WHY IT MATTERS

Myths & Reality

Teenage Pregnancy and Parenthood
Myths & Reality

Report of

The Working Group on
Teenage Pregnancy & Parenthood

Consultation Document

November 2000

Issued by
Department of Health, Social Services and Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábhálteacht Phoiblí
Unplanned teenage pregnancy and parenthood is a challenging issue to address. Whilst some teenage parents and their children live happy and fulfilled lives, far too many do not. The needs of pregnant and parenting teenagers vary greatly depending on individual circumstances including age, social support and financial situation. For those who are particularly young with little or no family or financial support it can and does cause considerable distress, not only to the young person concerned, but also to their families.

There is growing concern among statutory, voluntary and community organisations about the impact of teenage parenthood on the life chances of the young mother and her baby and agreement that concerted action is needed to address the issues around this problem.

It is widely recognised that teenage pregnancy and early motherhood can be associated with poor educational achievement, poor physical and mental health, social isolation, poverty and related factors. The consequences for teenage fathers range from becoming financially responsible for their child to experiencing emotional problems at being separated from their children if access is not permitted. Over the last ten years, research has increasingly indicated that some social and service interventions can contribute to a reduction in rates of teenage conceptions.

It is increasingly clear that socio-economic disadvantage can be both a cause and a consequence of teenage parenthood. Socio-economically disadvantaged young people are those most likely to become teenage parents. They then face limited prospects in the areas of education, training and eventual employment. Consequently, teenage parents, but particularly mothers, lose the opportunity to realise their full potential in the workplace and are often relegated to working in low paid, low status jobs or to unemployment and dependence on state benefits.

“Teenage conceptions tend to be both a symptom and a cause of social inequality. They can become a cycle of deprivation”.

(Tessa Jowell 1997)

HEA Summary bulletin: Reducing the rate of teenage conceptions. An overview of the effectiveness of interventions and programmes aimed at reducing unintended conceptions in young people. Health Education Authority, 1999
1.5 The aim of this report is to facilitate a reduction in the number of unplanned births to teenage parents and to minimise the adverse consequences of those births to teenage mothers and their children. The report contains an analysis of the birth pattern to teenage mothers and research evidence about associated risk taking behaviour among teenagers here. The report explains why efforts to reduce the rates of teenage pregnancy must focus on raising expectations among young people and on equipping them with the confidence and skills to manage relationships.

1.6 For the purposes of this report teenage parenthood is defined as the birth of an infant to a mother aged under twenty years. Teenage pregnancy is defined as a pregnancy in a female aged under twenty years. Sexual activity is defined as engaging in sexual intercourse.
2.1 There are approximately 1700 births to teenage mothers each year, as illustrated in figure 1. The number of births to teenagers remained fairly static during the 1980s, then declined for a period and since 1995 has been rising.

**FIGURE 1**
**Number of Births to Mothers aged <20 years in Northern Ireland**

Source: General Register Office for Northern Ireland

2.2 As illustrated in figure 2 the majority of teenage mothers are aged 18-19. There were no recorded births to girls under 13 during the period 1992-1998. Between 1990-1999 an average of 8 births occurred each year among those aged under 15, though the figures varied from 14 in 1996 to 3 in 1997. The number of births increases with maternal age, with a steep rise evident between age 15-17.

**FIGURE 2**
**Live Births in Northern Ireland from 189-1998 to Mothers aged <20**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;14</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>12</td>
<td>1.2</td>
</tr>
<tr>
<td>14</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>10</td>
<td>12</td>
<td>13</td>
<td>3</td>
<td>8</td>
<td>65</td>
<td>6.5</td>
</tr>
<tr>
<td>15</td>
<td>30</td>
<td>31</td>
<td>29</td>
<td>30</td>
<td>28</td>
<td>39</td>
<td>32</td>
<td>40</td>
<td>37</td>
<td>47</td>
<td>343</td>
<td>34.3</td>
</tr>
<tr>
<td>16</td>
<td>136</td>
<td>116</td>
<td>112</td>
<td>144</td>
<td>113</td>
<td>120</td>
<td>100</td>
<td>160</td>
<td>151</td>
<td>146</td>
<td>1298</td>
<td>129.8</td>
</tr>
<tr>
<td>17</td>
<td>326</td>
<td>343</td>
<td>348</td>
<td>344</td>
<td>314</td>
<td>270</td>
<td>269</td>
<td>326</td>
<td>347</td>
<td>335</td>
<td>3222</td>
<td>322.2</td>
</tr>
<tr>
<td>18</td>
<td>610</td>
<td>555</td>
<td>556</td>
<td>582</td>
<td>512</td>
<td>479</td>
<td>479</td>
<td>425</td>
<td>514</td>
<td>591</td>
<td>5303</td>
<td>530.3</td>
</tr>
<tr>
<td>19</td>
<td>794</td>
<td>806</td>
<td>738</td>
<td>756</td>
<td>624</td>
<td>630</td>
<td>541</td>
<td>619</td>
<td>594</td>
<td>607</td>
<td>6709</td>
<td>670.9</td>
</tr>
</tbody>
</table>

Source: General Register Office for Northern Ireland
Over time, the trend has remained consistent with birth rates increasing steadily with age as demonstrated in Figure 3.

The number of births to teenage mothers must be viewed against the backdrop of the overall birth rate that has declined in the last twenty years as shown in Figure 4. Although for all women the birth rate has dropped, the birth rate for women aged under 20 has not shown the same level of decrease. Indeed the birth rate for women aged under 20 has risen from 15.5 in 1995 to 17.35 in 1999.
2.5 While the total number of births to teenagers has not altered dramatically over recent years, there has been a significant decrease in the number of births to teenage mothers within marriage. In 1981 66.9% of births to teenage mothers occurred within marriage, in 1990 this had dropped to 23.9%, falling to 6.6% by 1998. This reflects a general trend in the population towards an increased number of births outside marriage. The trend among teenagers is, however, more pronounced than among those aged over 20 years.

2.6 There is clear evidence of regional variation in the local rates of teenage pregnancy. As illustrated in figures 6.1 and 6.2 those areas experiencing higher rates of teenage pregnancy are also those recognised as areas of deprivation. The level of deprivation is measured by the Jarman index. The higher the score, the higher the level of deprivation.
2.7 Even in those areas of where the rates of teenage parenthood are relatively low, they are high compared to other parts of Europe.

FIGURE 7
The percentage of all live births to mothers aged under 20 years in a number of European countries.

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Kingdom</td>
<td></td>
</tr>
<tr>
<td>Northern Ireland</td>
<td></td>
</tr>
<tr>
<td>Ireland</td>
<td></td>
</tr>
<tr>
<td>Austria</td>
<td></td>
</tr>
<tr>
<td>Finland</td>
<td></td>
</tr>
<tr>
<td>Denmark</td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td></td>
</tr>
</tbody>
</table>

Source: General Register Office for Northern Ireland

2.8 We continue to have a percentage of live births to mothers aged under 20 which is higher than almost all countries in Europe and almost 5 times as high as in the Netherlands, as illustrated in figure 7. Among 15-19 year olds the local birth rate and that for Scotland and England is broadly similar at around 30 per 1,000 women. Wales has higher rates of teenage births at 37.7 per 1,000.
2.9 It is accepted that teenage parenthood and teenage pregnancy are not synonymous terms and rates of teenage parenthood are influenced by termination rates, either spontaneous or induced.

**FIGURE 8**
Abortion rates by age group performed in England to Northern Ireland residents 1981 - 1997

Source: Abortion Statistics for England and Wales ONS

2.10 In 1998 at least 1,581 women from here had abortions performed in England. Of these 305 were in respect of women aged under 20. As illustrated in Figure 8 abortion rates do not vary significantly by age group. Given that some may not wish to use their home address these figures are probably an underestimate. As travel to England is a cost incurred by the individual those on low incomes may either not be able to access this service, or suffer additional stress and hardship as a result of doing so.
3.0.1 As already illustrated, young people living in areas of socio-economic deprivation are at greater risk of becoming teenage parents. The impact of deprivation on health has been addressed both locally, nationally and internationally.

3.1 PROMOTING SOCIAL INCLUSION

3.1.1 In March 1998 the Government published a White Paper, “Partnership for Equality” which considered what the Government could do, through the broad range of its programmes, to make Northern Ireland a fairer and more equal society. New Targeting Social Need (New TSN) was one of the approaches set out in the White Paper.

3.1.2 New TSN includes Promoting Social Inclusion (PSI), a new approach that will seek ways of helping people who are disadvantaged. PSI recognises the fact that actions needed to tackle problems of social exclusion do not always fit comfortably within administrative boundaries. It, therefore, focuses on getting Departments to work together, and with partners outside Government, to identify and tackle in a co-ordinated, coherent way those factors that contribute to promoting social exclusion.

3.1.3 On 16 June 1999 Mr. John McFall, Minister for Health and Social Services, identified teenage parenthood as one of four priorities to be addressed within the Promoting Social Inclusion initiative. As such, it was to be taken forward as an inter-departmental issue. Consequently, a multi-sectoral Working Group was established to address the issue of teenage parenthood here. The Group was asked to develop a co-ordinated strategy aimed at reducing teenage births and supporting teenage parents and their children.

3.1.4 Details of the Group’s membership and the full terms of reference are set out in Appendices One and Two.

“Sometimes things are so bad that it is difficult for people to lead what most of us would consider to be normal everyday lives - these are the people that that Promoting Social Inclusion is concerned with.”

Dr. Majorie Mowlam, February 1999

3 New TSN An agenda for targeting social need and promoting social inclusion in Northern Ireland, New TSN Unit, 1998.

3.1.5 The Working Group met on eight occasions. Subgroups consulted with a broad range of stakeholders and provided background information on specific issues.

3.1.6 In addition a one-day workshop and a series of focus groups permitted wider consultation with professionals, voluntary organisations, churches and young people. A list of organisations consulted and of those who contributed to the report is set out in Appendix Three.

3.2 POLICY CONTEXT

3.2.1 Many recent publications at a local, national and international level have emphasised the importance of tackling the issue of teenage parenthood.

3.2.2 The Social Exclusion Unit in London produced a major report on teenage pregnancy in 1999. The report emphasises the importance of a multi-sectoral approach to reducing teenage pregnancy rates and the consequential social exclusion experienced by many young parents. Much within the report also applies to the local situation. There are important legislative differences, however, which are unique to us. Firstly, the age of consent for sexual intercourse is 17 years compared to 16 years in England, Scotland and Wales, and secondly, the 1967 Abortion Act does not extend here.

3.2.3 Targets for the reduction in the number of births to teenagers are clearly set in the Regional Strategy, Health and Wellbeing into the Next Millennium. Well into 2000 further emphasises the requirement to implement interventions that reduce inequalities.

---

5 DHSSPS Health and Wellbeing: Into the Next Millennium Regional Strategy for Health and Social Well being 1997-2002
Department of Health & Social Services 1996
6 DHSSPS Well into 2000 Department of Health & Social Services 1997
3.2.4 Promoting sexual health has been recognised as a critical aspect in reducing teenage parenthood rates and the four Health and Social Services (HSS) Boards have each prepared sexual health strategies. A recent review of family planning services has highlighted the need for services specifically tailored to the needs of young people.

3.2.5 Relationships and Sexuality Education (RSE) for all children and young people has long been recognised as crucial in reducing rates of teenage parenthood. New RSE guidelines for schools have been developed by the Council for the Curriculum, Examinations and Assessment (CCEA) and will shortly be disseminated by the Department of Education. Their implementation will help young people appreciate the issues of sexual health and sexual activity within a wider social and emotional context.

3.2.6 The health and wellbeing of children has been endorsed in legislative and policy terms by the Department of Health, Social Services and Public Safety. The Children (NI) Order 1995, Article 18, places a general duty on authorities to “safeguard and promote the welfare of children within its area who are in need”. Within Health and Social Services (HSS) Boards this duty is interpreted as including both the needs of a teenage mother and her child. The Childrens Services Plan (CSP) within each of the HSS Boards seek to address the needs of children in a co-ordinated manner using a multidisciplinary approach. CSPs aim to improve the range and co-ordination of services provided to children and their families across the statutory, voluntary and private sectors.

3.2.7 In addition to a multidisciplinary approach at HSS Board level, the Interdepartmental Group on Early Years (IDGEY) has responsibility for co-ordinating government policy and strategy on childcare and pre-school education in accordance with international standards of good practice. The group comprises representatives from the Department of Higher and Further Education, Training & Employment (DHFETE), Department of Education (DE), Department of Health, Social Services and Public Safety (DHSSPS), the Education and Training Inspectorate and the Social Services Inspectorate.

3.2.8 The Childcare Strategy, Children First recognises that a safe and nurturing environment is critical in early life and focuses on the need to provide all...
children with high quality childcare. Sure Start, a recent government programme, is in part aimed at improving the health and social well being of children under the age of four living in areas of high social deprivation. The new Sure Start Maternity Grant links payment of a means tested maternity grant to the provision of health promotion advice, hence offering an opportunity to provide information and to influence health behaviours among mothers.

3.2.9 The Youth Service has traditionally been a key provider of opportunities for the personal and social development of young people, with over 100,000 teenagers participating in youth service activities in 1998/1999. A major review of youth services was recently conducted. It considered the current environment facing the Youth Service and concluded that the needs of young people would best be met by effective partnership arrangements that include the community, Government, schools and young people themselves.8

3.2.10 Within the education sector an agreed framework, within which policy and support services for pregnant schoolgirls and school age mothers will be developed, became operational in early 1998. The framework, prepared in response to the Save the Children sponsored research, ‘Pregnant Schoolgirls and School Age Mothers: Access to Education’,9 has been endorsed by the Department of Education, the Education and Library Boards and the Council for Catholic Maintained Schools. The starting point of the framework is that every pregnant schoolgirl or school age mother should be supported to complete full-time mainstream education and to continue in education beyond the age of 16 if they wish.

3.2.11 Recent policy developments ensure that young parents cannot be discriminated against when seeking employment. The Good Friday Agreement set out a commitment to equality of opportunity which was later confirmed in the Northern Ireland Act, 1998. The Act creates a statutory obligation on public authorities to have due regard to the need to promote equality of opportunity. Essentially these new duties are designed to place equality issues at the centre of public policy decision making and service delivery.

8 Youth Service Review, unpublished
9 Davies et al, ‘Pregnant Schoolgirls and School Age Mothers; Access to Education’, Save the Children, Belfast: June 1996
3.2.12 The Human Rights Act, which came into force on 2nd October 2000, includes the right to life, the right not to be punished arbitrarily and the right to education. This will have important implications for pregnant and parenting teenagers. In addition the Act prohibits discrimination.

3.2.13 Reform of the welfare system will also have a profound impact upon teenage parents. Teenage mothers are more likely to rely on benefits as their sole income and are more likely to remain on benefit for a longer period than any other group. Government has recognised that those dependent upon benefits often face a series of barriers to paid work, including financial disincentives and has committed itself to a fundamental reform of the welfare state. Through such initiatives as New Deal and the Working Families Tax Credit the Government aims to minimise the barriers that prevent people on benefits from starting or returning to work.

3.2.14 Housing policy also has an impact upon teenage parents. Possible reductions in housing benefit entitlement to those living within the private rented sector could well result in an increased number of teenage parents requiring social housing.

3.2.15 There are also important developments affecting health policy and local services which, while not specifically aimed at reducing teenage parenthood rates, will provide opportunities to improve the health and wellbeing of children and young people, including particular issues pertinent to adolescents. These include:

- Health Action Zones (HAZs), which foster new approaches to working in partnership, are developing local strategies to improve health and reduce health inequalities. The first two HAZs established here have identified young people as a priority;

- Healthy Living Centres, which are being established with the help of funding from the National Lottery, will fund innovative projects to promote health, especially in the most deprived areas;

- Health and Wellbeing Improvement Programmes will be introduced from April 2001 and will identify and meet local health and health-care needs.
WHY IT MATTERS

4.1.1 Although pregnancy in the teenage years may not necessarily be harmful, it is more likely to have adverse outcomes for mother and child, socially, economically and in terms of health status. These carry significant private and public costs. Teenage parenthood is more common in socially deprived areas and so the pattern of disadvantage is perpetuated.\(^\text{11}\)

4.1.2 A number of risks confront those who have children in their teenage years. Compared to women who are older, teenage mothers may face a higher risk of adverse health, educational and socio-economic consequences:\(^\text{12}\)

- Documented health risks include hypertension, anaemia, obstetric complications, depression, isolation, and poor nutrition.
- Educational risks include school dropout and gaps in education.
- Socio-economic risks include reduced employment opportunities, poorer housing, benefit dependency and low income.

4.1.3 The children of teenage mothers also face a greater range of risks, including an increased likelihood of prematurity, hospitalisation for accidental injuries, development delays, poverty and poor levels of nutrition.

4.1.4 The inter-relationship between teenage mothers and disadvantage is complex, as social, economic and environmental factors can be either determinants or consequences of early parenthood. Either way teenage parenthood is a major factor influencing the long-term prospects of young parents and their children.

4.2 WHO IS AT GREATEST RISK?

4.2.1 Regardless of their background all sexually active teenagers are at risk of becoming a parent, but there is research evidence that some are at much higher risk of teenage parenthood.\(^\text{13}\) Risk factors include the following:

---

\(^{11}\) Summary Bulletin: Reducing the rate of teenage conceptions. An international review of the evidence: data from Europe. HEA, 1999

\(^{12}\) Effective Health Care Bulletin, Preventing and reducing the adverse effects of unintended teenage pregnancies, February 1997, Vol:3, No: 1, NHS Centre for Reviews and Dissemination, University of York. P2

4.2.2 Some young people experience multiple risk factors. As a result, they are at much greater risk of becoming teenage parents.

4.3 RISK TAKING BEHAVIOUR

4.3.1 Taking risks and experimentation is often part of adolescent behaviour, however, some young people are more prone to risk taking behaviour than their peers, and consequently indulge in several different risk taking behaviours. The 1997/1998 World Health Organisation Health Behaviour of School Children Survey\textsuperscript{14} (HBSC) provides information on the health behaviour of children in a number of countries in Europe. Almost 6,600 local young people participated in the survey which aims to gain new insight into health behaviours and lifestyles and their context in young people’s lives. The findings from the local element of the survey, conducted by the Health Promotion Agency, have been published in The Health Behaviour of School Children in Northern Ireland which provides a more detailed assessment of risk taking behaviour among young people here.\textsuperscript{15}

4.3.2 The HBSC (NI) survey revealed that approximately 18.5\% of young people aged between 14-16 are sexually active, as illustrated in Figures 9 and 10.

\textsuperscript{14} Health Behaviour of School Children Survey, WHO

4.3.3 At age 15, 26% of girls and 30% of boys reported having had sexual intercourse (figures 9 and 10). Almost 75% of girls and 70% of boys at 15 have not experienced sexual intercourse. Comparison with other European countries indicates considerable variability between countries in the percentage of teenagers who are sexually active (figure 11).
FIGURE 11

The percentage of 15 year olds who report having had sexual intercourse. Comparison across a selection of European countries

4.3.4 Determining the age of first intercourse is thought to be significant, since those who engage in early first intercourse are thought to be at greater risk of unprotected sex and therefore, unintended pregnancy. The HBSC (NI) survey also revealed that, of those who are sexually active at 16, the average age of first intercourse was 13 years for boys and 14 years for girls. As illustrated in Figure 12, when questioned on their use of contraceptives the vast majority of those who had sexual intercourse reported using some form of contraception, condoms being the most popular choice. Earlier local studies carried out among different age groups revealed much lower levels of contraceptive use.16

16 NHSSB/Homefirst Community Trust, Young People’s Health and Social Needs, Department of Public Health/Homefirst Community Trust, 1997. Finlay et al. Adolescent Reproductive Behaviour in the Western Health & Social Services Board Area. A Study carried out by the Centre for Health & Social Research, University of Ulster. 1995
4.3.5 The Young People’s Health and Social Needs Study carried out by the Northern Health and Social Services Board in 1997, reported that within the Board’s area many young people failed to use any form of contraception at first sexual intercourse and where contraception was used it tended to be less effective methods such as condoms and withdrawal methods. The study also highlighted gaps in young people’s knowledge about sexual health issues and available sources of contraceptive counselling and advice.

4.3.6 Between the ages of 14 to 16 there is an increasing level of sexual activity among both boys and girls. This coincides with the age at which there is increased alcohol consumption, misuse of drugs and, among girls, a steady increase in cigarette consumption.

---

17 NHSSB/ Homefirst Community Trust, Young People’s Health and Social Needs, Department of Public Health/Homefirst Community Trust, 1997.
4.3.7 The link between alcohol consumption and teenage pregnancy is well documented. When under the influence of alcohol, young people are less inhibited and less likely to use contraceptives. Evidence suggests that an increasing percentage of young people are drinking and that some young people are drinking at an early age (10-11 years). As illustrated in figure 13, at all ages more boys are drinking every week than girls, there is a marked increase in alcohol consumption among girls between Form 4 and Form 5. A similar trend is evident for drug use where the proportion of girls reporting having ever tried drugs increases from approximately 15% in Form 4 to just over 30% in Form 5.

FIGURE 13
The percentage of students by form class and gender who reported drinking some form of alcohol at least once a week

4.3.8 Among school children, smoking is more common in girls than boys. By Form 5 almost 40% of girls smoke compared to 27% of boys (figure 14). While smoking does not have a direct impact on teenage pregnancy it is important for two reasons. Firstly it is indicative of risk taking behaviour, and secondly it has important health consequences for both mother and child.

---

4.3.9 Any of these behaviours survey can put young people’s health at risk. Individually, activities such as smoking, drinking or drug misuse can adversely affect health and well being in the longer term. There is, however, a proportion of young people who report engaging in a combination of these risk behaviours. This ‘clustering’ of risks is important, since it is this group of young people who are most likely to be risk takers and suffer ill health as a consequence.

4.3.10 The HBSC report also concludes that the burden of risk is not shared equally among all young people. Young people who are disadvantaged socially or economically, and who indulge in a combination of risk taking behaviours may be at particular risk of long-term problems.

4.3.11 The family environment plays a major part in determining many health behaviours and social attitudes in adolescence and adulthood. Among adolescents the role the family plays in this regard may decrease, as young people, in search of individual adult identity, tend to orientate themselves towards peer groups. Risk taking behaviour is often part of social interaction within these peer groups.
4.3.12 Adolescence is often seen as a time of heightened conflict between parent and child as the child strives towards self-definition and embarks on separation from the family.\textsuperscript{19} The HBSC study shows that poor family communication is associated with increased risk taking behaviour, particularly for girls, whilst the US National Longitudinal Study of Teenage Health\textsuperscript{20} indicated that a high degree of family ‘connectedness’ through communication and shared activities was associated with delayed first intercourse. As figures 15 and 16 illustrate, 15 year old pupils here experience more difficulty than students in most other European countries in talking to their parents about sensitive issues. It is particularly striking that in all countries both boys and girls experience more difficulty talking to their fathers than to their mothers.

FIGURE 15
The percentage of 15 year old pupils who report finding it difficult or very difficult to talk to their fathers:

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{fig15}
\caption{The percentage of 15 year old pupils who report finding it difficult or very difficult to talk to their fathers.}
\end{figure}

\begin{itemize}
\item Northern Ireland
\item Ireland
\item Germany
\item Belgium
\item Canada
\item Switzerland
\item Austria
\item Finland
\item Denmark
\item France
\item Greece
\item Norway
\item United States
\item England
\item Scotland
\item Wales
\item Portugal
\item Sweden
\item Hungary
\end{itemize}

\begin{itemize}
\item Male
\item Female
\end{itemize}

\begin{itemize}
\item 0
\item 20
\item 40
\item 60
\item 80
\end{itemize}
FIGURE 16
The percentage of 15 year old pupils who report finding it difficult or very difficult to talk to their mothers

Germany
Canada
Northern Ireland
United States
Switzerland
France
Norway
Finland
Greece
Ireland
Belgium
Austria
Scotland
Sweden
Wales
England
Portugal
Hungary
5.0.1 Teenage parenthood is a complex issue. In addressing what can be done to reduce the rate of teenage parenthood, it is vital to know what has been shown to be effective elsewhere.

5.1 PREVENTING UNINTENDED TEENAGE PREGNANCY

5.1.1 One factor strongly associated with deferring sexual activity is a good general education.21 A number of studies have shown that teenagers who have low levels of educational achievement and low aspirations for the future are much more likely to be sexually active, while those with educational aspirations were less willing to consider the possibility of teenage motherhood.22

5.1.2 School based sex education can be effective in reducing teenage pregnancy especially when linked to access to contraceptive services. The most reliable evidence shows that sex education does not increase sexual activity or pregnancy rates.23 The timing of sex educational programmes, however, also appears to be very important, as young people who are already sexually active at the commencement of the programmes are less likely to change their sexual and contraceptive behaviours.24

5.1.3 Increasing the availability of contraceptive clinic services for young people is associated with reduced pregnancy rates.25 When used properly, contraceptives are highly effective in protecting against pregnancy. Emergency contraception is effective if taken within 72 hours but is most effective in preventing pregnancy when the first dose is taken within 24 hours of unprotected sex.26

---

22 Cheesbrough et al, Reducing the rate of teenage conceptions, A review of the international evidence on preventing and reducing teenage conceptions: The United States, Canada, Australia and New Zealand, HEA, 1999, p24
23 Guttmacher Report 1998
24 Cheesbrough et al, 1999, p33
26 WHO Trial, The Faculty of Family Planning & Reproductive Health Care RCOG
5.1.4 Evidence from abroad suggests that teenagers do not volunteer information on sensitive matters\(^\text{27}\) and that teenage clinics in primary care are more effective in screening young people on issues of general and sexual health.\(^\text{28}\)

5.1.5 Those few studies that have demonstrated a reduction of teenage pregnancy provided multi-faceted programmes with links to contraceptive services or work experience.\(^\text{29}\) The lack of evidence on the effectiveness of other approaches in reducing pregnancy rates may be due to the fact that most of the studies did not have appropriate comparison groups, large enough sample sizes or long enough follow-up to detect significant effects.

5.1.6 Most of the evaluated programmes have focused on addressing the individual factors associated with teenage pregnancy, and have shown some success. Few programmes, however, have attempted to tackle underlying social, economic and other environmental factors associated with increased risk of pregnancy. A number of family support initiatives have been undertaken, but providing tangible outcome measures for such programmes has proved to be a considerable challenge.\(^\text{30}\)

5.1.7 While there has been limited evaluation of interventions targeting unintended teenage pregnancies there have been a number of innovative statutory and voluntary initiatives which have sought to address this issue. Notable examples were the peer education projects which emerged in the 1990s, such as Whiterock and Ballybeen. More recent examples include the ‘New Opportunities for Young Mothers’ run by Opportunity Youth.

5.1.8 Each of the four Health and Social Services Boards has sought to actively address and, as outlined previously, conduct research into the various issues involved in both preventing unintended teenage pregnancy and supporting teenage parents. One example is the Eastern Area Sexual Health Team, established in 1989, which has been involved in developing a range of

---

30 McAuley, Dr. Colette, The Family Support Outcomes Study Department of Social Work, Queen’s University of Belfast, 1999
innovative approaches. The team works closely with both the statutory and voluntary sectors and continues to be funded by the Eastern HSS Board. Another example, within the Western HSS Board is the ‘Girl Power’ project provided by Health Visitors and School Nurses it offers a resource package aimed at raising the self-esteem of young girls.

5.1.9 Following a review of the availability of sexual health advice for young people, which highlighted a number of difficulties in terms of accessing up-to-date, confidential information, the Southern HSS Board developed a website offering confidential advise to teenagers about sexual health.

5.1.10 Good antenatal care is associated with improved pregnancy outcomes for teenagers. Teenage girls’ fear of discovery, however, may delay or prevent their uptake of antenatal care. The health and development of teenage mothers and their children has been shown to benefit from programmes promoting access to antenatal care, targeted support by health visitors, social workers or ‘lay mothers’ and provision of social support, educational opportunities and pre-school education.31 32 33

• The Myths & Reality for Young People

5.1.11 While some of the risk factors are known, meetings with young people helped to focus on some of the more immediate factors involved in contributing to teenage pregnancy and parenthood.

5.1.12 Responses from group work sessions carried out in post primary schools by the Strabane Young People’s Health Project in January 1999, and by Barnardos Young Parents Network in December 1999, indicate four main explanations for teenage pregnancy:

---

5.1.13 The main message coming from the consultation process with young parents was that the current initiative on teenage pregnancy be taken seriously as an opportunity to ensure that appropriate information, support and services are available to young people. This would enable them to make informed choices.

5.1.14 Young people felt that family planning services should be more accessible and young-person friendly. The term ‘Family Planning Clinics’ was considered inappropriate and possibly off-putting. Young people are more concerned about practising safer sex and avoiding pregnancy than planning a family. Those who participated in the focus group considered the Brook model appropriate.

5.1.15 A study into adolescent reproductive behaviour carried out in the Western Health and Social Services Board area found that 61% of respondents had never used any form of contraceptive service provided by the Board. While fear of disapproval and concerns about confidentiality were factors they were not the main issues in most cases. Rather, the study found that one third of respondents were unaware of the existence of Family Planning Clinics, while others did not realise they were eligible to attend.\textsuperscript{34}

---

34 Finlay et al. Adolescent Reproductive Behaviour in the Western Health & Social Services Board Area. A Study carried out by the Centre for Health and Social Research, University of Ulster. University of Ulster, 1995
5.1.16 One group of young people raised the issue of access to services. It was pointed out that many young people cannot afford to travel to clinics such as Brook and a community resource in their areas would improve the accessibility of such services.

5.1.17 Community based one-stop shops may be an important way of reaching many young people in a way which does not label or stigmatise them. They could include both preventive and support services for young people.

5.2 SUPPORTING TEENAGE PARENTS

5.2.1 The School Aged Mothers project (SAM) is an innovative response to the needs of school age mothers. Its purpose is to support young women who are pregnant or who have a baby whilst of compulsory school age, to continue their formal education and to address personal development, antenatal and health issues in a supportive environment. It was piloted by Barnardos in partnership with the North Eastern Education and Library Board, Causeway Health & Social Services Trust and Ballysally Youth & Community Centre. Of those who participated on the pilot 75% sat their exams. This is a very significant outcome when compared to figures in the Save the Children study which showed that two thirds of young mothers felt they missed out on opportunities to sit exams.35

5.2.2 The holistic nature of the SAM project recognises that school age mothers have a complex set of needs to be addressed by a comprehensive support system involving all the relevant agencies. Peer support is also an important aspect of the programme, developing informal peer support networks which will reduce isolation and loneliness.

5.2.3 A study undertaken by Gingerbread Northern Ireland documented the experiences of young lone parents in Belfast and Newry and Mourne.36 The study found that the attitudes of parents, relatives and friends to young lone mothers remained largely unchanged since they had become pregnant. Where parental attitudes, however, were ‘worse’ than before, this had a negative effect on the physical health of respondents.


5.2.4 Respondents to the Gingerbread study indicated that health visitors and parents were the main providers of advice on caring for children. A large majority also stated a desire for further information on the care and upbringing of their children and particularly for information on stress management.

5.2.5 The majority of young lone parents who participated in the Gingerbread study lived in Housing Executive accommodation. While most were happy with their accommodation it was clear that there was little awareness of alternative housing support agencies. Significantly, the main factor that determined happiness was living with or near family members, clearly illustrating the importance of continued support and family networks for young lone mothers.

5.2.6 The Gingerbread study found that over 90% of young mothers needed support to enter the labour market. Their primary need was for support with childcare, with the vast majority relying on the extended family for this.

• The Myths & Reality for Young People

5.2.7 Through their work with local young parents, Barnardos’ Young Parents’ Network have identified a range of difficulties that young parents and their children face. These issues include difficulties in continuing their education, limited access to relevant training opportunities, economic disadvantage, stress, isolation and social exclusion. Negative, judgmental attitudes and stereotyping of young parents add to their stress and isolation, often preventing young parents from accessing services or becoming actively involved in the life of their community.

5.2.8 Young parents consulted within a focus group setting were aware of negative attitudes and prejudices towards them. This may compound their difficulties and reduce their willingness to access existing services. In many respects, negative attitudes and low expectations can result in a self-fulfilling prophecy, with young mothers underestimating their abilities and their potential to succeed as parents.
5.2.9 A number of difficulties were also identified for those who became pregnant whilst still in education. Such difficulties ranged from negative staff attitudes to a lack of home tuition. The study found that less than half of those mothers surveyed received any form of home tuition before their baby was born whilst 75% received no home tuition after the birth of their child.

“I felt very scared... I felt that I had let people down.”
Teenage mother
6.0.1 Teenage parenthood represents a complex interplay of factors some of which can be both a consequence and a risk of teenage parenthood.

6.0.2 The Working Group identified a number of issues which must be considered before proposing a strategic way forward. For simplicity, the major issues are each discussed separately. In reality it must be recognised that many are closely linked to or affected by one another and all must be considered within a broad holistic context.

6.0.3 Action to reduce teenage pregnancy needs to take place at a variety of levels, with individuals, communities, service providers, and social and economic policy makers all playing a part. A holistic approach tackling risk factors and based upon interagency collaboration is vital if a genuine response to young people’s social, economic, educational and health needs is to be developed.

6.0.4 There is potential for delivering more services for teenagers in their local community. Community based initiatives have been used to deliver programmes focusing on health, social and personal development in some of the most disadvantaged and deprived areas of Belfast.

• Issues for everyone

6.1 ATTITUDES

6.1.1 International comparisons indicate that lower rates of teenage pregnancy are associated with openness about sex. Where the climate is open and accepting, rather than ambivalent, and where messages are clear rather than ambiguous, outcomes seem to be more favourable.37

---

37 Reducing the rate of teenage conceptions. An international overview of evidence: Data from Europe. HEA, 1999
6.1.2 Ignorance about sex is a key risk factor in teenage pregnancy which needs to be addressed. The vast majority of adults support Relationship and Sexuality Education within schools. A minority, however, object and are very vocal in their condemnation of sex education within schools. Some argue that sex education is a matter for parents and that sex education in schools promotes sexual activity. Research indicates that those who learn about sex mainly from school are less likely to become sexually active under age than those whose family and friends were their main source. It also shows that good, comprehensive relationships and sexuality education does not make young people more likely to become sexually active at a young age. Indeed it can help them to delay starting sexual activity, and make them more likely to use contraceptives when they do. Sex education needs to be supported by open attitudes and a positive approach to the sexual health of young people.

6.1.3 Although the stigma attached to birth outside marriage is diminishing there is still societal disapproval of teenage parenthood. Young parents, participating in a workshop organised on behalf of the Working Group, perceived that they and their children were often viewed in a negative light. They were aware of this negative approach, not only within their local community but also from professionals with responsibility to provide support and advice. There was also a clearly perceived unwillingness to acknowledge the success of young parents who cope well with parenthood.

6.2 THE INDIVIDUAL IN CONTEXT

6.2.1 Teenagers are not a uniform group and vary widely in terms of their circumstances and life experiences. Their interactions with parents, siblings and peers will impact upon their attitudes and behaviours. Any initiatives must take account of the potential assets of the family and local community.

6.2.2 It is critical that we acknowledge that teenagers who become pregnant are not a homogeneous group. They come from all social classes and religious/ethnic groups. They vary widely in their circumstances and life experiences. Clearly the needs of a 15-year-old pregnant schoolgirl with little family support and no income are very different from those of a 19-year-old, who may be well prepared, and in a stable relationship.

6.2.3 Perhaps there is merit in identifying different priorities for different groups according to need. The focus may be on preventing pregnancy in those under 17 years, ensuring informed choice about pregnancy and parenthood from age 17-19, and supporting those who become teenage parents. Even within these three categories the individual needs and attitudes of teenage boys and girls must be acknowledged, and services should be tailored appropriately.

6.2.4 Teenagers in isolated rural areas are often overlooked and yet may experience similar difficulties as teenagers elsewhere, which are further compounded by their relative geographic isolation from a number of services and facilities.

6.3 SPECIFIC PROGRAMMES FOR YOUNG PEOPLE

6.3.1 There is a wealth of activity with a number of statutory and voluntary organisations engaged in initiatives to improve the health and social well being of teenagers and in particular to reduce the rate of teenage pregnancy and offer support to pregnant and parenting teenagers. A number of these promising approaches are outlined in Appendix 3.

6.3.2 As teenage parenthood rates are highest in areas of social deprivation there is a real need to target such interventions in these areas in partnership with local communities. The development of specific teenage programmes that build on the success of evaluated projects could provide a valuable contact point for teenagers to obtain information, advice and referral to specific services. Through a holistic approach they could provide a pivotal mechanism for the promotion of teenage health whilst promoting social inclusion and community ownership.

6.3.3 Teenage programmes should be tailored to the needs of individual communities and could include health promotion information and advice, especially on risk behaviours, access to peer education, links to health and social services, and information on housing and employment. Personal development should be a pivotal aspect of teenage programmes as confidence and positive self-esteem will underpin so many decisions made by young people.
6.3.4 The sustainability of such programmes will be dependent upon the issue of funding. There are concerns that many community based programmes receive only temporary, short-term funding. If community based teenage programmes are to be successful it will be necessary that successful programmes, as evidenced by rigorous evaluation, are funded to ensure their sustainability.

6.4 YOUNG MEN

6.4.1 Whilst the Family Planning Association NI’s Bout Ye project specifically targets young men, most sex education and sexual health services have been traditionally targeted at young women. The participation of boys and young men is critical and yet they have often been overlooked in past attempts to address teenage parenthood. Young men need access to reliable information and advice that will facilitate responsible personal decision making with regard to relationships and sexual activity. They may also need specific information about the consequences and responsibilities of fatherhood, including the responsibility to support their children.

6.5 SELF ESTEEM

6.5.1 It is recognised that young people with positive self-esteem are much less likely to become teenage parents. Positive self-esteem means that individuals have a favourable opinion of themselves and have confidence in the decisions that they make. Studies have demonstrated that if boys and girls have a meaningful relationship with at least one caring adult, it will encourage self-esteem and help prevent teenage parenthood. The caring adult need not necessarily be a parent but could be a relative, teacher or youth worker.

6.5.2 Efforts to reduce teenage parenthood rates in both the short and long term must focus on improving self-esteem among young people. This can only be achieved by action on a number of fronts:

• within the family, a nurturing environment that encourages children to make decisions and take action appropriate to their age;
• within schools, a focus on inclusion and positive reinforcement;
• within society, a culture that encourages responsibility rather than blame.

6.6 COMMUNICATION

6.6.1 Parents are an essential and valuable source of information, guidance and support for teenagers on matters of sexuality. Many parents, however, feel uncomfortable or embarrassed talking to their children about sex. As many of today’s parents were themselves provided with little or no education on sexuality it is no surprise that they feel unprepared to discuss sensitive issues with their teenage children. Steps have been taken to address this and to provide parents with the information and skills to talk openly with their children. Positive parenting programmes being run by health visitors in a number of Health and Social Services (HSS) Trusts are enabling parents to discuss sensitive issues with their teenage children. One successful programme is Speakeasy, run by the Family Planning Association. Parents who have participated in this programme found that it was helpful in improving communication skills.

6.7 MEDIA

6.7.1 In this information age, children and young people have access to a wide range of media including magazines, television and the Internet. While parents and teachers may aim to promote responsible attitudes and behaviour in personal and sexual relationships, images portrayed by the media include casual sexual relationships. Magazines, particularly those aimed at teenage girls, do provide educational material regarding sexuality but many focus on sexual partnerships at the expense of interpersonal relationships. This may cause problems for some teenagers who feel pressurised into living up to the sexual expectations of society as presented by the media. It is vital for those in contact with young people to acknowledge that they are constantly being bombarded by sexual imagery in the media and that the messages, either explicit or implicit, are powerful in influencing behaviour. The influence of the media can be either a positive or negative one and the potential to utilise it in a positive way should not be underestimated.
6.8 BUILDING POSITIVE PARTNERSHIPS

6.8.1 Causes of teenage parenthood are rooted in complex interactions between social, health, psychological and environmental factors. No one organisation or sector is equipped to deal adequately with all these factors. The development of strong, cross-sectoral partnerships is essential. The absence of partnerships and meaningful collaboration will inhibit the development of cross-sectoral action which is crucial if progress is to be made in tackling teenage pregnancy.

6.9 RESEARCH & EVALUATION

6.9.1 Surveys, including the Health Behaviour of School Children, and local research have helped to provide information on aspects of adolescent lifestyles, health and sexuality. Historically there was a limited amount of local research into pregnant and parenting teenagers. Recently there has been an increased focus on research, for example the FPA (NI) and University of Ulster at Jordanstown have initiated a three year study into the sexual attitudes and lifestyles of those aged under 25 years. Whilst a number of recent publications and reports have aided in the development of the local research base, there remain significant gaps particularly with regard to the evaluation of initiatives. These gaps undermine the ability to build on successful programmes.

• Issues for educators

6.10 RELATIONSHIPS AND SEXUALITY EDUCATION

6.10.1 Young people have the opportunity to make contact with a whole range of individuals and professionals. This may include parents, grandparents, peers, teachers, youth workers, doctors, nurses and social workers. Any or all of these individuals may play a pivotal role in influencing a young person’s personal and social development. While a whole range of people may influence young people, some have a more specific role to play.
6.10.2 Schools have a central role to play in the education of young people, specifically in regards to Relationships and Sexuality Education (RSE). While currently there are no formal guidelines within schools, many schools have been providing programmes on RSE. Formal guidelines on RSE drawn up by the Council for Curriculum Examinations and Assessment (CCEA) will be published and disseminated to all schools under cover of a Department of Education circular. It is anticipated that in line with this guidance schools will be required to state their policy on RSE within their prospectus.

6.11 SCHOOL BASED PROGRAMMES

6.11.1 In schools, an effective Personal and Social Education (PSE) Programme which includes RSE is essential in giving young people the confidence to assess situations, recognise risks and say with assurance what they want and feel to be right rather than succumb to pressure. Teachers play the central role in teaching PSE although other professionals, for example, school nurses, health visitors and other visiting professionals contribute to that role. Findings from a number of surveys have indicated that school children do not always perceive teachers to be the most appropriate persons to provide RSE as they are concerned about confidentiality. Embarrassment or apprehension is not conducive to an environment that encourages open discussion on relationships and sexuality. It is essential that teachers who are to teach RSE are comfortable doing so and receive extensive training to equip them with the necessary skills. In addition, teachers delivering RSE in schools should receive the full support of their principal and school governors. Within the context of the Health Promoting School the issue of risk taking behaviour in general, and sex and alcohol in particular, could be effectively addressed by the adoption of a comprehensive and integrated approach within the school.
6.12 PEER EDUCATION

6.12.1 Young people often respond better to information delivered by someone of their own age group whom they view as a credible source of advice. Peer education has been used effectively in England and the United States to deliver sexual health messages to young men and teenagers from ethnic minorities. Locally the Peer Education Network have played a pivotal role in the development and promotion of peer education since the early 1990s. The network was established by practitioners in order to assist professional development, to improve and explore peer education practice and to share information.40

6.12.2 Peer education offers access to and significant influence within disadvantaged communities and excluded groups. Existing successful projects have demonstrated close working relationships with professional groups such as health visitors, social workers, teachers, and probation officers.

6.12.3 Peer education is not a panacea but rather one model of addressing the issue of teenage pregnancy and parenthood and therefore should form part of an integrated approach. In order to effectively address teenage pregnancy and parenthood, emphasis needs to be placed on local implementation and ownership of initiatives and the development of local strategies.41

6.12.4 Peer education is a valuable resource that is under-utilised here. To be effective, peer education programmes will need to be validated and evaluated. Furthermore peer educators must be trained, preferably to accredited standards, and be confident enough to talk to other teenagers. Young parents as peer educators can be a valuable resource in delivering messages to other teenagers. In addition to the benefits to the recipients, peer educators are known to benefit in terms of skills, self-esteem and employment opportunities.

Accredited Peer Education should be made available and widely utilised. All Peer Education programmes should be evaluated.

6.12.5 Peer education, if carried out by trained and well informed young people, may be effective, but a lack of comprehensive evaluation in this area makes it difficult to determine the true effectiveness or otherwise of this approach.

6.13 YOUNG MOTHERS AND EDUCATION

6.13.1 Education is the key to improving the life opportunities of all young people. For all young parents education provides a possible route out of poverty and into the workforce. Most young parents want to work and support their children. Anecdotal reports would indicate that once a young woman’s pregnancy shows she may be asked to leave the school for reasons such as ‘insurance’ or for ‘her own sake’. Within schools the approach to teenage parents and the underlying attitudes vary widely. While some schools are very supportive others implicitly discourage young pregnant women from staying at school.

6.13.2 Concern has been expressed regarding the extent to which young women of compulsory school age who are pregnant or parenting receive adequate education. Their school and educational life is often disrupted and indeed is rarely resumed once they have their babies. There can be no doubt that real difficulties exist in providing these young women with comparable education to that which they would have received had they not become pregnant. Young women of compulsory school age are legally required to remain in education. They must be offered whatever support is needed to make this possible. Young women over compulsory school age must also be encouraged and facilitated to continue their formal education. Access to childcare, targeted programmes, careers advice and counselling may also be necessary to ensure a young parent’s reintegration into education and the workplace.

6.13.3 The issue of childcare has a particular significance for school aged mothers. The lack of childcare provision is cited by most young mothers as the single most important factor in determining whether or not they can return to school after the birth of their baby. For this reason childcare is provided on site for all School Age Mothers (SAM) projects. In the Northern Health and Social Services Board (NHSSB) area, Social Services funded this aspect of the programme. The issue of provision of childcare enabling all young mothers of compulsory school age, regardless of where they live or go to school, to complete their formal education needs to be addressed at a strategic level.

Daly et al, Assessment of services for pregnant and parenting school girls in North and West Belfast. North & West Belfast HSS Trust, 1994, p13
The existing Interdepartmental Group on Early Years may be an appropriate body to take this initiative forward, including establishing who has responsibility for funding this provision.

- **Health and Social Services Sector**

6.14 **SEXUAL HEALTH**

6.14.1 Among young people who are sexually active it is important that their health care needs are addressed. There has been a recent increase in the incidence of sexually transmitted infections among young people. Encouraging those young people who are sexually active to engage in safer sex will be vital in reducing the rate of Sexually Transmitted Infections (STIs) and teenage parenthood. These issues should be addressed, through the development of a sexual health promotion strategy. An effective sexual health promotion strategy would address issues relative to education, access to information and service provision and could build upon existing recent sexual health promotion strategies developed by HSS Boards.

6.14.2 Young people’s perceptions of family planning services are crucial to whether or not they use them. Services must ensure that they are tailored to the needs of young people, specifically that they meet the needs of young men. Timing and location of clinics will affect attendance by young people. Research indicates that 70% of consultations for contraception occur in general practice\(^43\) and a recent publication has also indicated that the availability of young or female GPs is linked to lower rates of teenage pregnancy.\(^44\) Some young people, however, may lack the confidence to visit a family planning clinic or doctor’s surgery for advice on contraception. They are concerned about how they will be perceived and treated by staff and whether they will be given advice at all. The image and name of a clinic may encourage or discourage use where specific family planning services are provided. Where services are targeted to young people a more user-friendly title could replace family planning. In socially deprived areas teenagers may encounter specific obstacles, such as the expense of transport, in accessing services. Ensuring that services are provided locally will help to remove such obstacles.

---


6.15 CONFIDENTIALITY

6.15.1 Young peoples’ concerns about confidentiality can result in their reluctance to seek information and advice and to use contraceptive services. They may fear that if they consult a doctor their parents will be informed. Even if they know that their discussion with a doctor or nurse will be treated in confidence, they may worry that their anonymity within the clinic setting may not be respected by others who are attending or by administrative or support staff.

6.15.2 Guidance exists for health professionals who can provide contraceptive advice or treatment to an under 16 year old without parental consent provided the treatment can be justified on the grounds of necessity, or that it can be demonstrated that the minor was capable of giving informed consent. HSS Boards child protection procedures cover what to do in cases where there is an issue of abuse or exploitation. For other professional groups, comparable guidance is not readily available. For example, there is uncertainty among teachers about what they can say and do and who has to be told if a young person reveals that they are, or are planning to be, sexually active.

6.16 ANTENATAL CARE

6.16.1 In general teenage mothers tend to have poorer antenatal care than older mothers. In part this may be due to the fact that the majority of teenage mothers were not planning to get pregnant and therefore it is unlikely that they will have taken preparatory steps that are now common among those planning a pregnancy, such as taking folic acid. Some teenagers may also deny that they are pregnant and fail to seek care. In addition because so many present late, they will not have had early advice on health promotion or early antenatal care.

6.16.2 Parentcraft education seeks to prepare mothers and fathers for pregnancy, labour, delivery and the initial post-natal period. Teenage parents in general and teenage fathers in particular have proven reluctant to attend such classes. There are a number of possible reasons for this:
• Fear of being ‘judged’;
• Lack of support to attend from either a partner or the girl’s own mother who themselves may not have attended preparation classes;
• The feeling of being in a large group of prospective parents, probably older and who may have a wider experience of life, e.g. in education or in the workplace;
• Reaction against authority.

6.16.3 In response to this situation a number of HSS Trusts have set up antenatal clinics and parentcraft programmes specifically for teenagers. One example is the Ulster Hospital, Dundonald, which identified the need for a teenage antenatal clinic and provided a service that co-ordinated antenatal visits and parentcraft classes. Initial outcomes have been reported as positive. In many areas, midwives and health visitors provide increased visiting and support during the antenatal and postnatal period. Examples of initiatives developed are outlined in Appendix Three. A number of Health and Social Services Trusts also have specific programmes in place for vulnerable young people, for example, those leaving care.

6.17 MULTIDISCIPLINARY NEEDS

6.17.1 The health needs of young women who are pregnant or parenting are very varied. They may often reflect a complex interplay of physical, emotional and social issues. As such, their health needs could be most effectively met if considered within a multisectoral model. The Children’s Services Plans developed by each of the four Health and Social Services (HSS) Boards adopt a multidisciplinary approach to the needs of children. The NHSSB have already included young parents as a group that require to be considered within their Children’s Services Plan and the WHSSB are considering a similar step. It would be beneficial if each HSS Board replicated this approach.
6.18 EMPLOYMENT

6.18.1 Government has stressed that employment offers the best means of moving out of poverty and social exclusion. It is widely acknowledged that the majority of teenage parents want to work. In reality, however, too few are able to do so. For many young parents, childcare and benefit dependency continue to be barriers preventing access to employment opportunities. For those teenage mothers who have left education without formal qualifications, employment opportunities are further limited. The current Labour Government has committed itself to removing such barriers to employment and initiatives such as the new Working Families Tax Credit and the New Deal for Lone Parents should help address some of these difficulties.

6.19 SOCIAL SECURITY

6.19.1 A mother aged under sixteen cannot claim benefit in her own right. Mothers aged over sixteen can claim Income Support though the amount payable is dependent upon a number of factors. A high proportion of teenage mothers rely on benefit, with ninety per cent of teenage mothers receiving Income Support. Teenage mothers are more likely to rely on benefits as their sole income and more likely to remain on benefit for a longer period than any other group. Despite popular misconceptions, the amount of benefit payable to teenage mothers is not generous and many young parents find it difficult to bring up a child on benefit. In addition, Government recognises that lack of opportunities to work acts is a major cause and consequence of social exclusion, contributing to ill health and the denial of future employment opportunities.45

6.19.2 The nature and level of benefits which pregnant or parenting teenagers may be entitled to is dependent upon a number of factors, such as age and personal circumstances. The complex nature of the benefits system can often lead to confusion on the part of a prospective claimant as to which benefits they may be entitled to and for which they should make a claim. In response

---

to this situation the Social Security Agency has produced a free booklet entitled Young People’s Guide to Social Security. The booklet provides general guidance on benefit entitlement and is available from Social Security Offices.

6.20 HOUSING

6.20.1 Little research has been carried out to specifically examine the housing circumstances of teenage parents. Data collated by the Northern Ireland Housing Executive (NIHE) would indicate, however, that where teenage parents leave the family home the majority move to NIHE accommodation and have little if any knowledge of alternative support agencies.

6.20.2 The NIHE’s experience is that following the disclosure of pregnancy and the birth of a child, a teenage parent is more likely to run into difficulties with regard to remaining in the family home and often will approach NIHE indicating that she is homeless. Quite often this can cause difficulties as lone parents may be rehoused in areas unfamiliar to them, removed from the traditional support structure of family and friends and with inadequate arrangements in place to promote access to necessary support services. A number of initiatives have been developed to help alleviate such difficulties. These include Barnardos PACT (Parents and Child Together) and Fold Housing Association in conjunction with Foyle Homeless, both of which aim to provide accommodation for homeless pregnant women in a supportive environment.

6.20.3 Lone teenage parents living in unsupported tenancies may face problems of social isolation. Rehousing teenage mothers as close to their families and communities as possible would alleviate isolation and facilitate access to necessary and desired support services.

6.21 NEEDS OF SPECIFIC GROUPS

6.21.1 No local research into cultural attitudes to sexual relationships in young people from minority ethnic communities has been carried out. It would appear, however, that young people from minority ethnic communities may face additional barriers in regard to attitudes towards teenage sexuality and
teenage pregnancy and access to information and services. In particular there may be difficulties in accessing information and literature in their first language.

6.21.2 Births to teenagers are not uncommon among Travellers. In a culture where people marry at an early age, the majority of teenage pregnancies among Travellers occur within marriage. Travellers have been identified as a disadvantaged group in many ways, particularly in relation to health, housing and education. Teenage mothers who are from the Traveller community encounter particular difficulties both in terms of access to support services, and educational and employment opportunities.

6.21.3 Many young people who are Travellers leave school before age 16. Because of their more limited educational experiences, access to Relationships and Sexuality Education may also have been curtailed. Within their communities, personal development programmes that include culturally sensitive information on sexuality would be beneficial.

6.21.4 Those with physical or learning disabilities may have very specific and individual needs which must be addressed by service providers.

6.22 THE CHALLENGE

6.22.1 All of the issues explored in this document are interrelated and must be seen within the broader context of social exclusion and the PSI initiative. Teenage pregnancy and parenthood remain both a cause and a consequence of social exclusion.

6.22.2 The challenge of reducing the number and consequences of teenage pregnancies has several layers of complexity. For young teenagers the challenge is to equip them with the knowledge and skills that will help them build self-esteem and strong relationships while postponing sexual activity. For older, sexually active teenagers the challenge is to motivate them to practice safer sex and to ensure that sexual health services and advice centres are accessible, tailored to their needs and welcoming.
7.1.1 The reality of recommending action to reduce the rate of teenage parenthood and the consequential social exclusion is difficult. Real change will take time. It requires the long-term commitment of all parties to address all the issues in an honest, open and constructive manner. It will require Departments and their partners outside Government to actively engage with and listen to young people and to shift existing resources to meet their needs.

7.1.2 Recommendations have not been divided specifically into those tackling prevention and those tackling support issues. Initiatives aimed at reducing the negative consequences of teenage parenthood are part of a continuum with the same fundamental underlying principles. All recommendations are listed under specific issues. Many will require a dynamic interagency approach to effect the stated goals.

7.1.3 All of the recommendations contained in this report are founded on the following approaches:

- **Involving Youth**
  Young peoples’ views should be sought and taken into account by those who make decisions on their behalf.

- **Acting in Partnership**
  Any initiative to reduce teenage pregnancy rates will only be effective if approached through a multi-sectoral partnership model.

- **Avoiding Personal Prejudice**
  All young people have the right to be treated in a non-judgemental manner.

- **Community Based**
  Work with young people should be undertaken at community level based on the principles and practices of community development.

- **Building on Success**
  Future activities should, where possible, build on existing, evaluated good practice.

- **Acting on Evidence**
  Action to reduce the problems associated with teenage parenthood must be based on an evidence-based approach.
### RECOMMENDATIONS

#### 7.1.4 RECOMMENDATIONS

<table>
<thead>
<tr>
<th>#</th>
<th>Improving Communication</th>
<th>Lead Organisation</th>
<th>Partners</th>
<th>Time Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Community based programmes and courses on parent/child communication should be further developed.</td>
<td>DHSSPS</td>
<td>DHFETE Education &amp; Library Boards/ Schools HSS Boards/Trusts Community &amp; Voluntary Organisations</td>
<td>1-2 Years</td>
</tr>
<tr>
<td>2</td>
<td>The potential of the media as a resource must be explored and utilised to provide messages that are factually correct and deal sensitively with adolescent issues.</td>
<td>HPA</td>
<td>SSA T&amp;EA HSS Boards/Trusts Education &amp; Library Boards/Colleges</td>
<td>1-2 Years</td>
</tr>
<tr>
<td>3</td>
<td>Local directories of resources offering information, advice or services to young people/young parents should be produced and disseminated.</td>
<td>HSS Boards/Trusts</td>
<td>Education and Library Boards Community &amp; Voluntary Organisations</td>
<td>1-2 Years</td>
</tr>
</tbody>
</table>

### ABBREVIATIONS

- **DE**: Department of Education
- **DHFETE**: Department for Higher and Further Education Training and Employment
- **DHSSPS**: Department of Health, Social Services and Public Safety
- **DSD**: Department of Social Development
- **NISRA**: Northern Ireland Statistics and Research Agency
- **NIHE**: Northern Ireland Housing Executive
- **HPA**: Health Promotion Agency
- **SSA**: Social Security Agency
- **T&EA**: Training and Employment Agency
- **R&D Office**: Research and Development Office
<table>
<thead>
<tr>
<th></th>
<th>Promoting Equal Opportunity</th>
<th>Lead Organisation</th>
<th>Partners</th>
<th>Time Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Guidelines on Relationship and Sexuality Education should be disseminated and implemented as soon as possible.</td>
<td>DE</td>
<td>Education &amp; Library Boards/HPA HSS Boards/Trusts Schools</td>
<td>0-12 Months</td>
</tr>
<tr>
<td>b.</td>
<td>A specialised programme of in-service training should be developed for teachers who are nominated to teach RSE.</td>
<td>DE</td>
<td>Universities HPA Community &amp; Voluntary Organisations Education &amp; Library Boards Youth Council For NI</td>
<td>1-2 Years</td>
</tr>
<tr>
<td>c.</td>
<td>Accredited programmes on peer education should be further developed. Peer Education should be widely available and rigorously evaluated.</td>
<td>DH SSPS</td>
<td>HSS Boards/Trusts Voluntary &amp; Community Groups Youth Services Education &amp; Library Boards/Colleges/Universities</td>
<td>1-2 Years</td>
</tr>
<tr>
<td>d.</td>
<td>Pregnant and parenting teenagers of compulsory school age must be encouraged and enabled to remain in education. Flexible education arrangements should be available to meet the individual needs of all pregnant /parenting teenagers wishing to remain in education.</td>
<td>DE</td>
<td>Education &amp; Library Boards DHFETE Schools/Colleges Voluntary &amp; Community Groups</td>
<td>1-2 Years</td>
</tr>
<tr>
<td>e.</td>
<td>Guidelines on the pastoral care of pregnant and parenting young people should be prepared and issued to all post-primary schools as soon as possible.</td>
<td>DE</td>
<td></td>
<td>0-12 Months</td>
</tr>
<tr>
<td>f.</td>
<td>A mechanism for the funding of childcare for parenting teenagers who wish to remain in education and whose families cannot help with childcare should be considered by the Interdepartmental Group on Early Years.</td>
<td>DH SSPS</td>
<td>Interdepartmental Group on Early Years DSD DE DHFETE</td>
<td>0-12 Months</td>
</tr>
</tbody>
</table>
## Recommendations

<table>
<thead>
<tr>
<th></th>
<th>3 Investing in Health</th>
<th>Lead Organisation</th>
<th>Partners</th>
<th>Time Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Community based teenage personal development programmes should be developed based on a community development approach. Such programmes should provide education, information, support and links to services and offer holistic programmes targeting risk taking behaviour.</td>
<td>DHSSPS</td>
<td>DHSSPS HSS Boards/Trusts Community &amp; Voluntary Organisations</td>
<td>2-4 Years</td>
</tr>
<tr>
<td>b.</td>
<td>A Sexual Health Promotion Strategy should be prepared with emphasis on the needs of young people including the specific needs of young men.</td>
<td>DHSSPS</td>
<td>HPA HSS Boards / Trusts Community &amp; Voluntary Organisations</td>
<td>1-2 Years</td>
</tr>
<tr>
<td>c.</td>
<td>Sexual Health Services must be tailored to the needs of young people including young men in particular. They must provide specific sessions for young people at accessible times and locations.</td>
<td>DHSSPS</td>
<td>HSS Boards / Trusts Community &amp; Voluntary Groups Primary Care</td>
<td>1-2 Years</td>
</tr>
<tr>
<td>d.</td>
<td>Staff working with young people should receive training on communicating with young people appropriate to their age and life experiences.</td>
<td>DHSSPS</td>
<td>HSS Boards / Trusts Community &amp; Voluntary Groups</td>
<td>1-2 Years</td>
</tr>
<tr>
<td>e.</td>
<td>Updated guidelines on the issue of confidentiality should be developed and disseminated to all health care professionals, administrators, educators and others who are likely to have dealings with young people about personal relations and sexual matters.</td>
<td>DHSSPS</td>
<td>DE DHFETE Voluntary &amp; Community Groups</td>
<td>1-2 Years</td>
</tr>
<tr>
<td>f.</td>
<td>Pregnant teenagers should receive antenatal and postnatal care in a setting tailored to their specific needs and sensitive to their issues.</td>
<td>HSS Boards</td>
<td>HSS Trusts Primary care Professionals</td>
<td>1-2 Years</td>
</tr>
</tbody>
</table>
## Recommendations

### 4. Entering Employment

<table>
<thead>
<tr>
<th>Lead Organisation</th>
<th>Partners</th>
<th>Time Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHFETE</td>
<td>T&amp;EA Business Community, Voluntary Organisations</td>
<td>2-4 Years</td>
</tr>
</tbody>
</table>

**a.** Initiativees should be developed to facilitate flexible employment and employment related opportunities for young parents.

### 5. Addressing Housing

<table>
<thead>
<tr>
<th>Lead Organisation</th>
<th>Partners</th>
<th>Time Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>NIHE</td>
<td>Community &amp; Voluntary Organisations, HSS Trusts</td>
<td>1-2 Years</td>
</tr>
</tbody>
</table>

**a.** Where appropriate, teenage mothers requiring statutory housing should be accommodated as close to their families and communities as possible. Access to necessary support services should be facilitated.

### 6. Building on Good Practice

<table>
<thead>
<tr>
<th>Lead Organisation</th>
<th>Partners</th>
<th>Time Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHSSPS</td>
<td>HPA R&amp;D office DHSSPS, NISRA, DSD Universities, Community &amp; Voluntary Organisations, Education &amp; Library Boards</td>
<td>2-4+ Years</td>
</tr>
</tbody>
</table>

**a.** The existing research base related to teenage health, education and social issues should be further developed.

**b.** All new interventions targeting teenage health, education and social issues must be rigorously evaluated. A database of evaluated interventions should be established.
7.1.5 In addition to the specific recommendations we recognise that there are important steps that could be undertaken to improve the focus on children, their health and their life opportunities. As a society this should include a greater emphasis on the following:

- Valuing children;
- Promoting self-esteem among children and young people;
- Promoting meaningful relationships between children and adults;
- Promoting educational opportunity and life aspirations for all but with particular emphasis on young people from disadvantaged backgrounds.

7.1.6 The Working Group hopes that the short to medium term recommendations outlined above will facilitate and advance cultural change. Teenage pregnancy affects teenage parents, their children and the wider community. It can cause social, emotional and physical health problems. Statutory agencies, voluntary and community groups and families must all work together to facilitate a reduction in teenage parenthood rates. Everyone has a responsibility to contribute to a culture that helps young people make responsible, informed choices and support young parents to realise their potential.
MEMBERSHIP OF THE STEERING GROUP

1. **Ms. L. Barclay**  
   Health Promotion Agency for Northern Ireland

2. **Dr. C. Beattie**  
   Eastern Health & Social Services Board

3. **Ms. M. Black**  
   North & West Belfast Health Action Zone (From November 1999)

4. **Professor T. Bradley**  
   N.I. Council for Postgraduate Medical & Dental Education

5. **Mr. J. Breen**  
   Department of Health Social Services & Public Safety

6. **Ms. P. Campbell**  
   Gingerbread NI (Until November 1999)

7. **Mrs. E. Donnelly**  
   Southern Education & Library Board

8. **Mrs. M. Graham**  
   North & West Belfast Health & Social Services Trust

9. **Ms. T. Hughes**  
   Ballybeen Women’s Centre

10. **Mr. I. Houston**  
    Youth Services, Department of Education

11. **Dr. C. Hunter**  
    Belfast Brook Advisory Centre

12. **Mr. P. Mageean**  
    Equality Unit, Department of Higher and Further Education, Training & Employment

13. **Dr. M. McCarthy (CHAIR)**  
    Department of Health Social Services & Public Safety

14. **Ms. T. McCrossan**  
    Barnardos Young Parents Network
APPENDIX ONE

15. **Ms. F. McKinney**  
Westcare Business Services

16. **Ms. J. Orr**  
Regional Information Branch

17. **Ms. M. Potter**  
Department of Education

18. **Ms. M. Reynolds**  
Social Services Inspectorate

19. **Mr. M. Rooney**  
The Housing Centre

20. **Mrs. A. Simpson**  
Family Planning Association (NI)

21. **Mrs. G. Smyth**  
Department of Health Social Services & Public Safety

22. **Ms. C. Spiers**  
Ulster Hospital, Dundonald

23. **Mrs. A. Sweeney**  
Gingerbread (NI) (From November 1999)

24. **Professor D. Whittington**  
University Of Ulster

25. **Ms. E. Teague**  
North & West Belfast Health Action Zone (Until November 1999)

SECRETARIAT

1. **Ms E. Melarkey**  
Department of Health Social Services & Public Safety (Until February 2000)

2. **Mr T. Reid**  
Department of Health Social Services & Public Safety (From February 2000)
The PSI Working Group on Tackling the Problems of Teenage Parenthood will develop a co-ordinated strategy through which relevant agencies will work together to:

- Contribute to a reduction of 10% in the number of births to teenage mothers by 2002;
- Address the difficulties which young parents and their families face during pregnancy and after birth so as to prevent young parents or their children from being socially excluded in either the immediate or longer term. In doing so it will be concerned with issues relating to young fathers as well as to young mothers.

In relation to both reducing unintended pregnancy and avoiding the exclusion of young parents it will be necessary for the Working Group to:

- Use existing research and other evidence and the advice of experts to analyse the issues and develop an understanding of the problems and their causes;
- Consider Departments’ roles and responsibilities in relation to the issue, including the effectiveness of any existing policies, programmes and structures with a view to identifying elements which work well and should be developed and areas where things could be done differently;
- Identify and examine options for the way forward including models of good practice from Northern Ireland and elsewhere; and
- Make recommendations as to what preventative and other measures are required, by whom, and within what timescales, and other mechanisms to be put in place to ensure progress.

The Working Group will provide recommendations in the form of a document intended for publication.
GROUPS CONSULTED OR INVITED TO CONTRIBUTE WRITTEN INFORMATION

1. Action MS (NI)
2. Advisory Committee on Travellers
3. Altnagelvin HSS Trust
4. Antrim Borough Council
5. Antrim Borough Partnership
6. Armagh & Dungannon HSS Trust
7. Association of Independent Advice Centres NI
8. Baha’i Assembly of Belfast
9. Ballybeen Community Forum
10. Ballybeen Women’s Centre
11. Ballymoney Borough Council
12. Banbridge District Council
13. Barnardos NI
14. Belfast Activity Centre
15. Belfast Brook Advisory Centre
16. Belfast City Hospital HSS Trust
17. Belfast Education & Library Board
18. Belfast Foyer-Simon Community
19. Belfast Interface Project
20. Belfast Traveller Sites Project
21. Belfast Travellers Education & Development Group
22. Board of Social Witness in the Presbyterian Church
23. Boys Brigade
24. British Deaf Association
25. British Red Cross
26. Brownlow Women’s Forum
27. Business Results Ltd.
28. Bytes Project
29. Carnlough Community Development Group
30. Carrickfergus Borough Council
31. Catholic Family Care
32. Causeway HSS Trust
33. Childline
34. Children’s Law Centre
35. Chinese Welfare Association
36. Chrysalis
37. Church of Ireland Board for Social Responsibility (NI)
38. Cinemagic
40. Committee on the Administration of Justice
41. Council for Catholic Maintained Schools
42. Council for the Homeless NI
43. Craigavon & Banbridge Community HSS Trust
44. Craigavon Borough Council
45. Creggan Health Information Programme
46. Darkley & District Community Association
47. Department of Education
48. Department of Environment
49. Department of Health Social Services & Public Safety
50. Department of Higher and Further Education, Training & Employment
51. Department of Social Development
52. Derry City Council
53. Derry Media Access
54. Derry Well Women Centre
55. Disability Action
56. Down District Council
57. Down Lisburn HSS Trust
58. Eastern HSS Board
59. Equal Opportunities Commission for NI
60. Falls Community Council
61. Families and Racism Research Project
62. Family Planning Association (NI)
63. Fermanagh District Council
64. Foreglen Youth Clu
65. Foyle HSS Trust
66. Foyle Leaving & Aftercare Group
67. Free Presbyterian Church in Ireland
68. General Consumer Council
69. Gingerbread NI
70. Girls Brigade
71. Glenshane Community Development Ltd.
72. Harpurs Hill Community Early Years Project
73. Health Promotion Agency For Northern Ireland
74. Homefirst Community Trust
75. Horizon
76. Include Youth
77. Learn & Grow
78. Lee Hestia Association
79. Lenadoon Community Forum
80. Lifestart Templemore
81. Lower Oldpark Youth & Community Drop in
82. Magnet Young Adult Centre
83. Mater Hospital HSS Trust
84. MENCAP
85. Morning Star Hostel
86. Moyllyn House Community Development Support Services Agency
87. Mulholland After Care Services
88. Mullaghbawn Women’s Health Initiative
89. N&W Belfast HSS Trust
90. Newington Residents Association
91. Newry & Mourne HSS Trust
92. NIACRO
93. NIMBA
94. NIPSA
95. North & West Belfast Health Action Zone
96. North Lurgan Youth Club
97. North West Community Network
98. Northern HSS Board
99. Northern Ireland Anti Poverty Network
100. Northern Ireland Childrens Holiday Scheme
101. Northern Ireland Council for Ethnic Minorities
102. Northern Ireland Council for Postgraduate Medical & Dental Education
103. Northern Ireland Council for Voluntary Action
104. Northern Ireland Disability Council
105. Northern Ireland Housing Executive
106. Northern Ireland Muslim Women Association
107. Northern Ireland Newpin
108. Northern Ireland Voluntary Trust
109. Northern Ireland Women’s Aid Federation
110. Northern Ireland Youth Forum
111. Northwest Forum of People with Disabilities
112. O’Gans Youth Club
113. Ocean View Youth Club
114. Old Warren Youth Initiative
115. Omagh Boys and Girls Club
116. One World Centre
117. Parents Advice Centre
118. Passionist Youth and Parent Resource Centre
119. Pavee Point Travellers Centre
120. Pennyburn Youth & Community Centre
121. Pennyburn Youth & Community Centre
122. Pop Bar Drop in Centre
123. Rainbow Project
124. Reach Across
125. Rocklands Environmental Action Group
126. Roden Street Community Development Group
127. Roden Street Youth Action Group
<table>
<thead>
<tr>
<th>Number</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>128</td>
<td>Royal Group of Hospitals HSS Trust</td>
</tr>
<tr>
<td>129</td>
<td>Rural Community Network</td>
</tr>
<tr>
<td>130</td>
<td>Save the Children (NI)</td>
</tr>
<tr>
<td>131</td>
<td>School of Social &amp; Community Sciences University of Ulster</td>
</tr>
<tr>
<td>132</td>
<td>Shankhill Young Women’s Project</td>
</tr>
<tr>
<td>133</td>
<td>Shell Livewire</td>
</tr>
<tr>
<td>134</td>
<td>Simon Community (NI)</td>
</tr>
<tr>
<td>135</td>
<td>Southern Education &amp; Library Board</td>
</tr>
<tr>
<td>136</td>
<td>Southern HSS Board</td>
</tr>
<tr>
<td>137</td>
<td>Southern Travellers Early Years Partnership</td>
</tr>
<tr>
<td>138</td>
<td>Sperrin Lakeland HSS Trust</td>
</tr>
<tr>
<td>139</td>
<td>St. Annes First Dungannon Scout Group</td>
</tr>
<tr>
<td>140</td>
<td>St. James Forum</td>
</tr>
<tr>
<td>141</td>
<td>Standing Advisory Commission on Human Rights</td>
</tr>
<tr>
<td>142</td>
<td>Star Neighbourhood Centre</td>
</tr>
<tr>
<td>143</td>
<td>STEP</td>
</tr>
<tr>
<td>144</td>
<td>Strabane District Initiative for Youth</td>
</tr>
<tr>
<td>145</td>
<td>Strabane Young People’s Health Project</td>
</tr>
<tr>
<td>146</td>
<td>The Lifestart Foundation</td>
</tr>
<tr>
<td>147</td>
<td>The Playhouse</td>
</tr>
<tr>
<td>148</td>
<td>Threshold Emotional Development Initiative</td>
</tr>
<tr>
<td>149</td>
<td>Traveller Movement (NI)</td>
</tr>
<tr>
<td>150</td>
<td>Tullysaran Youth Club</td>
</tr>
<tr>
<td>151</td>
<td>Ulster Community &amp; Hospitals Trust</td>
</tr>
<tr>
<td>152</td>
<td>United Hospitals HSS Trust</td>
</tr>
<tr>
<td>153</td>
<td>Upper Springfield Development Trust</td>
</tr>
<tr>
<td>154</td>
<td>Waterside Development Trust</td>
</tr>
<tr>
<td>155</td>
<td>Waterside Youth Club</td>
</tr>
<tr>
<td>156</td>
<td>Westcare Business Services</td>
</tr>
<tr>
<td>157</td>
<td>Western HSS Board</td>
</tr>
<tr>
<td>158</td>
<td>Women’s Opportunities Unit, University of Ulster</td>
</tr>
<tr>
<td>159</td>
<td>Women’s Resource and Development Agency</td>
</tr>
<tr>
<td>160</td>
<td>Workers Educational Association</td>
</tr>
<tr>
<td>161</td>
<td>YMCA Bangor</td>
</tr>
<tr>
<td>162</td>
<td>Young Parent’s Network</td>
</tr>
<tr>
<td>163</td>
<td>Youth &amp; Social Development (Methodists)</td>
</tr>
<tr>
<td>164</td>
<td>Youth Action</td>
</tr>
<tr>
<td>165</td>
<td>Youth Action, Derry</td>
</tr>
<tr>
<td>166</td>
<td>Youth Council for Northern Ireland</td>
</tr>
<tr>
<td>167</td>
<td>Youth Information Centre, Newry</td>
</tr>
<tr>
<td>168</td>
<td>Youth Sport Omagh, Ltd.</td>
</tr>
</tbody>
</table>
PROMISING APPROACHES

A) Preventing Unexpected Teenage Pregnancies

Brook Belfast
This voluntary organisation in central Belfast offers a free confidential contraceptive and counselling service for young people. Due to demand for the service the clinic can only offer services to clients up to age 19.

Ballybeen Women’s Project
This voluntary, community based organisation trains young people to become volunteer peer educators through the provision of intensive training in health and personal development and more specialised accredited training in communication and group work skills.

Creggan Health Information Project
Creggan Health Information Project facilitates a communication skills programme for parents. This includes a workshop on sex education and children.

Eastern Area Sexual Health Team
Established in 1989 within the Health Promotion/Public Health Department of the EHSSB the team have been involved in developing a range of innovative approaches and works closely with both the statutory and voluntary sectors.

Family Planning Association
Run the following accredited sexual health community education projects, to enable young people to make informed decisions about their personal and sexual lives. Based on a community development approach they are essentially personal development health programmes:

a. Choices
A personal development programme for young women under 25. Choices seeks to empower young women by providing education and information on relationships, sexuality and physical and emotional health in a holistic manner. Four separate projects are currently running, in EHSSB area, Strabane District Council Area, Fermanagh and the neighbouring border towns, and the North West.
b. Bout ye
A project aimed at young men under 25, “Bout ye” aims to provide an open environment for personal development by helping young men to become more aware of the issues surrounding sexuality and relationships. The programme is run in the EHSSB area.

c. Limelight
The aim of this programme is to train young people with a physical disability to become peer educators in sexuality and disability equality.

d. Roundabout
Trains young people to an accredited level to be sexual health peer educators in post primary schools. The scheme is the only peer education project in the UK delivering sex education within the school system, where the peer educators gain an accredited qualification.

N&W Belfast Health Action Zone
North & West Belfast Health Action Zone seeks to address health and social inequality, through a community development approach, in particular areas or communities and targeting particularly vulnerable groups. A range of initiatives are being taken forward, specifically one of six priority schemes of the Health Action Zone in North and West Belfast, will focus on co-ordinated approaches to improving sexual health and reducing teenage pregnancy as well as supporting teenage parents;

Opportunity Youth
This voluntary organisation delivers social and personal education to young people in a selected group of training organisations. This includes a sexual health component. A lunch hour contraceptive clinic is provided for trainees.

Provide personal development programmes for minority groups in Northern Ireland. These programmes include self-awareness and assertiveness programmes.

The Nucleus
This voluntary organisation based in the North West offers a holistic health programme for young people aged under 20 years. The programme includes a workshop on sexual health.
Upper Springfield Development Trust
This is a voluntary organisation base in Upper Springfield in NW Belfast. The group offers personal development programmes for young people which include a sexual health element.

www.coolsexinfo.org.uk
Developed by the SHSSB this unique website offers confidential advice to teenagers on sexual health. The site offers up-to-date information on sexual health issues and helps address problems of access to such information for those in isolated rural areas.

B Supporting Teenage Parents

Barnardos
This project provides a range of supports to young parents in their local communities, across Northern Ireland. Programmes are specifically designed for young parents which focus on issues which they identify as being important in their lives. These issues include personal development, child development, relationships and health. The project works with young parents to produce practical guides about becoming a parent and highlighting local supports and services. Barnardos have recently established the School Aged Mothers project and are working with young people in schools about the issues which face young parents.

Gingerbread
Next Steps offers home based support to teenage mothers who are referred to the project, currently available in two HSS Trust areas, by their Health Visitors. Next Steps aims to empower participants to reach personal goals. A wide range of support and information is offered, including access to welfare advice, training and help with childcare. The project also provides opportunities to meet with other young mothers.

Girl Power
A resource package aimed at raising the self-esteem of young girls is provided by Health Visitors and School Nurses in the WHSSB area.

Community Based Programmes
Regionally, community nurses have responded to identified need and initiated parenting programmes and drop-in centres for a number of age groups including school children, adolescents and parents. These initiatives facilitate discussion on sexual health and relationships. For parents, such programmes have helped them to develop communication skills to allow
them to discuss sexual health issues more openly with their children. Some of the initiatives are run in partnership with community and voluntary groups. Whilst most of the service provision is for young females a number are aimed at both sexes and a small number specifically target young males. A number of innovative programmes are being provided for parents to help them develop communication skills to allow them to discuss sexual issues more openly with their children.

**Parents Advice Centre**
Provides parenting skills programmes for parents which includes a workshop on sex education and children.

**Simon Community**
The Belfast Foyer run by the Simon community provides temporary housing and support to teenagers who have left or been asked to leave home.

**Speakeasy**
A parenting and sex education programme organised by FPA NI, designed to equip parents with the skills and knowledge to talk more openly about sex with their children.

**YAHOO (Youth and Health Outreach Project)**
A drop in advice centre provided by midwives in partnership with Ballymurphy Women’s Group offers health advice on a one-to-one basis and group work on parenting skills, sexual health etc to young people. Whilst most of the service provision is for young females, a number are for both sexes and a small number target young males.