young people, especially in health boards with smaller budgets for condom purchasing.

Preferred points of access for free condoms

To understand whether current points of access for free condoms align with young people’s preferences, we asked all survey respondents how they would prefer to access free condoms, if they were needed. Respondents could select up to three responses out of eight options.

Young people's preferred ways to get free condoms



Overall, options requiring minimal contact were strongly favoured. By far the most preferred way of accessing free condoms across all genders was to order online with condoms posted to home (61.2%), followed by pick up from a pharmacy (26.0%), dispenser in a public place (21.5%), or ordering online to a pick-up point (20.8%). Accessing free condoms from a doctor's surgery (14.6%) or youth club (5.4%) were the least preferred options. Distribution of responses was similar by gender and age groups, as well as by young people's living arrangements (e.g. whether they lived with their parents/carers, in a flat share, etc.).

In discussions with young people, anonymity and confidentiality at the point of access were identified as key considerations for services providing free condoms. The following specific features were mentioned by young people.

- **Easy and discreet access within community settings.** Discussions highlighted the importance of providing ways to discreetly access condoms in settings commonly used by young people. Dispensers in public toilets (e.g. in cinemas, shopping and leisure centres) that could be accessed electronically (e.g. via an app or QR-code) were seen as a good option by some, especially young men. Educational settings were described as acceptable points of access if young people could do so without being seen by peers, and if the process required minimal face-to-face contact with staff (e.g. condoms kept in a secure room with swipe card access via student ID card). Although preference for receiving condoms at home was similar among survey respondents living with parents/carers as those living in other circumstances, young people in workshops and small group discussions indicated that maintaining privacy in a parental home was an additional consideration. Post-to-home services were, however, described as acceptable if the package content was unidentifiable as condoms.

- **Easy and discreet access within health care settings** (e.g. GPs, sexual health clinics). Specific attributes described as conducive to access included:

- ⇒ A dedicated private space where condoms are laid out for young people to look at and pick from;
- ⇒ Location of this space in an area that enables the possibility of a quick visit (“in and out”);
- ⇒ Clear sign-posting to this space from the entrance to the building so that young people can avoid having to ask for directions.

‘I find the sexual health clinic the easiest, personally, just because of factors like Sandyford, like up on Sauchiehall Street, you walk in, they’re on a table, they’re all there, all the sizes, all the different kinds, and then you can look, grab and leave’.

(Woman, mixed gender group aged 19-21)

Experiences of accessing STI testing and contraception services

In the survey we asked intercourse-experienced respondents whether they had ever tried to get an appointment for STI testing or contraception services in either a GP surgery or specialist sexual health clinic, and if so, we asked about their experience of ease of accessing these appointments (Table 5). Young people were asked to answer based on their experiences prior to COVID-19 restrictions.

The proportion of intercourse-experienced young people who had never tried to access appointments was high in each of these two service settings. STI testing was the service with least attempted appointment making, with a majority *never* having tried to get an appointment for testing at a GP surgery or sexual health clinic (59.2% and 53.7% respectively; data not shown in table). These figures are higher among young men (65.2% and 61.1% respectively) than young women (54.8% and 48.7%). In terms of appointments for contraception, only 12.4% of intercourse-experienced young women had never tried to access an appointment to discuss contraception at a GP surgery, as opposed to 40.4% at a sexual health clinic (data not shown in table).

Among intercourse-experienced respondents who had tried to access appointments for STI testing or contraception services, approximately a third reported some degree of difficulty in either setting (Table 5). More respondents indicated that accessing appointments for STI testing was *difficult/very difficult* at a GP surgery than at a sexual health clinic (36.4% and 29.1%, respectively). By contrast, accessing appointments for contraception services in a sexual health clinic was experienced as difficult/very difficult by a greater proportion of respondents than accessing an appointment in a GP surgery (35.2% and 29.3%, respectively).

Table 5. Ease of accessing appointments for STI testing and contraception services among intercourse-experienced respondents who had accessed appointments

	Ease of accessing appointments for STI testing		Ease of accessing appointments for contraception	
	At a GP surgery (n=624)	At a sexual health clinic (n=711)	At a GP surgery (n=1031)	At a sexual health clinic (n=764)
Easy/Very Easy	33.8%	29.1%	33.7%	38.2%
It's ok	29.8%	23.8%	37.0%	26.6%
Difficult/Very Difficult	36.4%	29.1%	29.3%	35.2%

Denominators vary due to varying numbers of respondents having accessed services in different settings.

In small group discussions, a range of barriers to **STI testing** among young people were highlighted, including:

- Disconnect between messaging that young people should test regularly, but long waiting lists for asymptomatic testing within sexual health clinics (“a daunting process”);
- Perceived lack of specific information regarding the logistics of testing, including where to get tested, what is actually involved, and average waiting times at particular services;
- Embarrassment asking a health professional for an STI test (“asking is the most difficult part”);
- Perceived reluctance of GPs to carry out STI testing;
- A perception that sexual health clinics can be a intimidating environment for a test that should be routine and easily accessible;
- Stigma associated with being known to have sought STI testing (e.g. concerns that others might view this as “dirty”, although this was strongly contested by some young people, who instead framed testing as responsible).

“Waiting lists are quite long to get tested for routine check-ups and I think that’s a huge thing. It even puts me off sometimes because you have to think three months in advance, and especially most people don’t know what you’re doing in three months necessarily on a particular day”.
(Woman, mixed gender group aged 19-21)

“Before I got tested for the first time, I’d heard stories, like scary stories about them putting things inside you and stuff, which isn’t true and it’s like not scary at all. But when you don’t actually know what a STI test is, you don’t get much information about it, you get told that you should get tested, but you don’t actually know really what’s involved in a test. So that’s why I think it was quite daunting for me for the first time”.
(Woman, mixed gender group aged 19-21)

“...if you were going to the clinic that meant like people would think you were kind of dirty, like people would automatically assume if you were anywhere near a sexual health clinic that it was because you were like riddled with STIs”.
(Woman, mixed gender group, aged 19-23)

For contraception-related consultations, contraception users within the small group discussions (especially young women) described a range of access-related challenges they faced.

At sexual health clinics, long waiting times for consultations were often mentioned, with young people reportedly having to wait up to three months, especially for LARC methods. Consequently, sexual health clinics were sometimes described as not able to meet 'short-notice' needs for contraception, and were seen as only compatible for appointments that could be planned further in advance (e.g. renewal of an implant). Some young people expressed a view that long waiting times were caused by an insufficient number of sexual health clinics across Scotland.

At GP surgeries, long waiting times of up to several weeks were also a reported barrier to accessing contraceptive consultations, in addition to a perceived lack of transparency about which methods (including LARC) are available in specific GP surgeries, and a view that some GPs would prefer young people to obtain contraception through a sexual health clinic. Young people also described weak referral mechanisms between settings providing contraceptive services (e.g. not being clearly directed to an alternative service if a preferred method was not available via a GP surgery), which left them feeling that they had to navigate the complex system alone.

'I tried to book an appointment [to renew her implant] and it was like three months in advance I had to get it, and that's quite a long time to book an appointment for, and they ended up cancelling it and I had to book another one. And it was a bit frustrating because I feel like if I was trying it out for the first time, or whatever, like during that time I probably might have not used contraception if I was somebody else. Do you know what I mean? Because it takes ages. And I also think people are not aware you can get it from your GP when it comes to that sort of stuff. They think you might have to go the sexual health clinic, which is not true, some GPs do those kinds of services'.

(Woman, mixed gender group aged 19-21)

Preferences for accessing contraception services

In the survey, we asked all respondents about their preferences for accessing contraceptive services if needed, including the nature of the consultation (e.g. face-to-face or remote), the setting (e.g. in a GP surgery or sexual health clinic), and appointment booking options (Table 6). Young people were asked this question whether they had experienced intercourse or not, but they could choose to opt out of this question if they felt that a need for contraception would never be relevant to them (n=94). As our survey was conducted between June-July 2020, we asked respondents to imagine that COVID-19 related social distancing measures were not in place and everywhere was open.

Table 6. Preferences for accessing contraceptive services

Preferred type of appointment (N=1906)				
In person/face-to-face	By live chat/messenger service	I don't have a preference	By telephone	By video chat (e.g. by Zoom, FaceTime)
54.3%	21.7%	15.9%	6.6%	1.5%
Preferred setting for appointment (N=1897)				
Sexual health clinic	I don't have a preference	GP surgery	Pharmacy	
50.7%	25.6%	21.1%	2.6%	
Preferred booking option for appointment (N=1901)				
Online	I don't have a preference	By phone	Drop-in and wait (no need to book)	
60.6%	17.4%	13.3%	8.7%	

Among survey respondents, we found **preference for contraceptive consultations** that were:

In person

Meeting a health professional in person was the most preferred option for contraception consultations (54.3%), followed by a live chat/messenger service (21.7%). The least favoured options were consultations via telephone (6.6%) and video chat (1.5%). A further 15.9% did not indicate a preference.

In small group discussions, young people also expressed preference for in person consultations with health professionals. Face-to-face consultations were described as fostering more open discussion, providing the possibility for examinations and tests to be done there and then, and – most importantly – ensuring privacy. Video consultations were seen as uncomfortable and high risk in terms of confidentiality due to the possibility for being overheard by others (e.g. at the patient or health professional's home or at the clinic/surgery), although notably, none of the young people to whom we spoke reported having personally experienced a video consultation.

In specialised sexual health settings

Sexual health clinics were the most preferred setting for contraception consultations with approximately half (50.7%) of young people choosing this option, compared to in a GP surgery (21.1%) or pharmacy (2.6%). Approximately one quarter (25.6%) of young people did not express any preference for appointment setting.

During small group discussions, young people mentioned that sexual health clinics offered important benefits for contraceptive consultations, including: health professionals viewed as having more specialised knowledge on contraception and sexual health and greater comfort communicating about these topics with young people; access to a wider range of contraceptive options, and fewer concerns about patient confidentiality regarding contraceptive needs compared to with GPs. However, disadvantages of accessing contraceptive care in sexual health clinics were also frequently cited, such as the distance to clinics (*'too far to travel'*) and, as previously noted, long waiting times (*'where can you even go in Glasgow other than Sandyford – the waiting list is 2 months!'*).

Booked online

Booking appointments online was by far the most preferred option, selected by over half of respondents (60.6%). The least favoured option was to 'drop-in and wait' (8.7%). A total of 17.4% of young people stated no preference.

During small group discussions, online booking was unanimously described by young people as the most convenient approach. While seen as convenient for some, drop-in clinics were described as problematic if they involved longer times spent in the waiting area with other people, potentially threatening privacy.

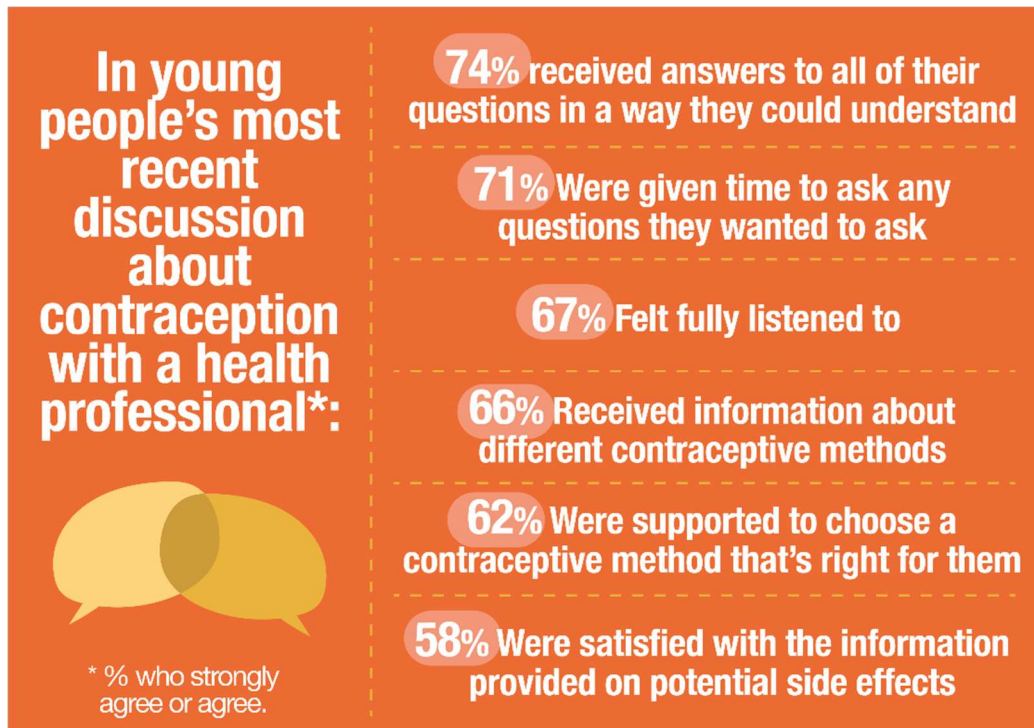
Discussing contraception with a health professional

In the survey, we asked intercourse-experienced respondents who indicated that they had ever used contraception with a partner (including condoms) (n=1349) to tell us about their most recent discussion with a health professional regarding choice of contraceptive method. Over one third (36.5%) of these respondents stated that they had never had a discussion with a health professional about contraception. Of these, 80.7% were young men, 16.1% were young women, and 3.3% identified their gender in another way.

Among those who reported that they had discussed contraception with a health professional (of which 84.5% were young women), almost three quarters (72.9%) had their most recent consultation at a GP surgery, 23.5% at a sexual health clinic, 2.3% at a pharmacy, and 1.4% at a hospital.

To better understand how young people perceived the quality of this most recent discussion, we asked respondents to state their level of agreement with a series of six statements reflecting different dimensions of a positive contraceptive consultation.

Overall, our data highlight that for each of these dimensions, a majority of young people (range from 57.7% to 73.5%; see graphic below) perceived these quality criteria to be present during their latest consultation. For each of the elements, however, a significant minority were dissatisfied, such as not being satisfied with the information provided on side effects (20.6%), not feeling supported to choose a method that was right for them (17.6%), not feeling fully listened to (17.1%), and not being satisfied with the information they received about different contraceptive methods (14.0%). Notably, consultations that took place with health professionals working in a sexual health clinic were rated more positively across each of the six quality dimensions as compared to GP surgeries.



Of the young people who answered these questions, over a third (n= 272)^{XIV} chose to tell us more about this most recent consultation via an open text box.

In a minority of these responses, young people evaluated their most recent consultation in positive terms, including descriptions of feeling heard, supported, not judged, provided with sufficient information (both within the consultation and to peruse afterwards), being reassured that all questions were welcome, and being satisfied with the contraceptive method chosen; for example:

I attended a drop-in session at my local sexual health clinic and was given advice about condoms as at the time the ones I had been using hurt. I also received an STI test per my request just to be safe and throughout the entire process the conversation between myself and the clinician was entirely comfortable and informative.

(Man, age 24, sexual health clinic appointment)

First appointment was discussing which one, second appointment was the actual implant, plenty of time to talk or ask questions.

(Non-binary person, age 20, sexual health clinic appointment)

I always feel more comfortable talking with a female physician. However, the most recent conversation was with my GP (male). He made me feel comfortable, not embarrassed and explained everything I needed to know and also gave me pamphlets and directed me to the NHS website for more info, I felt safe.

(Woman, age 22, GP surgery appointment)

^{XIV} Of the 272 respondents: 201 commented on an appointment with a doctor or nurse at a GP surgery, 63 on an appointment with a doctor or nurse at a sexual health clinic, 4 with a pharmacist, 1 with a gynaecologist, and 3 did not mention the type of healthcare professional with whom they spoke.

In contrast to these positive experiences, a majority of the 272 young people shared challenges they faced during their last consultation. Key themes and illustrative quotes are presented below.

Being pushed towards certain methods

Health professionals were sometimes described as applying a generic approach to contraceptive consultations, rather than individualised care. Certain methods, such as the pill and the implant, were sometimes seen as favoured options by health professionals that tend to be 'pushed' onto young people without any discussion on the underlying rationale or information on other options. This led to young people sometimes feeling that healthcare professionals' prescription preferences superseded their own.

"Felt I was treated in a very generic manner and no care was shown towards my specific needs"

(Woman, age 21, GP surgery appointment)

"GP's don't seem to care, they push the pill and don't tell you about the side effects. I wasn't told about any other options other than the pill. When I went back they just kept putting me on different pills. Told me I was 'too young' for the coil"

(Woman, age 22, GP surgery appointment)

"I asked if we could talk about a long-term reversible contraceptive and was told that as I was not in a relationship at the time it might be better to stay on the pill - with no explanation as to WHY it was better. I had only asked after a conversation with a friend who studies medicine and felt embarrassed that I'd bothered asking..."

(Woman, age 23, GP surgery appointment)

"I wanted to find out more about the options available, but was pretty much told to take the pill without any discussion as to side effects or current experiences with periods."

(Woman, age 22, GP surgery appointment)

Not being heard or respected

A strong sense of not being heard by health professionals during contraceptive consultations was evident in some responses. Young people described voicing concerns that were dismissed or ignored. Many accounts referred to feelings of being judged, discriminated, not taken seriously, and even treated as children.

"I didn't feel that my concerns were really listened to, I more felt that she was just eager to stop me worrying which while understandable didn't make me feel very heard".

(Woman, age 22, type of consultation not specified)

"I always feel like my sexual health conversations with professionals are viewed through the lens of race or assumptions. My first visit to a contraceptive clinic had the lady ask me if I was sure I'd only had one partner. This was humiliating and insensitive as I felt unheard".

(Woman, age 20, GP surgery appointment)

"When I had my IUD inserted, my GP was pretty rude, and treated me like I was a bit stupid. When I asked how to check the IUD stayed in place (I'd read on the NHS website beforehand that my GP would show me how to check), she snorted and said 'you'll just see it has come out.' I was not offered any pain relief when I had it inserted and was not in stirrups/given a blanket or anything to cover myself with".

(Woman, age 22, GP surgery appointment)

Dismissal of side effects

Young people described the lack of discussion about potential side effects, and dismissal of their own lived experiences of side effects with current or previous method(s), especially related to change in mood and depression.

"I was put on the POP as I couldn't use the combined pill. I felt I wasn't fully informed on the irregularity and how unpredictable my periods would become. After speaking to a nurse about my concerns, I was told to "stick with it" but I felt defeated."

(Woman, age 16, Sexual health clinic appointment)

"The GP I discussed with was a little bit condescending. After I had talked with him about some side-effects of taking the pill he didn't seem to take it as seriously (I was 14 at the time), seemed to just chalk it up to being young and still developing as such I stopped taking the pill due to major mood swings and such. The pill was originally just for bad periods, after for contraceptives we just used condoms as well as pulling out (both at same time)."

(Woman, age 17, GP surgery appointment)

"I had been experiencing unpleasant side effects from the pill I was on. When I told my doctor they seemed a bit sceptical of some of the side effects I reported but unsurprised by the others, and just gave me a different type of pill with no discussion of how these side effects had affected me, or other contraceptive options".

(Woman, age 22, GP surgery appointment)

Dismissal of interactions between contraception, other medication and health conditions

Young people's responses also highlighted a perceived inadequacy of health professionals' efforts to contextualise contraceptive options within relevant aspects of one's wider medical history, including other medications or health conditions. Responses particularly highlighted a disconnect between discussions about contraception and mental health.

"Being on medication for mental health/depression and being on hormonal contraception is a worry for me as I do not want it to interfere with my recovery or effects of my antidepressant. This was not discussed or asked about even though it is the main barrier for me going on contraception other than just using condoms".

(Woman, age 21, Sexual health clinic appointment)

"I have had discussions with 2 or three healthcare professionals so far. None of which I have found completely helpful...Discussion 1- with GP, She provided with information on 3 different types of contraceptives... when I raised the issue of concerns about side effects and interaction with my type 1 diabetes she told me "well they're better than getting pregnant". I felt patronised".

(Woman, age 24, GP surgery appointment)

"I am a female and have always used condoms with partners but the GP was dissatisfied with this and was keen on me using other contraception methods. I have to take into account that other methods could make my cluster migraines worse. The GP did not think this was an issue. They also did not fully talk me through my options and why condoms are seen, in their eyes, as not good enough".

(Woman, age 24, GP surgery appointment)

Limited time given to discussions

Perceived time constraints of contraceptive consultations were described as leading to one-way communication from healthcare professional to patient, rather than a two-way discussion with time and space for the patient to fully engage in informed decision-making:

"Decision was made very fast without knowing much detail."

(Woman, age 16, GP surgery appointment)

"I feel sometimes the doctors are rushed for time while discussing methods of contraception. I think as well side effects need to be talked about more openly. You can choose what you want it's given to you and you get a leaflet then describing a large list of side effects that you were unaware of after choosing that method and starting on it".

(Woman, age 24, GP surgery appointment)

"I have found that the GPs I have spoken to about contraception never really tell me about my other options because I take the pill so I am reluctant to consider any or ask for them"

(Woman, age 21, GP surgery appointment)

Accessing and using condoms and contraception during COVID-19

As our survey was conducted between June-July 2020, we asked young people whether COVID-19 related social distancing measures had made any difference to their access to, and use of, condoms and contraception. These findings are described more fully [elsewhere](#) [7].

Of those who used condoms and contraception (n=1588), one quarter said that COVID-19 related social distancing had made a difference to their access and use. 91% (n=361) of those who said their access was affected opted to tell us more about how.

Collectively, responses described **disrupted access** to services providing:

- **contraceptive care** that requires physical contact to administer
- **contraceptive support and guidance**
- **free condoms**
- **routine STI testing**

Overarching factors driving this disruption included:

Young people self-censoring their SRH needs:

Public health messaging about reducing pressure on health services led some young people to self-censor their need for freely provided condoms and contraceptive care, with some even discontinuing use.

"I feel embarrassed prioritising getting contraception over someone who could have a serious problem."

(Woman, 19, heterosexual/straight)

Confusion created by contradictory messaging on sexual health care and prevention:

Sudden changes to standard SRH care and routine advice on contraception and STI prevention, coupled with an inability to find reassurance online left many young people frustrated, anxious and confused.

"I have the implant which I was told lasted 3 years and it ran out a couple of months ago, now I've been told it lasts for 4 years? I've checked online and nothing backs this up. Very worrying."

(Woman, 24, heterosexual/straight)

Exacerbation of existing barriers to accessing condoms and contraceptive care:

Pre-existing access challenges, such as embarrassment about interacting with health care professionals, or difficulties getting appointments, were intensified by the pandemic. Young people's ability to advocate for their own SRH needs was inhibited by a range of factors, such as service gatekeepers, lack of confidence interacting with health professionals via telephone or video calls, and constraints to privacy. These, plus uneven access to social support and financial barriers to paying for products from online shops and pharmacies, widened health inequalities, exposing some young people to increased risk of an STI or unplanned pregnancy.

"I get my condoms from a youth group which is shut due to social distancing and do not feel comfortable getting them somewhere else"

(Man, 16, pansexual)

Outcomes of this disruption to SRH services that were evident in young people's accounts included:

Changes to sexual behaviour & prevention practices

e.g. having unprotected sex that would usually be protected, avoiding sex, stopping contraception

"I initially went to the sexual health clinic but due to Covid I spoke to a nurse from the GP on the phone. She told me to stick with my contraception method even though it was making me depressed and miserable. I eventually came off it but now am having unprotected sex"

(Woman, 16, heterosexual/straight)

"...we've had multiple occasions where we've not had intercourse due to lack of money to order condoms in and unable to obtain free ones where we know we can (university, the GP surgery)."

(Non-binary person, 24, queer)

"Due to not being able to get to the clinic to have my expired implant removed it's made me more hesitant on partaking in sexual activities"

(Woman, 18, heterosexual/straight)

"I have felt no need to continue my contraception use while having no sexual intercourse due to lockdown"

(Woman, 16, bisexual)

Unwanted contraceptive pathways

e.g. unable to continue preferred method, unwanted switching of method, unmet need for contraceptive advice

"Unable to have my contraceptive removed from my body."

(Woman, 21, heterosexual/straight)

"It's been a nightmare to get a new contraceptive method as understandably everywhere is closed, but... I'm stuck on a pill that isn't working well to keep me going till I can get booked in to get the coil"

(Woman, 22, heterosexual/straight)

"I haven't been able to use the contraception I would usually use as I can't get any access to a sexual health clinic due to COVID 19. This means I'm relying only on condoms, which isn't what I prefer."

(Woman, 24, heterosexual/straight)

"I have not been able to visit my GP surgery to get more contraceptive pill, and I do not know another way to get another prescription"

(Woman, 23, bisexual)

"Have struggled to get access to discuss contraception options as someone who wishes to start regular contraception"

(Woman, 22, heterosexual/straight)

Unmet need for STI testing

"I regularly attended or pre booked appointments with a sexual health clinic before or after sexual encounters mainly for a chat, information or peace of mind testing but recently from Covid 19 I found this a difficult task or I felt that it would not be or considered to be essential"

(Man, 22, bisexual)

"I've waited months past since I have had symptoms of an STI/D due to not wanting to break social distancing - not sure how sexual health clinics have been dealing with it."

(Man, 21, pansexual)

"Currently I have been trying to get a routine sexual health screening before I have sex with new people however due to lockdown the sex clinic in my area is only taking emergency appointments"

(Woman, 24, heterosexual/straight)

"I have been sexually active during the lockdown with multiple partners. It has been extremely disappointing that the sexual health clinics have (and still are) closed. I am unable to order STI postal kits. Why? I phone up the clinic and they said that they are not testing."

(Woman, 24, heterosexual/straight)

Accessing condoms and contraception via alternative routes,

e.g. ordering free condoms online, buying condoms or contraception online

"I had to get condoms delivered to my house for the first time."

(Man, 24, gay)

"Ordered off Amazon instead of free condoms in Boots pharmacy"

(Man, 17, bisexual)

"Don't feel that it is appropriate to go in and use the c card scheme at the pharmacy right now so buy my own"

(Man, 17, gay)

"Haven't been able to access free condoms on uni campus and have had to buy my own"

(Man, 19, heterosexual/straight)

"Girlfriend needed to get more of the contraceptive pill but during lockdown we couldn't seem to get an appointment at the doctors for this so we ended up buying the pill online from a pharmacist"

(Man, 23, heterosexual/straight)

"I have ordered my pill from an online pharmacy (yet had to pay) as it was easier than getting an appointment with my GP"

(Woman, 24, heterosexual/straight)



Section summary: Sexual and reproductive health services

- Almost half (46.0%) of survey respondents did not know or were unsure where to access free condoms in their local area.
- Young people's use of free condom services is further impeded by embarrassment about face-to-face interactions, concerns about anonymity, a perceived lack of understanding about the variety of condom options, and perceived lower quality of free products.
- Many young people indicate preference for free condom services that require minimal face-to-face contact, with online ordering of condoms posted home by far the favoured option across all genders.
- The majority of intercourse-experienced survey respondents had never tried to access STI testing at a GP surgery or sexual health clinic.
- Approximately 1 in 3 intercourse-experienced young people indicated difficulty getting an appointment for contraception or STI testing.
- Approximately one third of survey respondents who had used contraception (including condoms) had never spoken about the method(s) with a health professional.
- Major barriers to accessing sexual health services include: long waiting times for consultations, stigma about being known to use sexual health services, lack of clarity on which specific services are available in different settings, and an insufficient number of specialised sexual health clinics.
- Clear preferences for consultations about contraception with a healthcare professional include an online booking system, and in-person discussions within a specialised sexual health service setting. Very few young people report preference for accessing contraception consultations via pharmacy services.
- Despite clear preferences for consultations about contraception in specialist sexual health settings, almost three-quarters of contraception-using survey respondents had their most recent consultation at a GP surgery.
- Causes for dissatisfaction with contraceptive consultations include feelings of being pushed towards certain methods, not being heard or respected, dismissal of side effects, a dismissal of interactions between contraception, other medication and health conditions, and limited time given to discussions.
- COVID-19 has disrupted young people's access to, and use of, free condom and contraception services, leading to changes in sexual risk-taking and preventive practices, unwanted changes in contraceptive use, unmet need for STI prevention, and switches from freely provided to commercially sold condoms and contraception.

Recommendations

We conducted five workshops with 31 sexual health stakeholders – including young people, sexual health clinicians, and people involved in planning sexual health services – to co-develop a series of recommendations for future sexual health policy and provision. Each workshop focused on developing recommendations to address key challenges highlighted by the study findings. Ideas and discussion points from each workshop were brought forward to the following workshops to collect perspectives from multiple groups on the acceptability and feasibility of the suggested solutions. Details of this co-development process, including participants, are elaborated in [Appendix A](#).

During these discussions, it became clear that the complexity of factors shaping condom and contraception use highlighted by this study call for a coordinated, strategic and incremental response. Stakeholders noted that it would be important to prioritise improving the quality of information and services first, before investing in efforts to increase demand for sexual health services among young people. We have, therefore, organised recommendations into two stages:

- **First stage recommendations** focus on the development and strengthening of sexual health information and services;
- **Second stage recommendations** focus on expanding young people’s use of quality sexual health information and services.

Please note: *A detailed summary of stakeholders’ suggestions and perspectives regarding these co-developed recommendations is available in [Appendix C](#), including their views on perceived facilitators and constraints to enacting change.*

We believe that collaborating with a diverse group of young people to think through development and delivery of each of the below recommendations will be key in reaching successful outcomes.

First stage recommendations (developing and strengthening information and services)

1. **Establish structures that facilitate the meaningful and ongoing involvement of diverse groups of young people in high-level strategic planning regarding sexual health improvement among young people in Scotland.** Facilitating young people’s involvement in strategic planning might include establishing new structures (e.g. a young people’s sexual health collective, network or task force), or bringing young people into existing policy structures that support strategic planning.
2. **Invest in nationally-coordinated digital communications infrastructure and strategy for sexual health to lay groundwork for successful youth-focused sexual health promotion,** including building a trusted social media presence with a large following among young people on high-use platform/s (e.g. Instagram). Digital communications strategy should be co-developed with young people and adequately resourced, including a staff role for a specialist in digital communications/social media management.

3. **Establish a nationally-coordinated website^{xv} providing a digital hub for sexual and reproductive health in Scotland**, including functionality to order free condoms, digital tools to facilitate contraception decision-making and STI testing, and sign-posting to local services and information tailored to location of user. To ensure the website is trusted and widely used by young people, it should be co-designed with young people (among other key groups for targeted sexual health promotion), promoted via social media, regularly reviewed and updated, and potentially supported by an app.
4. **Involve young people in a review of current operation of free condom distribution schemes across health boards to inform development of core standards and modes of operation for local delivery.** Review should include consideration of range of products, distribution outlets (including online ordering), and advertising.
5. **Enhance understanding and training among sexual health service providers**, especially in general practice, about young people's experiences of contraceptive consultations to improve quality of these interactions.
6. **Collaborate with young people to review and streamline young people's access to sexual health services providing condoms, contraception and STI testing**, including working to improve information advertising service availability in different settings (e.g. specialist clinics, GP and pharmacy), improve referral between services, reduce the complexity of appointment booking, diversify choice of appointment mode (e.g. video, phone), and potentially expand models of service delivery.
7. **Further strengthen in- and out-of-school education (e.g. in schools, youth work settings) and support regarding condoms, contraception and STI testing, including via the national RSHP.scot resource**, to ensure young people of all genders have the knowledge and skills to negotiate positive sexual interactions, and prevent STIs and – if desired – pregnancy. Young people should be involved in reviewing and enhancing existing content, and co-developing any new resources or materials.

Second stage recommendations (expanding use of information and services)

8. **Develop a nationally-coordinated sexual health campaign** to promote use of free condom schemes and understanding among young people of all genders, including men, about different contraception methods and experiences. Campaign strategy and messaging should be co-developed with young people, communicated via social media (among other modes), and broadcast with sufficient frequency to ensure reach to new generations of young people.
9. **Invest in development of new, and wider promotion of existing, sexual health decision aids** (e.g. Contraception Choices, those relating to STI testing) to support young people's knowledge and informed decision-making, and provide health

^{xv} A national sexual health website already exists in Scotland (www.sexualhealthscotland.co.uk), but few young people participating in this study appeared to be aware of this. Further discussions are needed to ascertain whether to review, refresh and relaunch the existing website or whether to create a new one.

professionals with practical tools to discuss sexual health, including contraception and STI prevention, with young people.

Further research

Throughout the CONUNDRUM study, discussions with stakeholders identified several questions and ideas for **further research**:

- How can we improve sexual health literacy (including digital sexual health literacy) among young people?
- How can we work with young people to improve school-based education and support regarding contraception, condoms and STI testing?
- How does condom branding shape accessibility and use of condoms by young people?
- To increase quality, how would young people and health professionals (re-) design contraceptive health services?
- How can community pharmacies be better harnessed for delivering contraceptive and other SRH services?

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Appendices

Appendix A: Co-developing CONUNDRUM with young people and multi-sector stakeholders

We wanted to ensure that the evidence and insights generated through CONUNDRUM would reflect young people's experiences of condom and contraception use, and be of use to those working to support and improve young people's sexual health and wellbeing. Recognising that higher levels of engagement with policymakers and practitioners enhance the prospects of research having meaningful impact [8], we sought to collaborate throughout CONUNDRUM with individuals and organisations with a stake in young people's sexual health, including young people themselves. Specifically, we worked with over 100 stakeholders to co-develop:

- our study priorities and research questions
- the online survey
- recommendations based on study findings.

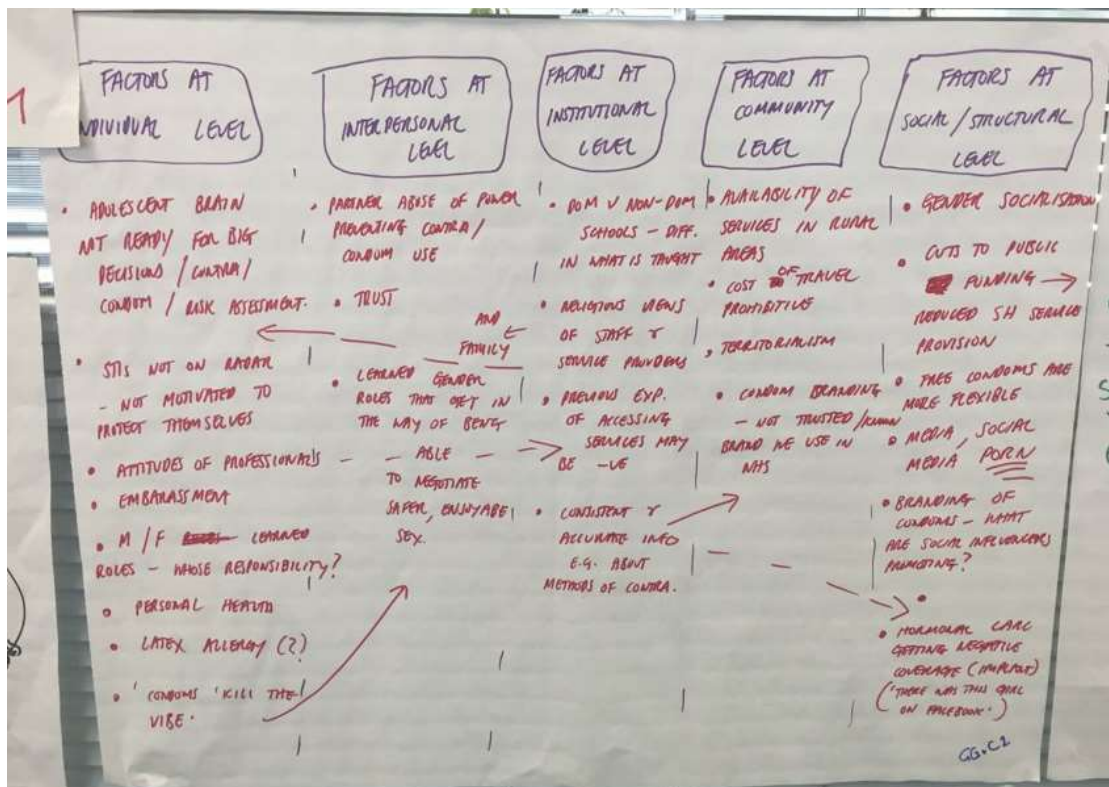
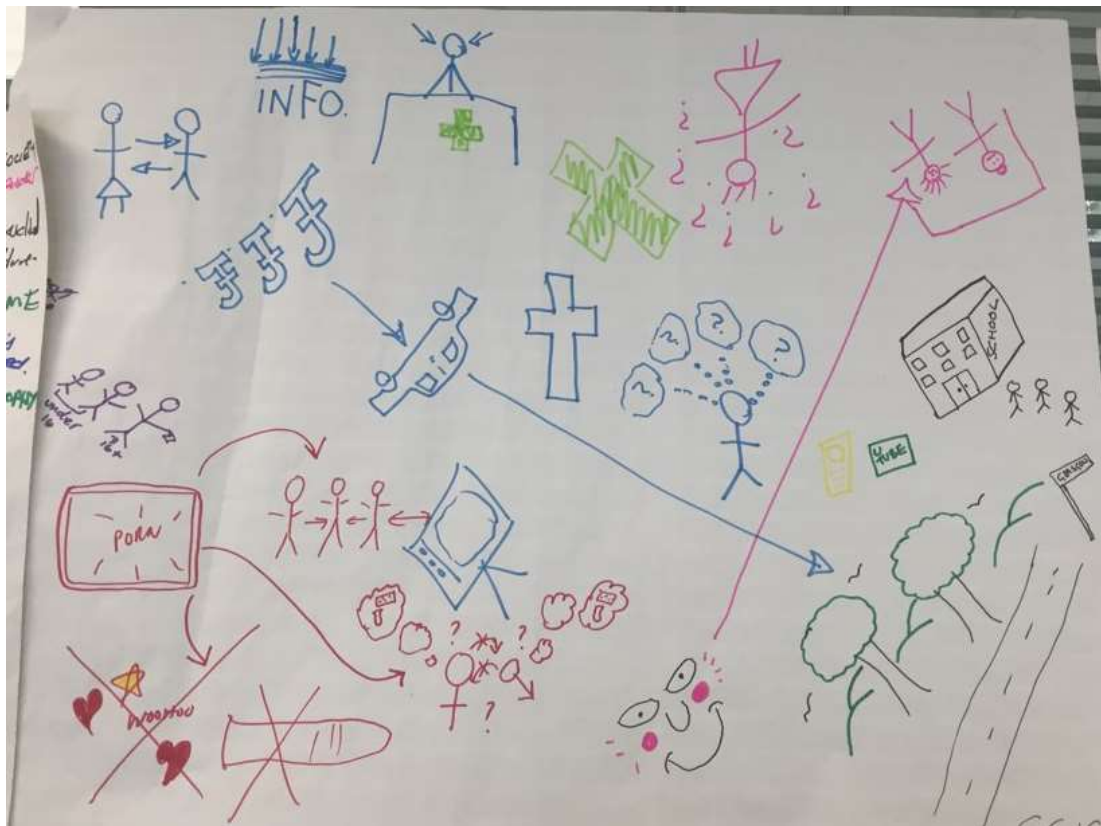
Co-developing study priorities and research questions

At the outset of the study, we conducted seven workshops with 60 stakeholders - one with stakeholders from policy and practice, and six with young people - to scope multiple perspectives on:

- factors shaping young people's use and non-use of condoms and contraception
- existing and potential solutions to increasing use of condoms and contraception
- priorities for, and potential uses of, new evidence on condoms and contraception
- the proposed design of the CONUNDRUM study, including acceptability of proposed methods to generate evidence with young people, and suggestions for recruiting a diverse range of young people.

We designed these sessions to help us better understand different stakeholders' perspectives on the 'problem' of changing condom and contraception use among young people, and to develop shared understandings of evidence required to address the 'problem'. In each of the workshops, we used [systems thinking](#) tools, including a creative drawing technique called [rich picture](#) (see images below) to open up conversations about the numerous factors shaping young people's use and non-use of condoms and contraception. In order to surface similarities and differences in perspectives from individuals located within different parts of the system (e.g. young people themselves, or professionals working in schools, sexual health services, youth work and other community settings), we encouraged participants to identify, organise and reflect upon factors across multiple ecological levels (individual, interpersonal, institutional, community, societal). Figure 5 summarises factors identified in the workshop with stakeholders from policy and practice, while Figure 6 synthesizes outputs from young people's discussions across six different workshops. Young people's drawings from the rich picture activity are used as illustrations throughout this report.

Images: Example outputs from rich picture activity designed to identify different factors and subsequent discussion to organize and reflect upon the factors identified, and connections between factors



Workshop with stakeholders from policy and practice

In October 2019, we conducted a face-to-face interactive workshop that brought together professionals involved in supporting young people's sexual health and wellbeing. Participants were 22 stakeholders working in multiple sectors, including:

- NHS-based (sexual) health improvement workers and leads
- School and family nurses
- Pharmacists
- Individuals from third sector youth work and sexual health organisations.

Participants were drawn from across the three health board areas funding the study, in addition to some representing organisations operating at national level. Identification and invitation of these key stakeholders was conducted in collaboration with study commissioners.



Workshops with young people

We conducted 6 workshops with 38 young people aged 16-24 between November 2019 to January 2020. Young people were recruited through youth organisations in the three health board areas:

Youth group/organisation	Health board area	Age group	Number of participants
Castlemilk Youth Complex	GG&C	16-17	7
I Youth Zone LGBT+ group (Greenock)	GG&C	16-19	5
sexpression Glasgow	GG&C	20-22	6
Hype Youth CLD (Livingston)	Lothian	16-17	6
6VT youth café (Edinburgh)	Lothian	16-19	6
Landed peer education project (Wishaw)	Lanarkshire	17-24	8
		Total	38

Across these six groups, there was considerable diversity in terms of participants' gender, sexual identities, sexual experiences, and broader life experiences (e.g. care experience).

Workshops were approximately two hours in duration, and were held in youth groups' usual meeting place or an alternative local community venue. Each workshop was moderated by two members of the research team (Christina McMellon, Carolyn Blake and/or Ruth Lewis). In two of the groups, a youth worker known to the young people opted to be present (with young people's agreement) for their own interest.

Figure 5: Factors shaping young people's use and non-use of condoms and contraception - policy and practice stakeholders' perspectives

Individual	Interpersonal	Institutional	Community	Societal/ Structural
<p>←-----Gender-----→</p> <p>←-----Faith and religion-----→</p> <p>←-----Mental health-----→</p> <p>←-----Poverty-----→</p> <p>←-----Porn-----→</p>				
		<p>Attitudes of professionals (including religious views) can have + or – impacts on YP (including teachers, youth workers, family nurses, sexual health nurses, health promotion, pharmacists)</p>		
<ul style="list-style-type: none"> - Not knowing where services are, or how to access - Embarrassment - Low knowledge - Low self esteem - Lack of motivation - Lack of aspiration - Capacity and accessibility issues (learning and physical disabilities) - Confusion about sexual health messages - Sense of agency/ autonomy - Cognitive dissonance - Denial and ambivalence - Ability to negotiate safer sex - Feeling judged - Fear of needles (testing) 	<p>Sexual partners</p> <ul style="list-style-type: none"> - Immediacy of sex with a new partner – view that ‘condoms kill the vibe’ and there is no time to build up trust - Learned gender roles that get in the way of negotiating safer, enjoyable sex - Archaic gendered ideas about who has responsibility for contraception, who has right to pleasure - Power imbalances between partners (e.g. abuse of power preventing contraception or condom use) - Negotiation skills - Level of vulnerability 	<p>Education</p> <ul style="list-style-type: none"> - Schools can facilitate conversations but can also shut them down - Condoms in schools would be gold standard, but some schools do not want condom provision (major barrier); - Free sanitary products have quickly become accepted – why can’t this be the same with condoms? - Religious schools’ flexibility and use of resources (e.g. God’s Loving Plan) - Is there a suitable private space in schools for YP to discuss needs? - Child protection issues 	<p>Community norms</p> <ul style="list-style-type: none"> - Norms, values and cultural expectations within local areas and communities - Religion may mean services are not offered on basis of perception about YP, or that YP don’t engage with services in first place - Territorialism – some YP can’t be seen in some areas (e.g. because of gang affiliation) so service location matters <p>Youth groups & youth work</p> <ul style="list-style-type: none"> - Youth groups are invaluable, but youth work has been decimated by lack of funding, with availability 	<p>Policy context</p> <ul style="list-style-type: none"> - Lack of focus on prevention - Lack of promotional campaigns - Is there in/consistency of prevention messages across services? - Cuts to public funding-> reduced SH service provision, and prevention as an easy target - Decisions to cut and centralise services means there’s lack of rural services - RSHP guidance-review - PPYP strategy and new SHBBV framework - Are there lessons to be learned from HPV vaccination? No problem

<ul style="list-style-type: none"> - Fear of pain (IUD insertion) - Adolescent brain not ready for big decisions/risk assessment - Latex allergy - Women’s concerns about weight gain using certain methods <p>Risk perception</p> <ul style="list-style-type: none"> - Reduced fear of STIs nowadays - STIs not on YP’s radar (“It won’t happen to me”) - Sense of STIs as inevitable for some YP (‘It’s like catching a cold’) - Sense of shame about STIs - May like LARC if it removes stress about getting pregnant 	<p>Peers & support networks (+ve and –ve influences)</p> <ul style="list-style-type: none"> - Peer pressure - Peer support - Rumours and myths <p>Families (+ve and –ve influences)</p> <ul style="list-style-type: none"> - Some young people’s enduring fear of parents finding out or knowing about sexual activity - Parents’ confidence communicating with children about sex may be inhibited by view that sexual cultures and expectations (e.g. anal intercourse) have changed since their own teenage years - Importance of early conversations between parents and children - Parents need to be supported about how to speak with children at different ages/stages of development about sex, relationships and prevention practices 	<ul style="list-style-type: none"> - Removal of nurses from schools means YP do not have an immediate or easily identified point of contact for support - Funding cut for youth worker involvement in schools <p>GPs</p> <ul style="list-style-type: none"> - Moving away from providing some services, but possibly GPs are increasingly comfortable talking about sexual health? - GPs may not be the obvious place for YP to access condoms and contraception <p>Specialist SRH services</p> <ul style="list-style-type: none"> - Funding shortages, and service pressures - Challenges getting appointments (may have to be on phone for a while) - Long wait times - Is the service model right? - Attitudes of professionals - Previous experiences accessing services may be negative 	<p>in rural areas a particular issue</p> <ul style="list-style-type: none"> - Cost of travel to groups can be prohibitive - Are we creating the right type of spaces to address paradoxes? What about churches, charities, night clubs? - Digital youth work as increasingly important 	<p>with uptake – it is accepted, and divorced from sex</p> <p>Mainstream society</p> <ul style="list-style-type: none"> - Tension between sexualised culture, but sex is still seen as shameful - Dominance of social media in young people’s lives – accurate info in competition with fake news and misinformation - Condoms seen as outdated so (how) can we glamorise them? - Hormonal care (esp. implants) is getting negative coverage (“the coil got lost in my auntie”, “there was this girl on FB...”) - Tinder culture - What are social influencers promoting? - Is porn influencing expectations around condom use by not showing them? <p>Research/evidence context</p> <ul style="list-style-type: none"> - Need for LD/ASN focus research
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		<ul style="list-style-type: none"> - Mixed/inconsistent practice - Availability of services in rural areas is minimal – accessing condoms or contraception can become a whole day out <p>Free condom services</p> <ul style="list-style-type: none"> - Branding queries - is Pasante a trusted/known brand? - Cost issues - Vast range of products – lack of choice could be a barrier, but so could too much choice if this is confusing - Face-to-face interactions as a barrier - Are pharmacies a good point of access for YP? - Do young people want postal services? - Free condom services as potentially more flexible to change than services relating to other forms of contraception. 		
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Figure 6: Factors shaping young people's use and non-use of condoms and contraception - young people's perspectives

Individual	Interpersonal	Institutional	Community	Societal/Structural
<p>Risk perceptions</p> <ul style="list-style-type: none"> - Main concern for sex between cisgender men and women is pregnancy prevention - STIs described as not a big concern for most YP (though may vary by sexuality) - Perception that 'pulling out' is widely practiced, and considered safe by some - Self-identified lack of knowledge about: <ul style="list-style-type: none"> • Hormonal and non-hormonal methods • Side effects of contraception (short and long-term), and negative interactions with other medications (e.g. antidepressants) • Morning after pill and its effects on body and menstrual cycle • Abortion – what it involves, and how people feel about it afterwards • Specific details about how STIs are 	<p>Sexual relationships</p> <ul style="list-style-type: none"> - Unequal power dynamics in relationships may be barrier to condom use (between MSM, and men and women) - Sense of injustice about unequal division of labour and responsibility related to researching, accessing and using contraception – guys don't know about it, aren't involved in the process of getting or using it, don't know anything about side effects. - Need for men to know more (and some want to) - Lack of confidence about talking to partner about contraception or condoms <p>Friends/peers</p> <ul style="list-style-type: none"> - Reliance on word-of-mouth/discussion with peers/friends to inform decision-making about contraceptive methods, including sharing of 'horror stories' and myths 	<p>Schools</p> <ul style="list-style-type: none"> - School sex education (RHSP) universally described as poor – Dislike of: scare tactics, lack of emphasis on pleasure, embarrassed teachers, reinforcement of heteronormative ideas about sex; absence of (or de-prioritised) discussion about LGBTQ+ identities and relationships - Emphasis on condom demonstrations but v. little on other contraceptive methods - Separation of sexes widely disliked as reinforces idea that men and women need different information <p>Sexual health services</p> <ul style="list-style-type: none"> - Inadequate interactions with GPs who are vague about, or underplay, side effects - Frequency of appointments required to access contraception is a barrier to consistent use 	<p>Religious/faith groups and organisations</p> <ul style="list-style-type: none"> - Viewed by some YP as having negative impact on access to accurate info, especially if they impact content of school sex education <p>Youth groups</p> <ul style="list-style-type: none"> - Can be important for interaction with trusted adults, but can still be embarrassing to ask - Important for finding peers that young people can talk to about sex (identified by young people as perhaps especially important among LGBTQ+ young people) 	<p>Porn</p> <ul style="list-style-type: none"> - Can eroticise barebacking (e.g. visual of cum on or in partner) <p>Social media</p> <ul style="list-style-type: none"> - Perception among some that there is not much content about condoms and contraception on social media, unless you go looking for it - YouTube as an important platform to get info (e.g. from sex ed video bloggers)

<p>transmitted (e.g. relative risk of different STIs, different sexual practices)</p> <ul style="list-style-type: none"> - Awareness that some info is inaccurate, but unsure which information sources to trust - Some use of menstrual apps for contraception 	<p>Wider support networks</p> <ul style="list-style-type: none"> - Shame about talking to <i>anyone</i> about condoms or contraception when young - Perception that there are very few adults that can be trusted to be forthcoming and able to give accurate information about contraception <p>Families</p> <ul style="list-style-type: none"> - Embarrassment about talking to parents - Gendered messages about contraceptive responsibility perpetuate idea that it's girls' responsibility to not get pregnant - Fears about parents finding out about condom or contraceptive use if live at home 	<ul style="list-style-type: none"> - Unacceptably long wait times and complicated booking systems to access specialist sexual health services (e.g. Sandyford) - Lack of reminders about need to restock contraception - Distance to health services can be a barrier for youth in more rural areas <p>Free condom services</p> <ul style="list-style-type: none"> - Postal services for condoms less viable if live with parents, but ordering via Amazon is practical if you can pick up at another location - Perception that free condom scheme points are not well-advertised – it's not always clear to YP where these are - Perception that free condoms are less good quality - Free condom scheme staff asking too many questions is a deterrent - Range and variety can be overwhelming 		
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Figure 7: Reasons for use and non-use of condoms and contraception expressed by young people in workshops

(NB reasons are expressed in young people's own terminology)

Why might young people use condoms or contraception?	Why <u>don't</u> young people use condoms?	Why <u>don't</u> young people use contraception?
<p>Contraception</p> <ul style="list-style-type: none"> - Don't want a kid - Don't want an abortion - To regulate period (pill) - To not get (someone) pregnant (main concern) <p>Condoms</p> <ul style="list-style-type: none"> - To prevent STIs (secondary concern) - For sex to last longer - To spice up oral sex (if flavoured) - Less mess from cum - Could feel better if ribbed - Attracted to packaging (e.g. if positive message, cartoon character, Pride colours) - Knowledge that protection from STIs is linked to prevention of cervical cancer - If they're easy to access (e.g. at a youth centre) 	<ul style="list-style-type: none"> - Might not have one - Might just forget - Don't have money to buy condoms - Not thinking about it if drunk or using drugs - Don't see them in porn - Cool not to use one - Condoms went out of fashion - Too tired to use one - Have run out - Embarrassment about penis size - Don't know what to buy (size) - Discomfort getting condoms (at school or in a shop – “everyone would know”) - Latex allergy - Transport/distance if live further out – “it's difficult to get condoms if you're out in the sticks” – using a postal service is OK if you live on your own or with a partner, but not if you live with parents - Idea that using condoms is somehow ‘anti-masculine’ (“if I have to use a condom, does it diminish my image as a ‘strong man’?”) - Poorly designed packaging conveying unrelatable messaging (e.g. related to love) <p>Partner barriers to using condoms</p> <ul style="list-style-type: none"> - There might be pressure not to use a condom from one person in relationship (in same-sex or mixed-sex relationships) - Girl might be trying to get pregnant to “trap” a guy - Partner says it feels bad 	<p>Access issues</p> <ul style="list-style-type: none"> - Can be hard talking to someone you don't know about your sex life - Getting contraception involves being asked a lot of Qs about your behaviour - Getting to GP can be difficult, especially in more rural areas - Challenges of getting an appointment with GP in first place, and further barriers if GP is male (no empathy for/undermining of side effects) - With the pill, you get a year's supply and it's easy to forget to get it restocked <p>Side effects</p> <ul style="list-style-type: none"> - ‘Bad effects on the body’ seen as a major barrier - Concern about ‘taking hormones’ - Lack of warning about side effects from health professionals (“you don't know what you're getting into when you change your contraception”) - Side effects of contraception are totally underplayed by professionals, e.g. especially impacts on mental health, but also on weight, skin

	<p>Motivation or skill-related</p> <ul style="list-style-type: none"> - Can't be bothered - "doesn't fit" (scepticism about this reason indicated by air quotes) - Don't know how to put one on properly - Hard to open packet in dark <p>Pleasure-focused</p> <ul style="list-style-type: none"> - Like the danger of not using one - Condoms suck the fun out of sex - Mood killer - Seeing cum on body/face or in partner is erotic and that's ruined by using condoms - Barebacking is normalised in porn (including among MSM) – it's about replicating the fantasy - Ruins heat of the moment - Don't like the feeling with / like the feeling without - More pleasurable without - Harder to make partner orgasm <p>Fear/anxiety about negative consequences of using a condom</p> <ul style="list-style-type: none"> - Condom might make a guy soft - Not sure what to do with it after – worried about people (e.g. parents) finding it - Men don't want to be embarrassed by penis size (e.g. if need a smaller size) <p>Lack of concern about consequences of not using a condom</p> <ul style="list-style-type: none"> - Already on the pill - Guys happy with just pulling out - Can just get the 'morning after pill' if needed - Sense of insulation from STI risk (suggestion by YP that this may vary by sexuality with, for e.g. MSM more concerned than straight men) - STIs seen as stigmatised, but easily treatable 	<ul style="list-style-type: none"> - Don't like changing contraception because of changes to periods - Men in relationships with women can trivialise side effects on mood <p>Misinformation and lack of support</p> <ul style="list-style-type: none"> - Hard to talk to parents - Rumours and "horror stories" that circulate through peers and also on social media, e.g. that implant can move around body; that IUD can "catch on insides" - Embarrassment about using the pill for period regulation if people (friends, parents) assume use is for contraception sexually active.
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Co-developing the online survey

We wanted to ensure that the online survey was comprehensible, relevant and accessible to young people, while also producing data that would be useful for stakeholders involved in supporting and improving young people’s sexual health (e.g. via services and health promotion). We therefore engaged in a multi-stage process to collaboratively develop and refine the online survey with input from over 20 stakeholders via workshops, virtual meetings, and written comments.

1. In the engagement workshops with young people we asked for suggestions for specific survey questions that would help address the knowledge gaps that they had previously identified. The foci and wording of these questions then fed into our question design.
2. Having drafted an initial survey based on stakeholders’ evidence priorities, we then asked multiple stakeholders to review and critique the questions, including the commissioners for the study, sexual health research colleagues, and sexual health promotion specialists.
3. After revising the questions based on this input, we then invited a second round of review and critique, this time by young adults from the Contraception Education & Reform Team – a university-based student group mobilised around policy issues relating to contraception.
4. Following further revision, the questions were then input into an online survey programme, with both the survey format and content then further tested and critiqued by a different group of young people (members of the TRIUMPH Young Advisory Group).

Co-developing the study recommendations

In October 2020, we conducted five virtual, interactive workshops with 31 stakeholders to co-develop recommendations, based on the study findings. Participants spanned several different stakeholder groups, including young adults, sexual health clinicians, sexual health promotion specialists, and policymakers with remits relating to sexual health and women’s health.

Participant organisations for workshops	Number of participants
Contraception Education & Reform Team (student-led think tank, University of Edinburgh)	8
Queen Margaret University students	5
Condom Distribution Network members	5
Scottish Government policymakers (Women’s Health Plan Team)	7
Sexual health specialists (clinical and non-clinical) from NHS, HPS, and Scottish Government	6
Total	31

After first being presented with key findings from the study, workshops participants were then divided into smaller groups (via virtual break out rooms) and asked to generate ideas for ways to solve some of the issues identified by the study. Key issues discussed were:

- Low awareness of free condom schemes and access points
- Preferences for accessing condoms (e.g. online ordering with post-to-home)
- Variable knowledge and understanding of multiple contraception methods
- Challenges to contraceptive decision-making during consultations with health care professionals (e.g. quality of consultations, information/influence from informal sources)
- “Contraception work”, including the heavy burden on young women to sort out contraception (what, where, how) and navigate partner involvement.

For each issue, groups were asked to discuss the following:

- In what ways could this issue be solved?
- What would be the ‘big asks’ and what are the ‘easy wins’?
- What are the main opportunities and constraints to addressing this issue?

Groups then came back together to share their reflections and suggestions for addressing the issue/s, with opportunities for further ideas to be contributed, in addition to wider discussion and reflection on opportunities and constraints relating to the suggested ideas.

Appendix B: Further methodological details

Data for CONUNDRUM were generated between October 2019 and October 2020. Approximately halfway through this period (March 2020), COVID-19 was declared a pandemic and the UK went into its first lockdown. Consequently, some of the planned study methods involving face-to-face interactions (e.g. focus groups, workshops to co-develop recommendations) that were due to take place in Spring/Summer 2020 were adapted to take place online. Ethical approval for CONUNDRUM, including methodological adaptations in the context of COVID-19, was granted by the University of Glasgow College of Medicine and Veterinary Life Sciences Ethics Committee.

Small group discussions

- Five small group discussions (SGDs) were conducted via Zoom between May and September 2020.
- Given the timing of the SGDs (e.g. during the initial months of the COVID-19 pandemic) and the sensitivity of the topic, we decided to prioritise recruitment of friendship groups in order to maximise young people's comfort participating in a digital SGD. Young people were recruited via youth organisations, higher education settings and existing contacts within the research team.
- Participants were 20 young people aged 16-24, living in Scotland.
- Each participant received a £20 voucher in recognition of their time.
- Two researchers moderated each of the 60-90 minute sessions.

Online survey

- The online survey was co-produced with stakeholders, including young people.
- The Typeform survey platform was selected due to its dynamic look, and easy navigation via multiple types of digital devices (e.g. smartphones, tablets, computers).
- The online survey was open between 22 June-31st July 2020.
- Eligibility criteria included: aged 16-24, resident in Scotland, and consent to take part.
- An opt-in prize draw (5 x £100) was used as an incentive for participation in the survey.
- The survey was advertised to young people across Scotland via:
 - Information and a video advert cascaded through email and social media (e.g. Twitter, Facebook, Instagram) by stakeholder organisations (e.g. local and national third sector youth organisations; sexual health services in multiple health boards).
 - Targeted social media advertising on YouTube, Instagram and Facebook, with focus on increasing respondents from groups underrepresented in the sample (young men, and those living in areas of higher social deprivation).
- The average time to complete the survey was 14 minutes, with a majority of young people filling it in via smartphone.
- Engagement with the survey was high (i.e. few respondents who started the survey dropped out before the end) and missing data were low (i.e. most respondents answered all questions relevant to them).

The number of survey respondents by health board area can be seen in Table 7 below. Data are based on 82% of the total survey sample who opted to share their full postcodes.

Table 7: Online survey respondents by NHS Health Board

NHS Health Board	N
Ayrshire and Arran	50
Borders	16
Dumfries and Galloway	31
Fife	97
Forth Valley	74
Grampian	77
Greater Glasgow and Clyde	542
Highland	77
Lanarkshire	134
Lothian	325
Orkney, Shetland, Western Isles*	5
Tayside	218
Total:	1,646**

*Health boards were combined due to small number of respondents.

**Total represents 82% of survey respondents who gave full postcode information.

Measuring and reporting gender in the online survey

We asked two questions about respondents' gender, with our question wording developed in collaboration with stakeholders, including young people, and informed by Stonewall guidance [9].

- First, we asked, 'What option best describes your gender?', with response options: Woman, including trans woman; Man, including trans man; Non-binary; I prefer to self-describe; and I prefer not to say. Due to small numbers of young people reporting non-binary identity, preference to self-describe or not say, we combined these respondents into a category titled "Identify gender in another way". Thus, we report our results by gender as follows: Women (which includes trans women), Men (which includes trans men), and Identifies gender in another way.
- Second, we asked 'Do you identify as trans?', with response options: Yes, No, Not Sure, and I prefer not to say. Approximately 4% of survey respondents reported identifying as trans.

Appendix C: Detailed summary of co-produced recommendations

Below, we present a summary of points raised by stakeholders – including young people, sexual health clinicians and policymakers – within the workshops held to co-produce a set of recommendations based on the study findings. Recommendation 1 (establishing structures to involve young people in strategic planning) is not included as this was not directly discussed in workshops, but rather emanates from our experience throughout CONUNDRUM of co-development with young people. For all other recommendations, further details are presented (e.g. about how the idea developed, what it might involve, and potential facilitators and constraints identified by stakeholders). For more information on the workshop methodology and participants, please see [Appendix A](#) (Co-developing the study recommendations).

Recommendation 2: Invest in nationally-coordinated digital communications infrastructure and strategy for sexual health	
Additional details	Perceived facilitators and constraints
<ul style="list-style-type: none"> • The importance of improving digital communications infrastructure to more effectively communicate sexual health information and messaging was repeatedly emphasised by young people throughout the project (i.e. in initial workshops, in focus groups, and in recommendations workshops). • Young people described official health bodies (e.g. NHS sexual health services) current social media presence and use for sexual health promotion as generally poor. For example, <i>not</i> having a national-level, NHS-endorsed Instagram account focused on sexual health in Scotland was described by young people as highly surprising and an important missed opportunity. • Developing a more strategic approach to digital sexual health promotion, including via social media, was also seen as a priority by policy and practitioner stakeholders in recommendations workshops. • Strategy development should be informed by up-to-date evidence regarding digital sexual health promotion, including via social media, and including consideration of peer-peer approaches. • A clear plan for evaluating digital sexual health promotion (e.g. reach, engagement) should be embedded within the strategy. 	<p><i>Facilitators/opportunities</i></p> <ul style="list-style-type: none"> • Policy and practice stakeholders noted that current policy discussions regarding post-Covid SRH strategy provide a timely opportunity for innovating digital communications, including reflection on what has (and has not) worked during the Covid era. • High access to, and use of, digital technologies among young people provides a potential facilitator for digital sexual health promotion. <p><i>Constraints/challenges</i></p> <ul style="list-style-type: none"> • Policy and practitioner stakeholders identified past experiences of bureaucracy and rules regarding social media use by SRH services as a cause for caution among the SRH workforce, and a barrier to be overcome in order to create a dynamic social media presence.

Recommendation 3: Establish a nationally-coordinated website providing a digital hub for sexual and reproductive health in Scotland	
Additional details	Perceived facilitators and constraints
<ul style="list-style-type: none"> ● The proposal for a national level website acting as a ‘one stop shop’ for ordering condoms and accessing information about free condoms and contraception was first suggested by young people during small group discussions. ● Developing a trusted and highly used national website was seen as a priority by all stakeholders in recommendations workshops. The existing sexualhealthscotland.co.uk website was mentioned by professional stakeholders, but did not appear to be known among young people. ● Suggested website content includes: <ul style="list-style-type: none"> ○ functionality for ordering free condoms ○ information about STI testing, condoms, and contraception methods, including information on possible side effects ○ tools (or links to tools) to support contraceptive decision-making (e.g. Contraceptive Choices) ○ signposts for young people about where they can get free condoms, contraception and STI testing locally, and waiting times for appointments (e.g. enter postcode and can view a list of free condom outlets and which different contraceptive methods are available in local settings). ● Website design should be high quality and co-developed with young people to ensure it looks contemporary and is considered trustworthy by young people (many young people commented on the “old-fashioned look” of some sexual health websites produced by NHS health boards, which was perceived as reducing their trustworthiness). Graphics and video blogs (e.g. first-person accounts of clinic visits, contraceptive experiences (including positive accounts, and also accounts that are transparent about challenges) etc.) were described as appealing for youth audiences. 	<p><i>Facilitators/opportunities:</i></p> <ul style="list-style-type: none"> ● Young people’s regular use of internet and social media for information-seeking were seen as facilitators for investing in improvement of digital resources, including a website. ● Study findings regarding young people’s preference for accessing sexual health information online from official health sources (e.g. NHS websites) was described by professional stakeholders as a strong rationale for investing time and funding in improvement of existing digital resources (e.g. NHS Inform website) and development of new resources (e.g. a companion Instagram account). ● If the website and app are well designed, they could provide an opportunity for greater control over consistency in sexual health messaging across health boards. ● Some health boards currently have free condom ordering apps presenting opportunities for learning to inform process of app development. <p><i>Challenges/constraints:</i></p> <ul style="list-style-type: none"> ● Concerns were voiced among stakeholders involved in running free condom distribution schemes that successful promotion of a website and online app for free condoms may dramatically increase ordering, with some smaller health boards potentially not able to respond to demand. ● Insights gained from development and use of existing condom ordering apps may be limited by low awareness and use among young people thus far. ● An app may not appeal to all young people due to:

<ul style="list-style-type: none">● Website should explicitly signal where content has been developed and approved by clinicians (including through video) to emphasize that the information is clinically reviewed and trusted by healthcare professionals.● Ongoing investment in regular updating of the website is key to ensuring trustworthiness and return visits by young people (e.g. all links should be up-to-date).● A clear plan for monitoring and evaluating website reach and usage should be developed early on.● Development of a complementary app with condom ordering functionality was seen as a useful and convenient tool by some stakeholders (mainly young people).● Additional suggested website and app features:<ul style="list-style-type: none">○ Needs to be compatible on older smartphones and a range of browsers to avoid digital exclusion.○ App would need discreet name and design (e.g. not a condom symbol).○ Reminder notifications on when to place a new condom order or renew a contraceptive method. Reminders could be via email that young person signs up to on a website, or a push notification on an app). Potential for notifications linked to personal health record were discussed, though there was recognition that this functionality would be complex (e.g. for reasons relating to data security and linkage of electronic health records).● Website and app should be promoted through, and accessible via links in, other trusted websites used by young people in Scotland (e.g. Young Scot).	<ul style="list-style-type: none">○ Potential for monitoring of digital activity by parents.○ Visibility of app on phones (e.g. by peers)○ Concerns about data security and permanence of 'digital footprint' if downloaded○ Relatively occasional use of app features (e.g. condom ordering) may not warrant downloading an app versus navigating to a website.
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Recommendation 4: Involve young people in a review of current operation of free condom distribution schemes across health boards to inform development of core standards and modes of operation for local delivery.

Additional details	Perceived facilitators and constraints
<ul style="list-style-type: none"> • Stakeholders from policy and practice commented that study findings on young people’s low awareness of free condom schemes were unexpected. • Raising awareness that free condoms are available and how/where they can be accessed was seen as high priority by all stakeholders, including young people. • Stakeholders from multiple groups agreed that distribution channels (e.g. online ordering) need to be reviewed and enhanced <i>prior</i> to awareness raising activities. • Conduct a nationally-coordinated assessment of local delivery (i.e. per health board) of free condom schemes, including products distributed, points of access, and current marketing. Collaborate with young people in each health board to review local delivery, and co-develop a set of core standards. • Prioritising online ordering and postal distribution of condoms (e.g. sent to home or pick-up points) was generally considered feasible, with suggestions including to: <ul style="list-style-type: none"> ○ Expand capacity and promotion of postal options across all health boards; ○ Work at local and national level to engage a variety of organisations as pick-up points for condoms that have been ordered online (e.g. in discreet locations within educational institutions, local shops, leisure centres, and other places that young people visit). • Consider installation of free condom dispensers in places where young people are present (e.g. corner of a shop, public toilets), with easy access features to dispense content (e.g. by using a QR-code). • Develop guidance for distribution of free condoms in schools and health facilities, e.g. need for discreet areas with privacy and clear signalling. 	<p><i>Facilitators/opportunities:</i></p> <ul style="list-style-type: none"> • Policy and practice stakeholders noted that consideration of online ordering is timely in the context of SRH service reconfiguration during/after COVID-19. • Redirecting resources from other condom distribution channels to expand capabilities for online ordering was seen as a possible way to address budget constraints. <p><i>Constraints/potential challenges</i></p> <ul style="list-style-type: none"> • Stakeholders involved in managing condom distribution schemes expressed concern about creating demand for orders of condoms by post that smaller health boards with smaller budgets may not be able to deliver on. • Young people recognised that funding constraints would likely limit possibilities for delivery on certain suggestions (e.g. free condom dispensing machines).

Recommendation 5: Enhance understanding and training among sexual health service providers about young people’s experiences of contraceptive consultations

Additional details	Perceived facilitators and constraints
<ul style="list-style-type: none"> • Stakeholders emphasised that study findings regarding dissatisfaction with contraceptive consultations, especially within general practice, resonated with their personal experiences (young people), and professional understandings. • Improving the quality of contraceptive consultations could be achieved via: <ul style="list-style-type: none"> ○ Wider promotion of existing digital tools (e.g. Contraceptive Choices website) to empower young people’s decision-making <i>prior</i> to booking and attending appointments, and to foster informed discussions with clinicians. ○ Explicitly framing the process of finding a contraceptive method that the user is satisfied with as a “collaborative journey” between users and healthcare professionals. ○ Training for GPs, nurses and potential gate-keepers (e.g. receptionists) to sensitize them to young people’s experiences of contraceptive decision-making and consultations about contraception (e.g. including covering aspects that are valued, and causes of dissatisfaction, e.g. dismissal of side effects). ○ Developing alternative feedback mechanisms for healthcare staff (especially GPs) that might not engage in training. ○ Broadening medical and nursing education curriculum on contraception to include consideration of users’ reported experiences of access challenges and side effects. • To limit young people’s embarrassment about having to raise the subject, and to normalise discussions about sexual health, some young people suggested that GPs and nurses should routinely ask young people of all genders in all general practice consultations about need for STI testing, free condoms and contraception. 	<p><i>Facilitators/opportunities</i></p> <ul style="list-style-type: none"> • Policy and practice stakeholders identified wider promotion of high quality existing resources (e.g. Contraceptive Choices) with potential for fostering improved clinical interactions as an “easy win”. • Routinely asking young men about their contraception needs was seen as a way to potentially sensitise men who have sexual relationships where pregnancy is possible to their roles and responsibilities in relation to pregnancy outcomes, and supporting partners in using their chosen method/s. <p><i>Constraints/challenges</i></p> <ul style="list-style-type: none"> • Engaging GPs in additional optional training in the context of their many existing mandatory CPD/training requirements was seen as a challenge. • Proposed broadening of discussion about contraception within medical and nursing education is constrained by an already full curriculum – these issues may not be seen as priority for inclusion. • There are tensions between some healthcare professionals’ view that some young people lack maturity to engage in informed contraceptive decision-making, and some young people’s experience of feeling they are not respected by healthcare professionals within contraceptive consultations.

<p>Recommendation 6: Collaborate with young people to review and streamline young people’s access to sexual health services providing condoms, contraception and STI testing</p>	
<p>Additional details</p>	<p>Perceived facilitators and constraints</p>
<ul style="list-style-type: none"> • Young people talked about wanting: <ul style="list-style-type: none"> ○ Better availability of a wider range of contraceptive methods, including LARC, within GP surgeries. ○ Clear, digitally accessible and up-to-date information advertising which contraceptive methods are available in specific settings within their locality (e.g. specific GP practices, sexual health clinics, pharmacies), and the average waiting time for an appointment. ○ Reduced waiting times for appointments. ○ Easy ways to book appointments (e.g. online). ○ Choice over appointment mode (e.g. in person, phone, video). ○ Consideration of live messaging as a more widely available mode for consultations. ○ Improved referral between services (e.g. if a GP does not have a contraceptive method chosen by a young person, they should identify where this method can be accessed and provide referral so that young people are not left to navigate the system alone). ○ Consideration of an opt-out system where young people would be sent information by their GP about STI prevention and contraception, and registered with a free condom scheme when they reach a certain age, or join a new GP practice. • Reviewing different service modes (e.g. in person, phone, video) currently available and ongoing monitoring of young people’s uptake and experiences of these is important; preferences may change over time as young people and clinicians become more familiar with telemedicine (e.g. video consultations). • There is scope for further research to better understand why few young people use community pharmacies to access contraception. 	<p><i>Facilitators/opportunities:</i></p> <ul style="list-style-type: none"> • Investment in online booking for appointments was seen by some as an “easy win” • Professional stakeholders noted that some third sector organisations (e.g. Rape Crisis, Women’s Aid) were thought to have ‘live chat’ messaging services, which may provide opportunities for learning about advantages and challenges of this communication mode for sensitive discussions. <p><i>Constraints/challenges</i></p> <ul style="list-style-type: none"> • Relying on GPs to make information available about contraceptive method availability and estimated waiting times for an appointment was seen as problematic by stakeholders from policy and practice (e.g. how would GPs be incentivised to input this information? Who would input and update it? Who would review and monitor it?). If information were not current, this could jeopardise trust. • Sharing information about which services were available locally through non-digital means (e.g. disseminating this information via local schools) was seen as easier in areas with fewer different services than in densely populated urban settings.

<p>Recommendation 7: Further strengthen in- and out-of-school education (e.g. in schools, youth work settings) and support regarding condoms, contraception and STI testing, including via the national RSHP.scot resource</p>	
<p>Additional details</p>	<p>Perceived facilitators and constraints</p>
<ul style="list-style-type: none"> • Improving school-based education and support regarding contraception and STI prevention was considered a priority by all stakeholder groups. • One way to do this would be to review resources (e.g. lesson plans) on national RHSP.scot website and ensure that they: <ul style="list-style-type: none"> ○ Aim to normalise discussions about STI prevention, including testing, between sexual partners prior to having sex; ○ Balance coverage of all types of contraception methods, and do not mainly focus on condoms; ○ Include discussion of potential side effects of different contraception methods; ○ Are inclusive of LGBTQI+ people, including recognition that not all people who use contraception identify as women; ○ Encourage men’s knowledge about contraception methods and involvement in supporting partners’ contraception use; ○ Address coercion and consent in relation to condom and contraception use with a partner. ○ Foster sexual health literacy skills (e.g. how to find accurate information, and evaluate the quality of different sources) • Improving young men’s knowledge and understanding about different contraception methods and “contraception work” was considered a priority by all stakeholder groups. Young men’s involvement in co-developing ways to achieve this was identified as key. • Beyond curriculum revision, stakeholders talked about schools as settings for sexual health promotion more generally, including: <ul style="list-style-type: none"> ○ Importance of having dedicated spaces within schools where young people can talk to identified, trusted individuals (e.g. school nurse, teacher) about sexual health. 	<p><i>Facilitators/opportunities</i></p> <ul style="list-style-type: none"> • Updating of lesson plans and other resources within the RSHP.scot resource was seen as relatively simple and actionable. • Young people’s involvement in updating existing/creating new resources was seen as key to their effectiveness. • Apparently widespread use of, and trust in, the RSHP resource by teachers in Scotland was cited as a facilitator to these updates potentially reaching a large number of young people. • Newly developed social media infrastructures (Recommendation 1) could support wider sharing of resources on the RSHP.scot website. • Likely to be value in collaborating with other partners (e.g. in youth work) to share learning about, and generate ideas for, engaging young people in digital sexual health education <p><i>Constraints/challenges</i></p> <ul style="list-style-type: none"> • Funding cuts to school nurses were repeatedly identified by stakeholders throughout the study as a threat to schools’ abilities to support pupils’ sexual health.

<ul style="list-style-type: none"> ○ Potential for student led-groups where young people can talk openly and frankly about sexual health and contraception. 	
<p>Recommendation 8: Develop a nationally-coordinated sexual health campaign</p>	
<p style="text-align: center;">Additional details</p>	<p style="text-align: center;">Perceived facilitators and constraints</p>
<ul style="list-style-type: none"> ● There was strong appetite from all stakeholder groups for a nationally-coordinated campaign (or multiple campaigns) focused on improving sexual health among young people. ● Consensus that services and information need to be improved <i>before</i> investing in awareness raising via a campaign. ● All stakeholder groups considered social media key to any future campaign/s strategy. <ul style="list-style-type: none"> ○ Young people emphasised value of creating eye-catching content (e.g. animations/films) that is easily viewed and shared via social media. ○ Working with influencers and other social media accounts followed and trusted by young people to be considered. ● Campaign/s could potentially focus on: <ul style="list-style-type: none"> ○ promoting awareness and use of free condom schemes, including via creation of a strong national-level condom scheme brand and providing clarity over who can access these (e.g. they are not just for school-aged young people) and how (e.g. promotion of online ordering and postal options); ○ promoting discussions between partners about STI testing ○ improving understanding among young people of all genders (including men) about multiple forms of contraception, and supporting men’s involvement in supporting partners’ contraception decision-making in relationships where pregnancy is a possibility. 	<p><i>Facilitators/opportunities:</i></p> <ul style="list-style-type: none"> ● There has not been a national level campaign promoting condom use among young people for many years, meaning it could potentially be easier to achieve policy support and resource. ● Stakeholders from all groups identified campaign leadership and/or endorsement by the Scottish Government as key to success. ● Campaign/s messaging and strategy should be co-designed with young people to ensure acceptability and wide reach. ● Use of social media was seen as a positive way to reach young people no longer in (or engaged with) education settings. ● Sports organisations were seen as an under-explored, yet potentially impactful sector for engaging young people, and perhaps especially young men, in sexual health promotion. Precedents regarding sport as a sector for mental health promotion were seen as providing opportunities for learning. <p><i>Constraints/potential challenges:</i></p> <ul style="list-style-type: none"> ● View that previous national campaigns have been limited in cases where information is not well disseminated across all health boards and councils. ● Developing messages that engage young men was seen as challenging, especially for campaigns regarding contraception. Involving young men in co-production of campaign development is considered key for addressing this.

<ul style="list-style-type: none"> • Strong view that campaigns need to work to engage with young people no longer in, or engaged with, formal education. Further suggestions for viable sectors and organisations to work with in developing and cascading campaign/s messages included via: <ul style="list-style-type: none"> ○ Sports clubs/organisations ○ Scouts ○ Dating apps ○ Local shops and services • Stakeholders emphasised that campaign/s should be cyclical (e.g. refreshed and run with sufficient frequency to reach new cohorts of young people), rather than one-off. 	
<p>Recommendation 9: Invest in development of new, and wider promotion of existing, sexual health decision aids</p>	
<p>Additional details</p>	<p>Perceived facilitators and constraints</p>
<ul style="list-style-type: none"> • Improving young people’s ability to find accurate information, and evaluate the quality of sexual health sources was seen as a priority by multiple stakeholder groups. • YP want digital tools to foster contraceptive decision-making, including informed discussions with clinicians and – potentially – partners. • Contraceptive Choices was identified as a high quality tool to support contraceptive decision-making that could be more widely promoted to young people in Scotland. • Decision aids supporting other aspects of sexual health (e.g. STI prevention practices) were not identified. 	<ul style="list-style-type: none"> • Policy and practice stakeholders identified wider promotion of high quality existing resources (e.g. Contraceptive Choices) with potential for fostering improved clinical interactions as an “easy win”.

For more information on this report, please visit
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#ProjectCONUNDRUM
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CONUNDRUM is a research study which seeks to understand use and non-use of condoms and contraception among young people in Scotland. This project was co-led by Dr Ruth Lewis and Ms Carolyn Blake and funded by three NHS health boards (Greater Glasgow & Clyde, Lothian, Lanarkshire), in partnership with Scottish Government.