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A HEALTH EDUCATION PROGRAM IN POLAND FROM THE PERSPECTIVE OF ADOLESCENT MOTHERS

ERGENLİK ÇAĞINDAKİ ANNELERİN BAKIŞ AÇISIYLA POLONYA'DA UYGULANAN BİR SAĞLIK EĞİTİMİ PROGRAMI

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ABSTRACT

Poland subscribes to an abstinence-only model of reproductive health education called "Education for Life in the Family." The aim of this study was to determine if the perceptions of adolescent mothers could be used to improve delivery of the Polish model of education. This study was conducted using focus group interviews with fourteen adolescent mothers aged 14-18 years. Discussion was centred on the characteristics of effective adolescent pregnancy prevention programs. The Polish model of education takes place in a relaxed atmosphere, where visual media constitute the predominant mode of instruction. Teaching can be described as a one-way transfer of information, with little potential for asking questions. There is little or no discussion concerning contraception. Any such discussion lacks a consistent message and is interlaced with lessons on behaviour deemed appropriate by the teacher. Emphasis is placed on the presence of infidelity in adolescent romantic relationships. This course seems to offer no instruction on family life. The Polish model should incorporate instruction relevant to the needs of adolescents that are sexually active or soon will be, there should be a strong focus on consistency of message, and care should be taken to ensure quality of teaching and proper pedagogic skills.

Key words: adolescent health, reproductive health, sexual health, qualitative research methodology

ÖZ

Polonya, 'Aile Yaşamı için Eğitim' adı altında cinsellikten uzak durmayı öngören bir sağlık eğitimi modelini benimsemektedir. Bu çalışmanın amacı ergenlik çağındaki annelerin görüşlerinin bu modelin geliştirilmesi için katkı sağlayıp sağlayamayacağını saptamaktır. Araştırma, 14 ila 18 yaş arasındaki 14 ergen anne ile yapılan odak grup görüşmeleri kullanılarak gerçekleştirilmiş; tartışma ise etkili ergen gebelik önleme programlarının özellikleri üzerine odaklanarak bu özellikler çerçevesi içinde yürütülmüştür. Polonya'daki üreme sağlığı eğitimi modeli görsel medyanın da yoğun bir şekilde kullanıldığı rahat bir ortamda yürütülmektedir. Öğretim, soru sorma fırsatının çok az olduğu tek yönlü bilgi aktarımı olarak tanımlanabilir. Doğum kontrolü ile ilgili çok az ya da hiç tartışma yapılmamaktadır. Nadiren yapılan tartışmalar ise tutarlı bir mesaj içermekten uzak olmakta ve öğretmen tarafından uygun görülen davranış biçiminin aktarılmasıyla son bulmaktadır. Özellikle ergenler arasındaki romantik ilişkilerde bağlılığın olmadığı vurgulanmaktadır. Bu sebeple verilen üreme sağlığı eğitimi dersleri aile yaşamı üzerinde öğretici bir etkiye sahip olamamaktadır. Polonya modeli cinsel anlamda aktif olan veya yakın zamanda aktif olması beklenen ergenlerin gereksinimlerini dikkate almalı, verilen mesajın tutarlılığı güçlü bir şekilde vurgulanmalı ve uygun pedagojik beceriler göz önünde bulundurularak bu model ile verilen eğitimin kalitesine özen gösterilmelidir.

Anahtar Sözcükler: Ergen sağlığı, cinsel sağlık, üreme sağlığı, nitel araştırma yöntemi

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INTRODUCTION

Adolescent reproductive health education (RHE) has been a topic of special interest over many years. The goals of such education have been well defined to include factual knowledge about the physical processes of one's own body and the body of a partner, fertility and contraception and the existence of and protection against sexually transmitted diseases (STDs) (Holzner and Oetomo, 2004). To see these goals realized, there are three types of RHE curricula currently in use. Abstinence-only programs focus on teaching that sexual abstinence is the only accepted means of preventing pregnancy and STDs in adolescents (Thomas, 2000). Abstinence-plus programs provide limited discussion on contraceptive methods, but with an especially strong emphasis on abstinence (Thomas, 2000). Comprehensive programs provide adolescents with unrestricted discussion on contraceptive access and use, decision-making and negotiation skills, and how to prevent sexually transmitted infections (Stewart, Shields, and Hwang, 2003).

As early sexual initiates, adolescents who actively engage in sexual activity are at a higher risk of pregnancy and STDs (Cooksey, Mott, and Neubauer, 2002). Adequately counselling adolescents about sexuality could delay the start of sexual activity and help reduce rates of pregnancy (Patton, Kolasa, West, et al., 1995). However, conflicting opinions exist as to which type of education is most effective at preventing these untoward effects of sexual activity. Some studies find comprehensive education to be more effective than abstinence-based models (Aarons, Jenkins, Raine, et al., 2000; Dodge, Sandfort, Yarber, et al., 2005). Conversely, others note the effectiveness of abstinence-based models (Cabezon, Vigil, Rojas, et al., 2005). Also, some state that no model has been proven decisively effective (DiCenso, Guyatt, Willan, et al., 2002). The risk of an unplanned adolescent pregnancy is probably the most profound consequence of early initiation of intercourse (Forste and Haas, 2002). Adolescent pregnancy is linked with a high level of poor social, economic, and health outcomes for both mother and child (Westall, 1997). It is subject to prevention efforts because teenage mothers are at an increased risk for premature childbirth and pregnancy complications and their infants for physical disability and morbidity (Kellogg, Hoffman, and Taylor, 1999). Also, the majority of pregnancies among unmarried teenagers are unintended (Brückner, Martin, and Bearman, 2004).

Reproductive Health Education in Poland

Poland currently subscribes to an abstinence-only model of education titled Education for Life in the Family/*Wychowanie do życia w rodzinie* (ELF). To a large extent, this model was developed in keeping with Roman Catholic traditions (e.g., sexual abstinence until marriage, disapproval of contraception, and adherence to traditional family models). This course is taught until the end of High School, only with permission from the adolescent's parent(s)/legal

guardian(s), and at the discretion of each school's respective Director. Additionally, the adolescent is not formally obligated to participate in the course. This curriculum calls for all schools to teach human sexuality, the principles of planned and responsible parenthood, family values, prenatal life, as well as the methods and means for planned parenthood (Pub. L. No. 17, Stat. 78). In addition to these topics, a later ordinance by the Minister of Education instructed that special emphasis be given to supporting the upbringing-role of the family, promoting an integral view of human sexuality, and developing pro-family, health promoting, and pro-social attitudes in adolescents (Pub. L. No. 67, Stat. 756).

Considering the general goals of RHE and the Polish model in particular, several studies find the quality of the Polish model as poor. The level of sexual education among Polish adolescents has been described as unsatisfactory and embarrassingly low (Rzepka and Czeok, 1996; Lew-Starowicz, 1991). One study of Polish adolescent mothers found more than 40% did not know their ovular period and only 11% cited school as their source of information about ovulation and contraception (Zarzeczna-Baran and Balkowska, 2002). These figures take on greater meaning considering that parents contribute only 8% to the sexual education of their children, while 26% of adolescent girls name peers as their main source of this information (Krzysiek, Czop, Milewicz, et al., 1997). Another study of pregnant adolescents found 44.6% did not consider pregnancy as a cause of amenorrhea (Jarząbek, Grys, Wachowiak-Ochmańska, et al., 2001). Also, a disturbing effect of attending ELF classes can be found in one cited study where 90% of students accepted the possibility of using condoms before attendance; this number then dropped to 82% following attendance (Izdebski, 2003). This figure could simply mean that a fraction of students had been swayed towards, for example, more religious standards of conduct. However, as the goals of this curriculum include, among others, preventing adolescent pregnancies and STDs, it is troubling to consider that sexually active students may have constituted part of this difference.

Adolescent Reproductive Health in a Polish Sociocultural Context

In some cases, abstinence-based education is much more likely to be effective in the context of a culture with a strong religious background model (Cabezon, Vigil, Rojas, et al., 2005). Poland notes a long history of religious influence, with 90% of the population belonging to the Roman Catholic Church (Central Statistical Office, 2006). However, research finds that the behaviour of Polish adolescents does not always overlap with Roman Catholic standards of conduct. Most Polish adolescent mothers already seem to come from households where issues of faith were not treated rigorously (Zarzeczna-Baran and Balkowska, 2001). Social acceptance of pre-marital sex has increased over the past decades, leading to a general consensus that any

emotionally-involved relationship sanctions engaging in sexual activity (Wróblewska, Strzelecki, and Matysiak, 2003). In Polish society, 52.5% of girls and 61.6% of boys aged 19 years have already initiated sexual activity (Pawłowska, Filipp, Pietrasik, et al., 2005). The average age of sexual initiation is 17 years for girls and 18 years for boys (Jarząbek, 2001). Sexually active adolescents aged 15-19 years most often use contraceptive pills (20.4%), followed by condoms (17.9%) (Izdebski, 2003). However, 62.7% of pregnant adolescents did not use any method of contraception prior to becoming pregnant and only 13.9% of non-pregnant, sexually active Polish adolescents reported not using any form of contraception (Pawowska, Filipp, Niemiec, et al., 2004).

For 2005, the adolescent birth rate [(live births per 1000 women aged 15-19 years)] in Poland was 13.5 and the incidence of STDs in the population aged 15-19 [(newly registered cases of syphilis and gonorrhoea per 100,000 relevant population)] was 1.3 (Children in CEE/CIS database, 2007a). Noteworthy is that both these figures have been decreasing since 1989. Compared to other countries in Central and Eastern Europe, these figures show that the state of adolescent sexual health in Poland is relatively good. For example, in Slovakia, Hungary, and the Czech Republic, adolescent birth rates were respectively 20.3, 20.4, and 10.9, and the incidence of STDs was respectively 8.0, 15.4, and 18.0 (Children in CEE/CIS database, 2007a). In 2004, the percentage of births which occurred in the total population to those aged 15-19 was 5.7% in Poland, 7.8% in Slovakia, 6.8% in Hungary, and 3.7% in the Czech Republic (Demographic and Social Statistics, 2004). In 2005, there were zero abortions performed for women under age 20 in Poland, 1600 such abortions were performed in Slovakia, 6800 in Hungary, and 3000 in the Czech Republic (Children in CEE/CIS database, 2007b).

Though these figures indeed present a relatively positive appraisal of adolescent sexual health in Poland, care must be taken when interpreting these figures in terms of adolescent pregnancy. One should assume that the true adolescent birth rate as well as the true number of abortions performed for women under age 20 is presumably higher. Firstly, Poland subscribes to a set of strict abortion laws, making abortion "basically illegal" (Ketting, 2005). These laws require a physician to first receive permission from the Public Prosecutor before performing an abortion. However, some evidence suggests that physicians are using medical abortion without having obtained previous approval (Bracken and Winikoff, 2005). Receiving an abortion is not considered a criminal offence. Secondly, in a culture where adolescent sexuality is still considered taboo, adolescent pregnancy is the object of much stigma, both for the young mother and her family (Kopacz, 2006). This stigma can be encountered both in urban and rural settings. Bearing in mind Poland's large emigrant population, it is a common practice for pregnant adolescents to

travel to a relative or family friend resident abroad where she may receive a legal abortion or carry the baby to term (Lazarus, 2005).

The aim of this study was to determine if the perceptions of adolescent mothers in Poland can be used to improve delivery of the Polish model of RHE. This study was conducted using focus group interviews with adolescent mothers. Focus groups have long been a practical means to examine values about health and disease (Bowling, 2002). They also allow one to study recognized social issues from the participants' own perspectives (Peterson-Sweeney, 2005). For this reason, at a ground level, adolescent mothers are in a unique position to comment on, and offer insight into, this RHE course. This study expands on available literature as RHE in Poland has never previously been studied in this respect, in either Polish or English language publications.

Social representations theory was used as a theoretical basis for this study. Social representations correspond to a common conception of a social entity and contain both descriptive and assessing overtones (Thrush, Fife-Schaw, and Breakwell, 1997). In groups of individuals, they add to a collective representation of reality (Stjerna, Lauritzen, and Tillgren, 2004). Social identities are then built upon assets accessible through the restructuring and incorporation of these social representations (Lloyd, Lucas, and Fernbach, 1997). With respect to RHE, "the conceptions of the world, of society, and society's relationship with nature that are taught are all collective theories, socially shared constructs, whose function is to transmit and disseminate a shared culture to a social whole" (Audigier, 1999).

METHOD

Data used in this study come from two focus group sessions, each approximately one hour long, held in February 2007. All participants were adolescent mothers resident in a Children's Home located in Kraków, Poland. The participants were also taking part in a national Polish study concerning the social determinants of adolescent pregnancy. The focus group was conducted following approval by the institution's Director, senior pedagogic personnel, and resident psychologist. All participants gave informed consent, including permission to audio-record the discussion. Recordings were transcribed verbatim and then translated into English by a native speaker. Transcripts were verified with original recordings by unbiased, third-party senior faculty. Reliability of the translation was confirmed through back-translation. In keeping with good practice, recordings were subsequently destroyed. The sessions were moderated by the author, a male medical doctor specializing in adolescent reproductive health research, and an assistant, a female midwife with extensive experience in sociological research methodology and analysis.

Each session took place inside the Children's Home. The comfort of familiar surroundings doubtless influenced the ease of discussion. Participation in the focus group was entirely voluntary. The first focus group

totalled six participants and took place in the early afternoon hours. The second focus group involved eight participants and took place immediately following the first group. Between these sessions, the second group did not have any contact with the participants of the first group, eliminating the potential for bias or any sort of information interchange. This amounted to 100% participation by all residents of the Home. Most participants came from Kraków, only a limited number came from surrounding urban areas in the Małopolska Voivodeship. Participants ranged in age from 14 to 18, most came from single-parent households, were from lower-middle class backgrounds, described themselves as Roman Catholic, all were ethnically Polish, currently in high school, and had regularly taken part in the ELF course within three months of the study. Participants were representative of adolescent mothers resident in urban areas of Poland, coming from communities where some adolescents do not have appropriate access to sexual education and to contraception (Lech, 2002).

All participants knew one another well, which allowed for a better provision of information about their shared perception of everyday life (Stjerna, Lauritzen, and Tillgren, 2004). Such a group setting lets all participants feel more at ease describing their experiences, beliefs, perceptions, attitudes, and reasons for specific behaviours (Villarruel, 1998). Discussion was centred on the baseline characteristics of effective adolescent pregnancy prevention programmes suggested by Kirby and Coyle, 1997, which was then followed-up with more specific dialogue, appropriate to the responses given. Each of these characteristics is respectively named in the results section. Open-ended dialogue facilitated a general to specific course of discussion, an approach especially effective when discussing sensitive issues, such as adolescent sexuality (Roberts, Oyun, Batnasan, et al., 2005).

These characteristics were chosen in particular because they represent evidence-based guidelines, are not biased towards any one cultural context, and focus largely on pedagogic as well as methodological processes, rather than content. In theory, these characteristics do not conflict with the points outlined in the Polish model. Such agreement should theoretically allow for their application in a Polish cultural context.

Transcripts were analyzed using thematic analysis (coding, clustering, "subsuming particulars into the general," and confirming) (Campbell, Pugh, Campbell, et al., 1995). The author and assistant first independently coded the transcripts. Themes were then proposed based on an understanding of the interviewees and the author and assistant's collective experience from data collection (Ware, Wyatt, and Tugenberg, 2005). Analyses were compared, themes identified and discussed, and either accepted or rejected by consensus between the author and assistant (Hendrickx, Lodewijckx, Van Royen, et al., 2002; Gray, Klein, Noyce, et al., 2005).

RESULTS

Each session took place in a very amicable atmosphere. Participants spoke freely and comfortably, without any reservation or hesitation. Participants were particularly enthusiastic to learn that the results of the focus group would be used for scientific purposes and were especially keen to share their experiences for the benefit of others. There were no overly dominant individuals and all participants seemed to contribute proportionally to the discussion.

Excerpts from the focus groups are used to illustrate the presence or absence of the characteristics of effective adolescent pregnancy prevention programmes. To ensure participant anonymity, excerpts are prefaced as [s#p#], meaning, for example, [session1participant1].

Characteristics: utilizing a variety of teaching methods; teachers who offer specific, skill building activities

Five participants in the first session and six participants in the second session were currently taking part in ELF classes. After having attended a number of classes, one participant in the first session and two participants in the second session had chosen not to participate in the course any further, having discontinued it at one and three months, respectively, before the study. However, as they already had experience with the course and had stopped attending at a relatively short time before the study, they were still invited to take part in the focus group. Their reason for not participating in ELF classes was explained as a question of need.

> [author] If I may ask, why didn't you participate?
>
> [s1p5] Because I had the class in junior high school and felt I didn't need it.

The "need" or, more appropriately, desire to participate in these classes was seen as a function of the negative characteristics of the course. In terms of positive characteristics, both groups could only say how the classes take place in a relaxed environment. However, when asked to evaluate the course as positive or negative, all participants unanimously rated it negatively.

> [assistant] Can anyone give an example of a typical lesson?
>
> [s1p4] Maybe this is a stupid example, but they display the anatomy of a boy and girl and just start talking. We get the same thing in biology class. I, for one, was shown movies, all the time movies, how a girl responds to boys, how this, how that. The movies were very stupid, nobody wanted to watch them.

Characteristics: teachers who believe in the program; clear and accurate messages about prevention

While developing in detail the negative characteristics, quality of instruction was called into question many times. Two such examples were consistently reported across both sessions. The first example concerned the

difficulty of asking questions during class. Participants implied mixed-gender lessons as the reason for this difficulty.

> [s1p2] You can't say anything; all the teachers do is talk.
> [assistant] Did you ever try asking the teacher questions?
> [s2p2] It's kind of stupid asking questions in front of the whole class.
> [author] Were you ever divided into groups?
> [s2p4] It depended on the lesson: most of the time we [boys and girls] were together, only rarely were we separated.

The second example concerned discussing contraception in a classroom setting, where clear and coherent instruction was often lacking and replaced with misleading information. On occasion, this yielded detrimental effects.

> [s1p3] Sometimes teachers say to use contraception. Then later they say it's better not to, because you won't be able to have children, because you won't be able to get pregnant.
> [s1p6] It leads girls down the wrong road, since first they teach you how to use it [contraception], then you stop. They never told you directly [to stop using contraception], but still they "said" it. Then two months later turns out the girl is pregnant and people start pointing fingers.
> [author] What would you have wanted to know about contraception?
> [s1p2] Above all else, that it is safe.

In the classroom, only natural family planning was developed in any detail. Other contraceptive methods were only briefly mentioned, with emphasis given to failure rates. Classroom discussion on contraception also seemed to be combined with instruction concerning arguably appropriate behaviour.

> [assistant] Did the teacher show you how to determine your fertile and infertile days?
> [s2p8] Yes, they showed us what everything depends on. (This participant went on to share her knowledge in extensive detail.)
> [s2p1] The teacher told us that wives should not use any protection, just keep a menstrual calendar and be available to only one partner.
> [author] In your experiences, what was there more of during these classes: didactic instruction or lessons concerning "appropriate" behaviour?
> [s2p3] Appropriate behaviour. They wave a finger at you and say "make sure not to..."

Characteristics: programs which are developmentally appropriate and culturally sensitive; focusing on sexual behaviours which lead to pregnancy

What seemed especially unique for an abstinence-based course in RHE was the emphasis these classes placed on infidelity in romantic relationships, attempting to define the concept for students. Oftentimes, however, the definition presented during these classes would conflict with the participants' own concept of infidelity.

> [s1p5] They never directly talk about sexual activity. All they do is talk about human anatomy, show some movies, talk about infidelity, and that's it. And it's not typical infidelity either, just that the boy looked at another girl and that is supposed to count as infidelity.
>
> [s2p6] It's often the case that when women cheat, it's because she fell in love with another man. But a man can cheat without there being love and for him it will only be a question of desire.
>
> [s2p7] They should talk about, in my opinion, the emotional consequences. Despite all else, following sexual initiation, everything changes. At least that was the case with me. Now everything is trivialized and just focused on preventing unwanted pregnancies or that you can catch some disease. They don't talk about the emotional side of things.

Characteristics: modelling and practice with regards to communication and assertiveness; openly discussing outside pressures related to sexual behaviour

Despite the title of the course, no participants felt empowered or any more knowledgeable about living in and/or heading up a family. This seemed not to be the fault of poor teaching, rather the overt lack of any instruction on the subject.

> [assistant] At some point, most people decide to have children and become parents. As the course title implies, was this ever talked about? About "life in a family"?
>
> [s1/all participants simultaneously] No. Never.
>
> [s2p5] All these lessons basically do is teach you to say "no" [to unwanted advances]. For example, a movie might show a situation where a boy may be bothering you and then you are supposed to say something to the boy, stupid stuff like that. They don't teach anything about families.

The views of adolescents have rarely been considered in designing policy and programs (Blum and Nelson-Mmari, 2004). Before concluding the focus group, participants were given the opportunity to offer their own suggestions for improving this course. Participants in both sessions were especially keen on including dolls (i.e. which mimic the behaviour of newborn children) as part of the curriculum.

> [s1p1] They should pair up a boy and girl and they should have this doll so they could see how—it's automatic—it cries

> whenever it wants, goes to the bathroom whenever it wants. They wouldn't be able to go out anywhere! The majority of girls would suddenly realize they don't want to get pregnant. They would know what the consequences are of having sex.

DISCUSSION

The aim of this study was to assess the experiences of Polish adolescent mothers with RHE and determine if their perceptions of this course could be used to improve delivery of the Polish model. This study allows for making three specific suggestions in this regard.

Interventions aimed at discouraging early sexual involvement are typically accepted by communities (Hardy and Raffaelli, 2003). However, one challenge of every RHE programme is catering the curriculum to meet the RH needs of its participants, while remaining sensitive to the cultural context in which it is taught. For this reason, the Polish model should look to incorporate instruction relevant to the needs of adolescents that are currently sexually active or soon will be.

Secondly, there should also be a strong focus on consistency of message. Comments offered by the participants of this study suggest that some teachers are presenting mixed messages and messages reflective of ignorance and/or poor quality teaching. Consistency of message should be fact-based, especially so in regards to the instruction of safe contraceptive and STD prevention methods which have been proven effective.

Lastly, care should be taken to ensure quality of teaching and proper pedagogic skills. A number of participants cited the futility of instruction limited to audio-visual media and instruction based only on textbook-sciences. RHE is a dynamic subject impacting many levels of adolescent development. Thus, the Polish model may prove more effective should it allow for better student interaction, a balance of single-gender and mixed-gender sessions, and discussion of deeper topics related to adolescent sexuality.

In summary, this study finds that the Polish model of RHE takes place in a relaxed atmosphere, where visual media constitute the predominant mode of instruction. Teaching can be described as a one-way transfer of information, with little potential for asking questions. Beyond natural family planning, there is little or no discussion concerning contraception. Any such discussion lacks a consistent message as to usage and is interlaced with lessons on behaviour deemed appropriate by the teacher. Mixed messages concerning contraceptive use have been linked to heightened pregnancy rates (King, 2000; Landry, Darroch, Singh, et al., 2003). Emphasis is placed on the presence of infidelity in adolescent romantic relationships. There is some discussion of the outside pressures related to sexual behaviour and discouraging unwanted advances through some amount of assertiveness training. This course seems to offer no instruction on family life.

In keeping with social representations theory, this study has allowed for developing a collective representation of how adolescent mothers resident in Kraków perceive the way in which the Polish model of RHE is taught. However, based on the results of this study, this social representation seems to differ from the social reality which ELF is meant to represent. Specifically, as a social entity, ELF constitutes a part of Polish culture which is shared by adolescents in general. Ideally, this culture should "enable communication to take place among the members of a community by providing them with a code for social exchange and a code for naming and classifying unambiguously the various aspects of their world and their individual and group history" (Moscovici, 1973). The recommendations of this study are meant to reconcile the differences which may exist between the social representation and the social construction of ELF in the general adolescent population. Reconciling these differences will also serve to build a culture more favorable for adolescent reproductive health and the prevention of unintended adolescent pregnancy.

One obstacle to improving delivery of ELF is the current sociocultural condition of Polish society, which has yet to see any greater social discourse concerning adolescent parenthood. As adolescent sexuality is a taboo topic, initiating multifaceted dialogue usually proves very difficult and may be the object of social reprimand. An additional obstacle deals with information-seeking, a normal element of psychosexual development. Polish adolescents tend to reference a variety of sources when seeking information concerning sexuality (Kopacz, 2006). In addition to school, these sources often include magazines, television, peers, and parents. Restricted access and the varying content of these sources, as well as consistently conflicting messages, have *de facto* lead to the lack of any authoritative source to which adolescents may definitively turn. Political opposition serves as another obstacle to reforming the current model of RHE in Poland. In one study, 40% of Polish teachers did not believe that more comprehensive sex education would make their students feel "more adult or free to engage in certain practices" (Trawińska, 1995). Despite this fact, the essential curriculum of ELF has remained unchanged since the course was first created.

LIMITATIONS

There were a number of limitations to this study. Firstly, bias may have been introduced by limiting the study to adolescent mothers. The participants may have felt let-down or disappointed by the education system and their comments may have been influenced to this effect. However, this study was designed to minimize as much as possible such potential for bias, limiting its scope only to gauging the perceptions of adolescent mothers. Discussion during the focus groups was limited in this regard and only relevant data were extracted. The author makes no evaluative claims through this study,

including but not limited to the quality, merits, intention, or design of the Polish model.

Also, this study was limited in sample size and restricted to experiences from schools located in the Kraków area. Therefore, the results should in no way be interpreted as nationally representative of Poland. As in most countries/cultures, adolescent pregnancy is a very sensitive topic, nowhere more so than in Poland where it remains a political and social hot-topic. For this reason, gaining access to such a sample group is a unique opportunity for scientific insight.

As is common in focus group studies, participants may also have felt inclined to give socially favourable answers (Raine, Jenkins, Aarons, et al., 1999). In this case, "socially favourable" means adopting a more critical stance to Poland's ELF. Again, this study was designed to minimize as much as possible such potential for bias, limiting the results to reliable qualitative data, based on sound focus group analysis, and drawing conclusions limited to this data.

The recommendations presented in this study, resulting from in-depth focus group analysis, were not submitted for approval by study participants prior to publication.

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