

Clinic in a Box: Sex Education and Support

A Pilot survey of the views of year 11 students at a
North West College

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Author: Dr Diane Grant

Research Assistants: Emma Cook, Caroline Chambers and Catherine Savage

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Liverpool John Moores University

Clinic in a Box: Sex Education and Support

Introduction

The United Kingdom has one of the highest rates of teenage pregnancy in Europe, with recent figures indicating that 4% of girls aged 12 to 18 years old in the UK became young mothers in 2006. The statistics also reveal that there are areas where the rate of pregnancies of girls between the ages of 15 and 17 is far higher than the national average. Locally the issue is that certain regions give cause for concern.

Recently published figures (ONS 2009) reveal the conception rate among under 18s rose in Liverpool (up 9.5%), in Knowsley (12.4%), in Sefton (5.8%), in St Helens (6.5%) and in Halton (21.5%) in just 12 months. In 1998 the rate for St Helens for under 18's was 55.5% with a projected figure showing a reduction in 2004 to 47.8% rising to 49.2 for 2007, the national average being 41.7, overall there has been an 11% reduction in the last ten years (for conception rates of 15-17 year old girls). The government's aim under the teenage pregnancy strategy launched in 1999 was to require all local authorities to have measures in place which would meet local reduction targets, to halve the conception rates for under 18's.

The national trend which highlights both conception rates which have generally reduced, with the latest figures for 2007 highlighting an increase in both conceptions and abortions. However the recent figures suggest that whilst there have been some improvements since the ten year strategy was set up there still remains many areas with high teenage pregnancy rates.

Clinic in a Box: Sex Education and Support

The government have highlighted key areas that they believe have contributed to the downward trends as being the active engagement of key mainstream delivery partners which includes all those who have a role to play in reducing teenage pregnancies, covering Health, Education, Social Services and Youth Support Services – and the voluntary sector. They also emphasise the availability of young people centred contraceptive and sexual health services that are able to deliver health promotion services, whilst also providing reactive services.

Some schools have been given a high priority to deliver personal, social and health education (PSHE) with local authority support to develop programmes of sex and relationships education (SRE) in schools with a clear focus on addressing key social issues affecting young people, such as sexual health and substance misuse.

These initiatives have come in partly due to the wealth of evidence of the long term cycles of deprivation and inequalities that can result from teenage pregnancy. Academic studies show that many teenage pregnancies are often related to social inequality which can affect their lives in many different ways. Some research has shown that young women who experience disadvantage in childhood are more likely to become pregnant as teenagers, than those who do not (Hoggart 2003). A study which looked at the causal effects of becoming pregnant before aged 20 and the ‘partnership outcomes’ found that becoming a teenage mother causes the mother to experience disadvantage in the ‘marriage market. The study found that early motherhood increased the likelihood that she would partner with poorly educated and unemployment-prone men (Ermisch and Pevalin 2004).

However, critics of government policy on tackling teenage pregnancy suggest that there is little evidence to support that a lack of knowledge ‘causes’ a pregnancy, or that increased knowledge can prevent it. According to Duncan (2007),

“The age at which pregnancy occurs seems to have little effect on future social outcomes, and many young mothers themselves express positive attitudes to motherhood, and describe how motherhood has made them feel stronger, more competent, more connected, and more responsible”. (Duncan, 2007, p. 308)

Clinic in a Box: Sex Education and Support

This concurs with Wilsby and Capell (2005) that having a baby provides many with a sense of responsibility and may bring some meaning to their lives. However, for some teenagers it is seen as a life choice.

This may resonate with for example, previously 'looked after' children and young people with a background of being in local authority care, and who have been found to be more likely to be associated with early pregnancy. The figures show that around 25 per cent of children that have been in care have had a child by the age of 16, and around half of women became mothers within 18 to 24 months of leaving care. It is also twice as common for young people who have grown up in care to desire to have a baby by the age of 20, compared with young people who have grown up within a family environment.

Further studies show that it is not only being in care that affects the likelihood of early pregnancy, but rather the type of care placement experienced by the young person can have long term impact on education and subsequent life chances.

A study using a sample of 11,000 males and females aged 16 to 44 published in the Lancet highlighted that sexually active young women who failed to gain any qualifications on leaving school at 16, were more likely to have a baby before they reached 18 years of age Wellings et, al, (2001) Excessively poor outcomes in education for young people who have been in public care have been found to lead to high levels of unemployment (Knight 2006).

A wealth of research supports that teenagers from lower working class backgrounds also have higher levels of conception rates. There is further evidence to support that they are more likely to carry the pregnancy through to term than better off families. The evidence shows that teenagers from moderately affluent backgrounds are more likely to abort their pregnancies than those from relatively deprived backgrounds, who tend to keep their baby (Ermisch and Pevalin 2005). The explanation for such differences is said to lie in the more liberal acceptance of young motherhood among underprivileged groups. Those whose parents were teenage mothers themselves,

Clinic in a Box: Sex Education and Support

were twice as likely to become a young mother compared to those born to older mothers (Ermisch and Pevalin 2003).

The numbers of abortions had steadily increased in the last 30 years (see Table 1) (A Matter of Choice, Joseph Rowntree Foundation 2004). However abortion rates vary across the country showing that there may be factors related to location and culture leading to a lack of uniformity in abortion rates.

Table 1 Teenage conception and abortion measures in England and Wales, 1972–2000

Year	Numbers of teenage conceptions (1,000s)	Numbers of teenage abortions (1,000s)	Abortion proportions
1972	130.6	27.7	21
1982	113.9	36.9	32
1992	93.4	31.6	34
2000	97.7	38.4	39

Source: ONS Birth Statistics Series FMI, Table 12.1; Wellings and Kane, 1999.

The national trend for conception rates for under 16s is contrasted below in Table 2, with the increased use of abortion over time.

Table 2

Year	Under-16 conceptions	Under-16 conception rate*	Percent leading to legal abortion
1998	7,855	8.8	52.9
1999	7,408	8.2	53.0
2000	7,620	8.3	54.5
2001	7,407	8.0	56.0
2002	7,395	7.9	55.7
2003	7,558	7.9	57.6
2004	7,181	7.5	57.6
2005	7,473	7.8	57.5
2006	7,330	7.7	60.2
2007	7,715	8.3	61.9

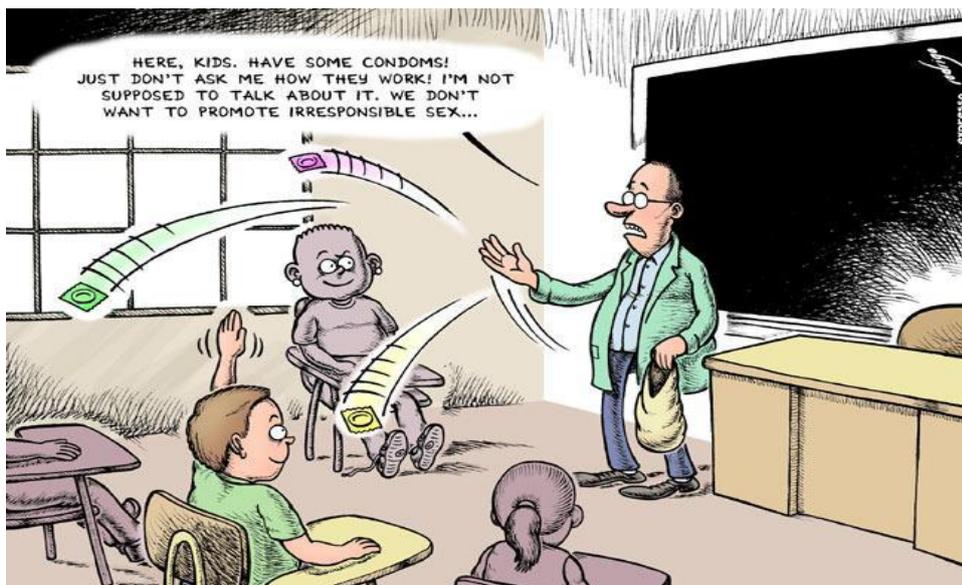
Sources: Office for National Statistics, 2009

Clinic in a Box: Sex Education and Support

In the St Helens area, just over a third of conceptions were aborted in 2007 compared to the rest of Merseyside area where the range varied between 45% in Knowsley and 58% in Sefton, indicating a larger percentage of pregnancies are seen through to a delivery from teenagers in St Helens than is experienced in the rest of the Liverpool area.

A study involving 248 fifteen year old females, found that most participants viewed teenage motherhood in a predominately negative light, but that women from rather deprived areas were more likely than their moderately affluent peers to predict they would keep a teenage pregnancy (Ermisch and Pevalin 2005).

Many intervention programmes have been set up which are focused on targeting the promotion of the use of contraceptives. For example, trying to tackle teenage pregnancy alongside alcohol and drug use. Most have focused specifically upon condom use in respect to its importance in preventing pregnancy, as well as sexually transmitted diseases, particularly targeting HIV (Lester and Coleman 2002). Moreover, Beverly Hughes the curriculum health minister for children is now making sex education a legal requirement within schools. However, studies have shown that sex education has made little improvement to the rates of teenage pregnancy (Singleton 2008).



Clinic in a Box: Sex Education and Support

Many claim that sex education should give more than just a biological perspective to 11 to 14 year olds, which is only what schools are currently required to do. Beverly Hughes claims that if children are able to discuss the issues with peers, including contraception methods that are available to them, it may reduce problems related to underage sex, such as sexually transmitted diseases and teen pregnancies. Singleton argues that compulsory sex education would not abolish teenage pregnancy, but would offer young people more support and advice which could help to lead to reductions (Singleton 2008). Sex education is therefore crucial, however it is not just about sex, but acquiring information, skills and the formation of attitudes beliefs and values according to Sutherland (cited in Andrews 2005).

In a large scale study involving data from 6,348 young women, investigating the type of contraceptions used amongst 16 year old girls for their first sexual intercourse, showed that 54% typically use a condom, 11% use both oral contraception (OC) and condoms with 4% using condoms only and 4% using emergency contraception, however 21% did not use any form of effective preventative method. The study concluded that young teenagers may not be using the OC efficiently and therefore become more vulnerable to pregnancy. One in ten girls in the study had also reported a previous pregnancy. The authors called for alternative contraceptive strategies to be considered for such young women (Parkes et. Al (2009).

Research has shown that those who are better informed about sex education make more positive choices about their sexual health and behaviour. In a nurse led drop in centre, providing sexual health promotion, contraception, STI reported that the average age of first intercourse was 15 years, and most visited the clinic *after* having sex rather than before (The value of the drop in service was that it made them feel more informed Ingram and Salmon 2004). and confident and that they felt they would take fewer risks.

From a health perspective, becoming sexually active at a young age and having unprotected sex increases the prevalence rates of sexually transmitted infections and accidental pregnancies, thus creating a huge strain on the National Health Service. The cost to the NHS was put at £63 million pound in 2002 (TPU, 2002). Clinic in a

Clinic in a Box: Sex Education and Support

Box is one of a variety of initiatives aimed at reducing teenage pregnancies within the UK. The idea of Clinic in a box was developed during the summer of 2000 and introduced in October that year. Priority areas for the service were identified using data on teenage conceptions based on electoral wards. Psychological health is also identified as a possible pre-cursor to teenage pregnancy and is linked to self esteem.

It is thought that many of those who become pregnant early in life have issues of low self esteem. The risk of teenage motherhood is estimated to raise possibly by 50% amongst teenage girls who have low self esteem scores. The reason for this is not clear, but the researchers believe it may be linked with an increased prevalence of unprotected intercourse (Emler 2001).

Locally, schools and colleges have provided this service in specified areas in and around Merseyside. Nationally Clinic in box is deemed successful because it is used in places young people are likely to be. It is mainly taken to youth clubs but other venues are always thought of. Family planning clinics are often located in health centres where teenagers sometimes find it embarrassing to attend. Another factor is that the health centres run at times that are inconvenient for young students. Those who wish do use them worry about being seen by family and friends, which is usually a big concern for young people.

Clinic in a Box: Sex Education and Support

Rationale for this study:

Clinic in a Box: Sex education and support in a North West College

A nurse led, 'drop in' was set up to deliver sex education support, (Clinic in a box), at a North West College and was held at lunch times, which appeared to attract a lot of students, given that many were not known to have a girl or boyfriend. Evidence of misuse of condoms was found, with some playing around with them occurring, being left around school tied to door etc. There was also the feeling that it may be being viewed by the boys as 'macho', to be waiting in the queue to get CiB, thereby giving the impression that many more students may be sexually active than as may be the case, and that peer pressure to be part of the 'group' who were obtaining these services was a factor in the numbers queuing up for CiB. The timing of the service was changed so that it operated after school hours, which subsequently resulted in a reduced take up of the service which then led to the service being withdrawn.

In response to both an increase in 2007-2008 of girls becoming pregnant whilst studying at the college and a desire to know what the views of students were the Headteacher contacted LJMU with a proposal to investigate the topic. The researcher was asked to carry out a small survey on the views of young people of year 11 on sexual education and support and other questions regarding their own aspirations for the future. An interview was conducted with a young student mother who came into the school to talk to the researchers following her return to schooling post pregnancy.

Methods

Out of a possible sample of 110 students less than half brought back parental consent forms, and others were engaged in preparations for examinations. In this phase a total of 35 students from year 11 in 2008 completed the questionnaire; they were asked to complete it and place in a envelope seal it and return to the researchers.

Clinic in a Box: Sex Education and Support

A focus group was arranged for two young student mothers and a parent, however on the day only one student came to the appointment and an interview was conducted.

Results

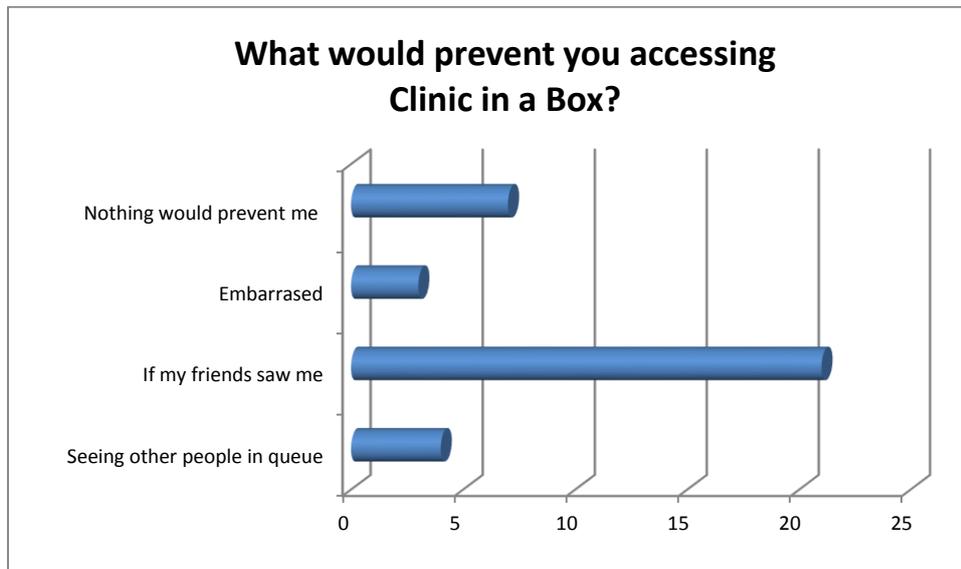
Twenty-eight girls and seven boys aged between 15 and 16 took part in the survey, 89% of whom had undertaken sex educational lessons. Out of those who had taken part 39% reported they had been embarrassed about the lessons in class. Whilst the majority felt that they knew already most of what was being imparted in the lessons (70%). Almost 83% felt that there was some information that was news to them, in particular the problem of sexually transmitted diseases.

In terms of how sex education was being delivered, over half (53%) felt that the lessons should be taught in an all boys/girls environment and not mixed as is the case at present. Most of the students felt it was the best place to receive sex education (86%), however a third of all students felt that it could be best delivered in a youth club or at home with parents. Some students indicated that they had received some sex education discussion with their parents (61%) compared to 19% who had never had any discussion on the subject.

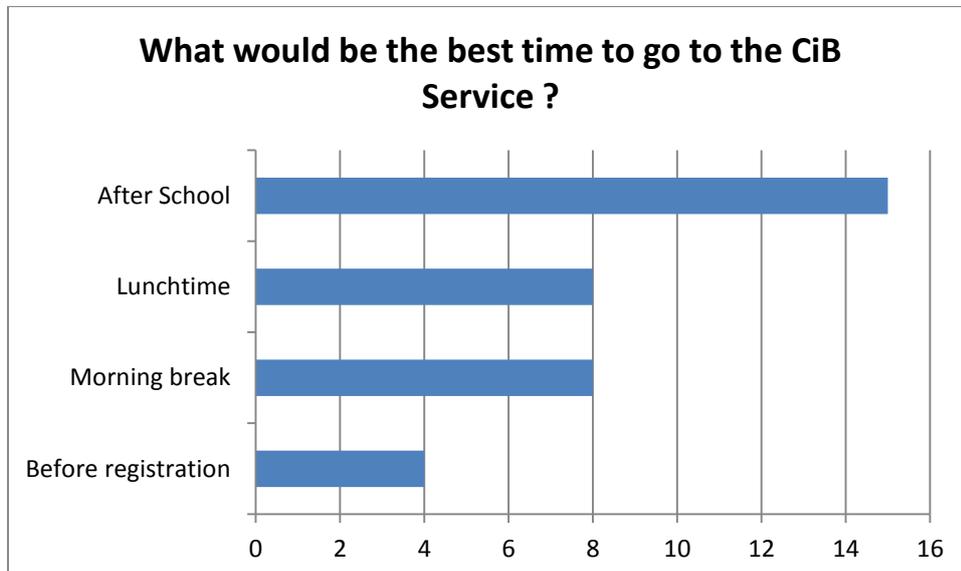
On the subject of Clinic in a Box (CiB), 23 students had been told about CiB in lessons but 12 had not (possibly due to absence etc).

The students were asked what would prevent them from accessing CiB, which elicited a variety of responses see Table 1 below.

Table 1.



It was thought by the school management that the times at which CiB was distributed may have been a factor in its popularity, thus the researchers asked what would be the best way to use the service.



N=35

Generally the preferred option would be an after school service, which was a reason for the decline in use of the service in the first place. Factors which may have affected attendance at this time may have been due to having to wait in a queue in the knowledge that a parent may be outside waiting for them, or just being visible in this queue as all the students file out of the entrance at home time. The provision of a discreet appointment system in school hours may provide an alternative solution.

Clinic in a Box: Sex Education and Support

Students completed an open ended question on what they perceived the consequences of early motherhood. Around half of the students believed that this would affect their education, with a quarter identifying motherhood with a reduced or limited social life. There were generalised comments made on the difficulties associated with motherhood, as making life more problematic for young people. Indeed some identified the need for the young person to mature very quickly in order to deal with the responsibility of bringing up a child and some viewed the physical changes of being pregnant as a consequence, *'it gives you stretch marks'*. Very few identified issues as related to potential young fathers specifically, this is an area that needs to be explored.

Given that only five of the sample disclosed using the service in the past the value of the service as a preventative measure seemed to be understood by the group, with 69% agreeing that if they were sexually active they would make use of the service. Out of those who stated they would not use the service a number of reasons were given, ranging from fear that the information disclosed would not be treated confidentially, and another reason was embarrassment.

One interview was conducted with a young mother who had returned to school having become pregnant at aged fourteen. The interview was conducted in the presence of her mentor and digitally recorded by the researcher.

Josie's Story

(extracts from an Interview: name of interviewee changed)

"I was 14, I was scared at first but happy too. I don't know I can't really remember"

She described herself as being a 'terror', in her own words, she 'went off the rails'. When she found out she was pregnant she could not tell her Mum, instead she ran away from home and stayed at her (then) boyfriend's flat, she did not know how her Mum found out.

The college became aware of Josie's situation and assigned her a learning mentor – this was a key intervention for Josie who following 18 months with her mentor now considers her as 'her best friend'.

Josie missed 10 weeks of school when she had her baby. She was proud of the fact that she missed so little of school and returned to school in the same class as her friends who are all currently studying for several GCSE's.

She has calmed down a lot since having her child and gets on well with her Mother who provides her with a lot of support, *"Mum looks after her (baby) when I go to school. And she goes to bed quite early cos she's lazy (laughs) well she's not lazy, she's good. She goes to bed after "In the night garden" about ten to seven or seven o'clock and then I can do homework then"*.

Josie acknowledges that the support that she received from her Mentor was crucial to her being able to cope,

"I tell her everything... I always talk to D, don't I?...tell her everything.

And how do you view D? *"More like a friend, a teacher or...?"*

Yeah a friend. Someone I always talk to. And I've got someone to tell my life story (laughs)".

She also obtains support from her local Sure Start centre in the form of nursery care, practical help, and the opportunity to meet other young mothers with whom she has formed good friendships. Her friend is eighteen and she is now fifteen but the age difference is secondary to their shared life experiences *"her little girls two but she's had him when she was fifteen so like she's.. she's eighteen now, but she knows like... we were taught like the same if you know what I mean? Like most eighteen year olds wouldn't go out with fifteen year olds but we class each other, like more grown up? We don't think about ages"*.

Clinic in a Box: Sex Education and Support

When asked about contraception and Clinic in a Box Josie admits to not really taking any control of her life and not bothering with contraception. She felt that she knew nothing about sexual relationships prior to her becoming sexually active. Her belief was that the few sex education lessons she had at primary and secondary school did not prepare her or give the required information she might have needed. She knows that some people use the (CiB) service and some misuse it,

“Yeah but some people just go and get condoms and blow them up...tie them to the handle of the door and things (laughs)”.

So do you think it serves a purpose? *“Erm, yeah. I think it would be alright to go, if someone really wanted to go”.*

When asked what advice she would have for improving the delivery of sex education to prevent teenage pregnancy she said,

“I don’t know, nothing makes a difference. If it happens it happens. I don’t think there’s anything they could say. They always say use a condom anyway, and it doesn’t happen does it? Everywhere, it’s always on telly, but people are still having babies”.

The evidence presented here presents somewhat limited views of teenage pregnancy but from different perspectives and through the use of dissimilar methods. The questionnaires can provide only limited responses to questions but can act as an indicator as to where further investigations should go. In terms of validity the sample size was small, however this may be due to the nature of the subject, perhaps parents did not consent or students were unable to attend due to examination preparation. The numbers in this pilot study are too few to make generalised comments on the views of all of the year 11 group, but some key points and themes emerged which would require further exploration using a qualitative approach.

Clinic in a Box: Sex Education and Support

The interview (selected extracts) gives rich insights into the feelings and beliefs of the person for whom teenage pregnancy is a reality, as her life alters and moves forward. The lack of knowledge of sexual feelings in relationships and the ineffectiveness of sex education service is conveyed, “*if it happens it happens*” here the unspoken implication as often happens emotions spiral out of control and no amount of education can prepare you for that moment. Often the young people are unprepared or too embarrassed to even discuss sex with their partner, let alone people who could help them, thus the resulting pregnancy is due to an immaturity of either or both parties to recognise their vulnerabilities or communicate their needs at the right time to prevent unprotected sex. The consequences of which are complex, multidimensional, and overwhelming for the student and her family support systems. In the data collected on questionnaires some open ended responses were received on the consequences of teenage pregnancies and other issues the main points are shown here.

- The main consequences of a teenage pregnancy as perceived by the students was that it affected your education, social life and imposed responsibilities that may be beyond the capabilities of the young persons involved.
- Sex education was useful in highlighting the issue of sexually transmitted diseases, but most of the sample knew about the biological aspects of sex education although our interviewee was not.
- Most of the sample felt that they would have preferred single sex education sessions where they could explore issues with either a male or female member of the staff.
- Clinic in a box was deemed to be located in the right place (school) as some only went to school and were not part of external organisation, however it was at the wrong time (lunchtime). Issues regarding the need for student privacy, students could be seen on the queue by staff and students alike.

Clinic in a Box: Sex Education and Support

- Most people would prefer for the service to be available after school, yet how would this impact on those requiring to meet a lift home?.
- Factors which may prevent students accessing the service was the fear of being identified in a queue, leading to a recommendation that an appointment system is in operation and a possible change of location in the school is considered as currently the office is on a main route in the school seen by staff and students alike.
- The extremely valuable contribution of the mentoring system was evident in this study and the impact this can have on bringing back a potentially 'lost' student to continue their education is to be commended.

Footnote

Since this report was finalised further data has been collected in the form of focus groups with learning mentors and students from year 10. This additional data will be incorporated into the findings and forwarded to the school when analysed.

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Clinic in a Box: Sex Education and Support

Notes page