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# **EVALUATION OF LEICESTER CITY'S TEENAGE PREGNANCY STRATEGY PREVENTION AGENDA Phase 1**

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## Contents Page

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The Brief .....	2
Methodology .....	4
History of the Strategy .....	6
The Findings .....	11
Sex & Relationship Education .....	18
Contraceptive Services .....	25
Promotion & Media Publicity .....	35
Engagement of Appropriate Agencies .....	40
Involvement of Young People .....	45
Summary & Conclusion of Phase 1 of the Evaluation .....	48

## Appendices

- Appendix 1 – Literature Review
- Appendix 2 – Mapping - background Information
- Appendix 3 – Interview Schedule

## **The Brief**

The Centre for Social Action, De Montfort University was commissioned by Leicester City Council to undertake an evaluation of their Teenage Pregnancy Prevention strategy. We have worked to the brief given us by Leicester City Council which stated:

*“Leicester City Council is seeking a consultant or research team to undertake an evaluation of all prevention aspects within the Teenage Pregnancy Prevention Strategy including*

- 1. Sex and Relationship Education (SRE) Provision*
- 2. Contraception (sexual health) services/provision*
- 3. Engagement of appropriate agencies*
- 4. Promotion and media publicity*
- 5. Involvement of young people*

*These will be investigated and assessed on the following areas*

- Experience and opinion of young people, parents and professionals*
- Factors that have enhanced developments since the strategy was implemented*
- Factors that have hindered developments since the strategy was implemented*
- What is working - good practice*
- What is not working?*
- Where improvements need to be made?*
- How young people and service users are involved*
- Gaps in local knowledge and provision*
- How it is perceived*

### **Overall aims**

*To investigate all aspects of the prevention agenda within the local Teenage Pregnancy Strategy in order to identify what factors appear to have enhanced or hindered its implementation.*

*To obtain an understanding on the activities and services that are being provided and an in-depth look at the quality, accessibility, communication and visibility of the services.*

*To make recommendations to inform commissioning of future projects and determining priorities to meet national and local targets and inform wider strategic plans and documents including the Children and Young People Single Plan and Local Area Agreements.*

### **Phase 1 Months 1-3**

- Undertake a literature review and consideration of national guidance and evaluation*
- Recruit and train the young people to work as peer researchers through and with existing partners and forums.*

- *Undertake consultation and investigation of all areas to inform the citywide analysis*
- *Provide monthly updates to the Teenage Pregnancy and Sure Start Plus Co-ordinator and Partnership Board Chair*
- *Complete the citywide report in three months and present to the Teenage Pregnancy and Sure Start Plus Partnership Board*
- *Identify the three differing neighbourhoods for in-depth research with the Teenage Pregnancy and Sure Start Plus Partnership Board”*

This is the report of Phase One of the evaluation.

Staff from the Centre for Social Action and Youth Affairs Unit, De Montfort University met with the Teenage Pregnancy Co-ordinator and renegotiated the time scale of the project in February to ensure that the consultation with young people took place during the Autumn rather than the Summer term. Under this agreement it was decided to complete Phase 1 of the report in early June and recruit and train peer researchers during the summer, with a view to starting the work of Phase 2 in the local areas during the Autumn term and completing the final report in late November.

## **Methodology**

### **Initial consultation**

The Centre for Social Action is committed to participative approaches in its research so an initial consultation was arranged with a practitioner, parent and two young people to discuss the issues involved in the research and receive suggestions of themes for investigation.

### **Interviews**

An interview schedule was drawn up and produced in two slightly different versions then interviews were arranged with managers and practitioners from different agencies involved in the strategy (see Appendix 3 for the interview schedules). A total of 17 interviews were conducted in person, mostly by telephone, although some were face to face and two additional responses were received via email. Those interviewed comprised staff from Connexions, the Youth Service, Social Care and Health, Healthy Schools, Education Welfare Service, Public Health, Community Midwifery, Community Health Services, Looked After Children nurse, DIVA, Voluntary Action Leicester (VAL), Turning Point, the Teenage Pregnancy Co-ordinator and the Chair of the Teenage Pregnancy Board. It proved difficult to arrange a personal interview with a School Nurse because of their pressure of work, although a response via email has been promised.

### **Literature Review**

A literature review on teenage pregnancy prevention and methods of intervention with young people was carried out using internet based databases, which was supplemented by a visit to the National Youth Agency to consult their specialist collection. The Literature Review is set out in Appendix 1.

### **Practice in other Local Authorities**

Six local authorities which had achieved 'green' status in 2005 alongside Leicester, in relation to their teenage conception rates, were contacted and asked for copies of their Action Plan. (Green status is assigned to those local authorities who are judged to be on target to achieve the aim of a 50% reduction in their local conception rates by 2010.) These comprised Darlington, Luton, Slough, Bradford, Walsall, Liverpool and Thurrock. Responses were late in coming because Co-ordinators were busy completing progress reports and Action Plans for the end of the financial year. Some information was supplied via the East Midlands Regional Co-ordinator including information from Luton and other Action Plans were received from all the local authorities apart from Thurrock. The Liverpool Teenage Pregnancy Co-ordinator made contact in person to discuss their work. Most areas were using similar approaches to develop their work on the strategy and had different strengths and weaknesses according to local conditions. Some examples of practice which seem interesting and innovative are included in relevant sections of the report.

### **Mapping Project**

Information from different sources has been collected and presented by Ward. The BLAST directory, the Teenage Pregnancy Progress report and Choices progress report were used as an initial starting point. Services listed in the

directory were contacted to confirm they were still operating. A survey of all the chemists supplying emergency contraceptives was carried out to check what they were now able to offer following restrictions on the services.

Visits were made to voluntary projects in the Spinney Hills and St Matthews area to find out about what services were provided for young people. This confirmed that very little explicit support or services were provided to young people on sexual health matters apart from the St Peter's Clinic, although there may be a degree of informal support. A survey of sexual health provision by BME communities has been conducted via VAL and may provide additional information.

Telephone calls were made to community projects in other areas to assess provision using contacts made during an audit of community development provision in Leicester in 2005.

Findings so far indicate that formal sources of contraceptive help are well documented. Additional sources of help are likely to include informal advice and sign posting from a range of sources including statutory and voluntary youth services, community centre workers and activists involved with tenant and resident associations.

In general, areas in the eastern side of the city have fewer formal sources of contraceptive services, mostly along with lower conception rates, which is likely to produce a high demand on St Peter's Health Centre.

Findings so far are included in Appendix 2 but it is proposed to view the mapping project as a 'work in progress' which can be added to during the life of the project taking account of local area initiatives to log services.

## History of the Strategy

Following publication of the Social Exclusion Unit report on teenage pregnancy (1999) and the establishment of national targets for the reduction of these, Leicester was identified as an authority with associated problems that impact on teenage pregnancy: low educational achievement, high social deprivation, high levels of turnover in social housing and communities with low income levels. Work started in Leicester as early as October 1999, where the then City West PCT formed a steering group to examine the issues and raise the profile of the teenage pregnancy problem for City West. By March 2000, the group enlarged to incorporate a city-wide focus, facilitated by the first Teenage Pregnancy Co-ordinator.

An audit of the strengths and weaknesses of local provision to prevent teenage pregnancy was carried out in early 2001. The weaknesses of the existing provision were identified as follows:

- “Public education – limited resources to co-ordinate and expand upon current work
- Schools and colleges – SRE has a low status amongst LEA and schools
- Emergency contraception – limited to Primary Care and Family Planning on weekdays only
- Boys and young men – the emphasis is negative and little is promoted to engage boys and young men
- Support in education – anecdotal experiences identifies exclusions when students are pregnant. Programmes that do support young parents in education are not co-ordinated
- Social housing – little co-ordination re social housing and/or flexible support
- Ante/post natal support – young pregnancy or parenthood not prioritised for support
- Training and employment – opportunities for young parents limited
- Childcare – inflexible, expensive and in great demand
- Minority ethnic communities – little local data available to inform position
- Professional development – capacity on courses are limited
- Links to other strategies – emphasis on young people is under developed”

At the local level a set of strategic goals drawn up:

- To establish the local co-ordination structures to facilitate the ‘joined –up’ approach
- To establish local and accessible advice and information for all young people
- To enhance the provision of Personal Social and Health Education (PSHE) and Sex and Relationship Education (SRE) in schools, colleges and youth settings
- To improve local youth contraception services
- To facilitate choice before 10 weeks gestation
- To increase the support available for pregnant young people and for early parenthood.

(Teenage Pregnancy in Leicester, 2002)

Data on teenage pregnancy rates analysed by ward was used to establish the geographical focus of the work on pregnancy prevention. This was initially focused on Braunstone, Beaumont Leys and New Parks with Eyres Monsell and Freeman added later.

Whilst the first Teenage Pregnancy Co-ordinator was in post a number of activities were initiated including creating and promoting a guide to services for teenagers – the BLAST directory - with strong participation from young people, Blue Box workforce training and support for young parents. The Choices Project was also established providing young people focused clinics for young people in the hot spot areas and support services for young parents. Connexions were involved from an early stage providing preventative services and support for young parents as part of the Sure Start Plus initiative.

A persistent challenge for the strategy has been the continual reorganisation and refocusing of agency structures and services throughout the Leicester city area which has acted as a backdrop and a distraction, while managers and practitioners have endeavoured to implement the work identified for themselves in the Strategic Plan.

Respondents who had been involved with the strategy from the beginning acknowledged that some good work had been done in the early period but felt this had not been sufficiently focused and co-ordinated.

*“In the early period the strategy initially covered a larger geographical area – Leicester, Leicestershire and Rutland. It employed a Health Promotion worker who initially worked for the county then exclusively for the city. He was successful in pulling partnership together but there was no real clarity regarding role. Lots of health promotion achievements, BLAST Directory and Professional Pathway then came demise of Health Promotion agency. Council split the role between agencies then withdrew funding. Experienced staff then left.”*

The Teenage Pregnancy and Sure Start Plus Co-ordinator who had made a significant start on the Strategy moved on in May 2004. The Partnership Board appointed the current Sure Start Plus Development Adviser as acting Co-ordinator for two days a week in the interim period. An Action Plan for 2004-05 was produced in order to secure the Local Implementation Grant.

The new Coordinator was appointed in February 2005 and was immediately involved in similar activity to write an Action Plan for 2005-8 and the 2004-5 Annual Report in order again to secure the grant. The Annual Report noted

*“The 2005-08 Plan is based on local consultation with young people and professionals through events and the strategic and delivery groups responsible for aspects of the strategy. A successful consultation day was held in March 2005 for existing and new partner agencies to contribute to the annual report and to inform and shape the future plan in line with the five outcomes of Every Child Matters.*



*The Co-ordinator presented a paper on the local Teenage Pregnancy Strategy and areas of priority for the future to the Management Board and Partners' Advisory Board for Leicester Federation. The recommendations presented included integrating the Teenage Pregnancy Strategy into the 2006 Children and Young People's Plan, increasing Board members' influence and involvement on the development and implementation of the 2005-08 Action Plan, referring the plan to Social Care and Health Scrutiny Committee and finally to cabinet to ensure that future funding is protected once the ring fencing is removed post-April 2006. Both boards endorsed the recommendations presented."*

It was later agreed that the Plan didn't need to go to Scrutiny.

*Clear plans are in place to ensure that the local strategy is mainstreamed and embedded into the Children's and Young People's Plan with the support and influence of cabinet and Social Care and Health Scrutiny and plans are in place to protect future Teenage Pregnancy funding."*

(Leicester City Teenage Pregnancy Strategy Annual Report 2004-05, 2005)

The next task was the need to recreate momentum and commitment to the strategy following the gap between co-ordinators – work on the prevention agenda had largely stood still during that period.

The Teenage Pregnancy Annual Assessment Feedback East Midlands report for Leicester City, covering the period 2003-4, had identified a number of weaknesses in the performance of the Board and the Strategy during this period. These can be summarised as follows:

- "Teenage pregnancy needs to be represented in relevant plans and strategies e.g. EYDCP Plan, Children's Centres, Housing Strategy, Sure Start Delivery Plans, Children's Centres, Extended Schools, Children's Trusts.
- The Board needs an agreed mechanism to review progress and forward action planning on at least a 6 monthly basis.
- Evidence is needed of monitoring of effectiveness and impact and clear plans for 'mainstreaming' what works.
- There need to be robust arrangements for commissioning work funded by the Local Implementation Grant, in line with Local Authority procedures.
- Coordination arrangements need to be strengthened. Many key agencies are not represented on the Teenage Pregnancy Board, or do not have close working links within teenage pregnancy structures.
- Multi-agency network forums run twice a year. It is unclear whether this structure provides effective links between operational and strategic planning levels. For example there are no sub-groups to the Teenage Pregnancy Partnership Board addressing particular themes of the strategy."

This perception is confirmed by a Board member who was around at that time.

*“There was at this time (after the first co-ordinator left) a lack of engagement with other partners on the Board and a severe problem with both the Action Plan and which projects were funded. Communication was a major problem and the lack of leadership from Leicester City Council.”*

These comments provided both the context and the agenda for the new co-ordinator to start to take action to address the issues identified.

Some time was spent strengthening the membership of the Board and encouraging a collective approach to decision-making. New agencies were involved such as Children’s Centres, Early Years, LSC and the voluntary sector. Members of the Education Department were encouraged to get more involved. A Board member welcomed the greater involvement of Education in the strategy since the co-ordinator was appointed, something that was not so apparent previously.

In order to develop an adequate monitoring and evaluation process steps were taken to ensure that this was made a requirement of all new projects funded by the Board. Some members feel that there should be even more accountability from projects. See page 17 for more information about this.

To address the absence of a structure for local delivery, a number of Task Groups were set up covering different aspects of the strategy, bringing managers and practitioners together to share information and agree plans. While these have helped to focus attention on the implementation of the strategy good communication between the Board and the Task groups is still essential for success.

The need for a robust commissioning process was another issue requiring attention. It was felt both by the co-ordinator and other Board members that the previous system had not been transparent enough. The new process adopted was more transparent this year, though it is still felt it could be further improved. Having a more open tendering process so it was not inevitable which agency was going to be funded was seen to be important, as it allowed for a wider range of groups and organisations to provide services.

Another gap was the absence of effective promotion and media activities and the DIVA agency was commissioned by the Board to supply this in partnership with a new Media Group set up to support them. See section Promotion & Media Publicity p 35 for more information about the media strategy.

An important milestone has been the national publication of teenage pregnancy rates in 2004 in England as indicators of how effectively each local authority is meeting its long term target. The statistics for Leicester City revealed that a decrease of 23.8% in the conception rates per 1000 population of young women aged 15-17 had been achieved by 2004, from the baseline of 1998, giving the city ‘green’ status as being ‘on target’, however there hasn’t been a consistent decline since 1998.

A letter from the East Midlands Regional Teenage Pregnancy Co-ordinator in February 2006 noted that there had been excellent progress on delivery across

the whole strategy and in particular the excellent SRE and peer education programme being delivered in schools and youth settings by the voluntary sector. It highlighted four issues discussed at the Teenage Pregnancy Board meeting as still needing attention:

- Clarifying and strengthening the role of Partnership Board members to ensure that all are able to carry out crucial responsibilities in delivering the Teenage Pregnancy Strategy in their particular agency or organisation.
- Need to increase the level of investment from all partner agencies. This was particularly important in order to ensure the continuity of the outstanding support and services provided through Sure Start Plus.
- Concerns about disinvestment from sexual health services by the PCTs and their lack of financial commitment to relevant services and staff training.
- Need to increase the commitment of all partners to the delivery of SRE.

The recently published 2006 Progress report notes *“Following the implementation of changes to the organisation of children and young people’s services in Leicester, existing Partnership Board members have agreed to disperse with the current Board once the Joint Commissioning Board (JCB) for children and young people has been established. The JCB will report to the Children and Young People’s Strategic Partnership. It is proposed that a Teenage Pregnancy Strategic Advisory Group will replace it with senior representation from key partners. Members will be responsible for aspects of the strategy and will inform and influence the JCB. The Teenage Pregnancy Co-ordinator will join the JCB to ensure that teenage pregnancy is fully integrated in future developments and enhance local investment.”* (Progress Report on Teenage Pregnancy in 2005-06, 2006)

## The Findings

This section will consider the findings of the first phase of the evaluation. It is divided into six parts: General Factors Affecting the Delivery of The Teenage Pregnancy Prevention Strategy, Sex and Relationship Education, Contraceptive Services, Promotion and Publicity, Engagement of Appropriate Agencies and Involvement of Young People.

### General Factors Affecting the Delivery of the Teenage Pregnancy Prevention Strategy

While the evaluation will be looking at the performance of various aspects of the prevention agenda, just as important are the various parts of the infrastructure helping to deliver the strategy, including the role of the Teenage Pregnancy Co-ordinator, the performance of the current post holder and the operation of the Teenage Pregnancy Partnership Board and the various Task Groups set up.

Respondents who attended the Teenage Pregnancy Partnership Board were asked for their views on the way in which the current structure, membership and performance of the Board either helped or hindered its performance, changes they would like to see in the way in which it operated and key issues they felt it needed to address in the future. Similar questions were asked about the operation of the Task Groups. People were also invited to comment on funding issues which they thought would be relevant. Key issues identified will be discussed in this section.

#### Teenage Pregnancy Co-ordinator role

The current Teenage Pregnancy Co-ordinator was clear that the existence of the post, its remit and the support available was a key factor in making the Teenage Pregnancy strategy work successfully.

*“The post is the lynchpin – having a person to give momentum and drive to the raising of the profile of teen pregnancy – seeing where the opportunities are – where to identify resources. It is a definite help to seeing the bigger picture.”*

#### Teenage Pregnancy Coordinator

This perception was supported by other respondents,

*“The co-ordinator post has helped with the delivery of the strategy.”*

*“It has been helpful to have a Teenage Pregnancy Co-ordinator located in the Federation and Trust – there is much less complacency and there is a freedom of overview – can take issues across the agency “*

A number of factors were seen to have helped the Teenage Pregnancy Co-ordinator be effective, these included support from managers as well as Teenage Pregnancy networks, and colleagues.

*“Factors which have helped with post include having a good line manager and being based in the Federation office with good access to people working in social care health, education, family centres, looked after children I have also had excellent support from the regional coordinator. She has created a regional group of co-ordinators with a strong and supportive approach to the work and sharing ideas and good practice.”* **Teenage Pregnancy Coordinator**

However some people did also see that there were factors that caused the role to be more limited than it might be. These included the location of the post, the broadness of the role, capacity the pace of work and the impact of the initiative nationally.

*“The drawback is that I can see where Teenage Pregnancy work could fit elsewhere and I want to make it happen, I want people to stay involved and not stay in silos. It’s down to the broad nature of the roles you have to adopt – you become a jack of all trades – prevention, SRE, contraception, stakeholders, support agenda – makes your head spin – plus an ever increasing work load. There are issues of capacity, the actual pace of the work is very fast – the pressure of work.”* **Teenage Pregnancy Co-ordinator**

Apart from one interview, respondents were not explicitly asked about their view of the work of the Teenage Pregnancy Coordinator, but she was mentioned spontaneously as being key to the recent achievements of the strategy by many people. In summary it was felt there was now a more focused, cohesive approach to delivering the strategy largely attributable to the energy and talent of the second Teenage Pregnancy Coordinator,

*“It has moved forward a lot over the last few years. Since the new manager things are more open and transparent. She has listened and taken note and targets are being met.”*

*“From 2004 onward I have seen a lot more proactive work opportunities and individuals willing to cross the line – there is better communication – it is not yet perfect – but has been a real mental and philosophical change”*

*“The Strategy has been very good since (the worker) has been in post – it is higher on people’s agendas – getting there”*

*“The Leicester Teenage Pregnancy Team offers good support – high quality direction that allows workers to develop cohesive strategy so the profile can be raised – people can plan their work more effectively, there was no culture of that previously”*

### **The Teenage Pregnancy Partnership Board**

There were mixed opinions about the current performance of the Partnership Board; this seems to be because people expected different things of it. Also factors which were seen as a strength by some people were seen as a hindrance by others.

In terms of factors which enhance the performance of the board there was support for the view that the Partnership Board was now working rather better than it had previously. There was praise from several people for the effort that the Teenage Pregnancy Coordinator put into running the meetings, ensuring people received papers on time and her tenacity in following people up.

*“People through the Pregnancy Board are more engaged – they have more ability and influence”.*

*“(Worker) has helped it to happen – well organised, enthusiastic – she is a strong strategic manager. Meetings are well organised, you get papers in advance, email and hard copy.”*

*“The Partnership Board has strengthened - it is more active than before – there is better attendance”*

Some people found the existing membership of the Board helpful – it was felt there was a range of the right organisations and people involved and the atmosphere at the meetings was positive.

*“Yes it’s helping through the range of agencies on its membership, it’s a way for different agencies to meet each other and network.”*

*“The Board is representative from a lot of agencies. We have a VAL rep -some other Teenage Pregnancy Boards don’t have that.”*

*“Education now come, they didn’t before, there is better clarity of vision”*

*“The Teenage Pregnancy Board doesn’t seem intimidating despite the numbers – it is a well functioning partnership group”*

However some people felt there was lack of suitable representation on the Board because membership did not include people at the right level or representing the right groups and hence this hindered the board reaching its full potential.

*“The Partnership Board is working now better than it ever has – difficult however when we don’t get key stakeholders”.*

*“There could be more from voluntary sectors”*

*“Need a change to ensure there is appropriate representation from agencies – those with a role to play”*

*“You need to widen the representation of the board without increasing the overall numbers on it. At present it doesn’t adequately represent the ethnic makeup of Leicester”*

The lack of regularity of attendance at the Board was an issue for some people who felt it tended to be linked to funding opportunities, while others found the number of meetings difficult to accommodate.

*"Attendance at meetings is often a problem both for me and for the number of people who don't attend"*

*"I think it (the Board) is changing structures but it has too many meetings, there's not enough time to read everything they send out."*

*"There is an issue with diaries, everyone rushing around"*

*"There is difficulty getting people attracted to the Board – I don't feel the Board really drive the work – you tend only to get full attendance when there is money involved"*

The level of strategic discussion that happened at the Board was an issue for a few people who felt there should be greater clarity and ownership of the strategic direction it intended to take,

*"There has been a change from preventative work to emphasis on work with young parents. This is because there has been no real discussion regarding the direction, philosophy or strategy of the work at the Partnership Board; things just grow like this shift in direction."*

*"The Partnership Board is currently not strategic enough"*

There was strong support for the Task Groups which had been set up by the Teenage Pregnancy Co-ordinator which were felt to bring the right kind of agencies together and enable people to check out initiatives and share examples of practice with each other.

*"Forums and steering groups – initially I was sceptical about how useful they could be –it has been helpful however – reflective of other people's work – reminds people of targets to meet and issues to get involved in"*

*"A strength (of the Task Groups) is the opportunity to monitor how various initiatives are working and check progress"*

*"They've helped by workers coming together sharing skills and developing new services"*

*"I do find it helpful, I have been to the group three times. Initially I didn't know what it was all about –it gives people a chance to share models of good practice. Annie (the Teenage Pregnancy Administrator) sends out dates and times, I'm still quite new however, getting the feel of it. We had a presentation about Deep Dive but I didn't really understand it, it would be good to explain it in a bit of more detail when people are generic"*

For a few people the number and timing of Task Group meetings created problems.

*"The day the meeting's held I can't get to – they tend to be held in the afternoon which is not convenient, it would be helpful to meet at a different time. Some people can't go".*

*"Be Healthy Group is very effective but there are too many meetings and it makes it difficult for people to always attend".*

### Agency Reorganisations

While the development of the new Joint Commissioning Board which would radically change the context of teenage pregnancy prevention work was welcomed by some respondents, proposed reorganisations such as merging the PCTs and other changes in decision making structures were generally regarded as hindering factors in delivering the strategy.

*"It all creates uncertainty, people don't know who they are going to be managed by. Key players go elsewhere, you don't know if they will be there"*

### Funding

Funding was a major issue for many people who felt that the way in which projects contributing to the Strategy were funded, either from mainstream services or through grants from the Teenage Pregnancy Partnership Board, was a key factor affecting their performance.

The way in which the Youth Service was funded through the Education budget had recently changed following restructuring of the Youth Service. This was felt to be a very positive move which gave the Youth Service manager more control over what was provided.

*"The Budget (via Education) was not originally focused on the Youth Service or managed through the Youth Service – it got merged more into community education – it has now moved. With the current structure you can see things going forward – the Youth Service can be more structurally present in initiatives."*

However projects which relied on annual funding were concerned about the difficulty of sustaining important work, finding the constant anxiety about money time consuming and distracting from their main tasks.

*"A weakness has been managing funding every year, how to keep going, it takes up agency time, we are hand to mouth, most of the way. There is concern that there isn't enough funding, as there is no mainstream funding to secure clinic's time – have to keep spending time to secure funding – have to go to people and beg, shouldn't have to be doing this all the time"*

*"When you get time limited funding, in 6-12 months' time you have to start spending time looking for other sources, that is detrimental to the work. Continuity of service is very important, we have been allowed to experiment by trial and error to assess where the best locations are. If funding on a project is discontinued where do young people go?"*



*"We get specific pots of money and can only ever plan for 12 months and always have to plan an exit strategy in case funding dries up. It takes a lot of effort away from work"*

*"Need more resources given to non-mainstream projects."*

While there was a general perception that voluntary agencies could lose out in funding decisions, one respondent suggested that statutory agencies could also be vulnerable.

*"Previously public sector had money and smaller agencies were struggling – now things are more at equilibrium. Funding is a real issue, PCTs are struggling – due to some work constraints – we can't give as good value. It would be ideal to be able to do work and plan without constraints – with BME ethnic young people, migrants, asylum seekers, there's a lot of demographic work we could do- have to prioritise and difficult to argue for money. Blue Box training due to funding has been cut down – I've hardly done any – I do usually work with school nurses, mentors, youth workers, residential workers. There is a group working with boys and young men and I have delivered Blue Box training to them"*

There was concern expressed about the issue of mainstreaming funding and the timing of this, this was mentioned particularly before funding decisions concerning the new financial year had been taken; these included how projects are funded from the Teenage Pregnancy Partnership Board, evaluation of funded projects and better communication.

*"There should be some detailed planning and work on how to explain and manage the transition from pump priming funding to mainstream – long standing issue. With regard to Health – the Sure Start guidance is not helpful – Health should be mainstreaming, but if they have no money we have to work smarter, use money more effectively – get funds from another source"*

*"I am pleased that the Teenage Pregnancy Board started to make decisions re sustainability and mainstreaming of projects. We need to ensure that from the start people need to look to sustained funding and do not see the Teenage Pregnancy Partnership Board as a source of funding in perpetuity."*

A particular meeting of the Partnership Board which was used to review and commission projects for the financial year 2006-7 attracted some comment. A few people expressed discomfort at the process which was adopted and hoped things could be done differently in the future. It is reported that others felt that although the meeting had been difficult some important decisions had been made which needed to happen. Methods of commissioning work in the future will be quite different with the advent of the new Joint Commissioning Board.

There was support for clearer feedback about the outcomes and achievements of projects funded by the Board, by representatives of some statutory services.

*"Need to link resourcing to evidenced needs and priorities – improve accountability. This is an issue – particularly concerning one of the pieces of*

*work – what does it provide by way of information? How will we know two years afterwards what has been achieved? We need clear criteria for funding”*

*“Evaluation – we need some better quality evidence of how services have made a difference in the voluntary sector. Mainstream services evaluate using the ECM outcomes- need to make sure we are all doing the same things”*

The respondent who wanted the Board to act in a more strategic manner suggested a number of ways forward that centred on improving communication and an acceptance of their accountability by the agency members represented.

*“We need more debate about the issues. More discussion about what is going well and what isn’t. Key issues - condoms and signposting must be a priority as must SRE, but the strategy is not just about delivery. The Board needs to acknowledge that each member has a responsibility to go back to their organisation and advocate for teen pregnancy. That the Board is not just somewhere to get funding from – that they need to have greater ownership of the decision making process and that not all the decisions are for the co-ordinator to make. It’s important to not always agree with each other. Another angle is how we can influence organisations to change their practices – this doesn’t get discussed. This kind of refocusing would not cost money but would be far reaching.”*

The next sections will look in detail at the five key aspects of the teenage pregnancy prevention agenda. Respondents were asked to specify for each theme the factor enhancing development, factors hindering, best examples of practice, practice not working so well, major gaps and improvements needed.

## **Sex and Relationship Education**

The national Teenage Pregnancy Unit circulated research findings in 2005, about factors which had been found to be strongly associated with successful reduction of teenage conceptions in their sample of local authorities. These were popularly known as the 'Deep Dive' findings.

The 'Deep Dive' findings emphasise the following factors in relation to SRE.

- "Strong delivery of SRE/PSHE by schools
- Strong focus on achieving 'healthy school' status driven by the LEA, usually found to be 20% higher than national average
- Strong delivery of PSHE in primary schools
- Use of DfES SRE guidance for training and support for schools including planned programmes of training for governors on the rationale for and importance of good quality SRE.
- LEA support to improve schools' PSHE delivery, including the development of exemplar lesson plans
- Investment in SRE resources and consultancy support for targeted schools
- Importance of role of Learning Mentor in schools supporting the PSHE curriculum
- Use of peer educators to deliver PSHE"

### **What is happening locally**

The SRE adviser and the Healthy Schools Co-ordinator in Leicester have been actively involved in the promotion of the Healthy Schools initiative to the primary and secondary school sectors, consultancy, promotion, recruitment and training of teachers on the DfES Certificate of Teaching of PSHE to teachers and Governor SRE training.

*"Thirty-eight schools in Leicester have achieved Healthy School status. The target of 50% of schools to have achieved this by December 2006 is on course to be met. Five teachers have completed their certification course and 5 more are expected to do so by April 2006. Three governors took part in training days. Eleven primary schools received up to date training in February on policy development and 12 in the Autumn term 2005 constituting 26% of total primary schools" (Progress Report on Teenage Pregnancy 2005-6).*

There is an SRE Resource Centre which is being built up with equipment such as the Virtual Dolls and dissemination to schools of a newsletter and the BLAST resources guide.

A voluntary agency, Turning Point is delivering SRE in schools via peer advisers which has been well received and highly praised by specialists in the field.

A Teenage Pregnancy Be Healthy Task Group has been established to oversee and implement the local action plan and improve sharing of information and local developments.

## **Respondents' views**

There was a general consensus among interviewees that SRE work in schools had been under developed during the life of the strategy and had only started to improve over the past 18 months with the hard work of the current SRE adviser. It was felt the current Teenage Pregnancy Co-ordinator had helped to ensure that representatives of the Education Dept were more fully involved in the work of the Board and the Task Groups than they had been previously. A senior education manager confirmed his commitment to working with the Leicester City Primary Care Trusts, the Teenage Pregnancy Coordinator and the SRE Advisory teacher.

Although the work of Turning Point within schools was quite well known and esteemed, a number of senior managers in other agencies did not have a very clear sense of what was happening regarding school based SRE. In some cases practitioners knew more about the performance of schools in their local area but did not have a full picture across the city.

*"I don't know a lot about what is going on in SRE in schools – it might be my fault but you usually hear about things if they are happening."*

A comment from within the education sector noted that there was lack of understanding of others' roles and the complexity of their situation.

*"There is a lack of understanding of how complex city schools are. Task Groups don't understand other people's roles"*

This may point up the need for more sustained communication about the work of the Education Department to other agencies. There was sympathy for the difficulties that had been faced by the education department regarding the condition of some of Leicester's schools, which had led to the resignation of the Director of Education in 1999 following a damaging OFSTED report. Progress has been made during the past 6 years and only one remains in special measures but this had limited their ability to respond to other initiatives.

The involvement of the Education Department with the Partnership Board and the hard work and commitment of the SRE Adviser were both seen as very positive aspects. The Healthy Schools initiative was seen as being well supported via Drug Action Team funding so it had the potential for being a strength regarding holistic healthy lifestyles approaches.

The SRE Adviser felt that certain difficulties she had experienced previously, such as the ability to do needs assessments with schools which had been blocked for years by them had now been lifted and she was able to get to work productively with schools. It was also felt that a lot of good work was happening with primary schools via the SRE Adviser who was consulting and advising them and thus having a direct influence on the way in which they did SRE.

Membership of the Be Healthy Task group was felt to be an asset because of the opportunity to monitor how various initiatives are working and to check progress. However it was felt to add to time that had to be committed to groups such as this.

The work of Turning Point within schools was viewed very positively, particularly the work of the peer educators which was seen as the key feature of the success. One respondent did warn however that it was important to ensure that young men were involved.

*“Turning Point do well when they go into schools, I get feedback. It is quite specialised however, can be just women talking to women, we need to ensure that young men don’t get left on the periphery.”*

Quite a number of factors hindering aspects of the work were identified by both Education managers and managers and practitioners in other agencies. These included lack of co-ordination of SRE, funding, difficulties engaging with schools and the level of SRE given to excluded students.

Within education there was a perception that prevention provision was not really coordinated properly across the PSHE agenda and there was a need for it to be upped across the age range from entering primary school right through to leaving school. It was felt there should be greater emphasis on teaching about relationships. The causes for this weakness were identified as a shortage of school nurses, particularly in the western end of the city, a lack of consultation and schools not always engaging enough,

The importance of finance to this sector was emphasised.

*“Main factors influencing levels of commitment is availability of DFES monies – Standards Fund and Vulnerable Children’s Grant”*

Trying to engage with schools from the outside was felt to create its own problems. It was reported that some schools had been very slow to return their SRE policies for vetting requiring numerous reminders.

It was recognised that within schools they faced a range of pressures which were seen to affect their ability to be involved in SRE, these included SATs, literacy, numeracy initiatives and re-organisation. The insufficient curriculum time allowed for PSHE and its uneven representation across schools, in terms of time and resources devoted to it was seen as a major constraint.

A survey of PSHE providers in schools was undertaken by the SRE adviser and the report produced in 2005 noted the lack of a clear strategy to develop PSHE at local authority level since the departure of the previous post holder. Many school staff responsible for PSHE were also reported to be holding other demanding responsibilities both within their subjects and also senior management roles. Only 14% received an allowance for the PSHE role. Interviewees wanted PSHE to be embedded in the curriculum and taught as a discrete subject, with more support, advice, guidance and INSET and more coordination. (Personal Social Health Education. Report on Provision in Leicester LEA, June 2005)

The difficulty of recruiting and retaining school teachers and governors for training was mentioned with some heads not prepared to provide cover time

with supply staff and people booked in for training courses not turning up on the day.

It was acknowledged that although schools might supply SRE policies for inspection there was little knowledge of how these were actually put into practice and discussion was currently underway regarding the need for an audit of practice within schools. The survey of PSHE providers that had recently been conducted had had to be anonymous, so the information could not be used to monitor performance.

There was a strong desire to have the resources to be able to develop SRE in schools further.

*"I would like to have the funding to develop resources for training, enough money to deliver training citywide, develop SRE training programme, time to develop and sell SRE policies in school and monitor properly"*

Outside the education sector there was support for a more committed and strategic approach.

There was recognition that the task group supporting the SRE advisor was performing a management function because the worker had had three different managers in the past 18 months. This was appreciated by the worker concerned.

*"I am supported by a multi-agency group and priorities for work are agreed every 7 weeks. Things are clearer now since strategy is monitored quarterly by city."*

The fact that the post up to April 2006 had been wholly funded by sources other than education was also felt to demonstrate a need for greater ownership.

*"There is a lack of support from Leicester City Council, no clear mainstream funding, a lack of political support, too much focus on the individual providing the service and not a sufficiently strategic approach to the subject. Strategically there is a need to acknowledge SRE – this needs to be owned by the city council and it needs to advocate for this within schools. This requires strong leadership within Children's Services for this issue. This I hope will result in mainstreaming the SRE project and prevent the uncertainty that this project has always had,"*

The position of excluded students was of concern to some practitioners interviewed including a peer educator, who noted that children who were excluded from school would miss out on SRE lessons and would need to be contacted by other means. Sometimes they could be reached in the community.

*"Excluded young people have been coming to the youth centre – we are developing SRE with them there."*

Recent reorganisation in this sector of education had meant the closure of one local project which had been receiving outreach sexual health work and the school nurses working with Pupil Referral Units in the eastern part of the city had noted that pupils were spending less time at the unit and were considering whether they might need to relocate their work to the homes of these children.

A number of respondents reported anecdotal evidence that SRE provision in schools was 'patchy' with some good work reported in some but others not so good.

*Some schools are better than others, there is a certain school and one teacher who is reported to be very good – young people from there are very well informed but in some others it is not high on the agenda"*

In some cases there were seen to be barriers to raising the profile of SRE in schools, for example reluctance from staff, variable commitment, concerns about the needs of black and ethnic minority students and also pressures of time.

*"It's hard in school to discuss sex and relationships – to embed SRE in the school strategy."*

*"There is reluctance by some schools and parents to engage, a failure to understand. We need to train parents before sex education begins – that would be a way of combating fear and apprehension"*

*"Schools can decide to buy or not to buy – some don't have PSHE – there is an issue with Islamic girls – there is an impression of piecemeal provision. We must keep at it as there is a new crop of year 9s every year."*

*"For schools it is a lack of time and lack of training. The local school was a failing school – it isn't a priority for them –keeping the school open was more important – the more social stuff gets put to one side. The size of school as well is an issue – it's too big."*

In some cases other agencies were in a position to contribute support to schools which was valued.

*"The Healthy Schools initiative has helped. School nurses do good work, the safer sex initiative has helped the strategy as a lot more professionals are willing to become involved."*

In the case of the Youth Service there needed to be a clear rationale for this work. The Youth Service manager had made the decision to withdraw the youth workers who were currently based in schools across the city and rethink what provision was most suitable for the school sector.

*"Previously we had 10 full-time youth workers based in schools – I'm not sure why they were there in some cases. I am currently exploring and looking at the model. They were working in community colleges on site – doing a lunch club –*

*doing after school work – but not really focused. I need to work out with schools what they want to purchase a youth worker to do.”*

### **Parent’s and student’s view of SRE provision in schools**

As part of the orientation for Phase 1, a student and a parent were interviewed to find out their views and thoughts about SRE and access to contraceptive support and services. The young woman we interviewed who had attended a secondary school in a hotspot area, had received one of the Turning Point lessons and welcomed discussions with young mums – but thought it was only available to girls, she was not aware whether it had been delivered in separate session to boys. Delivery of SRE was the *‘usual stuff’* by the science and PE teacher. She said she would be happy with mixed sex education teaching but thought there were times when boys mess about too much *‘Girls are used to dealing with and talking about these things but the boys are not and mess about showing off to their mates and the girls’*.

Our parent interviewee identified that there was too great a time-lag between what happened in primary school up to year 6 and what is delivered in secondary school from year 9 onward. She further thought that information on relationships should also be delivered in primary school rather than just in year 9.

This perception was reinforced by a health practitioner

*“We need to do more in year 7/8 –by year 9 they’re already sexually active”*

The parent would ideally like to see more *‘shocking images of STIs, HIV etc. More use of electronic babies and how to make informed and empowered decisions.’*

She also identified a need for more help for young people and their parents on how to navigate their way around the different services and initiatives. She would also like to see more opportunities, perhaps at schools where parents and children could attend together to discuss issues.

There was support from other respondents for more attention to be given to parents

*“Work with parents is a big gap in the Strategy - more should be done and could be done under the RESPECT agenda.”*

### **Other Local Authority Practice**

#### Liverpool

There is provision to actively involve parents in the delivery of the strategy in the Action Plan

The local Healthy Schools Task Group will include at least one parent  
There are plans to distribute Parentline Plus ‘Time to Talk’ posters & leaflets in all relevant community settings and actively consult & involve parents in PSHE/SRE programmes in schools



### Walsall

An audit has commenced to look at SRE policies within secondary schools, to ensure that policies reflect current 'best practice', and meet the requirements of the DfES guidance 2000 and are standardised across the borough.

### Luton

PHSE coordinators network is used to distribute information on new resources. Recommended digest of resources could still be developed

### Darlington

It is planned to create an under 16 focus group, including school representatives, to explore appropriate SRE programmes and support school-based SRE.

## **Conclusions**

Overall interviewees felt that the Education Department was not committing sufficient resources and effort to the strategy although there was sympathy for the difficulties facing Education managers in responding to all the current demands on the sector. While the work of the SRE adviser and the Healthy Schools coordinator was seen as having been key to enabling some progress to be made in getting schools more involved in the strategy, there was little knowledge of what was actually being delivered to students as part of school based SRE which was reported to be extremely patchy. Not all the secondary schools in Leicester are registered with the Healthy Schools Scheme but at least four of them and two of the special schools and units have SRE policies conforming to their requirements. By contrast it was widely acknowledged that the most effective SRE work was being carried out by trained peer educators in school and community settings through a voluntary agency with precarious annual funding.

Initiatives which were being carried out in other local authorities such as more direct work and encouragement of PSHE advisers, an audit of school provision and involvement of school students in the design of SRE lessons could not be attempted in Leicester because of lack of funding. Work directed at excluded students was also being affected by the closure of some projects working with them and the reduction of time that pupil were spending at Pupil Referral Units.

It was felt that schools would benefit from involving more community health and youth workers in delivering school based SRE and there should be more provision for 13 and 14 year olds. It was felt that more sustained attention needed to be given to promoting effective SRE lessons in schools by the Education Department.

## Contraceptive Services

The 'Deep Dive' findings suggest that important factors are:

- Existence of discrete, credible highly visible young people friendly contraception/sexual health services with a focus on health promotion as well as reactive services
- Services which are believed to be confidential by young people.
- Particular focus on meeting the specific needs of young men
- Condom distribution scheme involving a wide range of partners and/or access to emergency contraception in non-clinical settings.
- Access to full range of contraceptive methods including long term methods

### Respondents' views

Leicester provides a network of community pregnancy testing, condom distribution services and information and advice services across the city, involving trained staff from Community Family Planning, school and LAC nurses, Connexions Personal Advisors (PAs) and youth workers in some cases. A C card scheme enabling young people to register to get condoms from a variety of outlets is in the process of being set up in Braunstone and New Parks. It is perceived that services concentrated in the hot spot areas in the west of the city have a more explicitly young people focused character and have experimented with a variety of locations. There are nurse services targeted at looked after children and excluded young people but they are working predominately in the east of the city where there are comparatively fewer services. Free emergency contraceptive services for young people under 25 were originally available through pharmacies across the city, but following financial cutbacks on the part of Primary Care Trusts there is now a more restricted service available only at weekends and bank holidays. Training for pharmacists and Blue Box training of sexual health practitioners has also been cut back.

In the light of the cuts described above it was decided to contact chemists to see what services they were now offering so that up-to-date details could be included in the Mapping exercise. A number took the opportunity to comment on the withdrawal of the service and points they made are recorded below. Almost all the chemists listed in the BLAST booklet, apart from two Boots, were contacted in May and asked what they were now able to offer. Apart from one chemist who seemed to have misunderstood the information he had received, and was still offering a full service, all understood and were abiding by the directive they had received from the PCT.

At this current time 9 chemists previously listed are not offering any service at all. Reasons range from personal preference for religious reasons in some cases, lack of facilities within the shop, to uncertainty about the current situation in relation to funding. Three can offer a service on Saturdays and Sundays. Eleven will provide the service on Saturday only – 6 are open all day and 5 only open up to 1pm.

In conversation they made the following points:

- They felt this was an important service and regretted its withdrawal, although numbers making use of it, apart from areas of high student population, were not necessarily high
- The charge they now had to make for the pills was a deterrent to their younger clients and the limited times that other dispensing services were open during the week created difficulties for them
- They were not convinced that the financial savings made really justified the action
- They felt the PCT had not provided sufficient information about the change to the public or GPs by way of leaflets etc, with the result that some GPs were still referring individuals to them and their customers felt the change was purely for financial gain
- If they felt a particular individual was making too much use of this provision they would eventually refer her to her GP rather than continue to give out the pills
- Since most did not open on Bank Holiday and many did not on a Sunday the residual service they could offer was now very limited
- Many commented that once one or two of their usual clients had been in and discovered the changes, word seemed to get round the age group very quickly and people were no longer coming for the service
- One pharmacist commented that while she had previously dispensed the pill during the week, her locum on Saturday morning did not do so for religious reasons so effectively she was not able to offer even the restricted service
- Chemists in areas of high Asian population either did not provide the service or reported virtually nil requests
- One pharmacist was concerned that with the attendant cut in the training and accreditation of pharmacists to provide this service, new pharmacists coming into the service would not be able to provide it at all.

There is considerable variation between the funding and capacity of the different agencies involved in providing contraceptive services. Services provided through Connexions have relatively stable funding while some services provided through health sources are currently subject to cutbacks or have been refunded at a similar level to last year with consequently little capacity to expand.

There was general agreement from respondents that the existing geographical areas and at risk groups were the right ones to target. Some health practitioners were concerned that some new hotspots were emerging on the borders between the city and county such as Wigston, Syston, Groby, Thurnby Lodge and Hamilton which were likely to miss out on provision as county pregnancy prevention services tended to be targeted at their own urban areas. Some at risk groups, who it was felt were currently under provided for, included refugees, asylum seekers, commercial sex workers, drug and alcohol misusers, care leavers, young offenders and homeless people.

The main factors which respondents agree have enhanced the use and development of contraceptive services for young people are divided between

the activities of staff and their agencies and a certain type of provision for young people.

One respondent was keen to note that pregnancy prevention education and support had not been invented by the Teenage Pregnancy Prevention Strategy but was drawing on longstanding youth provision.

*"It's important to note the fact that the Strategy was building on historical provision to teenagers in the city for 9+ years"*

Respondents were clear that the existence of the strategy had had a galvanising effect on staff and was a very useful device for bringing together a range of different people and providing an ethos in which people could consult and share practice with each other which helped to improve services. Working as part of the Strategy was seen to create a common cause between staff. Several people also commented on the commitment of key individuals as one of the factors that helped the Strategy be effective.

*"There is commitment from people with a significant degree of knowledge, authority and understanding of the issues"*

*"The workers involved are very committed to making it work – they have perseverance – knowing young people need you and knowing people are doing similar things is very important."*

*"The existence of the strategy means I can ring people up and ask their advice. While I might have done that before, the fact that there is a strategy makes this more legitimate."*

The provision of targeted services for young people in the hotspot areas has provided many opportunities for different agencies and professions to work together. This is felt to be a very positive step allowing the deployment of different levels of skill to the benefit of young people.

*"The approach that agencies have taken has been very constructive – they have worked together to deliver. PCTs have tried to mainstream. The Teenage Pregnancy Strategy has had access to community development workers to disseminate practice and organise grassroots. We give consistent messages. The Teenage Pregnancy Strategy and the PCT try to be consistent. With sexual health and targeted work, that has set the stage for newer work including joint workshops which have fed into the PCT and the Action Plan".*

Some health practitioners and a peer educator suggested in interviews that a key factor for young people accessing health services was the degree of anonymity that the service or venue could provide, to ensure young people's privacy when using them and avoid attracting unwelcome attention from parents, relatives, parents' friends or their peers. When health services are offered as part of general provision for young people thus providing a degree of anonymity it was felt they are more likely to be used.

*“New Parks Youth Centre runs sports/dance drop-in, health and well being sessions. The School nurse prescribes, comes in. Young people find it easier to approach them in this setting.”*

*“Young people will come to use Connexions in town because of its neutral access – they won’t use their local school because of word getting round”*

*“The Youth House in Braunstone is a good location – young people can be there for anything –it is good when there are other things going on.”*

*“There needs to be a Saturday morning clinic as young people might not want their parents to know that they are going to a family planning clinic after school, so they can go without anyone being aware and they can get the help and support they need.”*

A number of experienced practitioners suggested there is a need for an outreach service to young people beyond the venues in current use. A mobile bus is seen as another form of anonymous provision which could be developed and used in a flexible way to reach young people in different areas.

*“You need to outreach – you can’t just sit back – we go outside to different locations to promote our name, it’s easier when young people can put a name to a face. We have used the Braunstone bus to do outreach. The bus is a great crowd puller –it would be good to have a bus to take to other areas. There is a double decker they use in the county – if we could have something similar for the city we could use it for different needs – promote drug and alcohol advice for instance. It would be good for the summer months. A static venue is ok but in summer young people don’t want to go in. A mobile bus does create issues about insurance, parking and who will pay for it, but if these issues could be overcome I would love one.”*

Some people also pointed out that the fact some services could respond quickly was important.

*“Here (Connexions) we have quite a lot of people trained to do pregnancy tests and condom distribution so someone can see somebody whilst someone else is also seeing somebody. It is quite a quick process.”*

Whilst people could identify a number of factors that helped in the delivery of contraceptive services to young people, our respondents also identified a considerable number of factors hindering the delivery of these services which tended to outnumber the positive factors. These can largely be classified under two main headings. The first are the barriers that exist to young people being able to access the services they need in ways they find helpful. These include the stigma attached to services of this kind and inaccessible and non young people friendly centres and venues. The second are the factors which act to limit the capacity of services to provide for young people in ways that professionals know are necessary. These include professional rules which proscribe restrictions to services and funding levels which determine the numbers of staff and hours during which the service can be provided. For

health professionals this led to a feeling that they were not doing as much as they could do.

As identified in the literature review contraceptive services provided for teenagers attract considerable publicity from the media and can be affected by the deep seated moral and religious attitudes adopted by adults. This can create considerable difficulties for health staff who can see the needs of young people but may be prevented from delivering the services which they feel are necessary. This can also affect the way in which publicity for young people has to be pitched in order to take account of adult sensibilities.

*“With contraception services these are difficult to develop in schools because of parent/governors, One school was offering a condom distribution service to its students but got stigmatised by the media and had to stop.”*

*“If doing general publicity you have to be discreet – you can’t offend people. This can be awkward in relation to what adults think is appropriate, but young people need direct information. They may miss out if the information is not “in your face” enough, especially concerning STDs”*

Contraceptive services supported by the Teenage Pregnancy Partnership Board in Leicester are targeted at the hotspots which have been identified, which are predominantly in the western part of the city the board supports all contraceptive services city-wide – PCTs fund Choices service which only covers city west. There are fewer contraceptive services for young people on the eastern side, funded by PCTs, which also happens to be where most of the residential homes and pupil referral units are located. This can create pressure on services for vulnerable young people.

*“In some parts of the city the strategy is not reaching the grass roots, there are gaps, for instance there are very few services on the east side. In one mainstream school we go into we heard about a young girl having unprotected sex. Because of where she was she could only be seen by St Peter’s Clinic to get access to contraceptives. She had to come out of school, had to lie to her parents, but when she got to St Peter’s she could not be seen in time – the clinic was full of teenagers – she then went to Connexions in the city centre, got a condom, but had no proper condom training to use. We can give the training but not the condoms. It doesn’t make sense.”*

A number of people pointed out that many mainstream services and venues for young people were not actually accessible or young people friendly. Health practitioners always have to be aware of the various factors which may be affecting young people’s use of particular services or venues. This can range from judgemental attitudes encountered from reception staff to uncertainty as to whether services are really aimed at them.

*“Sometimes a venue may not be user friendly if it is too much associated with other agencies such as community venues used by older people. Young people may be concerned that they will not be welcome, that they may run into people they know. There are other centres which may be seen as more for pre-school children and associated with Social Services”*

*"I previously set up a project in a Kirby Frith building which I eventually found out had a reputation from a previous manager. His actions and the fact that the centre had eventually been closed down left a legacy of mistrust concerning the venue so young people didn't come and I had to relocate.."*

There is some uncertainty regarding exactly what kind of professional worker young people feel most comfortable approaching for information on health and contraceptive issues.

*"Young people may have a fear of approaching clinic nurses, we have to get over that barrier somehow. School nurses have an advantage that the young people know them-we may use different terminology and language to them."*

*"Some of the family planning clinics do slightly different age ranges. They (young people) seem to think there will be lots of older people there which puts them off going there".*

*"Emergency contraception is also an issue and needs to be more accessible as young people often don't like going into pharmacies. Getting them a doctor's appointment or getting them to go down to St Peter's, it can feel quite uncomfortable to do that. Everyone is different but it is just making it more accessible to them. These clinics need to be more friendly, bright and child friendly"*

This is something that can be explored further with young people directly in the second phase of the evaluation.

The family planning nurses and the school nurses both had issues about restrictions placed on what they could do by their employers (health services). They felt that these put unjustified limits on their work, did not use their skills and abilities to the full and were detrimental to the service they wanted to provide to young people. A key concern they had was that school and looked after children nurses could not give condoms to young people, though they were well placed to do so.

*"The three nurses specialise in family planning but we are not able to use all our skills. Working with young people, we are working with condoms, pregnancy tests and emergency contraception. The medical clinic can prescribe longer term contraception. We hope to be able to expand this but there are issues with the Trust re prescribing. Young people know about condoms and prefer to use them, we could get youth workers to distribute these which would let us do more specialised family planning. Medics are not restricted in how they can prescribe, it is an anomaly that as nurses we don't have the same freedom."*

*"School nurses can't prescribe condoms although they can do condom training. Depends on the school what they are allowed to do and in the east of the city no school nurse clinics are allowed to issue condoms and there are no sexual health services attached. Young people are reluctant to use a pharmacy if they think their parents or neighbours will know"*

Many of the community health services feel under pressure with their funding and are anxious about their services being able to continue. The PCTs who are currently under financial pressure have had to make some cuts in pharmacy services and workforce training. Staff said they find it frustrating to have to worry about funding and take time out from their mainstream activities to raise money and also have no capacity to increase their services.

*"I'm concerned there isn't enough funding, there's no mainstream funding to secure the clinic's time, have to keep spending time to secure funding, have to go to people and beg – shouldn't have to be doing this all the time."*

*"There's been no increase in the annual budget resulting in a stop to any increase in nursing hours – this is hampering the development of the service."*

*"Money is the main problem – mainstream funding cuts in PCTs, funding streams coming to an end and sustainability issues not being looked at in agencies."*

*"With the BLAST directory we have no money to reprint although I can fit the work into my work plan."*

*"With the withdrawal of chemists' services – the Choices service has noticed an increase in demand for this form of emergency contraception."*

A lack of capacity meant that services could not be provided at times that staff felt might be important times for young people.

*"Hours are an issue – up to now we have not been able to provide a service at weekends or evenings - we are now training staff so this will improve"*

*"We don't have enough capacity – only 3 nurses – we can't offer the timings we would like, we also don't have any admin support"*

There was a wide perception from managers and practitioners across the different agencies that professional training was insufficient for both professionals and volunteers.

*"I have concerns about workforce development – only a drop in the ocean"*

*"There is not enough workforce training, we need more multi agency training. There is a massive hole in training particularly in relation to YOT and looked after children."*

*"There is not enough available education for professionals, but there should also be more available in the community. It's ok for 9-5 professionals but what about the volunteers providing out of hours service – people at weekends? I have tried to ensure with the C Card that lots of people are trained up with Blue Box. Would like to see 100s of people trained up so young people could turn to a wide range of people for advice etc. We need more training of community*



*people – it's quite a battle to get volunteers on to training – some young parents for instance –courses get oversubscribed."*

Health professionals welcomed their working relationship with youth workers and regretted that their capacity to offer contraceptive services to young people in partnership with them was being held back by the absence of a sexual health policy within the Youth Service.

*"In the case of youth workers – the sexual health policy when it is agreed will be very good – their potential is being held back by the current stalemate – it's disheartening."*

All respondents were invited to identify the gaps in current services and a wide range of issues were mentioned.

Some respondents felt there was a need for condom distribution to be better coordinated across the city. It was hoped that the new sexual health worker who had a city wide responsibility would be able to tackle this.

The need to publicise where young people can access different services and whether services are young people friendly was emphasised. An example was given that in Birmingham there were young people evenings and sessions across the city at services so young people could try them out.

The older group of young people in FE colleges were mentioned as a group which staff needed to think about and decide how they might be reached. Ways of publicising contraceptive services to young people and what worked best for them were felt to be gaps

*"There is a need for more snappy accessible information – such as radio or credit card sized information. This should be very clear and specific and provide signposting. We need it if too many young people don't know where to go for stuff, it should jump out at them from different media."*

*"I wonder if the BLAST directory is too specific to pregnancy and sexual health? It assumes young people are sexually active but some may just be thinking about it. Perhaps it should say more clearly where to get advice if you are at this stage."*

The lack of information services targeted at 13-14 year olds was again mentioned together with the need for more family planning services spread out across a broader geographical area and put in the places that young people and young parents are likely to be going to.

The need for more specialist work with young people from black and minority ethnic groups was identified as it was recognised that lots of south Asian communities access services. It was felt that African Caribbean young people can be marginalised and there needs to be a clearer definition of the needs of different groups within the broad category of black and minority ethnic communities. One respondent had a wide ranging sense of what gaps there were,

*"I don't think we have a full grasp of what we provide –there are low numbers at some clinics and we need to know why. The hotspots have condom distribution, pregnancy testing but this is not coordinated in the community and city wide. UHC and St Peter's strategic involvement has been weak – there is an issue about capacity – how can we improve this?"*

### **Future work**

A number of suggestions were made for new services which would address some of the issues identified:

- More resources for high quality locality based services where young people and their parents are able to just go round the corner to access them;
- Access to services and information made easier;
- Continue to improve access to pregnancy testing and condom provision through centres and by working with partners in local centres in multi agency young people's centres or First Stop Shops;
- Coherent strategy for First Stop Shops for young people linked to extended schools to enable services and messages to reach young people where they are;
- Do more work with local GPs to raise their awareness of ways in which their surgeries could be made more young people accommodating;
- Promote the Dept of Health standards describing what constitutes a young person friendly service especially to GP practices; this is being explored through the be healthy task group
- Invest more in the school nurse service to counter its current 'Cinderella status'.

Further exploration with young people is needed to gain their perceptions on these issues, since these points are what professionals tend to think is needed. This will be carried out in Phase 2.

### **Examples from Other Authorities**

#### Darlington

"Exist" Girls' group - group sessions with school nurses to look at sexual health issues

C card scheme is available 7 days a week throughout the town in both clinical and non clinical settings with provision targeted in hotspot wards. Young men access service in equal numbers to young women.

#### Bradford

Consultation event to review findings from South Asian young people on both service and education provision. Strategy has spent time and funding researching the needs of South Asian young people in the District which has created demand for specialist worker.

### Slough

16+Team and YOT to include section on Sexual Health, and provide information on local sexual health and contraceptive services as part of initial assessment.

Connexions, YOT, 16+Team, SSYP, DAT Residential Care Homes to develop a Condom Distribution Strategy and protocol.

### Liverpool

- A selection of calendars, posters, credit-card sized information leaflets and mouse-mats detailing service information will be developed using winning designs from the Sexual Health in Liverpool Schools Project.
- A directory of services will be developed using young people's designs
- Discussions will take place with Liverpool's Refugee & Asylum seeker teams to assess the need for a version of the above mentioned resources in additional languages

### Luton

Distribute condom boxes to pubs and clubs

Provide condoms to drug users as part of needle exchange scheme

### **Conclusions**

The delivery of contraceptive services for young people in the hotspot areas are currently reliant on a comparatively small number of very dedicated, very busy community health staff, The youth service has a key role to play in this area of service delivery but are currently operating below their capacity because of the absence of an agreed SRE policy . Health staff feel their capacity to deliver the services which are needed is being hampered by health service restrictions on their role and funding cuts which at best can only perpetuate the status quo when growth is needed and at worse are reducing services such as emergency contraceptives provided by pharmacies. The demand which used to be met by these outlets is now showing up in other places. The anxiety about funding and the need to keep justifying and raising money for their service had a demoralising effect and further lowered capacity due to staff needing to identify funds annually.

There is some uncertainty among staff concerning the exact motivation of young people in regard to their use of certain types of contraceptive services and their attitude to clinical nurse as opposed to youth worker based services. There is anecdotal evidence that young people are drawn towards health services which are located in general youth provision which can offer them some anonymity.

## Promotion and Media Publicity

Developing an effective process for promotion and media publicity is one of the requirements of the Teenage Pregnancy Strategy but there was no real attempt to develop this in Leicester until the summer of 2005.

Responsibility for the media strategy was not part of the remit of the original Teenage Pregnancy Coordinator and did not feature in the original Action Plan. This changed at a later date and the first co-ordinator commissioned an agency to develop a strategy for Leicester. What emerged was described as *“a long document with very little substance – working at a very high level- definitely not an Action Plan”* so there was no basis for any strategic work in this area. In the absence of this the first co-ordinator did some proactive work with the Leicester Mercury.

The Teenage Pregnancy Annual Assessment Feedback East Midlands Leicester City Report for 2003/2004 noted the following about the media strategy and media work in Leicester.

*“There has been work developing a media strategy. However it is unclear how proactive media work is co-ordinated, within the city or across the city/county boundary, by the Board or a designated sub-group. Similarly, it is unclear whether a robust reactive media handling protocol exists which would work across city/county boundaries. Last year’s Plan describes a joint county/city Media and Communications group, however there is no evidence presented of this group meeting. No identified communications leads in PCTs or Local Authority. No links to Chief Executive level, and no senior officer to act as media spokesperson for the strategy. Last year’s feedback recommended that the Board addressed targeting publicity to vulnerable or marginalised groups, and carried out an audit of use. This has not happened. Last year’s report also found that the national Sexwise database had not been updated since July 2002. It is unclear whether it has been updated 6 monthly, as required.”*

Following the appointment of the second co-ordinator the Teenage Pregnancy Partnership Board commissioned the Sheffield based media agency DIVA to develop media work in Leicester. This agency works with a number of Teenage Pregnancy strategies across the county and advises the national Teenage Pregnancy Unit.

The Co-ordinator then set up the Media Task Group containing representatives from Health, Leicester City Council, Connexions and the voluntary sector. The brief given to DIVA and the Media Group was to feed media opportunities to DIVA for them to pick up and also to refer to them any media enquiries about teenage pregnancy and sexual health issues for under 19s and agree a media protocol. Interviews with DIVA and a member of the Media Group reveal fundamental differences of opinion concerning the type of messages which should be given to the press and dissatisfaction with both DIVA’s performance and the support provided to the agency. DIVA were commissioned in July 2005 and were de-commissioned in February 2006, so were only active for seven months. Taking into account the 3 months it took to get all the protocols into

place this left a very short period to make effective media links and demonstrate what they could achieve.

DIVA organised features in the Leicester Mercury on teenage pregnancy issues, contraception projects and successes by young parents and interviews were arranged with the Teenage Pregnancy Co-ordinator. Some potentially damaging stories were also headed off but there wasn't sufficient time to achieve very much.

One particular incident concerning a media opportunity set up by DIVA which had a positive outcome but unsatisfactory process appears to have been decisive in confirming for one member of the Media Group that DIVA did not have anything special to offer to work with the media in Leicester. This perception was influential in the subsequent decision not to continue to fund DIVA and to make the media communication workers collectively responsible for media work in Leicester.

A number of key factors can be identified that affected this experience; these included a lack of ownership for the approach, the length of time taken to agree protocols, lack of agreement on essential messages for the media, limited access to a range of media and a perceived lack of competence of DIVA by some key people, and differing understandings of the monitoring and evaluation of the work of DIVA.

The decision to employ DIVA was made by the Teenage Pregnancy Board and while there had been some discussion with local media specialists this did not include a key member of the Media Group. Her perception was that there was a lack of initial discussion concerning the function of the media strategy, the rationale for the teenage pregnancy prevention messages and the rationale for employing an external media agency instead of building on the skills of the media specialists in Leicester.

*"I found the Task Group structured in a way that was difficult to work with. In my role I am used to going to new projects and setting out with them what they intended to achieve and working out how to support them. This time I went from zero to DIVA being commissioned – feeding them ad hoc media opportunities. I was struggling to understand what we wanted to achieve in prevention. The Task group did not establish their priorities. The brief just to give media opportunities to DIVA did not have strategic significance."*

It was also felt that it took a long time to agree protocols between DIVA and the Media group, with delays in Leicester which used time which could have been more productively used.

DIVA work on teenage pregnancy issues with a number of different local authorities and based on this experience have a particular view of what works best with the press in order to get positive stories in the media. They found that the Leicester group had a different view of what they should be communicating and it did not prove possible to reconcile these differing views, resulting in a lack of agreement on what were essential messages to press.

*“There was a lack of understanding of our role by some in the Media group – there was a lot of focus on messages – we are mindful of this but need a story of which the message is part. People didn’t get what we do – they wanted us to change perceptions via the press – I feel they had unrealistic expectations. Attendance at the group also dropped low, it would have been better if more people had been there, I felt people should have made a commitment. On one occasion I came to the group to make an important presentation and only had two people attending, one of whom was the Co-ordinator”* **DIVA**

*“Messages versus stories. There was a problem. DIVA wanted to give the media what they wanted – which was stories – we wanted to give the media what they wanted as well but we have the targets to meet – we wanted the stories to have particular messages.”*

Located outside Leicester, DIVA did not find it easy to diversify their media contacts so tended to make most use of the Leicester Mercury for their work. This sometimes cut across other planned pregnancy prevention messages, and was not felt to make best use of the outlets potentially available.

One of those working directly with DIVA said they had a lack of confidence in their essential skills of working with the media including poorly presented press releases and short deadlines which seemed to create extra stress without sufficient benefits to compensate.

It was acknowledged that DIVA had developed different types of work in other areas and that using them in a reactive role in Leicester might not have used all their skills.

*“DIVA did not bring with them learning from elsewhere. In Nottingham they were actively involved in media campaigns – they are good at this but it is not what we employed them to do. Perhaps we should have commissioned campaigns from them and got a better service for the money. They have a good reputation with Teenage Pregnancy coordinators but not with communications professionals.”*

Finally, there were different perceptions regarding the requirement to provide regular monitoring reports like the other projects funded by the Teenage Pregnancy Board. There was a lack of ownership of the monitoring and evaluation processes of the work, with DIVA feeling that this did not fit with how they usually worked with Boards and that it was difficult for them to justify themselves against the criteria and a Media Group member feeling that this demonstrated their ineffectiveness.

Other managers and practitioners had less direct contact with DIVA but some had found certain value in what they had provided finding it helpful and informative.

*“I dealt with DIVA a lot – before DIVA was in place I used to get calls for instant quotes from the media. I was able to pass them all on to DIVA. We’ve not really done enough proactive stuff. I tried to feed them with good work, I found*

*them useful. They didn't really have a chance. I learnt from DIVA how to say no to the press.*

*"On conception rate got positive reports, there was good stuff about peer trainers. I heard about problems with DIVA but thought they were OK. If any issues were coming up for example the mother with pregnant daughters in Notts /Derby area they were proactive – gave us advance warning. I wasn't at the Board for the decision."*

*"DIVA has been useful particularly about celebration of achievement, there was an event reported in the Leicester Mercury about young parents – DIVA cleared with people before it went in and the press was positive. I have not had direct need of them, but did forward information. Going through the Press Dept we were given an extra area of support. I didn't make the Pregnancy Board meeting when they were discussed."*

Some managers and practitioners from Health agreed with the decision not to re-fund their work.

*"I had worked with DIVA – there was a report in the Leicester Mercury which had some good and bad points. I was set up for an interview at short notice but then found the reporter had a different agenda and was getting quite aggressive. DIVA dealt with the reporter however and the report when it appeared was very good, I was pleased with that. I felt however the organisation was not good at communication, it was not helpful. It needed information at short notice and did not liaise properly with the Press Officer."*

### **Future activities for media and promotion work**

Since February 2006 new arrangements have been put in place to deliver media and promotion work.

The existing media group has been reorganised and still involves the communications officers from the city council, PCT and Connexions, youth voice – new members include the RYPEET peer workers as young people reps. They have held regular meetings since DIVA was decommissioned and have plans for new media activities and have produced a communications work plan to support the local teenage pregnancy and parenthood action plan.

### **Practice in Other Local Authorities**

#### **Bradford**

Adverts running on the back and sides of buses and on local radio. Evaluation with young people using questionnaires and focus groups run through local radio to help shape future campaigns on safer sex and STDs.

#### **Slough**

Radio Underdog broadcasts to include SRE component. Establish links with Asian Radio.

#### **Luton**

Produce Professionals Newsletter twice a year.

## **Conclusions**

It has taken a long time to develop an agreed approach to media publicity in Leicester and it is unlikely that any of the activities developed so far have had any noticeable impact on the young people to whom they were directed. Hopefully the new arrangements will prove more productive.

DIVA were commissioned by the Board on the basis of their previous work with other Teenage Pregnancy Boards but in retrospect some more detailed preparatory work and discussion with the people who would be working with them most directly might have helped. As it happened, the lack of confidence in DIVA and the rationale for employing them felt by an influential member of the Media Group proved sufficient to hinder any really productive engagement with them. For their part DIVA did not feel the need to change practices which they felt were effective and had been proved in other areas, so essentially there was a stalemate. It is clear that other members of the Board had found some value in what they provided and were not party to the decision to decommission them, but these benefits mainly involved having a known point to which to refer press enquiries and being warned in advance about potential stories in the media, services which could be provided by other media professionals. The lack of involvement of young people in the previous Media Group was not consistent with their participation in other aspects of the strategy.



## Engagement of Appropriate Agencies

All the representatives of the agencies interviewed believed that their own agency was demonstrating commitment to the Teenage Pregnancy Prevention Strategy through the funding of projects and the level of representation they were providing to the Teenage Pregnancy Partnership Board. In some cases however this perception was not shared by their colleagues.

### Connexions

*"We have a very high level of commitment to both prevention and support. We have been putting in national proposals for funding, leading with partners, working across the city and council and putting in place a three way funded Connexions Teenage Pregnancy co-ordinator."*

*"Given that priority on reducing NEET (young people not in education employment and training) numbers is not measured holistically against other factors impacting on young people's lives but is seen as a simple quantitative target, it is therefore difficult to establish good practice in relation to many issues for young people inc teenage pregnancy prevention. Our commitment has been very strong however –we have benefited from external funding for Sure Start Plus and the pilot. We have dedicated staff – some working on young parents and some on teenage pregnancy. We have a presence on the Board at senior level."*

### Education - Healthy Schools

*"Our Agency has expanded since 2001 into reduction of pregnancy and STIs, to ensure up-to-date SRE in schools, appropriate programmes and schemes of work in these areas and appointments of PHSE/SRE coordinators in schools. The Agency is highly committed to working with the Leicester City Primary Care Trusts and with the Teenage Pregnancy Co-ordinator and the SRE Advisory teacher".*

However, other colleagues felt that there was need for greater commitment from schools and the education department.

*"Education should look at the bigger picture, health and education don't communicate very well"*

*"Education is the weakest part of the strategy"*

*"Who is championing SRE – putting it forward within the department? They could do smarter. With only one adviser for the city, they need to get more. What is the point of a Healthy Schools policy if it is not delivering? Schools have more autonomy now – how can we ensure it happens –we need to improve the linkage between school and SRE work."*

*"Education not involved or committed unless money available"*

## **Health**

*"Our Assistant Director commitment is quite high and very supportive. We are highly committed in New Parks, very committed to deliver a good service. We are part of the Partnership Board, part of the process of getting a person into post to specialise in sexual health. We are open to change, we work in a multi-agency fashion, take on core responsibility."*

*"We work closely – are committed – we have 2 out of 3 members of Sexual Health team in Be Healthy Group"*

*"Previously LCWPCT was the managing body for Teenage Pregnancy. This was the Director of Public Health who managed the Teenage Pregnancy coordinator. When the city /county split happened this changed to be the Leicester City Council. I think there is a continual presence of the PCT on the Board and a commitment from practitioners. I think there is a need to strengthen the PCTs' understanding of their responsibilities re this area of work and the impact that they could possibly make. I do however think that this should be kept within their whole responsibility for sexual health and splitting the two can be divisive and create a 2 tier system eg condom provision at 19 but not 20".*

*"Health were addressing the issues before Choices was set up and we do support the service with permanent funding. It was a year pilot but is now permanent. Choices is unique in Leicester West PCT"*

Some colleagues were worried about the impact of funding cuts in health, particularly involving the emergency chemist service and the under provision of school nurses.

*"I am concerned that there appears to be a shortage of nurse trained staff working on the west side of the city which is having a direct effect on the delivery of the service."*

## **Social Care and Health**

*"I think our commitment has been good. I don't know about the past but I believe some work was done with a previous manager. I have come back and arranged meeting with senior managers after Board meetings, have tried to make sure it stays on the agenda but I know we probably could do more to keep this in front of staff. We will be a significant part of the Federation's Children's Trust. I am on the Pregnancy Board and have a high level commitment to it because I want to be on it. I have had experience of teenage pregnancy via my previous hospital interests. Our weaknesses are perhaps not being rigorous enough about getting back to managers or getting the views of practitioners. They know there is strategy but not enough about it".*

Comments from other colleagues show there was a range of opinions about their role.

*"Social care and health has been a big gap"*

*"Not much contact with Leaving Care Team"*

*“Social Services originally didn’t see the need to be involved. Current manager had experience in health and brought that perception into the work.”*

### **Youth Service**

*“We have a high level of commitment but we are still developing. The youth service in Leicester has only been a real youth service for over a year. We are having to start again – there was no strategic involvement previously but much more so now. For two years I have been trying to get agreement on an SRE policy and get this through. The staff won’t act on it until they get the policy written and approved. It should be in place by September this year – I will ensure that and it will be clear about work that can be done, when and what. It was highlighted in our OFSTED report that there was no involvement in the Teenage Pregnancy strategy. I joined the Board particularly as I had professional and personal experience on this in another authority, but as a Service we need to do more”*

Other colleagues valued the work of the youth service and were impatient for them to get actively involved in new service delivery opportunities.

*“There is lots of good youth service provision in Braunstone, New Parks”.*

*“The Youth service needs to invest in it get the resources to carry it out. They are key agencies – they work in so many different settings”*

*“When have we have youth workers in school –the girls go to talk to them – they are another key partner, could be strong”*

*“All the agencies are doing their bit – conception figures have come down – being able to continue is important and the youth service has helped”*

### **Voluntary Action Leicester (VAL)**

*“Our commitment is moderate to in between. We have two workers in the community. Their focus is on citizenship agenda and so teenage pregnancy work is a by-product of their main role. I sit on the Partnership Board and that is part of my role. That helps make it strategic.”*

Participants in the evaluation identified a number of factors affecting the engagement of agencies these included funding, agencies’ capacity and reorganisations, government targets and co-operation between groups.

*“It’s hard to make teenage pregnancy all these people’s responsibility, a lot of it is down to time and capacity.”*

*“We deal with 5% of the overall demand (re pregnancy services) so get 5% of the attention.”*

*“Reorganisation of public sector continually and money – when it’s not there people do not engage”*

*“Currently and in recent months the financial situation of the PCTs has been detrimental to multi-agency working and the ability to commit to initiatives. There is also the looming merger of PCTs and changes in organisational structure that have created uncertainty and reluctance to make decisions.”*

It was reported that agencies were cooperating well in New Parks to deliver the Strategy. This was seen to be due to the particular circumstances of the area which was one of high deprivation, but had not had SRB or New Deal initiatives like Braunstone and Beaumont Leys. Agencies had therefore come together naturally because they needed to do so; there had, as a consequence, been no competition for ownership of particular initiatives – no fights over money which had been seen as more of a communal resource. There had previously been a local Partnership Board but this was dissolved last year. At one time there had been 6-7 different networks of agencies all going but this was now changing and they were coming together to form one network, Education had not previously been so involved but this was now changing. They have now also got Boys Club and STAR Housing involved.

Some agencies or professionals were seen as not generally being so positively involved in the teenage pregnancy prevention strategy. GPs were mentioned by a number of respondents as a group of professionals which ought to be more involved in helping to deliver the strategy.

*“There is always room to improve GP surgeries to make them more approachable although the majority think they are doing it already– they are so busy and subject to so many initiatives. If it doesn’t bring money in or is high on someone’s agenda it won’t happen so much. GPs are not getting that information.”*

*“My experience with health services is that they are willing to work in different settings but there are other issues concerning GPs and their attitudes”*

The YOT was also seen as not being very involved in the strategy.

*“YOT hasn’t engaged – I’ve worked in YOT previously so I know there is not enough health support for young offenders”*

YOT has however very recently advertised a sexual health post with a remit to work with young offenders.

## **Examples of Practice From Other Authorities**

### ***Work with GPs***

#### **Bradford**

Training for GP practices on confidentiality and services for young people and a cross district/service training group will oversee the process over the next three years.

#### **Slough**

Hold workshop/training programme for GPs and Practice Staff based on RCGP/TPU ‘Getting it Right’ and Confidentiality Toolkit.

### Liverpool

A programme will be developed to support General Practices to make their services more young person-friendly. This will include support in:

- The development of service leaflets
- Policy development around working with under-16s
- Resource development
- Confidentiality training
- Getting it right for teenagers in their practice

All practices from wards with high conception rates will be invited to take part in the programme. At least one practice from each ward with high conception rates will have undergone training.

### ***Involvement with YOT***

#### Liverpool

- Youth Offending Team (YOT) panel members, mentors & sessional workers will receive systematic training around sexual health from the YOT liaison nurse
- Training will be delivered in line with TPU Guidance for Social Care Practitioners & Youth Workers
- Wider YOT staff membership will have access to advice & consultancy from the YOT Liaison nurse
- The induction package for the City YOT Team will incorporate sexual health awareness raising training

### **Conclusions**

All the major local authority departments had provided representatives to sit on the Board and all felt that they were able to demonstrate commitment to the strategy, although it was acknowledged that some agencies had only recently joined and some were currently underperforming because of internal policy difficulties. Funding constraints and restructuring were identified as major deterrents to involvement. There were particular local circumstances which had positively encouraged highly productive multi-agency co-operation in New Parks. Ways in which GPs and the YOT can be more fully engaged in the Strategy have been identified as a need and are under active consideration by the Board.

## Involvement of Young People

Agencies within Leicester have been committed to involving young people in their service delivery and creating opportunities for them to offer their views to decision-makers and in line with this a number of participation groups have been developed by the Youth Service and Leicester Federation. In relation to the Strategy, Connexions, Turning Point and the PCTs have all actively involved young people as peer educators, advisors and researchers at different times contributing both to the prevention and care and support agenda of the Teenage Pregnancy Prevention Strategy.

### Respondents' views

All managers and practitioners interviewed took steps to try to ensure that the services they offered were young people friendly and took account of young people's views. Young people were involved for example in recruitment, production of materials and funding applications. The following quotes describe some of the ways in which this was achieved.

*"Other agencies come in to us which is a good indication – young people are our business although I have visited other places for ideas. The involvement of young people is a strength of Connexions. Young people are involved in recruiting staff, designing premises, projects and publications. They are employed as sessional staff and trained as peer researchers."*

*"In anything we deliver we try to have a young people's panel. With the BLAST directory we had a group from Saffron spend time on the content and visuals."*

*"Our young people were involved as part of the interview panel for the researchers. We hold two focus groups at New Parks and Allexton – they do oversee us –they tell us what posters to use, choose sessions and help with funding applications. We are very much young people led. Some people are scared of working with young people, they fear a loss of control, but we have been lucky at New Parks. The young people know it is a different ethos here after school. We have managed to get adults to release ownership, I know what it is like because I was like that originally, but I was able change—it is possible."*

A number of organisations also spoke about how they do these things to ensure young people feel able to be involved.

*"We try to ensure our service is young people friendly through meeting with young people in school to take their views on the delivery of services and provision also via work with young people on school councils. We get feedback by teachers and young people and via the training of SRE advisers. We feel it is important to work with teachers to help raise their confidence in working within this area and advise them how to operate in a young people friendly way. This is in part is being done via the certification of teachers as well as nursing staff coming into school".*

*"Turning Point - We take a youth work approach . The young people we work with see our job descriptions they know how much we earn. We work collaboratively, our work in school is informal, peer led and interactive."*

*“Connexions – The environment is important so we pay attention to the rooms and have soft chairs, lighting, blinds and generally try to make it a discreet and welcoming place.”*

*“Choices - When we were set up we used the DoH best practice guidelines, and talked to young people about the service and got their feedback about procedures. Young fathers didn’t like the information cards initially and felt they were too big – they are smaller now with prompts.”*

Some more mainstream work in the health service tries to ensure that trainee health professionals are more sensitive to the needs of young people.

*“When we work with medical students we focus on the issue of medical professions discussing sex and sexual health with young people. It has changed how people view young people and health.”*

There is support for the involvement of young people as part of the decision-making process of the Teenage Pregnancy Partnership Board, although there is some disagreement over which young people should be involved and the best ways of preventing them becoming over ‘professional’.

*“We should look at ways of involving young people on the Board –we need to see if we can manage Board meetings better. We could split the meeting into two halves with one part made more informal during which young people’s views can be sought. If young people are part of the formal Board they may become professionals and therefore not fully representative – will they tell it like it is to us?”*

*“My perspective is that we have involved a lot of young people but I am not sure if we have got the balance quite right, we need to involve ordinary young people - they’re the ones. We should be able to reach them through agencies working with groupings of young people, all in a participative way. When strategic developments come from the Partnership Board, the Youth Council etc need to be there. There will be developments over the next 12-24 months.”*

*“There is an Issue regarding how we(the Board) ensure young people who are not parents are involved and young people as a whole are involved consistently”*

Some people had ideas of how young people could be involved in the future.

*“I think the PCT needs to ensure that all services are young people friendly and that some are specifically for young people. The PCTs will be commissioning bodies and I think that this needs to be clearly stated and monitored within contracts and commissioning processes.”*

*“I would like to have a young people focused community development worker – it would be good to have one in all the areas. It would be a pilot project and could be part-time, even involve a young parent. I will keep fighting for it –I do it*

*hard enough it will happen. The New Parks network of agencies will be a forum to push funding through perhaps via Big Lottery."*

### **Practice in Other Authorities**

#### Walsall

The teenage pregnancy team actively engage with the Respect Group, a group of looked after young people from across the borough. Projects/initiatives have aimed solely at raising self-esteem, making positive choices and sexual health awareness, and have predominantly used 'Arts' as the medium to engage the youngsters.

### **Conclusions**

There is a strong commitment to involving young people in Leicester and a number of agencies have devised particular ways to ensure their practice is fully reflective of young people's views. Over the years a number of young parents have been recruited as peer advisers and researchers and also employed to provide advice. Some respondents suggested that there was now a need to create more opportunities to involve teenagers who are not parents to redress the balance. There is also support for members to find ways to involve young people creatively in the work of the Teenage Pregnancy Partnership Board.



## **Summary and Conclusion of Phase 1 of the Evaluation**

The following points are presented as key findings from the first phase of the evaluation.

### The Board and Strategy

The operation of the Teenage Pregnancy Prevention Strategy has drawn representatives of different agencies in Leicester, both managers and practitioners, closer together in a sense of shared common purpose which has proved productive for partnership working.

All the major agencies in the city had provided representatives to sit on the Teenage Pregnancy & Parenthood Partnership Board and all felt that they were able to demonstrate commitment to the strategy, although it was acknowledged that some agencies had only recently joined and some were currently underperforming because of internal policy and financial difficulties. Funding constraints and organisational restructuring were identified as major deterrents to involvement.

The wide ranging nature of the Teenage Pregnancy Coordinator post and the energy and ability of the current post holder is widely regarded as having made a significant contribution to the effectiveness of the strategy, particularly in ensuring that the concept of teenage pregnancy prevention has been owned and embedded in all the relevant local authority strategic plans and that major agencies in the city have been involved as fully as possible and new ones recruited to the cause.

The introduction of Task Groups has been helpful in bringing practitioners together to share ideas and learn from each other. In the case of the SRE steering group, it has provided essential support to the SRE adviser during a period of departmental reorganisation

### Involvement of young people

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

### Contraceptive services

The contraceptive and advisory services provided for young people in the hotspot areas in community settings and centrally by Connexions, are acknowledged to be of good quality although there is some concern that numbers of young people attending some community clinics are comparatively low and practitioners feel strongly that they need more capacity. There is some uncertainty on the part of health practitioners about young people's preferred style of delivery for these services with regard to both location and worker and

provision in some areas is hampered by the lack of suitable venues. This is something that can be included in the second phase of the evaluation.

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

The delivery of contraceptive advice and services in the health sector as part of the strategy is dependent on a comparatively small number of highly dedicated family planning and school nurses and community health workers, who are committed to getting the most value out of limited time and resources.

There is a view that two particular health regulations are hampering their efforts to make the most of their services for young people. The limitations imposed on nurse proscripting in community settings is not felt to be helpful although it was hoped that this issue will be resolved shortly and the ban on school and LAC nurses issuing condoms to young people was criticised as over restrictive.

#### SRE and education

It is widely acknowledged that the most effective SRE work in the city is being carried out by trained peer educators including young fathers in school and community settings through Turning Point, a voluntary agency with precarious funding which has to be renewed annually.

It was felt that the Education Department was not committing sufficient resources and effort to the teenage pregnancy prevention strategy although there was sympathy for the difficulties facing Education managers in responding to all the current demands on the sector.

The work of the SRE adviser and the Healthy Schools coordinator has been key to enabling some progress to be made in getting schools more involved in the strategy, but there was little knowledge of what was actually being delivered to students as part of school based SRE which was anecdotally reported to be extremely patchy.

Initiatives which were being carried out in other local authority areas such as more direct work and encouragement of PSHE advisers, an audit of school provision and involvement of school students in the design of SRE lessons could not be attempted in Leicester because of lack of funding.

SRE work directed at excluded pupils was also being affected by the closure of some projects working with them and the recent reduction of time that pupils were spending at Pupil Referral Units.

It was felt that schools would benefit from involving more community health and youth workers in delivering school based SRE and there should be more SRE

provision for Years 7/8 to overcome the information gap between the end of primary school and Years 9/10. This perception will be tested out in Phase 2 through interviews with young people in the different areas.

### Other Agencies

The lack of an agreed Sexual Health policy within the Youth Service is seen as holding back the capacity of youth workers to make a more strategic contribution to the delivery of SRE sessions with young people and the provision of contraception services, although it is hoped that this issue will be resolved by the Autumn.

The Youth Service and its workers are highly valued by community development health workers and family planning nurses for the young people friendly settings they are able to create and their ability to engage with young people. They would like to delegate more of their routine services to youth workers in order to concentrate on more specialist services.

The Social Care and Health Department has only recently become more directly involved in a tangible way in the work of the strategy. It was suggested that there could be more linkage between the work of the Looked After Children nurses and the Leaving Care Team. This has since progressed and is part of the current action plan.

### Media

The development of media and publicity work within the Teenage Pregnancy Prevention Strategy was not fully addressed until July 2005. The agency – DIVA - commissioned by the Teenage Pregnancy Board to deliver this aspect of the work was decommissioned after only seven months with only limited achievements to show for the contract.

Competing views concerning ways in which work with the media should be handled hindered effective engagement in the publicity process. Alternative arrangements have now been put in place but with minimum funding available it is unlikely that sufficient promotional activity will take place in time for this to be a significant part of the evaluation.

### Issues for the future

The focus of the Teenage Pregnancy Prevention Strategy has varied since 2001 and it was the personal view of a few respondents that there have been varying degrees of emphasis on the prevention and support agendas at different times, during the life of the Strategy. There is support among members of the Board for an open debate about the future strategic direction of the work.

There is support for a review of the membership of the Teenage Pregnancy Board to ensure that agency representatives have sufficient knowledge and standing to make a full contribution to its work. It is further suggested by one member that it needs to be more representative of the ethnic make-up of Leicester.

There is strong support for greater involvement of young people in the decision-making of the Board and its successor organisation. It is felt however that this should be done in creative and informal ways that would enable ordinary teenagers to contribute, alongside others who may already be involved in youth councils and other representative bodies.

There is support for the current targeting of particular risk groups and geographical areas in Leicester, but it is claimed that the lower level of family planning provision on the eastern side of the city has an impact on work with looked after children, one of the at risk groups who predominately live in the east. More contraceptive services in the east could be helpful to this group.

Refugees and asylum seekers aged over 16 were identified as an at risk group who were receiving few services because of their legal status. It was suggested there should be greater attention to the needs of black and minority ethnic young people and young men although previous and current work with young fathers was acknowledged.

Some mainstream health clinics and GP surgeries are not felt to be young people friendly and it is suggested that targeted work aiming to change attitudes among GPs and other mainstream health providers who come into contact with young people, along the lines of recent work with housing providers, would be beneficial.

It was felt that the Youth Offending Team (YOT) had been insufficiently involved in the work of the Strategy although their male young offenders were a potentially important group to engage with. It was reported that they had very recently advertised for a Sexual Health worker however which would provide an opening for fuller engagements.

## **Conclusions**

The Leicester Teenage Pregnancy Strategy has reached a significant cross-road at this point in 2006. It has built on some solid work dating from its early days and having done some necessary consolidation is well poised to move on to the next stage in its life as an important part of the new plans for Children and Young People's Services. Its managers and practitioners have identified some issues which need sustained attention however, foremost of which must be the need to safeguard the financial position of crucial services and the availability of workforce training. At the next level there needs to be creative thinking on the best ways to address some longstanding issues around SRE services, greater availability of contraceptive services across the city, reaching professional groups who have hitherto resisted involvement and ways of making the best use of scarce resources – but by positioning Teenage Pregnancy on everyone's agendas and through the JCB, Teenage Pregnancy may have access to more resources and investment.

During the second phase of the evaluation we will be working in three areas of the city testing out the findings from this Phase 1 citywide study with groups of young people (in schools and the community), parents and practitioners. It is intended that this second phase will allow for specific detail on some of the

issues raised in this report to be developed and most importantly will enable the views and opinions of young people to be included in the evaluation. Two of these areas are New Parks and Eyres Monsell and it is intended to work with a school in the Spinney Hills area and other black and minority ethnic projects throughout the city.

## Appendix 1 - Literature Review

The following literature review was not designed to be totally comprehensive but to draw together some of the major findings on teenage pregnancy prevention. Database sources including Google Scholar and ASSIA were consulted, as well as the Teenage Pregnancy Unit website and the Library collection based at the National Youth Agency which includes project reports and practitioner based journals. It is a feature of the literature that very few of the interventions designed to prevent teenage pregnancy implemented in the UK have been evaluated to a depth and with a rigour which has allowed them to be included in research reviews in academic journals. Overwhelmingly, much of what is proposed as examples of successful intervention to prevent teenage pregnancy is based on practice in the United States.

The Social Exclusion Unit was charged to study the reasons for the high rate of teenage pregnancy and published their report in June 1999. They identified three factors as particularly significant in the failure of previous attempts to tackle teenage pregnancy:

- Low expectations: young people disadvantaged in childhood and with poor expectations of education or the job market are more likely to become pregnant. or a young mother or father
- Ignorance: young people lack accurate knowledge about contraception, STI, relationships and what it means to be a parent.
- Mixed messages; one part of the adult world bombard teenagers with sexually explicit messages and an implicit message that sexual activity is the norm. The other part restricts access to appropriate, confidential, contraceptive services.

The net result they decided was not less sex but less protected sex.

The Teenage Pregnancy prevention strategy which evolved from this initiative had two main goals

- To halve the rate of conceptions among under 18s in England by 2010
- To achieve a reduction in the risk of long term social exclusion for teenage parents and their children by getting more teenage parents into education, employment or training.

Cheesbrough, S., Ingham, R. and Massey, D. (2002) drew on evidence from Australia, Canada, the United States and New Zealand concerning the major influences on teenage pregnancy. The most striking are the socio-economic background of parents and teenagers and the educational aspirations of teenagers.

- Inequitable income distribution has been positively related to higher rates of teenage pregnancy
- Young women who perceive they have little to lose by becoming young mothers are more likely to engage in risk behaviour. Young people who expect to go on to higher education are less likely to become teenage parents
- Family disruption in early childhood, poor communication and support within families, a mother who was sexually active at a young age, lack of

supervision of children and abuse may indicate a greater likelihood of a teenager becoming pregnant.

- Multicomponent sex education programmes (that is, those incorporating life skills teaching, discussions of attitudes, value and relationships and parenting) have been found to be effective in reducing conception rates.
- Where gender relationships are equal and there is discussion about relationships and sexuality between couples, unintended conception is less likely to occur.
- Laws about sexual behaviour (such as age of consent) religion and levels of welfare assistance had no impact on teenagers' sexual behaviour.

The Health Development Agency (2002) reviewed the evidence and reported on the then consensus about what works to reduce teenage pregnancy rates. Good evidence was found for the effectiveness of the following interventions aimed at preventing unintended teenage pregnancy.

- School based sex education particularly linked to contraceptive service
- Community based education, development and contraceptive services
- Youth development programmes – focusing on personal development, education and vocational development
- Family outreach; effectiveness of including teenagers' parents in information and prevention programmes

Good evidence was found for the following characteristics of effective services and interventions:

- Focusing on improving contraceptive use
- Long-term services and interventions targeted at local needs of young women and young men
- Focusing on local high risk groups
- Including interpersonal skills development
- Taking key opportunities e.g. at clinic services for education and information
- Basing interventions and programmes on theory driven approaches
- Checking that interventions and services are accessible to young people – in terms of location, opening hours etc
- Selecting and training staff who are committed to programme and service goals and to the needs of young people and who will respect confidentiality where possible
- Making sure that information and education is in place before young people become sexually active
- Working with teenage 'opinion formers' and peer group influences
- Making sure that intervention are age appropriate
- Encouraging a local culture in which discussion of sex, sexuality and contraception is permitted
- Joining up services and interventions aimed at preventing pregnancy with other services for young people and working in partnership with local communities.

The most comprehensive review of the evidence concerning teenage pregnancy to date has been produced by Harden et al (2006)

It set itself to find out what is known about effective, appropriate and promising interventions that target the social exclusion associated with teenage pregnancy and parenting, which might therefore have a role to play in lowering rates of unintended teenage pregnancy and supporting teenage parents.

A systematic literature review was conducted which identified 669 relevant studies but only 7 were studies of UK based research. There was a more detailed study of 10 evaluations of intervention and 5 studies of young people's views, all multi-component studies and based in the USA.

They noted that research across Europe indicates that a combination of access to skills and services and a chance to gain education and employment needed to succeed reasonably well in society is associated with lower rates of teenage pregnancy. The findings from the UK are particularly interesting.

"Our review found that for young people in the UK, happiness, enjoying school and ambition can all help to delay early parenthood. When young people have grown up in unhappy and poor material circumstances, do not enjoy school and are despondent about their future they are more likely to 'gamble the odds' when they have sex or choose to try for a baby. Our review found that early childhood interventions and youth development programmes which promote healthy relationship and engagement with learning and ambition can lower teenage pregnancy rates by 39%. Dicenso et al (2002) found no evidence that more traditional sex education and access to contraception approaches reduce the number of pregnancies among young women. Knowledge and understanding about sex and access to good sexual health and contraception services may be important, but there is no evidence that they are sufficient on their own to lower the rate of teenage pregnancy."

Using evidence from American studies, numbers of teenage pregnancy reported by young women who received a high quality early childhood intervention or youth development programme was lower than among women who did not receive an intervention, but this effect was less marked on young men.

Young people who received early childhood and youth development interventions did better at school and had better attitudes at school and were more likely to be employed and financially independent. These factors could reduce their vulnerability to teenage pregnancy.

Dislike of school was a key aspect of young parents' accounts of their lives prior to becoming parents. Young people who were not parents, but who were vulnerable to unintended teenage pregnancy (because of their life experiences, sexual activity and social circumstances) had negative views about school compared to their less vulnerable counterparts. How young people coped with their dislike of school varied, but a common reaction was to 'bunk' or 'skive' off. Dislike of school discouraged some young people from going on to further and higher education. Reasons given for this dislike included boredom, a perception of lack of relevance of the curriculum, in some cases reaction to unfavourable comments from teachers, bullying, difficulty in making friends and lack of



support if experiencing difficulties at home. Recommendations included greater involvement of young people in decision making concerning aspects of school culture and training in skills of positive relationships and conflict resolution and anti-bullying strategies.

Hoggart, (2006) traces the factors influencing young people's sexual decision-making, particularly the policy and philosophical context concerning sex education that exists in Britain. She notes that in many areas of the UK a vociferous minority continues to resist attempts to provide young people with the sexual information, resources and knowledge they need to negotiate sexual relations and that in the UK the idea that teenagers under the age of 16 may be sexually active regularly provokes moral indignation. Focus groups with young women in London and the Midlands found that for a significant number, their acknowledgement that they did not think about the risks of their actions, that they were careless regarding contraceptive use and often engaged in 'unsafe' sex does not seem to be because they lacked knowledge about contraception but rather that they were not overly concerned to avoid pregnancy. Young women were still felt to struggle to negotiate 'risk free' sex with their sexual partners with suggestions that there is a strong sense of fatalism in much of the decision making with the view in one district that pregnancy was the price to be paid for risky sexual behaviour.

Wellings et al (2001) carried out a probability sample survey between 1999 and 2001 of men and women aged 16-44 years in Britain, recruiting 11,161 men and women to the survey, aiming to investigate sexual behaviour in Britain – particularly early heterosexual experience. Trends identified in 2000 include a stabilisation of the proportion having first heterosexual intercourse before age 16 years among women, a continuation of the increase in the proportion using no contraceptive method at first intercourse and an increase in the importance of school in the sexual education of the young, particularly men.

### **Teenage pregnancy prevention strategies**

The operation of the Teenage Pregnancy Strategy was evaluated by an independent research team from the London School of Hygiene and Tropical Medicine, Universal College London Medical School and the British Market Research Bureau and involved a tracking survey of well over 9,000 young people aged 13-21.

They found that in the first four years, the Strategy has been implemented with energy and enthusiasm in an atmosphere of cooperation and consensus among those involved. Teenage pregnancy has been taken seriously enough to secure engagement of senior policy makers and dedicated funding, resulting in rapid and efficient action. The local teenage pregnancy co-ordinator has been the lynchpin of implementation; their status in the community, their professional experience and the support they have received have been key to the success of their role.

During the first four years of the strategy, conception rates for women in England aged under 18 have fallen. The rate of decline has been steeper in areas characterised by higher social deprivation and lower educational attainment and in areas that have received more funding to implement the

Strategy. This clearly suggests that the Strategy has been well targeted at areas of greater need that have benefited the most. Linking decreasing conceptions to more specific markers of the extent and quality of Strategy-related activity at local level has provide most elusive.

The strength of association between teenage pregnancy, social deprivation and low educational attainment clearly shows that future efforts should be directed at tackling the underlying socio-economic determinants of teenage pregnancy.

Further work is needed to ensure that young people are well-informed about sexual matters including contraception. Although awareness of some STIs increased over the period of evaluation, many young people are not confident that they can access confidential services for advice and contraception and the proportion having recent unprotected sex increased over the period of evaluation. Longer-acting methods of contraception should be more widely available to young women.

Despite a positive association between total number of school SRE lessons received and not becoming pregnant, SRE still fails to meet the needs of many young people and is often received too late. The status and thereby the quality of SRE could be improved by making high quality PSHE mandatory within the National Curriculum.

More attention to parents was recommended including innovative approaches to improving communication about sex between parents and children which needed to be developed and evaluated rigorously.

## **SRE**

Forrest et al (2004) investigate what young people want from sex and relationship education and notes that students require detailed information about the transmission of STDs and the risks associated with certain types of sexual behaviour. Other questions raised by students suggest that some types of SRE may be failing to address the realities of young people's social and sexual worlds. Young people outlined a desire for information about how to form relationships and manage infidelity as well as how to identify and deal with jealousy, love and sexual attraction.

Measor, (2004) examined the way in which young women and young men obtained their information about sex education. She found that home and intimacy with parents, especially mothers are important for some, although not all girls in a way it is not for boys. The data she collected indicate family patterns where boys learn about sex and sexuality in ways that by and large do not include adults, or more especially trusted adults and where there appears to be some elements of exclusion from the family. She suggests that the different family experience of girls has 'primed' them to access and accept information from teachers and other adults like health professionals, in a way it did not boys. Boys have had no prior experience of 'talking' with adults they knew well which would allow them to practise ways of engaging with some of the most sensitive aspects of young male lives which may explain their tendency to disrupt such sessions in school. Some research findings suggest that boys are obtaining a significant part of their information on sex from sources such as

friends and pornography which are taboo and to some extent hidden. From their perspective however these supply them with a more explicit demonstration of the actual mechanics of sex which they find missing from school based sessions and which help them uphold aspects of masculinity such as the need to demonstrate knowledge and control.

Strange, Oakley and Forrest (2003) investigated young women's and young men's attitudes to sex education lessons taken together or separately. The findings confirmed that the majority of girls surveyed stated a preference for all or some of their sex education to be carried out without boys. The degree of harassment from boys they experienced when lessons were taken together illustrated the difficulty in finding a setting in which boys could be induced to take the lessons seriously.

Walker (2004) considered the issue of involving parents in sex education with their children. She cites research describing the ambiguities involved in providing sex education within the home and notes that in practice informal sex education seems rarely talked about as a course of action agreed between parents. The approaches eventually adopted vary and range from establishing an open ongoing dialogue between parent and child to being unwilling to discuss the matter and unapproachable. Research indicates children and young people benefit from open cultural attitudes to sexual matters, within family networks and the community and this helps to form the basis for effective health and educational strategies. It is noted that boys can miss out on sex education with father-son discussions not always being effective. It is suggested that health promotion initiatives can help parents realise that they have skills and are ideally placed as educators to provide

### **Contraception**

Paton (2003) reviews research evidence on the impact of access to family planning on conception rates and the incidence of STDs. He then goes on to consider changes in conception and STD rates in the first year of the Teenage Pregnancy Strategy following the increased availability of youth family planning services. These reveal that conception rates among teenagers fell by 3.5% whilst rates of STIs rose by 15.8%. There is no differentiation however between the impact of general service family planning services and those which are provided with more intensive sexual health advice and support.

Fleming and Boeck (2002) describe the work of a well regarded sexual health clinic for teenagers set up in response to high rates of teenage pregnancy in Nottingham and Clifton. The project involved a large number of different practitioners and agencies including young people as peer educators, a Peer Education Co-ordinator, an Outreach Nurse and a school link nurse (currently all the same person), a young person's drug and alcohol worker from the Drug agency Compass, a worker from the NSPCC, youth workers and youth work managers, the PCT's Health Promotion specialist, two nurses and a doctor from the Contraceptive and Sexual Health Service. KISS created, trained and supported a group of young people as peer educators. Young people have the opportunity to attend a weekly evening session at a youth facility which provides youth work sessions and a confidential clinic sessions. The project has been successful in attracting young men who were already attending the

youth centre. The peer educators provide information to their peers on sexual health issues and have demonstrated their expertise and attention to confidentiality issues. Kiss is embedded in the network of local services and specialist health services and young people who use the project are referred on to other services as appropriate.

### **Work with young men**

Rutter, (2005) describes a pilot initiative to promote the C Card in Middlesbrough. The aim of the pilot is to provide young people with access to free condoms and free sexual health advice through the establishment of a coordinated, targeted, community based condom distribution network. A secondary aim was to deliver training to service providers to improve practice in sexual health work in a range of settings with young people. The training was devised and delivered by the SRE coordinator and worker over two consecutive mornings. A media campaign focused on boys and young men promoted the C card through advertising displays on bus shelters, inside of buses, cinema and local radio. They also made use of two 12 foot x 2foot boards that are situated around the pitch at Middlesbrough football ground. Early indications are promising – 66% of young people registering for the scheme are young men, twice as many as young women. Some key factors were identified contributing to the success of the initiative.

- Young people have to be involved with the development of the scheme
- Totally co-ordinated whole team approaches need to be in place
- Policies and procedures have to be in place
- C Card training needs to be the same for every staff member and a multi-agency approach must be adhered to
- Cultural, ethical and moral issues must be respected
- The local community may be negative towards the scheme

Wright et al (2006) describes work with young men on condom distribution which appears to have successfully overcome the reluctance of teenage boys to access sexual health services. Staff working at a young people's clinic offered as part of the Archway Sexual Health Clinic in London found that young men were generally perceived as and sometimes behaved as a disruptive influence within this setting.. It was decided that condom distribution for this group needed to take place in a context of health education. A policy was introduced that when a group of boys attended at reception requesting condoms, a health adviser or nurse would see them individually or in small groups of up to four in an interview room. Reassurance was given regarding their confidentiality. Discussion on sexual health, contraception and safer sex was initiated together with a condom demonstration. Sessions were made as engaging as possible with anatomically accurate condom demonstration and examples of contraceptive device. Time was given to allow questions and general group discussion on issues regarding sex and sexuality in general and sexual health in particular. Once the young person had participated in sessions with the health adviser they were issued with a personalised club card that they could present at reception when they next needed condoms.

The new policy of accepting groups of young men if they wish to be seen together seems to have gone some way to overcoming reluctance to use services. It has been suggested that a 'bad' experience with condoms can put

young men off and having easy access to them before embarking too far on sexual activity may be more helpful

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## **Appendix 2 - Mapping**

### **Introduction**

The Mapping aspect of the evaluation is designed to log services which are available to young people to support them in managing their sexual experiences. These services range from the provision of contraceptives and pregnancy testing to wider social and relationship education which may be available at school and other community settings, and the formal and informal support and signposting available for young people provided by paid workers such as youth workers and nurses and other trusted adults. The report presents the picture of services as they were in May following decisions made at the end of the financial year.

This logging of services is presented via a Microsoft Excel file and organised by city ward. This procedure makes use of a resource provided by a council regeneration staff member which allocates post codes to wards. While this has been very useful it has not been infallible so in a few cases some informed guesses have had to be made. This gives a broad picture of where the resources are, but since people don't usually take account of these divisions in their ordinary lives it may be the case that people living in one ward where services look sparse can make convenient use of provision just over the boundary in a neighbouring ward.

Information from a number of different sources has been combined but this is not yet fully complete and work will continue over the life of the project. Some information has to be collected at first hand because it is not recorded in an accessible written form.

For the purposes of the file the city of Leicester wards have been divided into three groups.

The first sheet sets out the five wards in the hot spot areas.

The second sheet sets out the wards demonstrating the second tier of need according to the conception rates. It also includes services provided in the city centre.

The third sheet contains the wards which have the lowest conception rates, combining areas of predominately middle class settlement and minority ethnic groups.

The BLAST directory was used as the first point of contact. Most services listed here have been telephoned to confirm that they are still offering the same hours and provision.

Chemists previously offering emergency contraceptives were telephoned to check on their new hours. Because some have now left the scheme entirely there are gaps showing up in the emergency contraception provision. Their new hours are included.

The Choices Service annual report was used to log where services are currently being provided but not where they have been tried and withdrawn from lack of support.

**Connexions Outreach.** These outposts throughout the city provide an opportunity for condom distribution and additional advice and support from Connexions PAs.

**Education** With secondary schools, information on those which have registered with the Healthy Schools initiative has been combined with information from Turning Point on where their peer educators have been giving lessons.

**School and LAC nurse service** This is rather volatile at present with changes happening all the time, but information has been included of the schools, children's homes and pupil referral units which have school and LAC nurses visiting.

**Youth Service.** Information on what each youth centre is currently providing is apparently not very accessible. This sector is in a state of flux at present with the hope that they can become more directly involved in the teenage pregnancy prevention strategy, but changes due such as the eventual withdrawal of youth workers from schools will temporarily reduce the amount of support which can be offered until the sexual health policy has been agreed. Existing youth centres have been logged in recognition of the support and signposting that youth workers can provide young people on an informal basis. Schools and youth projects which have had sessions with the Young Fathers Project this year have been logged.

**Voluntary projects** Some have been included where they are providing a recognised service. Some long established services such as the Shama Women's Centre and the African Caribbean Centre were checked and confirmed they were not providing any particular sexual health services to young people at present. Once the VAL survey report becomes available there may be more projects to be included who are providing at least advice and support to young women.

### **Community support**

There are community activists, often female, connected with community centres and Tenant and Resident Associations who may provide a lot of informal support to young women. One such was identified up in Hamilton but there are probably others.

## **FINDINGS**

As is well known – outside of the hotspot areas the opportunities for young people to obtain condoms and pregnancy testing in settings they would find accessible to them is limited. Because of this the demand on the GUM clinic, St Peter's Centre and the Connexions central office is likely to be heavy.

Fosse and Westcotes wards which are centrally based in the city have very few community resources but tend to be areas of changing population, particularly students. They are well placed geographically however to access services at the Leicester Royal Infirmary and Connexions.



A ward such as Coleman however is under resourced but without a very strong identity as a community. Neighbouring wards such as Belgrave and Latimer however do have a number of voluntary projects for the local population, such as the Peepul Centre and the Belgrave Neighbourhood Project which may feature in the VAL report.

## **Appendix 3 - Interview schedules**

### **Teenage Pregnancy Prevention Strategy Managers/Policy Makers**

1) How long have you been actively involved with the teenage pregnancy strategy – eg as part of the management on the Board, task groups etc and/or responsible for delivering a service as part of it? Please specify

Length of involvement

Member of TPB?

Member of Task Group?

Practitioner delivering service

2) What is your current role in your agency and what specific responsibilities do you have for delivering the prevention aspects of the Teenage Pregnancy Strategy? eg SRE, contraception /sexual health, involvement of young people.

#### Own agency performance

3) How would you describe your own agency's level of commitment to the Teenage Pregnancy Prevention strategy both currently and in the past?

4) Would you describe it as having a strategic approach to the Teenage Pregnancy prevention strategy? If Yes how? If No why not

5) What have been the main factors influencing the levels of commitment of your own agency to the prevention Strategy? What has been its strengths and weaknesses?

6) What do you feel are the best ways of ensuring that the service you are delivering as part of the Strategy are young people friendly? Do you think your agency demonstrates this in its practice?

If Yes in what ways? If No what improvements would you like to see?

7) Are you aware of the DEEP DIVE findings regarding the type of services which are associated with most success in preventing teenage conceptions (prompt re this but Kirsty has circulated these very widely).

How do you think the services provided by your agency and others in Leicester city are matching up to these?

#### SRE/Sexual Health Services

8) Existence of discrete, credible, highly visible young person friendly, contraception/sexual health advisory services with a focus on health promotion as well as reactive services. Believed to be confidential by young people  
Particular focus on meeting the specific needs of young men

Sexual health promotion

Condom distribution scheme involving a wide range of partners and/or access to emergency contraception in non- clinical settings. Provide access to full range of contraceptive methods including long term methods

Strong delivery of SRE/PSHE by schools

Strong focus on achieving 'healthy school' status, driven by the LEA. Usually found to be 20% higher than national average

Strong delivery of PSHE in primary schools,

Use of DfES SRE guidance as driver for training and support for schools, including planned programmes of training for governors on the rationale for and importance of good quality SRE

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

Investment in SRE resources and consultancy support for targeted schools

Importance of role of Learning Mentor in schools supporting the PSHE curriculum

Use of peer educators to deliver PSHE

#### Workforce

Workforce training on sex and relationship issues within mainstream partner agencies

#### At risk groups

Targeted work with at risk groups of young people, particularly Looked After Children

#### Youth Service

Well resourced Youth service with a clear remit to tackle big social issues such as young people's sexual health.

9) What would you see as the key gaps?

10) Are there other services you are providing that you think are equally as important as these specified above?

11) What are the key activities you would most like your agency to be carrying out in the next few years in order to contribute to the Prevention agenda in the way you think is necessary?

12) How likely do you think it is that this will happen? If unlikely, what are the main factors that will hold you back?

**We will be asking some general questions now about how you think the Strategy has been doing. We are looking particularly at the prevention agenda -SRE provision, contraceptive and sexual health services, the involvement of appropriate agencies, promotion and media publicity and the involvement of young people**

14) The Leicester Teenage Pregnancy Prevention Strategy has been going since 2001. In the light of your current knowledge how would you sum up how

the provision of these particular services and approaches has evolved from then up until now?

15) Factors influencing the development of each aspect of the prevention agenda

**SRE Provision**

Factors enhancing development  
Factors hindering development  
Best examples of practice  
Practice not working so well  
Major gaps in provision  
Improvements needed

**Contraception and sexual health services**

Factors enhancing development  
Factors hindering development  
Best examples of practice  
Practice not working so well  
Major gaps in provision  
Improvements needed

**Involvement of appropriate agencies**

Factors enhancing development  
Factors hindering development  
Best examples of practice  
Practice not working so well  
Major gaps in provision  
Improvements needed

**Media publicity campaign**

Factors enhancing development  
Factors hindering development  
Best examples of practice  
Practice not working so well  
Major gaps in provision

**Involvement of young people (Prompt re relative numbers of young people involved as young parents or non pregnant teenagers if it is not mentioned in this question or the one below.)**

Factors enhancing development  
Factors hindering development  
Best examples of practice  
Practice not working so well  
Major gaps in provision  
Improvements needed

16) What for you would be the key issues in relation to the prevention agenda arising citywide that we should be investigating in more detail when we start to research our three areas?

17) Do you think the current focus of the Strategy on particular risk groups and geographical areas is directed in the right way, or would you like to see some adjustments to these?

18) Are there any issues arising for you with regard to the prevention projects which receive Teenage Pregnancy and Sure Start Board funding and those which are sustained from mainstream agency funding?

19) The current statistics show a significant drop in the number of conceptions of under 18s demonstrating that at the moment Leicester city is well on target to achieving its government objective in this field. What would be your assessment of the possible reasons for this?

20) In what ways do you think the current structure, membership and performance of the Partnership Board is helping the strategic planning and overview of the prevention aspects of the Strategy?

21) In what ways are its structure, membership and performance hindering the strategic planning and overview of the prevention aspects of the Strategy?

22) What changes would you like to see to the way in which the Board operates?

23) What for you would be the key issues that the Board needs to address in terms of future investment and improvements in order to progress the planning and delivery of the prevention Strategy?

### **For those who are members of task groups**

24) In what ways do you think the SRE, Be Healthy and Media task groups have helped to support the planning and delivery of services concerned with SRE, contraception and media health and media publicity? (Match group(s) to the individual)

25) What aspects of the operation of these groups do you think have hindered the planning and delivery of services concerned with prevention aspects of the strategy?

26) Do you have any other comments on the research or the Strategy?

## **Teenage Pregnancy Prevention Strategy Practitioners**

1) How long have you been actively involved with the teenage pregnancy strategy – eg as part of the management on the Board, task groups etc and/or responsible for delivering a service as part of it? Please specify

Length of involvement

Member of TPB?

Member of Task Group?

Practitioner delivering service

2) You are currently working in ..... Have you worked for a different agency during the period of the TPS? Which one?

3) What is your current role in your agency and what specific responsibilities do you have for delivering the prevention aspects of the Teenage Pregnancy Strategy? eg SRE, contraception /sexual health etc

### Own agency performance

4) How would you describe your own agency's level of commitment to the Teenage Pregnancy Prevention strategy both currently and in the past? How is this demonstrated?

5) What have been the main factors influencing the levels of commitment of your own agency to the pregnancy prevention Strategy? What have been the strengths and weaknesses of its provision?

6) What do you feel are the best ways of ensuring that the service you are delivering is young people friendly? Do you think your agency demonstrates this in its practice?

If Yes in what ways? If No what improvements would you like to see?

7) The following are the factors identified by the DEEP DIVE investigation as the most important preventative measures for reducing teenage pregnancy. Ask if familiar with them – they should have been well circulated by Kirsty ( Match these to the background of the people being interviewed)

How do you think the services provided by your agency and others in Leicester city are matching up to these?

### Sre/Sexual Health Services

Existence of discrete, credible, highly visible young person friendly, contraception/sexual health advisory services with a focus on health promotion as well as reactive services. Believed to be confidential by young people

Particular focus on meeting the specific needs of young men

Sexual health promotion

Condom distribution scheme involving a wide range of partners and/or access to emergency contraception in non- clinical settings. Provide access to full range of contraceptive methods including long term methods

Strong delivery of SRE/PSHE by schools

Strong focus on achieving 'healthy school' status, driven by the LEA. Usually found to be 20% higher than national average

Strong delivery of PSHE in primary schools,  
Use of DfES SRE guidance as driver for training and support for schools,  
including planned programmes of training for governors on the rationale for and  
importance of good quality SRE  
LEA support to improve schools' PSHE delivery, including the development of  
exemplar lesson plans  
Investment in SRE resources and consultancy support for targeted schools  
Importance of role of Learning Mentor in schools supporting the PSHE  
curriculum  
Use of peer educators to deliver PSHE

#### Workforce

Workforce training on sex and relationship issues within mainstream partner  
agencies

#### At Risk groups

Targeted work with at risk groups of young people, in particular Looked After  
Children

#### Youth service

Well resourced Youth Service with a clear remit to tackle big social issues such  
as young people's sexual health

8) What would you see as the key gaps?

9) Are there other services you are providing that you think are equally as  
important as these specified above to the prevention agenda?

10) What would you most like your agency to be doing in the next few years in  
relation to the strategy?

11) How likely do you think this is to happen? If No what are the main factors  
preventing this outcome?

**We will be asking some general questions next about how you think the  
Strategy has been doing. We are looking particularly at the prevention  
agenda -SRE provision, contraceptive and sexual health services, the  
involvement of appropriate agencies, promotion and media publicity and  
the involvement of young people**

12) The Leicester Teenage Pregnancy Prevention Strategy has been going  
since 2001. In the light of your current knowledge how would you sum up how  
the provision of these particular services and approaches has evolved from  
then up until now?

13) What in your view are the main factors that have enhanced the  
development of these preventive services and approaches?

#### **SRE**

Factors enhancing development

Factors hindering development

Best examples of practice  
Practice not working so well  
Major gaps in provision  
Improvements needed

**Contraception and sexual health**

Factors enhancing development  
Factors hindering development  
Best examples of practice  
Practice not working so well  
Major gaps in provision  
Improvements needed

**Involvement of appropriate agencies**

Factors enhancing development  
Factors hindering development  
Best examples of practice  
Practice not working so well  
Major gaps in provision  
Improvements needed

**Promotion and media publicity**

Factors enhancing development  
Factors hindering development  
Best examples of practice  
Practice not working so well  
Major gaps in provision  
Improvements needed

**Involvement of young people**

Factors enhancing development  
Factors hindering development  
Best examples of practice  
Practice not working so well  
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14) What for you would be the key issues in relation to the prevention agenda arising citywide that we should be investigating in more detail when we start to research our three areas?

15) Do you think the current focus of the Strategy on particular risk groups and geographical areas is what it should be, or would you like to see some adjustments to these?

16) Are there any issues arising for you with regard to the prevention projects which receive Teenage Pregnancy and Sure Start Board funding and those which are sustained from mainstream agency funding?



17) The current statistics show a significant drop in the number of conceptions of under 18s demonstrating that at the moment Leicester city is well on target to achieving its government objective in this field. What would be your assessment of the possible reasons for this?

18) Do you have any views on the way in which the Partnership Board currently operates?

For those who are members of task groups

19) In what ways do you think the SRE, Be Healthy and Media task groups have helped to support the planning and delivery of services concerned with SRE, contraception and media health and media publicity? (Match group(s) to the individual)

20) What aspects of the operation of these groups do you think have hindered the planning and delivery of services concerned with prevention aspects of the strategy?

21) What changes would you like to see in this area?

22) Do you have any other comments on the research or the Strategy?