**Relationship Status and Sexual Health Service Engagement among Young People in the United Kingdom: A Cross-Sectional Survey Study**

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**Abstract**

**Background:** Sexual health service engagement is important for the healthy sexual development of young people. Further, as later adolescence and early adulthood are critical periods for relationship development, sexual health needs may vary across this period and be associated with relationship status.

**Methods:** 468 participants, aged 16-25 years (mean age: 19.7 years) and living in the UK, completed an anonymous, online survey about their sexual health service use. To explore how relationship status is associated with engagement for 5 different sexual health services, we conducted chi-squared and multivariable logistic regression analyses.

**Results:** In general, engagement with sexual health services was low: 28.2% reported accessing free condoms, 21.4% reported STI testing, and 9.4% had used relationship advice services. Among women only, 57.2% had accessed services to start the pill and 19.6% had done so for pregnancy testing. Among all participants, those in relationships were more likely to have accessed sexual health services for free condoms (aOR: 1.71, 95%CI: 1.13,2.59). Among female participants, those in relationships were more likely to have accessed sexual health services to start the pill (aOR: 2.21, 95%CI: 1.45,3.36) and for pregnancy testing (aOR: 3.86, 95%CI: 2.20,6.78). There were no differences by relationship status for accessing sexual health services for STI testing or relationship advice.

**Conclusions:** Health care providers and relationship and sexual education providers should encourage all young people to engage with sexual health services, while also recognising that sexual health needs are likely to vary depending on relationship status.

*Keywords:* sexual health engagement, service use, young people, contraception, STI testing, condoms, pregnancy testing, relationships

**Summary Text:**

Sexual health service engagement among young people is important for healthy sexual development and needs may vary depending on relationship status. We explored how relationship status is associated with use of 5 different sexual health services and found that in general, engagement with sexual health services was low and that those in relationships were more likely to have accessed sexual health services for free condoms, to start the pill, and for pregnancy testing. Health care providers and relationship and sexual education providers should encourage all young people to engage with sexual health services, whatever their relationship status.

Sexual health is a state of physical, social, mental, and emotional well-being regarding an individual’s sexuality, not merely the absence of disease or dysfunction.1 Being knowledgeable about sex, practicing safer sex, and sexual pleasure are known to be associated with better sexual health.2-4 In the United Kingdom (UK), the National Health Service (NHS) has bespoke sexual health services which are accessible free of charge to all residents. These services include but are not limited to: specialized clinics, sexually transmitted infection (STI) testing and treatment, contraceptive services, health and relationship guidance, and counselling. Services may be offered in person or digitally, which may increase accessibility.5

Later adolescence and young adulthood are periods associated with identity and relationship development. During this time, people begin to explore and understand more about who they are as sexual beings and they typically begin to engage in partnered sexual activity.6 In the UK, average age of first mixed-sex intercourse for both men and women is now 16 year old.7 Further, young people in the UK experience the highest rates of STI diagnosis which may be associated with having more new sexual partners.8 As such, NHS sexual health services are well positioned to provide ongoing support for the sexual health needs of young people in the UK, both prior to and after sexual activity. However, service use is often suboptimal and engagement is higher when the specific sexual health needs of young people are better understood and considered.9

**Sexual Health Engagement**

A variety of factors, including age, gender, and sexual orientation are known to be associated with sexual health engagement. Litras et al. conducted a study with 35 male students aged 16-19 years old and found that to access sexual health information, young men typically engaged with friends, family, pornography, and the internet.10 Unfortunately, these may not always be the most accurate sources of information which can subsequently have a negative impact upon sexual knowledge due to the inaccuracies of online information.11,12 Additionally, young men may be less likely than young women to engage with STI testing services because of a fear of testing procedures and a perception that clinics and clinic décor are primarily tailored towards women.13 However, others have suggested that women may be less likely to engage with sexual health information compared to men as traditionally they are seen as passive gatekeepers of sex.14 Women also may engage less with sexual health services due to sexual double standards whereby if women behave in similar ways as men, such as having casual sex or buying condoms, they are judged more harshly.15 Therefore, some young women may be hesitant or may think it unnecessary or inappropriate to proactively learn about sexual health and instead may seek out help from clinics only when they become sexually active.16

People with various sexual orientations may also engage differently with sexual health services. For example, due to long-standing heteronormative sociocultural norms, heterosexual individuals may have easier access to information about sexual health through clinics, school education, or contact with more knowledgeable others17 and studies with LGBTQ+ individuals have found that this population often struggles to access appropriate sexual health information and services relevant to their specific needs.18,19 This may be primarily because schools in the UK have historically not included LGBTQ+ matters in the sex education curriculum and healthcare professionals do not have adequate training regarding the sexual health needs of LGBTQ+ individuals.20 As a result, LGBTQ+ people may feel it necessary to engage with their sexual health online as they can find a wider array of information, and most report feeling more comfortable searching for sexual health information online.21

**Differing Sexual Health Needs by Relationship Status**

Limited research also suggests that people may engage with sexual health services differently based upon their relationship status. As individuals who are not in relationships may have more new sexual partners, STI testing is recommended at least annually, and young women and others with a womb and ovaries are recommended to screen for chlamydia on change of sexual partner.8 As such, single people may engage more with STI testing services. Indeed, a qualitative study of 30 young adults (18-19 years) in Ireland found that two of the main reasons for seeking STI testing were emerging from a period of having had higher risk sexual relationships and having had unprotected sex with a casual partner.22 One participant in this study specifically reported that after splitting up with his girlfriend, he found himself having more sexual partners, and thus used STI testing services more frequently than he had before. However, participants in this study also reported that a common reason for seeking STI testing was because they were in a relationship and about to stop using condoms with their partner.22 As such, further exploration of the association between STI testing and relationship status is warranted.

Relationship status may also influence contraception and safer sex choices. Research by Brown found that when people are single, the use of contraception is complex and fluid.23 In two samples of young people, aged 14–20 years from the north of England, attitudes towards contraception differed greatly from person to person regarding the use of the pill and condoms to protect from STIs and pregnancy when single. However, participants in this study also reported that relationship status was a factor in making contraceptive and safer sex choices and that they felt that single people are more likely to use condoms compared to those in a relationship and that as the relationship progressed, couples were more likely to discuss and chose to use other methods like the pill or a long-acting reversible contraception (LARC). Similar findings were also reported from a sample of young women in Scotland.24 As such, people in relationships are likely to have different sexual health needs compared with those who are single and may therefore engage differently with sexual health services.

This study aims to explore how young people in relationships differ in sexual health engagement to those who are single. As UK sexual health services offer a broad range of services, we focused specifically on five which were expected to be particularly relevant to 16-25 year olds including: accessing free condoms, STI testing, relationship advice, starting the pill, and pregnancy testing. While this is primarily an exploratory project, it is expected that people in relationships will be more likely to have accessed services to start the pill than those who are single. We also expected that single individuals will be more likely to have accessed free condoms and STI testing services. We made no predictions about how or if relationship status would be associated with accessing relationship advice or pregnancy testing.

**Method**

Participation in the study was open to young people living in the UK, aged 16-25 years. Recruitment for the anonymous, online survey occurred between November 2022 and March 2023 via social media (e.g., Twitter, facebook, Instagram), posters placed on the campus of the participating university, and the university’s undergraduate psychology student participant pool. After accessing the study via link or QR code, interested individuals were presented with a detailed participant information sheet. Informed consent was provided by ticking a consent box at the bottom of this sheet, prior to completing any survey questions. Upon completing the questionnaire, participants were given a debriefing form with researcher contact information. All participants were also given the option to enter a raffle to win 1 of 9 Amazon vouchers (value: £20 or £25). A prize draw was conducted for every 40 participants that completed the study. If participants chose to enter the draw, in order to maintain data anonymity, they were asked to click a new link on the debriefing form which took them to a separate survey where they could provide an email address. Additionally, participants who accessed the survey via the student subject pool received 6 research credits. All study procedures were approved by the Faculty Research Ethics Committee at the University of Southampton (ERGO ref. 73135).

**Measures**

**Service Use.** Participants were presented with a list of 32 sexual health services (e.g., advice before having sex for the first time, advice about pregnancy options or abortion, emergency contraction, STI testing) and asked to “Tick all the services that you have used.” For this analysis, the following 5 services are considered as outcome variables: accessing free condoms, STI testing, relationship advice, starting the pill, and pregnancy testing.

**Relationship Status.** Participants were asked “Are you currently in a relationship?” (yes/no). Those who answered yes were asked “Are you currently in an open or non-monogamous relationship (i.e., you and your partner(s) have agreed to date and/or have sex with other people)? (yes/no). For this analysis, only participants who were single or in monogamous relationships were included in the analytic sample.

**Demographics.** To describe the sample and control for relevant variables in the analysis, questions were included on age, gender, race/ethnicity, and sexual orientation. Given the small number of participants who reported a nonbinary (n=8) or “other” (n=1) gender identity, these participants were combined with the female participants for data analysis. Participants were also asked about their sexual experience with the question: “Have you had sex before (oral, vaginal, anal)?” (yes/no).

**Analysis**

Descriptive statistics were used to describe the sample and the key independent and dependent variables. Initially, chi-square analyses and univariable logistic regressions (not reported) were used to compare those in relationships to those not in relationship on each of the 5 dependent variables. All participants were included in the analysis for free condoms, STI testing, and relationship advice. Only those who reported their gender as female were included in the analysis for starting the pill and pregnancy testing.

If a significant difference was found between the relationship status groups in univariable analysis, a multivariable logistic regression was run, controlling for age, sexual orientation, and gender (as appropriate), with relationship status as the independent variable and service access as the dependent variable.

**Results**

552 participants completed the study. After screening for missing data on key variables, the analytic sample includes 468 participants (*M* = 19.68 years; *SD* = 1.42), of whom, 257 (54.9%) reported being single and 211 (45.1%) reported being in a monogamous relationship. Most participants were female (n=388, 82.9%), white (n= 360, 76.9%), and heterosexual (n=334, 71.4%). Overall, 75.0% of the sample (80.3% men, 74.0% women, 77.8% gender diverse) reported ever having had sex. See Table 1 for full demographics.

132 people (28.2%) reported that they had accessed free condoms. Of these people, 72 (54.5%) were in a relationship and 60 (45.5%) were single. A Chi-squared test of independence showed that free condom services were used significantly more by people in relationships compared with those who are single, χ2(1, 468)=6.65, *p*=.010.

Among the 100 people (21.4%) who reported that they had used STI testing services, 56 (56.0%) were in a relationship and 44 (44.0%) were single. People in relationships were significantly more likely to use STI testing services than those who are not, χ2(1, 468)=6.12, *p*=.013.

With respect to relationship advice, 44 people (9.4%) said they had engaged with this service; 21 (47.7%) were in a relationship and 23 (52.3%) were single. There was no significant difference in relationship advice engagement by relationship status, χ2(1,468)=.14, *p*=.711.

Among female participants (n=388), 222 (57.2%) reported accessing sexual health services to start using the pill. Of these, 125 (56.3%) reported being in a relationship while 97 (43.7%) were single. A Chi-squared test revealed that the pill was used significantly more by those in a relationship compared with those who are single, χ2(1, 388)=17.40, *p*<.001.

Likewise, among female participants, 76 (19.6%) reported accessing services for pregnancy testing; 56 (73.7%) reported being in a relationship and 20 (26.3%) were single. Those in relationships were significantly more likely to use pregnancy testing services that those who are single, χ2 (1, 388)=26.67, *p*<.001.

In multivariable logistic regression analyses, after controlling for age, gender, and sexual orientation, relationship status remained significantly associated with free condom service use (aOR=1.71, 95%CI:1.13, 2.59). People in a relationship were 1.71 times more likely to use free condom services compared to those who are single. Older participants and male participants were also more likely to report having accessed free condoms. See Table 2 for full results. However, relationship status was no longer associated with STI testing service use after controlling for age, gender, and sexual orientation (aOR=1.59, 95%CI:1.00, 2.53). Older participants were more likely to report having used STI testing services; no other differences were found.

Among female participants, after controlling for age and sexual orientation, relationship status remained significantly associated with accessing sexual health services to start the pill (aOR=2.21, 95%CI:1.45, 3.36) and for pregnancy testing (aOR=3.86, 95%CI:2.20, 6.78). Female participants in relationships were more likely to have accessed both services. Older female participants were also more likely to report pill use; no other differences were found.

**Discussion**

Results of this study suggest that the association between relationship status and engagement with sexual health services depends on the specific type of service being accessed. Further, and as has been reported elsewhere,25 sexual health services, specifically free condoms, free STI testing, and free relationship advice, were underutilised by the young people in our sample.

Of the 28.2% of our sample who had accessed free condoms, those in relationships were more likely to have used this service than those who are single. This finding is counter to our original expectation and suggests that people in relationships may continue to use condoms more than expected for contraception and STI protection, perhaps using dual methods (i.e., hormonal contraception as well as condoms). This finding may also be due to the younger age of our sample. Relationships among younger adolescents are often relatively short in duration and tend to become more stable and longer lasting with increasing age;26 adolescents under the age of 14 years typically report that their relationships last a few weeks while 18-year-olds may report that that their relationships last for a year or more.27 Past research has also found that condom use substantially decreases as couples have sex with each other more often.28 As such, our finding may reflect that participants in our sample who report being in a relationship may be in shorter-term relationships or may be having sex relatively infrequently. As we did not measure relationship length or frequency of sex, these and other relationship characteristics could be explored in future studies. Alternatively, the association between relationship status and condom use may be due to a third factor, such as the rising cost of living, which may be causing young, sexually active people to be more likely to access free condoms through the NHS rather than paying out of pocket for them at a pharmacy.29 Future analyses may wish to consider the role of socioeconomic status in addition to relationship status when exploring service access, even in areas such as England where many health services are provided free of charge. Sexual health services may also wish to consider how their free condoms are accessed or distributed as there may be scope to increase outreach such as having NHS-provided condoms available on university campuses or halls, as well is in popular venues and night clubs frequently by young people.

Based on previous research suggesting that single people would be more likely to engage with STI testing due to typically having a greater number of recent sexual partners,22 we predicted that single individuals would be more likely to report having used STI testing services. However, after controlling for age, gender, and sexual orientation, relationship status was not significantly associated with using this service. This may suggest that, in addition to regular testing when single, participants in our sample also test when in relationships, perhaps as a precaution prior to stopping condom use, or perhaps as part of other health procedures, such as smear tests. These results may also be reflective of our younger population. As noted above, people in the 16-25 age range, particularly those at the younger end of the range, tend to have shorter relationships than those who are older. As such, participants in our study may report testing because they have recently entered a new relationship. Alternatively, because of the age of our sample, participants may not feel that STI testing is yet needed, regardless of relationship status. It is worth noting, however, that only 21.4% of our sample reported having used STI testing services. As the UK government recommends that everyone should have an STI screen at least annually if they are having condomless sex or sex with casual partners,8 our results suggest that older adolescents and young adults may not be testing in line with public health guidance. All sexually active young people, regardless of relationship status, should be encouraged to screen regularly, even if no symptoms are present. Further, health care professionals should ask patients in long-term monogamous relationships about their last STI screening date and recommend screening to those who have not tested previously or who have not tested since the beginning of their current relationship.

Regarding service engagement for relationship advice, we found no significant difference between people in a relationship and those who are single. As a possible explanation for this finding, we suggest that while people may seek relationship advice regardless of relationship status, the issues for which they seek advice may differ. For example, those with a partner may wish to improve their current relationship, while those who are single may seek information on how to better their prospects of finding a healthy relationship. However, given that only 9.4% of our sample reported having used this service, it may be that participants were unaware that this is offered by NHS Sexual Health Services. Alternatively, they may be aware but feel as though the service is not appropriate for them. Healthcare professionals and others offering relationship and sexual education to young people should be aware of the availability of this service in their local area and signpost those who would benefit from it.

In-line with our hypothesis, young women in relationships were found to have used sexual health services to start the pill significantly more than those who are single. This is consistent with prior research that indicates that contraception choices in relationships tend to progress towards using the pill as relationship length increases, trust is built, and couples have sex more often.24,28 This finding also persisted after controlling for age and sexual orientation. While using the pill is effective at protecting against pregnancy, it does not protect against sexually transmitted infections and so condom use should still be encouraged until both partners in a monogamous relationship have been tested. Given the substantial difference in prevalence of starting the pill (57.2%) and STI testing (21.9% among women), this may be a missed opportunity for healthcare professionals to recommend STI screening when starting or re-starting hormonal birth control and policy could be revised to encourage uptake of screening.

Finally, young women in relationships were also found to have accessed pregnancy testing services more than those who are single (73.7% vs. 26.3%), even after controlling for age and sexual orientation. Pregnancy testing through the NHS may be done as a first step when pregnancy is suspected, or it may be done as confirmation after preliminary positive testing at home. One reason for our finding may be that women who are married or in co-habiting relationships are more likely than those who are single to plan to have children, hence they may be testing to confirm an intended pregnancy.30 However, in a large sample (n=5686) of women drawn from a nationally representative study in Britain, 87.4% of pregnancies among women aged 16-19 and 60.1% of pregnancies among women aged 20-24 were reported as being unplanned or ambivalent.30 Women who are ambivalent about pregnancy are approximately 2.5 times less likely to use contraception than those who wish to avoid pregnancy.31 As such, younger women, particularly those in relationships, may be ambivalent towards pregnancy, less likely to use contraception, and consequently more likely to access pregnancy testing.

There are several limitations of this research. The first limitation is the cross-sectional nature of the survey which allows for correlational analysis only. Further, participants were asked about their current relationship status and so it is possible that they were reporting about accessing sexual health services in the past when they had a different relationship status. Given the young age of our sample and the low frequency in general of service use, we expect that this has not overly affected our results but future research is needed to confirm our findings. Second, being in a relationship is highly associated with ever having had sex χ2(1, 468) = 113.9, *p*<.001. As such, ever having had sex may be a confounding factor however, due to issues of multicollinearity and sample cell size, we were not able to explore this further in our analysis. Third, despite a large sample size and efforts to recruit a broad range of participants, 83% of respondents were female, reflecting the use of the undergraduate subject pool which draws from a heavily female-skewed student population. This reduces the generalisability of the sample and may have introduced bias particularly for accessing free condoms, which are more likely to be accessed by men. Finally, data were drawn from a larger study exploring sexual health service use among young people in general. As such, we do not have data for additional variables which may be relevant, such as relationship satisfaction and duration. These could be considered in future analyses.

In our analyses, and contrary to our hypothesis, people in relationships were more likely to access free condoms from sexual health services than those who were single. Additionally, among women, those in relationships were more likely to have accessed sexual health services to start the pill and for pregnancy testing. However, overall service engagement was low and prevalence of STI screening was suboptimal. Older adolescents and young adults are a key demographic for sexual health engagement due to the high burden of STIs within the population and key developmental changes in sexual behaviour and relationship formation. Health care providers and relationship and sexual education providers should encourage all young people to engage with sexual health services, while also recognising that sexual health needs are likely to vary depending on relationship status.

**References**

1. World Health Organization. *Sexual health.* World Health Organization; 2006 <https://www.who.int/health-topics/sexual-health#tab=tab_2>
2. Ford JV, Corona Vargas E, Finotelli Jr I, Fortenberry JD, Kismödi E, Philpott A, et al. Why pleasure matters: Its global relevance for sexual health, sexual rights and wellbeing. *Int J Sex Health* 2019; 31(3): 217-30. [doi:10.1080/19317611.2019.1654587](https://doi.org/10.1080/19317611.2019.1654587)
3. Giami A. Sexual health: The emergence, development, and diversity of a concept. *Annu Rev Sex Res* 2002; 13(1), 1-35. doi:10.1080/10532528.2002.10559801
4. Hooghe M. Is sexual well-being part of subjective well-being? An empirical analysis of Belgian (Flemish) survey data using an extended well-being scale. *J Sex Res* 2012; 49(2-3), 264-273. [doi:10.1080/00224499.2010.551791](https://doi.org/10.1080/00224499.2010.551791)
5. Minichiello V, Rahman S, Dune T, Scott J, Dowsett G. E-health: Potential benefits and challenges in providing and accessing sexual health services. *BMC Public Health* 2013;13(1), 1-7. doi: 10.1186/1471-2458-13-790
6. Hawes ZC, Wellings K, Stephenson J. First heterosexual intercourse in the United Kingdom: A review of the literature. *J Sex Res* 2010; 47(2-3), 137-152. doi: 10.1080/00224490903509399
7. Lewis R, Tanton C, Mercer CH, Mitchell KR, Palmer M, Macdowall W, Wellings K. Heterosexual practices among young people in Britain: Evidence from three National Surveys of Sexual Attitudes and Lifestyles. *J Adolesc Health* 2017;61(6), 694-702. doi: 10.1016/j.jadohealth.2017.07.004
8. Migchelsen SJ, Enayat Q, Harb AK, Daahir U, Slater L, Anderson A, et al. *Sexually transmitted infections and screening for chlamydia in England, 2022.* UK Health Security Agency, London; 2023. https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables/sexually-transmitted-infections-and-screening-for-chlamydia-in-england-2022-report
9. Perry C, Thurston M. Meeting the sexual health care needs of young people: A model that works? *Child Care Health Dev* 2008; 34(1), 98-103. doi: /10.1111/j.1365-2214.2007.00741.x
10. Litras A, Latreille S, Temple-Smith M. Dr Google, porn and friend-of-a-friend: Where are young men really getting their sexual health information? *Sex Health* 2015; 12(6), 488-494. doi: 10.1071/SH15055
11. Albury K. Porn and sex education, porn as sex education. *Porn Stud* 2014;1(1-2), 172-181. [doi: 10.1080/23268743.2013.863654](https://doi.org/10.1080/23268743.2013.863654)
12. Dubin JM, Aguiar JA, Lin JS, Greenberg DR, Keeter MK, Fantus RJ, et at. The broad reach and inaccuracy of men’s health information on social media: analysis of TikTok and Instagram. *Int J Impot Res* 2022; 1-5. doi: 10.1038/s41443-022-00645-6
13. Shoveller J, Johnson J, Rosenberg M, Greaves L, Patrick DM, Oliffe JL, et al. Youth’s experiences with STI testing in four communities in British Columbia, Canada. *Sex Transm Infect* 2009; 85(5), 397-401. doi: 10.1136/sti.2008.035568
14. Jozkowski KN, Peterson ZD. College students and sexual consent: Unique insights. *J Sex Res* 2013;50(6), 517-523. [doi: 10.1080/00224499.2012.700739](https://doi.org/10.1080/00224499.2012.700739)
15. Milhausen RR, Herold ES. Reconceptualizing the sexual double standard. *J Psychol Human Sex* 2002; 13(2), 63-83. doi: 10.1300/J056v13n02\_05
16. Reeves C, Whitaker R, Parsonage RK, Robinson CA, Swale K, Bayley L. Sexual health services and education: Young people’s experiences and preferences. *Health Educ J* 2006; 65(4), 368-379. doi: 10.1177/0017896906069381
17. Measor L, Miller K, Tiffin C. *Young people's views on sex education: Education, Attitudes, and Behaviour.* Routledge; 2012. [doi: 10.4324/9780203046692](https://doi.org/10.4324/9780203046692)
18. Campbell S. Sexual health needs and the LGBT community. *Nurs Stand* 2013; 27(32), 35-38.
19. Eiduson R, Murchison GR, Agénor M, Suarez L, Gordon AR. Sexual healthcare experiences of nonbinary young adults. *Cult Health Sex* 2022; 24(10), 1319-1335. doi: 10.1080/13691058.2021.1946595
20. Parameshwaran V, Cockbain BC, Hillyard M, Price JR. Is the lack of specific lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ) health care education in medical school a cause for concern? Evidence from a survey of knowledge and practice among UK medical students. *J Homosex* 2017; 64(3), 367-381. doi: 10.1080/00918369.2016.1190218
21. Magee JC, Bigelow L, DeHaan S, Mustanski BS. Sexual health information seeking online: A mixed-methods study among lesbian, gay, bisexual, and transgender young people. *Health Educ Behav* 2012; 39(3), 276-289. soi: 10.1177/1090198111401384
22. Balfe M, Brugha R. What prompts young adults in Ireland to attend health services for STI testing? *BMC Public Health* 2009; 9, 1-10. doi: 10.1186/1471-2458-9-311
23. Brown S. ‘They think it's all up to the girls’: gender, risk and responsibility for contraception. *Cult Health Sex* 2015; 17(3), 312-325. doi: 10.1080/13691058.2014.950983
24. Williamson LM, Buston K, Sweeting H. Young women and limits to the normalisation of condom use: A qualitative study. *AIDS Care* 2009; 21(5), 561-566. doi: 10.1080/09540120802301857
25. Tanton C, Geary RS, Clifton S, Field N, Heap KL, Mapp F, et al. Sexual health clinic attendance and non-attendance in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). *Sex Transm Infect* 2018; *94*(4), 268-276. [doi: 10.1136/sextrans-2017-053193](http://dx.doi.org/10.1136/sextrans-2017-053193)
26. Connolly J, McIsaac C, Shulman S, Wincentak K, Joly L, Heifetz M, et al. Development of romantic relationships in adolescence and emerging adulthood: Implications for community mental health. *Can J Commun Ment Health* 2014; 33(1), 7-19. doi: 10.7870/cjcmh-2014-002
27. Carver K, Joyner K, Udry JR. National estimates of adolescent romantic relationships. In: Florsheim P, editor. *Adolescent romantic relations and sexual behavior: Theory, research, and practical implications*. Mahwah, NJ: Lawrence Erlbaum Associates; 2003. p. 23-56.
28. He F, Hensel DJ, Harezlak J, Fortenberry JD. Condom use as a function of number of coital events in new relationships. *Sex Transm Dis* 2016; 43(2), 67-70. doi: [10.1097/OLQ.0000000000000390](https://doi.org/10.1097%2FOLQ.0000000000000390)
29. Webster P, Neal K. The ‘cost of living crisis’. *J Public Health* 2022; *44*(3), 475-476. doi: 10.1093/pubmed/fdac080
30. Wellings K, Jones KG, Mercer CH, Tanton C, Clifton S, Datta J, et al. The prevalence of unplanned pregnancy and associated factors in Britain: Findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). *Lancet* 2013; 382(9907), 1807-1816. doi: 10.1016/S0140-6736(13)62071-1
31. LaCross A, Smaldone A, Angelson J. Ambivalence toward pregnancy as an indicator for contraceptive nonuse: A systematic review and meta‐analysis. *J Midwifery Womens Health* 2019; *64*(4), 385-394. doi: 10.1111/jmwh.12969

**Data Availability Statement:** Upon acceptance, data will be made available through the University of Southampton data repository. A doi will also be generated at that time.

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**Table 1.** Demographic Information for the sample (n=468)

|  |  |  |
| --- | --- | --- |
|  | Frequency | Percent |
| Race/Ethnicity |  |  |
| White | 360 | 76.92 |
| Mixed | 25 | 5.34 |
| Asian | 54 | 11.54 |
| Black | 21 | 4.49 |
| Other | 8 | 1.71 |
| Gender |  |  |
| Male | 71 | 15.20 |
| Female | 388 | 82.90 |
| Non-binary | 8 | 1.70 |
| Other | 1 | .20 |
| Relationship Status |  |  |
| Single | 257 | 54.91 |
| Coupled | 211 | 45.09 |
| Sexual Orientation |  |  |
| Heterosexual | 334 | 71.40 |
| Homosexual | 25 | 5.3 |
| Bisexual | 97 | 20.7 |
| Other | 12 | 2.6 |
|  |  |  |

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**Table 2.** Multivariable Binary Logistic Regression Results for Relationship Status (Independent Variable) and Service Engagement (Dependent Variable)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Variables |  | Free Condoms | | STI Testing | | The Pill | | Pregnancy Testing | |
|  |  | aOR | 95% CI | aOR | 95% CI | aOR | 95% CI | aOR | 95% CI |
| Relationship Status |  | **1.71** | **1.13, 2.59** | 1.59 | 1.00, 2.53 | **2.21** | **1.45, 3.36** | **3.86** | **2.20, 6.78** |
| Age |  | **1.17** | **1.02, 1.35** | **1.54** | **1.31, 1.80** | **1.25** | **1.06, 1.48** | 1.19 | .98, 1.44 |
| Gender |  | **1.85** | **1.07, 3.20** | .75 | .38, 1.51 | - | - | - | - |
| Sexual Orientation |  | .73 | .47, 1.14 | .66 | .40, 1.08 | .89 | .56, 1.41 | 1.13 | .63, 2.03 |