

# **The Evaluation of the Leicester Teenage Pregnancy Prevention Strategy**

## **Phase 2 Report**

**Informed by the T.P.U. Deep Dive  
Findings**

**Centre for Social Action  
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# **Leicester Teenage Pregnancy Prevention Strategy Evaluation**

## **Phase II - Executive Summary**

There were three strands to the second phase of the evaluation of the Leicester Teenage Pregnancy Prevention Strategy. These were:

- Consultation with young people
- Interviews with local practitioners
- Interviews with parents

Two areas for investigation were identified, New Parks and Eyres Monsell, as well as areas of black and minority ethnic community settlement such as St Matthews, Belgrave, Spinney Hills and Highfields.

### **Methodology**

Seven young people were recruited as peer evaluators - six young women and one young man. Six of them were parents. One additional young evaluator was also recruited through a youth centre and was employed specifically to interview young people and parents from the black and minority ethnic communities. The seven peer evaluators took part in four days' compulsory training to equip themselves with the skills they needed to be peer researchers and design the question schedules.

Riverside, New College and Crown Hills were selected as the community colleges which would host sessions for the peer researchers to interview students and facilitate group sessions.

Peer evaluators interviewed young people in community centres in New Parks and Eyres Monsell and also centres catering for minority ethnic young people in St Matthews and Highfields. The young researcher also interviewed Asian young people at the Jain Temple in Leicester.

There were 14 interviews with parents comprising four white British from New Parks and Eyres Monsell and ten Asian people from different faith communities.

There were 12 interviews with practitioners comprising five mainly youth workers from New Parks and Eyres Monsell and five workers from Belgrave, St Matthews and Highfields. Of the latter five, one was a voluntary youth leader, two were health workers including one from St Peter's Clinic, while the rest were youth workers. The remaining two practitioners were staff from two of the participating colleges.

### **What young people told us**

The team of Peer Evaluators carried out 45 questionnaires with 48 young people in schools and community venues. 33 females and 15 males completed questionnaires.

Three group sessions were held in schools by the peer evaluators and a total of thirty young people took part. Eleven were male and 19 were female. They were aged between 14 and 16 with the majority being age 15. Six young people also completed questionnaires as part of a Black and Minority Ethnic Booster sample. There were four females and two males in this sample. All six were Indian with 5 giving their religion as Jain, and 1 as Hindu.

### **Views on SRE lessons**

Not everyone could remember having SRE lessons. Of those that did some found them interesting and informative while others felt they were boring and uninformative.

Young people seemed to value receiving information and were more negative about sessions that they felt were not informative enough. There was felt to be insufficient attention to the relationships aspects of SRE as opposed to the sexual aspects. Young people from the Black and Minority Ethnic groups were on the whole least positive about their experiences of SRE in school from teachers.

Overall, for these young people the delivery of interesting, interactive information about sex education that covered a wide variety of topics and allowed them to talk about relationships would meet far more of their needs than the current lessons.

### **Sessions from outside educators**

Turning Point was praised by the few young people who had received lessons from them for talking about relationships and the real effects of being a single parent. Other lessons were praised including those delivered by school nurses for using equipment to demonstrate the proper use of condoms which made the information easier to understand.

### **Sources of information**

Family and friends appeared to be considered the best to provide information about sex and relationships, but nurses and doctors were the single most popular choice, perhaps because they were felt to be better at keeping confidences. Peer educators felt that young people wanted to be able to talk to their parents more than they actually felt able to. It was suggested there was not enough out of school information on contraception and young people needed to be informed of where they could get contraceptives free of charge.

### **Finding out about services and using them**

Friends, fellow students and school, as well as youth workers were the major sources of information about sexual health services for the young people we spoke with.

### **Barriers to accessing services**

Barriers to young people using services comprised personal reasons such as lack of confidence, embarrassment and being scared to walk in. Organisational factors included opening times and having to travel to the service. Confidentiality was important to young people, as was not having to tell a lot of people their business in order to access the service. In the Black and Minority Ethnic Group Booster sample, two of the oldest young people were explicit about cultural taboos in the Asian community about talking about sex and having boyfriends which they saw as the main barrier to accessing services.

### **Ideal services**

Young people wanted free, confidential, pregnancy tests, contraception and STD tests with services having longer opening times and being open on more days, different waiting areas for young people, different sessions for different age groups (e.g. 12 -15, 16+) and possibly even women only sessions. More promotion of services was needed. Staff offering sexual health services should not be judgemental and should be easy to talk to, as well as being patient and more understanding of young people. The research found that many young people said they would be interested in being involved and helping to improve services.

### **What Parents told us**

#### **Views on the Teenage Pregnancy Prevention Strategy**

Most parents had some awareness of the government's strategy to reduce the rate of teenage pregnancies and all thoroughly approved of it. It was notable that all Asian

parents placed more stress on the impact this had on young women's choices regarding training and work than white British parents from New Parks and Eyres Monsell.

### **SRE**

Some white British parents were critical of the effectiveness of the SRE their children had received. Because it was relatively unusual for Asian parents and teenagers to openly discuss sexual matters within the family, not all Asian parents were very aware of the issues covered within sex education at state or private schools. Some who did were challenged by the explicitness of the material covered in state schools. Some Asian parents felt the SRE lessons in private schools were not as helpful as they could be as some aspects were missed out. Like the young people themselves these parents suggested that the more emotional aspects of sex and relationships should be covered,

### **Community sexual health services**

All the white British parents supported the idea of locally based youth sexual health services and were mostly relaxed about their young people potentially accessing condoms from this source. Some felt that these would be a more acceptable source of information for their children than either schools or parents. Most Asian parents felt that more sources of information would be helpful but not all would be comfortable with free condoms being distributed.

### **Groupwork with parents**

Parents were asked if they would find it useful to join a group with a trained worker to learn how to talk more to their children about sexual health issues. Both white British and Asian parents in this study supported the idea and thought it might be helpful although they did not necessarily feel the need for it themselves.

## **What practitioners told us**

### **Experiences in schools**

- 2 out of 3 schools in the study area were not providing SRE for their Year 10/11s because of pressures on the school curriculum
- Using outside staff for SRE such as Turning Point and school nurses had produced very positive results in two schools who provided information
- One school noted there was insufficient attention to relationship education which needed younger people than regular teachers presenting it
- Single sex SRE sessions worked better than mixed in one school
- There was no current work with governors or learning mentors in two schools who provided this information

### **Experiences in New Parks**

Partnership working in New Parks, particularly between health and youth services was seen as crucial to developing effective sexual health services in the area, including the new C Card initiative. Services seemed to work best when camouflaged within regular mainstream youth provision, but service delivery had to be consistent or attendance might flag.

### **Experiences in Eyres Monsell**

Compared to New Parks this was felt to be a neglected area with insufficient youth and community provision of the quality required to attract large numbers of young people on a regular basis and enable youth workers to address a range of issues with them. There appeared to be few sources of contraception and sexual health advice acceptable to young people available, with the youth service unable to play a

full role regarding sexual health issues until a new sexual health policy had been agreed. A culture of low expectations among young people meant that teenage pregnancy was not necessarily seen as a disadvantage.

### **Experiences in Black and Minority Ethnic areas**

Attitudes within some local communities meant that there were few community based sexual health services in some areas and Asian young women in particular felt worried about using them for fear of recognition. Some good local services in one area would not be used by other groups nearby because of community perceptions about the ethnic groups living there.

### **Needs of young people**

In all areas young people were perceived to need:

- Confidential, anonymous sexual health services with knowledgeable, understanding workers, such as youth workers or Choices nurses, in accessible, acceptable locations
- More sources of free contraception and sexual health services delivered in ways that protected young people's privacy
- Use of new technology to provide information such as websites and text numbers which could preserve privacy and confidentiality
- More issue based youth work in BME areas
- More services aimed at young men and male youth workers.

### **Recommendations to the Teenage Pregnancy Partnership Board and Leicester's Children and Young People's Strategic Partnership**

#### **SRE**

- Greater engagement with schools, via a review and other activity, concerning the current content of SRE they provide, its provision throughout the secondary school from years 7-11, methods of delivery and ways in which this can be given higher priority within the curriculum. This might also include the distribution of standardised information in question and answer formats of what to do and where to go in the event of various emergencies arising for young people in the course of their sexual relationships.
- Consideration of ways in which young people can be consulted and have greater input into the content of SRE in schools throughout Leicester and other information resources. This will need to be realistically resourced.
- Special attention to the content of SRE lessons in schools and colleges with a high proportion of minority ethnic students, to ensure this is as detailed as possible in the absence in some cases of accessible ways of acquiring this information within their communities. Schools appear at present to be the most socially acceptable way in which this information can be given to many young people from these communities.
- Support for the creation of more peer educators to deliver SRE lessons, including more young people from the Black and Minority Ethnic communities and young men.
- Encouragement for schools to routinely use outside staff such as peer educators, school nurses and youth workers to deliver SRE lessons, and financial commitment from outside agencies such as Health, Youth Services



and Connexions to make this possible. This aspect of the Healthy Schools standard can also be highlighted by SRE education staff.

### **Sexual Health Services and Information**

- Greater availability of free condoms at a wider range of outlets throughout Leicester whose location is well publicised to young people.  
This may be provided through C Card schemes but this particular form of provision should not be regarded as the only means of distribution, as there may be some young people who are not comfortable with this level of scrutiny. Informal distribution via youth centres should also be used, thus implying a rapid resolution of the sexual health policy issue.
- Greater availability of local sources of emergency contraception to replace the well used local pharmacy schemes.
- More capacity for Choices clinics which are well regarded by young people
- Greater provision of sexual health services with trained workers embedded within general youth provision.
- Greater investment in youth provision which can be staffed most days of the week in areas throughout the city, where young people will have somewhere to turn for immediate advice and signposting when emergencies arise.  
Adoption of agreed sexual health policy by the youth service.
- More publicity of sexual advice services via posters in supermarkets, shops, hairdressers, youth centres, community centres etc and also exploration of the use of internet and text services as ways of disseminating information.
- Greater awareness of and attention to issues of confidentiality and privacy in the provision of sexual health services to young people.
- More sexual health training for workers in contact with young people including part-time workers and volunteers.
- Greater attention to ways of involving young people in the design and delivery of sexual health services and information.

### **Work with Parents**

- Consider development of work with parents on sexual health issues throughout the city
- Outreach to women active in the voluntary sector within the Asian communities and involvement of them in planning for a day event as a platform for discussing the issue.
- Develop dialogue with organisations such as Federation of Muslim Organisations to start engagement on issues of young people's sexual health knowledge and services for them.

The full report will be available on-line on the Leicester Teenage Pregnancy reports website <http://www.leicester.gov.uk/your-council--services/social-care-health/young-peoplefamilies/leicester-childrens-trust-arrangements/teenage-pregnancy-and-parenthood-partnership/teenage-pregnancy-documents>

## Methodology

The evaluation brief set out that Phase II of the evaluation of the Leicester Teenage Pregnancy Prevention Strategy would focus on three areas. After presentation of the Phase I findings, the Teenage Pregnancy Co-ordinator and Board, in discussion with the research team, decided to focus on services in two areas of the city - Eyres Monsell and New Parks and services for members of minority ethnic communities in Leicester. Eyres Monsell was chosen because there was thought to be a lack of services in this area. New Parks was chosen because it was thought to have a wider range of services available. The Board was also keen to find out about service provision as experienced by members of minority ethnic groups.

There were three strands to the second phase of the evaluation of the Leicester Teenage Pregnancy Prevention Strategy. These were:

- Consultation with young people
- Interviews with local practitioners
- Interviews with parents

The research was carried out in a variety of schools and community venues. Successfully carrying out the fieldwork and containing it within a six week period over October to mid November was quite demanding, so the methodology goes into some detail as a guide for anyone who may seek to replicate the work elsewhere.

### Research with young people

The evaluation plan set out the involvement of peer evaluators to carry out the fieldwork with young people. This also coincided with our values as Social Action Researchers, as we promote the active involvement in research of those people who would be most affected by the findings - young people. In particular, for them to be involved in deciding how and what information was gathered, as well as to have a role in the collection, analysis and presentation of the information.

There are many recognised advantages to carrying out peer evaluation work. One of the major ones is the opportunity to address the power imbalances that can exist within traditional research. This means that young people would not feel that they were powerless in comparison to those carrying out the fieldwork with them. It was hoped that working with young people as researchers would allow for interesting data to be gathered as young people would feel comfortable talking to researchers closer to their own age. Also young people would be able to offer their insights into the information collected as they were also part of the analysis of the data.

### Recruitment and Selection of Peer Evaluators

In order to recruit peer evaluators, posters and flyers were distributed to youth workers and youth agencies. All the young people completed an application form and were invited to an information and selection day, so that they could find out more about what the job entailed and we could make an assessment of their skills and abilities. In the event, the majority of young people who

came to the Information and Selection day came through the Connexions service. The Connexions Personal Advisors who put them forward were on the whole incredibly positive about the young people. This included one PA coming in from leave to ensure that her young person's application form reached us before the deadline. Fourteen young people came to the information and selection day; by the end 11 were still interested in the work and we felt all were suitable. In fact due to college commitments only 7 were available and these formed the team of peer evaluators. There were 6 young women and one young man and 6 of them were parents. One additional young evaluator was also recruited through a youth centre. She spoke several community languages, and was employed specifically to interview young people and parents from the black and minority ethnic communities. She worked separately to the core team of peer evaluators. Her findings are presented separately.

Employment arrangements including CRB checks, payment etc were organised through the local Connexions service. Funding was also available to pay for child care for those peer evaluators who had children. All the peer evaluators' expenses were paid. In the event, there were difficulties around being able to provide addresses for the previous five years for young people who had moved several times, and therefore CRB checks were not finalised in time for just over half of the young people. However, Connexions allowed all of the peer evaluators to take part on the project on the condition that they were not on their own with young people in the schools or community venues at any time.

### **Training of Peer Evaluators**

Four days compulsory training took place in order to equip the young people with the skills they needed to be peer researchers. The training programme was written to cover issues such as; why the evaluation was being undertaken, what was needed for an evaluation, different methods of gathering data, ethical issues and practicalities. The young people also tried out the exercises that could be used in a group session and used these to develop their own session to deliver with young people in some schools. During the training the young people worked with the CSA researchers to develop the questionnaire that was used in schools and community settings.

The young people also had the opportunity to gain accreditation with NOCN (National Open College Network) in 'Understanding Research Interview Procedures'. They could gain 2 credits at either level 2 or 3. Although the majority of the young people were initially interested in undertaking this, in the event, only around half of the young people were able to participate. Reasons for this included time pressures as most of the peer evaluators were young parents and some were already working, and also needing to have undertaken enough fieldwork to base their OCN report on.

### **Practicalities**

The CSA research team co-ordinated the practical arrangements needed for the research to take place. This included booking nursery places, organising taxis to take the peer evaluators to the research sites, and accompanying them for these sessions. The researcher also took along the paperwork such

as copies of the questionnaire needed by the peer evaluators and the copies of 'How to Survive at 16 +' that was given to all the young people who took part. The researcher also logged and authorised timesheets for the peer evaluators. We found using an office mobile phone to call and text the peer evaluators about the arrangements and generally keep in touch with them worked well for us.

### **Fieldwork - Negotiating access to colleges and youth centres**

It had been agreed with the TPP Board that we should try to negotiate access to a community college which would act as a focus for fieldwork within each area. However there could not be a direct college link for the Eyres Monsell area since young people from that ward attended a number of different schools, including county ones. Having consulted a statistician in the Education Department three possible city Community Colleges were identified which received Eyres Monsell students and Riverside Community College was agreed as the most practical one to approach. Two other city community colleges were also selected, one of which needed to have a significant proportion of students from minority ethnic backgrounds.

A letter signed by Sheila Lock Corporate Director of Children's Services and Hilal Barwany Project Manager Leicester Federation and Chair of TPPP Board explaining the purpose of the research was sent to the Principals of each chosen college before the end of the summer term inviting their cooperation with the research. One of the chosen colleges declined to take part, so an alternative college with similar characteristics was approached. A staff member of New College contacted us during the school holidays agreeing to take part in the research and we resumed negotiations in the Autumn term with Riverside and Crown Hills Community Colleges. Their Principals delegated the decision to take part in the research to the key members of staff responsible for SRE and PSHE within the school and eventually, after persistent communication, consent was obtained and a relationship was forged with the key teachers in each of the three schools – Riverside, New College and Crown Hills.

It soon became clear however just how much work pressure these staff were under and the difficulties of communicating with individuals who had teaching commitments and so could not guarantee to be near a phone during working hours. One teacher could provide a window of possibly half an hour's access by telephone each day at lunchtime, but the two others very soon expressed a preference for communication by email. This however did not necessarily guarantee a speedy response to queries, due presumably to the volume of other school business. Each teacher however showed strong commitment to the research and cooperation with the research team. They had the ultimate responsibility for informing their students about the research and encouraging their cooperation and also arranging for parents to give their consent for their children to take part (see page 7 for more information about the process of consent).

In all three colleges this eventually resulted in dates for the peer researchers to attend sessions at each school being agreed, parental consent or otherwise being confirmed and young students from the college being available to take

part on the day, mostly having already given their consent and being aware of the purpose of the exercise. This was a time consuming process but, given the chances of a whole range of things going wrong on the day, the fact that all three sessions at Community Colleges were successfully achieved as initially arranged is something of a tribute to the partnership developed between school staff, the CSA research team and the peer researchers.

### **Fieldwork in community venues**

It was agreed to arrange for the peer evaluators to interview young people in community centres in New Parks and Eyres Monsell and also centres catering for minority ethnic young people in St Matthews and Highfields. The Asian young researcher also interviewed Asian young people at the Jain Temple in Leicester. We did not conduct any special sessions with looked after or excluded young people since these had to be dropped as a consequence of our revised budget for the research.

These community contacts also took some time and effort to arrange since it took a while to contact busy youth workers and convey to them a sense of what the research was all about and what we would require of them. Practitioners working outside of the 'hotspot' areas tended to have less direct knowledge of the work of the Leicester Teenage Pregnancy Prevention Strategy. We also had to rely on them to enthuse their young people sufficiently for them to agree to take part, since we would be working with them in their own time without the framework of SRE lessons in school. We then had to match their proposed session times to when our peer researchers could be available.

In New Parks we arranged a session with the New Parks Youth Centre Focus Group and the Allexton Centre on one of the Choices clinic days. Arranging sessions in Eyres Monsell took a while longer. With the fine weather in late October, youth workers reported that they were having very low attendance at youth sessions and we needed to delay our contact with them for a few weeks. In one case we were reliant on the youth worker organising a late afternoon session with any young people were around at the time, since the regular 7-9pm meetings did not suit our peer researchers with childcare responsibilities. We eventually organised sessions with the Eyres Monsell Area Youth Panel which has representatives from all the youth centres in this area and a late afternoon session at the voluntary sector Clubs for Young People.

When organising interviews in areas with a predominately minority ethnic population, we aimed to try and balance as much as practical the various ethnic and religious groups, so that we had interviews with Asian young people who belonged to the Jain and Muslim religions and a group of African Caribbean young women. Both the Contact youth centre in St Matthews and the Ajani Woman and Girls Centre in Highfields recruited young people for us who were willing to be interviewed and set up sessions for us. The Ajani Centre at that time was not working specifically with teenage young women, so their ability to bring together a small group of that kind, at a time suitable for our peer researchers to interview was particularly valuable.

Although we interviewed relatively small numbers of young people at each of these community sessions, in total they helped to broaden the range of backgrounds of the young people who took part in the research. All the youth workers involved were particularly helpful since they not only took on the extra work of preparing and arranging these sessions for us, but also found additional time to be interviewed for the practitioner views section of the report. In a similar way to the schools, a partnership was built up which enabled all the community sessions with the peer researchers to take place successfully on all the days and times that had been arranged. A payment of £50 for each of the community groups who took part is being arranged.

### **Issues arising in the fieldwork with young people**

There were some issues particular to carrying out fieldwork with young people. The issue of consent is always important when considering carrying out research with young people. We had to ensure that the young people who took part in our research freely gave their informed consent, and that the peer researchers were sufficiently trained to obtain this.

Young people were informed at the start of each questionnaire or group session that they could stop at any time, or could choose not to answer any questions if they wanted. In other schools sessions took place in lesson time and so it was important that young people knew that they were not under any pressure to take part.

We designed information leaflets and consent forms for young people and tried to make these accessible through the use of age-appropriate language and definitions. Despite this, at a group session in one school, half the young people opted out of taking part. When discussing this with the teacher afterwards, we found that they had been made nervous by the formality of the information sheet and consent form. These elements needed to be present for ethical purposes; however in the future if we had a longer timescale on a project we would aim to make the sheets more young person friendly and involve the peer evaluators in creating them, which was not possible in this case due to pressures of time. Parents of children taking part in school sessions were also sent information sheets and consent forms giving them the opportunity to opt their children out of taking part if they wished. At Crown Hills where the young people come from predominately Muslim backgrounds 10 parents chose to opt their children out of participation in the research. This did not happen in the other two colleges however.

We also offered young people the opportunity to be interviewed in pairs rather than individually. However, in practice we found this did not work well once the peer researchers started going out into colleges as they found there were difficulties involved in interviewing two or three young people at the same time, in terms of being able to write down all their comments. Although this was introduced because the researchers had found literature advocating this when talking to young people about sensitive issues, it was not used on all occasions as it was easier for the peer evaluators to carry out an interview with one young person at a time.

Group sessions, individual interviews and joint interviews were held in colleges, while individual and joint interviews were conducted in community settings such as youth centres.

### **Analysis of the information from young people**

Questionnaires were inputted into a computerised qualitative analysis package called NVivo. Findings are presented according to topic and divided into findings from the group session and interviews. The peer evaluators attended a day towards the end of the fieldwork phase where they went back through the findings and commented on why they thought we had got the information that we had collected and what its meanings were. Their analyses and recommendations are also presented in this report.

### **Interviews with parents**

We obtained the views of some parents from New Parks, Eyres Monsell and people from the minority ethnic communities. Our sample of parents comprises 14 – 4 white British and 10 Asian people.

We had initially hoped to use the schools as a means of making contact with parents of teenagers, but the amount of time and effort it was taking to arrange the peer research fieldwork soon made it obvious that this was unlikely to happen. We placed some details about the research in the school newsletter put out by New College and invited parents to get in touch with us if they were interested, but received no contacts. Pinpointing parents of teenagers between 13-18 within community settings proved difficult and for ethical reasons we could not offer any financial inducements for them to take part, although we did provide a small value High St voucher as a 'thank you' after the event.

We eventually made contact with the STAR Tenant Support teams in both New Parks and Eyres Monsell who agreed to help us. They were able through their records to identify potential interviewees who had children of the right age and staff approached them individually to see if they were interested in taking part. This took several weeks to organise. Initially STAR staff suggested that they had found 7 parents from each area for us to interview. However by the time it came to confirming the arrangements most of them no longer wished to take part. It is unsurprising in areas such as New Parks and Eyres Monsell that parents with busy demanding lives had other priorities to getting involved in research without any obvious benefit to themselves. In the event staff from Eyres Monsell found two women for us to interview and staff from New Parks offered 4 names of two women and two men. The men when contacted turned out to have less knowledge about and interest in the research than we had anticipated so they were not interviewed. This meant 4 white women - two from each area – took part in telephone interviews. This was now so close to the end of the fieldwork period that no other attempts were made to find more parents in either area.

This sample of 4 is very small indeed and cannot be representative of majority views in either area. However the women in both wards had very similar views and attitudes and most of them had apparently had children themselves



at an early age. All of them were committed to taking as many preventive measures as possible with regard to their own children, which may be representative of at least one shade of opinion and experience in the New Parks and Eyres Monsell communities.

It was felt to be important to obtain the views of Asian parents and in the event it proved possible to interview 10. Five of them were recruited and interviewed by the Asian researcher comprising 4 women and one man who had Jain, Hindu and Sikh backgrounds. A community health worker in Spinney Hills was successful in recruiting 5 Muslim women to be interviewed and these sessions were conducted either by telephone, or face-to-face in their home, or at centres of various kinds.

In view of the sensitive nature of the content of the research it will be obvious that this sample is likely to be self selecting, in that people who disapproved of these issues being discussed or investigated would not volunteer to be interviewed. It is the case therefore that virtually all the Asian people interviewed, although still acknowledging the cultural constraints they experienced from their background and community, were open to discussing sexual health education and services. While they recognised their views were not necessarily representative of all members of their community, they illustrate the diversity of opinion that does exist and which can be tapped into when engaging with this community.

### **Interviews with practitioners**

We conducted a total of 12 interviews with practitioners. These comprised 5 mainly youth workers from New Parks and Eyres Monsell and 5 workers from Belgrave, St Matthews and Highfields. Of the latter 5, one was a voluntary youth leader, two were health workers including one from St Peter's Clinic, while the rest were youth workers. The remaining two practitioners were staff from two of the participating colleges.

In a number of cases these were the same people who also were arranging sessions with the peer researchers so the interviews had to be fitted in between the other arrangements. Most of these interviews with youth workers had to be rearranged more than once because of pressure of work, in one case three times, but all were eventually carried out. Workers were asked about their knowledge of young people's use and perception of sexual health services and the sexual health resources available in their neighbourhoods.

We hoped to interview school staff in all three Community Colleges to obtain background information about the SRE lessons they provided and their perceptions of young people's needs. They were the same teachers who we worked with to arrange the sessions with the peer researchers and so their work pressures made this difficult for them. In the event we managed to obtain information from staff in two colleges. In one college we conducted a telephone interview with a full-time first aider who was also the Healthy Schools coordinator, who had been at the College for longer than the staff member who arranged the peer researcher sessions. She did not have teaching responsibilities, but nevertheless the interview had to be done in two

stages because of demands on her time. In another college the teacher responsible for PSHE completed a question schedule by email over several weeks, but this did not allow for any probing of the answers. The third college staff member did not respond to our request for an interview. The two separate demands of this research undoubtedly created considerable pressure on already fully stretched teachers.

## Information from young people consulted at school and in the community

This section draws on information gathered from young people using questionnaires, group sessions and a booster sample of young people drawn from the diverse communities of Leicester.

### Who took part in the consultation

In total, 84 young people contributed to the evaluation. 45 questionnaires were completed with 48 young people, and 30 young people took part in the group sessions. Six young people also took part in a booster sample of young people from black and minority ethnic groups.

#### Total numbers of young people who took part

Gender	Number of people
Male	28
Female	56

Age	Number of people
13	5
14	22
15	26
16	6
17	8
18	4
19	3
20	1
Mixed age group answered	2

Target group	Number of people
Eyres Monsell	14
New Parks	23
Black and Minority Ethnic community young people	11
Black and Minority Ethnic community Booster sample	6

Ethnicity	Number of people
British	42
Irish	1
Mixed white black Caribbean	3
Mixed white black African	1
Mixed white and Asian	1
Mixed other	1
Indian	18
Pakistani	1
Other Asian	2

Turkish and English	1
Black Caribbean	3
Black African	4
Other black	1
Other ethnic group	British Other ethnic group
	British Irish
	British other black
	British Indian
	Skipped question

<b>Religion (self categorised)</b>	<b>Number of people</b>
Christian	11
Muslim	9
Rastafarian	1
Sikh	2
Sikh/ Hindu	1
Jainism	5
Hindu	6
None or none given	49

### **Peer evaluator questionnaires**

The team of Peer Evaluators carried out 45 questionnaires with 48 young people in schools and community venues. 33 females and 15 males completed questionnaires.

Interviews via questionnaires were carried out in schools and community sites in the two geographical areas and to gather information from Black and Minority Ethnic young people. The number of questionnaires completed in each area varied depending on the number of people who attended community sites, the number of young people who opted out of taking part, and the number of sites who were able to accommodate the peer evaluators during the fieldwork phase. For this reason, different numbers of questionnaires were completed for each group. 14 were completed in Eyres Monsell, 23 in New Parks, and 11 were completed in the Black and Minority Ethnic community group. (Full details of the sample are presented in Appendix IV a).

### **Group sessions**

Three group sessions were held in schools by the peer evaluators. A total of thirty young people took part. Eleven were male and 19 were female. They were aged between 14 and 16 with the majority being age 15. (Full details of the sample are presented in Appendix IV b).

### **Black and Minority Ethnic groups Booster Sample**

Six young people also completed questionnaires as part of a BME Booster sample. There were four females and two males in this sample. All six gave their ethnicity as being Indian. 5 gave their religion as Jain, and 1 young person was Hindu.

In the main, the results from this group will be presented separately as these questionnaires were carried out by a researcher working separately to the team of peer evaluators.

## **Findings from the young people**

### **Sex and Relationship Education (SRE) in school from teachers**

The young people were asked what Sex and Relationship Education (SRE) they had received in school, when they had received this and what they thought of it.

The types and models of SRE described in the young people's responses reflect their memory and impressions of it from the various schools which they attended. The research does not reflect SRE practice in all schools in Leicester, but the experiences of young people from areas of the city which have been officially designated as high risk areas in relation to teenage pregnancy, and also that of young people from communities where there is a particular need for good quality SRE in schools because of their restricted access to this information elsewhere.

29 young people said they had had SRE delivered in school. One young person reported not receiving this because they were home schooled. In other cases, this could be that the young people do not remember that they had received any SRE, or that indeed they had not.

The ages when young people received these lessons ranged from year 5 (ages 9-10), year 8 (12-13 year olds), year 9 (13-14 year olds) and year 10 (14-15 year olds). There was little evidence of participants receiving sex education below the age of 9.

Some young people thought the lessons were useful and interesting, saying this was because the lessons had been informative. However, others did not agree. Reasons for the more negative opinions ranged from lessons not being informative enough, being useful but not at their age, or being boring. Young people seemed to value the information that they received and were more negative about sessions that they felt were not informative enough.

In the group sessions, young people were asked to take part in a number of individual written exercises and group activities. In one exercise, young people were given a picture of a suitcase and asked to write down all the things that they had taken away with them from their Sex and Relationship Education (SRE). Responses included:

- Legal age for having sex
- STIs
- Contraception- condoms, femidoms, pills
- Abortion
- The mechanics of sex including erections
- Pregnancy and birth

- HIV and AIDS
- Rape
- Puberty and periods
- Teenage mums

Abortion was mentioned by a few young people. This was interesting as it was not a topic that came up very often considering the subject being discussed. The peer evaluators discussed this as part of their analysis and recommended that information also be provided to young people about what is involved in having abortions in terms of the procedures and feelings involved.

Sexual assaults were only mentioned once. This topic was not raised with the young people as it was outside the scope of the research; however it may highlight a lack of education around negotiating safe sex and consent.

The young people who took part in the group sessions appeared to remember a greater number of topics that had been covered in their SRE sessions than the young people who completed questionnaires. There tended to be a certain amount of overlap between the answers in each group session, and it could be that the young people helped remind each other, and took reminders from the teachers where present, to remind them of what they had covered. Many young people in one group also talked about Turning Point coming in to teach them. There was some level of awareness of Turning Point in the questionnaire data though not a high level.

Several young people also commented on what they thought of the lessons:

- *Bit boring*
- *OK*
- *Interesting*
- *Interesting and informative*
- *Important*
- *The teacher could talk more about the diseases and risks when having unsafe sex*
- *It was boring most of the time, we watched videos and we just had to sit there.*

Once again, young people appeared to want more interactive teaching methods and several young people mentioned that they had practised how to put condoms on a model penis. This type of activity appeared to be one that did stick in the memory of young people.

In the group session the young people did an exercise to find out more about what they thought about aspects of sex education. The exercise called the four faces consisted of statements being read out by the peer evaluators and young people were asked whether they agreed, strongly agreed, disagreed or strongly disagreed with these.

The statements relating to SRE in schools were:

- I don't think relationships and feelings are discussed enough in sex education at school
- Single sex groups are best for learning about sex, relationships and contraception

Many young people agreed that relationships and feelings were not discussed enough in sex education at school. Young people commented that:

*"Don't talk about relationships, only what happens in sexual intercourse"*

*"Don't talk about feelings and marriage"*

*"Don't talk about how it begins"*

*"They always talk about bad things, not good things the relationship brings"*

Opinions on whether single sex groups were best for learning about sex, relationships and contraception were more varied. Some young people felt that it could be embarrassing to talk about these issues in front of members of the opposite sex. Others felt that it was important to learn about the opinions of both genders. There was no definitive answer either way about which was best. Overall, the delivery of interesting, interactive information about sex education that covered a wide variety of topics and allowed for young people to talk about relationships as well is probably more important to young people than having single sex groups for these sessions.

#### Eyres Monsell interviews

Eleven questionnaires from young people living in Eyres Monsell discussed SRE delivered in school. These are likely to represent a number of different schools including possibly county ones in view of the dispersed education this group receives.

Young people remembered SRE in schools from teachers covering a range of topics including STIs, penis and condoms, how to put condoms on, different types of contraception, AIDS, periods. Also some mentioned pregnancy, babies and what it is like to be a parent.

Young people had a range of opinions of these sessions describing them in the following ways:

- *Rubbish*
- *Interesting, learnt a lot*
- *Quite interesting, you feel it's important because you need to know for personal experience*
- *Educational, think learned from it and made me more aware of AIDS which is not spoken about enough.*
- *Very good*
- *OK at the time*
- *Useful information*

#### New Parks interviews

Eleven questionnaires from young people from New Parks discussed SRE delivered in school. Very little SRE had been provided in the local school New College in the current year, so lessons discussed probably took place in previous years. Young people remembered SRE from teachers including a

range of topics. They mentioned contraception, sexual intercourse, STDs, how to use contraception, pressures to have sex, puberty and periods as well as safe sex. They also mentioned the use of video as a teaching method,

*"Watched a video of a woman having a baby and cartoons about having sex then teacher asked if we had any questions."*

Young people commented that it was:

- *Useful but not at this stage*
- *Alright*
- *Funny at the time, didn't really take it on board*
- *Good, learnt a lot*
- *Boring, quite helpful*
- *Ok, not very informative*

#### Black and Minority Ethnic young people's opinions

Seven questionnaires from the Black and Minority Ethnic sample discussed SRE delivered in school. These young people were interviewed in the community and attended a range of neighbourhood state schools as well as private schools.

All had some SRE from secondary school. Two young women mentioned lessons in primary school as well. They remembered SRE in schools from teachers as covering contraception, periods, the science side of things, how to use a condom, STI. Once again they had been shown videos and one mentioned the information had been given in a science lesson.

SRE lessons were regarded as OK but not always very informative, sometimes they felt that the information was not matched to their age very well. Young people said they thought that it was:

- *Not informative*
- *Crap*
- *Embarrassed.*
- *Not much detail but OK*
- *Wasn't very informative*
- *Could have been better.*

Young people from the Black and Minority Ethnic groups were on the whole least positive about their experiences of SRE in school from teachers. Otherwise, topics covered appeared to be broadly similar, though again, less topics were reported by young people in this group. Suggestions for improvement to SRE in schools included making sessions more informative and interactive and ensuring more emphasis was placed on SRE in the curriculum.

#### **SRE in schools from outside groups**

Young people reported that they had had SRE lessons in school from Connexions, Health Visitors, School Nurses, Turning Point and a local nurse.



They remembered these sessions talked about different forms of contraception and how to use them, abortion, Tampax, babies, and periods.

In some cases young people could remember someone had come in, but were not sure who however they did remember the topics covered - STDs, contraception, talking about condoms and the pill and being given condoms. Young people again tended to be positive about these sessions they had received. Turning Point was praised for talking about relationships and the real effects of being a single parent. Other lessons were praised for using equipment to demonstrate the proper use of condoms which made the information easier to understand. Young people again appeared to be positive about the vast majority of these sessions because they were provided with more information.

### **Sex education outside school**

Fewer young people said they had received sex and relationship advice and information outside school. Those who did report this received it from:

- Their mum
- When their sister had a baby
- Allexton Youth Centre
- Magpie Centre
- Youth workers
- Street Vibe Youth Project
- Friends
- De Montfort University (possibly via a student on placement in New Parks.)

All 8 of those who reported receiving information at a youth club or from a youth worker answered their questionnaires while at a youth centre. Advice ranged from not to have sex (from their mum) to getting leaflets and learning about contraception and STDs.

### **Who do you think is the best to give information about sex and relationships?**

Young people were asked who they thought were good people to give them information about sex, contraception and relationships. Their answers are presented in the table below.

<b>Who is best to give you information?</b>	<b>Total number of people for ages 13 to 16</b>	<b>Total number of people for ages 16 +</b>	<b>Total number of people for mixed age group questionnaires</b>	<b>BME booster sample total number of people</b>	<b>Total number of people</b>
Nurse/ doctor	12	9	1	6	28
Parent	12	7	1	1	21
Youth worker	10	5	1	4	20
Friend	7	7	0	3	17
Teacher	8	2	0	4	14

Connexions PA	5	3	0	2	10
Magazines	2	2	1	2	7

Other sources of information they mentioned included school, outside agencies coming to youth club, 'people who know', and relatives for example a brother who just had a baby, an Auntie or a cousin.

Family and friends appeared to be considered the best to provide information about sex and relationships. Nurses and doctors were the single most popular choice, and this could be related to the information gathered by the next question that young people were asked about who they felt comfortable talking to about these issues.

### **Who young people feel comfortable talking to about sexual health and contraception**

Young people had answered in the previous question concerning who they thought was best to give them advice; in this question they were asked whether they felt comfortable talking to the people they had suggested. 37 people replied 'yes they did'. Other comments showed what a personal issue it was and included:

*Not with parents but comfortable talking with the doctor and youth worker*

*Comfortable talking in a group*

*Comfortable talking to parents but not sure about doctors*

*Yes but comfortable talking about different things with each person*

One person who thought youth workers were best placed to give this information had not found a youth worker themselves that spoke about these issues.

When discussing these results with our Peer Evaluators, they thought that young people felt confident talking to people where they had confidence that what they discussed would be kept confidential, and that this was why nearly half our sample had reported that they thought that doctors and nurses would be best placed to give information. They also thought that there was some amount of mis-match between those who young people thought were best to give them information and those they actually reported feeling comfortable talking to. They felt that young people wanted to be able to talk to their parents more than they actually felt able to. The peer evaluators suggested working with parents to make them feel more able to talk with their children about sex.

One part of the Four Faces exercise was young people responding to the statement 'Teachers are the best people to talk to us about sex, relationships and contraception'. There were concerns raised in one school about the confidentiality of talking to a teacher about sex, relationships and contraception. A young person had discussed an issue with a teacher and this had become known in the school. This had damaged the trust other young people had and they reported that they no longer felt comfortable talking to teachers about these issues. This again highlights how important

confidentiality is to young people and how it affects who they feel they can talk to.

Also in the group sessions young people were asked to draw someone with traits that would show who or what their ideal specimen was for delivering information and advice about sex and relationships. There were a number of traits that were mentioned on a number of occasions. These included:

- *Being a good listener*
- *Good talker- can give good advice*
- *Friendly, happy, likes to smile*
- *Confidential*

Other ideal traits included one group who wanted someone with experience to talk to, although another group wanted someone young. The overall ideal appears to be someone who is young yet has the important information and experience and is approachable.

### **Do you feel you know enough about contraception and sexual health?**

Most (28) of the young people who answered this question in the interview said they did feel they knew enough about contraception and sexual health. Of the boys who answered this question, ten said that they knew enough, and four said that they knew some. Eighteen girls said that they knew enough, ten said they knew some, and three said that they didn't know enough. This suggests that levels of awareness are roughly similar for boys and girls though it is possible that girls are more likely to admit that they would like to know more.

Young people who felt they know enough made the following comments:

*Know more from experience*

*Read a lot of leaflets, have had kids, should know enough*

*Learn through speaking to friends and family*

*Because I have a kid now!*

Young people who said they knew some gave this additional information:

*Feel you can always know more (enough parents don't tell kids about)*

*Need to learn more about subject*

*Some little things don't know about (always learn more)*

*Just know the basics*

*Would like to know more about STIs etc*

*How to be safe*

New Parks was the only area where a few people (3) said that they didn't feel that they knew enough. Four out of the six young people spoken to in the Black and Minority Ethnic Booster sample said that they knew enough about contraception. One young person reported that they knew some, and one young person reported that that they didn't feel that they knew enough.

Comments from the young people in the Black and Minority Ethnic booster sample included:

*"I only know basic information e.g. you should use a condom to stop getting pregnant. I hardly know about any other forms of contraception, as in how to use them, side effects."*

*"I feel my knowledge about contraception has improved especially through the practical presentations "*

*"They should cover stuff at school as I hardly know anything, I didn't even know what contraception meant until you just told me! It's hard to talk to parents so that's why I think schools should do more lessons surrounding it."*

*"I feel that currently I am equipped with more than enough information as I don't think I would really be having sex before I got married anyway."*

One of the Four Faces statements in the group sessions (see p14) asked young people to consider if there was enough information for young people. The statement read 'There is enough information about contraception and where it is available for young people'.

There was some level of agreement that there was enough information available about contraception; however comments included that there was not enough information provided outside school. Other young people commented that there are plenty of leaflets but that young people needed to be informed of where they could get contraception free of charge.

Overall, the majority of young people felt that they knew enough about contraception and sexual health but there was a clear need for more information, with many young people commenting that they knew about some things but would always welcome more detailed information. Some of the comments from those who felt that they knew enough were based on the young person having found out because of their experiences or because they are already parents. Clearly, it would be preferable for young people to have enough information to prevent unplanned pregnancies rather than being wise after the event. Others might also seek to find out more information at the time they needed it, for example talking to a teacher when they wanted to know more, or seeking further advice when they became sexually active after marriage.

### **Why do you think teenagers get pregnant?**

Young people were asked in the interviews why they thought teenagers got pregnant, their responses included:

- *Lack of sex education, need more awareness, think it is a good thing*
- *Stupid, want to grow up fast.*
- *Peer pressure/ pressure to have sex*
- *Don't know all the facts*
- *Accident*
- *Didn't use contraception*
- *Drunk/ taken drugs*

The Peer Evaluators felt that a collection of responses from the young people could be grouped together and classed as 'unrealistic expectations' of what would happen if people had a baby:

- *Being popular/ having friends*
- *Getting a house*
- *Getting money*
- *Didn't want to work/ to leave school*
- *Helping relationship*
- *Trapping boyfriend*
- *Feeling loved*

Comments from the Black and Minority Ethnic community young people in the booster sample as to why teenagers got pregnant included:

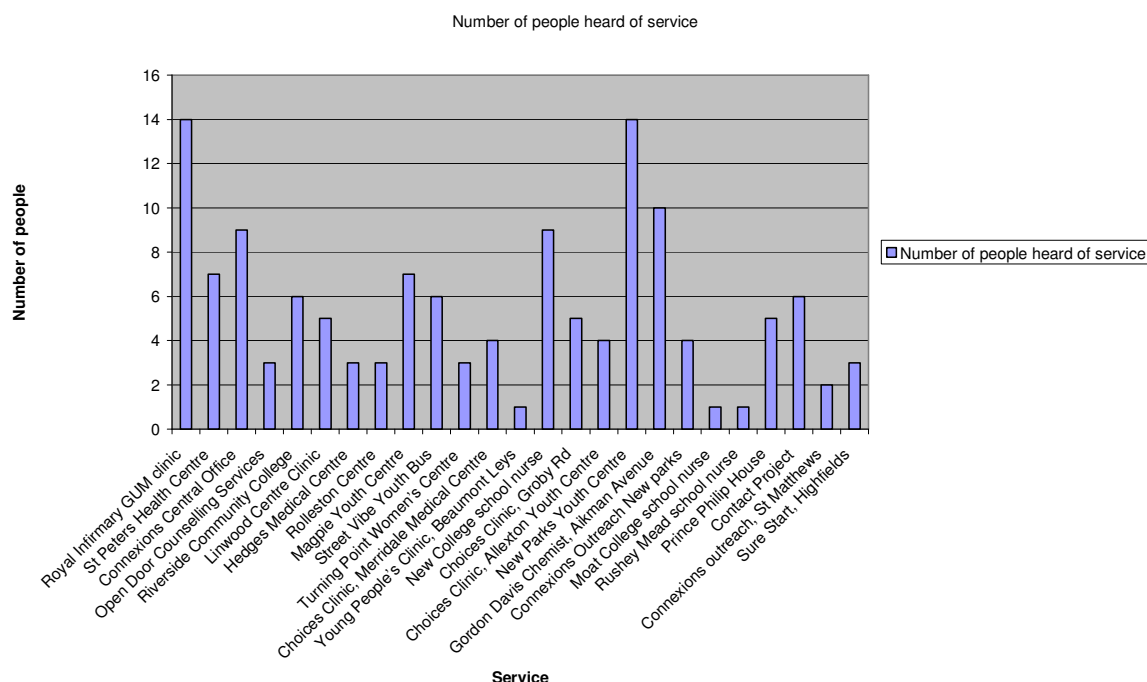
*"I reckon it's because of stupidity of young people or maybe they are unable to afford contraception. Also some young people think it's cool to be pregnant or want to gain benefits from having children (money from the council). In other cases it could be that they want to be parents. Although, it's more likely, that they don't know where to go for advice i.e. lack of awareness about where clinics are and what support they can offer".*

*"Because of lack of knowledge, could be the most obvious reason but I also think it's because of immaturity of the person. It could be because they want to experiment ... Also another reason may well be peer pressure".*

These highlight key areas for future service developments, both in terms of the needs of young people for sex education in order to avoid unplanned pregnancies, and also in terms of tackling unrealistic views of young people around what would happen if they were to become young parents. Young people who had received information about this, such as that provided by Turning Point, welcomed the opportunity to learn about the reality of being a young parent.

### **Services young people had heard of**

In the interviews young people were shown a list of sexual health and contraceptive services and asked which they had heard of. This graph demonstrates the level of awareness of services found by the peer evaluators.



These findings should also be seen in the context of where questionnaires were carried out. It is entirely probable that few young people had, for example, heard of school nurses services at Moat College or Rushey Mead School because no questionnaires were carried out at these schools. It does highlight however that some services, for example Connexions central office, St Peter's Health Centre, New Parks Youth Centre and Gordon Davis chemist are either useful sources of information and contraception or young people, or have found useful methods of advertising their services to young people.

Looking at the information found by the team of peer evaluators, it was found that on average 3.2 services were mentioned per questionnaire. Girls were on average aware of slightly more services than boys. The difference between the number of services young people on Eyres Monsall and New Parks had heard off was not great. The levels of awareness within the Black and Minority Ethnic booster sample were much higher than the levels of awareness of any other group. This could be an artefact of the research, perhaps the young researcher working separately to the core team asked this question in such as a way to gather more information than that found by the core team, or perhaps there are differences in levels of awareness between those groups. This does suggest an opportunity for further investigation in the future. (See Appendix IV for further breakdown of the figures)

### **If you have used any of them, what did you think of it?**

39 out of 45 questionnaires contained an answer to this question. Just over half reported that they had not used any of the services. The questionnaire was deliberately designed not to include any questions that were felt to be overly personal, and so it is not possible from our findings to state whether these young people did not use services because they were not yet sexually active.

Other comments included:

- *St Peter's is alright but get shy getting contraception from them in a brown paper bag*
- *Contact project is helpful and supportive*
- *GPs are very helpful*
- *Choices nurses were good, felt comfortable due to the way they approached me*
- *New College school nurse- really put mind at rest on queries*
- *New Parks Youth Centre- really helpful*
- *New Parks Youth Centre- useful for what I need*
- *Open Door- very informative, made feel comfortable*

Again, young people appeared to be positive about the services that they had accessed. Recommendations included the need for free contraception and leaflets to be provided in nice packaging that did not identify the contents, i.e. not brown paper bags.

### **How did you hear about services?**

Friends, fellow students and at school as well as youth workers were the major sources of information about services for the young people we spoke with. Young people could say as many as they wanted.

The full breakdown is presented below.

<b>How did you hear?</b>	<b>Number of people</b>
Friends	19
School/ fellow students	10
Youth club/ worker	8
Family	5
Connexions	4
Near where I live/ pass them	3
Generally knew it/ word of mouth	2
The places themselves	2
Leaflets	2
Specialist	1
Girls session	1
Teacher	1
Other	Because is it a hospital Normal doctor Streetvibe team Every chemist sells condoms Through this focus group Doctors all her life and youth centre where she goes and chills

It can be seen that friends, schools and youth clubs and workers are very important sources of information for young people. Schools and youth clubs could be targeted with publicity about services in the future as these appear to be places where young people find out about services.

### **Do you think there are things stopping you using these services?**

22 young people said that there was nothing stopping them from accessing services. Some linked this to their age, others to their levels of self-confidence. However, suggestions around making services more accessible may still benefit these young people by making their use easier.

Responses from young people who felt there were things stopping them use services can be split into personal reasons for not going and reasons related to the service itself for example embarrassment (this was quite a common response to this question) unconfident and finding it scary to walk in.

Young people from the interviews felt there were some constraints on their using services and these included opening times and having to travel to the service. Confidentiality was important to young people, as was not having to tell a lot of people their business in order to access the service.

In the Black and Minority Ethnic Group Booster sample two of the oldest young people were explicit about cultural taboos about talking about sex and having boyfriends which they saw as the main barrier. The other young women were anxious about being seen to be using such places and talking about personal things to people they didn't know.

### **Suggestions for improvements**

Young people were asked about making it easier to access services. Responses could be grouped into three different sections –venues, staff and provision. This information comes from both the interviews and the group sessions. Some young people also said that they needed more self confidence to help them access services. However, some young people reported that they already felt comfortable going so did not need any changes.

With regard to venues a number of young people wanted venues to open longer and for more varied hours and some suggested services open 24 hours a day. They also mentioned different sessions for different ages (e.g. 12-15, 16+) and one suggested women only sessions. They suggested services to be run out of centres that were also used for other purposes such as youth centres, and drop in centres. They felt it would be easier to use services if they were not too clinical looking, relaxing, music playing, welcoming or had a separate waiting area. They wanted somewhere discreet '*somewhere where you feel safe*'. They also wanted to be able to go with someone else.

The recurrent themes about desirable qualities for staff offering sexual health services was that as people they should not be judgemental and should be easy to talk to, as well as being more understanding of young people and patient – '*Down to earth - not uptight*' or '*Staff more laid back*'. It was suggested that more women staff would help and a few mentioned that having young people working in sexual health and contraception services would make it easier for them to use them, as they wanted staff more on '*our level*' and with personal experiences. Other things they mentioned were the need to feel more comfortable and relaxed and have more encouragement.



With regard to provision they wanted a place where under age young people could get contraception in confidence, more promotion such as posters and pieces in the newspaper, and more local services. Young people felt there was a need for free contraception and more information about both services (including knowing centre opening times) and contraception. They wanted simple booklets, leaflets to be given out in town. They suggested being able to get information from the library, they suggested telephone lines or an internet service to help preserve anonymity.

One group was asked to rank their ideas in order of importance. The highest priorities for a service were for free pregnancy tests, contraception and STD tests. The next most important factor was around making services easier to access through having longer opening times and being open on more days. Young people then wanted places they could go with friends. After that, they ranked bright places with different waiting areas (so not waiting with other patients, for example in a GP waiting area, as then everyone would be there for the same reason). After this came having different sex groups when accessing services. The least important change they wanted was having music playing that was suitable for people of any age.

The peer evaluators explained that young people found it hard to access services sometimes. It was easy for young people to access services in school, but that outside of school their parents would often want to know where they are. Services needed to be available at times and locations that young people could access them, or be available in locations that young people were able to go to anyway, for example in youth clubs.

### **Would you like to be more involved in making services better?**

Young people were asked if they would like to be more involved in making services better. 34 people said that they would. This raises the point that there may be a large number of young people in Leicester who would be willing to dedicate their time to helping improve services.

### **Conclusions from consultation with young people**

Key themes from this evaluation appear to be that young people appreciate any information and services that they can access, yet there is a strong demand for more of both. Young people are keen to find out more about sex, relationships, pregnancy, STIs and the realities of being teenage parents. They are keen to have more accessible services and to be able to contribute to making these easier for other young people to find out about and use.

## What Parents Told Us

The interviews with parents were designed to explore their views on the sex education lessons their children received at school and the other kinds of services they thought might be helpful.

Having identified that there were Asian parents who might not necessarily allow their children to take part in sex education lessons our question schedule for parents was structured in three sections. The first two questions of the first section that all parents were asked aimed to explore their awareness of the aims of the teenage pregnancy prevention strategy. They were then asked if they had given their consent to their children taking part in sex education lessons at the schools they attended. Depending on their response to this they were then asked questions from two separate schedules. (See Appendix III)

In the event only one parent in this sample - an Asian Hindu mother - expressed the desire to withdraw her child from these lessons on religious grounds. However it emerged during the interview that she had not actually been given the opportunity to do so by the private school in question. Nevertheless we did ask her the questions from the “children withdrawn” schedule so that we had a sense of some of the reasons for these views. The 13 others, Asian and white British parents were all asked the questions from the “children not withdrawn” question schedule.

### **Awareness of Government teenage pregnancy prevention strategy**

Parents were asked if they were aware of the Government’s initiative to reduce the number of teenage pregnancies. Two out of five of the non Muslim parents were aware of the Government initiative. Four out of five of the Muslim parents had heard of the initiative. Three out of four of the white British parents had also heard about it

This indicates a degree of awareness of the national strategy among these parents. However, none of the parents had any clear sense of what was being done locally to implement the strategy.

Parents were then asked to comment if they agreed with the government that it was undesirable for teenagers to have children at that young age (for Asian parents it was specified this was outside marriage). All the parents were unanimous in their agreement with this. It was notable that all Asian parents placed more stress on the impact this had on young women’s choices regarding training and work than white British parents from New Parks and Eyres Monsell.

*“For teenagers under 18 – it’s a little bit too young, they are not grown up enough, they would be wasting their life away”* **Parent Eyres Monsell**

*“Yes definitely, I have been checking with other people, they should give prevention lessons. It is difficult for young parents, it has an impact on life, it lasts into your 30s and 40s, they miss out on opportunities”* **Muslim Parent**

*“Yes, because it increases responsibilities and can lead to job difficulties and therefore have financial problems which have an effect on both the mother and the baby. Young people should have a proper education and train before having children”* **Hindu Parent**

Parents were then asked whether they had agreed to their children attending sex education lessons in their schools. All the New Parks and Eyres Monsell parents had children at state secondary schools although one was a county community college. Of the 10 Asian parents, 6 had children at state secondary schools including one at a county community college, while 4 had children at private independent schools. All but one parent were happy to allow their children to attend sex education lessons whether in the state or private schools. The Muslim parents positively consented to their children's involvement in sex education either at state or private school

*“They do get sex education lessons – I am happy for them to take part but I believe children should have some knowledge from home”* **Muslim parent - child at private school**

The non Muslim Asian parents we spoke to whose children were at state school approved of their participation in the lessons, while the two whose children were at private schools did not think they had been given any choice in the matter.

*“I do not remember having a choice, but if I did have the choice I would say no. Because in our religion it says we should not teach our children about these sort of things. I think this sort of information would be better provided by people in the community or by the parents or friends of the family”* **Hindu parent - child at private school**

### **Parents' knowledge of the content of SRE**

Parents were then asked if they knew the type of issues that the sex education lessons had covered and whether their children had benefited from them. This question exposed some cultural differences in the readiness of parents in this sample to talk about sexual matters to their children at home and their awareness of the content of the lessons.

Most of the New Parks and Eyres Monsell parents wanted to be frank with their children about sexual health matters as they themselves had been young parents, and most have talked with children about the lessons.

*“My son told me a lot about it. He thought they were very informative the way they showed boys and girls how to use a condom – what contraceptives are, what the different types are like, how to keep safe and healthy. How sex involved love and respect – sex is fun and enjoyable but not involving a fly by night relationship. I thought it was excellent – the information they were about to provide for my son was wonderful. They did have an outside person who went in – this was a youth worker from one of the centre – someone the young people could trust – the other people doing it was the form tutor and the head mistress.”* **Parent New Parks - child at county community college**

*"She already knew everything by then because I had told her. I am encouraging her not to go down the same road as me. School didn't teach her anything – there were some very basic lessons at age 12 - they got more specific later on. ... The lessons need to be as explicit as possible - what the impact of having a baby at such an early age can do – should be full blown in-your-face – they did cover STIs. I have given more explicit information to my daughter. She didn't learn anything much at college, it was a non event, neither did her friends as some of them ended up pregnant."* **Parent Eyres Monsell**

Some parents were more informed than others about the content of sex education lessons.

*"I was happy about the sex education – they went to a faith based school, so it was different. They were taught about having sex within marriage, not having children outside marriage, told about cleanliness and periods, wet dreams, masturbation, relationships. They were told about respecting their body and looking after their body."* **Muslim parent - child at private school**

Some parents felt the lessons were not as helpful as they could be as some aspects were missed out. Like the young people themselves these parents suggested that the more emotional aspects of sex and relationships should be covered, others that there should be more about STIs. Some questioned whether the SRE was undertaken in the best way and whether there was a place for single sex groups.

*"They should make it more like a discussion and sit in a circle, not like a regular class. I have asked some colleagues at work – they were only told about the pill and pregnancy – they were not told about STIs and ways of protecting themselves. My children never told me about the lessons – I have not needed to ask. There could be an initiative from school to talk to the parents."* **Muslim parent – children at state schools**

Some of the parents who took part explained how rare it was within Asian families for parents and children to openly discuss sexual health matters; such closeness would require unusually self confident children and parents. They explained they would find it very difficult. Some parents expressed a concern that by talking about sexual matters they might encourage sexual activity. In some other cases parents were content for the school to teach their children about these matters however some remained vague about the details.

*"Teachers are able to put it across better than parents. It's hard as a parent to talk about these sort of things and for teenagers to listen to us!"* **Hindu Parent – child at private school**

Where the Asian parents were aware of the explicitness of some of the content of state school sex education, this came as a challenge to some of them. One however when giving it further consideration recognised such information might be necessary,

*"At first I was shocked as it was a little embarrassing and I felt it was too early, but in this country I feel it's a real issue and so it was useful."* **Jain parent – child at state school**

Some parents felt the information was given to their children too young; they felt they should wait a year or so before covering such issues.

*"The children were shown how babies were made, contraception and periods. I felt as if they were taught at a very young age. I feel that it would have been better if they were taught about these sorts of things at the age of 12/13. . . .I think it would have been better to show this at a later age as young people like to experiment."* **Sikh parent– child at state school**

*"The age at which the lessons are happening is important – I would like to know how they are delivering the lessons. Some children are very ahead but some are very innocent, they don't know about resources. There needs to be some assessment of groups – boys and girls should be taught separately. When I was in secondary school –I was taught in a mixed setting - it didn't help – there was too much information and I didn't understand."* **Muslim parent - child at private school**

### **Perceptions of wider community perspectives**

Since our sample only had one parent who would have liked to have withdraw her child from sex education lessons, we asked parents interviewed later in the fieldwork if they knew parents in their community who would prefer to withdraw their children from sex education lessons at school and what reasons they would give for this action. All these parents were Muslims. They felt that such parents might be anxious about what their children would be taught – for example if it might cover issues such as homosexuality, or they might fear that the young people might consider talking about sex outside marriage and contraception condoned sexual behaviour and could lead to experimentation.

*"They are worried about what their children will be taught, concerned about what information they will be given and at what age. They are concerned about the child losing their innocence. Parents don't know what they will be taught – perhaps they should know – parents need to be open and approachable."*

One Muslim parent said that she had changed her views on the issue.

*"I did think like that myself before coming to England. In the last 4 years however since working in my charity I have become far more aware of what is going on –I now think it is a good idea."*

A few parents said they felt that such parents needed to change their views and that sex and relationship education was important for young people in their community. One Muslim parent felt strongly that her community needed to accept the reality of their children's lives in modern Britain and not try to shield them from the experience.

*"In the Asian community Hindus and Sikhs are moving on a bit – but Muslims seem stuck – they are not moving on. They will use religion as an argument - but they are not using the needs of the society. What do we expect of our children? We are not living in the 1930s - we are not living in a religious environment outside – we have to have open minds - my children are influenced by the society around them. We cannot have control over what children learn and do. We should help and support them but we don't do it in reality. School should have involved parents more – it would open up a dialogue. Because children are afraid they don't come to parents when they get into trouble and the parents are afraid of what the family and society will think of them and worried about who will marry them."*

### **Community based sexual health services**

Parents were asked whether they would support community based sexual health services for their young people and whether there were sufficient services of these kinds available locally.

All the white British parents supported the idea of locally based youth sexual health services and were mostly relaxed about their young people potentially accessing condoms from this source. Two felt that these would be a more acceptable source of information for their children than either schools or parents.

*"I would say so, lots of times kids can't talk to their parents – it would be somewhere to go to talk to someone."* **Parent Eyres Monsell**

*"Yes – it's probably easier if schools are not involved –I'm happy for them to get condoms there."* **Parent New Parks**

One parent and her son in New Parks was already receiving advice on sexual health issues from a Connexions worker and felt that there were services available for young people to use in the area. They mentioned the youth club, the health clinic and Connexions.

There were different views from parents in Eyres Monsell however, who felt there was a lack of services and information, and particularly commented on the loss of services in the area,

*"Services around here seem to be disappearing slowly – the chemist doesn't provide emergency contraception any more –even though an abortion costs more on the NHS than providing emergency contraception. . . You need to have more leaflets about for some that don't use youth clubs or mix with the 'good' kids.. . You have to blast everywhere with leaflets, put them up in hairdressers and supermarkets where young girls go, everywhere that will have them – kids don't read papers, no good having adverts there – youth centres should have them - saying what services are available."* **Parent Eyres Monsall**

She had been concerned enough about the situation with her daughter's friends where there seemed nowhere they could go, to take some very practical action on her own initiative

*"I have bought pregnancy testing kits and had my daughter's friends round using them in my house and seen the look of relief when they find it is OK. They can't just be left to pretend it is not happening to themselves. I have sat there and talked to them for an hour – what are you doing with your life?"*

**Parent Eyres Monsell**

One parent commented on what might be useful for young people, but like some other parents was concerned that giving contraceptives to young people under 16 could possibly encourage sexual activity.

*"I'm not sure – a centre would be useful if it was there and children could go to it. Doctors are not always sympathetic – they could get advice. I'm not entirely sure about getting contraceptives under age however – it might encourage them – it depends on the situation."* **Parent Eyres Monsell**

Although several parents raised the question of whether more information and access to contraception would increase experimentation, young people did not raise this concern in their questionnaires and group sessions.

All the Asian parents involved were aware that in responding to this question they needed to address some difficult and sensitive issues. They basically supported the attitude within their culture that young people should not be involved in sex before marriage, but some were aware nevertheless that this was happening on quite a significant scale and Asian young women who got pregnant had very few places to go to for help and faced a huge stigma within their community if they were found out. They were sympathetic enough to this situation to want there to be more support available. They accepted theoretically that greater availability of contraceptives might help to prevent an unwanted pregnancy, but could not entirely overcome the concern that increased access to contraceptives could encourage more sexual activity which was not necessarily desirable. As noted above this perception could be shared by white British mothers as well.

*"On principle it would be a good idea (community based sexual health services for young people). It could provide advice – there is an issue regarding contraception however if it is available through these channels. The principle is quite sound if you accept that young people are sexually active. It is probably very necessary – but I would find it difficult. It would depend on the quality of the staff – the organisation behind it would need to be reputable and accountable. The service is not a problem as such, the attitude of the general community is a problem."* **Muslim parent**

*"Yes they should have more. They should also be taught more at school. Although, I think parents should be more involved and should have more open relationships with their daughters"* **Jain parent**

One parent noted that even if young people could get contraceptives there were still real issues about them being able to use them, due to a lack of privacy in many homes.

*"A lot of Asian girls would be scared about having contraceptives. In Asian families –there is no privacy as such – in big extended families in small houses children share a bedroom – there would be nowhere to keep contraceptives which would be safe and not be discovered – they would have to store them elsewhere."* **Muslim parent**

Others pointed out that confidentiality was a very important issue.

*"Group sessions with Asian girls would be a non-starter, they would not trust their confidentiality".* **Muslim parent**

*"More Muslims are using St Peter's Clinic – but if you are single you can still be recognised there – I have felt exposed using it even as a married woman. It depends on their level of confidence – they need someone to support them."* **Muslim parent**

*"It is difficult to say, due to confidentiality issues, although I feel that a confidential place may be useful for young people e.g. a youth centre or family planning session at the surgery as there would be lack of assumption."* **Sikh parent**

Some parents made suggestions for new services.

*"Texting and mobile phones would be a good way of helping – or phone line service. They would not be seen going in or out of a building or clinic – it could be advertised in schools and colleges. It would be anonymous."* **Muslim parent**

*"Better teaching, have more leaflets and more booklets available so they know what is going on. Services should be available more locally in public places e.g. library."* **Hindu parent**

### **Media influence**

Parents were asked if they had noticed any sexual health advertising in the media aimed at young people and what they thought of it. Some had noticed some use of the media, and most supported the idea in principle if the message was appropriate.

*"I've seen the new advert about Chlamydia - it made me laugh – I don't know what a 14 year old would make of it. It needs to be more dramatic, in your face, it needs pictures of what it can do to young people – it's too softly softly. I know there are some kids living in places around here which are like a war zone – they think if they get pregnant they will get a house and a person to love them – they need to understand it won't be like that."* **Parent Eyres Monsell**

*"A recent session on VOICE East Midlands was an important breakthrough. There was a phone in on sexual health issues on community radio during Ramadan. It was the first time such things had been discussed openly and it attracted a lot of attention and was very successful."* **Muslim parent**



Some parents mentioned the use of media to 'scare' young people – some thought this was a good idea, but others did not think it was an effective tactic.

*"I have seen a poster – it depends on who they are targeting. Young people tend to react and say 'why are they trying to scare us?' They don't like being spoken down to, you need to give them more choice. If it's from the government – it puts people's backs up, it has to be from people their own age, people they respect. Young people feel there are constant restrictions, they are surrounded by rules, there is so much pressure."* **Muslim parent**

Some parents had suggestions of how the media could be used more.

*"It may be useful to have adverts like this on Asian channels such as Zee TV/Sony"* **Hindu parent**

*"It may be an idea to put warnings before the starting of a movie at the cinema like the smoking one"* **Sikh parent**

### **Participation in a group for parents**

Parents were asked if they would find it useful to join a group with a trained worker to learn how to talk more to their children about sexual health issues. The Muslim parents in this study supported the idea and thought it might be helpful although they did not necessarily feel the need for it themselves. One thought it would attract more mothers than fathers.

*"A group would be very good – if it was good people would come, it would give them a better understanding of the world. Let them know things are not the same as when they were young. It is now a new millennium, they must be forward thinking, they have to move with the times."* **Muslim parent**

Other Asian parents were also enthusiastic.

*"Yes I would find it very useful as then I would know what to say to my daughters, even though I do try to explain to them now that they should not get involved with boys or have any boyfriends!"* **Hindu parent**

*"We need to do more work with parents and get parents supporting children in the home so they are less likely to get involved. Getting young people to go into schools to talk to students would be good."* **Muslim parent**

All the parents from New Parks and Eyres Monsell did not think they needed such a group themselves, but thought others might benefit.

*"Parents who don't know how to talk to their children – might need some help – some are bashful or don't think it will happen to their daughter – that is not a good attitude to have"* **Parent Eyres Monsell**

*"I'm doing OK – have a good relationship with the boys. Might like to think about that for the future with my girl however."* **Parent New Parks**

### **Other comments and messages to the Board**

From the interviews with parents a number of suggestions for the LTPP board arose. These included working with community groups such as the Federation of Muslim Organisations in Leicester, and women's and community groups to discuss these issues.

*"People are realising that young people are more aware and sexually active – it is similar to issues around drug abuse – small organisations are being set up. I do think it is a good idea to look into the community and think about how to engage young people, I hope young people will benefit from it."* **Muslim parent**

There was a recognition that there needed to be more information and support for young people.

*"There needs to be a lot more out there for young people as the rates of teenage pregnancy are high therefore, we must be going wrong somewhere. Other countries do not seem to have these problems and maybe we could learn from them. Could it possibly be because we are teaching them too early about the birds and bees? I think more research needs to be done. I think there is a high rate among Asians as well, although as generations are changing I feel parents are more open minded then before and so can talk about it."* **Sikh parent**

### **Conclusion to consultation with parents**

These parents' views are not representative of all those within their communities, however, they do show a sympathy and awareness of the difficulties faced by young people which could provide an opening for more engagement. Although this subject is a sensitive one, the very fact of having to think about it and talk to their own or other children and colleagues about the issues proved very stimulating for them. Many women from all the minority ethnic communities are active in voluntary or paid community work and are becoming aware of a whole range of issues affecting their young people. Engaging their cooperation in a process of looking at the issues and coming up with solutions that meet the need of young people, but can also be owned by wider community members could be a very fruitful approach.

# What Practitioners Told Us

## Perspectives from school staff

### Nature and extent of SRE lessons

Staff at each of the community colleges were asked about the SRE lessons in their colleges. More detailed information was subsequently provided by the two staff who were interviewed individually.

At Riverside at present it is the Year 9s who are getting SRE and the visits from Turning Point. Years 10/11 have had SRE sessions in the past but there is no room in the curriculum for this at present, although the PSHE teacher hoped to introduce something for them in the future.

New College has recently emerged from special measures so that in giving attention to their core curriculum, subjects such as SRE have of necessity assumed a lower priority. In previous years SRE lessons were provided by class teachers and also used the Turning Point peer educators. However the teacher principally responsible for PSHE left in 2005, leaving a gap that had not immediately been filled, although there had been a well received visit from a school nurse team. Up to the Autumn term 2006 it was Year 7 who received the main SRE input. Years 8-11 had been getting no real SRE lessons at all; issues might only get raised in the 15 minute sessions of tutor time. Several initiatives had been taken in the Autumn term of 2006 by the Principal who had involved a consultant to provide advice on the development of SRE and had talked to staff at New Parks Youth Centre about the possibility of doing sessions with young people. There are apparently plans to employ a new staff member at the College to cover these issues.

In Crown Hills every student in Years. 8, 9 & 11 has six 50 minute SRE lessons and Year 7s cover sex education in Science. The groups are mixed ability and gender. The teacher responsible for PSHE teaches Years 8 & 9 together with colleagues in the Life Skills Faculty and teaches the Year 11 groups on her own. It covered a range of topics.

*“Year 8 - puberty, sexual intercourse, contraception including condom demonstration*

*Year 9 – boyfriend /girlfriend relationships, other forms of contraception, STI's, Sex: when & why?*

*Year 11 - contraception, STI's, Sex: When & why? Parenting”*

Staff from two of the three colleges contributed their perspectives on a range of aspects to do with the provision of SRE in schools, one via an interview and the other via email.

### Use of outside staff in delivering SRE

Both schools mentioned the use of outside trainers, including Turning Point peer educators who had been used in a previous year by one college. The school nurse worked with year 11 in one college and the school nurse team with year 9s in another. The involvement of the school nurse was not standard in one of the colleges but was actively welcomed in the other.

*"Last year we had the school nurses come in and do the SRE lessons – I felt that worked well and I would want to encourage that to happen again, no other teachers were involved. Some teachers feel quite uncomfortable and even embarrassed about talking about it (SRE) –I think they feel quite relieved to have someone else taking that part."*

Their contribution was seen to be in the content of the information which was provided and their approach to putting it over.

*"They gave a certain consistency to it – they were all basically working from the same sheet – they had a very good knowledge about what they were taking about. Because they were outsiders and part of the school nursing team they actually provided a different type of approach – to the extent it was more rewarding for students to have an outsider in preference to a teacher. It brought variety as it was different from some of the other curriculum activity. They talked about places within the community that young people could visit if they had problems and wanted somewhere to talk. There wasn't just information given but signposting to resources."*

Staff were asked what factors influenced the type and content of SRE that students received. A need to compensate for aspects of the curriculum not covered in primary schools was identified as well as having enough time within the curriculum.

*"I feel SRE is covered well and that we build on work previously done, however more could be done in Year 7 on puberty as many of our main feeder schools do not make any provision due to Governors' request."*

*"My main concern is making sure SRE has some allocated time and it is planned. I understand the school will be having a new member of staff in the school and the community that will be responsible for certain areas in connection with the teenage pregnancy strategy. We've got a consultant in an advisory capacity planning for this which the Principal has initiated."*

Staff were asked how they thought young people gained from the SRE.

*"They have a thorough knowledge of how their bodies work, about sexual intercourse, birth, STI's, the use of a condom and where to get them. I think I do not provide enough discussion opportunities and advice on relationships and feel an adult nearer their age group may be more appropriate"*

*"The school nurse session was very well received - there was a lot of information and opportunities to meet the wide spectrum of young people we have. We have a diverse area of need – by the way we followed on those lessons we tried to include everybody and all their abilities and knowledge levels. We split them up between the sexes for the sessions, it did bring up some different issues (from previous mixed sessions) and people did feel more comfortable –they were less embarrassed in single sex settings."*

Staff were asked what support they received from the LEA for their SRE and the work of the SRE adviser was the key resource mentioned. Her support in providing training and resources was regarded as crucial.

*“My contact with (SRE adviser) is very useful and supportive and I would not like to lose her input. I have had ‘blue box’ training with her which was helpful and adequate.”*

For the teacher there was access to additional training.

*“The PSHE Certification is very useful in prompting me to reflect on current practice here. The feedback from the students during your research highlighted the need for more work on relationships.”*

Both schools where staff were interviewed were involved in the government sponsored Healthy Schools initiative which gives direction regarding the content of the SRE lessons to be provided. The two colleges were at different stages in relation to the initiative; one was renewing their accreditation, while the other had just registered but had not yet implemented all the provisions. Strong school involvement in Healthy Schools is a Deep Dive finding.

Neither college was very far advanced in communicating with governors about the SRE policy and issues. Both recognised it was important and needed addressing but for one school the fact they only had an interim executive board at present was a limiting factor. In a similar way the involvement of learning mentors was an untapped resource at present in both schools.

*“Again this is an area that needs developing and there is a lot of scope for their involvement. I feel students need a contact to go to in confidence. Not an easy thing I know”.*

Having enough resources to deliver SRE was not seen as a problem in either school.

*“We have a lot of resources in the faculty and there are a lot on the market that are regularly being advertised. I have previously used a theatre group when I worked in Braunstone but I don’t have a contact for them now. I thought their presentation was excellent and the follow up activities and would like to use them again.”*

One staff member was concerned that her school SRE resources appeared to be better than those of the school nurses and was aware of their limited budget.

School staff were asked what their key messages to the Board would be on these issues. Greater promotion of the strategy and the use of outside people to deliver SRE in schools were the key points they made.

*“To promote the strategy more so more colleges appreciate its importance and give the time to delivering SRE adequately. We are very fortunate here*

*at my college to have the time, specialist teachers and a Faculty who passionately believe in this area of the curriculum.”*

*“You need consistent awareness –you need up to date messages and ensuring the transfer of information is user friendly. You need access to the nursing team or other people like that such as the peer educators from Turning Point. They are brilliant at putting the message across. The school nurses as well are very good at what they do .You need both; one to cover what it is like when you have a baby and the other is useful for young people who are taking risks and want to know how to look after themselves.”*

### **Implications for the Board**

- Review of coverage, content and methods of delivery of SRE in state schools in Leicester.
- Support for use of outside staff in SRE delivery such as peer educators, school nurses and youth workers.
- Promotion of SRE to other community colleges.

## Consultation with Practitioners in the Community

We asked practitioners in New Parks, Eyres Monsell, St Matthews, Belgrave and Highfields to give us their perceptions of the nature, extent and effectiveness of sexual health services in their areas, the factors which have contributed to this situation, current gaps and the attitudes to and use of these services by the young people known to them.

### St Peter's Health Centre

St Peter's Health Centre in Highfields in Leicester is a long established and well known service which offers two sexual health youth clinics for young people under 25 a week. Since it is known that this potentially offers young people an anonymous service, potentially well away from their home area depending on where they live, it seemed a useful exercise to find out how many young people from our two target areas were using it. The statistician at St Peter's made a special calculation of the numbers of young people under 18 visiting the clinic for the first time and applied a post code analysis. This shows that low numbers of young people from New Parks and Eyres Monsell are making use of the service in relation to the overall total. A few young people from New Parks will use the clinic in Beaumont Leys and twice as many as their counterparts in Eyres Monsell will travel to St Peters.

### First contact numbers of young people under 18 from NP and EM using St Peter's Health Centre April 2005- March 2006

	New Parks		Eyres Monsell	
	F	M	F	M
Beaumont Leys (area clinic	11	1	-	-
St Peters clinic	62	1	36	5
Total numbers	1287			

Young people of Indian origin are the most numerous minority ethnic group using the clinic, although comments from the young people of similar origin elsewhere in this report indicate how difficult they would find this. It would seem to suggest that they would have to be in considerable need to take such a step. A worker from the clinic suggested that only the most self-confident Asian young people used the clinic. (See Appendix 4 for table showing the ethnic origin of young people using St Peters HC).

It has been suggested that young people local to Highfields are least likely to use the service. Despite being located in the heart of the African Caribbean community the clinic has only attracted 41 young people from this group in a year which would seem to be comparatively low. There are also very low numbers of young people from Pakistani and Bangladeshi communities who would be likely to be living in the areas close to St Peter's.

There were two comments from clinic staff on the nature of young people's use of the clinic over the past few years. One was to the effect that over the past five years more young people are arriving with complex needs – including psychologically based sexual problems, with fewer needing simple

information such as had been the case in the past. This might suggest that young people are starting to find basic information and resources from elsewhere and are using St Peter's for more specialist counselling and advice. The statistician notes that there are fewer repeat visits from young people under 18 than in previous years.

*"We are now seeing more complicated cases than we used to. When I started dealing with young people with sexual health needs, it was relatively straightforward, it was about pills, injections and condoms, I now find cases have more to them. Young people have been in previous relationships – people are having sex earlier but some young people are not able to deal with the consequences of that, there is a need for more psycho-sexual counselling to help them with their emotions. They are not able to manage their sexual lives..."*

### **Consultation with practitioners in New Parks**

Comments about sexual health services in this area are supplied by a youth worker and community development health worker. New Parks Youth Centre, which is situated close to New College, is open five days a week and has a lunch-time drop-in session at the centre each day. On Mondays they have a Health Shop as part of the session with school nurses in attendance and there is a Focus Group of young people who are responsible for the decision making in the youth centre. The Allextion Youth and Community Centre is a multi function centre which offers a children's nursery, Connexions out reach and a youth centre. There is a Wednesday evening youth session and a Choices clinic on a Thursday. The Choices nurse in written communication writes:

*"We have tried a few clinics within this area. We have used the youth centre on a school lunchtime which was a 'health shop' working with school nurses. The general health messages, delivered by the school nurses, seemed to get a bit lost within the demand for condoms. This ran from March 03- Dec 04. This clinic was then moved to a community centre, Allextion and was offered after school with a variety of activities available for the young people from January 05- to the present."*

While the Monday sessions at New Parks Youth Centre no longer have the clinic nurses, the school nurses are still providing sexual health sessions and youth workers can provide pregnancy testing and condoms as staff have had 'Blue Box training' - this is training on different types of contraception. This autumn the C Card initiative has finally been launched which together with STI testing has widened the sexual health provision in the area, as there are now 11 outlets in New Parks for people to access condoms and other services. The C Card enables young people to register to receive a card which will entitle them to free condoms from various outlets in the area. They will receive sexual health advice before being given the card and will have to re register after a set period. Drop ins have also been introduced where people can get , for example, Chlamydia tests.

However there was also recognition that more was needed.



*"If you consider whether there are enough ways of getting emergency contraception, then I don't think there is enough and we still have issues to do with that because currently you can only access it at one point, which is at Allexton."*

There is some outreach work with young people in the area, though it was hard to sustain.

*"We do a lot of outreach – but with me having to take a step back and do development – there was no one standing outside doing the outreach to young people. I've got a DMU student for a year now doing the whole of the outreach – she's fantastic and we've also got consistency with youth workers which we didn't have previously."*

### **Factors contributing to the level of provision in New Parks.**

Partnership working between the Youth Service and the PCT was identified as a key factor in ensuring the level of provision of sexual health services within the area.

*"The fantastic thing in New Parks is that you have a multi-agency office –it's based in a youth service so that works fantastically, but you are scrimping and saving to afford provision, to afford the condoms– I beg, steal and borrow to get resources."*

Multi-agency working was also seen as helpful in creating the right conditions to launch the C Card. Whilst this was recognised as a strength people also recognised that multi-agency working could take more time.

*"We've known for the past two years we've needed to do something, but it was actually getting all the agencies on board that took time – because we didn't just want to look to the youth service and health, we wanted to look to the bigger picture and get Sure Start on board . . . You've got to remember my job is very generic but there is only one of me to cover the whole of New Parks, it's quite time restrained – and this is such a tiny part of my job it is unbelievable."*

The wide ranging role of the community health development worker was also seen as a strength.

*"Because I'm a generic worker I have no age boundaries. I am very much cradle to the grave so it opens up opportunities for sexual health provision because I am not guided or driven by targets. My targets are very qualitative rather than quantitative which really helps."*

New Parks had also managed to overcome the barrier faced by youth work staff elsewhere of the absence of an agreed sexual health policy by using a health based one.

*"We've managed quite well and that's because I wrote quite a robust sexual health policy. Because I have overall responsibility for sexual health provision in New Parks, and I coordinate it, they (the youth service) have basically done*

*a service level agreement to have youth workers adhere to my sexual health policy so that's not been too much of an issue. It would be fantastic if the city policy could be finished however. It would make life so much easier if it was completed."*

However the impact of cuts particularly in health was recognised.

*"You have got the Choices specialist nurses - who do a fantastic job but with their funding cuts (in 2006) it's made it nearly impossible for them to offer the service provision they should – there's only two of them and they cover half of the city so it's almost impossible for them to offer us more than an hour a week."*

### **Perceptions of current provision**

The Choices clinic moved from New Parks Youth Centre to the Allextion Centre in Jan 05 and one of the reasons given was that young people from outside the area (who were students at New College) were using the service and those attending the Allextion Centre were more likely to be local residents. The venues are very different in that the New Parks Youth Centre is exclusively for young people, while Allextion centre is multi use and the youth centre shared space with other activities which attracts adults. The clientele is also different as the good sports facilities at Allextion traditionally attracted more young men to the centre while New Parks Youth Centre attracted more young women. At the time of interview the numbers of young people attending the Choices clinic at Allextion were lower than they had been when the clinic first started there and also lower than the average attendance when the clinic was based at New Parks Youth Centre.

The workers interviewed drew different inferences from this situation however. For one, the New Parks Youth Centre had worked better as a site for this kind of provision, as the venue was located near New College with lunch-time sessions whose timing suited young people well and the clinic was suitably camouflaged within the general youth provision.

*"I think they preferred it before we moved to Allextion. Using the Youth Centre was never a problem for young people. It was open every day and on a Monday lunchtime with the Choices clinic they could be coming in for something else. It was also possible to arrange private time on demand. When we had Choices on a Monday with two nurses we could get about 50..., but Thursdays at Allextion are not now so well attended – I'm not pleased about it."*

The other worker had the view that the clinic had worked perfectly well when it first started at Allextion, and that it was the inconsistency of provision due to financial constraints which had had a more damaging effect on young people's confidence in the clinic and their willingness to attend it.

*"In relation to attendance a lot of that is down to consistency. The clinic has been open and closed –it's been quite sporadic – one minute we've got funding the next minute we haven't. Eight to nine months ago it was a fantastically well used clinic, I was very impressed with it, but because we*

*have been open and closed and commitment has lapsed, it's really gone downhill. That is what the new launch next week is for to try and get it up again – we know it has the potential to do well – there was no problem with attendance prior to the lack of consistency.”*

The need for resources and sustainability were also recognised as important.

*“Sometimes it's just lack of resources and time for workers as well My job's development, it's not geared on face to face, it's about initiating projects and making them sustainable and then it's ensuring with the funding cuts within the youth service that we've got staff provision to actually provide it.”*

### **Gaps in provision**

Practitioners were asked what they saw as gaps in services in the area. Even in New Parks which was felt to be one of the better areas for sexual health information and services it was felt that there were particular gaps in services to be found.

The loss of emergency contraception in the area was felt to have increased a possible risk of pregnancy as some young people might find it hard to go elsewhere.

*“A lot of people say it's just a bus trip into town but if you've not got that £2.50, and your mum expects you home from school at a set time the tendencies of you going down there in that constrained time frame are quite limited, so I wouldn't be surprised if we didn't have a number of unwanted pregnancies and terminations because we couldn't give young people access to emergency contraception. We used on odd occasions to take people down to the pharmacist to ensure that they got that, but with the cuts now – instead of saying to a young person just walk two minutes down the road – now, we have to say ‘you've really got to take a bus into town and go to Boots’. I am aware some do that – I would hope more would but they don't.”*

Work with parents to inform them about the services provided was felt to be a particular gap.

*“Issues about informing parents. There's a huge gap, we don't do any work with parents about talking to young people around sexual health.”*

Work with young men was also felt to be under developed and this was linked to a shortage of male workers throughout the city.

*“There is a real gap for that. On teenage pregnancy and contraception we target girls and we do try to do stuff and hope if girls are sensible enough it will rub off. There is a lack of male workers however and as a female worker there are some questions you get asked that you just don't know the answer to. We need funding to have sessions, but we have not got the capacity at the moment.”*

It was noted that the gender balance of young people attending both youth centres was different.

*“At Allexton the attendance is predominantly male, also at our new provision on Wednesday night but that’s accidental – it may be because we have the basket ball court and sports hall. Although as it happens our only male worker attends on that day which might explain why there are more males. You might get boys at lunchtimes here (New Parks Youth Centre) but the evening sessions tend not to be boys. There are a huge lack of male workers in New Parks and that’s for Sure Start, Health and the Youth Service. It also occurs across the city. We did have a male worker at this centre – it worked well, we trained him in pregnancy testing and condom distribution and the young girls felt more comfortable talking to him.”*

### **Using city centre services**

It was suggested that although young people would usually prefer local services there could be special circumstances such as retaining confidentiality which might make central services more attractive for them

*“The motivation could be issues around confidentiality. Sometimes if you have been working with a young person for a long time and giving out contraceptives and stern advice – sometimes if they find themselves in a predicament they may not be comfortable about telling you, because you’ve built a relationship and they don’t want to disappoint you.”*

However in other circumstances local services would be seen as preferable.

*“It’s a question of accessibility. In New Parks young people don’t drive so they would prefer to have local services where they know the youth workers and nurses and it’s welcoming. In the city they can encounter a stigma because of where they come from - they could get negative experiences. Although I don’t know if that is real or just an impression.”*

The statistics from the St Peter’s clinic presented earlier confirm this perception in a certain extent that some young people do go outside the area, but numbers are very small compared to young people from other areas in the city.

### **Young people’s needs**

Knowledgeable, trustworthy, workers and accessible, acceptable, locations where sexual health services can be successfully embedded were seen as crucial for young people. Confidentiality and anonymity were seen as important – both in terms of workers and venues.

*“They want to trust the people they are working with and feel confident about them. They want to learn about when people consider it is the right time for sex – issues of sexuality and relationships. I don’t think they are as comfortable with school nurses – although you can get some good ones. The Choices trained nurses are brilliant and being based in a youth centre offers young people a better association with them – it’s cooler.”*

### **Involvement of young people**

Practitioners were asked if they thought they consulted enough with young people about the delivery of sexual health services and overall they thought that not enough work was done involving young people, and some included themselves in this. They felt there was considerable room for improvement.

### **Messages to the Board**

Practitioners were asked where they thought the Board should focus their priorities for the next few years. The main suggestions were to improve PSHE work and make sure it covers STIs, to develop the youth service and ensure more access to resources, more funding for workers and condoms and pregnancy testing. Finally there was felt to be a need for more training for staff.

### **Conclusions to services in New Parks**

New Parks is an area where sexual health provision has been well received and used by young people and a prime factor has been partnership working between Health and the Youth Service at a local level. The issues which have limited the involvement of the youth service elsewhere have been overcome with very productive results. The Youth Centre is strategically located near to New College and open every day and the youth clinics and health staff have been successfully embedded within the youth provision. It is clear however that consistency of provision is necessary to ensure use by young people and uncertainties in funding can affect even a well regarded service. This has provided a secure base however from which to launch the C Card initiative and assess how well this might meet the needs of young people.

### **Consultation with practitioners in Eyres Monsell**

A key characteristic of Eyres Monsell is that this is an area where sexual health clinics have been tried unsuccessful in the past. The Choices nurse writes:

*“Choices offered a drop-in clinic from the Hedges Medical Centre on Mondays between 12-2pm. This time was chosen because of the availability of the doctor. This clinic closed due to the small number of attendees. Following the closure of the nurse-led clinic, the practice nurse will see under 25s for pregnancy tests and condom supplies for anyone who would have attended the Choices clinic i.e they did not necessarily have to be registered with the clinic. This is still continuing. We also attended the Kingfisher Youth Club one evening a month with varying response from Oct 03-March 04. This stopped due to staff shortages.”*

The youth worker at Kingfisher has the view that the clinic didn't work because the young people associate the club with much younger children – there is a Junior Club on a Friday and a Sure Start nursery.

There are three youth clubs in the area but they are not as well resourced as those in New Parks. Kingfisher has an evening drop-in on Mondays, Tuesdays and Thursdays at 7-9, while the Magpie Youth Centre is open for the same time on Tuesday and Thursday, with a different clientele. There is a

third voluntary sector youth club which is open one night a week in the evening on a Monday. There is an Area Forum made up of representatives from all three clubs which meets once a week on Wednesday.

While the youth workers have run sexual health information and advice sessions as part of their programmes from time to time, they do not offer condoms or pregnancy testing due to the current absence of an agreed sexual health policy for the youth service.

This area has a distinctive culture whose influence on sexual health provision and young people's attitude to accessing it is well known to the youth workers. Three youth workers from the area contributed their views from the statutory and voluntary sectors.

### **Background**

Some of the workers in Eyres Monsell were explicit concerning their perception of a lack of financial investment in the area in general and specifically in relation to sexual health information and services.

*"Eyres Monsell is a forgotten and missed out estate, there is just nothing there. It has been that way for years. There's not as much money pumped into Eyres Monsell as may be in some other areas, it kind of gets a shoddy deal on several fronts"*

This was combined with geographical, cultural and educational factors which contributed to a feeling of isolation and some division within the community. The fact that young people in the area go to a number of different schools was also seen as significant.

*"Eyres Monsell tends to be quite a segregated area. I find it quite an isolated estate – it's on the edge of the city and it has a majority white population. We get a sense from young people of 'we're us, they are them – we don't get on with them, we don't go there, we don't mix – we get attacked if we go to other places,' and they don't go into particular areas where the ethnic majority is the other way round".*

The lack of resources for youth work and a shortage of buildings on the estate, necessitating most to be multi-use, results in a lack of identification by young people of places and sessions that belong to them exclusively and are seen as somewhere they would want to go. Attitudes to the youth provision were perceived as very different to those of a neighbouring ward, where young people appeared to feel more ownership of the numerous centres available.

*"In Eyres Monsell it is harder to get people in through the door – you're more having to explain to them why it might be a good experience for them to attend. There's nowhere really where they can go freely and meet and relax – if they could have something like that then we could pick them up in there and deal with the issues. Even with detached work there is no real one place where everyone goes to hang out. "*

## **Access to sexual health resources**

Workers said for young people in Eyres Monsell there is a general sense of having nowhere to go to access sexual health advice or resources where they feel comfortable. Territorial factors may also affect how far young people are prepared to travel within the estate. Youth workers summarised the issues as:

- Not enough provision, not offered regularly enough. If it's only once or twice a month – it's difficult to access. Would need information on dates and times when clinics are open
- Lack of partnership working
- Lack of communication in the area
- Lack of buildings where young people feel comfortable. The community centre was viewed as a bit formal and the Rolleston Centre, attached to a school, was not seen as confidential enough
- No condom availability, with some uncertainty as to whether the health centres will give them to young people on demand
- Emergency contraception availability reduced dramatically
- Youth Service in final stages of completing its sexual health and relationships education policy which is viewed as having inhibited the capacity of the workers to deal with the issues.
- No secondary schools in the area and the spread of young people across a number of schools, including county schools
- The large size of the estate, and the fact that young people can be reluctant to travel to the other side of it.

*“In terms of emergency contraception there is a lack of resources there. There's not much stuff specifically for young people – if there is it's not as well advertised. There's not much work in core community work networks within the area, so information doesn't get around as easily, there's no secondary schools in the area and Eyres Monsell young people tend to be spread across county schools. I do detached work in the area and talking to young people you find that beyond the school nurse professional doing PSHE at school they are not much aware of where they can go that's specifically for them.”*

Some young people can count on help from parents to negotiate the hurdles to accessing sexual health resources, but as this worker notes, this is not the case for all young people.

*“Even with Health centres like this the population will still be divided, because there will be the young people whose parents are aware of what's going on in their lives and supportive in helping and encouraging them to go along and use the GP and they are not at fear of being caught out if they go and do that, or there's the other side where there is a taboo where there are many reasons where that is not possible.”*

Young people who do not attend youth sessions may be reached via detached work in the evenings, but this form of practice does not always allow for the informal support which may be needed to get young people to the sexual health resources.

*"It's difficult when you do detached work as you are aware of good services that are available but when you are working out in the evening, you can't say 'let's go and see these places' if there are issues about young people not feeling comfortable about spelling, or they are worried about confidentiality issues – you can try and reassure them and talk to them out on the streets, but whether this translates to them actually turning up and presenting to any of these services – it's a different matter."*

### **Attitudes to confidentiality**

Confidentiality was seen to be a key issue for the young people and arose from a feeling of being under close scrutiny within the community. Young people were seen as reluctant to access services in full view of others; in a local survey young people said *'that rumours would spread'*.

*"Everyone knows what everyone else is doing. I found that when setting up a sexual health clinic at Kingfisher and Saffron –young people didn't feel comfortable about coming to a service like that, somewhere where their peers could see them going in and could know why they were there. That then makes it difficult to advertise the service to make everyone aware of what the service does and when you can come and what time you can come, without facing confidentiality issues again"*

*"With regard to precautions and pills, a lot won't access their GPs – they're so afraid of a breach of confidentiality that unless something happens such as they get pregnant or have an abortion they won't access them."*

One of the outcomes of this fear of discovery and lack of acceptable advice and resources is the supervised pregnancy testing in the home of a trusted and concerned adult community member recorded in the parents' section earlier in this report.

### **Consequences for young people**

Youth workers were asked what they thought young people in Eyres Monsell did in the absence of local sexual health services.

*"There are large consequences (of this gap) because there are large numbers of young parents in the area. Becoming pregnant is not necessarily regarded as a dire consequence. It shouldn't necessary have to be so but it is obviously better if it's planned and the parents are ready for it. But there is a sense that if you get pregnant, you get pregnant, there are other people around and there are groups you can go to."*

It was felt young people were unlikely to travel to central resources such as the St Peters' clinic or Connexions as in Eyres Monsell people stay in their own areas and would only access services when they thought they might be pregnant. The statistics from St Peter's confirms this low use of a city centre resource.

*"It's probably likely they are having unprotected sex, in fact quite likely in view of the number of conceptions in the area, people know what they are doing; the older ones don't mind if they have unprotected sex, they don't mind if they*



*have a family. Some make a conscious decision; it is more likely to happen in the heat of the moment when they are younger."*

The fact that many young people in the area go to county schools where it was felt sexual health services are better might help the situation for some.

### **What young people would like**

In the absence of a good local model of practice youth workers feel that young people have fairly limited ideas of what they would like, but privacy, advice and free condoms were felt to feature prominently.

*"A lot of free condoms – there are comments that it would be nice if they could go to other places than the youth club – but have a youth worker there and have some privacy so people don't see them."*

*"Confidential advice, access to condoms and other precautions – leaflets giving guidance on advice, somewhere to talk, to someone they don't know at all preferably."*

### **Hopes for new sexual health provision in Eyres Monsell**

Practitioners were invited to suggest what they would like to see provided in Eyres Monsell to overcome some of the problems identified. They felt a need for a new facility for young people where sexual health services would be just a part.

*"If there was somewhere newly created – a lot more modern – the drop-in internet café kind of style – where you could have a separate room, where somebody could be available, someone to have a chat to, get condoms or be told there was specific times when you could come back for a pregnancy test – it would be a benefit."*

Others wanted to be able to offer more within existing services, both in the day time and evening, have male workers to help more young men use services, and provide young people with more information, free condoms, pregnancy testing and signposting. People mentioned the need for 2-3 centres to cover both sides of the estate or the wish to offer mobile provision.

*"It's difficult, they would need to go to a regular place so it remains confidential. . . I would like Choices to come in and run a service at the Magpie centre, advertised by word of mouth. . It would be based in a different community centre where young people could go in and out on a private basis for the first hour say 6-7. In the second hour they could go into the (Magpie) youth work centre and receive a service from the Choices worker. Young people who were older and more confident would use it (there)."*

*"The Choices service could be part of a mobile bus - it could do a joint service with drug education etc. People would use it if the provision had 2-3 purposes."*

Consulting and involving young people more was seen as a way of developing services in the area, though it was acknowledged that currently

there is not much of a culture of young people or adults getting involved in the area.

*"They are not involved very much at present. It's a dual thing because there is no capacity and history of community involvement, let alone young people's involvement at present. The idea of getting involved and doing stuff is not necessarily even appealing to young people, so the message to do so is not easy for them. It would be worth getting a core group of young people involved and start with a sexual health type of project, something to show there are easy and enjoyable ways to participate and get involved."*

More use of new technology was also suggested as a good way of getting information to young people, for example texting and telephone help lines and a website.

*"You need to pass information on in the way that young people want to access it these days, Leaflets are limited – you should do email and text."*

The C Card, already operational in New Parks, might possibly be regarded as a good model but one of the youth workers suggested that some young people in Eyres Monsell might need quite a lot of convincing concerning its usefulness to them. This could take the form of questioning the limits to the number of condoms given at one time and perhaps being suspicious of the amount of information they are expected to give and how confidential the service is.

*"Is this another way of adult society tracking what they are doing, another way of monitoring them? They are concerned about confidentiality; will their name be on the card, will it be entered on a data base?"*

### **Messages to the Board**

Practitioners were invited to identify some key actions that needed to be taken by the Board to achieve their objectives. They felt it is important to recognise that young people have a right to services, and that there are gaps in promotion, advertising and publicity, making people aware of what is going on and that it is for young people which need to be addressed. It was felt this would ensure a clearer view of which services worked and which didn't.

*"I have found it difficult in the past to differentiate when services haven't worked whether it is a matter that people don't want to use them, or people don't know they are there".*

It was also mentioned that funders need to allow more time for services to become established.

*"If a service starts up and doesn't attract young people immediately, they only get a short pilot period before it gets withdrawn, which can happen before it has really been given a chance to succeed."*

Support for no cost sexual health training in the voluntary youth sector was also mentioned.

### **Conclusions about provision in Eyres Monsell**

Eyres Monsell appears to suffer from a series of interlocking problems which have limited the extent to which sexual health services have been able to succeed in the area. Without their own local college like New Parks, Eyres Monsell young people are thinly spread through a range of city and county colleges. This means that youth provision in the area has to be concentrated in the evenings, but it is suggested that the quality and quantity of this is not really meeting their needs. A low level of investment in resources in the area has created the situation where there is a limited choice of venues where sexual health services can be located and none which apparently meet the young people's confidentiality requirements. Even a low level youth centre based sexual health service is not possible at present until the youth service sexual health policy has been finalised and implemented. A similar issue has also stalled the proposed new voluntary sector sexual health provision in Clubs for Young People.

The original Choices clinic in the health centre described at the start was probably too explicit as a location to attract all young people and a monthly clinic in the youth centre was probably too infrequent to meet their needs. In the absence of the kind of partnership between health services and youth services developed in New Parks, and the community development thrust which has helped to build up interagency cooperation, a culture of low expectations has built up among young people in Eyres Monsell in which teenage pregnancy can still be viewed as a positive life choice. It is by no means clear that greater availability of condoms and other contraceptives will significantly reduce the pregnancy rate in this area without sustained intervention on a number of fronts to raise these expectations.

### **Consultation with practitioners in Belgrave, St Matthews, Highfields**

These areas contain the major areas of settlement of Asian and African Caribbean communities. Only St Matthews has a good range of sexual health clinics and an open access voluntary youth project which can offer advice and resources, but use of these services tends to be restricted to the immediate area because of attitudes to the Somali community on the part of other minority ethnic communities. There are no services available in Belgrave and Highfields has very few clinics apart from the citywide St Peter's Clinic. The Hitslinks service which provided pregnancy testing in Highfields was subject to the voluntary sector cuts, as was some of the youth and community services which had a more explicit focus on sexual health. The comments are supplied by three youth workers and two community health workers.

### **Attitudes to SRE**

Practitioners were asked about what young people told them about the content of SRE lessons they received at school. They said young people talk of the level being too low and not covering all the topics they would like, however they recognised that some young people would like to learn about sex and relationships in the school setting.

*"Young people say they are quite vague, they tell you stuff you already know. They talk about how you become pregnant but don't cover STI, gay or bi-sexual issues. The good thing is the show and tell sessions, but they only talk about condoms, they don't cover other contraceptives and they don't cover rape, bullying or peer pressure. There are two types of pupil - one type would like to learn from a teacher – the others talk to youth workers and would prefer to get information from them, they would be scared to ask a teacher."*

*"I'm not sure about this. I have asked young people and tend to get short abrupt answers, like 'crap' and 'rubbish'. There's too much peer pressure and the teacher's approach is too clinical. I have also come across young people who say 'I didn't do it, my mum objected.'"*

As the parents themselves recognised the workers also felt there was a need for greater communication between schools and parents.

*"Parents are worried that the information will encourage young people to be sexually active, the school needs to sit down with parents and explain what the information is all about. Some parents take their children out of lessons for cultural reasons. I don't know what goes on (in SRE) and whether if schools and teachers talk to parents a few more would let their children participate. Children do find them helpful, it's a change from the video on a birth that I was shown."*

There was also some indication that some young men were looking to other types of resources such as pornography for more explicit sexual information, however it was pointed out they would not be getting information about STIs this way. The use of pornography by young men as a source of information has been noted in other research on SRE in schools.

### **Availability of services**

Services were recognised to be limited in these areas sometimes in response to community attitudes to sexual health services.

It was recognised that sex and sexual health issues were a taboo subject as far as Asian people were concerned, so having health clinics as the only source of information on the subject in their area was not the best way of disseminating this kind of information. People would only go to clinics when there was literally no other option for them, which would usually be too late as far as any preventive measures were concerned.

*"There is the Contact Project which offers one to one contact with young people and provides pregnancy testing, STI screening - all the stuff that the youth team can provide – we have all done Blue Box training. I have done work on advice in relation to termination. There is also a youth project at the neighbourhood centre. We are a little bit more personal and will do a lot of one-to-one work. If we get a repeat contact we will work and support young people. We will work through an assessment process and we can provide more intensive work than a general youth club is able to do."*

### **Use of services by young people**

It was recognised that young people in Belgrave in particular were reluctant to use an explicit sexual health clinic in their own area because of concerns about confidentiality. This led them to use services outside the area sometimes even in other cities.

*“Most young people use their friends and lectures at school. They go to the City centre Connexions or they go to the school nurse. Quite a lot are scared of going to clinics because they think they will be seen when they go in, or they might meet someone they know. Some people don’t want to talk to people they don’t already know. They might find they have to go to a totally different area where no-one will know them”.*

As with Eyres Monsell the close knit community was seen to inhibit young people using services locally.

*“Belgrave is very close knit – every one tends to know each other. If you had a young people’s clinic – there might be a stigma attached to it, people would know where they were going. You would need to have general youth provision with a section on sexual health – it would make it easier for people to use.”*

One worker at a sexual health clinic wondered if having sessions on Saturdays might attract some young people. It was also felt that young people had to find alternative sources of information for themselves.

*“Young people get most of their education from their peers, the media, TV, magazines. Unfortunately not enough go to clinics particularly those who live in the area. – they worry about going to a clinic – who you might see.”*

*“They get knowledge and advice from peers and the internet, rather than their GPs”*

This contrasts with what young people reported as the best sources to give information about sex and relationships. Young people did report that peers were a good source of information about sex and relationships but far fewer suggested that magazines were so useful.

However some young people did use local services.

*“We have a mixture of all sorts of young people. We do see Asian young people but only those with the confidence to walk through the door. If they don’t have that they won’t attend – Asian young people do come in who are having a sexual relationship but can’t tell their parents.”*

*“In terms of young men - we have one of the highest rates of attendance in the East Midlands – although it is still less than young women.”*

Also African Caribbean young women are said to be using a range of services.

*“Some think they are good – some think they are rubbish. If you talk them in person you might find they’ve had a bad day when they get the impressions that they are all rubbish. They are using the services. If one girl finds out something their friends will all know about it as well, they are taking more precautions.”*

While youth services might provide sexual health information in other areas, it was suggested that youth provision in Highfields was under developed and youth workers should be encouraged to do more issue based work, as currently the emphasis was felt to be too much on activities such as table tennis, football and pool.

The degree of desperation felt by young people was seen as affecting their readiness to use services such as a city centre clinic.

*“It is needs driven – some people will go to an awful lot of trouble to get themselves there. Young people will access the service –we are on a lot of bus routes and close to the city centre. Some young people don’t access us because of transport and cost deterrents”*

For some the only solution was to consult with services in a different city from Leicester some going as far afield as Nottingham or Birmingham.

*“I know of young girls in Belgrave who will not go anywhere local, young girls will go to Birmingham and Nottingham for an abortion. . . St Matthews is more open because of the diversity of the community. Somalis will access services despite experiencing some of the same barriers. It’s about trust, it’s a difficult issue.”*

### **Factors contributing to the state of sexual health services**

In a similar way to New Parks, the good quality of sexual health services in St Matthews was put down to partnership working.

*“Multi-agency and partnership working with Sure Start has opened doors, particularly for our young parents. I believed barriers were breaking down but some young people still feel some of the services are still a bit chemical. Being relaxed and non-judgemental like us works very well. Resources have helped – Sure Start put money into virtual dolls –it means we can expand our activities. If young women talk to us about having a baby we can let them borrow a doll just to get a sense of what is involved.”*

Young people from an African Caribbean background were said to be confident about accessing services which were felt to be paying more attention to their needs. However there was concern that a culture of minimum information might be continued into the next generation of Asian young people, and that because the conception rate for young Asian women is low, prevention is not seen as an issue.

*“Because the numbers of conceptions are low in the Asian community, people feel there is not as much need for education on safe sex and contraception. If*

*they grow up in this culture they may miss out on open information and there is a danger that their children will then go through the same thing. They don't get the same access to opportunities as the west of the city where they are more open about sex and sexual relationships."*

### **Confidentiality**

Youth workers stressed the paramount importance of confidentiality issues to young Asian women which affected every aspect of their approach to accessing sexual health advice and resources. Once again young people's concerns about GPs keeping confidence were mentioned.

*"Confidentiality is a key issue. There may be community women who help young people, it depends on who they feel comfortable with. I believe things might be a little more relaxed but reputation and status is very important and to protect themselves girls will go right away from their own areas. They will not go to St Peter's or their GPs if they are not convinced it will be confidential..."*

As with the parents, workers were concerned about the reluctance to discuss sexual issues resulted in nowhere for Asian young people to go for advice.

*"Asian young people want to start sexual relationships and the culture has to accept that they do develop. They have no chance to go for advice and we see them trying to keep quiet and becoming pregnant without knowledge, they can know that we do keep confidences. We need to try and get the message across but sex is still a taboo subject..."*

*"My mother says the only solution is to educate the parents, get them to break down the barriers and explain sex as a natural and a human thing."*

Taboos of a different nature prevented young women from Belgrave accessing services in the geographically closer but culturally different neighbourhood of St Matthews.

*"They wouldn't come into St Matthews to those services. There is a taboo about St Matthews in Belgrave, it's seen as a place where hoodlums and gangsters hang out. Anyone seen there would face questions from friends or family... In St Matthews - people will go to St Peter's, even the Choices Clinic in New Parks -they are starting to know about this."*

### **Loss of services**

There had been some loss and reduction in important sexual health services in St Matthews and Highfields which was seen as significant and other ways were needed to try and replace them.

*"Hitslink was a very big service which was lost. Highfields Youth and Community centre had some youth workers who did a variety of safe sex and sex education, they lost that through cuts to the voluntary sector"*

*"Pregnancy testing has suffered some reduction as trained staff have moved on, so there are fewer staff trying to rotate the weekly services. It is lacking in a bit of money. I have pushed for young people to be trained as trainers so they can deliver training to their peers and approach their friends."*

The particular and valuable role the voluntary sector could play in service provision was felt to be unrecognised.

*"You have to use the valuable experience and contacts of the voluntary sector, they are not recognised for the work they do. They do provide value for money and are one of the cheapest forms of provision. Most of the community groups do know the needs of their community."*

### **What young people want**

It was said by workers in the area that young people wanted confidential services and needed to be sure no one could access their information. They said young people want informal, accessible services which could offer some privacy like their peers in New Parks and Eyres Monsell. They saw a need for jargon free information and approachable staff.

*"They are hoping to find people who will signpost them in the right direction. They are looking for factual information and staff who will support them so that if they are doing it, they will be told how to do it right and to be careful. They don't expect to be asked why are you doing this? Services are generally getting better about sex."*

*"They will not go to Connexions for sexual health advice, they associate it with careers guidance –they can approach a PA but some say they would rather use GUM or a youth centre."*

African Caribbean young people were said to prefer local services to more central ones.

*"They use local ones more. For them local means community, they know the worker; they don't know people in central services. They are not worried about people seeing them access services – depends on what they have."*

A one stop shop was seen to be the most important factor to avoid endless repetition of their details. A week day afternoon was thought to be the most accessible time for clinic visits.

*"Once they have spoken to one health worker they do not want to have to speak to two or three others. They want times when places are accessible to them. We have on some Thursdays, between 3-5pm, had 48 young people attending and 60 at one time. We have a city wide catchment. I don't know about evenings as a time – it clashes with other things they may want to do. On Saturday mornings you might only get 18 + young people, younger people don't get up until 10 am."*



### **Work with looked after young people**

In this particular area youth workers and community nurses were in touch with young people in care and were able to offer support, however the degree to which these young people move about was a hindrance as it was not easy to build any rapport with them on a one off visit or convey any useful information.

Confidentiality issues were as important to this group as any others.

*"It seems to be the case however that young people are anxious about issues of confidentiality in the residential home and feel that this might regularly be broken by staff. The nurse builds up trust about confidentiality. There is a recent example of this – in one care home the care staff said that a particular young man was not sexually active as he had not spoken to them about it. When talked to by the nurse however it turned out that he had been sexually active, his girl friend was now pregnant and he needed advice on what he should do next. He had kept all this knowledge to himself."*

### **Work with young men**

It was acknowledged that work with young men was less well developed than that with young women and more effort should be made concerning it.

*"You have youth clubs and centres but the focus is very much on young women. Workers perpetuate stereotypes by mostly doing physical activities – football with young men., There is a view that men don't talk - the work needs to be more challenging with them."*

*"The culture is all about women, it assumes men don't talk about these things but you can engage on a one-to-one basis. You need to have some form of seminar or meeting, ask for suggestions and find out what they want."*

One local agency had just appointed a male worker and another centre will do one-off sessions with young men from time to time.

*"Sure Start has just recruited a male worker to work with fathers which is the first real break through. We did offer a programme. We did a session with a provocative title to bring young men in, their partners as well sometimes. We gave them vouchers, it was a first opportunity for them to buy books on the subject which some did."*

### **New approaches to sexual health services**

As in the other areas better provision of contraception in camouflaged settings – such as community centres was proposed.

*"You could use some of the community centres – people could provide sessions with advice and information. They would be a place they could go to talk about relationships. They need to have contraceptives available."*

A greater availability of contraception e.g. in youth clubs or condom machines in health centre toilets, as well as information about STIs was seen as important.

*"I would like a one-stop sexual health shop on every street corner – I would have contraception and STI testing under one roof so young people are not sent from one place to the other for their sexual health needs"*

More consultation with young people was proposed, carried out in ways that paid proper attention to the diversity within the community and that actually acted on what young people said, rather than *'just go through the motions, they should not do it if they are not willing to change their practices as a result of what is said'*. It was pointed out that young people came from a wide variety of ethnic groups – including African Caribbean, Pakistani, Indian, Somali, Turkish, Kurdish young people and that to work effectively with young people a understanding of these communities and cultures was needed.

*"There are a lot of assumptions made. There is a need for a young people's forum where young people can say what they want to see available. It's the only way to ensure they will use something, otherwise young people will say we know all about this stuff already."*

Some people saw a role for young people as peer educators.

*"You need training to empower young people to deliver sex education in schools and youth groups. One Asian group from a school created postcards on sexual health, Try to remember children go off if they are unhappy at home. You need to empower them to make them feel good about themselves."*

It was acknowledged that work of this kind could be controversial but suggested that this could be overcome if the right approach was made within the community.

*"If any work is done in this area it will meet with resistance but if people use proper consultation with the community they can overcome resistance – use people from the community to act as advocates - explain in an open and honest consultation. This is what is needed. You could use the health forum in Highfields which has health professionals."*

### **Conclusions about provision in Belgrave, St Matthews and Highfields**

It was acknowledged that Asian young people in Belgrave and Highfields faced acute barriers to accessing sexual health information and resources because of the lack of provision in the area and cultural attitudes to sexual practices. African Caribbean young people and those in St Matthews had a better range of services available and more self confidence in accessing them.

The difficulties involved in finding ways of ensuring sufficient confidentiality for any services provided locally is acute however and long-term work with the adult community to start to change attitudes may be the most productive approach. Internet, text message and telephone advice line services may provide, in their views, the safest options for these young people. Ensuring that those who attend state schools receive detailed lessons very closely geared to their needs may also help.

## **Phase II findings in relation to Phase I and Deep Dive findings**

The following section will consider our findings from Phase 2 of the research, in relation to the conclusions from Phase 1 which we aimed to explore further in the different areas. We will also consider our findings in relation to the national Deep Dive research, regarding the factors associated with the most effective implementation of a teenage pregnancy prevention strategy.

### **Sex and Relationship Education (SRE)**

#### **Peer educators**

It was one of the conclusions in Phase 1 reflecting widely held views that the most effective SRE work in the city is being carried out by trained peer educators, including young fathers, in school and community settings under the auspices of Turning Point, a voluntary agency with precarious funding which has to be renewed annually.

What we found in Phase 2 was that lessons from Turning Point peer educators received some of the most positive endorsements from young people we questioned. Young people were more likely to remember the content of interactive teaching sessions. Phase II also found that many young people were interested in being more involved in the design and delivery of sexual health services and so there may be a pool of potential peer educators.

#### **Commitment from Education SRE staff**

In Phase 1 it was felt that the Education Department was not committing sufficient resources and effort to the teenage pregnancy prevention strategy although there was sympathy for the difficulties facing Education managers in responding to all the current demands on the sector. It was also felt that the work of the SRE adviser and the Healthy Schools coordinator has been key to enabling some progress to be made in getting schools more involved in the strategy. But there was little knowledge of what was actually being delivered to students as part of school based SRE which was anecdotally reported to be extremely patchy.

In Phase 2 of the evaluation we found that the activities of just one member of staff, the SRE coordinator, appeared to be crucial to both our interviewees and her work as a key contact for training and resources was warmly endorsed. There appeared to be little sense however of any other promotion of SRE from outside sources connecting the work in schools with the wider strategy. Two out of our three colleges who were located within the TPPS hotspot areas had more limited provision of SRE than the college outside these areas, who ironically had least knowledge of the work of the Strategy. In this college where there was a strong commitment to SRE, the teacher responsible for the subject felt there should be greater promotion of SRE to other colleges so that more of them appreciated its importance and gave the time to delivering SRE adequately. Their provision was driven by a

passionate belief in the value of this area of the curriculum. Both of the other colleges appeared to be under a degree of pressure regarding their curriculum in which it was felt there was not enough time to deliver this subject fully.

In relation to our Phase 1 conclusions concerning the patchy nature of SRE provision in Leicester, our findings from young people and practitioners seemed to indicate a considerable variation in the content and delivery of SRE in different schools throughout the city.

### **Health and youth worker support for SRE**

In Phase 1 it was felt that schools would benefit from involving more community health and youth workers in delivering school based SRE and there should be more SRE provision for Years 7/8 to overcome the information gap between the end of primary school and Years 9/10. Delivery of school based SRE by workers other than teachers was supported by both students and school staff in Phase 2. This approach also forms part of the standard required for Healthy Schools accreditation. Young people interviewed wanted SRE lessons to start earlier than they currently did. However, parents were worried that starting SRE at an earlier age might lead to experimentation.

Deep Dive research findings record the factors in SRE delivery associated with effective reduction of teenage conceptions. The difficulties already mentioned of carrying out interviews with school staff meant that not all these factors could be fully investigated.

One of these factors is the **strong delivery of SRE/PSHE by schools**. In Phase 2 we heard comments by young people, practitioners and parents concerning SRE both in the colleges we targeted and others in Leicester. This revealed that in many cases there was a perception that these lessons were not consistently providing young people with the information they felt they needed to negotiate their sexual relationships in their teenage years. Deep Dive suggests a need for a **strong focus on achieving 'healthy school' status**, driven by the LEA usually found to be 20% higher than national average. In Phase 2 we found two of our colleges were engaged with this initiative; one was renewing its accreditation which endorsed a commitment to SRE which was already present, the other had registered early in the year but had not been able to make significant progress on implementing the provisions because of other demands on staff time.

The Deep Dive findings see the **use of DfES SRE guidance as the driver for training and support for schools, including planned programmes of training for governors** on the rationale for and importance of good quality SRE. In Phase 2 we found that staff in two of the colleges were receiving outside support in the form of resources and training via the SRE coordinator, including local training on contraception and involvement in the PSHE Certificate. Neither college however were involved in planned programmes of training for governors although this was acknowledged by both staff to be a crucial issue. One college, in the throes of reorganisation, was working with an interim Board of Governors. It was not possible to check the degree to

which LEA support to improve schools' PSHE delivery, including the development of exemplar lesson plans was effective.

Another key finding from the Deep Dive research was that the **investment in SRE resources and consultancy support** for targeted schools was an important factor. In Phase 2 we found that staff in both schools we interviewed felt they had sufficient resources for SRE and praised the support they received from the SRE coordinator. One college had engaged a separate external consultant to advise on the further development of this aspect of the curriculum.

Deep Dive sets out the importance of the **role of Learning Mentors and peer educators in schools** supporting the PSHE curriculum. In Phase 2 we found that neither of the two colleges where staff were interviewed currently used Learning Mentors to help deliver SRE; however two out of the three community colleges had made use of peer educators at some time but this was likely to be just one or two visits a year.

## **Sexual Health Information and Resources with the Community**

### **Contraceptive and advisory services**

The contraceptive and advisory services provided for young people in the hotspot areas in community settings and centrally by Connexions, were acknowledged to be of good quality in Phase 1, although there was some concern that numbers of young people attending some community clinics were comparatively low and practitioners felt strongly that they needed more capacity. There was some uncertainty on the part of health practitioners about young people's preferred style of delivery for these services with regard to both location and worker and provision in some areas was hampered by the lack of suitable venues.

In the second phase of the evaluation we found that sexual health services in New Parks provided within a youth centre setting which was open five days a week had been well used and well regarded by young people. However usage of services like these by young people could be affected by a change of venue and inconsistent resourcing, with low numbers reported in November at the clinic held at the Allexton Centre, hopefully on a temporary basis. Sexual health provision in Eyres Monsell has been hampered by a more limited youth provision and lack of suitable venues where young people's privacy could be protected when using sexual health services.

We did not find strong evidence that central Connexions was viewed as an important source of sexual health advice and resources by the young people we interviewed, although help from local Connexions staff had been appreciated in one particular case. However statistics provided by Connexions show it had 97 contacts in the quarter Oct-Dec 06 at its central office where staff were able to provide advice and condoms, in addition to carrying out 64 pregnancy tests and issuing an extra 1,626 condoms. This clearly shows that some young people make use of it. However, it may be that perceptions of the role of the agency are variable across Leicester. Some

young people may be getting better signposting to the central office and awareness of the range of services on offer there than others, or finding access to it easier than others. The sexual health side of Connexions' work has not been promoted extensively throughout the city so it is possible that clusters of awareness among specific groups can coexist alongside comparative lack of knowledge or disinterest on the part of others. This could be an issue that needs further attention.

Choices clinics are well regarded by young people but are more thinly spread this year following resource cuts. Both school and Choices nurses are respected by young people as sexual health workers and potentially regarded as adhering to higher standards of confidentiality than some other workers. Young people also wanted to be able to discuss these issues with youth workers though not all young people had found a youth worker they could approach yet. However far fewer young people from Black and Minority Ethnic communities seemed to have access to youth workers than their white counterparts in the areas studied.

### **Privacy and confidentiality**

In the first phase of the evaluation there was anecdotal evidence that young people are drawn to health provision which is available within multi activity settings such as youth centres and Connexions so their privacy can be protected. There was support for mobile youth provision such as the Braunstone Youth Bus which draws young people in, can deliver multi activities and provide a youth focused resource in areas without suitable venues. If funding and logistical issues could be overcome, the provision of a second youth bus for work throughout the city would be supported by professionals.

What we found in Phase 2 was that locating sexual health provision within venues where young people's privacy can be protected was confirmed by both young people and practitioners to be of paramount importance. Young people would not support clinics in venues where they felt exposed and likely to be seen by others in the community. Outside the two areas we studied, one of the most successful voluntary youth projects offered a street level open access youth centre where young people's needs could be assessed in depth and sexual health services could be offered on demand, thus avoiding unwanted attention. Young people tended to use explicitly labelled local and city centre sexual health clinics only when their personal circumstances made this absolutely unavoidable. There was some practitioner support for the use of a multi-purpose mobile bus to address the lack of suitable venues in the right locations in an estate such as Eyres Monsell.

### **Sexual health policies**

The lack of an agreed Sexual Health Policy within the Youth Service was seen in Phase 1 as holding back the capacity of youth workers to make a more strategic contribution to the delivery of SRE sessions with young people and the provision of contraception services, although it was hoped that this issue would be resolved by the Autumn. At the end of 2006 however there was still no agreed sexual health policy for the Leicester city youth service

which is still affecting their capacity to engage effectively in the work of the teenage pregnancy prevention strategy throughout the city.

In Phase 2 we found that only youth workers in New Parks are able to demonstrate how effective their partnership working can be, because they are able to make use of a health service derived sexual health policy as 'cover' for their work. In Eyres Monsell there is a general lack of sexual health services acceptable to young people and a reluctance on their part to go elsewhere for services, so youth centres could play a significant part in boosting the availability of condoms in the area, but the statutory youth service workers are unable to do so until this issue is resolved and the voluntary sector youth workers were similarly stalled with their management.

The Deep Dive findings set out that the **existence of discrete, credible, highly visible, young person friendly**, contraception/sexual health advisory services with a focus on health promotion as well as reactive services are part of an effective teenage pregnancy prevention strategy. It also states it is important they are believed to be confidential by young people. In Phase 2 of our evaluation we found that there appear to be relatively few established services of this kind available to young people within the areas we studied and throughout the city which fulfil all these criteria. Some which offer a range of provision may not be viewed as fully young people friendly, while those that are seen as more approachable may not be in a position to offer all the sexual health services which are needed. This is particularly marked for young people from Black and Minority Ethnic communities in the areas of the city where they live. The C Card scheme launched in New Parks just as our research was finishing may start to bridge this gap and it is hoped that the appointment of a part-time citywide sexual health worker will help to widen the range of provision available to young people.

The Deep Dive findings also suggest that a particular focus on **meeting the specific needs of young men** is important. We found there was no particular provision specifically for young men in the areas we studied. However, more young men appeared to be attracted to a particular youth centre in New Parks which had better sports facilities than other centres in the area, and thus young men formed a high proportion of users of the Choices clinic located there. Earlier in the year the voluntary organisation Turning Point had supported peer education work by young fathers. A conference aimed at workers highlighting ways of working with young fathers was held in the Autumn during our Phase 2 research and a voluntary youth project ran some sexual health programmes aimed at young men. This provision tends to be ad hoc however and a lack of male youth workers in the city is cited as one of the reasons for this gap.

In the absence of a citywide worker, until very recently, sexual health promotion has tended to rely on the energy of individual workers and projects. At the time of the research the 'blast directory' for young people which provided information on sources of sexual health information had not been updated since 2005 due to insufficient funding. However 30,000 teenage pregnancy credit cards have been ordered and will be disseminated to all

young people's services, promoting Sexwise the telephone helpline and RUTHINKING the young people's website on sexual health issue.

**A condom distribution scheme** involving a wide range of partners and/or access to emergency contraception in non-clinical settings was one of the Deep Dive findings, and also the provision of access to the full range of contraceptive methods including long term methods. In Phase 2 the C Card scheme was launched in New Parks, just as the research was coming to an end. This was the culmination of successful partnership working in the area. Access to emergency contraception has become more restricted with the cuts imposed on a free emergency contraception scheme operated by pharmacists. The full range of contraception is available in a selection of local and city centre clinics, not all of which will be viewed as young people friendly. Young people wanted to be given a greater number of condoms when accessing them and for these to be provided in pleasant but neutral bags, which would not be easily recognised.

## **Involvement of young people**

### **Involvement in sexual health service content and delivery**

In Phase 1 it was noted that the involvement of young people has been a strength of the Leicester strategy which has built on an existing ethos of commitment to youth involvement in the city. Young people were involved at the very beginning of the strategy in the production of the BLAST directory and actively participate in many of the current pregnancy prevention and care and support projects. There is a feeling however that more opportunities need to be given to teenagers who are not parents to get more directly involved in the work.

In Phase 2 we found that virtually all our health and youth work practitioners acknowledged that the young people they worked with were insufficiently routinely involved in commenting on and participating in the sexual health services they received. This was felt to be regrettable but in many cases it was perceived that there was a lack of time to do this effectively, or it was not a priority subject with the young people who were part of official participation groups. In community colleges in relation to SRE young people might have the opportunity to comment on a lesson delivered by an outside group such as the school nurse team as part of evaluation, but not otherwise directly influence the content of what was being taught to them in the school.

Provision for the involvement of young people in this way is an implicit part of the DfES Healthy Schools Standard however eg

"A healthy school has mechanisms in place to ensure pupils' views are reflected in curriculum planning, teaching & learning and the whole school environment, including those with special educational needs and specific health conditions, as well as disaffected pupils, young carers and teenage parents." [www.wiredforhealth.gov.uk/PDF/audittool.doc](http://www.wiredforhealth.gov.uk/PDF/audittool.doc)

It was notable in our interview findings that there were numbers of young people volunteering their services to be peer mentors and get involved in disseminating information of this kind, which indicates an untapped resource within the youth population.



## Youth Services

Deep Dive findings note that reductions in conception rates are associated with **effective Youth Service provision, protected Youth Service budgets and a strategic approach to youth service provision.**

We found in Phase 2 of the evaluation that the Youth Service in Leicester is currently not able to operate fully in the ways recommended by Deep Dive. There is understaffing and resourcing in some areas and a lack of capacity to act strategically in relation to teenage pregnancy prevention until policy issues are satisfactorily resolved with the workforce.

## Workforce training

The Deep Dive findings indicated that in authorities who had most successfully reduced teenage conceptions, mainstream partner agencies such as Youth Service, Social Services and Connexions took responsibility for ensuring that their **frontline staff had adequate training in SRE.** In the second phase of the evaluation we recorded that the full-time workers from all sectors we interviewed had all received good training in sexual health in the past. Funding restrictions had meant that not all agencies had been able to maintain the same level of workforce training, although Connexions during the financial year had been able to train 59 city based members of their staff in a range of sexual health programmes and also six workers from other agencies at one session as part of a bi-monthly Partnership Practitioner Forum. Voluntary sector full-time workers would like access to more free sexual health training and it was noted that part-time and volunteer workers did not usually have opportunities to receive sexual health training.

# **Implications of the evaluation findings for the Leicester Teenage Pregnancy Prevention Strategy**

## **Sex and Relationships and Education**

There are very clear messages from the young people who took part in our research that the SRE lessons they received needed to start at a younger age and cover more issues. Also, many of them wished to have a bigger role in the design and delivery of SRE in schools. The young people felt that the lessons did not cover the subjects beyond the mechanics of sex that were important to them, including relationships and emotions and what to do and where to go if they found themselves pregnant. In some cases student knowledge was well in advance of what was being taught and there needed to be some acknowledgement and response to this if the lessons were to be effective. It was also felt that it would be better if the lessons were delivered by someone other than school teachers. Our interviews with parents indicate that not all of these suggestions from young people are likely to meet with approval from some Asian parents who are challenged by the explicit content of sex education lessons in state schools, but they are wanted by their children.

Implications for the Teenage Pregnancy Prevention Partnership Board and Leicester's Children and Young People's Strategic Partnership are as follows:

- Greater engagement with schools, via a review and other activity, concerning the current content of SRE they provide, its provision throughout the secondary school from years 7-11, methods of delivery and ways in which this can be given higher priority within the curriculum. This might also include the distribution of standardised information in question and answer formats of what to do and where to go in the event of various emergencies arising for young people in the course of their sexual relationships.
- Consideration of ways in which young people can be consulted and have greater input into the content of SRE in schools throughout Leicester and other information resources. This will need to be realistically resourced.
- Special attention to the content of SRE lessons in schools and colleges with a high proportion of minority ethnic students, to ensure this is as detailed as possible in the absence in some cases of accessible ways of acquiring this information within their communities. Schools appear at present to be the most socially acceptable way in which this information can be given to many young people from these communities.
- Support for the creation of more peer educators to deliver SRE lessons, including more young people from the Black and Minority Ethnic communities and young men.

- Encouragement for schools to routinely use outside staff such as peer educators, school nurses and youth workers to deliver SRE lessons, and financial commitment from outside agencies such as Health, Youth Services and Connexions to make this possible. This aspect of the Healthy Schools standard can also be highlighted by SRE education staff.

## **Sexual Health Services and Information**

Young people wanted a greater variety of sexual health services with better publicity of them and better access to them. Being able to trust that the worker they talked to would maintain confidentiality and that they could access information and advice in private when they needed it was also paramount. This was particularly important for Asian young people who would not feel either safe or confident making use of explicitly labelled sexual health services in their immediate neighbourhoods. Locally based sexual health services in the hotspot areas are likely to be better used and more effective than city centre ones.

Implications for the Board:

- Greater availability of free condoms at a wider range of outlets throughout Leicester whose location is well publicised to young people. The city community safer sex project started in October 2006 and it is anticipated that this should make an impact on the general availability of contraceptives across the city. A C Card scheme has just started but this particular form of provision should not be regarded as the only means of distribution, as there may be some young people who are not comfortable with this level of scrutiny. Informal distribution via youth centres should also be used, thus implying a rapid resolution of the sexual health policy issue.
- Greater availability of local sources of emergency contraception to replace the well used local pharmacy schemes.
- More capacity for Choices clinics which are well regarded by young people.
- Greater provision of sexual health services with trained workers embedded within general youth provision.
- Greater investment in youth provision which can be staffed most days of the week in areas throughout the city, where young people will have somewhere to turn for immediate advice and signposting when emergencies arise. Adoption of agreed sexual health policy by the youth service.
- More publicity of sexual advice services via posters in supermarkets, shops, hairdressers, youth centres, community centres etc and also exploration of the use of internet and text services as ways of disseminating information.

- Greater awareness of and attention to issues of confidentiality and privacy in the provision of sexual health services to young people.
- More sexual health training for workers in contact with young people including part-time workers and volunteers.
- Greater attention to ways of involving young people in the design and delivery of sexual health services and information.

## **Work with Parents**

There was a clear message from young people that in many cases parents were a wanted source of information on sexual health matters, but many young people reported that they were not able to discuss these issues with their parents, even though this was something they wanted to do. Interviews with a small sample of parents however, particularly those from the Asian community, revealed the difficulty some, but not all, had in breaching the cultural taboos in their community about talking about sexual matters within the family.

All parents accepted that sex was a difficult topic and often there was not freedom of communication between parents and children from all backgrounds on the topic. There was support from all parents for the provision of parent groups with a trained worker to explore this topic and provide advice on ways in which this subject could be raised with their children.

There was also support from this particular sample of parents for more discussion within Asian communities of the provision of sexual health information and advice services for young people and suggestions of some forums where this could be raised.

Implications for the board:

- Consider development of work with parents on sexual health issues throughout the city
- Outreach to women active in the voluntary sector within the Asian communities and involvement of them in planning for a day event as a platform for discussing the issue.
- Develop dialogue with organisations such as Federation of Muslim Organisations to start engagement on issues of young people's sexual health knowledge and services for them.

## **Overall Conclusions**

As mentioned in the Phase 1 report, an evaluation of an organic process such as a teenage pregnancy prevention strategy can only be a snapshot at a moment in time. Within the lifetime of this project some pre-existing sexual health services have had to be reduced because of financial constraints, while other resources such as sexual health staff and outlets for condom distribution have received a significant increase. Leicester has clearly been successful in

achieving an initial significant reduction in numbers of teenage conceptions, but has now to enter the next stage to ensure this reduction is maintained and reduced further.

In listening to young people it is clear that there seems to be two kinds of mismatch of need and provision occurring which is potentially acting as a deterrent to their use of services. One is between what young people want to know about sex and relationships and what parents and teachers are able and prepared to tell them, and the second is between the privacy they want and need as self protection in accessing sexual health advice and contraception and the public self disclosure that is forced on them by the way some services are made available. Within the services we looked at, two models seem to have worked relatively successfully for young people; publicised sexual health services on offer at the same time as general youth activities, so that consulting them is not too obvious and one-to-one unpublicised sexual health advice and resources from trusted workers in youth centres on demand.

The issue of SRE in schools is important, because this is potentially the only place in which virtually the whole age group can be given access to the sexual health information that is needed at different ages, in an environment that is non stigmatising because everyone is doing the same thing. Community based services will not necessarily reach everyone and are likely to remain limited in some areas. It seems in some cases however that this potential is being lost by an overloaded curriculum within schools, to the extent that there is no room to do SRE effectively, or irrelevant information is being delivered in an uninteresting fashion by the wrong people for the task.

Enabling and encouraging young people to have more say in the content and delivery of the sexual health curriculum and the ways in which it is promoted and also engaging more with parents, could inject some new thinking and novelty into existing practice with beneficial effects all round.