

SOUTH EDINBURGH HEALTH FORUM

Health Education focus group

‘Would there were no age between ten and three-and-twenty, or that youth would sleep out the rest, for there is nothing in between but getting wenches with child, wronging the ancients, stealing, fighting.’ – The Shepherd in Shakespeare’s *The Winter’s Tale* (III, iii).

Abstract

The South Edinburgh Health Forum has been concerned during the past year with the health education of young people, and the extent to which it influences subsequent behaviour. Alcoholism, drug use, and teenage pregnancy are current problems. In Dundee an innovative programme has introduced the teaching of sex education by pupils as young as 14. (1) At the same time, in an effort to combat childhood obesity, ‘A new programme to help children kick-start a healthy regime has been launched in Edinburgh’ (2). Health education is a live issue in Scotland. In an effort to make a contribution towards solving these problems, the SEHF identified a small focus group of young people between the ages of 13 and 22, and asked their views on the extent to which the programmes of health education that they had experienced had been helpful.

Our findings were that on the whole the ‘Personal, Social and Health Education’ programmes had indeed been helpful and relevant, in a variety of schools, including a Roman Catholic secondary school. However, the link between under-age drinking and unwanted pregnancy had not been made, and students had noticed variable quality in the teaching, depending on whether it was given by specialist teachers. Sex education in particular would benefit from being given in an informal setting, not in the usual classroom format. More emphasis was needed on the emotions and relationships. Video material needed updating, and the dangers of internet chat-rooms needed to be stressed. The prevalence of smoking among teenagers should be addressed.

Introduction

During the year 2009-10 it had been brought to the attention of the Forum that there were issues around under-age drinking, drug use, and teenage pregnancy that needed to be addressed. It was therefore decided to seek the advice of a focus group of young people on the extent to which they feel that existing programmes of health education meet their needs.

It should perhaps be added that teenage pregnancy has been with us throughout the ages, but in former times such teenagers have often been married: the extended nature of contemporary education means that such pregnancies tend to interrupt schooling in modern times and interfere with the student’s progression into adult life. At the same time, the age of puberty is falling.

‘Despite the establishment of a national teenage pregnancy strategy in 1999, teenage birth rates in the UK are the highest in western Europe’. (3) Specifically in Lothian, there is a high rate of sexual activity among teenagers: according to one study, 32.7 per cent of girls aged 14-16 and 27.5 per cent of boys had experienced sexual intercourse. (4)

In order to explore the issue of health education further, a group of young people living in South Edinburgh was identified. Their ages ranged from 13 to 22, and they were invited to a meeting after school on a weekday afternoon. Where appropriate, parents were consulted. The facilitator had been CRB checked.

The group met on 23 February 2010, in an informal setting, with refreshments provided. Present were six young people from south Edinburgh from a variety of backgrounds – one young man from S2, one young woman in S3, one young woman and one young man from S5, and two students from Edinburgh University, studying medical sciences. The format was a discussion group led by Heather Goodare (HG), with Helen Ogg (HO) also participating and taking notes. The ground rules were stated: no one would be identified by name, and all would have the opportunity to see any resulting report and if necessary make corrections or additions.

Notes on discussion

The discussion was opened by HG, who initially reminisced about the kind of health education she had received (or rather, not received) at her boarding school during WW2: in fact, no information about reproduction in the context of human biology had been offered, and the pages on the reproductive system of the rabbit had been cut out of the class biology books. Things had now changed radically, and for the better. The participants then gave an account of the kind of education that students were now receiving.

K, at Edinburgh University, who had been at school in Kinross, described the health education as ‘Soc Ed’ (or social education). It comprised information on sex, drugs, social responsibility and STIs. He had had no information from his parents up until the age of 16/17. Sex education was introduced in Primary 7.

C, also at Edinburgh University, who had been at school in London, had begun health education at the age of 10/11. There had been talks about nutrition and nits, and then later about sex: nothing at that stage about relationships. At secondary school she remembered two distinct slots, and the quality of the information very much depended on the teacher – eg a music teacher delivered some of it on the subject of drugs. There was a particular focus on not getting pregnant, and knowing about drugs.

Ce, at a South Edinburgh high school, said her experience was that the same teacher (often a guidance teacher) was responsible for the lessons. In Primary 6/7 the sex education was very basic, concentrating on the mechanics. The lessons were given to the whole class, boys and girls. She thought a nurse might have been involved at some point. When the girls were taught about periods a nurse was definitely involved. Her opinion was that the education was given at the right age and in the correct amount of depth. The teachers were very ‘matter of fact’ about it. In secondary classes PSHE sessions were delivered according to the registration class.

L, from another South Edinburgh high school, with a Muslim family background, said that her experience was very similar to Ce’s, with sex education starting in P6/7 and

again reiterated after puberty in S3/4. The issue of pregnancy had been discussed prior to lessons in S3/4. L thought that the technical aspects of sex education were fine, but that there should be more emphasis on relationships and what they involved. There was never any mention of 'love' or 'respect'. The overwhelming message was that pregnancy was always a total mistake and that when you reached 16 you must protect yourself from STIs and becoming pregnant.

S, from the same school as Ce, added that there was quite a bit of emphasis on STIs. One of his most useful experiences had been a whole day's conference on sex matters, facilitated by outside 'experts'. No teachers were present, and pupils attended in 'friendship groups'. This encouraged free and frank discussion and the asking of any question at all – and encouraged clarification of what some young people had thought. There was a lot of information available in the form of leaflets, particularly about contraception, where to obtain free condoms, and from organizations like Caledonia Youth, who provide free confidential advice. K mentioned that he had also been told of drop-in centres that offer advice.

Cd, from an independent secondary school, told us that it was his form teacher who delivered the PSHE lessons in primary school. He thought that the 'jokey' videos were OK - if a bit dated. In P7 they had tackled 'Choices for life'. He had access to a number of information leaflets and stickers. The information on drugs was helpful, and seeing what they actually looked like was also very helpful. Some of the education had recently been given in biology lessons, which presented a slightly different emphasis. They had learned about STIs in S2. All in all he thought the education he had received so far had been quite comprehensive.

S agreed that the videos that are played to young people are very dated and a fresher approach would be less open to ridicule.

C told us that in the part of London where she had spent her schooldays, they had also been taught about abusive relationships.

L said she thought it would be useful to include material about abusive relationships in the Scottish curriculum – and perhaps more about the legal aspects of relationships also (under-age sex for men and women). In an earlier conversation she had expressed the view that health education should continue after the age of 16. The feeling at the moment was that education authorities assumed that on gaining the age of 16 students were 'on their own' since they had reached the age of consent, whereas in fact they might still need support and information.

S said he thought it would be more helpful to teach PSHE in a classroom of comfy seats – maybe in a circle rather than the classroom format. He also thought that material such as how to behave in computer chat-rooms should be taught, and how to keep safe on the internet.

In general discussion it was agreed that alcohol could certainly be the reason behind many teenage pregnancies. (This observation is borne out by recent research in European cities. (5)) The lowering of inhibitions and not being in a state to use protection for sex were cited as reasons. The group agreed that there were many ways of getting drunk. It was often an end in itself, and alcohol was relatively easy to get hold of and use, no matter what the actual age of the teenager was. PSHE lessons did not really make the connection between use of alcohol and unprotected sex and its consequences. In many ways using alcohol was seen as more acceptable than using drugs or having unprotected sex, and parents seemed to be accepting of their teenagers' experimenting with it. Over indulging in drink was often used as an excuse for unprotected sex. Most of the teenagers were aware of what constituted a unit of alcohol, but the difference between what was safe for adults compared with that for teenagers with a lower body weight was not spelt out.

The harmful effects of drugs were emphasized – as was 'keeping yourself safe'. We touched on whether or not the young people knew about the 'morning after' pill. Right through the age group there was awareness, but not detailed knowledge of it or how to obtain it, or whether it had any side effects. Most would talk to the school nurse or a guidance teacher if it were necessary – but most said they would talk to their parents initially. C mentioned that one of her colleagues, now teaching in Australia, had said that teenagers there are taught that the morning after pill should only be taken a maximum of three times in a lifetime. There were dangers in taking it more often. This information came from a pharmacist in eastern Australia rather than a teacher (pupils may not be taught this). This message had not been spelt out to young people in Edinburgh.

None of the young people were aware of their contemporaries opting out of PSHE lessons. Most thought it would be possible.

Telephone Interview with Se

Se was unable to attend the discussion group, but took part in a telephone interview with HO. It was felt important to include the views of a student attending a Catholic school. Se attends a Roman Catholic secondary school in South Edinburgh, and is in S2.

Her experience mirrored almost exactly that of the young people from other South Edinburgh high schools. In Primary 6 and 7 there had been lessons about sex – how the body worked, and what the mechanics of sex and reproduction were. It had been presented in a matter of fact way, with information on periods etc for the girls.

In S1, everyone had PSE lessons, following the 'keeping myself safe' course. All students had been given a large loose-leaf folder covering sex education and other topics, to which they could refer for various questions. In Se's opinion some of the video material was dated and would benefit from updating. She also said that there was some apprehension amongst her fellow pupils – and some nervousness – in PSE lessons. It depended very much on the teacher whether or not a calm atmosphere could be achieved.

Se also said that there seemed to be no particular shying away from advice on contraception – such items were presented in a matter of fact way, without any ‘faith’ spin.

She also mentioned that for her (and some of her friends) it would have been helpful to know before she went to high school what a leap it would be in terms of social interaction – and maybe it would have been helpful to have that pointed out in P6/7.

Although the school does have a uniform policy, there is still an amount of competition among certain groups of pupils to wear the latest fashion, which in itself is divisive.

Follow-up meeting with Ce and Cd

In Week 2 we met again with Ce (f) in S3 and Cd (m), in S2 (the youngest members of the group). It was valuable to learn:

1. Dealing with bullying needs more training. Often intervention from teachers simply makes the issue worse, confronting the bully and extracting an insincere apology or other show of remorse, but in fact sweeping the bullying under the carpet.
2. It would be useful for young people to know whether there are any ‘safe’ limits for alcohol for young people. The information given is usually about adults and relates to adult weights.
3. The information about drugs is incessant – but there is little or nothing about alcohol itself being a drug.
4. When pregnancy does occur, it would be helpful for the school to support the pupil rather than encouraging them to be out of school for the duration of the pregnancy.
5. There is among some pupils the propensity to smoke. Usually it is done outside school – it is thought that sometimes this is to relieve the tension arising from family/boyfriend/relationship problems. Also it might be considered ‘cool’. More could be done in PSE lessons on the hazards of smoking.
6. It would be helpful to have more in PSE about the emotional side of relationships.
7. The wearing of uniform was seen as helpful by Cd, as a way of ironing out differences in background, but unhelpful by Ce, who preferred the policy at her school, where students could wear their own clothes.

The position of school-leavers

We were hoping to seek also the views of a 16-year-old girl who had already left high school, but she could not come to a meeting owing to work commitments. We sent our report to her for comments, but at this time she was unable to respond as she was suffering from severe sickness, which turned out to be caused by early pregnancy. At the time of writing we understand that she plans to have the baby, but also to continue with further education. This story reinforces the view expressed by L that health education should provide also for the needs of students who are over 16 but may still need information and support. Attaining the age of ‘consent’ involves responsibilities as well as rights.

Summary of the main findings and recommendations

- It is encouraging that all schools (including independent and faith schools) in south Edinburgh are following the standard curriculum in relation to personal and social education.
- Our sample of young people between 13 and 22 are happy and comfortable in discussing aspects of the PSE curriculum.
- Without exception, all the young people commented that the video/DVD material used to teach about sex needed updating. The use of images from the 70s and 80s detracted from their learning.
- Missing from PSE was any mention of relationships or love or respect. The emphasis was always on 'keeping yourself safe'. There is independent evidence that the meanings given to sexual behaviour by young people are just as important as learning about the mechanics. (6)
- The message was that pregnancy was always a total mistake, and that it was important to protect yourself from pregnancy and STIs. Any positive messages about love, marriage, and parenthood, when appropriate and at a suitable age, were missing.
- In many cultural backgrounds starting families early is encouraged and respected: teaching that early pregnancy is 'always wrong' might be accidentally leading or encouraging a negative image for these cultures.
- It was the opinion of the young people that teachers need specialized training to be able to deliver a PSHE curriculum competently. When it was done well, it was fine, but when done by non-specialist teachers it was not so helpful. It was not something to be taken on by a teacher who happened to have a free period, without appropriate training.
- There was an awareness of contraception methods, and in particular that the 'morning after' pill existed. None of the young people were aware of any potential risks associated with it, nor did they know exactly how to go about getting it – although most would approach parents or school nurses/guidance teachers.
- No link was made in PSHE between alcohol and potential pregnancy.
- Young people would like to know what a 'safe' number of units of alcohol is in relation to body weight. However, this should not imply that drinking at young ages (12/13) is okay in moderation, when in fact it could lead to developmental problems.
- Pupils who get pregnant should not be excluded (or sent away) from school. They should be offered flexible arrangements for further education.
- More needed to be done to alert students to the dangers of internet chat-rooms, and include information on how to report online abusive/suspicious behaviour (to charities etc). – refer to the 'red panic button' which facebook (a social networking site) is refusing to implement.
- The provision of health education should continue beyond the age of 16.
- The hazards of smoking also needed to be given more emphasis.
- Teaching in friendship groups may be beneficial, as suggested by two members of the focus group – however the school paying a company to carry this out for a day may be too costly for some schools' budgets.

Conclusion

The World Health Organization suggests that the promotion of sexual health ‘requires a positive and respectful approach to sexuality and sexual relationships’ (7). We should like to suggest that such an approach, where romantic relationships are regarded positively, but accompanied by respect for others, is likely to be more acceptable to young people, and achieve a more responsible attitude to parenthood, than the negative messages that seem to emanate from some aspects of personal and social education as it is now delivered.

It also seems from an important systematic review of research on teenage pregnancy that health education should be seen in the round, and that ‘sex education and better sexual health services . . . are not effective on their own’. (8) The topic needs to be set in the context of the education of the emotions as a whole, and sex education should be ‘complemented by early childhood and youth development interventions that tackle social disadvantage’. (8) These comments are borne out by the group we consulted.

Warm thanks are extended to our group of young people, who gave up their time voluntarily in order to discuss these issues. We are particularly indebted to Catherine Rushworth, who drew our attention to some helpful papers. We hope to bring their recommendations to the attention of the educational and health authorities, and to improve the health and welfare of all our citizens for the future.

Helen Ogg and Heather Goodare, South Edinburgh Health Forum, April 2010

References

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