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Teenage facilitators: barriers to improving adolescent sexual health

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· Introduction

Hull, a city in the north-east of England, has a high rate of conception amongst young women aged between 13 and 16 years, relative to the rest of Britain. No-one is quite sure why this is the case, but there are many theories. Some believe that young women deliberately get pregnant to get government housing. Others say that young people lack the skills to access information and contraception, or that services themselves are failing those under 16 years. Another group believe that this is a cultural issue and that young teenage pregnancy is perfectly acceptable in some parts of the city; and so it goes on.

The British government is concerned about the levels of teenage pregnancy in England and has set targets to reduce the rate by at least half. What is not clear, however, is whether young teenage conception is a problem for anyone else. Do teenagers in Hull, their parents, other professionals or people in the wider community see it as a problem? The goal of the Faculty of Public Health Medicine is that *"women should become pregnant by choice"*. Perhaps if there is a problem, it can be seen as not teenage pregnancy in itself, but whether teenagers are becoming pregnant by choice. If they are not becoming pregnant by choice, what then are the barriers to improving adolescent sexual health? What changes would need to be made to increase effective contraceptive use amongst teenagers? What methods do we have for finding this out?

Current research indicates that many factors may contribute to young teenage conception. These include: educational factors, developmental,

psycho-social and skills factors, service provision and use and cultural factors (Peach *et al* 1994). It also states that without a multi-agency, 'whole community' approach, these factors cannot be addressed effectively. The idea of a 'whole community' approach is explained by Ashton and Seymour (1988) who say that health education *"is only able to make its full contribution to the reduction of teenage pregnancy and sexually transmitted disease when it is part of an integrated community-based programme and supported by public policies which set out to influence the entire health field in relation to sexual attitudes and the expression of human sexuality"*.

The government Health Authority responsible for the Hull area (East Ridings Health Authority) is interested in finding out two things in relation to young teenage conception:

1. Which of the above factors are operating in those places with the highest young teenage conception rate?
2. How can the idea of a 'whole community approach' best be implemented to address these factors?

One of the Health Authority's main concerns is the effectiveness of services providing information, referral and clinical sexual health services for young teenagers. They are keen to know what changes are needed to make improvements. To try and answer some of these questions, they funded the Young People and Sexual Health project, which is based at the Department of Public Health Medicine in the University of Hull.

• The project

The Young People and Sexual Health project is using a participatory approach to involve young people, parents, workers and the wider community in:

- Identifying factors which influence the way young people make decisions about sexual health.
- Evaluating the provision of information, referral and clinical sexual health services to teenagers, including education, youth and social services, community and voluntary agencies.
- Finding ways to improve teenage sexual health.
- Planning and monitoring the changes suggested.

We discovered that few people knew of, or understood, the concept of PRA. Our first task, therefore, was to introduce the concept of participation to a variety of key people. Most important of these were those who would have to give permission for young people under 16 to be involved, such as teachers, parents and youth workers. We had to make them understand that we would not ask personal questions; that information would belong to the participants; that there would be complete confidentiality for individuals and organisations; and that everyone, regardless of age, literacy level or disability could make a worthwhile contribution. We did this by demonstrating PRA tools wherever possible and by training workers, teenagers and parents in the approach. This has given us the added bonus of creating a pool of local facilitators from different backgrounds who are happy to publicise, support and actually work in the project. The training is in the process of being accredited, which means that participants, if they wish, can gain a national qualification.

• Teenage facilitators

For several months we have been meeting weekly with a group of 15 year-olds (three young women and four young men) for sessions usually lasting two hours. We met this group through local youth workers who

described them as 'non attenders', young people who regularly truant from school. After a 'taster' session in which they mapped their local area, the whole group were keen to learn more. During the first weeks they worked on becoming a team and on learning basic PRA tools and techniques. For legal reasons, two youth workers also attended the sessions. The workers were interested in PRA for their own work and it was a challenge to involve them in such a way that they did not dominate the group. Whilst we have not been completely successful in this, they have been encouraged to develop their own skills and a comfortable balance has slowly been achieved. Some of the work done by the young people is described below.

Leaflet evaluation

During a session on evaluation, we looked at ways in which sexual health information leaflets could be evaluated using participants' own criteria (Figure 1). First the whole group discussed what needed to be included for teenagers to read, enjoy and understand sexual health leaflets. These were listed on a large sheet of paper.

The young people then split into pairs, taking one leaflet at random from a pile. Each pair was given a sheet of coloured card with a circle drawn in the middle. Using the 'evaluation wheel' (Pretty *et al*, 1995) they divided the circle into equal parts, each part representing one of the criteria they had listed before. The resulting triangles were then shaded in to show the extent to which the leaflet complied with each criterion. Finally they pasted the leaflet next to its evaluation wheel and presented their work to the rest of the group. Comments included: *"3D effect on writing is attractive; all the leaflets had too much writing and this is not the way young people will take information in; most leaflets are boring; cartoons and 'super stars' would be more eye catching; no leaflet was amusing; some pictures are not relevant to the text; pictures are very clinical, too small and old fashioned; illustrating steps for contraceptive use is good if done clearly."*

Figure 1. Leaflet evaluation using the evaluation wheel

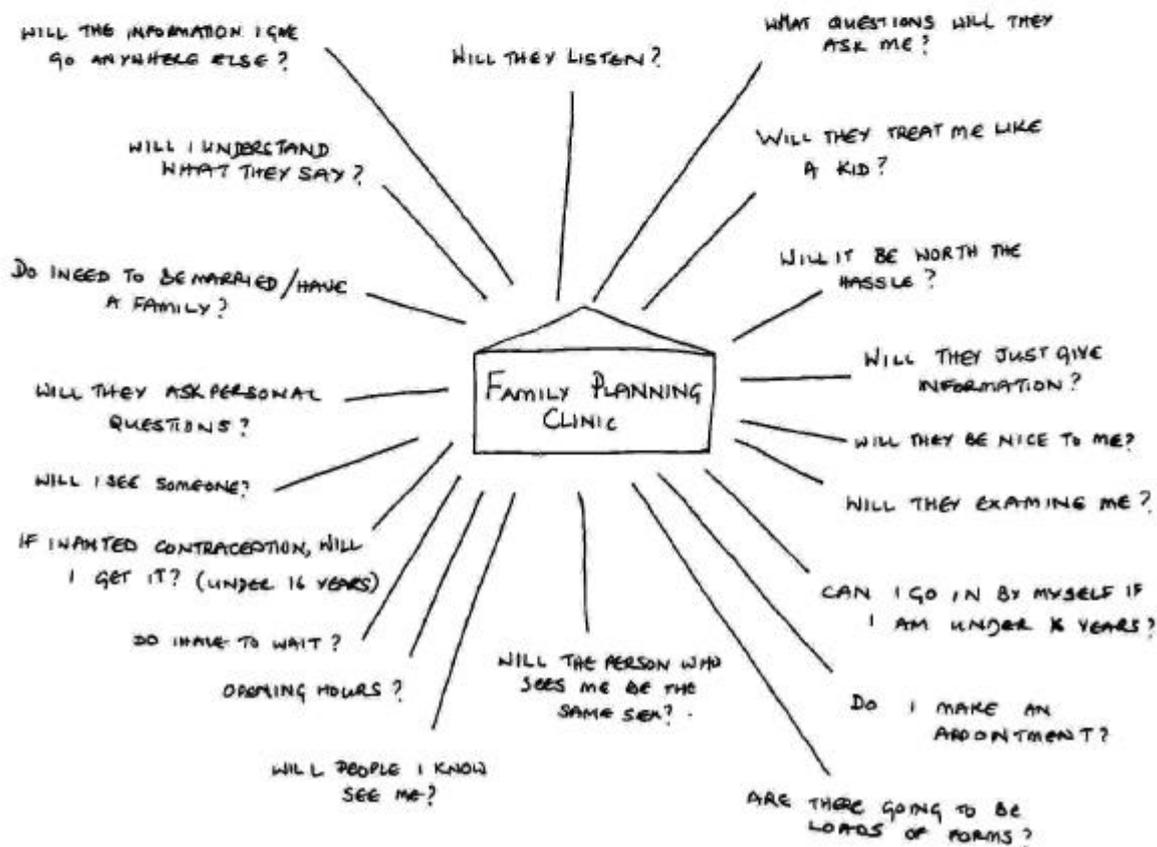
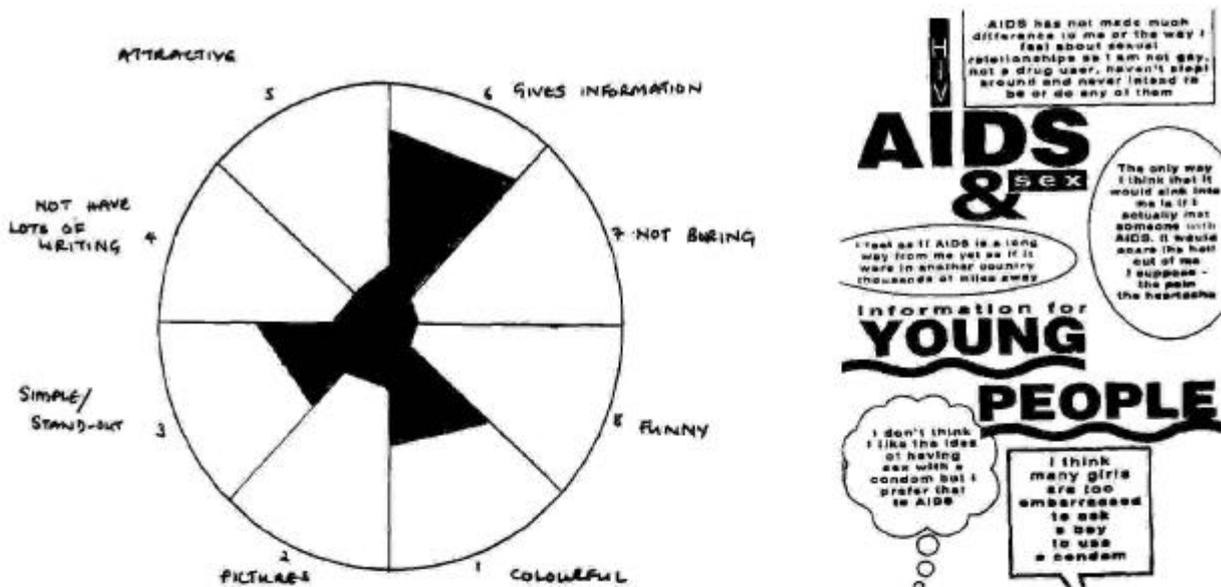


Figure 2. Young people's concerns when visiting a family planning clinic

Tool development

This group has also been developing their own tools. In their first session they were asked to design tools that would allow other young people to express their concerns about going to a clinic for advice about contraception.

They elected to split into two groups according to gender. Each group decided who would play the roles of facilitator, reporter and observer. When they finished designing their activity, they tried it out on the other group. The young men's group developed the following activity: They drew a picture of a clinic on a large sheet of paper and gave this to the participants. Their facilitator asked the participants to draw spokes from this building and to write or draw the queries that a young person would have when going to a clinic (Figure 2).

These young men and women will continue to develop tools over the next few weeks. Their aim is to gather information from a wide variety of young people and from sexual health workers in their area and put together a video which answers questions such as those above. They are concerned about teenage literacy levels and would also like to make a cassette tape to complement sexual health information leaflets. Until they are confident, we will facilitate their activities. They aim to work in schools and youth clubs, on the street where young people congregate, with young people in residential care, with those with specific learning difficulties and with disabilities and if possible, with young people in prison.

• **Conclusions: PRA with young people in Britain**

Working with young teenagers under the age of 16 in Britain requires planning, but can be enormously satisfying for all concerned. Young people's ability to contribute to decision-making is often underestimated and the process can bolster confidence and self-esteem in some young individuals. The Barnardos publication about children, ethics and social research has been very useful in this respect (Alderson, 1995).

Some additional points to bear in mind include the fact that facilitators and trainers should be 'police checked' to reveal their conviction history; teachers need details of activities well before work can be done in schools and in some cases parental consent is required; in institutions, sufficient numbers of facilitators need to be present so that work can be done simultaneously with the adults in charge; confidentiality is paramount and young people must always be able to choose whether they participate. On the street, young people can just walk away if they don't like the activity. In schools and youth clubs if you can secure a corner during normal recreational activities, participants will be able to come and go as they please. In a formal classroom situation, it is difficult for young people to opt out.

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