"We're Talking About Sex": [1]
Young Adults and Sexual Health in Northern Ireland

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SIT Ireland, Spring 2008
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[1] Malachi O'Hara, interview with the author, April 18th, 2008. The researcher would like to acknowledge Aeveen Kerrisk and Bill Rolston for their guidance throughout the project, James Morris for editing, and all respondents involved in the research for their enthusiasm and support. Please contact the researcher before quoting from the text at morris2@southwestern.edu
Word Count (not including appendices): 10,040

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GLOSSARY

DENI- Department of Education for Northern Ireland
HYPE- Health for Youth Through Peer Education
BROOK- the Brook Advisory Centre
FPA- Family Planning Association
GUM- Genital Urinary Medicine
HAZ- Health Action Zone North and West Belfast
HIV- Human Immunodeficiency Virus
HPANI- Health Promotion Agency for Northern Ireland
RSE- Relationships and Sexuality Education
STI- Sexually Transmitted Infection
HIV/AIDS- Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
SPUC- Society for the Protection of the Unborn Child

RESPONDENT INFORMATION: Demographic Information of Respondents

Name, organization or affiliation, official job title, age (or approximate age), race, gender, nationality.

Michael Anderson, UCD School of International Politics and Relations, Professor and PhD Candidate, forties, white Caucasian, male, Republic of Ireland.

Anna Marie Burns, Artillery Youth Center, Youth Coordinator, 25, white Caucasian, female, Northern Ireland.

John McComb, Include Youth, Give and Take Project Manager, mid-thirties, white Caucasian, male, Northern Ireland.

Mary Crawford, Brook Clinic, Director, mid-thirties, white Caucasian, female, Northern Ireland.

Joanna Gregg, Belfast Health and Social Care Trust Sexual Health Team, Coordinator, thirties, white Caucasian, United Kingdom.

Georgie McCormick, Family Planning Association (fpa), Manager of Training and Services, forties, white Caucasian, female, Northern Ireland.

Malachi O'Hara, HYPE organization, Senior Peer Educator, 28, white Caucasian, male, Northern Ireland.

Dr. Dirk Schubotz Queen's University School of Sociology, Social Policy and Social Work, Research Fellow, thirties, white Caucasian, male, Germany.

INTRODUCTION

Walking up the stairwell into the Brook Advisory Centre I noticed smiley-faced sperm painted on the walls amidst sexual health statistics. As I entered the main lobby I looked around the room and saw a variety of brightly colored, witty safe sex posters. There was a picture of a couple with "Make sure lucky is the only thing you get tonight!" written underneath. Pamphlets were strewn about a table that covered everything thing from sexuality to STI's. There was alternative music playing in the background, the sun was shining through the windows, and I generally got a good vibe inside the clinic. I felt very comfortable, and I thought to myself, "If I needed help I wouldn't mind getting it from this clinic." Despite the comforting environment of the sexual health clinic, I had to remind myself that it was not being inside that was the point; it was actually getting to the clinic that was the main obstacle.[2]

My first interview took place at the Brook Advisory Centre with director Mary Crawford. As I waited in the sitting room to meet with Mary, I tried to absorb my surroundings in an attempt to understand how a young person living in Belfast might feel about the clinic. I had so many questions racing through my mind: how do young people find out about sexual health clinics? What obstacles do young people face in terms of accessing sexual advice or contraception? What is sexual education like in schools? However, there was one reoccurring question that continued throughout the research. How does this project compare or contrast to my own experiences concerning sexual health and education in the United States?

Within the context of Northern Ireland, sexual health of young adults is often at the forefront of discussion, and "it is widely accepted that the sexual health of the population of Northern Ireland is poor."[3] Teenage pregnancy rates in Northern Ireland are among the highest rates in Europe with "approximately 1,700 babies born each year to young women under 20 years."[4] An increase in HIV/AIDS and other sexually transmitted infections has also been a key concern for government and is now seen as a "priority issue." [5] Abortion is still illegal in Northern Ireland, resulting in thousands of women traveling to England and other countries each year to access abortion procedures. In general, sexual health in Northern Ireland has emerged as pressing issue infused with characteristics of the society itself, such as morality and religion.

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[2] Excerpt from observation journal, April 14th, 2008, Brook Advisory Centre.
[3] RSE: Making it a reality report summary 2008: 4.
[4] Guidance for post-primary schools, 2001:3.
[5] RSE: Making it a reality report summary 2008: 4.

Initially, I sought to explore the topic of sexual health education in schools in Belfast. However, as the three-week period of research progressed, the project assumed a personality of its own, incorporating elements of sexual health organizations, pro-life viewpoints, community based sexual health initiatives, and youth organizations. This resulted in a more comprehensive glimpse at sexual health education from a variety of venues utilizing interviews, participant observation, and content analysis. I was particularly motivated to address this topic because I feel that sexual health should be a priority for all, especially for young adults. Similarly, as a female I know that being able to make informed, confident decisions concerning our bodies is very important. Because I am so invested in this subject, speaking with sexual health agencies and organizations came very naturally. I had no obstacles interacting with respondents and identifying with their viewpoints; however, when I ventured into more fundamental, conservative ground I had to rely strongly on my skills as a social researcher to remain as objective as possible. I was confronted with views that were starkly different from my own, which was challenging in a very beneficial way.

Overall, this research project addresses several issues concerning sexual health and education in Northern Ireland. First of all, when educating young people about sexual health, they must have consistent, thematic, and reliable information from a variety of sources such as formal education, peers, and parents. This education should emphasize personal growth and development, highlighting self-confidence, personal preference, and tolerance of others. Secondly, relationship and sexuality education in schools must also be as consistent as possible to ensure that pupils are receiving information that they not only need to know, but also *want* to know about. Finally, one must recognize that several factors exist within the Northern Ireland context that contributes to the poor level of sexual health. The media, religion, and ideas concerning morality have a strong impact on young adults in terms of accessing sexual health care. The future of sexual health for young adults in Northern Ireland depends largely on sexual health clinics and organizations, community groups, and education in schools.

METHODOLOGY

This project is grounded in qualitative and ethnographic research methods, primarily interviews, participant observation, and basic content analysis. Information

from leaflets, handouts, and brochures supplied by various sexual health organizations also aided in my understanding of the topic. This research was conducted between April 7th and April 28th, 2008, in Belfast, Northern Ireland. For this research, informal, semi-structured interviews were the predominant source of data, conducted along a loose set of interview questions. However, most interviews incorporated an element of discussion in which the interviewee and I exchanged information, ideas, attitudes, and opinions concerning the overall topic of sexual health and education within Belfast. In an attempt to remain as objective as possible, these "exchange sessions" were usually initiated by the interviewee[6]. Each interview lasted between twenty-nine and forty-four minutes. Most interviews took place at an office or place of work of the respondent. All interviews were digitally recorded and four interviews were transcribed for reference during analysis. However, my final interview with Joanna Greg of the Sexual Health Team took place in a café, and I was unable to transcribe the interview due to overriding background noise.

For the majority of the interviews I prepared questions beforehand in accordance with information I had collected on the individual or the organization. However, as the interviews progressed, I often asked new questions that were not previously prepared.[7] Also, I often was not able to ask many questions, as several respondents simply began talking about their organization, not necessarily in need of guidance. The one interview in which I followed my questions most closely occurred with Dr. Dirk Schubotz, a fellow Sociologist. I assume that the respondents are particularly invested in the issue of sexual health and well being of young adults in Northern Ireland, resulting in a pool of interviewees more than willing to discuss their view and opinions with me. During interviews, I began by addressing the purpose and time frame of my research, as well as the major themes for my project. We usually engaged in small talk before formally starting the interview. Upon the approval of respondents, I recorded the interview, and also took notes while disregarding personal or identifiable information if requested. After several of the recorded interviews I lingered with respondents and discussed more personal issues, such as my own background and interests, as well as the respondents corresponding information.

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[6] For a complete listing of sites, times, and dates of observations and interviews, please refer to Appendix A
[7] For a complete listing of the interview schedule used for each respondent, please refer to Appendix B

Concerning the methodology for this research, I find it particularly important to recognize my previous research experience and social science background. I entered this research with a somewhat defined set of guidelines for which to conduct social research. I drew upon several techniques from my home university, especially when creating diagrams in which to frame the themes for this research. In terms of sampling, I utilized snowball sampling when approaching respondents for interviews, as well as drawing upon my relationships with those established in the area of sexual health and education in Belfast, such as my project advisor Dr. Bill Rolston. Dr. Rolston has extensive research experience within this topic and was able to take on a dual role in my research as both advisor and informant. These informants were able to put me in contact with other respondents or organizations they felt might be pertinent to my research. I contacted all respondents by either phone or email, often drawing upon my relationship with previous interviewees to aid in setting up an interview.[8] For example, when I contacted Anna Marie Burns at the Artillery Youth Center I mentioned to her that I had spoken with Malachi O'Hara from HYPE who suggested I contact her for an interview. This strategy of "name-dropping" or "networking" helped to legitimize my role as a researcher and put me in contact with those I might have not reached otherwise. However, the selection of respondents was opportunistic, in which I depended on the willingness of the individual to take time out of his or her day to speak with me. I was not able to arrange meetings with a couple of organizations that would have added to this research. However, given the time frame of three weeks, I believe that the interviews collected constitute a pertinent and valid base for this project.

Another limitation within my methodology concerns the relative breadth of viewpoints expressed by the interviewees. Most of my respondents stem from a more liberal, holistic approach to sexual health and education, which resulted in limited data. In addition, I entered this research with a fixed set of ideas and beliefs concerning sexual health and education for young adults, mimicking the liberal mindsets of my respondents. While I began the research with objective intentions, as the weeks progressed I began to notice the prominence of my own personal convictions. The project then became much more personalized rather than primarily detached. I identified with aspects of the

[8] See Glossary and Respondent Information Section

research, deliberately utilizing myself as a focal point in attempt to try and understand what it would be like to, perhaps, seek advice about abortion or contraception in a Northern Ireland context. Looking back, my own biases were very much influential in the shaping and progression of this research, particularly when seeking respondents. In reflection, seeking interviews with those from fundamental or religious backgrounds would have added another dimension to this research. Similarly, I was unable to meet with teachers or administrators in schools, a viewpoint that would have appropriately supplemented my data collected on sexual health organizations.

The second element of methodology, participant observation, was not as extensive as hoped. Nevertheless, I attended four different events, beginning with an interactive opportunity at the Genital Urinary Medicine (GUM) Clinic at the Royal Victoria Hospital.[9] My role in each of these contexts differed. For the GUM clinic, I arrived with a friend who was utilizing the clinic's services. I sat in the lobby and observed the registration and waiting process to see a doctor or nurse. The second observation was an attempt to contact picketers at the Brook Clinic, particularly a pro-life organization called Precious Life. After arriving at the clinic, I waited between thirty to forty-five minutes and observed no picketers. The third interaction occurred at the Family Planning Association, in which I spoke with a woman representing both SPUC (The Society for the Protection of the Unborn Child) and Precious Life. After observing this woman, I spoke with her about her work with these pro-life organizations. My role as researcher was discussed. Finally, I attended the Donegal Pass Women's Center meeting as a researcher. The last interaction, which ultimately turned into an in-depth interview, occurred at the Artillery Youth Center in North Belfast. I arrived with the intention of observing a Young Parenting Club; however, the young mothers were unable to attend, so I spent the duration interviewing the project leader, Anna Marie Burns.

One limitation within the participant observation section of this research concerns inconsistency. Originally, I had hoped to work with one to two youth clubs, meeting each group two to three times. This would have allowed me to foster relationships within the group. However, my participant observation became sporadic and less intentional than the interviews I had scheduled. Upon reflection, consistent and repeated participant

[9] See Appendix A for more information

observation with one to two groups would have helped in my understanding of youth's viewpoints and opinions concerning sexual health and education. However, most of the respondents worked one-on-one with young people, offering insight into their opinions concerning sexual health services and education within Belfast.

PREVIOUS RESEARCH AND LITERATURE

For this topic, most of the background reading and literature concerns previous research conducted on relationship and sexuality education, attitudes and opinions of young people towards sexual education, annual reports of sexual health organizations, guidelines for relationship and sexual health education in schools, and supplemental national research concerning attitudes and behaviors of young adults in Northern Ireland. I believe that contextualizing these resources in relation to my own experiences and observations was the most useful approach to the topic. Research that was very influential, but will not be overviewed are as follows: "Out of the Shadows: A report on the sexual health and wellbeing of people with learning disabilities in Northern Ireland," (Simpson, Lafferty, McConkey 2006), "RSE: Making It a Reality, RSE in Schools in North and West Belfast," (Report Summary 2008), recent annual reports and factsheets for the Brook Advisory Clinic, the Family Planning Association, and the Artillery Youth Center, as well as extensive internet research concerning sexual health organizations in Belfast and Northern Ireland.[10] For this research I did not utilize traditional texts because I felt that recent research, annual reports, and website information was much more relevant in terms of the specific context of Northern Ireland.

The piece of research that was very much influential during my project was conducted in 2002 by Audrey Simpson, Bill Rolston, and Dirk Schubotz in coordination with the Family Planning Association (FPA[11]) and also the University of Ulster. The Community Fund, more commonly known as "lottery money", funded "Towards Better Sexual Health". The purpose of this research was to produce a profile of the sexual attitudes and lifestyles of young people ages 14 to 25 in Northern Ireland. Initiated by Audrey Simpson of the FPA, this research was aimed towards those under 25, or "a

[10] Please refer to bibliography for additional information.
[11] The Family Planning Association acronym is actually listed in lowercase lettering (fpa), but for the purposes of this research paper I will use "FPA."

particularly vulnerable section of the population in relation to sexual health."[12] According to the FPA, sexual health can be defined as "the capacity and freedom to enjoy and express sexuality without exploitation, oppression, physical or emotional harm."[13] One thousand young people from varying backgrounds completed a survey questionnaire; however, the research was supplemented by seventy-one focus groups, and an additional publication was produced voicing fifteen narratives of interviewees. As for the sample, most respondents were between ages fifteen and seventeen, were in full-time education, and lived at home with a parent.[14] There were slightly more female respondents than males, and 45 % of respondents identified with the Protestant faith as opposed to 38.7% who identified as Catholic.[15]

The focus themes within this questionnaire addressed sex education, sexual attitudes, sexual intercourse, sexual orientation, and use of contraception and sexual health services. More specifically, respondents were asked about relationships and sexual activity, abortion, contraception, sexuality, and pornography. Layered within these themes the survey addresses factors that impact such attitudes and behaviors like socioeconomic status and religious affiliation. Approximately half of the respondents had experienced sexual intercourse and over a third of those before the age of 17, the legal age of consent in Northern Ireland.[16] This finding continues to state "more than half of the respondents who had sex before they were 16 said they did not know enough about safer sex techniques."[17] Approximately half of the respondents were satisfied with their first sexual experience, while others wanted to know more about consent and how to say "no" to sex. The study found that a significant number of respondents were under the influence of either alcohol or drugs during their first sexual experience. Sexually active respondents averaged six partners, combining the figures for both men and women.

One finding that was of particular importance to this research was the venues in which young adults receive the most helpful information concerning sexual health and well being. The top three sources included friends or peers, schools, and books or

[12] Towards Better Sexual Health, 2002: 9.
[13] FPA Policy Statement: Abortion, 2008.
[14] Towards Better Sexual Health, 2002: 15.
[15] Towards Better Sexual Health, 2002: 16.
[16] Towards Better Sexual Health, 2002: 35.
[17] Towards Better Sexual Health, 2002: 40.

magazines; however, most young people preferred this information to come from schools, parents, and friends.[18] This finding suggests that a disconnect exists between reliable, consistent information that would allow young people to make well-informed decisions and the information that they are actually receiving. Similarly, when asked about information received in schools, the topics that were most likely to be omitted were homosexuality, wet dreams, orgasm, and masturbation.[19] Therefore, most sexual education in schools was reported as being more "biological" as opposed to emotions and relationship-focused. When speaking with Bill Rolston about the research, he mentioned an absence of information about "lovemaking" and the celebration of one's sexuality[20].

Overall, this research had several implications for the well being of young people in Northern Ireland. First of all, previous to this study there had been no comprehensive research conducted on the topic, and despite limitations within the research such as the opportunistic sampling style, there is much validity to the findings. Agencies that cite this research, include, but are not limited to: the Health Promotion Agency, the Family Planning Association, The Brook Sexual Health Clinic, The North and West Belfast Health Action Zone, and the Belfast Health and Social Care Trust Sexual Health Team. The Sexual Health Team focuses on RSE (Relationship and Sexuality Education) training for teachers in Northern Ireland. At the conclusion of the research, the authors discuss the findings and offer suggestions for sexual health education and well being for young adults in Northern Ireland, for example, lowering the age of heterosexual and homosexual sexual consent to mimic that of the United Kingdom, 16, as opposed to Northern Ireland's age of 17. Lowering this age would decriminalize those engaging in underage sexual activity, establish consistency for young adults, and work in accordance with the legal age of marriage of 16 years of age. The researchers also suggest community-based education programs that incorporate the parents of young adults, and a more comprehensive, holistic, and consistent implementation of sexual health education in schools.[21]

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[18] Towards Better Sexual Health, 2002: 20.
[19] Towards Better Sexual Health, 2002: 21.
[20] Bill Rolston, informal meeting with the author, April 9th, 2008.
[21] Towards Better Sexual Health, 2002: 67.

In tune with the sources of information that young people receive, it is necessary to overview the current RSE guidelines for post-primary schools according to the Northern Ireland Council for the Curriculum Examinations and Assessment Board. However, when speaking with Joanna Gregg of the Sexual Health Team, she mentioned that new guidelines were due out soon; however, the guidelines mentioned in this research are still considered current. These guidelines work in accordance with the "general aim of education to foster all aspects of the individual," in which RSE is deemed as essential.[22] The booklet begins by addressing the importance of RSE with the earlier level of maturity of young people, increased independence during post-primary years, affects on self-esteem and overall well-being of the individual, and the importance of informed decision-making.[23] The purpose of this booklet is as follows:

> To develop a policy statement in relation to RSE which reflects the ethos of the school and complements existing policies in relation to, for example, Personal, Social and Health Education (PSHE) and/or child protection; and to provide a programme of RSE which is appropriate to the needs and maturity of the pupils.[24]

However, within the aims and purpose of the course specifically, the guidelines stress the importance of personal development, self-esteem, and overall well-being of the individual. This theme is reoccurring, begins in primary education, and is incorporated into several different circulars. Joanna Gregg of the Sexual Health Team (who provides RSE training for teachers in Northern Ireland) states, "One can argue that the real change occurs at the primary level with the importance placed on personal development and self-confidence. The RSE has to rely on a strong base."[25] However, the guidelines are simply that; *guidance* for schools. The information presented is not mandatory, yet should be incorporated into a framework that aligns with the "ethos of the school."[26]

The guidelines provide a very thorough program for developing and implementing RSE policy in schools, as well as ways in which to develop a program of RSE. While external health professionals and organizations are allowed to work in schools, the guidelines stress a collaborative effort between the external organization, the

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[22] Guidance for post-primary schools, 2001: 1.
[23] Guidance for post-primary schools, 2001:2.
[24] Guidance for post-primary schools, 2001:5.
[25] Joanna Gregg, interview with the author, April 24th, 2008.
[26] Guidance for post-primary schools, 2001:9.

teachers, and the administration. Gregg, when discussing outside sexual health organizations, stated the importance of teacher participation and collaboration. Once the outside organization leaves, the RSE education should not stop. She continued to state that RSE should, and can, be implemented in a cross-curricular fashion, allowing for themes within RSE to be addressed in areas such as health education, home economics, religious education, and physical education. Regardless of the curricular, the opportunities for implementation are endless. By building upon each key stage of development, the RSE guidelines incorporate information appropriate to the age and maturity level of the pupils. The RSE guidelines suggest a three-pronged approach that addresses growth and development, sexuality, and relationships. The conclusion of this booklet offers several resources that teachers can access such as reference books, videos, and local organizations relating to sexual health.

MAIN BODY

To address the main themes that I gathered from my research in Belfast I have developed a series of flow charts to describe cause and affect relationships. Each flow chart will be presented, followed by a description, interpretation, and evaluation of the diagram. I will draw upon previous research as well as my own observations and experiences to support these conclusions. I will begin by addressing what sources influence young adults in their decision-making processes concerning sexual health and well being in accordance with findings from "Towards Better Sexual Health."

Flow Chart A:

SOURCES OF INFORMATION → INDIVIDUAL → BEHAVIOR

Individuals receive partial or inconsistent information from informal sources, impacting often risky or unsafe behavior, misconceptions about what young people are actually doing sexually, and ideas concerning sexuality and gender roles.

In this flow chart, informal, outside sources such as peers/friends and books or magazines directly influence the individual, often resulting in misinformation that can lead to risky or unsafe behavior. The "individual" in this diagram refers to all young people in Northern Ireland, regardless of racial or ethnic background or sexual orientation. However, target group guidelines as determined by the Health Action Zone for young people are especially helpful, as they articulate who might be at particular risk.

The guidelines suggest that those in primary and post-primary education, those excluded from formal education, those "looked-after" and leaving care, those within the criminal justice system, homeless youth, those with physical or learning disabilities, those with mental health difficulties, and those with family conflict are especially targeted groups.[27] "Risky or unsafe behavior" in terms of sexual behavior can be defined as unsafe sex, or "any kind of intimate activity that involves contact with someone else's body fluids…unprotected penetrative sex or oral sex," or "pulling out" before ejaculation.[28] Similarly, it is important to note that risky or unsafe behavior can also include the consumption of drugs or alcohol, engaging in anti-social or criminal behavior, or becoming a victim of crime.[29]

When speaking with Malachi O'Hara, senior peer educator at HYPE (Health for Youth through Peer Education), about peer influences he states:

> Young people, as in adolescents and teenagers, during that period of their lives, other relationships such as those with their family or their community become less relevant, and the peer relationship takes paramount importance[30].

Mary Crawford, director of the Brook Advisory Centre, also addressed the issue of misinformed young adults, particular in young teenage men. The Brook Advisory Centre works to establish relationships with young adults, encouraging discussion about their sexual activity. Mary remarked that many "boys" come in with "all these stories" about various sexual activities in which they have been involved. She elaborated on experiences within the clinic by recalling:

> After about the third or fourth visit you actually find out that they have not had penetrative sex at all, but because of their peers or because they feel they have to say all of this they come to us with all these stories[31].

This critical stage in life, in which peer relationships come to the forefront, leave young people particularly vulnerable, whether or not they are engaging in sexual activity.

The primary consequences of unsafe sex are the transmission of STI's and unplanned pregnancies; however, consequences of early sexual activity can extend into

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[27] A Strategy to Promote the Sexual Health and Well-Being of Young People in North and West Belfast Summary, 2007: 3.
[28] Safer Sex Made Simple, 2006.
[29] You don't have to be drunk to be doing real damage, 2006.
[30] Malachi O'Hara, interview with the author, April 18th, 2008.
[31] Mary Crawford, interview with the author, April 14th, 2008.

other realms of the young adult's life such as education, employment, and emotional health. The Give and Take Project (within the organization Include Youth) supports "some of the most vulnerable and in need young people throughout Northern Ireland." [32] By referring young adults to the Give and Take Program, the team works to improve employability, develop and strengthen training skills, and increase self-esteem. Within the Personal Growth and Development section of the Give and Take Program, the counselors and advisors target sexual health and well-being. John McComb, who directs the Give and Take Program states, "we are trying to address some of the other issues that are going on for the young person as well,"[33] such as self-esteem and confidence. The Give and Take Program recognizes the vulnerability of youth during the teenage years and early 20s. The young people within the Give and Take Program would be particularly vulnerable, having come mostly from foster care backgrounds, or lifestyles that have been unstable. McComb also remarked on the relationship between unsafe sexual behavior and employment, suggesting that youth need to be properly informed about safe sex practices to avoid impacting other areas of life.

Overall, utilizing research projects such as "Towards better sexual health," and personal experiences from sexual health organizations that work one-on-one with youth, the consensus seems to be that peer and media influence is overriding during particular vulnerable ages. Having recognized these influences, sexual health organizations such as HYPE are utilizing peer education as a venue through which to reach young people. Malachi O'Hara, when reflecting about the peer education process at HYPE, states:

> They [young people] can appreciate and understand better if peers, people the same age are speaking to them... essentially we deliver sexual health and relationship education programs to young people in the hope that the young people we work with will then pass it on to other young people in their peer groups[34].

Malachi O'Hara, who is 28 years old, is the perfect example of a peer educator. The moment I met Malachi, I felt completely at ease. He was dressed like friends I might see around my college campus, his tone and inflection were relaxed, he cracked jokes throughout the interview, and the interview environment was very relaxed. When I

[32] [include] youth strategic plan 2005.
[33] John McComb, interview with the author, April 17th, 2008.
[34] Malachi O'Hara, interview with the author, April 18th, 2008.

entered the HYPE offices I was greeted by a staff in their 20s and 30s, which I regard as relatively young ages for sexual health education workers. Malachi remarked that part of why their organization is so successful is because HYPE is "unique in Northern Ireland. There is no other organization like us, no other team like us"[35]. HYPE educators pride themselves on their ability to connect with youth on an equal playing field. Community nurses established this organization in 1999 after an initiative to address the issue of teenage pregnancy in North and West Belfast. After a successful evaluation in 2003, HYPE became funded by the Belfast Trust Fund, previously the North and West Belfast Trust. HYPE works in a variety of contexts, including schools, youth groups, and community groups. Instead of lecturing a class about sexual health, HYPE opts for small group discussions and exercises in which the individual is encouraged to ask questions and engage with other young adults. When discussing feedback from youth, Malachi states, "they're really positive about the type of work we do…it's informal, participative group work. They learn from that."[36]

Other services that HYPE offers include drop-in clinics in which young adults can be seen by both a doctor and a nurse. They can also speak to peers about sexual health, and perhaps most importantly, utilize services free of picketers or opposition when entering the HYPE offices, which are located in the Social Services building of West Belfast. Similar to HYPE, the Artillery Youth Center located in North Belfast was established in 2002 and is run by a group of young adults. The Artillery Youth Center works with young adults ages 15 to 25, and also runs programs for young parents, paying particular attention to personal development. Anna Marie Burns, a vivacious 26-year old mother of two directs the young parent's group. Five young mothers worked in collaboration with HYPE and the Brook Advisory Centre to supplement their personal development theme with sexual health information. Meeting each week the young mothers discussed sexual health issues, learned safe sex practices, and engaged in conversation at the youth center. Before I met Anna Marie, I walked the 2.5 miles from my dormitory to Victoria Parade, the street on which the youth center is located. The area, while filled with kids playing and laughing, is a working-class neighborhood with

[35] Malachi O'Hara, interview with the author, April 18th, 2008.
[36] Malachi O'Hara, interview with the author, April 18th, 2008.

high-rise housing. The youth center's doors were covered in thick metal siding, and the center itself was located in a sea of concrete walls. From the outset, the center was a bit intimidating; however, once inside, I was surprised at how comfortable and warm the environment became.

Youth are welcomed into the center to take classes, pick up a game of pool, use the Internet, or make a cup of tea. The decision to incorporate sexual health into the young parent's group was a collaborative effort, as Anna Marie remarks, "I thought that sexual health was a big one because there was a lot of stuff that we didn't know about."[37] Another young mother who was present at the interview stated the information about STI's shocked her, reflecting on her own naiveté concerning STI information. Anna Marie continued to stress the importance of the environment of the youth center as a safe place in which young mothers could open up and talk about sexual health issues at ease with one another. This informal setting is ideal for peer education, and judging from the information received from Anna Marie, the young parent's course in sexual health proved to be very beneficial for all involved.

Finally, the Family Planning Association (FPA) also seeks to educate youth about safe sex practices and sexual health, particularly in a community setting. Georgie McCormick, who manages the community education projects and workers in Northern Ireland, reflected on the importance of a collaborative effort when educating youth about sexual health. When asked about FPA's role in schools, Georgie replied:

> No, no it's community education… well, we do some work with schools but primarily it's self selection so young people chose to come to them as opposed to being in a formal class setting[38].

Young people involved in these education programs are able to set their own agenda, develop their own themes, and ultimately, shape the format of their project. Georgie sees this aspect as a major strength of their education programs stating, "It's self-selected, people are here because they want to be, and they can leave at any time." This type of community education program allows the young people to open up about the topics they wish to discuss, resulting in a freer environment much like the Artillery Youth Center.

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[37] Anna Marie Burns, interview with the author, April 24th, 2008.
[38] Georgie McCormick, interview with the author, April 21st, 2008.

In order to address the multitude of information sources that young people are bombarded with concerning sexual health and well being, several factors have proven effective. First of all, young adults will continue to receive information from peer groups, so strategizing ways in which to target those peer groups is one venue in which to educate youth. HYPE has created a successful peer education program with very positive feedback from young adults, and the young parent's club at the Artillery Youth Center is comprised and led by women in their early twenties. Creating an environment in which peers can interact, ask questions, and engage with one another creates a safe-place for sexual education to take place. Secondly, the locale of the program will also impact those in attendance. The Artillery Youth Center is a non-invasive environment in which young parents can make themselves a cup of tea and discuss sexual health matters at ease. Similarly, it is a priority for FPA to create a "safe environment" during their education programs. Finally, a curriculum in which the material is self-selected by the young people is both beneficial and engaging for youth. Georgie remarked that because youth are taking part in topics that are on their mind, they are most usually satisfied with FPA programs. The incorporation of peer education, a safe environment, and a self-selected curriculum are three ways in which outside organizations are educating young adults about sexual health and well-being. Although these organizations have varying combinations of those three aspects, each has modified their program to fit the needs of their participants.

Flow Chart B:

ETHOS OF SCHOOL → RSE EDUCATION → PUPIL

Depending on the ethos of the school, the RSE education will be tailored to fit those needs, resulting in varying RSE policies and programs from school to school. Some schools may even choose to omit certain portions of RSE, depending on factors such as religious affiliation, parental input, and gender breakdown of the school. This results in varying sexual and relationship education from pupil to pupil.

In addition to religious education, there are six statutory divisions of learning for post-primary students in Northern Ireland: Language and Literacy, Mathematics and Numeracy, the Arts, Modern Languages, Environment and Society, Physical Education, and Science and Technology. In both primary and post-primary schools, RSE should be

housed in the school's provision for health education or within personal and social education.[39] Both guidelines stress the importance for a cross-curricular approach with RSE. The framework for RSE was established by the Department of Education for Northern Ireland in 1987, stating that each school "should have a written policy on sex education endorsed by the Board of Governors and communicated to parents."[40] Issues that arise from these guidelines concern the un-uniform pattern of RSE, and also the "urban legend" that RSE will encourage young people to engage in early sexual activity. Despite the governor's awareness of RSE as "essential," the implementation of RSE ultimately must conform to "the moral and religious principles held by parents and school management authorities."[41]

When speaking with Malachi O'Hara of HYPE about the variety of schools they work with, the conversation turned to a discussion of Catholic maintained schools. Because HYPE caters to the needs of their partnership organization or school, they will often alter their main program to work in accordance with the ethos of the school. Malachi mentioned that at an all-boys Catholic school they were unable to do a condom demonstration. The HYPE team devised a series of flashcards that depict proper condom usage that was also aligned morally with the school. The variance among schools is enormous, as some schools prefer a nurse or health official to cover RSE, others invite outside organizations such as HYPE, and many prefer to have a health education teacher administer the RSE.

When speaking with Dr. Dirk Schubotz concerning his research "Towards Better Sexual Health," he states:

> It was…it depended on where you went. If I went into groups that had sexual health programs, for example, they would have been more open to discussing that. I also went into schools where they were quite protective in terms of what could and could not be discussed.[42]

For the latter mentioned by Dirk, many schools would not allow the survey to be distributed due to questions concerning sexuality and abortion. He was also quick to

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[39] Guidance for primary schools, 2001: 12; FPA Factsheet Relationship and Sexuality Education in Schools, 2005.
[40] FPA Factsheet Relationship and Sexuality Education in Schools, 2005.
[41] Department of Education for Northern Ireland Relationship and Sexuality Education, 2001.
[42] Dirk Schubotz, interview with the author, April 22nd, 2008.

mention that very liberal schools existed as well, many having students participate in projects on topics such as abortion. HYPE, because of their flexibility, has managed to remain on good terms with state schools, Catholic schools, and independent (integrated) schools. Voluntary schools, or grammar schools, on the other hand, rarely utilize HYPE's services. Predominately middle and upper middle class students, areas that house grammar schools do not have the teenage pregnancy issues of many communities in North and West Belfast. According to a recent report, "Peoples from socially disadvantaged backgrounds do significantly less well than other peoples…they constitute only 7% of enrollment in grammar schools." [43] Because HYPE works only in North and West Belfast, predominantly working-class communities, their clientele becomes specified. However, during our interview, Malachi seemed to suggest that despite location, grammar schools shy away from HYPE for other reasons. He states:

> …nobody gets pregnant at grammar schools, nobody gets a sexually transmitted infection, or becomes a father… obviously, because they're all middle class (laughter)…we have done some taster sessions, maybe like a presentation, but the schools are kind of, I don't know …maybe there is some sort of inbuilt snobbery (laughter) or expectation that their young people are able to resolve these issues or are aware enough anyways.[44]

Social class provides yet another layer to the inconsistency in RSE throughout Northern Ireland, particularly Belfast.

Concerning other schools, HYPE has fostered several strong relationships resulting in a wide variety of programs. Up until the last few years, HYPE was not allowed to discuss contraception in boy's Catholic schools. Because HYPE caters to the needs of the school, they remain on neutral ground. Other sexual health organizations such as the Brook Advisory Centre and FPA are not nearly as "fortunate." When speaking with Mary Crawford at Brook, she mentioned that HYPE carries two brochures concerning sexual health services in Belfast: one with Brook's contact information and one without. "Brook are never, well, will not be welcome in Catholic schools because of other issues that people may have with them," Malachi states. Those "other issues" include Brook's confidential services to young adults, primarily free contraception.

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[43] Future Post-Primary Arrangements in Northern Ireland: Advice from the Post-Primary Review Working Group, 2004.
[44] Malachi O'Hara, interview with the author, April 18th, 2008.

However, the FPA is even more controversial than Brook, predominately because of their pro-choice approval. While they function from a liberal viewpoint, the FPA also caters to young adults, offering sexual health courses that are self-selected. When discussing feedback from youth, Georgie McCormick, manager of training services at FPA, states:

> …often information comes from a prohibiting stance, so it's not sort of a celebration of sexuality and developing sexuality and excitement about growing up…we see our work more around developing your personal preference around the expression of your sexuality, developing and understanding consent in your life, and preparing yourself through your sexual development and sexuality for the adult world, and whatever relationships you decide to have in that…so often we would see young feeling a bit bombarded because often the unspoken is that… it's too delay things or prohibit them.[45]

In this sense, the FPA has noticed that sexual education in schools is not holistic in the sense that information is often targeted at reducing teenage pregnancy rates and the spread of STI's, omitting other information that may be at the forefront of young adult's minds. Similarly, Malachi O'Hara of HYPE states:

> Young people see the sexual health information that they may get in a formal education establishment as, biological, less-relationship focused and kind of mechanical. Where by what we do is a lot of work around relationships, talking about the issues around sex and sexual health.[46]

Reflecting on feedback from young adults in formal school settings, Malachi mentioned that they often want programs to last longer, follow a theme, and include more information.

Overall, inconsistencies that exist from school to school are leaving pupils with partial information from a source which they feel should be the predominant provider of sexual health information.[47] Although there are outside organizations that aid in the RSE curriculum, those organizations are often limited by the ethos of the school in terms of appropriate subject matter. The future of sexual health education in Northern Ireland, according to respondents, should be consistent, holistic, and thematic. Also, RSE must be implemented and regulated in schools. Nearly all respondents mentioned controversial topics such as contraception, abortion, and homosexuality, and their

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[45] Georgie McCormick, interview with the author, April 21st, 2008.
[46] Malachi O'Hara, interview with the author, April 18th, 2008.
[47] Towards Better Sexual Health, 2002: 19-20.

absence from many schools. These topics should be approached in a way that complies with guidelines in terms of tolerance and respect for both oneself and other individuals.[48]

As a researcher, I noticed reoccurring themes within these guidelines such as the prominence of teaching from a moral standpoint. For example, the guidelines state "pupils should be encouraged to appreciate the value of stable family life, marriage, and the responsibilities of parenthood,"[49] which implies that family life, marriage, and parenthood should be striven for; however, this statement might not align with the values of all young people. Because RSE is operating in a Northern Ireland context, the existence of "ethos" cannot be extracted from a formal school setting, particularly if the school is religiously affiliated. However, seeking to provide pupils with RSE that is as objective as possible by providing uniformed, non-biased information will ultimately establish consistency. Similarly, sexual health organizations in Belfast must continue to engage youth in dialogue about additional topics. If such topics were addressed in formal school settings, pupils would be able address their own sexual health questions from the source they would prefer to learn from: schools.

Flow Chart C:

OUTSIDE MORAL INFLUENCES + INDIVIDUAL'S BELIEFS → SEXUAL HEALTH SERVICES

Outside moral influences, such as the ethical climate of the society and family ethos, adjoin with the individuals' own social and moral values, producing attitudes and opinions towards accessing sexual health services.

> You know, it was so different for us when we were young. It was all about fear. We were just too afraid to do anything. Now excuse me for being blunt, but when we were young, were told that one drop of sperm would crawl up our leg and get us pregnant… Now there are fourteen year-olds dropping kids all over the place![50]

I could not help but chuckle as I listened to Leslie talk about her sexual education experiences growing up in the predominately Protestant area of Sandy Row in Belfast. Now in her 40s, Leslie has joined the Donegal Pass Women's Group and is currently working on a sexual health accreditation with about five other women. The women hope

[48] Guidance for post-primary schools, 2001:23.
[49] Guidance for post-primary schools, 2001:8.
[50] Leslie (pseudonym), informal conversation, April 23rd, 2008.

to take several courses and then go out into their community and educate young adults about sexual health and well-being. There are several community initiatives targeted towards young adults in Belfast, from both liberal and conservative perspectives. The women of the Donegal Pass Group feel that information about contraception and STI's is vital to ensuring that young people make informed decisions. Other groups, such as Precious Life, the Society for the Protection of the Unborn Child, and the Life League also seek to reach young adults; however, their tactics often differ from community education programs such as those suggested by the Donegal Pass Women's group. These pro-life groups, also including the Free Presbyterians, picket both the Brook Advisory Centre and the FPA. Four days out of the week, these two sexual health clinics are key points for fundamental pro-life organizations. The number of picketers varies, from two or three people to a group of fifteen. Also, the tactics in which picketers use to deter or solicit young people may vary. Mary Crawford from the Brook centre states:

> We've had some pretty horrendous pickets of candlelit vigils of people wearing mantillas all dressed in black, carrying a red rose and a baby coffin. The Life League has a bucket that has fetuses in it, plastic fetuses with red paint in it. They have horrendous posters that they've put up outside in relation to abortion.[51]

From the viewpoint of sexual health clinics, these pro-life organizations represent one of the main obstacles when young adults are accessing sexual health services. When I spoke with Mary Ann[52], a representative of Precious Life, I saw the "horrendous posters," and I was offered pamphlets that depicted dead aborted fetuses. All the information was incredibly graphic. As I spoke with Mary Ann, a woman who worked for the FPA assumed the picketers had "grabbed" me on my way in to access sexual health services. Before entering the building she turned to me and said, "She's talking nonsense to you. It's not factual." At the time, my role as "objective researcher" was in full gear and I did not take much notice to what the woman had said. However, after the meeting and when previewing some of the pamphlets from Mary Ann at Precious Life, I began to realize how incredibly profound the experience had been. If I had, in fact, been on my way to access information or contraception from the FPA as a young person living in Northern Ireland, the presence of the picketers would have been extremely

[51] Mary Crawford, interview with the author, April 14th, 2008.
[52] Pseudonym, informal interview, April 23rd, 2008.

intimidating. As a researcher I was able to look at the interaction much more objectively, but only upon reflection of the experience did I realize the obstacles young people must overcome to access such services.

In Northern Ireland, the ethical climate is very pronounced. With the infusion of church and state, the line drawn between what is moral and immoral is quite clear. The Abortion Act of 1967, which regulated abortions by registered practitioners in the United Kingdom, did not extend to Northern Ireland. The FPA factsheet concerning abortions in Northern Ireland states:

> Abortion is only legal in exceptional circumstances – if the life or the mental or physical health of the woman is at serious or grave risk. In the absence of clear guidelines, the law remains ambiguous and the provision of abortion is often determined by the moral views of individual doctors or by unwillingness to test the law.[53]

Three years ago, the FPA mounted a case against the Department of Health, requesting clarity in the guidelines for those that are able to access abortions in Northern Ireland. After losing the first case and winning the second, the FPA is still waiting for redrawn abortion guidelines from the Department of Health. Georgie McCormick of the FPA states:

> So we're still waiting on those… and with the devolved government now the assembly up and running that could well have an impact…I don't think I'm wrong in saying this that a huge majority of those assembly members would be anti-choice.[54]

With policies concerning abortion guidelines still pending, the general consensus about the morality of the act in general remains the same. However, Georgie was quick to mention that the times are changing, stating that when they opened the FPA clinic nearly twenty years ago, most woman accessing their services knew very few women that had received an abortion. Today, most women that contact the clinic know other women that have undergone some type of abortion procedure. "Women are talking to each other," Georgie states, suggesting that regardless of the policy, women will continue to travel to England and other countries to receive abortions.

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[53] FPA Policy Statement: Abortion, 2008.
[54] Georgie McCormick, interview with the author, April 21st, 2008.

However, those in opposition have an agenda as well. Organizations such as Precious Life have no way of identifying what exactly a young person may be accessing when entering a sexual health clinic. The main tactic is to reach everyone, especially young women. Mary Crawford of the Brook Advisory Centre states, "They [young people] had been circling the block, waiting until the picketers left before they went in," when discussing the Sunday afternoon clinic in which the pro-life religious organization Life League pickets. Malachi O'Hara of HYPE mentioned how fortunate their organization was to be free of picketers stating:

> Our target group are vulnerable and isolated young people, so we're very wary that if we become an organization that is picketed, vulnerable and isolated young people would not use our services.[55]

In addition to societal attitudes and policies concerning abortion, religion also plays a predominate role influencing young adults. In the "Towards Better Sexual Health," nearly 84% of respondents identified as either Protestant or Catholic.[56] Within the same research, "pupils at Catholic maintained schools were least likely to be taught about contraception and safer sex."[57] Similarly, atheists were most likely to approve of abortion with Catholics as the mostly like to disapprove of abortion in non-extraordinary situations.[58] This finding points to the more conservative attitudes of the Catholic Church towards contraception and abortion. However, both Georgie McCormick of FPA and Malachi O'Hara of HYPE mentioned the extensive work they have conducted with Catholic youth groups and Catholic schools. While sexual health organizations are gaining access into religious settings, overall social views are still very much conservative, projecting onto the young people of Northern Ireland.

Another taboo subject, homosexuality, seems to produce much controversy as well. When speaking with Dr. Dirk Schubotz of Queen's University about sexual orientation, he remarked on his current research, which includes attitudes and opinions of 16 year-olds concerning sexuality. When asked about bullying in schools due to sexual

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[55] Malachi O'Hara, interview with the author, April 18th, 2008.
[56] Towards Better Sexual Health, 2002:16.
[57] Relationship and Sexuality Education in Schools Factsheet, 2005:2.
[58] Towards Better Sexual Health, 2002:31.

orientation, Dirk qualified it as "horrendous."[59] Attitudes about homosexuality are still very conservative as over half of the respondents said that "sex between men was always or almost mostly wrong," and over one-third spoke about sex between women in the same fashion.[60] When speaking with Malachi O'Hara of HYPE, he mentioned that his peer education team works to incorporate themes of tolerance within their programs. Problems such as bullying and discrimination based on sexual orientation are a civil rights offense, and Malachi makes a point to inform his students about their rights, regardless of how they identify sexually. Furthermore, the HYPE teams works to combat sexism, involving students in exercises that talk through media messages and stereotypes in accordance with gender.

Media messages, through venues such as television and magazines are a prominent source through which young adults learn about sex. "The media bombards society with overt and often misleading information," influencing young people's sexual behaviors (FPA factsheet RSE in schools 2005: 3). Because peers and media come to the forefront when informing youth about sex, dialogue between parent and child is often difficult. Research in 2002 which sampled young people ages 15 to 17 at Catholic maintained post-primary schools states "68% of pupils find it difficult to talk to their parents about sex and sexuality," despite the fact that 78% of parents indicated they would like to talk to their child about relationships and sex.[61] Mary Crawford of the Brook Advisory Centre remarked about how she has to "deal" with parents on a regular basis stating:

> So you get that: parents wanting the best for their children, and actually it causes difficulty for them down the line. We would spend a bit of time every week with a parent who is concerned.[62]

She was referring to an incident in which an angry mother phoned when she found her daughter had accessed contraception from Brook without her approval. Young people, depending on their living situation and family life, may face additional obstacles when accessing sexual health care. While many parents would want to be involved in their

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[59] Dirk Schubotz, interview with the author, April 22nd, 2008.
[60] Towards Better Sexual Health, 2002: 52.
[61] Relationship and Sexuality Education in Schools Factsheet, 2005:2.
[62] Mary Crawford, interview with the author, April 14th, 2008.

child's decision-making processes, there still exist many obstacles for both parties when fostering a collaborative relationship.

In terms of accessing sexual health services such as contraception, STI testing, abortion counseling, and information concerning sexuality, young people in Northern Ireland are faced with several venues of opposition. The ever-present media impact ideas concerning appropriate and expected sexual behavior, religious convictions aid in formulating ideas and attitudes towards contraception, homosexuality, and abortion, and parental input is often negative or non-existent. This combination of opposition is topped off with protests by pro-life organizations, often successfully deterring young adults from accessing sexual health services.

CONCLUSION

After spending three weeks immersing myself in nearly all aspects of sexual health information, I was able to draw three main themes from the data I had collected. First of all, previous research such as "Towards Better Sexual Health" and annual reports from sexual health organizations have much insight in terms of ways to improve sexual health and well being of young adults in Northern Ireland. The recommendations made by the authors of "Towards Better Sexual Health" are in accordance with what I have observed from my research as well. Young adults have several sources from which they receive information concerning sexual health. By targeting those sources that may produce unreliable information, such as peers, the youth of Northern Ireland have a much better chance at making well-informed decisions. Peer education programs are an excellent way to both educate and engage youth in a sexual health dialogue. Organizations such as HYPE operate successfully because of positive feedback from youth. Because young adults want their primary source of sexual health information to be in a formal school setting,[63] RSE guidelines should be developed and implemented to align with the needs of students. By incorporating an element of self-selection in sexual education programs, young people will be able to address topics that are one their minds. Similarly, community based programs should exist to bring parents into the picture, fostering discussions and relationships about sexual health between parent and child.

[63] Towards Better Sexual Health, 2002:19-20.

Concerning RSE in a formal education setting, there should be holistic programs that are as objective as possible, minimizing inconsistency between schools. RSE policies should be regulated to ensure that students, parents, teachers, and administration are all active in the implementation stages of RSE. Finally, there must be an acknowledgement that the social and ethical climate of Northern Ireland, while conservative, is changing. However, young adults should be able to access sexual health clinics with as few obstacles as possible. The Brook Advisory Clinic and the Family Planning Association have worked incredibly hard to ensure confidential sexual health services to young adults, and nearly all of their services are free. Overall, the level of sexual health in Northern Ireland is improving, but initiatives to continue reliable and consistent information, services, and education should continue.

At the beginning of this research, I did not realize how drastically different Northern Ireland was in relation to the United States concerning sexual health education. Because religious education remains a component in formal education in Northern Ireland, there was a dynamic that I was very unfamiliar with. I had to overcome yet another obstacle: the fact that abortion is illegal in Northern Ireland. Coming from a very pro-choice viewpoint, this subject alone was very difficult for me to cope with. However, the most challenging aspect of this research was the confrontation of religion and opinions about morality. My conversation with Mary Ann from Precious Life was more than just an observation; the interaction challenged my own values and beliefs to the very core. Although I have conducted previous research on extremely fundamental religious organizations, not until this experience did I come to terms with the importance of mapping and addressing your personal convictions.

As for the scholarship, there were minor limitations in terms of methodology and the respondents and groups I was able to contact. This research would have benefited from observing and interacting with youth, as well as individuals from more fundamental, conservative backgrounds. For future research I would recommend an approach that incorporates young people from both ends of the political and religious spectrum. Similarly, observing RSE in a formal education setting from a variety of schools would add another needed dimension to the topic.

Not only was this project extremely interesting and rewarding, the research process became a three-week period of self-education. As I collected data and interacted with respondents I was educating myself about sexual health and awareness, adding exponentially to what I knew previously. I now have a revived sense of promoting confidence and awareness concerning my sexual health and the sexual health of those around me. At several points throughout the research I would discuss what I had learned with my friends, informing them as a peer educator. This research has inspired me to go out into my own community and promote an awareness of sexual health. I look forward to taking this knowledge and applying it to different areas of my life, especially with my continued focus in Sociology.

BIBLIOGRAPHY

Brook Advisory Centre. How to stay safe from sexually transmitted infections. London: Brook Advisory Centre, 2006.

- - -. Safer sex made simple. London: Brook Advisory Centre, 2006.

Costello, Steve. Future Post-Primary Arrangements in Northern Ireland: Advice from the Post-Primary Review Working Group. Deni.gov.uk. Jan. 2004. Department of Education for Northern Ireland. 30 Apr. 2008 <http://www.deni.gov.uk/index/22-postprimaryarrangements-new-arrangements_pg/resources/22-ppa-research_and_reports_pg/22-ppa-rap-cr_pg.htm>.

Department of Education for Northern Ireland. Guidance for Post-Primary Schools: Relationships and Sexuality Education. Belfast: Northern Ireland Council for the Curriculum, Examinations and Assessment, 2001.

- - -. Guidance for Primary Schools: Relationships and Sexuality Education. Belfast: Northern Ireland Council for the Curriculum, Examinations and Assessment, 2001.

- - -. Relationships and Sexuality Education (RSE) . Bangor: Department of Education

Curriculum and Assessment Branch, 2001.

Family Planning Association. FPA Policy Statement: Abortion. London: Family Planning Association, 2008. fpa.org.uk. Jan. 2008. Health Promotion Agency. 27 Apr. 2008 <http://www.fpa.org.uk/attachments/published/346/Abortion.pdf>.

- - -. Relationships and Sexuality Education in Schools Factsheet. Belfast: Health Promotion Agency, 2005.

- - -. Sexual Behavior and Young People Factsheet. Belfast: Health Promotion Agency, 2005.

- - -. Towards Better Sexual Health Main Findings Factsheet. Belfast: Family Planning Association, 2002.

Health Action Zone North and West Belfast. How is it for You: A Survey into the Sexual Health Services Needs of Young People in North and West Belfast Executive Summary. Belfast: Department of Health, Social Services, and Public Safety, 2007.

- - -. RSE: Making it a Reality Report Summary. Belfast: Health Action Zone, 2008.

- - -. A Strategy to Promote the Sexual Health and Well-Being of Young People in North and West Belfast Summary. Belfast: Health Action Zone, 2007.

Health Promotion Agency. Focus on Alcohol: A guide to drinking and health. Belfast: Health Promotion Agency, 2006.

- - -. You don't have to be drunk to be doing real damage. Belfast: Health Promotion Agency, 2006.

[include] youth. Strategic Plan 2005-2008. Belfast: [include] youth, 2005.

Mother & Child Campaign. Women have a right to know: harmful effects of induced abortion. Dublin: Mother & Child Campaign, n.d.

Precious Life. Reality: Your guide to good sexual health. Belfast: Precious Life, 2006.

Precious Life Ministries. Did You Know...? Belfast: Precious Life Ministries, n.d.

Schubotz, Dirk, Audrey Simpson, and Bill Rolston. Telling It Like It Is: Young People's Experiences of Relationships and Sex in Northern Ireland. London: Family Planning Association, University of Ulster, 2003.

- - -. Towards Better Sexual Health: a survey of sexual attitudes and lifestyles of young people in Northern Ireland. London: Family Planning Association, University of Ulster, 2002.

Sexual Health Direct. Your guide to emergency contraception. Belfast: Family Planning Association, 2006.

Simpson, Audrey, Attracta Lafferty, and Roy McConkey. Out of the shadows: a report of the sexual health and well-being of people with learning disabilities in Northern Ireland. London: Family Planning Association, 2006.

Women's Counselling Network. Before you choose abortion you have the right to know... the Breast Cancer/Abortion Connection. Belfast: Women's Counselling Network, n.d.

Women's Network. Considering Abortion? Belfast: Women's Network, n.d.

APPENDIX A: Sites, Dates, and Times of Observations and Interviews

- GUM Clinic Observation, Royal Victoria Hospital, 110 Saintfield Road, Belfast, on Monday, April 24th, 2008. Arrive 7:45AM, Depart 9:30AM.
- Informal interview with Mary Crawford, Brook Clinic, 29a North Street, Belfast on Monday, April 14th, 2008. Arrive 9:50AM, Depart 11:20AM.
- Informal interview with John McComb, Include Youth Offices, 3 Rosemary Street, Belfast, on Thursday, April 17th, 2008. Arrive 9:50AM, Depart 10:40AM.
- Informal interview with Malachi O'Hara, HYPE office at Social Services, 16 College Street, Belfast, Friday, April 18th, 2008. Arrive 2:50PM, Depart 4:00PM.
- Brook Clinic Observation, 29a North Street, Belfast, Saturday, April 19th, 2008. Arrive 2:00PM, Depart 2:45PM.

- Informal interview with Georgie McCormick at the Family Planning Association, 24-31 Shaftesbury Square, Belfast, on Monday, April 21st, 2008. Arrive 9:20AM, Depart 10:30AM.

- Informal interview with Dirk Schubotz at the Queen's University School of Sociology Building, Belfast, on Tuesday, April 22nd, 2008. Arrive 1:50PM, Depart 2:45PM.

- Family Planning Association Observation, 24-31 Shaftesbury Square, Belfast, Wednesday, April 23rd, 2008. Arrive 1:15PM, Depart 1:40PM.

- Informal meeting with Michael Anderson at Best on the Row Café, Sandy Row, Belfast, on Wednesday, April 23rd, 2008. Arrive 2:00PM, Depart 3:45PM.

- Donegal Pass Women's Meeting at Donegal Pass Forum Building, Belfast, on Wednesday, April 23rd, 2008. Arrive 6:45PM, Depart 8:30PM.

- Informal interview with Joanna Greg of the Sexual Health Team, Student's Union Café, Queen's University, Belfast, on Thursday, April 24th, 2008. Arrive 12:45PM, Depart 1:55PM.

- Observation and informal interview with Anna Marie Burns, Artillery Youth Center, Victoria Parade, Belfast, on Thursday, April 24th, 2008. Arrive 6:45PM, Depart 7:45PM.

Advisor Meetings:

- Wednesday, April 9th, 2008, Student's Union Café, 4:00PM.

- Thursday, April 17th, 2008, Student's Union Café, 3:15PM.

- Wednesday, April 23rd, 2008, Student's Union Café, 4:30PM.

APPENDIX B: Interview Schedule

Interview with Mary Crawford:

- What is your official job title and description? Also, how long have you been working here?
- What are the demographics of the young people that access your services?
- Do young people find the Brook Clinics easily accessible?
- What ways do young people find out about Brook?
- Tell me about the Belfast office opening "amid controversy" according to the Brook website?
    - What are reasons for social controversy?

- What types of education programs do you have? Have you found these to be effective when working with youth?
- Does Brook get picketed?
- What is the process of STI treatment at Brook?
- What is the waiting time like to see a counselor at Brook? Are young people offered tea or coffee? What is there for young people to do while waiting?
- What is the gender breakdown of the Brook staff?
- Do you offer education programs in schools?

Interview with John McComb:

- What is your official job title and description?
- What age range do you work with/ what is the gender breakdown?
- What are the core aspects you wish to address when working with a young person?
- How do most young people find out about your organization?
- How does sexual health education factor into the Give and Take Program?
- What are the strengths and limitations of your organization in your opinion?
- Do you address drug and alcohol education with youth?
- What do you hope to achieve when you first meet a young person?

Interview with Malachi O'Hara:

No specific Interview Schedule

Interview with Georgie McCormick:

- What is your official job title and description? How long have you been working with fpa?
- What sexual health education programs does fpa offer in Belfast?
- What is the fpa's relationship with post-primary schools in Belfast?
- Does fpa get picketed?
- What type of feedback are you receiving from young people that access your services, or young adults within your education programs?
- Can you tell me about fpa's long-term and short-term goals in Northern Ireland?
- What are the strengths and weaknesses of fpa in accordance with young adults?

Interview with Dirk Schubotz:

- What is your official job title and description? What is your focus within the discipline?
- How did you become involved in the 2003 research "Telling It Like It Is" with Bill Rolston and Audrey Simpson of fpa?
- What were your strategies when getting into contact with young people for that research?
- What have been the subsequent implications, if any, of that research?
- What are your own reflections on the research? What were the strengths and limitations?

- Do you have suggestions for future research concerning sexual health opinions and patterns of young people in Northern Ireland?
- What projects are you currently involved/ have you continued with this subject?

Interview with Michael Anderson:
No specific Interview Schedule

Interview with Joanna Gregg:

- What is your official job title and description? How long have you worked with the Sexual Health Team?
- What sexual health organizations, if any, are you partnered with in Belfast?
- What is the RSE training like for teachers?
- Could you tell me about current RSE guidelines?
- What do teachers think about the training, and also, are they implementing and utilizing their training once their return to their respective schools?
- Do you offer training to outside organizations like different community groups?
- Do work at all directly with young people?
- What are the strengths and limitations of the work of the Sexual Health Team, in your opinion?
- What are the short term and long-term goals of the Sexual Health Team?

Interview with Anna Marie Burns:
No specific Interview Schedule

APPENDIX C: Interview Transcriptions

NAME: Mary Crawford
DATE/LOCATION: Monday, April 14th, 2008, Brook Advisory Clinic offices
START TIME: 10:05AM
END TIME: 10:55AM
DURATION OF INTERVIEW: 18:17

MARY: Brook opened in September 1991 and I was employed in November of that year, and I've been here since then so someone else came to set it up. There's a lot of controversy about it because…. I think Northern Ireland is divided into people who are either for or against it, there is little gray area in terms of sexual health where young people are concerned. So people who have strong views in relation to that, and we had a lot of picketing and a lot of bother during our first year that we opened of people protesting against the services provision. Now, seventeen years on we have pickets on SPUC, Society for the Protection of the Unborn Child picket on a Thursday evening, Free Presbyterians picket on a Friday afternoon, a group called Precious Life picket on a Saturday afternoon and a group called Life League picket on the Sunday. So we're open seven days a week and at least four of those days we have some form of picketing outside. Some worse than others. We were looking for our peace prize when we first opened because the two communities came together to oppose us (laughter) but actually we found out that they didn't picket at the same time. Certainly the Free Presbyterians don't like to be seen with Catholics. A number, two of the groups are particularly Catholic, one is Protestant and the other is probably…I would thought primarily Catholic but I wouldn't be sure. We recently opened our clinic here in Belfast, we opened two days a week when we opened. Thursday evening and Sunday afternoon because those were easy times for young people to access services. Town is open late on Thursday evening and on Sunday afternoon young people don't have to actually account for all of their time so they can go somewhere that parents might not know. Legally, you can get contraception without your parents knowing and a lot of parents

don't actually know that. So we would get phone calls from parents saying, "You gave my daughter contraception, I'm taking you to court." The first time that happened I was kind of thinking, "Oh right! Okay." (Laughter) Then, the second time I began to say, "This is my name, this is my address, please come back and talk to your GP, talk to your solicitor, get the information," and then we never hear from them again. Parents don't know that. The age of consent here is 17, whereas in England, Scotland, and Wales it is 16. So there is controversy over that as well because there is work going on as well about reducing the age of consent. A lot of our young people think that it is 16 anyway, so there is confusion over that. Access to services is difficult because a lot of the community family planning clinics are open during the day, they're not open during the evening, or after school so it's difficult for young people to actually access them. If you live in a society where people don't believe there should be sex before marriage, then you automatically have a difficulty in this type of service provision. If you're starting line is "you must be married," then everything else falls out under that. There is a myth that most young are engaged in sexual activity, but most young people under the age of 16 in Northern Ireland aren't engaged in penetrative sex. They might be involved of some other activities (knock on door) Yep? Oh great, this is Rachel and she's one of our administrators.
RACHEL: Oh hi!
CARLY: Hi, I think I spoke with you on the phone actually. Thank you!
MARY: That's lovely, thanks a million. Alright, see you later. So yes they may be expressing their sexuality in other ways but not actually through penetrative sex. The abstinence programs haven't taken off as much here as they have in certain parts of America. Now there would be groups that would be very keen on that, and certainly from research that I know of, 10 % of young people, well, 10% of all of us, do everything. We smoke, we drink, we have sex early, we do drugs. 10% of us do nothing, we don't do any of those things. The other 80% dabble in and out of either doing things or not doing things. So for us we're looking to protect the 80 % and help have an impact on the 10% of those of us that are involved, whereas the abstinence groups then are working with 10% that aren't doing anything anyway, and trying to impact on the 80%. So, if you kind of see it in that way, and how that works, then it's a way of keeping them in mind, who you're working with and what you're doing. Our clinics very quickly became very popular, despite the pickets, and often, on a Sunday afternoon, we would finish at 4 o'clock. At 10 to 4 the picketers would leave and then the young people would just fall in the door, at least ten or fifteen of them! They had been circling the block, waiting until the picketers left before they went in. Now they're left, concerned, we really don't know how many the picketers are pulling off. At one stage we would have go out to people to bring them inside the building, depending on what was going on and how big the pickets were. We've had some pretty horrendous pickets of candlelit vigils of people wearing mantillas all dressed in black, carrying a red rose and a baby coffin. The Life League have a bucket that has fetuses in it, plastic fetuses with red paint in it. They have horrendous posters that they've put up outside in relation to abortion.
CARLY: How many people are-
MARY: Well, there could be two or three or there could be fifteen. So it really depends on how organized they are and what they're interested in. When Precious Life first started they had a particular vendetta against me, so I had to look at my own home security, and look and how I came in and out of work and where I was, safety in my house in relation to that. Somebody sent out letters to all my neighbors saying about how I sent 70-odd women a week to England for abortions and that where good people remain silent evil triumphs. That was really interesting when they did that. I live in a community where I am well known and I am very much part of that community, so my neighbors came with the letters saying, "Oh my God what is this about?" But they were actually more concerned for my children then they were for me because they were saying, "Whatever you chose to do, you chose to do," but what if they did something to you when you were with your child? You know, so the women in the area were great. Georgie will talk to you about abortion, so there's no point in my going over all of that because she'll go over all of that with you. We refer any young person coming to us who is, who has an unknown planned pregnancy considering an abortion, and we send them all over there. So we don't do any abortion work. We are pro-choice organization, however, it's partly to do with our funding, that we don't actually talk to young people about abortion, they go to the fpa. There are tactical there anyway, so it's easy. We just send them straight there rather than getting into conversation with them ourselves.
CARLY: Well, earlier I went to Victoria Hospital, and they have a GUM Clinic there. I went to check it out, so when people come in to get tested or treated, does that actually happen here?
MARY: yes, over the past, we've been fighting for that for years for funding. We've got funding in the last 18 months for doing Chlamydia testing, so any young person that comes in, and actually our highest rates

of positive Chlamydia's are from opportunistic testing of pregnancy, and then they get treated and their partners get treated here. If the doctor, the doctor then does an assessment, and if the assessment identifies that they need further screening then they would be sent to GU. That's where we always have someone from GU sitting on our management committee. In terms of our management committee we would, Audrey Simpson for example sits on that from the fpa, we have a woman who runs the family planning course at Queen's that's on that, someone from the Equality commission, so we identify that we do acknowledge the skills that we need for our management committee and that would include GU, young people, and diversity general would sit on that. We have, so we started off with two clinics, then we rapidly went to a third clinic then a fourth one and then we got funding five years ago for two clinics on a Tuesday and Wednesday. Just after that we got funding for the Sunday clinic and that was a really big deal getting funding for the Sunday clinic, which is great. Because our Monday clinics are mad for emergency contraception after the weekend. So we were trying to cut down on the numbers coming in on Monday to level it out, but in fact all we've done is expand the service. So, we cover to (?) ten thousand visits a year of young people and about a quarter of those would be for emergency contraception.
CARLY: Okay, because I saw as I was playing around on the Brook website last night that there is a men's-
MARY: Yep, we have a men's clinic on Saturday s. From 4 to 5:30.
CARLY: So, the rest of the time during the week is just for women, or-
MARY: No, no. It can be men as well, in fact it tends to be that quite young men would come on a Saturday. So the age, when we first opened we were the same. We were up to 25s for everybody, and then we got so busy that we had to, we said to our funders, okay give us more money or we have to do something about the age, and they sent no more money and we said okay, so we're drop the age for young women, this was in 2000, from 25 to 19. So you can come to us up to you were 19. But for young men, since some young men come perhaps later, we thought we should leave the age up to 25. So we left that age up to there, so it's the older young men that come during the week, they come for Chlamydia testing, and it's groups of young teenagers would come in on a Saturday. It's quite a difficult clinic on a Saturday because… they're all over the place! They come in groups and they tell you all their sexual activities that they're involved, and we're working to build relationships so even when you come for contraception, you only three months pill the first time and probably the second time because we want to know what's going on. If you're under the age of 16 we want to encourage you to delay your sex, so it's not about, for us, saying it's about abstinence, but we're saying that there are consequences to what happens if you start early sexual activity. We know what those are, we know how it affects you educationally, we know that it affects you emotionally, and we know it affects you in terms of your employment. So we know, and those are all kinds of discussions we'd be having, but with the young men, they come into with all these stories. After about the third or fourth visit you actually find out that they have not have penetrative sex at all or because their peers or because they feel they have to say all of this they come to us with all these stories. So, if they're under, say for example the age of 14, it turns mandatory reporting, then that's a difficulty because we do report a 13 year old coming in and telling you all these fantastic stories about their sexuality, or the expression of their sexuality in terms of what they're doing, and then we find out three weeks later, actually, they haven't done that at all! (Laughter) So, from that point of view, we hold confidentiality very strongly and we're known to be confidential so our young people see brook as the place to come to for services, for service provision because the confidentiality. We have a large number of pregnancy tests that we do, but quite a low percentage of positive tests. But that shows that our young people are engaged in risky behavior, so… we need to get hold of those young people and anybody that's coming in for a pregnancy test, we really want to be having a wee discussion with them about what's going on and what they're doing, and accepting putting themselves at risk. Everyone that comes in gets the double dutch (?) story which is use a condom to prevent an infection and use contraception to prevent pregnancy. So we are very strong on that message, so everybody, that could be the minister of health walking out of here with flavored condoms (laughter) We're known for wherever you go, you'll get a condom from Brook because that's what we reflect strongly. We're really trying to help make informed choices, so we want young people to have that information, and that again can create difficulty with people if they don't want young people to have information. We believe that you have to have the information in order to make the responsible choice, and at the same time if you don't, if you keep coming back to us, because you've been involved in risky behavior… We don't have a problem with that either because at least you're trusting us to come back to us, and that's what we'll say even if you don't do what we suggest, please still come back and talk to us and let us know what's going on. Because you have to have somewhere to go to.

CARLY: So to establish that relationship?
MARY: Absolutely, to make sure that things are okay.
CARLY: Yeah, I saw that on your website on your mission, or vision, to help young people make informed choices. So when young people come in here to get contraceptives, in the states, Planned Parenthood you can go in and get birth control, you just have to meet with someone and make an appointment. Is that similar here?
MARY: Yes, we would have done some work with Planned Parenthood in the past, but when a young person comes in, there is a little sheet, they write down their name, their date of birth, and what they've come for, which means they don't have to say to the receptionist, "Oh, I had unprotected sex last night and now I need the morning after!" (Laughter) Because you kind of want to level it out and see what's going on here, and then be calm about all of it. So the first thing they do when they come in is that they register with a counselor. That's different from any other family planning clinic and it's different from even the agency HYPE?
CARLY: I have yet to contact them, but I know who they are.
MARY: Well if you get to, they have peer educators they don't actually have counselors, although they're a youth provision so we would say that that's our main difference from any other family planning clinic apart from our skills when working with young people. You have to come in and give a name, address, date of birth, contact number, what you've been involved in, what you've been doing, what's going on in your life, are you drinking, are you taking drugs, what age is your partner, what would your parents think if they knew you were down here, there's a whole list of things that you have to go on through. So you have to give quite a bit of information. Young men hate that! They hate giving personal information in order to get a packet of condoms (laughter) that if they were really desperate they could go down to the garage and put money in and get them. So they think that that's mad to give this much information, now we need this information partially for our funding, but also partially to work out how our service provisions should operate. Because you'll see, I'll give you a quick tour as well. So then after you come in here, and every young person that comes in for the first time you have to be seen by a counselor. So after that you go back out and wait and then the nurse or doctor comes and they'll bring you upstairs to the treatment floor, and they go through your medical history with you and one problem is that people don't know their medical history. So you know we're trying to be encourage to parents to actually tell them their medical history. Because we actually had a mum phone up and say "You gave my daughter contraception, it's a contraindication of her medication, and… really you're in big trouble." So, I said to her, "Look, we can't confirm that your daughter has been here, when someone comes in they are asked about their medical history. So if she had a medication she would need to say it then." And the Mum said, "Well she doesn't know it because the doctor and I decided not to tell her!" (Laughter) So you're then kind of taking a deep breath and then say, "Legally, she can go to any doctor for anything, so it might be the time to talk to your GP about telling your daughter what her medical condition is." So you get that: parents wanting the best for their children, and actually it causes difficulty for them down the line. We would spend a bit of time every week with a parent who is concerned. Although, it could be a parent phoning up to say their daughter is pregnant and what can they do. And they're devasted and they're trying to work out what they need to do. We send the parents to the Parents Advice Center, because we say "we're the advocates for the young people not the advocates for the parents." But that doesn't stop us from conversations and being empathetic to parents who find it very distressing.

NAME: John McComb
DATE/LOCATION: Thursday, April 17, 2008, Include Youth Offices
START TIME: 10:05AM
END TIME: 10:41:32AM
DURATION OF INTERVIEW: 36:32

JOHN: I'd say, as you probably already know Give and Take is a project that is managed under the umbrella organization Include Youth. That's our parent organization. Include Youth is mostly about promoting rights and best practices (?) Include Youth and individuals join practitioners join as well and we have a resource library, do a lot of training with practitioners do a lot of policy work. Include Youth, most of it's direction is policy driven and political. So our director would spend a lot of time at Stormont where the actual legislation is put together. So there are only two practice projects within Include Youth that actually work face-to-face with young people. The Young Voices project and then the Give and Take

Scheme. Include Youth has been around quite a long time, from 1979 under a different name, it was a terrible name, it was Northern Ireland (?) but it wasn't very catchy so we had a name change a number of years ago so it's much better. The Give and Take Scheme has been around a long time as well for a voluntary organization, because projects come and go usually due to short term funding like a two year cycle, one year cycle, so it's been around from '89 so that's quite a long time for a voluntary project. So basically the two main aims of the organization are pretty much the same as when the scheme was set up. It was noticed, back in '89 there was a government training scheme named YTP, Youth Training Program, and it was noticed that there were a significant number of young people that weren't able to cope with the demands of that mainstream training. It was also through research and stuff and it was noticed that a large number of these kids were coming through KERR? That weren't able to go out and do 9 to 5 days just because of all the other difficulties that arise, they just couldn't sustain it. So it was found that something different, something else, needed to be available for these young people and that's where the whole pioneer of Give and Take came about. So the two main aims are to improve the long- term employability of these young people and to raise their confidence and self-esteem because most of the young people that are known to come through our doors are, their views of themselves aren't particularly good. You have to do a lot of work in trying to build up their self image. The three ways in which we deliver the program is through supported work placements. So a young person joins the scheme and obviously when meet them they're not ready to go out and do any kind of programs so we do a lot of preparation work with them. We do an induction program, I can give you a copy of that before you go if you like, which is a series of exercises, and it's meant to create discussion between the project worker and the young person. We starting to talk about what sort of work they'd be interested in, what they're kind of skills are, what qualities do we feel like they have, but also doing really practical stuff, which some people would look at and go, "Well my God that's really basic," you know talking to them about what to do when your alarm clock doesn't go off in the morning. How do deal with that scenario and that situation, but we have to go right back to the beginning for these young people because they haven't learned that previously. They tend to be young people who have been out of a structured routine for a long time. The sort of young people that come to Give and Take have usually been in and out…haven't completed their education. So they're meant to stay until 16, the June after their 16th birthday and a lot of our young people haven't been in school since 12, 13, 14…and have some of them have attended what's called Alternative Education Projects and others haven't been given, or they've been given home tuition, which usually amounts to 18 hours a week (? Not sure couldn't hear him). The rest of the week… not much else. So they're completely out of structure and routine. Getting up in the morning, you know that's a big area for us, a big challenge when working with the young people. They're used to staying up until three or four in the morning playing video games and then sleeping in until lunchtime, you know? So that's a big part of what we do. Young people can't walk in off the street and join, it's a closed scheme. So you not see posters or anything advertising the scheme, obviously there are costs for each young person that's one the scheme and we have contracts with Social Services Trusts. The vast majority of young people that come on the scheme are young people that have had an experience with KERR and most of them tend to be stumbling between children's homes when they come to us or in foster care. They're at that stage in their lives, 16 or 17, when there are plans being put in place to move them out, or they've just moved out. That's where, after being in a reasonably stable foster care placement or stable children's home, they move back into their community, often without family. That's often where difficulty occurs, and we offer that package of support. We try to address the employment and training aspects and then other organizations we would partner ourselves with would be Bernardo's and other charity organizations. We are trying to address some of the other issues that are going on for the young person as well. So we're not trying to do it in isolation we're trying to do it with the other organizations that are brought in to work with these young people. Very often our referrals would come from what's called the (?) Leading After Care Teams within Social Services. So we're in quite a good place to work with those 16 and 17 year olds who are getting ready to move out of their… it's a very, very difficult transition period for these young people.

CARLY: Is that the normal age you get?

JOHN: Yes, a vast majority. We go up to 21 but the vast majority are 16 and 17, and we often place them in the scheme nominally for a year, but if they're not ready to move on in a year than we don't move them on. There's no point in moving them on if they're not ready so, so young folks are with us two, three years before they're ready to move on to mainstream. I suppose on of our main goals is, we get a young person ready to access mainstream training and employment. We do our work with them and hopefully the end result is that they are ready to access mainstream training or employment. Originally we didn't have

employment as particularly being high up on our list because the young people, with very little qualification… people used to say to me, "You know that's not what it's about, it's about putting into place those kind of developmental skills that they can take and you know, that will be with them for the rest of their lives." But, we got some money from Europe in December and we're going to employ an Employment Liaison Officers. So we're actually starting to think about trying to make connections with some employers, some of the bigger local employers, but also some of the bigger multi-national companies like Marks & Spencers, Tescos. To see if we can make links with them to see if they will not only offer our young people work placements but at the end if a person is successful at their workplace, holds it down for a specified period of time that they'll then offer them employment. The first model (?) is that we would remain involved for a further six months or something. So that's exciting for us, don't know how it's gonna go, but it's a big move for the young people, not just getting them ready for another training program but potentially, hopefully, getting them ready for employment. The supported work placement is absolutely core to what we do a lot of individual, intensive, work-related personal training to try and get them ready for placement we then source them to the correct placement and support them through their journey in that work placement. Sometimes several work placements, and that can be… because of difficulty holding it down, or it could be because of their age. It's very hard to work sometimes with young people everyday, so, some young people come to Give and Take and use for several different types of work places and they're just ticking them all off the list trying to find a career. "I want to try hairdressing, nope, not or me." I think that's positive myself, you know because-
CARLY: I still don't know what I want to do!
JOHN: Exactly! (Laughter) Some days I wake up and I wonder! So some young people come on this scheme with a very clear idea about what sort of work they're after. We use that focus in the program as well to try and find our with their aims, what their interests are, to try and find something suitable and appropriate for them. We make sure in the work placement that there is a nominal supervisor so the young person is not just going in to work and sitting in the corner with nothing to do that there is some purpose to them being there. So the supervisor will look after them on a day to day basis. Each young person in the scheme gets two members of staff attached to them as well which is quite resource-intensive. We work with small numbers, so you know so that is what helps it work! The project worker will take them through their induction through the various different work placements, visit them every week at their work placement, maintaining a high level of contact with the young person so that we try and deal with any issues or problems when they are arising. So, for example, if Donna, our project worker down here went down to visit a young person at their placement and they weren't at work, she would then try and go and find them rather than saying, "Oh, okay, I'll call again next Tuesday then they'll be here." It doesn't work for our program, we'll go and find them and try to find out what's going on.
CARLY: So you're very proactive in that sense.
JOHN: Try and sort it out there and then before it becomes too much of an issue for the people that are offering us the work placement. They don't actually make money, the young people get money, their expenses. But we don't offer the placement organizations any money, and we're also not able to say to them, "You know, look here, take this young person as a volunteer, they're gonna turn up on time, they're gonna be reliable, they're gonna work really hard, they're gonna be a real asset to your organization." We can't even say that, so you are relying on a grain of good will. It would surprise you how many employers, not only in the private sector but also we would use a lot of placements in the voluntary community sector (11:21) that are willing to give young people chances you know? That's one of the most difficult parts of the job is finding the right placements for the young people… it's almost a separate job for the project workers to go and find placements. When we talk about our young people and let them know we've got (?) experience or whatever sometimes that can be a barrier for us. The eyes kinda roll and they just automatically view them as troublemakers, but we try and be philosophical about that be like, "Well if that's their view that then it was going to be a good training or work placement experience for the young person." We're meant to be about setting a positive experience for the young people, so we kind of just chalk them off (laughter). But it would surprise you that some of the placements in private sectors, some of the business people, who maybe you don't know what's happened in their past, maybe they've had some tough times as well. It's almost embarrassing the lengths that some have gone to help young people. We kind of pulling the reigns back and saying, "Look, you don't need to be paying their bail money (laughter) you know that's not your role here!" That's the absolute the cornerstone for us is getting these young people support through these different types of work placements so that hopefully by the end of their time one the scheme they're ready to access either mainstream traning or employment, and have an idea about

what it's like to hold down a job, a full time job. So the work placements will accept them up to four weeks as a trial placement because it's very difficult for us to go in somewhere and say, "Look can you take this young person on for a year?" That's a big commitment. So the first four weeks are a trail period- a trial period for the young person to prove themselves, a trial period for the young person to say, "Well they're not…" they actually want to do that line of work. A trial period for the placement provider to decide whether or not the young person fits in. So we do a review after four weeks and for four weeks we also usually ask for two or three work days a week, so it's gentle! It's like dipping the big toe in the water, just to see how things go. Then we'll have a wee review meeting after four weeks, now if everything is working out then we'll try to push the days and hours along a bit. Sometimes that is difficult for us because the young people that come through us, through our doors, have all these other professionals working with them, appointments here, psychologists here, and psychotherapy, and du nuh nah nuh na… So sometimes it's hard to get them out five days a week but you know we do try and get them out doing as many days and hours as are practical, but also that they're ready for. I think that's also one of our other keys is that we work at the pace of the young person, and if after four weeks if that two or three days is still where they're at then we'll stay there, we'll not push them too far, or else you're gonna end up setting them up to fail. So it's a very individual program for each young person that joins the scheme. So they're then reviewed every three months there after, and I would say, I don't have the statistics at hand, but usually young people would try two or three or four different work placements situations during their time with us.
CARLY: So how many young people do you work with per year? I remember you saying you had "small numbers…"
JOHN: Small numbers but we're right across Northern Ireland, so we've an office in Armaugh, Belfast, Ballymena, and Derry. So we've contracts with all the social services right across Northern Ireland. So during any one year… it's around about 130 young people that are coming through our doors. That would be some young people that stay with us the whole year and longer, and then some young people who don't even get through the induction program because they're not ready for it. But we're always hoping that young people will come back and we often get re-referrals after the original referral just wasn't the right timing for them, they weren't in the right place, you know, when all those other things were going on in their lives. They need to settle down but within a few months they then come back and we'll work much better so we're always more than happy to see them again.
CARLY: In terms of seeing someone from the beginning to a "successful" end, how many people do you think-
JOHN: Well, you know we have targets and we're hoping that with our European money our target is now 40% of our young people will get into employment…which is very high! Really high. In order to get the money we'll have to aim high, so we thought let's just go for it and see what we can do. We have a working partnership with the local careers, it's called DEL, Department of Education and Learning, with the Careers Service, so we work very closely with them. That's one of the biggest areas for us- the "move on" the leaving. We can do lots of with the young people while they're here and they staff they're working with are social work and youth work trained. We feel that we've a good track record of engaging with these hard to reach young people. We could do loads with them but its, I suppose, for the time and support. The next big challenge is, if we're like the first big rung on the ladder for these young people then the next big challenge is getting them out in (?) So we have a working partnership with the Careers. So Careers come in a meet the young person quite early on during their time with us and help design what's going to be the best plan for the young person, what's the most appropriate training for them, what type of work placements will do. Then we'll meet the young person (?) and their time, the rest of their time with Give and Take so that our young people will not have that strain of going around to Careers and facing problems. About two or three months before a young person is due to leave, we then bring the Careers officer in and they help us decided what's gonna be the best and most appropriate move-on option for that young person. Our links are pretty strong so a lot of our young people will leave Give and Take and will be put on the Government Training Scheme, which is called Training For Success, used to be called Job Skills.
CARLY: That's earlier what you said was sometimes too intense for young people to start out in?
JOHN: To start out in, yes, it would have been, "No way are they gonna cope with training for success!" We put them in the Give and Take and then hopefully, they will be ready. A lot of young people do move on to Training for Success but we're not putting employment into the nexus hoping to see a significant number employed. For the mainstream government program… we would be hitting about 60% of our young people that move on to mainstream training. Out of that 60% we're now hoping that there'll be a number of those that obviously won't go into mainstream training but will go into employment. We're also

increasing our numbers with the trust sthat we're contracted to, so we're hoping that's gonna give us young… we (?) so just always be sending us the young people with a whole range of difficulty in thinking- there is a few that are going through the social services team that have the impression of Give and Take being "last chance to learn." We have fought against being a dumping ground, we still want to work with those young people because we don't want to turn them away, but we also want to make it so our employers (?) where our young people can get jobs. Send us young people who need a little bit of support and we'll go through with getting them a job as well. The scheme has been changing and developing, and this has been our next big thing, this whole employment thing that's why I keep going on about it! (laughter) So the second part of the scheme is training, the profile of our young people would be, I mean, you've looked on the website… a lot of our young people have learning difficulties, numerous illiteracy problems, and come to us having no qualifications at all I mean right from, we'd be getting young people who can't even read or write, or sign their name.

NAME: Malachi O'Hara
DATE/LOCATION: Friday, April 18, 2008, HYPE offices
START TIME: 3:05PM
END TIME: 3:49 PM
DURATION OF INTERVIEW: 44:15

M: So you keep hearing our name in a positive manner? (Laughter)
CARLY: Yeah! Definitely in a positive manner! Everyone I've talked to has said, "Have you talked to HYPE?" and I'm like, "Well, I'm talking to them this Friday!"
M: So this is your independent piece of research sort of focusing around youth and sexual health?
CARLY: Well I'm majoring in Sociology and I'm really interested in gender and sexuality and religion so I thought this might be a good way to kind of compliment that. Plus it's interesting! So it's a lot easier to do something if you're interested in it!
M: Well that's true! That's what makes this job good because we're all from a youth work background, something similar to that and it makes this job so interesting. Then as well, sexual health.
C: What is your official title and job description?
M: Okay, I'll give you the brief synopsis, who HYPE is, what we do, what we came from, okay? So HYPE stands for Health for Youth Through Peer Education, are you familiar with the peer education model?
C: No.
M: Okay, it's a model that's generally used in health promotion that is about young people speaking to other young people. Now, I'm sort of moving out of that bracket, but as you can see, we have a pretty young team here. The reason for that, or the academic understanding, is that young people, as in adolescents and teenagers, during that period of their lives, other relationships such as those with their family or their community become less relevant, and the peer relationship takes paramount importance. Therefore, they can appreciate and understand better if peers, people the same age are speaking to them, or approximately the same age. Essentially, what we do is deliver sexual health and relationship education programs to young people in the hope that the young people we work with will then pass it on to other young people in their peer groups. We're unique in Northern Ireland, there is no other group like us, no other team like us. We're multi-disciplinary; in that we have peer educators, the senior peer educators which is my role, team nurses, our team leader, and admin support. We have the team nurses because we can also deliver drop in clinics, and various other services. My role as senior peer is to coordinate group work programs, to provide to inductions for the peer educators, to provide some basic training, and to deliver some additional training to health professionals, foster careers, community workers, and other youth workers. The role of the peer educator is to deliver the peer education programs, and the role of the nurse is to deliver outreach services but the nurse also has a training role and will also compliment the senior peer with delivering training to health professionals, etc. So that's that. Sorry that's a lot! (Laughter) You'll get that (points to recorder) there.
C: Yeah that's why I use it!
M: I go on a speed. So that's kind of who we are. HYPE came out in 1999 with a bid from community nursing to tackle the historic, and still ongoing rates of teen pregnancy in North and West Belfast. That was a project for three years, and pending a very successful evaluation in 2003, HYPE became mainstream funded by what was North and West Belfast Trust, that's now become Belfast Trust. So we're mainstream funded, which is really great because obviously a lot of projects maybe health services will run for three

years, do very well and then disappear. But this has become mainstream funded so just like any other school nursing, family planning clinics, we're accounted for… We've gone through some expansion, previously the team was three peer educators, the senior peer, and one nurse, and a team leader and an admin assistant. We now have four full time peer educators, two full time nurses, because we have more and more clinics. We do those in partnership with various community organizations. That's really been a great benefit for us. We have a raft of volunteers, and the intent with the volunteers is that people can volunteer for a while and then should a vacancy arrive and they're interested, they are already skilled and ready to step in. One of our volunteers who, in I'd known your particular interest was in sexuality and gender I would have had her here! She's a Swedish girl and she studies Social Anthropology at Queen's. That's her specialization.
C: Oh cool!
M: Yeah, so she's been volunteering with us for about 18 months and she now works part-time for us. She has lots of background in youth work anyway, but that's her specialization. She's really helped to invigorate some of our stuff around gender and sexuality, such as homophobia, challenging misogyny and sexism. Kind of different exercises and pieces of work that we can do that's kind of paramount to our work. Sorry I'm just rambling!
C: No, no that's good! So, the education programs that you do, do you go into schools?
M: Yes, that would be the bulk of our work, this is kind of our board (motions to large dry erase calendar), the peer board, this is what we are doing all our different projects. As you can see, it's quite buried, it's interesting about this.
C: I see Castle High-
M: Yeah! Do you know Castle High School?
C: Well I was looking online for high schools in this area, because I was trying to figure out how I could get in contact with administrators or principles or anything. A lot of people have suggested talking to you guys?
M: I would suggest, maybe try a variety of schools? Castle High is something that we've had a long term partnership with and they're very progressive. It's a state school… which means that there are no particular faith issues around what we can and cannot talk about. The kind of schooling system is broken into four in Northern Ireland, do take this as definitive, I know it's four… the council for Catholic maintained schools, which is basically Catholic schools. State sector, generally described as Protestant schools, although that's not particularly true, independent schools which include the integrated schools, and then the voluntary schools, which tend to be grammars. So it might be interesting to do something in different schools and see kind of what is the sexual health policy at CCMS school as opposed to a state school? So just to look at the differences. Castle High is someone that we have a great partnership with, and they're a great school to work in, they're very small. They won't last for very long.
C: Oh really?
M: It kind of goes back, there was a feud a few years ago when kind of the schools split along the lines of the feud within the Loyalist community… lots of issues there. So, the bulk of our work is in schools, but we do work with youth groups, so we do some evening work, so you see Maribone, which is kind of Ardoyne on a Wednesday. We're in Sally Gardens which is Polglass, and they tend to targeted at areas where there is a high rate of teen pregnancy. We work with youth training organizations; we work with Youth Justice Agency as appropriate. We also work in residential and care homes. Then of course specific interest groups whether that's LGBT groups, ethnic minorities, young people with learning disorders. We work with all the young people, that's what great about this is that one day I'll come in and be at a mainstream school and in the afternoon I'll be working with young people with learning difficulties, and in the evening I'll be out with young offenders. So, the variety is great. We kind of have a standardized program that we would like to deliver to everyone, unfortunately, that can vary dependent on the ethos of the partnership organization that we're working with. When it's in a school it can be a limited number of weeks within a school time frame. Youth organizations are generally our best kinds of programs because we can go there for ten weeks and we can deliver the whole gambit of sexual health and relationship education. Generally their tends to be no barriers on what we can talk about. Some of our schools, because of the relationship we've built with them over the last 7 or 8 years, it's gone from a perspective of where we can't talk about the issue of contraception to being able to address contraception if young people mention it, to, okay you can talk about contraception as a one hour session, okay you can bring in the contraceptive pack and the condom demonstrator and show young people how to use them. But that's because of the relationship we've built with them, we're kind of unique, no other organization can do that. Brook are never, well, will

not be welcome in Catholic schools because of kind of other issues that people may have with them. We are, and we work in quite a few Catholic schools.
C: I spoke with Mary Crawford at Brook and she said that just opening the clinic in Belfast was controversial anyway…
M: yeah, I don't mean to be maybe presumptive, but sometimes the moral climate of parts of Texas may be similar to the moral climate in Northern Ireland (laughter)!
C: (Laughing) People get real fired up about stuff.
M: Yeah, there's a kind of, you should have a look at, there's some sort of stuff… how do I- I want to put this politically right…just in Northern Ireland about the, sort of, the positions and powers of influence of people of a particular religious belief that represent less than 1% o the population which is the Free Presbyterians and their positions in government and their positions in business, and of the sectors that they're influential. They've done really well (laughter). So, unfortunately-
C: Yeah, I know, she was telling me that the Free Presbyterians, I think picket on Friday afternoons. They get picketed four days every week, which just amazes me. I think I might go and observe, which would be interesting.
M: We don't get picketed… I think we're kind of lucky, we're aware of courting (?) in case we do get picketed. Our target group are vulnerable and isolated young people, so we're very weary that if we become an organization that is picketed, vulnerable and isolated young people would not use our services. We're lucky we haven't yet, and I hope that we don' t in the future. We do some work in partnership with Brook and we promote their services, unfortunately, we've to produce some leaflets that don't include Brook because certain schools are not allowed to mention Brook. It's a stipulation, we're not allowed to mention them, yet if you speak to young people, where do you go for contraceptive advice and information the first thing they say is Brook. Yeah, picketer are… yeah (laughs). So at the moment we're not.
C: So what about, more specifically, well, everyone I've interviewed so far has been kind of older, and in more administrative positions, and I really want to get a more "young voice." Could you maybe shoot back to me with what you've been collecting from young people? I know that's kind of a really big question-
M: No, okay. Um… we're quite good. We evaluative everything in a sort of 360 kind of arc. We get feedback from young people on each individual session, we then critique ourselves on each session afterwards when we do our evaluation. At the end of our programs young people evaluate the whole program, the partner agency will evaluate the whole program and that's from anecdotal feedback from young people that they're speaking to and also the perception of the youth worker, or the pastoral care, that happens to be in a particular organization. We produce our own kind of report on the whole program. There are consistent themes: young people want it to be a longer program, they want more information. They're really positive about the type of work we do, it's not me standing lecturing for an hour and a half or two hours, it's informal, participative group work. They learn from that. We do a baseline quiz in our first week which is just to get a level of, to inform us what level they may be at. Then we'll do that at the end of the program and you can see the differentials in about how much they've actually learned about those things. The kind of standard is that young people see the sexual health information that they may get in a formal education establishment as, biological, less-relationship focused and kind of mechanical. Where by what we do is a lot of work around relationships, talk about the issues around sex and sexual health. We have a whole section on sexuality, looking at in from a more holistic perspective then just whether you're gay or whether you're straight, that it's broader than that, that it's your attitudes to sex, how you're socialized to feel about sex, what your fantasies, your desires, talking about your sex drive. We also talk around other issues, drugs and alcohol and their impact on sexual health. That's a big one, I think probably a big one everyone. A lot of young people, first sexual experience under the influence of drugs and alcohol, and then if you use drugs and alcohol you're less likely to use contraceptive methods, and all the complications that that leads to. I think young people come from the perspective that it needs to be earlier, it needs to be consistent, and it needs to be a theme. One of the schools that we work with is a school called Hazelwood, and currently we're working with year nine and that's kind of more appropriate relationships, peer pressure, personal safety stuff. Year ten we do another kind of program and it's more relationships, year eleven is then the full gambit of sex and sexual health. So it builds successively on it, year by year by year so that when they're leaving the school in Year Twelve they'll had four years of working with us at some stage or another. Hopefully that should lead to no pregnancies (laughter), or sexually transmitted infections. The pregnancies are something that you can kind of trace, the sexually transmitted infections you can't. We can't measure the impact that we may be having as a service on STI's. That's our ideal, working with that sort of school where we'd be in a program that would build

successively. Unfortunately, not all schools can do that, can incorporate us in, or are wiling to do that. Okay, I've gone on. Sorry.
C: So what ages would you work with?
M: 11 to 25. Everything is age appropriate.
C: And then have you had a partnership organization or school in which you've completed the whole process? Starting from year-
M: Yeah, Hazelwood would be the one. That's only come about this kind, previously we've done this short, one hour sessions and that's all you get the whole academic year, but now we're starting to build more strategically that it is year 9 you get three sessions, each for an hour and a half, year 10 it's sort of two hour sessions- four of those. Year 11 it's a six week program, and hour and a half each session, year 12, so Hazelwood is the one, and that's kind of evolved this year. They're really progressive, they're an integrated school. That might be an interesting one to visit.
C: Does your organization get contacted or do you go out?
M: We get contacted. We don't pimp ourselves (laughter) so much because that may create controversy that would get us picketed. We rely on the fact of word of mouth. Teachers meet each other at conferences together or training days and "Well who does your sexual health?" "Brook does ours, they're really good." "At a Catholic school?"
"Yeah, oh they do this for us and they do don't do it that way." That's kind of helped us to start expanding. Unfortunately grammar schools don't, because nobody gets pregnant at grammar schools, or nobody gets a sexually transmitted infection, or becomes a father… obviously, because they're all middle class (laughter). So that's kind of the perception and we don't work in any grammar schools at the moment. We have done some taster sessions, maybe like a presentation, but the schools are kind of, I don't know why. Maybe there is some sort of inbuilt snobbery (laughter) or expectation that their young people are kind of, able to resolve these issues or are aware enough anyways. I don't know who they use for the provision of their sexual health education whether it's in house or whether there are certain faith-based initiatives people will use. That would be interesting to look at too.
C: So what exactly do you have to omit if it's a religious school?
M: Depends on the school. One of the schools we work in is a boys school… we don't talk about contraception. Wait, we do now, we used to not talk about contraception but we can't bring contraceptive methods in, so we can't do the condom demonstration. Instead we have devised a flash-card method, this is the process of putting on and disposing of a condom, they're randomly jumbled and young people are broken down into small groups and then they have to go through and get it in the right order. Then the facilitators, well, I should say co-facilitators because we co-facilitate everything, will then give them the correct order. That's about us being innovative, about saying, "Okay, we're not allowed to bring a condom…" but the key aspect for a young men, and the only viable (?) or not sex are their only options of contraception so we need to tell them this how can we do this without using a demonstrator. Well, this is one way. That's about us being imaginative, trying to think of different ways around things.
C: What is the most taboo subject right now?
M: With the legal complication of abortion kind of means that it's one those ones that we don't touch with a barge pole. We have a process and a pathway that if anyone comes to our drop-ins or our clinics or speaks to us, our referral is to fpa. That's appropriate, that's what everyone should be doing in health services. In schools we're obviously not allowed to address it, but because of the legal question mark that's hanging over it at the moment, we don't really do it as a topic. I think it's something that we're sensitively sensitively approaching. I don't know if you're aware but last year the department of health produced draft guidelines on… abortion and that's because there is complications in the law in that it's not very clear. The fpa mounted a legal challenge to say, "Right you need to clear these up so that people are aware exactly what it is." It goes back to an 1861 statute which is an Offenses Against the Person. That means, that was then thrown out by the assembly, those guidelines that were proposed by the dept. of health, so the dept. of health, I think, went back to the drawing board to redraft those guidelines. That would be the one because we don't really touch it but we have a pathway should someone, you know if a young person approaches me and says, "You know I'm pregnant, but I don't want to have a child," it's referred to the fpa.
C: In schools, if you're not allowed to approach a subject, but a student asks about it, what exactly do you do?
M: Come to our drop-in.
C: Oh okay, so you just refer them-

M: Yes, come to our drop in, you can speak to one of us, you can speak to a nurse, you can speak to a doctor. It's just because the concern is that I cater to one young person, if we're not allowed to talk about contraception and I go into open spiel about condoms, the pill or the implant or the morning after pill… just takes one young person in that class to feed it back to mother, mother is very indignant, phones the priest, blah blah blah… we get picketed and all our good work of 8 years goes down the drain. So, we are very careful, it's because we don't want young people to suffer. So we're very careful about how we do that. Sexuality is not an issue and it's never been debarred in schools, and actually we're very… I'm a gay man myself so we're very quick and we're very clear about stuff around sexual orientation. We've had a lot of progressive teams in the UK over the last few years which ensures that people of LGBT orientation have almost full legislative equality apart from civil partnerships and other minor issues, not having full marriage. We have almost full equality, and that includes in schools. So if a young person is being harassed because he or she is black, or Asian or a different religion, the school will be very quick to deal with that. If a young person is gay, the school is not. We're very clear in our session, that we tell our young people, it's about informing them of their rights. If that's happening, the school has a duty to protect them. Obviously, we don't tell the young people about the particular pieces of legislation because that's over their head, but, informing them of their rights. And we're very clear, particularly in boys schools, everyone is gay, but no one actually is gay. You know that kind of, "You're queer, you're gay…" but nobody actually is gay, often I will come out depending on the group as appropriate and we challenge that and we tell them, "If you're at your workplace, or if you're in a training organization, when you leave school, and you're behaving like that, you can lose your job, and you need to be aware of that." In school that shouldn't be happening and your school should be doing something about that. Also it empowers the young people that may identify as lesbian, gay or bisexual. It also gives power to everyone else. So we're really quite hot on that one, we did some training with SHOUT project, which is an LGBT program in January, and they're putting like a pack together, so they did their pilot with us. It was really, really good and we amended some of the exercises and made them appropriate to the work that they're doing. Yeah, I think that's it. Those are kind of the two big issues, then of course challenging sexism and how we can. That's built in throughout the whole program, we do some scenarios where, this girl has had a few partners but she doesn't want to have a boyfriend, blah blah blah, what kind of names might be used to describe her? Then we flip that, and use a boy and what would people say? So it's quite challenging those ideas, and then we reflect as well on women's sexuality, how it can be oppressed or denied, or controlled, where men's sexuality can be, nudge nudge kind of, celebrated or encouraged. We get young people to look at that.

C: You've been here since the beginning?

M: No, no no. I've been here about two and a half years. My background, I studied Politics in England, and then worked for a big corporation for a year and hated it. Then started at, been volunteering for along time started to get involved in youth work and that's kind of where it's taken me.

C: For further contacts, I've been trying to get in contact with the Alessie Center, a Young Parenting Program, and a girl that did the same program that I'm in a couple of semesters ago worked with them and so my advisor said, you known, maybe you could do something similar, but I haven't been able to get in contact with them. I really want to get in contact with and hang out with young people my age, talk to them about their lives and just what's going on. Do you have any suggestions for other youth groups or organizations that would be open to someone sitting in and hanging out?

M: Yeah… you could try, have you heard of the Rainbow Project? It's a gay and bisexual men's project. You could try some of the Sure Start programs, they have young parents groups. We've just completed a program with a group of young parents. That's Artillarly Youth Center, I can give you their number right now (exits room). Okay, it's Artillary which is Belfast 028 90351332. If you speak to Anna Marie Burns, just tell her that I put you in contact with her. We did a young parents group and it was a group of five women who aged between 20 and 28, some of them were out of our age range but that's okay. One of our target groups is young parents and we did a whole sexual health program with them. They're a great group. I would try Stuart Kirk at the HIV support center. He's cool. It's a really great center they do holistic therapy and treatments, health, support and advice for those living with HIV.

I think the youngest we have working with us is 21 and the oldest is, well one of our nurses is 53, but she's been a community nurse for a long time and she knows. She's great.

C: So is there a reason for not having a website? Is that to kind of, keep it on the down low?

M: Yeah, yeah. One of the things that we've talked about numerous times is doing Bebo, kind of like Facebook, Myspace, all those kind of social networking sites but there's a whole raft of issues among child

protection, confidentiality issues, so we're a big statutory organization so that idea comes in here (motions with hands) and a month later (laughter) it's beating it's way through the organization. It'll take time, but that would be something we'd love to have. I suppose we don't have money for a website but it would be great and we would love to have something like that. Even if it was just an information page with referral services. Young people, and the feedback from young people is that they would use our website if we had it, they know they could just type in the HYPE team on bebo and they'd be able to find it, what are the clinics, what symptoms they might have if they have an STI. People are aware of us, and increasingly so, but, again, we don't want to be target number three on the access of evil for certain groups because it's broken fpa and they get picketed.
C: I was going to say that maybe since you're not so visible it kind of works in your favor. Keeping it a little bit vague-
M: Then as well if those people are "HYPE? What do they do?" they can come and find out "Well oh you actually work in Catholic maintained schools and okay maybe we can't picket you…" Also, if we do become picketed we could lose that relationship with those schools. Recently in Northern Ireland, Amnesty International was put off of certain Catholic schools because they had a slight change in policy around use of abortion and reproductive rights.
C: Wow. Amnesty?
M: Yeah, Amnesty…
C: What do you feel are kind of the major strengths and limitation of HYPE as an organization?
M: Major strengths is that we are a unique team, we have nurses, we have the peer educators, and that allows a lot of diversity in what we do. Some of the grammar schools we're worked in only want a nurse, because it's formal and profession. That allows us a great degree of flexibility, also we're unique in Northern Ireland, there's no other organization- there are other organizations that promote sexual health, but not as we do. Brook is a clinical drop-in, it provides services, we go and provide education programs. Other organizations do include sexual health but we're specifically all sexual health. Our weakness maybe that the capacity of the team doesn't allow us to do as much as we'd like to. At the moment I have the guys doing youth work, Sunday night we have group work, Monday we have a group, Tuesday night we have two, Wednesday we have another one and Thursday we have another one. So that's six nights of group, and there are six of us that are working as peer educators. So everybody is working a lot, and if we had a lot more staff, if we had more nurses, we could have drop-in clinics all over the place. We could do more peer education programs. We're historically North and West Belfast, and that's where our funding is from, to work in North and West Belfast, but recently it's now Belfast Trust, but that funding has not yet been matched by South and East. So, that kind of leaves the question mark hanging over, can we do work in South and East Belfast? South and East pregnancy rates are a lot lower, but pockets in certain areas, it's as high areas in the North and West. Demarkets, Lower Armough, Donegal Pass, Tuckmorna, Balnaphi, Volybing, they're all kind of working-class residential areas in South and East Belfast and they do have the same kind of pregnancy rates as in- some of them, not all of them, but some of them. At the moment, if we got the demand for service from South and East, as we have from North and West, we basically can't do it. There is a fine line between quantity and quality. If people are doing 15 groups in a week, they're brain dead, they're emotionally tired, they're physically tired. Therefore the quality of education that they're delivering to young people is not going to be that good. So we try and limit it to around 6 or 7 groups per person. There are so many myths and misconceptions and then this kind of outdated tradition of masculinity where men don't need to ask questions and don't need help and are aware of everything and young boys of 13 and 14, fall for it hook line and sinker! (Laughter) Because that's what may be represented in the media and in the environments around them where men don't need help, men know all the answers. If you don't know about sex or you're not sexually active or promiscuous then you're not a man. So it's about challenging those things. Part of the role of peer educators is to act as role models for young people. We try to exclusively use the term "partner" to be neutral when we're talking about sex. We try to, as I said, counter sexism.
C: It was just interesting because I was kind of thinking back to my own sexual education in high school, I think we got one or two sessions but it was, I come from a very small school so I had 200 people in my entire high school and it was, each year got a session to themselves for an hours so we were all in an auditorium, someone was lecturing to us…it kind of went in one ear and out the other. I learned much of what I know from my sister, who is two older than me, she told me about Planned Parenthood, where you can go. Also, my parents. I was just interested in if sexual education in the United States, is so much more,

I guess "progressive" in the sense that we talk about abortion and things like that, well what is it like here? What are kids getting here? I just was interested…
M: The climate is changing, so it's not part of the curriculum, but it's not audited. So therefore schools can, we teach it, but they can interpret as they will. There is a new GCSE called Learning for Life and Work, and it includes a lot about sex, sexual health, relationships, citizenship, employability, you know that sort of thing. My sexual health education in school was in my first year, we had a priest give us a short talk followed by a video which was a panel discussion headed by a nun. Then, we saw a baby being born. So sex was functional about having kids. Then in around fourth or fifth year we had this faith-based organization who came in and were really… some of the stuff they did was really, really bad upon reflection. You know, born again virgins and kind of silver-ring thing maybe some sort of precursor to that, or you know this man that wasn't gay anymore because he was saved, and that's really kind of, I don't imagine that those kind of people would be allowed in schools now because the legislation around that would prevent that in the UK. I don't know about America?
C: Um… probably not.
M: States schools?
C: Not in state schools, maybe in private schools. Definitely not in states.
M: The rest of it came with going to university. (laughter) Suddenly all these sexual opportunities! I have to find out for myself… I was lucky again I had a big sister who was nine years older than me and from the age of 11 or 12, "If you're gonna have sex, wear a condom," and that was drilled into me. So that was life. A lot of kids don't get that. The UK is kind of, we haven't really had a campaign, but we have a current campaign against STI's and it's mostly gonorrhea, Chlamydia, but we haven't had a public health campaign about STI's since the late '80s and it was HIV. The Labour Government removed it from one of their six key targets in 1997. I can't remember, it was so long ago. Because in 1997 we were doing really well, STI's were on the decrease, teen pregnancy wasn't that, well it was an issue, but is wasn't on the agenda that much. It was kind of like a steady rate, and HIV was on the decrease, so hey we're doing well so take it off the priority list and then years later we have a disaster. Again.
(Short discussion followed, then interview was concluded)

NAME: Georgie McCormick
DATE/LOCATION: Monday, April 21st, 2008, fpa offices
START TIME: 9:30AM
END TIME: 10:05AM
DURATION OF INTERVIEW: 34:39

C: What is your official title and your job description?
G: Manager and training services, so that means that I manage community education projects and workers. There's five here at the moment, there is two workers, one in Derry one in Belfast that would work with young men under 25. Two workers, one in Belfast and one in Derry who work with young women under 25. Georgia, who you met as you came in, she works with young homeless people 16 to 25. Mark works with people with learning disabilities, and their parents and supporters, and we just employed someone to work with parents. Then we have an unplanned pregnancy clinical service which I manage, and I also provide training.
C: Within those sexual health programs, the education programs, do you go into schools?
G: No, no it's community education… well, we do some work with schools but primarily it's self selection so young people chose to come to them as opposed to being in a formal class setting.
C: Well, I was just going to ask what your general relationship is with schools in your area?
G: Schools are very….yeah, they really want to bring us in but it's really… (sighs) Part of it is the fact that we think schools should be developing their own environment, so we'll quite happily work with teachers. The difficulty is if we go in and do something then they there's usually nothing actually embedded in the school. Often, the school environment is a more formal environment; theirs is often restrictions within that in terms of how you work. Most of our energy goes into community education work.
C: So from the services you offer young adults, what kind of feedback are you getting form them?
G: We work needs-led so we work in terms of the young people setting their own agenda, develop their own themes. So it's really very positive (laughter) because we're giving them what they want and it's an

interesting topic and it's very relevant to their lives. From that point of view, it's always terribly popular. Some of the recent feedback we get from young people is that often they're tired of sexual health information. So sometimes they feel a bit saturated with things like contraception and STI's and often information comes from a prohibiting stance, so it's not sort of a celebration of sexuality and developing sexuality and excitement about growing up! It's more kind of coming from, reducing STI's or reducing teen pregnancy, whereas we come from a pro-choice stance in terms of expression of adult sexuality so we see our work more around developing your personal preference around the expression of your sexuality, developing and understanding consent in your life, and preparing yourself through your sexual development and sexuality for the adult world, and whatever relationships you decide to have in that, and obviously consent in relationships coordinates with that. So often we would see young people a bit saturated with information and feeling a bit bombarded with that because often the unspoken is that… it's too delay things or prohibit them.
C: If a young person calls here and has questions about abortion-
G: They're given the information.
C: It's a non-directive counseling?
G: Um hm. The counseling services is separate from the education service. The counseling service works to BICP standards, so we have a counseling coordinator, I manage the service, there are two counselors who work here and one in Derry. So if anybody phones up, regardless of their age, and wants to get information over the phone they're given the information in term of their stage of pregnancy, what the law is here, often young people in particular may not know when their period was so we clarify just what we mean by a stage of pregnancy, we talk them through getting support or how they're feeling about their pregnancy, and then if they want to make an appointment they do so to see a counselor. Then we'll send that off, kind of as a structured piece of work because, well, there is a profound decision at the end of it. But we are very up front and very public about our pro-choice services and also very public about our desire to have a service for women in Northern Ireland in terms of reproductive health care and abortion. What we don't do is give out loads of numbers and send people off because really for us the best demission (?) for young women in Northern Ireland, especially when you've got a closed messages with lots of negative messages. If you get sexual health agencies not wanting to talk about abortion you can imagine what it must feel like. That even organizations that are funded to do the work are prohibiting themselves from doing it!
C: They refer people to you-
G: There is nothing stopping people from giving information about abortion. What people often feel is that they don't have the backups servicing whereas we do. In our guideless, the RSE guidelines issued by the Department of Health, there's clear guidance in how people should be taught about abortion. So there is absolutely no reason why people shouldn't be doing those except schools often prohibit it despite the fact that they're actually directed to do it. It's not compulsory, but-
C: So you can talk about it in schools?
G: Of course you can. Have you got a copy of the RSE guidelines for schools?
C: I've downloaded it online, I don't have a hard copy-
G: Well if you look, they give a very clear, literal primary and post-primary education what topics you'd be including… and abortion is there. There's no reason except individual schools, either chose to take a particular stand on it, but certainly from the Department of Education's point of view, they say that it's okay to discuss it. From our point of view then, if someone contacts us the initial contact for abortion, they want to know about it. So we're quite up front to say, "If you make an appointment to see the counselor, she'll help you work through that." Part of it also is a consciousness around your pregnancy in terms of the support network, how you're feeling about it, your own values, your concerns during the operation itself, what's informing that message and how you're gonna be afterwards. Then if a woman decides if a woman wants to make an appointment with a clinic in England then we support her to do that, and we keep information on clinics. We don't have any special relationship with any of the clinics because we have no control over them, but we would every now and then when we get money go over and see them and see what it feels like to be there. So basically the last time I did it I had the first flight there at 7 o'clock in the morning, got to the clinic at around 9 o'clock. I didn't like sit beside a woman and go through but I identified one woman and kind of sat outside where she was and watched the process and just spent time to see how much time you actually spend there and she was being signed out at half 5. So that's from 9 o'clock when you hit the clinic, now if you're coming from just outside Derry say, and you're traveling to Altergrove Airport to get the 7 o'clock flight you need to be there at about 6 o'clock… half five, so you

need to be leaving home at about four o'clock in the morning so you're probably up at about three? You're not leaving England again until possibly the last flight, which is probably 8 o'clock at night. You get back into Belfast 9, half nine, and then you journey home.
C: That's a really long day.
G: So we need women prepared for that as well as the culture shock of going from a very closed environment to one where it feels like everybody in the world is having an abortion (laughter) and also the British limit is up to 23 weeks 6 days, and most women contact us round about the five week mark. The big social changes that have happened are that women, pregnancy tests are becoming- I mean you've even got one that's spelling it for us now because we're so stupid (laughter). It really annoys me! Well it says "pregnant" now, but they're tests that now say "pregnant," because they have to spell it out for us. That's the point that women often, even if it says pregnant will need someone with them, it's the process of internalizing the result, we're not that stupid that we can work out positive or negative, it's just the realization coming to them anyhow. Because pregnancy tests are much more effective now and efficient at detecting pregnancies we'll often get women, the first day their period is late doing a test, so we will get women coming to us right at about five weeks wanting to look at the option of abortion. They need to wait until they're at least 8 weeks before they'll go over to England. So it's kind of… it's a culture shock, it's just a huge culture shock because women will go online as well and they misread the information because the information online looks as if it's, because we're part of the UK we can go over there and get it but we can't because it's costs somewhere in the reach of £ 500. The operation, plus your travel so it's a bit of a shock.
C: That's a lot of money. Another question that I have, when I went to Brook, Mary Crawford was telling me that they get picketed a couple days a week, do y'all have any picketers?
G: Four days a week.
C: Is it the same schedule as Brook?
G: It's probably the same people as them, I think the one, I think it's Precious Life mostly. I don't really know to be honest with you because I train myself not to look at them. We moved from University Street and it was much more visible to us then because we were in one of those big town houses and so pickets were right outside the building were here we're three floors up now so I manage to ignore them. They're there four days a week and…(gets quiet) they just stand there with their pictures and sometimes they, well they certainly harass women there's no two ways about that. They pick on young women in particular. They say things like, "Your womb will explode," or they threaten women that if women try to ignore them going in they'll catch them coming out. We've had agencies in the building complaining to the police, we have had social workers, because we do other kinds of education work here one-to-one with young people, maybe young people in transition from care, or young people with learning disabilities we do one-to-one sessions. So they harass everybody, I mean to them you're a woman, so regardless of what you're going in for. They don't know. They don't anything, they just assume that that's what it's always about. So we've had social workers complain to the police but it makes no difference.
C: The education programs that you mentioned earlier, can you go into a little more depth about what exactly you do with youth in the community?
G: Well there's the sexual health topics, like how your body works, STI's, contraception, and then we will open a range of other things that will affect that like personal and sexual relationships, we look at your life stages and we do some work that you're probably familiar with of getting in America and Australia in resilience in terms of developing autonomy. Also, a sense a belonging in your community, friendships, or whatever. So we particularly look at how you develop autonomy in terms of your personal preference and in terms of developing skills around consent and informed decision making. So we do quite a bit of life stage work, and we do how you might, consent might be in your life when you're 11 or 12, and how it might be. We would look at scenarios like bullying, responsibility for not just your own safety but the safety of others and how you look after each other. We do a lot of stuff around romance and what it means in your life and what it can mean in your relationships. Often we come to the conclusion for young women that's whats (?) all that time, and they're kind of like a presentation of being responsible for the romance and still believing in the fairy story and that's good, because we don't want to take that hope away because everybody has a right to hope for that and dream for that, but the negative part of it is that it can encourage a lack of self esteem, or a lack of confidence, or give young women the responsibility for keeping things nice when they're far from nice. We do quite a bit about how to romanticize yourself, and make yourself feel good, what is really looking after someone as opposed to being romantic so if you're not feeling great and you have your period and your friend goes to the chemist for you, that that was romantic because

someone knows you're feeling badly! So there's lots of things that we would explore around that. We do quite a lot of around encouraging diversity around sexual preference, sexual orientation. In terms of human rights and equality legislation and preparing for citizenship, we do a lot around encouraging young people to be good critics of services and given them confidence to use services and sometimes that adult world, Brook's very much a young person friendly environment, but not all young young people can get to Brook, we've got quite a good provision for family planning services in Northern Ireland, and young people should be able to use them with confidence because government is paying for them (laughter). So it's looking at that environment and how you use it and how you're confident in it and how to challenge the adult negativity coming at you around that and how to see yourself as a young adult and your rights to good services and challenge negative attitudes and not internalizing negativity. We also do quite a bit of work around developing sexuality and who you share that with in terms of young adults who may be precedent around young people.
All of the projects are Northern Ireland wide now. I would do quite a bit of work in the Republic in terms of training and stuff like that and we also have some responsibility developing work in Scotland, so I manage two community education workers from Glasgow.
C: Within your groups, how many young people would there be typically?
G: Probably somewhere between 5 and 12.
C: Is it like a continued program?
G: We do anywhere from 4 to 10 weeks, often what happens is the workers kind of work towards 6 to 8 weeks, and young people seem to want a few more (laughter). So very much that, we usually block out, the community education people who manage community projects usually want about 6 to 8 weeks of a block, and that's what we'll negotiate. We'll also do accredited work, so they can get accreditation through a college network, but it's a very structured course so it's not needs-led. So there' s the needs-led stuff where young people set they're own agenda, and then there's the accredited work which is part of a national employment standard that's recognized within that so it's credited. That has similar elements in it, it looks at diversity, family life, lifestyles, contraception, how your body works, STI's, so there are some core components, but we meet often so it's a different pace of work, but it's not all academic in that you're collecting portfolios, collages, young people write really funny things like one young woman who was in foster care most of her life, part of it is they have to comment on family structures so she wrote, "Foster families are shit." (Laughter) That was her evidence, and you can't argue with it because that was her experience, so from that point of view it's different kind of learning it's very much coming from their perspective, their world, how they see their world, and as long as they've discussed it, given it a good shot, conduced some (?), then that's put through for accreditation, and that's probably 8 weeks. It would probably be an 8 week course of two hour sessions.
C: So in terms of working within the community, what do you feel like are the strengths and limitations?
G: Strengths are that it's self-selected, people are there because they want to be, and they can leave at any time. So that's a huge strength when you've got people that are choosing to be here. That can be the absolute negative thing because they chose not to be here. The difficulty is the dynamics that can happen in communities also impact on your delivery, so unlike working in the schooling environment where either the school has given you a slot and you're working through your stuff and the young people are going to be there, you could go out and do community projects and something could have happened in the community and young people will either bring that into the room or get distracted by it, there's more likely to be some sort of kick off or fight. So there could have been three people in your group that could have been arguing in the community or their families could have been arguing, certainly I've been working here from the eighties, when there was more civil (?) that would have been a big thing, sometimes in the past because of the high suicide rate in some of the communities that would have been a big issue that would have needed to have been discussed. Paramilitary activity in the past has come into it in terms of, that's difficult to work if there's a lot of you know paramilitary- the discussions often have to be inhibited because a young person needs to be careful what they say, and we have to be careful that we don't do too much exposure so if we're doing something around sexualities we need to be careful that we're not exposing someone because those kids are going from what's a relatively safe environment, that's our job to create it, and then to the streets, unlike schools where they might go back into the school environment and get distracted with something else, they go straight, right out into the street, or sometimes into an abusive family situation. So community work has elements of it that, because it's informal, you're in an informal setting, it's very alive in terms of the young people, what young people bring in, you create a permission given environment which is 80% of our work, young people will fill it (laughter).

C: What are a few community organizations that you would work with or partnership with?
G: Well for some of the projects that have been around now we are well known, the Choices Project for young women is always booked up because often you'll get youth workers who used us two years ago with a new group of young women, so they'll bring you back in. A lot of this is reputation, and Neil who is the young men's worker, he just got his material together to shoot out to other community and youth groups in the area, and we'll work with church groups, we will go anywhere! Absolutely! Also, we're very upfront about what we do, but because we do it from a position of respect of other people's value bases we don't expect everybody to be pro-choice, of course we don't, but if we're challenged, we'll say well that's where we come from, but certainly the debate can be anything that goes on and as long as our job is to maintain the safety and allow the group to do the discussion, so yeah… I think I've worked more with Catholic churches in the last ten years than anybody else!
C: In terms of abortion and the future of Northern Ireland, what does fpa see happening? What are your short term and long term goals?
G: Politically? (Laughter) As far as our work goes we will continue to do it obviously, there's some changes that are happening in the world whether we want them to or no for instance we would know from our help line that women are accessing the abortion pill online. There is a website called womenonwaves.com, they have the women on web where women can go through an assessment and then send off for the pill. Now, we obviously can't recommend that because we don't know what they're getting, so there's health concerns there, but if more and more women do that we're gonna have to look at that we're gonna have to say well this is the new backstreet abortion and we can't let it happen without some sort of monitoring. Also how the RU486 is distributed are legislated in the UK and will affect us, or in Great Britian will affect the whole of the UK, because if women in London at some point can go to a clinic somewhere and purchase the pill, there's no stopping someone from Ireland going over there buying it and bringing it back. So how that's legislated for in England will affect women here and that's gonna happen no matter what happens here and also, I think the women on waves charge something like 70 or 80 euros to send somebody this, whatever this is. There's also a diversity of cultures, so world travel has gone up, cheap flights matter. We have a post coming on board where, we're developing a dvd which looks at women's lives in terms of making a decision, so we hope to have that released by the summer, and then we have a post coming on board which we hope to us to look at social change for women because, we know some women go to Barcelona and Amsterdam and yet the figures that we get are only form English clinics. There's a whole group of women out there that aren't accounted for. There's those women and then there's the women taking the pill off the Internet. We don't know what's happening to them. They do an online consultation and we don't give that information out generally.
C: Is that legal?
G: Well our law is kind of a bit… it's not illegal for the women on web to sell it to women. It's debatable on whether it's legal for women here to take it. It probably would be illegal for me to get it off the web and sell it to you because I'd be doing it in Northern Ireland. Certainly if a doctor got it for a women off the web and gave it to her. So I think the law says that it's illegal for some women to procure an abortion for somebody. Our laws are, well, it's like the twilight zone basically.
C: someone was telling me about guidelines for abortion that needed to be clarified in the somewhat recent past? Do you know anything about that?
G: About three years ago we took a case out against the Department of Health and it dragged on for nearly four years. We lost the first leg of it, and then we won the second time. The judge directed the Department of Health to draw up guidelines because it was clear here that some women were accessing abortions but we didn't know what guidelines doctors were using to do that. So we asked for clearer guidelines for GP's but also we'd get phone calls here from consultants and GP's wanting information. Which is silly. So we're still waiting on those… and with the devolved government now the assembly up and running that could well have an impact on, shouldn't have, because the legal system has directed that it happened, this could have given that we have a new government and given that I don't' think I'm wrong in saying this that a huge majority of those assembly members would be anti-choice. Along with the guidelines there's the Sexual Health Strategy, which we're still waiting on as well. So those two things have kind of been… there's the social aspect of it, there's the personal aspect of it for women, when we deal with on a daily basis, and women still continue to choose to terminate pregnancies, that's a reality. They've slightly changed in how they do that, it used to either be self-harming or traveling over to England. Now they're still traveling over to England, but some now, they're probably less concealed pregnancies now, certainly less self-harming, backstreet procedures I'd say probably, well we don't know, but I certainly haven't come

across any. What we do know is that new backstreet abortion is downloading stuff off the Internet and also accessing clinics in other countries. So that's what women are choosing to do on a personal level and then at a social level there's some changes happening for instance one of the questions we ask women now is, "Do you know anyone that's had an abortion?" A majority of women will say yes, whereas when we started this service 20 years ago most women were saying no, so women are talking to each other more. Women are being more open in their world. Also there could be women are now accessing the stuff online, there might be a change in attitude to us in having some change in legislature decisions that allows medical induction up to 9 weeks. So there could be social change happening that we haven't monitored or evaluated. But politically not a lot has changed except that the guidelines have been asked to clarify. Just looking at the laws here, trying to get clarity in the law! It's about consistency and transparency which was absolutely absent, and that's what we're asking for!