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Sexual health beliefs, attitudes and perceptions among Black and Minority Ethnic youth

Trends in risky sexual behaviour, such as non-use of contraception, increased multiple sexual partners and regretted sex, has heightened the intense public concern regarding the sexual health of young people in the UK (Tripp and Viner, 2005). Central to this paper, certain Black and Minority Ethnic (BME) groups have been identified as bearing a disproportionate burden of sexual ill-health (Fenton et al., 2005; Sinha et al., 2005; Tripp and Viner, 2005). For example, UK national surveillance data (Health Protection Agency, 2006) and localised surveys within service settings (Low, 2002) indicate higher numbers of new cases of Sexually Transmitted Infections (STIs) among Black groups, and lower numbers in Asian groups, when compared to White groups.

Although various sexual health surveys have been extremely valuable in identifying ethnic variations in risky sexual behaviour and sexual health outcomes, few studies have been conducted to improve our understanding of why these variations in sexual health exist (Fenton et al., 2005; Sinha et al., 2005). By exploring the sexual health attitudes of BME youth, this research endeavours to provide a valuable insight.

Method

Fifty in-depth interviews were conducted among BME people aged 16-23. All were conducted in London. A snowball method of recruiting participants was used to ensure the sample was ethnically diverse, in addition to representing a variety of religious affiliations, risky sexual experiences and sexualities. Participants were recruited from a variety of locations across London to help achieve this diverse sample: invitation from an earlier survey (n=18, see Testa and Coleman 2006); youth sexual health clinics (n=11); and a variety of community groups (n=21). The research centre's own Ethical Policy for undertaking research among young people was adhered to during this research. In addition to this Policy, research conducted in medical settings was ethically approved by the National Health Service Research Ethics Committee.

All interviews were digitally recorded with participants' permission and transcribed verbatim. The transcripts were coded using NUD*IST (6.0) qualitative data analysis software and were thematically analysed.

Results

Of the 50 BME young people (aged 16-23) that were interviewed, almost equal numbers of males (n=24) and females (n=26) were present. The majority (70%) were aged 16 to 18. Participants were invited to self-classify their ethnicity and religious affiliation without prompting. Most of the interviewees were Black (n=18), Asian (n=14) or of Mixed Background (n=10). The remaining groups were Latin American (n=4), Middle Eastern (n=3) and Other Background (n=1). Religious affiliation was

described as Other Christian (n=14), Muslim (n=9), no affiliation (n=9), Hindu (n=6), Sikh (n=5), Church of England (n=3), Roman Catholic (n=3), and Other (n=1). Four interviewees described themselves as gay, five as bisexual and the remainder as heterosexual.

Themes

From the analysis, three major themes emerged: 1) conflicting sexual norms and values, 2) learning about sex and related attitudes, and 3) religion versus ethnicity as an explanatory variable for sexual health attitudes and risky sexual behaviours.

Theme 1: Conflicting sexual norms and values

BME adolescents reported experiencing dichotomous, and often conflicting, sexual norms and values between their family and/or local cultural and religious community, and life 'outside'. This theme was evident, at least to some degree, in all interviews. For the majority of the participants, the expectations and values connected to sex within the family were rarely, if ever, discussed. In contrast, expectations among peers influenced by the dominant cultural norms and publicised through the mass media, defined young people developing sexual interest and engaging in sexual behaviour (including risky activities) as 'normal'. The contrast in expectations and values participants described in their family and community compared with life 'outside' was frequently reported as a source of anxiety:

"Mostly in my culture you're not allowed to have sex, yeah - unless you're married…first you have to bring the families together…it's like, tradition, innit? That's how the culture is, but I'm just enjoying my life, to be honest. As long as you say 'no - I'm not gonna tell my dad, I'm not gonna tell your dad. You're not going tell your mum - not gonna tell my mum, yeah?' And you keep it. But if you spill it out, if someone tells you're in big trouble 'specially if you're a girl and you're a Christian or Muslim and your parents find out. They're gonna be disappointed in you."
Black African Muslim male, aged 17

The conflicting norms and values experienced by young BME people had a significant influence on a number of risky sexual behaviours, as well as an inability to discuss sex and relationships with family and fellow community members. Some young people felt that social expectations within the family and community prevented any discussion or recognition of young people's sexuality, and need for information or support:

"Our parents, they're not teaching us [about sex]…so you go home and don't think that way. We close part of us, and that's the way they want us to act."
Black African Muslim female, aged 19

Theme 2: Learning about sex and related attitudes

The vast majority of participants expressed the value and necessity of accurate and clear information about sex and relationships. An appreciation and desire for good sexual health education was universal among the BME youth interviewed. 'Good' sexual health education was described both in terms of avoiding physical outcomes such as unintentional pregnancy and STIs, in addition to psychosocial matters including being sexually responsible and resisting peer pressure to have sex.

However, despite this universal view towards the value and importance of SRE, there were striking examples of how some participants showed poor knowledge in certain areas. This was particularly evident in the area of STIs and ways in which to avoid transmission, and was mirrored by individuals' experiences of risky sexual activity. For example:

"I know that condoms don't really work, 'cos they haven't worked for my friends and they ended up getting pregnant."
Indian Sikh female, aged 16

"If someone got let's say syphilis or HIV, they [others]

always think of you as promiscuous…they always say, 'Oh, she was promiscuous'. They will never think that you can get STDs [Sexually Transmitted Diseases] through toilet seats."
Black African Muslim female, aged 19

This occasional lack of knowledge mirrors findings from survey research whereby young people from BME groups, on the whole, were less knowledgeable about sexual health than White British students (Coleman and Testa, 2007). This suggests an inadequate provision of SRE in school, probably compounded by the lack of information received from home or their community (indicated in the conflicting norms in Theme 1). This is particularly significant given that adequate knowledge and information provision is an essential precursor to avoiding risky sexual activity.

While some young BME people found teachers approachable regarding SRE, the majority of participants expressed a preference for an independent sexual health professional or 'sexual health expert' to deliver SRE in school. Young BME people valued an objective and knowledgeable professional discussing sex and relationships, in addition to being more assured of confidentiality since they are external to the school:

"A teacher might just be talking about their own experiences, whereas a professional has dealt with situations, they know what they're talking about. I think that a teacher would be biased."
Middle Eastern Muslim male, aged 17

The recognised value for SRE was reflected in the leading preference to receive information from school over all other possible alternatives (such as family, friends or internet). This desire clearly ties in with young BME people's preference to maintain (or to resist breaching) the dichotomy between the family/community and life 'outside' (Theme 1).

Theme 3: Religion versus ethnicity as an explanatory variable for sexual health attitudes and behaviours

In exploring the relationships between ethnicity and sexual health beliefs, attitudes and risky sexual behaviours, it was evident that religion played a significant influence. This finding was evident when the interviewers prompted or probed for more explanations behind certain attitudes and viewpoints. To illustrate, Muslims referred to their faith and the Qu'ran frequently and explicitly when describing personal or community views on sex and relationships:

"I don't particularly agree with it [sex before marriage], but some people might agree with it. It's not as if we [students at school] argue about it. It's just like, we sort of respect each other, in the sense that 'Oh, you agree with that, and I agree with this.' We just agree to disagree basically…because it's down to religion."
Middle Eastern Muslim male, aged 17

Overall, young BME people's sexual health attitudes and experiences were better explained and understood by their religious context than ethnicity. This may in part be due to religious principles being more tangible and clearly attributed to scripture than non-religious cultural norms and values more frequently conveyed through social interaction. Christian and Muslim participants in particular reported similar sexual attitudes across a number of topics including same sex relationships and sex before marriage. These participants encompassed diverse ethnicities indicating that religion is an essential, if not more sensitive, variable to understand sexual attitudes among BME participants.

Discussion

Interview findings among the diverse sample of 50 young people offer fresh insights into ethnic and religious drivers of sexual beliefs, attitudes and risky sexual experiences that ultimately influence young BME people's sexual health. The results of this study contribute to the evidence-base by presenting explanations for the variations in sexual health reported by surveillance and survey data. In light of these results, we highlight the following implications for BME youth sexual health education, of

relevance to policy, practice and future research.

Addressing conflicting sexual norms and values

There is a clear need to understand and address the conflicting sexual norms and values between home and local community versus the wider community and world, faced by many BME youth. Indeed, 'mixed messages' about sex and relationships are known to be a key contributing factor to young people's poor sexual health (Social Exclusion Unit, 1999). Our findings indicate that these polarised messages on sexual matters are particularly important for BME youth. Although derived from a small and deliberately selected sample, our findings suggest that work to bridge these messages are particularly required among Asian and Black African communities.

Appropriate sex and relationships information

Young BME people's perceptions that their family and community fell short of engaging in discussions about sexual matters resulted in a greater reliance on school-based sex and relationships information. In the UK, the content and delivery of school Sex and Relationships Education (SRE) within Personal Social and Health Education (PSHE) requires guidance and legislation to improve its 'patchy' coverage (OFSTED, 2002). While arguments for the statutory inclusion of SRE in PSHE are posted for the benefit of all youth, the over-reliance of this as a source of information among BME youth adds significant weight.

Role of religion in BME youth sexual health

Ethnicity is generally identified as a vital explanatory variable of sexual health attitudes among BME adolescents. However, our research has clearly demonstrated both the importance and necessity of recognising and responding to religious heterogeneity due to its role shaping young BME people's sexual attitudes. It can be argued that while ethnicity is a valuable explanation of variations in sexual health, in isolation as a proxy for ethnocultural identity, ethnicity has limited explanatory power. This research clearly adds weight to the plausibility that the individual role of religion is masked by the widespread use of ethnicity (separate from other ethnocultural variables) to explain sexual attitudes and risky sexual behaviours. In further conclusion, even where the individual does not identify themselves as 'religious' they frequently reported religious expectations within the parameters of their family and/or community's religious doctrine nonetheless.

As a final note, the results of this study add further credence to the growing evidence-base of ethnic and religious differences in sexual attitudes and risky sexual behaviours among BME youth. Through a detailed exploration, this research adds a degree of explanation behind the recognition that certain BME groups are at greater risk of poor sexual health. The conflict of norms and values, and the over-reliance on school-based SRE increase the necessity for specialist agencies working with BME groups. Moreover, there is a clear need to provide appropriate sexual health education and services that are tailored to groups identified by their ethnicity and, in particular, their religious beliefs. The findings further underline the need to understand and respond to these differences to improve young people's sexual health. We conclude by advocating the need to develop and implement further research, policy and practice to take into account the influence of religion and faith on young BME people's sexual health.

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