



Eastern Health Board

TEENAGE HEALTH PROMOTION INITIATIVE

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October, 1994

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SUMMARY

The adverse effects of teenage pregnancy both for mother and baby are many: shortened education, higher post-neonatal mortality rates, higher rates of sudden infant death syndrome and a greater number of childhood illnesses and accidents.

Those at risk for teenage pregnancy are young people who engage in sporadic sexual activity, those with partners who are not supportive of preventing pregnancy, those with family or friends who had an adolescent pregnancy, those who are not achievement orientated and those who have not matured enough to think about the consequences of sexual behaviour.

Primary prevention i.e. delaying the initiation of sexual activity is the principal means of preventing adolescent pregnancy.

Community Care Area 8 is the largest area of the Eastern Health Board. There are approximately 3,000 births per year in the area of which 4% are to teenagers. While this proportion seems small, over 50% of teen pregnancies in the area occur in one suburb. This suburb has a high level of unemployment, deprivation and a large young population.

A primary prevention programme has been developed in a large school which services this target area. The aims are to reduce the number of teenage pregnancies in the area. The objectives are not only to provide information but also to alter attitudes and behaviour of young people in relation to sexual activity. In doing this, emphasis is placed on decision making, taking responsibility, communication skills and self-esteem enhancement. It also deals with management of peer pressure, the problems of alcohol misuse and health effects of early sexual activity in a facilitatory manner.

In developing this programme, advice was sought from the Eastern Health Board, Department of Health Promotion Unit, Department of Education, School Management & the Parents Council of the School. The students of the school were also consulted to establish their needs and priorities. Eight teachers from the school underwent an intensive training course facilitated by the Social Health Education Association (SHEA). This was overseen by the Eastern Health Board.

This report documents results of the pilot programme which was conducted over a 6 week period in the 1992/3 school year and the results of the extended programme which was conducted over the entire 1993/4 school year.

While only six classroom sessions could be allocated to implementing the pilot programme, evaluation by teachers, pupils and questionnaire was favourable and encouraging. There was a considerable increase in knowledge at the end of the programme and some important positive changes in attitude e.g. on completion of the programme significantly more of these 14 year olds realised that they are not emotionally capable of having a baby even though they may be physically able.

However, results showed that only 30% of the pupils would "always say no" to sex and 23% of them said they had intercourse in the past. Past sexual activity was associated with feelings of being "not important".

Based on the findings of the pilot study, the programme was continued among second year pupils and became a subject on the curriculum for the full academic year. Evaluation was conducted this time using a control school for comparison. There was a large increase in knowledge and a small change in attitudes. For example, pupils from the intervention school were more likely to say that avoidance was the best way to prevent pregnancy (19% versus 2%). However, between 14% and 25% of both groups said they had sex in the past. Their concerns in the event of pregnancy (e.g. not knowing what to do) and their unrealistic expectations (e.g. getting a job and leaving home) are highlighted.

There is considerable enthusiasm and hope among health board and school management for the continued success of the programme. There have been a number of positive spin-offs which can not be identified from the questionnaire. Teachers report more self-esteem and greater assertiveness among the pupils. Their belief and commitment to the programme resulted in a health education teacher being employed fulltime by the school and the programme being extended on a phased basis to all pupils in classes between first and fourth year with a greater emphasis on alcohol and drug related issues.

The effectiveness of this programme will depend on there being a reduction in teenage pregnancy rates in the coming years.

INTRODUCTION

Young people today reach reproductive maturity at an earlier age than did their counterparts at the turn of the century. Earlier physical maturation places children at risk for earlier sexual activity. There are no data indicating that adolescents mature psycho-socially at an earlier age today (1).

Data from the United States confirm that there has been an increase in sexual activity among teenagers aged 15 - 19 years. In the 1980's, approximately 45% of young women in this age group were sexually active before marriage and it is estimated that 36% of them became pregnant within 2 years of their initial sexual experience (2). The medical problems associated with teenage sexual activity are increasing, including teenage pregnancy and complications from sexually transmitted diseases (9).

The advent of HIV and AIDS has accelerated an interest in sex education and the problems associated with teenage sexual activity (12). In a survey of teenagers in the U.K. 80% of 13 - 14 year olds and 48% of 15 - 16 year olds felt that most people were sexually active by 16 (12), adding to the pressures that young teenagers experience.

Teenage sexual activity may be part of a lifestyle that includes certain other health risk behaviours such as smoking and drug taking. Sexually active teenagers are more likely to have friends who are sexually active than those who are not.

CONSEQUENCES OF TEEN PREGNANCY

- Adolescents who have children are more likely to experience shortened education (1).
- Findings of higher post-neonatal mortality rates, higher rates of sudden infant death syndrome and a greater number of illnesses and injuries experienced by children of adolescents suggest that supervision of these children may be less than adequate (1).
- 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 and disadvantaged neighbourhoods and schools and career prospects may play a role (2).

RISK FACTORS FOR TEENAGE PREGNANCY

A young person who lacks family support and has undefined goals is at highest risk of early sexual activity. Pressure from peers and sexual partners may also be factors (1). Chronic economic disadvantages, bleak outlook and hopelessness are associated with earlier pregnancy, childbearing and more pessimistic attitudes on the importance of marriage, family and career (2). The following adolescents tend to be at risk of pregnancy (3):

- 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 oriented;
- e) those whose mothers, sisters and friends have had an adolescent pregnancy;
- f) those whose fathers are absent from the home.

Parental supervision plays a part in the likelihood of teenagers having a sexual relationship: In a survey of parents who said they "always stayed up when their teenagers were out", 20% of those teenagers were non-virgins; for parents who usually stayed up, 30% - 40% were non-virgins; for parents who sometimes stayed up 40% of the teenagers were non-virgins; but for parents who never stayed up 50% - 60% of their teenagers were non-virgins. This indicates that opportunity is a major factor in the likelihood of a relationship progressing to sex.

APPROACHES TO PREVENTION

Primary Prevention

Delaying the initiation of sexual activity is the principal means of preventing adolescent pregnancy (3), (11). It appears that there has been little uniformity in the timing, quality and quantity of sex education programmes offered to adolescents in school and therefore it is difficult to evaluate the impact of such programmes.

School sex education by itself appears to have little or no effect on adolescent sexual activity or pregnancy rates. 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 (2).

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 (2).

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. Evaluations of the effectiveness of these programmes are needed (3).

It has also been suggested that education about the responsibilities of parenthood should be provided and that it is important to make available career possibilities that are attractive enough to encourage the postponement of parenthood (4).

Secondary Prevention

While some adolescents, particularly older adolescents with steady partners, use contraception effectively, nevertheless there are major problems with adolescent contraception (3):

- the most effective methods depend on user compliance for their effectiveness. Some adolescents may not be mature enough to assume this responsibility.
- adolescents may be uncomfortable acknowledging their sexuality and sexual activity.
- adolescents may believe that sexual activity should be spontaneous and that use of contraception implies lack of spontaneity.
- adolescent sexual activity, particularly experimental sexual activity, is often sporadic and unpredictable.
- Many adolescents do not wish to use contraception and some may wish to become pregnant.

A survey of 315 15-16 year old British students in 1991 showed that 26% had sex previously without contraception. Those who had sex before the age of sixteen were almost twice as likely not to use contraception compared with those over 16 years (64% compared with 35%). Those under 16 were twice as likely to have sex within a short relationship compared with those over 16. Thirty-five percent (35%) of the under 16 year old group knew a "close friend with a sexually transmitted disease", compared with 12% of the over 16 year old group (10).

The study concluded that young teenagers are more likely to expose themselves to risks and are less likely to use contraception effectively than their older counterparts (10). However, even when contraceptives are supplied within schools, many young teenagers do not obtain them until after they have become sexually active (11).

Tertiary Prevention

Early prenatal care and regular attendance at ante natal 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. Some young people will require assistance in placing their children for adoption and will need special counselling in relation to this (3).

It is of interest to note that in the Netherlands teenage pregnancy is not a high priority problem as few teens become pregnant. This has been attributed to (5):-

- the role of the general practitioner in the health care system. Approximately 90% of those who want contraceptive care visit their family doctor. Many adolescents obtain contraceptives in this way.
- a well developed network of family planning clinics. Seventy percent (70%) of the clients of this system are younger than 25 years of age, a quarter less than 18 years of age. Reduced or zero fees are charged to adolescents, if necessary.
- adolescents are given sufficient knowledge of reproduction and contraception to avoid unintended pregnancy. Most learn through conversation at home, but also important are television, newspapers, films and books. Information from school appears to be less important.

Senderowitz suggests that if we want young people to avoid pregnancy, we must approach the problem comprehensively (6). We must provide information, along with services that will enable them to do it, and create a message that is clear enough, strong enough and pervasive enough to get through. Any combination of programmes has to include a solid base of information, which a good sex education

programme can provide. She concludes that while sex education alone may not be the answer to teenage pregnancy problems, it is the indispensable first step.

INFLUENCE OF PEERS AND PARENTS

It seems that peer influence plays a major part in the initiation and maintenance of adult substance using behaviour. In the past decade, in the United States in particular, the approach to preventing smoking and excess alcohol intake and drug abuse among adolescents has dramatically changed. Peer training in social skills and life skills have, to a large extent, replaced the traditional approach. Powerful behavioural strategies are used to change the factors that support adolescent adoption and maintenance of tobacco and drug usage. The approach minimises reliance on the dissemination of knowledge, on arousing fear concerning the long-term health outcomes. It highlights the immediate social and physiological consequences and tries to improve adolescents' short term social skills.

In trying to understand peer pressure, it is important to be aware that the most important factor in friendships is similarity i.e. where teenagers share similar habits, attitudes etc. Often there are conflicting influences on adolescents exerted by the parents on one hand and by the peers on the other. It is useful to try and identify in what areas in the adolescent's life parents are influential and in what areas peers are (7). It seems that in areas related to the immediate life and environment such as alcohol and drug taking, peers are more influential. In issues related to basic values such as educational aspirations, parents are more influential. There is some evidence that while parental and peer influences are synergistic, parental influences on a given topic at a certain point in time seem to outlast those of peers.

Modelling or social learning seems to be the most important mechanism in peer influence. In relation to adolescent drinking, peers are more important than parents for the initiation of drinking behaviour, but parents are more important for setting the frequency and pattern of drinking. In addition to providing a behavioural model, peers can also act as a source of information about drugs. Users of drugs rarely rely on parents as sources of information. The media are also an important source of information.

Children at risk from adverse peer influence have low self-esteem, a feeling of not belonging and lack interpersonal communication, situational and judgement skills. It is suggested that positive peer influence programmes should try and address these issues. One American study evaluated 5 different models of prevention programmes. A peer group model and a parent effectiveness model were part of the programme. It was found that only the peer group model, focusing on problem solving, group dynamics and risk taking behaviour surpassed the control group in terms of self-reported use of solvents and cannabis. In relation to alcohol, the parent effectiveness group which taught parents effective parenting styles and improved family communication did just as well as the peer group model.

It would seem that peer-led strategies are effective in reducing habits such as smoking and drug abuse. The evidence in relation to alcohol is not clear. Such programmes have been centred for the most part in white middle-class populations, so questions of generalisability must be raised. Similarly, the cognitive ability of peers to deliver such programmes must be open to question (7). In all programmes, the peer counsellors participated in detailed training sessions.

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 awareness and special parent teen events, some reduction in teenage pregnancy has taken place (8). The programme targets girls aged 12 to 17 years and to date over 400 have participated in the programme, over half of whom said they were sexually active when they entered the programme. The programme offers 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 adolescent 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.

PROJECT AIMS

The ultimate aim of this project is to reduce the number of teenage pregnancies. The specific objectives are:

1. To educate young teenagers about the risks of sexual activity and pregnancy at a young age.
2. To create an awareness of the consequences of teenage pregnancy both for mother and baby.
3. To enable young people to make informed decisions.
4. To emphasise the concepts of self-esteem, respect and friendship.
5. To discuss important factors associated with teen pregnancy e.g. alcohol and peer pressure.
6. To endeavour to delay the onset of sexual activity in teenagers.

PHASE 1

THE PILOT STUDY

BACKGROUND

Community Care Area 8 (CCA8) has a population of 188,600 (1991 census). The area is the largest and most populated Community Care Area of the Eastern Health Board. It is predominantly an urban region including areas such as Coolock, Kilbarrack, Raheny, Swords, Malahide, Portmarnock & Howth. Approximately 15% of the area is rural, such areas are in the north of the county.

A health report prepared in 1991 showed that in 1990 there were 2,960 births in the area of which 16% were to single mothers and 52% of all single parent births occurred in areas around Coolock, Darndale, Priorswood, Edenmore & Kilbarrack.

A similar picture emerged for teenage pregnancy. Although only 4% of all births were to teenagers, such births were more likely in areas around Darndale, Coolock & Priorswood. In 1990, 50% of births to teenagers occurred in these areas. Following publication of the report it was decided to develop a health promotion programme for teenagers and to focus on the areas with the highest teen pregnancy rate.

METHODOLOGY

Colaiste Dhulaigh is a large, 1,000 pupil, vocational educational college. It is situated in Coolock and accepts pupils from many areas, but students in the junior cycle are generally from the local area; Coolock, Darndale, Priorswood. A teenage health promotion programme delivered through Colaiste Dhulaigh would reach teenagers from the area we hoped to target.

The school was approached and the idea of developing a health promotion programme with the Health Board was suggested. The proposal was agreed by the school management. It was also agreed that teachers were the ideal people to implement any such programme and that it should be delivered in the classroom. In order to decide the content, method of delivery, target age group and training needed, much investigation was undertaken including:

- a literature search
- meetings with teachers and school management
- meetings with students from 2nd, 3rd, 4th & 5th Years.
- a meeting with the school's parents' council
- advice was sought from the Eastern Health Board, The Health Promotion Unit of the Department of Health & Department of Education
- meetings with possible training sources.

STUDENTS VIEWS:

A Senior Registrar in Public Health medicine and a Head Social Worker from the Eastern Health Board visited the school and met with a representative sample from all classes (except first years). Students from each class (age range 12 - 18 years) felt that one of the most important issues for them was peer pressure and how to resist it. Other areas raised were relationships, respect, health effects of teenage pregnancy & early sexual activity, decision-making, puberty & contraception, alcohol and drugs. Even at that early stage, a difference in attitude between boys and girls towards early sexual activity was obvious. Boys who said they were sexually active were regarded as being "macho", but girls were seen as quite the opposite. Having spoken to pupils, it was agreed by both health and teaching professions that second year students (aged 13 - 15 years) were the most suitable for the pilot programme.

PARENTS' VIEWS:

Parents welcomed "sex education" in the school. They voiced concerns about rearing teenage children. Their main concerns were not knowing where their teenagers were in the evenings - could they be watching pornographic videos or possibly drinking alcohol or using drugs?

TRAINING

TEACHERS:

The second year group in Colaiste Dhulaigh in the 1992/93 school year consisted of 8 classes, each with 25 pupils approximately. Ideally, 8 teachers should be trained and if possible, 4 female & 4 male staff.

After much discussion it was decided that the Social Health & Education Association (SHEA) should facilitate training. The trainers, Ms. T. Normand & Ms. H. Jones each had teaching and psychology backgrounds, were trained in family planning and had vast experience in health education and in group skills. It was recognised that in addition to sex education, the concerns of pupils and issues raised by teachers would have to be addressed and delivered in a comprehensive, facilitatory and supportive manner within the pilot health promotion project.

SELECTION OF TEACHERS

A notice in the school staff bulletin (November, 1992) invited interested teachers to apply for training. It was agreed that 8 people would be involved, most of whom had previous experience in health education. A meeting took place with the Eastern Health Board, school management, teachers and trainers. It was decided to have 5 training days with a final 6th day allocated to evaluation of the training.

CONTENT OF TRAINING PROGRAMME FOR TEACHERS

Purpose:

- to provide teachers with an opportunity to reflect on their own attitudes to health issues
- to develop skills and a methodology for working with groups
- to develop a programme and the materials necessary to implement a pilot programme in Spring, 1993.
- to evaluate the programme and training component after implementation.

OUTLINE OF TEACHER TRAINING:

DAY 1	Expectations, exploration of own attitude, self-esteem, positive knowledge
DAY 2	Interpersonal communication, feelings, personal responsibility, sexuality
DAY 3	Working with groups, motivation, changing roles
DAY 4	Facilitation skills
DAY 5	Programme development
DAY 6	Evaluation of training

PILOT PROGRAMME CONTENT:

Six double class periods, i.e. 80 minutes each were allocated to the administration of the programme. The overall content of these 6 sessions had been worked out on one of the training days. The exact details were agreed at a number of meetings held after completion of the training. The target group were in 8 classes, each teacher having responsibility for one class. Unfortunately, only 2 of the classes were previously known to the teachers. This proved to be a major disadvantage because of the time needed to create a comfortable, trusting relationship with a formerly unknown group.

Preliminary Session

A preliminary session with the students was held to describe the approach and style of the training, to define roles and to create a supportive environment.

Session One:

There were 3 aims for this first session: to establish the atmosphere, to make the contract between teacher & pupil and to learn students' names. The methodology was explained. This would not be like normal classes, the seating would be different (no desks, chairs arranged in a circle). The focus would be on discussion, sometimes in a large group and sometimes in smaller groups. Some of the topics to be discussed would include *feelings, relationships, puberty and pregnancy*, areas which can cause embarrassment or anxiety. Students were invited to make suggestions as to how they could make a set of rules to prevent anxiety and to help them get the most out of the sessions. It was emphasised that the quality of the experience for them would depend on their level of participation. By asking questions like "what rules do we need to get the best out of this", the students developed their own contract, agreed by the entire group. It was an essential item for each subsequent session. If there was any disruptive behaviour, reference was made to their contract.

Session Two:

This session focused on feelings, self-esteem and relationships. A flip-chart was used to collect as many "feeling" words as possible. A distinction was made between physical feelings like "tired" or "hungry" and emotional feelings like "angry" or "happy". The aim was to increase awareness of feelings. After a short discussion, feelings were linked to self-esteem. The idea of a relationship was introduced by brainstorming their definitions. Small groups were then asked to list as many different kinds of relationships they could. Groups were then asked what makes a relationship good and what makes a relationship bad. Links were made between good relationships and feelings of self-esteem.

Session Three:

This was primarily an information session on Puberty. An exercise was done to establish a common language. This involved a "brainstorming" on body parts. All the common terms for male and female genitalia were written up beside the "proper" words. A video on Puberty was then shown. It was emphasised that even though young teenagers may physically be able to reproduce at this stage of development, emotionally they are not. Links with the previous two sessions were made e.g. as well as *physical changes*, there are *changes in feelings and relationships* too.

Session Four:

The students were asked for as many words as possible related to sexual activity. The flip-chart was used to show all answers. These included kissing, hugging, intercourse etc. The area of peer pressure, choices and options were introduced as follows:

Four mixed groups were asked "what would you like in a relationship with the opposite sex?" Then the same groups were allocated one of the following options:

- Not being sexually active,
- Holding hands and kissing,
- Having intercourse with a condom,
- Having intercourse without a condom

Each group was asked to list the advantages and disadvantages of each activity. Answers were discussed in the large group.

Information on conception was given. A TRUE & FALSE questionnaire was used to focus on as many as possible of the common myths about conception. Before the end of the session, a box was used to collect questions. These were taken away to be answered at the next session.

Session Five:

The questions from the previous day were dealt with initially. The main topic for this lesson was RESPONSIBILITY in terms of sexual behaviour. Working in pairs, the students examined what responsibilities they had at present. After feedback to the main group, they were again grouped to answer these questions:

1. What responsibility do I have to my family?
2. What responsibility do I have to my friends?
3. What responsibility do I have to my boy/girlfriend?

The last question introduced the next part of the lesson which was on contraception. After a brainstorming of methods, the students were shown the main kinds of devices available and relevant information was given on each.

The idea of the "egg" was introduced. The "egg" was supposed to symbolise a baby. The students were to be responsible for "caring" for it 24 hours a day for a number of days, usually over a week-end. Issues arising out of this exercise were to be discussed at the following session.

Session Six:

As this was the last session it was important to deal with any outstanding issues which were previously omitted because of time constraints.

The dangers of disinhibitors were discussed e.g. alcohol, drugs. Feedback from the students who took the egg was obtained.

COSTS

The Health Promotion Unit of the Department of Health generously funded the pilot project. The costs of the pilot study were as follows:

Teacher training X 6 sessions	£850
- two facilitators	
Class Room:	
Materials: Books	£110
Video	£ 15
Other equipment	£ 60
Expert Lecture	£ 40
Rent of room for training	£300
Meals during training	£240
Gift for teachers	£100
Secretarial Support	£100
TOTAL	£1,815

At the end of the programme, £1,435 remained unspent.

IMPLEMENTATION:

Due to pressure of time at school (the programme was to be implemented during the third school term) only 6 sessions could be made available. From the outset, trainers and teachers agreed that the potential of the programme could not be realised with such a small amount of time devoted to it. As the complexities and details of issues to be covered in the classroom unfolded, this became all the more obvious e.g. one teacher said that all six sessions could have been spent dealing with alcohol issues.

EVALUATION

Evaluation took place in three ways:-

1. **TEACHER EVALUATION**
2. **STUDENT EVALUATION**
3. **QUESTIONNAIRE EVALUATION**

1. **TEACHER EVALUATION OF PILOT PROGRAMME:**

Each lesson was evaluated immediately afterwards and a more in-depth, lengthy discussion was held when the entire programme was completed.

The main criticism was that the time allocated was far too short. The methodology represented a major change for the students, who were familiar with the didactic style and found the shift to the more open, participatory style very difficult. This shift was also difficult for teachers who were no longer just givers of information but, instead, became facilitators of awareness, of self-esteem and of responsiveness to others. It was perhaps unrealistic to expect students to respond positively, in a trusting manner to an unfamiliar teacher after one session. In the first 2 sessions those teachers who had unfamiliar students found it took longer to establish a relationship with the class, while at the same time they were under pressure to complete each lesson. This could be avoided by having sex education as just one module of a health education programme. Indeed, the same participatory method can be effectively used in dealing with other important topics like alcohol, drugs, AIDS etc.

The allocation of time for each topic should be reviewed.

SESSION 1 - More progress with the programme could be made if the students were known to the teachers before the programme began. There would be less time needed for the contract and "ice-breakers".

SESSION 2 - Many of the less able students found this section difficult. Establishing a link between feelings, self-esteem and relationships was too vague. For these students, this area needs more worksheets, more of a focus is needed, and more time to become familiar with the new vocabulary. The more academic students handled this better. Nevertheless, it was felt that they would benefit from more specific worksheets.

SESSION 3 - The video "Growing-Up" (15) was enjoyed by most. Some students complained it was "too childish". It had been originally planned to separate the sexes for this lesson, unfortunately this was not possible. Again, more time was needed than available, particularly for the discussion on emotional changes associated with puberty.

SESSION 4 - This was probably the most important session. For the first time many students got a chance to think about their options in the area of sexual activity. It was also the first time they could hear the responses of the opposite sex. The area of peer pressure was explored and they became aware of their decision-making processes (or lack of, in many cases). The worksheet on myths about conception was very successful. It was a pity more time wasn't available for the associated discussion.

SESSION 5 - Talking in general terms about responsibility was too vague. More worksheets were needed here. The contraceptive kit opened the discussion on all areas. Many groups continued this into the next session.

SESSION 6 - This was used to finish the last session and answer any questions which had not been adequately dealt with. Concern was expressed that baseline questionnaires may have focused the students on the latter part of the programme which dealt with specific issues rather than on the broad concepts of good relationships which was the aim of the start of the programme.

2. EVALUATION BY STUDENTS

At the end of the programme, students were asked to state:-

- a) *what they like about it*
- b) *what they disliked*
- c) *what should be done differently in the future.*

Of the 296 comments received, 166 (56%) were positive.

The most common statement was that they enjoyed being able to talk openly and honestly and take part in discussions on subjects not usually dealt with in this way. Other comments emphasised the importance of having an understanding teacher; being able to discuss subjects one would usually be too embarrassed to talk about; feeling more confident; learning about puberty, pregnancy and

contraception; knowing that its' right to resist peer pressure in certain circumstances; taking time to think about self.

Thirty-seven (12%) of comments related to parts of the programme which were not enjoyed. These included:

- Working in groups, writing question sheets and coping with embarrassing questions. Thirty-five percent (35%) of girls' comments in this section were that they did not like mixed sex groups. Boys did not document any difficulty with mixed sex groups.
- There were 93 (31%) suggestions for the future. The most common was that a six week course was too short (35%); 24% wanted more video material; 11% wanted more discussion on health aspects of early sexual activity. Other suggestions were to have more role play, that the boys should be more serious and that the programme should begin in the 1st Year of the post primary cycle.

3. QUESTIONNAIRE EVALUATION

Students completed a self-administered confidential questionnaire at the start of the programme and on its completion. The questionnaire was devised with the help of a senior psychologist from the Department of Education, an Addiction Counsellor, the School's Guidance Counsellor and a Senior Registrar in Public Health Medicine. Teachers did not know the content of the questionnaire or the pupils responses. Eastern Health Board personnel gave each questionnaire to the pupils and collected same. The questionnaires were computer coded and analysed on the Statistical Package Epi-Info. The chi-squared test (X^2) was used.

RESULTS

The questionnaire aimed to assess knowledge, attitude and behaviour towards puberty, pregnancy, relationships, maturity and sexuality in teenagers.

One hundred and thirty-one (131) second year pupils completed questionnaires prior to implementation of the programme and 120 completed a questionnaire after implementation.

AGE AND SEX

Of those who completed "pre" questionnaires, 72 (55%) were boys and 59 (45%) were girls. Of the 120 who completed "post" questionnaires, 63 (54%) were boys while 57 (46%) were girls. There was no statistically significant difference between the two groups. The mean age of the "pre" questionnaire group was 14.1 while of the "post" questionnaire group, it was 14.2.

KNOWLEDGE

Fourteen questions relating to knowledge were asked. These assessed knowledge of puberty, pregnancy, contraception and sexually transmitted diseases. There was a large increase in knowledge after the intervention.

TABLE 1 KNOWLEDGE ASSESSMENT BEFORE AND AFTER INTERVENTION

(* ANSWERED "TRUE" TO THE STATEMENT)

N=131 N=120

STATEMENT	BEFORE* NO. (%)	AFTER* No. (%)	P VALUE
<i>A girl has a period every month</i>	126 (95)	115 (95)	NS
<i>The ovary releases an egg every month</i>	103 (78)	103 (85)	NS
<i>The egg is released 14 days before the next period</i>	42 (32)	58 (48)	<0.01
<i>The egg is released during the period</i>	62 (47)	39 (26)	<0.01
<i>Pregnancy can occur at any time of the month</i>	73 (56)	87 (73)	<0.01
<i>Pregnancy can occur after first intercourse</i>	93 (70)	114 (94)	<0.01
<i>You can get HIV by having sex once</i>	119 (90)	101 (84)	NS
<i>Condoms are the best way of preventing pregnancy</i>	98 (75)	53 (44)	<0.01
<i>Masturbation is normal</i>	101 (76)	114 (94)	<0.01
<i>You can't get pregnant if you take a shower after having sex</i>	59 (45)	32 (27)	<0.01
<i>Pregnancy can occur during a period</i>	53 (40)	65 (54)	<0.01
<i>Full penetration must occur before pregnancy results</i>	61 (47)	39 (32)	<0.01
<i>Pregnancy is most likely to occur 2 weeks after a period</i>	54 (41)	43 (36)	NS

Nine questions were answered significantly better after the programme was piloted and none of the questions was answered less well. Some questions were answered very well at the outset, consequently any significant change would have been difficult to obtain after the intervention in these cases.

ATTITUDES AND BEHAVIOUR

Attitudes and behaviour were assessed by asking questions about teenage behaviour and about feelings towards themselves and other teenagers. Attitude and behaviour modification takes considerably longer than the six week pilot study allowed. Given the limitations in measuring attitude change in this situation, any small change in attitude over such a short period of time would have deemed the programme successful and worthy of continuation. In order to measure behaviour change, it will be necessary to follow this cohort of students over the next 2 - 3 years.

The group were asked to give their opinion on statements, based on a five point scale, i.e. strongly agree, agree, not sure, disagree, strongly disagree. They were told that there were no right or wrong answers. Comparisons were made between pre and post questionnaires. The students were asked:

TABLE 2: *If your boyfriend/girlfriend asked you to have sex, what would your reaction be:*

QUESTION	PRE- NO.	%	POST-NO. (%)	P VALUE
I would like to say no	39	(30%)	35 (29%)	NS
I would like to say no, but I might not be able to	10	(8%)	23 (19%)	<0.01
I would probably agree	37	(28%)	36 (30%)	NS
I would agree straight	46	(34%)	27 (22%)	<0.01

A definite shift in attitude occurred here. By the end of the pilot study, it appeared that the students were considering more carefully the consequences of agreeing to sex. Significantly fewer students, after the programme, said they would agree straight away to sex ($X^2 = 4.9$; 1d.f.; $P < 0.05$). Significantly more said that they "would like to say no but might not be able to" ($X^2 = 6.77$; 1d.f.; $P < 0.01$). However, the number who said they "would always say no" did not alter significantly neither did the number who said they "would probably agree". The small number who would always say no is of concern. When examining the changes separately for boys and girls, the following emerged:

TABLE 3: BOYS

QUESTION	PRE- NO.	%	POST- NO. (%)	P VALUE
Always say no	8	11%	6 (10%)	NS
like to say no, but might not be able to	3	4%	12 (19%)	<0.01
probably agree	25	33%	21 (33%)	NS
agree straight away	39	52%	24 (38%)	NS

The above Table indicates that initially 52% of boys said they would agree straight away to having sex. After the programme that proportion dropped to 38%. More boys said they "would like to say no" after implementation of the programme ($X^2 = 7.3$; 1d.f.; $P < 0.01$). These results are encouraging and indicate that the programme enabled them to consider their attitudes and behaviour in a responsible fashion. However the small number who would always say no to sex both before and after the programme is disappointing. It confirmed the initial impression the health personnel developed of the boys' attitudes.

The fact that 85% of the boys indicated (at the pre-intervention survey) that they would agree to sex is worrying. Eventhough this proportion dropped to 71% after intervention, their attitudes cause concern.

TABLE 4: GIRLS:

QUESTION	PRE- QUESTIONNAIRE NO.	%	POST- QUESTIONNAIRE NO.(%)	P VALUE
always say no	31	53%	29 (51%)	NS
like to say no	7	12%	11 (19%)	NS
probably agree	12	20%	14 (25%)	NS
agree straight away	9	15%	3 (5%)	NS

Table 4 shows that after intervention, 5% of girls said that they "would agree straightaway" to sex and 51% said they "would always say no".

There was a large difference, at the outset, between the number of boys and girls who said they would "agree straight away" ($P < 0.001$), 52% of boys compared with 15% of girls.

Girls were more likely than boys to "always say no", 53% compared with 11% ($P < 0.001$).

The following tables show the questions asked to assess attitude and behaviour. Responses given by the students are presented:

TABLE 5

QUESTION/ STATEMENT	PRE NO. %	POST NO. %	P VALUE
Most 15 year olds are emotionally able to have a baby	86 66%	61 49%	<0.01
Most 15 year olds are physically able to have a baby	120 89%	104 86%	NS
People who play sports are usually healthy	114 85%	107 88%	NS
People are likely to have sex when they drink too much	112 84%	100 83%	NS
Smoking is bad for you	124 93%	114 94%	NS
Drugs change the way you feel	115 86%	104 86%	NS

Table 5 shows that after the programme, more students felt that 15 year olds were not emotionally mature enough to have a baby even though they were physically mature enough. "Dummy" or testing questions were included e.g. "smoking is bad for you" to assess the degree to which genuine answers were being given. By examining the responses to these questions, it is clear that the students were answering truthfully.

TABLE 6: *If you were to become a parent in 6 months, how would you feel?:*

	PRE		POST	
	Number	%	Number	%
Proud	33	25%	36	30%
Sad	25	19%	30	25%
Happy	38	29%	33	28%
Angry	37	28%	33	28%
Worried	89	68%	89	74%
Ashamed	39	30%	42	35%
Confused	75	57%	83	69%
Wouldn't Know	79	60%	80	67%
Wouldn't Care	11	8%	9	7%

The above Table shows the predominant feelings the students would have if they were to become a parent in 6 months time. They are: worry (68%), confusion (57%), wouldn't know what to do (60%). These feelings did not change significantly after intervention.

Table 7 shows that significantly fewer students said they would mind the baby themselves on completion of the programme. Over 50% said they would get a job; 36% said that they would give up school; 20% said that they would get married while 21% said they would leave home and live with their partner.

TABLE 7: *If you were to become a parent soon, what would you do?*

	PRE		POST	
	Number (N = 131)	%	Number (N = 120)	%
Have the baby adopted	7	5%	12	10%
Mind the baby myself	69	53%	22	18%
Give up school	45	34%	43	36%
Get married	15	11%	24	20%
Leave home and live with boyfriend/girlfriend	24	18%	25	21%
Get a job	71	54%	67	56%
Carry on as usual	29	22%	30	25%
It's not my problem	4	3%	4	3%
Get help	87	66%	85	71%
Don't know what I'd do	27	21%	35	29%

Of those who said they'd get help, 63% said they would approach a parent for help; 43% a friend; 31% a sister; 13% a priest and 9% a teacher.

TABLE 8: *The following statement was presented: " I do not want to have sex until....."*

	PRE		POST	
	No.	%	No.	%
I marry	30	23%	29	24%
I'm in my twenties	30	23%	33	27%
I leave school	29	22%	33	27%
I fall in love	67	51%	57	47%
I'm living with someone	20	15%	22	18%
I'm on contraceptives	38	29%	29	24%
I meet someone I fancy	52	40%	48	40%

The above Table indicates that only 24% of students said they would wait until they were married to have sex and the same proportion indicated that once they were on contraceptives they would be prepared to have sex. The answers before and after implementation of the programme did not alter significantly. It is worrying to note that 40% said they would be prepared to have sex when they met someone they fancied.

TABLE 9: *97% of students said they had a boyfriend/girlfriend in the past. This meant:*

	PRE		POST	
	No.	%	No.	%
having a special friend	57	43%	74	62%
holding hands	33	25%	43	36%
kissing	87	66%	90	75%
being happy	76	58%	78	65%
put under pressure	7	5%	5	4%
respect	47	36%	53	44%
heavy petting	37	28%	35	29%
intercourse	26	20%	28	23%

Having a boyfriend or girlfriend for the majority of students meant having a special friend, being happy and kissing. However, for one-fifth of them it also meant intercourse.

TABLE 10: *When asked if a sexual relationship was important in teenagers, the following were the responses:*

	PRE		POST	
	No.	%	No.	%
Yes, it improves it	42	32%	30	25%
Yes, everyone is at it	34	26%	28	23%
No, I have not found the right person	46	35%	44	37%
No, I'm too young	63	48%	64	53%

Table 10 showed that while the proportion who felt a sexual relationship was important dropped after the programme, this didn't reach significance. Furthermore, the number who felt a sexual relationship was not appropriate increased slightly but was not statistically significant.

TABLE 11: The students were asked about their feelings before and after the programme. These were the responses:

ANSWERS	PRE- No. (%)	POST- No. (%)	SIGNIFICANCE
Happy	118 (90%)	97 (81%)	P < 0.05
Lonely	12 (9%)	21 (17%)	NS
Carefree	63 (48%)	67 (56%)	NS
Good	76 (58%)	80 (67%)	NS
Important	60 (46%)	51 (43%)	NS
Sad	10 (8%)	17 (14%)	NS
Afraid	13 (10%)	22 (18%)	NS
Well liked	86 (66%)	86 (72%)	NS
Not well liked	11 (8%)	12 (10%)	NS
Left Out	15 (11%)	17 (14%)	NS
Fed Up	42 (32%)	35 (29%)	NS
Not important	19 (15%)	17 (14%)	NS

At the end of the programme, significantly fewer students felt happy. As their own evaluation shows, this was not because they did not enjoy the programme. Their evaluation was very favourable. The reason fewer felt happy may be because they were now questioning their attitudes and behaviour.

Of those who said they had sex before, 52% also felt "not important" compared with 28% of the total group. This association was significant ($X^2 = 7.25$; 1 d.f; $P < 0.01$).

DISCUSSION

The proportion of births to single and teenage mothers has risen steadily in Ireland over the past twenty years. Between 1981 and 1991 the number of births outside marriage has more than doubled (from 3,900 in 1981 to 8,770 in 1991). Births to teenagers over the same period have also doubled (from 1,500 in 1981 to 2,500 in 1991). Given the adverse consequences of teenage pregnancy both for the mother and the baby there is a need to reverse this trend. However sex education in itself does not effect adolescent sexual activity or pregnancy rates. One of the principal means of preventing teen pregnancy is by delaying the initiation of sexual activity. Our programme aims to do this by focusing on the needs of teenagers as expressed by themselves and by experts in the field. This programme not only imparts knowledge but also deals with peer pressure, self-esteem, decision making, responsibility and relationships in a facilitatory manner. The usual teacher-pupil relationship was set aside.

Whether sex education is provided in Irish secondary schools depends on many factors. There is no agreed programme in Ireland at present even though a need exists.

At the time of researching this programme it became evident that teachers are willing and eager to become involved teaching sex education in schools.

In introducing a programme as sensitive as this, considerable time was spent in obtaining the agreement of The Parents Council, School Management, Eastern Health Board and Departments of Health and Education. This was time well spent as each organisation provided valuable advice.

Knowledge about "growing-up", puberty, contraception, pregnancy and sexually transmitted diseases was assessed before and after the programme. Nine of the questions were answered significantly better after intervention e.g. there was a large increase in the proportion who knew that pregnancy can occur after first intercourse (70% before and 94% after, $p < 0.0000001$); that taking a shower after intercourse will not prevent a pregnancy occurring (54% before and 73% after $P < 0.005$); that condoms are not the best way of preventing pregnancy (25% before and 55% after, $P < 0.000001$).

The students were asked to agree or disagree with the statement:

"A girl can get pregnant at any time of the month". While this statement is not correct the teachers purposely impressed upon the students that at a young age, there may be no safe period so it would be pointless for young teenagers in trying to calculate when such a safe period might occur. Hence, in responding to this question, significantly more students, after the programme, felt that pregnancy can occur at any time of the cycle (56% before and 73% after $P < 0.005$).

For some statements there was already a high level of knowledge at the outset consequently there was little room for improvement after the programme had been implemented.

The improvement in knowledge of these teenagers can be directly attributed to the programme. They showed a greater understanding of physiology, puberty, pregnancy and contraception.

At the time the programme was being implemented, there was a change in the legislation on the availability of condoms. Consequently, the answers given on condom availability (before and after the programme) are difficult to interpret. However, the following indicates the beliefs of students before these changes were made (i.e. at the "pre-questionnaire" stage):

- 99% said condoms were available in pharmacies
- 34% said they were available in supermarkets
- 27% said they were available at Petrol stations
- 1% said they available in churches.

Attitude change is difficult to attain. Attitude and behaviour modification take considerably longer than this 6 week pilot study allowed. Given the difficulty and limitations in measuring attitudes it was felt that if any small change occurred over this short period of time, the programme would be worthy of continuation and expansion.

On completion of the programme significant and encouraging changes in attitude occurred. It was clear that the students were now considering the consequences of agreeing to sex. Fewer students would now "agree straight away" to sex. More said that they "would like to say no but might not be able to", an indication that they would prefer not to have sex. This also highlights the importance of peer pressure in their decision making. Those who said they would probably agree to sex did not alter (30% before implementation and 29% after). The programme needs to direct attention to this group who were mainly boys. The proportion of boys who said they would agree or probably agree to sex is a cause of concern (85% at the start of the programme and 71% on its completion). Based on this information consideration should be given to introducing the programme at an earlier age i.e. in 1st year. It should also be continued in every class on an annual basis and structured to meet the cognitive ability and maturity of the class.

The attitudes of the girls were very different to those of the boys i.e 15% of girls would agree straight away to sex. These results confirmed the initial impression health care staff had of the boys after speaking to them.

Another encouraging outcome of the programme was that the students realised that 15 year olds are not emotionally able to have a baby even though they are physically capable of this.

The programme highlights the mixed and negative feelings of the students. One of the teachers said that this was probably the first opportunity these students had to talk about themselves and their feelings in an open and supportive atmosphere. This opened up problems with self-image and confusion about how they feel. Given that there are so many external factors which influence emotions, the programme could not alter these.

When faced with the prospect of becoming a parent negative and mixed feelings became obvious. Most would be worried, confused and would not know what to do. It is interesting that 10% (after programme implementation) would consider adoption. There was a large drop in the number who said they would mind the baby themselves. Over 50% said they would get a job if they were soon to become a parent. Such reactions highlight unrealistic expectations in this regard. The fact that one-third felt they would have to give up school is disappointing.

It is encouraging that after the programme more students see their boyfriend/girlfriend as a "special friend" and "being happy". However, for 23% it meant sexual intercourse. Feelings of "not being important" were associated with previous sexual activity. This factor and the finding that over 25% felt that sexual activity was important in a young teenage relationship is a cause of concern. A health promotion programme geared towards this group should be considered.

THE FUTURE

Following evaluation of this programme by teachers, students and health professionals in Community Care Area 8, it was decided that its benefits were clear and that it should continue.

However some adaptations were built-in. The programme was made available for 2nd year pupils (13-15 year olds) and 4th year pupils (15-16 year olds). It is now a subject on the curriculum. The students have weekly sessions.

On-going training and support for teachers are necessary. From the unspent funds allocated by the Health Promotion Unit, £750 has been granted to the teachers for on-going training throughout the year. The remainder is set aside for further evaluation. At the end of the school year, knowledge, attitudes and behaviour of pupils who have undergone the programme this year in the school will be compared with those of a similar age in a control school.

CONCLUSIONS AND RECOMMENDATIONS OF PILOT PROGRAMME

1. Evaluation of this programme shows that it was worthwhile. It has benefits both for the students, teachers, health professionals and general community health.
2. School sex education needs to have a greater priority and should focus on teenage needs.
3. It is clear that more than just "sex education" in schools is required. A wider focused health promotion programme such as this one, is needed, including issues such as relationships, decision-making, peer-pressure, self-esteem, contraception, pregnancy and how life with a baby is different.

4. A 6 session course, as attempted here, is too short. For maximum effectiveness this programme needs to be part of the school curriculum and be available for the complete school year.
5. Once established, consideration should be given to expanding the programme to all years in post-primary schools, appropriate to age and maturity of the teenager.
6. Teachers need ongoing training.

PHASE 2

TEENAGE HEALTH PROMOTION INITIATIVE

Summary of Pilot Programme

This Health promotion initiative was introduced on a pilot basis in a North Dublin Community School during the 1992-1993 school year. Second year pupils (aged 13 - 15 years) were targeted. An evaluation was carried out:

- a) by teachers
- b) by pupils
- c) by public health doctors. This was a scientific evaluation based on questionnaire results.

The outcome of the pilot study was favourable. There was a large increase in knowledge among the students. There was also an encouraging change in attitudes. The report stressed the need for more than "just sex education". It recommended a wider focused health promotion initiative which would include issues such as relationships, decision-making, peer-pressure, self-esteem, contraception and pregnancy.

One weakness of the project was that being a pilot study it was conducted over a 6 week period. Even though the results were good, it was felt that definite recommendations about its future implementation could not be made on such a short programme.

It was agreed with the school that this programme be continued for the school year 1993-1994 and be conducted for the full school year among second year pupils. Eight teachers, who had received initial training, would continue to be facilitators and would receive on-going training during the year.

Extension of the Study into the 1993/94 School Year

Following completion of the pilot programme and assessment of the evaluation the school management together with the Eastern Health Board felt that the programme should be extended on a phased basis within the school. Furthermore, on-going training of the teachers should also take place. This decision was made for a number of reasons:

- teachers and pupils felt the programme was beneficial
- teachers said they saw a change in the general attitude among the pupils
- pupil/teacher relationships improved

- pupils have become more assertive
- it appeared to have a positive impact on pupil behaviour
- the scientific evaluation was positive

For the 1993/94 school year, it was decided to continue the programme with second year pupils but to conduct it over the full school year rather than over 6 weeks. The on-going training needed by the teachers was again facilitated by SHEA and funded by the Health Promotion Unit. The training took place each Wednesday evening outside school hours. The content of the programme was the same as that for the pilot focusing on group discussion, encouraging assertiveness and self-esteem, and empowering pupils to resist peer pressure. A major component was to persuade the pupils that sexual activity at their age was not a good idea. The emphasis was not simply on sex education but also on other factors which may influence teenage health e.g. alcohol and drugs. The philosophy of the programme was to be facilitatory rather than directional, to discuss the issues in a non-threatening and open manner, all the time aiming to encourage a healthy lifestyle.

Questionnaire Evaluation

The scientific questionnaire used in the pilot study was also used to evaluate the 1993/94 programme. This questionnaire was developed by Teachers, a Psychologist from the Department of Education, a Specialist in Public Health Medicine and an Addiction Counsellor. However, this time it was decided to examine the programme by comparing the intervention school with the control school which did not receive this programme.

The control school is situated 3 miles from the intervention school. It is a community school and was judged to be the best match in terms of geography and social class. It was felt, however, that students attending the control school may be more academically orientated. This control school also had a sex education programme and was anxious to get involved with this new approach. However, the teachers were not shown the questionnaire and remained unaware of the content of the programme.

The questionnaires were administered by health care staff. They were confidential. Analysis was done by Eastern Health Board Public Health Doctors using the Epi-Info Statistical Package.

The results of the questionnaire evaluation are as follows:

The mean age of the pupils was 14 years, there was no age difference between the two schools. There was no sex difference between the two schools; 58% of pupils in the intervention school were boys compared with 60.8% in the control school.

TABLE 12 - Knowledge

	Statement	Intervention School		Control School		P Value
		No.	%	No.	%	
1.	Periods happen once a month	118	96.7	92	90.2	<0.05
2.	The ovary releases an egg once a month	101	82.8	79	77.5	NS
3.	The ovary releases an egg 14 days before the next period	36	29.5	39	38.2	NS
4.	The ovary releases an egg during the period	78	65	71	69.6	NS
5.	Girls can get pregnant at any time of the month (a YES answer is judged correct)	76	62	45	44	<0.05
6.	A girl can get pregnant the first time she has intercourse	108	89.3	77	75.5	<0.01
7.	If a boy ejaculates outside the vagina, the girl can get pregnant	74	61.2	33	32.4	<0.0001
8.	The most likely time to get pregnant is 2 weeks after the period	64	52.4	54	52.9	NS
9.	A girl can get pregnant during the period	85	69.6	37	36.3	<0.000001
10.	Taking a shower after having sex stops a girl from getting pregnant	115	95	94	92	NS
11.	Masturbation can be normal	106	86.8	65	63.7	<0.0005
12.	Someone can get HIV by having sex once	101	82.8	86	84.3	NS

It can be seen from this Table that pupils in the intervention school had much better knowledge than those in the control school.

Significantly more pupils from the intervention school said that the best way to avoid pregnancy is "not to have sex" i.e. 19% versus 2% for those in the control school.

TABLE 13 - Attitudes/Behaviour: The Pupils were asked their opinion on the following statements using a 5 point scale:

Statement	Intervention School		Control School		P Value
	Agree/Strong Agree		Agree/Strongly Agree		
	No.	%	No.	%	
15 year olds are physically able to have a baby	97	80.2	86	84.3	NS
15 year olds are emotionally mature enough to have a baby	77	63.6	62	60.8	NS
People who play sports are usually healthy	109	90.1	90.	89.1	NS
Sex is more likely to happy when you drink too much alcohol	82	67.7	65	63.7	NS
Smoking is bad for you	122	100	101	99	NS
Drugs change the way people feel	103	84.4	90	88.2	NS

TABLE 14 - Attitudes and Behaviour

The pupils were asked how they would describe myself as:

Reply	Intervention		Control		P Value
	No .	%	No.	%	
Happy	106	86.9	93	91.2	NS
Lonely	6	4.9	8	7.8	NS
Important	51	41.8	47	46.1	NS
Sad	4	3.3	5.	4.9	NS
Afraid	6	4.9	8	7.8	NS
Well liked	75	61.5	82	80.4	<0.01
Not well liked	5	4.1	6.	5.9	NS
Feeling left out	8	6.6	11	10.8	NS
Fed up	30	24.5	15	14.7	NS
Not important	10	8.2	6	5.9	NS

No major changes in attitude or behaviour were identified using the questionnaire. It is clear that the majority of pupils felt that young teenagers were physically able to have a baby but were emotionally unable to. They were also aware of the risks involved in taking alcohol and drugs

It is disappointing to see that less than half of the respondents felt important and that between 15% and 25% of them were “fed-up”. It is obvious that there are many other influences affecting the lives of these young people which this programme could never attempt to tackle.

TABLE 15 - Attitudes and Behaviour

The pupils were asked how they would feel if they realised they were going to become a father/mother soon

Reply	Intervention		Control		P Value
	No .	%	No.	%	
Proud	26	21.3	13	12.7	NS
Sad	27	22.1	14	13.7	NS
Happy	38	31.1	23	22.5	NS
Angry	34	27.9	16	15.7	<0.05
Worried	96	78.7	83	81.3	NS
Ashamed	33	27.0	37	36.3	NS
Confused	63	51.6	55	53.9	NS
Wouldn't know what to do	71	58.2	60	58.8	NS
Wouldn't care	-	-	1	1.0	NS
Embarrassed	39	32	42	41.2	NS

TABLE 16 - Attitudes and Behaviour

The pupils were asked what would they do if they were to become a father/mother soon:

Reply	Intervention		Control		P Value
	No .	%	No.	%	
I'd have baby adopted	1	0.80	11	10.8	<0.001
mind the baby myself	81	66.9	52	51	<0.05
give up school	50	41.3	19	18.6	<0.001
get married	17	14.0	10	9.8	NS
leave home and live with boyfriend/girlfriend	22	18%	20	20%	NS
get a job	76	62.8	44	43.1	<0.01
carry on as usual	24	19.8	25	4.5	NS
don't know what I'd do	23	19	35	34.3	<0.01
its not my problem	3	2.4	-	-	NS
talk to someone about it	96	79.3	84	82.3	NS

TABLE 17 - Attitudes and Behaviour

Of those who said they would talk to someone, the following were the replies:

Who they would talk to	Intervention		Control		P Value
	No .	%	No.	%	
Sister	33	34.4	24	28.6	
Brother	17	17.7	12	14.3	
Mother	59	61.5	45	53.6	
Father	28	29.2	32	38.1	
Friend	62	64.6	59	70.3	
Priest	5	5.2	15.	17.9	<0.001
Teacher	7	7.3	7	8.3	

Almost 60% said they would not know what to do if they were to become a parent. This highlights the need for on-going health promotion throughout the teenage school years.

The unrealistic expectations, for example, giving up school and getting a job, further shows the need for on-going health promotion in this area.

When asked if you ever had sex in the past, 30 (24.6%) of pupils from the intervention school said they had compared with 22 (21.6%) from the control school. The difference was not significant.

TABLE 18 - Attitude and Behaviour

The students were asked to complete the following statement "I do not want to have sex until"

Reply	Intervention		Control		P Value
	No.	%	No.	%	
I marry	27	22.1	18	17.6	NS
I'm in my twenties	26	21.3	26	25.5	NS
I leave school	24	19.7	19	18.6	NS
I fall in love	49	40.2	64	62.7	<0.001
I'm living with someone	11	9.0	12	11.8	NS
I'm using contraceptives	37	30.3	36	35.3	NS
I meet someone I fancy	46	37.7	32	31.4	NS

TABLE 19 - Attitude and Behaviour

They were asked if they ever had a boyfriend/girlfriend; 118 (96.7%) of the intervention school and 95 (93%) of the control school said they had. This meant:

Reply	Intervention		Control		P Value
	No.	%	No.	%	
having a special friend	66	55.9	65	65	
holding hands	34	28.8	40	40	
kissing	85	72	72	72	
being happy	77	65.3	71	71	
under pressure to have sex	4	3.4	10	10	<0.05
respected	49	41.5	46	46	
touch intimately	22	18.6	28	28	
having sex*	14	11.9	17	17	

*Note: 14 said they had sex, but 30 said they did in another question!

It is encouraging to see that after intervention the pupils felt less under pressure to have sex 3.4% versus 10% in the control school. This can be attributed to the programme.

TABLE 20 - Attitude and Behaviour

The students were asked their opinions and importance of a sexual relationship at their age:

Reply	Intervention		Control		P Value
	No.	%	No.	%	
Yes, it improves the relationship	16	13.2	15	14.7	NS
Yes, everyone is at it	12	9.9	17	16.7	NS
Yes, I'd get called names if I didn't	3	2.5	5	4.9	NS
No, I am too young	57	47	52	50.1	NS
No, it is too big a step for me	43	35.5	39	38.2	NS
No, it is too risky	84	69.4	68	66.7	NS

CONCLUSIONS AND RECOMMENDATIONS

- 1..The programme continued to show success following its extention in that there was a large increase in knowledge. However, attitude change, as depicted in the questionnaire evaluation, was not as great as hoped.
2. School management felt that attitudes of pupils did change as a result of the programme. They reported better pupil/teacher relationships, greater self-esteem and assertiveness among the pupils.
3. As a result of the findings, the school has decided to extend the programme to all pupils in classes between first and fourth year. They have also decided to amend it by including more material on alcohol and drug related issues.
4. There are many other areas within Eastern Health Board with a high teenage pregnancy rate. Consideration should now be given to extending it to these areas.
5. In order to maximise the effectiveness of this programme, it must be allowed to be developed and improved over time. Teenage pregnancy rates must be monitored continuously.
- 6.The whole future of this programme depends on the cooperation and commitment of any school to which it may be introduced.

ACKNOWLEDGEMENTS

I would like to acknowledge the following who made this research possible:

Mr Eoin Metcalfe and Ms Mary Jackson, Health Promotion Unit of The Department of Health for their valuable advice and generous funding

Mr Adrian Charles, Eastern Health Board for his support and timely advice

Ms Ruby Morrow, Senior Psychologist, Department of Education for her help in devising the questionnaire

Mr John O Riordan, Principal and Mr Philip Mc Hugh Vice-Principal of Colaiste Dhulaigh VEC for permitting the project to be undertaken in the school, for re-organising time-tables and for releasing the eight teachers for training

The eight teachers who gave up their free time to undergo training and then had the courage to take up the challenge of implementing such a demanding and sensitive programme in the school

The Parents Council whose advice was sought in the early stages

Mr Michael Cox, the year head for Second Year pupils

The students who participated in the pilot study and who gave us such a valuable insight into teenage culture

The Health Promotion Committee of Community Care Area 8, Eastern Health Board which developed the programme.

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