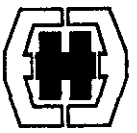

EASTERN HEALTH BOARD

Teenage Health Initiative

Report and Evaluation of a Pilot Project aimed at Reducing Teenage Pregnancies in the Eastern Health Board Area 1997-1998.

Margaret Acton,
Programme for Children and Families

Mary Hynes,
Department of Public Health

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Summary

Teenage pregnancy presents many adverse effects for mother and baby: prenatal problems, higher neonatal mortality rates, higher rates of sudden infant death syndrome, behavioural problems, and lower scores on intellectual tests.

Those at risk of teenage pregnancy are younger adolescents who have not matured enough to think about the future consequences of sexual behaviour, those engaged in sporadic sexual activity, those who do not have a partner supportive of preventing pregnancy, those who are not achievement orientated, those with family and friends who had an adolescent pregnancy.

Primary preventative programmes should aim at delaying the initiation of sexual activity. Figures show that in 1996 6.7% of all births in the Eastern Health Board region were to teenagers and 6.6% in 1997. Studies link economic disadvantage to high levels of teenage pregnancy, though the reasons for this link still need to be established.

A consultative process on Women's Health (EHB) identified teenage pregnancy as a health issue. In response the Eastern Health Board established the Teenage Health Initiative as a primary preventative programme which aims to target teenagers at risk of pregnancy. The objectives are to educate young people in positive knowledge and to bring about changes in attitude and behaviour in relation to their personal development and sexual activity.

Programmes enable young people to develop communication and decision making skills, understand peer pressure and its consequences, and improve self esteem. The health effects of early sexual activity are dealt with.

Training was offered to youth organisations and resource centres dealing with young people. Many of these organisations provide "second chance education" to early school leavers. Guidelines from the National Council for Curriculum and Assessment: Department of Education helped in designing age related programmes, and parents and managers of youth centres were informed of programme content. Legal advice was sought on matters of early sexual activity. Programmes were designed in consultation with young people. Group numbers were small which was very beneficial to participants giving them an opportunity to discuss sensitive topics in safe surroundings.

This report documents results of the pilot programme which commenced in February 1997 and ran until April 1998. Duration of programmes varied from centre to centre as much preparatory work was required with young people prior to addressing personal issues. There was a much greater uptake of the intervention programme by girls than boys. Some trainers had difficulty engaging males in programmes and further exploration of intervention strategies suitable for males is required.

There was a significant increase in knowledge at the end of the programme as well as some changes in attitude towards sexual activity and relationships. There was a great interest both from trainers and teenagers on sexually transmitted diseases and a clear demonstration of changes in both information and attitude towards them following the programme. Attitudes and values in relationships changed when more

teenagers said that having a boyfriend/girlfriend meant "having a special friend" and "respect".

Trainers in youth organisations report better interpersonal skills and raised self esteem amongst the young people. Trainers are of the opinion that all people working within youth organisations should have this type of training, particularly in self-esteem enhancement. Some have reported that great interest has been generated amongst other teenagers following intervention, and that a "waiting list" has been compiled for those interested in future courses. Such intervention programmes should reach all young people at risk of teenage pregnancy both within and outside the formal education system. Working with small groups seems more effective in providing teenagers with suitable conditions to explore sensitive issues.

If we are to address all the predisposing factors associated with teenage pregnancy we need to explore in greater depth programmes which may be more appropriate for the boys who had difficulty engaging in groups. That combined with the current initiative which has proved so beneficial could help us to look forward to a reduction in teenage pregnancy rates in the coming years.

We would like to acknowledge the following who made this study possible:

1. Those who provided training, for bringing their professionalism, expertise and insights into a wide range of topics.

2. Ms. Jean Hoey, for her contribution in the analysis of statistics.

3. Women's Health Department, Eastern Health Board, who provided funding for all costs incurred and secretarial support.

4. The youth/resource workers (trainers) who brought much enthusiasm to the training and then delivered programmes which proved very beneficial to young people.

5. The young people who participated in the programmes and especially those who promoted the initiative to other teenagers.

Chapter One

1.1 Introduction

While the total number of births to teenagers in Ireland has not changed significantly in the past 20 years, the number of births to single teenage mothers has been rising. In 1972, 24% of births to women under 20 were outside marriage. By 1992, the figure had risen to 89.3%[1]. In 1997, 2, 894 women aged under 20 years gave birth in Ireland, representing 5.5% of all births. The majority (95%) of these births were non-marital. Just over 9% of these women had one or more previous children.

Births to teenage mothers (< 20 Years) in the Eastern Health Board region as a % of all births by Community Care Area in 1996 and 1997				
Area	*1996*		*1997*	
	Number	*% of all births**	*Number*	*% of all births**
1	*77*	*4.3*	*76*	*4.1*
2	*89*	*4.8*	*69*	*3.7*
3	*79*	*5.3*	*72*	*4.9*
4	*212*	*10.2*	*210*	*9.6*
5	*184*	*8.3*	*174*	*7.5*
6	*192*	*7.8*	*237*	*9.7*
7	*186*	*9.7*	*174*	*9.1*
8	*164*	*5.5*	*164*	*5.0*
9	*122*	*5.2*	*148*	*5.7*
10	*99*	*6.1*	*98*	*5.8*
Total	***1,404***	***6.7***	***1,422***	***6.6***

Source: RICHS (EHB computerised child health records)
*calculated on basis of births for which maternal age recorded

The table above shows that 6.6% of all births in the Eastern Health Board region in 1997 were to teenagers. The figure for 1996 was 6.7%. There was considerable variation in the percentage of teenage births between Community Care Areas. Area 6 had the highest percentage of teenage births, at 9.7%. Area 2 had the lowest, at 3.7%[2].

Chapter Two

Literature Review

2.1 Associated Risks of Teenage Pregnancy and Parenthood

While the number of births to teenagers has not changed significantly for almost two decades there are, however, many associated risk factors in such circumstances. Adolescent pregnancy and parenthood frequently bring in their train physical, psychological and social problems for mother and child.

2.2 Physical Risks

Younger adolescents are at greater risk for negative birth outcomes including preterm delivery, low birth weight, and neonatal mortality[3]. Findings of higher rates of sudden infant death syndrome and a greater number of injuries experienced by children of adolescents suggest that supervision of these children may be less than adequate[4].

In a recent study at a Dublin teenage antenatal clinic Fitzpatrick reports that one quarter of teenagers attending his clinic booked after 20 weeks, 60% said that they were afraid to come earlier and 75% had unreliable menstrual dates[5]. The study emphasised that the obstetric and neonatal outcome of teenage pregnancy can be significantly improved by intensive ante-natal care[6,7,8].

Other physical risks to the adolescent mother include sexually transmitted infections, including HIV, and reproductive health problems.

2.3 Psychological

Young teenage mothers sometimes display feelings of inadequacy, worthlessness, depression, and poor self-esteem[9]. While teen mothers show nurturing ability, some regard their children as dolls, something to hug rather than teach and to interact with[10]. Several studies suggest that school aged children of adolescents exhibit more behavioural problems and score lower on intellectual tests than school aged children of adults. While it is unclear why this is so, it is suggested that poor parenting, lower socio-economic status, disadvantaged neighbourhoods and schools and poor career prospects may play a role[11].

2.4 Social

Teenage parents are often subject to social isolation in run down estates away from their extended family[12]. Child care provision is a problem for adolescent mothers, making it difficult for them to finish their education, thus leading to poor job opportunities, and in such circumstances they may be poorly supported and may become severely depressed[13]. Teenage parenthood can leave little time for exploration of teen concerns such as peer relations, dating, schooling, and career choices[14].

2.5 Sexuality and Socio-Economic Factors

Teenage pregnancy can be viewed under two broad headings, issues of sexuality and socio-economic factors.

2.5.1 Sexuality

There has been an increase in the rate of non-marital intercourse amongst the adult population in the past 20 years in Ireland, which parallels the experience of many industrialised nations. There has been a corresponding decrease in the age of first intercourse. A large scale study of British 16-19 year olds found that 50% of 16 year olds had experienced vaginal intercourse, and of those, 15% by the age of 14

years[15]. In a study conducted by the Midland Health Board on a mixed group of 1,638 16-18 year olds, 32% claimed to have had sexual intercourse[16]. Young people have become increasingly sexually experienced throughout recent history. This may be due to early physical maturity and social pressures[12]. Studies in Britain and Ireland point to a link between high levels of ignorance about sexuality and pregnancy. A study conducted of 112 pregnant teenagers in Dublin found that 55% of the girls had "no idea at all" regarding the menstrual cycle, and 10.7% had a rough idea[17].

Fitzpatrick found that only 39.2% of the antenatal teenagers were correct in their knowledge of the time of maximum fertility in the menstrual cycle[5].

In the study conducted by the Midland Health Board, 96% of the sample knew the normal duration of pregnancy, but only 25% of males and 51% of females knew the most likely time for a girl to become pregnant during the monthly cycle[16].

2.5.2 Socio-Economic Factors

Non-marital births and teenage parenting are more highly represented in the lower socio-economic groups in society in Ireland and Britain[18].

In a study of 37 industrialised nations, a relationship was found between high levels of teenage pregnancy and low levels of socio-economic development[19].

Fitzpatrick found that 89.2% of the adolescents attending his antenatal clinic were from social class 3-5 and 10.8% were from social class 2. There were none from social class 1[5].

As to why women from situations of economic disadvantage are highly represented amongst those who become mothers under the age of 20 is the subject of much theorising. Young women with restricted employment opportunities cannot achieve economic or social independence via a job[20].

Although the link between economic disadvantage and high levels of teenage pregnancy has been proven, the reasons for this link still need to be established[1].

2.6 Adolescents at risk of teenage pregnancy

The following adolescents tend to be at risk of pregnancy.

a) Younger adolescents who have not matured enough to think about the future consequences of sexual behaviour;

b) those engaged in sporadic sexual activity;

c) those who do not have a partner supportive of preventing pregnancy;

d) those who are not achievement orientated;

e) those whose mothers, sisters and friends have had an adolescent pregnancy;

f) those whose fathers are absent from the home[21];

g) adolescents who lack emotional support and stability may look to early sex and motherhood to provide emotional closeness[22].

Chapter Three

Approaches to prevention

3.1 Primary Prevention

Delaying the initiation of sexual activity is the principal means of preventing adolescent pregnancy[21,23].

Sex education courses do result in significantly higher rates of contraceptive use among those who attend, but no positive or negative relationship between sex education and teen pregnancy has yet been demonstrated. Contrary to popular myth, there is no correlation between contraceptive education and earlier initiation of intercourse[11].

Pregnancy rates have been reduced by a programme in South Carolina that addresses messages emphasising decision-making and communication skills, self-esteem enhancement and knowledge of anatomy and contraception to the entire community, including clergy, parents, teachers and community leaders[11].

There has also been considerable interest in the US in school based clinics which have emphasised both primary and secondary approaches to pregnancy prevention.

Other approaches have included giving adolescents responsibility for a "child" (an egg or doll) for days or weeks with the adolescent having full 24 hour responsibility for its care and well-being, role play and dramatic presentations concerning sexual responsibility, and organising parent-child communication programmes.

Strachen and Gorey demonstrated that teenagers who participated in such a programme had more realistic notions about the responsibilities and demands involved in child rearing. The study which investigated the effect of the infant simulator suggests that interventions which facilitate adolescents' realistic appraisal of future consequences help support their future goal directed behaviour, such as graduating from high school, attending college and making the decision to delay sexual activity, thus postponing pregnancy[24].

3.2 Secondary Prevention

Secondary prevention aims at preventing pregnancy in sexually active adolescents. Studies indicate that sexually active adolescents may have difficulties using contraception for the following reasons:

1. Immaturity

Adolescents' views of invulnerability lead to beliefs that pregnancy could never happen to them thus leading to ineffective preventative practices, especially in the high risk teenager[25]. In order to use contraceptives effectively one has to have the ability to plan ahead. This ability develops gradually during adolescence, and may not be present in younger teenagers. While adolescents may know about contraceptives, obtaining and using them requires a degree of confidence that many teenagers lack[26].

2. Embarrassment and poor compliance

All methods of contraception demand continuing motivation. Due to the disorganisation in the lives of teenagers many find it difficult to achieve such motivation. They are embarrassed to go to a GP, fearing the lack of confidentiality, or of being examine[26]. Fitzpatrick reports that while over half the teenagers in his study said that they had used contraception in the past, the reported compliance in the majority was poor. He stresses

that education rather than availability appears to be a greater problem in this group[5].

3. Adolescents' belief that the use of contraceptives implies the lack of spontaneity

Many teenagers do not want to use contraceptives as this may imply that they are promiscuous[27]. The psychological development of most adolescents make them less than ideal users of contraception[27,28].

4. Adolescent sexual activity is often sporadic and unpredictable

A study conducted by the Midland Health Board showed that out of 449 16-18 year olds 82% claimed to use contraception. However, only 70% of the group used contraception on the first occasion of sexual intercourse[16]. McHale reports that 21% of 2,754 pupils (15-18 years) had sexual intercourse. The mean age of first intercourse was 15.5 years. The study shows that 72% reported having used a condom at first intercourse, but of the 475 pupils who had sexual intercourse regularly, only 67% used condoms all the time, with 33% using them sometimes or never. Over half reported that first intercourse was with a casual partner and 35% and 9% respectively claimed that alcohol and non-prescribed drugs were a contributing factor. While the level of knowledge within this group regarding sex education was generally high, over $1/3$ of the sexually active respondents had been involved with high risk behaviour[29].

5. Poor knowledge of fertility

Fitzpatrick found that, in general, adolescents' knowledge of reproductive function was poor. Over half were unaware of their own cycle related fertility. Over 80% of the teenagers said they had just one sexual partner to date, and almost 90% were involved in a continuing relationship with the father of the baby[5]. Buckley had similar findings saying the young

women interviewed were sexually naive and became pregnant through alcohol abuse on the part of their boyfriends[30].

3.3 Tertiary Prevention

Early prenatal care and regular attendance at antenatal care sessions reduce morbidity to adolescent mothers and their children. During later pregnancy and in the postpartum period, emphasis should be directed towards the care of the child and the avoidance of rapid subsequent pregnancies. Programmes which help young people to make informed choices in relation to sexuality and sexual activity would be desirable.

3.4 Peer Education

Peer education in relation to substance abuse prevention programmes has been introduced in the US in the past decade, and has been shown to be effective. Powerful behavioural strategies are used to change the factors that support adolescent adoption and maintenance of tobacco and drug usage. The approach highlights the immediate social and psychological consequences of substance abuse and tries to improve adolescents' short term social skills. Children at risk from adverse peer influences have low self esteem, a feeling of not belonging, and lack interpersonal communication, situation and judgement skills. It is suggested that positive peer influence programmes should try and address these issues. The cognitive ability of peers to deliver such programmes must be open to question and supervised by peer counsellors[31]. There is very little specific information on peer groups addressing teenage pregnancy. However, one programme from the US called "Teen Talk" seems to indicate that through a combination of peer group activity, adult volunteer follow up, teen drama, academic incentive and special parent teen events, some reduction in teenage pregnancy has occurred[32]. The programme targets girls aged 12-17 years and to date over 400 have participated. Over half said that they were sexually active when they entered the programme.

Issues addressed included factual information about sexuality, responsible decision making, dealing with peer pressure, and making career choices in an atmosphere that stimulates participation of teens. However, the programme offers individual follow up through trained adult volunteers.

To conclude it appears that peer influence plays a major part in the initiation and maintenance of adolescents' substance using behaviour. There is little documentary evidence stressing or suggesting the value of the peer group in addressing sensitive issues such as teenage pregnancy. Peer education programmes could be explored in the future for primary, secondary and tertiary prevention of teenage pregnancy and its consequences.

3.5 Project Aims

1. To enable young people to develop the concepts of self esteem, respect and friendship.
2. To enable young people to explore communication skills and how such skills can impact on decision making.
3. To educate young teenagers in positive knowledge regarding fertility, conception and contraception, and to challenge common myths concerning these issues.
4. To educate young teenagers about the risks of sexual activity, in particular sexually transmitted infections.
5. To help young people explore peer pressure in relation to decision making.
6. Finally, to enable young people to make informed decisions, which might include the delay in onset of sexual activity.

Chapter Four

Programme Development

4.1 Background and Method

A consultative process on women's health was conducted in the Eastern Health Board Region in 1995. The problem of teenage pregnancies was acknowledged by many groups. Underlying causes suggested were lack of education and assertiveness, poverty and segregation within the educational system. The Eastern Health Board in response prioritised an initiative which would identify ways of reaching the most vulnerable sections of young people and target them with special educational programmes within and outside the educational system with a view to minimising teenage pregnancies.

The teenage health initiative was established in November 1996 and a co-ordinator was appointed to develop, implement, document and evaluate the Initiative. Six community based organisations catering for teenagers and younger children were funded by the Eastern Health Board to employ a part-time resource worker to implement age appropriate programmes to young people at risk of pregnancy. These organisations are:

1. Dochas Family Resource Centre, Clondalkin

2. Neighbourhood Youth Projects 1, Inner City

3. Neighbourhood Youth Projects 2, Inner City

4. St. Helena's Resource Centre, Finglas

5. Geraldstown House, Ballymun

6. Neighbourhood Youth Project, Blakestown/Clonsilla

A number of teachers in socially disadvantaged areas had, at a previous stage, expressed interest in training for such programmes. At that time the Department of Education was developing teacher training in relation to the Social Personal and Health Education Programme. Consequently, this initiative focused on other youth organisations as well as the six initiatives funded by the Eastern Health Board rather than on schools.

Youth workers and resource workers had varying qualifications and levels of experience and shall be referred to as **trainers.**

In order to decide the content, method of delivery and age related programmes the following procedures were undertaken:

- Literature search

- Regular consultations between a Public Health Specialist in the Eastern Health Board and the co-ordinator of the initiative to discuss evaluation methods, policy issues and other matters as they arose throughout the project

- Meeting with co-ordinators and youth workers in each organisation

- Advice from the National Council for Curriculum and Assessment: Department of Education

- Discussion with suitable trainers

It was envisaged that age appropriate health programmes for teenagers and younger children would be delivered throughout many disadvantaged areas in the Eastern Health Board.

Based on the literature review such programmes should include training on self esteem, communication skills, decision making and peer pressure, as well as "sex education". Evaluation of such programmes would assess changes in knowledge, attitude and behaviour of young people.

Contact was made with youth organisations within the Eastern Health Board area. Most of these organisations offer second chance education to early school leavers while others provide after school programmes to children of various ages.

Each youth centre interested in the Initiative was contacted by the co-ordinator. Appointments were set up to meet the manager (where possible) and the trainer who was interested in the programme. The objectives, duration and content of the training were outlined as well as the expectation that a programme would be implemented as soon as possible after training.

It was explained to the trainers and managers that this type of work could lead to disclosures of child abuse and Department of Health guidelines were recommended in the event of same. Trainers expressed great enthusiasm for this type of intervention programme, stressing that they were facing many issues regarding sexuality and sexual health on a regular basis, but felt unskilled to deal with them.

4.2 Training

Three groups were trained in Dr. Steevens' Hospital, Eastern Health Board, between February 1997-July 1997. This consisted of 34 people in total. Two further groups were trained in 1998 and evaluation of their programmes will take place at a later date.

The groups were facilitated by two teachers, both with psychology backgrounds. Others who provided training input were:

1. Health Advisor; Genito-Urinary Medical Clinic, St. James' Hospital. **Subject:** Sexually Transmitted Infections.

2. Irish Family Planning Association. **Subject:** Contraception. Workshops were also provided on fertility awareness, and the possible myths that surround it.

3. Education Officer. Drugs and AIDS Service, Eastern Health Board. **Subject:** Drugs, HIV and AIDS in relation to sexuality.

4. Senior social worker (Eastern Health Board). **Subject:** Session on issues relating to procedures in the event of disclosure of child abuse.

Trainers were enabled to:

a) Reflect on their own attitudes to health and personal development issues.

b) Develop skills and a methodology for working with groups.

c) Develop a programme and the materials necessary to implement a programme.

d) To evaluate the programme and training component after implementation.

4.3 Outline of Training Programme

Day 1: Expectations, exploration of issues in relation to implementing a programme. Participants were trained in techniques so they could establish a good atmosphere within groups, how to make contracts, learn names and establish boundaries. The setting for such a group would be informal, chairs arranged in a circle. Various games and exercises were used to promote group bonding and listening skills. Participants were then invited to explore their own expectations and concerns around this training, and invited for suggestions regarding what would make the training successful for them. They were then asked to reflect on issues which could impact both positively and negatively on their future work in the context of the young person, the community, the agency and themselves. It was emphasised that while confidentiality is essential within this type of programme, it would not be possible if a child disclosed that he/she is at risk.

Day 2: Working with groups. Facilitation skills, group dynamics. Information was given on the stages of group life, individual roles within groups, and the role of the facilitator. These issues were explored in depth, with use of brainstorms, role play, and games.

Day 3: Self esteem, relationships, sexuality. Participants were invited to explore self esteem issues, again using reflection, discussion, games, and brainstorm. Personal lifelines were explored and advice given on how best to use this method with young people. Flip charts were used for the brainstorms and participants were asked to explore the language and range of feelings, and how best to assist young people to understand and express such feelings, particularly in the context of self esteem. Training on relationships and sexuality was viewed holistically i.e. seen as part of the psychological, physical and spiritual development of an individual.

Participants were enabled to reflect on their own attitudes and messages received regarding sexuality and gender issues. A flip chart was used to brainstorm the language which may be used by young people in describing body parts and sexual activity. Participants were advised how to use such methods when designing programmes within their organisations. Information from the National Curriculum and Assessment Unit, Department of Education provided guidelines on age appropriate programmes. Various games and role play were used in this session, where participants were posed questions as if from the young people. This type of exercise helped to minimise discomfort around the subject, as well as focus attention on how to respond to questions.

Day 4: Interpersonal communications, peer pressure, role play. Communication styles were explored and clarified with much emphasis on assertiveness training. Participants were enabled to reflect on how to design programmes for young people in the context of decision making skills and peer pressures, especially in relation to sexual activity.

Day 5: Positive knowledge on fertility, conception, contraception, sexually transmitted diseases. This was primarily an information session on puberty, fertility and the exploration of common myths around both. Information on contraception was provided including an input by the Irish Family Planning Association. Participants were enabled to become familiar with various methods of contraception and received information on such methods. Videos such as "Growing Up", "Changes" and "Warts and All" were shown. A health advisor from the GUM clinic (genito-urinary-medicine) facilitated workshops on Sexually Transmitted Diseases (STDs). Trainers were given factual information on STDs as well as insight into the popular myths young people may believe regarding the subject. Apart from information giving, this session focused on sexual health, with much emphasis on primary prevention and early treatment of

STDs. Participants expressed great surprise that they knew very little about this subject prior to training, and in particular that some STDs are present without symptoms, and that early diagnosis and treatment is readily available.

Day 6: a) Exploration of issues in relation to disclosure of child abuse. b) Workshop on HIV/AIDS/Drugs in the context of sexual health. Since this type of programme for young people could lead to disclosures of child abuse Department of Health guidelines were explained and recommended in such an event. A senior social worker facilitated this session. A workshop was conducted by an education officer (EHB) on HIV, AIDS and drugs in relation to sexuality. Trainers were challenged on their own attitudes in relation to the above so that they could deal with these issues if they arose in their programmes.

Day 7 & 8: Programme Development: The trainers were given an opportunity to design a programme which could be implemented with young people. This enabled the trainers to view the various materials available on the market, and to share information on materials which they may have used previously.

Day 9: Evaluation of Training: The trainers were invited to return at a later date to evaluate their training.

Note: While training for trainers was initially designed to run for two consecutive days per week over four weeks, this was later changed to one day per week for eight weeks in order to facilitate organisations.

Chapter Five

Programme Implementation

5.1 Issues of Implementation

Thirty four people (five males, twenty nine females) were trained in the period between February 1997 and July 1997. Out of this number twenty one trainers implemented programmes. Many youth organisations had staff changes and consequently in certain cases the person trained had to take up other duties and could not deliver a programme. Others moved to new jobs and were unable to implement programmes there at that time. Trainers, however, continued to work within the youth services and hoped to implement programmes at a later stage. One organisation had difficulties relocating to a new premises.

On completion of training participants felt that it would be necessary to consult with the young people in the organisation and design programmes based on their needs. Shorter one-to-one type programmes were offered in certain cases where homeless young people were in short term hostel accommodation.

Prior to implementing a programme, trainers were advised to discuss its content with both the management committees and individual parents. This would be feasible since groups were small, and perhaps parents of members of the group would become interested in similar programmes for themselves at a later stage. Attention was drawn to policy issues and the following questions were dealt with by the Eastern Health Board legal advisor.

1. The legal age of sexual consent.

2. Referral of an underage person to a Family Planning Service without parental consent.

3. Legal implications of underage sexual activity.

4. Sexual activity where one partner only is underage.

5. Giving information to a young person without parental consent.

6. Parental refusal of programme.

7. Can a male claim rape by a female?

This information was then circulated to each trainer prior to drawing up policies or programmes.

Children and young people (10 to 18 years) received the programme. In general, parents expressed enthusiasm about the course. Parental consent was given in all cases.

5.2 Content and Time Scale of Programmes

Trainers designed age appropriate programmes which included some or all of the following topics:

Care of the body
Self esteem
Friendship
Listening skills, trust building
Feelings
Communication skills, with emphasis on assertiveness
Understanding influences
Peer pressure
Puberty
Periods
Conception
Contraception
Sexual Responsibility
Genital Geography (male & female)
Exploring Sexuality
Relationships
Values in relationships
Decision making skills and goal setting
Sexually transmitted Diseases
Parenthood

Programmes were implemented to groups ranging from eight to eighteen years of age. One programme only from each organisation was selected for evaluation, even though many trainers implemented a wide range of programmes to varying groups within their organisations. Twenty one programmes given by twenty one trainers were selected for evaluation. The number of young people who commenced the evaluation programme was 142, the number who completed was 98. The average duration of implementation was 2 $^{1}/_{2}$ hours per week but the number of weeks varied from 8 to 32, the average being 20. This variation was attributed to the fact that much group building was required with some groups prior to implementing programmes dealing with sensitive issues. Group numbers were small, on average eight to ten, though some were bigger and some were smaller. Trainers designed programmes in consultation with the young people and had to allow great flexibility in order to deal with issues as they arose. Five groups were of mixed gender and of these three had to be separated as programmes developed. Trainers reported that this was due to aggressive behaviour and lethargy on the part of the boys. It was also necessary in many cases to take breaks such as weekends away, day trips, recreational activities, sports, trips to the cinema, McDonalds and bowling.

Chapter Six

Evaluation

6.1 Methodology

Evaluation took place in three different ways:

1. Qualitative interviews for teenagers

2. Quantitative questionnaires for a) teenagers and b) younger children

3. Trainer evaluation

6.2 Qualitative Evaluation

Six focus groups were facilitated by the co-ordinator to assess changes in knowledge, attitude and behaviour following implementation of the programmes. These processes and interactions were identified firstly by several readings of the transcripts keeping in mind the aims of the programme. Re-reading was essential, as some concepts were more evident than others.

The texts were highlighted according to the main concerns of the programme – Knowledge, Attitudes and Behaviour. From these sub-headings were created such as self-esteem, communication etcetera. The transcripts were imported into a qualitative analysis software tool {NUD*IST} where text was coded and structured and a 'tree' was built indicating levels of ideas.

6.3 Quantitative Questionnaire

Teenagers and younger children completed a confidential questionnaire before and after the programme. The co-ordinator of the Teenage Health Initiative administered the questionnaire to the adolescents. However, it was felt it would be more appropriate for somebody familiar to administer the questionnaire to the younger children. The questionnaires were computer coded and analysed by using the SPSS software package. The questionnaires aimed to assess changes in knowledge, attitudes and behaviour in relation to puberty, fertility, pregnancy, sexuality, sexual health and relationships.

6.4 Age and Sex

One hundred and forty two (142) young people in total completed the pre-questionnaire and ninety eight (98) the post-questionnaire. Of this number 47 were under 13 years of age and completed the pre-questionnaire designed for this age group, while 38 completed the post-questionnaire. The remaining 95 young people were over 13 years and completed the pre-questionnaire; 71% were female, 26% were male and 3% were unknown. Sixty young people over 13 completed the post-questionnaire, 83% were female, 15% were male and 2% were unknown.

Discrepancies in pre and post numbers were due to the following reasons:

1. Some teenagers secured employment.

2. Some returned to school.

3. Some left due to family problems.

4. Some were dismissed for misbehaviour and two boys were sent to detention centres.

6.5 Trainer evaluation

A semi-structured questionnaire was administered to trainers to assess their impression of the impact the intervention programme had on young people. Trainers completed this questionnaire in consultation with the young people on their programme. The questionnaire also estimated their impression of training, support, materials, and/or difficulties in implementing programmes, as well as policy issues and ideas for the future.

Chapter Seven

RESULTS

7.1 Qualitative Evaluation of Six Focus Groups

The analysis of six small discussion groups, which were conducted to ascertain levels of change in knowledge, attitudes and behaviour following implementation of the programme, yielded important information. It must be stated that the evaluation demonstrates only short-term outcomes.

7.2 Positive Knowledge

"And you know the facts from the myths, like if you're told something you can put people straight." {Focus Group 3}

For the purposes of coding, positive knowledge was defined as acquired knowledge on conception, contraception and sexual health. The level of positive knowledge increased in every group following the programme.

The participants were invited by the moderator to recall what they had learned as a result of the programme. Answers and subsequent text was coded into three areas: **Sexual Health, Conception** and **Contraception** in keeping with the chosen definition for **Positive Knowledge.**

{1} Sexual Health

This included statements by the participants about their newly acquired knowledge of STDs, AIDS and disease prevention. The texts were identified as practical knowledge acquired from the programme.

"The pill can protect you from pregnancy but it can't protect you from disease". {Focus Group 1}

"You learn about the diseases and that, and ... it was good. Because she explained it better to us". {Focus Group 2}

"And how you can catch different diseases and that, and what have to do to prevent getting the diseases". {Focus Group 6}

"And what you have to do to stop catching them. About sleeping around and all". {Focus Group 6}

"Just all the ways of catching STDs and about HIV and how you catch AIDS". {Focus Group 6}

"It makes you more cautious, like with STDs and that". {Focus Group 6}

"Learning ... and all about the STDs and knowing that there is clinics there for people if anything does happen to them. So there is treatment for most of them". {Focus Group 4}

"The stuff about Sexually Transmitted Diseases, I thought an awful lot about that. Like, for me, AIDS. Catching AIDS and all, like I didn't know there was so many ways of catching, or how many ways people say you can catch it, but you can't really". {Focus Group 1}

"Same, like STDs, AIDS was the only thing I knew about". {Focus Group 1}

"The STDs, I thought that was great, very interesting all about the different diseases and all, even cold sores, that it's a virus and all, I didn't know that". {Focus Group 1}

"...say I was having intercourse with a fella, there's things that I never knew about and now I know the risks I'm taking". {Focus Group 1}

Many of the participants were more aware, as a result of the programme, of the risks involved in sleeping with someone without protection:

"Well I think boys and girls can be at risk". {Focus Group 4}

"Yeah, there's an awful lot of risk". {Focus Group 1}

This area of sexual health seemed to have a great effect on the groups and the awareness of STDs and contraception had affected sexual behaviour in some as a direct result of the programme. {see Behaviour below}

{2} Conception

Positive knowledge about conception was also evident following the delivery of the programme.

"You would know what you're doing, you are not just having sex, you know where it's going, what it's doing, how you could get pregnant". {Focus Group1}

"She learnt us all things that we didn't know. Like about babies and sex and all ..."{Focus Group 5}

"About your womb, and like you know, about eggs, how a baby is produced because I never knew, I just thought you had a baby, it was in your womb and that was it. I never knew about producing eggs..." {Focus Group 1}

Participants were more aware of the facts about getting pregnant and the shortcomings of some methods like withdrawal.

"Like I thought, if the boy doesn't have a condom and like if he pulls out that you couldn't get pregnant". {Focus Group 1}

"you'd know in ways how you'd get pregnant, I knew but pulling out and all if he was still inside the vagina you could still get pregnant ..." {Focus Group 1}

{3} Contraception

This part of the programme had a very positive effect on many participants and served to increase positive knowledge in many cases.

"Yeah, all new, I didn't know there was such thing as female condoms!" {Focus Group 2}

"We got to use the contraceptive kit...like you know what to expect". {Focus Group 3}

Gaining knowledge in this area would enable the participants to make informed decisions about their sexual activity. We shall see later on in the discussion on Behaviour if this newly acquired knowledge was reflected in their subsequent sexual behaviour or purported future behaviour.

7.3 Attitudes and Behaviour

"I learned that I'm worth some thing, that I'm somebody, before I started this I didn't think much of myself". {Focus Group 1}

Changing attitudes were assessed under several sub-headings/indexes - self-esteem, relationships and communication among the more important with regard to the programme's aims and objectives. All these indexes are inter-linked, but were separated for ease of analysis. The concept and experience of peer pressure as articulated by the participants was interwoven with these sub-headings.

{1} Self-esteem

Areas in the text coded as self-esteem were positive views of self, respect for self and feelings of confidence and self-worth expressed by the participants. The new assertiveness experienced by the groups is evident and informed decisions are made.

"... making decisions, it makes you respect yourself more". {Focus Group 1}

"I'm more responsible now. We're more responsible now for our lives. We don't let young fellas put us down". {Focus Group 2}

"We learnt to lift your head up and keep it up if you were in a fight, or never let anyone put you down, like, and a choice you have for yourself. Don't let anyone walk all over you". {Focus Group 2}

"And don't let anyone insult you, you know. Like if you don't want to do it you don't have to". {Focus Group 2}

"You have to stand up for your rights, walk out, just turn your back on them and walk out". {Focus Group 2}

When asked by the moderator about their reactions to the self-esteem content of the programme, the response was overwhelmingly positive:

"I respect myself more now". {Focus Group 6}

"[I have] a lot more confidence and self esteem". {Focus Group 3}

"It makes you a lot more confident". {Focus Group 3}

"You can stand up for yourself and be confident". {Focus Group 3}

"Yeah, and even if you didn't agree with someone else's opinion like, your able to take it on and challenge it". {Focus Group 3}

"Yeah, because you're more aware now what you're doing". {Focus Group 3}

"You think more of yourself and you respect yourself more now". {Focus Group 4}

"I learnt a lot more about myself, how to respect myself, and I'm a lot more ...secure, I was a lot more insecure before the course, but now I just think a lot more". {Focus Group 4}

One participant related a story that illustrates the learning process as a result of the programme. The participant shows a real insight into the effects that low self-esteem can have as you grow up.

*"Like before that, **before we did this course**, like I wouldn't think anything of that. You know, but now like, even when he's [her younger brother] going to sleep like, I do say 'you're the best boy in the world' and all.*

You know to make him feel good... he does be happy then. Like he does be smiling and I know like he understands what I'm saying...Because if you have a child, and keep saying he's stupid and he can't do anything he's going to grow up thinking that then for the rest of his life. Like rather than taking part in anything, like saying 'I can't do that'". {Focus Group 1}

The process of feeling good about yourself and seeing the most positive aspects is not something many are used to, for many the programme changed the negative feelings they had about themselves prior to the programme.

"Sure I was writing good things and bad things about yourself, like ... at the start, you'll always have the most bad things and then as you keep on doing it you'll have more good things". {Focus Group 5}

{2} Relationships

The area of relationships with boys was crucial to the small group discussion and many participants articulated the change the programme had made to their attitude to relationships, in particular sexual relationships. A new assertiveness, awareness of the importance of their views and the process of informed decision-making was recorded.

"You have to be able to say no...It's not just what boys want. It's what we want as well". {Focus Group 2}

"I know like everyone has a mind of their own, and I know what to look out for, and you'd know what to do, and you'd know what's happening and what's going on around you". {Focus Group 1}

"You would know what you're doing, you are not just having sex, you know where it's going, what it's doing, how you could get pregnant". {Focus Group 1}

"Yeah, I would rather wait a while and learn more about them and who they were with before, not asking, but you know the way people say I was with him before, you know, before I'd have sex with him and I go on about contraception." {Focus Group 1}

"... that's what I mean, you miss nothing like, if that what he wants, you're better off without them". {Focus Group 1}

"Yeah, but from this course I'd have to know the person very well, and I wouldn't have sex with anyone that I wouldn't have feelings for. But I know there are some people who do". {Focus Group 1}

"Yeah, it makes you more like cautious. Like if you're having sex with someone you'll say like 'hold on, use a johnny'". {Focus Group 6}

One participant had related her new views on contraception to her boyfriend. The moderator was eager to know if this had made any difference to his activities:

"Yeah in contraception and all that". {Focus Group 1}

There is evidence of the spread of knowledge actually beyond the group to the participants' peers.

{3} Communication

The interaction in the groups, as evident from the transcripts, was indicative of improved communication skills and the participants felt they had opened up more among themselves and with their family.

"And we let each other express our feelings". {Focus Group 3}

"And we can talk about anything in a group and you'd know nobody would go outside the group and talk about it". [Focus Group 3}

"Yeah, and even if you didn't agree with someone else's opinion like, your able to take it on and challenge it". {Focus Group 3}

"They'll listen to what you have to say... because you're more aware now what you're doing". {Focus Group 3}

"it helps you communicate and you need to talk about yourself and all". {Focus Group1}

"Yeah, I got much more self confidence like, and I could talk to me parents about it...And I could never talk to them about anything like that I'd be too embarrassed, but, now I'd be able to sit down and talk to them about it". {Focus Group 3}

{4} Behaviour

Behaviour change was coded as text relating to perceived change in sexual behaviour as experienced by the participants or proposed future strategies in relation to this. Positive changes were associated with contraceptive use and avoidance of spontaneous sexual activity. There

were other behavioural changes associated with decision-making and communication {see above} and these are evident throughout.

"I wasn't using contraception and I thought it was all right". Moderator: "And would you use it now?" "Yes". {Focus Group 1}

"I said I'm just letting you know that I'd just have to get to know you before I'd sleep with you. I was telling him we were doing this course and I was saying I'd have to know you a while and would have to love you before anything would happen, and I wouldn't be pressured to do anything". {Focus Group 1}

"It makes you more cautious, like with STDs and that". {Focus Group 6}

"Yeah, it makes you more like cautious. Like if you're having sex with someone you'll say like 'hold on, use a johnny'". {Focus Group 6}

"Well you stopped sleeping around". "I know". {Focus Group 6}

This participant had stopped sleeping around which is a very positive result for the programme's ultimate objective.

{5} Peer Pressure

"When you're forced to do something ... forced to smoke, or drink and have sex". {Focus Group 5}

Saying no to peer pressure can be very challenging and very hard. Results here indicate that those who stood against their peers when they did not want to do something gained a sense of confidence and self-worth.

Positive aspects reported as a result of the programme include:

"I learnt how to say no and all". {Focus Group 5}

"Yeah, you know like, like, you can just say stand up for yourself, and be confident to say no like". {Focus Group 3}

"No, like I just like said I didn't want to do it like. And the rest did like, and they just took on that I didn't want to do it. So they just left it at that". {Focus Group 3}

The moderator asked of the participants: And if you were in a situation, like just say, the gang wanted to do something and you didn't want to do it, do you think it would change your decision making there?

"I wouldn't do it. I'd say no". {Focus Group 1}

"Yeah, I'd never be peer pressured into anything". {Focus Group 1}

{6} Peer pressure and sexual activity

"Ah, well there are just some girls who are in a relationship and they really are say, mad about the fella and like just say the young one would say oh well he can have any young one he wants and if I don't do this with him now he is just going to leave me and get somebody else who will do it". {Focus Group 1}

"And they're having sex , but they don't know they are doing. They are just doing it because everyone else is doing it... And half them are getting pregnant, they don't know about contraception or anything, they are just listening to what the fellas are saying and they're saying 'ah, it will be all right'". {Focus Group 2}

*"Really, cause we are all going out in group, but we are all going out with someone, but if there is someone there without a boyfriend, they feel in the way, and they think I have to have a fella. So they get a fella even if he treats them like s****". {Focus Group 1}*

"They don't want to lose them because they would be on their own again". {Focus Group 1}

{7} Peer Education – For and Against

The moderator asked the groups what they thought of the idea of peer-led education – the idea of peers as deliverers of programmes such as the present one.

For

"Yeah, 'cos they'd want to help you". {Focus Group 2}

"Yeah, it would be easier". {Focus Group 3}

"I think it would be good, because ... like they're near the same ages and they're probably going through the same things that we're probably going through". {Focus Group 1}

Against

"Probably you wouldn't get listened to". {Focus Group 2}
"It would be very hard to get listened to because they'd say "Ah, she's the same age, don't listen to her like". {Focus Group 2}

"..'cos some people like, just say like your sister is two years older and talking to you, you just don't listen to them". {Focus Group 3}

"...but you'd feel very embarrassed like, I know like you're still going to be talking to people older but, if it's only two years older you'd feel very embarrassed talking about it". {Focus Group 3}

"No, I wouldn't like that. No. Someone older than you. With someone older you'd listen because they know more, but with someone younger how would they know, if they are around the same age?"
{Focus Group 1}

"I still wouldn't like it. I'd rather someone older than me". {Focus Group 1}

"You wouldn't trust them". {Focus Group 1}

"Yeah, just because you'd be able to talk more. Say she was, ____ was doing it or something, I 'd say she's a fool. But like do you know what I mean, I wouldn't listen ..." {Focus Group 1}

The participants were predominantly against the idea of peer education yet some felt they could help someone older to deliver a programme if asked:

"Probably if they asked us, yeah". {Focus Group 2}

"Yeah. I could probably like, we could probably like help out with it. Like we'd know what to do we would and tell them and show them, make it easier for them, 'cos we know the hard bits and they probably won't". {Focus Group 2}

{8} Parent Education

The moderator asked the groups for the views on parent education – the idea of having a similar programme for their parents. Most were in favour and saw it as a valuable thing for their parents {particularly mothers}.

"Yeah, 'cos the parents would be able to understand then, about what you'd be doing. Yeah, I think it would be good, because then a parent could understand what their teenager is going through". {Focus Group 3}

"'Cos they mightn't know what we know, and we mightn't know what they know". {Focus group 2}

"And we could help each other out in that way". {Focus Group 2}

"Yeah, I think it would, because some parents when they were younger, they weren't allowed talk about it. So I think that parents would want to know about it". {Focus Group 3}

The idea of providing a similar programme for parents can help avoid the situation where the teenager knows **more** than the parents (which, in some cases may lead to conflict).

"She doesn't know half the stuff I know. Because when I go home and she says "what were you talking about?" and I have to explain to her. One night I said something to her and she said "where are you getting all this from?" she didn't even understand. We think we're great because we know and they don't". {Focus group 2}

"I wouldn't tell her anything that we've confided in, but I'd tell her the basic things like what we're doing, and she was real interested and all. And I'd say she'd be interested in doing it herself". {Focus Group 1}

"Because they probably don't know like, what we know like, they hadn't got it when they were younger, if you know what I mean, and we have it now, like so, there must be things about their bodies that they don't know about". {Focus group 1}

"My Ma was always saying, she'd love something like that when she was our age". {Focus group 1}

"She hasn't got a clue. And she has had five kids". {Focus Group 1}

Very few of the participants were against the idea of parent education. Those who were thought it was *"too late"* for their mother as *"they're after having their kids and all now". {Focus Group 5}*

Note:

The participants were asked about the size of the group – should it be large or small and why? All preferred a small intimate setting where everyone gets a chance to be heard. Communication and trust were reported as important when considering this issue.

"A smaller group, because like, and people you know as well, because you can talk about it, and trust them". {Focus Group3}

"No you wouldn't be able to talk like. And everyone would probably be talking at the same time, and you'd never really get a chance to say that you had to. So I think a small group is better". {Focus Group 3]

"Yes, a small group, because you feel an awful lot more comfortable, like, in just a small group, and you can talk to each other". {Focus Group 3]

"Everyone always has something to say, everyone has their own opinions. We wouldn't be as close. You wouldn't have everyone here, we were all here 'cos we all used to talk, we were real close".
{Focus Group 1}

7.4 Conclusion

The results of the focus groups are encouraging and offer us a descriptive, exploratory and subjective insight into the groups' feelings and experiences surrounding the programme's content, implementation and outcome. The experiential views of the teenagers provide important indicators for the importance of such programmes and the demand that exists. Thus the continuation of such programmes is crucial to the primary and secondary aims of teenage health education (especially more 'at risk' populations), as one participant said: *"It's a lot clearer now". { Focus Group 2}*

Teenagers enjoyed being part of a small focus group where they could enjoy being part of safe surroundings. They were not afraid to ask questions and were not inhibited when presented with information and terminology which they had not previously understood. There were no negative comments from the focus groups regarding the course delivery or content. Some expressed that they would like it to continue longer. Most focus groups felt that it would be beneficial to provide such programmes for parents, however, there were mixed feelings on the idea of peer education. Regarding future programmes teenagers felt that every aspect should be continued *"Because we didn't know anything it was all very new to us". {Focus Group 1}.*

They suggested to include in future programmes the following:

1. Information and discussion on pregnancy risks
2. Raising a family on your own
3. To develop an outreach aspect in peer education programmes
4. To provide similar style programmes for parents

7.5 Quantitative Evaluation

Participants completed a self-administered questionnaire at the beginning of the programme and at the completion. The questionnaires were computer coded and analysed on SPSS.

Assessment of self esteem in under 13 age group prior to and following intervention

The following statements were used to assess participants' level of self esteem pre and post intervention

Table 1 Statements to assess self-esteem
*denotes the answer 'No' to the statement, all other figures represent 'Yes' answers
Pre N = 47 Post N = 38

Statement	*Pre No. {%}	*Post No. {%}	P value
I like being my age	42 {89}	36 {95}	NS
Boys and girls like to play with me	43 {92}	38 {100}	NS
My family never gets angry with me	28 {60}	17 {45}	NS
I have lots of friends	37 {79}	36 {95}	<0.05
I have lots of fun with my family	38 {81}	33 {87}	NS
I like being a boy/girl	44 {98}	35 {97}	NS
I am a failure at school	*31 {66}	*31 {82}	NS
My family make me feel that I am not good enough	*41 {87}	*34 {90}	NS
I am no good at doing important things	*28 {60}	*22 {58}	NS
I am happy most of the time	43 {92}	37 {97}	NS
I usually quit when school is too hard	13 {28}	9 {24}	NS
I have never taken anything that did not belong to me	13 {28}	18 { 48}	NS
I often feel bad about myself	16 {34}	12 {32}	NS
Most boys and girls play games better than I do	*37 {80}	*25 {70}	NS
Most boys and girls are smarter than I am	*35 {74}	*21 {55}	NS
I like everyone I know	30 {65}	25 {66}	NS
I am as happy as most boys and girls	42 {91}	32 {84}	NS
I like to play with children younger than I am	21 {45}	14 {37}	NS
I often feel like quitting school	23 {49}	18 {47}	NS
I can do things as well as other boys and girls	43 {94}	32 {87}	NS
I would change many things about myself if I could	27 {57}	18 {47}	NS
I like the way I look	33 {72}	31 {82}	NS
There are times when I feel like	15 {32}	14 {37}	NS

running away from home			
I always tell the truth	13 {28}	8 {21}	NS
I feel my teacher thinks I am not good enough	8 {17}	12 {32}	NS
I worry a lot	29 {62}	21 {57}	NS
I find it easy to talk to adults	39 {83}	30 {81}	NS
I am listened to by adults	40 {85}	32 {89}	NS
I find it easy to talk to friends	42 {91}	34 {92}	NS
My friends listen to me	41 {87}	36 {97}	NS

One of the variables reached significance after intervention. However, 14 of the statements were answered very well at the onset, making change difficult to observe in these cases. The proportion who answered "no" to the statement "I am a failure" increased following the programme pre (66%) post (82%). Although this did not reach statistical significance it shows, nevertheless, a favourable trend.

7.6 Knowledge

Of those 95 who completed 'pre' questionnaires 67 {71%} were female 25 {26%} were male, and 3 {3%} were unknown. Of the 60 'post' questionnaires, 50 {83%} were female and 9 {15%} were male, and 1 (2%) was unknown. In all cases pre N = 95 and post N = 60.

Table 2: Knowledge Assessment Before and After Intervention

* denotes 'yes' answers only Pre N = 95 Post N = 60

Statement	*Pre No. {%}	*Post No. {%}	P value
A girl has a period every month	89 {94}	56 {93}	NS
The ovary releases an egg once a month	66 {69}	51 {85}	<0.05
The ovary releases an egg 14 days before the next period	30 {32}	42 {70}	<0.00001
The ovary releases an egg during the period	24 {25}	14 {23}	NS
A girl can get pregnant at any time of the month	61 {64}	48 {80}	<0.05
A girl can get pregnant the first time she has sex	77 {81}	56 {93}	NS
If a boy 'cums' outside the vagina a girl cannot get pregnant	36 {38}	18 {30}	NS
A girl cannot get pregnant during her period	47 {49}	27 {28}	NS
If a girl takes a shower after having sex then she cannot get pregnant	38 {40}	9 {15}	<0.001
Masturbation is a normal part of growing up for boys and girls	76 {80}	50 {83}	NS
Condoms are the best way to stop pregnancy	65 {68}	40 {68}	NS
Someone can get HIV by having sex once	80 {84}	52 {87}	NS
Condoms are available in chemists	90 {95}	59 {98}	NS
Condoms are available in supermarkets	58 {61}	46 {76}	<0.05
Condoms are available in petrol stations	47 {49}	32 {53}	NS
Condoms are available in churches	1 {1}	3 {5}	NS

Five of the statements were answered significantly better. The majority of the statements were answered well at the onset making change difficult to observe. There is evidence of the dispelling of myths surrounding pregnancy following the programme as we can see from the significant results.

Table 2.1: Knowledge Assessment of STDs

*denotes 'No' answers only all other figures represent 'yes' answers

Pre N = 95 Post N = 60

Statement	*Pre No. {%}	*Post No. {%}	P value
The pill protects girls from HIV infection	*63 {66}	*50 {83}	<0.05
Being HIV positive means you have AIDS	28 {29}	8 {13}	<0.05
You cannot get HIV infection from hugging or kissing on the lips	34 {36}	18 {30}	NS
STDs can be passed through oral sex	55 {58}	41 {68}	NS
You can get STDs from toilet seats or towels	*40 {42}	*31 {52}	NS
Untreated STDs can result in infertility in women	38 {40}	36 {60}	<0.05
Genital warts can be picked up from skin contact alone	34 {36}	36 {60}	<0.05
Genital warts are linked with cervical cancer in women	17 {18}	24 {40}	<0.01
Genital herpes is caused by the virus that causes cold sores	26 {27}	37 {62}	<0.0001
Treatment of genital herpes result in complete cure	*21 {22}	*21 {35}	NS
Thrush in the vagina is always caused by sexual contact	*49 {52}	*33 {55}	NS
Discharge from the vagina always means infection	*56 {59}	*43 {72}	NS
STDs always cause a discharge	*29 {30}	*36 {60}	<0.001
Pubic lice usually cause pubic itch	71 {75}	49 {82}	NS
The itch of Scabies disappears immediately following treatment	19 {20}	22 {37}	<0.05

Seven of the statements were answered significantly better after the intervention. It must be noted that many of the statements were answered well at the onset making change difficult to detect.

7.7 Attitudes and Behaviour

Table 3: If your boyfriend/girlfriend pressured you to have sex:

* denotes 'yes' answers only Pre N = 95 Post N = 60

Question	*Pre No. {%}	*Post No. {%}	P value
Would you discuss or talk about it first	38 {40}	31 {52}	NS
Would you say no	33 {35}	24 {40}	NS
Would you like to say no, but feel you might not be able to	6 {6}	7 {12}	NS
Would you agree	19 {20}	5 {8}	NS

Although none of the above reached significant levels all demonstrated an encouraging improvement following intervention, for example, less of the participants said they *"would agree"* if pressured to have sex and more said they *"would discuss or talk about it first"*.

Table 4: Statements to assess Attitude and Behaviour

*denotes those who answered 'agree' to the statements

Question	*Pre No. {%}	*Post No. {%}	P value
Most 15 year olds are physically able to have a baby	77 {81}	48 {80}	NS
Most 15 year olds are emotionally mature to have a baby	28 {20}	12 {20}	NS
Young people are more likely to have sex when they drink too much	81 {85}	56 {93}	NS
Drugs change the way young people feel	88 {93}	56 {95}	NS

None of the above reached significance following intervention. However, all were answered well at the onset.

Table 5: What did [having a boyfriend/girlfriend] mean?

* denotes 'yes' answers.

Answer	*Pre No. {%}	*Post No. {%}	P value
Having a special friend	48 {50}	44 {73}	<0.05
Holding hands	27 {28}	17 {32}	NS
Kissing	48 {50}	30 {50}	NS
Being happy	57 {60}	49 {82}	<0.01
Put under pressure	7 {7}	3 {5}	NS
Respect	58 {61}	47 {78}	<0.05
Going all the way but not going all the way	24 {25}	5 {8}	<0.01
Sex	33 {35}	14 {23}	NS

Following the programme four of the statements were answered more favourably and were found to be statistically significant. More of the participants said that having a girlfriend/boyfriend meant having a *"special friend"* and *"being happy"*. It is very encouraging to note an increase in the number who said *"respect"*. Less said that it meant *"going all the way but not going all the way"* which is a very positive result. While *"sex"* did not reach significance statistically it is nevertheless showing encouraging trends.

Table 6: At the moment I do not want to have sex until:

* denotes 'yes' answer

Answer	*Pre No. {%}	*Post No. {%}	P value
I marry	7 {7}	9 {15}	NS
I'm in my twenties	12 {13}	12 {20}	NS
I leave school	8 {9}	6 {10}	NS
I fall in love	46 {48}	39 {62}	<0.05
I'm living with someone	16 {17}	13 {22}	NS
I'm on contraceptives	16 {17}	17 {28}	NS
I meet someone I fancy	35 {37}	13 {23}	<0.05

Two of the above reach significance following intervention. It is encouraging to note that more of the participants answered *"until I fall in love",* and less said *"Until I meet someone I fancy".* This would indicate that teenagers are reflecting on values in relationships.

Table 7: What does it mean to you to have a baby?

Answer	Pre No. {%}	Post No. {%}	P value
Help you to get more money	11 {12}	7 {12}	NS
Cause problems at home	36 {38}	22 {37}	NS
Help you to get your own house or flat	11 {12}	9 {15}	NS
Stop you going to school	24 {25}	15 {25}	NS
Make you feel more grown up	19 {20}	7 {12}	NS
Stop you from going out with friends	39 {41}	26 {43}	NS
Make it harder for you to get a job	22 {23}	25 {42}	<0.05
Improve your relationship with your boyfriend/girlfriend	22 {23}	14 {23}	NS
Someone of your own to love	57 {60}	41 {68}	NS

A higher proportion said that it would *"make it harder to get a job",* following the programme, indicating perhaps an increase in awareness of the level of responsibility inherent in starting a family, and the fact that having a job seemed important.

Table 8: If you said you'd get help, who would it be from?

Answer	Pre No. {%}	Post No. {%}	P value
Sister	34 {37}	21 {37}	NS
Parent	60 {65}	44 {79}	NS
Friend	38 {41}	36 {64}	<0.05
Aunt	18 {20}	9 {10}	NS
Teacher	4 {4}	7 {12}	NS
Parent/Boyfriend/Girlfriend	45 {49}	36 {64}	NS

Following intervention more said that they would get help from a friend indicating that participants may realise the value of such support. A small percentage specified other help, including: *cousin (1) counsellor (2) doctor (4) social worker (1) youth leader (1) brother (4) family planning clinic (1).*

Table 9: If I was going to become a father/mother soon?

Answer	Pre No. {%}	Post No. {%}	P value
I'd have the baby adopted	3 {3}	3 {3}	NS
I'd mind the baby myself	68 {72}	42 {70}	NS
I'd give up school	21 {22}	12 {20}	NS
I'd get married	9 {9}	6 {10}	NS
I'd leave home and live with my girlfriend/boyfriend	21 {22}	10 {17}	NS
I'd get a job	54 {57}	31 {52}	NS
I'd carry on as usual	20 {21}	16 {27}	NS
I don't know what I'd do	25 {26}	17 {28}	NS
It's not my problem	2 {2}	3 {5}	NS
I'd get help	44 {46}	40 {68}	<0.05

The proportion of participants who said they would *"get help"* if they were going to become a mother/father soon reached significance following the programme indicating a more realistic approach to having a child although the proportion that said they would *"mind the baby myself"* remained high.

Table 10: Assessment of Self Esteem

* denotes answers "strongly disagree" and "disagree" together, all other figures represent answers "strongly agree" and "agree" together.

*Pre N = 95 Post N = 60

Answer	*Pre No. {%}	*Post No. {%}	P value
I am just as good as anyone else	82 {86}	51 {85}	NS
I feel I have a number of good qualities	81 {85}	48 {80}	NS
I feel I do not have much to be proud of	*65 {68}	*39 {65}	NS
I am able to do things as well as most people	79 {83}	47 {78}	NS
I wish I could have more respect for myself	*44 {46}	*28 {47}	NS
I feel good about myself	71 {75}	46 {77}	NS
I often feel I am a failure	*49 {52}	*38 {63}	NS
Sometimes I think I am no good at all	*53 {56}	*25 {42}	NS
I am usually happy with myself	74 {78}	48 {80}	NS

Although none of the above reached significance it is interesting to note that the majority of statements were answered very well at the onset making change difficult to observe by quantitative methodology. Since respondents ticked the same answers all the way down this could be classified as a response set indicating that the questionnaire used was not suitable for this group.

7.8 Trainer evaluation

Trainers were asked to describe what impact the programme had on the participants, both from their own observations and from discussion with the groups.

There was an overview that young people on the programme enjoyed having an opportunity to discuss sensitive issues in a safe setting without stigma or embarrassment. Such a setting gave young people an

opportunity to discuss their own lives and how they feel about issues affecting them and their families.

Teenagers expressed amazement at their previous lack of knowledge and acceptance of the myths concerning pregnancy, sexuality, and sexual activity. One trainer stated *"They realised that information they previously had was incorrect and they were constantly amazed at what they did not know. They now realise that they have good opinions and are less intimidated about their feelings and questions".*

Increased self esteem was noticed by trainers when shyer members in the group began to speak up and the more "bossy" ones allowed others to speak. Teenagers said they were able to think about and explore their own feelings, values and opinions and could reflect on choices available to them regarding decision making.

Trainers noticed increased self esteem by young people participating more fully in group work and activities during the sessions. Life experiences were explored through lifeline exercises and were found to be very beneficial. One trainer said that while self esteem improved it is an on-going process and she intends providing such training on an ongoing basis. Trainers reported that teenagers became more respectful of rules and responsibilities and now tended to carry out tasks. They also became more aware of their rights and responsibilities in relation to sexual activities by development of their self awareness. A trainer said that the teenagers in her group became less sexist, more aware of sexual double standards and less homophobic.

Teenagers expressed that they could communicate more effectively following intervention programmes. This was described as *"listening to*

each other", "respecting other peoples opinions" and *"speaking for yourself".*

Increased respect for each other was noticed by a reduction in "slagging", name calling and negative comments. Criticism became more challenged *"They've come to understand that they don't have to accept criticism from anyone".*

Trainers expressed great satisfaction with the style of training i.e. the experiential method combined with information. This allowed them to reflect on their own attitudes towards sexuality and relationships so that they could understand more fully how to implement a programme. Some felt they would like a longer training course in relation to the information content. However, owing to the demands of their organisations, difficulties may arise by extending the duration of training.

A wide range of current materials was made available to trainers and they in general expressed satisfaction with the materials. However, some felt they would like more games and quizzes, particularly for males and younger children.

Trainers expressed that the enthusiasm support and availability of the Teenage Health Co-ordinator was very helpful and enabled them to get on with the work.

Trainers were asked to describe any difficulties they had encountered in running programmes. Some did not experience any obstacles, others reported difficulties such as changes in time table, poor attendance and difficulty in obtaining consensus on policy issues. Trainers were encouraged to refer teenagers to social and counselling services as necessary. However, when dealing with young people who had been

sexually abused or involved in prostitution trainers felt they would like more skills in providing support in such circumstances. While they had participated in a workshop facilitated by a senior social worker on procedures in the event of such disclosures, trainers felt that longer in depth knowledge of the consequences of child abuse would enable them to deal with victims. This could be provided in the future. In all cases of disclosures, referrals to social services had already taken place in the past.

It was envisaged that programmes would be implemented fairly soon on completion of training. However, in most cases trainers had to spend a number of months building relationships within the group prior to implementation of a programme. This was achieved through outings, informal meetings, weekends away, activities such as arts and crafts, painting, games, and group bonding exercises. The time scale for implementing programmes varied from one centre to another. Trainers reported that it was necessary to extend their original plan from eight weeks to twenty weeks in certain cases. The reasons offered were *"due to the groups hunger for information and commitment"* plus *"needs that arose and girls' interest".*

Where possible the programme was offered to both boys and girls, though the uptake was much higher with girls. Though some mixed groups worked very well, some trainers found it necessary to separate males and female as the programme developed. Reasons cited for this were disruptive behaviour on part of the boys who preferred to remain together, and girls wishing to move on with the programme. One girl commented *"The lads will slag him for asking even if they are dying to know the answers".* A trainer reported in relation to boys in his programme *"It is not a matter of not being interested. The boys come into the group each time with such a burden of pressure, macho behaviour, confusion, induced hate, fear, aggression and inability to cope and express emotions*

that any issue and method involving trust, intimacy, sensitiveness and expression of feeling is extremely intimidating to them. It was necessary for me to stand back and realise the amount of baggage brought in every time by the males and begin to find ways to deal with it".

Another trainer reported that it was possible to engage the boys in the programme when they were away on weekend breaks since it was combined with outdoor activities. It was also felt that boys need more visual type programmes instead of discussion or written exercises.

A few trainers implemented brief programmes in organisations which provide short term placements to homeless teenagers. In such cases the information content was vital as some of the young people were engaged in high risk sexual activities.

Trainers were asked for suggestions regarding future developments in relation to themselves, the organisation, the young people and the parents. Many felt that all members of organisations dealing with young people should have this type of training, particularly in relation to self esteem enhancement. Some expressed enthusiasm about providing a similar type programme for parents and exploring new methods of engaging males more fully in the programme. One trainer said that the teenagers in her group expressed such enthusiasm following the programme that there is now a "waiting list" of other interested teens.

Those providing broader health education programmes to various age groups, expressed that they would like to establish links with local schools and in this way provide community type health education programmes. Some felt that they would welcome an accreditation of the training provided by the Eastern Health Board.

Some trainers would like to explore peer education as a follow up for those who have received the intervention programmes.

Following implementation of programmes trainers felt that they would like further information on:

Domestic Violence
Sexual Orientation
Eating Disorders
Parenting Skills

Workshops were provided over two days on these topics using facilitators from relevant organisations. Evaluation revealed that trainers found the experience very worthwhile and would like follow up on all issues, most especially parenting skills.

Trainers reported that the following policies were implemented in some organisations:

1. Parental/guardian consent must be given prior to implementation of programme.

2. Confidentiality should be maintained on personal questions unless the child is at risk.

3. Two workers should be present when implementing a programme.

4. Age appropriate programmes should be adhered to.

5. All young people would have the programme.

6. Procedure in the reporting of disclosure of child abuse.

7. Consensus should be reached among staff on the aims and objectives of the teenage health initiative and other health education programmes prior to implementation.

Trainers were asked what worked well for the groups in terms of delivery of programmes. Responses included the use of videos, games, quizzes, activities for the boys, and longer more detailed programmes for the girls. Young people also enjoyed discussion, brainstorm, the use of art, and the contraceptive kit, as well as setting tasks for individuals, role play, visual charts and worksheets. For those who include the infant simulator *"Baby Think It Over"* in intervention programmes they reported that the practical hands-on experience of what it is like to have the responsibility of a baby worked well. Small group sizes allowed for openness and it was essential not to include new members once programmes began, since this disturbed the group dynamics.

Trainers reported that it was valuable having adequate time for planning and implementing programmes and this allowed them to build up good relations between trainers and young people.

When asked what changes they would make in implementing future intervention programmes the following suggestions were made:

1. Encourage more participation from boys. It was suggested that boys' groups would have to be more activity based, "more visual with less literacy input". Managing disruptive behaviour in boys needs further exploration. Incorporate male trainers into boys' groups if possible.

2. Further exploration of self esteem materials.

3. Run a parallel programme with parents.

4. Videos and information on pregnancy and childbirth.

5. Access outside speakers on specific subjects such as HIV/AIDS.

6. Explore broader issues of health. Trainers felt it was important to avoid rigidity when designing and implementing a programme, both in terms of content and duration. "It is important to allow for problems when working with young people and to have a compassionate and encouraging approach".

Chapter Eight

Discussion

8.1 Trends

While the number of births to teenage mothers has not changed significantly in Ireland over the past 20 years, the proportion of births to single teenagers has risen from 24% in 1972 to 89.3% in 1992[1]; Official British Statistics on Irish abortion reveal rising numbers in all age groups having abortions in the UK. Figures for teenagers rise from 556 in 1981, 700 in 1991 to 766 in 1996. Irish women who did not give an Irish address are not included[33].

Given such statistics and the possible adverse consequences of teenage pregnancy both for mother and baby there is a need to provide young people with the knowledge and skills to make informed choices regarding sexual activity and pregnancy. Intervention programmes should be provided both within and outside the formal education system. Sex education must aim to delay the initiation of sexual activity. This can be achieved by implementing programmes which not only impart knowledge but also deal with peer pressure, self esteem, decision making, communication skills and relationships in general.

The teenage health initiative targeted those at risk of pregnancy, particularly early school leavers. Preventative programmes in the past have ignored fathers. Although only a few studies have examined risks factors for teen fatherhood there is some evidence suggesting that teen fathers have an early history of difficulty in school. One British study found that academic qualifications were the best single predictor of early fatherhood, men who completed GCE and A levels were only half as likely to become young fathers as those without such qualifications[34].

8.2 Preparation

It is important to consider the time span which may be required in order to plan, implement, document and evaluate a programme. This may take up to two years depending on certain factors. It was necessary at the initial stages to select suitable trainers and clarify with them and their managers what the expectations were on behalf of the EHB. It was also necessary to negotiate time for training and programme implementation. Since this was a pioneering initiative within organisations, a number of trainers expressed apprehension at the initial stages in relation to the design, implementation and evaluation of programmes. Trainers reported that it was necessary to spend months preparing groups before programmes could be introduced. This was achieved through group formation exercises and activities.

While our trainers set out to engage males in programmes, uptake was generally greater with girls. Difficulties with boys' groups were attributed to aggressive behaviour, poor co-operation and difficulty in expressing emotion. Drop out rates of teenagers from intervention programmes were related to such behaviour as some boys were dismissed from youth centres and others were sent to detention centres. Such occurrences are virtually inevitable in these situations. It was necessary to spend many months preparing young people for this type of intervention programme. Youth organisations provide the necessary facilities and outlets for such group building through activities such as sports, outings, games and crafts.

While the Eastern Health Board trained 34 trainers, 13 of these were unable to implement programmes at that time. This was due to organisational changes which obliged the trainers to take up other duties. Other trainers moved on to new jobs. However, since these trainers continued to work within the youth services they plan to implement intervention programmes at a later stage.

8.3 Flexibility in Programme Delivery

Due to the variation of needs within youth organisations, there is no set programme to cater for such demands. Consequently it is imperative to provide trainers with information, support, material and skills which would enable them to develop programmes tailored to the needs of their particular group. Trainers in the pilot project were initially surprised by this approach and expected instead a more rigid format of intervention programme. However, they came to accept it, support it and found that it worked well in practice.

8.4 Evaluation of self esteem

Literature shows that self esteem is an important factor in delaying the initiation of sexual activity. Both the qualitative and trainer evaluations were impressive in reflecting improvements of self esteem and assertiveness following intervention. However, it was disappointing that the results of the quantitative evaluation did not show such changes. This may be due to the following difficulties in relation to the test used.

A) The questions were complex

B) A response set, where respondents ticked the same answers all the way down the questionnaire

C) The questions appeared at the end of the questionnaire and young people may have lost concentration at this point of the process

The accuracy of using questionnaires and checklists as instruments for assessing self esteem is questionable. Such instruments focus on individuals' verbalisations of their feelings towards themselves, ignoring the aspects of self-concept that they are either unwilling or unable to reveal about themselves[35].

8.5 Role of Co-ordinator

The Co-ordinator's role begins by designing a programme and seeking out personnel with expertise to implement the various parts. The co-ordinator needs to became familiar with age appropriate programmes and obtain legal advice regarding sexual activity relevant to intervention programmes. In order to negotiate, consultation must take place between the co-ordinator, managers and future trainers in youth centres at the initial planning stages. The content and time scale for training must be clarified as well as issues relating to Health Board expectations and evaluation of programmes. Parent representatives may be included at this stage, though it is preferable that trainers would consult individually with parents if possible prior to programme implementation.

The co-ordinator must explore existing materials for trainers, and attempt to obtain or direct them towards such materials. This is an on going process given the diversity of needs in the centres. The co-ordinator is required to be available to trainers on a regular basis and follow up any queries or concerns which may arise. Since trainers may be embarking on this type of work for the first time, the co-ordinator needs to be supportive and sympathetic to any difficulties or suggestions offered by trainers. An intervention programme such as the teenage health initiative may highlight other aspects of health care such as domestic violence and eating disorders. The co-ordinator needs to provide on-going work shops and training as required. The co-ordinator may be required to conduct the evaluation of the programme by administering questionnaires to young people, facilitating focus groups, and producing a report on the findings.

8.6 Materials

While high quality age appropriate materials are available, it is sometimes difficult for youth workers in disadvantaged areas to access such material. There appears to be a need for a central repository of resource material to facilitate the delivery of intervention programmes. The co-ordinator of the teenage health initiative may decide to compile a specific pack of materials to complement the training provided.

8.7 Parent Education

Young people in the study had the perception that parents have poor knowledge regarding sexuality, fertility and sexual health. This is supported by an ESRI national study of women's health needs which found that a substantial proportion of the female population still did not have accurate information on when they are at greatest risk of pregnancy[36]. Therefore, this points to the need for parent education.

8.8 Peer Education

Young people expressed mixed views on the subject of peer education, some feeling that young people would be less credible than older educators. There is a need for careful selection of "peers" and careful management of such programmes. In designing programmes for young people in the formal school setting it is necessary to reflect on this methodology - smaller groups, segregated or mixed, parent and peer education. Delaying the initiation of early sexual activity is the primary aim of the Teenage Health Initiative. There is evidence from our study that young people are engaging in worrying levels of sexual activity. We need, therefore, to open the debate regarding services for those young people who are sexually active, particularly in relation to contraception, STDs and health education in general.

8.9 Policy Issues

In order to assist trainers to draw up policies in their organisations it was necessary to consult Eastern Health Board solicitors on legal issues regarding teenage sexuality and programme implementation. Given the level of prior sexual abuse in some groups, issues arose regarding policy and procedure. With the evidence of current sexual activity amongst teenagers in our study, organisations need to consider how these issues would be handled prior to implementing intervention programmes. Trainers were encouraged to discuss with their managers and individual parents the content of the programme and the method of evaluation. Information on age related programmes was obtained from the Department of Education.

8.10 Knowledge

The evaluation of the teenage health initiative attempted to assess changes in knowledge, attitude and behaviour among teenagers at risk of pregnancy. Changes in knowledge were evident in the qualitative evaluation in relation to conception, contraception and sexual health. The quantitative analysis resulted in similar findings, indicating significant increase in knowledge about puberty, fertility, contraception, pregnancy and STDs. These findings are consistent with changes in knowledge found in a previous pilot project conducted in the Eastern Health Board in 1993[37]. Knowledge of the menstrual cycle improved showing that more teenagers now had a better understanding of ovulation and fertility. Popular myths concerning sexual activity and pregnancy were challenged and again teenagers clearly demonstrated changes in knowledge post intervention. Knowledge improved in relation to the transmission of STDs, myths concerning them and the consequences of unprotected sex. Great awareness of the risk of cervical cancer was indicated when 18% prior to intervention agreed that genital warts are linked to cervical cancer in women this figure increased to 40% post intervention.

Teenagers expressed great interest in their new found knowledge regarding STDs. This is welcomed since teenagers had poor knowledge of STDs prior to the programme. Such information appears to be a vital part of future preventative programmes.

For some statements there was already a high level of knowledge from the onset. Therefore, there was little room for improvement following the programme. For example in the pre-test 81% agreed that a girl can get pregnant the first time she has sex, and 93% in the post test.

8.11 Changes in attitude and behaviour

Encouraging changes in attitude and behaviour were noticed following intervention when more teenagers thought that having a boyfriend/girlfriend meant having a special friend and being happy. The importance of *'respect'* in a relationship also increased. Clearly this type of programme enabled teenagers to challenge their values and reflect more deeply on issues concerning relationships. Following intervention, more teenagers stated that they would not want to have sex until they "fell in love", and less said "until I meet someone I fancy". This could indicate that teenagers are reflecting on decisions concerning their sexual activity. Following intervention less teenagers said they would agree to sex if pressurised, and more said they would discuss and talk about it first.

Teenagers may have had an increased awareness of the level of responsibility involved in having a family and the importance of having a job in this event. Following intervention more teens felt it would be harder to get a job if they had a baby, and less thought it would make them feel more grown up.

The qualitative evaluation demonstrated very encouraging changes in young peoples attitudes and behaviour, saying they had increased respect for themselves, more confidence, and were able to resist peer pressure - *"I learned how to say no and all" {Focus Group 3}*

Further changes in attitude were noticed by trainers who said that following the programme young people participated more fully in the sessions, completed tasks, had improved communication skills, and exhibited more respect for the opinions of others.

Levels of self esteem in teenagers were assessed by using the Rosenberg test. However, this style of questionnaire appeared to be inappropriate. Other methods to measure young peoples self esteem could be explored in the future. Those which are more culturally appropriate such as the Porteous Problem checklist, designed by Prof. Porteous, Cork University, could prove more relevant to the teens in our programme.

Evaluation of self esteem through the qualitative and quantitative methods described will be the major focus of the next phase of the programme.

Uptake of the intervention programme was higher with girls than boys. When boys attend they may require a different type of programme than girls. They may exhibit more disruptive type behaviour and have difficulty engaging in issues of personal development and sexual health. Further exploration of suitable styles and techniques required are vital if we are to address fully all the issues involved in teenage pregnancy.

Chapter Nine

Conclusion and Recommendations

1) The evaluation has established that this type of intervention programme brings about significant changes in knowledge, attitude and behaviour for teenagers on sexuality and sexual health. Such programmes should be continued in all organisations dealing with young people.

2) Programme content should include subjects such as relationships, self esteem, communications, peer pressure, decision making as well as information on fertility, sexuality and sexual activity. This type of programme empowers young people to consider their choices in relation to sexual decision making.

3) Many months may be required to build group confidence prior to implementation of a programme.

4) Programmes should be designed in consultation with young people and a feasible time frame provided in order to implement them. Broader health education programmes should be incorporated as required.

5) Working with small groups provides a safe atmosphere for young people and enables the trainer to deal with issues as they arise. Similar programmes could be provided for parents.

6) In certain circumstances it may be necessary to provide a different type of programme for males and females. Boys tend to prefer programmes which includes activity based exercises, audio-visual materials, with less emphasis on discussion and literacy. Trainers need to approach mixed groups with a degree of flexibility, and redesign as necessary programmes to cater for the groups' needs. An equal number of males and females should be trained to implement programmes in order to create a gender balance.

7) Peer education with an outreach aspect could prove beneficial to teenagers at risk.

8) Trainers need on-going support and training, and an up date of materials where possible. While trainers are advised to refer young people to social and counselling services as required, further education for trainers on parenting skills, domestic violence and the consequences of child abuse would help when dealing with victims.

9) Future projects should aim to evaluate changes of self esteem in young people, and further methods of assessing such changes need to be explored.

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EASTERN HEALTH BOARD

Teenage Health Initiative

Report and Evaluation of a Pilot Project aimed at Reducing Teenage Pregnancies in the Eastern Health Board Area 1997-1998.

Margaret Acton,
Programme for Children and Families

Mary Hynes,
Department of Public Health

October 1998