PROMOTING SAFER SEX

An examination of agencies within the New Plymouth area providing sexual health education programmes for adolescents

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ABSTRACT

The aim of this report is to identify and describe community agencies in the New Plymouth District that provide sexual health and education programmes to adolescents. Sexual health education appears to reduce unplanned pregnancies and sexually transmitted diseases. When compared to other OECD countries, New Zealand has one of the highest adolescent birth and abortion rates. The incidence of sexually transmitted disease is also rising.

Seven local organisations were identified and participated in this study. I met with representatives from five of the organisations. Two organisations responded to my questionnaire by way of written report. Six of the eight local High Schools also returned details of the sexual health and education programmes they provide to their students. A wide range of topics are discussed ranging from pubertal issues to sexual intercourse and pregnancy.

Results from community organisations highlighted similarities and differences between the agencies. Course content attempts to deal with adolescent sexuality in the broad context of adolescent behaviour. Providers agreed that sexuality has to be considered within the context of issues relevant to adolescence. Therefore programmes need to contain not only sexual health information but also other issues important to adolescents such as relationship building skills and vocational goals.

This report is able to be used as a resource for statutory and voluntary social services and health professionals in the New Plymouth area.

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ABBREVIATIONS

HFA	**Health Funding Agency**
CHE	**Crown Health Enterprise**
PHN	**Public Health Nurse**
FPA	**Family Planning Association**
STD	**Sexually transmitted disease**
GP	**General Practitioner**
WINZ	**Work and Income New Zealand**
CFA	**Community Funding Agency**
SAFER Centre	**Sexual Abuse Family Education Rehabilitation Centre**

DEFINITION OF TERMS

The definitions relevant to this report are outlined as follows.

Adolescence

The developmental period of a person ranging from 12 years to 19 years.

Adolescent

A person aged between the ages of 12 years and 19 years.
I will at times interchange the term adolescent with young people (person) or teenager.

At risk and risk taking behaviours

This is defined as those adolescents who succumb to "behaviours or activities that promote the probability of adverse psychological, social, and health consequences" (Stoiber, 1997:654).

Sexuality

I have used the Department of Health's (1990) definition that describes sexuality is an "acceptance of ourselves as sexual beings, our feelings about being male or female, the way we express our sexual feelings and the way in which we communicate these feelings to others" (p. 1).

Sex education

A technical exercise where information is given regarding physiology, anatomy and development (Chambers, 1991:1).

Sexuality education

A comprehensive program that explores "feelings, attitudes, values, behaviours, pressures, risks, communication, decisions, and health", (Chambers, 1991:1) by giving young people the opportunity to take responsibility for their own wellbeing.

Supervision

A formal and explicit process that provides oversight and accountability to practice. It ensures workers practice to the best of their ability and that certain organisational, professional and personal objectives are met (Children, Young Persons & Their Families Agency, 1998:4).

Chapter 1

INTRODUCTION

The aim of this report is to identify the range of educational services which assist adolescents to determine and develop their sexuality and enable them to establish safe and responsible relationships to enhance their sexual well-being. The research was conducted in the provincial New Zealand city of New Plymouth. My interest in this field stems from my experience of working with teenagers known to me through my area of employment as a statutory social work supervisor. Many of these young people become sexually active at an early age. Many do not use any form of contraception and do not see a connection between sexual intercourse and pregnancy. Others make no distinction between sexual intercourse and sexuality and more often than not, some do not have the skills to develop or maintain positive and meaningful relationships. Unfortunately this perception implies a naive and unrealistic cognitive capacity to comprehend the probable consequences of one's actions.

Nearly every day I see young people who are at a stage in their lives where the process of changing from child to adult is exciting yet at times confusing and for some isolating. The issue of sexuality is only one area of change they will undergo in their lives. Sexuality is a complex and confusing aspect of life and the way we resolve needs, desires, values and social expectations in this area has the potential to lead to outcomes ranging from great personal satisfaction to considerable conflict and pain. Although at times sexual questions, conflicts and crises may begin prior to adolescence, most would agree that adolescence is a period which may bring on an upsurge of sexual drives, the development of sexual values and the initiation of sexual behaviours (Moore and Rosenthal,

1993). With the advent of puberty the power of peer group expectations as well as the communication of mixed messages about sex from the adult generation make dealing with sexuality a difficult yet exciting challenge for adolescents.

This report will describe the services and programmes provided by agencies on sexual health education for adolescents in my own locality, New Plymouth. My purpose in selecting this topic was two-fold. Firstly, it was to help me develop research and information gathering skills. Secondly, it was to assist me in my job. Research has shown that it is more common for sexually abused children to become "voluntarily" sexually active at an earlier age than children not abused (Saphira, 1983; Conte, 1987; Von Dadelszen, 1987; Conte, 1991; Moore, Morrison and Glei, 1995; Eaton, 1998). Despite the incredible amount of work, time and energy social workers invest with young people, the behaviours of some teenagers continue to place them in an "at risk" category health-wise.

It was not until I started this research that I discovered the collective knowledge of the social work staff in New Plymouth was minimal in terms of knowledge of agencies providing information and programmes or courses on sexual health for adolescents. It was therefore not surprising to see that this lack of knowledge regarding appropriate service providers was reflected in some of our young peoples behaviour. Although this research project highlighted gaps in our networking system it has also opened new doors which were unknown to my workplace and more importantly directed us to further services focused on helping young people.

Early in the identification process, I decided to write to the eight High Schools within the target area. It seemed logical to also survey schools concerning

sexuality programmes since this is the place where the majority of adolescents regularly spend a large amount of their time. Furthermore, I assumed that if programmes were taught in the school they would be more readily accessible to adolescents than those from the community-based organisations. This I thought would surely suggest that adolescents do receive consistent and reliable information on issues concerning sexuality. What I found was that seven organisations provided sexual health education to adolescents while at least six out of eight High Schools also had some form of sexuality education in their curriculum.

Research Objectives

The aim of this report is to identify the organisations within the New Plymouth District boundary of the Taranaki region which provide sexual health and education services for a target population of adolescents. I also aimed at determining what, if any, sexuality education adolescents receive at school. I have chosen the New Plymouth District simply because it is where I work and the information gathered, I hope, would benefit co-workers and our clients.

The following are the objectives which I set myself to achieve. The first step in this study was to identify the service providers who presented and/or provided programmes and information relevant to adolescents. Once this was completed I began identifying the course content information of each service provider. I also determined how each of the services gauged their accessibility to adolescents. Training was an issue of interest. I therefore gathered responses from the organisations on what training the presenters receive and established what on-going learning is required. I also report on the providers methods and frequency of supervision.

Prior to beginning this research, I assumed that the Service Providers were community-based. I therefore focussed on who funds the agencies or how funds were raised; the Management structures, decision-makers and how decisions are made.

Regarding schools, the objective of the survey was to determine whether High Schools provide students with a sexuality education forum and the outcomes of these.

Target Area

As previously mentioned I chose the New Plymouth District because of its accessibility and it seemed logical that knowledge of local service providers would enhance my practice as a social work supervisor.

According to Statistics New Zealand (1996) the New Plymouth District has a population of 68,112 or 1.9% of the New Zealand population. Of interest is that 84.2% of all people are of European ethnicity (compared with a national figure of 74.8%) while only 13.4% claim Maori descent (compared with 15.1% of New Zealand). The area's Pacific Island and Asian populations are small with figures being approximately 0.8% and 1.3% respectively. In relation to age-groups, just over 15% of the population are aged 10 to 19 years. Despite the fact that the Taranaki region contains all of New Zealand's current hydrocarbon fields, the unemployment rate in 1996 was 8.6% (compared with the national figure of 7.7%). Another issue of concern is that nationally, 34.7% of those aged 15 years and over have no formal qualification yet New Plymouth has a figure of just under 40% of young people with no qualifications.

New Plymouth covers an area totaling 2324.26 kilometres (New Plymouth District Council pamphlet titled "Options") making it the largest district in New Zealand. Eight High Schools lie within the region's boundary.

New Plymouth city is the main urban area of Taranaki and is dominated by the snow capped mountain, Taranaki. The area has a strong agriculture base with an emphasis on farming, particularly cattle farming. As mentioned previously, New Plymouth is considered to be New Zealand's Energy Centre with oil and gas production ongoing as well as a major natural gas fueled power station and other petrochemical industries. 14.2% of those working in the New Zealand mining industry are employed in the region. Other specialist industries of interest include heavy and light engineering, horticulture, a variety of uncrowded beaches - having some of the best surfing and wind sailing areas in the country, with walkways, parks and the protected Sugar Loaf Islands (New Plymouth District Council pamphlet titled "Options"). .

Outline of Report

This report is presented in five chapters with Chapter One introducing the subject area, research objectives and aims. New Plymouth is also introduced as the target area. Chapter Two discusses the literature from a national and international level concerning sexuality education programmes and adolescent behaviour. Also included in this chapter is a brief discussion on legislation directly affecting the area of sexuality education programmes.

Chapter Three describes the research methodology. The reasons for choosing a simplified survey method and the research process are discussed.

Chapter Four details the findings of the research. An overview of each provider and discussion of their roles and functions they provide to the community is examined. Gaps are identified as are weaknesses and strengths.

Chapter Five is the final chapter . The conclusions of this study are discussed and a number of policy recommendations are made.

Chapter 2

LITERATURE REVIEW

Background

This chapter discusses a number of issues from various sources (both from the local and international front) relevant to sexuality education in schools. It begins with a brief section that outlines the policies and legal framework within which sexuality education is taught in schools.

In New Zealand sex education is not compulsory for all students, so if parents are opposed to it children may be removed from classes. By comparison, Denmark, which implemented sexuality education into their school curriculum seven years after this country, teaches sex education as a compulsory subject. Included is a discussion taken from Marg Flyvbjerg's (1996) research on Danish sexuality education programmes. Owens (1992) was commissioned by the Family Planning Association to review the available literature on American intervention programmes specifically targeted at reducing adolescent pregnancy. The factors that he believes are likely to ensure a successful intervention programme are cited.

The final section in this chapter discusses issues concerning adolescent sexual behaviour. Although this latter section is generalized to international teenage sexual behaviour, some New Zealand studies are explored and findings documented.

Legislative Overview

While it is compulsory for the Health syllabus to be taught in New Zealand schools, sex education is only one component of the Health syllabus. Yet due to the sensitivity and potential for objections by parents, sexuality education can only be provided with the Board of Trustees specific approval. The Education Act 1964, gave Boards of Trustees authority to either approve or reject any programmes. Even after the amendments and the advent of "Tomorrow's Schools" the powers of the Board were not repealed. Section 105c of the Education Act 1964 defines what these powers are. Should a Board decide to approve a sexuality education programme, consultation with parents is a legislative requirement as the community has the legal right to express their views and opinions on the topic. This process enables parents and the community to choose and make decisions on sexuality education content they believe appropriate for the students within their community. Parents also have the legal right to withdraw their children from sexuality education classes.

Until its repeal in 1990 the Contraception, Sterilisation and Abortion Act 1977 prohibited the giving of contraceptive advice and the supplying of contraceptives to people aged less than 16 years (except by parents or "authorised" medical or education specialists). Now, however, the Contraception, Sterilisation and Abortion Act 1990 allows those aged less than 16 years to access knowledge on the use of, as well as the purchasing of, contraceptives. The Privacy Act 1991 ensures that details relating to inquiries remain confidential. Although age cannot be a determining factor for refusing a contraceptive prescription, it is a criminal offence for a child under the age of 16 to have sexual intercourse (Crimes Act 1961). This obviously may be a factor for refusing to give a child contraceptives.

The Provision of Sexuality Education in New Zealand

Generally, the purpose and aims of sexuality education programmes are to provide students with information relating to their physical, mental, social and emotional growth and development; fostering relationships and reducing the level of adolescent pregnancies by promoting health and preventing diseases through responsible behavioural changes (Department of Education, 1973: 6; Glennon, 1986: 2; Chambers, 1991: 1; Owens, 1992). The legislative changes of 1964 in New Zealand enabled schools to achieve outcomes in this area, however difficulties occurred which reduced the effectiveness of these programmes.

Although enacted in 1964, the sex education component of the health syllabus of the Education Act was a controversial topic even nine years later. In 1973 increasing pressure was being mounted on schools to share responsibility with parents in the personal and social development of young New Zealanders (Department of Education, 1973: 5). Included in this responsibility was sex education. However a number of factors were said to hinder this promotion and delivery. Chambers (1991: 2) cites these reasons as staff being unwilling, untrained, uncomfortable and/or disinterested in teaching the subject; that there were already too many subjects to cover in the academic curriculum; and staff believed the law restricted them from providing information on sexuality to students.

Chambers (1991) also found that schools each had their own interpretation of the health syllabus to the extent that "the state of sexuality education in [New Zealand] schools can only be described as widely varied" (p. 2). Although nearly 35 of his surveyed schools adhered to health syllabus guidelines, most

were "sufficiently vague (especially at secondary level) to allow for a range of delivery" (p. 2).

The ability of schools to introduce and maintain sexuality education programmes is dependent on their Board of Trustees, as every Board has the power to either approve or reject a programme (Education Act 1964). When considering the different socio-economic, cultural and religious groups within the country, it is easy to see why New Zealand cannot provide adolescents with consistent messages about sexuality.

Studies within New Zealand (Lynskey and Fergusson, 1993; McEwan, Aukett and Hills, 1988) support the need for sex education to be a component of the education curriculum. Lynskey and Fergusson (1993:513) claim that even though it has been an issue of contention, providing sexually active teenagers with school based contraceptive and counselling advice is necessary. They further argue that adolescents today engage in sexual activity at an early age and often deviant behaviours, such as drug and alcohol abuse, juvenile offending and that mental health issues such as anxiety, suicide and depression accompany this activity (ibid: 513). This means that there is an added danger of unsafe sexual practices. Providing programmes for adolescents would be a means of establishing contact, support and assistance (ibid: 511). An earlier study by McEwan et al (1988:143) reported that students identified four major sources of contraceptive education with the majority claiming their knowledge came from school education classes and that "sex education should be based not on how to have sex, but on contraception, how not to get pregnant". In contrast, Dr Melvin Anchell (cited in Moran, 1998) claims that sex education taught in the classroom setting is wrong. It is, he says, a parental responsibility as "a parent's sensibilities regarding what is best for sons and daughters, are

ten thousand times more correct than the opinions of therapist social workers, iconoclastic social scientists, and educators, who consider themselves oracles of sexual knowledge" (ibid: 28). The persistence of this view has meant that many teenagers remain in ignorance, and some become pregnant as a result of this.

OVERSEAS STUDIES

Sexuality Education in Denmark

While the age of first coital experience in New Zealand and Denmark is similar (Flyvberg, 1996: 52), New Zealand adolescent (young women aged 15 to 19 years) birth rates are nearly four times higher (Midland Health, 1996:35). Since 1971 Denmark has made sexuality education a compulsory part of their state school curriculum (Flyvbjerg, 1996: 5) and today "teenage sexuality is an accepted part of life in Denmark. It is an accepted practice that Danish teenagers may take their partners home to sleep the night. Parents accept this and appear to pass no judgement on it" (Flyvbjerg, 1996: 52).

The original goal of sexuality education was to "develop openness and security and to give students adequate knowledge on which to base their behaviour and attitudes" (Flyvbjerg, 1996: 5). Now however, the goals have been developed and encompass a more holistic approach to well-being. They state that "students acquire insight into the conditions and values that affect health, sexuality and the family and understand the importance sexuality and family life have for health, and its interaction with the environment; teaching will combine the individual student's experiences and understanding, to develop self confidence and love of life, as well as supporting each student to develop his/her personal identity in how they relate to others; teaching will empower

each individual student to act in ways that show responsibility for their own health and the health of others" (Flyvbjerg, 1996: 5).

The teaching system is vastly different compared to that seen in New Zealand. Flyvbjerg (1996: 22) states that from year 1 to year 10, all students remain with the same teacher. This teacher is responsible for teaching a variety of subjects including sexuality education. Underpinning this is the belief that the sense of responsibility and trust that develops allows for the provision of a seamless service thereby making "it easier to deliver quality pastoral care to the student" (Flyvbjerg, 1996: 22). Also, Danish parents do not have the right to withdraw their children from sexuality education classes whereas in New Zealand, parents do have this ability.

Since its introduction, sexuality education has allowed for an openness about sexual matters. It has stressed the importance of love, responsibility, caring, nurturing and respecting the opinions of others. This "helps mould responsible young adults who care for their own health and the health of others" (Flyvbjerg, 1996: 53).

Sexuality Education in the United States of America

Trying to curb the rate of unplanned adolescent pregnancies has seen an abundance of sex and sexuality education programmes being introduced into the American education system. On evaluation however, Owens (1992:12) claims that a number of these programmes have not achieved the stated objectives. A successful intervention programme needs to consider the teenager within their environment. Owens (1992) describes the common features of successful programmes as being "planned, [having] had a sound theoretical basis, were intensive, and long term, with follow-up. Evaluation was

built into the programme so that it could be responsive to the participants' perceptions and needs. Sexuality was approached as a normal, integral part of the adolescents life, the goal being to deal with it as just one facet, or expression, of the range of possible problems areas that a teenager encounters in the transition from child to adult" (p. 73). In recent years, the Federal Government has also sponsored sexual abstinence programmes to reduce the numbers of adolescent pregnancies.

LITERATURE REVIEW OF ISSUES CONCERNING ADOLESCENT SEXUAL BEHAVIOUR

Adolescent Sexual Behaviour

A number of New Zealand studies have investigated the sexual experiences of adolescents (Barnes and Maxwell, 1980; Cameron, 1980; Trlin and Perry, 1983; Lewis, 1987; McEwan and Aukett, 1988; Brander, 1991; Dharmalingham, Pool and Hillcoat-Nalletamby, 1997) with results being well documented. Health concerns for teenagers have been identified as the consequences of their high risk taking behaviours and included in these risk-taking behaviours is the area of sexual behaviour and responsibility (Ministry of Health, 1996: 20).

During the past 20 years, the birth rate to younger mothers has fallen significantly in New Zealand and elsewhere. However, compared with other OECD countries New Zealand still has relatively high levels of unplanned teenage pregnancies (Midland Health, 1996: 34,39). Taranaki is recorded as having a low adolescent birth rate (Midland Health, 1996:38). The promotion of better maternal outcomes for babies of adolescent mothers is essential. Some consequences are discussed below.

Health Consequences of Early Childbearing

Sex education is particularly important for younger teenagers, as the physical effects of very early childbearing can be serious. Although the risk of childbearing is much greater for those aged 10 to 14 years (as compared to those aged 15 to 19 years) some complications are more common in teenagers than older women. These complications include: hypertensive disorders which if left untreated can lead to eclampsia; obstructed labour may result if pregnancy occurs soon after the onset of menarche as the pelvis is not yet developed, or may occur if the young woman has not received adequate nutrition during her adolescent growth spurt; vesicovaginal fistula may follow obstructed labour and if not repaired will severely compromise the young woman's life, while urinary incontinence (although not fatal) may cause social isolation (World Health Organisation, 1993: 23-25). Regardless of age, child-bearing involves some risk and young women who have not reached their full physical and physiological maturity are almost three times as likely to die from complications in childbirth as older women. The World Health Organisation (1993: 15) reports that young women aged between 15 and 19 years have up to a 200% higher risk of dying during pregnancy or delivery than those who are older. Those younger than 17 years with no primary health care worker have a 5 to 7% chance of dying from pregnancy related causes.

Health Consequences for the Child

The adverse effects that early childbearing has on the mother are similarly seen in the disadvantages for the child. Babies have a lower chance of survival when their birth weight is low as this makes them more susceptible to illnesses and infections. The sudden infant death syndrome rate is higher for babies of adolescent mothers (Department of Health, 1992: 15; Public Health Commission, 1994: 203). However, rather than being a direct consequence of

age, Wilson, Clements, Bathgate and Parkinson (1997: 40) argue that some factors such as low birth weight and premature birth are more likely to be due to socio-economic status and adolescent behaviours such as smoking.

Child Abuse, Neglect and Murder

Children of adolescent mothers are at greater risk of maltreatment than children of older mothers (Dukewich, Borkowski and Whitman, 1996: 1031). Bolton (1990 cited in Dukewich et al, 1996:1031) claims that 36% to 51% of all abused children are raised by adolescent mothers. He stresses that the numerous contextual similarities between adolescent parents and the maltreating parents such as poverty, social isolation and a poor understanding of child development may collectively provide the foundations for the development of abusive behaviours.

In the United States of America statistics reveal that one third of mothers who kill their newborn babies are aged between 14 and 17 years (Dowling and Burke, 1998: 35). In reality this percentage may only be a portion of the true number as it counts for only bodies found. The pregnancies are often hidden from family, friends and at times even boyfriends. After delivery of the baby (usually self-delivered) the body is then disposed of in, for example garbage bins, rivers and toilet bowls.

Abortion

A consequence of the high fertility rate is reflected in the number of unwanted pregnancies which may lead to an induced abortion. In the case of an unsupported teenager, the abortion is likely to take place later in pregnancy which exacerbates the risks to life, health and fertility (World Health Organisation, 1992: 26). Today a greater proportion of adolescents resolve

their unplanned pregnancy through induced abortion (Midland Health, 1996: 43).

Sexually Transmitted Diseases

Sexually transmitted diseases (STDs) are the most common group of communicable diseases reported in the majority of countries. They continue to occur at unacceptably high levels particularly among the adolescent and young adult age-groups who have the highest rates of partner change (World Health Organisation, 1993: 29; Dickson, Paul and Herbison, 1993: 133).

The Department of Health (1992: 17) in New Zealand report that in 1991, 55 of the 302 people with AIDS were between the ages of 20-29. Dickson et al (1993: 133) claim that in mid-1992, 85% of the people with AIDS were either homosexual or bisexual men and only 5% were presumed to have been infected by heterosexual contact. Given that the incubation period for the development of AIDS is ten or more years, it is more than likely that these young people were infected with the virus during adolescence.

Sexual health education is vital to the promotion of safer sexual practices for adolescents, whether gay, straight or bisexual.

Conclusion

Since 1964 schools in New Zealand have had the right to introduce sexuality education into their curriculum. Both primary and secondary schools are required to comply with legislative requirements that relate to health education. It is therefore the responsibility of schools to include in their curriculum a focus on family studies and moral education particularly as expressed in health and

physical well-being and social sciences, with programmes reflecting local community and student needs. However, the current legislative framework still makes it possible for schools to avoid the responsibility to provide sexual education.

As adults, we need to empower young people and allow them the opportunity to take responsibility for their decisions. While acknowledging adolescence as a time of transition with accompanying psychological and emotional turbulence for many young people it is necessary that we ensure they have the knowledge to make informed decisions. If we provide the resources a generation of young people endowed with the ability to cope in the every changing environment and its accompanying pressures will be seen.

Chapter 3

METHODOLOGY

Introduction

In order to identify service providers and describe their sexual health and education programmes it was necessary that I survey the New Plymouth area to see exactly what was being offered and who was doing the providing. Generally a survey is defined as a method of collecting information from people about themselves (Statistics New Zealand, 1995:9; Rea and Parker, 1992:2; de Vaus, 1991:3; Fink and Kosecoff, 1985:13) and by either probability or non-probability sampling (as described by Statistics New Zealand, 1995; Rea and Parker, 1992; de Vaus, 1991) a sample population is selected. The information collected from the sample group is generalised and said to reflect the views and characteristics of the target population (de Vaus, 1991:60). The collected data is then analysed using various quantitative and statistical techniques (Fowler, 1993; Rea and Parker, 1992; Fink and Kosecoff, 1985; Sonquist and Dunkelberg, 1977; Moser and Kalton, 1971). This survey did not attempt to provide such a sample. Rather, 100% of providers were surveyed in one locality to obtain a full range of sexual health and non-sexual health services. Although the New Plymouth area has some features which distinguish it from others, it is not atypical of New Zealand as a whole (see Chapter 1).

Before choosing this particular method I needed to be clear about the purpose of the research and decide what it was that I wanted to achieve. Patton (1990) says that "purpose is the controlling force in research" (p. 150) and that researchers "are interested in investigating a phenomenon in order to get at the

nature of reality with regard to that phenomenon" (p. 152). I wanted to provide a complete survey of the sexual health education programmes and courses provided by statutory and voluntary agencies in the area, in order to create a resource that could be used by social workers and health professionals. Once I was clear about the purpose, my simple survey method seemed the most practical and logical to display and highlight results. I have tabled some results in Chapter 4 to highlight similarities and differences between providers and to identify gaps in provision, in the hope that these might be filled.

Despite using a quantitative method of research in the survey, I chose to also adopt a qualitative methodological type approach in the interviews and recording of some results. Although the majority of results are not recorded as direct quotations, the process allowed participants to express their thoughts, ideas and experiences. Their information is not able to be easily measured nor statistically tested. Although there was a questionnaire, the interviews were semi-structured. This approach also allowed service providers to describe their programmes which provided an interpretation of their perception, involvement and experience of the adolescent world (Jayaratne & Stewart: 1991). The use of both open and closed questions (also a characteristic of quantitative methods) was employed giving me the opportunity to probe for further information. Foddy (1993) discusses the advantages and problems when constructing questions surmising that a "judicious mix of open and closed questions is best" (p. 152) as responses will then "reflect the respondents' worlds rather than the researchers" (p. 152). Data produced in this manner is considered to be rich in detail. Lastly, the approach gave interviewees the choice to respond to questions without necessarily having to meet with me (also a common characteristic in quantitative methods).

Questionnaires

It is necessary that researchers rely on their skills as emphatic interviewers or observers in order to collect unique data about the problem they are investigating. Researchers may have a list of topics for discussion and information gathered may be in an unstructured, structured or semi-structured form. Researchers may also seek to uncover the participants own narrative or experience of the topic.

As mentioned previously questionnaires were prepared (Appendix 1 and 2) initially for my own benefit, ensuring a consistency of questions to the providers. This would allow a consistent collection and comparison of data. However because of time constraints (of both provider and myself) I decided to contact each by telephone, explain the purpose of my research, ask if they provide sexuality programmes to adolescents and if they did, whether they would be prepared to meet with me and inform me of their programme. If they agreed to do this, I would then send them a questionnaire. The purpose for sending the questionnaire was that I believed this might minimise the tension sometimes seen in an interview-type environment, inform providers of the information I was interested in collecting, give providers the opportunity to answer only questions they felt comfortable with and possibly reduce the interview time. At the end of the initial telephone conversation an appointment time was made with each provider nominating a time. All providers were visited at their workplace.

Originally, I contacted some High Schools by telephone. After explaining (usually to the receptionist) the purpose of my telephone call, I was either put "on hold", or a message was left for the appropriate person to contact me -

which they never did. After a few weeks of waiting I decided to send a questionnaire to all High Schools (Appendix 2) within the target area.

Selection of Service Providers

Rather than using a sample population, which would not allow me to achieve my objectives, I aimed at a "complete coverage" (Moser and Kalton, 1971:54) of known service providers. This was more difficult than expected as I had to collect, analyse and present results from seven providers and eight schools. It wasn't until I actually started to collect the information that I realised an enormous amount of time and energy would be needed to analyse, present the results and draw conclusions.

As mentioned previously my knowledge of local agencies providing the services was minimal. I was however aware of groups providing information/programmes on violence while others worked specifically with children and/or adolescents. It was these groups I initially contacted about my research subject. After discussing the issue, these groups then suggested other providers. From this word-of-mouth method (all completed by telephone) I made contact with a number of local agencies, five saying they provide sexuality education programmes for adolescents. I had also heard over the local Iwi radio station of a group running a programme on AIDS awareness. While speaking with this group I was advised of two other groups who were providing similar services for adolescents but when contacted only one group had a programme specifically for teenagers.

In all, seven vastly different groups (for example one group abiding by Christian philosophies while another having a feminist perspective) within the target area

had developed and were providing services that taught adolescents how they were able to determine and develop their sexuality. The programmes would also assist the teenagers to know that safe and responsible relationships would not only enhance their sexual well-being, but increase their life potential.

The Interviews

As previously stated appointment times were scheduled with interviews being conducted at the providers workplace. Unfortunately not all went to plan as will be discussed later. However, Patton (1990:143) states that you must "always be suspicious of data collection that goes according to plan". I was initially concerned that I was asking these groups to spend a good hour or so of their time talking to me when they would probably be meeting with a client. As a social worker I am aware of the time and demands placed on them by the community and the (sometimes) little recognition they receive. I was however heartened by their enthusiasm and willingness to share and totally impressed with their skills and initiative.

The interviews were semi-structured. Although I received a response to all questions, at times the order of the questions would change. Sometimes, even though only one question was asked the response answered a number of the other questions. From the interviews, I gathered all information I had intentionally set out to gain without having to apply a rigid and inflexible approach to questioning.

Data collection methods

In response to the varying circumstances of the providers, four different

methods were employed to collect data. The methods used were: two groups responded to the questionnaire by returning a written response. Due to an unplanned reshuffling of their timetables they were unable to meet with me at the scheduled time. Moser and Kalton (1971: 256) refer to this method as "mail questionnaires". With Rea and Parker (1992:86) they discuss not only the advantages but also warn of the problems when analysing the data. The most noticeable disadvantage I faced with this method was having to accept their response as final. I was unable to probe nor seek clarification without taking up more of their time. This was also the case with information received from the schools.

The remaining five interviews were all face-to-face. However, the recording of their responses differed. I recorded one provider's interview by way of tape recorder. I transcribed the information. Three other providers talked while I wrote their responses. Another participant had recorded their responses on the questionnaire prior to my visit. The only action I needed to take on this latter visit was to clarify these written statements. Any further comments were recorded on the questionnaire. This same provider shared an office with a colleague and this other person, at times, would contribute to the interview when necessary. Apart from this occasion, the remaining four interviews were conducted on a one-to-one basis. Prior to concluding the interviews I had each provider confirm (verbally) my written statements. Any incorrect statements were changed prior to my leaving the interview place.

Regarding the High Schools, in total eight questionnaires were forwarded (included was a self addressed stamped envelope) and six returned. In this instance, my aim of obtaining a complete sample was not achieved. Further, I would have to speculate about why these schools failed to respond, and

suggest that perhaps these were schools not providing sex education for their pupils, and thus creating a gap in service provision.

Data Analysis

I transcribed the one interview from the audio tape and even though I found it to be time consuming (and in a way glad I had not taped any other interviews) I believe it is the preferable method to record information. This is because I was able to take time with the provider and absorb what they were saying rather than worrying about whether I had written the correct information down. Although having the interview recorded seemed intrusive there was a more relaxed and natural interaction between the provider and myself. An obvious disadvantage when not using a tape to record the interview is the lack of quotations in the finished work. Since qualitative analysis deals with words, getting correct information "rests on the ability to systematically identify and interpret meaningful patterns of response and inter-relationships in what is said by and/or observed about respondents" (Reviere, Berkowitz,Carter & Ferguson, 1996:64).

In order to analyse the data, responses were re-written on to separate sheets of paper (each provider having their "own" sheets of paper). I then hung these pieces of paper onto my walls. By doing this similarities and differences were easily observed. I then tabled the responses from questions 3,6,7,8,9, and 14 and compared the themes - target group, training, supervision, evaluation of the programme, awareness of other similar providers and funding.

A similar method was used with the High School responses. All responses, except question 6, from the High Schools were re-written. With only six High

Schools responding the analysis was a relatively simple exercise.

Ethical Issues

The purpose of this report was to identify and examine agencies providing sexual health programmes to teenagers. An earlier section outlines the methods employed to collect data. Without restating that information it is sufficient to say that once I had identified the agencies each was contacted and asked whether they would share their information with me. The interviews were conducted only if the provider agreed. Oral consent was gained. At no time were providers pressured into participating. Prior to meeting with the agency representative questionnaires were forwarded therefore giving each the opportunity to read the questions and decide whether they would answer all, some or none of the questions. Providers could withdraw from the project at any time. Once results were collated and analysed the final document would outline available services of the providers. The report would also be made available to social workers and other interested groups. This meant that all information from the interviews had to be recorded accurately as generally the wider public would have access to it.

Finch (1984:71) believes that since research is a political act involving aspects of power it has the potential to exploit those studied. However, due to the nature of this report there were no issues of power. This is because I was working in consultation with the organisations. They were advising me of their services and therefore described only the information they wanted to be made available. In this respect, both participant and researcher appeared to be dependent on each other. By this I mean that while the participant was viewing me as a vehicle that would make their services accessible to a wide range of

people, I viewed them as assisting me in my employment as well as helping me gain a post graduate qualification. In this respect, there was no conflict of interest nor conflict in roles. I believe we were clear about our own expectations and what was required from the other.

Due to the purpose of this research and the accessibility of the final document there are no issues regarding confidentiality. Neither is there any potential harm to the participant, university or myself.

Once these ethical factors were taken into account, it was agreed (with my research supervisors) that the nature of the report did not require the approval of the Massey University Human Ethics Committee. In saying this however, I believe my professional ethics as a social worker have guided my actions continually throughout this project. Being aware of ethical issues is an ongoing process for social workers.

Summary

Despite forwarding the questionnaires to providers prior to meeting with them, the interview process was lengthy but very enlightening and an excellent way of making useful contacts in the community. Because of the links between our agencies, the conversation at times ranged beyond the strict confines of this project. This no doubt was a reason why the interviews were lengthy. On average each interview lasted approximately ninety minutes. I clearly benefitted from the sharing of information from a professional and academic level. Professional relationships and alliances were forged and our respective agencies have now begun liaising with each other.

The interviews gave providers an opportunity to share their view of adolescence and their responsibility to provide what they believe are appropriate services to the age-group that might enable them to make informed decisions about their sexuality. Their determination to work with this age-group highlights their commitment.

There is also no doubt that High Schools have the opportunity to play a significant role in educating students (and possibly parents) on sexuality. Legislation provides schools with the opportunity to do so but community values coupled with schools' philosophical perspectives may at times adversely affect a schools' ability to develop and implement appropriate programmes.

Chapter 4

RESEARCH FINDINGS

Introduction

This chapter presents the findings from the analysis of information provided by seven service providers and six High Schools in New Plymouth that were identified as providing sexual health programmes to adolescents (some through a sexuality education programme). Funding agencies demand that providers consistently meet the needs of individuals and groups. Should consistency and accountability be achieved an organisation's funding is likely to continue and thus a continuity of services. By designing appropriate programmes that are effective and targeted to the client base demonstrates a knowledge of client needs. Achieving better outcomes for clients is accomplished by constantly monitoring performance and evaluating service delivery.

This chapter is divided into a number of sections. In the first section I outline the non-sexual health services of the providers and consider issues such as funding, training and management structure. Next this information is analysed. Following this section I will highlight the sexual health education programmes and discuss gaps each provider has identified. Prior to concluding the chapter I will outline my findings from the High schools. Tables of information for both service providers and schools are included.

GENERAL INFORMATION ABOUT SERVICE PROVIDERS

Health Promotion Unit

The Health Promotion Unit has been established as a department of Taranaki Healthcare for approximately five years. There are currently four workers employed to develop, promote and deliver programmes. The primary areas of focus are sexuality, smokefree issues, healthy lifestyles and alcohol awareness. The Unit has identified a number of aims of the organisation. These aims are focused around sexual responsibility and include reducing the number of unplanned pregnancies, reducing the incidence of sexually transmitted diseases and reducing the abortion rate.

Although the Unit prepares, co-ordinates and teaches programmes to school students (in the school setting) it views itself more as a promoter of health rather than an educator of health. This was explained as a health educator providing relevant information and teaching techniques to, for example, a public health nurse. The public health nurse would then teach the programme to a particular group. The Unit believes health promotion is about the community taking control of the processes. They (the Unit) would act as facilitator and/or trainer. In order to promote itself within the community the Unit creates an awareness of current health issues through media campaigns. Even though they perceive themselves as facilitators and trainers, the Unit works with both community groups and other professionals. This allows them to maintain their role as facilitator and trainer as they provide health education training and information to educators. However, it was acknowledged that the Unit does initiate programmes for some community groups when required. By identifying and working with those people who are missing out on mainstream education and health the Unit will make submissions on policies

that are likely to affect the health of the public locally. They identify mainly Maori and low income earners as those outside of the mainstream.

Despite being a Crown Health organisation, the Unit does not perceive itself to be outside the realms of community based groups. Rather it structures its information and programmes so that it complements the existing programmes of other service providers.

The Unit does not provide services to any primary schools within the New Plymouth area. However, of interest is that Unit members were recently invited to speak with children from an Intermediate school. The brief was to discuss the issue of AIDS only. No information regarding sexuality was to be discussed.

As with most statutory and crown agents, Taranaki Healthcare is a very management-structured environment with the most senior of positions being a Chief Executive Officer. The Unit is accountable and reports to their team leader, who reports to the Unit Manager.

Supervision occurs on a monthly basis. However, the Unit has no formal mechanism for this in place. There is a need for the Unit to keep up to date with information regarding health and as such, the teams' knowledge on health research, techniques and literature is current.

Family Planning Association (FPA)

The FPA was first established in 1936 and was at that time in danger of facing criminal charges for distributing "obscene" information to women about contraception. Now they openly state their goals as being "to increase

the availability of information so people of all ages can make informed choices about their sexual and reproductive health; to increase access to quality sexual and reproductive health services, and to strengthen the Association and ensure its financial viability and its accountability to clients, funders, staff and members" (From FPA Information pamphlet, undated).

The Association has been a major promoter of classroom sex education and sexual health clinics in New Zealand schools. They claim to be non-judgmental in their approach and believe individuals, especially teenagers, need to make informed decisions about their sexual and reproductive health. All educators are qualified and work with children of any age (from pre-school to secondary school), young people from community groups, community groups or people interested in sexual health. Educators are also available to work with parents and early childhood groups.

The training educators receive is provided by the FPA. Topics covered in the training includes physiology and anatomy, relationships and communicating about sexuality within the family. Training is ongoing with educators attending relevant courses throughout the country. This ensures they are kept up to date with information and procedures.

The FPA also have clinical services that provide a wide range of services from advice on contraception, cervical screening, STD screening and treatment, pregnancy testing, coping with premenstrual syndrome and menopause advice and treatment, to performing operations. In Auckland the Association provides a counselling service including vasectomy counselling. Counsellors offer help to people who need to talk about fertility, relationships, unplanned pregnancy, sexual abuse or any matter affecting their health.

FPA provides training for other health and education professionals. Courses are attended by medical practitioners, teachers, community, youth and statutory social workers. The courses contain information on sexual and reproductive health. At the end of every course all participants are asked to complete an evaluation. Results are collated and performance monitored.

Also available for the public is a mail order service. The FPA's Resource Unit produces and provides a wide range of resources and pamphlets on sexuality and sexual health. This Unit is located in Auckland.

Other education services include courses and workshops relating to menopause, relationships, fertility, women's sexual health, sexuality for people with disabilities, male sexuality, sexual orientation and gender issues.

Formal supervision for the educator occurs once per month for approximately one hour. Sometimes this occurs by telephone as the supervisor is based in Wellington. Informal supervision occurs approximately once or twice weekly.

More than half of the FPA's annual budget is funded by the Government through Regional Health Authorities while other funds are received from sale of resources, donations, fees, grants as well as contract fees.

A national body manages the FPA. The Taranaki educator although being primarily independent is accountable to the managing body through her education service manager.

Team Xtreme

Team Xtreme was founded in Auckland in 1993 as a division of Lifeways Trust

Incorporated but are now a division of Gateway Community Trust Incorporated. Their philosophy is Christian based and centers on the premise that adolescents have the ability to realise their potential as unique individuals and by being aware of the issues that contribute to their health and well-being they will eventually be able to establish a basic set of life principles that will provide them with a foundation for a constructive life. Although this may mean confronting and challenging their own personal values, attitudes and actions, by doing so adolescents will gain the skills to reason, view situations and consider consequences including future effects on their personal health and the health of those around them. This learning will help them make positive choices and confident decisions, increase their own self esteem, confidence and motivation.

Team Xtreme Taranaki are a group of life skills educators and have been serving Taranaki schools since 1994. They describe themselves as being "passionate" about young people. Their work involves building a young person's self esteem, assisting in skill development which helps to set goals and assisting the young person to make positive decisions. Team Xtreme also supports the peer education concept as they believe young people are able to learn from others of their own age group.

Supervision, or peer review occurs after each class where each of the presenters evaluates their performance as well as considering how receptive or non-receptive the students were. A formal evaluation is completed by students at the end of the block course.

A life skills education programme is also provided by Team Xtreme. This programme includes the teaching of concepts such as uniqueness, (by

introducing individuals to their uniqueness and alerting them to ways in which society can squeeze them into moulds, the young person will learn to deal with society pressures and demands) and self-esteem. The building and the increasing of one's self esteem will help individuals gain a positive view of themselves thereby allowing them to concentrate and further develop their self image.

Another programme issue is termed "brain food". This, they claim, helps individuals appreciate that what they feed their minds can have a major effect on how they respond in certain circumstances. Following on from this is decision making. This helps students understand the processes that govern decision making. Due to the pressures and stresses Team Xtreme regularly see in today's environment, another component of the programme is anger management. By accepting and learning to manage their feelings young people will not be controlled by them, therefore self control is promoted. Coping with peer pressure is arguably one of the most challenging stresses for the age-group and so by re-emphasising their uniqueness, students are taught methods which will assist them to cope with both negative and positive aspects of peer pressure. There is also a personal challenge component called "challenge exposure" utilising outdoor activities aimed at building group dynamics and working relationships. The activities include abseiling, confidence courses, horse riding, rock climbing and team building. Finally, goal setting - by promoting forward thinking students will learn how to plan for their future (Team Xtreme pamphlet).

The target group is 12 to 15 year old students. An adult self esteem course is also provided.

Regarding training, Team Xtreme educators undergo an intensive in-house twenty week course, a three day course on HIV as well as other relevant courses throughout the year. Participation on these courses where interactive learning is encouraged builds their skills in character development, leadership, communication, vision and goal setting and research.

Funding is an ongoing issue. Although they are a division of an Auckland based group, Team Xtreme Taranaki still has to apply for grants from various community organisations.

The Management structure includes a National Director, Regional Manager and Regional Co-ordinator. There are currently five teams nationwide and each team has an advisory board.

Rape Crisis

Rape Crisis is a service provider that supports and empowers women and children survivors of current and historical sexual assault. The support and empowerment are provided by women through counselling and education.

Rape Crisis offers a 24 hour crisis telephone line, advocacy and support through the legal system, "community education where educators are available for speaking engagements, workshops, public relations functions, training courses or providing information, public and private sector employment training for courses on sexual harassment awareness, assistance in setting up a sexual harassment free work environment and sexual harassment policy drafting service" (Rape Crisis pamphlet titled "Education Programmes").

Training is an ongoing process. Prior to teaching in the schools, the New

Plymouth educator attended an adult educator course gaining a teaching certificate. She has also attended relevant courses pertinent to young people and has the opportunity to attend youth workshops. Peer supervision occurs on site regularly while outside supervision occurs approximately once monthly.

One of the advantages is obviously working with trained counsellors who are available to discuss issues when required.

Funding occurs at a local level and two people are employed to regularly apply for funds from different local and national sources. Rape Crisis's organisational structure is that of a collective with each of the 23 collectives within the country being autonomous and independent but having a common link through the national body. Each collective is a strongly political body that provides a public profile for the issue of rape and works towards the elimination of violence against women and children. A number of collectives form part of a region and each region nominates a woman who becomes their representative. The regional representatives form the core group and it is the core group who are the decision makers for the organisation. This group employs the workers at the national office and direct how things should be run.

New Plymouth Young Peoples Trust

The New Plymouth Young Peoples Trust was established approximately seven years ago as a referral agency. At the time young people would be referred from the Trust to different agencies for assistance. The Trust then started receiving referrals and young people were referred back to the Trust. Today it is an information, referral, support, counselling, education, advocacy and consultancy centre mainly for young people up to the age of 25, although no one is turned away. The aims of the Trust are that clients receive a service

which is "effective and non judgmental, focused on the immediate needs of young clients and delivered from a young person's perspective by bringing other appropriate services to the young people at the centre. A safe environment is provided in which people are encouraged to seek help and support, assisting young people towards personal growth, confidence and the making of their own decisions, providing accurate, up to date information and appropriate referral to young people, culturally sensitive, to keep the belief that young people have the right to be heard" (Young Peoples Trust pamphlet).

All staff receive training. This is usually provided by other Trust employees, the Trust Co-ordinator, the FPA sexuality educator or a representative from the Health Promotion Unit. Training was explained as being an ongoing process as the Trust believe it necessary to keep up to date with information on issues affecting young people. Staff also need to be multi-skilled. They do not believe that a reliable service is provided unless they are aware of issues affecting their client group. Some issues described included Work and Income New Zealand entitlements (and generally the WINZ "system" of payment), relationships, sexuality issues, rights of young people and purchase/finance agreements. The Trust also have a number of medical doctors and solicitors available to provide immediate assistance to young people who may require specialist intervention.

Peer supervision occurs regularly. Every course or programme is evaluated at its completion.

The Trust also has cultural advisors who participate in some of the courses especially if the course is being attended by young people of similar ethnic origin. The advisors are also available to assist during programme design.

The management of the Trust is under the control of a Management Board. They approve all programmes. The Trust Co-ordinator is directly accountable to the Board. A Youth Management Committee has also been established.

Funding is an ongoing concern. They have received funds from Community Funding Agency, Midland Health and continue to apply for other grants from various sources.

The final two service providers forwarded their information to me in writing. No follow up with either has occurred and therefore the information has been taken directly from their submitted written reports.

Public Health Nurses

Public Health Nurses (PHNs) are trained medical providers. They have been a part of the New Zealand health care system for many years. They have been restructured on numerous occasions with job descriptions also changing. Currently, a number of community people rely and are dependent on their expertise for health assistance. PHNs are seen regularly in schools, places of employment and training schemes.

Health Clinics within schools are run by the PHNs, making them extremely accessible to all students. All students are advised of clinic hours as are parents. Due to this accessibility, PHNs see themselves as the health resource people for schools and the school's community. Some PHNs are actively involved in the school and although they may not provide actual programmes are available for confidential one-to-one consultations with students.

PHNs attend training run by the FPA sexuality educator. They also have regular

in-service courses which ensures their knowledge is current and they attend teaching methods courses. Supervision occurs regularly.

Health funding is from Midlands CHE and although this has now been restructured, funds are still coming through. PHNs are one sector within Taranaki Healthcare Limited and therefore fall under that organisation's management structure.

SAFER Centre

The SAFER (Sexual Abuse Family Education and Rehabilitation) Centre was established in 1989 as a counselling agency providing crisis counselling for victims of rape and sexual abuse. This still occurs today. However, the Centre has developed and also provides physical, sexual, psychological abuse prevention programmes for specific individuals or specified groups. These target groups and individuals have been identified by either the SAFER Centre or an external agency.

Training for these programmes is extensive and ongoing as trainers need to keep abreast of current trends. Supervision is provided regularly, with trainers having fortnightly clinical sessions with a visiting (out of town) psychologist, monthly peer sessions with a local psychologist and monthly personal supervision.

As mentioned previously, the SAFER Centre provides counselling related to most behaviour problems with the exception to specialist drug and alcohol and mental health issues. The services are available to all age groups independent of gender. The Centre has two specialist child counsellors.

ANALYSES

The main issue of interest for me was that five community agencies provided some form of sexual health education programmes for adolescents compared with two groups that are either partially or fully funded by a Crown entity. This demonstrates that the majority of community-based agencies are given the responsibility to provide and maintain services despite there being no assurance that funding will continue from one year to the next. The actual number of community agencies providing sexual health education programmes changes when one considers that individual counsellors/therapists and other New Plymouth counselling agencies such as the Aurora Centre, Relationship Services, Barnados and the Taranaki Family Centre also provide one-to-one sexuality counselling for clients. Although these professionals do not provide specific programmes for groups or individuals they do discuss sexuality issues with their client should the need arise. Combined with this is the fact that the community groups also provide a number of other services, that each programme trainer receives some form of formal supervision and understandably all evaluate performance which no doubt is necessary to ensure objectives are being met and therefore funding will continue.

One provider (Health Promotion Unit) claimed it did not have a formal supervision mechanism in place. However, some form of peer review occurred albeit on a monthly basis. Without this type of oversight I would argue that it would be difficult for the employer to ensure agency objectives were being met, that "safe" practice is being promoted and that there is inability to measure consistency between the employee's work and the goals of the organisation.

Most also receive some form of public funding which suggests a high level of accountability to the funding agency(s) and that the services are meeting the needs of the community.

SEXUAL HEALTH AND EDUCATION PROGRAMMES

The following are the sexual health education programmes of the seven identified service providers. Also discussed are the gaps or concerns of the provider in terms of funding, resources, training and advertising.

Health Promotion Unit

The Health Promotion Unit provides information on sexuality in a number of ways. They work with BENT which is a gay and lesbian group and assist individuals come to terms with their sexual orientation. The Unit receives referrals from schools and use the peer sexuality programme concept. This is their main method of working. Issues discussed on the peer sexuality training include sexual and non-sexual relationships, discussing the influences on sexual activity such as peer pressure and recognising the link between alcohol, drugs and unsafe sex. Target group are students in forms four to six.

Gaps the Unit has identified include the lack of resources. For example, if there was more money, they could employ more people and do more work. I was told that "we want to keep working with people other people have difficulty working with".

The unit advised that they want to work "in the gap" and identified "gaps" as being "no one is working with parents on teaching them how to talk to their kids about sexuality". Also, although some groups are now working in this

area there are not many groups working with disabled people and teaching them about their own sexuality. Sexuality, the Unit believes, needs to be taught to children at a young age but unfortunately the majority of primary schools do not allow this.

Family Planning Association

The FPA educator is contracted by groups, including schools, to provide sexuality programmes to their students. The programmes are pre-existing and approved at a national level however every educator has the ability to adapt the programmes as they see fit.

The Taranaki educator provides both one-off sessions, usually 1 ½ hours in duration, and school programmes. A programme for schools is run over three weeks with each session being approximately one hour per week. The youngest students in a classroom setting are form four students. Prior to beginning each course and again at the end of the session, the educator has each student fill out a "Safer Sex Quiz". The purpose is to determine the level of knowledge each student has on safe sex. Course content includes puberty changes, how a person becomes pregnant, physical intimacy continuum and dealing with pressure.

Interactive learning is promoted however educators are aware of students possibly being embarrassed and shy. Programmes are presented with clarity and relevance and learning is made to be fun.

Team Xtreme

The aim of Team Xtreme Taranaki is to prevent youth issues by providing greater self esteem amongst the young people of Taranaki. Team Xtreme

Taranaki is contracted to provide programmes to schools. The sexuality education programme is based on forming and maintaining a loving relationship, valuing ones sexuality and respecting yourself in spite of pressures. Team Xtreme also promote the concept of no premarital sex, admittedly unusual in the current times, given that many people do not marry. However Team Xtreme's focus is realistic in that provided teenagers are given all the information regarding sexual health choices will be made on an informed basis.

In order to break away from the traditional classroom setting, four or five team members provide the programme to each class. The purpose is to allow small group discussions that will hopefully provide a non-threatening environment in which students will be able to express themselves more freely. The target group of their programme are 14 to 17 year olds. Team Xtreme Taranaki provides an eight week challenge programme, with each session being approximately one hour in duration. The programme is described as a "strategy of prevention" in that the educators challenge and positively influence behaviour through discussion, storytelling, drama, team building activities and small group interaction.

Although this group is aware of other service providers they believe their programme is more focused on "values".

The participant from Team Xtreme was not sure whether there were any gaps in the service they provided nor was she sure as to whether there were any gaps in the area of adolescent sexual health education.

Rape Crisis

The aim of all education courses is to provide quality education that will promote healthy relationships, raise an awareness of sexual violence in our community and empower people to work together towards a safer society.

School courses are provided for third to sixth form pupils. The duration of the programme is dependent on the school with programmes running from only one hour to five one hour sessions. Course content includes sexual harassment, date rape, relationship and friendship issues, gender issues (for example, what is it like for the opposite sex), development and confidence growing for girls (such as having a sense of who they are and being valuable), changing girls' perspectives about being female especially when they say that the "bad thing about being a girl is that you're not a boy", considering perspectives and myths regarding behaviour expectations.

Interactive learning is emphasized with students role playing different scenarios as well as discussing the scenarios. Each programme is evaluated by the students. Feedback has been positive.

In 1996 Rape Crisis New Plymouth wrote letters to a number of High Schools offering courses on date rape. It is interesting to note that no school responded until the educator personally contacted the schools. Four referrals were later received. However, the educator was told that the subject of date rape was only to be discussed with older students - this still stands in some schools today. Also, 7th formers do not participate in sexual health education programmes as they are "too busy". Today, Rape Crisis provides sexual health education programmes to a number of schools.

The educator, rather than identifying gaps, raised some concerns. These were that some schools are reactionary and only ask for programmes after an event. To enable her to provide a more focussed programme, the educator wanted to know exactly what it was that motivated the school to contact her. She also believed that her role and purpose in the school would be far more effective if she was aware of programmes students had previously participated in. Although she does not hesitate to provide programmes, the educator does not believe students gain much of an awareness of the sexual health issues by only attending one or two sessions. While critical of schools that refuse to educate students on sexual health matters, the educator also voiced her concern towards schools that choose to ignore sexual health information. The educator also stated that even when she prepares sexual health education programme packages to schools some teachers have commented that her information is not necessary as "it doesn't happen to our girls", or "our girls aren't like that". The educator believes that adults or those in teaching or positions of leadership have to be educated about sexuality instead of believing and perpetuating the myths.

New Plymouth Young Peoples Trust

A number of programmes are run by the Trust. One course is described as a two hour "one-off" information session where participants are given information on AIDS awareness, alcohol dependency/issues, pregnancy help and awareness for teenagers, STD awareness, self awareness and sexual orientation.

Another course provided runs for six to eight weeks. Included in this course are the above topics which are covered more fully. Participants bring their own sexuality issues with them and some find the forum a safe place to discuss

these issues.

One of the gaps identified by the Trust was the lack of substantial evaluation and monitoring (in relation to sexuality education). An example I was told concerned a young woman who told her partner he didn't need to wear a condom during sex as she was taking the pill and therefore couldn't get pregnant. This example the Trust believed highlighted the fact that there was "too much information" being distributed yet the information was "not being fully understood". They believe that the right design for services should be to "keep it simple and build on it" and that all information has to be age appropriate.

Public Health Nurses

Public Health Nurses receive referrals from teachers, parents, other agencies or people self referral. They provide programmes in schools by assisting teachers although some PHNs may do one to two sessions with students. Each session is approximately one hour in duration and FPA resources are used as course content. The target group PHN work with are all high school students as well as Intermediate students. When necessary, PHNs do provide sexual health education programmes for adolescents at school but this is usually at the request of the actual health teacher and the programmes are formatted.

PHNs have identified time has being a gap. They say that it is a constraint as they only have so many hours at a school. They believe more hours, if not a full-time position, are necessary.

SAFER Centre

The SAFER Centre provides two programmes both having a sexuality component built in to the designs The first programme discussed is an educational sexual harassment and bullying programme presented to adolescent groups. Course content includes information relating to the process of offending behaviour, cycle of behaviour and dealing with behaviour and where to seek assistance (for both victim and offender).

The programme is a one-off 90 minute presentation and any referred adolescent attends. These young people have been identified as being "at risk" from various community groups the young people associate with. Although the presentations usually occur at the premises of the referring agency venue locations are always negotiable. The trainers who deliver this programme have all received specific training as sexual abuse counselors and group facilitators. Ongoing training is an essential requirement. Satisfaction is usually evaluated by the referral agency.

The second sexuality education programme provided by the SAFER is called the "CHANGE" programme. It targets only medium to high risk adolescent sex offenders. The programme is considered to be an educational therapy programme. Course content includes education relating to addiction, offending cycle and contributing factors, causation, effects on victims and social systems, emotional issues related to offending, past abuse, victim empathy, self esteem and relapse prevention.

Referrals are received from the Department of Child Youth and Family Services. Others as identified by the SAFER Centre are also placed on this programme - in negotiation with the young person's family.

Due to the seriousness of the offending, the programme is based on SAFER Centre premises. Depending on the level of risk, the young person may stay on the programme from six months to two years with some young people staying on the programme longer than 2 years. Each young person has at least one hour on a one-to-one basis with a counselor per week, as well as 1.5 hours of group therapy. At times the young men have home work to complete.

The SAFER Centre is contracted by STOP to provide this programme. The SAFER Centre is the only agency in New Plymouth offering this level of service. It is therefore necessary that they maintain links with other national service providers. The programme targets only medium to high risk male adolescent sex offenders.

SUMMARY

Initially, I was interested in knowing whether agencies advertised their services to the public. This interest was due to the fact that we as social work group did not know many of them and so I assumed that other members of the public would be in a similar situation. Now, after meeting with the groups, I am aware that the advertising of services is not necessary. This is because most groups are contracted to provide services to a specific group by way of referral and more importantly that the public are aware of the agencies. This is not to say that the groups have never advertised. The Rape Crisis participant explained that she had to actively canvass schools and promote their programmes to the community. It now seems that all the groups are well established and their services well-known (except by statutory social workers) within the common work environment. All agencies were aware of other providers of sexual health programmes and most are aware of the lack of resources

targeted for the disabled.

Although five groups provided some form of regular supervision to their programme presenters there was a variation in the type and quality. Whereas some presenters receive supervision on a regular basis (such as Rape Crisis and SAFER Centre), others receive it irregularly using a peer review process (such as Health Promotion Unit and Team Xtreme).

Throughout the year four groups regularly make application to various bodies for funding. In comparison two groups are fully funded by government while one group receives partial funding from government.

Table 4.1 below highlights the identified results of the service providers.

Table 4.1: SELECTED SIMILARITIES AND DIFFERENCES OF SERVICE PROVIDERS

	TARGET GROUP	*TRAINING*	*REGULR SUPERV*	*EVALUATE*	*? OTHERS*	*FUNDING*
HPU	TEENS	IN HOUSE	NO	YES	YES	GOVT
FPA	TEENS	YES	NO	YES	YES	OTHERS/ GOVT
PHN	FM 2 PLUS	YES	YES	YES	YES	GOVT
YPT	TEENS	YES	YES	YES	YES	ONGOING
RC	ANY	YES	YES	YES	YES	ONGOING
TM XTRM	3-6 FM	YES	YES	YES	YES	ONGOING
SAFER	TEENS	YES	YES	YES	YES	ONGOING

Key to table:

HPU - Health Promotion Unit

FPA - Family Planning Association

PHN - Public Health Nurse

YPT - New Plymouth Young Peoples Trust

RC - Rape Crisis

TM XTRM - Team Xtreme

SAFER - SAFER Centre

REGULAR SUPERV - Whether supervision (as earlier defined) is provided ? OTHERS - Whether groups are aware of other sexual health education programme providers

SCHOOL SURVEY RESULTS

I did not ask the schools to identify themselves so have labelled them as school 1, 2 through to school 6. By allowing the schools to remain anonymous I have not been able to seek clarification. The anonymity was deliberate as the purpose of the study is to determine whether schools are providing sexual health education programmes. I am not seeking to evaluate the programmes.

The course content between each school is similar however different classes receive different information. I have documented the results of course content only as other responses are tabled (Table 4.2).

Course Content

School 1 teaches pubertal changes to their form 2 students. Included in these lessons are information relating to internal/external changes, periods, erection,

wet dreams, masturbation, emotions and hygiene. A father/parent/son night is organised with this age group as well. The older classes receive information pertaining to relationships, body changes and image, healthy relationships and sexuality. There are some group discussions on STDs and safe sex.

School 2 starts teaching years 7 and 8 students about pubertal changes and hygiene while year 9 students begin considering issues such as STDs and contraception. The following year, the year 10 students revisit issues discussed over previous years. Year 11 classes talk more in depth about contraception, pregnancy, AIDS and HIV. Unit standards for the year 12 students are currently being investigated.

From fourth form, school 3 introduces issues such as conception, human reproduction and physiology. The fifth formers begin discussing relationships, contraception, STD's, sexual harassment and sexual abuse. Both sixth and seventh formers receive further information on contraception and STDs.

School 4 described their year 10 programme. During these classes an emphasis is placed on relationships and consequences of having a sexual relationship. Other course components are gender stereotyping (including issues such as gender roles, body image, tasks), puberty, maturation, contraception (STDs and AIDS), consequences of relationships (chances and choices) and a module concerning rights and the law.

School 5 teach similar concepts. They have listed as their course content issues concerning biological changes, sexuality needing to be considered as only one aspect of self, societal pressures (being influenced by media, peers,

own belief system), value of self, choices and responses, keeping self safe and communicating and understanding emotions. School 5 informs students of various agencies and services within the community should they require support and/or further sexual health education.

School 6 gave me a complete copy of their course content. Students begin the health education programme in form three. Course structure for third formers is divided into two units. The first unit deals with issues of self-esteem, periods, self evaluation and appraisal, families (and family break up), friends, anger and stealing. Unit two introduces concepts and issues surrounding smoking, boyfriends, conception, contraception, alcohol, assertiveness, decision making, body image, being "sunsmart" and vandalism. In form four, the first session seeks to determine students views on the holistic concept of health. Further classes include a session called "Uniquely, Individually Me". Issues relating to alcohol, drugs, relationships, mental health, body image, food and eating habits and lifestyle choices are discussed. During the second term, students are introduced to an interactive workshop called "Sexwise - Theatre in Health Education Trust". Fifth formers review some of the previous issues but now gain more in-depth information regarding sexual decisions, contraception, STDs, alcohol and drugs. The time spent in these classes reduces when students enter the sixth form. Students receive approximately 16 hours per year from the health education curriculum.

Course components includes sexual decisions and relationships, contraception, STDs, cervical smears, sexual pressure, date rape, keeping safe, pregnancy, alcohol, drugs, depression and end with a self appraisal of their lifestyle. Seventh formers receive approximately 10 sessions of the health

curriculum per year. They discuss issues such as stress management, nutrition, alcohol and drugs, relationships, alcohol, contraception, STDs, pregnancy and rape.

Table 4.2 demonstrates other differences and similarities between six of the High Schools within in the New Plymouth area.

Table 4.2: DIFFERENCES AND SIMILARITIES IN HIGH SCHOOLS

SCHOOL 6	YES	FM 3 TO 7	UP TO 12 HRS	HEALTH TEACHER	HEALTH CO-ORD	3 IN 3 YEARS
SCHOOL 5	YES	FM 4 & 5	VARIES	PHN, FPA, OTHERS	PARENTS CNSULTS TEACHRS OTHERS	6
SCHOOL 4	YES	FM 4 & 5	8 HRS	SCHOOL	HEALTH CO-ORD	2
SCHOOL 3	YES	FM 4 TO 7	UP TO 40 HRS	SCHOOL PHN	SCHOOL PHN	1
SCHOOL 2	YES	FM 3 TO 6	UP TO 13 HOURS	PHN SCHOOL	SCHOOL CNSULT	NO
SCHOOL 1	YES	FM 2 TO 6	2 WEEKS	SCHOOL	HEALTH DEPT/ CHURCH	NO
	PROVIDER	***CLASSES***	***DURATN***	***WHO TEACHES***	***WHO DEVELPED***	***OPPOS-ITION***

Key to table:

DURATN - Length of course

PHN - Public Health Nurse

FPA - Family Planning Association Educator

CNSULTS - Consultants

Discussion of Tabled Results

There is a great variation among the schools regarding the sexual health education programmes. The only similarity appears to be that all schools provide these programmes.

School 1 reported that a number of their teachers teach the course. They listed these teachers as being science teachers, RE teacher, transition teacher and other school teachers. Their course developers included Health Department representatives as well as ecclesiastical leaders.

School 2 only uses school teachers or a public health nurse to teach the programme. The school teachers are the trained health teachers from years 9 to 12. The years 7 and 8 students are taught by their classroom teachers. The course was developed by the health teacher along with a Massey College of Education consultant.

School 3 also uses a number of people to teach the programme. Form 4 students are taught by a public health nurse and science teacher, while form 5 students are taught by the transition teacher. The sexual health programmes are taught to form 6 and 7 students by self management teachers. These teachers also developed the course for their respective classes.

The School 4 health teacher teaches the course while the school health co-ordinator developed the programme for the school.

School 5 uses an array of teachers to provide course information to their students. This school reported that class teachers, school counsellor, school health teachers, public health nurses, the Rape Crisis educator and Family Planning Association educator all at some point teach the sexual health programme to their students.

The health teachers from school 6 teach the sexual health programme. The course was developed by the health co-ordinator.

Opposition Towards Programmes

The opposition schools have experienced (see final column) has been that although school 1 has not received any formal complaints they have had some queries from parents regarding contraception. School 1 identified itself as a Catholic school. School 3 claimed that one parent was displeased with the human physiology course, particularly the diagrams. Some parents from school 4 were concerned that homosexuality had been discussed during a lesson. School 5 has seen 6 parents complain to them as the lessons challenged and contradicted their belief systems. The school considers this as being minor since they have a roll of at least 400. School 6 reported that 3 parents had made a complaint to the school and as such removed their children from the classes.

Gaps in School Programmes

Although schools need to be commended for including sexual health programmes in their curriculum I would argue that attitudes towards the programmes by some members of the teaching staff make the courses ineffective. I would also suggest that some schools have programmes not because they want them but because of the provisions (and possibly

understanding) of the health syllabus. In other words it seems as though the programmes are "fillers" and not to be taken seriously. These comments are based on statements from the providers (such as the Rape Crisis representative), the length of the entire programme (for example a few hours over a term), that the programme is not offered to particular form classes and the right parents have to withdraw their children from these classes. I would have to speculate that these attitudes are perpetuated because the classes do not assist a person to progress academically, that teachers may fear or feel uncomfortable with the subject, parental opposition and because of the social and intellectual front schools need to uphold in order to attract students and funding.

Conclusion

In conclusion it would seem from the information gathered that adolescents who live within the New Plymouth District Council's boundary have the opportunity to be informed about issues regarding their sexual health. The information given to school attending teenagers appears to be similar which would suggest that, a part from any intellectual disability, most adolescents receive similar messages about their sexual health and well-being regardless of the schools they attend. Thankfully teenagers do not all behave in a similar manner so it is therefore probable to suggest that a number of other mitigating factors impact on adolescents that causes some form of interference with the processing of information. When considering the adolescents that come to notice of my workplace I consider this "interference" to be factors such as familial supports, familial and personal history, cognitive development, school teacher attitudes and societal and peer pressures (to name but a few).

For those adolescents who for various reasons no longer attend school community agencies also provide information about sexual health. But realistically it is not likely that many would self-refer to a provider. It is a common misconception that access to community agencies is dependent on referrals from social or health care providers. Promotion of agencies is one way to rectify this although usually the costs associated with media campaigns are too expensive for community groups. Under-resourcing such as under-funding and reduced staff levels were common themes from the participants. However providers of these services were very much aware of their clients needs in an ever changing and challenging environment.

Chapter 5

CONCLUSION AND RECOMMENDATIONS

Concluding Discussion

The focus of this thesis has been to identify agencies and High schools within the New Plymouth District Council boundary that provide sexual health and education programmes to adolescents. My purpose in choosing adolescents was intentional. I work with teenagers everyday and regardless of the resources invested in them they prove to be the most difficult group to engage with. More often than not they lack relationship building skills and if they do form a relationship many lack the skills to maintain that relationship. Due to their lack of attachments some may view sexual intercourse as a means for being wanted. They may brag about their sexual encounters regardless of the inherent dangers we as adults see within these relationships. Their unsafe decisions will usually have long lasting effects resulting in an inability to achieve a state of complete physical, mental, social and sexual well-being. Thus, they need comprehensive sex education to help protect them from adverse situations and consequences.

The study revealed that seven local organisations (other than schools) provide adolescents with sexual health and education programmes. The programmes are either held at schools or on-site. All organisations develop their own programmes according to their particular policies and philosophies and interestingly enough, the programmes have similar, if not identical course components. One programme was targeted at the adolescent sex offender. What this would suggest is that despite the different philosophies, programme

developers are receiving similar information (and are therefore aware of the issues needed to improve the sexual health of adolescents), have developed appropriate programmes and coupled them "fun" with learning styles and practices to inform students. Teaching techniques are also similar. All educators ensure participants are actively involved in the learning.

Schools also play a role in the provision of sexual health education to students. They are legally required to provide this. The questions used for the High Schools also considered course content, queried who the person was that taught the class, whether the school had received any complaints and more especially at whom were the programmes targeted. Six High Schools in the New Plymouth area advised of their programmes course information. Like the community groups, programmes between schools were similar. I was not able to determine teaching styles. However, some schools did report that they use community group representatives to assist in the teaching.

Other counselling agencies have advised they also provide sexuality and sexual health information to clients. This occurs in counselling sessions. These agencies reported that they do not have specific programmes. What is clear from this report is the importance of a systematic approach to intervention that understands what works, why it works and with whom it works.

The previous tables highlight the ongoing problems community groups are regularly faced with. Having previously worked for a community agency I am aware of the continual struggle for funding and the constant under-resourcing often seen within community organisations even though the client base expands on a daily basis.

New Zealand has had the ability to teach sexual health in the classroom for a number of years, yet despite this, statistics show that compared to other OECD countries we still have relatively high levels of teenage pregnancies (Midland Health: 1996:34). Changes need to be made. Adolescent sexual health is an issue requiring a multi-disciplinary approach. It is neither feasible nor realistic that one Government agency take sole responsibility for planning and effecting change. I believe it necessary that the Government Departments involved in Health, Welfare and Education take a joint pro-active role in adolescent sexual health. This can be done by reviewing and analysing religious, economic, legal and policies to ensure they foster rather than inhibit health promoting behaviour.

Information generated from this study demonstrates some very important issues pertinent not only to New Plymouth but also New Zealand. These will be discussed further and policy recommendations made. Each recommendation has been categorised under "Schools" or Community" depending on responsibility to action. I am aware however that some may be appropriate for both providers.

RECOMMENDATIONS - SCHOOLS

Programme Contents

That programmes deal with adolescent sexuality in terms of adolescence - the transition from childhood to adulthood. Therefore programmes need to include practical issues such as vocational goals, cultural values and personal understanding.

A clear finding from the report reveals that New Plymouth has an extremely

high number of people (aged 15 years and over) that have no formal qualification. I believe that single-focussed school programmes are limited. Owens (1992:77) suggests an involvement with parents by either hiring them as teacher aides or introducing a home visiting programme for disadvantaged families.

Peer Educators/Mentors

That peer education programmes be developed thus creating a pool of peer educators and counsellors. These peer educators can assist in the teaching of sexual health.

Early implementation of Programmes

That sexual health programmes be introduced early into the school curriculum. This would also allow for a measuring of outcomes.

It is fair to say that messages become more effective when they occur often, intensively and early. Adolescents need to have opportunities to develop and practice skills before they actually need them.

Programme Teachers

That appropriate teacher role models be established in schools who have the knowledge and skills to work competently and effectively in the area of adolescent sexual health.

That culturally appropriate educators be involved in the delivery of programmes.

Training

That teachers have training specific to the delivery of sexuality education and that in-service training courses occur regularly.

Permanent Health Centres and Support Services

That to assist with the high pregnancy and STD rates, schools have a campus Health Centre.

That as a separate section of this Centre, students have easy access to other professionals involved in the area of adolescent health. A collaborative inter-agency approach should be investigated. Agencies involved in the inter-agency approach could include counsellors, G.Ps, police officers, medical nurses and social workers.

Free Contraception

That as a function of the permanent health centres, both contraceptive advice and contraception be provided free for all students.

Support for Pregnant Teenagers

That pregnant teenagers be actively supported and encouraged to remain at school as long as possible during their pregnancy. They should also be advised of accessible, affordable and culturally appropriate parenting programmes.

Teenage Mothers and Education

That teenage mothers be encouraged to return to school as soon as they are able. Obvious issues this raises includes childcare and breastfeeding routines.

Compulsory Sex Education

That sex education be introduced as a compulsory school subject. Discussion and consultation will be necessary to determine the age children will begin the learning.

RECOMMENDATIONS - COMMUNITY

Support for Teenage Mothers

That support groups for teenage mothers be established. As mentioned previously, these young mothers should also be advised of accessible, affordable and culturally appropriate parenting programmes.

Building Service Alliances

That the building and maintaining of relationships with others in the field of adolescent sexual health be an ongoing process.

Groups who are therefore providing similar programmes should not view others as competitors rather they should be viewed as a resource and support. In this way, gaps will be closed, quality information will be delivered to adolescents and more effective evaluation methodologies may be developed.

Biculturalism

That programme developers respect and understand Maori values so that programmes are less euro-centric. A commitment towards this will see appropriate Maori advisors having input into the programmes.

With the ever increasing attendance of children in te kohanga reo and kura kaupapa it is absolutely vital that policy reflect a Maori perspective and that

educational resources (including teachers) be developed.

Whanau and Iwi Input

That notwithstanding the previous suggestion, culturally appropriate programmes need to be developed and taught by Maori educators. The place of teaching is also a critical factor as is the inclusion of whanau. The approach should be whanau focussed.

Youth Advisors

That all sexual health programme drafts be submitted to a youth committee or that a representative from a local youth council be invited to participate in the programme development. This will ensure that information is age-appropriate and worthwhile. This person would not only validate the appropriateness of the programme but is likely to be more aware of the problems facing the local teenagers.

Visibility of Service Providers

That agencies make themselves visible to the public and that they conitnue to actively promote their services. Unless an individual is referred or advised of a community service through informal networks it is not likely that an adolescent would self-refer unless it was the last resort. As statutory social workers we need to provide assistance to these adolescents before we are the "last resort".

Effective Evaluation

That a measure be developed allowing both policy-makers and programme developers to gauge the effectiveness of programmes over time.

I believe the need for a well designed effective method of evaluation extends to both school and community group developers. Although participant feedback is invited, I argue that this feedback is only useful to the organisation requesting it. Critical feedback will undoubtedly bring about programme changes while positive responses may ensure the continuation of the programme. Programmes effectively evaluated should produce a reduction in the adolescent pregnancy numbers and STD rates. An evaluation process may also yield a reduction in adolescent high risk behaviours.

Improved Funding

That government acknowledge the seriousness of adolescent health and that their concern is reflected by an improved funding process and by increasing the funds organisations receive.

FINAL COMMENT

I believe it necessary that adolescents take responsibility for their decisions. However, prior to making choices they require information that will enable them to make informed decisions. Although I cannot enforce my values, beliefs and behaviours on them, as a statutory social work supervisor I have a responsibility to provide clients with appropriate opportunities that will assist them develop confidence and necessary life skills. In order for me to do this I need to ensure they are aware of all appropriate resources. This means I have to be aware of and promote the resources to my colleagues.

Due to this research project I have now met a number of wonderful people committed to working with adolescents. I believe the professional networks I have formed will be long lasting and prove beneficial to adolescents, my

work colleagues and employer. This should see an improvement in our service delivery. Already we have forwarded referrals to a number of agencies and have contracted with another to provide holiday programmes for our adolescents. By increasing our pool of resources we hope our adolescents will view their sexual health as a resource for everyday life.

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APPENDICES

APPENDIX 1

Questions for Providers of Sexual Health/Sex Education programmes

1. How are adolescents referred to your programme?

2. Programme information:

(a) Where is the venue?

(b) How long is the entire programme?

(c) How long is each session?

(d) Description of programme contents.

3. Define you target group.

4. Describe accessibility to the programme.

5. How do you advertise this programme?

6. Training:

(a) Has you presenter(s) received any specific training for this programme?

(b) Who provides this training?

(c) Is there a need for ongoing training? Please explain.

7. Supervision:

(a) Are presenters provided with supervision?

(b) How often do presenters receive supervision?

8. Do you evaluate client satisfaction with this service. If so, how is the

programme received?

9. Are you aware of other organisations providing a similar service?

10. Would you like to know the other organisations providing a similar service?

11. Am I able to share your organisations name with others involved in similar programmes?

12. Are there any "gaps" in this service you provide? If so please describe.

13. Describe other services your organisation provides.

14. What funding does your organisation receive? Who are the funding sources?

15. Describe your management structure.

16. How long have you been established?

APPENDIX 2

Questionnaire for High Schools

1. Does your school provide a sexual health/sex education programme?

2. What classes are provided with this programme?

3. What is the length of the course?

4. Who teaches the course (i.e. outside agency, school teacher, Public Health Nurse etc.).

5. If the course is taught by school personnel, who developed the programme?

6. Please describe course content.

7. What, if any, opposition has there been against the programme?